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**BOTSFORD
HOSPITAL**

**28050 GRAND RIVER AVENUE FARMINGTON
HILLS, MI 48336**

**Feb. 16,
2012**

VIOLATION: PATIENT RIGHTS: INFORMED CONSENT

Tag No:
A0131

Based on interview and record review, the facility failed to:

1. Ensure that 3 of 3 patients (#6, #3 and #5) or their families or guardians were informed of the risks and benefits of psychotropic medications and provided with written information per policy;
 ---Resulting in patients and families not being afforded the opportunity to make informed decisions on the risks and benefits of psychotropic medications according to facility policies Findings include:

1. The facility failed to ensure that 3 of 3 patients (#6, #3 and #5) or their families or guardians were informed of the risks and benefits of psychotropic medications and provided written information

Facility policy #08.001 states:

"Before initiating a course of psychotropic drug treatment for a recipient, the prescriber or a licensed health professional acting under the delegated authority of the prescriber shall do both of the following:

- (a) Explain the specific risks and the most common adverse effects that have been associated with that drug.
- (b) Provide the individual with a written summary of the most common adverse effects associated with the drug."

Record Reviews and Interviews:

On 2/16/12 at approximately 1220 hours patient #6's clinical record was reviewed. There was a completed Patient Advocate designation form and an "Informed Consent for Psychotropic Medications" form with a note stating,

"patient's wife (the Patient Advocate) did not want to consent to Ativan." On 2/11/12 Ativan was ordered and on 2/13/12 it was documented as administered. There was no documentation of information being provided to the Patient Advocate on Zyprexa, which was ordered and administered on 2/14/12. These findings were verified by the Unit Manager.

On 2/16/12 at 1145 hours patient #3's clinical record was reviewed with the Recipient Rights Officer (RRO). The facility's form titled "Informed Consents for Psychotropic Medications" provides blank space for the patient's physician to sign-off that: "the patient, family or guardian has been informed of the possible risks and benefits of taking the prescribed medication." The physician did not sign for Remeron although it was ordered. There was no documentation that the patient or family received written information on Zyprexa or Remeron. Documentation of this information being provided by the designated decision-maker was not noted in the patient's record or elsewhere. These findings were verified by the RRO.

On 2/16/12 at approximately 1215 hours patient #5's clinical record and "Informed Consent for Psychotropic Medications" form was reviewed with the Psychiatric Program's Unit Manager. There was no clear documentation of a Physician's statement of informing the patient/family/guardian of the risks Zyprexa and no documentation of written information being provided for Trilafon or Remeron. These findings were verified by the Unit Manager who was unable to find evidence of informed consent.

VIOLATION: PATIENT RIGHTS: ADVANCED DIRECTIVES

Tag No:
A0132

****NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY****

Based on observation, interview and record review the facility failed to:

1. Attempt to determine whether 2 of 2 patients with full guardians (#2 and #7) had advance directives, per policy.
2. Inform all patients of policies (titled "Medical Futility" and "Resuscitation Not Indicated") which may limit patient rights to formulate advance directives and that their advance directives may not be honored if one physician determines that the patient is "medically futile."
3. Comply with the State of Michigan Public Health Code requirements for informing surrogate decision-makers of physician orders to limit medical treatment.

Findings include:

1. Attempt to determine whether 2 of 2 patients with full guardians (#2 and #7) had advance directives, per policy:

Facility Policy D104P, titled "Durable Power of Attorney for Health Care" states:

- 1.A."It shall be the responsibility of the Patient Services Department to inquire upon admission of all adults whether that individual has formulated an Advance Directive"
2. "If the individual is unable to answer for any reason, Patient Services personnel will inquire of the patient advocate/representative to obtain admitting information whether that individual knows if the patient has formulated an Advance Directive"

Interviews:

On 2/15/12 at 1150 hours, the Director of Risk Management and Patient Advocacy stated that all patients receive a Patient Folder upon admission. This folder contains a publication titled "The Durable Power of Attorney for Health Care" booklet that states:

(Hospital name) is required by law to ask all people [AGE] and older admitted to the hospital if they have a Durable Power of Attorney for Health Care."

On 2/15/12 at 1300 hours the Psychiatric Unit Director of Nursing (PU-DON) was asked to explain the procedure for following-up on whether a patient has an advance directive if they have a guardian and advance directive information was not clarified prior to admission to the psychiatric unit. The PU-DON stated that it is not routine to follow-up on this and that she wasn't aware of a policy or procedure for obtaining information on advance directives if it isn't done prior to admission to the unit.

Patient Findings:

Patient #2's clinical record, reviewed on 2/16/12 at approximately 1230 hours, contained documentation that the patient had a full guardian. No documentation of attempts to obtain information from the guardian on whether the patient had advance directives was noted. The "Inpatient Information Verification Form" dated 2/13/12, for verifying this information was left blank other than a notation by nurse #2 stating who had guardianship and that the patient had refused to sign. On another admission form, the "Geropsych Patient Statement", also dated 2/13/12, the patient's level of understanding patient rights was rated by Nurse #2 as: "(patient) not understanding" The findings were verified by the Unit Manager.

Patient #7's clinical record, reviewed on 2/16/12 at approximately 1235 hours, contained documentation identifying the patient having a full guardian. No documentation of attempts to obtain information from the guardian on whether the patient had advance directives was noted. The "Inpatient Information Verification Form" dated 2/11/12, for verifying this information was left blank other than a notation by an unidentifiable staff member noting that the patient "refused" to sign this form and other unit admission forms. These findings were verified by the Unit Manager.

2. Inform all patients of policies (titled "Medical Futility" and "Resuscitation Not Indicated") which may limit patient rights to formulate advance directives and have hospital staff comply with them and ensure policies that comply with the State of Michigan Public Health Code.

The facility's "Patient Folder," provided to all patients upon admission, contains a pamphlet titled, "The (Hospital name) Commitment to the Rights of Patient." It states that patients are entitled to: "Formulate advance directives and to have hospital staff who provide care in the hospital comply with them and not condition care or discriminate against you based on whether or not you have an advance directive." There is nothing in the "Patient Folder" with information on facility policies that may limit a patient's right to have their advance directive honored.

M.C.L.A. 333.5655 Recommended medical treatment for advanced illness; duty of physician to inform orally and in writing; requirements.

Sec. 5655.

In addition to the requirements of section 5654, a physician who has diagnosed a patient as having a reduced life expectancy due to an advanced illness and is recommending medical treatment for the patient shall, both orally and in writing, inform the patient, the patient's patient surrogate, or, if the patient has designated a patient advocate

and is unable to participate in medical treatment decisions, the patient advocate, of all of the following:

(b) That the patient, or the patient's patient surrogate or patient advocate, acting on behalf of the patient, has the right to make an informed decision regarding receiving, continuing, discontinuing, and refusing medical treatment for the patient's reduced life expectancy due to advanced illness.

Facility Policy M137 P, titled "Medical Futility," under Procedure, states:

A. The medical determination that a particular treatment is futile should be made by the responsible physician...

B. After the Decision that a Specific Treatment is Medically Futile and should be Withdrawn or Withheld

1. The physicians must communicate the decision with the patient, family, and/or surrogate decision makers.

4. The physician or other health care giver present during the discussion will document in the chart the extent and result (agreement, disagreement, or need for further time) of this discussion.

Facility policy R117P, titled "Resuscitation Not Indicated," states:

"It is the policy of (Hospital name) to respect the patients or patient representative/patient advocate's informed choice for resuscitation if it is a medically appropriate option; however, the physician is not obligated to offer cardiopulmonary resuscitation (CPR) and advanced cardiac life support (ACLS) therapies if these are determined to be medically inappropriate."

Procedure:

A. Determine that CPR/ACLS (resuscitation) therapies are not medically appropriate.

1. Physician makes decision based upon evidence of quantitative futility such as:

a. Terminal cardiac arrest despite optimal treatment for progressive shock states.

b. Patient is in the late stages of an incurable or terminal disease in which resuscitation will serve only to prolong the dying process.

c. Patient's vital functions continue to deteriorate despite maximal therapies.

d. Widely accepted scientific data indicates no likelihood of survival.

B. Communicate medical recommendation to patient or patient representative/patient advocate and document the communication in the medical record.

3. Physician writes order to reflect plan of care on the Code Status Designation/ Physician Order form.

C. Resolve disagreement regarding plan of care (if applicable).

1. If the patient or patient representative/patient advocate disagrees with the plan of care a referral should be made to the Ethics Committee.

Interview:

On 12/15/12 and 12/16/12 at approximately 1500 hours, the Director of Risk Management and Patient Advocacy (Dir. RMPA) were interviewed regarding the above facility policies. The Dir. RMPA verified that there is no information in the "Patient Folder" informing patients of the above policies ("Medical Futility" and "Resuscitation Not Indicated") which may limit their rights to formulate advance directives and have them honored by the facility. The Dir. RMPA also verified that patients/surrogate decision-makers are not provided with written information on facility policies when a physician determines medical futility and writes an order for No CPR.

3. Based on interview and record review, the facility failed to comply with Michigan State law for 1 of 1 patients (#3) when making advance directive decisions for a patient with reduced life expectancy by failing to provide written information of medical treatment recommendations and decision-making rights to patient #1's surrogate decision-maker. Findings include:

M.C.L.A. 333.5655 Recommended medical treatment for advanced illness; duty of physician to inform orally and in writing; requirements.

Sec. 5655.

In addition to the requirements of section 5654, a physician who has diagnosed a patient as having a reduced life expectancy due to an advanced illness and is recommending medical treatment for the patient shall, both orally and in writing, inform the patient, the patient's patient surrogate, or, if the patient has designated a patient advocate and is unable to participate in medical treatment decisions, the patient advocate, of all of the following:

(b) That the patient, or the patient's patient surrogate or patient advocate, acting on behalf of the patient, has the right to make an informed decision regarding receiving, continuing, discontinuing, and refusing medical treatment for the patient's reduced life expectancy due to advanced illness.

(c) That the patient, or the patient's patient surrogate or patient advocate, acting on behalf of the patient, may choose palliative care treatment including, but not limited to, hospice care and pain management.

(d) That the patient or the patient's surrogate or patient advocate acting on behalf of the patient may choose adequate and appropriate pain and symptom management as a basic and essential element of medical treatment.

M.C.L.A. 333.5657 Availability of form to patient, patient surrogate, or patient advocate; compliance with MCL 333.5656; placement of signed form in patient's medical record; signed form as bar to civil or administrative action. Sec. 5657.

(1) If a physician gives a copy of the standardized, written summary developed and published before July 1, 2002 or a copy of the updated standardized, written summary made available under section 5656 to a patient with reduced life expectancy due to advanced illness, to the patient's patient surrogate, or to the patient advocate, the physician is in full compliance with the requirements of section 5655.

(2) A physician may make available to a patient with reduced life expectancy due to advanced illness, to the patient's patient surrogate, or to the patient advocate a form indicating that the patient, patient surrogate, or patient advocate has been given a copy of the standardized, written summary developed and published under section 5656 before July 1, 2002 or a copy of the updated standardized, written summary developed and published under section 5656 on or after July 1, 2002 and received the oral information required under section 5654. If a physician makes such a form available to a patient, to the patient's patient surrogate, or to the patient advocate, the physician shall request that the patient, patient's patient surrogate, or patient advocate sign the form and shall place a copy of the signed form in the patient's medical record.

Patient Findings:

On 2/16/12, from 0900-1400 hours, review of patient #3's clinical record revealed the following Code Status Designation /Physician Order forms:

a. A form dated 11/23/11, was signed by physician #1, indicating that the patient was not to receive CPR, a breathing tube with use of ventilator or cardioversion. A Palliative Care consult was ordered. The physician signed a certification stating that he/she had discussed the above code status and medical treatment options with the patient's legal representative who was in agreement. The surrogate did not sign the patient acknowledgement portion of the form, verifying agreement. There was no documentation indicating that the patient's surrogate received the above information in writing or was offered the opportunity to sign the form or informed in writing of decision-making rights.

b. A form dated 11/25/11, was signed by physician #2, indicating that the patient was not to receive CPR or other life sustaining measures and a Hospice was ordered. Physician #2 signed a certification that he had discussed the above (code status and limited medical treatment options) with the patient's legal representative and verifying

agreement. The surrogate did not sign the patient acknowledgement portion of the form. There was no documentation indicating that the patient's surrogate received the above information in writing or was given the opportunity to sign the form or informed in writing of surrogate decision-making rights.

c. The above findings (regarding patient #3) were verified by the Psychiatric Unit Manager on 2/16/12 at approximately 1400 hours.

Interview:

On 2/16/12 at approximately 1500 hours, the Dir. RMPA stated that it is not facility policy or procedure to provide copies of the "Code Status Designation/Physician Order" or any document indicating the patient's code status and limited medical treatment orders to the patient or surrogate decision-maker when the physician orders changes in Code status and limitations in medical treatment.

VIOLATION: MAINTENANCE OF PHYSICAL PLANT

Tag No:
A0701

Based on observation and interviews, the facility failed to provide a sanitary environment on 2 of 2 units observed, the Psychiatric and Intensive Care Units resulting in increased risk of infection. Findings include:

Observation and Interviews:

On 2/15/12 from 1015-1045 hours the Psychiatric Unit was observed. The following soiled or unsanitary conditions were noted:

- In the patient lounge, 3 wheel chairs with dusty, soiled wheels were noted. Two had white substances on the arm rests and one had a red substance on one arm rest. Two chairs had a dried brown substances on the seats. The floor was soiled with brown and white streaks and dust was noted.
- Room 405, 1 chair soiled with a white substances and one chair with dust on the seat and sides and a soiled floor near the doorway.
- A pink chair in the hallway between rooms 406 and 407 was observed to have dirty areas in the corners of the seat cushion.
- Room 404- a brown substance was observed on the tile near the floor, that runs along the walls.
- Group Therapy Room- 4 damaged, soiled chairs were noted. Also, damage to the wall board was noted.
- Restraint/Seclusion Room- A brown substance was noted on one wall. The floor was soiled with a brown substance.
- Medication room- floor was soiled and poles for IV's and Blood Pressure equipment were soiled and dusty.

The above findings were verified by the Psychiatric Unit's Manager. The Unit Manager was unable to identify which pieces of equipment had been cleaned or provide a policy for ensuring that patient furniture and equipment is cleaned between patients.

On 2/16/12 at approximately 1015 hours, during a tour of the ICU (Intensive Care Unit) the following soiled or unsanitary conditions were noted:

- Rooms 154, 159 and 165- bathroom floors soiled with brown substances.
- Room 158- corners dusty, bathroom floor corners soiled with a brown substance and wall tile running next to the floor soiled with a brown substance.
- Clean Utility- floor dusty in corners.
- CCU East Nursing Station- Patient medication refrigerator had a layer of dust along the lower portion of the door.

The above findings were verified by the ICU's Unit Manager.