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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 15-030-9012

Riveredge Hospital

Summary: The HRA substantiates the complaint that Riveredge did not follow Code procedures when it did not include the guardian in the care and decision making of the recipient.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Riveredge Hospital (Riveredge). It was alleged that the facility did not follow Code procedures when it did not include the guardian in the care and decision making of the recipient. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Illinois Probate Act of 1975 (755 ILCS 5).

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

To review these complaints, the HRA conducted a site visit and interviewed the Chief Nursing/Compliance Officer, the Medical Director, the Clinical Director, the President of Medical Staff, the Chief Executive Officer, and the Director of Clinical Services. Relevant hospital policies were reviewed, and records were obtained with the consent of the guardian. Guardian letters of office were obtained.

COMPLAINT SUMMARY

The day the recipient was admitted to Riveredge the guardian called and spoke with the nurse on staff at length about her ward's medications (the ward has a private psychiatrist who prescribes medications, as well as a Guardian ad Litem). She sent her Letter of Office and with it, a letter stating to staff that they should contact her for any and all changes to her ward's medications. The nurse stated that she was noting all directions and would present them to the attending physician. On Sunday the 1st the physician ordered a blood draw without the guardian's consent. On the 4th the recipient allegedly called the guardian and told her that staff had increased the medication Tegretol to 400 mg three times daily. Allegedly, the nurse had stated to the ward that the hospital staff did not have to call the guardian. The physician refused to put the recipient back on 300 mg as requested by the guardian. The physician reportedly

insisted that they put the recipient at maximum level to see what would happen and when he was sent home he was so affected by the medication that he could hardly walk.

FINDINGS

The record shows that the recipient was admitted to Riveredge on 1/31/15 and discharged 2/13/15. The recipient's Discharge Summary states, "The patient is a 22-year-old Hispanic male who states, 'My life sucks, my mom makes up stuff and my grandma is annoying.' He said he became angry at this grandmother who was saying things that he didn't want to hear. He became vulgar and verbally abusive. He apparently became threatening enough that his mother called the police. When the police arrived, the patient took a baseball bat and began swinging at them, telling the police to shoot him. He was tazed, disarmed, and taken to the hospital for acute inpatient psychiatric treatment. He has a history of bipolar disorder and schizoaffective disorder. He had been on a complex medication regimen including Wellbutrin, Topamax, Tegretol, Thorazine, and Propranolol with which the patient apparently has been compliant. Nonetheless, he was threatening violence and suicide which required in-patient psychiatric treatment. Patient states he has had 35 prior psychiatric hospitalizations since age 14, most of them at ... He states there has been numerous suicide attempts including overdoses, swallowing screws, trying to hang himself. No history of ECT. He has a diagnosis of posttraumatic stress disorder (PTSD) and borderline personality disorder as well..."

There are two Medication Reconciliation forms included in the record. Both are completed on 1/31/15, the day the recipient was admitted to Riveredge, and one states that the information is provided by the recipient and his guardian, and the other indicates that the information is provided by "bottles/lists." These two forms do not match in the types of medications listed or in the dosages. The recipient's Discharge Summary, completed 2/24/15, lists the following medications at the time of the recipient's discharge: Bupropion (Wellbutrin) 100 mg daily, Carbamazepine (Tegretol) 400 mg at 9, 1, 5, and 8 daily, Thorazine 12.5 mg daily, Lorazepam (Ativan) 0.5 mg at 9, 1, and 5 daily, and Propranolol 20 mg at 8 p.m. daily, 30 mg at 9 a.m. daily, and 40 mg at noon daily. Topamax (Topiramate), which was administered daily, is not included on this list.

The record contains the Patient Consent for Psychotropic Medication. This form contains a written statement saying "No med changes without legal guardian's consent." It also indicates that on 1/31/15 the recipient gave consent to Propanolol, Thorazine, Tegretol, Wellbutrin, Topamax, Benedryl, Melatonin, and Bupropion. In the section which includes verbal consent, it indicates that the guardian had consented to Ativan on 2/02/15 and Trileptal 400 mg on 2/08/15. The Trileptal consent is signed by a staff person and witness. Except for the Trileptal, the consent form does not include dosages.

The Physician Orders for medication are included in the clinical record. They indicate that on 2/01/15 the recipient's Wellbutrin (Bupropion) was decreased to 100 mg each morning, and on 2/04/15 the Tegretol dose was increased to 400 mg three times daily. The Medication Administration Record (MAR) contains a handwritten "consented" within the section indicating an increase in the Tegretol medication dosage on 2/05/15.

The recipient's Master Treatment Plans are included in the record. The Plans are not signed by the guardian but indicate her presence by phone.

On 1/31/15 Physician and Nurse Progress Notes state, "Per request from Mom, who is the guardian, Mom clarified pt medication. I informed Mom of the doses of Thorazine is [sic] not an accurate dose, but Mom stated, 'This is what she and her doctor gives.' Pt Mom then stated pt had a stroke at age 9 yrs old from By- meds [sic]. She also stated pt, behavior changes in the afternoon hours. She stated pt also suffers from PTSD. Continue to monitor each 15 minutes for safety. Dr notified, order given. Pt placed on CO [close observation] each 15 min. for Special Precaution the remainder of the shift."

On 2/04/15 Progress Notes state, "Mother (guardian) called stating that patient should have been on 300 mg of Trileptal when admitted, not 200 mg. Mother was informed by nurse that Trileptal was increased to 400 mg tonight by Dr... Mother was upset telling writer that she refused to have patient take higher dose. Writer informed Dr... at approx.. 11pm, Dr... informed writer to let the mother know that the dose would not be decreased. Once speaking to [guardian] again, she consented to pt taking 400 mg Trileptal TID." The HRA notes that the recipient was never administered Trileptal and his physician did not order this medication however there is a guardian consent for Trileptal phoned in on 2/08/15 and witnessed by another staff person.

On 2/04/15 Psychiatric Notes state, "The patient was staffed in multidisciplinary staffing today- see updated treatment plan. Pt. is attempting a flight into health which I warned him against. Mom feels he's not a risk of harm to self/others (?)."

On 2/06/15 a Social Work Individual/Family Therapy Note shows that the recipient met with the therapist and the recipient's mother (by phone) in a family session: "Pt's mother said that pt is 'doing really well and was happy that he hasn't received a PRN since he has been in the hospital. Writer listened supportively to pt's mother and answered questions regarding treatment progress and discharge." On 2/09/15 at another Individual Therapy Session the notes state, "Writer and pt called pt's Mom and guardian and provided an update on pt's treatment. Pt's mother expressed concern about pt's blood tests. Writer will return call after staffing with Dr..." On 2/10/15 the notes state, "Per pt's mother's request, writer faxed psych eval to pt's attorney. Writer talked to pt's mother at length about pt's treatment progress and discharge plan."

On 2/09/15 a Psychiatric Progress Note states, "The patient was staffed in multidisciplinary staffing today- see updated treatment plan. Guardian (Mom) agrees to increased Tegretol now to try to establish therapeutic blood level, he has achieved therapeutic levels at lower doses. Plan- increase Tegretol."

On 2/12/15 a Family Therapy Note states, "This writer began session by asking pt for an emotional checkin. Pt stated he was feeling ready to go but was concerned because his Tegretol level had not been taken yet. This writer engaged unit nurse about this who was already on the phone with pt's mother. She informed everyone that the Tegretol level was to be drawn Friday morning, prior to patients discharge. This writer stated that would still work out since the soonest transportation could pick pt up was at 4:30 pm. Pt accepted this. Pt's mother did not: she wanted doctor to get his level drawn today. Unit nurse explained that pt had already taken

his morning medication and the Tegretol levels could not be taken after this. She again explained that the psychiatrist had written the order for it to be drawn tomorrow morning.... Pt asked about Tegretol level and this writer explained doctor wanted it taken day of discharge. Pt stated 'okay.' This writer then attempted to call pt's mother with pt. She could not be reached. Voicemail with discharge and aftercare plans was left."

Hospital Representatives' Response

Hospital representatives were asked about the complaint. They indicated that the guardian in this case, although she lives quite a distance from the hospital, was able to attend all treatment planning sessions by phone. These treatment planning sessions are held at least weekly or more often as needed. The recipient's physician and social worker as well as nursing staff and others were in attendance, and the guardian was able to actively take part in any discussion as it transpired. Additionally, treatment plans were sent to the guardian along with information about medication, so that the guardian was able to make informed decisions regarding them. Staff also indicated that when consent is obtained by phone there is a staff witness and this witness signs the consent form. Staff were shown the Consent for Medications form and they acknowledged that the guardian had only signed consent for Ativan and Trileptal.

Staff were interviewed about the Progress Note entered on 2/04/15 which indicated that the recipient's medication was changed without the consent of the guardian, that the guardian refused the increase in a medication and was then persuaded to consent to it, and that the medication mentioned was not part of the recipient's treatment plan or the physician's medication orders. The hospital staff indicated that entry must have been a mistake- the recipient was never prescribed Trileptal as indicated in the note, even though a staff person had written on the consent form that the guardian had consented to its administration. The medication which was increased was probably Tegretol as reflected in the Physician Orders and Medication Administration Record. Additionally, the physician indicated that the progress note entered on 2/09/15 was in error since it states that the recipient had achieved the therapeutic level of Tegretol but it was increased nonetheless. The physician stated that this probably meant to say that the recipient had not achieved therapeutic level and consequently the dose was increased. Staff indicated that generally the recipient and/or guardian consent to a given medication and then the physician may titrate the dosage until the desired effect or therapeutic level is achieved. Staff were asked about guardian consent for blood tests/levels, and they indicated that they do not require guardian consent for these procedures as they are part of the consent for the medication.

STATUTES

The Mental Health Code mandates that from the time that services begin, legal guardians and other substitute decision makers are to be included in all facets of care. Information about a recipient's rights must be shared orally and in writing with the adult recipient upon commencement of services, or as soon as his condition permits, and with the guardian. A recipient aged 12 or older and any guardian must also be informed upon commencement of services of the right to designate a person or agency to receive notice should the recipient's rights be restricted. The recipient is allowed to select a preference for forced emergency treatment and

the facility is to communicate a selection to any guardian (405 ILCS 5/2-200). If any guaranteed right under the Mental Health Code is restricted, including the right to refuse medication, then the facility must promptly give notice to the recipient, his guardian, and to any person or agency so designated. (405 ILCS 5/2-201).

The Mental Health Code allows recipients and their guardians the right to refuse generally accepted mental health services. If these services include psychotropic medication, the physician, or designee, must advise the recipient, in writing, of the side effects, risks and benefits of the **proposed** treatment as well as alternatives to the extent that it can be understood by the recipient. The same written information must be provided to the guardian. The physician must also determine and state in writing whether the recipient has the capacity to make a reasoned decision about his treatment. If the recipient lacks the capacity to make a reasoned decision about his treatment, the treatment can only be administered to prevent the recipient from causing serious and imminent physical harm to himself or others or upon a court order (405 ILCS 5/2-102a-5, 2-107, 2-107.1).

The Probate Act of 1975 has the same intentions when it calls for appointed guardians to secure and oversee appropriate care for their wards and to be assured that providers will rely on their directives:

To the extent ordered by the court...the guardian of the person shall have custody of the ward and ...shall procure for them and shall make provision for their support, care, comfort, health...and maintenance...(755 ILCS 5/11a-17).

Every health care provider...has the right to rely on any decision or direction made by the guardian ...that is not clearly contrary to the law, to the same extent and with the same effect as though the decision or direction had been made or given by the ward (755 ILCS 5/11a-23).

HOSPITAL POLICY

Riveredge provided the hospital policy and procedure for Informed Consent for Psychotropic Medication (No. 704.12). It states, "Patients who are receiving medications and when appropriate, parent/guardian shall be given a clear, concise explanation of the proposed medications, the indications, benefits, risks, alternative treatment options and right to refuse medication. Patients/guardians are to provide informed consent for psychotropic medications."

The policy directs the physician and/or nurse to discuss with the patient and/or parent/guardian the proposed medications and give them information on psychotropic medication providing medication teaching on specific medications. The physician then writes the order for the medication and the physician/nurse signs the Patient Consent for Psychotropic Medications form. The physician/nurse are to ensure that the patient/parent and/or guardian sign the consent prior to medication administration. The policy also states, "If the patient began medications prior to admission he/she should continue on the medication but the consent form must be signed by the patient and/or guardian. In case of phone approval from a parent or guardian, the

Physician/RN will document the telephone approval on the Patient Consent for Psychotropic Medications form using the verbal consent section." The policy also indicates that phone approvals obtained by nursing staff should be witnessed. Both staff and witness are required to sign the consent form.

CONCLUSION

Generally medical records clarify the clinical strategies utilized in patient care. In this case though, the record obfuscates the recipient's clinical experience. Progress Notes are at times illegible (such as all physician notes), nonsensical (such as nurse's notes 1/31/15), or even completely in error (physician notes from 2/04/15 and 2/09/15). The notes do, however, indicate that the hospital administered medication without the consent of the guardian and then made changes to the recipient's medication regimen without the consent of the guardian. Consent for treatment or exercising the right to refuse it is a necessary first step in the inclusion of guardians in the care of their ward. This is particularly troubling since the guardian informed the staff at her ward's admission that he had suffered a stroke from medication error when he was 9 years old. Additionally, the guardian had the input and oversight of the recipient's personal psychiatrist, so she brought valuable information to the recipient's treatment decisions. Unfortunately, it is not clear that the hospital honored this input. The HRA substantiates the complaint that Riveredge did not follow Code procedures when it did not include the guardian in the care and decision making of the recipient.

RECOMMENDATION

1. Train staff to honor the role of the guardian. Begin by obtaining consent from the guardian for all treatment, including medication. Include the guardian in all facets of the recipient's care and ensure that they are given the information necessary to make informed decisions. Ensure that the decisions and directions of the guardian are relied upon to the same extent as those of the ward.

SUGGESTION

1. The physician's notes in this case are not legible. Encourage physicians to be aware of their handwriting, or else have their notes transcribed.
 2. There were too many errors in this hospital record. Impress upon staff the importance of the clinical record and remind them that they are held responsible for their documentation.
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RESPONSE

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



Riveredge Hospital

July 24, 2015

Ashley Casati, HRA Chairperson
Illinois Guardianship and Advocacy Commission
1200 S. 1st Ave. Box 7009
Hines, Illinois 60141

Re: #15-030-9012

Dear Ms. Casati:

This letter is in response to the Human Rights Authority findings for the investigation identified above.

Preparation and submission of this Plan of Correction does not constitute an admission of or agreement by the hospital with the alleged or conclusions set out in the Conclusion and Recommendation sections of the HRA Response Report. The Hospital submits this Plan of Correction in accordance with regulations and the Plan of Correction documents the actions taken by the hospital to address the cited deficiencies.

Recommendation

1. Train staff to honor the role of the guardian.
 - a. Issue discussed in Medical Staff Executive Committee and members encouraged to include guardians in care decisions.
 - b. Issue discussed in unit and department meetings and attendees encouraged to include the guardian in all facets of care and remain in contact with the guardian throughout the ward's hospitalization.

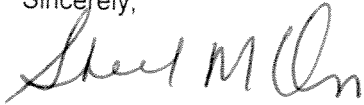
Suggestion

1. Legibility
 - a. Reminder provided to each physician of the importance of legible documentation in the medical record.
2. Errors in medical record
 - a. Topic discussed in unit and department meetings. Attendees reminded of their role in protecting the integrity of the medical record and importance of accurate documentation.

Riveredge Hospital and their medical staff are concerned to hear of any potential quality issues and strive to provide the best and safest environment for our patients to receive care. We value the input from our patients and families and welcome feedback to improve our patient care.

Thank you for allowing us the opportunity to provide information regarding the actions taken in response to allegations related to care. Please feel free to contact me if you have any questions. I can be reached at (708)209-4185.

Sincerely,

A handwritten signature in black ink, appearing to read "Sheila M. Orr". The signature is fluid and cursive, with the first name "Sheila" being the most prominent part.

Sheila M. Orr, RN, BSN, JD
Chief Compliance/Nursing Officer
Riveredge Hospital