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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 14-030-9013
Riveredge Hospital

Case summary: The HRA substantiated the complaints that the facility did not follow Mental Health Code requirements when the facility did not follow the guardian's directives for the ward's medications, when the facility discontinued all the recipient's medications for three days and did not inform the guardian, and when the physician would not return the guardians' phone calls. The HRA did not substantiate the complaints that a guardian was not allowed to be present for her ward's admission into the facility, that the facility restricted the recipient's visitation for no adequate reason, and that the recipient felt that he was pressured to consent to medication. The facility 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 (Riveredge). It was alleged that the facility did not follow Mental Health Code requirements when a guardian was not allowed to be present for her ward's admission into the facility, when the facility did not follow the guardian's directives for the ward's medications, the facility restricted the recipient's visitation for no reason, the recipient felt that he was pressured to sign consents for medication, the facility discontinued all the recipients' medication for three days and did not inform the guardian, and the physician would not return the guardians' phone calls. If substantiated, these would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Illinois Probate Act of 1975 (755 ILCS 5).

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

To review these complaints, the HRA conducted a site visit and interviewed the Chief Nursing/Compliance Officer, a Registered Nurse and attorney for the hospital. Relevant hospital policies were reviewed, and records were obtained with the consent of the guardian. Guardian letters of office were obtained from the parents/guardians.

COMPLAINT SUMMARY

The recipient was seen at a hospital emergency department from where he was transferred to Riveredge because of bed availability. The allegations are listed chronologically.

Day 1- Tuesday, October 22nd. In advance of the recipient being transferred to Riveredge, the guardian called Riveredge Intake and gave a list of the recipient's current medications, the ADR (Adverse Drug Reaction) list (Risperdal, Geodon and Abilify) as well as the recipient's other complex history and faxed the guardianship letter of office. The guardian then called again to verify receipt of all documents. The guardian asked to be present for the recipient's admission, however she was allegedly denied this request. The guardian then asked to visit with the recipient the night of his admission or the next night and was denied visitation- she was told that visitation is Tuesday and Thursday nights from 7-8 p.m. and Saturday and Sunday from 1-3 p.m. She was told that visitation on any non-scheduled night would require a physician's approval. The recipient called his mother and told her he was scared, however she was prevented from seeing him.

Day 2- Wednesday, October 23rd. The guardian called the physician several times; left messages, but received no call-back. She spoke with her son's personal therapist and expressed some worry about her son's safety. At 9:00 p.m. the recipient called his mother and said his medications were changed. The guardian called Riveredge, where the nurse confirmed that the physician had ordered Depakote and Risperdal. The guardian then told the nurse not to administer these medications because the recipient has a history of severe dystonic reaction to Risperdal which had caused him a prolonged hospitalization in the past. The guardian again contacted the recipient's personal therapist, who stated he would call Riveredge and he also wrote a letter to the facility regarding the recipient's medication concerns and the request to have him transferred to another hospital as soon as possible. This letter was faxed on the following day.

Day 3- Thursday, October 24th. The Riveredge physician met with the recipient's guardian and he said he did not know that the recipient had a legal guardian- he had not checked the legal section of the clinical record. At the meeting, the guardian and the recipient's physician discussed the recipient's medications at length. The physician felt very strongly that the recipient would benefit from taking Depakote, so the guardian reluctantly agreed to a very low dose (500 mg at bedtime). It was agreed at this meeting that all changes in medication would be agreed to by the guardian before they were administered to the recipient. That night the guardians visited their son. He was cold, scared, jittery, and shaking and he told his guardians he had not received any medication since his admission. This was confirmed by his nurse.

Day 6- Sunday, October 27th. The recipient called his parents and stated that the physician had told him not to take his sleeping aid before bed because the night before he had left his room, and holding the walls of the unit, he had stumbled down the hall, finally falling to the floor, where two nurses had to lift him back to his bed. The guardians were not informed of this incident. The recipient also stated that he felt pressured by the physician to consent to medications.

Day 8- Tuesday, October 29th. The nurse at Riveredge told the guardian that the physician had doubled the dose of her son's Depakote. The guardian had not been informed of this change.

FINDINGS

The record shows that the recipient was admitted voluntarily to Riveredge at 4:57 p.m. on 10/22/13. The recipient's Presenting Problem is described in his Discharge Summary and it states, "The patient is a 21- year old Caucasian male with a history of bipolar disorder and ADHD. He states he tried to choke his 14- year old sister to sleep, not to kill her. He admits, however, he stopped choking her only when his friend intervened, and that he might have killed her had there not been someone to stop him. He said he was angry at her for something childish, which apparently had something to do with a bicycle light. The patient himself states he does not know what overcame him, such that he became so violent. He seemed surprised at his own aggression. He said he had been compliant with medications including Concerta, Focalin, Seroquel, and Tenex. The patient himself does not feel the medication is particularly efficacious. We did speak with his mother, however, who states he has serious reactions to atypicals. Seroquel had been effective for him, and when he went off the medication, he became completely unmanageable. She says the same thing is true of the stimulant medication that he is on, and that efforts in the past to make radical changes in the medication have brought disaster, and many months of trying to reestablish a baseline. The patient's behavior is too dangerous for outpatient treatment." The recipient's diagnosis is listed as Bipolar Disorder, mixed, and Attention Deficit Hyperactivity Disorder.

The record contains no indication that the guardian requested and/or was denied visitation during the admission process. Also, there is no record of the phone calls made to the physician or any discussion with the physician outside of the family session held on 10/24.

The record states that the nurse completed a Medication Reconciliation of the recipient's previously scheduled medications on 10/22 at 6:45 p.m. at which time his regularly scheduled medication was stopped. The record then shows that the recipient was seen by a psychiatrist on 10/23/13 at 4:00 p.m. when orders were placed for Ambien, Thorazine, Depakote, Tenex, Focalin, and Seroquel. The Medication Administration Record (MAR) shows that the recipient received none of his regularly scheduled medication or newly prescribed medication until after the guardian spoke with the physician and gave her consent on 10/24/13 at 8:00 p.m. The record contains the Patient Consent for Psychotropic Medication form. It indicates that the patient has a legal guardian and that on 10/24/13 the guardian gave consent to the following medications: Ambien, Thorazine, Depakote, Seroquel, Tenex, Focalin, and Concerta. No dosages are given and the form is not signed by the guardian, indicating phone consent. At this time the Risperdal was removed from the regimen due to lack of guardian consent. The (MAR) is included in the record and it indicates that the recipient's Depakote dose was increased to 1000 mg on 10/28/13- the only administration of this level of Depakote. The MAR shows no other revisions of the recipient's medications.

The record contains a letter written by the recipient's guardians on 10/23/13 and given to Riveredge staff that day. It states,

To Riveredge Physicians and Staff:

As [the recipient's] parents and <u>legal guardians</u>, we insist upon prior notification of *any* [all emphasis placed by author], medication change and withhold all consent until consulted. In spite of [the recipient's] documented **ADR to Risperdal, Geodon, and Abilify**, [the recipient] was

prescribed Risperdal and Depakote on 10/23/13 without our consultation. In light of [the recipient's] extensive medication history and documented episodes of **ADR to Risperdal, Geodon, and Abilify**, which resulted in dystonic reactions, catastrophic deterioration, neurologic sequelae and long term hospitalization, we are best qualified to discuss his medication history, potential medication changes and the prevention of irreversible sequelae…." This letter also requests a transfer of the recipient to another hospital as soon as possible.

Physician progress notes written 10/24/13 describe the family meeting with the guardians and their son that day: "I spoke to guardian at length regarding pt's history of meds and reactions thereto. Mother stated terrible reaction to Risperdal, Geodon, and Abilify. Seroquel has been good …. [the remaining is illegible]."

The record contains a letter forwarded to the hospital staff on 10/25/13 from the recipient's Clinical Therapist, who had worked with the recipient and his family since 2010. It includes a lengthy description of the recipient's clinical and medical history and outlines his treatment program. For the recipient's medical history it states, "[The recipient's] medical history includes chronic constipation which is regulated with medication, inguinal hernia around age one which included surgery in Russia (his country of origin) to repair it, and two severe reactions to medications. The first was a dystonic reaction to a combination of medications and the second was an accidental overdose. He also received a BCG [TB vaccination] in 1997 in Russia for the treatment of TB. This was followed up with a nine month round of INH [TB treatment]. Test x-rays did not show signs of TB after this."

Physician Progress Notes from 10/28/13 state, "Pt. presents in fairly good spirits. He explained …(illegible)… some sleepwalking- like experience…. I told him to try to avoid taking the evening pills if possible." There is no mention of this event in the progress notes and no indication that the guardian was notified of it.

The Riveredge Visitor Sign-in Log is included in the record. It indicates that the recipient's guardians visited their son on 10/24/, 10/26, 10/27/and 10/29. The record does not show any restriction of the recipient's visitation while he was a patient at Riveredge.

Hospital Representatives' Response

The Chief Compliance Officer (CCO) was interviewed about the guardians not being allowed at their son's admission. Staff indicated that family members' presence would never be declined while a recipient was being admitted into the hospital. She indicated that there is no documentation in the medical record to indicate that the family was denied access. Additionally, the Riveredge Hospital Intake Specialist was interviewed and reported that she contacted the family at the referring ED and provided information by fax regarding Intake. The family then faxed guardianship paperwork to the Admissions Department. The Intake worker indicated that that the mother stated she was not coming to the hospital due to providing support to her other child, but she requested to be contacted by the case worker assigned to the case.

The CCO was interviewed about the hospital staff not following the guardians' directives for the recipient's medications. Staff stated that the patient was admitted with multiple scheduled

medications. These medications were then discontinued at the time of admission as part of the medication reconciliation process. The medications were then reordered on 10/23 after the recipient was seen by his psychiatrist. The patient received no regularly scheduled medications until after the psychiatrist had a lengthy conversation with the guardians on 10/24/13 and the guardians provided consent for all medications, except Risperdal, which was then discontinued by the psychiatrist. Other than one dose change for Depakote, on the day prior to discharge, no other meds were changed or added.

The CCO was asked about the visitation rights of the recipient. She indicated that there is no indication from the record that the recipient's right to visitation was ever restricted. The hospital provides scheduled visitation on Tuesday and Thursday from 7-8 p.m. and Saturday and Sunday from 1-3 p.m. Additional visitation is possible but must be approved by the recipient's physician. The Visitor Log shows that the family visited on all scheduled visitation days during his hospitalization. There is no indication from the record that the guardian wished to visit with the recipient at times other then the scheduled visitation.

The CCO was interviewed about the complaint that the recipient felt pressured to consent to medications. Staff indicated that the recipient did not consent to medications during his hospitalization- his guardian consented to his medications on 10/24/13 after she spoke with the recipient's physician. The recipient did not object to his proposed medication, and was given written medication information on each medication, however due to the guardian's objection to the original medication order, the physician and recipient relied on the decision of the guardian for his medication.

The CCO was interviewed about the discontinuation of the recipient's scheduled medications for three days without informing the guardian. She indicated that the recipient presented on multiple medications at admission. All medications were then discontinued as part of the medication reconciliation process and reordered on 10/23/13 after the patient was seen by a psychiatrist. The psychiatrist ordered the same medications but added Depakote and Risperdal. The recipient received no medications until after the psychiatrist met with the family on 10/24/13 and the guardian provided consent for all the medications except Risperdal, which was then discontinued by the psychiatrist. The medications were immediately initiated once consent was received. The patient admission time was 10/22/13 at 4:57 p.m., medication was ordered by the psychiatrist on 10/23/13 at 4:00 p.m., consent was received from the guardian on 10/24/13 at 7:00 p.m., and the medications were initiated on 10/24/13 at 8:00 p.m., leaving a two-day period in which the recipient did not receive medication. Staff indicated that medications are ordered by physicians, whose clinical decisions drive all orders and at times physicians stop the current medication regimen in order to start with a "clean slate." Staff was asked about the fact that the recipient's Depakote was doubled in an order issued by his physician on 10/28/13 and staff stated that this was the clinical decision of the physician at the time.

The CCO was interviewed about the physician returning guardian's phone calls. She stated that the physician met with the guardians on 10/24/13 and notes of this meeting are in the clinical record. Generally speaking, when a guardian calls to speak with a physician and he/she is not available, a note is placed on the chart to contact the guardian. There is no log containing a record of calls made and there is no way to monitor whether or not physicians return calls. The

hospital practice is to have the social worker who is assigned to the case call family members who have questions, as it is not practical for physicians to return family calls.

STATUTES

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 **proposed** 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).*

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. The policy also states, "If the patient began medications prior to admission he/she should continue on the medication but the consent form must be signed by the patient and/or guardian. In case of phone approval from a parent or guardian, the Physician/RN will document the telephone approval on the Patient Consent for Psychotropic Medications form using the verbal consent section." The policy also indicates that phone approvals obtained by nursing staff should be witnessed. Both staff and witness are required to sign the consent form.

Riveredge provided the hospital policy and procedure for Patient Rights (No. CS-702.10). It states, "In accordance with the Mental Health Code of Illinois, all patients 12 years and older have a right to phone, mail, and visiting. When communications are restricted, the hospital shall advise the patient that h/she has the right to require the hospital to notify the affected parties of the restriction and to notify such parties when the restrictions are no longer in effect."

CONCLUSION

There is no indication from the record that the family in this case was not allowed to be present when the recipient was admitted into Riveredge, and the report of the Intake worker indicates that the guardian was unable to be present because she was caring for another child, who was also tragically affected by this event. The HRA does not substantiate that Riveredge did not follow Mental Health Code requirements when a guardian was not able to be present for her ward's admission into the facility.

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. Additionally, every health care provider has the right to rely on any decision or direction made by the guardian to the same extent as though the decision was made by the ward. In this case, the guardians made every attempt to provide for their ward's health. The record shows the grave concern, not just from the guardians, but also from recipient's personal therapist, regarding the medications that were ordered and administered to the recipient during his hospitalization. Letters were sent from the therapist regarding the recipient's past medication overdose and severe adverse reaction to medications. Additionally, the guardians also sent medication information to the hospital before their son's admission, wrote to the hospital staff insisting on prior notification of any medication changes, and withholding all consent until they were consulted. Despite these efforts, the physician ordered medication that was contraindicated for the recipient, and even doubled the dosage of one medication, without consulting with the guardian or then notifying them of the changes. The record provides no

clinical justification for these actions. The HRA substantiates the complaint that Riveredge did not follow the guardian's directives for the ward's medications.

The record shows that the family visited the recipient each day that was a scheduled visitation opportunity and there is no indication that they asked the physician for visitation in addition to these times, or that the visitation was restricted in any way. The HRA does not substantiate the complaint that Riveredge restricted the recipient's visitation for no reason.

The record does not provide any information regarding the recipient being pressured to consent to medication, and further, the consent for all medication was derived from the guardian because of the guardian's knowledge of the recipient's past reactions to some medications. The record does indicate that the recipient often discussed his medications with his guardian and relied upon the guardian to monitor his medication. The HRA does not substantiate the complaint that the recipient felt he was pressured to consent to medication.

The record shows that the recipient went without his regularly scheduled medication from 4:57 p.m on 10/22/13 until 8:00 p.m. on 10/24/13- over two days. It is not clear why the physician or a nurse could not have secured phone consent for these medications, which the recipient was already taking, instead of waiting until after the guardians were present on 10/24/13. If there was a clinical justification, it is not present in the record, and the guardians were not made aware of it. Additionally, three of the medications that the recipient was taking prior to admission have warnings regarding their abrupt cessation: Tenex (blood pressure may spike), Concerta (may cause depression), and Seroquel (may produce withdrawal symptoms such as nausea, vomiting, and difficulty falling asleep) (See Medline Plus, a division of the U.S. National Library of Medicine). The HRA substantiates the complaint that Riveredge discontinued all the recipient's medications for two days and did not inform the guardian.

The interview with Riveredge staff confirmed that generally most communication with families is with the recipient's social worker. Additionally, there is no way to monitor whether physicians return guardian phone calls. The recipient in this case, however, had complex physical problems with medications in the past, and these concerns could not have been properly addressed by the social worker but would more appropriately be addressed by a physician. Again, the role of the guardian is to provide for the health of their ward and to be a key member of the treatment team, and in doing so, they must be afforded the opportunity to discuss problems and concerns with the physician, who directs patient care. The HRA substantiates the complaint that the recipient's physician would not return the guardian's phone calls.

RECOMMENDATION

1. Train staff to honor the role of the guardian. 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 the decisions and directions of the guardian are relied upon to the same extent as those of the ward.

2. It is not acceptable that the hospital practice does not encourage physicians to return guardian phone calls. Especially if the recipient has had severe reactions to medication in the

past, the physician is the appropriate professional with whom to discuss these issues. Ensure that physicians are reminded of the duties and rights of guardians and encourage their communication with guardians in all matters of guardian concern.

SUGGESTION

1. Staff indicated that the recipient in this case did not give consent for his medications, but rather, consent was given by his guardian for his medication. Ensure that recipients are given written medication information on proposed medication for their informed consent, and that if they refuse, the medication is not administered except to prevent the recipient from causing serious and imminent physical harm to himself or others.

2. The physician's notes in this case are not legible. Encourage physicians to be aware of their handwriting, or else have their notes transcribed.

3. The visiting hours seem very limited- only six hours per week. Perhaps the facility needs to review expanding the visiting hours.

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: #14-030-9013

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. Directed staff to communicate with physicians if family/patients are requesting contact.
2. Physician Communication – See above actions.

Suggestions:

1. Informed Consent
    a. Informed consent practices are followed at our facility. Patients do not receive medication without informed consent. This was not breached in this allegation.
2. Legibility
    a. Legibility was discussed at the Medical Staff Executive Committee and physicians reminded to provide legible documentation.

3. Visitation Hours
    a. Off-hours visitation is available when clinically indicated with a physician order. This is an option that is frequently utilized to accommodate clinical need and family schedules.

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