FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 11-030-9020
ADVOCATE ILLINOIS MASONIC MEDICAL CENTER

Case Summary: The HRA substantiated the complaint that the facility did not follow Code procedures when it did not include the guardian in the care and decision-making of her ward, and restrained and administered psychotropic medication to the ward in violation of the Code. Attached is the provider response and corrective measures.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Advocate Illinois Masonic Medical Center (Illinois Masonic). 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, and restrained and administered psychotropic medication to the ward in violation of the Code. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107).

Illinois Masonic is part of the Advocate Health Care system, a faith-based, not-for-profit health system. The hospital contains a 35-bed inpatient adult behavioral health unit.

To review these complaints, the HRA conducted a site visit and interviewed the Chairman of the Department of Psychiatry, the Medical Director of the Inpatient Behavioral Health Unit, the Coordinator of Social Work, and two Behavioral Health Unit Registered Nurses. Hospital policies were reviewed, and the adult recipient's clinical records were reviewed with the guardian's written consent.

COMPLAINT SUMMARY

The complaint involves a recipient who was admitted to the Illinois Masonic behavioral health unit on 3/21/11. The complaint alleges that the hospital would not honor the guardian's request not to administer antipsychotic medication to her ward even though the ward had been a patient there one month before and the hospital staff were aware that the guardian objected to antipsychotic medication. The complaint indicates that the guardian repeatedly alerted the hospital that her ward had a history of neuroleptic encephalopathy (brain damage due to an adverse reaction to antipsychotic medication) as the result of a hospital-induced overdose which

resulted in many neurological problems, including a sensitivity to many medications. The complaint indicates that not only did the hospital administer medication that they knew the guardian did not consent to, but they refused to discontinue the use of medication despite the guardian's objection which was voiced to the doctor, nursing staff, social worker, and others. The complaint alleges that the hospital abused the use of PRN (pro re nata or "as needed") medication, and restraint.

FINDINGS

The record shows that the recipient was admitted to Illinois Masonic from his nursing home on 2/22/11 after he became paranoid and agitated at the facility where he lived. The History and Physical, completed on the recipient on 2/23/11 states, "….Pt. has a diagnosis of Schizoaffective disorder, bipolar type. Pt. has difficulty controlling his anger, is impulsive, has anger outbursts, has paranoid ideations, also admitted to hearing voices. Pt reports fair sleep and appetite. Pt is minimally cooperative with the interview and most of the patient's history was obtained from the pts mother. Pts mother reports pt was initially depressed after she and his father divorced after which pt began to have all of these behavioral problems. She reports he smokes too much, 3-4 packs of cigarettes per day. He has been treated by [two neuropsychologists]. She states he has anger problems, becomes aggressive when he doesn't get what he wants. She states he has never been in special education in school, but after he graduated high school and his parents divorced, be began to have all of these problems. Per mother, he had been 'overdosed on Prolixin' 2 years ago by his doctor which caused him to have 'neuroleptic encephalopathy'." She also reports he had questionable EEG's which may have shown some seizure activity such as absence seizures and partial complex seizures. Pts mother states she is his power of attorney and refuses to give consent for any psychotropic medications. …She states all of the neuroleptic medications make him worse and believes Prolixin caused him to have 'neuroleptic encephalopathy'. The Social History section indicates that the recipient was given a 30 day notice of discharge from his nursing home and was unable to return there. It also states, "He visits with his mother, who is an audiologist, and father, who is a psychologist, on weekends". This document also states, "I discussed with the pts mother that pt needs a neuroleptic medication for his psychosis but she continues to refuse to consent to any medications". There is no guardian consent for medication within the record.

The recipient's Medication Administration Record shows that the recipient was administered the following psychotropic medications during his hospitalization from 2/21/11 until 3/01/11:

Tegretol, 20 ml po (orally) 12 times as scheduled medication
Lorazepam, 2 mg po prn for anxiety on 2/26/11, 2/27/11 at 1:15 am, 2/27/11 at 6:31 am and 3/01/11
Lorazepam 2 mg injection for anxiety on 2/28/11 for anxiety
Geodon, 20 mg injection for agitation given on 2/25/11, 2/28/11 at 3:50 pm and 11:59 pm

The record does not contain a physician statement of decisional capacity and there are no Restriction of Rights documents for the emergency medications. Although the record contains a Safey Plan that is completed by recipients upon admission, there is no Preference for Emergency

Intervention document. The recipient's guardian is noted in the record to prefer restraint to medication for emergency intervention.

The record indicates that the recipient was discharged 3/01/11.

On 3/21/11 the recipient was again admitted to Illinois Masonic. Emergency Room documentation shows that a petition and certificate were completed by hospital staff at 4:30 p.m. on 3/22/11. The petition for involuntary admission indicates that no certificate was attached with the petition because a qualified examiner was not immediately available or it was impossible after diligent effort to obtain a certificate. The petition is dated 3/21/11 and it does not indicate that the recipient or the guardian was provided with a copy of the petition. The form offering Rights of Recipients of Mental Health and Developmental Disabilities Services is dated 3/22/11 at 7:30 p.m. The record contains documentation that the recipient's mother is plenary guardian of the recipient and has power of attorney for health care.

The emergency room record shows that the recipient was medically cleared at 6:30 p.m. on 3/22/11. The same record indicates that the recipient was placed in restraints and seclusion at 6:20 p.m.: "Restraints used, Patient placed in hard restraints... Patient persists in exhibiting aggressive or violent behavior that has significant potential for injury to self or other people, Patient is a Flight Risk,…." The record contains a Notice Regarding Restricted Rights of Individual that appears to correlate to this event. It is dated 3/22/11 and indicates that the recipient was placed in restraints and seclusion, however the reason for the restraint is not described and the duration is not indicated. The remainder of the form is not completed. The Code mandated documentation of 15 minute checks on the recipient is not included in the record. The emergency room record shows that the recipient was then discharged to the behavioral health unit at 7:22 p.m.

The recipient completed a request for voluntary admission on 3/22/11 at 8:00 p.m. It is unclear whether he was given rights information at this time as the form is not signed by the recipient or staff. The record contains a *30 Day Readmission Assessment* form which indicates the reason for admission as increased agitation, paranoia, aggression, and impulsivity. It also states that the recipient was non-complaint with medication after discharge and noncompliant with treatment. A hand written note states, "Pt's mother is his guardian and refused to let him be properly medicated." In the section titled *Comments for Change in Discharge Plan* it states, "Unless pt is properly medicated, [referring facility] will not be able to meet patient's needs." And in the section titled *Significant events since last discharge* it states, "Not properly medicated."

The record contains the recipient's *Discharge/Expiration Documentation.* It states, "The patient is a 24-year-old male with a history of schizoaffective disorder who was transferred from [nursing home] after being aggressive with staff and peers having paranoid ideation. The patient was also breaking the rules at the nursing home by smoking in inappropriate places. The patient was also at Advocate Illinois Medical Center a month ago for a similar reason. In the emergency room, the patient was not cooperative with the interviewer. He refused to answer the questions. The patient continued to be uncooperative with the psychiatric interview. The patient came out

of the emergency room with his penis hanging out. He refused to answer questions. The patient was admitted for further psychiatric evaluation, management, and stabilization."

The recipient's *Hospital Course* states, "While in the hospital treatment consisted of medical assessment, individual therapy, group therapy, milieu therapy, pharmacotherapy, art therapy, social intervention, staff intervention, and medical co-management. The patient was placed on seroquel 50 mg daily, and also carbamazepine [Tegretol] 400 mg twice daily. …The patient's treatment plan was discussed in staffing and medications were titrated. Seroquel XR was increased to 150 mg twice daily and Tegretol 400 mg twice daily with a good therapeutic response. With ongoing medication, group therapy, and milieu treatment, the patient continued to improve target symptoms.

On evaluation on April 7, 2011, the patient was calm and cooperative, compliant with medications, denied any suicidal or homicidal ideations, and denied any auditory or visual hallucinations. At this time safety precautions were discontinued and the patient was discharged in stable condition."

The recipient's psychiatric evaluation, completed 3/23/11, is included in the record. In the *History of Present Illness* and *Past Psychiatric History* it states, "According to the patient's mother, the patient has difficulty controlling his anger. He displays impulsiveness. He exhibits outbursts of anger. He also has paranoid ideations. The patient has been treated by Dr… and Dr… as an outpatient who are his neuropsychiatrists. The patient's mother states that his neuropsychiatrist is not available for the patient any more. Patient's mother wants to find a new neuropsychiatrist. The patient's mother states that the patient gets aggressive when he does not get what he wants. The patient's mother stated that after he graduated from high school, his parents divorced and he began to have all of these problems. The patient's mother states that the patient overdosed on Prolixin that had been given to him by his doctor two years ago. This caused the patient to have neuroleptic encephalopathy. The patient's mother also reports that he had questionable electroencephalograms that may have shown some seizure activity, namely absent seizure or partial complex seizures. The patient's mother states that she is patient's power of attorney but refuses to give consent for any psychotropic medications.

The patient had rapid cycling bipolar disorder according to the patient's mother. He has had 29 psychiatric admissions in the past. The patient had an overdose of intramuscular Prolixin in 2007 and had developed neuroleptic encephalopathy that required 7 months of hospitalization. The patient has been in and out of many different nursing homes since becoming emancipated at age 21, however he could not stay in any one nursing home long enough due to violating regulations, especially smoking regulations. The patients' mother states that the patient ended up being admitted to the hospital numerous times because he would get kicked out of the nursing home. Then, he had no other place to go. The patient's mother states that the patient would get adverse reactions to most antipsychotic medications that include Invega, Risperdone and Seroquel. The patient's mother strongly denies any further use of antipsychotic medication for the patient." The recipient's medications, listed two paragraphs below state, "Carbamazepine [Tegretol], 400 mg by mouth, twice daily, Lorazepam 2 mg as needed by patient, Ziprasidone [Geodon] 10 mg given intramuscularly [im] every 4 hours as needed by patient, and Seroquel, 15 mg by mouth each evening at bedtime."

A Physician's Progress Note, written 3/24/11 indicates, "We will increase Seroquel to Seroquel XR 50 mg po each morning and 100 mg po each evening. Pts mother has given consent to increase Seroquel up to 300 mg."

There is one Medication Notification form in the record which indicates that the patient and guardian have been given verbal and written information on the benefits and side effects of the stated medication and it indicates that patients and guardians have been advised of their right to refuse medication. The form lists Tylenol 400 mg twice daily and Seroquel XR 150 mg each 12 hours. The form is not signed by the patient or the guardian and it is dated 4/4/11. The record does not contain a physician statement of decisional capacity. Also, the record does not contain Preferences for Emergency Treatment, although there is a similar Safety Plan for recipients and it indicates that the recipient is helped to calm down by going to his room, being left alone, and laying down. The guardian's preference for restraint in lieu of medication is noted in the Progress Notes. The record contains the recipient's care plan, however there is no indication it was shared with the patient or guardian. The record does not contain any Restriction of Rights Notices for events occurring on the behavioral health unit.

Patient Progress Notes (PP Notes) written 3/24/11 state, "Pt agitated, paranoid, delusional. Became impulsive, observed pushing another patient onto ground. Pt take to QR, prn Geodon, 10 mg/ Ativan 2mg given in the left gluteus with staff assistance. Pt remained in the QR. Continues to sleep. Will monitor closely and intervene as necessary."

Problem Intervention Evaluation Plan Notes (PIEP Notes) for 3/25/11 show that the recipient was administered an injection of Geodon for "anxiety and agitated behavior." The notes state, "At beginning of shift, patient was observed pacing the hallway, patient appeared to be anxious and responding to internal stimuli. Patient was redirected to room multiple times, but was not able to remain in room. Patient continued to wander into hallway; appeared unable to comprehend directions from staff. Patient was given 10 mg Geodon IM in right gluteus, with three staff present. Patient was cooperative with administration of injection. Patient fell asleep shortly after receiving medication; slept well overnight."

PIEP Notes from 3/26/11 show that the recipient was administered an injection for "agitation". The notes state, "At beginning of shift, patient was observed pacing in the hallways and wandering in and out of his room, intermittently pulling his pants down. Patient appeared suspicious of others and internally preoccupied. Writer approached patient and explained the need to give medication to help him calm down and rest. 10 mg Geodon IM was given with one additional staff present. Patient cooperative with receiving injection. Patient went to bed shortly after receiving medication, slept well overnight." There is no Restriction of Rights Notice for this event. Again, on 3/28/11 the notes indicate that the recipient, "Was up and wandering in hall and attempting to enter other pt rooms until 0030, He was given IM Geodon and Ativan. Slept well after that."

PP Notes from 3/27/11 indicate continuing guardian concerns: "This writer informed by Nursing Supervisor that pt's mother called to complain about two aspects of nursing care for her son: 1) he is receiving PRN doses of a medication of which she disapproves, and 2) staff RN was

rude to her on the phone. This writer told supervisor that he heard the staff RN's management of the phone call and that it was professional and appropriate, and also informed her that the pt is receiving and tolerating PRN doses of the medication worrying the mother. Supervisor asked this worker to consult with MD covering and did so. No changes in care at this time."

Physician Progress Notes from 3/27/11 mention the concerns expressed by the guardian: "…His power of attorney/guardian very strongly felt that the patient was receiving medications that he had had reactions to in the past. I am unable to discern what kind of reaction he had to intramuscular Geodon but it appears [recipient] benefits from antipsychotics at this point in time even when they're used intramuscularly as PRN's. will monitor very carefully for the emergence of extrapyramidal signs and neuroleptic malignant syndrome. At this point in time no adverse reactions are discerned or reported. Will switch his Tegretol to tablet form to facilitate transition to nursing home formularies."

PP Notes from 3/28/11 indicate the guardian preference for emergency intervention: "Pt mother called this writer and informed me that she doesn't want the pt to be placed on any antipsychotic medications. Pt mother was informed of pt disorganized bizarre behavior as well. Pt mother stated that if pt acts out, that pt should be placed in restraint without medications. Pt mother was informed to follow up with her concerns with the social worker as well as the attending doctor. Pt stated that the doctor was not the greatest."

PP Notes from 3/29/11 state: "Pt received PRN Ativan 2 mg at 0830 for anxiety/agitation, will monitor closely and intervene as needed." There is no other information regarding this event. Later, at 9:40 a.m. the notes indicate: "Pt medicated on emergent basis due to pt hitting self on right side of head with right fist. Unable to redirect with additional staff present. Geodon 10 mg IM given for relief of self harming behavior. Overall response to medication positive with decrease in agitation and relief from hitting. No adverse effects of medication noted." After this event there is a note regarding the guardian: "Spoke with mom and discussed issues of patients hosapitalization and care. Mom expressed concerns about patient receiving prn medications. Explained prn med protocols on the unit and clinical rationale for administration of medication. Mom expressed concerns about continued care…"

PIEP Notes from 3/29/11 show that the recipient received prn Geodon (does not indicate injection). "Pt affect is flat with irritable mood. Pt is disheveled in appearance with fair hygiene. Patient was observed going into another patient's room; he had taken items and putting on clothes belonging to other patient. He was agitated and was unable to respond to staff redirection. He was insisting on putting large amounts of skin cream on his hair. He was talking, but his speech was disorganized and without sense. Pt was flailing his arms and walking in circles; would not respond to staff attempts to engage/redirect him. He stares at others for long periods of time and appears to be very preoccupied at those times. Patient continued to verbalize that he is ready for discharge as well. Pt has no group participation and has little interaction with peers. Pt. denies suicidal ideation and homicidal ideation this shift. Pt is scattered in thoughts and is responding to internal stimuli at times. Pt room is cluttered and disorganized. Pt was given prn Geodon. Pt behavior had improved after medication. Pt gait was steady and had more organized thoughts. Pt was noticed to be talking on the phone holding a logical conversation as well. Intervention: provide medication and limit setting on behavior."

PP Notes from the same day state: "Pt anxious, agitated, restless, preoccupied, psychotic, paranoid. Attempted to grab staff member. Exhibiting bizarre behavior, observed wandering into other patients' rooms. PRN Ativan 2 mg PO given at 0830. PRN Seroquel 50 mg given at 1427…." Later, at 3:18 p.m. the notes state: "Pt increasingly agitated/anxious, verbally threatening, screaming in milieu. Pt. received PRN Ativan 2 mg IM in the right deltoid at 1509." An addendum to the notes was added at 21:21: "Nursing Supervisor …received a phone call from [recipient's] mother; she is very upset that [recipient] has received Geodon and threatens to sue. I have informed the Nurse Manager." Later, at 21:51 another entry states, "Received a phone call from [recipient's] mother, who used curse words and invective, talking non-stop for approximately 6 minutes, stating, 'You people are making me sick! What kind of person is that [doctor]? My son can't even talk from that Geodon! You sound like a pull toy, telling me you'll pass on the message to [the doctor]. You can't even give a glass of water without a doctor's order; what kind of nurse are you?'"

Physician Progress Notes from this same day reveal concerns that were again expressed by the guardian: "Pt seen, chart reviewed, discussed with staff. Pt is a 24 year old male with history of Schizoaffective Disorder. Pt has been bizarre, delusional, attacking staff and going into other pts rooms on the unit. He reports fair sleep and appetite. Pt was seen this morning and had cream all over his face and head. Pt states he was giving himself a facial. Writer spoke with pts mother who stated that pt becomes worse on Geodon. She was upset because being his Legal Guardian, that her wishes for not giving him any prn meds was not followed. She has little insight into pts condition and psychosis. Pt continues to state that he is hearing voices and feeling paranoid. He has poor insight and judgment. We will continue Geodon IM today. Add Seroquel 50 mg po each 4 hours prn. Meeting with pts father scheduled for tomorrow morning. Increase Seroquel XR to 150 mg po twice daily…."

PIEP Notes from 3/30/11 show that the recipient received an injection due to: "Pt remains preoccupied, responding to internal stimuli, psychotic, irritable. Pt anxious, restless, observed pacing in milieu. Bizarre. PRN Ativan 2 mg PO given per request at 0924. Agitated, screaming in milieu. PRN Geodon 10 mg IM given in the right deltoid at 1054 with security/staff present. Focused on retrieving clothes; however continues to remain on EP [emergency precautions] per MD order. …."

PIEP Notes from 3/31/11 show that the recipient received an injection of Geodon along with seclusion: "…Midway through the shift, pt became increasingly internally preoccupied and began charging at staff. Pt subsequently used his shoe to crush the light fixture in the ceiling. With staff support, pt willingly took IM PRN medication and agreed to stay in the Quiet Room until he felt calm. Pt periodically yelled out, 'What was that'? interpreting peers' unrelated comments in the hallway as threats towards him. Mood remained irritable and anxious for the majority of the shift, with affect flat and appropriate to mood. …" Also on this date the record indicates that the recipient received another injection due to: "Pt. remains preoccupied and psychotic. Pt lacks insight into illness. Pt difficult to redirect and continues to ask for his shoes, although he has been told numerous times he cannot have them due to emergency precautions. Medication adherent. Pt. observed laughing to self and appears to be responding to internal

stimuli. Pt. restless, pacing in milieu. Pt. hitting walls and banging on the nursing station door, unable to redirect. PRN Geodon given @ 2145 with staff present."

Physician Progress Notes from 4/01/11 reflect another conversation with the guardian: "Writer attempted to call and had Dr…[recipient's outpatient physician] paged today again, after she did not return this writers calls for the past 2 days. Per pts mother, she is the only 'neuropsychiatrist' she trusts and will only allow us to change pts medications after speaking with her as this doctor told her that pt should never be put on any neuroleptic medications. Per mother, pt has history of encephalopathy from 'overdose of Prolixin' 5 years ago. Due to history of encephalopathy, Ativan was discontinued yesterday and the pt is only receiving prn Geodon and Seroquel XR 300 mg/day at mothers discretion as she also refuses to allow us to increase seroquel or switch to oral Geodon, which pt has been responding to."

PP Notes from 4/01/11 state: "…Pt states his mood is good and that he feels agitated sometimes. Pt has been administered Geodon 10 mg IM three times yesterday and one time this morning due to aggressive, agitated behavior. When asked if Geodon helps him, he said that he likes it because it calms him down, but also makes him drowsy and he is worried about falling down if he walks around the halls. He also reports a fast heart rate and that it's hard to catch his breath after administration, but he likes the effect of the med overall."

PP Notes from the same day, entered at 10:02 p.m. state: "Pt increasingly agitated, menacing. Punching windows of nurses station. Threatening violence towards staff and unit. Threatening to break light fixture in hallway. Pt actively psychotic, displaying increasingly escalatory behavior. Pt at risk to self and others, requiring emergency administration of antipsychotic medication. PRN Geodon 10 mg administered with multiple staff present. Will continue to monitor and provide further intervention as necessary."

Physician Progress Notes from 4/04/11 indicate that the physician made contact with the recipient's former psychiatrist: "She reports she was unaware of any type of encephalopathy in the pt and that she recalls the mother talking about it but she never saw it. She reports that she believes the pt reponds well to Atypical antipsychotics and stated that she had him on Abilify or Seroquel and Tegretol. She stated she feels the combination of an atypical antipsychotic with a mood stabilizer would help the pt and that she did notice that Typical antipsychotics caused the pt to become more agitated as he has been on Haldol and Trilafon in the past. She reported that she had done a quantitative EEG on the pt which was not diagnostic of encephalopathy in the pt and that she told the mother that it did not indicate or confirm any type of encephalopathy or brain damage in the pt….."

PIEP Notes for 4/2/11 show multiple administrations of medication: "Pt psychotic, paranoid, irritable, angry, labile. Anxious/agitated, banging on nursing station door. Restless, pacing in hallway. Verbally abusive towards staff. PRN Geodon 10 mg/Benadryl 50 mg IM given at 0904 in the right deltoid. Continues to pace in milieu. Reports pain of 6 out of 10 in his head, PRN Tylenol 650 mg PO given per request at 0946. Became extremely agitated during the afternoon, making swinging movements in the air, very restless, using profanity at staff, anxious, paranoid. PRN Geodon 10 mg IM given in the left deltoid at 1419. ADLs [activities of daily living] poor. Cooperative at times, med adherent. Appetite good." An addendum to this entry

indicates, "Pt at risk to self and others in milieu. PRN Geodon 10 mg IM given at 0904 and 1419 with good result."

PP Notes from 4/03/11 indicate that the recipient received Geodon 10 mg IM twice, once at 0829 for being extremely agitated, verbally threatening, spitting, intimidating, and displaying lunging behaviors towards staff, and at 3:49 p.m. for "pacing hallway, punching walls, …unable to be redirected."

PP Notes from 4/4/11 indicate that the recipient received Geodon 10 mg IM at 8:32 a.m. for "aggressive, agitated, and bizarre behavior." Progress notes from this date state, "Continue PRN Geodon, still no permission from guardian to administer PO Geodon." At 9:46 a.m. the notes state, 'Pt amxious, agitated/restless, pacing in milieu. Observed making punching gestures in the air. Remains delusional, paranoid, responding to stimuli. Pt at risk to self/others requiring emergency medication. PRN Geodon 10 mg /Benadryl 50 mg IM given in the left deltoid at 0946 with staff present…."

PP Notes from 4/05/11 state, "Pt extremely agitated. Pt stood up in RN's face using punching gestures being verbally abusive as RN attempted to communicate with him. Pt stormed out of soothing room, spilling some medication on the floor using inappropriate language. Difficult to redirect, anxious, restless, continues to pace in milieu. Remains psychotic, irritable, paranoid, preoccupied, angry/hostile. Pt continues to be at risk to self/others, requiring emergency medication. PRN Geodon 10 mg /Benadryl 50 mg IM given at 0906 with staff present…."

PIEP Notes from 4/6/11 show that the recipient received prn medication: "pt agitated. Hitting the walls in his room. Pt verbally threatening, took his shirt off and stated, 'you want to fight?' pt flexing muscles in the hallway yelling that he wants to 'f--k staff up.' Security present. Prn adm. Pt is in room at this time. Remains highly unpredictable." PP Notes indicate that the recipient was administered PRN Geodon 10 mg /Benadryl 50 mg IM at 2:00 a.m. and 9:00 a.m.

The Medication Administration Record for the period of March 22, 2011 until April 7, 2011 shows that the recipient received the following administrations of Geodon:

Ziprasidone (Geodon) 10 mg injection for agitation on
3/24/11 at 8:29 a.m.
3/25/11 at midnight
3/26/11 at 12:15 a.m.
3/26/11 at 2:15 p.m.
3/27/11 at 11:20 a.m.
3/27/11 at 5:00 p.m.
3/28/11 at 12:29 a.m.
3/28/11 at 4:14 p.m.
3/28/11 at 9:29 a.m.
3/29/11 at 1:20 a.m.
3/29/11 at 7:06 p.m.
3/30/11 at 2:56 a.m.

3/30/11 at 10:54 a.m.
3/30/11 at 11:59 p.m.
3/31/11 at 11:56 a.m.
3/31/11 at 4:00 p.m.
3/31/11 at 9:45 p.m.
4/01/11 at 10:30 a.m.
4/01/11 at 9:59 p.m.
4/02/11 at 9:05 a.m.
4/02/11 at 2:19 p.m.
4/03/11 at 8:29 a.m.
4/03/11 at 3:45 p.m.
4/04/11 at 9:46 a.m.
4/05/11 at 9:06 a.m.
4/05/11 at 4:27 p.m.
4/06/11 at 2:27 a.m.
4/06/11 at 8:45 a.m.
4/07/11 at 4:12 a.m.

The recipient was discharged on 4/07/11.

HOSPITAL REPRESENTATIVES' RESPONSE

The Chairman of the Department of Psychiatry prepared a comment on the issues presented in the case and asked that they be included in the report:

"….Before I respond to the specific concerns before your commission, I would like to make some general comments that puts this case in perspective. Let me begin by saying that after the initial hospitalization in February, where Dr…had been unable to treat [the recipient] with the appropriate meds because of the concerns of the guardian, we were under no obligation to admit him to our unit again in March. She was not the treating physician at [the referring nursing home], nor was the patient in our emergency room. We provide care to the care facility and felt a moral obligation to respond. [The attending physician] should be commended for taking on a patient that some of her peers may have been somewhat reticent to do.

Also, in the 10 years or so that I have been in charge of our unit 631, we have never had a situation where we have not been able to engage a patient's guardian in the treatment of his/her ward. That is not to say, that there have not been differences of opinion, but we have always been able to have a dialog.

This is not a situation where the doctor has unilaterally or autocratically treated this patient, on the contrary, records will show that [the physician] painstakingly, almost on a daily basis, tried to explain, educate, and counsel the guardian on the diagnosis and treatment of this patient. It will show that [the attending physician] tried her best to go along with the guardian's wishes, the titration of her regular meds was deliberate and slow. The patient had a history of 25 or more admissions for severe symptomatology that was characterized by hearing voices, agitation-impulsive, often violent behavior towards self, others and destruction of property,

inappropriate behavior, poor social skills, paranoia, with impaired functioning. These are consistent with a chronic recurrent psychosis necessitating both, routine meds but also PRN (or emergency meds) when the patient exhibits behavior that requires such intervention. This is in keeping with the Mental Health Code and standards of clinical care. The record will also show that [the attending physician] and the treatment staff not only administered these meds when they were clinically appropriate but documented the positive effects of these interventions. At no point during either hospitalization, was there any evidence of an adverse or deleterious effect of the meds prescribed.

The Mental Health Code provides for going to court when there is a conflict, and we have, several times in the past, taken an involuntary patient, who refuses medications that are necessary because their judgment has been impaired due to their underlying psychiatric condition, to court. The Mental Health Code says 'patient/guardian'. It is one thing to have a patient who is felt to be incompetent by virtue of his illness, it is entirely a different picture when you have an upstanding citizen, an educated individual, a caring mother but one who does not see her son's behavior as indicative of mental illness. And this becomes even more difficult, when she says she would rather have her son in restraints than have him on meds.

[The attending physician] did what any caring physician would have done; she turned to the family to look for a resource that the family would trust. Both the biological father and the guardian gave us the name of [recipient's former physician], the guardian said she would allow for meds if this doctor would OK it.

Perhaps, the salient aspect of this case, Madam Chair, is the note which [the attending physician] wrote after she spoke to the family recommended doctor. Per her notes, not only did [the recipient's former physician] not confirm the presence of any encephalopathy but also said he would be best managed on an atypical antipsychotic and a mood stabilizer, the very meds that [the attending physician] had prescribed.

It is our contention that [the recipient] received medical care that is in keeping with the accepted standards of care. That being said, we, here at Advocate Illinois Medical Center, will attend to any recommendations from your commission that would help us provide better care for our patients."

Hospital staff were interviewed about the complaint. They stated that the recipient presented with many symptoms and he remained very delusional, very aggressive and often violent throughout his hospitalization. They indicated that the recipient's behaviors could not have been controlled by Seroquel alone, which the guardian verbally agreed to, and although the staff and the guardian had numerous conversations about Geodon, the guardian would not consent to its use. Staff confirmed that Geodon was only given as an emergency medication. Staff believed that the clinical justification for the injected Geodon was always clearly demonstrated in the record, and was necessary for the safety of the recipient and others. They also stated that the recipient always accepted the medication and it was not forced. The HRA asked about the presence of other staff members and security for some of the emergency medication administrations, and they stated that they were present only for support and there was never a need for hands-on restraint. Staff also commented that they are a recovery unit and do

not want to offer restraint as an option. Staff confirmed that the recipient was never placed in restraints during his hospitalization. They were reminded that the record contained a Notice of Restriction of Rights form for restraint and medication, however they were unaware of that event.

Hospital staff were asked about the role of the guardian in patient care. They stated that guardians are appointed for many reasons, and in some cases are appointed for purposes of housing, etc. and not for clinical decision making. Staff stated that they offer all caretakers the opportunity to participate in weekly staffing, and traditionally they do not have problems with family members not consenting to their treatment plans. They stated that care plans are not sent to guardians, however the guardian in this case had many conferences with staff via phone and staff felt that although the recipient may have needed a guardian, in this case the guardian was wrong- that the recipient benefitted from antipsychotic medication.

STATUTORY BASIS

Under the Mental Health Code, a person is subject to involuntary admission when they are asserted to be in such a condition that immediate hospitalization is necessary to protect themselves or others from physical harm. Any person 18 years or older may present a petition to the facility director of a mental health facility for an involuntary admission (405 ILCS 5/3-601 a). The Code also outlines the specific requirements for the completion of the certificate, and this includes the names and addresses of the spouse, parent, guardian, substitute decision maker, if any, and any close relative or friend (405 ILCS 5/3-601 b, 2). Additionally, the Code mandates that no later than 24 hours after admission, a copy of the petition and statement shall be given or sent to the recipient's attorney and guardian, if any (405 ILCS 5/3-609).

From the time that services begin, legal guardians and other substitute decision makers are to be included in all facets of care. Information about a recipient's rights must be shared orally and in writing with the adult recipient upon commencement of services, or as soon as his condition permits, and with the guardian. A recipient aged 12 or older and any guardian must also be informed upon commencement of services of the right to designate a person or agency to receive notice should the recipient's rights ever be restricted. The recipient is allowed to select a preference for forced emergency treatment and the facility is to communicate a selection to any guardian (405 ILCS 5/2-200). If any guaranteed right under the Mental Health Code is restricted, including the right to refuse medications, then the facility must promptly give notice to the recipient, his guardian, and to any person or agency so designated (405 ILCS 5/2-201).

The Mental Health Code allows recipients and their guardians the right to refuse medications:

> *An adult recipient of services or 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 developmental 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. The facility director shall inform a recipient, guardian, or substitute decision maker, if any, who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services (405 ILCS 5/2-107).*

Likewise, service planning and decisions on proposed treatment with psychotropic medications and electroconvulsive therapy include the recipient's and the guardian's views:

> *A recipient of services shall be provided with adequate and humane care and services 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…or any other individual designated in writing by the recipient.* (405 ILCS 5/2-102 a).

> *If the services include the administration of authorized involuntary treatment, the physician…or designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as the alternatives to the proposed treatment…. 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…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. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only pursuant to the provisions of Section 2-107 [an emergency] or 2-107.1 [a court order]*. (405 ILCS 5/2-102 a-5).

Finally, the Probate Act of 1975 has the same intentions when it calls for appointed guardians to secure and oversee appropriate care for their wards and to be assured that providers will rely on their directives:

> *To the extent ordered by the court…the guardian of the person shall have custody of the ward and…shall procure for them and shall make provision for their support, care, comfort, health…and maintenance….* (755 ILCS 5/11a-17).

> *Every health care provider…has the right to rely on any decision or direction made by the guardian…that is not clearly contrary to the law, 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).

Restraint is a therapeutic tool that the Mental Health Code carefully regulates. Although its use is to prevent harm, the Code outlines specific measures to ensure that it is safely and professionally applied:

> *"Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized. In no event shall restraint be utilized to punish or discipline a recipient, nor is restraint to be used as a convenience for the staff.*
>
> *(a) Except as provided in this Section, restraint shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities. No restraint shall be ordered unless the physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of restraint is justified to prevent the recipient from causing physical harm to himself or others. In no event may restraint continue for longer than 2 hours unless within that time period a nurse with supervisory responsibilities or a physician confirms, in writing, following a personal examination of the recipient, that the restraint does not pose an undue risk to the recipient's health in light of the recipient's physical or medical condition. The order shall state the events leading up to the need for restraint and the purposes for which restraint is employed. The order shall also state the length of time restraint is to be employed and the clinical justification for that length of time. No order for restraint shall be valid for more than 16 hours. If further restraint is required, a new order must be issued pursuant to the requirements provided in this* Section….
>
> *(c) The person who orders restraint shall inform the facility director or his designee in writing of the use of restraint within 24 hours.*
>
> *(d) The facility director shall review all restraint orders daily and shall inquire into the reasons for the orders for restraint by any person who routinely orders them.*
>
> *(e) Restraint may be employed during all or part of one 24 hour period, the period commencing with the initial application of the restraint. However, once restraint has been employed during one 24 hour period, it shall not be used again on the same recipient during the next 48 hours without the prior written authorization of the facility director.*
>
> *(f) Restraint shall be employed in a humane and therapeutic manner and the person being restrained shall be observed by a qualified person as often as is clinically appropriate but in no event less than once every 15 minutes. The qualified person shall maintain a record of the observations. Specifically,*

> *unless there is an immediate danger that the recipient will physically harm himself or others, restraint shall be loosely applied to permit freedom of movement. Further, the recipient shall be permitted to have regular meals and toilet privileges free from the restraint, except when freedom of action may result in physical harm to the recipient or others…. (405 ILCS 5/2-108).*

The Mental Health Code defines seclusion as " the sequestration by placement of a recipient alone in a room which he has no means of leaving. The restriction of a recipient to a given area or room as part of a behavior modification program which has been authorized pursuant to his individual services plan shall not constitute seclusion, provided that such restriction does not exceed any continuous period in excess of two hours nor any periods which total more than four hours in any twenty-four hour period and that the duration, nature and purposes of each such restriction are promptly documented in the recipient's record."

HOSPITAL POLICY

Illinois Masonic hospital provided policy and procedure regarding the stated complaint. Policy #20.123.002 Involuntary Psychiatric Admissions indicates that a patient may be admitted to the psychiatric unit after a Petition for Involuntary Admission is completed and submitted along with a Certificate for Involuntary Admission completed by a Physician, Qualified Examiner, or Clinical Psychologist. Upon completion of the Petition, the patient receives a copy of both the Petition and the Rights of the Admittee. The individual who gives the recipient the above documents must certify at the bottom of the Petition that they have given these documents to the recipient within 12 hours of their admission. The policy states that before any treatment can be initiated, a Certificate must be completed. Prior to the examination for the first certificate, the examiner must 1) Inform the recipient of the purpose for the examination and inform him that he does not have to speak with the examiner, and 2) Inform the recipient that any statements that he makes may be disclosed at a court hearing to determine the issue of his being subject to involuntary admission. The first certificate is completed prior to the patient going to the unit.

Illinois Masonic policy #20.007.010 Identification of Appropriate Decision-Maker defines "Substitute Decision Maker": "Substitute Decision Maker means the individual who has the authority to make decisions on behalf of a nondecisional patient; this individual may be a legal guardian, an agent with Durable Power of Attorney for Healthcare, or a surrogate decision-maker based on the Illinois Health Care Surrogate Act. A Substitute Decision Maker will make decisions for the patient conforming as closely as possible to what the patient would have done or intended under the circumstances." "Decisional Capacity" means "the patient's ability to understand and appreciate the nature and consequences of a decision regarding his or her medical treatment or forgoing life-sustaining treatment and who is able to reach and communicate an informed decision. …Decisional capacity is a clinical determination, as opposed to incompetency, which is a determination by a judge that a patient is globally incapable of making decisions on his/her behalf, a determination that must be made in court prior to assignation of a legal guardian." The same policy defines Legal Guardian as "An individual who has been appointed by a judge as such, following the adjudication of a patient as incompetent to make his/her own healthcare decisions".

Illinois Masonic policy #20.123.010 Rights (Behavioral Health Unit) states that upon admission, or as soon as the condition of the recipient permits, every patient, or the guardian of a person under guardianship, will be informed of his rights under the Mental Health Code verbally and in writing and this is documented on the Rights of Recipients form. The recipient and the guardian are informed of the possibility of the restriction of these rights and are informed of the right to designate a person or agency to receive notice if such a restriction occurs. The name of this person or agency is documented in the patient care record.

Illinois Masonic policy #20.123.008 Administration of Medications on Psychiatric Units states that when psychotropic medications are administered to a patient, both the physician and the registered nurse will explain the medication properties, indications, and possible side effects to the patient prior to administration. This same information is provided to the patient in writing. Policy states that when a psychotropic medication is administered to a patient and the patient is unable to comprehend the information about the medication, the patient will be given this information as soon as his/her condition improves. This policy also states that patients will not be forced to take medications, and if the patient refuses, the reason for the refusal should be documented in the medical record. Emergency administration of psychotropic medication is allowed only if needed to prevent serious and imminent physical harm to the patient or others.

Illinois Masonic policy #20.123.071 Informed Consent for Mental Health Treatment Provided in a Mental Health Facility states that an adult, or the patient's guardian, can refuse generally accepted mental health treatment unless the services are necessary to prevent serious and imminent physical harm to the patient and others. It states, "The Facility Director /designee will inform the patient or guardian of alternate services available, risks of alternate services, as well as the possible consequences to the patient of refusal of such services. If the treatment is not an emergency, a petition for an order allowing administration of treatment over the refusal of the patient, his parent, or his guardian may be filed."

Illinois Masonic policy #20.123.011 Rights- Restriction of (Behavioral Health Department) states that "Whenever any rights of a patient as specified in the Mental Health and Developmental Disability Code are restricted, the person responsible for overseeing his/her care informs the patient of this restriction and the reason thereof. If the patient is a person under guardianship, his/her guardian is also notified of the restriction and the reason thereof. …The restriction, the reason for the restriction, and any persons contacted regarding this restriction are promptly recorded in the patient care record." The guardian is also asked if he/she wishes anyone else to be notified of the restriction of rights, and the guardian is given a copy of the Notice of Restriction of Rights form.

Illinois Masonic policy #90.017.031 Utilization of Restraint and Seclusion comports with the requirements outlined in the Mental Health and Developmental Disabilities Code except that the procedure does not include the notification of the guardian or providing a copy of the Notice of Restriction of Rights to the guardian.

CONCLUSION

The record demonstrates that the staff on the behavioral health unit admitted the recipient in March, 2011 even though they were aware that his guardian would not give consent for Geodon. Nevertheless this medication was administered to the recipient even though the guardian called the hospital, almost daily, to voice her objection. There is no evidence from the record that the guardian was given rights information upon admission of her ward, that she was sent a copy of the petition, that she was part of the care plan development, that she was notified when the recipient's rights were restricted, or that she was presented with the side effects, risks, and benefits of the proposed treatment, and offered alternatives should she refuse it. No matter the clinical justification for the treatment protocol, the guardian has been judicially appointed as the recipient's substitute decision maker, and the Mental Health Code and Illinois Advocate Hospital policy honor this appointment. Additionally, it is not clear from the record why the hospital would have accepted the recipient a month after they had discharged him, knowing that his guardian would not consent to antipsychotic medication, and then continue to administer it repeatedly after her many objections. The Human Rights Authority substantiates the complaint that the facility did not follow Code procedure when it did not include the guardian in the care and decision making of her ward.

The Mental Health Code strictly regulates the application of restraint. In this case, the emergency department record contains a Notice of Restriction of Rights for restraint and medication and a restraint episode is listed in the emergency department notes. The Notice document is not completed and the record is missing many of the Code mandated components of restraint, such as the justification that the restraint is necessary to prevent the recipient from harming himself or others, what events led up to the need for restraint, the clinical justification for the length of the restraint, the Notice of Restriction of Rights, and the record of 15 minute checks. Additionally, the Notice was not issued to the guardian, whose letter of office was included in the paperwork and sent with the recipient from his nursing home, and her contact information is included in the admission documents. The Human Rights Authority substantiates the complaint that the hospital did not follow Code procedure when it restrained the recipient.

The record shows that the guardian, who has the legal right to refuse medication for her ward, exercised this right repeatedly by demanding that her ward not be administered Geodon. Staff reported that the refused medication was only given in emergency situations, when the recipient was clearly an imminent physical threat to himself or others. Some incidents in the record agree with this description, however some do not. The incident on 3/25/11 shows that the recipient "was observed pacing in the hallway, patient appeared to be anxious and responding to internal stimuli…patient was redirected to room multiple times, but was not able to remain in room." Also, on 3/26/11 the record states, "…patient was observed pacing in the hallways and wandering in and out of his room, intermittently pulling his pants down. Patient appeared suspicious of others and internally preoccupied." Neither of these incidents suggest dangerousness to the extent that emergency forced medication would be warranted. Additionally, staff reported that the prn medication was always accepted by the recipient, however incidents such as the one on 4/01/11 show that multiple staff were present for the injections and on 3/30/11 that both staff and security were present, suggesting that the recipient resisted these injections, and the progress notes describe several events as "emergency" administrations of medication. In either case the facility is lacking the Code mandated documentation to support their treatment: Consent for psychotropic medication that is accepted,

and Notice if the medication is refused. The HRA substantiates the complaint that the facility administered psychotropic medication in violation of the Mental Health Code on those occasions.

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 their ward's 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. Review with emergency room staff the Code mandated regulations for restraint. Add to the restraint policy the Notice of Restriction of Rights to guardians.

3. Review with staff the Mental Health Code mandated right of recipients and their guardians to refuse medications. Ensure that the recipient and their guardian are informed of their right to refuse medication, and if it is refused by the recipient or his guardian, then it is not given unless it is necessary to prevent the recipient from causing serious and imminent physical harm to himself or others, and no less restrictive alternative is available. Ensure that in these cases a Notice of Restriction of Rights is issued to the recipient and his guardian.

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. The HRA notes that the medical center uses the words "power of attorney" and "guardianship" interchangeably in reference to the patient's mother in this case, although the HRA recognizes that the descriptors may have come from the mother herself. However, there are differences between powers of attorney and guardianships, most notably a power of attorney does not take effect unless an individual lacks decisional capacity (one reason why a physician statement of decisional capacity is so important) and a power of attorney can be revoked at any time by the patient; a guardianship is in effect and remains in effect upon court appointment and cannot be revoked without court involvement. The HRA suggests that legal guardianship be clearly documented and referenced in a patient's record.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

Advocate Illinois Masonic Medical Center

836 West Wellington Avenue || Chicago, IL 60657 || T 773.975.1600 || advocatehealth.com

March 22, 2012

Jill Quinto, HRA Chairperson
Illinois Guardianship and Advocacy Commission
1200 S. 1st Avenue
P.O. Box 7009
Hines, IL 60141-7009

Regarding: HRA Case # 11-030-9020

Dear Ms. Quinto:

We appreciate the opportunity to have our response to the HRA's report 11-030-9020 to be included as part of the public record. Advocate Illinois Masonic Medical Center disagrees with the allegations in the complaint that the hospital abused the use of PRN medications and restraint and disagrees that the guardian was not included in the care and decision making of her ward. The patient record shows almost daily phone conversations of the attending psychiatrist (or social worker) with the guardian, with painstaking details of the medical care of the patient attempting to explain and educate on the diagnosis and treatment of the patient. The guardian never visited the hospital to meet with the treatment staff either informally or at the scheduled weekly team staffing meeting. The patient had a history of 25 or more admissions for severe symptomatology that was characterized by hearing voices, agitation-impulsive, often violent behavior towards self, others and destruction of property, inappropriate behavior, poor social skills, paranoia with impaired functioning. These are consistent with a chronic recurrent psychosis necessitating both, routine meds but also PRN (or emergency meds) when the patient exhibits behavior that requires such intervention. This is in keeping with the Mental Health Code and standards of clinical care. The record will also show that [the attending physician] and the treatment staff not only administered these meds when they were clinically appropriate but documented the positive effects of these interventions. At no point during either hospitalization, was there any evidence of an adverse or deleterious effect of the meds prescribed.

Further, the facility disagrees with the HRA's substantiation that the facility administered psychotropic medications in violation of the code.

The patient's receiving routine, albeit sub therapeutic dose of Seroquel and Tegretol was in accordance with the wishes of the guardian, as evidenced by the phone conversation documented in the chart. The administering PRN Geodon was in keeping with the provisions of the code regarding emergency administration of psychotropics. The chart is replete with numerous episodes of the behavior that warrant such emergency administration.

In the two cases cited by the report as not meeting such a threshold are the following responses:

The patient's highly intrusive disorganized behavior, entering into other patients' rooms, not responding to verbal redirection of the staff posed a serious threat of a possible hostile response by another fragile unknowing patient. The second example is the patient walking round with his penis hanging out of his pants, may seem initially harmless, but the earlier ED record review shows that this was followed by impulsive outbursts of verbalization that were highly provocative, and are well documented in the chart. It would have been very difficult to keep this patient harm-free from other unknowing fragile patients.

It is absolutely critical to note that the clinical care of this patient met the high standards of care. We would welcome any public review of this. The patient progressed to a safe discharge, free of any adverse effects. Subjectively the patient even accepted that the meds administered were helpful to him. We do however recognize an opportunity for improvement with regard to completion of necessary forms and documents and appropriate notice of rights. As such, our action plan incorporates suggestions and recommendations made by your Advocacy Commission.

We appreciate the opportunity to work with you in our belief that it is patient that always comes first. For any questions, feel free to contact Karen Kittle, Director, Clinical Operations, at 773-296-5810 or Gloria Umali, Director, Risk Management, at 773-296-5539.

Sincerely,

Susan Nordstrom Lopez
President
Advocate Illinois Masonic Medical Center

Attachment: Advocate Illinois Masonic Medical Center Action Plan for Guardianship and Advocacy Commission Report #11-030-9020

Advocate Illinois Masonic Medical Center
Action Plan for Guardianship and Advocacy Commission Report #11-030-9020
March 15, 2012

Recommendation/Suggestion	Action Plan	Accountability	Time Line
Recommendation #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 their ward's 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 medications, information on the rights of their wards and to be informed when these rights are restricted, and the ability to refuse services for their wards.	Conduct educational session for Behavioral Health (Unit 631) and Emergency Department (ED) staff on rights of guardians and including documentation of the guardian's involvement in the integrated progress note and/or problem, intervention, evaluation, plan (PIEP) not as appropriate.	-Anna Scaccia, Manager, ED -Mary Summins, Manager, Unit 631 -John Pucker, Clinical Nurse Specialist	Complete by March 31, 2012 & conduct annual education on this topic
Recommendation #2: Review with emergency room staff the Code mandated regulations for restraint. Add to the restraint policy Notice of Restriction of Rights to guardians.	Review current Restraint Policy to validate that Notice of Restriction of Rights to guardians is present. Noted in language below: Policy #90.017.031 Utilization of Restraint and Seclusion states: "patients with a behavioral health diagnosis will be provided with a copy of the *Illinois Mental Health Restriction of Rights Form* (Attachment B)", and the Attachment B form clearly states: "***Guardian of Person must be notified***" Validate that all appropriate hospital social worker teams reviewed above policy and guardian	-John Pucker, Clinical Nurse Specialist Karen Kittle, Director Clinical	Completed March 8, 2012 Completed March 15, 2012

	notification requirements related to restriction of rights. Include a review of Policy #90.017.031 Utilization of Restraint and Seclusion and Restriction of Rights Form discussion in above noted educational session for Behavioral Health (Unit 631) and Emergency Department (ED) staff being conduction on rights of guardians.	Operations -Anna Scaccia, Manager, ED -Mary Summins, Manager, Unit 631 -John Pucker, Clinical Nurse Specialist	 Completed by March 31, 2012 & conduct annual education on this topic
Recommendation #3: Review with staff the Mental Health Code mandated right of recipients and their guardians to refuse medications. Ensure that the recipient and their guardian are informed of their right to refuse medications, and if it is refused by the recipient or his guardian, then it is not given unless it is necessary to prevent the recipient from causing serious and imminent physical harm to himself or others, and no less restrictive alternative is available. Ensure that in these cases a notice of Restriction of Rights is issued to the recipient and his guardian.	Conduct education on Mental Health Code guardian rights, relevant hospital policy and documentation requirements for Behavioral Health (Unit 631) and Emergency Department (ED) staff. . Include a review and discussion on Policy #20.123.008 Administration of Medications on Psychiatric Units and Policy #20.123.011 Restriction of Rights in above noted educational session for Behavioral Health (Unit 631) and Emergency Department (ED) staff Monthly audit of restriction of right documentation compliance including guardian notification as applicable (minimum or 10 charts per practice setting).	-Mary Ellen Cherry, General Counsel, Advocate Health Care -Anna Scaccia, Manager, ED -Mary Summins, Manager, Unit 631 -John Pucker, Clinical Nurse Specialist -Anna Scaccia, Manager, ED -Mary Summins, Manager, Unit 631	Complete by April 30, 2012 Completed by March 31, 2012 & conduct annual education on this topic Implement April 1, 2012

Suggestion #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.	Conduct education on Mental Health Code with a focus on guardian rights, relevant hospital policy and documentation requirements for Behavioral Health (Unit 631) and Emergency Department (ED) staff.	-Mary Ellen Cherry, Associate General Counsel, Advocate Health Care	Complete by April 30, 2012
Suggestion #2: The HRA notes that the medical center uses the words "power of attorney" and "guardianship" interchangeably in reference to the patient's mother in this case, although the HRA recognizes that the descriptors may have come from the mother herself. However, there are differences between powers of attorney and guardianships. The HRA suggests that legal guardianship be clearly documented and referenced in a patient's record.	Include education on terminology related to power of attorney versus guardianship definitions in addition to above topics for Behavioral Health (Unit 631) and Emergency Department (ED) staff.	-Mary Ellen Cherry, Associate General Counsel, Advocate Health Care	Complete by April 30, 2012