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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 17-030-9016

Monroe Pavilion Health and Treatment

Case summary: The HRA substantiated the complaint that the facility administered the wrong dosage of medication to a recipient even after the Agent for Power Of Attorney for Healthcare reminded them of the correct dosage and even attempted to obtain the medication for the recipient. However the HRA did not substantiate that as a result of this error the recipient became psychotic and absconded from the facility. A non-public response from the provider has been received by the HRA.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Monroe Pavilion Health and Treatment Center (Monroe Pavilion). It was alleged that the facility administered the wrong dosage of medication to a recipient even after the Agent for the Power Of Attorney for Healthcare reminded them of the correct dosage and even attempted to obtain the medication for the recipient. As a result, the recipient became psychotic and absconded from the facility and remained missing for two days. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5), the Nursing Home Care Act (210 ILCS 45), the Illinois Administrative Code for Skilled Nursing and Intermediate Care Facilities (77 Ill. Admin. Code 300 et seq.), and the Illinois Power of Attorney Act (755 ILCS 45).

Monroe Pavilion is a private, 136-bed intermediate care psychiatric facility located in Chicago. All residents are determined to have mental illness.

To review this complaint, the HRA conducted a site visit and interviewed the Facility Administrator, the Psychiatric Rehabilitation Services Director, the Director of Nursing and the Registered Nurse. The HRA obtained the recipient's record with written consent.

COMPLAINT SUMMARY

The complaint indicates that the recipient was a patient at a Chicago area psychiatric hospital, where he was treated for audio and visual hallucinations and was then transferred from there to Monroe Pavilion on 12/21/16. Before the recipient's arrival at Monroe Pavilion, the Agent for Power of Attorney for Healthcare (POA agent) called there at 10:00 a.m. to ensure that

the facility received faxed medical paperwork for the recipient and she was allegedly told that the facility had received the fax. Later that day the POA agent again called Monroe Pavilion to check whether the recipient had received the 275 mg of Clozaril that was ordered as part of his treatment from the referring hospital. The nurse at Monroe Pavilion then indicated that she did not have the blood test necessary to dispense the medication and that it was too late that day to order it. When the POA agent stated that she would call the hospital to get a copy of the tests faxed to Monroe Pavilion, the nurse informed her that the Clozaril was not on hand and would not be available until 3 a.m. The POA agent then allegedly told the nurse that she would drive from her home one hour away to get the medication that the recipient needed since she had the medication which was prescribed by his attending physician at the former hospital. The POA agent also called the referring hospital where the recipient had received treatment, and asked them to fax to Monroe Pavilion the necessary blood work, which they did immediately. The POA agent called Monroe Pavilion and they confirmed receipt of the information. The POA agent also informed the facility that she was driving there with the 275 mg of Clozaril. At 10:00p.m. on 12/21/16 the POA agent called the facility and was told that the nurse had just administered 200 mg of the Clozaril to the recipient. The nurse stated that the physician had changed the order to 200 mg of Clozaril nightly for 30 days and then added 75 mg for a total of 275 mg thereafter. The POA agent questioned this statement, since it had taken a very long time to stabilize the patient on 275 mg which was working well for him when he was discharged. She was told to speak with the physician but was unable to reach him that night. On 12/22/16 the POA agent met with the Director of Nursing, the Care Plan Coordinator, and the Social Worker and expressed her frustration. The POA agent indicated that the recipient's attending physician at his referring hospital explained to the POA agent that the recipient required 275 mg of the medication and any missing dosage would put him in harm's way. The POA agent asked the staff to check the physician's order for accuracy and to verify that the recipient had indeed received the 200 mg dose at least. When the POA agent asked to see the discharge paperwork with the prescribed dosage, the staff stated that due to HIPAA regulations the POA agent could not see or be given a copy. The POA agent attempted to call the physician at the referring hospital on the 12/22/16 and 12/23/16 but did not receive a response.

On 12/24/16 at 9:00 a.m. the POA agent received a call from Monroe Pavilion stating that the recipient had walked out of the building and left. The POA agent asked if the recipient had been experiencing audio or visual hallucinations or hearing voices and the attending nurse did not know. The nurse was then asked to contact the social service director, but he said he had no way of contacting her. The POA agent asked if the police were notified and they indicated that a missing person report cannot be filed until after the person is missing for 24 hours. The POA agent then left her home to search the streets of Chicago for her son. She called Monroe Pavilion at 4:00 p.m and asked them to file a police report, which they did. At 5:00 p.m. the POA agent received a call from Monroe Pavilion that the recipient had walked back into the facility. The POA agent then met with her son and he said he had heard voices that told him go to the Ferris Wheel at Navy Pier and get on. He allegedly was slumped over in a chair, his eyes barely open, mumbling, "Take me to [the hospital where he had previously been stabilized]." The POA agent then took the recipient and all his belongings back to the hospital where he had been in treatment just three days previous. The same staff who had stabilized the recipient on Clozaril were again on duty and remembered the recipient. The emergency room attending psychiatric physician told the POA that the recipient's physician was on duty the night that

Monroe Pavilion staff had called for the medication order and she confirmed that the order had been misread by the Monroe Pavilion staff.

FINDINGS

The Monroe Pavilion Admission record shows that the recipient was admitted on 12/21/16 with a diagnosis of Schizoaffective Disorder Unspecified, and it lists the recipient's mother as "Guardian Person (Healthcare) and Estate" along with her contact information. Admission documents show that the recipient had recently (October and November) of 2016 received psychiatric treatment at two local hospitals and was then stabilized on medication at a Chicago area hospital before being voluntarily admitted to Monroe Pavilion. Monroe Pavilion did not evaluate the recipient for decisional capacity, however they provided the admission note from the hospital where the recipient was treated in October and in it the physician stated, "… the patient has not been declared as lacking decisional capacity."

The first entry into the progress notes, entered at 10:00 p.m. states, "Resident arrived at facility around 4:00 p.m. Ambulatory via ambulance accompanied by 2 attendants. Res denies pain with no signs/symptoms of distress. Denies voices or suicidal ideations. Vitals and assessments normal. Resident pacing floor and becoming anxious while awaiting completion of admission for medication administration. Mother of resident equally anxious and constantly called facility from 5p.m. -10:00 p.m. until admission was complete. Will continue to monitor."

On 12/22/16 at 9:00 a.m. progress notes state, "Resident asleep in bed at this time. Writer advised patient to come to nursing station for morning medications. Staff went a second time to get resident. At this time resident stated, 'I am not taking any medicine.' PRSC [Psychiatric Rehabilitation Services Coordinator] aware of resident's behavior." Again at 9:00 a.m. on 12/23/16 the progress notes indicate that the resident refused his morning medication. A Social Service note entered on 12/22/16 also indicated that the recipient "… is being non-compliant with medication." Facility staff indicated that this medication was the recipient's vitamin and fish oil caps.

Social Service notes from 12/22/16 indicate that the POA agent requested the medication information that had transferred to Monroe Pavilion from the referring hospital: "Consumer's mother has contacted this writer to attempt to receive documentation from consumer's last hospital stay at [referring hospital]. This writer has informed her that the facility cannot provide documentation from other facilities, that she must contact [the referring hospital] to request the documents. Will follow up as needed."

The record includes the Physician's Order-Cycle, written 12/21/16 by an LPN. In the section titled Orders, there are six enumerated hand-written orders, three of which address the order for Clozaril:

1. Albuterol.
2. Clozapine [Brand name Clozaril] 200 mg tab PO QHS [each bedtime noted as 9:00 p.m.] X 30 days.
3. Clozapine 200 mg tab PO QHS along with Clozapine 75 mg PO QHS starting after 30 days.

4. Clozapine 25 mg tab PO QHS. Take 25 mg PO QHS. Take 3 tabs along with 200 mg Clozapine PO QHS.
5. Fish oil cap
6. Vitamin D

The Section listing Medications correlates with the Section listing Orders.

The Medication Administration Record (MAR) is also included in the record. The Medication section lists the same medications as above, except that the last order for Clozapine (#4 above) adds "After thirty days", which was not in the physician order. The MAR indicates that the recipient was administered 200 mg of Clozaril on 12/21/16, 12/22/16 and 12/23/16. The MAR does not show any refusals of the recipient's psychotropic medication.

Progress Notes from 12/24/16 at 8:00 a.m. state, "Staff reported resident ran out of facility, staff attempted to redirect/[illegible] resident, resident ran down street. Director of Nursing/[illegible]…Mother …notified… [illegible]…." Another entry at 9:50 a.m. is completely [illegible]. A Social Service note was entered for this event and it states, "Consumer left the facility AMA at approximately 8:05 a.m. on 12/24/16. Consumer did not sign an AMA form, staff attempted to redirect consumer and counseled him regarding the possible hazards, danger, and risks of leaving the facility, but consumer continued to walk down the street. The consumer's mother was called. Social Service Director, Director of Nursing, and Administrator were notified. Both doctors were made aware. Police was contacted and nurse is awaiting their arrival to conduct a police report."

Progress Notes from 3:00 p.m. state, "This writer called 311 spoke with …, she stated that someone will be out here to the facility to file report." Notes entered at 4:55 p.m. indicate that the resident had returned to the facility: "Resident returned here at facility this writer asked resident why did he walk out, resident stated he was hearing voices, writer then asked where did he go, resident stated the voices told him to go to Navy Pier." The notes then indicate that the resident's mother had arrived and had taken her son back to the referring hospital at 5:00 p.m.

The clinical record contains the form for Informed Consent for Clozaril, 275 mg orally each night signed on 12/21/16 by a staff person, but not signed by the recipient or his POA. Hand written at the bottom of the form is the statement, "Resident Refuse [sic] … to sign to sign form will cont to encourage Resident to sign." The record does not contain a physician statement of decisional capacity.

Facility Representatives' Response

Facility representatives were interviewed about the complaint. They indicated that the nurse might not have read through the entire order that was transcribed from the referring hospital and thus the recipient received 200 mg of Clozaril instead of the 275 mg that was ordered by the physician. They also stated that they were not aware that the POA agent had the medication from the referring hospital that she was bringing to Monroe Pavilion. They confirmed that they never accept medication or even a prescription for medication from someone outside the facility. Generally, the referring hospital will call the prescription in to them and then it must be ordered by the recipient's physician. Staff were asked about the consent for

medication and they indicated that if the recipient refuses to sign the consent then they make repeated attempts to get it signed, however in this case the recipient refused to do so. Staff indicated that the same holds true for the recipient's departure from the facility. They stated that theirs is not a locked facility and the recipients are free to come and go. For this reason, they do not call police for missing person reports and they do not file Incident Reports for recipients who leave on their own. Staff indicated that they look upon mental illness as a disability and their job it to help the recipients live successfully with this disability. They honor all refusals of services.

Staff were asked about the POA agent's request to view the recipient's file. They answered that HIPAA regulations prevented them from sharing other hospitals' information. HRA staff reminded them that the law allows access to any part of the record upon which the facility relies to make medical determinations regarding the recipient. Staff were amenable to training which addresses this subject.

STATUTES

The Mental Health 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 individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient" (405 ILCS 5/2-102).* The Nursing Home Care Act also includes substitute decision makers in the development of the recipient's services plan: *"A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measureable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable."*

The Nursing Home Care Act (210 ILCS 45/2-106.1(b)) states, *"Psychotropic medication shall not be prescribed without the informed consent of the resident, the resident's guardian, or other authorized representative. 'Psychotropic medication' means medication that is used for or listed as used for antipsychotic, antidepressant, antimanic, or antianxiety behavior modification or behavior management purposes in the latest edition of the AMA Drug Evaluations or the Physician's Desk Reference. The Department shall adopt, by rule, a protocol specifying how informed consent may be obtained or refused. The protocol shall require, at a minimum, a discussion between (i) the resident or the resident's authorized representative and (ii) the resident's physician, a registered pharmacist (who is not a dispensing for the facility where the resident lives), or a licensed nurse about the possible risks and benefits of a recommended medication and the use of standardized consent forms designated by the Department. Each form developed by the Department (i) shall be written in plain language, (ii) shall be able to be downloaded from the Department's official website, (iii) shall include information specific to the psychotropic medication for which consent is being sought, and (iv) shall be used for every*

resident for whom psychotropic drugs are prescribed. In addition to creating these forms, the Department shall approve the use of any other informed consent forms that meet the criteria developed by the Department. In addition to any other penalty prescribed by law, a facility that is found to have violated this subsection, or the federal certification requirement that informed consent be obtained before administering a psychotropic medication, shall thereafter be required to obtain the signatures of 2 licensed health care professionals on every form purporting to give medication, certifying the personal knowledge of each health care professional that the consent was obtained in compliance with the requirements of this subsection." Subsection (c) states, "The requirements of this Section are intended to control in conflict with the requirements of Sections 2-102 and 2-107.2 of the Mental Health Code with respect to the administration pf psychotropic medication."

The Illinois Administrative Code Part 300 for Skilled Nursing and Intermediate Care Facilities (Title 77 Part 300 Section 300.1610) states:

1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State, and local laws.

The Illinois Administrative Code Part 300 for Skilled Nursing and Intermediate Care Facilities (Section 300.1620) outlines the required compliance with physician medication orders:

a) All medications shall be given upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable). These medications shall be administered as ordered- by the licensed prescriber and at the designated time.

b) Telephone orders may be taken by a registered nurse, licensed practical nurse, or licensed pharmacist. All such orders shall be immediately written on the resident's clinical record or a telephone order form and signed by the nurse or pharmacist taking the order. These orders shall be countersigned by the licensed prescriber within 10 calendar days.

c) Review of medication orders: The staff pharmacist or consultant shall review the medical record, including licensed prescribers' orders and laboratory test results, at least monthly and, based on their clinical experience and judgement, and Section 300. Appendix F, determine if there are irregularities that may cause potential adverse reactions, allergies, contraindications, medication errors, or ineffectiveness. This review shall be done at the facility and shall be documented in the clinical record. Any irregularities noted shall be reported to the attending physician, the advisory physician, the director of nursing and the administrator, and shall be acted upon."

The Nursing Home Care Act states, "Every resident, resident's guardian, or parent if the resident is a minor shall be permitted to inspect and copy all his clinical and other records concerning his care and maintenance kept by the facility or by his physician. The facility may charge a reasonable fee for duplication of a record." (210 ILCS 45/2-104 d).

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 not 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).

HIPAA regulations (45 C.F.R. 164.524 (a)) also guarantee "…a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set…." with certain exceptions noted. A "designated record set" is defined in part as "A group of records maintained by or for a covered entity that is: …used, in whole or in part, by the covered entity to make decisions about individuals." (45 C.F.R. 164.501). Further, Section 164.524 provides guidance on access implementation including timely access (less than 30 days),

written notices of access denials, a means to complain about denials and provisions for allowing access to other records not subject to the denials.

HOSPITAL POLICY

Monroe Pavilion provided policy (Residents Rights) which shows that "The resident may refuse treatment (showers, meds, dressing changes), to the extent permitted by law." The policy also indicates that access to resident records must follow HIPAA guidelines.

Monroe Pavilion provided policy and procedure for the administration of medication (Clinical Manual Medication Administration). In part, the procedure outlines guidelines for the administration of medication:

- An order is required for administration of all medication
- Medications are administered by licensed personnel only.
- Check medication administration record prior to administering medication for the right medication, dose, route, patient and time.
- Read each order entirely
- Remove medication from drawer and read label three times; when removing from drawer, before pouring and after pouring.
- If there is a discrepancy between the MAR and label, check orders before administering medication.
- If the label is wrong send medications to pharmacy for relabeling or call pharmacy to send a new label. Ig MAR is wrong, reenter the order.

CONCLUSION

It is difficult to determine what happened in this case with regard to the recipient's medication due mostly to a confusing record of events regarding the physician orders and how they were transcribed. What we do know is that the clinical record shows that the recipient was ordered 275 mg of Clozaril to be administered nightly. The Medication Administration Record shows that the recipient instead received 200 mg of the medication nightly. Although the HRA cannot determine that this discrepancy caused the recipient to become psychotic and leave the facility (gone for the period of one day and not two as indicated in the complaint), the staff administered the wrong dosage, and this is a serious violation of the Nursing Home Care Act and Administrative Code. It is exacerbated by the fact that the recipient's POA agent contacted the facility and made every attempt to ensure that her son receive the correct dosage. The HRA understands that the facility cannot accept medication from outside the facility, however it seems reasonable that staff would realize the seriousness of the situation by the POA agent's attention to it and make every attempt to fill the order that was prescribed by their own physician. Additionally, the record is missing the recipient's informed consent for the medication and also an updated physician statement of decisional capacity as mandated by the Nursing Home Care Act and the Mental Health Code. Given that the POA agency becomes affective when the recipient cannot make decisions for himself, a decisional capacity statement is very important and a Code requirement for the administration of psychotropic medication. In this case the

recipient could very well have regressed to the point where he required the assistance of his POA agent and a statement written by a physician months before would no longer be relevant when he is hearing voices which are directing him to walk several miles to Navy Pier. The HRA substantiates the complaint that the facility administered the wrong dosage of medication to a recipient even after the Power Of Attorney agent for Healthcare reminded them of the correct dosage and even attempted to obtain the medication for the recipient. However the HRA cannot substantiate that as a result of this error the recipient became psychotic and absconded from the facility.

RECOMMENDATION

1. Complete staff training on all aspects of the administration of medication, including compliance with prescribed orders. Ensure that physician orders are transcribed accurately, adhering to facility policy. Ensure that recipients sign informed consent for all psychotropic medication and include in the record a physician statement of the resident's decisional capacity, completed when the recipient is admitted to the facility and as often as necessary thereafter.

2. Train all staff in the Illinois Power of Attorney Act rights and responsibilities. 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. Include in the training the POA agent's right to access an individual's record if the POA is in effect.

SUGGESTION

1. Remind staff to write legibly when entering information into the clinical record.

2. Document resident medication refusals in the MAR.

3. The admission record incorrectly referred to the POA agent as the guardian. Ensure that substitute decision-makers are accurately identified as the legal implications are different depending on the type of substitute decision-maker.

4. Review the protocol for reporting a missing person, especially if the individual is actively psychotic and/or a family member, POA agent or guardian requests notification.