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HUMAN RIGHTS AUTHORITY-SPRINGFIELD REGION

REPORT 15-050-9004
Blessing Hospital

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving complaints of possible rights violations in the care provided to an adult patient at Blessing Hospital's Behavioral Center in Quincy. Complaints state that the Center:

1. Did not involve the patient's legal guardian in treatment and discharge planning.
2. Did not consult the guardian for psychotropic medication consent or provide the guardian written information on proposed psychotropic medications.
3. Forced the patient to sign a request for discharge in order to be transferred.
4. Restricted the patient's communication, forced medication to which she was allergic and confined her to a room without the need to prevent harm, harassment, intimidation or serious and imminent physical harm and without providing the guardian written notice.
5. Confined the patient with a painful back on a hard surface in a cold room.

Substantiated findings would violate rights protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

The Center provides in and outpatient services to people of all ages, the inpatient side with two eighteen-bed adult units and one up-to-eighteen-bed adolescent unit.

The HRA visited the hospital and discussed the matter with administrators and staff directly involved in this patient's care. Relevant policies were reviewed as were sections of the patient's record with proper authorization.

COMPLAINT SUMMARY

According to the complaint the patient's legal guardian was never consulted for treatment or discharge planning. The guardian tried repeatedly to speak with the physician about treatment in general and discharging but he never returned her calls and never spoke to her until the

morning of discharge. She allegedly arranged aftercare services herself and had no help from the caseworkers. The complaint goes on to say that prescribed medication information was never shared either and the guardian had no idea which medications were being given or adjusted. The patient reportedly called her guardian one day and said that the caseworker forced her to sign a request for discharge form so they could send her to a state hospital. The guardian had also called one afternoon and was told that the patient approached the nurses' station with a shank and was given a forced Haldol injection to which she is allergic. They reportedly confined her to an observation room where she was restricted from using the phone for manipulative behaviors. The phone restriction was extended with no in or out calls and the guardian was not notified in writing. Finally, it was said that the patient had to endure a hard mattress in the observation room with a painful back and had to ask for a blanket because the room was so cold.

FINDINGS

1. The Center did not involve the patient's legal guardian in treatment and discharge planning.

A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. (405 ILCS 5/2-102a).

A clinical therapist explained that nursing sets up most of the treatment planning at admission. Therapists meet with patients and any guardians from there and at the first session on they contribute their agreements or preferences about treatment and discharge. In this case he took over for another therapist who went on vacation in the middle of the patient's hospitalization. He said that both were quite involved with the guardian and consulted her frequently, which their documentation should show. They always try to engage families who know patient baselines better than they do and the history they can share is important. In his experience this guardian seemed consumed with discharge rather than treatment going on in the hospital. She initially would not allow the patient to return home and the Center was exhausting all options for suitable placement and aftercare because of her violent history. An administrator added that the guardian was far away and not usually available in person. Quite a lot of communication between them was over the phone. She said in general they determine guardianships early and try to have related paperwork on file. Guardians are involved with consents and all areas of care and the staff are alerted to guardianship status as they were in this case.

Regarding the claim that the psychiatrist never returned the guardian's calls, the psychiatrist said he knew she wanted to talk with him and that the staff told him three, four maybe five times. He said he spoke to her once on the day of discharge and felt it unnecessary to talk with her otherwise as they have appropriate staff to do that. He said he believed the other psychiatrists at Blessing handle it the same. Administrators were followed up for their response on his comments. They agreed that the instance was inappropriate and he should have been more responsive. They said it is not Blessing practice for physicians to ignore guardians and that

this was a unique and difficult case. The matter was brought up in recent nursing and doctor meetings.

The record was reviewed for support. Notes reveal that a therapist met with the patient the morning following admission, July 19. A biopsychosocial history was completed in which the patient's guardian was relied upon for the vast majority of information. The assigned therapist wrote that on the 21st she met with the patient to introduce herself and review treatment issues. The patient verbalized understanding, was given a copy of her care plan, and asked that her mother be consulted. It was also noted that the guardian called and asked to speak with the therapist or doctor. The therapist met with both the next day and talked about their discharge and placement wishes. Each agreed that going back home was not an option at that time and the guardian signed a release for potential residential settings. The guardian was called on the 24th for a report on the patient's progress in treatment and placement. The therapist reached one facility and got her on a waiting list while the guardian rejected two other proposals. Phone calls were made to four other agencies later that day and an updating message was left for the guardian. More contacts were made as the guardian was apprised through the 27th when she returned messages and gave verbal approval to reach other programs. Numerous contacts were made to other programs and the guardian about placement and various treatment issues on the 28th, 29th, 30th and the 31st according to the documentation. One facility was going to meet with the patient and the others either denied admission or the guardian considered them inappropriate.

The newly assigned therapist met with the patient on August 4. He spoke with her and her guardian maintaining the same vein, this time relaying how the situation was becoming urgent, how fewer options were available and that finding something farther away would be likely. He spoke with the guardian again on the 6th and informed her of another denial. He proposed another program and she consented to his contact. There was a similar exchange on the 8th and on the 11th the therapist and psychiatrist spoke with the guardian about the need to take the patient home. She eventually agreed and the therapist offered several outpatient programs for choice. He arranged behavioral health and psychiatry intake appointments at one of them, his discharge sheet clarifying that these were intake appointments only.

The care plan notes the guardian's wishes to be notified of behavioral emergencies. Therapist entries verify that a copy was given to the patient but not whether given or sent to the guardian. Various admission/nursing entries reflect phone contact with the guardian during the admission process, in one instance when she gave verbal consent to "all consent forms" and within two days following that when the patient's rights were covered with her as well. Therapist and nursing documentations reference a few, perhaps not all, reported instances where the guardian wanted to talk with a physician. The first on July 22 when she asked the therapist or psychiatrist to reach her and the therapist returned the call. The next on August 7 when she insisted on talking with the attending psychiatrist about the use of emergency medication; she was informed that he was aware, and again on the 9th when she wanted to discuss with another on duty psychiatrist why he was keeping the patient in a back room. The nurse explained to her that "Dr usually does not call families therapists do". A message was left for him anyway and he declined to return the call, referring back to the attending or therapeutic team. There is no record of any physician contacting her until the day of discharge on the 11th.

CONCLUSION

Blessing's policy on care plans (BBC-310) states that the interdisciplinary team consists of the physician, nursing, therapists, activity staff and other ancillary departments as appropriate. Plans are to include the patient and/or significant other's perception of his/her needs which are documented and incorporated into the plan. Discharge planning will involve the treatment team, the patient, the patient's family and significant others, with whom the therapist works in conjunction to identify progress and post discharge treatment (BBC-550). The hospital's patient rights handout lists the right to receive from physicians detailed information about their diagnosis, treatment and prognosis and to participate in the development and implementation of their care plans.

There is more than sufficient evidence in the record to demonstrate how the guardian was involved in treatment and discharge planning to the extent she wanted. The problem is not in how the therapy or nursing staff included her throughout the process but in how the psychiatrist disregarded her, three, four maybe five times until the morning of discharge by his own admission. Administration claims an isolated incident but that is disputed when a nurse writes of telling the guardian that doctors usually do not call families, when another psychiatrist refused to call her about what she considered an urgent treatment matter and when the attending said to us there are other staff to do that; it seems to be practice at the Center. Physicians cannot be expected to spend hours on the phone with families, but this occasion was extreme and failed to allow guardian inclusion as required under the Code and the hospital's policy and patient rights statement. A violation is substantiated.

RECOMMENDATIONS

Retrain treatment team staff including physicians on the role of guardians and their inclusion. Provide documentation of completion.

Program policy on care plans (BBC-310) gives significant others, not legal guardians, honorable mention for the opportunity to provide their perceptions and does not include either as part of the treatment team. The Code meanwhile assures a more prominent role by mandating guardian participation in plan formulation and periodic review. The policy should be revised to accurately meet the intention so that it is accurately followed. (405 ILCS 5/2-102a).

SUGGESTIONS

Designate guardian participation on care plans and be sure that copies are provided to them.

Blessing's Digital Patient Guide on its website offers under Our Commitment to Care a patient after stay survey in which they are asked to comment on doctor communication. The Center should be sure that all of their patients are given or have access to this opportunity. Comments from this patient's guardian could prove useful.

The patient's application for voluntary admission does not include witness signatures or a required statement of why she was not suitable for informal admission. Admitting staff should be trained to complete this in every instance. (405 ILCS 5/3-300).

An August 8 certificate was left incomplete without a signed declaration that the psychiatrist advised the patient of her rights before carrying on with the exam. All physicians and qualified examiners must be trained to complete this requirement in every instance. (405 ILCS 5/3-208).

2. The Center did not consult the guardian for psychotropic medication consent or provide the guardian written information on proposed psychotropic medications.

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. The physician or the physician's designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing. 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 or 2-107.1…. (405 ILCS 5/2-102a-5).

An adult recipient of services or 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 or electroconvulsive therapy. 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 or electroconvulsive therapy. 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).

Nursing staff said they go over written drug information with patients and guardians to get consents, which is done in person with the guardian if present. Otherwise, verbal consents are obtained and the written materials are sent. In this case all consents for medication were approved by the guardian over the phone and providing written information should be documented. The psychiatrist was asked where in the record he documents the patient's decisional capacity and he said he does not do that, he assumes they have capacity when they come in. The Code's requirement was pointed out and administration informed us later that a capacity designation has been added to consent forms.

Two consent to medication forms were found in the record. One completed on the day of admission, July 18, listed twelve medications, about half of them psychotropics. The patient's signature was included followed by the guardian's verbal consent, twice that day. Orders

followed accordingly. Nowhere in the record was it documented that the written information about the medications was actually forwarded to the guardian at that time however. There is mention of the therapist going over medications with the patient and her guardian on the 22nd, but no indication of whether written information was shared in that exchange. The second form was done for Haldol PRN on August 7. It was signed by the psychiatrist on the 11th but not signed at all by the patient or her guardian and had no indication of verbal consent from either, suggesting it was the emergency medication used that day which matches the medicine administration record for a one-time shot.

CONCLUSION

The program's Psychotropic Medication policy (BBC-410) states that it is intended to provide patients/guardians with decisional capacity with pertinent and timely information concerning prescribed medications. Distribution of medication information and the patient/guardian responses are documented on the interdisciplinary patient education record.

The staff were certain they got written consent from the patient and verbal consent from the guardian when medications were first prescribed, and the documentation supports that. They were uncertain however as to where the sharing of written information with the guardian was documented, and the record supports that as well. There is no reference to that in a patient education record or in therapist, nursing, progress or psychiatry notes from the records provided. Without documented proof, the complaint that the guardian was not provided with written information on proposed psychotropic medications is a substantiated violation of program policy and the Code.

RECOMMENDATION

So they may effectively exercise the right to refuse medications, ensure that all guardians are given written drug information immediately whether they are present or not and document on patient education records or elsewhere in the record.

SUGGESTIONS

Consent forms in this file made it to the treating psychiatrist days after being signed by the patient and started. With capacity statements now added, the Center must be sure that physicians get them before medications are administered. (405 ILCS 5/2-102 a-5).

Policy (BBC-410) should include the requirement for prescribers to document patient decisional capacity at the time medications are proposed. (405 ILCS 5/2-102 a-5).

3. The Center forced the patient to sign a request for discharge in order to be transferred.

A voluntary recipient shall be allowed to be discharged from the facility at the earliest appropriate time, not to exceed 5 days, excluding Saturdays, Sundays and holidays, after he gives any treatment staff person written notice of his desire to be discharged unless he either withdraws the notice in writing or unless within the 5 day period a petition and 2 certificates conforming to the requirements of paragraph (b) of Section 3-601 and Section 3-602 are filed with the court. (405 ILCS 5/3-403).

The staff said that voluntary patients can request to be discharged at any time and will be given a "5-day" form to do so. The psychiatrist and the therapist named in this complaint both insisted they did not coerce this patient into signing one in order to be transferred. The therapist did not recall specifics on what transpired but said the patient requested discharge earlier and then rescinded, but at no time was she forced in either direction.

The record includes four requests for discharge notices. One was signed by the patient on July 22 and rescinded by her on the 23rd. Psychiatry and therapy entries make no mention of it in the same time frame. The second was signed on July 27 and was rescinded on the 31st and a third on August 5, rescinded on the 6th, again without psychiatrist or therapist documentation on how they came about. The fourth was signed on August 7 and was not rescinded. According to the psychiatrist at 11:15 a.m., "[Pt.] has now been rejected by all residential facilities in our treatment area will need to be court proceedings [sic] for transfer to an extended care psychiatric hospital." The therapist wrote that he and the psychiatrist informed the patient of another failed placement pursuit "…and therefore she once again submitted a five day notice. The plan at this time will be to complete a petition and proceed with the court hearing. I spoke with the patient['s guardian] at 11:20 a.m. She was very upset…continues to blame all institutions…and now we want to abandon her to a state hospital. I explained the court process which she does not wish to proceed. I have suggested if she has a legal question concerning possible commitment or her rights and responsibilities as guardian that she contact her attorney." A petition was completed at 3:40 p.m., followed by a certificate on the 8th and on the 11th. The therapist wrote on the 11th that by mutual decision with the guardian, the patient was to be discharged home.

CONCLUSION

Center policy states that transfer or discharge of patients is initiated upon physician order and within the Code's guidelines. Voluntary patients may request discharge and withdraw in writing. Involuntary discharges occur with petitions and certificates in effect (BBC-560).

The Code says in 5/3-403 that it is the patient, not the treatment staff who decides when the right to request discharge will be exercised. In this case the patient's placement options were running thin to nil and on one morning, twenty-four days into hospitalization the psychiatrist decided to seek commitment, the patient signed a request for discharge, called her mother to say she was forced into doing it, and a petition followed a few hours later. Still, responsible staff assure she was not coerced, and while the claim is not discredited the finding is suspicious but not factual. The complaint is <u>not substantiated</u>.

SUGGESTION

Telling a guardian to call her attorney if she had legal questions about her rights and court proceedings is disconcerting and immensely unhelpful to anyone whose loved one is facing involuntary commitment. Offer help in contacting the Guardianship and Advocacy Commission instead. (405 ILCS 5/3-206).

4. The Center restricted the patient's communication, forced medication to which she was allergic and confined her to a room without the need to prevent harm, harassment, intimidation or serious and imminent physical harm and without providing the guardian written notice.

5. The Center confined the patient with a painful back on a hard surface in a cold room.

Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation…. Unimpeded, private and uncensored communication by mail, telephone, and visitation may be reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation…. (405 ILCS 5/2-103).

An adult recipient of services or 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 or electroconvulsive therapy. 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 or electroconvulsive therapy. 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 5/2-107a).

Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to: (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian; (405 ILCS 5/2-201).

Seclusion may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. In no event shall seclusion be utilized to punish or discipline a recipient, nor is seclusion to be used as a convenience for the staff. (405 ILCS 5/2-109).

"Seclusion" means the sequestration by placement of a recipient alone in a room which he has no means of leaving. The restriction of a recipient to a given area or room as part of a behavior modification program which has been authorized pursuant to his individual services plan shall not constitute seclusion, provided that such restriction does not exceed any continuous period in excess of two hours nor any periods which total more than four hours in any twenty-

four hour period and that the duration, nature and purposes of each such restriction are promptly documented in the recipient's record. (405 ILCS 5/1-126).

A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment…. (405 ILCS 5/2-102a).

Nursing staff described how the patient spoke with her guardian frequently on the phone and usually got upset afterwards. Conversations with her guardian ended up splitting the staff in that it was difficult to know what the patient needed or if she had any complaints and then try to respond appropriately. The day it was decided to place her on a phone restriction for example, the patient called her guardian and complained about not getting pain medications and being in a cold room instead of bringing it up with nursing. The mother called them in turn and accused them of not helping the patient and being untruthful with her. A nurse commented that the patient was given pain relief and blankets and she would have been happy to provide that earlier if she had known. She also called maintenance and they came to address any problems in the room. This kind of splitting went on throughout her hospitalization. A restriction was placed on calls, in and out, for a couple days as they were considered manipulative. The patient's behavior seemed to improve afterwards.

Regarding the use of emergency medications, a nurse described a situation when the patient approached the nurses' station saying she had a shank, which is anything that can be used as a weapon. Although she never actually produced one, a room search revealed a sharp plastic object. Once that was discovered the patient became verbally and physically aggressive with the staff and had to be calmed with medication. As to whether the patient was allergic to Haldol, the medicine given for that emergency, they said that allergy information is always provided by patients, guardians and other record contents. There were no reports of allergies to Haldol in this case and there seemed to be no adverse effect from the injection.

Restriction notices are always completed and all guardians are notified by telephone and mail. A nurse involved in the phone restriction remembered filling out the notices and asking staff to mail them, which she said should be reflected in the record.

It was also offered that the cold room in question is not used for seclusion and patients are not confined there unless in restraints. It is used for safety precautions where the patient can be observed on camera without roommates, but they are not secluded and can move in and out of it as they need, say for using the toilet or phone. The HRA observed the room while it was in use. An occupying patient left for a moment and then returned while we were still there, a few minutes later. The room was chilly but not cold and the mattress was thin but not necessarily hard, without of course testing it for more than a few seconds. The door remained open.

Restriction notices were reviewed from the record. One on August 9 cited a twenty-four hour phone restriction for manipulative calls. The nurse checked off that she provided a copy to the patient and that the guardian was to be notified. Another was completed for a twenty-four-hour extension and included all the same.

An earlier restriction notice was done on August 7. It placed restrictions on the patient's privacy as her room was searched after claiming to have a shank. It also restricted her right to refuse medication because she became physically aggressive, charging at the staff and turning over a table in the meantime. Orders were written on that day for Haldol, injection or by mouth, every four hours as needed for agitation. Medication administration records show that an injection was given once. Outcome evaluations from the record state that the patient lunged and charged at staff and then turned over a table and that she was safely deflected from anything further. She acknowledged the behavior and willingly accepted the shot. The documentation followed up with a call to the mother about the incident. As found in complaint #2, there is no documented informed consent by the patient or guardian or the sharing of written drug education for either of them when Haldol was prescribed and given.

Allergies were listed on a nursing intake form at admission. They included Keflex, Thorazine, Ativan, Lamictal and strawberries. The same were entered electronically on the adult psych. profile chart. Scheduled orders, medicine administration records and nursing notes reflect that the patient was given Ibuprofen, Tylenol or Naproxen for back pain as she requested. Notes also show that the patient was given numerous pillows and blankets during her time in the special observation room.

CONCLUSION

The Center's special procedures policy and patient rights policy (BBC-630 and 760) state that the program assures least restrictive and humane services while protecting safety. Restrictions, when necessary will be fully explained to the patient and any guardian, family or significant other. Notices must be completed and given to the patient's guardian, power of attorney and person of choice.

The phone restriction applied in this patient's case failed to meet qualifications under the Code; manipulation falls short. And, banning all calls exceeded the Code's limits to only that communication which is harmful, harassing or intimidating. A rights violation is substantiated. By all documented indications the patient accepted a single injection when it became necessary to prevent serious and imminent physical harm and after she was able to be redirected. The documentation is confusing on one hand calling the injection forced by completing a restriction notice and on the other by nursing entries that say she accepted the injection after the situation was deflected. Since she consented to the Haldol injection, Blessing violates her right to first provide informed consent and her guardian's right to refuse it. If it was intended that she had no choice regardless and the injection was going to be given either way, then her right to avoid forced medication after a less restrictive alternative was successful was violated. A rights violation is substantiated. There is no evidence from the record that the patient was indeed allergic to Haldol, but perhaps if she or the guardian were given an appropriate opportunity to provide informed consent when the drug was prescribed it might have come up. The patient was not confined to any room according to the staff and the lack of a seclusion-related restriction notice in the record. Based on their descriptions and our observations, the room does not meet the Code's definition of seclusion. The documentation also refers to many instances of when pain medication was given whenever the patient complained and that during her stay in the

observation room she was comforted with pillows and blankets once the staff were aware of her complaints. A violation of the right to adequate and humane care is not substantiated.

RECOMMENDATIONS

Retrain all staff including nurses and physicians on the Code's qualifications for phone restrictions. (405 ILCS 5/2-103).

Stop the practice of banning all calls and restrict only those that are potentially harmful, harassing or intimidating. (405 ILCS 5/2-103).

Nurses and physicians must provide written drug materials and obtain informed consent for all scheduled psychotropic medications before they are administered. (405 ILCS 5/2-105 a-5).

SUGGESTION

The HRA cautions against PRN orders for emergencies without informed consent. Use one-time emergency orders instead, or, get consent. Always provide written drug information whenever psychotropics are used, emergency or not. (405 ILCS 5/2-102 a-5).

Policy (BBC-410) states that if the patient or guardian refuses medication more than two times, the physician may request through court order the administration of the medication. This policy has no Code support and it must be removed. Any adult patient and/or his legal guardian may refuse medications as many times as they like unless it is necessary to prevent serious and imminent harm and no less restrictive alternative is available. The policy should be revised to accurately reflect the right to refuse and the emergency/court process that follows. (405 ILCS 5/2-107 and 107.1).

RESPONSE

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

BLESSING
Health System

P.O. Box 7005 Quincy, IL
217-223-8400
www.blessinghealthsystem.org

March 9, 2015

James Bakunas, Vice Chair
Illinois Guardianship and Advocacy Commission
401 S. Spring Street
521 Stratton Building
Springfield, Illinois 62706

Re: 15-050-9004

Dear Mr. Bakunas:

Blessing Hospital has reviewed the findings and recommendations from the Guardianship and Advocacy Commission outlined in the letter dated January 28, 2015. Please be assured that Blessing Hospital strives hard to provide quality mental health services to its patients and to abide by the Mental Health and Developmental Disabilities Code and that we take any complaint or dissatisfaction with services seriously. While we believe the interviews and documentation support that the guardian was involved in the decision making, we do recognize improvements can be made to further enhance the care we provide and for the record to adequately reflect compliance with the Mental Health Code.

Based on the Guardianships suggestions, we immediately implemented the following:

- Reeducation of our treatment team and physicians as to the role of the guardian and their inclusion in treatment and discharge planning
- Revision of our care plan policy to assure guardian participation in care plan formulation with periodic review
- Reeducation of admitting staff to complete "not suitable for informal admission" required statement on all voluntary admissions
- Reeducation of emergency department physicians to document that they have advised the patient of his/her rights before performing an exam
- Reeducation of staff to ensure guardians are given written drug information timely whether present or not and document in the record
- Reeducation of our staff and physicians regarding the Mental Health Code and patient rights relating to phone restrictions
- Reeducation of physicians to obtain informed consent for scheduled psychotropic medications before they are administered in nonemergency situations.
- Revision of policy on psychotropic as recommended.

BLESSING
Health System

P.O. Box 7005 Quincy, IL
217-223-8400
www.blessinghealthsystem.org

We hope by our action plan outlined herein, you will see that we are addressing the concerns raised. We appreciate the guidance and opportunity to improve our services. Thank you.

Sincerely,

Carolyn Bailey
Administrative Director
Blessing Hospital

Cc: Mr. Jon Burnet, HRA Administrator
Mrs. Maureen Kahn, CEO
Ms. Laurie Steinbrecher, Director
Ms. Connie Scott, Administrative Director