
**FOR IMMEDIATE RELEASE**

# HUMAN RIGHTS AUTHORITY- CHICAGO REGION

## REPORT #14-030-9012

## RIVEREDGE HOSPITAL

Case Summary: The HRA substantiated the complaint that the facility did not follow Mental Health Code requirements in not providing guardians the dosage information on their ward's medications and changing medications and dosages without notifying guardians. The complaint that staff behaved inappropriately was also substantiated. The HRA did not substantiate the complaint that the recipient was locked in his room because other recipients had problems on the unit. The facility's response is included with the report.

## INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Riveredge Hospital. It was alleged that the facility did not follow Mental Health Code requirements in not providing guardians dosage information on their ward's medication and changing medications and dosages without notifying guardians, locking recipients in their rooms because other recipients had problems on the unit, and staff behaving improperly. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Hospital Licensing Act (210 ILCS 85).

Riveredge is a 210-bed private psychiatric hospital located in Forest Park, Illinois.

To review this complaint, the HRA conducted a site visit and interviewed the Chief Nursing/Compliance Officer, a Registered Nurse and attorney for the hospital. Relevant program policies were reviewed as were sections of the recipient's record upon written consent of the guardians. Guardian letters of office were obtained from the parents/guardians.

## COMPLAINT SUMMARY

The complaint alleges that guardians were asked to sign medication consents for their 13 year old that had no dosage range and the dosage was changed without the input or the informed consent of the guardians. Also, youth were reportedly placed on "lockdown", locked in their rooms for extended periods of time because other patients on the unit had behavioral problems. Additionally, staff on the unit allegedly behaved inappropriately: pushing a patient, hitting a patient and then saying they were just "joking" and calling a patient "retarded."

## FINDINGS

The record shows that the recipient was admitted to Riveredge Hospital on 10/07/13. His Discharge Summary outlines his presenting problems: "He stated that many times he feels like he wants to be with his biological mom and biological father; they both died. His biological father died in 2001 and his biological mother died in 2009; both died with overdose on drugs. Right now, he lives with his biological mom's sister, his aunt, who adopted him. She is going through a divorce with her husband. There are a lot of financial stressors and emotional stressors and increased tension and agitation. He states he was very close to his aunt and right now they are arguing with each other every day. He has problems with sleep, but he takes melatonin since he started on medication [Ritalin] for his attention deficit hyperactivity disorder symptoms." His Hospital Course section indicates that "With the consent from the guardian, Wellbutrin SR was begun, which was monitored, titrated, and adjusted during his hospital stay." The recipient was given a final diagnosis of Attention Deficit- Hyperactive disorder; Oppositional Defiant Disorder, and Bipolar Disorder NOS.

The recipient's Discharge Summary includes a narrative describing his medication while hospitalized. He was seen by his physician on 10/09/13 and 10/10/13 after experiencing some suicidal thoughts. His Wellbutrin was continued and his Ritalin was titrated upward. On 10/11/13 the recipient had a family session and he later developed a rash. All of his medications were stopped and he was given Benadryl for his rash. On 10/17/13 the recipient became agitated and received an emergency administration of Zyprexa for his agitation and he continued on Benadryl. On 10/21/13 the recipient was seen by his therapist and he was very hyperactive. In response to his increased hyperactivity Ritalin was incorporated back into his medication regimen. On 10/23/13 the recipient's Ritalin was increased and with his guardian's consent Risperdal was added to his medications, and it was increased and adjusted throughout his stay. The recipient had family therapy sessions on 10/11, 10/18, 10/23 and 10/28. The guardian was present telephonically for two staffing conferences on 10/10 and 10/22. Although the record shows that the guardian gave informed consent for medications, it does not indicate that the guardian was consulted or notified when the medications were titrated.

The record contains the Patient Consent for Psychotropic Medications. It indicates that on 10/25/13 the guardian gave signed informed consent to Risperdal 0.5 mg. Zyprexa is listed below it but the guardian’s signature is not included on this medication. The form contains a section which lists medications for which there was verbal informed consent given, and this section includes the guardian’s verbal consent for Ritalin ER, Wellbutrin SR, Melatonin and Ritalin, with no dosages given. In the comments section a notation states, “Mother will think about consenting Risperdal.” It is dated 10/19/13. There is no indication from the record that the guardian objected to the recipient’s medications.

The record contains progress notes from the recipient's hospitalization. These indicate that the recipient was placed in the quiet room to sleep because he and his roommate were loud and horseplaying (10/8, 10/15), that he provoked peers and tested limits (10/10, 10/12, 10/15, 10/16, 10/17, 10/21, 10/22, 10/23, 10/24, 10/27), was hyperactive (10/11, 10/19, 10/21, 10/23, 10/24, 10/25), playful (10/11,), fed the negative behaviors of peers (10/13, 10/18, 10/19, 10/23), sought negative attention (10/17, 10/25), was involved in threats of fighting with peers (10/17/), and displayed poor boundaries (10/19). The number of times in which he was horseplaying are too numerous to list. The record shows that throughout his stay the recipient required redirection from staff numerous times for each behavioral event as he was unable to self regulate his actions and impulses. The record indicates that on 10/05 the recipient was asked to go to the music room because he was screaming and cursing, and on 10/08 he was also sent to the quiet room due to horseplay with peers. The record does not indicate that the recipient was placed in his room for any length of time except to sleep and there is no indication of a negative interaction with staff, however there is a note entered on 10/25/13 in the progress notes that the guardian had contacted the Guardianship and Advocacy Commission "due to the patient's complaint of staff mistreating patient. Pt.'s mother reported that she accepts need for patient to be monitored while starting medication. Writer assured mother that unit manager would be notified of her concerns. Contacted unit manager who agreed to communicate these concerns to attending psychiatrist." It is not clear from this entry or from other notes if this entry refers to the behavior of staff as described in the complaint. There is no further notation on actions taken by the unit manager.

Hospital Response

The CCO was interviewed about the guardian's concern regarding consent for medications with no dosage range. She indicated that during the recipient's stay at Riveredge the guardian gave verbal consent for all medications and written consent for one medication (Ridperdal). She indicated that the Riveredge consent form does not indicate a dosage range. Further, the Mental Health Code does not require dosage as one of the requirements of informed consent. She stated that it is expected that the physician/designee provides the necessary information for a recipient and/or guardian to consent for medication and written medication binders are available on every unit. Also, the guardian actively participated in the treatment planning as evidenced by her presence at multiple family sessions as well as telephonically for staff conferences where the physician was present.

The CCO was interviewed about the complaint that medication regimens were changed without the knowledge of the guardian. She stated that the guardian consented to all medications prior to their administration. Additionally, the guardian was actively involved in the treatment planning process during family sessions and staffing. Although there were numerous medication dose revisions during the course of the recipient's hospitalization, there is no documentation to indicate if the guardian had been contacted related to these changes, however the guardian's consent offers a blanket consent to the medication. Generally speaking, the Chief Compliance Officer did not feel it was practical to obtain guardian consent each time a medication was changed, however she indicated that the Consent form will be taken to the Medical Executive Committee for discussion of the inclusion of "dose change" language.

The CCO was interviewed about the complaint that the youth were locked in their rooms for extended periods of time. She responded that there were two days in which the patient had experienced a medication reaction (rash) and had been treated with Benadryl, which made him sleepy. For the remainder of his stay, the patient followed unit schedules, attending groups daily. She noted that the record shows several times in which the recipient was redirected to his room due to disruptive behavior during group, however he then returned to group. The unit has a daily quiet time for one hour, during which the recipients decompress and process their treatment. She noted that the recipients are never "locked" in their rooms. The doors remain open and staff monitor the recipients during these times. Also, recipients are given snacks and activities during quiet time.

The CCO was interviewed about the complaint that staff behaved inappropriately with the youth. The Unit Manager stated that the guardian had complained of staff horseplaying with the recipients and being too familiar with the recipients in their interactions, however there was no mention of name calling or any other harmful behavior. She indicated that during the recipient's 21- day stay, the documentation shows that the recipient demonstrated poor boundaries, provoked his peers, and it was repeatedly noted that he was involved in horseplay. She stated that it is impossible to know if some of these "playful" interactions were misconstrued by the patient or guardian. When the guardian expressed dissatisfaction with staff these concerns were directed to the Unit Manager. The Unit Manager addressed the issues immediately when they were raised by the guardian. The staff involved were questioned and re-educated on the appropriateness of therapeutic interactions and boundaries being maintained at all times. The Chief Compliance Officer indicated that the guardian had been satisfied with the discussion and the subsequent action. The complaint was not submitted to the Illinois Department of Public Health.

## STATUTES

The Mental Health Code states, "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 (405 ILCS 5/2-102a)."

The Mental Health Code mandates that 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 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 medication, 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 generally accepted mental health services. If these services include psychotropic medication, the

physician must advise the recipient, in writing, of the side effects, risks and benefits of the treatment as well as alternatives to the extent that it can be understood by the recipient. The physician must also determine and state in writing whether the recipient has the capacity to make a reasoned decision about his treatment. If the recipient lacks the capacity to make a reasoned decision about his treatment, the treatment can only be administered to prevent the recipient from causing serious and imminent physical harm to himself or others or upon a court order (2-107, 2-107.1). The physician must also advise the guardian in writing of the side effects, risks and benefits of treatment as well as alternatives to the treatment. (405 ILCS 5/2-102).

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)."

The Hospital Licensing Act (210 ILCS 85/9.6) sets mandatory standards for hospitals' response to alleged abuse. "Abuse" is defined as any physical or mental injury or sexual abuse intentionally inflicted by a hospital employee on a patient at the hospital. "Mental injury" means intentionally caused emotional distress in a patient from words or gestures that would be considered by a reasonable person to be humiliating, harassing, or threatening and which causes observable and substantial impairment. The Act prohibits any act of abuse by any hospital staff (a), and mandates that any staff member who has reasonable cause to believe that any patient with whom they have direct contact has been subjected to abuse in the hospital must promptly report or cause a report to be made to a designated hospital administrator responsible for providing these reports to the Illinois Department of Public Health (IDPH). Additionally the Act outlines the mandatory response elements:

"Retaliation against a person who lawfully and in good faith makes a report under this Section is prohibited.

Upon receiving a report under subsection (b) of this Section, the hospital shall submit the report to the Department within 24 hours of obtaining such report. In the event that the hospital receives multiple reports involving a single alleged instance of abuse, the hospital shall submit one report to the Department.

Upon receiving a report under this Section, the hospital shall promptly conduct an internal review to ensure the alleged victim's safety. Measures to protect the alleged victim shall be taken as deemed necessary by the hospital's administrator and may include, but are not limited to, removing suspected violators from further patient contact during the hospital's internal review

All internal hospital reviews shall be conducted by a designated hospital employee or agent who is qualified to detect abuse and is not involved in the alleged victim's treatment. All internal review findings must be documented and filed according to hospital procedures and shall be made available to the Department upon request.

Any other person may make a report of patient abuse to the Department if that person has reasonable cause to believe that a patient has been abused in the hospital.

The report required under this Section shall include: the name of the patient; the name and address of the hospital treating the patient; the age of the patient; the nature of the patient's condition; including any evidence of previous injuries or disabilities, and any other information that the reporter believes might be helpful in establishing the cause of the reported abuse and the identity of the person believed to have caused the abuse.

Except for willful or wanton misconduct, any individual, person, institution, or agency participating in good faith in the making of a report under this Section, or in the investigation of such a report or in making a disclosure of information concerning reports of abuse under this Section, shall have immunity from any liability, whether civil, professional, or criminal, that otherwise might result by reason of such actions. For the purpose of any proceedings, whether civil, professional, or criminal, the good faith of any persons required to report cases of suspected abuse under this Section or who disclose information concerning reports of abuse in compliance with this Section, shall be presumed.

No administrator, agent, or employee of a hospital shall adopt or employ practices or procedures designed to discourage good faith reporting of patient abuse under this Section.

Every hospital shall ensure that all new and existing employees are trained in the detection and reporting of abuse of patients and retrained at least every 2 years thereafter.

## HOSPITAL POLICY

Riveredge provided the hospital policy and procedure for Informed Consent for Psychotropic Medication (No. 704.12). It states, “Patients who are receiving medications and when appropriate, parent/guardian shall be given a clear, concise explanation of the proposed medications, the indications, benefits, risks, alternative treatment options and right to refuse medication. Patients/guardians are to provide informed consent for psychotropic medications.”

The policy directs the physician and/or nurse to discuss with the patient and/or parent/guardian the proposed medications and give them information on psychotropic medication providing medication teaching on specific medications. The physician then writes the order for the medication and the physician/nurse signs the Patient Consent for Psychotropic Medications form. The physician/nurse are to ensure that the patient/parent and/or guardian sign the consent prior to medication administration.

Riveredge provided the hospital policy and procedure for Informed Consent- Pediatrics and Adolescents (No. 702.05). It indicates that when verbal consent is necessary to provide treatment, the physician will write the order and the nurse "Notifies the parent/legal guardian of the M.D.'s order and requests verbal consent via telephone to administer and titrate medications per Physician's Orders."

Riveredge provided the hospital policy for Patient Neglect and Abuse (No. 600.48). It states, "All employees are expected to treat our patients in a courteous, dignified manner. A professional disposition is required at all times. Neglect and/or abuse of any Hospital patient will not be tolerated and employees guilty of such behavior will be subject to serious disciplinary measures, which can include termination. Neglect and Abuse include, but may not be limited to:

- Unnecessary or unreasonable force
- Striking a patient
- Use of obsene, violent, and/or profane language
- Willful failure to respond to a patient's needs
- Failure to provide necessary patient care
- Infliction of physical or mental abuse
- Causing another to mistreat a patient

The action steps required for this allegation include a thorough investigation of the incident by the Department Manager and documentation of all statements made the patient, witnesses, and other appropriate staff. The CEO then reviews the results of the investigation and determines if and what disciplinary action must be taken.

Riveredge provided a form, Riveredge Hospital Guidelines- Therapeutic Boundaries, which outlines the responsibilities of employees in their interactions with patients. It states, "Staff members are to render care in a manner that respects the personal dignity and rights of each patient. Any form of patient abuse/neglect will not be tolerated and staff members are to support facility policy and procedures in this regard." The form lists 10 directives for staff interactions and the form is then signed by employees.

## CONCLUSION

The Mental Health Code states that once services begin, guardians must be included in all facets of care. The Probate Act goes further to state that guardians shall provide for their ward's support, care, comfort, health, and maintenance. And Riveredge policy as well states that after physician's have ordered medication for adolescents, the nurse "notifies the parent/legal guardian of the M.D.'s order and requests verbal consent via telephone to administer and titrate medications per Physician's Orders." In this case, changes were made to the recipient's medications, however, there is no indication that the parent/guardian was informed beforehand or notified afterwards. Staff indicates that informed consent is a "blanket consent" and that it is impractical to contact parents/guardians for all changes. The HRA disagrees. Dosage alters the effect of medication to such an extent that a medication can easily progress from therapeutic to debilitating. Parents/guardians, both as caretakers and members of the treatment team, are in a perfect position to observe the behavioral changes that medication causes in their children/wards, and these recipients should be allowed the benefit of their valuable advocacy. The HRA

substantiates the complaint that Riveredge did not follow Mental Health Code requirements in not providing the guardian dosage information on her ward's medication and changed medications and dosages without notifying the guardian.

The record does not show that the recipient was ever locked in his room or that he remained in his room for extended periods of time. The HRA does not substantiate the complaint that recipient was locked in his room because other recipients had problems on the unit.

The complaint received by the HRA included the allegations that Riveredge staff had behaved inappropriately by pushing patients, hitting patients and then saying they were just "joking" and calling a patient "retarded." These allegations, if true, do not comply with the Mental Health Code mandate for humane care and would constitute abuse and mental injury according to the Hospital Licensing Act, and should have been reported to the Illinois Department of Public Health. Hospital staff, however, confirm that the guardian reported horseplay and playful interaction that was "too familiar", and no name calling or other harm was mentioned. Staff were then interviewed and re-educated, with no report to IDPH. The HRA reminds staff that reports are made of "allegations" of abuse and then it is the investigation which determines whether or not abuse occurred, and it is always best to report the complaint and follow the course of the investigation. Either way, the HRA feels that the record and staff report indicate that inappropriate behavior occurred on the part of staff. The HRA substantiates the complaint that Riveredge staff behaved improperly with recipients.

## RECOMMENDATIONS

1. Train staff to include the guardian in all facets of the recipient's care and ensure that they are given the information necessary to provide for the care and health of their ward. Ensure that parents/guardians are given written information on the side effects, risks and benefits of the treatment as well as alternatives, and notify them of proposed changes to the medication regimen.

2. Riveredge has an excellent training tool, *Riveredge Hospital Guidelines- Therapeutic Boundaries*, which sets forth strict rules for the interactions between staff and recipients, and it is signed by all employees. Review with staff these guidelines and the Hospital Licensing Act mandates (above) relating to the reports of abuse.

**RESPONSE**

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

Riveredge Hospital

June 19, 2014

Nicole Erickson, HRA Chairperson
Guardianship and Advocacy Commission
1200 S. 1st Ave. Box 7009
Hines, Illinois 60141

Re: #14-030-9012

Dear Ms. Erickson:

This letter is in response to the Human Rights Authority findings for the investigation identified above.

Preparation and submission of this Plan of Correction does not constitute an admission of or agreement by the hospital with the alleged or conclusions set out in the Conclusion and Recommendation sections of the HRA Response Report. The Hospital submits this Plan of Correction in accordance with regulations and the Plan of Correction documents the actions taken by the hospital to address the cited deficiencies.

Recommendations

1. Include guardian in all facets of recipient's care
    a. Issue discussed in Medical Staff Executive Committee and members encouraged to contact guardians for inclusion in care decisions.
    b. Revised the Informed Consent for Psychotropic Medication form to include language related to medication dosage changes.

2. Therapeutic boundary training
    a. Therapeutic boundaries training and acknowledgement form will be reviewed and signed by all staff during annual competency training.

Riveredge Hospital and their medical staff are concerned to hear of any potential quality issues and strive to provide the best and safest environment for our patients to receive care. We value the input from our patients and families and welcome feedback to improve our patient care.

Thank you for allowing us the opportunity to provide information regarding the actions taken in response to allegations related to care. Please feel free to contact me if you have any questions. I can be reached at (708)209-4185.

Sincerely,

Sheila M. Orr, RN, BSN, JD
Chief Compliance/Nursing Officer
Riveredge Hospital