FOR IMMEDIATE RELEASE

Northwest Regional Human Rights Authority
Report of Findings
Case #22-080-9003
UW Health/SwedishAmerican

Introduction

The Human Rights Authority (HRA) opened an investigation into potential rights violations regarding the care of a mental health patient at UW Health/SwedishAmerican in Rockford, Illinois. ***The complaints are that the patient's right to adequate and humane care in the least restrictive environment was ignored, the right to receive a copy of petition and records was disregarded and the right to a voluntary admit was not based on consent and capacity but by threat.*** Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4)

UW Health/SwedishAmerican is the only hospital that offers inpatient psychiatric services within the city limits, and services 12 counties within Northern Illinois and portions of Southern Wisconsin at two locations. The UW Health/SwedishAmerican Rockford Emergency Department (ED), services roughly 70,000 patients yearly and is a Level II facility. The hospital's ED has a special needs unit (SNU) which offers emergency mental health services. The hospital also has an inpatient psychiatric program, referred to as the Center for Mental Health (CFMH), which has the capacity of 42 licensed beds (adults and children) and services an average of 23 patients daily. The HRA discussed relevant policies with representatives from the ED, CFMH and Legal Counsel.

Complaint Summary

The complaint stated, while on the unit, the patient reportedly slept in the soothing room in which the temperature remained at 64 degrees, due to roommate issues and the unavailability of any other room. The patient asked to review a copy of their hospital chart, including the petition and was reportedly not permitted chart access while on the unit. Per the complaint, the patient felt intimidated by staff into signing a voluntary admission application rather than being admitted based on their consent and/or capacity

to consent. The patient stated the intimidation surrounded their admission which stemmed from being told to "sign the voluntary admission application or their personal rights would be lost".

Record Review

ED

While meeting with the attending nurse, the patient was asked what brought the patient to the ED. The patient provided the following statement, "Extreme agitation with a focus of hurting self or others if no help is received, write that down word for word", which led to the patient being placed on suicide precautions at 3:16pm. The patient was given an oral dosage of Ativan 1mg at 4:12pm. Per the medical records received, the patient and the Assessment and Referral (A/R) counselor met and signed the voluntary admission application at 5:00pm. The A/R counselor acknowledged that the patient had been examined , was clinically suitable, and had the capacity to consent to admission; a copy of the admission was provided and the rights of being a voluntary admittee was explained, per the signed voluntary application.

The A/R Counselor and patient began completing the SNU/Psychiatric assessment at 5:17pm, and while completing the assessment, the patient shared the following: "needs to be chemically sedated until taking his Celera again". Per the nursing note, the A/R counselor, on-call psychiatrist and attending physician consulted and agreed that the patient would "benefit form hospitalization and the patient was in agreement"; at 6:04pm, the patient was provided with copies of paperwork and no questions were asked. Shortly after this interaction, the attending physician completed an observation and a physical exam of the patient and recommended hospitalization, which was shared with the patient. Per the records, the attending physician discussed the recommendation with the patient who " was agreeable and stated a full understanding and denied further questions when asked."

CFMH Unit

The patient was accepted on the CFMH unit later that evening at 7:44pm, per the nursing note the patient provided the reason for being on the unit as personal issues, increased levels of anxiety and needing an appropriate medication schedule. After arriving on the unit, the patient shared with the staff having shoulder pain and was offered and decline Tylenol for its ineffectiveness but did accept dosages of Trazadone 25mg at 9:58pm and 11:01pm. The patient complained of not being able to sleep due to their roommate at 12:15am and staff directed patient to the soothing room, where they slept for 6.25 hours that night.

On the patient's first day at 6:29am, the patient requested and received medication for shoulder pain. During the morning assessment with the unit psychiatrist at 11:22am, the patient explained making the statement " I may hurt myself or someone else" yesterday and needed "to get access to medical attention" but not an actual suicide plan. Per the psychiatrist's assessment, "in my opinion the patient has the capacity to make this decision regarding treatment", in which the patient agreed to receive treatment by giving verbal consent, developed a discharge plan to be released within 1-2 days and was afforded the opportunity to ask questions as well. Later that afternoon, patient met with the unit therapist and while in session the patient shared current stressors (personal issues, shoulder pain and insomnia) and provided the following treatment goals ("medication monitoring, improve mood and increase coping skills") and also accepted outside therapy referrals to begin after discharge. During the therapeutic sessions with the psychiatrist and the therapist, the patient only shared an ongoing issue of insomnia and did not request copies of his records or ask questions, according to the documentation, but agreed to follow the developed treatment plan.

Per the nursing note, on the patient's second day on the unit, a meeting with the nurse **practitioner occurred**, whose assessment of patient revealed that the initial symptoms were improving and for the patient to follow the current treatment plan. The patient reported that the current pain medication regimen was not working and requested an increase, which was relayed to the physician on call and increased. On the morning of the patient's third day on the unit, while meeting with the unit nurse, the patient discussed dissatisfaction with the medicinal treatment being received for pain and declined all suggested alternatives that were provided (Ice, heat, etc.). The discussion transitioned to the benefits the patient could receive by utilizing the assigned room and hospital-issued bed, according to the nursing notes, and the patient chose to sleep on the floor in the hall. Per the nursing notes, it is documented during the evening shift, the patient would request medication to address the shoulder pain and would sleep at least 6 hours a night and did not bring up any other issues or concerns. At 2:42pm, the patient requested a discharge form, reviewed the form with a unit nurse and then declined to sign. While on the unit, the patient participated in various therapeutic group settings, individual sessions and medication monitoring, which included accepting and declining various medicines. The patient was discharged from the unit on the fourth day at 11:54am, with a copy of an agreed upon discharge plan, scheduled follow-up appointments, and information on community resources; all records are available digitally.

Policy and Procedural Review

The HRA conducted review of the hospital's **"Patient Rights and Responsibilities"** policy regarding patient access to medical records. Per the policy, the patient will "have access to your medical and billing records and challenge their accuracy and request copies of your medical record in a reasonable time at a reasonable cost". While reviewing the medical records, there was no indication that the patient requested copies of his medical records, but there are instances that copies were offered to the patient. The first instance was after the patient voluntarily agreed to an inpatient stay; the A/R counselor documented reviewing the documents and providing copies, but there were no questions asked. The second instance occurred during the discharge meeting; it was stated that the patient agreed with the discharge plan, left with all belongings and records were not sent out due to providers and patient having access to digital records. The hospital also has a free digital medical record system, that allows a person to access all their health information (appointment, providers, prescriptions and visits) at any time .

Interviews

Corporate Counsel

The HRA inquired about the patient receiving a dosage of psychotropic medication in the ED and a completed restriction of rights form was not present in the records. According to corporate counsel, per the hospital policy, when patients receive psychotropic medication , the procedure used should be documented in their record and could not speak on why it wasn't documented.

Director of Center for Mental Health

At the beginning of the site visit, the Director apologized for the absence of HRA requested staff members who were present during the patient's admission. There was discussion about the patient being on suicide precautions and it was mentioned that all patients who are seen in the SNU are placed on these precautions. Per the medical records received, there were two involuntary petitions completed and the HRA inquired whether this is normal procedure. The Director stated typically the involuntary petition is not restarted unless the initial is not available. Per the Director, when hospital staff are completing the voluntary admission application with patients, they use the terminology directly from the application to reduce confusion.

When discussing sleeping arrangements, the HRA brought up that the patient slept on the floor and how this is addressed. Per the Director, all rooms are double occupancy, and the hospital staff ensure that all patients are comfortable, and accommodations are made for any and all patients to meet their needs, as was done in this case for this patient.

Per the nursing notes, it was pointed out that the unit nurse continued to offer the patient their bed to sleep in and the patient declined daily. The Director also stated that the soothing room has been utilized when the unit is at capacity or differences/needs can't be worked out with roommates. The HRA was unable to delve into any discussion of roommate or temperature issues for this particular admission, due to specific staff not being available.

Clinical Program Manager

While on the unit, the Clinical Program Manager reiterated that this patient was seen daily by members of the therapeutic team (psychiatrist and therapist) who constantly gauged the patient's well-being and overall health (by adjusting medications, when the patient stated something wasn't working). Per the nursing notes, there were no requests from the patient to review their records at any time.

Assessment & Referral (A/R) Counselor

The HRA questioned if at any time was the patient denied access to their records, and per the A/R Counselor, the process of reading and going over the patient's rights is completed by the A/R Counselor. The A/R Counselor pointed out in this particular admission, per the nursing notes the A/R counselor explained the patient's rights and completed the voluntary admission application with the patient, who documented that there were no questions asked, indicated that the patient understood documents being signed and provided the patient with copies of their paperwork. While in the SNU, the patient's documents are kept with their belongings, which are locked up and once they arrive on the CFMH unit, all of the patient's belongings are locked in their respective cubicles.

Conclusion

Complaint: ***The patient's right to adequate and humane care in the least restrictive environment was ignored.***

Per the Mental Health and Developmental Disabilities Code's section on treatment planning, " the Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the

treatment being provided(405 ILCS 5/2-102a)." In the complaint summary the patient reported sleeping in a cold room; per the nursing notes, the staff attempted to redirect the patient to sleeping in the assigned bed numerous times and was declined by the patient each time. **A rights violation is not substantiated.** The hospital staff provided the patient with various alternatives regarding sleeping arrangements and allowed the patient to make the choice that worked best for him.

Complaint: ***The patient's right to right to receive a copy of petition and records was disregarded .***

Per the Mental Health and Developmental Disabilities Code, "Within 12 hours after his admission, the respondent shall be given a copy of the petition and a statement as provided in Section 3-206. Not later than 24 hours, excluding Saturdays, Sundays and holidays, after admission, a copy of the petition and statement shall be given or sent to the respondent's attorney and guardian, if any" (405 ILCS 5/3-609). In reviewing the nursing notes, during the intake and assessment session, there was discussion on the best treatment option for the patient and all parties agreed on a voluntary admission. The crisis counselor provided the following statement: "patient was explained necessary paperwork and signed inpatient forms, patient was provided copies of necessary paperwork and had no questions at the time", which occurred at 6:04pm. **A rights violation is not substantiated,** because the patient was admitted involuntarily but eventually signed a voluntary application which negated the need to provide a copy of the petition within 12hrs of admission as his status changed. Further, there is no documented request in the medical records that the patient requested to review or copy his record including the petition as allowed under the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4, 5) which requires service recipients, ages 12 and older, to have access to their records upon request.

Complaint: ***The patient's right to a voluntary admit was not based on consent and capacity and but threat.***

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. For purposes of consenting to voluntary admission, a person has the capacity to consent to voluntary admission if, in the professional judgment of the facility director

or his or her designee, (405 ILCS 5/3-400(a, b)". Based on the records received there was no evidence that the voluntary admission application was coerced upon the patient. Numerous times throughout the admission process, it was noted that the patient agreed with the going the voluntary route. Per the nursing notes, the admitting physician wrote the following: "patient was seen by crisis, and after they consulted with the psychiatrist , we are all in agreement that the patient would benefit from inpatient hospitalization, the patient is agreeable to this." It was noted during the patient's closing therapy session that the patient shared being happy that he was able to resume his psychiatric medication. **A rights violation is not substantiated.**

Overall Suggestion

The HRA offers the following suggestions:

1. The HRA would suggest UWHealth/SwedishAmerican, develop or update the "**Voluntary Admission in the ED Policy**" to include the following statement, *"staff are to comment in the medical record if the patient is clinically suitable, has the capacity to consent, signed the form and was provided a copy."* The rationale will ensure that pertinent details (time/date signed, reason why patient is not appropriate for an informal admission, and valid signatures of the patient and staff member) are noted. This is a safety measure for all parties involved which eliminates confusion if the form was explained and received by the patient.

2. UWHealth/SwedishAmerican review with staff the importance of accurate documentation in patient's medical records.

3. The HRA would suggest UWHealth/SwedishAmerican, personnel review the grievance/complaint process with patients during intake. The rationale is that patients will be informed of this service and if an issue arises while hospitalized, the patient can have it addressed immediately.

The HRA would like to thank the staff of UW Health/SwedishAmerican in Rockford, Illinois for their cooperation with this investigation.