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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 16-030-9010
LORETTO HOSPITAL

Case Summary: The HRA substantiates the complaint that the recipient's physician would not speak to the recipient's guardians and did not receive consent for the recipient's medications or the changes he made to the patient's medications, and that he restricted the recipient's visitation for no reason. The HRA does not substantiate the complaint that the recipient received forced medication and the HRA lacks substantiating evidence that the physician threatened the recipient with hospitalization if he questioned the physician's medication orders.

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 recipient's physician would not speak to the recipient's guardians, did not receive their consent for the recipient's medications or the changes he made to the patient's medications, restricted the recipient's visitation and phone for no reason, administered forced medication to the recipient for no adequate reason, and threatened the recipient with hospitalization if he questioned the physician's orders. If substantiated, these allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.), the Medical Patient Rights Act (410 ILCS 50/3 (a)), the Illinois Probate Act (755 ILCS 5/11a-17a) and the Centers for Medicare and Medicaid Administrative Rule (42 CFR 482.13 Patient's Rights).

Loretto is a private community hospital located in Chicago. The hospital contains a 36 -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 of Behavioral Health, the Quality Co-Coordinator, and the Attending Physician by phone. Relevant hospital policies were reviewed, and records were obtained with the written consent of the guardian. The guardian's Letters of Office is included as part of the clinical record.

COMPLAINT SUMMARY

The guardian's ward (and adult son) was admitted to Loretto from the nursing home where he resided. He was admitted to Loretto on 9/04/15 at approximately 1:00 a.m. and was assigned the same physician who attended him at his nursing home. That day the guardians allegedly requested to speak with the recipient's physician, however they were told he could not be contacted. The following day the guardians again visited the hospital and requested to speak with the physician but reportedly were told they could not. They then requested the recipient's chart, but were told they could not have a copy. They were allowed to review the chart, however, and allegedly found that his current medications were abruptly discontinued and a new medication regimen was ordered all without the knowledge or consent of his guardians. The recipient has a very complicated medical condition and has suffered from severe adverse reactions to medications in the past. While the guardians waited to visit with their son, two security guards reportedly arrived to escort them out of the building. On Sunday, September 6th, the guardians again attempted to see their son and security was waiting at the reception desk, where they learned that the physician had written an order prohibiting visitation and phone contact with their son as per the complaint. The recipient's mother was calling the recipient's case manager when her son, the recipient, texted her that he was on his way back to his nursing home- the recipient had been discharged with no notification to the guardians. The recipient also informed his guardian that even after he was released from the hospital the physician reportedly continued to pressure him to make changes in his medication regimen, asking him, "Do you want to go back to the hospital?"

FINDINGS

The hospital record shows that the recipient and his guardian met with the recipient's physician on 8/19/15. Notes from this visit state, in part, "Pt seen by Dr… with mother present. Dr. informed of history. Pt. …[illegible] he's 23 he's here due to behaviors. States his mind went blank. Has been on Concerta, Seroquel, Tinex, Depakote, born in Russia here for 22 years. He never asked why he takes medication. He takes it because his parents give it to him. Meds help me stabilizing my moods. Anger management sometimes I drink I just don't care. I was thinking I shouldn't be on medications. I never ask why? I informed him he's 23 he should know what meds he's taking and not ask Mom. He takes Seroquel with water. Mother states afternoons and evenings are his worst time. Ritalin mother states …[illegible]. He's had numerous MRI's and EKG's never tried to hurt himself had severe dystonic reaction to Resperdal – Geodon and Abilify. Pt stated Concerta is extremely high dose. He denies hearing voices or seeing things denies drugs or alcohol. Mother states good at cheeking pills. He was selling them he's been a drug dealer 1:1 done by AP no med changes check mouth after each …[illegible] pass." Notes from 9/3/15 indicate that the same attending physician was notified by the recipient's guardian that the recipient had been texting to his brother that he intended to commit suicide and the physician ordered the recipient to be sent to Loretto Hospital for a psychiatric evaluation.

The record contains a Petition for Involuntary/Judicial Admission completed at the recipient's nursing home on 9/3/15 at 7:30 p.m. and stating, "Resident texting his brother that he wants to commit suicide. During conversation with nurse he has plans to overdose self with pills; says he does not want to be here." An Inpatient Certificate was then completed at Loretto on 9/4/15 at 3:00 a.m. which states, "The patient has a history of bipolar affective disorder and

has expressed suicidal ideation with a plan to overdose on pills." The recipient then completed an Application for Voluntary Admission on 9/4/15 at 4:13 a.m. The Voluntary Admission indicates that the recipient wants his parents notified of his admission as well as any time his rights are restricted.

The Loretto Hospital Inpatient Registration form shows that the recipient was admitted to Loretto on 9/04/15 at 3:23 a.m. On the hospital Authorization to Use or Disclose Health Information form the parents of the recipient are identified as guardians along with their contact information. The recipient's Behavioral Health Consent form is also included and it is not signed by the recipient, the guardians, or a witness.

The recipient's Psychiatric Evaluation is included in the record. It states, "The patient is a 23-year old male. The patient states he is in the hospital because he was in a nursing home and he mentioned that he was having some suicidal thoughts. The patient states that he was having thoughts of taking overdose, and thus he was brought out for mental health evaluation. The patient states that he has had suicidal attempts in the past and just gotten depressed that he is having was (sic) some mood swings. Things have gotten worse and his medications adjusted. The patient denies any medical problems." In the Subjective section of the evaluation it states, "The patient states that he is taking his medication. States that his mood is getting better. He feels like things are going properly along. His mother___ his dad is __ . [all spaces provided in the record). The patient is a little anxious. Still have insight problems."

Physician notes from 9/04/15 state, "The patient at this morning states he is doing better. The patient has visitors from his parents yesterday. They are very destructive to the ___, very destructive to the patient's treatment. Due to that they will ____to follow rules." (all spaces provided in the record). The Progress Notes from the recipient's treatment episode are included in the record. Throughout the recipient's stay he is described as cooperative, compliant with his medications, able to socialize with his peers, he states frequently that he is fine and does not require hospitalization, his mood is described as appropriate with a bright affect, and he follows all staff directives. The record does not reflect any decompensation on the part of the recipient and his hospitalization is non-remarkable. He was never administered forced emergency treatment or placed in restraints.

The record contains an Admission Note from 9/04/15. It states, "Admitted 23 y/o patient from [Chicago area nursing home] with a diagnosis of Bipolar D/O. Patient claimed to be feeling suicidal to his family members who then contacted the nursing home staff. Patient arrived on the unit calm and cooperative with staff he went through belongings and body check to ensure safety on the unit. Patient has a medical history of ADHD [Attention Deficit Hyperactivity Disorder], HTN [Hypertension], Acne, and constipation. Patient states that before he was transferred he informed the NH that he no longer feels suicidal he does not know why he felt depressed at that time but he is now looking forward to returning to the NH. Patient denies auditory/visual hallucinations and suicidal/homicidal ideations. Patient has guardianship his parents names are …they are aware of the admission documents are in the chart. Patient has been informed of unit rules and is in his room quiet, will continue to monitor for unpredictable behavior."

On 9/05/15 the progress notes describe what could be the event described in the complaint: "During the visiting hours, Patient's guardians became hostile, threatening, and causing a disruption in the milieu; evidenced by, demanding to review private documentation beyond the regular business hours, refusing to leave, demanding to see the administrator oncall, and demanding that we call Doctor … [attending physician]. Charge nurse, nursing supervisor …, Dr…., and unit manager were notified. Multiple quality and respectful measures were used to attempt to have the visitors to leave the unit, from offering that they return to the hospital at the normal business hours, to having the nursing supervisor to speak with them about other appropriate options. However, the visitors continue to refuse to leave even beyond the visiting hours. This had become a safety issue for the staff, the parents, and the visitors. Furthermore, their imposition compromised other patient information, confidentiality, and 'HIPPA'. Security called to assist with escorting the visitors safely from the unit."

The hospital record contains the Letters of Office naming the recipient's parents as plenary guardians on 9/03/10. On 9/05/15 the attorney for the guardians forwarded a statement to the hospital which stated, "We, [the parents], as legal guardians of [the recipient] request that our right to information regarding [the recipient's] condition, treatment, and medication be respected. We, as guardians, expect any future changes in [the recipient's] condition, treatment, and/or medication to be communicated to us as quickly as practicable and an explanation of any past changes be given as soon as practicable. We, as guardians, expect that in the case of treatment and/or medication changes those responsible for ordering the changes communicate them to us. We regret that this right has not been recognized and that it has been necessary to engage legal representation to ensure that this right be respected. Attached are the Letters of Office verifying legal guardianship. This document contains the signatures and contact information for the guardians, copies of their drivers' licenses, and contact information for the law office representing the guardians.

The hospital record also contains an historical record of the recipient's medical history provided by his guardians. In order to portray the complexity of the recipient's clinical needs as well as the complexity of his reactions to various treatments, a small portion of the document is presented here:

Recipient has suffered severe ADR (adverse drug reaction) to Risperdal, Geodon and Abilify
1996-2003
Attempted trials of Ritalin, Dexedrine, Adderal, Concerta, Stattera. Introduction of Wellbutrin, Luvox, Paxil, unsuccessful with wild, out of control dysinhibitory behaviors. Buspar, Depakote introduced.
2000
Risperdal started due to hair pulling, digging large holes in walls, hoarding nails, gravel
2003
Weaned off Concerta- changed to Straterra in addition to C Buspar, Depakote, Risperdal
Hospitalized due to ADR with dystonic (involuntary muscle) due to interaction between Celexa, Straterra, and Risperdal. Medication washout completed and then restarted on Adderal, Tenex, Risperdal, weaning Celexa. By 6/2003 discontinued Adderal, due to behaviors and changed back to Concerta.
2005

ADR and dystonic reaction to Risperdal, treated with Cogentin. Changed to Abilify.
ADR and dystonic reaction to Abilify. Weaning off of Abilify, with worsening behaviors and repeated dystonic reactions. Started Geodon- ADR with dystonic reaction to Geodon. Severe dystonic reaction persisted despite Cogentin and discontinuation of Geodon. Catastrophic deterioration: painful, spastic, uncontrolled motor movements, manic behaviors, neck turning, rigidity, tongue hanging, drooling, inability to feed self, difficulties with speech/ambulation, agitation.
Hospitalized from 8/2005 until 2/2006….

The hospital record contains the Physician's Order Sheet from the recipient's nursing home from which he was transferred to Loretto. His psychotropic medications include: Quetiapine (Seroquel) 800 mg nightly at bedtime and 200 mg twice daily, Divalproex (Depakote) 1000 mg nightly at bedtime, and Methylphenadine (Concerta) 10mg every evening and 72 mg every morning.

The hospital record contains the recipient's Medication Administration Record. It shows that the recipient was administered the following medications: Desyrel (Trazodone) and Zolpidem (Ambien) for sleep daily, Duloxetine HCL (Cymbalta) and Asenapine Maleate (Saphris). Cymbalta 60 mg each morning, and Saphris 5 mg each 12 hours were administered on 9/04/15, 9/05/15, 9/06/15, 9/07/15 and one time for each on 9/08/15. The record contains a Notice of Psychotropic Medication form and indicates that medication information was given for Cogentin 2 mg, Ativan 2 mg as needed, Geodon, Trazodone 100 mg, Zolpidem 100 mg and Saphris 5 mg. The form is not signed in the area designated for the patient's signature and it is not dated and does not include the medication Cymbalta. There is no indication that the guardians received information regarding the recipient's medications, and there is no indication they gave consent or were given an opportunity to refuse.

The hospital record contains two Notices Regarding Restriction of Rights of an Individual. The first of these is written on 9/04/15 at 5:00 a.m. and indicates that the recipient received a restriction from visitors. The reason given is "exacerbation of symptoms during" (sic). The Notice indicates that a copy was given to the recipient and a copy was mailed to the guardian. The second Notice was completed on 9/05/15 at 5:04 a.m. and indicates that the recipient received another restriction from visitors. The reason given is "exacerbation of symptoms" and it indicates that a copy was given to the recipient and a copy sent to the guardians.

The record contains the recipient's Discharge Instructions, issued 9/08/15 at 9:16 a.m. The instructions have an area for the guardian's signature, which is not signed, nor is it signed by the Discharge Nurse. Additionally, the recipient's Patient Information and Transfer Form have an area for the guardians' names and contact information, and these are not filled in. There is no entry in the progress notes for the recipient's discharge.

The guardians for the recipient forwarded a formal complaint to the hospital CEO on 9/09/15. In part, it states:

My husband, … and I are court appointed Legal Guardians for our 23 y/o son, ….

On 9/4/15 [the recipient] was admitted to Loretto's Behavioral Care Unit under Dr... 's care. Both [the attending] and Loretto staff denied us communication with [the attending] throughout [the recipient's] hospitalization. We were initially denied any information on [the recipient's] status despite guardianship information having been faxed. After our lawyer contacted the unit, the Letters of Office were located and we were informed by [the recipient's] nurse that all previously scheduled medications had been discontinued and two new psychotropic medications had been ordered.

We were shocked at this revelation. At [the recipient's] admission to [his nursing home], I met with [the attending] to discuss [the recipient's] complicated medication history and severe Adverse Drug Reactions, which included severe dystonia and tardive dyskinesia, necessitating lengthy hospitalizations and long term sequelae. [The attending] assured me during this meeting that he would not change any of [the recipient's] medications without first discussing it with us.

By 36 hours after admission without contact from [the attending] we requested the Nurse Supervisor ..., intervene on our behalf. When told that the doctor could not be contacted, we requested [the recipient's] chart. We indicated we would visit with [the recipient] while they made the chart ready. We returned to the nursing station with ½ hour left in visiting hours. After much delay, we were lead to a private office near the nursing station and given the hardcopy to view.

Informed consent had not been obtained from either [the recipient] or us in regard to 2 new psychotropic medications, and the Notification of Psychotropic Medications form was blank. There were PRN orders for Ambien and Desyrel; both given to [the recipient] on 9/04/15 with neither his knowledge/consent nor ours. There were PRN orders for 2 different doses of Haldol (which has a high incidence of dystonia, tardive dyskinesia), Ativan and Cogentin. We were gravely concerned about the risk of ADR in our son and asked to view the computerized chart. Eventually, we viewed the Nursing Notes and medication Profile but were denied access to Physician Notes. Any questions we had were met with the response: "You need to speak with the doctor."

When we requested that [the nurse supervisor] again attempt to reach [the attending], she called his answering service and was told that if the staff called his cell phone, he would speak with us. [A supervisor] was also in the office with us. When both [the supervisor] and [the nursing supervisor] left for the nursing station, we waited for the promised phone call. Instead, 2 Loretto security guards arrived informing us that we were to be escorted off the unit. We informed them that we were waiting to speak with the doctor. [The supervisor] and another unidentified male returned to the office and began shouting at us that we were "endangering patient safety" and threatened to call the police if we did not leave. [The nursing supervisor] returned to the office stating she had spoken to [the attending] and: "I have spent enough time with you." When we insisted that we had the right to communication with our son's doctor, [the supervisor] told us that he would accompany us to the hospital lobby phone. In the lobby, we called the Operator and were told that [the attending] would only speak to us from the nursing station phone.

We also requested that another attending be assigned to our son, but were told that request could not be processed until Tuesday, 9/8.

When [the recipient] asked [the attending] about his medications, he was simply told that 'they had been changed"; when [the recipient] asked [the attending] to call his legal guardians, [the attending] told him, "I don't talk to parents."

When we arrived on Sunday 9/6 at regularly scheduled visiting hours, we were denied visitation. [The nurse supervisor] informed us that [the attending] had written a "No Visitation" order. No explanation was given. [The nurse supervisor] also informed us that no information about our son's status would be given to us until a Case Manager was assigned on Tuesday, 9/8; five days after admission, due to "HIPPA laws."

On 9/7 a letter was hand delivered by our lawyer for [the attending] and Administration outlining our grievances and requesting resolution.

[The recipient] was discharged on 9/8 as an "unexpected discharge" without notification or involvement in discharge planning. We only learned of our son's discharge when he texted us from a van on his way back to [the nursing home]. [The case manager] called to inform us of [the recipient's] discharge after the fact. When I described our experience, [the case manager] related that [the attending] had been told by staff that we were "disruptive to patient's treatment/unit and would not follow unit rules." In no way did our request for information and communication in an office away from patients constitute an interference in either our son's treatment or the well-being of the unit. Our demeanor was respectful but persistent. [The attending] and the Loretto staff violated our son's patient rights and prevented us from fulfilling our duties as Legal Guardians…"

It is not clear from the record if the hospital investigated the complaint.

HOSPITAL REPRESENTATIVES' RESPONSE

Loretto Hospital provided a written response to the HRA concerning the complaint, which was included in the record received from the hospital. This letter, quoted verbatim, is addressed to no one and is neither dated nor signed:

[The recipient] was transferred from [an area nursing home] and admitted to Loretto on 9/04/15 under the care of Dr… who was also the attending psychiatrist before his admission. Dr… was also acquainted with the patient and medical records before his admission. According to the psychiatric evaluation, [the recipient] was 'acutely suicidal' and symptomatic upon admission. Per [the recipient] 'things have gotten worse.' Dr…'s inpatient reassessment was based on [the recipient's] diagnosis; his desire for care, treatment and services in compliance with the hospital's policy and the Joint Commission's Standard of Care. The reassessment also allows for a re-evaluation of the medication regimen, possible adjustment and change to dosages to reduce patient's symptoms and ultimately stabilize his health. [The recipient] also denied any minor or adverse side effect to medication adjustment.

Loretto Hospital acknowledged [the guardians] as legal guardians of [the recipient], and also provided access to his records as permitted by the mental health statutes without disrupting the health and well-being of [the recipient] while he was on the unit. Planning for care, treatment and providing for [the recipient] was individualized; Dr... holds a difference of opinion in regards to the guardians' attitude toward [the recipient's] plan of care despite visible and stated improvement from [the recipient] about his mental health. Dr... also advocated and made restricted visitations as part of [the recipient's] treatment plan to optimize the benefit of care. Nonetheless, the guardians' input on care remains valuable and not discounted.

Loretto Hospital and Dr... unequivocally acknowledge the patients' right of informed consent, the right of his guardians and need for effective communication between all parties involved. The goal was not to alienate [the recipient's] guardians, but to provide mental health services as allowed by law to him while being mindful of how the dynamics of such relationships may ultimately affect the reason for inpatient admission. While we affirm that effective communication fosters patient safety and quality of care, our common purpose can only be achieved when it is understood by all who participated in the care of [the recipient].

[The recipient's] endorsement of legal documents allows for the proper adherence to written policy and compliance with rights of individuals receiving mental health and developmental services. The rights of everyone involved in the care of [the recipient] as allowed by both the Joint Commission's Standards of Care and the State of Illinois's Mental Health Code were properly respected. Loretto Hospital and Dr... acknowledges the sentiments echoed by [the guardians] in their complaint. Our goal was to provide quality patient care with dignity, respect, and compassion.

Loretto Hospital regrets the inability of [the guardians] to reach Dr... during their visit to the Behavioral Health Unit. However, Dr... is called for routine orders and only for emergent cases. Loretto Hospital has a grievance process and procedure for patients and families to express their dissatisfaction regarding the care received which also provides peaceful ending to conflict and retribution. Loretto Hospital will continue to engage patients and family members in a mutual understanding of treatment and services while remaining very cognizant of the law as well as, not compromise the quality of care. We will also continue to engage and encourage all practitioners to strive for every opportunity to improve relations with patients and family members.

Loretto Hospital has a continuous improvement process. The Hospital has established and monitors metrics to evaluate improvement efforts and outcomes routinely, it ensures all staff members understand the metrics for success; ensures that patients, families, providers, and care team members are involved in QI activities. There are established processes that allows for the coordination of databases that are used for quality data analysis and reporting; coordination of root cause analysis and other occurrences. There is also process modification related to findings from occurrence reporting trends.

The mission and vision of Loretto Hospital are a driving force for value creation to patients, employees and other stakeholders. We affirm the belief that sustainable value creation requires more than adherence to external standards; rather, it requires a shift in mindset in order to make

a proactive lea towards sustainable value. Compliance requirements are embedded into routine procedures and processes to enhance effective organizational and clinical decision making. We encourage an environment that supports safety, encourages blame-free reporting, addresses maintenance and improvement in patient safety issues in every department throughout the facility. Also, there are established mechanisms for the disclosure of information related to errors. Employees are routinely observed during leadership rounding on the usage of 'AIDET', the fundamentals of patient and family communication. The leadership of Loretto Hospital remains committed to practical initiatives that improve patient outcomes and patient safety in a comprehensive, methodical, and systematic manner.

The HRA also completed a site visit and interviewed hospital representatives and the attending physician (by phone) about the complaints. Staff were asked about their ability to contact physicians regarding patient care. They indicated that the physician is in the hospital from 5-10:30 a.m. daily and after that time he may be at other locations. Staff indicated that an attempt will be made to contact the physician by phone, as was done in this case, and that not hearing back from the physician after several days' attempts is an exception to the general hospital practice.

The attending physician for this patient was interviewed by phone regarding the complaints. He indicated that there was nothing going on that the guardians should be upset about. He indicated that he was and continues to be the recipient's physician and the guardians are disruptive to the recipient's care. The physician was asked about the clinical rationale for the addition of new medications when the recipient was admitted to Loretto and he stated that the recipient was admitted because he was depressed (the physician also stated the recipient was psychotic, which is not substantiated from the record), so he ordered medications (there was no clear rationale based on the presenting needs of the recipient). The physician was then asked about the abrupt cessation of medication without providing a timeline in which to taper the recipient off of former medications and he then challenged the HRA to provide the timeline for weaning off psychotropic medication; he demanded to hear from the HRA what the period was for the medications the recipient was administered. When he was reminded that the standard practice for the administration of psychotropic medication recommends that the patient be tapered off of very powerful medication, he again demanded exact periods for tapering off of these medications. The physician did not acknowledge the right of the guardians to provide input into the care of their ward or their consent to treatment or medication and their right to refuse. Additionally, he stated that he never threatened the recipient by suggesting that he could be hospitalized again if he did not take his medication.

Hospital staff were interviewed about the recipient's restriction of his right to visitation. They indicated that visitation is on Tuesday and Thursday from 6-8 p.m. At the time that the guardians in this case were present in the hospital they were asking questions and disrupting the milieu. The Nurse Manager indicated that he has a responsibility to the other 35 patients, who can easily become unstable when they become aware of a problematic situation. He stated the guardians were escorted into the doctor's lounge where they persisted in seeing the medical record for the recipient. Staff indicated that the patients' files are stored electronically and that it is difficult to view individual patients' records without risking their seeing other patients' records as well. Staff indicated that generally records are obtained from the medical records department.

The HRA pointed out that the first Restriction of Rights Notice was completed at 5:00 a.m. on the day that the recipient was admitted into the hospital (Friday, 9/04/15) and that the event which is described in the progress notes states that it had occurred during visiting hours on 9/05/15. Staff could not explain this discrepancy. Staff were also asked why the guardians had not signed the recipient's Discharge Planning documents and why they were not informed of the recipient's discharge and they were unaware that this was the case.

Hospital staff were asked who wrote the response to the HRA complaint that was received along with the record. Staff did not know who the author was, but supposed that it was the Chief Experience Officer. Staff were also asked if the grievance was investigated by the hospital and it was unclear if the staff involved were interviewed or what the results of the investigation were. The staff present at the site visit were not present for the event which resulted in the restriction of the recipient's visitation rights.

There is no indication from the record that the recipient was ordered Haldol, however he was ordered Ativan as a PRN medication which was never administered to him.

Hospital staff acknowledged that they have not included guardians in the care and decision making for recipients that is necessary to be in compliance with the Mental Health Code. They admitted that informed consent should be obtained for all treatment and medication as well as care planning, and they have made changes to encourage this inclusion, but they concede that they have a lot more to do to be successful in this area. They indicated that they make every effort to be respectful of guardians because they realize the importance of their role.

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 with the inclusion of the guardian in all aspects of care:

"(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).

"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 Mental Health Code states, “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. The facility director shall ensure that correspondence can be conveniently received and mailed, that telephones are reasonably accessible, and that space for visits is available. Writing materials, postage and telephone usage funds shall be provided in reasonable amounts to recipients who reside in Department facilities and who are unable to procure such items. Reasonable times and places for the use of telephones and for visits may be established in writing by the facility director. 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, provided that notice of such restriction shall be given to all recipients upon admission. When communications are restricted, the facility shall advise the recipient that he has the right to require the facility to notify the affected parties of the restriction, and to notify such affected party when the restrictions are no longer in effect…” (405 ILCS 5/2-103)

The Mental Health Code states, “The Secretary of Human Services and the facility director of each service provider shall adopt in writing such policies and procedures as are necessary to implement this Chapter (recipient rights). Such policies and procedures may amplify or expand, but shall not restrict or limit, the rights guaranteed to recipients by this Chapter.” (405 ILCS 5/2-202).

The Medical Patient Rights Act states, “The following rights are hereby established: (a) The right of each patient to care consistent with sound nursing and medical practices, to be informed of the name of the physician responsible for coordinating his or her care, to receive information concerning his or her condition and proposed treatment, to refuse any treatment to

the extent permitted by law, and to privacy and confidentiality of records except as otherwise provided by law." (410 ILCS 50/3 (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).

Under the Centers for Medicare and Medicaid Administrative Rules (42 CFR.13) "A hospital must protect and promote each patient's rights. (1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible. (2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care…. At a minimum: (i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital. (ii) The grievance process must specify time frames for review of the grievance and the provision of a response. (iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion." (42 C.F.R. 482.13).

HOSPITAL POLICY

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

CONCLUSION

The Probate Act directs providers to rely on any decision or direction made by the guardian that is not contrary to law, to the same extent and with the same effect as though the decision or direction had been made or given by the ward. The Mental Health Code intends for guardians to participate in treatment planning, to be informed in writing of proposed treatment and to be given the opportunity to refuse treatment. Sadly in this case, neither the ward nor the

guardians were given the opportunity to provide informed consent to the medication protocol that was ordered for the recipient, who has suffered numerous adverse drug reactions throughout his life, and it was not first determined in writing whether he had the decisional capacity to give consent. Additionally, when changes were made to the recipient's medications, the attending physician did not consult with the guardians and did not take calls to consult on the revised course of treatment. In fact, the physician stated that the guardians "have nothing they should be upset about" and the record clearly shows that he undermined the guardians' role in the care of their ward. He also ordered a restriction of the recipient's right to visitation, and it appears from the record that this decision was made before the parents presented to the hospital to visit their son. The second restriction only states, "exacerbation of symptoms" as the reason for the restriction, but the record never shows what symptoms the guardians exacerbated or any effect from their presence whatsoever. Also, there is no Restriction of Rights Notice to coincide with the event which took place on the evening of 9/05. Additionally, had the physician spoken with the guardians and considered their input into the medication that was ordered, the event on the unit which is the focus of this complaint might have been prevented. However, judging by the physician's response to the HRA at the site visit, it would have been difficult if not impossible to discuss any treatment with the physician. The hospital and the physician are again reminded that guardianship is a court ordered duty that entrusts guardians with the care and decision making for their ward. The hospital's statement in the written response which was included in the record and states, "*[The recipient's] endorsement of legal documents allows for the proper adherence to written policy and compliance with rights of individuals receiving mental health and developmental services. The rights of everyone involved in the care of [the recipient] as allowed by both the Joint Commission's Standards of Care and the State of Illinois's Mental Health Code were properly respected*" is absolutely false and demonstrates the provider's misunderstanding of the rights of recipients and their guardians.

The HRA substantiates the complaint that the recipient's physician would not speak to the recipient's guardians and did not receive consent for the recipient's medications or the changes he made to the patient's medications, and that he restricted the recipient's visitation for no reason. The HRA does not substantiate the complaint that the recipient received forced medication and the HRA lacks substantiating evidence that the physician threatened the recipient with hospitalization if he questioned the physician's medication orders.

RECOMMENDATIONS

1. Train all staff, including physicians, in the Mental Health Code and the Illinois Probate Act, especially in the rights of guardians and their role as caretakers and decision makers for their wards. 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, including decisions regarding discharge. 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.

2. Instead of the currently used Notification of Psych Meds. form, develop and implement a Consent for Psychotropic Medication form and include on it a signature line for guardians.

3. Ensure that visitation is only restricted consistent with Mental Health Code provisions (405 ILCS 5/2-103).

4. Ensure that patients and their guardians have adequate information about medical conditions, proposed treatment and physician information as required by the Medical Patient Rights Act (410 ILCS 50/3(a)).

5. Provide the HRA with a copy of the patient rights policy and statement that clearly documents recipient/guardian participation in treatment planning, the right to informed consent, the right to refuse treatment, the right to visitation, the right to information about one's medical condition and proposed treatment, and the right to have physician information.

SUGGESTIONS

1. It is not clear from the record that the formal complaint submitted by the guardians was investigated. If it was, the relevant information was not communicated to the Director of the Mental Health unit. The HRA suggests that the provider review the law regarding the handling of grievances and adhere to these mandates, including a written response to specific complaints.

2. There is no note in the record indicating that the recipient was discharged and when. The guardians were informed after their son left the hospital and no discharge planning took place to address the recipient's needs going forward. We suggest that the provider's discharge process be outlined in a policy and procedure statement and that guardians are included in this process. Also, ask staff to include a discharge note in the progress notes indicating that a patient has been discharged, the time of discharge, and to whom he was discharged.

3. It is difficult if not impossible to determine exactly what happened in this hospitalization because the record is unclear (documents are not signed, dated or there is no documentation) and although some of the staff have some information, no one has the all the information. The HRA suggests that when a formal grievance has been issued, or a complaint has been filed with the HRA, that a staff person is assigned to review the record, compile the information and the statements of the staff, and assemble a sampling of hospital representatives who can address the complaint.

4. There are blanks in the physician notes in the clinical record. Ensure that mechanically transcribed notes are reviewed by the physician and these omissions are corrected.

5. There appeared to be some initial question regarding a guardian's right to access records. The Mental Health and Developmental Disabilities Confidentiality Act guarantees a guardian's right to inspect and copy a recipient's record upon request. (750 ILCS 110/4) Educate staff on this requirement.

RESPONSE

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

Loretto Hospital

645 South Central Avenue •Chicago, Illinois 60644 • Tel: (773) 626-4300 • Fax: (773) 626-2613

July 21, 2016

Ashley Casati, Chicago HRA Chairperson
Guardianship and Advocacy Commission
1200 S. 1St Avenue, Box 7009
Hines, Illinois 60141

RE: Case #16-030-9010

Dear. Ashley:

The following are the actions taken in response to the above case investigation:

1. A comprehensive training was conducted with the staff with respect to the mental health code centering on guardianship rights and responsibilities. Attached to this letter are the power point presentation used as the training guide for staff, pre and post tests administered to staff, and sign in sheets verifying attendance.
2. The unit has adopted IL 462-0012 (R-01-10) Consent for Services. The form is more comprehensive and is included with this letter.
3. A copy of our organization's policy titled "Guardianship, Patient Rights and Restriction of Rights are included with this letter.
4. This item was addressed during staff training.
5. A question asking if a patient has a legal guardian or power of attorney is included on the Behavior Health Reservation Screening Form. A copy of the form is included with this letter.

Respectfully,
Jerome Phillips

Jerome Phillips, Director of Behavior Health
Loretto Hospital

Committed to Your Good Health

Behavioral Health inservice on guardianship, event reporting, safety rounding, patient belongings and contraband check, restraint & seclusion.

Pre-test

1. Patient safety rounds are required to be started only at 00, 15, 30, and 45 during a one hour interval. True False
2. It is okay to go to a patient's room during safety rounds, verify their presence, then record their location, behavior, and breathing after you sit down. True False
3. It is okay to record a patient's status on safety rounds by listening at the door for breathing. True False
4. Safety rounds are required to be recorded in real time the moment a patient is observed during rounding. True False
5. One of the purposes of environmental rounds is to identify and remove potential contraband items from patient rooms. True False
6. Environmental rounds are completed by a person from the outgoing shift only. True False
7. It is acceptable to ignore a patient asking a question because we are busy. True False
8. It is appropriate to use the threat of a PRN or restraints to manage an escalating patient True False
9. It is appropriate to provide information individual calling and stating that I am a patient's mother/sibling and it is verified that they are listed on a face sheet as emergency contact. True False
10. The following is an event that should be entered in clarity as a patient complaint. " I have not talk to my social worker today." The staff person locates social worker and makes notification to that person of patient's request and social worker then sees the patient. True False
11. An employee discovers contraband items in the form of a weapon or suspected drugs. Reports it to charge nurse, and then delivers it to public safety. This is the appropriate way of doing this. True False
12. Seclusion does not require a physician's order as long as the door to the quiet room remains open. True False

_______________________________ _______________

Employee name (Print) Date

_______________________________ _______________

Reviewer's signature Date

Behavioral Health inservice on guardianship, event reporting, safety rounding, patient belongings and contraband check, restraint & seclusion.

Post-test

1. Patient safety rounds are required to be started only at 00, 15, 30, and 45 during a one hour interval. True False
2. When conducting safety rounds to insure that a sleeping patient is breathing normally, the person must observe the normal rise and fall of the patient's chest. True False
3. It is okay to record a patient's status on safety rounds by listening at the door for breathing. True False
4. Safety rounds are required to be recorded in real time the moment a patient is observed during rounding. True False
5. One of the purposes of environmental rounds is to identify and remove potential contraband items from patient rooms. True False
6. Environmental rounds are completed by a person from the outgoing and oncoming shift. True False
7. It is acceptable to ignore a patient asking a question because we are busy. True False
8. When patient is beginning to verbally escalate, it is appropriate to use the intervention of empathic listening to identify the reason is verbally escalating. True False
9. Along the verbal escalation continuum according to CPI standards refusal is a higher level that release along that continuum. True False
10. It is appropriate to use the threat of a PRN or restraints to manage an escalating patient. True False
11. It is appropriate to provide information individual calling and stating that I am a patient's mother/sibling and it is verified that they are listed on a face sheet as emergency contact. True False
12. Information involving guardianship or power of attorney is identified at the point of the initial screening. True False
13. Proof of guardianship of is established when a phone call is received by the person who is the named guardian or power of attorney on the intake screening, True False
14. The following is an event that should be entered in clarity as a patient complaint. "I have not talked to my social worker today." The staff person locates social worker and makes notification to that person of patient's request and social worker then sees the patient. True False
15. Patient writes a complaint on a piece of paper and gives it to a Staff person. Per hospital policy this is a grievance and must be entered in clarity. True False
16. An employee discovers contraband items in the form of a weapon or suspected drugs. Reports it to charge nurse, and then delivers it to public safety. This is the appropriate way of doing this. True False
17. Because of gender issues a male staff person working on the female unit should not search a patient's belonging's it must be a female per hospital policy. True False

18. Seclusion does not require a physician's order as long as the door to the quiet room remains open. True False
19. Seclusion is a formal of behavior restraint. True False
20. Patient's placed in four point behavior restraint's must remain for the full 4 hours and cannot be released to go to the bathroom. True False

______________________________ ______________

Employee name (Print) **Date**

______________________________ ______________

Reviewer's signature **Date**

Behavioral Health Guardianship, Safety Rounding, Event reporting, Patient Belonging Checks Restraint and seclusion policies In-service

Safety Rounding

- Standard practice is Q15 minutes on all patients
- Record all entries at the point of observation
- Must open doors to physically see the patient
- Rounds must be rotated hourly
- Upon completion must be handed directly to the next person
- What to do If there is a assignment conflict with completing rounds i.e. off unit test

Verbal De-escalation of agitated patients

- NVPCI Non Violent Physical Crisis Intervention (CPI) Model
- Crisis Development Model
  - Identify changes in a patients behavior i.e. anxiety
  - Intervene early an appropriately
  - Do not overreact or get into power struggle
  - Empathize with patient, listen to him/her
  - Determine needs of patient and respond honestly
  - Establish therapeutic rapport
  - Never threaten a patient with injection or restraints

Patient Belongings and Contraband Checks

- All patient belongings are check thoroughly and recorded on the patient belonging sheet.
- Patient is given a copy of their belonging inventory sheet
- If any contraband is found during the body check the following must happen
  - Illegal drugs or weapons Public Safety is called and they come to the unit to pick up the contraband.
  - Staff witness the acceptance of the contraband
  - The actions are recorded in clarity with specifics including that Public Safety was notified and picked up the contraband.

Verbal Escalation Continuum

- Questioning
  - Information seeking
  - Challenging
- Refusal
- Release
- Intimidation
- Re-establishment of Therapeutic Rapport

Restraints and Seclusion

- May be initiated by an RN on emergency basis
- Requires face to face examination by Licensed Practitioner MD, APN, Clinical Psychologist, etc within 1 hour of initiating restraint
- MD order is required for both Restraint and Seclusion
- Reason for restraint must be clearly documented
- Restriction of rights form is required
- All de-escalation attempts must be documented

Event Reporting Patient Grievance Process (Definitions)

- Complaint: A written or verbal concern or objection from a patient or a designated representative regarding the quality or appropriateness of care. Can be addressed and resolved by informal means.
  - Does not get entered into Clarity portal
- Grievance: A formal written or informal written complaint that is made to the hospital by a patient, or patient's representative, regarding the patient's care(when the complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to hospital's compliance with CMS condition's of participation.
  - This is entered into Clarity portal as "Patient/Visitor Compliments or Concerns.

Event Reporting Patient Grievance Process (Definitions)

- Patient Representative: An individual who is authorized to act on behalf of the patient for purposes of resolving complaints or grievances involving the patient i.e. Legal Guardian, Power of Attorney.
- Staff present: includes any hospital staff present at the time of the complaint, or who can quickly be at the patient's location.

Event Reporting Patient Grievance Process

- The following are examples of grievances
  - A written complaint of any kind by patient or their representative. This includes inpatient, outpatient, or discharged patient.
  - A written complaint attached to a survey
  - Patient or their representative telephones the hospital regarding patient's care.
  - Whenever a patient or his/her representative requests that their complaint be handled as a formal grievance.
  - If a patient care complaint cannot be resolved at the time of the complaint by staff, is postponed for later resolution, requires investigation.

Guardianship and Power of Attorney

- Guardianship or Power of Attorney representation are determined at intake.
- If a patient has an identified guardian or power of attorney then the case management team must be notified.
- Guardianship or Power of Attorney must be verified before sharing any patient information.
- Guardianship or Power of Attorney is verified once copies of the above named documents are received and placed in patient's clinical record.
- Information of what can be shared is determined by type of guardianship

GUARDIANSHIP INSERVICE
12/30/2015

Mental Health Specialists	Signature	Date
BEASON, MICHELLE		
CALDWELL, SAMIERA		
CAMPBELL, JESSE		
CAMPBELL,ERIC LEROY		
CONWAY,IESHA	[signature]	1-21-2016
GAUSE, MAURICE		
GAYDEN,BRENDA E.	B. Gayden	12-30-15
GREEN, LEON		
GUTHRIE, DEXTER		
HUNT,ROBERT JOE		
INGRAM, CHARNEIA	Charneia Ingram	12-30-15
JACKSON, SHANTE	Shante Duncan Jackson	12-30-15
JACKSON,LABARON		
JONES,TIMMY LEE		
KILONZO,JACQUES J.		
LONDON, KENNETH		
MOREHEAD,KENNETH TIKI		
ONEAL,BEYON		
O'NEAL,SHANNON		
PIERSON,NATHANIEL W.		
PORTER, ARTHURENE		
ROBINSON,LYNDA D.		
SCHAFFER,CHARLES		
SODE, IRETOMIWA		
SWILLEY,LUNDY	[signature]	1-21-16
SYLVA,EARL N.		
TALLIE, HENDERSON		
TATUM, DAVID		
TOLEFREE,DAROLD SHARRON		
WHITE, GREGORY	Gregory D. White	12/30/15
WHITEHEAD, ELAN		
WILBURN, EARL		
WILLIAMS,VIDAL P.		
WRIGHT, REGINA		
YOUNG, JAMES		

Expressive Therapists	Signature	Date
BULOSAN, JAMES		
SALEMI, JEANINE		

Intake Coordinators	Signature	Date
ARNOLD, DESIREE		
PARKS-LEE, PATRICIA		
READ, SHAKITA		
ROMERO, LUIS		

GUARDIANSHIP INSERVICE
01/13/16

Name	Signature	Date
Nurse Manager		
ALLI-BALOGUN, OLANIYI	[signature]	01/13/16
Registered Nurses		
ADEBOYE, BENJAMIN	[signature]	1/13/16
AMEDU, JULIE	[signature]	1/15/16
BRIGHT,VIVIAN YVETTE	Vivian Bright	1/13/16
CANCINO,PRESENTACION	PCancino	1-15-16
CEBEDO, CATHERINE	[signature]	1/15/16
CLERMONT,MWENYA	[signature]	1/21/16
CORPUZ,LEODA	[signature]	1-15-16
DILINILA,ROBERTO GAPASI JR	OUT OF THE COUNTRY DIF	
FIELD-WOOLRIDGE, KORA	Kora Field	1-13-16
GRUBB,HAROLD K. JR.	Harold Grubb	1-13-16
GUTANG,AILEEN	Aileen Gutang	1-12-16
MARKOVIC,JESSICA	MEDICAL LEAVE	—
MASON, MARCUS	[signature]	1/13/16
MCDUFFIE,LOIS G.	Lois McDuffie	1-12-16
POWELL,CHARLOTTE R	Charlotte Powell	1/15/16
SAMUKA,MANI A.	Mani Samuka	1/15/16
SUTTON, DELYONIA	OUT OF THE COUNTRY	
URIBE,DEWIYANI A.	[signature]	1-12-16
WOODS, SHEILA	Sheila Woods RN/BSN	01/21/16
WYNTER,JOSCELYN MICHAEL	Joscelyn Wynter	1-15-16
YESUFU,OLALEKAN	[signature]	1-12-16

Name	Signature	Date
Registry Registered Nurses		
ADENIRAN, ADEREMI	Remi Aden	1/21/16
ATA,MUHAMMAD	[signature]	1/15/16
BLACKMON,TYNETTA	[signature]	1/15/16
DUNN,LATANYA MICHELLE		
EVANS,ANTOINNETTE N.	A. Evans	1/15/16
HARRIS, JOSIE	[signature]	1-15-16
HART, MINA	Mina Hart	1-12-16
IVY, SHERANN	Sherann Ivy	1-15-16
JOHNSON, DANITA	Danita Johnson	1-12-16
OGBEBOR, EVANS	DID NOT TAKE Removed FROM SCHEDULE	
RASAKI,ADENIYI JAMIU	[signature]	1-15-16
SMOTHERS, SHAY	S. Smothers, RN	1/15/16
TAYLOR,ONETHA URSULA	O. Taylor, RN	1/21/16
THOMPSON, OGE	O. Thompson	1-12-16
WHITE, MASHONNA	Did not take test Removed FROM schedule	
WILSON, NEIL	Neil Wil[illegible]	1-12-16
DASOLA ADEKUNLE	D. Adekunle	1/13/16

Name	Signature	Date
WARD CLERKS		
REED, ADRIENNE	Phyllis Ross	1-13-16
ROSS, PHYLLIS	Adrienne Reed	1-15-16

GUARDIANSHIP INSERVICE

01/13/16

Mental Health Specialists	Signature	Date	
BEASON, MICHELLE	Michelle Beason	1/13/16	
CALDWELL, SAMIERA	FMLA	FMLA	FMLA
CAMPBELL, JESSE	[illegible]	1/15/16	
CAMPBELL,ERIC LEROY	[illegible]	1/15/16	
CONWAY,IESHA			
GAUSE, MAURICE	[illegible]	1/15/16	
GAYDEN,BRENDA E.			
GREEN, LEON	[illegible]	1/15/16	
GUTHRIE, DEXTER	[illegible]		
HUNT,ROBERT JOE	[illegible]	1/14	
INGRAM, CHARNEIA			
JACKSON, SHANTE			
JACKSON,LABARON	LaBaron Jackson	1/15/16	
JONES,TIMMY LEE	[illegible]	1/14/2016	
KILONZO,JACQUES J.	WORKER'S COMP	WORKER'S COMP	
LONDON, KENNETH		1-19-16	
MOREHEAD,KENNETH TIKI	Kenneth Morehead	1/15/16	
ONEAL,BEYON	B. O'Neal	1-15-2015	
O'NEAL,SHANNON	S. O'Neal	1-15-16	
PIERSON,NATHANIEL W.	Nathaniel Pierson	1/15/2015	
POP'.ER, ARTHURENE	[illegible]	1/15/15	
ROBINSON,LYNDA D.	Lynda D. Robinson	1/13/16	
SCHAFFER,CHARLES	FMLA	FMLA	FMLA
SODE, IRETOMIWA	[illegible]	1-15-16	
SWILLEY,LUNDY			
SYLVA,EARL N.	[illegible]	1.15.15	
TALLIE, HENDERSON	Henderson Tallie	1-13-16	
TATUM, DAVID	[illegible]	1-15-16	
TOLEFREE,DAROLD SHARRON	WORKER'S COMP	WORKER'S COMP	
WHITE, GREGORY			
WHITEHEAD, ELAN	Elan Whitehead	1/13/16	
WILBURN, EARL	[illegible]	1-15-16	
WILLIAMS,VIDAL P.	Vidal Williams	1/15/16	
WRIGHT, REGINA	MOVED OUT OF	TOWN	
YOUNG, JAMES			

Expressive Therapists	Signature	Date
BULOSAN, JAMES	[illegible]	1/15/16
SALEMI, JEANINE	Jeanine Salemi	1/15/16

Intake Coordinators	Signature	Date
ARNOLD, DESIREE	[illegible]	1/15/2015
PARKS-LEE, PATRICIA	[illegible]	1/15/15
READ, SHAKITA	Shakita Read	1-15-2015
ROMERO, LUIS	[illegible]	1/15/16
FOUNTAIN, DOROTHY	Dorothy Fountain	1/13/16
Henderson, Ceola	Henderson, Ceola	1/15/16

State of Illinois
Department of Human Services

CONSENT FOR SERVICES

NOTICE TO INDIVIDUAL: The purpose of this form is to record the nature of the services to be provided for which your written consent is needed and to make sure that you know who is to perform these services and where they are to be performed. The form also records that someone has explained to you any risks associated with these services and why the services are needed. Please read the form carefully and ask questions if you do not understand any part of it.

1. I, (individual's/authorized person's name) ______________________, consent to and authorize the performance on/administration to (individual's name) ______________________, of the following services (describe services to be rendered):

2. I understand that these services are to be carried out at (facility name) ______________________, or under the supervision of (physician's name) ______________________
I understand that (physican's name) ______________________ is authorized to delegate the performance of all or part of the services to other employees of ______________________ as is consistent with their respective professional education, experience and license.

3. In the course of the provision of these services it may become necessary to perform additional services without stopping to explain why and to request consent. I authorize the physicians and staff to use their judgement and do whatever they deem advisable in my best interests except that (list any exceptions):

4. The nature and purpose of the services, possible alternative methods of achieving this purpose, risks involved, and any possibility of a complication have been explained to me by (physician's name) ______________________ and I understand the explanation. It has also been explained to me that my refusal to consent to any of the above services may result in these consequences:

5. No guarantees or assurances have been made to me as to the results of the provision of these services and I understand that an undesirable result does not necessarily indicate an error in judgement.

6. This consent is valid until ______________________, unless it is revoked in writing prior to that time.
(calendar date)

I have read this consent form and I understand it. The explanations referred to above were given to me before I signed this form.

______________________ Witness to signature

______________________ (Individual or authorized person)

Date: ______________________

______________________ (Capacity of authorized person)

Time: ______________________

Individual did not sign this consent because:

LORETTO HOSPITAL
POLICY

Effective Date 10/06 Reviewed 3/08, 4/11, 5/14; 11/15 Revised 3/16	**SECTION: Patient Care Services** **TITLE: Guardianship, Patient Rights and Restriction of Rights** **AUTHORIZED BY:** [signature] 3/16 **Jim Renneker, MSN, RN, FACHE** Date **VP and Chief Nursing officer**	**POLICY NUMBER:** **PCS 1326.1.8a** **PAGE 1 of 2**

Policy:

Loretto Hospital shall provide all rights to patients pursuant to the Illinois Mental Health Code and shall only restrict those rights to protect the patient or others from harm. All staff will know the rights and the procedures and standards for restricting those rights.

All patients have a set of rights that is outlined on the **Rights of Individuals Receiving Mental Health Services IL 462-2001 (R-2-00).** Patients have additional rights that relate to their admission and discharge procedure. They are as follows:

Guardianship

"Guardian" means the court appointed guardian or conservator of the person. (Source: P.A. 80-1414.) Legal Guardianship status must be verified by receipt of the court order designating who has legal guardianship of the individual and the specific type of guardianship i.e., plenary, financial, medical, etc.,

Power of Attorney

A legal document which grants permission of another person to act on behalf of the patient. The power of attorney must be specific as to the POA role in the patient's care and must be received and verified. The Power of Attorney must have the notarized signature of the patient and the person acting on his/her behalf.

1. A patient's healthcare information is protected by applicable HIPAA laws, and is shared with a legal guardian or power of attorney in accordance with the specifics of guardianship order or power of attorney.

Informal Admission

The patient who is admitted on an Informal Legal Status has the Rights of the Informal Admittee." Refer to the IPU Policy 1502.4

Voluntary Admission

Patients admitted under the Voluntary Admission status have the Rights of Individuals and the right of the Voluntary Admittee, located on the application for voluntary admission. IL462-2202M(R-2-00). Refer to IPU policy I502.5

Involuntary Admission

The patient admitted on an Involuntary Legal Status has the Rights of the Individuals and the Rights of the Admittee as outlined on the Petition for Involuntary/ Judicial Admission (MHDD-5) IL462-2005 (R-1-10). Refer to IPU policy 1502.6

Any restrictions of rights and the reason for the restriction shall be documented in the recipient's record using the Notice for Restriction of Rights. The patient and the Facility Director or Designee will receive a copy, a copy will be sent to the guardian and any other person that the patient specifies.

Procedures

The staff nurse must orally review the rights of the individual with every patient and provide them with a copy. Additionally, the staff nurse must review, with the patient, their rights based on their admission status providing them with a copy. If the patient has a guardian, they must also be provided with a copy of the forms included in the patient's legal status.

Whenever any of the rights of a patient is restricted, a written notice of the restriction must be given to the following:

- the Patient
- the guardian, if the patient is under guardian
- the person (s) designated by the patient
- an agency designated by the patient (i.e., Guardianship and Advocacy Commission)
- Facility Director (must maintain a copy for three years)
- Any agency or attorney in fact under a Mental Health Preference Declaration or a Durable power of Attorney for Health Care.

Attached are the Rights of the Individual Receiving Mental Health Services.

Reference:

Administrative Policy #1101 Non-Discrimination
#1102 Patient Rights and Responsibilities
Illinois Mental Health and Developmental Disabilities Code Revised 2011

Loretto Hospital

645 South Central Avenue, Chicago, Illinois 60644 ***Time given to RN:*** __________

RN assigned:__________________

Behavioral Health Reservation/Screening Form

Please instruct the referring facility to fax the following documents so that the reservation screening process can be completed.

- **Most recent:** *History and Physical *Labs *Petition and Certificate *Medication Administration Record *Last 7 days of RN/MD notes

If a patient has an HMO, Notify the Crisis Department when the patient arrives on the floor. Fax the insurance contact information to the Crisis Department – x5868

Intake coordinator completing this form:____

Date _______________ Time intake started__________am/pm Transferring Facility________________

Psychiatrist ______________________________________ Unit/Floor________________

Medical Physician __________________________________Phone________________

Contact Person____

Patient's Name: Last______________________________**First** ______________________

Sex ___Age _________D.O.B.____________________Diagnosis ______________________

Address____Phone#________________

Does the patient have a legal guardian or power of attorney? Yes No

Name of Guardian/POA_____________________________________Phone#________________

Medicare#____________________________Social Security#_______________________

Medicaid recipient#/HMO member#____

Room # Assigned_________________Reservation received by________________________

Other payment source____ No Benefits____

Name of individual verifying benefits____

Copy of provider card obtained? Circle one Yes No

If patient is being referred from nursing home or group home will he/she be allowed to return post discharge? Circle one Yes No If not why?____

____

____

Reason patient is being referred for screening____

____

____

Has patient been diagnosed with an Intellectual disability (Formerly mental retardation)? Yes No

If yes Mild, Moderate, or Severe? (Circle one) Autism Yes No NA

Completion Date:________________________ Time:_____________________________________