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HUMAN RIGHTS AUTHORITY-NORTH SUBURBAN REGION

REPORT 20-100-9012
NORTHWEST COMMUNITY HOSPITAL

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of potential rights violations in the care provided to a mental health patient at Northwest Community Hospital in Arlington Heights. Allegations were that Emergency Department staff were rude to the patient, and Behavioral Health staff failed to provide psychotropic drug information and adequately monitor her for drug side effects. Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Part of Northwest Community Healthcare, the hospital's Emergency Department sees over one hundred seventy patients each day, about a quarter of whom have mental health needs. The Behavioral Health program, called Generations, includes 52 inpatient beds, forty dedicated to adults and twelve to adolescents. The HRA held interviews with representatives from administration and both departments. Relevant policies were reviewed as was the patient's record with authorization.

COMPLAINT SUMMARY

Emergency nursing staff were reportedly very rude to patients in general, snapping at them, yelling at this patient for being on the phone while others wanted to use it. On the behavioral health unit, the patient was allegedly given Seroquel without benefit of first seeing drug information, and soon after she fell unconscious for about two hours without being monitored.

FINDINGS

According to the records, the patient arrived by ambulance at the Emergency Department just before noon on July 31, 2019, along with a police officer's petition for involuntary admission. She was described as tearful, crying and laughing intermittently, and a psychiatric evaluation was ordered. The patient was noted to be resting quietly in her room without incident

over the next several hours, during which time an inpatient certificate was completed followed shortly thereafter by a voluntary admission application. At 5:08 p.m., about thirty minutes before her transport to the behavioral health unit, a nurse wrote that the patient was verbally abusive and refused care. There were no references as to how or why she was considered abusive or what transpired there, and by her transport at 5:30 p.m. she was calm and cooperative. A unit nurse later quoted the patient in an admission summary as saying that emergency personnel were mean to her, so she refused treatment. There was no elaboration on that in the record, however a third nurse noted on the next day that the patient was upset about marital problems and talked about how emergency personnel did not get her medication regimen straightened out, how they lied about calling her husband; she talked about her private psychiatrist and then again about her husband not bringing her medication list from home.

The emergency nurse told us she did not recall this patient or the situation specifically but that the entry would be accurate if she wrote it. She did not remember an incident with telephones. They prefer patients not use their own cell phones and allow them access to staff phones, which can be a problem sometimes when staff need to use them. Likewise, the unit nurse verified her entry about the patient's complaints but could not recall anything specific. They suggested that she was more likely upset with another provider and had filed a complaint at the hospital about unrelated matters.

Regarding the use of Seroquel, records showed that Ambien, Benadryl, Depakote, Haldol and Cogentin were prescribed on the first night, July 31st. Seroquel was ordered and started the next day, and each medication was accompanied by consent documentation which verified by patient and nurse signatures that drug information was provided, although there were no written physician determinations about the patient's capacity to give consent.

The original Seroquel order was for 100mg which was given on August 1st and 2nd. A nursing note from the morning of the 2nd referenced the patient's complaints about her medication and how it made her dizzy, and she continued to be monitored for medication effects and overall safety. A psychosocial note from the afternoon on the 2nd stated that the patient was unable to complete an assessment because she was lethargic, had mumbled speech and she said the medication made her too drowsy. The treating psychiatrist met with her that afternoon as well and he wrote of her complaints about over sedation. He subsequently reduced the Seroquel to 25mg. The lower dose was offered the next day but was refused and not given. Nothing in the record indicated that the patient was ever unconscious. Apart from not being able to complete that one assessment, she was otherwise found to be interactive in the milieu and participated in group sessions that morning and evening per the surrounding documentation. All entries throughout the 1st, 2nd and 3rd concluded with plans to continue monitoring her for safety.

Asked how informed consent is achieved, the Behavioral Health staff explained that the physician talks with patients during evaluation about proposed psychotropics, their risks, benefits and side effects while giving other options. The charge nurse will share written education materials on the medications, cover those with patients and have them sign consents. The program's director and the treating psychiatrist said they assume patients to have decisional capacity unless they present other evidence, which typically would be identified in the Emergency Department. About the patient's experience with Seroquel and her monitoring, the

physician said that indeed, sedation is a big side effect of the drug. He said the nurses reported the patient's complaints to him, and he met with her, reduced the dose and she no longer complained. He believed this patient was monitored appropriately and adequately; nurses make rounds every fifteen minutes and patient care techs do as well. He tells all patients who take these types of medications that they will feel tired and to let them know when they are concerned.

CONCLUSION

The hospital's Patient Rights and Responsibilities statement calls for "Considerate and respectful care in a safe and secure setting…." Its Code of Conduct and Ethics policy states similarly that patients will be treated with respect and dignity. The Mental Health Code meanwhile guards all recipients with adequate and humane care. (405 ILCS 5/2-102a).

Although this patient's experience in the emergency room and her complaints of rude staff are not discredited, there is simply no supportive detail or evidence to say that her right to respectful, humane care was violated. The complaint is unsubstantiated.

In summary, Northwest Community's Informed Consent for Psychotropic Medication policy's stated purpose is to assure that patients receive adequate information so they may provide informed consent—for medication administrations after informed consent is obtained—from a competent patient 18 years or older. The prescribing physician will give verbal explanations while the nurse will provide written education and then complete the consent form. The Mental Health Code requires almost the same, except that,

> *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 Section 2-107 [an emergency] or 2-107.1 [court order] or (ii) pursuant to a power of attorney...."* (405 ILCS 5/2-102a-5).

The Code also states that a recipient shall be provided adequate and humane care in the least restrictive environment, pursuant to an individual services plan. (405 ILCS 5/2-102a).

The complaint is that information on Seroquel was not provided before the medication was started and that the patient was not adequately monitored for side effects. Whether the materials were actually given or not, the record documents that they were, and the patient signed in verification for each one. That aspect of the complaint is not substantiated. The whole issue however is informed consent, based on one's determined decisional capacity, which is a Code requirement that is missing from the record and policy. A violation is substantiated. The record proves overwhelmingly that the patient was continually monitored for medication effects and general safety throughout each day, and, when she complained to nurses about feeling over

sedated from Seroquel, they alerted the physician who met with her and lowered the dose on the second day. The patient's right to adequate and humane care pursuant to an individual plan was not violated. The complaint is unsubstantiated.

RECOMMENDATION

-Add the Code's required decisional capacity statement to policy and instruct all appropriate staff to comply. (405 ILCS 5/2-102a-5).

SUGGESTION

-Use of the term "competent patient" in the program's informed consent policy is confusing. It is unclear whether the term is meant to be interchangeable with "capacity" or if it means a person who is legally competent, has no appointed guardian in other words. Competence is typically considered a legal determination while capacity a medical one that can change given a person's condition. Section 2-102 a-5 makes no stipulation on legal status, only on decisional capacity as determined by a physician. The hospital should review and revise as necessary.

RESPONSE

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