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Northwest Regional Human Rights Authority
Report of Findings
Case #21-080-9011
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, Illinois. **The complaints are that a patient's right to refuse medication and treatment was ignored and guardian notification was inadequate and disregarded.** Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Medical Patient Rights Act (410 ILCS 5/5).

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), and has capacity for 46 patients (adults and children). The HRA discussed the case with representatives from the CFMH, ED personnel and administrators. Relevant policies and the patient's record with authorization were reviewed.

Complaint Summary

Per the complaint, the patient was admitted to the ED and transferred to another hospital without notifying the guardian and forcibly given psychotropic medication.

Record Review

Emergency Department Review

The patient was brought to the emergency room by local law enforcement, after being found sitting in the middle of traffic at 5:57pm. The involuntary admission petition was completed at 6:02pm by law enforcement. While meeting with the Attending ED Physician, the patient reported having " suicidal thoughts" at 7:58pm and it was determined to continue with the involuntary admission. While meeting with the ED Nurse, the nursing note states " patient

anxious and upset about being in the ED, patient was offered, accepted and administered one time dosage of Ativan and Haldol" via verbal consent and the medication consent form was signed by two other nurses at 8:09pm. The Assessment and Referral Counselor (A/R Counselor) per the nursing note provided the following clinical perspective and observation " *patient is cooperative with assessment, answers questions appropriately but keeps eyes closed during assessment*". While completing the assessment, it was noted that the patient's legal status was listed as "guardianship" and further in the nursing note the name of the guardian is provided at 9:02pm. The Assessment and Referral (A&R) Counselor noted after conferring with the Attending ED Physician that the patient would be transferred to another facility due to no availability of beds. The Attending ED Physician by signing the first inpatient certificate at 9:15pm, confirmed that the patient's rights were reviewed and explained to the patient. There are no notes that indicate the guardian was contacted or attempted to be contacted during the patient's assessment nor while the patient waited to be transferred to another facility. The patient was accepted for a transfer to at an outside facility at 2:04am on the following day and was discharged and transported to the new facility at 7:16 a.m.

Medication Review

Per the nursing notes, the patient asked for medication while meeting with the Attending ED Physician briefly after arriving at the hospital. At 9:09pm, the patient was given 2mg of Ativan and 5mg of Haldol intramuscularly via the upper left arm. Per the hospital psychotropic medication consent the following statements are what the patient agrees to: "*I understand the benefits, risks and alternatives to the medicine; I have enough verbal or written information about the medicine; I understand the information given to me; I understand the information given to me; I intend to fully comply with it; I will immediately let the staff know and my doctor know about any side effects; I have had the choice to ask questions and get answers; I will ask any other questions as soon as I think of them; No guarantee has been given by anyone as to the results I may have; and I have been given the chance to agree or disagree*." In the medical records provided, there are copies of the hospital psychotropic medication consent form signed by two nurses which stated the patient gave verbal consent. There is no notation or mention of capacity determination of the patient .

Interviews

Assessment and Referral Counselor

The Assessment and Referral Counselor noted in the nursing notes, during their assessment that the patient is under guardianship, but stated that patient "gave verbal consent" for medication.

Manager of Emergency Services

Per the Manager, in July 2021 the hospital updated the intake computer program to list the guardian on the home page; it is highlighted to easily identify the guardian. Also, on every page of the record, if there is guardian, the guardian's name is highlighted to remind staff to reach out to the guardian for consents and notification.

Director of Emergency Services

During the site visit, the Director stated that the staff in the ED do not typically assume to move forward with consent when there is a guardian listed, the practice is to notify the guardian once this information has been identified, unless the need is emergent for the patient.

Director of Center for Mental Health (CFMH)

Per the Director, in this case the guardian should have been notified of the patient's admission and transfer to another facility. The identity of the guardian for the patient was known, as demonstrated in the records and previous uploaded advanced directive. The HRA inquired if the hospital has a transfer policy to inform the receiving hospital if there is a guardian associated with the case. The Director stated "the hospital does not have a policy, but if the hospital has the information, it would be in the patient's medical records." The HRA followed up with the Director on the implementation of the computer programming regarding notification of a patient having a guardian listed. In January 2022, the Director provided the following information, " guardianship paperwork is on the patient's story board on the front of the electronic record, the line is highlighted, if there is an advanced directive (AD) and if a transfer occurs the AD is forwarded to the next facility".

Policy Review

The **"Informed Consent – Psychotropic Medication" Policy,** points out the role of the ED Physician is " to determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment". The hospital-issued **psychotropic medication consent form (SHMH-0202)** has nine bullet points of agreement to consent to the medication that is eventually signed by the patient or the guardian and has a back side which the hospital psychiatrist completes and states the patient has the capacity to "make a reasoned decision regarding their treatment."

"The Advanced Directive" policy states that the hospital is to "ensure patient advance directives are followed based on the practice outlined in this policy". The medical records show that the patient had a guardian listed and this is noted more than once in the nursing notes. The hospital personnel have reported that this policy was updated in July 2021, and that guardian information is highlighted throughout the patient's record. This was done as reminder to staff to make sure contact with the guardian is made.

Findings

Complaint: The patient's right to refuse medication and treatment was ignored.

Per the Mental Health and Developmental Disabilities Code, "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" (405 ILCS 5/2-107). Although, it is noted in the medical record that the patient requested and was agreeable to the dosages of psychotropic medication received , there was never an indication that the patient had the capacity to make the request or give verbal consent. Per the Mental Health and Developmental Disabilities Code, "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" (405 ILCS 5/2-102(a)). **A rights violation is substantiated.**

Recommendations

1. Hospital personnel must ensure that the hospital-issued "**Psychotropic medication consent form**" page 2 is always completed by the physician ,which documents whether or not the patient has the capacity to "make a reasoned decision regarding their treatment." This will ensure that the physician's written determination of consent capacity is completed as required by the Code.

Suggestion

1. Ensure that the hospital-issued "**Psychotropic medication consent form**" is revised and updated to document if a patient gives verbal consent for medication and that the appropriate steps are taken by hospital staff when verbal consent is provided. The updated form will provide a check and balance for all scenarios when psychotropic medication is given and if the patient provides consent, provides verbal consent, or refuses medication.

Complaint: Guardian notification was inadequate and disregarded.

Per the Mental Health and Developmental Disabilities Code, "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" (405 ILCS 5/2-107). Per the Mental Health and Developmental

Disabilities Code "…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)).

Per the Medical Patient's Rights Act states "a) Each patient admitted to a hospital, and the guardian or authorized representative or parent of a minor patient, shall be given a written statement of all the rights enumerated in this Act, or a similar statement of patients' rights required of the hospital by the Joint Commission on Accreditation of Healthcare Organizations or a similar accrediting organization. The statement shall be given at the time of admission or as soon thereafter as the condition of the patient permits, (b) If a patient is unable to read the written statement, a hospital shall make a reasonable effort to provide" (410 ILCS 50/5 (a-b). While the patient was being assessed, it was noted in the nursing notes that there was a guardian associated with this patient. During the site visit, it was noted by hospital administrators, that the guardian should have been notified of the patient's admission and transfer. **A rights violation is substantiated.** The hospital has already taken precautions to ensure that any admission of a patient that has a guardian listed results in immediate guardian notification. The hospital has adopted the procedure of ensuring the guardian section is highlighted on the home page of the patient record to remind the staff to contact the guardian, effective July 2021, via the updated policy.

Suggestion

1. Ensure that hospital personnel document in the nursing notes if and when the guardian or designated Power of Attorney agent has been contacted. This will show that the hospital made reasonable efforts to inform, and/or get consent from, the guardian regarding the patient's current medical needs and plan of treatment.

The HRA would like to thank the staff of UW Health/SwedishAmerican Hospital in Rockford, IL 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.