FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 17-030-9011
Hartgrove Hospital

Case Summary: The HRA substantiated the complaint that Hartgrove did not follow Mental Health Code and Power of Attorney Act mandates when staff refused to acknowledge a recipient's Agent for Power of Attorney for Healthcare. The provider response is attached.

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Hartgrove Hospital. It was alleged that the facility did not follow Mental Health Code and Power of Attorney Act mandates when staff refused to acknowledge a recipient's Agent for Power of Attorney for Healthcare.

If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.) and the Illinois Power of Attorney Act (755 ILCS 45/).

Hartgrove Hospital is a 128-bed behavioral health hospital located in Chicago.

To review these complaints, the HRA conducted a site visit and interviewed the Corporate COO, and the Director of Risk Management. Relevant hospital policies were reviewed, and records were obtained with the written consent of the guardian. The guardian's Letter of Office is included as part of the clinical record.

COMPLAINT SUMMARY

The recipient was involuntarily admitted to Hartgrove Hospital on 8/22/16 after being hospitalized at another hospital for psychotic behavior. The recipient's Mother/POA agent (Agent for Power of Attorney for Healthcare) personally signed involuntary admission paperwork and also signed to have the recipient transferred to Hartgrove. She then faxed her POA document to Hartgrove. Upon admission at Hartgrove the intake staff and the nurses from the Behavioral Health Unit allegedly would not speak to the POA agent. Reportedly, the POA agent did speak with the recipient's attending physician on 8/23/16 and she informed her that her son had been diagnosed with schizophrenia at age 16 and had been taking the medication

Clozaril since 2010. Reportedly the POA agent informed the physician that Clozaril was a last resort anti-psychotic medication that was prescribed for her son when other medications had failed to stabilize him. The concern regarding Clozaril was that if dosages are missed, then the patient must be started on very low dosages so that blood platelets are not affected, resulting in a discontinuation of the medication altogether. The POA agent informed the physician that the Clozaril prescription is registered and that she could contact the data bank for dosages, etc. The physician asked if the Mother was the recipient's guardian and she told her that she was the POA and that the documentation had been faxed to the Behavioral Health Unit. Allegedly the physician never spoke to the Mother/POA agent again until 9/08/16 when the Mother received a call stating that the recipient would be discharged to her home. Also, the facility Risk Management representative reportedly called the Mother and told her that the POA document was invalid because it was not notarized; it was a copy of the original document, and it had not been filed with the Court. The same document was accepted by the facility on 9/12/16.

FINDINGS

The record shows that the recipient was admitted to Hartgrove Emergency Department (ED) on 8/22/16 at 10:34 a.m. He was then transferred to the inpatient Behavioral Health Unit where he remained until discharge on 9/19/16. On 8/22/16 the recipient completed a voluntary application for admission which was accepted that day. The recipient was then assessed by his Attending Physician on 8/23/16: "The patient is a 21 year old male who was admitted to the inpatient unit on 8/22/16 for medication noncompliance, increased paranoia, and aggression, found by his mom and police in a nearby property, not wanting to leave the property. Patient with increasing aggression, which the police brought him to the emergency room for further evaluation. The mom states the patient has been noncompliant with medicine over the last three days. The mother reports an extensive psychiatric history with multiple hospitalizations this is the third psychiatric hospitalization this summer. The mom is highly confused as the patient has been compliant with Clozaril from 2010 to August of 2016, Clozaril 400 mg q.h.s. [every night] for schizoaffective disorder and he stopped taking it over the last couple days after a recent hospital admission from 7/08/16 to 8/13/16. The patient's mother does not know why the patient got upset yesterday and was on private property unwilling to leave. The mother states it was a 'dispute manager and police.' The patient states he was in the right. The patient thinks that he is in the hospital this time for 'medication transfer from Clozaril to Ativan for generalized anxiety disorder.' The patient thinks he was 'cursed by someone at school causing him to have schizoaffective disorder.' The patient thinks he does not have schizoaffective disorder and thinks he just has problems with anxiety. The patient remains bizarre and delusional, staying in his room, not interacting with staff. The patient denies auditory hallucinations, visual hallucinations. The patient denies suicidal or homicidal ideation. When asked if the patient has had auditory hallucinations in the past, he states maybe. He does state having weird delusions and hallucinations that he will not specify during his last hospitalization. The mother reports an extensive psychiatric history where she has his file faxed to the intake worker. The mother states that just this summer he was at [two local hospitals]. This was after the patient drove into an 18-wheeler. The patient now has no license and no car. The patient was at school, but was unable to function and became medication noncompliant. The patient is uncooperative with the primary team, disorganized, disheveled, not taking care of himself, not willing to leave the room to discuss why he is here further. The patient states he does not want to be on any medication, but

will take Ativan for his anxiety and is insistent that he has generalized anxiety disorder and not schizoaffective disorder." The assessment also states, "The patient has a supportive mother who is highly active in his treatment and care. The patient is unwilling to talk about where he lives, his friends, and his social support. The patient will not talk about any legal history. The patient will not talk about any leisure activities or social supports that he has."

An Interdisciplinary Treatment Plan revision was completed on 8/26/16 which indicates "patient refuses contact with mother." There is no indication that the POA agent was included in the treatment planning. Additionally, there is no physician statement of decisional capacity in the record.

A Physician Progress Note from 8/29/16 is included in the record and it states, "The patient states that he is doing better today. The patient is out of his room, interacting with staff and going to groups. The patient states that the food energizes him, and he likes the cakes that he had today. The patient states that his mood is fine, and does talk about verbal abuse from his mother over the last couple of months to years. The patient is able to talk about his history, where he was able to attend college for 2 years approximately 3 years ago, as well as 1 year of college at UIC. …The patient states that things got bad approximately 6 months ago, and his mother was helping him manage his medicine. The patient states currently he wants no interactions with his mother, as he thinks she was harming him. The patient states that he will stay compliant with the medicine Clozaril and does like how it is working. Concentration is improving. Appetite is improving. The patient still remains bizarre, talking about what occurred 6 months ago, with the patient feeling that he was having an 'immaculate birth' where he thought he could get a woman impregnated if he hit a semi-truck head-on. The patient states that the kids at U of I told him about this, and he did know the specific girl he thought he could impregnate, and she was from… The patient remains bizarre, confused at times. The patient needing further psychiatric evaluation."

A Physician Progress Note from 8/31/16 is included in the record and it states, "The patient had a poor weekend as he refused Clozaril medicine Friday, Saturday and Sunday. The patient received IM [intramuscular] injections Friday, Saturday, and Sunday. The patient appeared to be refusing medicine and would not go to bed. The patient today discussed these events and states that he was just acting out behaviorally, did not want to go to bed, did not want to take his medicine. The patient states he likes the medicine and does not know why he was refusing it. The patient states the IM medications were helping him. The patient does state he will take the medicine Clozaril 400 mg. The patient is asking if EP [elopement precaution] can be taken off. It was discussed with the patient that he needs to be taking his medicine in order to take the EP off. The patient is agreeable to this. The patient states he is sleeping and eating well. He has good energy and concentration, just does not know why he randomly decided to refuse the medicine for three nights. The patient will start taking it today…."

The record contains a list of phone calls received by the recipient's social worker from the patient's POA agent. On 8/23/16 the POA agent called and left a message, on 8/24 she called and requested an email address where she could send a medication history, on 8/25 she called and requested a phone call, stating, "she will be contacting a lawyer since she has not received a

phone call…to give her information about her son", and on 8/26 she requested a phone call, stating, "It's been 5 days since my son got admitted and I have not received a phone call."

The record shows that over a period of several days beginning on 9/01/16 the recipient was administered a Neuropsychological Evaluation (the recipient refused several times). The Preliminary Summary, written 9/02/16, describes the recipient: "[The recipient] has little insight into his mental health and other problems. He denied that he experiences auditory hallucinations; however his presentation upon testing suggests that he may be responding to internal stimuli, as his eye contact was poor, and he was observed staring intently at no identifiable person or object at various times. [The recipient] explained that he experienced auditory hallucinations before being admitted to Hartgrove. More specifically, he stated that he was hearing voices before being admitted to Hartgrove, telling him to kill himself to achieve 'Immaculate Conception' with a female acquaintance. He reported that he believes his mother to be against him, but cannot provide examples to support this. [The recipient's] compliance with the testing process was highly inconsistent, as he refused to participate on several occasions, and seemed to become easily overwhelmed by the testing process, making it difficult to complete testing.

At the time this assessment was initiated, [the recipient] was fully oriented to time, place, and situation. His speech was observed to be slow and he was monotone. At times it was unclear if he heard the instructions, but would eventually respond several moments later. [The recipient] had difficulty repeating sentences back to the examiner exactly as the examiner said them, which may be a result of inattention. On the first day of testing he was compliant and completed most tasks in a timely manner. Over the next two days he became emotionally withdrawn and agitated, refusing treatment and became aggressive with staff. [The recipient] explained to the examiner that he generally prefers to be by himself, and feels that his life is better on his own. Preliminary neuropsychological data indicates impairments in his neurocognitive functions, including his memory recall and sustained attention." The diagnostic impression was Schizoaffective Disorder, Bipolar Type.

The record contains an Authorized Visitors of Inpatients form indicating that the recipient's mother (also named guardian on this form), was given consent for visitation and telephone contact on 8/22/16. The form is initialed by the recipient and witnessed.

The record contains social work notes which outline the interactions between the hospital and the recipient's mother/POA agent:

8/24/16 states, "This social worker has received multiple calls from patient's mother. Messages express her frustration of the lack of information that has been given to her regarding her son's hospitalization… Pt.'s mother called this writer, writer answered. Patient [mother?] once again expressed frustration. This social worker explained to patient's mother she was unable to disclose any information regarding her son as there is not a consent form in his chart allowing us to do so. Patient's mother became irritable, stating she had POA. This social worker advised her to email this information. Per multiple sources, the POA that was released to HGH is not a legal document. Document has not been signed by the patient, only initialed. Paperwork also is not notarized. No information will be disclosed to [the patient's POA] unless otherwise

authorized by patient." Later in the same day the social worker entered notes in the record regarding her visit with the recipient: "Writer met with patient to complete a Safety Crisis Plan and Behavior and Sympton Identification Scale; however patient refused to meet. Social worker briefly checked in with patient, asking about medication compliance and authorization to speak to his mother. Patient refused consent to speak to mother. …During the brief meeting with the patient, he asked that we do not contact his mother. He is also refusing to return back to his mother's home and wishes to go to New York. Patient was unable to elaborate and clarify his reason behind moving…"

8/30/16 Patient's mother has left several messages over the weekend and has also sent an aggressive email including medication recommendations and a request for a phone call (see attachment). Patient's mother also included an attachment of her POA; same document that was sent before which is not a legal document." The attachment states, "I am forwarding again a copy of my son, [recipient], signed HIPPAA Release Authority, to his agent of his POA, [recipient's mother]. Please forward this to Dr… so you both can talk to me regarding [the recipient's] care. Also please see if [the recipient] will sign a release for you to talk to [recipient's private physician] he will explain why [the recipient] is on Clozaril, since [the attending physician] is not understanding [the recipient] has schizophrenia and Clozaril is the only medication that has helped him since his hospitalization at … in 2010 to present. I am concerned he is not taking his 400 mg of Clozaril since 8/25/16. Per the Clozaril data bank drug information, if a dosage of Clozaril is missed more than 2 days the dosage should not be started at the same dosage. [The recipient] needs to be started at a lower dosage of Clozaril 100 mg or 150 mg, not 400 mg. [The recipient] is clearly not in a state of mind that he can care for himself and as agent of his POA I have a right to speak to you and [the attending physician] with regards to [recipient's] care. Please have Dr… call me on… ."

8/30/16 "… Patient denied having any contact with his mother over the weekend. This social worker shared that his mother has been calling numerous times attempting to obtain information about his wellbeing, replying, 'that's how she is.' This writer reminded patient he can always provide consent for this writer to contact his mother, however patient stated, 'I rather deal with this on my own.' No consent has been obtained thus far."

8/30/16 "Patient's mother contacted this social worker via telephone. Patient's mother was communicated that her son has not given consent to speak. Patient's mother expressed frustration and stated that if 'anything happens to my son I would like him transferred to [a local hospital], she shares that he has been there 'many times.'"

9/06/16 "This writer contacted patient's mother to let her know about son's decision to give consent to speak to her. Mother asked several questions about aftercare options, such as finding him a group home, psychiatrist and therapist. Mother also inquired about the medication the patient is taking and is requesting a log of when her son took his medication as well as any changes in dose. Mother asked for a family session, however this writer shared that patient declined the offer for a family session."

9/06/16 "…During this time, patient and social worker revisited discharge plans. Patient had denied consent to speak with his mother, thus far, however patient has given verbal consent to

contact mother as of 9/06/16. Patient indicated he was not comfortable signing anything and would rather give verbal consent. Patient's change of mind came after this social worker and patient explored placement options upon discharge. Patient verbalized he would like to return back home under the care of his mother and feels safe doing so. This social worker offered patient the option to have a family session together, with his mom on the phone to discuss discharge; patient denied. He stated he'll just go back home without calling her. Patient appeared to be comfortable with his decision and was able to verbalize reason for wanting to go home."

9/07/16 "This writer and [attending physician] met in effort to contact pt.'s mother and give her an update on discharge plans. Discharge is being moved up to Thursday 9/08/16 from Friday 9/09/16. This is an effort to give mother and patient enough time to schedule aftercare appointments before the weekend. At first, mother did not agree with her son being discharged a day earlier, however after the reasoning behind the change was explained, she was opened to the idea. Mother agreed to come on 9/08/16 for a family session in order to discuss further care for the patient. During this time additional aftercare options were discussed, such as psychiatry at [a local mental health center] and getting linked to [a mental health outpatient program]. Unfortunately, at this time, patient is not willing to participate in any aftercare planning or family sessions therefore we are unable to assess whether patient is willing to look into other placements. Patient has refused to sign any consent forms so far. Patient's mother inquired about medication compliance and medication dosage. Information was released however no information was faxed over to her as she requested, since patient had not signed a consent form to do so. A family session is scheduled for Thursday 9/08/16."

9/08/16 "This writer met with patient in efforts to have family session with mom and [physician] in order to discuss discharge plans for tomorrow 9/08/16. Patient refused to be part of family session. This writer and [physician] met with patient in his room due to council rooms being occupied. Patient was lethargic and minimally engaged a different mood and affect than he portrayed earlier in the day. Patient stated that his 'mood changed' no explanation was given. This writer and [physician] discussed with patient potential aftercare options in order to continue a structured program which appears to work for him. Per patient's mother, she has recommended an IOP [intensive outpatient] program at … that patient can be part of while mother is at work. Mother's main concern is taking him home, unable to care for him due to her work schedule and afraid he could run away. Patient refused to sign a consent form to release information in order to send a referral packet to …. Patient was willing to give verbal consent, however, due to verbal consent not being valid when sending confidential documents, nothing was sent. …"

9/08/16 states, "Writer, Dr. … patient, and patient's mother met for a family session in effort to complete discharge paperwork. Per the Dr., patient was cooperative and hopeful prior to the arrival of this writer with mom. Patient and Dr… had met prior to the arrival of his mother and expressed he wanted to play basketball and engaged in other activities he enjoyed upon discharge. However, upon arrival of this writer and mom, patient regressed to his defiant behavior. Patient was not cooperative and began to shake his leg. Patient was visibly anxious; unable to identify what was bothering him. After much prompting he was able to verbalize that he did not appreciate his mother being so 'controlling' and 'un-empathetic'. Often times, mother

attempted to talk over patient, however after being redirect, she allowed him to speak. In short, patient refused to go home, stating he wanted to 'stay here' and asking this writer to look for alternative placement options. This writer agreed to do so, however it was explained to him that it was difficult to do so without consent to send information to nursing homes. Patient continued to refuse to sign consent…"

A Social Work note from 9/09/16 states, "This writer was notified that the Power of Attorney that patient's mother has provided has been activated. POA is valid and notarized. Consent forms have been signed by mother in order to fax packets to several nursing homes in effort to find adequate housing for the patient."

A Physician Progress Note from 9/12/16 states, "The patient this morning is seen and doing well. The patient said he is happy, in a good mood, and excited for discharge. When discussing discharge plans and the need for an intensive outpatient program, the patient is more open to this and states he will look into it and does agree to sign the papers. The patient is overall happy and looking forward to discharge, however during group meeting that consisted of the social worker, myself, and the patient's mother, the patient has severe aggression with his head down. He began tapping his right leg, does not want to cooperate. States he will not go home to Mom, he will not go to an IOP, and he wants placement at a nursing home or group home. Further discussion was made in evaluation of why patient does not want to go home and what he dislikes with his Mom, the patient ends up leaving the room, upset, not wanting to talk anymore, the patient refuses to sign papers for the team to send information to group homes and nursing home. The patient completely regressed in a mere 5 to 10 minutes. The patient intermittently will not take his medications; however, he has been taking his medications since 9/5/16. The patient picks and chooses when he wants to cooperate and act appropriately. The patient is saying that he wants a group home or nursing home; however, he will not sign paperwork to expedite the process. The patient at this time is not making adequate decisions for himself. The patient remains irritable and impulsive stating he will do something one minute and then refuse to do it the next. The patient at this time cannot make adequate decisions for himself and we will activate the power of attorney per patient's mother to sign for consent for the patient's records to be sent to nursing homes and group homes. The mother is on board with the process and the POA has been evaluated by risk management and human resources as well as Hartgrove Hospital's attorney who agrees that the POA is acceptable for the mother to be able to sign for the patient's health records to be sent to group homes and nursing homes."

HOSPITAL REPRESENTATIVES' RESPONSE

Hospital representatives were interviewed about the complaint. They reported that when the staff first received the POA document they reviewed it and it was not complete- the last few pages were not included so there were initials from the recipient but not a signature (the form contains the recipient's signature on pages four and five). Staff said that later they realized there were signatures on the form and it was presented to the legal department, who then accepted it. Hospital representatives also indicated that the COO had spoken with the POA agent and told her what the hospital needed and the POA agent produced a new document with additional pages and they then granted the POA. Hospital representatives were asked if they knew that POA documents do not require notarization and they affirmed that they were aware of this fact.

At issue for the hospital is the fact that the POA is contingent upon the loss of the recipient's decisional capacity. In this case the recipient presented as psychotic at times and then at other times he was not. Also, he frequently reversed his decisions on whether or not he wanted contact with the POA agent, whether or not he wanted to go home, whether or not he wanted phone calls. Also, the hospital staff at first thought that the recipient was a first time admittee- they were not aware that the recipient had a long history of multiple admissions because he had not reported this. Also, the recipient appeared to be triggered by his POA agent and her presence initiated several of his outbursts. Thus, it was difficult to assess the difference between the recipient's psychosis or the possible fear of an abuser as per the hospital.

Hospital staff were questioned about the physician statement of decisional capacity which is a Mental Health Code requirement for the administration of psychotropic medication and they indicated that they thought there was a statement but they did not produce one. The staff indicated that the patient had a confusing presentation and that at times he appeared to have decisional capacity but at other times he did not. The recipient did sign medication informed consent for Thorazine and Clozaril but signed a refusal for all other medications.

Hospital representatives were interviewed about the difficulty the POA agent encountered in making contact with the recipient's physician and other staff. The COO indicated that staff will be re-educated regarding the need for contact between the physician and the POA agent.

STATUTES

The Mental Health Code guarantees all recipients adequate and humane care in the least restrictive environment. As a means to this end, the Code outlines how recipients are to be informed of their proposed treatments and provides for their participation as well as the participation of substitute decision makers in this process:

"(a) A recipient of services shall be provided with adequate and humane care and service in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan. [Section 2-200 d states that recipients shall be asked for their emergency intervention preferences, which shall be noted in their treatment plans and considered for use should the need arise].

(a-5) If the services include the administration of…psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment. …. If the recipient lacks the capacity

to make a reasoned decision about the treatment, the treatment may be administered only (i) pursuant to the provisions of Section 2- 107 [to prevent harm]…." (405 ILCS 5/2-102).

The Illinois Power of Attorney Act (755 ILCS 45/) outlines the duties and responsibilities of health care providers in relation to health care agencies:

(a) It is the responsibility of the agent or patient to notify the health care provider of the existence of the health care agency and any amendment or revocation thereof. A health care provider furnished with a copy of a health care agency shall make it a part of the patient's medical records and shall enter in the records any change in or termination of the health care agency by the principal that becomes known to the provider. Whenever a provider believes a patient may lack capacity to give informed consent to health care which the provider deems necessary, the provider shall consult with any available health care agent known to the provider who then has power to act for the patient under a health care agency.

(b) A health care decision made by an agent in accordance with the terms of a health care agency shall be complied with by every health care provider to whom the decision is communicated, subject to the provider's right to administer treatment for the patient's comfort or the alleviation of pain; but if the provider is unwilling to comply with the agent's decision, the provider shall promptly inform the agent who shall then be responsible to make the necessary arrangements for the transfer of the patient to another provider. It is understood that a provider who is unwilling to comply with the agent's decision will continue to afford reasonably necessary consultation and care in connection with the transfer.

(c) At the patient's expense and subject to reasonable rules of the health care provider to prevent disruption of the patient's health care, each health care provider shall give an agent authorized to receive such information under a health care agency the same right the principal has to examine and copy any part or all of the patient's medical records that the agent deems relevant to the exercise of the agent's powers, whether the records relate to mental health or any other medical condition and whether they are in the possession of or maintained by any physician, psychiatrist, psychologist, therapist, hospital, nursing home or other health care provider (45/4-7). ….

Also, each health care provider and others who act in good faith on any direction or decision of the agent will be subject to any type of civil or criminal liability or discipline for unprofessional conduct for complying with any direction or decision made by the agent, even if death or injury to the patient ensues (45/4-8 a).

HOSPITAL POLICY

Hartgrove Hospital provided their policy and procedure regarding Patient Rights (No.: RI-1.1). It states, "Hartgrove Hospital recognizes that patients have a fundamental right to considerate care that safeguards their personal dignity to be free from abuse, neglect, or exploitation and respects their cultural, psychosocial, and spiritual values. Understanding these values guide us in meeting the patient's care needs and preferences. Therefore, patients are involved in resolving dilemmas about care, treatment, and services. Emergency Services staff will ensure the rights of recipients will be reviewed and provided to the recipients during the

admission process as obligated under the Illinois Department of Mental Health and Developmental Disabilities Code. Information will be provided in a manner tailored to the patient age, language, and ability to understand."

CONCLUSION

The clinical record for this recipient describes a patient who throughout his hospitalization remained very psychotic and at times delusional. The history of his illness was described in his initial Psychiatric Assessment which states, "The mother reports an extensive psychiatric history with multiple hospitalizations and this is the third psychiatric hospitalization this summer." The notes also indicate the recipient had multiple mood changes for no apparent reason, bouts of aggressiveness, that he did not know what his diagnosis was and thought he was being medicated for anxiety instead of schizophrenia. A Neuropsychological Evaluation completed on 9/02/16 indicated that the testing suggested the recipient was responding to internal stimuli. This presentation continued throughout his time at Hartgrove and even at the end of his treatment episode his physician described his behavior in a family session as, "The patient completely regressed in 5-10 minutes." It is clear from the record that the recipient was never stabilized while hospitalized at Hartgrove, and the record does not contain a physician statement of decisional capacity to determine his ability to make treatment decisions for himself. All of this serves to demonstrate the need for a substitute decision maker, such as the recipient's POA agent. The POA agent in this case was the only person who was legally authorized to present to the hospital an accurate and meaningful history of the recipient's mental illness, his medication history, and input into the effects of various treatment protocols that had been attempted throughout his life. The POA agent brings invaluable advocacy for the recipient and it should not be disregarded. Especially since the recipient in this case was returning to his parents' home, it was absolutely vital that his POA agent be involved in all decision making regarding his care. Also, even if the Hartgrove staff did not accept the POA document, all they would have needed to do was contact the POA agent and the missing pages could have been faxed to them almost immediately. The HRA substantiates the complaint that Hartgrove did not follow Mental Health Code and Power of Attorney Act mandates when staff refused to acknowledge a recipient's Agent for Power of Attorney for Healthcare.

The record shows that the recipient's physician spoke with the POA agent the day after he was admitted to Hartgrove on 8/21/16 and then did not speak with her again until 9/08/16, even after numerous phone calls and emails. The POA agent even asked the Hartgrove staff if they would speak to the recipient's private physician, but even this was ignored. This is unacceptable. Hartgrove representatives indicated that they realize the importance of contact between physicians and substitute decision makers and will initiate a training to address this issue.

RECOMMENDATION

1. Train all staff in the Illinois Power of Attorney Act rights and responsibilities. If there is a question regarding the legality of the POA document, contact the POA agent and request additional information. If there is a question as to the need for a POA agent, insist that the

recipient's physician evaluate the recipient and enter a written statement of decisional capacity into the clinical record as often as necessary.

SUGGESTION

1. Train physicians to be responsive to substitute decision makers, and to allow them input into the formulation of the recipient's care plan and treatment.

RESPONSE

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

HARTGROVE
Behavioral Health System

First Hospital in the Nation to receive The Joint Commission Disease Specific Certification Gold Seal of Approval® for Trauma-Informed Care and Neuroscience-Based Psychiatric Services

LeJuan Robinson
Director of Risk Management/PI
5730 W Roosevelt Road
Chicago, IL 60644

May 31, 2017

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

Hartgrove Behavioral Health System is in receipt of the report and recommendations for case #17-030-9011.

With respect to the recommendations outlined, departments with potential to be are exposed to substitute decision maker cases have been trained in the Illinois Power of Attorney Act rights and responsibilities. These departments have further been trained regarding steps to take when legality of documents arise. Additionally physicians have received training on appropriate documentation standards for decisional capacity review.

We at Hartgrove take every opportunity to improve upon logistical and clinical processes. The report recommendations have been carefully reviewed and implemented to reflect the most update legal practices. Your assistance in this matter has been most appreciated.

Please do not hesitate to contact me with any additional questions or requests at LeJuan.Robinson@uhsinc.com or (773) 413-1870.

Sincerely,

LeJuan Robinson
Enclosures: 1