FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 10-030-9021
Swedish Covenant Hospital

Case Summary: The HRA did not substantiate the complaint that the provider did not follow Code procedures when it disclosed private information from a recipient's record to an unauthorized party.

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Swedish Covenant Hospital in Chicago. It was alleged that the facility did not follow Code procedures when it disclosed private information from a recipient's clinical record to an unauthorized party. If substantiated, these allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5), the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110 et seq.) and hospital policies.

Swedish Covenant Hospital is an independent, nonprofit teaching hospital under the auspices of the Evangelical Covenant Church, and it incorporates a 25-bed Behavioral Health Unit.

To review these complaints, the HRA conducted a site visit and interviewed the Associate General Counsel, the Behavioral Health Nurse Manager, and the social worker on duty at the time of the alleged incident. Relevant program policies were reviewed as were the recipient's records upon written consent. The recipient is an adult.

COMPLAINT SUMMARY

The complaint alleges that on 2/05/10 when the recipient was in the process of Intake into the Behavioral Health Unit of the hospital, his landlord, who took him to the hospital and was with him at the time of his admission, received test results regarding the recipient that he did not authorize him to have.

FINDINGS

The clinical record indicates that the recipient was brought to Swedish Covenant Hospital on 2/05/10 by his sister and a friend/landlord/sponsor. The recipient's sister petitioned the recipient, which was completed at 2:00 p.m., and an accompanying certificate was then completed by an emergency department physician, also at 2:00 p.m. The physician's clinical observations include the following statement: "Patient presents as guarded with labile effect; he is pleasant at times but belligerent, defensive, and demanding of others. He exhibits poor short term memory, unable to recall details of events within the past 24 hours. Patient's family reports having witnessed similar behaviors for the past few days, adding that he has not been eating or sleeping, and he reports having racing thoughts. Patient presents as confused with fragmented speech. He is unable to care for himself." On the same day, at 6:40 p.m., the recipient completed an application for voluntary admission and was accepted for admission.

The record contains a Consent for Release of Verbal Information, To Receive Telephone Calls, and To Receive Visitors form. This form, dated 2/05/10, and signed by the recipient (also witnessed by nurse), indicates that he authorizes his friend/landlord, to receive verbal information regarding his presence in the facility, visits, telephone calls, and verbal information regarding treatment progress. This release is then crossed out from corner to corner.

Case Management/Social Service Progress Notes from 2/09/10 indicate that the recipient's landlord/sponsor is still receiving treatment information: "SW met with Pt to discuss the follow up plan for Pt. SW obtained a verbal permission for SW to communicate with pt.'s sister …[phone number given]. Obtained info needed. Also placed a call to …, pt.'s landlord and sponsor [phone number given] and left a number to call back." Later, on the same day, another entry in the Progress Notes states, "SW informed Pt. regarding the release and assisted Pt. with the changes that he made. Pt. has signed the request for Discharge. Also informed of Pt.'s landlord/sponsor that he will have a 30 day notice for his place when he returns. Pt. will have to go to inpt. rehab if pt. wants to come home to stay. …, landlord and sponsor feels frightened to have Pt. return without the return (sic). Pt. will not consider inpt. options and accept(sic) 30 day notice from landlord. Pt. also informed Pt.'s sister that Pt. may be able to stay with his sister if needed. SW will continue to communicate with Pt. and Pt.'s family members regarding the DCP. SW met with Pt. to discuss the follow up plan for Pt. SW obtained a verbal permission for SW to communicate with Pt.'s sister [name and phone number given]. Obtained info needed. Also placed a call to …, Pt.'s landlord and sponsor [number given] and left a message to call back." The record contains no information regarding the sharing of test result information.

The record contains a revised Consent for Release of Verbal Information, to Receive Telephone Calls, To Receive Visitors form. This form is dated 2/09/10 and is signed by the recipient (and witnessed by nurse). It indicates that the landlord has been removed from the visitation and phone call release but that he still remains on the release for verbal information regarding treatment.

Hospital representatives were interviewed regarding the complaint. They stated that the recipient signed the release for his landlord/sponsor to receive information about his treatment,

make phone calls, and visit the recipient when the recipient was admitted. However several days afterward, the landlord told the social worker that he was issuing a 30 day notice for the recipient to vacate his premises. The recipient became very upset about this development, since this meant he would have to leave his apartment, and he then crossed through the original release and he and his social worker wrote a new one, denying the landlord visitation and phone calls. The Consent for Release of Verbal Information was authorized by the recipient on both the original and revised documents.

STATUTORY BASIS

The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/5) states that all records and communications shall be confidential and shall not be disclosed without written release.

HOSPITAL POLICY

Swedish Covenant Hospital policy on Patient Confidentiality (08-630-11) states that patients' rights are protected in accordance with the Mental Health and Developmental Disabilities Confidentiality Act. As such, all communications with or about patients is confidential and information regarding patients is not given out without a written release of information form signed by the recipient. The only exception is made for an advocate of the Guardianship and Advocacy Commission or an attorney who has been retained by the recipient or the recipient's family or the court, and they are given information that the recipient is on the unit. All other information requires a release.

CONCLUSION

The recipient in this case signed a release for his landlord to receive information regarding his treatment on the day he was admitted to Swedish Covenant Hospital. He later revised this form but again authorized the hospital to share information regarding his treatment, although he had decided to terminate his visits and phone calls. The hospital followed the recipient's signed and witnessed directives as indicated on the release forms. The HRA does not substantiate the complaint that the facility did not follow Code procedures when it disclosed unreleased information from a recipient's clinical record to an unauthorized party.

SUGGESTION

1. Social Service Notes indicate that on 2/09/10 the social worker obtained verbal permission to talk with the recipient's sister. Although the record confirmed that written consent had previously been obtained, the HRA wants to stress that the Mental Health Code as well as hospital policy requires written consent for the release of information.