FOR IMMEDIATE RELEASE

North Suburban Human Rights Authority
Report of Findings
Vanguard Westlake Community Hospital
HRA #14-100-9016

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Vanguard Westlake Community Hospital. The HRA notified Westlake of its intent to conduct an investigation pursuant to the Guardianship and Advocacy Act (20 ILCS 3955) after receiving a complaint that alleged that consumers are often being seen by the treating psychiatrist late into the evening hours, sometimes after the consumer has been asleep for the evening. It was also alleged that a consumer was given emergency medication without justification.

The rights of consumers receiving services at Westlake Community Hospital are protected by the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102 and 5/2-107).

Background

Vanguard Westlake Community Hospital is a 282-bed facility located in Melrose Park. The hospital's Mental Health and Addiction services provide comprehensive care for children, adolescents, adults, and seniors in both inpatient and outpatient settings. The services include emergency/crisis care, a 25-bed inpatient treatment program, outpatient therapy, short and long-term residential programs and home visits.

Method of Investigation

To investigate the allegations, the HRA requested masked (clinical data removed) records for all consumers that received emergency medication during a specific timeframe; one consumer met the criteria. This consumer's record was received and reviewed. Also reviewed were hospital policies relevant to the allegations. The HRA met with hospital personnel to discuss the allegations and also discussed the allegations with adult consumers who were receiving services at the time of the HRA visit.

Findings

The clinical record reviewed revealed data on an adult consumer involuntarily admitted to the hospital. The record showed that the consumer received emergency medication on –what seemed to be - four separate occasions. The first time, progress note documentation indicated that the consumer was observed agitating peers and staff; she was difficult to redirect and unable to process. The note documented that she was given a PRN (as needed) medication. A Restriction of Rights Notice (ROR) was completed documenting that the consumer received medication because she was provocative, intimidating and she was not able to accept direction.

The second time, a lone progress note entry for that day indicated that the consumer's "patient and staff interactions" vary as it ranges from calm to aggressive. It was noted that she was cycling very quickly. The consumer was observed threatening other consumers and calling them names. It was documented that redirection at the time of the escalation was successful. A ROR was completed on this date and it was documented that the consumer's right to refuse medication was restricted because she was not following directions, she was provoking others, and she was going down the men's hallway.

The third time, both the ROR and progress notes documented that the consumer was loud and disruptive; she was yelling, screaming, highly agitated and threatening physical harm. The fourth time, both the ROR and progress notes documented that the consumer and another consumer had a physical altercation and the consumer was given emergency medication.

At the site visit, hospital personnel stated that emergency medication is given when the consumer is unable to follow directions and when there is a threat of harm to self or others. It was stated that RORs are reviewed to ensure that there are no patterns concerning the use of emergency medications. Staff members are to complete detailed documentation regarding the need for emergency medication in both progress notes and the RORs.

The adult consumers interviewed stated that they were aware that they had the right to refuse medication. The consumers offered that they took medication willingly and had not required emergency medication.

The hospital Patient's Refusal of Medication and Conditions for Emergency Use of Medication policy states (in part) that upon admission to the inpatient psychiatric unit, the patient or the patient's guardian is informed of his right to refuse medication and the circumstances in which emergency medications may be administered. If the patient refuses medication, the patient may receive medication only if the patient demonstrates behavior that causes serious and imminent physical harm to the patient and/or others and documentation in the medical record notes the need for emergency medication. The policy goes on to state that if the patient is refusing medication and the patient's behavior is a serious and imminent threat to self and/or others, prior to emergency administration of the medication, the RN is responsible for the following: documents such refusal in the medical record and review patient's identified preferences for treatment; documents the specifics of the patient's behavior to support the presence of a serious and imminent threat to self/others; completes a restriction of rights form.

Regarding the allegation that the psychiatrists visit late into the evening, the Psychiatrist (who is also the Chairman of psychiatry) firstly offered to the HRA that he is very busy and at times he might be seeing his patients in the later evening hours. He went on to say that during the period in question, vacations were a factor so it was very possible that the covering psychiatrists had rounded late. When asked, it was stated that there were no time limits for rounding in the medical bylaws. However, if unit staff believe that a physician is consistently rounding late, that staff is to alert program management.

Of the two consumers interviewed, one stated that he sees his Psychiatrist in the morning hours; the second consumer stated that he sees his Psychiatrist (the Psychiatrist in attendance at the site visit) usually between 8:30-9:00 p.m. and he would prefer earlier hours. The HRA notes that during a previous site visit to Westlake on an unrelated matter, three consumers stated that they wished their treating psychiatrist would not come to the hospital so late at night.

Conclusion

Pursuant to Section 5/2-107 of the Illinois Mental Health and Developmental Disabilities Code, "(a) An adult recipient of services or the recipient's guardian, if the recipient is under

guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. 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 HRA found the documentation surrounding the medication occurrences confusing. During the first occurrence, progress notes documented that she was given PRN medication, yet a ROR was completed. If in fact it was emergency medication, then the consumer's right to refuse medication was violated. Being provocative, intimidating and being unable to follow directions does not meet the criteria of prevention from causing serious and imminent physical harm to the consumer or others. And, the HRA takes issue with the documented statement that the consumer was agitating staff. Staff members should never become agitated at a consumer and a consumer should never receive emergency medication for this reason. During the second occurrence, "threatening other consumers and calling them names" does not meet the need to prevent serious and imminent physical harm without further explanation of the observed threatening behavior.

Pursuant to Section 2-102(a) of the Illinois Mental Health and Developmental Disabilities Code, "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."

Based on the information obtained from hospital personnel and the consumers interviewed, it is concluded that at times the consumers are seen by the treating psychiatrist late into the evening hours. Best practice dictates that most consumers would respond to treatment during more reasonable hours.

Recommendations

1. Hospital personnel must ensure that medication refusals are documented in the medical record and that staff member's review the consumer's identified preferences for treatment. Documentation must include the specifics of the consumer's behavior (avoiding catch-phrases like agitated, unable to follow directions, etc.) to support the presence of a serious and imminent threat to self/others. Ensure that detailed restriction of rights forms are completed for all emergency medication.
2. Hospital administration must ensure that consumers are being seen by the treating psychiatrist during reasonable hours.

Comment

The HRA appreciates that the psychiatrist is a busy man, but seeing consumers should not be the last on his list of things to do that day.

RESPONSE

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

1225 WEST LAKE STREET
MELROSE PARK, IL 60160
708.681.3000

September 1, 2014

Guardianship and Advocacy Commission
Ms. Julie Sass, Rights Coordinator
9511 Harrison Street, W-300
Des Plaines, IL 60016-1565
RE: HRA #14-100-9016

Dear Ms. Sass:
Westlake Hospital received the report of findings from the above case. I have met with the nurses on the behavioral units at Westlake Hospital to review the policy and interpretation of the policy specific to the use of emergency medications versus medications ordered on an as needed basis. Examples of documentation of behaviors that led to the use of emergency medications were reviewed and analyzed for appropriate elements of documentation. The team also reviewed examples of Restriction of Rights forms that allowed them to review the accompanying documentation of behaviors in the record and the appropriate use of an emergency or as needed medication.
A plan was put in place for all Restriction of Rights forms to be reviewed concurrently to ensure appropriate documentation is noted in the medical record and that the appropriate intervention was instituted. The results of the concurrent review are shared with staff as a means of coaching and counseling as necessary. The results of the concurrent review are posted on the units, shared at staff meetings and reviewed at the Quality Committee of the hospital.
The behavioral health units will have a new director soon and her responsibility will be to continue to monitor for compliance with the above action plan.
This writer was responsible for meeting with the individual physicians to discuss rounding on patients during reasonable hours. All physicians are aware and this discussion also continued at the Department of Psychiatry quarterly meeting. Patients are encouraged to address their concerns with physician visits and can approach individual staff and/or physicians, discuss at the twice daily community meetings or contact administration. This writer is responsible for reviewing these concerns and meeting with the physicians. Physicians who do not change practice patterns are referred through the appropriate chain of command of the medical staff department.
Westlake Hospital requests that all findings be posted along with our response in the public record which may be posted on the Commission's Web Site.

Sincerely,

Ruth Matthei
Chief Nursing Officer