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HUMAN RIGHTS AUTHORITY – CHICAGO REGION

REPORT 18-030-9021
Hartgrove Hospital

INTRODUCTION

The Human Rights Authority (HRA) reviewed the care and treatment provided to a minor in the inpatient program at Hartgrove Hospital, a psychiatric facility in Chicago. The complaints under investigation were that:

1. A patient and her guardian were, at times, prohibited from communicating with each other.
2. The patient's social worker and physician refused to speak with the guardian.
3. The patient was given psychotropic medication without informed consent and the guardian was denied access to medication information in the record.
4. The patient was given forced psychotropic medication without adequate reason.
5. The guardian was asked to sign admission related documents and medication consents on discharge.

The rights of Hartgrove patients, their parents and guardians are protected by the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110). Substantiated findings of these complaints would constitute Code and Act violations.

The Hartgrove Behavioral Health System provides a range of services including inpatient, outpatient and partial hospitalization to children, adolescents and adults. The HRA visited one location and discussed these complaints with risk management and intake personnel as well as the attending physician. Program policies were reviewed as was the medical record with authorization.

COMPLAINT SUMMARY

It was alleged that a young patient's mother/guardian gave verbal consent for admission to Hartgrove which was over an hour away from home. The guardian was not allowed to talk to the patient by phone over the first weekend and was told to call the social worker on Monday. The patient reportedly reached the guardian on the first Sunday evening and said she was taking medications but did not know what they were, and the guardian had not been informed. On another evening the patient called to say she was forced to take Thorazine for yelling and cursing when she was not allowed to use the phone earlier in the day. The complaint further states that the guardian left messages for the social worker and physician but got no responses except to be told the physician did not talk to parents. The guardian appeared a few days later to demand the patient's release and was asked to sign a discharge request form which she did. She reportedly asked to see medication information in the record at that time and was denied, instead being told the physician would call her. The physician never did. Discharge occurred on the following Monday, and on arrival they had her sign admission documents including rights and releases. She agreed to sign all except for medication consents.

FINDINGS

1. The patient and her mother/guardian were, at times, prohibited from communicating with each other.
2. The patient's social worker and physician refused to speak with the patient's guardian.

The chart revealed the sixteen-year-old's admission to Hartgrove on Friday, November 17, 2017 following a SASS (Screening, Assessment and Support Services) evaluation in her hometown some eighty miles away. There was nothing by way of nursing, social work, psychiatry or restriction documentation to suggest that she was not allowed to use the phone at any time to call out or receive calls or that she or her guardian complained of not being able to call, only several references through the ten-day stay to phone use between the two and whether the conversations had positive or negative effects.

The physician said that he knew of no reason to restrict the patient from the phone or from reaching her mother and vice versa. He could recall no instance when she was prohibited from calling anyone or from receiving calls. He said he saw the patient for the first time on rounds early in her hospitalization and nothing related was brought up. The other staff in our interviews were also unaware of any phone restriction.

A couple social work entries showed their efforts to reach the guardian. The first was an initial behavioral assessment where the writer noted her phone conversation with the guardian on the first Monday, the 20th, regarding the patient's situation and plan of care. The second notation came from an assigned social worker who left the guardian a message to call him on Wednesday, the 22nd, and a subsequent note about the return call shortly after which stated the guardian was angry about the lack of communication and that the social worker informed the physician who would contact the guardian. And for the physician, one of six psychiatric progress notes included in the record mentioned a call from the guardian on Thursday, the 23rd. The

physician wrote that the guardian had called that day and requested discharge but was advised against it because of the patient's continuing suicidal ideation. There were no other documented attempts at communication with the guardian.

The social worker provided a written statement to the HRA in which he stated, in summary, that in addition to his conversation with the guardian on the 22nd, he made multiple attempts to contact her without success. When they did speak, she just yelled at him and wanted to discuss nothing but discharge. Regarding his own contact with the guardian, the physician remembered that this was a difficult case in that they could not get her to come in and he tried reaching her every day, leaving messages. An emergency services worker who leads the intake/admission process at the hospital confirmed that they had a hard time getting the guardian to come in as well.

CONCLUSION

Hartgrove policy states that recipient rights will be distributed and applied to patients and guardians in compliance with the Mental Health Code. The Code calls for every recipient to be provided with unimpeded, private and uncensored communication with persons of his or her choice, including by telephone, which can only be restricted to prevent harm, harassment or intimidation (405 ILCS 5/2-103). Guardians are always afforded participation in treatment planning and decision-making (405 ILCS 5/2-102), which naturally involves conferring with social workers and physicians.

It is possible that the patient and her guardian were not allowed to talk on the phone over the first weekend but there is no evidence of it either by record or staff recollection, so the complaint is unsubstantiated. While the staff assured us that the guardian was difficult to reach and convince to appear at the hospital, the first social worker spoke with her on the first business day and, according to the documentation, talked at length about the patient's needs and treatment course. There was one reference from the second social worker having talked with the guardian on the third business day and one reference from the physician on the fourth business day about the guardian calling to discuss discharge. A rights violation is unsubstantiated. It is troubling however, that none of their "multiple attempts" and tries to "call her every day, leaving messages" were documented.

SUGGESTIONS

Hartgrove managers should look into whether there are rogue staff members on weekend shifts who needlessly keep patients and families from phone communication.

All treatment team personnel should be reminded to thoroughly document each and every attempt to reach guardians, particularly when they are chronically absent.

FINDINGS

3. The patient was given psychotropic medication without informed consent and the guardian was denied access to medication information in the record.
4. The patient was given forced psychotropic medication without adequate reason.

According to orders and administration records, Latuda, Lexapro and Depakote were started and given on the first full day, Saturday, the 18th. Informed consent forms showed that "phone consent" was obtained from the guardian that morning, which was verified by two nurses' signatures. It also confirmed that verbal information about the medications were explained, however the section where it requires a psychiatrist or advanced practice nurse to discuss the medication even if nurses obtain consent was left blank for all three. Corresponding medication education sheets for all three verified patient teaching by nurses, but only through verbal methods. There was nothing to indicate whether written drug information was shared with and/or forwarded to either the patient or her guardian.

The physician explained that in general, written drug information is shared immediately with patients and on discharge with guardians, but sooner if they are available. Asked why the consent form's signature sections for physician education was left blank, he said that "some things didn't get done." Neither he nor the other staff interviewed could say whether drug materials were ever provided in this case.

The record referred to the guardian's visit at the hospital on the evening of the 22nd, by her signature on a discharge request form and an evening nursing shift note that stated the patient and guardian had some time together. This was the guardian's only appearance per the record other than the day of discharge to collect the patient, and nothing related to any request to see the record or to get drug information was noted. No one in our interviews had knowledge of any such request from the guardian.

A one-time dose of Olanzapine was given by mouth on the 26th for agitation as revealed in the chart. Thorazine was never given. Nursing entries surrounding the administration described the patient's anxiety, perseveration and otherwise isolative behavior; there was nothing mentioned about a need to prevent physical harm or that the medication was forced on her.

The physician said he remembered providing a phone order to the nurses who said the patient was having a hard time calming down. He verified the by-mouth route as opposed to an injection and did not think there was any struggle with the patient in taking it.

CONCLUSION

Hartgrove policy states that a parent or guardian will provide informed consent for minors. Under necessary conditions for informed consent: "1. The patient (or parent or guardian) has the capacity to give an informed consent. The attending psychiatrist may determine if a patient has the decisional capacity necessary to provide informed consent." The policy also outlines steps for obtaining treatment consent from absent parents, but nowhere does it ensure that written drug information is provided or sent to them. An emergency exception is noted in the policy as well, but only states that it is for when delay of treatment may result in harm.

The Code meanwhile, calls for written drug information to be provided to patients before treatment is started and the same written drug information to be given to their substitute decision makers (405 ILCS 5/2-102 a-5). An adult has the right to refuse treatment, including medications, in which case shall not be given unless necessary to prevent serious and imminent physical harm and no less restrictive alternative is necessary (405 ILCS 5/2-107). Under the Confidentiality Act, those who may copy and inspect records, upon request, include "…the parent or guardian of a recipient who is at least 12 but under 18 years, if the recipient is informed and does not object or if the therapist does not find that there are compelling reasons for denying the access. …. Nothing in this paragraph is intended to prohibit the parent or guardian…from requesting and receiving the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed, including medication…." (740 ILCS 110/4).

In this case the prescribing psychiatrist failed to meet with the patient to discuss medications, according to the consent forms. Moreover, written drug information was not provided to the patient or the guardian at the time the medications were proposed, which is a must if any patient or guardian is to be adequately informed. A rights violation is substantiated. Recently issued HRA Case #18-030-9014 cites the same finding at Hartgrove, and the hospital's pending response can satisfy this recommendation if satisfactory. There is simply no information or evidence to verify whether the guardian's alleged request for record information was ever given and denied. Although the complaint is not discredited, it remains unsubstantiated. The HRA contends that a sixteen-year-old patient's views of treatment and choice should be respected as well. One unscheduled medication was given by a phone order to help the patient calm down, but there was no documented indication that the dose was forced over her objections. The complaint that she was given forced medications is unsubstantiated.

RECOMMENDATION

-Require appropriate staff to forward written drug information to absent guardians and document completion in the record and according to policy requirements cited in the next section of this report.

-Revise consent policies to include the Code's mandate to provide written drug information.

SUGGESTIONS

-Hartgrove's informed consent policy states that the attending psychiatrist *may* determine if a patient has the decisional capacity to provide consent. The Mental Health Code states meanwhile that the physician *shall* determine and state in writing whether the patient has decisional capacity. The HRA suggests that the policy wording be revised to reflect the Code's intention to always determine and document decisional capacity for adult patients (405 ILCS 5/2-102a-5).

-The policy should also be revised to include the Code's only standard for emergency medications: "…to prevent serious and imminent physical harm and no less restrictive alternative is available." (405 ILCS 5/2-107).

-Managers should meet with physicians and nurses to be sure that the stated practice of sharing written drug information with guardians on discharge is not the actual practice.

FINDINGS

5. The patient's guardian was asked to sign admission related documents and medication consents on discharge.

The record contained an application by an adult for a minor's admission, a universal consent to examination and treatment form, a rights of individuals receiving services form, a consent for medical screening and a notice of privacy practices that all listed "vc", or verbal consent by the guardian, dated the 17th, day of admission. All but the latter two included the guardian's added signature, which the staff we interviewed verified was on the day of the patient's discharge, November 27. The actual signature date was not added.

The staff described how difficult it was to get the guardian to come to the facility for a family counseling session or to complete required documents. Emergency services staff in particular said that sometimes they have no choice but to enter verbal consents, and they do try to arrange for a parent or guardian visit to complete the documents with signatures. They typically notify the receptionist or operator of when they might come and then have the materials ready.

CONCLUSION

A section of Hartgrove's informed consent policy entitled, Procedure for Informed Consent during Admission, states that admission paperwork and informed consent documentation are filed in the patient's record. "In the event a guardian is unable to be present for admission, additional steps are taken to secure the guardian's consent for admission and treatment. 1. Emergency Services [intake] staff will secure verbal consent (via phone) for

admission. The verbal consent must be witnessed by two staff members on the verbal consent for treatment form. 2. …staff will arrange a specific time for the guardian to come to the hospital to complete admission and consent paperwork, including rights information, in person. The staff will facilitate arrangement of transportation and/or make arrangements for the paperwork to be mailed/couriered to the guardian's residence, if necessary. 3. …staff will maintain responsibility for following up with the guardian until admission paperwork and consent forms are completed. The staff will communicate this process with the Director of Emergency Services and the Director of Social Services." A policy related to a minor's admission and discharge specifically is outlined pursuant to the Code's process in Chapter III.

The MH Code allows the admission of a minor upon application of parent or guardian. The application may be executed by a parent or guardian, or in their absence a person in loco parentis (405 ILCS 5/3-503). A parent or guardian may request the minor's discharge, and the patient must be discharged at the earliest appropriate time not to exceed five days unless court documents are filed (405 ILCS 5/3-508). Admission and discharge rights along with advocacy contact information are included on admission forms under 3-503. In addition, a list of rights of individuals receiving mental health services must be shared with patient and guardians whenever services commence (405 ILCS 5/2-200). Although written psychotropic medication information must be provided to patients and their guardians, there is no requirement for psychotropic medication consent forms to be signed by them (405 ILCS 5/2-102a-5).

It was evident by staff statements and the file's documentation that the guardian of this patient was not readily present or available, and it is recognized that she may have had transportation issues living more than an hour away. Although not the best practice, verbal consent is a necessary reality in this circumstance. The problem here is the staffs' admitted lack of documented effort to get the guardian's signature for admission and treatment, to advise her in writing of their rights and to adequately provide informed consent for medications. None of the steps that Hartgrove establishes in policy were taken to get her signatures before the day of discharge, and it seems they missed an opportunity to have her complete them when she visited on the 22nd. A policy violation is substantiated.

RECOMMENDATIONS

-Retrain emergency services and social work staff to facilitate and or arrange a guardian's visit to complete admission and consent documents, to mail/courier these documents and to document their efforts.

-Enter actual parent/guardian signature dates when following up on their signatures for verbal consents.