FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY-NORTH SUBURBAN REGION

REPORT 21-100-9010
AMITA HEALTH ALEXIAN BROTHERS BEHAVIORAL HEALTH HOSPITAL

Introduction
On 4/6/2021 the North Suburban Regional Human Rights Authority (HRA) opened an investigation of possible rights violations regarding care for a recipient of mental health services in AMITA Alexian Brothers Behavioral Health Hospital. The complaint alleged that hospital staff did not work with or inform the recipient's Power of Attorney agent to provide proper informed consent for the treatment and did not provide hearing aid batteries to the recipient, rendering the recipient functionally deaf. Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Illinois Power of Attorney Act (755 ILCS 45).

AMITA Alexian Brothers Behavioral Health Hospital is a 141-bed mental health care facility located in Hoffman Estates, Illinois.

Method of Investigation
To proceed with this investigation, the HRA reviewed the recipient's clinical record (with authorization) from the service provider and obtained additional case information through an interview with members of the recipient's clinical care team, and follow-up written requests from the hospital's Director of Patient Safety and Quality. The HRA also reviewed relevant hospital policies, provided by the hospital. The HRA acknowledges and appreciates the full cooperation of AMITA Alexian Brothers Behavioral Health personnel in this investigation.

Case Summary
A recipient of services was admitted to Alexian Brothers Behavioral Health Hospital (ABBHH) for a mental health evaluation at 9pm after being transferred from Alexian Brothers Medical Center (ABMC) at 1:54pm that same afternoon. The recipient was admitted to both facilities on a petition for involuntary admission. The petition included the recipient's Medical Power of Attorney (POA) agent's phone number and address, and a handwritten note on the petition reads "Patient unable to participate due to clinical condition." The POA agent had not been contacted by ABMC upon admission by petition, and ABBHH did not contact the POA agent about the recipient's hospitalization until 3pm the day following admission.

According to the record, at 9:45 pm on the night of admission the recipient was treated with

psychotropic medications Olanzapine (10mg injection) and Quetiapine (25mg tab). At 10:14pm an intake assessment was performed. The following morning at 9:48 am and 10:48 am, the provider administered Olanzapine (5mg injection) to the recipient. A doctor's note in the record indicates "This morning, in the context of screaming, yelling, threatening, the patient had to be given emergent Olanzapine". The provider confirmed in follow-up questions that the recipient was administered this injection for "imminent danger." No further details about this emergency medication administration are found in the documentation, and the provider could not provide any restriction related documents. During the interview, the hospital told the HRA that they did not know if the recipient was advised about the medications administered, or about his right to refuse treatment, but stated that it is the hospital practice to "advise the patient (even during high agitation) what is being ordered by the MD and given".

The afternoon following admission at 1:30pm, the doctor completed a hospital form titled: "Physician Statement for Power of Attorney for Health Care to make Health Care and Mental Health Decisions". This form verifies that the recipient was unable to give informed consent and/or authorization for any health care decisions, and that consent and/or authorization for health care decisions should be obtained from the POA agent. The record also contains the hospital's Psychotropic Medication Consent, timed at 3pm the same day. This form documents the first contact with the recipient's POA agent and indicates that the POA verbally consented to including Olanzapine in the recipient's treatment plan and were educated over the phone about common side effects and risks of Olanzapine. At 3:15pm that afternoon, the attending psychiatrist performed a psychiatric evaluation in communication with the recipient's POA agent. The recipient of services remained in ABBHH for seven days before being transferred to a different provider.

The availability of the recipient's hearing aid batteries was in question. The provider informed the HRA that although the recipient was not admitted to the hospital with additional hearing aid batteries, he showed ". . . signs of effective communication using his current hearing devices in numerous instances." The provider elaborated that those instances included but were not limited to, "the Nursing Assessment, History & Physical Exam, Psychiatric Evaluation, Psychosocial Assessment, as well as communications throughout his stay in various group and individual settings." The provider stated in a letter to the HRA that a Case Manager note in the record from a week after admission indicated "in accordance with POA request hearing aid batteries were replaced as requested," however the provider did not furnish that portion of the record for the HRA investigation.

Policy Review

To satisfy the HRA request for relevant hospital policies ABBHH furnished the hospital's Durable Health Care Power of Attorney, Informed Consent, and Consent for Psychotropic Meds policies. The Informed Consent policy indicates that all hospital patients must be informed of their rights under the Mental Health and Developmental Disabilities Code, and sets the standard that the "patient is knowledgeable about the nature of his or her procedures, treatments, and planned program." The HRA found that this policy appropriately addresses the rights of service recipients under the Mental Health and Developmental Disabilities Code (405 ILCS 5). The Consent for Psychotropic Meds policy indicates that all psychotropic medications must have informed consent upon administration. Psychotropic medications may be administered in an emergency situation without obtaining consent . . .as defined by the Illinois Mental Health Code." In order to align with the Code, this policy should require the determination of capacity before psychotropic

medications are administered. The Durable Health Care Power of Attorney policy indicates that a power of attorney "shall be exercised whenever a health care provider believes a principal may lack capacity to give informed consent to health care." The procedure section of this policy does not indicate a timeline for execution of the POA, which is aligned with the Illinois Power of Attorney Act (755 ILCS 45).

Case Findings

The complaint that AMITA Health Alexian Brothers Behavioral Health Hospital (ABBHH) did not work with the recipient's Power of Attorney agent to provide proper informed consent for the treatment is ***substantiated.*** The complaint that the hospital did not provide hearing aid batteries to the recipient, rendering the recipient functionally deaf, is ***not substantiated***.

Analysis

Before contacting the recipient's medical Power of Attorney, the provider administered four instances of psychotropic medication to the recipient with no documentation in the record to indicate if he had the capacity to make a reasoned decision about the treatment or was given the opportunity to refuse treatment. This is a violation of 405 ILCS 5/2-102. (a-5) which states "If the services include the administration of . . . psychotropic medication, the physician . . . 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 . . . 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."

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.

By providing treatment to a recipient who lacked capacity to participate in their treatment with informed consent, and by not communicating admissions and treatment rights to the medical POA agent, the provider also violated the Illinois Power of Attorney Act (755 ILCS 45) Section 4-7.(a) which states: *Whenever a provider believes a patient may lack capacity to give informed consent to health care . . ., 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.*

AMITA Health's Consent for Psychotropic Meds policy indicates that emergency medication without consent must be administered according to emergency medication standards defined in the Mental Health Code. The standards in 405 ILCS 5/2-107 indicate: "A recipient of services . . . and the recipient's substitute decision maker must be informed of the recipient's right to refuse medication . . . The recipient and the recipient's . . . substitute decision maker shall be given the opportunity to refuse generally accepted mental health . . . services, including . . . medication. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available. . ."

The provider confirmed in follow-up questions that the recipient was administered an injection of

Olanzapine (on the morning following admission) for "imminent danger", and case notes indicate the basis for "imminent danger" was the recipient's "screaming, yelling, threatening". However, this is a description of verbal behaviors, which could be common symptoms of mental illness. Lacking the documentation to demonstrate that the recipient (who was a frail nonagenarian) posed a serious and imminent physical threat, the provider does not demonstrate that the need for emergency medication rose to the standard set by 405 ILCS 5/2-107 or the hospital's own Consent for Psychotropic Meds policy. Furthermore when psychotropic medication is administered in cases of "imminent danger", the provider must follow the Code standards around restriction of rights: "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 . . . the recipient; . . . the Guardianship and Advocacy Commission; . . . and the recipient's substitute decision maker . . . The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefor in the recipient's record." The provider did not notify the recipient, the Guardianship and Advocacy Commission, or the recipient's substitute decision maker, and a restriction form was notfound in the record. (405 ILCS 5/2-201)

The HRA did not find enough evidence to suggest that the hospital violated any statutes with its handling of the recipient's hearing aid batteries. Case notes suggest that the recipient's lack of capacity to make an informed decision was more likely due to his state of agitation and diagnosis of dementia than an inability to hear.

Recommendations

1. Update AMITA Health's Consent for Psychotropic Meds policy to require the determinations of capacity before psychotropic medication are administered (in accordance with 405 ILCS 5/2-102 and 2-201). Retrain appropriate staff, and provide the HRA with proof of completion.
2. Retrain appropriate staff on AMITA Health's Durable Health Care Power of Attorney, Informed Consent. Provide the HRA with proof of completion.
3. Retrain appropriate staff on updated Consent for Psychotropic Meds policies, including the standard requirements for emergency medication administration and the issuance of a restriction ofrights, set by 405 ILCS 5 sections: 2-107 and 2-201. Provide the HRA with proof of completion.

AMMENDMENT TO REPORT

February 17, 2022

The provider responded to this report during the negotiation stage of this investigation by furnishing additional relevant case documentation that had not previously been submitted to the HRA. The following case note is not timed, but the provider told the HRA that it describes ***one*** of the emergency Olanzapine administrations (5mg injection) from the morning after admission: *Patient is … angry and resistive. Refused all medications given – spit them out . . . yelling and pushing table on another patient in threatening manner, instigating fight.*

This new information does not change the overall Case Findings, but it demonstrates that there ***was*** an appropriate need for emergency medication in ***one of the four*** instances of psychotropic

medication administered prior to receiving informed consent from the recipient's medical POA. According to 405 ILCS 5/2-107, a documentation that psychotropic medication is necessary to "prevent the recipient from causing serious and imminent physical harm" may supersede the need for a capacity determination or informed consent. Although the record sent to the HRA after the investigation period documents a need for emergency medication, the provider still did not indicate if the recipient, the Guardianship and Advocacy Commission, if so designated, or the recipient's substitute decision maker had been notified about this instance of restriction of rights, as required under 405 ILCS 5/2-201.

RESPONSE

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

NORTH SUBURBAN REGIONAL HUMAN RIGHTS AUTHORITY

HRA CASE NO. 21-100-9010

AMITA HEALTH ALEXIAN BROTHERS BEHAVIORAL HEALTH HOSPITAL

Pursuant to Section 23 of the Guardianship and Advocacy Act (20 ILCS 3955/1 *et seq.*), we have received the Human Rights Authority report of findings.

IMPORTANT NOTE

Human Rights Authority reports may be made a part of the public record. Reports voted public, along with any response you have provided and indicated you wish to be included in a public document, will be posted on the Illinois Guardianship and Advocacy Commission Web Site. (Due to technical requirements, your response may be in a verbatim retyped format.) Reports are also provided to complainants and may be forwarded to regulatory agencies for their review.

We ask that the following action be taken:

X We request that our response to any recommendation/s, plus any comments and/or objections be included as part of the public record.

_____ We do not wish to include our response in the public record.

_____ No response is included.

Jeffrey Maitland
NAME

Director, Quality & Patient Safety
TITLE

April 14, 2022
DATE

March 31, 2022

Illinois Guardianship and Advocacy Commission
9511 Harrison Avenue, W-335
Des Plaines, Illinois 60016-1565

Attn: Teri Steinberg, Chair, Human Rights Authority, N. Sub Region

RE: HRA #21-100-9010

Dear Ms. Steinberg**,**

Thank you for allowing AMITA Alexian Brothers Behavioral Health Hospital (ABBHH) the opportunity to address the concerns relating to documentation of proper informed consent with power of attorney. However, this letter does not address any actions that were taken at Alexian Brothers Medical Center as this is a wholly separate hospital with its own leadership and should not be included in the ABBHH report.

In response to the report's recommendations, an online training module entitled *Legal Procedures During Medication Administration and Emergency Medication* has been developed by the nursing education and development team. The materials for the course can be found attached.

The education module was approved at the executive level and has been disseminated to all nursing staff as of March 29, 2022. The expectation is to have 100% compliance for completion with 30 days.

Thank you for the opportunity to review this record and address the concerns raised by the report. Should you have further questions feel free to contact Jeffrey Maitland, Quality Director at (812)-391-0192.

Respectfully,

Jeffrey Maitland
Quality and Patient Safety Director, Alexian Brothers Behavioral Health Hospital

AMITA Health Alexian Brothers
Behavioral Health Hospital
Hoffman Estates
1650 Moon Lake Blvd.
Hoffman Estates, IL 60169

800.432.5005

AMITAhealth.org

LEGAL PROCEDURES DURING MEDICATION RECONCILIATION AND EMERGENCY MEDICATION ADMINISTRATION

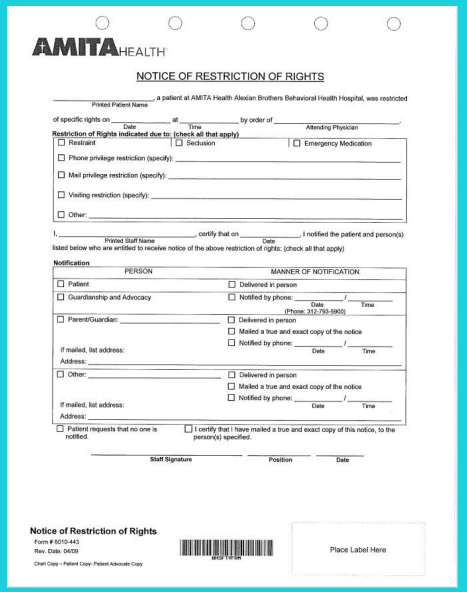
AMITA HEALTH®

In sickness and in health™

During Emergency Medication

Any time an emergency medication (Psychotropic) is given against the patients will for imminent danger, a **restriction of rights** form is completed.

Original to the Chart and copy to the patient. A copy is mailed to anyone the patient requests or the parent/guardian/POA.



AMITA HEALTH

NOTICE OF RESTRICTION OF RIGHTS

_____, a patient at AMITA Health Alexian Brothers Behavioral Health Hospital, was restricted
Printed Patient Name

of specific rights on _____ at _____ by order of _____.
Date Time Attending Physician

Restriction of Rights indicated due to: (check all that apply)

☐ Restraint ☐ Seclusion ☐ Emergency Medication

☐ Phone privilege restriction (specify): _____

☐ Mail privilege restriction (specify): _____

☐ Visiting restriction (specify): _____

☐ Other: _____

I, _____, certify that on _____, I notified the patient and person(s)
Printed Staff Name Date

listed below who are entitled to receive notice of the above restriction of rights: (check all that apply)

Notification

PERSON	MANNER OF NOTIFICATION
☐ Patient	☐ Delivered in person
☐ Guardianship and Advocacy	☐ Notified by phone: ____/____ Date Time (Phone: 312-793-5900)
☐ Parent/Guardian: _____	☐ Delivered in person ☐ Mailed a true and exact copy of the notice ☐ Notified by phone: ____/____ Date Time If mailed, list address: Address: _____
☐ Other: _____	☐ Delivered in person ☐ Mailed a true and exact copy of the notice ☐ Notified by phone: ____/____ Date Time If mailed, list address: Address: _____

☐ Patient requests that no one is notified. ☐ I certify that I have mailed a true and exact copy of this notice, to the person(s) specified.

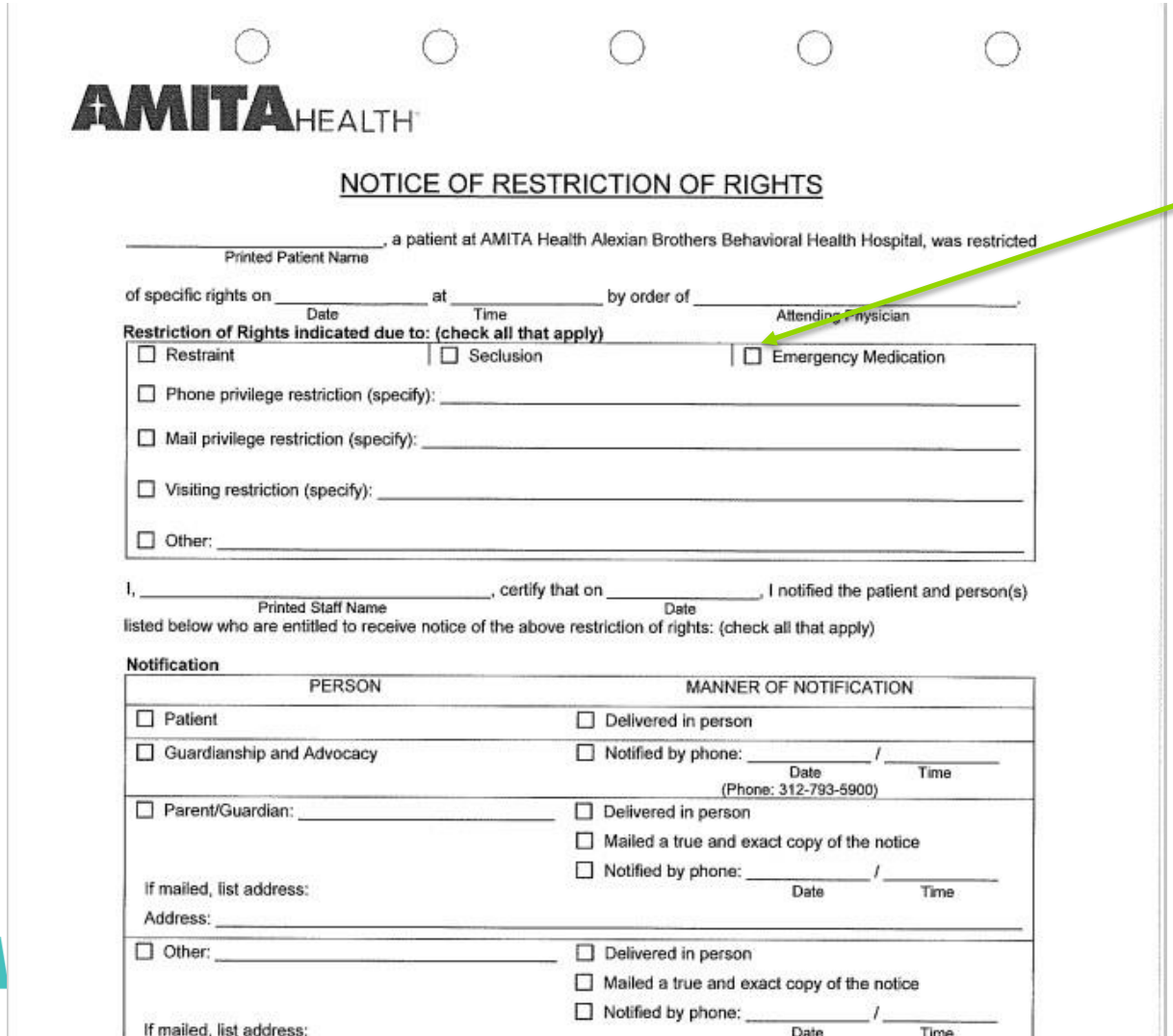
_____ _____ _____
Staff Signature Position Date

Notice of Restriction of Rights
Form # 6010-443
Rev. Date: 04/09
Chart Copy – Patient Copy- Patient Advocate Copy

MRSP 19199

Place Label Here

Restriction of Rights



AMITA HEALTH

NOTICE OF RESTRICTION OF RIGHTS

_____, a patient at AMITA Health Alexian Brothers Behavioral Health Hospital, was restricted
Printed Patient Name

of specific rights on _____ at _____ by order of _____.
Date Time Attending Physician

Restriction of Rights indicated due to: (check all that apply)

☐ Restraint	☐ Seclusion	☐ Emergency Medication

☐ Phone privilege restriction (specify): _____

☐ Mail privilege restriction (specify): _____

☐ Visiting restriction (specify): _____

☐ Other: _____

I, _____, certify that on _____, I notified the patient and person(s)
Printed Staff Name Date
listed below who are entitled to receive notice of the above restriction of rights: (check all that apply)

Notification

PERSON	MANNER OF NOTIFICATION
☐ Patient	☐ Delivered in person
☐ Guardianship and Advocacy	☐ Notified by phone: _____ / _____ Date Time (Phone: 312-793-5900)
☐ Parent/Guardian: _____ If mailed, list address: Address: _____	☐ Delivered in person ☐ Mailed a true and exact copy of the notice ☐ Notified by phone: _____ / _____ Date Time
☐ Other: _____ If mailed, list address:	☐ Delivered in person ☐ Mailed a true and exact copy of the notice ☐ Notified by phone: _____ / _____ Date Time

Check this box when completing this form due to emergency medication administration

Date Time Attending Physician

Restriction of Rights indicated due to: (check all that apply)

☐ Restraint	☐ Seclusion	☐ Emergency Medication

☐ Phone privilege restriction (specify): _____

☐ Mail privilege restriction (specify): _____

☐ Visiting restriction (specify): _____

☐ Other: _____

I, _____ (Printed Staff Name), certify that on _____ (Date), I notified the patient and person(s) listed below who are entitled to receive notice of the above restriction of rights: (check all that apply)

Notification

PERSON	MANNER OF NOTIFICATION
☐ Patient	☐ Delivered in person
☐ Guardianship and Advocacy	☐ Notified by phone: _____ (Date) / _____ (Time) (Phone: 312-793-5900)
☐ Parent/Guardian: _____	☐ Delivered in person ☐ Mailed a true and exact copy of the notice ☐ Notified by phone: _____ (Date) / _____ (Time) If mailed, list address: Address: _____
☐ Other: _____	☐ Delivered in person ☐ Mailed a true and exact copy of the notice ☐ Notified by phone: _____ (Date) / _____ (Time) If mailed, list address: Address: _____

☐ Patient requests that no one is notified.

☐ I certify that I have mailed a true and exact copy of this notice, to the person(s) specified.

_____ (Staff Signature) _____ (Position) _____ (Date)

Notice of Restriction of Rights

Form # 6010-443

Rev. Date: 04/09

Chart Copy – Patient Copy- Patient Advocate Copy

BHSF TYFRM

Place Label Here

POA/Guardian **MUST** be notified if the patient has one!

Attestation

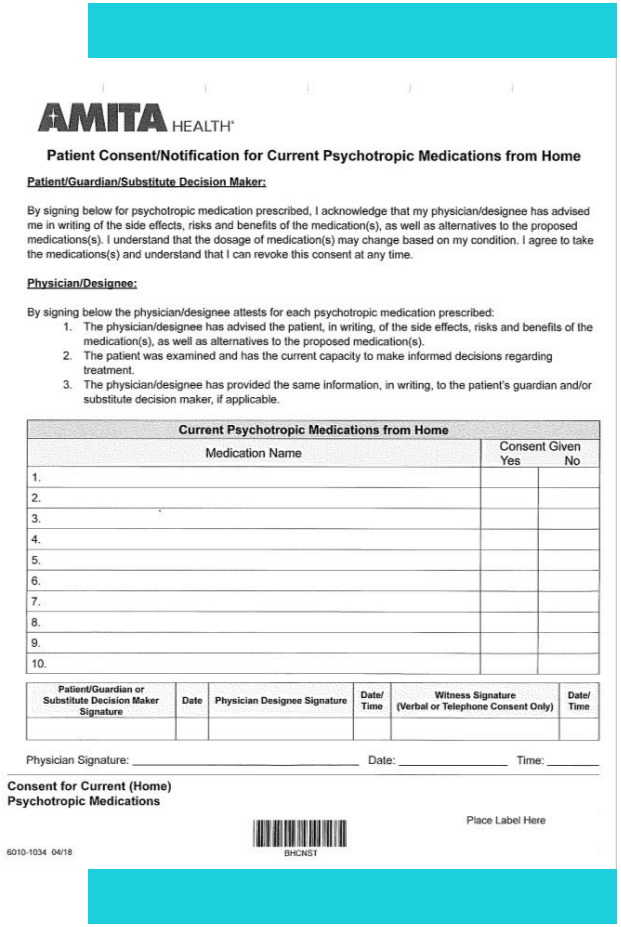
I understand that any time an emergency medication (Psychotropic) is given against the patients will, a **restriction of rights** form must be completed and the patient's Guardian/POA must be notified.

Yes

No

During Medication History

- When obtaining medication history, the Patient Consent/Notification for Current Psychotropics from Home form **MUST** be completed



AMITA HEALTH

Patient Consent/Notification for Current Psychotropic Medications from Home

Patient/Guardian/Substitute Decision Maker:

By signing below for psychotropic medication prescribed, I acknowledge that my physician/designee has advised me in writing of the side effects, risks and benefits of the medication(s), as well as alternatives to the proposed medications(s). I understand that the dosage of medication(s) may change based on my condition. I agree to take the medications(s) and understand that I can revoke this consent at any time.

Physician/Designee:

By signing below the physician/designee attests for each psychotropic medication prescribed:

1. The physician/designee has advised the patient, in writing, of the side effects, risks and benefits of the medication(s), as well as alternatives to the proposed medication(s).
2. The patient was examined and has the current capacity to make informed decisions regarding treatment.
3. The physician/designee has provided the same information, in writing, to the patient's guardian and/or substitute decision maker, if applicable.

Current Psychotropic Medications from Home		
Medication Name	Consent Given Yes	No
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Patient/Guardian or Substitute Decision Maker Signature	Date	Physician Designee Signature	Date/ Time	Witness Signature (Verbal or Telephone Consent Only)	Date/ Time

Physician Signature: _____ Date: _____ Time: _____

Consent for Current (Home) Psychotropic Medications

Place Label Here

6010-1034 04/18

BHCNST

By signing below for psychotropic medication prescribed, I acknowledge that my physician/designee has advised me in writing of the side effects, risks and benefits of the medication(s), as well as alternatives to the proposed medications(s). I understand that the dosage of medication(s) may change based on my condition. I agree to take the medications(s) and understand that I can revoke this consent at any time.

Physician/Designee:

By signing below the physician/designee attests for each psychotropic medication prescribed:

1. The physician/designee has advised the patient, in writing, of the side effects, risks and benefits of the medication(s), as well as alternatives to the proposed medication(s).
2. The patient was examined and has the current capacity to make informed decisions regarding treatment.
3. The physician/designee has provided the same information, in writing, to the patient's guardian and/or substitute decision maker, if applicable.

Current Psychotropic Medications from Home		
Medication Name	Consent Given Yes	No
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Patient/Guardian or Substitute Decision Maker Signature	Date	Physician Designee Signature	Date/ Time	Witness Signature (Verbal or Telephone Consent Only)	Date/ Time

Physician Signature: _____ Date: _____ Time: _____

Consent for Current (Home) Psychotropic Medications

Place Label Here

6010-1034 04/18

BHCNST

IF the patient has a guardian or substitute decision-maker, they **MUST** receive the same informational material in writing! (Scan, email, mail, or paper)

Document in a separate note after the POA/Guardian is informed in writing.

If no POA or ROI documents are available

Emergency Medication administration

- If there is no documentation of a POA or a Release of Information,
  - Nurse may not call but complete the Restriction of Rights form when emergency meds are given
  - Chart in record, “unable to contact family due to no Release of Information documentation”
  - When/if an ROI is obtained, then call and mail the form

Home Medication/Medication Consent

- If there is no ROI documentation, then do not contact family.
  - If family calls, state “I cannot confirm or deny that the person is here due to privacy regulations. But if you have information regarding a POA for this person that you are calling about, please fax to_***_____, or email to __***____ or drop off at ABBHH.”

    *** Obtain unit fax # or Case Manager email

- **Then escalate to Manager/Director to determine next steps.**

Attestation

I understand that any time a home medication is psychotropic, consent **MUST** be given by the patient or substitute decision-maker.

Attestation

Educational material shared during the consent gathering process **MUST** be given in writing to both the patient and the substitute decision-maker.