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HUMAN RIGHTS AUTHORITY – NORTHWEST REGION
Report 14-080-9005
SWEDISHAMERICAN HOSPITAL

## INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship & Advocacy Commission opened an investigation after receiving complaints of potential rights violations in the care provided to a patient at SwedishAmerican Hospital in Rockford. Allegations were that the hospital did not involve the patient's agent under a Power of Attorney for Health Care (POA) or his designated family member in treatment and discharge planning, and then administered psychotropic medication without informed consent, discharged the patient to another facility without consent, and did not provide the agent with patient rights and grievance information.

Substantiated findings would violate rights protected under the state and federal hospital requirements. (755 ILCS 45/4-7) (405 ILCS 5/2-102) (77 Ill. Admin. Code 250.240) (42 C.F.R. 482.13).

SwedishAmerican Hospital is a not-for-profit locally governed healthcare system headquartered in Rockford, with a network of 30 primary care clinics, an outpatient cancer center, and a home health agency which includes a full spectrum of wellness and education programs. In all encounters associated with mental health issues, the hospital serves approximately 4400 individuals on an annual basis.

To investigate the complaint, an HRA team met at the hospital where it interviewed the following hospital staff: the director of risk management, chief clinician, administrative supervisor, a nurse and a social worker. The patient whose care is under this review was interviewed separately. A record review was conducted with the consent of the recipient. Pertinent hospital policies were also examined.

## COMPLAINT SUMMARY

The complaint states that a patient was taken to the hospital emergency room after a fall. The family member contacted the hospital while the patient was there and

informed them that she was the POA agent and asked that the hospital keep her informed. She reportedly received no phone calls from the hospital. The patient expressed wishes to have the family member informed about his care. Reportedly he was given psychotropic medications against the wishes of the family member, transferred to a nursing home without his consent, and the hospital would not allow the family member or the aide to go with the patient. The patient was allegedly not given rights or grievance information. The patient told the HRA that he currently supports these claims. As the HRA's investigation proceeded, the patient did not concur with the family member on all of the aforementioned complaint issues.

FINDINGS

Interviews

It was explained that it is the responsibility of the admitting/registration staff, in collaboration with the patient care staff, to conduct an assessment and provide a copy of the Patient's Rights and Responsibilities to the patient and any designated support person.

Both the nurse and the social worker stated that the hospital registration form completed at admission on 6/10/13 has the name, address, and phone number of the family member of the applicant who was identified as the POA agent and listed as the "person to notify". The nurse stated that the first day the family member was in the hospital to visit the patient was on 7/6/13, 4 days prior to the discharge date of 7/10/13. The social worker added that the sister was out of the country from the date of admission of 6/10/13 through 7/6/13. The administrative supervisor stated that the hospital staff attempted on several occasions to meet with the family member, but the family member was usually out of the country. The nurse added that she, the physician and others on the nursing staff, contacted the family member by phone to communicate treatment and discharge planning for the patient. The nurse went on to state that per request from the family member, the patient's medical records were provided to the family member for review on 7/12/13. Per the chief clinician, there were many attempts by hospital staff to work together with the family member and many hours went into attempting to communicate and obtain cooperation from the family member.

On the question about medication issues, the director of risk management stated that there is no informed consent for psychotropic medications, although they were administered. The patient was not offered a Psychotropic Medication Consent Form to sign. She explained that the psychiatric unit of the hospital is trained in psychotropic medication procedures, but the patient was not on the psychiatric unit, he was in the "non-psychiatric medical part of the hospital". The director of risk management added that "her staff will have to be trained regarding the proper procedure for administering psychiatric medications including

determining and documenting capacity". Both the nurse and social worker stated that the patient informed them that the family member forced him to write a letter stating that he wanted her to have full control of his treatment and discharge planning because he cannot decide for himself. The patient informed the nurse and social worker that he can make his own decisions.

The director of risk management stated that the patient did not have a key to the home where he lived with the family member who yet remained out of the country. Although the patient had a caregiver, the hours for care are only 3 hours per day. It was explained by the social worker that several days and numerous hours were spent inquiring with local nursing homes, rehabilitation facilities as well as other help agencies in the community on behalf of the patient to determine discharge placement. After such an extensive search, a nursing home facility was agreed upon by the patient. The social worker added that the patient did not want to return home with the family member due to his fear of emotional and physical neglect to the point where the patient expressed a desire to revoke the family member from her power of attorney agent status; however, the patient later decided not to revoke the POA. The social worker went on to state that the patient did not even want the family member to know the time or the place of his discharge. And, although the family member and caregiver were present on the 7/10/13 discharge date, per the patient's request, the hospital security guards escorted the patient to the hospital transport vehicle keeping the family member at bay. The nurse stated that a referral was made to an agency for the alleged elder abuse.

Regarding the claim that SwedishAmerican did not provide patient rights and grievance information, the social worker said that an assessment on the patient was completed at registration by the admissions staff. At that point, a verbal explanation as well as written material was presented to the patient regarding patient rights and responsibilities, including a patient handbook that includes complaint and grievance information. The staff told us that a grievance by this patient or his family was never filed.

Records

The hospital registration form dated 6/10/13 lists the family member as the person to notify. Per the progress notes dated 6/11/13, the nurse spoke with the family member by phone regarding the treatment plan for the patient. On 6/13/13, the nurse discussed the need for additional care in the home with the family member by phone as written in the progress notes. On 6/17/13, the nurse wrote that she attempted to contact the family member by phone to discuss discharge planning, but could only leave a voice mail message. The physician contacted the family member by phone on 6/19/13 and 6/25/13 regarding treatment and discharge planning and on 6/29/13, although the family member remained out of

the country, she did make a phone call to the nurse to discuss a medical procedure and the patient's medications, as stated in the progress notes. The family member came to the hospital to visit the patient on 7/6/13, in addition to calling the nurse by phone on 7/7/13 and 7/8/13 being upset that the patient was soon to be discharged per the progress notes. Email correspondence between the medical staff dated 7/8/13 and the Medical Record/Discharge Instructions dated 7/8/13, both depict the physician and the nurse meeting with the patient and the family member to discuss the discharge of the patient. The family member did not want the patient to be discharged because she stated that the patient was dizzy and unstable. On the 7/10/13 discharge date, the nurse documented in her progress notes that the patient was fully aware and in agreement of the discharge to a local nursing facility, but the family member was also present and the patient did not want to talk to her and stated to the nurse that he did not want her to know his new location. The patient was fine with the presence of his caregiver. It was further documented that at the request of the patient, the hospital security guards kept the family member at a distance while they escorted the patient to the hospital van. The Release of Information Request, signed by the POA agent and dated 7/12/13, confirms that the medical records of the patient were made available and picked up by the family member. The HRA found no release signed by the patient allowing for the records to be disclosed to the family member.

Documentation showed that Ativan and Depakote were started on June 10, 2013, the day of admission, as prescribed by the attending physician on the medical unit. A psychiatrist evaluated the patient on June 19 and declared in his notations that the patient had the capacity to make treatment decisions.

In preparation for discharge, the Medical Record/Discharge Instructions dated 7/8/13 state that medication information sheets, listing Ativan and Depakote as psychotropic drugs, were given to the patient and family member along with written instructions on the side effects of the medications. The progress notes dated 7/6/13 state that per the patient, he did not write the letter stating that he gives the family member full control of his treatment and discharge planning. The patient stated that he is able to make his own decisions.

Per the progress notes written on 7/3/13, the patient did not have the key to the home owned by the family member and the family member would not allow him to come back to the home. On 7/7/13, the progress notes state that the patient attempted to contact the family member because he stated that she refused to give him the key to their home.

The progress notes dated 6/26/13, 7/8/13, 7/9/13 and 7/10/13 state that the patient was in agreement with being discharged to a nursing home or rehabilitation facility instead of returning home. The social worker contacted several local nursing homes and rehabilitation facilities on behalf of the patient per progress

notes written on 6/27/13, 7/3/13 and 7/9/13. Per progress notes dated 6/29/13 and 7/10/13, the patient was fearful of the care he would receive if he returned home with the family member. The email by the nurse to the medical staff denotes that the patient wished to revoke the power of attorney held by the family member. The progress notes dated 7/10/13 and the email dated 7/10/13 both state that the patient did not wish the family member to be made aware of his discharge location. The progress notes dated 7/3/13 state that the patient requested of the medical staff, not to speak with the family member due to the previous elder abuse he had experienced in the home. The progress notes dated 6/29/13 speak of the referral that was made to an elder abuse agency.

The family member was not present at registration, therefore per the progress notes written on 7/6/13, the family member was given a copy of the Patient Bill of Rights which included complaint and grievance information, along with the hospital's Mission Statement. Examples of these documents were reviewed by the HRA.

CONCLUSION

The SwedishAmerican Patient Services and Procedure Manual establishes the standard for rights dissemination when it says that "It is the responsibility of the admitting/registration staff, in collaboration with the patient care staff, to provide a copy of Patient's Rights and Responsibilities to patients or their legal guardians upon admission to the hospital, in accordance with the laws of the state of Illinois. Patients shall receive consideration, respect, and recognition of personal dignity at all times under all circumstances because each patient is a unique individual with a personal and cultural value and belief system. Patients and their families have the right to receive complete and current information from their attending physician, communicated in terms they can understand, regarding diagnosis, treatment and prognosis, and all outcomes of care, including unexpected or adverse outcomes".

According to the SwedishAmerican Patient Services and Procedure Manual, "Patients should not be subjected to any procedure without their voluntary, competent and understanding consent, or the informed consent of their legally authorized representative".

The SwedishAmerican Patient Services Policy Manual Advance Directives refers to decisional capacity as being the "ability to understand and appreciate the nature and consequences of a decision regarding medical treatment or forgoing life-sustaining treatment and the ability to reach and communicate an informed decision in the matter as determined by the attending physician".

The SwedishAmerican Hospital Informed Consent for Psychotropic Medications Policy addresses the psychiatrist's role in the hospital as "to determine

and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment…. To document the above information in a progress note and by having the patient/guardian/POA sign a Psychotropic Medication Consent Form".

The registered nurse's role for both the hospital and emergency room is "to reinforce the psychotropic medication education that was initiated by the physician, to provide written material about the psychotropic medications for patient/guardian/POA use, and to document the education/reinforcement of the education in the computer with 24-48 hours after the initiation of the medication".

According to the SwedishAmerican Hospital Patient Services Policy and Procedure Manual, "Patients may not be transferred to another facility unless they have received a full explanation of the need for a transfer and alternatives to the transfer, and they willingly consent to the transfer. Patients have the right to be informed of any continuing health care requirements following discharge from the hospital".

The SwedishAmerican Patient Complaint and Grievance policy states that "Upon admission, all patients and families are provided with a written information sheet that explains the patient's rights and responsibilities in compliance with the Illinois state mandate. If a verbal concern is not resolved by the staff present, is postponed for later resolution, requires investigation, and /or requires further action for resolution, it becomes a grievance. Reasonable efforts should be made to resolve and respond to all patient grievances in a timely manner to achieve compliance with CMS Conditions of Participation".

According to hospital licensing regulations (77 Ill. Adm. Code 250.240) regarding admission and discharge:

*d) Discharge Notification*

*1) The hospital shall develop a discharge plan of care for all patients who present themselves to the hospital for care.*

*2) The discharge plan shall be based on an assessment of the patient's needs by various disciplines responsible for the patient's care.*

*3) When a patient is discharged to another level of care, the hospital shall ensure that the patient is being transferred to a facility that is capable of meeting the*

Under the Illinois Power of Attorney Act (755 ILCS 45/4-7):

*4-7. Duties of health care providers and others in relation to health care agencies. Each health care provider and each other person with whom an agent deals under a health care agency shall be subject to the following duties and responsibilities:*

*(a) It is the responsibility of the agent or patient to notify the health care provider of the existence of the health care agency and any amendment or revocation thereof. A health care provider furnished with a copy of a health care agency shall make it a part of the patient's medical records and shall enter in the records any change in or termination of the health care agency by the principal that becomes known to the provider. Whenever a provider believes a patient may lack capacity to give informed consent to health care which the provider deems necessary, the provider shall consult with any available health care agent known to the provider who then has power to act for the patient under a health care agency.*

And per the Mental Health and Developmental Disabilities Code (ILCS 5/2-102):

*(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 or 2-107.1 or (ii) pursuant to a power of attorney for health care under the Powers of Attorney for Health Care Law [FN1] or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act.*

According to the Medicare/Medicaid Hospital Conditions of Participation (42 C.F.R. 482.13):

*(a) Standard: Notice of rights--*

*(1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.*

*(2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance….*

*(b) Standard: Exercise of rights.*
*(1) The patient has the right to participate in the development and implementation of his or her plan of care.*
*(2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment.*
Complaint: The hospital failed to involve the patient's agent under Power of Attorney or his designated family member in treatment and discharge planning. The hospital registration form provided the hospital staff with the contact information of the designated family member, who was not present at admission and was out of the country until approximately 4 days prior to the discharge of the patient. The progress notes depict that although the hospital was satisfied with the patient's decisional capacity, every effort was made by the staff to continually keep the family member involved in treatment and discharge planning by telephone and later in person, all in compliance with their policies, the Power of Attorney Act and CMS Conditions. In addition, medical records were requested by the family member for review and were provided by the hospital records department. The HRA notes that although the POA had not been revoked, there did not appear to be a release signed by the patient allowing for the records to be disclosed to the family member in spite of the fact that the hospital had previously determined the patient to have capacity. The complaint is not substantiated.
Complaint: The hospital administered psychotropic medication without informed consent. The director of risk management stated that the patient was not on the psychiatric unit of the hospital, although psychotropic medications were administered. The hospital staff on his unit did not offer the patient a Psychotropic Medication Consent Form to sign. There is no documentation by any physician regarding whether the patient had the capacity to make a reasoned decision about the medication until nine days after Ativan and Depakote were started. The complaint is substantiated, based on the lack of a consent form pursuant to policy, the lack of a decisional capacity statement at the time psychotropics were started pursuant to policy and the Mental Health Code and when written drug information was provided on discharge and not at the time they were proposed pursuant to the Mental Health Code.
Complaint: The patient was discharged to another facility without his consent. The social worker assisted the patient regarding discharge planning by locating a nursing home, with the patient's documented consent. The progress notes detail the efforts made by the social worker, along with the desire of the patient not to return home with the family member. This discharge process undertaken here

followed policy and Administrative Code requirements. The complaint is not substantiated.

Complaint: The hospital failed to provide the patient with rights and grievance information. According to the documentation, a verbal explanation and written material was presented to the patient upon admission, including a patient handbook detailing patient rights and the procedures regarding complaints and grievances. Progress notes confirm that 4 days prior to discharge, when the family member was present, a copy of the patient bill of rights was presented to the family member upon request. The complaint is not substantiated.

RECOMMENDATIONS:

1. The Mental Health Code states that any section of a hospital where mental health treatment is provided is considered a mental health facility (405 ILCS 5/1-114). Due process rights under the Code, particularly for informed consent, must be applied whenever and wherever psychotropic medications (405 ILCS 5/1-121.1) are prescribed in the hospital just as it is on the psychiatry unit or in the emergency department. SwedishAmerican's informed consent for psychotropic medications policy must be enforced hospital wide.
2. Train all prescribers to document decisional capacity pursuant to the policy and the Code (Informed Consent for Psychotropic Medications; 405 ILCS 5/2-102a-5).
3. Using consent forms is a best-practice standard and is required by hospital policy. Training must include that policy requirement.
4. Ensure that all written psychotropic drug materials are shared at the time they are proposed to satisfy *informed* consent rights under the Code (405 ILCS 5/2-102a-5).

Suggestion:

1. Ensure that a signed consent to release information/records to the family member is in the file when a patient has been determined by a physician to have decisional capacity.
2. Establish a system whereby the pharmacist can flag psychotropic medications, thereby assisting the medical staff in ensuring that procedures according to the Mental Health Code are incorporated.