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Northwest Regional Human Rights Authority
Report of Findings
Case #21-080-9014
UW Health/SwedishAmerican Hospital– Rockford, IL

Introduction

The Human Rights Authority (HRA) opened an investigation into potential rights violations at UW Health/SwedishAmerican Hospital in Rockford. **The complaints are that the hospital failed to consult a guardian regarding treatment services and admission and failed to provide notice of admission and rights to a guardian.** Substantiated findings would violate protections under the Hospital Licensing Requirements (77 Ill. Admin. Code 250) and the Mental Health and Developmental Disabilities Code (405 ILCS 5).

UW Health/SwedishAmerican's Emergency Department (ED) sees about 73,324 patients each year and is a Level II trauma center. The hospital has a special needs unit (SNU) within the hospital's ED. Currently UW Health/SwedishAmerican is the only hospital that offers inpatient mental health services in the city limits. The hospital's Assessment and Referral (A/R) team is made up of counselors that are available for screening the mental health needs of patients on a twenty-four-hour basis. The hospital has an inpatient psychiatric program, referred to as the Center for Mental Health (CFMH), which has capacity for 46 patients (adults and children). The HRA discussed the case with representatives from the CFMH, ED personnel and administrators. Relevant policies were reviewed as was the patient's record with authorization.

Complaint Summary

Per the complaint, the patient was admitted to the hospital improperly by not notifying and or confirming with the guardian and services were provided without adhering to treatment requests from the listed guardian on file.

Record Review
ED Record Review

The patient was brought into the ED after requesting assistance via local law enforcement on March 23, 2021, via a signed involuntary admission petition at 4:21pm. Once the patient was brought back to the SNU at 4:40pm, the ED Nurse reached out to the guardian and explained why the patient was in the hospital, and per the nursing note, the guardian "gave verbal consent for treatment to the RN and the A&R counselor". The Physician Assistant completed an assessment on the patient and suggested the following recommendation, "hospitalization for further evaluation" at 5:02pm after consulting with the ED Physician. Through the consultation

with the ED physician, the follow-up plan was made: *"is recommended for further hospitalization, shared impression, prognosis and plan of continued care with patient who was agreeable, patient stated full understanding and denied further questions when asked, patient will be hospitalized in fair condition"*. The patient began completing an evaluation with the A&R counselor at 5:27pm. During the evaluation it was noted that the patient reported suicidal ideations and stated, " had one plan all day, including to run into traffic, slash throat , or jump off a bridge" In reviewing the nursing note at 5:40pm, there is a notation which states that the patient has a guardian and identifies who the guardian is. Per the nursing notes the A/R counselor consulted with the on-call psychiatrist and physician assistant to determine the best course of action, in which the disposition reached was "engage the patient in individual group services on an inpatient basis". The nursing note stated, "the patient was explained necessary paperwork and signed inpatient forms; patient was provided with copies of the necessary paperwork at this time", which was at 5:50pm as documented by the A&R Counselor. After being in the ED for a few hours, the guardian called back at 6:10pm and the ED Nurse "discussed the labs, potential plan to admit to CFMH and patient's allergies" per the nursing notes. After this interaction, it was noted that the guardian then called the ED operator "irate and was in contact with the ED nursing supervisor". The patient's belongings were secured in the SNU closet, and a request was made for hypoallergenic linen and gown around 6:37pm. A message was left for the charge nurse and nursing supervisor regarding the guardian's concerns at 6:58pm.

A voluntary admission application signed by the patient was accepted, which stated, " I designate the following person(s) to be notified of admission and whenever my rights are restricted", which listed the guardian and was also signed by the A&R counselor at 9:00 pm. The A&R counselor also signed the application stating the following statements were true regarding the patient based on their observation: *" that the above person has been examined and is considered clinically suitable for voluntary admission, that the individual has the capacity to consent to voluntary admission, explained the rights on the back of the form and will give the person a copy of this form in English, will provide a copy of the form to anyone the person designates (parent, guardian, relative, attorney or friend who accompanied him/her and witnessed the signature and verified the individual's consent)"*. At 10:38pm, the ED Nurse/A/R Counselor spoke with the guardian, who angrily expressed "not being notified of the treatment being provided to the patient and all decisions should come from the guardian". It was explained that the patient opted for inpatient treatment through a voluntary admission application and was "agreeable" to the plan. It was noted that the guardian expressed concern that the "patient's medication will be changed without permission." The guardian was provided with the contact information of the facility director to voice concerns and issues, after attempting to explain guardianship and how the facility proceeds. Later in the night, the A/R counselor received a call from the guardian at 11:21pm, who expressed concerns that "the hospital has not been honest, will make medication changes without notification and tricked the patient to complete the voluntary admission application." There was discussion with the guardian regarding treatment location preference for the patient to remain at the hospital or transfer to a facility in Chicago and the guardian stated "no" to a transfer. The counselor also followed up with the guardian regarding the patient's admission being inpatient and the response was again "no".

CFMH Record Review

The patient arrived to the CFMH unit on March 24, 2021, at 12:14am and shortly after arrival, the unit nurse spoke with the guardian at 12:51am. During this discussion, the unit nurse and guardian reviewed the patient's medication administration record and compared it to the patient's list of medication at home. The guardian expressed concerns that certain medications would not be taken, and the nurse explained that the unit psychiatrist would have to verify psychiatric medication and the hospitalist would verify nonpsychotic medications before the patient could receive anything and the guardian agreed. The patient signed the psychotropic medication consent forms for all prescribed psychotropic medications in the presence of the psychiatrist. The second day in the hospital, the patient met with the psychiatrist at 8:39am, who noted in the nursing notes that the patient "wanted to stay, signed in voluntary, gave verbal consent for treatment understands the risks and benefits of proposed treatment plan and has the ability to participate in treatment". There is no statement or mention about the patient's capacity to make a reasoned decision about the mediation. The unit psychiatrist had a conversation with the guardian, after explaining that previously prescribed medications would be restarted and the guardian wanted particular medications restarted, as ordered by outsider provider.

Later that afternoon, per the nursing notes, the patient met with the unit therapist for their first session at 3:28pm and developed a treatment plan, which included medication monitoring and attending groups while on the unit. On the third day of admission, the patient expressed a desire to speak with unit psychiatrist to complete a discharge request while meeting with the unit nurse. Around 11:24am, the patient met with the attending psychiatrist, and it was determined that any medication changes would occur with and through the outpatient provider. Later in the afternoon, while meeting with the unit therapist at 12:10pm, the patient expressed wanting to be discharged the next day. The unit therapist explained the request would be discussed with the guardian later in the day. Around 4:48pm on March 25, 2021, the unit therapist spoke with the guardian to discuss discharge options and it was agreed that discharge would occur the next day. During this discussion, the guardian put in a request that patient's noon medications be increased and a follow-up call from the unit psychiatrist before the discharge.

Per the discharge summary on March 26, 2021, the unit psychiatrist noted at 9:49am, the patient had no issues and was suitable for discharge; the psychiatrist explained to the guardian that any medication changes would be handled by the patient's outpatient provider. Per the notes, the guardian was not pleased with that response from the unit psychiatrist regarding not changing a medication dosage. The psychiatrist stated the goal was to get the patient acclimated on the current medications. The unit therapist reported in the closing note at 10:55am, that the guardian was "involved in the treatment and aftercare planning for the patient, contacted daily by therapist and attending psychiatrist and no medication adjustments were made." The patient confirmed an understanding and displayed agreement with the discharge plan and was released to family with follow-up instructions and scheduled appointments. Medical records were sent to outside providers at 1:12pm.

Legal Documents

The HRA received copies of the patient's legal documents. The first court order received which was dated June 4, 2010, was "Letters of Office - Guardian of Person", which stated the guardian "***is authorized to have under the direction of the court, the custody of the ward and to do all acts required of her by law";*** this is the order the hospital had on file. On March 25, 2021, a court order was entered that stated the following: **" *Guardian of person continues in full force and effect, the Guardian is to remain informed as to all medical care and shall be involved in all treatment discussions and decisions; further, all medical providers shall obtain the Guardian's consent to such treatments when required by Illinois statues and laws, should conflict arise between medical recommendations and consent by the Guardian, the issue shall be brought to the attention of the court and the guardian ad litem as soon as possible before action on such recommendations (absent emergent circumstances), all medical personnel providing services to, including but not limited to SwedishAmerican Hospital shall comply with this order fully, the court retains jurisdiction over this matter, should further orders be needed based on the medial needs and medical treatment of him".***

Medications

The patient signed the hospital issued psychotropic medication consent form, along with the ED physician and agreed to take prescribed psychotropic medication while in the hospital. In reviewing the session that the ED physician had with the patient regarding medication and treatment while admitted, it was noted that the "patient was given opportunity to ask questions, gave verbal consent for treatment and understands risk and benefits of proposed treatment plan and has the ability to participate in treatment". On the Psychotropic Medication Consent Form, there is a notation that sates, "whenever possible, please give a copy of this form and written medication information to patient, guardian and any designee". The nursing notes mention that the ED physician had a conversation with the guardian, resumed the patient's previous medications (which were previously confirmed with the nursing staff) and stated, "not changing any of the psych meds". The patient took a majority of medications orally or topically when offered and at other times declined or refused dosages, which was documented in the medication administration record.

Interviews

Director of Emergency Services

The Director stated in reviewing the nursing notes, there is documentation that the guardian called and spoke with the A/R Counselor while the patient was in the ED and agreed to having the patient admitted. Also, the Director stated there is documentation that shows the guardian went over the patient's labs with nursing personnel. The Director stated that the patient is known to the ED and receives outpatient services on a monthly basis.

Assessment/Referral Counselor

The HRA inquired if there was any contact with the guardian and per the A/R Nurse, the guardian requested that the patient receive hyper allergenic items while in the hospital. Also, the A/R stated there was conversation with the guardian regarding the patient's admission, which was agreed upon, and the guardian did not want the patient transferred.

Behavioral Therapist

Per the Behavioral Therapist, the patient repeatedly disclosed some family issues in the sessions. The HRA inquired if the issues rose to the level of contacting other entities or agencies out of concern and the therapist stated, "no." While on the unit, the patient made strides and improvements while attending various group settings. The therapist stated while in the ED , the guardian made a specific request for hyper-allergenic clothing and bedding and the hospital accommodated those requests. The therapist referred to the nursing notes and reiterated that the guardian was constantly updated and involved in the patient's care plan.

Director of Center for Mental Health (CFMH)

Per the Director of CFMH, the unit nursing staff tries to build relationships with listed guardians to ensure there is an open line of communication, and the patients receive the appropriate services and treatments. The Director stated there was initially some confusion on the particulars of the guardianship document that the hospital had on file and did apologize to the guardian about the misunderstanding (the hospital's interpretation). To eliminate guardianship misunderstandings in the future, the director explained that the hospital added a new feature to the patient's record. The new feature includes having the patient's guardianship paperwork at the front of their electronic health record and if there is an advanced directive on file, that line is highlighted in the record. The HRA inquired about what forms the hospital had on file for the patient, because the HRA had received copies of court orders from the guardian during the investigation. The Director stated receiving the updated court documents that were issued on March 25th and uploading them to the patient's record after the misunderstanding.

Findings

Complaint: The hospital failed to consult the guardian about admission and treatment.

Per the Mental Health and Developmental Disabilities Code, "Any person 16 or older, including a person adjudicated a person with a disability, may be admitted to a mental health facility as a voluntary recipient for treatment of a mental illness upon the filing of an application with the facility director of the facility if the facility director determines and documents in the recipient's medical record that the person (1) is clinically suitable for admission as a voluntary recipient and (2) has the capacity to consent to voluntary admission" (405ILCS 5/3-400). Based on the nursing notes, the patient signed a voluntary application, after assessment and discussion on what the need was, and the A/R counselor verified the patient's capacity to consent to the admission. Throughout the notes there were conversations with the guardian, who was notified of the patient's presence and admission, and at numerous times throughout the patient's stay gave

permission for treatment and confirmed the patient's medications and allergies over the telephone. The Mental Health and Developmental Disabilities Code states "If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated. 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" (405 ILCS 5/2-102(a-5).

The physician administering treatment and medication determined that the patient understood the risk and benefits, as well as being able to fully engage in the treatment plan. Also, the physician had phone conversations with the guardian and explained the treatment plan, continuation of the medications that the patient previously took and reiterated their effects. Per the Illinois Probate Act, " Every health care provider and other person (reliant) has the right to rely on any decision or direction made by the guardian, standby guardian, or short-term guardian that is not clearly contrary to the law, to the same extent and with the same effect as though the decision or direction had been made or given by the ward. Any person dealing with the guardian, standby guardian, or short-term guardian may presume in the absence of actual knowledge to the contrary that the acts of the guardian, standby guardian, or short-term guardian conform to the provisions of the law. A reliant shall not be protected if the reliant has actual knowledge that the guardian, standby guardian, or short-term guardian is not entitled to act or that any particular action or inaction is contrary to the provisions of the law (755 ILCS 5/11a-23(b))". From the time of arrival, the hospital personnel reached out, discussed, and received input (current medication listing, specific clothing, and bedding products) from the guardian regarding the patient's care and treatment. Although the hospital, according to the nursing notes, continually provided the guardian with updates and discussed treatment planning and discharge planning, there was no notation that the hospital provided the guardian with any written documents, specifically medication/drug information. **A rights violation is <u>substantiated</u>.**

<u>Recommendations</u>

1. UW Health/ SwedishAmerican personnel, should develop a guardian notification system within the patient's medical record across all units to ensure that the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) and Illinois Probate Act (755 ILCS 5/11a-23) requirements are met. This shall include the following: appropriate identification, notification, consultation, consents for treatment, treatment development, participation of identified guardians and providing written documentation to identified guardians.

2. Train all hospital personnel on the guardian notification system and provide proof of completion to the Northwest Human Rights Authority.

Suggestion

1. It would be beneficial for the hospital to develop a written policy regarding guardianship notification and treatment involvement and ensure staff are trained. The rationale is that all staff will be aware of the exact steps in involving the guardian in the treatment and services of the patient.

Complaint: Failure to provide notice of admission and rights to guardian.

Shortly after the patient arrived at the hospital, personnel reached out to the guardian to explain the reason why the patient was being hospitalized. The guardian was also designated to be notified on the voluntary application, which was accomplished as well. Per the nursing notes the guardian gave verbal consent for treatment to be provided, but there were no notations that the rights of recipients were provided (orally or written) to the guardian. The Mental Health Developmental and Disabilities Code states "**(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, and every recipient who is 12 years of age or older and the parent or guardian of a minor or person under guardianship 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 5-200). **A rights violation is substantiated.**

Recommendation

1. Hospital personnel must provide guardians with the copies of the recipients' rights and all prescribed drug information while the patient is hospitalized.

2. Follow the Mental Health Code, which states "the physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment" (405 ILCS 5/2-102a-5). UW Health/ SwedishAmerican prescribers must be retrained to adhere to documenting this in interaction in the patient's medical record and provide proof of completion to the NW HRA.

Overall Suggestions

1. The hospital has an electronic medical record system, in which an alert can be utilized for the following :
   i. Guardian notified of admission and contacted.
   ii. Guardians has been engaged in the treatment and discharge planning process.
   iii. Guardian has been provided copies of the recipient's rights and prescribed medication summary.

The rationale is that hospital staff will be reminded if the guardian has been notified or not and for some reason a misstep occurred, this would act as a friendly reminder for the personnel to follow-up immediately.

The HRA would like to thank the staff of UW Health/SwedishAmerican Hospital in Rockford, IL their cooperation with this investigation and would humbly request that a copy of updated policies and procedures be forwarded to the HRA.