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HUMAN RIGHTS AUTHORITY – CHICAGO REGION

REPORT 19-030-9019
Chicago Lakeshore Hospital

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation into a complaint of potential rights violations in the treatment of a patient at Chicago Lakeshore Hospital (Lakeshore). Lakeshore is a 101-bed private behavioral health hospital that is located on Chicago's Northside. Lakeshore provides various treatment services to over 5,000 patients annually. All patients treated at this facility have a mental health diagnosis.

The complaint investigated is that a guardian was not provided with a notice of rights nor allowed to participate in the development of a service plan. Substantiated findings would violate protections under the Mental Health Code, Care and Services Sections (405 ILCS 5/2-102 & 405 ILCS 5/2-200).

The Human Rights Authority met with the hospital's CEO, intake clinician, director of risk management, clinical director and a case manager regarding the complaint. Relevant policies were reviewed as well as the patient's records with proper authorization.

COMPLAINT SUMMARY

It was reported that a patient was received at an area hospital due to a walk-in admission. There it was reportedly determined that the patient needed inpatient care. The guardian was notified and agreed with the medical treatment plan. The patient was transferred for care from that hospital to Lakeshore, however the guardian was allegedly not notified where the patient was transferred. It was also reported that the guardian was not included in the treatment plan at the new facility nor given a notice of rights.

FINDINGS

"Lakeshore" Record Review

The record indicates that the patient arrived in early April and was discharged thirteen days later. The patient completed an initial intake assessment with a physician and it was determined that the patient was oriented to person, place, time and situation. The patient also signed all patient rights forms and consent forms for admission. The record details that the patient was reported to be fixated with harming his father. The intake assessment also stated that the patient's father was aware of the situation.

About two hours after the intake assessment, the patent was given a history and physical examination. During the examination the patient was asked general questions about marital status, living situation and past medical history. The form for the examination does not list any capacity questions, but it does reaffirm that the patient was oriented to person, place, time and situation. The examination form lists the patient's chief complaint as "thoughts of hurting his father." The history examination form makes no mention of the patient being under guardianship, nor does the intake assessment form refer to guardianship.

The record also contains a master treatment plan that was completed a few hours after intake. The master treatment plan does refer to the patient's legal status, and this patient's admission status was marked as voluntary. There are no capacity questions on the master treatment plan and it is also lacking an emergency treatment preference section. However, the master treatment plan does have a section that references patient involvement; this section is signed and dated by the patient, nursing staff, social work staff and the physician.

There is a consent for medication form in the record. This form serves as an acknowledgment of the agreed psychotropic medication the patient will take. This form lacks a capacity statement, but it does have a place to secure parent or guardian consent. The form also lists a place for documentation of telephone consent from the guardian. The form in the record is signed and dated by the physician, a witness and the patient.

There are "clinical services collateral contact/progress notes" (progress notes) included in the record. These progress notes detail various interactions between staff and the reported guardian. One such interaction occurs a couple of hours after the patient had arrived, the assigned case manager confirms receipt of a guardianship order. This interaction is followed up by the case manager informing the front desk about the guardian's request to not allow a service agency to visit the patient.

The record contains several progress notes of interactions between the guardian and members of the treatment team, yet the record lacks verification of the guardian receiving medical information for prescribed medications as well as all patient rights information. The record also does not contain any mention of the guardian participating in the treatment plan or consent/agreeing with the proposed treatment plan; the record also does not mention the

treatment team attempting to reach the guardian regarding the initial treatment. However, the record does indicate that the guardian met with the treatment team in person four days after patient was admitted into the hospital. Furthermore, the progress notes state that the facility, the patient and the guardian had a family session via phone to review the treatment plan. Finally, the progress notes detail the treatment team followed several of the guardian's requests. Some of the requests that the treatment team followed included changing the patient's outside community-based service agency, providing prescription information to the new community treatment agency, providing information to an outside psychiatrist and limiting visits from individuals working for one particular provider.

Site Visit and Staff Interviews

The HRA conducted a site visit to Lakeshore on October 23, 2019. During the site visit the HRA asked the staff present whether the patient reported to have a guardian. The intake clinician reported that the transferring hospital "did not provide any guardianship paperwork to the facility," thus a guardian was not immediately known. The clinician furthered that the patient did not self-report the presence of a guardian during the intake assessment. The staff then reported that this was the patient's first admission to the facility so there was not a historical record of the patient being under guardianship.

The case manager furthered that she did speak with a person reporting to be the guardian by phone after the patient was admitted. The case manager stated that she requested the guardianship paperwork. She informed the HRA that once the paperwork was received the guardian was notified and included in the care of the patient. The HRA asked the case manager if the guardian received medication information, she informed the HRA that after it was known there was a guardian for the patient, "all information for medication was forwarded to the guardian." She reaffirmed that the guardian was included in the entire treatment process, once it was known there was a guardian.

The CEO informed the HRA that she personally reached out to the guardian because of complaints that were received. The CEO stated that she spoke with the guardian after discharge, but the facilities Chief Medical Officer reached out to the guardian in April of 2019. She also stated that she had administration follow up with the guardian in May of 2019. Finally, she informed the HRA that the Illinois Department of Public Health and Office of Inspector General had recently conducted an interview with the facility regarding similar matters.

The HRA then asked the staff if the patient presented with capacity to consent to medications. The intake clinician and the case manager concurred that the patient was oriented and able to consent to medications. The record does reflect that the patient signed a consent for scheduled medications form in front of two witnesses. However, the form lacks a capacity statement. When questioned about this the staff maintained that the patient had capacity to consent to medications. The clinician also noted that the patient never refused any medications during the time on the unit.

The HRA asked the staff if the patient made his emergency treatment preference known. They stated that the patient's preference was emergency medication. The HRA informed the staff that this was not noted in the treatment plan. The clinical director was called into the conference room to locate the preference in the medical record. The clinical director asserted that the facility has moved away from restraint of patients and typically uses seclusion or intramuscular medications at times of emergency. The facility did produce a form that listed potential escalators for patients. The form also lists a patient's preferences for de-escalation, however the form does not emphatically list a patient's emergency treatment preference.

Finally, the HRA requested policies on admission procedures, medication administration, medication refusal policy, emergency treatment preferences and patients' rights, as they had not been received. The director of risk management provided the HRA with the requested policies.

Policy Review

The HRA reviewed Lakeshore's policy on "Patients' Rights/Restriction of Rights" (NS 59). The policy was updated and last revised in November of 2016. The policy details that "on admission to the facility and during the patient's hospitalization, the patient will be informed of his/her rights according to federal and state rules and regulations." This policy is hospital wide and further states that the patient has the right to mail, visitation and unimpeded, uncensored and private phone calls. Yet, this policy does not meet the standards set by the Code, "(a) upon commencement of services, or as soon thereafter as the condition of the recipient permits, every adult recipient, as well as the recipient's guardian or substitute decision maker … shall be informed orally and in writing of the rights guaranteed by this Chapter[.]" (405 ILCS 5/2-200) The policy fails to ensure notification of guardians, as it does not clearly communicate to staff that guardians need notification.

This policy also establishes the procedures for medication against the patient's will. The portion of the policy is largely in line with the Code however it does not address adults with guardians. The policy does address minors with guardians; it states, "if the patient is a minor, and a non-DCFS Ward, the parent/guardian must receive prompt notification by telephone." However, the Code requires, "whenever any rights of a recipient of services … 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 … and the reason therefor to: (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian[.]" (405 ILCS 5/2-201)

The HRA reviewed the policy on "Administration of Medication." (NS 37). This policy was also last updated and revised in November of 2016. The policy details the procedures for how medications are administered, refused and monitored. The policy dictates that all "adults must sign medication consent form for all psychotropic medications before administrating." It furthers

that for patients under the age of 18 a parent, guardian or DCFS must give consent to medication before it is administered.

The most influential part of the policy is that it details to staff the procedures of what is required upon medication refusal. The policy states the following:

> "(a) every patient has the right to refuse any medication, including PRN's. Documentation of the refusal is made in the progress notes by using the refusal stamp. (b) If a patient refuses medication it will not be given, unless deemed to prevent the patient from causing serious harm to self or others; in which case the attending physician is notified … (d) if medication is given to a patient to prevent causing serious harm to him-self or others, a restriction of rights is completed for each episode. (e) fully document the patient's behavior and events … (f) the physician assess the need to order psychotropic medication for ongoing patient safety. [The Physician] determines continuation based on court petition"

This policy is also largely in line with the Code but once again it does not address adults with guardians, who would require receipt of the same written drug information, notification of the right to refuse medication and any restricted right to refuse (405 ILCS 5/2-102a-5 & 5/2-201)

Lastly, the HRA reviewed Lakeshore's "Multidisciplinary Treatment Plan" policy. The policy states that a treatment plan should be initiated within twenty-four hours (24hrs) of admission. It furthers that the patient shall participate in the formulation of the treatment plan and the patient's goals for treatment must be included. Finally, the policy states that the treatment plan is "reviewed by the multidisciplinary team including community case manager, family/guardians, or any individual important to the care and welfare of the patient." This policy concurs with the Code section 5/2-102 as it mandates 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 …"

CONCLUSION

A guardian did not receive a notice of rights.

The Code mandates that "(a) upon commencement of services, or as soon thereafter as the condition of the recipient permits, every adult recipient, as well as the recipient's guardian or substitute decision maker … shall be informed orally and in writing of the rights guaranteed by this Chapter which are relevant to the nature of the recipient's services program." (405 ILCS 5/2-200) This record contains evidence that the guardian met with staff in person in April, but there is no documented indication that the guardian received or signed a notice of rights in writing. Thus, a rights violation is substantiated.

A guardian was not allowed to participate in the development of a service plan.

The record has many "progress notes" that illustrate that the guardian was aware of the treatment provided. The facility also adhered to many of the guardian's requests. The facility maintains that once they were aware of the guardian, they included the guardian in the care and services provided. The master treatment plan was formulated without the guardian as it was created before the facility had documentation that there was a legal guardian, yet there is a progress note that details the guardian was invited but unable to attend the treatment plan review. However, a key component of service planning is the guardian's inclusion for treatment. Lakeshore did not determine in writing whether the patient had decisional capacity before starting psychotropic medications, and there is no record evidence that written drug information was shared with the guardian once he was reached in addition to the rights information that would have explained his ability to refuse any prescribed treatment. Based on the information available a Code violation is <u>substantiated.</u>

<u>RECOMMENDATIONS:</u>

1. The facility should update the "Patients' Rights/Restriction of Rights" (NS 59) policy to address all potential guardian notification of patient's rights as mandated by the Code. Staff should then be retrained on this policy.

2. There should be a revision to the consent for scheduled medication form. The form lacks a determination of a patient's capacity to consent for medication. The Code mandates that "the physician shall determine and state in writing whether the patient has the [decisional] capacity to make a reasoned decision about the treatment." (405 ILCS 5/2-102a-5).

3. The facility should require appropriate staff to forward notice of rights and written drug information to absent guardians and document completion in the record and according to policy requirements. (devise a form or checklist to ensure completion by staff)

4. Finally, the Code also mandates that when administrating psychotropic medication, "the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risk, and benefits of 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." Therefore, the HRA would recommend documenting that medication information was provided to guardians and substitute decision makers in the record.

5. The Administration of Medications policy should be revised to include provisions for guardians to receive written medication information, information about the right to refuse medication/treatment and notice of any restrictions to the right to refuse.

SUGGESTIONS:

The HRA found would like to suggest the following:

1. The HRA would strongly suggest adding language to the master treatment plan that clearly illustrates a patient emergency treatment preference pursuant to 5/2-102a. The HRA would also advocate that the facility document notifying the guardian of the patient's preference in writing via mail or fax.

2. Consider adding items to the intake and examination forms questioning the existence of a guardian.

3. Consider revising the Administration of Medication policy to include direct verbiage from the Code as follows: "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."

RESPONSE

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

Chicago Lakeshore Hospital

To Whom It May Concern,

January 24, 2020

Please accept our response in regards to the findings identified in your letter of December 23, 2019, resulting from the investigation conducted on October 23, 2019 (Reference #19-030-0-9019), involving a complaint of failure to notify or involve a patient's legal guardian regarding rights and treatment.

As stated in your letter, at the time of admission, this facility's Intake Department staff was not aware that a guardianship was in place. The transferring facility did not provide this information and the patient failed to disclose that he had a guardian. Again, as stated in your letter, it is documented in the initial assessments that the patient was oriented to person place, time and situation, and he was able to cooperate with the assessments. As such, and as he met admission criteria, he was allowed to sign documents, and consent to medications.

Upon discovery that the patient had a guardian, the guardian was involved in treatment planning and care, and frequent contacts with the guardian were well documented. However, as stated in your letter, staff failed to obtain signatures from said guardian on the medication consents, treatment plan documents and notice of rights documents.

As recommended, the facility will be revising the policies identified in your letter (Patient Rights/Restriction of Rights – NS 59; Administration of Medication – NS 37; Multidisciplinary Treatment Plan – NS 68) to ensure the policies specifically address notification / involvement of guardians of adult patients and documentation of same, using language taken directly from the code where appropriate. Additionally, as recommended, the following forms: Patient Rights and Consent for Medication, will be reviewed and revised as approved by the Medical Staff to reflect involvement / notification of guardian of adult patients. Staff will be re-trained on the policy and form revisions, to ensure understanding and compliance.

The observations and recommendations provided by the Illinois Guardianship and Advocacy Commission are appreciated and welcomed in our effort to continually improve the care provided to our patients. Please do not hesitate to contact me if I may provide further information.

Sincerely,

Amber Ware

Amber Ware

Director of Risk Management, Quality and Performance Improvement

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