FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY – NORTHWEST REGION
REPORT 14-080-9007
ROCKFORD MEMORIAL HOSPITAL

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of potential rights violations in the care provided to a patient with behavioral health needs at Rockford Memorial Hospital in Rockford. Allegations were that the facility failed to involve the patient's agent under a Power of Attorney or his designated family member in treatment planning and failed to provide him with patient's rights and grievance information.

Substantiated findings would violate rights protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5), the Illinois Power of Attorney Act (755 ILCS 45) and the Medicare/Medicaid Conditions of Participation for Hospitals (42 C.F.R. 482).

Rockford Memorial Hospital is a 396-bed-licensed facility that first opened its doors in 1885 as the community's first hospital. The Inpatient Behavioral Medicine Unit provides care and mental health treatment to men and women with diagnoses of severe depression, psychosis, suicidal ideation and other serious behavioural health needs including people with both mental health and substance abuse issues. The unit has 14 adult beds and 10 private rooms. It is staffed by a care team of psychiatrists, nurses, social workers, mental health technicians and both recreational and art therapists.

To pursue the matter an HRA team visited the hospital where the program director, a physician involved with the patient's care, a social worker and two attorneys were interviewed. Policies were reviewed as were relevant sections from the patient's records with written authorization.

COMPLAINT SUMMARY

The complaint states that the hospital failed to involve the patient's agent under a Power of Attorney or his designated family member in treatment and discharge planning. The patient reportedly expressed his wishes to have the Power of Attorney agent/designated family member involved. The complaint concludes by saying that the facility failed to provide patient rights and grievance information to the patient.

FINDINGS

Interviews

The program director stated that on the Application for Voluntary Admission dated 9/26/13, the patient signed that he understood that a copy of the form will be provided to whomever the patient designates (parent, guardian, relative, attorney or friend). On the initial treatment plan dated 9/26/13, the staff discussed and the patient agreed that his family members

are his support and he wanted them involved in his treatment planning. The program director went on to say that the hospital staff honored the patient's wish to have family members involved in treatment planning by discussing the patient's progress, whether it was face to face or by phone. On 9/26/13, the patient signed an Authorization for Release of Medical Information form consenting to release his medical information to his sister. The patient's sister provided to the hospital the Illinois Statutory Power of Attorney Healthcare and the Appointment of Attorney in Fact forms, and requested that these forms become a part of the patient's file. Although, the patient did not lack capacity in making his own medical decisions, the hospital accepted these forms in recognizing that the patient wished to have the sister involved in his treatment planning. The physician states that she has contacted the sister, who is always out of the country, on several occasions via telephone, email and by text, continuing to make every effort to keep her involved in the treatment planning for the patient. The program director and the social worker both stated that they have involved the sister in treatment planning and discharge planning whenever they could locate her, but she is usually out of the country. Per the social worker, the physician and hospital staff met with the sister and the patient on the discharge date of 10/4/13 and explained in detail the discharge planning. Both the patient and his sister were presented with discharge documents. The social worker stated that the sister and the patient informed her that they fully understood the discharge plan.

The program director stated that upon admission to the hospital on 9/26/13, the admissions department provided the patient with a Right of Individuals Receiving Mental Health and Developmental Disabilities Services form, with an explanation about the form. The hospital staff then asked the patient to sign the form if he understood the rights that had been explained to him. The patient signed the form. The Consent For Treatment/Assignment Of Benefits form and the hospital's Patient Care Partnership pamphlet, which contains information on how to complain to the hospital, was also given to the patient upon admission with copies retained in the patient's file. The social worker stated that neither the patient nor the sister informed her or anyone else on staff they wished to file a complaint or grievance. The social worker went on to say that if a complaint was spoken verbally or in writing, and if it did not get resolved through service recovery, which is an immediate acknowledgment and response, it would then proceed to the grievance process. The social worker then concluded that no complaint was made in any form by the patient or his sister.

RECORDS

The Application for Voluntary Admission form was signed by the patient on 9/26/13. By the patient signing the form, he is stating that he has been informed of the rights of a voluntary admittee and that he has been given a copy of the rights of individuals. The physician also signed the form. By the physician signing the form, the physician is stating that the patient has the capacity to consent to voluntary admission. Progress notes by the nurse dated 9/26/13 state that the "patient signed a voluntary admission and had his rights of individual read and reviewed with copies provided to the patient." On the 9/28/13 Psychological Assessment, staff discussed the patient's living arrangements with him. The patient stated that he lives with his sister, but she is often not home. The treatment plan dated 9/29/13 states the following: "Treatment plan discussed with patient/guardian/conservator/designee: Yes, during treatment planning team. Family/Significant other involvement in treatment plan: Family is involved. Family Contact: Patient agrees to contact." On 9/30/13 the psychiatric progress report states that the staff will

have a family meeting with the patient and his sister prior to discharge. On the 10/2/13 progress notes, the patient had a meeting with the physician in which the patient and the staff agree that the meeting went very well. The sister was not present and out of the country. On the Psychiatric Report by the physician dated 10/3/13, it is noted that the physician and the staff will meet with the patient and the sister on 10/4/13 to discuss discharge procedures. On 10/4/13, the physician and staff had a meeting with the patient and his sister, the patient's cousin and care provider. The physician stated that discharge summary was discussed at length and in detail, with the physician answering all questions that arose.

On 9/26/13 the patient signed a Right of Individuals Receiving Mental Health and Developmental Disabilities Services form, and a Consent for Treatment/Assignment of Benefits form, which is supported by the patient's file. The patient and physician signed a consent for psychotropic medications form on 9/26/13. Written documentation by the physician dated 9/27/13 states the following: "Reviewed medications at length with patient and also discussed in telephone call with sister per patient request. Risks, benefits, possible side effects, including TD, rationale for use and alternatives to these medications reviewed and patient and sister consent to the following". The written documentation goes on to list the medications. There is no capacity statement on the consent for psychotropic medications form, and no capacity statement is found in the record on any other progress notes or psychiatric assessments.

The physician states that she has contacted the sister, who is always out of the country, on several occasions via telephone, email and by text, continuing to make every effort to keep her involved in the treatment planning for the patient. This is supported by the psychiatric progress notes written by the physician on 9/27/13, 9/30/13, 10/4/13, and progress notes by the nurse dated 9/26/13.

CONCLUSION

The Rockford Memorial Hospital policy states that the Behavioral Medicine Unit will develop an appropriate individual plan of care for each patient addressing specific assessed needs by the Behavioral Medicine Unit's interdisciplinary team of qualified professionals in compliance with the Mental Health and Developmental Disabilities Code.

The policy states that the patient's identified social worker and/or designee is responsible for contacting a patient's family member or significant other to involve them in the patient's care. The patient and/or family are involved/informed in the development of the patient's individualized plan of care at initial development and at ongoing review treatment team meetings. The HRA contends that the physician and hospital staff complied with this policy in regard to the patient and his sister, which is supported by records in the patient's file.

Hospital policy states that discharge planning begins on admission and is finalized immediately prior to the patient's discharge. The plan serves as a guide for the patient, family, and continuing care providers in directing treatment needs following discharge.

Rockford Memorial Hospital policy states that the Complaint Management/Grievance Process is to provide an effective method by which the patient/customer may express any concern or complaint regarding care/service, have their concern/complaint received, addressed and resolved, when possible, in a professional, efficient and timely manner and in accordance with regulatory standards.

The policy states that "a complaint is an expression of concern or dissatisfaction, whether verbal or written, provided by the patient/customer regarding quality of care of service. A grievance is any complaint that could not be resolved through service recovery. The grievance process is the organized approach to receive, address and resolve any complaint that could not be

resolved through service recovery or any complaint, verbal or written, regarding quality care/service. Service Recovery is an immediate acknowledgement of and response to a patient/customer complaint/concern or service failure that is addressed and quickly resolved in such a way that the patient/customer is feeling satisfied."

Under Section 5/2-102a of the Mental Health Code,

2-102. (a) 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. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided.

According to 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.

According to regulations that govern the delivery of Medicare/Medicaid funded services in hospital settings (42 C.F.R. 482.13):

A hospital must protect and promote each patient's rights.

(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. The hospital's governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum:

(i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital.

(ii) The grievance process must specify time frames for review of the grievance and the provision of a response.

(iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the

patient to investigate the grievance, the results of the grievance process, and the date of completion.

Complaint: The hospital failed to involve the patient's agent under Power of Attorney or his designated family member in treatment planning. The program director stated that on the Application for Voluntary Admission dated 9/26/13, the patient signed that he understood that a copy of the form would be provided to whomever the patient designates (parent, guardian, relative, attorney or friend). On the initial treatment plan dated 9/26/13, staff discussed and the patient agreed that his family members are his support and he wanted them involved in his treatment planning. The patient's sister provided to the hospital the Illinois Statutory Power of Attorney Healthcare and the Appointment of Attorney in Fact forms, and requested that these forms become a part of the patient's file. Although the patient did not lack capacity in making his own medical decisions, the hospital accepted these forms in recognizing that the patient wished to have the sister involved in his treatment planning. According to the documentation, there were several meetings involving the sister either in person or on the phone. Attempts were made to contact the sister while she was out of the country. The hospital staff included the sister in medication discussions and discharge planning. Finally, the patient's physician stated that she has contacted the sister on several occasions via telephone, email and by text, continuing to make every effort to keep her involved in the treatment planning for the patient, which is supported in the patient's record. The complaint is not substantiated.

Complaint: The hospital failed to provide the patient with the patient's rights and grievance information. The program director stated that upon admission to the hospital on 9/26/13, the admissions department provided the patient with a Right of Individuals Receiving Mental Health and Developmental Disabilities Services form, with an explanation about the form. The hospital staff then asked the patient to sign the form, only if he understood the rights that have been explained to him. The patient signed the form, which is supported by the patient's record. The Consent For Treatment/Assignment Of Benefits form and the hospital's Patient Care Partnership pamphlet, which contains information on how to complain to the hospital, was also given to the patient upon admission with copies retained in the patient's file. The physician added that at admissions, written material regarding the right of the patient to consent or disagree with the use of psychotropic medications, was given to the patient, along with an explanation in regard to the side effects, risks and benefits. The sister was not present, being out of the country. The patient's sister provided to the hospital the Illinois Statutory Power of Attorney Healthcare and the Appointment of Attorney in Fact forms, and requested that these forms become a part of the patient's file. Although the patient did not lack capacity in making his own medical decisions, the hospital accepted these forms in recognizing that the patient wished to have the sister involved in his treatment planning. The social worker states that neither the patient nor the sister informed her or any other staff, that they wished to file a complaint or grievance. Based on the evidence, the complaint is not substantiated.

SUGGESTIONS

1. Require Rockford Memorial physicians to document specifically about the patient's decisional capacity for psychotropic medications. (405 ILCS 5/2-102 a-5)
2. Ensure that Rockford Memorial physicians provide to the patient and any substitute decision maker written information about psychotropic medications. (405 ILCS 5/2-102 a-5)

RESPONSE

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