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REPORT OF FINDINGS
INGALLS MEMORIAL HOSPITAL — 13-040-9009
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary— The Authority made corrective recommendations that were accepted by the service provider. The public record on this case is recorded below; the provider did not request that its response should be included as part of the public record.]

INTRODUCTION

The Human Rights Authority (HRA) has completed its investigation into allegations concerning Ingalls Memorial Hospital. This general hospital has an adult and adolescent psychiatric unit. The complaints alleged that the hospital: 1) did not explain the voluntary admission application and rights information, 2) did not involve the guardian in treatment planning, 3) administered psychotropic medication without informed consent and in the absence of an emergency, and, 4) denied visitation from an attorney/family member. If substantiated, these allegations would be violations of the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.) and the Illinois Probate Act (755 ILCS 5/11a-23).

METHODOLOGY

To pursue the investigation, the hospital's Associate General Counsel, the Medical Director, the Attending Psychiatrist and an Assessment/Referral Counselor were interviewed. The complaint was discussed with the recipient's mother. Sections of the adult resident's record and a copy of his Guardianship Order, dated May 18th, 2006, were reviewed. This order appoints the recipient's parents as co-guardians over his personal care and finances. Relevant hospital policies were also reviewed.

COMPLAINT #1 The Code's Admission and Notification Processes

The complaint stated that the social worker, who completed the Voluntary Application, did not explain the form and rights information. It was reported that the social worker told the recipient that he could be released from the hospital in five to seven days if he signed the voluntary form or that he could be detained for possibly ten days if he refused. Thus, the recipient's mother told him to sign the voluntary form, and he complied. Additionally, it was reported that the recipient was not asked whether or not he wanted someone to be notified of his admission to the hospital or possible rights restrictions.

FINDINGS
Information from record, interviews and program policies

According to the record, the recipient was a direct admission to the hospital's behavioral health unit in the early morning hours on Sunday, April 7th, 2013. In other words, he was not seen in the admitting hospital's emergency department. He had been petitioned for involuntary psychiatric hospitalization on April 6th and refused to sign many of the admission forms upon his transfer to the receiving hospital. A petition and a certificate documented that the recipient had physically attacked a staff person at his residence on the 5th. Then, he had alleged that his belongings were missing and had threatened to harm others and to break into the medicine room at his home on that next night. And, he reportedly continued to make threats after the police were called to his home. The petition and the certificate asserted that the recipient needed immediate hospitalization because he was reasonably expected to engage in physical harm to self or others.

An "Integrated Assessment" report stated that the recipient was oriented to person, place, and time on the admission day. His insight and judgment were poor. He reportedly was agitated because his mother and sister were arguing because he needed to be admitted to the behavioral health unit. He refused to cooperate with the assessment and called the assessment worker a "prostitute." He was provisionally diagnosed with a Mood Disorder and the Attending Psychiatrist was notified. The recipient signed an Application for Voluntary Admission on the admission morning at 8:45 a.m., which was also signed by an Assessment and Referral Counselor who affirmed that rights under this status were admonished and that she gave the recipient or guardian a copy of the form. The voluntary application documented that the recipient did not want anyone to be notified about his hospital admission or whenever his rights were restricted Additionally, the record contained a copy of the "Rights of Individuals Receiving Mental Health and Developmental Disabilities Services" stating that "…you have other rights that concern procedures of admission and discharge. These rights do not appear on these pages. However, you DO have a copy of these procedural rights; if you have admitted yourself voluntarily, look on the back of your voluntary application." The recipient and the assessment worker signed the form indicating that rights were orally explained and given in writing.

The hospital's Associate General Counsel first responded to the complaint by letter stating that the recipient's mother and his sister were with him when he was voluntarily admitted to the unit. His family members reportedly were very upset because he needed to be admitted to the hospital and became increasing loud and disruptive on the unit. The assessment worker tried to explain that he needed to be admitted to the unit because of physical harm and threats to others. The recipient told the assessment worker that he would not sign any forms for sharing his medical information with others and that no one was to be notified of his admission to the hospital. The letter stated that the recipient obeyed his mother's orders and only signed the voluntary application.

At the site visit, the HRA was informed that the hospital's behavioral health unit is managed by a private healthcare company. The Assessment and Referral Counselor, who completed the Voluntary Application, reported that she has been employed by the outside healthcare company since 2010 and that she does about eight mental health assessments on a busy day. According to the assessment worker, the recipient's mother said that she was the legal guardian, but she does not remember seeing a copy of the guardianship order at intake. She said

that the recipient's mother believed that she could sign him into a mental health facility and that she tried to explain that a guardian cannot do this according to the law. She also tried to explain the involuntary and voluntary admission process for psychiatric hospitalization, but his family struggled with understanding them.

On questioning, the assessment worker told the HRA that the recipient had the capacity to sign a voluntary application, although the integrated assessment report previously mentioned stated that his insight was poor. She could not recall whether or not the recipient's mother had reviewed the voluntary application before she told him to sign the document. She said that the recipient did not ask any questions about the voluntary application nor did he "seemed slow to respond." She denied telling the recipient that he could be discharged from the hospital in five to seven days if he signed a voluntary application or that he could be detained for possibly ten days if he refused. She said that his rights including the right to request discharge were explained.

The recipient's mother acknowledged that she was provided with a copy of the Voluntary Application. She disagreed that the recipient was asked about rights concerning notification, although the application and the assessment worker indicated otherwise. She does not remember whether or not the staff person made a copy of the guardianship order during the admission process but she had the document with her at the time.

Ingalls Memorial Hospital "Admission Information" policy allows for recipients to be admitted to its behavioral health unit on a voluntary or involuntary basis. It states that the guardian may not admit a ward to a mental health facility unless the individual has the capacity to consent to such admission and requests this under Article IV of the Mental Health Code. It states that a recipient has the capacity to voluntarily consent if the facility director or designee determines that the individual understands that he or she is being admitted to a mental health facility and may request discharge at any time under Section 5/3-400 of the Code. The hospital policy does not mention the informal type of admission allowed under the Mental Health Code.

CONCLUSION

Sections 5/3-400 of the Mental Health Code states that,

> (a) Any person 16 or older, including a person adjudicated a disabled person may be admitted to a mental health facility as a voluntary recipient for treatment of a mental illness upon filing of an application with the facility director if the facility director determines and documents in the recipient's medical record that the person (1) is clinically suitable for admission as a voluntary recipient and (2) has the capacity to consent to voluntary admission.
>
> (b) A person has the capacity to consent to voluntary admission if the facility director or his or her designee determines that the person is able to understand that: 1) he or she is being admitted to a mental health facility, and, 2) he or she may request discharge at

> any time. The request must be in writing, and discharge is not automatic.

Section 5/3-401 (b) states that,

> Upon admission the right to be discharged shall be communicated orally to the recipient and a copy of the application shall be given to the recipient and to any parent, guardian, relative, attorney, or friend who accompanied the recipient to the facility.

Section 5/2-113 (a) states that,

> Upon admission, the facility shall inquire of the recipient if a spouse, family member or an agency is to be notified of his admission to the facility. If the recipient consents to release of information concerning his admission, the facility shall immediately attempt to make phone contact with at least two designated persons or agencies or by mail within 24 hours.

The complaint stating that the hospital did not explain the voluntary admission application and rights information is unsubstantiated. Although the Authority does not discount the complaint and the recipient's mother account of the incident, we found no written evidence to support this. The Assessment and Referral Counselor told the HRA that she explained the voluntary form to the recipient and to his guardian and that rights information was provided. She also affirmed the same on the voluntary application. She said that the recipient had the capacity to consent to voluntary admission and that he did not want an agency or any person to be notified. No violations of 5/3-400 (a) (b), 5/3-401 (b) and 5/2-113 (a) of the Code or the hospital's policy were found.

SUGGESTION

1. The hospital should consider including the Code's informal admission process in its policy.

<u>COMPLAINTS # 2 and 3 Guardian Involvement and Medication</u>

The complaint stated that the guardian had requested that the recipient's medications should not be changed, but Ritalin and Celexa were discontinued without involving the guardian in the decision. It was reported that the guardian had been considering discontinuing the Ritalin, but the recipient's private psychiatrist said that he should have been weaned off the Celexa. It was also reported that Seroquel was added to his medication regimen and was administered without informed consent and in the absence of an emergency.

<u>Information from record, interviews and program policies</u>

A form for general treatment recorded that the recipient had refused to sign the document. Acetaminophen 325 mg, Senokot or Milk of Magnesia and Maalox as needed were ordered upon his admission to the unit. The admitting nursing note stated that the recipient

complained of having pain in his right thigh. He denied having suicidal or homicidal ideations. He was seen by the Attending Psychiatrist on that same morning.

According to a "Psychiatric Evaluation" report, the recipient was cooperative upon examination. He was described as being oriented to person, place, time and situation. His affect was labile with occasional flight of ideas, and developmental problems were noted. His insight was limited. He told the psychiatrist that he had graduated from high school and was in regular classes. He was diagnosed with Bipolar Affective Disorder, Asperger Disorder versus Autistic Disorder and Moderate Retardation. Celexa 30 mg, Lamictal 200 mg, Xanax 0.25 mg once daily, Lithium 600 mg twice daily, and Ritalin 20 mg three times daily had been prescribed prior to the recipient's hospitalization. Celexa and Ritalin would be discontinued because the medications could increase the recipient's manic and flight of ideas symptoms. Seroquel would be started to help with his racing thoughts. The evaluation report stated that the recipient's guardianship order does not specifically cover mental health issues. However, the HRA notes that the recipient's parental co-guardians were authorized to make all decisions concerning his care and finances by the court. The psychiatrist wrote that he was planning on making a determination about the case after he talked to the recipient's family on that next day.

On the 7th (the admission day), the medication records documented that the benefits, risks, and alternatives to all of the medications above, with the exception of Ritalin, were provided. There was no mention that medication information was shared with the recipient and his guardian(s) on the document. The form also indicated that the right to refuse treatment was explained. It was signed by the Attending Psychiatrist, but the recipient's guardian(s) did not sign the medication consent form. The Medication Administration Records (MARs) documented that Seroquel was discontinued because the guardian had refused the medication. There was no indication that Seroquel was administered as stated in the complaint. The same day, Xanax 0.25 mg, Lamictal 200 mg, Diphenhydramine 25 mg, Docusate Sodium 200 mg, Lithium Carbonate 600 mg and multivitamins were administered as scheduled, and Acetaminophen 325 mg and Norco 5 mg were also given.

On the 7th, the nursing notes detailed that the recipient's mother had called many times, and she told a nurse that she did not want any medication changes. She also requested that the Attending Psychiatrist call her and the recipient's private psychiatrist. According to the note, the psychiatrist told the nurse that he would call the recipient's mother in the morning, but there was no evidence of this found in the record. Another note stated that the recipient's mother was upset because he told her that he had signed forms for his belongings and for the administration of the medication, Norco. His mother told the nurse that she wanted the staff to call her regarding his care. The nurse tried to explain that the recipient had only signed for his belongings. However, his mother told the nurse, "This is why we need to be contacted/talked to and not him. Please document that." The record contained a "Patient Belongings Inventory" form signed by the recipient on the admission day, but there were no signed medication consent forms found in the chart reviewed.

On the 8th, the MARs reflected that the same dosages of Diphenhydramine, Lithium Carbonate, Norco and multivitamins were administered one time. A nursing note stated that the recipient was compliant with medication and that medication education had already been done.

Also, the nursing note recorded that the recipient's treatment plan included updating his mother about his behaviors and x-raying his right leg. He was seen by the Attending Psychiatrist and discharge orders were given. An x-ray of his right leg was done. The recipient was discharged to his mother on that afternoon. He reportedly was given medication and was instructed to follow up with his private psychiatrist. Although the nursing notes above were dated April 7th, 2013, we noticed that the recipient was actually discharged from the hospital on the 8th.

According to the hospital's letter, the Attending Psychiatrist had considered changing the recipient's medications, and he had talked to the recipient, but not the guardian about possibly administering Celexa, Lamictal and Xanax, and adding Seroquel to his medication regimen. The letter and other documentation initially provided by the hospital referenced that Acetaminophen, Lamictal, Diphenhydramine, Norco, Docusate Sodium, Lithium Carbonate and multivitamins were administered on the 7th. Diphenhydramine, Lithium, Norco and multivitamins were given on the 8th. According to the hospital, these medications were administered as requested by his guardian and had been previously prescribed with the exception of Norco. On the second admission day, the psychiatrist reportedly made a determination that the recipient would be discharged because his guardian would not allow him to change any of his medications and treat him.

At the site visit, the Attending Psychiatrist said that he had first examined the recipient on the 7th at 2:00 p.m. He said that Celexa and Ritalin were discontinued because the medications can cause agitation. Contrary to the complaint, the psychiatrist said that Celexa can be abruptly discontinued without side effects. He said that the recipient's mother had refused to consent to the administration of Seroquel when he met with her about his care. However, we found no documentation of the meeting in the record. The hospital's Associate General Counsel said that there was some confusion about the guardianship order as reflected in psychiatric evaluation report. The psychiatrist explained that he initially believed that a legal guardian could only make medical decisions for the person based on information provided by a social worker. The hospital's counsel and the psychiatrist asserted that the recipient's mother was very involved in treatment decisions.

According to the hospital's "Psychotropic Medication Education" policy, education regarding the use of psychotropic medications will be provided prior to administering the medications. This information also must be provided prior to the administration of any changes to the medication. Psychotropic medication may include anti-psychotic, anti-depressant, anti-anxiety and mood stabilizing drugs; and, anti-cholinergic medications are exempt from this policy. The patient, guardian and/or legal representative shall be informed in a language that they can understand about the need for the medication, side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment. The patient, guardian and/or legal representative is considered as being competent if the person has sufficient capacity to generally understand the nature of the patient's condition, the proposed treatment, the risks, and the alternatives to the treatment.

CONCLUSION

According to Section 5/2-102 of the Mental Health Code,

> (a) All recipients of services shall be provided with adequate and humane care and services, 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, the recipients' substitute decision maker, if any, or any other individual designated in writing by the recipient.
>
> (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 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 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 Section 5/2-107 ….

Section 5/2-107 states that,

> An adult recipient of services…must be informed of the recipient's right to refuse 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 harm to the recipient or others and no less restrictive alternative is available …. psychotropic medication or electroconvulsive therapy may be given under this Section for up to 24 hours only if the circumstances leading up to the need for emergency treatment are set forth in writing in the recipient's record.

The Illinois Probate Act Section 5/11a-23 states,

> Every health care provider and other person (reliant) has the right to rely on any decision or direction made by the guardian … as though the decision or direction had been made or given by the ward.

The record documented that the hospital was informed that the recipient is under guardianship on the admission day. Whether or not the hospital was provided with a copy of the document during the admission process is unclear. Initially, the psychiatrist believed that the guardianship order did not include mental health issues, which might explain the hospital's letter stating that he had discussed medication with the recipient, but the guardian(s) were not

mentioned. Later, the hospital's Associate General Counsel reported that there was some confusion initially about the guardianship order. A medication form documented that Celexa, Lamictal, Xanax, Lithium and Seroquel were recommended, but there is no signature on the form indicating that the guardian was in agreement to the administration of the psychotropic medications recommended. The medication records documented that Xanax, Lamictal, Lithium, Diphenhydramine, Docusate Sodium, Acetaminophen, Norco and multivitamins were administered on the 7th and the 8th. The hospital told the HRA that Lamictal, Lithium, Diphenhydramine, Docusate Sodium, Acetaminophen, Norco and multivitamins were given according to the guardian's wishes and had been previously prescribed with the exception of Norco.

According to the complaint and a nursing note, the guardian did not want any medication changes, which implies that she was in agreement to the psychotropic medications recommended above with the exception of Seroquel. The record indicated that Seroquel was discontinued and that the medication was not administered. The psychiatrist said that Celexa and Ritalin were discontinued because the medications can result in agitation. We note that a physician determines what medication is appropriate or contraindicated in a patient's care, but this information should be discussed with the patient and guardian. The psychiatrist told the HRA that he did meet with the recipient's mother concerning treatment decisions, but there was no documented reference of contact between them at least about medications. Also, the recipient's mother said that she never received a call from the psychiatrist or a staff person, although she provided her contact information and a left message for the psychiatrist to call. Yet, the hospital's attorney, the psychiatrist and a nursing note asserted that the guardian was involved in the recipient's care during his stay at the hospital. By documentation, medication information was shared with the recipient, but the record does not reflect that the information was provided orally and in writing and that the same information was shared with the guardian.

It is the intent of the law that a recipient's guardian shall be involved in any decisions that directly affect the well-being of the recipient. The complaint stating that the hospital did not involve the guardian in treatment planning, administered psychotropic medication without informed consent and in the absence of an emergency is substantiated only in regard to the guardian's involvement in treatment planning. The hospital violates the Sections 5/2-102 (a) (a-5) of the Code, the Illinois Probate Act Section 5/11a-23 and program policy that require informed consent for psychotropic medication. We found no clear evidence that Seroquel was administered as stated in the complaint. No clear violations of Section 5/2-107 (a) were found.

RECOMMENDATIONS

1. Ingalls Memorial Hospital shall obtain guardians' consent prior to administering scheduled and non-emergent psychotropic medications pursuant to Section 5/2-102 of the Code, the Illinois Probate Act, Section 5/11a-23, and program policy.

2. Ensure that written medication information is provided to recipients and guardians. Ensure discussions regarding medication changes and treatment include guardians.

3. Review program policies and consent laws regarding substitute decision making with all appropriate staff. Under the Probate Act of 1975, if a court adjudges a person to be disabled, as in this resident's case, a guardian of his person is appointed because it was found by clear and convincing evidence that the resident lacked sufficient understanding or capacity to make or communicate responsible decisions concerning personal care (755 ILCS 5/11a-3).

COMPLAINT # 4 Visitation

The complaint stated that the recipient was denied visitation with an attorney family member on the admission day. It was reported that family member had called the unit and told a staff person that he was an attorney wanting to visit the recipient.

Information from record, interviews and program policies

On Sunday, April 7th (the admission day), the record indicated that the recipient requested that no one should be notified about his admission to the hospital during the intake process. Later, on that same day, he signed consent forms to release his medical information to his mother, his private psychiatrist, and the attorney/family member identified in the complaint. Although the family member in question is reportedly an attorney, the HRA noticed that the attorney/client relationship box was not checked on the form. The record lacked the indication that the attorney/family member was denied visitation or that he had talked to a staff person on the unit. However, the Psychiatric Summary Report and the hospital's letter stated that the recipient's mother was restricted from visiting because of her behavior on the unit and the physician's concerns about the intimidating effect on the patient's mental stability. The recipient's family members, especially his mother, reportedly were belligerent, disruptive, threatening to call lawyers, and to sue everyone. A physician's order, dated April 7th, 2013, documented "Visitation/Restriction Today," but there was no justification for the restriction found on the form. At 11:00 a.m., a corresponding notice stated that rights were restricted due to "[hindrance] to patient care," but the specific right denied was not checked on the form.

The Medical Director told the HRA that sometimes recipients change their minds about notifying someone about their hospital status and sign a release of information after they are placed on the behavioral health unit. Sometimes, the staff might tell a recipient that someone has called concerning the individual if no authorization to release information has been signed. Although the authorization form does not require the time of completion, the hospital's Associate General Counsel said that the recipient must have signed the releases on the 7th after 3:00 p.m. She said that the staff person, who completed the forms, started work at 3:00 p.m. and that visiting hours end on Sunday at 3:00 p.m. The Attending Psychiatrist said that the restriction to keep the recipient's mother from visiting on the 7th was reasonable based on staff's report. He said that visits are rarely restricted and that patients are allowed to have visitors seven days a week. Additionally, the psychiatrist said that the recipient's family was confrontational, but they were not loud when he met with them after the visitation restriction order was written.

Ingalls Memorial Hospital "Telephone Information" policy states that the hospital recognizes that family members and friends are usually anxious to obtain information regarding patients. Therefore, the hospital's behavioral health policy is to provide information about a

patient's status daily to individuals authorized by the patient, parent or guardian. It states that an adult patient must complete the "Visiting and Information Authorization" form before information will be provided to anyone who calls the unit concerning the individual. The caller will be informed about confidentiality without acknowledging the presence of a patient on the unit if the individual does not complete the form. If the patient refuses to complete the form at intake, the individual will be informed that he or she can complete the document at any time during their hospitalization.

According to the hospital's "Behavioral Health Services General Information" notice, visiting hours are from 5:00 p.m. to 6:00 p.m. on Tuesday and Thursday, and 2:00 p.m. to 3:00 p.m. on Saturday and Sunday, and 4:00 p.m. to 6:00 p.m. on Holidays. It states that all visitors must know the patient's phone/visitation code. Visitors who are disruptive or intoxicated will not be allowed on the unit. The notice also includes the hours during the day that patients can make and receive phone calls.

The hospital's "Patient Rights; Denial of" policy states that, upon admission, patients will be asked whether someone and/or agency should be notified if rights are restricted. This information should be documented on the voluntary application for adult patients. In the event that rights are denied by the patient's physician, according to state regulations, the notation shall include as follows: 1) the date and time the right was denied, 2) the specific right denied, 3) good cause for denial of right, and, 4) the physician's signature. The policy states that good causes for restricting rights are as follows: 1 and 2) the specific right would be injurious to the patient if allowed to exercise or there was evidence that rights of others would be seriously infringed upon, 3) the facility would suffer serious damages if not denied, and, 4) there is no lesser restrictive means of protecting the interest specified above. The staff are directed to inquire whether or not the patient wants his or her initial notification request to be followed at the time of the restriction and to document the response in a progress note.

CONCLUSION

Sections 5/2-103 of the Code states that,

> (c) Unimpeded, private and uncensored communication by mail, telephone and visitation may be reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission.
>
> (d) No facility shall prevent any attorney who represents a recipient or who has been requested to do so by any relative or any family member of the recipient, from visiting the recipient during normal business hours, unless the recipient refuses to meet with the attorney.

Section 5/2-200 states that,

> Upon commencement of services, or as soon thereafter as the condition of the recipient permits, every adult recipient, as well as the recipient's guardian or substitute decision maker, and every recipient 12 year of age or older and the parent or guardian of a minor or person under guardianship shall be informed orally and in writing of the right to designate, a person or agency to receive notice under Section 2-201 or to direct that no information about the recipient be disclosed to any person or agency.

Section 5/2-201states that,

> Whenever any rights of a recipient of services are restricted, a notice of the restriction shall be promptly given to the recipient and to any person or agency she designates including the Guardianship and Advocacy Commission.

The Authority cannot substantiate the complaint stating that the recipient was denied visitation with an attorney family member on the admission day. We found no evidence of this in the record or clear violations of the Sections above. However, the investigation revealed that the recipient's mother was restricted from visiting on the 7th because of disruptive behavior and intimidating behavior and threatening to sue the staff. Although the hospital suggests that the restriction meets the requirements of intimidation under Section 5/2-103 (c) of the Code, the physician's order lacked an explanation of the good cause for the restriction as required by program policy. The notice also lacked the specific right denied and the record lacked documentation that the recipient was asked again whether any agency or person should be notified of the restriction as required by the hospital's policy.

RECOMMENDATION

1. When a restriction is initiated, the staff should follow the hospital policy and document the good cause on the physician order, and the specific right denied on the notice; the recipient shall be asked again about notification and the response should be documented in the record.