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HUMAN RIGHTS AUTHORITY-CHICAGO REGION

REPORT 18-030-9027
PRESENCE ST. MARY OF NAZARETH HOSPITAL

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation into care and services at St. Mary of Nazareth Hospital in Chicago after receiving complaints that a behavioral health patient was not provided an appropriate admission with adequate and humane care and that the hospital failed to allow guardian consent, opportunity to refuse treatment and visitation. Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Part of the Presence Saints Mary and Elizabeth Medical Center, St. Mary's has a one hundred-twenty-bed capacity behavioral health unit that serves adult patients. The HRA met with those involved in the patient's care to discuss the matter. Relevant policies were reviewed as was his medical record with authorization.

COMPLAINT SUMMARY

The adult patient was allegedly taken from his nursing home to St. Mary's for a hernia repair but on arrival the surgeon refused to proceed opting instead for a psychiatric admit on review of the patient's history, and subsequently the patient did not receive care for his medical condition. During his stay on the psychiatric unit he was reportedly given Thorazine without appropriate consent and without the guardian's opportunity to refuse the treatment. It was also said that the guardian, who lived an hour away, was allowed only thirty minutes to visit and once was not permitted to look in on the patient as he slept.

FINDINGS

Not provided an appropriate admission with adequate and humane care:

Emergency Department (ED) nursing entries showed the patient arrived on referral from a surgeon's office. He denied wanting to harm himself or others but appeared actively psychotic, talking and laughing to himself, which was described by the nursing home staff as baseline behavior. The first physician to see him wrote that the patient was there for abdominal pain and a psychiatric evaluation. He had an earlier appointment with the surgeon for a stoma evaluation but given the parastomal hernia and being a new patient with unknown history to the surgeon, he was sent to the ED for a cat-scan and further workup. The patient denied having pain and he was described by his nursing home escort as being rather calm that day. The physician noted contact with the patient's guardian who provided a brief history, and the cat-scan was carried out which resulted in negative findings. The patient was to be admitted on a general medicine floor with ongoing consults from the surgeon according to the plan. An internal medicine physician took over from there and completed a history and physical wherein he described the patient as limiting in engagement and very agitated. A petition for involuntary admission and a first certificate were prepared in the meantime.

A behavioral health social worker visited the patient early the next day during which time the patient's behavior seemed to worsen. He wrote that he saw the patient talking to himself, yelling at the wall and exhibiting aggressive outbursts; his thought process was disorganized and delusional. The worker would continue to assist on the medical floor as needed. An initial psychiatric evaluation began soon after. The evaluator stated that the patient appeared labile, paranoid with hallucinations, unpredictable, uncooperative and easily agitated. The involuntary admission was recommended. The internist's discharge summary to psychiatry referenced the gastroenterology, psychiatry and general surgery consults he involved and how the patient remained uncooperative, aggressive and refused all care. Each of the physicians' reports noted the patient's need for psychiatric care for stability. The patient was deemed medically cleared and his transfer to psychiatry proceeded. Nursing entries stated that the patient was calm when moved and that his guardian was notified of the admission. A second petition and a second and third certificate were promptly filed in the courts. All the documents cited psychotic symptoms of Schizophrenia and the patient's inability to contract for safety and care for himself as reasons he was subject to involuntary admission.

The internist continued to follow the patient through his stay on the psychiatric unit for the next eight days along with ongoing consultation from the original surgeon as called for in the care plan and according to the record. Discussing discharge plans with the guardian two days into his admission, a social worker reminded her that the patient was medically cleared before arriving on the behavioral health unit and that per the surgeon's notes, "…the surgery is one thing and the post op care required is another and his non-compliance will make the post op care very difficult and cause multiple potential complications, some that may lead to his death. If this surgery is to be done, then a place with residents and students would be much better since they would have the resources needed to help him get through the post op period." Nursing notes from there stated that the patient continued to swat away at the staff, or much worse, when trying to examine his colostomy. These instances carried on much of the time, almost daily, and he was said to be calm and comfortable otherwise. After several days of struggling with the patient to assess and care for his skin, he was cleared to return to the nursing home, but the original surgeon had recommended surgery at a larger facility and the guardian insisted on having it at

one of a few mentioned alternative locations. Social workers spent the next few days trying to approve transfer to one of those locations until arrangements were made for the patient to see another surgeon as an outpatient first, after his discharge from St. Mary's. His psychiatric condition was considered moderately improved according to the attending's note, and he returned to the nursing home the next day. A discharge notice was sent to the courts and attorneys.

The HRA interviewed the hospital's operations director, the internist and a psychiatrist for their opinions on why the patient was more appropriate for a psychiatric admission versus a medical one for the hernia. They informed us that he was, in fact, on a medical section of the psychiatry unit and that they believed he was indeed subject to involuntary admission given his presenting behaviors and inability to care for his needs. They explained that the surgeon refused to perform the hernia repair for safety reasons, a likely risk that the patent would tamper with it given his psychiatric condition. He kept messing with his G-tube and was so aggressive in refusing any colostomy care. All of this was explained to the guardian who insisted on going through with the surgery "no matter what". According to the physicians, the guardian wanted the procedure done elsewhere as she distrusted St. Mary's. Social services worked very hard on finding alternative transfers without success, reaching at least six other hospitals, and eventually connected with a physician who had previously seen the patient. That led to his discharge back to the nursing home with arrangements to see this provider.

CONCLUSION

A hospital Admission Criteria policy identifies the psychiatric medical unit specifically and lists as qualifying situations, among others, a patient's inability to adequately care for his/her basic physical needs and guard from serious harm, associated medical conditions not requiring hospitalization but conflict with or exacerbate psychiatric conditions, and, associated physical conditions such as tube feeding.

Under the Mental Health Code, a person may be detained to evaluate for an involuntary admission for up to twenty-four hours whenever a petition that asserts the need and includes the signs and symptoms of a mental illness is presented (405 ILCS 5/3-600; 601). A certificate must accompany the petition within that time that states by clinical observation that the patient requires immediate hospitalization (405 ILCS 5/3-602). Within twenty-four hours of admission, excluding holidays and weekends, a second certificate must follow and be promptly filed (405 ILCS 5/3-610; 611). In all cases, recipients of services shall be provided adequate and humane care and services in the least restrictive environment, pursuant to individual service plans (405 ILCS 5/2-102a).

This patient was sent to the ED by a surgeon who was concerned about the patient's psychiatric stability and the post-operative self-care that would likely be affected. He was medically cleared by several doctors in the ED, all of whom concluded that the patient needed psychiatric care. Two petitions were presented, unclear why two, but both were filed, and certificates followed them in-line with the Code's requirements. All documents asserted the need for the involuntary admission. He was placed on the medical side of the psychiatry unit where he was continually monitored by the internist and nursing staff, as much as he would

allow, which seemed to be a humane protection. When the surgeon continued to refuse to treat the patient, the hospital explored other options and released the patient when options were arranged. A violation of his rights is unsubstantiated.

COMMENT

Although the HRA necessarily defers to the clinical judgments of the physicians involved and the Code-compliance undertaken, as disability advocates we question the ultimate need for this patient's psychiatric admission given a number of reasons. First, when the receiving ED staff described him as actively psychotic, his nursing home escorts said this was his baseline behavior and that he was actually calm that day; the petition and certificate were already underway. Second, according to the documentation's timelines, the patient's behavior worsened the longer he stayed at St. Mary's, escalating from actively psychotic to physically aggressive. Third, adding to this suggestion is the fact that he required ten emergency injections within the eight days of his hospital stay; the last just before his discharge as detailed in the next section of this report. Fourth, although he was so imminently dangerous that he needed numerous emergency medications, he was discharged the moment an alternative physician was found to evaluate his potential surgery. And fifth, while petitioners are free to speculate a person's subjectivity to involuntary admission, being actively psychotic as a baseline, in itself, and the risk of surgery aftercare are no reason to commit a person, and this patient and his guardian never had their day in court to plead the case. Finally, it seems reasonable in respect of this patient's medical condition, his disability and apparent inability to effectively express himself, that the initial surgeon and St. Mary's team alike could have relied on the guardian's authority under the Probate and Surrogate Acts to arrange a plan to accommodate his post-surgery risks instead of wasting his time.

Not allowed guardian consent and the opportunity to refuse treatment:

Clozaril, Depakote and Thorazine were prescribed on admission day according to the record. A consent form for the medications was entered as well, and it was signed by the physician and a staff witness who noted the patient refused to sign. Boxes to signify patient capacity, the advisement of side effects, risks and benefits, the patient's receipt of drug information and his consent to take the medications were left unchecked. Nowhere in the record was there evidence that written drug information was provided to the patient or to his guardian.

Each medication was offered and given to the patient, some voluntarily and some involuntarily per the administration record. Clozaril and Depakote, were accepted voluntarily every day except for a few refusals. Thorazine, was given twice voluntarily and then ten times involuntarily. One of the forced injections was to prevent the patient from harming the staff while his colostomy bag was changed; two were given for being agitated, restless and pacing the hallway, and the remaining seven for more physically harmful threats to the staff, like hitting or killing them. Restriction notices were completed in all instances but only four indicated that an emergency preference was considered, and none indicated that the guardian was notified.

The psychiatrist we interviewed said they typically sign the consent form while marking the capacity determination and risk advisement, but in this case, it may have been a situation where one of the prescribers sees the patient outside the hospital and was simply continuing the medication regimen. Still, they can fax or mail drug information to guardians but were not sure what occurred here. They contended however that this guardian was in routine contact with the hospital via phone and that she was aware of his treatments. We spoke with a nurse involved in some of the emergency administrations, and she said they usually call guardians for consent. Regarding the specific emergency incidents, she could not recall exactly but thought he was always trying or threatening to hit the staff. It was also added that the patient did not want to wear his colostomy bag, that there was stool coming out of his stoma and he would throw his bag at people.

CONCLUSION

Program Medications and Psychotropic Medications policy states briefly that the physician shall state in writing or verbally of side effects, advise patients of their right to refuse and complete a consent form. It misses the Code's intentions that,

> *"…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…. 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 the physician's 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…pursuant to the provisions of Section 2-107…."* (405 ILCS 5/2-102a-5, emphases added).

> "*The recipient and the recipient's guardian…shall be given the opportunity to refuse…medication. If such services are refused, they shall not be given unless…necessary to prevent the recipient from causing serious and imminent physical harm…and no less restrictive alternative is available."* (405 ILCS 5/2-107).

> *"Whenever any rights of a recipient…are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction…to: (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian."* (405 ILCS 5/2-201).

The complaint is that the patient's guardian was not given a chance to provide informed consent or an opportunity to refuse Thorazine. We find that to be true, given the lack of documentation otherwise in the record, and not only for Thorazine but for Clozaril and Depakote as well. There was no statement of the patient's decisional capacity about the treatment, neither by the internist who prescribed two of the medicines nor the psychiatric who prescribed one.

There was also no indication that written drug information was shared with him or his guardian, which would allow either the chance to make informed decisions, including the opportunity to refuse at any time they like, regardless of whether these were reconciled prescriptions. Further, according to the ten notices, the guardian was never informed of the patient's restricted right to refuse treatment. A violation is substantiated.

RECOMMENDATIONS

Retrain and require all nursing and physician staff to provide *written* psychotropic drug information to every recipient and substitute decision maker whenever psychotropics are proposed. (405 ILCS 5/2-102a-5).

Require all physician staff to determine and state in writing whether a recipient has the capacity to make reasoned decisions about the proposed treatment. (405 ILCS 5/2-102a-5).

Require all designated employees to promptly notify guardians whenever their wards' rights are restricted. (405 ILCS 5/2-201).

Revise the Medications and Psychotropic Medications policy and the consent form to accurately reflect these requirements.

SUGGESTION

The hospital must remind all appropriate staff to use behavioral language as observed rather than general terms when documenting supportive needs for involuntary, emergency medications, and, to always consider using a patient's emergency intervention preference, if any.

Not allowed visitation:

The staff were unable to speak to the complaint that the guardian was only given thirty minutes to visit the patient and that another time she was prohibited from looking in on him when he was sleeping, which might be considered unreasonable. They had no recollection of this happening and said that the guardian never brought this to their attention. They offered that visiting hours are 6:30 p.m. to 8:00 p.m., seven days per week and that it may have been after hours that she appeared since she lived some distance away. A physician's order is typically required for off-hour visits, but they do make exceptions and likely would have in this case.

The HRA reviewed the program's visits policy, and for the most part, complies with the Code by establishing reasonable visiting hours. It states that only people 18 years and older may visit and that visiting privileges may be revoked if the patient does not cooperate with his/her treatment plan.

Under the Code,

> *"…a recipient who resides in mental health…facility shall be permitted unimpeded, private and uncensored communication with persons of his choice by mail, telephone and visitation. …. "Reasonable times and places for the use of telephones and for visits may be established in writing by the facility director. Unimpeded, private and uncensored communication…may be reasonably restricted…only in order to protect the recipient or others from harm, harassment or intimidation…."* (405 ILCS 5/2-103).
>
> *"…the facility director of each service provider shall adopt in writing such policies and procedures as are necessary to implement this Chapter. Such policies and procedures may amplify and expand, but shall not restrict or limit, the rights to recipients guaranteed by the Chapter."* (405 ILCS 5/2-202).

Without more facts, this remains the guardian's word against the provider's and the complaint is not discredited but unsubstantiated. The program's visitor policy however, is stricter than the Code when it chooses the ages of visitors, calls visits a privilege and uses it as a penalty for not complying with treatment. Recipients shall be permitted visits with persons of *his* choice and individual exceptions can be made when necessary to prevent harm, harassment or intimidation. In addition, visitation is a guaranteed right under Chapter II, not a privilege, and St. Mary's may not restrict rights because they are exercised, including the right to not cooperate with treatment plans. A policy violation is substantiated.

RECOMMENDATIONS

The policy must be revised to include individual determinations of when certain ages of visitors are therapeutically necessary. (405 ILCS 5/2-103; 2-202).

Item #14, the statement about visiting privileges being revoked for un-cooperation, must be removed. (405 ILCS 5/2-102a; 103; 107 and 2-202).

RESPONSE

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

Presence℠
Saints Mary and Elizabeth Medical Center

October 10, 2018

Ms. Sheila Orr, CoChair
Chicago Regional Human Rights Authority
Illinois Guardianship and Advocacy Commission
1200 South First Avenue
P.O. Box 7009
Hines, Illinois 60141-7009

Dear Ms. Orr,

Re: # 18-030-9027

Enclosed please find the Presence Saints Mary and Elizabeth Medical Center (PSMEMC) responses to the recommendations stated during the Guardianship and Advocacy Investigation. Report number: 18-030-9027.

The Inpatient Behavioral Health Multi-Disciplinary Team has reviewed the findings submitted to Presence Saints Mary and Elizabeth Medical Center pursuant to Section 23 of the Guardianship and Advocacy Act (20 ILCS 3955/1 et seq). We request that our response to any recommendations and comments be included as part of the public record. Our response is included in this document.

Exhibit 1: Education and Retraining

Management thoroughly re-educated staff on the importance of documentation and reminded staff to use behavioral language as observed, rather than in general terms when documenting supportive needs for patient care. Management re-educated staff to promptly notify guardians whenever a patient's rights are restricted. The Medication and Psychotropic Medication policy was updated and reviewed with staff to accurately reflect the appropriate requirements. Staff were retrained to provide written psychotropic drug information to every recipient and substitute decision-maker. The Visitor Regulations Policy was revised to meet Mental Health Code requirements and was reviewed with all staff.

Exhibit 2: Visitation Regulations Policy

The following items were added to the Visitation Regulations Policy:

1. A patient in a mental health facility shall be permitted unimpeded, private, and uncensored communication with persons of his/her choice by mail, telephone, and visitation per the Mental Health Code (405 ILCS 5/2 - 103).
2. Unimpeded, private, and uncensored communication may be reasonably restricted only in order to protect the patient or others from harm, harassment, or intimidation per the Mental Health Code (405 ILCS 5/2 - 103).

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Exhibit 3: Medications and Psychotropic Medication Policy

The following items were added to the Medications and Psychotropic Medication Policy:

1. The physician or the physician's designee shall advise the recipient or decision maker in writing of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment. (405 ILCS 5/2 - 102a-5)
2. The patient and the patient's guardian shall be given the opportunity to refuse medication. If such services are refused, they shall not be given unless necessary to prevent the patient from causing serious and imminent physical harm. (405 ILCS 5/2 - 102a-5),
3. Whenever a patient's rights are restricted, the professional responsible for overseeing the implementation of the patient's services plan shall be responsible for promptly given notice of the restriction to (1) the patient and (2) if such patient is a minor or under guardianship, his/her parent or guardian. (405 ILCS 5/2 - 102a-5)

For all questions or concerns, the contact person is:

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Sincerely,

Dana Clark

Dana Clark, MSN, RN
Regional Chief Nursing Officer &
Vice President of Operations Mid-City Chicago