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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 15-030-9001
St. Anthony Hospital

Case Summary: The HRA did not substantiate the complaint that a recipient was forced to sign a voluntary application for admission and forced to accept emergency medication for no adequate reason. Also, it was not substantiated that hospital staff would not consult with the recipient's outpatient treatment team to get the background information needed to treat the recipient. Additionally, it was not substantiated that another patient's record was included in the recipient's record and the hospital staff made treatment decisions based on this other patient's information. Finally, it was not substantiated that the recipient was not given all of her clothing when she was discharged.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at St. Anthony Hospital. It was alleged that the facility did not follow Code procedure when a recipient was forced to sign a voluntary application for admission and forced to accept emergency medication for no adequate reason. Also, hospital staff allegedly would not consult with the recipient's outpatient treatment team to get the background information needed to treat the recipient. Additionally, the complaint alleges that another patient's record was included in the recipient's record and the hospital staff made treatment decisions based on this other patient's information. Also, the recipient was reportedly not given all of her clothing when she was discharged. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5).

St. Anthony Hospital is a community hospital that contains a 30-bed inpatient adult behavioral health unit.

To review these complaints, the HRA conducted a site visit and interviewed the Director of Acute Care and Psychiatry, the Director of Quality Resources, and the Clinical Nurse Manager of the Behavioral Health Unit. Hospital counsel provided written responses compiled from the responses of the interdisciplinary team regarding the allegations. Policies were reviewed, and the adult recipient's clinical records were reviewed with written consent.

COMPLAINT SUMMARY

The complaint indicates that the recipient was admitted to St. Anthony ER after cutting her wrist and taking an overdose of medication which she believed was a side effect of an earlier outpatient administration of ECT (electroconvulsive therapy). The complaint alleges that after being admitted for medical treatment the recipient was forced to sign a voluntary application for admission and forced to accept medication that she refused. Allegedly, hospital staff would not consult with the recipient's outpatient treatment team to get the background information needed to treat the recipient. Additionally, the complaint alleges that another patient's record was included in the recipient's record and the hospital staff made treatment decisions based on this other patient's information. Also, the recipient was allegedly not given all of her clothing when she was discharged.

FINDINGS

The clinical record shows that the recipient was triaged at St. Anthony Hospital on 2/27/14 at 3:50 p.m. Triage notes state, "Brought by [fire department], pt aox1 [oriented to time] laughing states took 13 pills of trazodone unknown dose unknown time, color good, skin warm dry to touch." While being treated following the poison control center protocol, the notes indicate: "Patient ripped ekg [electrocardiogram] cables, combative at the time of taking ekg. Placed on 4-point restraints, Dr… notified." The recipient was admitted to the telemetry unit on 2/28/14 and then transferred to the medical/surgical unit and from there to the Psychiatry Unit on 3/03/14. The Discharge Note written before the recipient's transfer to Psychiatry states, "Patient is a 36 year old female with complaint of suicide attempt admits of taking 13 pills of Trazodone but doesn't know dose and time she took them. Poison control was called by ER. She was admitted to the Telemetry Unit and was placed with 1:1 with a sitter. Patient reported that she took Tylenol PM last night and woke up here. Patient reported to have had hallucinating last night, she also reported that she was able to read other people's minds and they could read hers. She also reported that this was the first time that she felt this way since she has had ECT. Psych was consulted. Patient remain (sic) stable and was transferred to Med surge. Patient although still clinically cleared, will need inpatient psych. Patient was then transferred to the psych unit."

Progress Notes entered on 3/03/14 from the St. Anthony Hospital Psychiatric unit describe the recipient's arrival at the unit: "Pt admitted to unit at 9:00 p.m. from [medical/surgical bed]. Prior to that, she was in telemetry. Voluntary admission form signed. Dr… notified, orders given. Dr… notified. Pt stated that she came to our ER after trying to OD on Tylenol PM and slashing her left wrist while in the bathtub. Pt has been receiving ECT at [a Chicago area hospital] with [a physician there]. Pt had a treatment on 2/24 then cancelled the appointment on 2/26. She said that while in the bathtub, she realized that she did not want to hurt herself and called the ambulance. Pt lives with her friend… and hopes to return to her apartment. Pt denies smoking, drug, or alcohol abuse…. She has a superficial cut to left wrist, photo taken for chart. Pt reports to use birth control but does not take any psych medications since she is having ECT. Patient refused 2100 medications since [her physician] told her not to take anything during treatment. She does not have any personal belongings or valuables since she was brought in naked. Body check performed by mental health worker. Pt oriented to unit rules and regulations. She was given amenity kit, shown to room, and wished to shower."

The clinical record contains a Consent for Diagnosis and Treatment form, dated 2/27/14 and initialed by a witness with the notation, "per ER RN … patient can't sign." The record contains two Inpatient Certificates. The first is completed on 3/01/14 at 9:00 p.m. and includes the following description of clinical observations which substantiate the need for immediate hospitalization: "Confused, delusional, hallucinations, [illegible word], homicidal and suicidal." The second Inpatient Certificate is completed on 3/06/14 at 3:10 p.m. and offers the following justification for immediate hospitalization: "Pt is severely depressed, suicidal, hopeless, helpless, attempted suicide in seek of ECT." There is a Petition for Involuntary Admission in the record, completed on 3/06/14 at 12:00 p.m. by a Social Worker. The signs and symptoms of mental illness that indicate the need for involuntary admission are, "Patient is severely depressed with suicidal ideations, who cut her wrist with multiple stitches, experiencing poor judgment and insight." The record contains a Rights of Individuals Receiving Mental Health and Developmental Disabilities Services form. It is signed by the recipient on 3/03/14. On this date the recipient also signed a Consent for Diagnosis and Treatment form, which is included in the record.

Nursing Notes from 2/28/14, written while the recipient was being treated in the telemetry unit state, "Pt. has been seen at [local hospital] for depression. Dr… gave nursing staff phone number to call to arrange for transfer about 6:00 p.m. About 6:00 behavioral health case manager at [hospital] was paged. No response. This and the number was endorsed to night nurse... . Will continue to monitor."

The record contains an Application for Voluntary Admission completed by the recipient on 3/03/14. The record also contains the Medication and Treatment Consent form, and although it is signed by the physician and the recipient, it does not indicate which medications are consented to. The record contains the recipient's Medication Administration History Report, which indicates that the recipient never received forced or emergency medication while on the behavioral health unit.

There are two Patient Property Checklist forms in the record. They are both dated 3/03/14 and both are signed by the recipient. One form states, "No belongings at Admission" and the other indicates a pair of pants, a shirt, a pair of underwear, and a t-shirt. The notes written when the recipient was transferred from the Emergency Department to the psychiatric unit states, "…patient has no belongings noted before transfer/discharge to the 4th floor."

Notes from the Emergency Department written on 2/27/14 at 5:07 p.m. state, "Patient persists in effort to remove lines, tubes, equipment, or dressing." At this time restraints were applied to the recipient's upper and lower extremities. The restraint order form and flowsheet are included and these indicate that the recipient remained in restraints from 5:15 p.m. until 11:30 p.m. The recipient was observed continuously and was offered toileting and foods/fluids.

The recipient's hospital record contains the progress notes from the psychiatric unit. Notes entered on 3/03/14 state, "Pt woke up asking for the telephone to call the brother, pt ask when can she be transfer (sic) to [previous treating hospital], pt was told that social services will work on that this morning. Pt stated okay she will wait til the morning."

Progress Notes entered on 3/04/14 state, "Earlier this shift, this writer rec'd call from house manager that pt has a power of attorney individual who has concerns of pt medications and seeking pt to be transferred to [former hospital] for ECT which pt receives there. Pt confirms she has power of attorney. This writer then contacted [attending physician] and informed him of wish of individual and pt to be transferred. [Attending physician] states will discuss with pt tomorrow. Rec'd order to discontinue Paxil, Risperdal, and Trazodone. This writer reminded pt to discuss issue of wanting transfer with her social worker and [attending physician]."

Progress Notes entered on 3/06/14 state, "Patient is being transferred to [previous hospital] because St. Anthony does not provide ECT treatment." Notes from 3/07/14 state, "Pt in the hallway, talking on the telephone. She has been visible in the milieu, attending all of the AM groups and meetings. This pt has been focused on being transferred to the hospital where she is accustomed to going. She was, however, very attentive and participated in the issues group with good insight. This pt has no verbalized complaints of pain, and denies any suicidal or homicidal thoughts as of the time of this entry. Continue to monitor this pt every 15 minutes per SP [special precaution] status."

The recipient was transferred to her home on 3/08/14. Progress Notes at this time state, "Pt was discharged per MD orders and medically cleared. Discharge instructions and pt verbalizes understanding, no prescriptions was give [sic]. Mood and behavior is appropriate at time of discharge. Personal belongings given. Pt escorted to 2nd floor lobby to family."

HOSPITAL REPRESENTATIVES' RESPONSE

Hospital representatives were interviewed about the complaints and they provided written and oral responses which are both provided herein. Hospital representatives noted that the recipient was brought to the hospital on 2/27/14 by the fire department because she was found without a coat and shoes in ten degree weather. She indicated that she took pills to go to sleep. When she presented to the Emergency Department the recipient was laughing and screaming inappropriately and she indicated she had taken 13 pills of Trazodone. While the recipient was receiving treatment protocol per the poison control center, she ripped off the EKG leads and was placed in 4-point restraints and administered Ativan for agitation. The recipient was admitted to the telemetry/surgical unit where she informed staff that she continued to have suicidal ideation and she reported that she had been receiving treatment for depression at a local hospital. At that time, staff were instructed to contact that hospital to arrange for a transfer. Meanwhile, the recipient was transferred from the telemetry unit to the medical floor upon completion of the poison control protocol.

Staff were interviewed about the recipient being forced to sign a voluntary application for admission. They indicated that the recipient was initially treated for an attempted suicide in the emergency department and then transferred to telemetry for monitoring and for these treatments she signed a Consent for Medical Treatment. While in the telemetry unit the recipient signed an Application for Voluntary Admission as well as the Consent for Medical Treatment, the Confidentiality of Information Acknowledgement Peer Patient Agreement, and the Rights of Individuals Receiving Mental Health and Developmental Disabilities Services. Generally speaking, staff indicated, patients are not admitted to the Behavioral Health Unit unless a petition

or voluntary application for admission has been completed. If the patient is determined to be a danger to herself or others and she refuses to sign a voluntary, then the process of admission is halted and a petition for involuntary admission is completed and filed. The involuntary petition that was in the record was completed in anticipation of transferring the recipient to her requested hospital, however the recipient was then discharged to her home on the recommendation of her personal physician. Staff indicated that a petition is completed per hospital policy in case of an attempted elopement en route to the hospital.

Staff were asked about the allegation that the recipient was forced to accept medication. They indicated that the recipient was administered one dose of Ativan in the Emergency Department when she was removing the EKG leads and became combative and uncooperative. In order to complete the poison control protocol, the recipient was medicated and placed in restraints, however she did not at any other time receive forced medication. Additionally, the recipient informed hospital staff that her treating psychiatrist had prohibited the recipient from taking medication while she was receiving ECT, so she refused all medication and then later the orders for medication were all discontinued.

Upon admission to the hospital the recipient had informed staff that she was in outpatient treatment at another hospital. Several attempts were made to contact the program to obtain information and/or secure a transfer to that hospital, however the hospital did not respond. Documentation reflects that the patient inquired about her transfer to the treating hospital and she was advised that social services would continue to work on a transfer. On 3/04/14 the psychiatry nurse received a call from the recipient's hospital stating that the recipient had a power of attorney, who wished to have the recipient transferred to the hospital where she received ECT treatment. The recipient's attending physician at St. Anthony agreed to discuss the issue with the patient the following day and at this time he also discontinued all medications for the recipient. The following day the recipient signed a release to have her records transferred to the hospital and the attending physician completed the discharge summary and all transfer forms and orders were completed for a transfer. After the transfer process was completed, the hospital contacted St. Anthony on 3/08/14 and the recipient's physician discontinued the transfer due to his wish to treat the patient in an outpatient setting. The recipient was discharged to her home with her belongings as is noted in the record. Staff indicated that the only belongings the recipient had during her hospitalization were the amenities provided by the hospital so that she participate in milieu activities in street clothing.

The hospital counsel reviewed the clinical record and found that there were no other patient records comingled with the recipient's. All treatment decisions were based upon the evaluations and progress of the patient. Additionally, the fire department run sheet identified the recipient with one name, which was different from the name given in the Emergency Department and also different from that given on the psychiatry unit.

<u>STATUTES</u>

The Mental Health Code guarantees all recipients adequate and humane care in the least restrictive environment. As a means to this end, it outlines how recipients are to be informed of

their proposed treatments and provides for their participation in this process to the extent possible:

"(a) A recipient of services shall be provided with adequate and humane care and service 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. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan. [Section 2-200 d states that recipients shall be asked for their emergency intervention preferences, which shall be noted in their treatment plans and considered for use should the need arise].

(a-5) If the services include the administration of…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. …. 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 [to prevent harm]…." (405 ILCS 5/2-102).

Should the recipient wish to exercise the right to refuse treatment, the Mental Health Code guarantees this right unless the recipient threatens serious and imminent physical harm to himself or others:

"An adult recipient of services…must be informed of the recipient's right to refuse medication… The recipient…shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication... If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available. The facility director shall inform a recipient…who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services" (405 ILCS 5/2-107).

The Mental Health Code states, "Any person 16 or older may be admitted to a mental health facility as a voluntary recipient for treatment of a mental illness upon the filing of an application with the facility director of the facility if the facility director deems such person clinically suitable for admission as a voluntary recipient" (405 ILCS 5/3-400). "The application for admission as a voluntary recipient may be executed by: the person seeking admission, if 18 or older; or any interested person, 18 or older, at the request of the person seeking admission; or a minor, 16 or older…. The written application form shall contain in large, bold-faced 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" (5/3-401). The Code also states, "No physician, qualified examiner, or clinical psychologist shall state to any person that involuntary admission may result if such person does not voluntarily admit himself to a mental health facility unless a physician, qualified examiner, or clinical psychologist who has examined the person is prepared to execute a certificate under Section 3-602 and the person is advised that if he is admitted upon certification, he will be entitled to a court hearing with counsel appointed to represent him at which the State will have to prove that he is subject to involuntary admission" (5/3-402).

The Mental Health Code states, “No mental health facility shall require the completion of a petition or certificate as a condition of accepting the admission of a recipient who is being transported to that facility from any other inpatient or outpatient healthcare facility if the voluntary recipient has completed an application for voluntary admission to the receiving facility pursuant to this section”(5/3-400c).

Additionally, the Code states that whenever any rights of the recipient of services are restricted, notice must be given to the recipient, a designee, the facility director or a designated agency, and it must be recorded in the recipient's record (ILCS 405 5/2-201).

The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/5) states that all records and communications shall be confidential and shall not be disclosed without written release.

The Mental Health Code states that, "Every recipient who resides in a mental health or developmental disabilities facility shall be permitted to receive, possess, and use personal property and shall be provided with reasonable amount of storage space therefor, except in the circumstances and under the conditions provided in this Section [to protect the recipient or others from harm]…. When a recipient is discharged from the mental health or developmental disabilities facility, all of his lawful property which is in the custody of the facility shall be returned to him" (405 ILCS 5/2-104).

HOSPITAL POLICY

St. Anthony Hospital provided policy (PC78 A020) and procedure for admission of patients to the Psychiatric unit from the Emergency Department. It states, “1. The ED physician will evaluate the individual who presents to the ED to determine his/her physical and psychiatric needs. 2. An attending psychiatrist may refer individuals in need of psychiatric services to the ED for evaluation by the ED physician. 3. Once the ED physician determines the need for inpatient hospitalization, the psychiatrist on call or the patient’s attending psychiatrist will be consulted by the ED physician. 4. The patient must be medically stable prior to admission to psychiatry. 5. If an individual does not have a family physician or psychiatrist on staff at St. Anthony‘s Hospital, the psychiatrist on call will be contacted to discuss the need for inpatient hospitalization and the type of admission (voluntary or involuntary).”

St. Anthony policy (PC 78 1010) also states that patients seeking admission to the psychiatric unit must first sign a voluntary admission form prior to being allowed entry to the unit. All individuals admitted on an involuntary basis will have a Petition and first Certificate completed prior to admission to the locked unit. The procedure for admission from the Emergency Department is as follows: "1. The ED will notify the charge nurse on the psychiatric unit that a patient with a psychiatric problem is in the ED and needs assessment. 2. The psychiatric charge nurse will assess the patient for appropriateness of admission to psychiatry at St. Anthony's. If the patient is unknown to psychiatry staff or has not been admitted to the psychiatry unit for over 6 months or has a history of volatility, then an RN, MSW, MHC, or experienced MHW may complete a face to face assessment of the patient in the ER. 3. When the psychiatric unit determines that the patient is appropriate for admission, the ER staff will obtain a signed Voluntary Admission form. 4. When the patient refuses to sign in voluntarily, the psychiatry staff will be notified and may attempt to get the Voluntary Admission form signed later during the ED stay. 5. If the patient remains unwilling to sign the Voluntary, the ED staff are responsible for completing the Petition and 1st Certificate."

St. Anthony Hospital provided the policy for Patient Property which is distributed to all residents on the behavioral health unit upon admission. It states that upon admission, valuables are secured in the Unit Safe and all other property is stored in the Locked Contraband room until the Patient is discharged. All jewelry such as pins, brooches, necklaces, dangling earrings, and all large and potentially dangerous jewelry is not allowed as a precaution for all the patients' safety. For patients who are on suicide precaution, policy (PC78 S025) states that the staff will search the patient's clothing, belongings, and room for potentially dangerous objects with the patient present for the search. Items taken from the patient are labeled and stored in the patient belongings locker area (not the patient's closet).

St. Anthony Hospital provided the policy for Administration of Medications (#PC78-A005). It states that no patient will be forced to take medication. If the patient refuses medication, the reason for the refusal is to be documented in the patient's medical record. Emergency administration of psychotropic medication is done to prevent serious and imminent physical harm to the patient or others.

St. Anthony Hospital provided the hospital Privacy Practices which describes how medical information may be used, and disclosed, and how patients can get access to their medical information. This policy ensures the protection of patients' medical information and guarantees that information may be disclosed only with the patient's permission.

CONCLUSION

The hospital record for this recipient indicates that she was admitted to St. Anthony for a suspected suicide attempt and that she was offered a voluntary application for admission after being treated in the emergency department and then on the surgical unit. The recipient signed all admission forms indicating that she was apprised of her rights and indicating willingness to receive treatment until she could transfer back to her hospital. The record does not indicate that the recipient ever received any forced medication and that the Ativan dose she received while in

the emergency department was not for psychiatric treatment but necessary in order for staff to implement the poison control protocol. The record also documents several attempts by staff to contact the recipient's own physician, along with their attempt to transfer her to her requested hospital, however she was then recommended by her own physician to continue with outpatient therapy. The hospital counsel reviewed the recipient's entire record and stated that she found no other patient's records comingled with the recipient's, however she did note that there were several names used by the recipient which were given to the fire department and admission staff. These names all related to the recipient and were recorded with the patient's identification number. With regard to the patient's clothing, she was admitted with no clothing and was given clothing the day that she was admitted to the Behavioral Health Unit so that she could interact on the unit in street clothes. The recipient was then discharged with all her belongings.

The HRA does not substantiate the complaint that the facility did not follow Code procedure when a recipient was forced to sign a voluntary application for admission and forced to accept emergency medication for no adequate reason, that hospital staff would not consult with the recipient's outpatient treatment team to get the background information needed to treat the recipient, that another patient's record was included in the recipient's record and the hospital staff made treatment decisions based on this other patient's information, and that the recipient was reportedly not given all of her clothing when she was discharged.

SUGGESTION

1. The HRA notes that when this recipient was in the process of being transferred to another hospital for continued treatment at her request, the St. Anthony staff completed a petition for involuntary admission as required under its policy which may constitute a violation of her rights under Article IV of the Mental Health Code (see Section 3-400c). We caution the hospital against such policy and practice as written and encourage revisions to comply with the Mental Health Code.

2. The medication consent form signed by the physician did not list the medications; the HRA also cautions the hospital to ensure that consent forms are complete before securing recipient signatures.