FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY – NORTHWEST REGION
REPORT 14-080-9015
KATHERINE SHAW BETHEA 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 Katherine Shaw Bethea Hospital (KSB) in Dixon. Allegations were that the patient was not given an explanation of her rights, medications of the patient were taken away, and she experienced abuse and harassment from other patients.

Substantiated findings would violate rights protected under the Medical Patient Rights Act (410 ILCS 50/5), the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-100,102) and the Medicare/Medicaid Conditions of Participation for Hospitals (42 C.F.R. 482.13).

According to its website, KSB Hospital offers extensive behavioral healthcare services, in both inpatient and outpatient settings. The BHC (Behavior Healthcare) unit has 2 psychiatrists, and a psychologist. The nursing staff have considerable experience and training in therapy, communication, and critical care. Patients attend group therapy sessions throughout the day in to order to learn new skills and treatments. The KSB emergency department serves approximately 1150 patients per year with psychiatric conditions as the primary diagnosis. The inpatient unit admits approximately 500 patients yearly, while the outpatient department estimates to serve 959 patients.

To investigate the complaints, an HRA team met at the facility where it interviewed the director of nursing operations, director of behavior healthcare, a

chief nursing officer and 2 nurses. Policies were reviewed as were relevant sections of the patient's file with written authorization.

COMPLAINT SUMMARY

It was said that on 3/11/14, the patient voluntarily checked into the hospital for deep depression and migraine headaches. Documents regarding patient rights were allegedly provided to the patient without any explanation. The medications that the patient had with her were reportedly taken away and no medication was administered to the patient for the 22 hours that she was at the hospital. The complaint goes on to allege that while on the behavioral health unit, there were 2 incidents during which the patient felt that she was threatened and harassed by other patients. One incident reportedly occurred in a group therapy meeting where another patient kept touching her face and the staff did nothing to stop this, resulting in her having to leave the room without receiving the benefit of the meeting, the other in the hallway at the facility when she felt verbally threatened.

FINDINGS

Interviews

The director of nursing operations stated that the patient voluntarily came to the emergency department at KSB Hospital for deep depression and migraine headaches, on 3/11/14 at 2:41 p.m. In general, when the emergency staff discovers that a patient has psychotropic medications with them, the standard procedure is that the medications are removed from the patient and taken to the hospital pharmacy or given to family members who are present. The director of nursing operations stated that in this particular case, the patient did not have medications with her. She and her staff believe that when the patient stated that they took her medications away, the patient was referring to not having her regular medications ordered immediately upon admission. The medical doctor and psychiatrist were notified and a psychiatric evaluation was completed. The psychiatric evaluation is usually completed within 24 hours. A major depressive disorder was the disposition diagnosis. The patient agreed to a voluntary admission to the hospital behavioral health unit on 3/11/14 at 3:34 p.m. At 3:43 p.m. the patient completed

an Application for Voluntary Admission agreeing to be admitted for further evaluation and treatment. Upon signing the application, the patient confirmed that the rights of a voluntary admittee were explained to her and written documentation was provided to her.

The nurse stated that within several minutes after the patient was admitted to the hospital behavioral health unit, additional documents regarding patient rights and responsibilities were given to the patient with a verbal explanation that included confidentiality and psychotropic medications along with contact information for the IL Guardianship & Advocacy Commission and Equip for Equality. After assuring the nurse that she understood the documents, the patient signed them. The nurse and chief nursing officer and physician also added their signatures to the documents.

Per the nurse, on 3/11/14 a treatment plan was established but the patient refused to sign the plan because the patient said she was not suicidal.

The chief nursing officer stated that the patient first received medications for her migraines on 3/12/14 at 11:00 a.m. Per the psychiatrist orders, she was given Topamax which is a daily medication for migraine pain. The medication Imitrex is for immediate relief of migraine pain including nausea, vomiting, and sensitivity to light/sound. The Imitrex had to be ordered and was given to the patient later that afternoon around 1:00 p.m. The psychotropic medication Ativan was offered to the patient for depression, but she refused to accept it. When the HRA requested the documentation regarding the patient's refusal for Ativan, the chief nursing officer stated that as a standard procedure, the nurses are not required to document the refusal of psychotropic medications.

According to the nurse, on the morning of 3/12/14, the patient was present at 2 of the morning group therapy sessions which provided the patient with cognitive behavior therapy along with mood and stress management strategies. The patient was cooperative and participated in the group sessions. The nurse went on to say that the patient did not inform any of the staff that there was a problem with someone touching her face. There was no observation and no documentation by the staff that the patient experienced any problems at all during the sessions.

Per the nurse, on 3/12/14 the patient was upset later that afternoon because of an agitated patient on the unit. The agitated patient was yelling, but never yelled directly at the patient and did not have any interactions or physical contact with the patient. The facility's security guards were near the agitated patient at all times

during this incident. The nurse went on to state that later in the shift, a code for responding to aggressive behavior was called on another patient not associated with this incident, and all the patients were locked in their rooms for security purposes. The patients can come out of the rooms, but only the staff has a key to enter the rooms. The nurse added that "the patient was upset and crying at this time stating that she was not safe. I reinforced several times that she is safe, the door is locked. I sat with her and rubbed her back while I talked to her." The patient then requested to be discharged and signed a 5-day discharge form. When the psychiatrist arrived to see the patient, the nurse communicated the situation to him, including the patient's request for discharge. An appointment was made with the health department by the nurse on behalf of the patient for follow-up on an outpatient basis. The psychiatrist approved the request for discharge on 3/12/14 at 3:43 p.m. and the patient was discharged. Although the patient did not meet the criteria for involuntary admission, the discharge was considered to be AMA (Against Medical Advice) by the psychiatrist. The nurse added that at no time did the patient request to file a complaint or grievance regarding any experience that she thought she may have had at the hospital or with the staff.

RECORDS

The hospital chart report from the emergency room department dated 3/11/14 depicts the arrival time of the patient at 2:41 p.m. The Psych Inpatient Admission progress notes state the following: "Patient was secured in the emergency room. Rights of individual and admittee were read, verbalized understanding, copies given. Patient was calm and cooperative, ambulated". Both the hospital Inventory List and Valuables List forms dated 3/11/14 were completed in the emergency room and do not have medications listed among the possessions that the patient brought with her to the hospital. The discharge from the emergency room and voluntary admission to the hospital behavioral health unit occurred at 3:34 p.m. on the same day, with the diagnosis of a Major Depressive Disorder. The Application for Voluntary Admission was signed and dated by the patient on 3/11/14. The application included a detailed description of the rights of the patient as an admittee, including contact information for the Illinois Guardianship & Advocacy Commission.

The form entitled Rights Of Individuals Receiving Mental Health And Developmental Disability Services was signed and dated by the patient and the nurse on 3/11/14. The Confidentiality, Responsibility For Personal Belongings & Consent For Physical Inspection & Room Checks form was signed and dated on

3/11/14 by the nurse and the patient. The patient signed the Notification of Admission on 3/11/14. The Consent for Psychotropic Medication for the Ativan was signed by the patient as well as the physician, on 3/11/14. The physician determined that the patient had decisional capacity as noted on the consent form as well as the progress notes dated 3/11/14 and 3/12/14.

The Multi-Disciplinary Treatment Plan dated 3/11/14 was signed by the nurse, but the patient refused to sign. The plan listed the following problem areas for the patient: emergency treatment-medication/restraints/seclusion, discharge planning, risk for suicide and ineffective coping. The nurse stated that the patient informed her that she was not suicidal, and would not sign the form. The emergency room progress notes written by the psychiatrist on 3/11/14 denote the following statement by the patient, "I don't want to be alive".

Progress notes by the nurse dated 3/11/14 depict that the patient received the medications Topamax at 11:00 a.m. and Imitrex later the same day, for migraine headaches. There is no documentation regarding the refusal by the patient when the nurse offered her the Ativan. The patient was educated regarding psychotropic medications per nurse progress notes dated 3/11/14 and a pamphlet explaining Ativan was given to the patient. During the site visit, the HRA requested a copy of the pamphlet from the file of the patient and it was provided.

The nurse progress notes from group therapy sessions dated 3/12/14 state that the patient willingly participated, "engaged appropriately and followed directions/demonstrations". The sessions consisted of cognitive behavior therapy along with mood and stress management strategies.

According to the progress notes by the nurse dated 3/12/14, due to an episode involving an agitated patient on the unit, the patient states that she does not feel safe. The nurse writes that she has assured the patient that she is safe as well as all the other patients, her door is locked and only the staff can enter, and the security guards are handling the situation. Per the patient's request, a 5 Day Discharge form was provided to her and she signed it on 3/12/14. The psychiatrist records that he evaluated the patient on 3/12/14 and honored her request for discharge as she has maintained decisional capacity and intends to follow-up with an appointment that was scheduled by the nurse for the following day with an outpatient facility. The patient signed the Discharge Instructions form, which included signatures by the nurse, physician and the psychiatrist.

CONCLUSION

The KSB policy in regard to the admission of a patient for BHC (Behavioral Healthcare) services states that "When a mental health patient presents to the emergency department requesting voluntary admission to the BHC unit, the patient will be seen and evaluated by the emergency room physician. After the physician has evaluated the patient, he/she shall consult with the psychiatrist on call. The decision to admit will be made by the psychiatrist. The psychiatrist will call the unit with admitting orders including preliminary diagnosis. The BHC staff will initiate the admitting process by reading and explaining to the patient the Rights of the Admittee and The Rights of Individuals and then asking the patient to sign the voluntary application".

According to the KSB Patient's Rights Policy, "The patient can expect to be treated with consideration, respect, recognition of the individuality and personal needs, including the need for privacy in treatment, recognition of psychosocial, spiritual, and cultural values. The Behavior Healthcare Unit, in administering the best possible care to each patient, shall protect individuality, dignity and fundamental human, civil, constitutional and statutory rights. The staff will inform the patient of his/her rights and their rights will be respected by all hospital staff, medical staff and visitors. Each patient shall receive a copy of the legal rights and the Patient's Bill of Rights. The admitting staff will document the same on progress notes".

The Medication Administration Policy states that "The use of a patient's medications brought from home is discouraged. Upon admission, the patient should be advised that he/she may not take his/her medications that he/she brought with them. The medications should be sent home with the family. If the medications are not sent home, they must be sent to the Pharmacy".

Per the Patient Care Decision Policy, "If a patient refuses recommended treatment/medications, the physician or other hospital personnel observing the communicated refusal must document the same in the progress notes or nursing narrative notes".

The KSB Patient Abuse Policy states that "The patient can expect that any BHC staff member having knowledge or suspicion of patient shall report this abuse. Patient abuse is any action or failure to act, viewed to be reckless/careless toward the patient. Every effort will be made to assure the safety of patients and staff. The patient has the right to considerate and respectful care in a safe environment".

The Complaint and Grievance Policy denotes that “It is the policy of KSB Hospital to respond to customer concerns, complaints, and grievances in a timely and effective manner, and to respond in a manner that complies with the law, regulations, and Medicare Conditions of Participation”.

According to the Medical Patient Rights Act (410 ILCS 50/5):

> *50/5. Statement of hospital patient's rights*
> *§ 5. Statement of hospital patient's rights.*
>
> *(a) Each patient admitted to a hospital, and the guardian or authorized representative or parent of a minor patient, shall be given a written statement of all the rights enumerated in this Act, or a similar statement of patients' rights required of the hospital by the Joint Commission on Accreditation of Healthcare Organizations or a similar accrediting organization. The statement shall be given at the time of admission or as soon thereafter as the condition of the patient permits.*
>
> *(b) If a patient is unable to read the written statement, a hospital shall make a reasonable effort to provide it to the guardian or authorized representative of the patient.*
>
> *(c) The statement shall also include the right not to be discriminated against by the hospital due to the patient's race, color, or national origin where such characteristics are not relevant to the patient's medical diagnosis and treatment. The statement shall further provide each admitted patient or the patient's representative or guardian with notice of how to initiate a grievance regarding improper discrimination with the hospital and how the patient may lodge a grievance with the Illinois Department of Public Health and the Illinois Department of Human Rights regardless of whether the patient has first used the hospital's grievance process.*

According to the Mental Health Code (410 ILCS 5/2-102) under Care and services; psychotropic medication; religion:

> *§ 2-102. (a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment….*

(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.

Under Section 5/2-200, Notice of rights, the Code states:

2-200. (a) Upon commencement of services, or as soon thereafter as the condition of the recipient permits, every adult recipient, as well as the recipient's guardian or substitute decision maker, and every recipient who is 12 years of age or older and the parent or guardian of a minor or person under guardianship shall be informed orally and in writing of the rights guaranteed by this Chapter which are relevant to the nature of the recipient's services program. Every facility shall also post conspicuously in public areas a summary of the rights which are relevant to the services delivered by that facility.

And per Section 5/3-401, Applications; forms; right to discharge, the Code states:

a) The application for admission as a voluntary recipient may be executed by:

1. The person seeking admission, if 18 or older; or

2. Any interested person, 18 or older, at the request of the person seeking admission; or

3. A minor, 16 or older, as provided in Section 3-502.

(b) The written application form shall contain in large, bold-face type a statement in simple nontechnical terms that the voluntary recipient may be discharged from the facility at the earliest appropriate time, not to exceed 5 days, excluding Saturdays, Sundays and holidays, after giving a written notice of his desire to be discharged, unless within that time, a petition and 2 certificates are filed with the court asserting that the recipient is subject to involuntary admission. Upon admission the right to be discharged shall be

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

The Code of Federal Regulations (42 C.F.R. § 482.13), Title 42, Public Health, under the hospital conditions for Medicare/Medicaid participation:

§ 482.13 Condition of participation: Patient's rights.

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.

(b) …Standard: Privacy and safety.

(1) The patient has the right to personal privacy.

(2) The patient has the right to receive care in a safe setting.

(3) The patient has the right to be free from all forms of abuse or harassment.

Complaint: The patient was not given an explanation of her rights. The KSB policy states that the patients will receive rights and responsibilities documents, including an explanation and written progress notes by the staff. The nurse stated that the documents included information regarding confidentiality, psychotropic medications and advocate contacts. Progress notes dated 3/11/14 denote that the aforementioned documents were given to the patient with an explanation in the emergency room as well as upon admission to the inpatient psychiatric unit, and the patient informed the staff that she understood the documents.
The complaint is not substantiated.

Complaint: The medications that the patient brought with her were taken away and no medications were administered to her.

The staff at KSB adhered to their policy that states, upon admission any medication that the patient brings with them to the hospital shall be removed from the patient and either sent home with the family or presented to the hospital pharmacy. Nurse progress notes state that on 3/11/14, the patient received Topamax and Imitrex medications for migraine headaches. The nurse stated that the patient refused the psychotropic medication Ativan. There is no documentation by the nurse or any other staff regarding the refusal of Ativan. The KSB Patient Care Decision policy states that staff must document in progress notes the patient refusal of recommended medications. The records do not support the verbal statement by the nurse that the patient refused Ativan. Therefore, the complaint is substantiated in part, that KSB violated their Patient Care Decision Policy.

Complaint: The patient received no support from when she was threatened and harassed by other patients. According to the KSB Abuse Policy, the staff shall ensure the safety of their patients. The policy goes on to state that the patients have a right to a safe and secure environment. Staff progress notes dated 3/12/14 state that the patient demonstrated interest and cooperation in the group therapy sessions without any instances of distress or harassment. The 3/12/14 nurse progress notes depict the actions by the staff to ensure that the patient did not receive direct confrontation verbally or physically by the agitated patient that the security staff engaged. The patient was secured in her room with the nurse remaining with the patient to provide comfort and assist the patient in understanding that she is safe. Therefore, it is concluded that the complaint is not substantiated.

RECOMMENDATIONS

1. Adhere to the KSB Patient Care Decision Policy that states "If a patient refuses recommended treatment/medications, the physician or other hospital personnel observing the communicated refusal must document the same in the progress notes or nursing narrative notes".

SUGGESTIONS

1. Document prescribed medication refusals in the medication administration record.

RESPONSE

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

KSB HOSPITAL
KATHERINE SHAW BETHEA HOSPITAL

February 11, 2015

Mr. Erin Wade, Chair
Human Rights Authority
Guardianship and Advocacy Commission
Northwest Region
4302 N. Main Street, Suite 108
Rockford, IL 61103

RE: #14-080-9015 KSB Hospital

Dear Mr. Wade:

Please accept this letter as a response from Katherine Shaw Bethea Hospital to your letter of January 21, 2015 stating the following recommendations and suggestions:

RECOMMENDATIONS

1. Adhere to the KSB Patient Care Decision Policy that states "If a patient refuses recommended treatment/medications, the physician or other hospital personnel observing the communicated refusal must document the same in the progress notes or nursing narrative notes".

SUGGESTIONS

1. Document prescribed medication refusals in the medication administration record.

Summary:

With regard to the above referenced case, the patient did not refuse medications. All medications that are ordered on a scheduled basis are entered in the electronic medical administration record (MAR) as administered or not administered with the reason such as "patient refused". The MAR is maintained as part of the legal electronic medical record.

The medication in question was Ativan which was ordered on a PRN (as needed basis) for anxiety. PRN medications are offered to the patient when he/she portrays symptoms of need. In this case, the nurse assessed the patient for anxiety and documented on 3/12/2014 at 0900 "The patient states she does not feel anxious today" which was written in the nurse's notes according to our policy. We feel our nursing staff followed our policy as to where to document the refusal.

Mr. Wade, if I can be of further assistance or if you have any questions, please do not hesitate to contact my office at (815) 285-5514.

Sincerely,

Linda Clemen

Linda Clemen, RN, BSN, MS
VP/Chief Nursing Officer

LC/msc

NORTHWEST REGIONAL HUMAN RIGHTS AUTHORITY

HRA CASE NO. 14-080-9015

KSB HOSPITAL

Pursuant to Secton 23 of the Guardianship and Advocacy Act (20 ILCS 3955/1 et seq.), we have received the Human Rights Authority report of findings.

IMPORTANT NOTE

Human Rights Authority reports may be made a part of the public record. Reports voted public, along with any response you may have provided and indicated you wish to be included in a public document, will be posted on the Illinois Guardianship and Advocacy Commission Web Site. (Due to technical requirements, your response may be in a verbatim retyped format.) Reports are also provided to complainants and may be forwarded to regulatory agencies for their review.

We ask that the following action be taken:

_X_ We request that our response to any recommendation/s, plus any comments and/or objections be included as part of the public record.

____ We do not wish to include our response in the public record.

____ No response is included.

Name: *Linda Clemen*

Title: *VP/Chief Nursing Officer*

Date: *2/11/15*