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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 11-030-9009
SAINTS MARY AND ELIZABETH MEDICAL CENTER

Case Summary: The HRA substantiates the complaint that Saint Mary's did not follow Code procedure when it did not include the guardian in the care and decision-making of her ward.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Saints Mary and Elizabeth Medical Center (St. Mary's). It was alleged that the facility did not follow Code procedure when it did not include the guardian in the care and decision-making of her ward. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107).

Saints Mary and Elizabeth Medical Center is the former St. Mary of Nazareth and St. Elizabeth Hospitals that were operationally joined in 2003 under the Resurrection Healthcare System. The St. Mary of Nazareth Hospital incorporates a 38-bed behavioral health unit.

To review these complaints, the HRA conducted a site visit and interviewed the Director of Behavioral Health, the Nurse Manager, the Coordinator of Guest Relations, and the Social Work Coordinator. Hospital policies were reviewed, and the adult recipient's clinical records were reviewed with written consent.

COMPLAINT SUMMARY

The complaint involves a recipient who was admitted to St. Mary's on an emergency basis from his group home, where he had an altercation with another resident. He was evaluated in the emergency department and then admitted voluntarily to the Behavioral Health unit.

The complaint alleges that the recipient's group home staff contacted the guardian in the early morning of 10/17/10 to report that they were transporting the recipient to St. Mary's to be evaluated for aggressive behaviors. The staff gave the guardian the hospital emergency department phone number and assured the guardian that they would contact her when the ward was admitted. The guardian specifically confirmed with the group home staff that the recipient's

guardianship papers would accompany the ward. Although the group home had included the guardian's contact information and letter of office in the recipient's admission paperwork, the hospital staff did not contact the guardian and would not give the guardian any information regarding her ward when the guardian contacted the hospital. The complaint alleges that the guardian called each day for five days requesting that her ward's physician contact her, and she spoke with eight staff members, both in the emergency department and the behavioral health unit, however the ward's physician did not contact the guardian until her ward had been a recipient there for 5 days, and then she spoke with an associate of the attending physician and not the actual attending. When the guardian made contact with the recipient's associate physician after 5 days, the physician reportedly stated that he did not have to talk with her and hung up the phone. The complaint alleges that the guardian never received any assessment or evaluation results to determine her ward's status or his plan of care and never consented to any medication.

FINDINGS

St. Mary's Emergency Department Progress Notes indicate that the recipient, age 20, was admitted on 10/17/10 at 7:15 a.m. having been transferred by ambulance from the recipient's group home where he had become aggressive with another resident. He was medically evaluated and cleared in the emergency department and then transferred to the Behavioral Health Unit where he signed a voluntary application for admission.

The emergency department medical record and progress notes show that the recipient had his blood drawn (7:45 a.m.) and a CT scan performed (10:50 a.m.) during the process of his medical clearance. He also received an administration of Ativan, 2 mg orally because, "pacing, doesn't want lay down [sic]." At 12:00 p.m. the record shows that the recipient was assessed by a SASS agent who described the recipient's mental status as, "Client makes no sense", "Client is incoherent", and "Client is displaying odd behaviors and is incoherent." This document indicates that there is no parent/guardian involved in the assessment.

At 4:30 p.m. on 10/17/10 the progress notes indicate "Pt. punching glass, meds ordered and given." The medical record shows that Ativan, 2 mg was administered intravenously at 4:30 p.m. and the record states that the patient "refused injection." The record also shows that the recipient received Geodon, 2 mg by injection at the same time. There is no Restriction of Rights Notice in the record. There is another form in the record for 10/17/10, an SBAR (Situation, Background, Assessment, Recommendations) form which indicates that emergency medications and a CT scan were given in the emergency department and this form lists "Mom's cell #" and her name.

The petition for involuntary admission document, completed by a crisis worker in the emergency department at 4:40 p.m. on 10/17/10, gives the following statement to support the hospitalization: "Patient is aggressive and responding to internal stimuli. Pt. is unable to contract for safety." The document lists the guardian's name, relationship to the recipient, and her contact information (although it does not state that she is the legal guardian). The Rights of Individuals Receiving Mental Health and Developmental Disabilities Services form is included in the record and for the signature of the individual receiving services it states, "Pt. refuses to sign." The first certificate, completed by a physician in the emergency department at 4:40 p.m. on 10/17/10

states, "Patient sent to E.D. B/C of aggressive behavior at nursing home and is responding to internal stimuli. Patient is unable to contract for safety." The application for voluntary admission, completed the following day at 5:15 p.m., is included in the record and it gives the guardian's name, relationship to the recipient, and contact number. The consent for treatment, also in the record, is not signed by the recipient, and in the area stating the reason the patient is unable to sign it states, "Unable to sign." The acknowledgement of privacy practices notice is also not signed by the recipient and the form indicates that the patient is incapacitated and no responsible party is available for signature prior to discharge. The letter of appointment of guardianship is included in the record as well. The record also contains an authorization for release of information that was given verbally by the recipient for contacting his mother (she is not listed as guardian) on 10/19/10. The Patient/Family Education record, completed on 10/17/10 at 8:30 p.m. states, "Pt. is sedated, unable to participate in pt. teaching during Intake, pt not ready to learn at this time."

At 9:00 p.m. on 10/17/10 an inpatient behavioral health Nursing Admission Data Base was completed for the recipient. It states that the recipient does not make his own healthcare decisions, but it does not indicate the recipient's decision maker. For the recipient's mental status examination the answer is "sedated" and "no info given" for all of the categories.

On 10/18/10 at 10:44 a.m. the recipient was given a psychiatric evaluation. The mental status examination states, "This is a white male somewhat slowed and disheveled and does have some superficial scratches on his left shoulder from the altercation. He is wrapped around in a blanket and is currently calm. His speech is regular rate and rhythm, fluent and spontaneous and somewhat slowed at times. His thought process is concrete. Thought content- He is currently denying being sad and/or irritable. He denies wanting to hurt himself or other people. He does admit to poor coping regarding the library book and an altercation with the other resident in the nursing home. He does wish to return back to …. He currently denies any kind of auditory or visual hallucinations and/or paranoia. He does not have thought block. He is not restless or irritable. His mood is OK. His affect is blank. He is alert and oriented x3. His insight and judgment is poor."

On 10/19/10 the recipient's social worker completed a Psychosocial Assessment. It indicates that the recipient does have a guardian and it gives the guardian's name. The social worker states that the information in the assessment is gathered from the patient, the chart and the pt.'s mother.

The record contains a medication reconciliation form which lists the recipient's scheduled psychotropic medications: Depakote, 500 mg orally twice a day, Lamictal, 5 mg orally twice a day, and Remeron, 15 mg orally at bedtime. The recipient's PRN (as needed) psychotropic medications are: Ativan 1 mg, Haldol, 5 mg, Trazodone, 50 mg, and Cogentin, 2 mg. There are three medication consent forms in the record. The first, completed on 10/17/10, does not indicate that the recipient has the decisional capacity to consent to the medications prescribed and does not indicate that that the patient has been advised of the risks, benefits and side effects of the medication. The medications listed are: Trazodone, Ambien, Haldol, Depakote, Lamictal and Remeron. On the signature line it states, "Pt. refuse to sign." The second medication consent form, completed 10/20/10, does not indicate that the patient has the decisional capacity

to understand the medications prescribed and does not indicate that the patient has been advised of the risks, benefits and side effects. Risperdal is the medication and the checked response indicates, "I have received information on the medication prescribed." The signature line states, "refused." The third medication consent form, completed on 10/21/10, has the checked physician statement, "I have determined that the patient has capacity to understand medications prescribed." Risperdal is again the medication listed. On this form the recipient has checked, "I refuse to sign consent but I am willing to take medication." There is no indication from the record that the guardian was provided with written materials on prescribed medications or given the opportunity to refuse medications on behalf of the ward.

The record (progress notes from the behavioral health unit) indicates that the recipient was admitted there on 10/17/10 at 9:00 p.m. Notes indicate that the recipient was sedated when he arrived but that the following day at 10:28 a.m. he signed a voluntary admission form. Notes from 10/28/10 state, "pt.'s mother called the unit but there was no release of information signed by the pt. yet. Pt.'s mother was loud and shouting over the phone to the staff and saying that she is the legal guardian. Chart was checked and there were no papers to justify that she is the legal guardian. Charge nurse requested her to fax the papers but pt.'s mother was already angry and does not want to listen. Pt. was also guarded…."

Progress notes from 10/19/10 state, "Pt. requested that writer call his Mom and gave writer verbal consent to call. Writer spoke with [guardian]. [Guardian] was frustrated the she couldn't get any information about my son–I'm his legal guardian.' Writer informed [guardian] that the guardianship papers were not sent with pt. from [nursing home]. Writer looked through pt.'s chart for papers. Writer informed [guardian] that pt. gave consent for staff to speak with her. Writer provided contact info. She stated pt. has a history of ADHD and Bipolar disorder. Psychosocial history completed and placed in chart."

Progress notes from 10/20/10 state, "Per request, during rounds today, associate psychiatrist called pt.'s mother but [guardian] did not answer and voicemail did not pick up. Writer called [guardian] this afternoon; she was 'very upset' that she was 'not called by the doctor.' Writer told her that associate psychiatrist did call, but she stated, 'I had my phone with me all day.' Writer then asked [guardian] if she had specific questions for the psychiatrist and writer would follow up and call again. [Guardian] did not provide this information, but remained displeased. Writer informed [guardian] that [staff] from nursing home will come see pt. on the unit tomorrow afternoon 10/21/10."

Progress notes from 10/20/10 indicate that the recipient was unhappy that he was not discharged that day and "requested to see [his physician]. On 10/21/10 the recipient was still requesting to see his physician because he wanted to go home and "He's afraid that if his doctor will make him stay longer." On 10/22/10 an entry states "MSW spoke with pt.'s mother regarding discharge planning needs and to follow-up with plan for post discharge placement. Pt.'s mother requested MD to call her and had also notified unit MSW of request to speak with MD. Informed pt.'s mother that MD will be notified again re request to speak to pt.'s mother." Again that day notes indicate that a staff member from the recipient's nursing home visited the recipient and brought another set of guardianship papers to the hospital. That same day an entry

in the notes states, “Pt.’s mother called back very nasty tone, angry, needy and demanding wants him to be released to N. Home today, pt. focused on discharge…”

The record indicates that the attending physician never saw the recipient except for the initial psychiatric evaluation, although all orders were written by this psychiatrist. The physician who was seeing the recipient while he was in treatment was an associate of the attending psychiatrist.

HOSPITAL REPRESENTATIVES’ RESPONSE

Hospital representatives who worked with the recipient were interviewed regarding the complaint. They stated that the recipient had been admitted into the emergency department because of aggressive behavior at the nursing home and because there were no beds on the behavioral unit the recipient remained in the emergency department for a day, which does not usually happen. They stated that the recipient had come in on an involuntary petition (this is not supported by the record, see above) and was certified in the emergency department by a physician there. Staff said that generally, every attempt is made to notify the persons indicated by the recipient on his admission paperwork. In this case, staff acknowledged that there definitely was a delay in the emergency department in contacting the family. Staff were asked who the attending physician was and then it was noted that a different physician, an associate of the attending physician, actually “attended” to the recipient throughout his hospitalization. Staff were asked in a separate phone interview if the fact that there were two physicians, one who wrote all orders for the recipient and was listed as the attending physician and another who actually saw the recipient, could have caused some of the communication problems in notifying the guardian and staff stated that this might have contributed to the problem. They stated that the attending psychiatrist visits weekly on the unit and that her associate meets with the recipients in her absence. Staff also stated that they had spoken with the guardian on 10/19/10 and that they did not have the authority to speak with the guardian about the recipient's care without the letter of office since the recipient was a legal adult.

Hospital staff were asked if Restrictions of Rights Notices were issued in the emergency department and they confirmed that they are completed however there were no notices for the emergency medications administered on the 10/17/10. They were also asked if guardians are included in treatment planning and they confirmed that they are included, however there was not a place for a guardian signature on the recipient’s treatment plan and there is no indication the guardian was sent a copy of the plan. Staff confirmed that the guardian was not included in the discussion of the risks, benefits and alternatives to suggested medication, however at that time it was not clear that the recipient had a guardian.

Hospital representatives reported that on 2/21/11 the Chairman of Psychiatry, the Director of Behavioral Health, the Coordinator of Guest Relations, and other staff conducted a meeting with the guardian to address her concerns. Although the physician who hung up on the guardian was not present, the staff said that the Chairman had spoken with this associate privately. At this time, the hospital staff felt that they had reached an accord with the guardian and that the matter was not only settled, but the guardian expressed gratitude to the hospital staff for their recommendation of a more suitable placement for the recipient. The HRA requested to

speak with the recipient's physician and were given contact information, however the HRA was unable to reach the physician.

STATUTORY BASIS

The Mental Health and Developmental Disabilities Code provides for the inclusion of the guardian in all aspects of treatment from the time that services begin:

"A recipient of services shall be provided with adequate and humane care in the least restrictive environment, pursuant to an individual services plan. The plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian…."(405 ILCS 5/2-102).

If treatment includes the administration of psychotropic medication, then the guardian must be advised in writing of the side effects, risks and benefits of the treatment:

"If the services include the administration of…psychotropic medication the physician or the physician's designee shall advise the recipient in writing of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information that is communicated. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment. The physician or the physician's designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing." (405 ILCS 5/2-102 a-5).

The Mental Health Code also allows the guardian to refuse treatment for the recipient:

"An adult recipient of services, the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or development disability services, including but not limited to medication. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available." (405 ILCS 5/2-107 a).

And, whenever a guaranteed right of the recipient is restricted, the recipient and their guardian must be given prompt notice of the restriction and the reason therefore. (405 ILCS 5/2-201 a).

Additionally, the Illinois Probate Act of 1975 defines the duties of the guardian:

"To the extent ordered by the court and under the direction of the court, the guardian of the person shall have custody of the ward and the ward's minor and adult dependent children;

shall procure for them and shall make provision for their support, care, comfort, health, education and maintenance, and professional services as are appropriate….The guardian shall assist the ward in the development of maximum self-reliance and independence." (755 ILCS 5/11a-17a).

Also, the Probate Act gives direction to providers to rely on guardian decision making:

"Every health care provider…has the right to rely on any decision or direction made by the guardian….to the same extent and with the same effect as though the decision or direction had been made or given by the ward." (755 ILCS 5/11a-23).

HOSPITAL POLICY

St. Mary's hospital does not have policy specific to guardian inclusion. However in several other policies the guardian is mentioned. Policy #1408.75 Restriction of Rights Notification states that when the rights of a patient are restricted the guardian must be notified. Also, in policy #1408.75 Discharge Planning and Procedure- Social Services it states that guardians must be informed and in agreement with discharge plans, and policy #300.40 Living Will, states that guardians must be notified if the physician is unable or unwilling to comply with the provisions of the recipient's Living Will. The policy on Voluntary Admission includes a directive to notify the guardian by mail of the admission, and the Involuntary Admission policy directs staff to obtain contact information regarding the recipient's guardian or other designee.

CONCLUSION

The hospital record shows that the guardian as well as the recipient in this case were both denied their court ordered rights under both the Mental Health and Developmental Disabilities Act and the Probate Act. The law is clear that from the time that services begin, legal guardians are to be included in all aspects of their ward's care. In this case, emergency room documentation reveals that the recipient's mother's/guardian's name and her contact information was provided when the SBAR form was completed at 4:30 p.m. on 10/17/10. Even if the hospital did not have guardianship proof at this time, someone had provided this information for the guardian (either the recipient or his group home staff), yet the hospital staff did not contact her nor would they address her questions when she contacted them. Additionally, the guardianship could have been confirmed by a phone call to the recipient's group home or the probate court, since this is public information. The record then continues to demonstrate a pattern of disregard for the guardian's input continued throughout the recipient's hospitalization, even when it is clear from documentation that he was unable to make decisions for his own care.

Additionally, it is not clear under what authority the hospital emergency department withdrew blood and conducted a CT scan on the recipient. The recipient did not come to the hospital on a petition for involuntary admission. There is no signed consent for treatment in the record. Several documents from the emergency department show that the recipient was incapacitated, either by his symptoms or by forced medication throughout his emergency department episode, and thus unable to understand his treatment or consent to it. There is no

indication of a danger to his health or life to require the recipient to give blood or a CT scan. The SASS document states that he is "incoherent", the consent paperwork states he is "unable to sign", the Acknowledgement of Privacy Practices says he is "incapacitated", the teaching record states, he is "incapacitated", and the Nursing Admission Data Base states he is "sedated" and even acknowledges that he does not make his own healthcare decisions. Still, the recipient was brought to the hospital at 7:15 a.m. on 10/17/10 and treated for almost 10 hours before a petition was completed at 4:40 p.m. that day, meaning that for almost 10 hours he was treated with no authority to do so by the hospital. Also, while still in the emergency department the recipient received emergency medication against his objection, and he was not given a Restriction of Rights Notice, denying him and his guardian due process under the law. Finally, the recipient was not examined by a psychiatrist within 24 hours after admission as mandated by the Mental Health Code.

The record shows that the guardian called the Behavioral Health unit several times each day over the course of her ward's hospitalization requesting that his physician contact her. It is not clear why the physician would not contact the guardian (even without proof of guardianship), however there seems to have been some misunderstanding regarding the physician who actually attended to the ward's care. This, however, is not the guardian's fault and should not have prevented her from exercising her court ordered right to receive medication information, take part in treatment planning, refuse services for her ward, and receive notice when his rights were restricted. The HRA would hope that whenever an identified and concerned parent calls repeatedly over a period of days that staff would make every effort to make use of this valuable advocacy for the betterment of the recipient's care and the efficacy of their treatment, however when the parent is also the legal guardian, the hospital is bound by law to include them in the care and decision making for the recipient.

The HRA substantiates that the facility did not follow Code procedure when it did not include the guardian in the care and decision-making of her ward.

RECOMMENDATIONS

1. Train staff both in the Emergency Department and on the Behavioral Health unit to honor the rights of guardians and ensure that they are included in all facets of care to include the admission process, the development of treatment plans and their update, the information on the risks, benefits and alternatives to prescribed psychotropic medication, information on the rights of their wards and to be informed when these rights are restricted, and the ability to refuse services for their ward.

2. Develop policy and procedure for the inclusion of the guardian in the care and decision-making of the ward.

3. Train staff that if there is a question regarding guardianship, this public information can be obtained by contacting the probate court, or in this case, by contacting the recipient's group home.

SUGGESTIONS

1. The Mental Health Code outlines the process for admission for persons involuntarily held for evaluation and treatment of mental illness. The HRA suggests a review of this law with emergency department staff noting that, although guardians cannot consent to involuntary admission or involuntary medication over the ward's objection, the Code allows that once services begin the legal guardian is to be included in all aspects of the ward's care.

2. Ensure that recipients, and their guardians if applicable, are provided a Restriction of Rights Notice each time they are denied their Code mandated rights.