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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 15-030-9018
LORETTO HOSPITAL

Case Summary: The HRA substantiated the complaint that the facility staff did not inform the guardian that his ward was admitted into the hospital, did not share vital medical information with the guardian or his ward's psychiatrist, and did not obtain the guardian's consent for the ward's medication and changes made to the medication regimen.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Loretto Hospital (Loretto). It was alleged that the facility staff did not inform the guardian that his ward was admitted into the hospital, did not share vital medical information with the guardian or his ward's psychiatrist, and did not obtain the guardian's consent for the ward's medication and changes made to the medication regimen. If substantiated, these allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

Loretto is a private community hospital located in Chicago. The hospital contains a 56 - bed behavioral health unit.

To review these complaints, the HRA conducted a site visit and interviewed the Director of Behavioral Health, the Clinical Nurse Manager, and the Mental Health Specialist. Relevant hospital policies were reviewed, and records were obtained with the written consent of the guardian. The guardian's Letter of Office is included as part of the clinical record.

COMPLAINT SUMMARY

The complaint alleges that the plenary guardian of the recipient was not contacted when his ward was admitted to Loretto and as a result he notified several staff, including the hospital President and CEO, the Chief Experience Officer, and the Director of Behavioral Health yet no one would address his concerns. Additionally, the complaint alleges that although the guardian expressed concern that medication that had caused problems for his ward were currently being prescribed for him, the ward's physician still prescribed these medications, without contacting the ward's guardian or his personal psychiatrist. The complaint also alleges that the staff did not

obtain consent from the guardian or the recipient for the medication he was prescribed or the changes that were made to his medication regimen.

FINDINGS

The hospital face sheet for this recipient indicates that he was admitted at 4:28 a.m. on 5/05/15 and his "person to contact" is listed as his father, along with contact information. The record contains the Petition for Involuntary/Judicial Admission, completed by staff from the recipient's group home, on 5/04/2015 at 8:00 p.m. for the stated reason that "This resident said he is having thoughts of killing himself, that he cannot control his thoughts. He also said he will harm his roommate, who he has kicked and punched today." The petition indicates that the recipient was detained at a local hospital where he was then certified by a hospital resident at 8:57 p.m. on the same day for "History of bipolar disorder with suicidal ideation and violent acts toward others." Transfer documents show that the recipient was then transferred to Loretto at 3:15 a.m. on 5/05/15. On 5/05/15 at 4:45 a.m. the recipient signed an Application for Voluntary Admission and was given the Rights of Voluntary Admittee information as well as the Rights of Individuals Receiving Mental Health and Developmental Disabilities Services. The guardian Letter of Office is included with the petition and certificate, showing that his father is the plenary guardian of the recipient.

The recipient's Psychiatric Evaluation was completed on 5/05/15 and dictated at 11:53 a.m. It states, "The patient states that he was brought to the hospital because the place that he was staying called 911 states that he has been off on his roommate [sic]. Someone had gotten a push. The patient was very, very guarded with the information and he is very, very paranoid. States he told people that he has felt suicidal and the home health that he was staying at and so they called 911 they had him picked up and bring [sic] in for an evaluation. The patient is still seeing [sic] a little confused about being picked up. He states he has been on medication in the past. He cannot recall everything that he has been on, but he has been on medication to help with the thinking and help him with some voices to help him with his mood_ situation."

The recipient's Notification (Consent) for Psychotropic Medication dated 5/05/15 at 4:41 a.m. is included in the record. It indicates that the recipient has given informed consent for the following medications: Cogentin, Depakote, and Risperdal. There are no dosages provided. The form states, "The signature of the patient/parent/guardian indicates agreement with the use of the medication(s) listed above and attests to their understanding of the benefits, and possible risk of the prescribed medication(s). The patient/parent/guardian was provided with the hospital's Patient Medication information form, which outlines the patient's right to refuse treatment." This form is signed by the recipient but it is not signed by the guardian. The recipient's Physician Orders for medication indicate the following dosages: Cogentin 1 2mg tablet to be taken orally each evening, Depakote, 1 250 mg tablet orally each morning and 2 500 mg tablets orally at bedtime, and Risperdal, 1 0.5 mg tablet orally twice daily. This regimen was revised during the recipient's hospitalization to result in the following at the time of discharge: Depakote ER 500 mg twice daily, Paxil 20 mg in the morning, Cogentin 1 mg twice daily, and Geodon 20 mg twice daily. There is no informed consent for any revisions.

Progress Notes from 5/05/15 at 2:45 p.m. state, "Writer had attempt [sic] to call guardian 3 time to the following numbers… . No answer or wrong number, nurse …. has provided me with the following number … At 2:30 p.m., also writer attempted to reach guardian again but no answer left message."

The clinical record contains a letter from the recipient's guardian written to the President and CEO of Loretto on 5/06/15. The letter states:

This letter shall serve as a formal complaint with the poor level of service I received from a number of your staff when my son was admitted into your hospital on yesterday at approximately 3:00 a.m.

You should know that my son was diagnosed with schizophrenia a few years ago and has a very difficult time articulating, advocating, and making knowledgeable decisions, which is why the Circuit Court of Cook County, Probate Division, appointed me, his biological father, plenary guardian of my son, who is a disabled person, authorizing me to have under the direction of the court of the ward and to do all acts required by law.

I personally find the above to be quite impossible if your staff fails to contact me when my son has been admitted. It took having to conduct thorough research and to go through many SWAT maneuvers to get information that I have a legal right to.

I spoke with your assistant, who transferred me to [the Chief Experience Officer]. [She] listened to my concerns and suggested that I speak with [the Director of Behavioral Health]. I spoke briefly with [him] and he stated that he would call me back once he confirms that your organization was in receipt of the guardianship paperwork and had more information on my son. Instead of [the Director of behavioral Health] calling me back, [the Assistant to the CEO] called sharing with me that Loretto Hospital was in compliance and had 24 hours to contact me and also shared with me that [the referring hospital] was to blame for this whole ordeal because they did not contact me or my son's residential facility, informing us where he was being transferred to.

She stated that my son was stable and that was it. I was dissatisfied with her accusatory remarks and her failure to give me additional information on my son so I requested to speak with her manager … [He] was unavailable. I contacted your assistant in hopes that she would transfer and delegate someone in leadership to handle my concern; once again, she transferred me to [the Chief Experience Officer] who tried to contact the manager and [the Director of Behavioral Health] in hopes that my questions and concerns were being addressed, but to no avail. I contacted your assistant again; this time she told me that she had spoken with you and that she was instructed to tell me to follow proper protocol and also stated that your organization is in compliance and has a 24 hour window to contact me. When I asked her for documentation or proof stating such, she told me, in a rude manner, to get a computer; I guess she meant for me to go online and conduct the research myself. I was shocked and appalled by this highly unprofessional remark and shared with her that her rude behavior would not be tolerated and told her that after this point, I was recording the call. She remained silent throughout the duration of the call.

I called [the Chief Experience Officer] once again, received her voicemail and informed her that I was recording the call. Approximately one hour later, at the end of the day, [the Director of Behavioral Health] called back trying to answer all of my questions and concerns. In doing so, he informed me of my son's medications. I am concerned about Geodone; he had a negative response to this medication in the past, had your staff contacted me, they would have known that…."

Progress Notes from 5/07/15 at 9:03 a.m. state, "Patient guardian call, extremely upset, yelling at writer complaining of not been call [sic] the patient got admitted, writer inform [sic] guardian the attempt was made and left message, guardian become [sic] to use inappropriate leangues [sic] with writer and ask to speak with doctor stating (the damn doctor is going to call me I don't give a damn what you say, transfer me to … now) Writer attempted to transfer but guardian hangup [sic] the phone."

The HRA then received a document from the guardian memorializing a conference call meeting which was held May 8, 2015 and included hospital staff as well as the guardian (the recipient's physician was not in attendance). At this conference the guardian attempted to find out why the staff had not contacted the recipient's private psychiatrist, and what the hospital protocol was when a patient with a documented guardianship is admitted into the hospital. The Director of Behavioral Health indicated that the hospital must notify the guardian immediately. The guardian notes show that he had spoken with the Director of Behavioral Health earlier and was assured that the recipient was not being administered Geodon, but that it was on hold. The guardian noted the areas that were then covered in this call:

1. The planned date for the ward's discharge.
2. Questions regarding the ward's behavior: Had he had any altercations /episodes since being admitted? Had he displayed any indication that he was having thoughts of harming himself or others? Was he eating?
3. Questions regarding visitation.
4. Questions regarding the names and titles of staff who would be treating the ward
5. Request for a review of the ward's record (Guardian was told that he could not review or obtain a copy of the file until the ward was discharged).
6. The guardian's notes state, "I asked what medications my son was being administered? [The Director] said Geodon 20 mg, Paxil 20 mg, and Depakote 500 mg. I was furious! I asked [the Director] why would his hospital go behind my back and administer medication that was in question. I had to remind them that my son was not a guinea pig or lab rat. I did not appreciate this at all." This conference call was not documented in the recipient's clinical record.

A letter dated May 6, 2015 from the Chief Patient Experience Officer documents the initial response to the guardian's complaint:

Thank you for taking the time to share your concerns with us. Our goal at Loretto is to provide quality medical care and service to all our patients. As Chief Patient Experience of Loretto and on behalf of senior Management and the Board of trustees we want you to know that your critical feedback is essential in order for us to improve our skills and provide quality care to our patients.

We want to assure you that we take all patient complaints very seriously. We are currently investigating your complaint and I will follow up with you upon completion of the investigation. You will be provided with a written notice of the date of completion of my investigation, any relevant findings, actions taken if applicable, and/or if legally permissible. The written notice will include the name of a contact person if further contact is necessary. If I am unable to resolve your complaint within seven days from receipt, I will contact you by phone to provide an update until it is resolved…."

On 5/13/15 the HRA received a copy of two physician orders for medication each dated 5/11/15 and completed by the recipient's attending physician. These prescriptions added Paxil 20 mg and Geodon 20 mg to the recipient's medication regimen, and neither of the medications were consented to by either the guardian or the recipient. As a result of these revisions, the guardian then forwarded an email on 5/13/15 to the HRA that stated, "I am in receipt of my son's new prescription; it appears that at least 2 of his medications have been changed without my or his private psychiatrist's approval. Dr. [recipient's attending physician], Loretto Hospital,

failed to contact me or my son's doctor to talk to her about this change. I am livid as I have shared my concerns with several staff at Loretto concerning this and nothing was done about it."

The record shows that the recipient was discharged on 5/11/15. The Discharge Summary states, "The patient was initially admitted in the hospital to work on his mood. The patient had been feeling depressed. The patient states that since _ at hospital [sic] to take his medication. The patient denies any side effects with the medications; deny any problem with his medicine at this time. He was medication compliant. He is without any untoward effect. He is being discharged and told to continue with medications, which is Depakote ER 500 twice a day, Paxil 20 mg in the morning, Cogentin 1 mg twice a day, and Geodon 20 mg twice a day."

A final letter dated 6/19/15 from the Chief Patient Experience Officer was sent to the guardian which stated, in part, "*We investigated your concerns and determined that upon the initial intake the paperwork received for your son was not complete at the time you contacted us. Upon notification the department manager spoke with you to obtain the appropriate documentation in order to provide you with the necessary information. We later spoke with you about your concern. We have communicated to the staff on the unit regarding verification of appropriate documentation…"*

HOSPITAL REPRESENTATIVES' RESPONSE

Hospital representatives were interviewed about the complaints. They stated that the recipient in this case had presented to the hospital after being seen at two other facilities. The paperwork that accompanied the recipient was a petition for guardianship and not an actual Letter of Office so they had to contact the guardian to ensure that he had been appointed the plenary guardian. Staff indicated that after the guardian was contacted he refused to cooperate with the staff in any way and his focus continued to be on his lack of notification when his son was admitted. Staff indicated that they received the Letter of Office within the first 12 hours of the recipient's hospitalization. They stated that they then contacted the guardian but he refused to make himself available to them, instead telling them that he was out of town and unable to sign documents. Staff indicated that they even offered to amend the visiting hours so that the guardian would have the opportunity to visit his son, however he was unwilling or unable to do this. Staff indicated that they were in touch with the guardian every day and they had offered him everything they could to address his concerns, however he was uncooperative with all suggestions as if he didn't want a resolution. Staff also stated that the guardian had contact with the physician and that they have never had problems with physicians being available to guardians. The HRA asked staff if there was any documentation of any conversation between the guardian and the staff or the guardian and the physician and they indicated that there was no documentation. The HRA indicated that even after staff became aware of the guardianship, the recipient's medications were revised and the very medication that the guardian objected to was then prescribed for the recipient, without informed consent. Staff expressed that this was the physician's decision, which they have no control over. The HRA pointed out that the record contained no indication of the guardian's informed consent for either treatment or medication for the duration of his son's hospitalization. Staff responded that the recipient had decisional capacity and was able to sign in voluntarily, thus he was able to consent to medications and care.

STATUTORY BASIS

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).

The Mental Health and Developmental Disabilities Code provides for the inclusion of the guardian in all aspects of treatment:

"A recipient of services shall be provided with adequate and humane care 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…."(5/2-102). As indicated above, the guardian must be advised in writing, of the side effects, risks, and benefits of all treatment- the same information that is provided to the recipient in writing (5/2-102 a-5). The Mental Health Code also allows the guardian to refuse treatment for the recipient:

"An adult recipient of services, the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication. The recipient and the recipient's guardian or substitute decision maker 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." (405 ILCS 5/2-107 a). Additionally, the Code states that upon commencement of services or as soon thereafter as the recipient's condition permits, the guardian shall be informed orally and in writing of the rights that are guaranteed by the Code which are relevant to the recipient's services plan, and the recipient's preferences for emergency treatment

are to be communicated to the guardian (5/2-200). And, whenever a guaranteed right of the recipient is restricted, the recipient and his/her guardian must be given prompt notice of the restriction and the reason therefore. (5/2-201 a).

The Illinois Probate Act of 1975 defines the duties of the guardian:

"To the extent ordered by the court and under the direction of the court, the guardian of the person shall have custody of the ward and the ward's minor and adult dependent children; shall procure for them and shall make provision for their support, care, comfort, health, education and maintenance, and professional services as are appropriate….The guardian shall assist the ward in the development of maximum self-reliance and independence." (755 ILCS 5/11a-17a).

Also, the Probate Act gives direction to providers to rely on guardian decision making:

"Every health care provider…has the right to rely on any decision or direction made by the guardian….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).

Illinois Hospital Licensing requirements (77 Ill. Admin. Code 250.2280 d) state, "A policy and procedure manual shall be maintained for the psychiatric service. The manual shall include procedures for the care and treatment of patients with specific procedures for the care of suicidal and assaultive patients. They shall identify the relationship with State agencies and community organizations providing psychiatric services. It shall also describe plans for the evaluation and disposition of psychiatric emergencies." Section 250.2280 e 2 states, "The following additional requirements for psychiatric units in general hospitals and psychiatric hospitals shall be provided for patient care units: A) Adequate office space for psychiatrists, psychologists, nurses, social workers, and other professional staff, B) Conference room, day room and dining room. C) Patient's laundry room."

The Mental Health Code states, "Every mental health facility shall maintain adequate records which shall include the Section of this chapter under which the recipient was admitted, any subsequent change in the recipient's status, and requisite documentation for such admission and status" (405 ILCS 5/3-202).

HOSPITAL POLICY

The HRA requested but did not receive the hospital policy regarding guardian rights.

CONCLUSION

The face sheet for this recipient's record shows that he was admitted to Loretto hospital at 4:28 a.m. on 5/05/15. This information sheet also identifies his father as the next of kin and "person to notify" and his phone number is included, as well as the number of the recipient's group home. Staff indicated that a petition for guardianship was part of the recipient's transfer paperwork, so it seems reasonable that the hospital would have notified the resident's home to determine if there was a guardian and to notify him of the admission. This recipient had had

medical issues with certain psychotropic medications in his past, and as indicated in his admission paperwork, he was unable to even identify which medications he was taking, thus necessitating his guardian's valuable input (and also the reason that a guardian was appointed by a judge to act as a substitute decision maker). Notes from the record show that staff did not attempt to contact the guardian until 2:45 p.m. that afternoon. However, even more egregious is the fact that even after receiving the documents identifying the guardian, and even after the guardian objected to a specific medication that caused harm to his son in the past, the hospital continued to prescribe that very medication and without the informed consent of the recipient or the guardian. This is inexcusable and a violation of the recipient's as well as the guardian's rights under the law. Also, even the staff reported that they were in daily contact with the guardian and the guardian had open contact with the physician; there was no documentation of these calls in the record. The HRA substantiates the complaint that the facility staff did not inform the guardian that his ward was admitted into the hospital, did not share vital medical information with the guardian or his ward's psychiatrist, and did not obtain the guardian's consent for the ward's medication and changes made to the medication regimen.

RECOMMENDATIONS

1. Train staff to honor the role of the guardian. Begin by training staff to ask about guardianship as soon as the recipient presents to the hospital. Make every effort to contact the guardian immediately after staff are made aware that the recipient has an appointed guardian and obtain 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. Develop policy and procedure for these components of the law.

SUGGESTIONS

1. The record from Loretto Hospital was received with a letter stating, "We do not have any other records or written information." At the site visit we learned that we did not receive the entire record, especially the Medication Administration Record, which we felt was important to the investigation. We suggest that the hospital make every attempt to provide the true patient records and cooperate in every way with HRA investigations.

2. The medication consent form did not include dosages. Since dosage has such a profound impact on the effect of medications, particularly psychotropic medications, we suggest that all consent forms include this information so that patients and their guardians are adequately informed to make a decision regarding consent.

3. The record was sorely missing documentation. The HRA suggests that the staff document phone calls to and from the guardian, document any issues that affect the clinical decision making, and any problems and their resolutions as they occur during a treatment episode.

4. The hospital staff were not prepared for their site visit. The room chosen for the visit was a staff break room and twice during the visit staff members walked into the room. Also, voices could be heard from outside the room where staff were talking in the hallway. Both of these situations could present a confidentiality issue for the hospital. The HRA has had a long and very positive relationship with Loretto Hospital and has always been invited into a conference room to discuss confidential matters related to patient care, and we suggest that the hospital continue with this longstanding practice. Also, staff presented to the site visit with no information or documents related to the case, and they had forgotten that the site visit was scheduled for that day, delaying the start of the meeting and limiting the staff input. The HRA reminds hospital representatives that HRA members are volunteering their time (and must be excused from their regular employment) to attend site visits, so we ask that they are given the professional courtesy of staff who are prepared and have input into these very important issues addressing patient care.