FOR IMMEDIATE RELEASE

Northwest Regional Human Rights Authority
Report of Findings
Report 20-080-9026
SwedishAmerican Hospital

Introduction

The Human Rights Authority (HRA) opened an investigation into potential rights violations at SwedishAmerican Hospital in Rockford. The complaint is that a patient was not provided with adequate and humane care, rights were not appropriately rendered, and the patient did not receive a copy of the petition or medical records. 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).

A division of the University of Wisconsin Health system, SwedishAmerican's Emergency Department (ED) sees about 70,000 patients each year, some 14,000 of the patients seen are for mental health reasons/purposes and the hospital has a special needs unit (SNU) within the ED. The Assessment and Referral (A/R) team are staff members 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). 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

The allegations state that while in the ED there was no communication between patient and staff regarding what was occurring, and the patient was never provided a copy of the involuntary admission petition. The allegations also state that the patient asked staff if she could leave and smoke a cigarette; when the response was "no" the patient attempted to leave and was "taken down" by security personnel. The allegations also state the patient felt detained on the hospital's mental health unit, because she did not receive a copy of the involuntary petition and felt obligated to sign a voluntary admission application, when asked.

Record Review

ED Record Review

The patient was brought to the ED by concerned relatives at 4:14pm on February 19, 2020, due to exhibiting unusual behavior and the relatives discussed a sense of fear for their safety due to the behavior and actions exhibited by the patient. While in the examination room, the patient was not cooperative with providing background information once in the examination room. While in the ED, per the security incident reports received the patient had two separate encounters with the hospital security personnel. The first encounter occurred around 6:36pm; the patient came out of the room, inquired about seeing the attending doctor and wanted to leave. Security personnel tried to calm the patient down and redirected her to go back into the room, but the patient refused. Security personnel continued to help the patient by "grabbing her arm and walking her back in." Security remained on standby and the patient was using profanity and proceeded to walk towards the emergency exit. The patient again was redirected back to the room and ignored the command. The security officer "proceeded to grab by the coat arm right side" and walked her back to the patient's room. Once the patient was returned to the room, she was asked to change into a hospital gown and proceeded to raise the gown up and exposed herself to security.

After consultation with the Assessment & Referral Counselor (A/R), the attending physician and the on-call psychiatrist, it was determined that the patient would be involuntarily admitted to the Center for Mental Health Unit at 8:43pm. The first petition was completed at 8:58pm and by 9:38pm the patient was notified that there was not a bed available on the CFMH unit and she would remain in the SNU until there was availability. While waiting in the SNU room, the patient was provided with warm blankets, juice, and a nicotine patch. Later that night, per the security incident report at 1:18am, the patient came out the room requesting water, which led to the second encounter with security personnel. The patient was asked to return back into the room and was told that the nursing staff would come and address the request shortly. The security officer asked on more than one occasion for the patient to return to the room, which the patient ignored. The security officer spoke with the nursing staff who wanted the patient returned to the room. The patient was approached by the security officer, who "gained control of her upper right arm" and escorted her back to the room and closed the door. The patient remained in the room until transfer was made to the CFMH unit later in the day.

CFMH

In reviewing the nursing notes, the patient arrived on the CFMH unit at 2:42pm, and a copy of the involuntary petition, rights and responsibilities were provided to the patient by the A/R counselor. After the patient settled into the room, the first appointment on the unit was completed, which was a physical; the patient was deemed stable at 5:06pm. On the third day, during the first counseling session, according to the medical

record, the patient developed treatment goals with the assistance of the therapist and signed a voluntary admission application at 4:00pm on February 21, 2020.

During the morning shift on the fourth day, it was noted in the nursing notes, that the patient signed a five-day discharge request with a unit nurse who reminded the patient that weekends are not included in the day count of the discharge request. The patient continued to attend group sessions while on the unit. Per the nursing notes, the patient also persistently requested to be discharged during sessions with the unit psychiatrist, and it was determined from a "clinical perspective" that the patient was safe to discharge. The patient was discharged to family on February 26, 2020 at 1:03pm in agreement with the discharge plan.

Medications

During the patient's first inpatient psychiatric session that was noted in the nursing notes, verbal consent was given to the unit psychiatrist that the patient agreed to adhere to the treatment plan by participating in group sessions and medication monitoring. While on the unit, the medications that the patient took ranged from over the counter, psychotropic to smoking cessation.

Interviews

Director-Center for Mental Health

The HRA team brought up the issue of the patient not being allowed to smoke a cigarette at the hospital or in the parking lot, which allegedly led to an encounter with hospital security. The Director of CFMH stated the campus is smoke-free and this includes the hospital and the parking lots. This stance has been taken at all the affiliated hospital campuses and at the other two non-affiliated hospitals in the area.

CFMH Unit Nurse

The CFMH Unit Nurse pointed out that if a patient insisted on wanting to smoke a cigarette, the hospital would offer them a nicotine patch or candy to meet this need for them.

CFMH Nurse Manager

The HRA team pointed out that it is noted in the medical records that this patient signed a discharge request, which was honored, but there is no copy in the file, and inquired if this was an oversight. The CFMH Nurse Manager was not sure why the document was not included in the records. The Nurse Manger pointed out that the staff have been trained in proper discharge request procedures within the last year. The CFMH Nurse Manager concurred with the psychiatrist that initially the patient was very manic and then praised the team after being prepared for discharge.

Manager of Clinical Programming

While discussing the missing discharge request, the Manager of Clinical Programming reiterated that unit staff have completed discharge training, are fully aware of the procedures and the missing documentation might have been an oversight.

CFMH Attending Psychiatrist

Per the Attending Psychiatrist, this patient was very manic in her interactions with staff once she arrived on the unit. The therapeutic focus of the team was to try and get the patient stabilized. The HRA asked if there were any issues regarding the patient's medication preferences and compliancy. The psychiatrist stated that the patient provided verbal agreement to the medication and the treatment goals on the first day of admission, which was noted. Later, during a session, the patient advocated for the nicotine patch to be given at an earlier time frame than what was initially prescribed. The attending psychiatrist stated that due to the patient's advocacy, a time change for the patient to receive the nicotine patch was approved and adhered to by the nursing staff while on the unit.

Policy Review

"The Voluntary Inpatient Admission" policy states "Any person aged 16 or older may be admitted as a voluntary patient for treatment of mental illness upon the filing of an application with a psychiatrist, if deemed the person is clinically suitable for admission and has the capacity to consent." The patient completed the voluntary application during a clinical/therapeutic session with the assigned therapist during the third day of admission, per the application. Per the application for voluntary admission that was completed and signed by the unit therapist, the patient was "clinically suitable for voluntary admission".

The "**Informed Consent – Psychotropic Medications"** policy updated as of May 12, 2020 states, "the administration of emergency psychotropic medications in the emergency department with informed consent and when informed consent is not possible". The ED physician's job is to ensure the patient has been educated and have the capacity to give consent for the medication or to refuse the medication. The hospital developed a form that the patient signs that states understanding of the benefits/risks, purpose of the medication, and possible side effects by agreeing to either taking or refusing the prescribed medication. Based on the medications that were prescribed to the patient during her admission and the records received, the patient agreed to take Trazadone and Atarax by signing the forms.

The **"Discharge with Five-Day Request"** policy states, "After the patient gives his/her request, the facility must discharge the patient at the earliest appropriate time." Per the medical records received, there is written documentation that the patient requested and signed a discharge request with nursing staff over the weekend but there is not a physical copy of the discharge request in the patient's file.

The "**Patients' Rights and Responsibilities"** policy states "A patient is to be informed of the nature of their illness and treatment options, including potential risks, benefits, alternatives, costs, and to participate in those health care decisions." While reviewing the medical records, there is documentation that the patient discussed her treatment options and benefits with the psychiatrist on the first day on the unit and agreed to the terms provided.

Conclusion

Complaint: The patient was not provided with adequate and humane care.

Per the 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. 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" (405ILCS 5/2-102(a)). **A rights violation is not substantiated**. During a daily psychiatric session, the patient complained that she would like to have earlier access to the daily nicotine patch. This request was granted and when the patient asked at 4:00am the next day, the nursing staff honored and followed this documented change of medication administration timing. Although, in the initial complaint it was stated that while in the ED, the staff would not allow the patient to smoke, there was no evidence of an altercation occurring due to not be allowed to smoke and no notation that the patient inquired about smoking.

Complaint: The patient's rights were not appropriately rendered.

Per the Mental Health and Developmental Disabilities Code, at the start of services, individuals aged 12 and above will be told of their rights, verbally and orally, and within 12 hours of admission, they will be given a copy of their petition (405 ILCS 5/2-200). **A rights violation is not substantiated.** In reviewing the medical records received, **form (IL 462-2005) Petition for Involuntary Admission and the form (IL 462-2202M) Application for Voluntary Admission,** both have certifying statements that were signed and dated by hospital staff which indicate that the rights and responsibilities were explained to the patient. During this involuntary admission hospitalization process, the patient was informed that due to overcrowding in the CFMH unit there were no beds available, but a transfer would occur once there was availability. This action and documentation in the nursing notes demonstrates that the patient was informed along the way of what was occurring pertaining to the hospitalization.

Complaint: The patient was not given a copy of their petition or medical records timely.

Per the Mental Health and Developmental Disabilities Code, within 12 hours of admission patients must receive a copy of the petition (405ILCS 5/3-609). According to the medical records received, the petition was date and time stamped that the CFMH unit received a copy on February 20, 2021 at 2:43pm; in addition, patient rights and responsibilities were explained to the patient during the transition period from SNU to CFMH unit. Also, in reviewing the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4), patients aged 12 years and older are authorized to be provided a copy of their medical records when requested. **A rights violation is not substantiated**, based on the physician signature on the petition for involuntary admission form (**IL 462-2005)** which states that the respondent (patient) was provided with a copy of the form. There is nothing noted in the record that the patient requested her record, but there is a notation that upon discharge, the patient was provided with a discharge packet which included the medical records.

Overall Suggestion

The HRA offers the following suggestions:

1) Hospital personnel should ensure that when documented in the nursing notes; the signed copy of the **Request for Discharge** form **(IL 462-0019)** is included in the patient's medical records.

2) To adhere to hospital policy regarding informed consent for psychotropic medication, ensure that this form is completed by all patients who are prescribed medication and then include in their medical records.

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

RESPONSE

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