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HUMAN RIGHTS AUTHORITY - NORTHWEST REGION

REPORT 08-080-9011
SWEDISHAMERICAN HOSPITAL

Case Summary: Violations were found regarding the failure to provide the recipient a copy of her records free of charge. The Authority's record on the case is recorded below; the facility's response is not part of the public record.

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation of possible rights violations in the treatment of a mental health recipient within the emergency and the psychiatric departments at SwedishAmerican Hospital. Complaints alleged that the hospital:

1. Did not have cause and authority to detain, restrain and treat a recipient.
2. Used excessive force in restraining the recipient.
3. Did not provide medical treatment for resulting injuries.
4. Did not inform the recipient of her rights.
5. Did not provide the recipient her records until after multiple requests and charged an unreasonable fee.

Substantiated findings would violate rights protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110).

Located in Rockford, the facility has an emergency department with a small special needs area where counselors from the assessment and referral division can evaluate a patient's mental health needs. The Center for Mental Health provides inpatient care at the hospital and has 20 beds on the adult side.

Representatives from administration and the departments involved were interviewed. Hospital policies were reviewed as were relevant sections of an adult recipient's record upon written authorization.

To summarize the complaints, a hospital crisis worker reportedly badgered the recipient to sign a voluntary admission application in the emergency room without explaining the application's purposes or legal consequences and eventually had her admitted involuntarily based on misinterpreted and non-factual information. At some point the recipient was trying to move toward a wheelchair when a security guard allegedly twisted her arm behind her back and yelled

at her to sit down; he threw her to the ground, banged her face against the floor and slid her across the room before a second guard intervened to help her, saying to his partner that he had gone too far. A stretcher was brought in the room and a third guard joined in to apply restraints. The restraining was said to be done over-aggressively and that after the recipient spat out a chipped tooth, the first guard hit her across the face with his left forearm forcing her head sideways into the mat causing severe neck pain. The allegations further suggest that the recipient was given an injection and was taken to the psychiatric unit where her injuries were left untreated. The complaint concluded by stating that the recipient was provided a copy of her medical record only after making several requests and was charged an unreasonable fee.

FINDINGS

According to the record, the recipient arrived at the emergency department by ambulance just after 2 p.m. on 11/07/06. At about 2:30 p.m. a triage nurse wrote that the recipient was there for depression and thoughts of suicide because of chronic breast pain; she was teary-eyed and unwilling to share her medical history. The nurse completed a petition for involuntary admission immediately and quoted the recipient as saying if no one would help her breast pain she would cut them open, take a handful of pills and walk into Lake Michigan. The nurse completed the petition thoroughly and signed it in affirmation that the statements were true. She entered in a corresponding note that the recipient had settled in her room in the meantime and that she was aware of her rights and responsibilities.

An assessment and referral counselor visited the recipient at 3:45 p.m. and wrote that she reported having chronic fatigue, a decrease in appetite, minimal sleep, that she was not taking her medications and felt hopeless. The counselor's report that was dictated later stated that the recipient was very unpredictable; she said she was not seriously suicidal although she had previously told a physician and a nurse that she was. The report went on to state that she refused to sign a voluntary admission application so the involuntary was enacted.

Patient notes entered by the attending nurse at about 4:30 p.m. stated that the recipient made a suicidal statement to him and that she was hostile, irrational, grandiose, unpredictable and unable to contract for safety. Close observation was maintained as security stood by.

The physician completed a certificate for emergency admission at 5:05 p.m. and declared by signature that he explained the purpose of his examination to the recipient beforehand. He stated on the form that he believed she was a danger to herself, that she said she would walk into Lake Michigan and not come out and that she also had thoughts about overdosing. His report that was dictated about twenty minutes later repeated these suicidal statements. It indicated that he talked with the recipient in depth and that she said she was uncertain about what she meant and felt unsafe going home.

The nurse's entries from 5:45 on stated that the recipient refused offers to take Ativan and pain medications. She was described as being combative soon after, striking out at him, another nurse and security guards. The physician was alerted to the situation, and the recipient was given an Ativan injection. Restraints were applied by 6:00 p.m. as she was unresponsive to redirections according to the order. Observations were recorded until the restraints were removed about twenty-four minutes later. There was no rights restriction notice for the restraints and injection within the chart.

Security guards documented their accounts of the incident in detail. The first guard, who

was alleged to be the aggressor, stated that he was called to the room at 5:50 where he found the counselor telling the recipient why she was being admitted. She continued to object, and he and the counselor sought out the physician who said she would need to be restrained if unwilling to go on her own. Per the guard's report, he and a second guard approached the recipient to escort her to a wheelchair when she began to swing and kick at them. They each held an arm, and she fell forward toward the bed. She kept moving back and forth on the floor to break away as they tried to hold her up. A third guard, the nurse and an emergency department tech helped get the recipient on the bed. She leaned forward and spat. He wrote that he moved her back down by the shoulder and placed his left hand on the right side of her face to keep her from spitting. The second guard's report stated that he had been on standby at the recipient's room since 2:30. Around 5:30 the counselor was talking to her about admission and soon after the struggle began. The same group of employees mentioned before were encouraging her to get in the wheelchair but she kept refusing. The two guards moved her toward the chair holding each arm when she started to swing and kick. She lost her balance and fell forward; they guided her to the floor and gained control while telling her to quit fighting. The others were able to help get her to the bed; she spat, and one of the guards held her head to the left and told her to quit as the restraints were applied. The third guard reported that he came into the area to find the first two guards holding the recipient's arms. She was saying they had no right to do this to her and she began to struggle. He described how they took her to the bed to be restrained, how she sat up and spat, and how the first guard placed his hand on her face and held her head to the side. A fourth guard's report stated that he came on the scene after the restraints were on. He saw her head being held to the side as she kept saying, "You're choking me", to which the guard holding her head replied, "You're still talking so I'm not choking you." He and another guard, along with the counselor and the physician, transferred the recipient to the psychiatric unit where the restraints were removed immediately since she had calmed down. He then quoted her as saying she was not usually this way, but the first guard reminded her of someone from an abusive relationship, that she had a flashback, and that was why she fought and spit.

The guard who allegedly harmed the recipient is no longer employed at the hospital so we were unable to verify his account personally. The second guard was interviewed about the incident and he said he remembered the events as they are documented. At no time did his partner get physically abusive with the recipient and he never told him he went too far. She was verbally strong toward him although he never touched her except to restrain. He said that after the recipient was informed about being admitted she was given opportunities to walk alone or to use the wheelchair. At some point she lost it and started kicking and swinging. The counselor also said that she saw nothing abusive or inappropriate from the guard, but she remembered the recipient yelling, calling him the "N" word. On justifying an involuntarily admission, the counselor said that the recipient was unpredictable and that she had made suicidal statements to various staff in the emergency department. She believed the recipient was in imminent danger and a high risk to let go. She discussed voluntary admission with her and covered particular rights information about it as she always does. Admission was ultimately refused, and she went to the psychiatric unit with her where the petition and rights information were shared. Her supervisor added that they also train emergency department staff about rights and how to advise them, as referenced in the nurse's documentation shortly after the recipient's arrival. Whenever someone is petitioned they go over information like why they are there, why they are not able to leave and what they may be facing.

The counselor noted on the petition that she gave the recipient a copy of it and shared

rights information once on the psychiatric unit. Admission assessments from a unit nurse showed that the recipient had bruises on her shoulder, knees and shins, and a cracked and swollen upper lip. Darvocet and a medical consultation were ordered that night. On the following day the recipient complained of an ache in her shoulder and soreness in her jaw and arm. A physician visited her in response to the medical consultation, and according to his report, he ordered Vicodin and Ultram, ointment for her lip and images for multiple left arm complaints following an apparent altercation with a security guard. Images taken that day of the left shoulder, the left humerus, the left forearm, and the left ribs found no abnormalities.

The attending psychiatrist's admission report from 11/08 stated that the recipient acknowledged her suicidal statements and that she was not stable for discharge. He completed a second certificate at 10:30 a.m. and signified that he explained her rights beforehand. He wrote on the form that the recipient was depressed, made suicidal statements and was not eating. He discharged her however on 11/09, stating in a summary that she displayed appropriate behavior, that she denied suicidal ideations and appeared stable.

Regarding the matter about record access and copying fees, the complaint was clarified after this review began to say that an abstract copy was eventually provided without charge after the hospital required their release authorization form to be filled out completely. Two letters of request from the recipient to the hospital were submitted in the clarification. The first was dated December 1, 2006, and it asked that the entire medical record be provided with prior notification if there was to be a charge. The second was dated December 19, 2006, and it repeated the request while disputing the need to complete the hospital's authorization form entirely. The record provided to us by the hospital for this review included a completed authorization form dated 10/17/07. A notation was added to the form directing that the recipient was to be told about copying costs and that she set a $30.00 limit. A second notation stated that the cost would be $87.20 for the entire record and that an abstract would be sent free of charge. It also stated that the full charge applied if the recipient still wanted the entire record.

A supervisor from the hospital's health information management office explained that an abstract copy does not include every document, like nursing/progress notes, petitions and certificates. She said that when the recipient completed the authorization form in October 2007 she was contacted about the final cost and agreed to take an abstract without charge. The abstract was sent on 10/23/07. She also said they were not aware that mental health records could be released free of charge to indigent recipients and that her office is making the adjustment.

CONCLUSION

Under the Mental Health Code, a person who is asserted to be subject to involuntary admission may be held in a facility whenever a petition that lists acts, behaviors, threats and symptoms of mental illness is completed and can be detained for evaluation on the petition alone up to twenty-four hours until a qualified examiner determines whether to execute a certificate based on clinical observations. A copy of the petition along with attached admittee rights information must be provided within twelve hours of admission (405 ILCS 5/3-208 and 5/3-600 et seq.). Restraints may be used only as a therapeutic means to prevent serious physical harm and not as punishment or as a convenience to staff (405 ILCS 5/2-108). Adult recipients must be given an opportunity to refuse medications and may not be given them if refused unless it is

necessary to prevent serious and imminent physical harm and no less restrictive alternative is available (405 ILCS 5/2-107). Notice of any restricted right under the Code, including the right to be free from restraints and unwanted medications, must be provided to the recipient and to anyone he or she chooses (405 ILCS 5/2-201). No recipient shall be subjected to abuse or neglect, which are defined as intentional physical or mental injury and the failure to provide adequate medical care resulting in physical or mental injury (405 ILCS 5/1-101.1, 5/1-117.1, and 5/2-112). All services must be adequate and humane (405 ILCS 5/2-102).

In this case the recipient was detained in the emergency department for evaluation and eventually admitted by authority of a completed petition and a certificate. Corroborative documentation by two nurses, a crisis counselor and a physician supported the need. The documentation and statements given during the interviews were also consistent in suggesting that the recipient became physically harmful and needed the restraints and injection after being encouraged to walk on her own or use a wheelchair and after being allowed to refuse the medications earlier. Although there is no doubt that she came away from the incident with bruises, abrasions and a swollen lip, we have no factual evidence to say that one of the guards was too rough or abusive with her; the injuries could have come from her struggle and resistance. Per the record and interview statements, rights and responsibilities information was shared with the recipient during her first hour in the emergency department and she was given a copy of the petition along with admittee rights information once on the psychiatric unit. A medical consultation was ordered her first night there, and medical attention was provided within twenty-four hours. A violation of the recipient's rights is <u>not substantiated</u>.

A missed step in the care provided by the emergency department was in not completing a restriction notice when the recipient was restrained and injected, which would have given her the opportunity to have someone notified of what was happening to her and is a <u>substantiated violation</u> of the Code's process. SwedishAmerican has policies and procedures in place for the involuntary detention, evaluation, restraint, treatment and care of the psychiatric patient. They have been developed and revised over the last few years to meet Code requirements and rights protections as these issues were raised, and they now include the need for restriction notices. In the time since this recipient was in the hospital, SwedishAmerican has also stepped up training and quality monitoring in the emergency department with 100% review for behavioral restraint use and has created a new psychiatric tech position to help facilitate individual and overall care as it is being provided. We offer no further recommendations.

The Confidentiality Act for mental health records states that a recipient who is 12 years of age or older shall be entitled, upon request, to inspect and copy his record. A reasonable fee may be charged for duplication, but when requested in writing by an indigent recipient, one copy of those records where disclosure is authorized by the Act must be provided without charge (740 ILCS 110/4).

The hospital's policy on patient record access states that all requests for copies must be made in writing on an authorization form. Action must be taken within thirty days of receipt, sixty days if maintained off site. The hospital may provide a summary in lieu of the entire record set if the requestor agrees (#HIPAA-04-0). According to the Privacy Rules, authorization forms must contain specific elements about who is authorized to release and to whom, for what purposes, types of records, validation time frames, and various notices about redisclosure (45 C.F.R. 164).

The recipient made written requests for copies of her medical record, but as explained in the complaint, there was some back and forth about filling out the hospital's authorization form

and duplication costs. According to this record the recipient agreed to fill out the hospital's form in October 2007, and an abstract was provided to her a few days later. The hospital is required to secure appropriate authorizations so it is understandable why the form is necessary. But we think she should have received her whole record free of charge, at least those sections of the record that fall under the Confidentiality Act, since she made the hospital aware of her inability to pay the total fee. A violation is substantiated.

RECOMMENDATIONS

1. Advise indigent recipients who present payment concerns about the option to submit requests for records without charge.
2. Revise policy to include the Confidentiality Act fee waiver.

COMMENTS

One guard's report quotes the recipient as saying repeatedly that she was choking while another guard was holding her head to the side. He was also quoted as responding with, "You're still talking so I'm not choking you." This is perhaps not the best response, and it might have been more appropriate and reasonable for him to lighten his grip instead without having to let her go. Even though the guard is no longer there, we suggest that this be reviewed with current security staff.

A treatment plan referenced on 11/09 that the recipient was upset about security handling her roughly upon admission and a nurse entered a progress note stating that she said they beat her up. As mentioned previously, she told a physician about an altercation with security as well. There is no indication that her complaints were addressed, either by the Center for Mental Health or the hospital's administration. A complaint of that nature, particularly when made with apparent bruising and a fat lip, should have triggered attention as a priority grievance.