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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS
Case # 11-090-9039
Graham Hospital

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a compliant of possible rights violations at Graham Hospital. Complaints alleged the following:

1. Medication was given without a patient's consent; the patient thought he was having blood work drawn but really received a medication shot.

If found substantiated, the allegations would violate the Medical Patient Rights Act (410 ILCS 50/3), Illinois Hospital Regulations (77 Il Admin Code 250), and the Mental Health and Developmental Disabilities Code (405 ILCS 5/2).

Fulton County is the hospital's primary service area but the facility also services the surrounding 5 counties. The hospital holds 124 beds, with 49 acute beds for skilled, long-term nursing. The hospital employs 750 employees within the whole health system, with approximately 500 in the hospital and 20-30 in the emergency department. The facility services 17,500 patients in the emergency room per year but did not have specific statistics on patients with mental health issues that are serviced in the emergency room. The facility has a contract with a local community mental health center to evaluate patients with mental health issues.

COMPLAINT STATEMENT

The complaint alleges that a patient was having an anxiety attack and was taken to the hospital's emergency department (ED). While at the ED, the staff reportedly told the patient that they were drawing blood work but instead gave the patient a shot of Paxil. The patient was not aware that he was receiving the drug. The patient was informed later by another physician that Paxil was in his system.

FINDINGS

Interview with staff (7/12/2011)

The HRA began the investigation by discussing the complaint with the Graham Hospital staff. The staff explained that the patient was brought to the hospital ED by a local nursing home staff member. The patient was allegedly becoming verbally abusive with the nursing home staff

while visiting the facility, so the nursing home staff member drove the patient to the hospital ED. Once the patient arrived at the emergency room, he explained that he was suffering from a panic attack and thought that he was receiving a throat x-ray. The staff said that the patient was disoriented and kept making declarations such as someone was trying to kill him and that he was on government commission boards. The staff stated that he had a flight of ideas while at the ED. While at the facility, the nurse attempted to have the patient dress in a gown and then asked the patient to go to the emergency room's "safe room" which he went to willingly. The nurse was in the "safe room" with the patient listening to his complaints. The facility said that the patient had an arrowhead in the room that he would not allow the staff to remove. The staff explained that the patient would look at the arrowhead and then look at the nurse who was in the room with him. The facility ran blood work and urine samples on the patient with his consent. Eventually, the facility gave the patient one Paxil tablet which he took willingly.

The staff explained that the patient was being seen by a physician in the area. The patient's regular physician said that she knew the patient well and she could tell he was not taking his medication. She directed the ED physician to administer the medication that he was not taking, which was Paxil and then discharged the patient. The community mental health facility that contracts with the hospital was not contacted. They explained that the community mental health provider performs evaluations and may refer the patients to another facility. The patient's physician said to not pursue a psychiatric evaluation so the hospital did not contact them. The hospital explained that it is typical for an ED physician to call a patient's primary care physician in order to understand the patient's history and to request an opinion on the situation. The staff explained that the patient did not frequent the ED for treatment. The staff also explained that Paxil is not administered in an injection, only in pill form.

The staff explained that when a patient arrives at the ED, they have the patients sign consent for all emergency room treatment. The patient was hesitant about signing the consent for because he wanted assurance that it was not documentation for admission into a psychiatric unit. The ED staff assured him that it was not an admissions document and he signed the consent. The facility stated they do not have consent forms for individual medications; they only have the initial form for ED treatment. The staff stated that if they requested consent for each medication that they administered every patient, it would lessen the efficiency of the department. They stated that they could not function if they had to receive consent for each medication. Patients do not want to sign their name every time they are given medication.

The HRA called the hospital at a later date and confirmed specifically that there is no consent for psychotropic medication, only the treatment consent form that was provided to the HRA. The staff member did state that patients can always refuse medication and, if they do so, the refusal will be documented.

The staff proceeded to explain that they asked the patient if he would take the Paxil and explained what the patient's physician told them over the telephone. They stated that the patient was happy to oblige with taking the medication because he was nervous that he would go to the psychiatric ward.

The verbal consent for the Paxil was not documented although the staff explained that the treatment was discussed with the patient. They stated that they would not have forced the medication on the patient and that he willingly took the medication. They also said that Paxil was the only drug given and it was given orally. They said that the patient's symptoms indicated that he was anxious, paranoid, delusional and manic and he was identified as a mental health patient when he entered the hospital. The staff said that mental health patients are not treated differently than other patients. Occasionally they may have to take a mental health patient into the safe room if they have problems. They stated that the safe room is not a seclusion room and they rarely use restraints on patients.

The staff said that when a mental health patient enters the ED, the nursing staff attempts to have them put on a gown in case they have any items that may hurt them or staff. The next step is having blood work and a urine test. The physician then evaluates the patients and talks to them. The physician explains why the blood work and the lab were needed and then explains to the patient that they may be at the ED for an extended period of time because contracted counselors may be busy. Then the physician tells the patient that the counselor will determine how to proceed and the patients are generally agreeable with the scenario. The ED staff also completes a physical on the patient. The blood work and urine sample are to see if the patient has any controlled substances in their system. It is also to see if they have any medical problems. The staff explained that their main responsibility is to make sure the staff is safe.

The staff explained that the patient was aware that he could refuse the medication. When the patient signed the consent form for ED treatment, the right to refuse medication is reviewed. The patient had the right to refuse medication and could leave against medical advice (AMA). All patients can refuse the medical screening but most comply with the screening. The staff attempts to convince each patient to comply with the physician's advice but some refuse.

Record Review

The HRA reviewed documents related to the complaint in this report. The front page of the emergency record states that patient's ED service date and time was 4/21/11 at 3:24pm. And ED note written by the physician states that the patient's chief complaints were that he "Anxious and agitated, angry, delusional, paranoid and manic. This started today. He has experienced situational problems and exhibited a behavior change. He has had anxiety. Has been angry and paranoid. The patient has had mild grandiose delusions. No suicidal thoughts or self-injury inflicted. The symptoms are described as moderate." The Emergency Room Nursing Documentation states that the "Pt was brought in by staff from [nursing home facility] for bizarre behavior. [Nursing home facility] staff states that pt was being agitated and very paranoid and delusional. States that everyone is trying to kill me. Pt is having flight of ideas in the ED. States that his dog died the other day and then the next day the Jehovah's witnesses were harassing pt the next 2 days. Then he had a vision of his mother dying. Then his aunt died. States this all happened in a few days. States I just had a panic attack at the [nursing home facility] and all I wanted to do was to come have an x-ray of my throat. Pt keeps speaking about a lawsuit against [community mental health facility] and how he has 3 lawyers with the mentally challenged act facility and conspiracy [sic]." At 4:11pm, the nurse documentation reads "Registration in to obtain consent to treat. Pt asked this RN, security guard and registration if

this was consent to admit to a psych ward multiple times after having it explained multiple times. Pt then signed the consent form." In reviewing the authorization for treatment form, it reads "I hereby give my consent to Graham Hospital, its employees, other physicians, or mid-level providers for medical and diagnostic treatment, and for nursing students, interns, paramedics and other health-related trainees to participate in my care under the supervision of the physician." The release proceeds to discuss releasing information for payment, independent physicians/contractors, pathology services, assignment of benefits, and personal responsibility.

The nursing documentation also reads in the disposition/discharge section that there are "No learning barriers present. Discharge instructions provided and reviewed with the patient. Reviewed medication side effects, precautions, dosing and course; prescription given to patient." The HRA spoke to the facility and verified that they have no written documentation explaining side effects for psychotropic medication. The HRA saw no written documentation indicating capacity to make informed decisions on treatment, other than the statement that no learning barriers are present.

In the physician emergency room note, under Progress and Procedures, it reads "Discussed case with patient's primary care provider, [physician's name] restart medications and okay to discharge home." The document also states that the patient is to follow-up with a psychiatrist and medical doctor and that the discharge instructions were verbalized by the patient. On an emergency room order report, it states that the medication order was "Paxil 20mg PO" and that it was a verbal order read back to the physician and verified. This was at 4:40 on the 4/21/11. The HRA saw no evidence of what was said to the patient regarding the Paxil.

Also, in the nursing documentation it reads "Blood samples drawn by lab" at 4:11pm, which was after the consent to treat was authorized by the patient. There was also a urine sample taken at 4:16pm which, again, was after the consent to treat was authorized.

In researching Paxil on the U.S. National Library of Medicine website, it states "Paroxetine (Paxil) comes as a tablet, a suspension (liquid), and a controlled-release (long-acting) tablet to take by mouth." The website does not state that Paxil can be injected.

The HRA reviewed a document titled Patient Registration Authorization for Treatment Policy. Under consents, it reads "An authorization for treatment shall be obtained for outpatient, emergency room, admission and observation patients." Under a section titled Acceptable Methods of Consents, it reads "Written by the patient, guardian or POA for Healthcare and witnessed by a Graham Medical Association employee," and also "Given verbally by the patient, guardian or POA for healthcare to two Graham Hospital Association employees who then document the authorization form as being verbal consent, from whom it was taken, their relationship to the patient and the date and time consent was received."

In the patient's rights document it states "You have the right to consent to or refuse a treatment, as permitted by law, throughout your hospital stay. If you refuse a recommended treatment, you will receive other needed and available care." The rights document also states "You have the right to be well-informed about your illness, possible treatments and likely outcome and to discuss this information with your doctor."

In reviewing a document titled Psychiatric Evaluation Patients, the policy reads "Graham Hospital is a non-psychiatric hospital. Any patient accessing care at this facility that requires psychiatric treatment (emotional illness, suicide ideations, and alcoholism or drug abuse) will be managed through referral and transfer to a behavioral health facility and/or management through consultative psychiatric services on a temporary basis, until the patient's clinical condition has stabilized to allow for psychiatric facility transfer." In the Practice Guidelines section, it reads "All medical complaints shall be stabilized. Patient must be medically cleared prior to transfer to appropriate behavioral healthcare." The Psychiatric Evaluation document and another document titled Mental Health Flowchart both indicate that the hospital does contact a local mental health center to evaluate patients with mental health issues.

The HRA also reviewed a document titled Suicide Precautions. The document illustrates the guidelines for patients under suicide precautions which included the precautionary levels and amount of time spent checking the patients based on those levels. In the document it reads "All Patients placed on moderate and high level observation will have a restriction of visitors and removal of permanent room contents, i.e. telephone, pillow speaker, oxygen and suction tubing, cords not currently in use, etc." The document also reads "All harmful objects shall be removed from the patient's possession" and, as part of the procedure it reads "Remove all personal items including clothing from room. Label and place patient's belongings at the nurse's station until discharge. If family is present send belongings home with them." The document also reads "Remove all items staff member feels might present danger with a particular patient."

The HRA saw no consent or references to consent for psychotropic medication in any reviewed documentation.

MANDATES

The HRA reviewed mandates relating to the complaint in this case. The Mental Health and Developmental Disabilities Code defines a mental health facility as "§ 1-114.'Mental health facility' means any licensed private hospital, institution, or facility or section thereof, and any facility, or section thereof, operated by the State or a political subdivision thereof for the treatment of persons with mental illness and includes all hospitals, institutions, clinics, evaluation facilities, and mental health centers which provide treatment for such persons" (405 ILCS 5/1-114).

The Mental Health and Developmental Disabilities Code (MHDDC) reads "(a-5) If the services include the administration of electroconvulsive therapy or 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 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. If the recipient lacks the capacity to make a reasoned

decision about the treatment, the treatment may be administered only (i) pursuant to the provisions of Section 2-107 [an emergency]" (405 ILCS 5/2-102).

The Medical Patient Rights Act reads "(a) The right of each patient to care consistent with sound nursing and medical practices, to be informed of the name of the physician responsible for coordinating his or her care, to receive information concerning his or her condition and proposed treatment, to refuse any treatment to the extent permitted by law, and to privacy and confidentiality of records except as otherwise provided by law" (410 ILCS 50/3).

FINDINGS

Complaint #1 - Medication given without patient's consent, patient thought he was receiving blood work drawn but really received a medication shot.

The complaint states that the Graham Hospital ED gave medication without the patient's consent and that the patient thought that blood work was being taken when he was really receiving a medication shot. The complaint stated that a patient received a shot of Paxil and was told by another physician that Paxil was in his system. The Graham Hospital staff stated that the patient was brought to the ED by another facility that he was visiting and was experiencing a flight of ideas when he entered the facility. The staff explained that they contacted the patient's primary care physician who said that the patient was not taking his medication and asked the hospital to give him Paxil. The staff stated that the blood work that was done is standard procedure for the facility to see if the patient is on any controlled substances and that the patient was not given any medication via injection. Also, that Paxil is a drug that is not even administered by injection. In reviewing the documentation, the HRA saw that blood work was drawn, consent for general treatment was signed, but saw no indication that the patient was injected with medication. The HRA saw that Paxil was ordered for the patient. Although the exact allegations in this complaint appear to be unsubstantiated and the patient seems to have received needed medical care from the facility, the HRA has still discovered that there may be a gap in the hospital's procedure for administering psychotropic medication as required in the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102). The facility did not have a written explanation of side effects nor was there a written determination of the patient's capacity to make reasoned decisions regarding treatment. When a facility provides mental health treatment, whether it is in a psychiatric unit or stabilizing through medication in the ED, the facility is required to adhere to the Mental Health and Development Disabilities Code. Although the exact allegations are unsubstantiated, the HRA **substantiates** a violation of the 405 ILCS 5/2-102 of the Mental Health and Development Disabilities Code in regard to informed consent procedure for psychotropic medication. The HRA offers the following **recommendations:**

- When a patient has mental health needs enters the ED, follow Mental Health Code requirements for informed medication consent, including the provision of written side effect information and a written physician's determination of decisional capacity.

- Create policy for ED that adheres to the Mental Health and Development Disabilities Code in regard to informed consent for psychotropic medication.

- Train/educate ED staff on the implemented policy.

The HRA also offers the following **suggestions:**

- The HRA suggests not only reviewing the Mental Health and Development Disabilities Code for psychotropic medication but also reviewing the entire Code to assure that the facility is in compliance (such as emergency medication, restraint use, seclusion, etc.) creating procedure and policy that ensures the facility is in adherence with the Code.
- In reviewing the Suicide Precautions policy, the HRA feels as though the policy could lead to some possible rights restrictions and non-compliance with the Mental Health and Development Disabilities Code. For example, the policy states that patients placed on moderate and high level observation will have a restriction of visitors and removal of telephone, which could impede on the Code's guaranteed right to have visitors and phone communications (405 ILCS 5/2-103). The same policy also restricts some personal property which is also a potential violation of patient's rights (405 ILC 5/2-104). If restrictions occur, they must occur in compliance with the Code section 405 ILCS 5/2-201. Although the HRA suggested that the facility conduct an overall inspection to assure that their facility is in compliance with the Code, the HRA also suggests the facility specifically focus on creating policy to assure compliance with restricting rights within the Code.
- The HRA reviewed the rights policy but did not see a signed verification that the rights were communicated both verbally and in written form to the patient per 405 ILCS 5/2-200. In the interview section, it was stated that the patient was happy to oblige in taking the medication because he was nervous that he would go to the psychiatric ward and this is a concern to the HRA for two reasons; this lack of trust may be indicative of the patient not fully understanding his rights, not understanding that the facility cannot legally mislead patients in this way and also because the patient may have been afraid of being committed if he did not take the medication which could compromise the patient's right to refuse. The HRA suggests that the facility create policy that complies with 405 ILCS 5/2-200 so that the facility is in full compliance with the Mental Health and Developmental Disabilities Code, to alleviate patients' fears when receiving treatment from the facility, and to better ensure patients' understanding of their rights.
- The HRA did not see any situation where the patient was forced to change into a gown, but in the interview the staff indicated that they attempt to have mental health patients dress in a gown when they enter the ED. Although no problem was seen, the HRA would like to reiterate to the facility that changing into a gown is ultimately the patient's decision and they have the same right to refuse changing into a gown as they do to refuse medication and treatment, unless a physician determines there is life/health endangerment.