FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
SILVER CROSS HOSPITAL— 16-040-9018
HUMAN RIGHTS AUTHORITY— South Suburban Region

INTRODUCTION

The Human Rights Authority has completed its investigation into allegations concerning Silver Cross Hospital. This general hospital has an adult psychiatric unit with 20 beds. The complaint stated that the hospital failed to provide adequate and humane care and services as follows: 1) the recipient was told that she would be seen daily by a psychiatrist, a general medical physician and a social worker but this did not occur, 2) the recipient had to request occupational therapy three times before she was seen by a therapist, 3) psychotropic medication was prescribed without informed consent, 4) the recipient had to sleep in the isolation room for two nights because her roommate snored too loudly, and, 5) the recipient's right to confidentiality was breached during group therapy by a staff person.

If substantiated, these allegations would be violations of the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.) and the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/5 [a]).

METHODOLOGY

To pursue the investigation, the hospital's Risk Manager, the Director of Corporate Compliance, the Director of Behavioral Health, a psychiatrist, and a Mental Health Technician who matched the group leader's description provided in the complaint were interviewed. The complaint was discussed with the recipient as well as her record was reviewed with written consent. Relevant program policies were also reviewed.

Findings
Complaint #1and 2 Inadequate Care

The complaint stated that a nurse (s) told the recipient that she would be seen daily by a psychiatrist, a general medical physician and a social worker. However, she was seen a total of four times by two different psychiatrist during the first eleven days of her admission to the hospital and was not seen by a social worker. Additionally, the complaint stated that the recipient had to request occupational therapy three times before she was seen by a therapist. It was reported that the recipient was receiving outpatient physical therapy for her leg and her arm prior to her hospitalization. It was reported that

the hospital's failure to provide timely occupational services made her regressed in this area.

Information from the record, interviews and program policies

According to the record, the recipient was transported by ambulance to the hospital's emergency department for a mental health assessment on March 28th, 2016 around 8:00 a.m. Her family was at the hospital and reported that she had not slept for the past three days. However she said that she was "feeling great" and did not understand why she was being evaluated. She was described as pacing and crying and asked to talk to her father around 9:20 a.m. Her father was escorted to the examination room and she started shouting at him and told him to leave. She was examined by a physician and a social worker and denied having suicidal or homicidal ideations. She was diagnosed with Major Depression and Insomnia. She had screws and a metal plate in her left arm and reported that she had been involved in a car accident about three weeks prior to her hospital visit. Also, she had other physical problems and was voluntarily admitted to the hospital's behavioral health unit on that same day around 5:30 p.m.

The admitting nursing note documented "scabs" on the recipient's left leg and her left arm due to a car accident about two weeks ago prior to her arrival to the unit. The admitting physician's orders included psychotropic medications, a consultation for wound care and group therapy sessions. For the 29th, a History and Physical Report, completed by a physician of internal medicine, documented a thyroid problem and a previous anterior cruciate ligament injury. Later, the recipient was diagnosed with Bipolar Disorder because of manic behavior during an initial psychiatric evaluation conducted by the covering psychiatrist (a). Another progress note indicated that social services were involved with the recipient who signed a release of authorization form because she wanted her mother to be called about a family meeting. A treatment plan was developed that included goals such as compliancy with medication and group therapy sessions. For the 30th, the physician of internal medicine noted that the recipient did not have any complaints, cough or pain. Another progress note indicated that she was seen by the Attending Physician who documented limited insight, mood instability and irritability. For the 31st, the covering psychiatrist (a) noted that the recipient said that she was feeling great, but the staff reported that she was having problems sleeping. Another progress note stated that the recipient was tearful and yelling during a family meeting because her family wanted her to comply with medication.

For April 1st, the covering psychiatrist (b) wrote that the recipient was anxious about her job, irritable and judgement was fair. For the 2nd, the recipient was tearful and told a nurse that the covering psychiatrist had "only spent 5 minutes" with her on that previous day. And, "he would [not] let me talk. He did [not] remember me from yesterday…. He told me I was getting too close and to open the door and I was just trying to get closer because I could [not] hear him. He asked to have me escorted out." Another progress note indicated that she was seen by the physician of internal medicine on that same day. The physician noted that the recipient was doing exercises for her upper extremity and wanted to be seen by the hospital's therapist for further recommendations.

An order for an occupational therapy evaluation and treatment was written on that same day. For the 3rd and the 4th, the covering psychiatrists (a and b) wrote that the recipient continued to present with manic and demanding behaviors and disagreed with her medical diagnosis of bipolar disorder. Her record documented that she was seen by an occupational therapist for an assessment on the 4th and reported that she had received one week of outpatient [therapy] and did not want to get behind. An evaluation report included a recommendation that occupational services should be continued during her hospital's stay. A second order for additional treatment was written.

For the 5th, the recipient told the covering psychiatrist (a) that there was nothing wrong with her and again disagreed with her medical diagnosis. She was reportedly seen by the physician of internal medicine on the 5th and the 6th. The physician noted mild limited extension of the recipient's left arm was observed at her elbow. Her surgical scars on her left knee was healing with no evidence of infection. Mederma ointment for her scars was ordered as requested by the recipient. It was documented that occupational services were provided on the 5th. For the 6th, the Attending Physician wrote that the recipient was irritable, verbally redirectable and did not exhibit any psychotic symptoms. She was reportedly focused on being discharged from the hospital and was willing to participate in a family therapy session on that next day. For the 7th and the 8th, the covering psychiatrists (a and b) noted that the recipient was agitated, manic, and was still having problems sleeping. And, she placed "clippings" from newspapers' all over the television in the day room. A request for discharge form dated on the 8th and signed by the recipient was found in her record.

For the 9th, the recipient's outpatient psychiatrist wrote that she was jumping from one subject to another subject and was talking about problems concerning her hospitalization. She told her outpatient psychiatrist that she wanted to be discharged from the hospital so that she could return to her job. For the 10th, the covering physician of family practice wrote that he saw the recipient and that her anterior cruciate ligament injury was healing. For the 11th, the physician of internal medicine noted that the recipient had no cough, pain, and was going home on the same day. However, a nursing note explained that she was not discharged as planned from the behavioral health unit. The recipient's mother reportedly had refused to pick her up because she would not agree to take medication. Another note documented that the recipient asked a nurse to call her friends and asked if she could stay with them. However, her friends told the nurse that her mother told them to say no. It was documented that occupational services were provided on the 11th and that she made good progress with her left shoulder and that she should follow up with outpatient services upon her hospital's discharge. Her record indicated that she was discharged from the behavioral health unit on that next day.

The hospital's Vice President of Patient Care Services responded to the complaint by letter stating the recipient was seen by a physician every day of her hospital stay with the exception of the admission day and the scheduled discharge day and the actual day of discharge. It was explained that the recipient was admitted to the behavioral health unit on the afternoon of March 28th, 2016 after the physicians had made their rounds. Her scheduled discharge from the hospital was delayed because her parents refused to pick her

up and she had no other resources available. She was discharged from the unit on that next morning before the physicians made their rounds. It was explained that social workers do not see patients individually on a daily basis. The recipient reportedly attended group therapy sessions every day of her hospitalization. At the site visit, the staff interviewed repeated that the recipient was seen daily by a physician with the exceptions of the three days mentioned above.

According to the hospital's letter and the staff interviewed, the recipient did request occupational therapy when she was seen by a physician on April 2nd. An order was written for an occupational evaluation on the same day. However, the assessment was not done until the 4th because the occupational therapy department does not evaluate patients on Saturdays and Sundays. The HRA was informed that the recipient was seen by the occupational therapy staff on the 5th and the 11th as mentioned above in the report.

Silver Cross' "Professional Services Plan" policy states that its behavioral health unit provided intensive treatment for patients suffering from acute psychiatric disorders.

The hospital's "Behavioral Health Services Inpatient Unit Standards Including Admission History/Assessment of a Patient" policy states a medical history as well as a behavioral health admission history will be completed within 24 hours of admission to the unit. The patient will have a problem list and a corresponding treatment plan will be initiated upon admission, including short term goals, target dates and interventions. The patient and patient's family, if applicable are encouraged to actively participate in the treatment planning process. A high degree of collaboration with the attending psychiatrist, nursing, social services, recreational therapy, and other ancillary staff is maintained at all times. The patient's treatment will be guided by the treatment plan in order to promote, maintain, restore health, and prevent illness and effect rehabilitation."

The hospital's "Rights of Individuals Receiving Mental Health and Development Services" policy includes the right to adequate and humane care and services in the least restrictive environment, pursuant to an individual treatment plan.

The hospital's "Standards of Care for Social Work Services" policy states that the social worker will provide necessary individual and family counseling, and educational material to the patient and family members regarding the individual's illness and treatment. The social worker will participate in group treatment and provide supervision for the behavioral health staff who facilitate process-oriented groups.

CONCLUSION

Section 5/2-102 (a) of the Code states that a recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individualized services plan.

The complaint stated that a nurse (s) told the recipient that she would be seen daily by a psychiatrist, a general medical physician and a social worker. However, she

was seen a total of four times by two different psychiatrist during the first eleven days of her admission to the hospital and was not seen by a social worker during the first eleven days of her admission to the hospital. Based on the recipient's record, the hospital's letter and the staff interviewed, the recipient was seen daily and sometimes twice daily by physicians with the exception of the admission day and the day she was actually discharged. Also, social services were involved with her and her family during her hospital stay. The staff interviewed and the hospital's policy indicated that social work services are provided as needed and her services plan did not require a daily visit by each treatment staff member assigned to her case.

The HRA does not substantiate the complaint. The Authority finds no violations of Section 5/2-102 (a) of the Code or program policy on social work services or its rights policy that include adequate and humane care and services.

The complaint stated that the recipient had to request occupational therapy three times before she was seen by a therapist. There was only one progress note written on Saturday, April 2nd, 2016 found in her record concerning her request for occupational services. On that day, the physician of internal medicine noted that the recipient was doing exercises for her upper extremity and told him that she wanted to be seen by the hospital's therapist for further recommendations. An order was written on that same day. She was seen by the hospital's occupational therapy department on that next Monday because this department reportedly does not evaluate patients on the weekend days. A second order for additional physical therapy services was written based on the occupational therapist's recommendations. Her record indicated that services were provided as ordered.

The Authority does not substantiate the complaint. The HRA finds no violations of the Code's Section 5/2-102 (a) or program policy that includes admission history and assessment of patients.

Complaint #3 Medication

The complaint stated that Geodon was prescribed but the recipient was not provided with medication information. Additionally, the complaint stated that the physician asked the recipient to leave the room because she requested verbal and written information about Divalproex Sodium (Depakote) that had been ordered due to medication side effects from Geodon.

Information from the record, interviews and program policies

According to the hospital's emergency department record, Ativan 2 mg Intravenously and Haldol 5 mg and Ativan 2 mg Intramuscularly (IM) were administered on March 28th, 2016 around 1:00 p.m. However, there was no explanation for the medications given or informed consent found in her record. She was voluntarily admitted to the behavioral health unit on that same day. The admitting physician's orders included Haldol 5 mg orally or IM and Cogentin 1 mg or 2 mg IM as needed every four hours and

Ativan 1 mg or 2 mg orally or IM every six hours as needed. Later, the orders indicated that Lexapro, Geodon, Divalproex Sodium (Depakote) and Trazodone were added to her medication regimen. A medication consent form signed by the recipient documented her approval for the administration of Haldol 2 mg to 40 mg, Ativan 0.5 mg to 2 mg and Lexapro 5 mg to 20 mg. The physician signed the medication consent form on the admission month but the exact day of the month is unclear. It documented that medication information was provided and that dosages may change based on her condition. Her record lacked a physician's determination statement concerning whether or not she had the capacity to make a reasoned decision about the treatment. Also, the HRA noticed that the State of Illinois Department of Human Services' medication consent form does not require a date indicating when the recipient signed the document.

According to the admitting nursing note, the recipient was hyperverbal, liable and highly impulsive. She was hitting the phone and yelling that she was "innocent." She was asked to stop talking on phone but there was no documentation whether she complied with redirections. According to the Medication Administration Records (MARs), Haldol 5 mg and Ativan 2 mg IM were administered at that time. For the 29th, a mood stabilizer medication was recommended by the covering psychiatrist (a) and refused. Also, the recipient refused Lexapro 10 mg on that same evening and the medication was not administered. According to the MARs, Ativan 2 mg twice and Lexapro 10 mg were administered on the 30th. The covering psychiatrist (a) noted that Geodon 20 mg orally nightly would be started on the 31st. There was no clear documentation that medication information was provided. Lexapro 10 mg and Geodon 20 mg were administered on that same day.

For April 1st, the covering psychiatrist (b) wrote that the recipient was concerned about medication side effects and medication information was provided. It was documented that she had agreed to comply with medication. Lexapro 10 mg and Geodon 20 mg were administered on the 1st and the 2nd and Ativan 2 mg was administered on that latter day. The covering psychiatrist (b) wrote that the recipient blamed Geodon for her angry mood on that next day. According to the MARs, Ativan 2 mg twice and Lexapro 10 mg were administered on that same day. Geodon was refused and the medication was not given. For the 4th, the MARs indicated that Depakote 500 mg, Ativan 2 mg and Lexapro 10 mg were administered, and she was allowed to refuse Geodon. The covering psychiatrist (a) documented that Depakote 750 mg orally daily would be started and that the medication risks and benefits were explained and that the recipient had agreed to the plan. And, the psychiatrist wrote that the recipient was fully not compliant with medication and said that she would only take medication if her outpatient psychiatrist came to the hospital and told her to do so. Also, a social services note stated the recipient wanted her outpatient psychiatrist's approval for Depakote. A second medication consent form indicated that Lexapro 5 mg to 30 mg, Depakote 750 to 1500 mg, Geodon 20 to 160 mg, Haldol 2 to 40 mg, Ativan 0.5 to 2 mg and Cogentin (no dosage range was noted) were prescribed. However, the box stating "I do not agree to take the medication (s) above" was checked on the medication consent form signed by the recipient. It was signed by the physician on April 10th or the 11th. Again, the medication consent form does not require a date indicating when the recipient signed the document.

For the 5th, the recipient told the covering psychiatrist (a) that she was taking medication against her will because her outpatient psychiatrist told her to do so. She said that she was taking the medication so that she could be discharged from the hospital. Depakote 500 mg, Ativan 2 mg and Lexapro 10 mg were administered. She was allowed to refuse Depakote 500 mg at night. For the 6th, the Attending Physician wrote that the recipient did not exhibit any psychotic symptoms and was compliant with medication. According to the MARs, Depakote 250 mg, Depakote 500 mg twice, Ativan 2 mg and Lexapro 10 mg were administered. Depakote Extended Release (ER) 1500 mg orally at night was ordered on that same day. For the 7th, the covering psychiatrist (a) noted that the recipient was agitated and that Depakote had been increased to 1500 mg orally on that previous day and that the medication would be decreased to 250 mg orally in the morning and 1000 mg orally at night. According to the MARs, Depakote ER 1000 mg, Ativan 1 and 2 mg and Lexapro 10 mg were administered.

For the 8th, Depakote 250 mg, Ativan 2 mg and Lexapro 10 mg were administered, and she was allowed to refuse Geodon and Depakote ER when offered. For the 9th, the recipient told her outpatient psychiatrist that Depakote had been started because Geodon did not agree with her. She said that she had refused Depakote on that previous day and had slept better without the medication. Her outpatient psychiatrist documented that the recipient believed that the Geodon had been discontinued but the medication is still ordered. The psychiatrist ordered Trazodone 100 mg at bedtime for sleep. For the 10th and the 11th, the MARs indicated that Lexapro 10 mg and Depakote 250 mg were given. She was allowed to refuse Geodon and Depakote ER when offered. Trazodone 100 mg was administered on the 10th. The medication was decreased to 50 mg and was administered on the 11th. According to the nursing notes, the recipient accepted Ativan 1 mg orally to decrease her anxiety about her failed discharge plans on the 11th. She refused Depakote upon her discharge from the hospital on the 12th and said that she would take the medication if her outside psychiatrist told her to do so.

A Discharge Summary Report written by the covering psychiatrist (a) stated that the recipient presented with hypomanic symptoms during her hospital's stay. She initially was not agreeable with taking Geodon and had started to comply with Depakote. She continued to have pressured speech and was observed many times having problems sleeping. She still did not fully comply with medication even though her outpatient psychiatrist visited her on the behavioral health unit. According to the Discharge Summary Report, Depakote 250 mg in the morning and 1000 mg at bedtime and Geodon 20 mg at night and Lexapro 10 mg were recommended on the discharge day.

The covering psychiatrist (a) told the HRA that some recipients do not want to take medication and that they have the right to refuse medication. She said that sometimes a patient might change their mind and agree to take the medication. She said that once the nurse enters the orders by phone that medication information is provided. According to the covering psychiatrist, that the recipient was given medication information, and she was discharged from the hospital because her symptoms improved. The investigation team

and the staff discussed the need for a capacity statement in the recipient's record. The staff seemed unaware of this requirement under the Code. There was discussion about the medication consent form used by the hospital that does not require a date indicating when the recipient signed the document. The first medication consent form documented her approval for the administration of Haldol, Ativan and Lexapro. The second medication consent form clearly documented her refusal for Depakote, Haldol, Ativan, Geodon, Lexapro and Cogentin. However, the first five medications were administered in the absence of a documented emergency. The HRA notes that Cogentin was not given during her hospital stay. Haldol and Ativan IM were administered by the emergency department staff and by the behavioral health staff on the admission day. A nursing note stated that the recipient was hitting the phone and yelling which might meet the need for emergency medication on the admission day if more descriptive information had been documented in her record.

The hospital's "Informed Consent for Psychotropic Medication" policy revised on May of 2016 states that psychotropic medication may only be administered with the adult patient's or guardian's informed written consent. The policy states that medication may be administered without consent up to 72 hours in an emergency. Within 24 hours of administration of psychotropic medication, the psychiatrist or designee shall advise the recipient, in writing, of the side effects and the frequency of the side effects to the extent of the person's ability to understand the information communicated. The staff are directed to provide handouts of the prescribed medication and side effects. Medication consent shall be effective for the duration of the patient's hospital's stay and can be revoked at any time. A recipient's verbal refusal to accept psychotropic medication shall always override his or her prior written consent and such refusal shall be documented in the clinical record.

The hospital's "Refusal of Medication" policy directs the nursing staff as follows: 1) to discuss with the patient their reasons for the refusal of medication and to explain that the physician has ordered the medication as part of their treatment plan, 2) to encourage the patient to talk to their physician about medication, 3) to document the patient's refusal and all discussion about this issue in progress notes, and, 4) to document the patient's refusal in the electronic medication administration record. According to the policy, medication may be administered over a patient's wishes if the individual's behavior presents an imminent threat to self or others or by court-order. A restriction of rights notice shall be initiated in all instances when medication is administered over a patient's objections. The restriction shall be documented including a description of the events leading up to this action and attempts to intervene with lesser restrictive approaches in the progress notes.

The hospital's "Rights of Individuals Receiving Mental Health and Development Services" policy includes the right to refuse medication. If such services are refused they will not be given except to prevent harm to self or others. The policy provides for the recipient's informed consent except in emergency situations and a notice whenever rights are restricted.

Subsequent to the site visit, the hospital's Director of Behavioral Health provided the Authority with a copy of the hospital's "Informed Consent for Psychotropic Medication" policy revised on October of 2016 that reportedly would be submitted for approval. The proposed revisions are as follows: 1) the psychiatrist or designee shall advise the recipient, in writing, of the side effects and the frequency of the side effects to the extent of the person's ability to understand the information communicated prior to the administration of psychotropic medication, 2) the psychiatrist shall make a determination during the initial examination and document if the patient has the capacity to make a reasoned decision about the use of psychotropic medication in his or her treatment, and, 3) the nursing staff shall provide patients with handouts outlining the purpose of the prescribed medication and their side effects prior to the administration of psychotropic medication.

Additionally, the Authority was provided with a copy of the State of Illinois Department of Human Services' Consent To Medication form that requires the date and time the recipient signs the document. According to the Director of Behavioral Health, the medication consent form had been revised several months prior to the recipient's hospital stay, but the staff was not using the form.

CONCLUSION

According to Section 5/2-102 of the Code,

> (a) All recipients of services shall be provided with adequate and humane care and services, 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 recipients' substitute decision maker, if any, or any other individual designated in writing by the recipient.
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> (a-5) If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with recipient's ability to understand the information communicated. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment. The physician or designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only [i] pursuant to Section 5/2-107 ….

Section 5/2-107 states that,

> An adult recipient of services…must be informed of the recipient's right to refuse 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 harm to the recipient or others and no less restrictive alternative is available …. psychotropic medication or electroconvulsive therapy may be given under this Section for up to 24 hours only if the circumstances leading up to the need for emergency treatment are set forth in writing in the recipient's record.

According to Section 5/2-201 of the Code, whenever any rights of a recipient of services are restricted, the recipient shall be promptly given a notice of the restriction.

The complaint stated that Geodon was prescribed but the recipient was not provided with medication information. Additionally, the complaint stated that the physician asked the recipient to leave the room because she requested verbal and written information about Divalproex Sodium (Depakote) that had been ordered due to medication side effects from Geodon. The recipient's record supports that medication information was provided for Depakote but there was no mention that verbal and written information was provided about Geodon. The HRA finds many problems with this complaint. Her record contained two medication consent forms dated on March and April of 2016 but the exact day of the month is unclear. The second medication form clearly indicated her refusal for Geodon, Lexapro, Depakote, Haldol and Ativan. However, these medications were administered and in the absence of a documented emergency and a physician's statement indicating whether or not she could make a reasoned decision about treatment. The exact date that the physician sign the consent forms is not legible on the documents.

The recipient's record indicated that emergency medication was administered twice on March 28th, 2016. In the first instance, a nursing note indicated that Haldol IV and IM and Ativan IM were administered by the emergency department staff. However, there was no documentation of the specific threats to support the need for emergency medication found in her record. In the second instance, a nurse documented that the recipient was hitting the phone and yelling on the behavioral health unit. She was instructed to stop talking on the phone. Haldol and Ativan IM were administered at that time. It is unclear whether or not this met the need for emergency medication because there was no documentation concerning her response to redirection before the medications were administered. In both instances, the recipient's record lacked restrictions of rights notices for the emergent medications administered on the 28th.

The Authority substantiates the complaint as presented above. The hospital violates Sections 5/2-102 (a-5), 5/2-107 and 5/2-201 of the Code and program policies that require written consent for psychotropic medication based on a patient's capacity to give consent, the right to refuse medication in the absence of an emergency and to provide notice to the patient and anyone she chooses when rights are restricted.

To correct the problem, the hospital reportedly has revised its "Informed Consent for Psychotropic Medication" policy and requires a physician's capacity statement to be documented in the recipient's record pursuant to Sections 5/2-102 (a-5) of the Code. Additionally, the hospital has started using a medication consent form that requires a date indicating when the recipient signed the document.

RECOMMENDATIONS

1. The hospital shall follow Section 5/2-107 (a) requirements that emergency medication should only be given if there is a risk of serious and imminent physical harm documented in the recipient's record.

2. Complete restriction of rights notices when emergency medication is administered under Section 5/2-201 of the Code and program policy.

SUGGESTION

1. To facilitate informed consent specify a dosage versus a range of dosages on the medication consent form.

Complaint #4 Isolation Room

The complaint stated that the recipient had to sleep in the isolation room on a hard bed for two nights because her roommate snored too loudly.

Information from the record, interviews and program policies

The record contained many progress notes documenting that the recipient had problems sleeping during her hospital stay. A nursing note indicated that the recipient was unable to sleep due her roommate snoring and was assisted to the quiet room on March 30th at 12:30 a.m. Another nursing note stated that the recipient was given room 1662 so that she could rest on that next evening. However, she stayed awake all night and was observed walking with another patient and requested as needed medication and came to the nursing station to talk.

According to the hospital's letter, the recipient was allowed to sleep in the low stimulus room, which is referred to as being the isolation room in the complaint. On the night of March 30th, the recipient reportedly approached a staff person about her roommate's snoring and accepted the low stimulus room as an alternative sleeping arrangement because there were no more beds available on the behavioral health unit. Again, she was offered the low stimulus room because she was unable to sleep on that next night. The nurse, who completed the progress note on March 31st, did not recall any problem regarding these arrangements when she was interviewed by the hospital's administration. The hospital's letter stated that the recipient's sleeplessness might have been related to her manic-state that led to her being hospitalized, according to documentation in her record. At the site visit, the Director of Behavioral Health reported

that the low stimulus room is located behind the nursing station and is usually used when restraints are needed. The HRA observed the low stimulus room that contained only a bed hard bolted down on the floor in the middle of the room.

The recipient told the HRA that she was given a pair of earplugs but still could not sleep because of her roommate's loud snoring. She reported that she had agreed to sleep in the "isolation room" because the behavioral health unit was overcrowded. However, she still could not sleep because the bed was "rock solid" and the staff said that she was not sleeping well. She said that she recently had been in a traumatic car accident and should have been provided with a medical bed.

The hospital's "Rights of Individuals Receiving Mental Health and Developmental Disabilities Services" policy include the right to adequate and humane care and services in the least restrictive environment.

CONCLUSION

Section 5/2-102 (a) of the Mental Health and Developmental Disabilities Code states that a recipient of services shall be provided with adequate and humane care and services in the least restrictive environment.

The complaint stated that the recipient had to sleep in the isolation room on a hard bed for two nights because her roommate snored too loudly. Based on the investigation, the recipient accepted the low stimulus room as an alternative sleeping arrangement because there were no more beds available on the behavioral health unit at that time. The HRA understands that the bed was very hard and might have increased the recipient's inability to get a good night sleep. However, the Authority cannot substantiate a rights violation because the hospital made reasonable efforts to resolve the problem.

The HRA finds no clear violations of the Code's Sections 5/2-102 (a) or program rights policy that include adequate and humane care and services.

<u>Complaint #5 Confidentiality</u>

The complaint stated that a staff person disclosed the recipient's protected medical information without her consent. It was reported that a group leader told the recipient that she was "manic bipolar" during a group therapy session in front of other patients. Additionally, it was reported that the recipient tried to talk to the group therapy leader about the confidentiality issue and he said that he was a "diabetic."

The HRA reviewed progress notes indicating that the recipient had attended group therapy sessions during her hospital stay. However, there was no documentation concerning a possible breach in her right to confidentiality found in her record. The hospital informed the Authority that the behavioral health staff including the student interns did not recall the recipient when the complaint was shared with them. The hospital's letter documented that all newly hired staff are trained during orientation on

confidentiality and that training on this subject is provided annually. At the site visit, a Mental Health Technician told the HRA that his duties include facilitating broad-based psychoeducational groups on the unit. He reported that he has been a therapy group leader for six years and usually runs groups on the weekends. He did not remember the recipient involved in the complaint and said that he would have to get the patient's chart because he does not know the person's medical diagnoses. He said that he would refer a patient to his or her physician concerning medical information in their chart.

The hospital's "Confidentiality, Behavioral Health Services Department" policy directs all staff and physicians to make every effort to keep confidential any and all information regarding patients and their care, pursuant to the Mental Health and Developmental Disabilities Confidentiality Act and the Mental Health and Developmental Disabilities Code. Exceptions to this may occur within the Good Faith Reporting policy (duty to warn). Also, it directs employees to refrain from discussing a patient in front of the individual or within hearing range of other patients.

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The hospital's "Patient Information, Disclosure of" policy states that patient's records or any information contained therein are disclosed to someone other than those persons entitled to access only upon the written consent of those persons entitled to access.

CONCLUSION

Section 110/5 (a) of the Mental Health and Developmental Disabilities Confidentiality Act states that records and communications may be disclosed only with the written consent of those persons who are entitled to inspect and copy a recipient record.

The complaint stated that the recipient's right to confidentiality was breached during group therapy by a staff person. According to the hospital's administration, the behavioral health staff did not remember the recipient when the complaint was discussed with them. A Mental Health Technician/therapy group leader told the HRA that he did not recall the recipient and denied disclosing her protected medical information. The Authority does not discredit the complaint, but the HRA found no evidence to substantiate the complaint.

The HRA finds no violations of Section 110/5 (a) of the Act or program policies on confidentiality and disclosure of patient's information

RESPONSE

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

SILVER CROSS HOSPITAL

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Judith Rauls, Chairperson
Regional Human Rights Authority
West Suburban Regional Office
PO Box 7009
Hines, IL 60141-7505

December 19, 2017

RE: Case# 16-040-9018

Dear Ms. Rauls,

Please accept this letter as response to your notice dated November 13th and received by Silver Cross November 21, 2017. We have reviewed the report of findings and recommendations following your investigation. Thank you for your thoughtful review and consideration of actions already taken. We offer the following as additional evidence of compliance with Sections 5/2-107, & 5/2-201 of the Code.

Recommendations:

1. The hospital shall follow Section 5/2-107 (a) requirement that emergency medication should only be given if there is a risk of serious and imminent physical harm documented in the recipient's record.
2. Complete restriction of rights notices when emergency medications is administered under Section 5/2-201 of the Code and program policy.

Response:

Policy Review/Revision(s): (enclosed)

- Informed Consent for Psychotropic Medications has been revised as previously proposed to the Commission to include physician exam and documentation of psychotropic medications.
- Restriction of Rights policy has been revised to clarify documentation required for emergency medication administration.

Staff Training & Communication:

- November 16, 2017: BHU Staff Meetings included a Director led discussion regarding documentation of behaviors which require emergency medication administration and restriction of rights completion.
- December 15, 2017: Email to BHU staff regarding documentation of behaviors requiring emergency medication and completion of restriction of rights.
- December 19, 2017: BHU Staff Meetings including behaviors that constitute risk of serious and imminent physical harm and the documentation requirements for use of emergency medications followed by a Read and Sign tutorial for all RNs to complete.
- January 18, 2018: An RN Only Staff Meeting is scheduled which will include a review of all requirements for restraints, seclusions and emergency medications.

Thank you for allowing us to respond to this patients concerns. We appreciate identifying areas for improvement which allow us to provide exceptional care to our patients.

Yours sincerely,

Ann Carpenter

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