FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT #16-030-9020
RIVEREDGE HOSPITAL

Case Summary: The HRA substantiated the complaint that the facility did not follow Mental Health Code requirements when a recipient's physician visited him after bedtime so the recipient did not have the opportunity to speak with him, and also that the physician revised the recipient's medication regimen even though the recipient was uncomfortable with the medication. The HRA did not substantiate that the facility lost the recipient's request for discharge form, delaying his discharge, and that the recipient was unable to make phone calls during regular business hours. The accepted provider response follows the report.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Riveredge Hospital. It was alleged that the facility did not follow Mental Health Code requirements when a recipient's physician visited him after bedtime so the recipient did not have the opportunity to speak with him, that the physician revised the recipient's medication regimen even though the recipient was uncomfortable with the medication, that the facility lost the recipient's request for discharge form, delaying his discharge, and that the recipient was unable to make phone calls during regular business hours. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-100 et. seq.).

Riveredge is a 110-bed private psychiatric hospital located in Forest Park, Illinois.

To review this complaint, the HRA conducted a site visit and interviewed the Chief Compliance Officer, the President of Medical Staff, the Attending Psychiatrist, the Director of Clinical Services, and the Chief Executive Officer. Relevant program policies were reviewed as were sections of the recipient's record upon written consent.

COMPLAINT SUMMARY

The complaint indicates that the recipient had been hospitalized at another area hospital for about a week before being admitted to Riveredge. In that time he had been prescribed a medication regimen that he felt was working for him. The complaint alleges that upon admission to Riveredge, the recipient was prescribed new medication that he felt anxious about taking. The complaint also alleges that the recipient's physician visited him at 10:00 p.m. when the recipient was in bed, asleep, so his missed visiting with him. The complaint also alleges that the facility misplaced the recipient's Request for Discharge form and they had him sign a new one, delaying his discharge unnecessarily. Finally, the complaint indicates that the recipient was unable to make phone calls during regular business hours so he was unable to address personal business, such as banking, which can only be done during business hours.

FINDINGS

The recipient was admitted to Riveredge on 4/27/16 with a diagnosis of Bipolar Disorder, manic phase, and Polysubstance Abuse, severe. The recipient's Psychiatric Evaluation, completed on 4/27/16 (but signed as 4/18/16 by his physician), states, "This 27-year-old African American male was hospitalized under my care from 3/04/16 through 3/25/16 with a diagnosis of bipolar disorder, manic phase, and polysubstance abuse, severe. The patient was stabilized on a regimen of Zyprexa and Depakote and left the hospital in stable condition. Since that time he was recently hospitalized at [a Chicago area hospital] for the past two weeks, and was discharged just one day prior to this admission. There, he was given a regimen, according to him, of Haldol Decanoate injections, received just prior to discharge, Xanax 2 mg twice a day, and Adderall. The patient apparently went home to where he was living with his girlfriend and her mother and got into an altercation with his girlfriend. The police were called and he was escorted off the premises and taken to [a Chicago area hospital] for his manic posture. The patient was agitated and belligerent. He voiced homicidal ideation toward his girlfriend. Upon presentation here, the patient is floridly manic, unable to stop talking, pressured, etc. and clearly in need of acute inpatient psychiatric treatment." The record shows that on the same day the recipient consented to the following medications: Olanzapine (Zyprexa), Xanax (Alprazolam), and Depakote (Divalproex) and that during his hospitalization he was administered the scheduled medications of Tegretol (beginning 5/02/16), and Depakote. The recipient was also ordered Xanax, Haldol, and Ativan as PRN or 'as needed' medication. On 5/02/16 the record shows the recipient was started on Tegretol, however there is no consent in the record for this medication. A physician note entered on 5/02/16 offers the clinical reason: "The patient is holding to his 5 day release request. His DVP [Depakote] level is only… (illegible) I suggest we …(illegible)…to Tegretol to avert larger doses of DVP." There are no indications from the record that the recipient received this information or consented to the medication.

The clinical record indicates that the recipient's physician met with him several times during his hospitalization:

1. 4/27/16 Psychiatric Evaluation dated for 4/18/16 and there is no time indicated.

2. 4/29/16 Psychiatric Progress Note but time is not legible.

3. 4/30/16 Psychiatric Progress Note but time is not legible.

4. 5/02/16 Psychiatric Progress Note but time is not legible.

5. 5/03/16 Psychiatric Progress Note but time is not legible.

There are two Requests for Discharge signed by the recipient in the record. One appears to be a copy of a request that was signed on 4/27/16 and another that was signed by the recipient on 4/30/16. Therapist Notes written on 4/30/16 mention the recipient's concern regarding his request: "…After our session ended, Pt. asked the writer to see if his 5 day was in the chart, which he supposedly signed when he was admitted this past Wednesday. There was no documentation in his chart showing he signed a 5 day. He went to his room and showed the writer a copy of a 5 day he signed back in late March. He was informed this 5 day is old and no documentation is shown that he had signed one when he was first admitted. He was given a new 5 day to sign and given a copy of it. He could be heard in his room yelling and cursing that the hospital was conspiring against him to stay longer…." The recipient was discharged on 5/04/16, within the statutorily mandated timeframe.

The record does not reflect a restriction on the recipient's phone use, however Therapist Notes from 4/30/16 indicate that the recipient was preoccupied with contacting his bank: "…He would speak to himself that he has to pay his uncle's debt, and wanted to call an office number to make sure his SSI benefits check had been deposited. He was redirected by staff and eventually he calmed down." The record does not show that the recipient asked for or was denied phone access for times outside of the scheduled phone use periods.

Hospital Representatives' Response

Hospital representatives were interviewed about the complaint. With regard to the physician visiting hours, the two physicians present indicated that they generally have visits with patients within the hours of 6:00 a.m. and 10:00 p.m. The recipient's physician indicated that the timing of his visits is dependent on the events occurring within the hospital and is affected by emergencies, the presence of family members or guardians who wish to speak with the physician, and the willingness of the patient himself to meet with the physician. The recipient in this case refused to meet with the physician for one of his scheduled visits and situations such as these may alter the remaining visits for the day. The physician indicated that at times a patient may request to be awakened by the physician in lieu of missing an appointment, and other times a patient may not want to be disturbed. Staff were interviewed about the physician's notes and the fact that the time of his visits with patients is not legible and neither are his notes. Staff acknowledged that his handwriting is not legible at times and that he should be reminded of this fact and required to be more careful.

Hospital representatives were interviewed about the recipient being ordered Tegretol. The physician indicated that the recipient was on a large dose of Depakote requiring numerous pills throughout the day, and because the history of the recipient's non-compliance contraindicated numerous medications, and because the recipient's symptoms were not improving, the physician decided to prescribe Tegretol. The recipient's Attending Physician indicated that he had discussed the medication with the recipient and the recipient had approved,

although he also stated that he was aware there was no consent in the record. Staff further reported that a recipient would never be forced to take a medication and always has the option to refuse or to request a consult with his physician regarding his medication regimen. In addition, the hospital has implemented a new electronic medication prescribing system. The facility has put in place a "hard stop" for the administration of medication without the proper consent documented.

Hospital representatives were interviewed about the recipient's Request for Discharge. They acknowledged that there were two Requests in the record, one signed the day the recipient arrived, and another one, signed on the day the recipient requested it. It appears the original Request was misplaced, however the recipient was discharged within the statutorily mandated period of 5 days. Hospital representatives indicated that they have initiated a procedure where all Requests for Discharge are discussed each day at the administrative meeting and Request for Discharge information has been added to the daily census so that proper tracking takes place and timely filing of court papers, if necessary. The Request for Discharge is also taped to the front of the recipients' chart. Also, there have been two instructional memos distributed to all clinical staff that outlines the 5-day process.

The hospital representatives were interviewed about the recipient's ability to make phone calls. They indicated that phone times on the unit are 10:00-10:30 a.m., 6:00–6:30 p.m., and 8:30-9:00p.m. Monday through Friday. On weekends there is additional time between 12:30 p.m. and 1:00 p.m. Also, phone calls can be made outside of phone times when clinically indicated and approval obtained from the physician or case worker. Staff confirmed that there was no charting to indicate the recipient requested additional phone time or that it was denied.

STATUTORY BASIS

The Mental Health Code guarantees all recipients adequate and humane care in the least restrictive environment, and describes the requirements for the administration of psychotropic medication and its refusal:

"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 5/2-102a-5).

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

"An adult recipient of services…must be informed of the recipient's right to refuse medication… The recipient…shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication… If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less

restrictive alternative is available. The facility director shall inform a recipient…who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services" (405 ILCS 5/2-107).

The Mental Health Code states, "Any person 16 or older may be admitted to a mental health facility as a voluntary recipient for treatment of a mental illness upon the filing of an application with the facility director of the facility if the facility director deems such person clinically suitable for admission as a voluntary recipient" (405 ILCS 5/3-400). "The application for admission as a voluntary recipient may be executed by: the person seeking admission, if 18 or older; or any interested person, 18 or older, at the request of the person seeking admission; or a minor, 16 or older…. The written application form shall contain in large, bold-faced type, a statement in simple nontechnical terms that the voluntary recipient may be discharged from the facility at the earliest appropriate time, not to exceed 5 days, excluding Saturdays, Sundays and holidays, after giving a written notice of his desire to be discharged, unless within that time, a petition and 2 certificates are filed with the court asserting that the recipient is subject to involuntary admission" (5/3-401).

The 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)

HOSPITAL POLICY

Riveredge provided the policy for the Discharge Request of Voluntary Patient (5-day) (ID:1711784). It states, “In order to protect patient rights, it is the policy of Riveredge Hospital that the legal rights of any individuals admitted to Riveredge Hosptal as a voluntary patient will be safeguarded, and that any discharge request made by a patient and/or parent/guardian will be handled in accordance with the Illinois Mental Health and Developmental Disabilities Code within the timeframe allowed. The procedure indicates that unit staff will receive requests for discharge and advise the requestor about the completion of the Request for Discharge form. This form is then sent to Assessment and Referral (A&R). A&R will then record the information in the Court Book. Staff who received the written request for discharge must notify the Charge Nurse, Physician, and Program Therapist or Director of Clinical Services that the request was received. The Attending Physician determines the need for discharge or if additional time for

treamtnet is needed. If the patient is to be discharged, the earliest appropriate time is to be set, but not to exceed the time allotted by the Mental Health Code.

Riveredge provided the policy for Telephone Usage (ID: 1680715). The policy indicates that patients have the right to make and receive unimpeded, uncensored and private phone calls. The patient's right to make and receive calls can only be restricted by the Attending Physician in order to protect the patient or others from harm, harassment, or intimidation. The Physician must document a clear individualized therapeutic justification which demonstrates the necessity for each restriction for each patient. Each unit establishes the times at which the patient would most likely be on the unit and not engaged in therapeutic activity. These times will be communicated to the parents, relatives and others for their convenience in telephoning.

CONCLUSION

The complaint in this case indicated that a physician had visited his client after 10:00 p.m. so that the recipient had missed his visit. During a site visit, his physician confirmed that this may sometimes be the case. This seems non-therapeutic and counterproductive and the HRA advises against it based on the standard of adequate care. If the clinical services, visitation, phone calls and all other activity has been terminated for the day and recipients have gone to bed, then they should not be awakened to speak with their physician, which is a vital component of their treatment episode. Nor should they miss out on this important care because they were unable or unwilling to awaken. Also, the times at which this physician visited his patient are completely illegible. The HRA substantiates the complaint that the physician visited the recipient after he had gone to sleep, so he missed his visit.

The complaint in this case charged that the recipient's physician had revised the recipient's medication regimen and added Tegretol, causing the recipient anxiety and fear about his medication. Although the Attending Physician provided a clinical justification for the change, it is not clear from the record that the physician presented this information to the recipient. Additionally, there is no recipient consent recorded in the documentation. Also, the physician's notes are so illegible, it is difficult if not impossible to decipher what actually transpired during the physician visits. The HRA substantiates the complaint that the physician revised the recipient's medication regimen even though the recipient was uncomfortable with the new medication.

The complaint indicates that the facility lost the recipient's Request for Discharge, thus delaying the recipient's discharge. Because there are two Requests in the record this complaint is probably true, however the recipient was discharged within 5 days of his original request. The HRA does not substantiate the complaint that the facility lost the recipient's Request for Discharge form, thus delaying his discharge.

The complaint in this case charged that the recipient was unable to make phone calls during regular business hours. The unit phone times allow for calls during business hours and patients may request additional times from their physician or case worker. The clinical record does not show that the recipient requested additional times to make calls and does not show that

he was denied a request to make calls. The HRA does not substantiate the complaint that the recipient was unable to make phone calls during regular business hours.

RECOMMENDATION

1. Work with physicians to ensure that their visits are completed before bedtime. Ensure that recipients are not awakened at night to visit with their physician and ensure that they do not miss visits because they are asleep.

2. Consent is bedrock of all treatment. Ensure that if services include the administration of psychotropic medication, the physician or the physician's designee advises the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives. Ensure that this consent is documented in the clinical record.

SUGGESTIONS

1. The Attending Physician notes are inaccurate and illegible. Although poor handwriting by physicians is a common practice, in this case it is extreme. Remind the physician to complete his notes accurately and in such a way that they can be read.

2. Ensure that notices for discharge are properly tracked and acted upon as per the Mental Health Code and hospital policy.

3. The allowable phone time amounts to only 1 ½ hours per day with an extra ½ hour on weekends although more time can be requested via a physician or case worker. Consider reviewing whether or not the allowable time is sufficient and/or ensure that recipients are aware that they can request additional phone time when needed.

RESPONSE

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

Riveredge Hospital

November 8, 2016

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

Re: #16-030-9020

Dear Ms. Casati:

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

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

Recommendations:

1. Work with physicians to ensure that their visits are completed before bedtime to minimize disruption to the patient sleep cycle.
    a. The topic of Limited Rounding Times was been discussed at the Executive Committee of the Medical staff. The recommendation made and accepted to limit rounding times to 6:00am – 10:00pm. This information was communicated to the Medical Staff members via memo on July 27, 2016.

2. Ensure that informed consent is obtained by the Physician or designee and that consent is documented in the medical record.
    a. Riveredge Hospital recently implemented a new electronic medication/prescribing system. A "hard stop" has been put in place to prevent the administration of medications without proper consent documented. The system requires staff to indicate if the psychotropic medications have been consented. The staff are still required to completed the paper form and obtain signatures but this is another safety mechanism to ensure proper consent is obtained and documented.

Suggestions:

1. Legibility and accuracy of physician documentation
    a. Riveredge Hospital does not accept the characterization that the physician documentation is inaccurate. We have reinforced the need for legible documentation from all staff, including physicians.
    b. Riveredge IT department is exploring options for electronic documentation for physicians to address legibility issues.

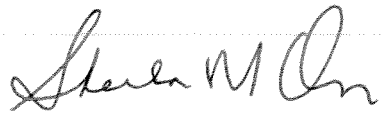
2. Ensure that notices of discharge are properly tracked and acted upon per Mental Health Code and hospital policy.
    a. All 5-day requests for discharge are discussed daily in the administrative meeting. Request for discharge information has been added to the daily census so that proper tracking takes place and timely filing of court papers, if indicated. There have been 2 instructional memos distributed to all clinical staff that outline the 5-day process.

3. Phone time
    a. The Medical Staff and clinical leadership discussed the current process and time allotments for phone time and found them to be adequate. We have a process built in for additional phone time when needed/requested. Patients are educated on phone times via the patient handbook and daily Community Group.

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

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

Sincerely,



Sheila M. Orr, JD, BSN, RN
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Riveredge Hospital