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HUMAN RIGHTS AUTHORITY - NORTHWEST REGION

REPORT 10-080-9019
ROCKFORD MEMORIAL HOSPITAL

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving complaints of potential rights violations in the care provided to a mental health patient at Rockford Memorial Hospital. The following allegations were made:

1. A physician verbally abused and ridiculed the patient.
2. A physician disregarded the patient's input about prescribed medications.
3. The hospital failed to return the patient's property.
4. The hospital failed to provide adequate care for the patient's headache pain.
5. The hospital failed to provide the patient with a required grievance process.

Substantiated findings would violate rights protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5), the Administrative Code for Hospital Licensing Requirements (77 Ill. Admin. Code 250) and Medicare/Medicaid hospital participation standards (42 C.F.R. 482).

A subsidiary of the Rockford Health System, Rockford Memorial has nearly four hundred beds, twelve of which make up the adult psychiatric unit. We visited the hospital where the issues were discussed with representatives from administration, legal and psychiatry. Related policies were reviewed as were sections of the patient's records from her last two admissions with written authorization.

COMPLAINT SUMMARY

The patient is a frequent visitor at Rockford Memorial. She has grown tired with how a particular psychiatrist treats her, constantly talking to her in abusive, rude and demeaning ways, often bringing her to tears. He reportedly raises his voice at her, snaps at her when she asks to speak with him and threatens to have her committed to a nursing home. It was also said that the same psychiatrist does not listen to what the patient has to say about prescribed medications,

insisting she take a particular one and persists until she agrees to take it. During her most recent hospitalization, the patient's husband brought her some clothes and a stuffed cat pillow. He was told to leave the items at the front desk, and the patient allegedly got everything except for the pillow which was not returned at discharge. During another recent admission, the patient was pregnant and experienced migraines and vomiting. The complaint states that she begged staff for something for her headache pain and was given nothing but Zofran for nausea. She was taken to a high risk pregnancy unit later that night, but according to the complaint that took too long. Finally, it was reported that the patient and her husband presented their concerns to administration but felt as though they were not provided with full explanations of why things happened as they did.

FINDINGS

The physician named in the first two complaints said that this patient has had numerous admits to the hospital and that he has treated her some of those times, but not recently. She often presents to the emergency department claiming to be suicidal. He described her as a woman of limited intelligence, saying she has an abusive husband and that they have encouraged her to stay away from him or to take a break if living with him was so intolerable. The physician said that at no time has he verbally abused or ridiculed her; he has never threatened to have her committed to a nursing home, which he has no authority to do in the first place. On the complaint of disregarding the patient's input about medications, he said he does not recall prescribing to the patient during her most recent hospitalizations. In previous ones, he did the same thing as with all patients in that he covered medication needs and specifics and gave the chance for any questions and concerns. He does not badger anyone into taking them and if this patient or any other refuses to take what is proposed he would discuss other options with them and ultimately offer something else.

Administrators told us that they spoke to the physician about these complaints as well and found no evidence of them happening. The patient never said to them however that she was verbally abused, only that the physician was rude to her. If abuse was suspected, the claim would go to a medical affairs officer and there would be an immediate resolution to any substantiated finding. Credible allegations are also shared with professional regulation and the public health departments.

We reviewed the patient's records and found no documented support for the first two complaints. There is no evidence within them that this physician treated the patient or had any interaction with her during her last two stays, a history and physical report reflecting that he last treated her well over a year before. All recent medication orders, progress and assessment entries and discharge plans were submitted by other physicians. Consent for psychotropic medication forms were signed by the patient, indicating her agreement in taking what was being prescribed.

Regarding the third issue, failing to return the patient's property, the hospital's counsel provided a written statement in which he stated there was no supportive documentation and that the item in question, a Morris the cat pillow, was not listed by the patient on her valuables log at

the time of admission. The statement went on to suggest that nevertheless, because one staff member remembered the patient's husband bringing in the pillow, the hospital would reimburse her.

The hospital provided us a copy of a grievance response letter to the patient. The letter informed her that the pillow had been kept from her for safety reasons. It acknowledged that the hospital was responsible to return it and offered to pay for reimbursement should the patient provide a replacement receipt. It also gave simple instructions on how to get the reimbursement. We were told that so far the patient has not brought in such a receipt.

The fourth complaint alleged that the hospital failed to provide adequate care for the patient's headache. According to the staff, including an administrator from a women's and children's center at the hospital, the patient was assured sound care under physician supervision wherever she stayed in the hospital. It was explained that during one of her recent hospitalizations she was pregnant, experiencing nausea and vomiting. Although she was admitted to the psychiatry unit initially she was under the watchful care of an OB/GYN consult, and soon after admission was transferred to a high risk pregnancy unit where she could be treated for the vomiting and upper abdominal pain she had developed. There she was given an I.V. for dehydration, Zofran for nausea and Norco for pain. Her medical issues were resolved after a short stay and she was stable enough to return to psychiatry.

According to the chart from that hospitalization, an Emergency Department physician noted that the patient was positive for barbiturates and opiates, Tylenol with Codeine. At 1644 she complained of pain at six on a one-ten scale, which she said started two days earlier. She reported taking Tylenol for migraines but discontinuing all other medications when she learned she was pregnant. She was given Tylenol with Codeine following exams and observations a few hours later at 2014 while still in the Emergency Department; she said she felt better an hour or so later. An ultrasound verified her pregnancy, and an OB/GYN physician completed an exam where he noted the patient as having nausea but no headaches.

She was admitted to psychiatry that night, and her psychiatrist requested another consult from internal medicine which was completed the next day. In that consultation report the patient complained of abdominal pain, requested Toradol and said that Zofran was not helping much, all of which the physician deferred to the OB/GYN Department.

During her short time in psychiatry the patient was prescribed Tylenol every four hours but she declined two doses at 0615 and 1215 the following morning. Same for Zofran, offered but refused that afternoon. She was there for one full day when she was transferred to a high risk pregnancy unit at 1830. Admission reports stated that the transfer was to address nausea, vomiting and abdominal pain. She was to be given an I.V. for hydration and for Zofran and Reglan for nausea as well as Norco as needed for headaches. There were no further complaints of headache pain in the record, and she returned to psychiatry two days later with nothing new to report.

The last complaint was whether the hospital provided the patient with a required grievance process. Administrators said that she complained of a psychiatrist's inappropriateness,

the loss of her pillow, not being transferred sooner to the high risk pregnancy unit and about an attitude a sitter had on that unit. The directors from each unit met with her personally on two occasions and discussed the issues at length. The psychiatry director addressed the issues on her unit and the women's and children's center director addressed the issues on her unit. Both prepared a written response to the patient.

A copy of that response was shared with the HRA. It listed six concerns the patient presented: a psychiatrist's inappropriateness, disrespectful staff, loss of her pillow, her husband not being notified of her condition that warranted transfer, not being transferred in a timely fashion and the sitter's attitude. It stated that an investigation was completed but there was no explanation of how that was done or what was discovered, if anything, in the meantime. The letter apologized for any experience the patient had that was short of respect and quality. The only complaint that was addressed in the response was the missing pillow, which the hospital offered to reimburse as described earlier.

CONCLUSION

Rockford Memorial's code of conduct states that each employee must treat patients, customers and coworkers in a way that demonstrates respect. Abusive behavior will not be tolerated, and all employees must conduct themselves in a manner that reflects favorably on the Health System (A1.03). Psychiatry department policies state that all patients will be provided with adequate and humane care and treatment, which follows the same theme under the Mental Health Code (405 ILCS 5/2-102). The Code adds that no recipient shall be abused (405 ILCS 5/2-112), including by mental injury (405 ILCS 5/1-101.1).

With only a few physicians on staff it is likely that the psychiatrist in question and this patient crossed paths during her recent hospitalizations. But, neither the record nor the physician's recollection can verify that. Hospital administrators said they approached the physician too and found no evidence to suggest that abuse occurred on his behalf. Although the patient's perceptions are not discredited, Complaint #1, that the physician verbally abused and ridiculed her is not substantiated.

Psychiatry unit rights policies state that the patient participates in treatment planning. If s/he requires the administration of authorized involuntary treatment, the physician or designee is to advise the patient in writing of the proposed medication's side effects, risks, benefits and alternatives. The physician shall determine and state in writing whether the patient has the capacity to make a reasoned decision about the treatment (Section 2060, Inpatient Psychiatry; #03). The Mental Health Code provides for the same (405 ILCS 5/2-102).

Records from the patient's two most recent hospitalizations at the time of this review included consent forms for Remeron, Trazodone, Ambien and Lexapro. The forms suggest that the medications' particulars were discussed with her and her signature implies that she had some input and agreed to take them, none of which were prescribed by the physician in question. Complaint #2, a physician disregarded the patient's input about prescribed medications is not substantiated.

According to patient valuables policy, the hospital is to provide for the safekeeping of items but will not be responsible for anything unsecured. Patients are expected to claim stored valuables at the time of discharge. If an item is not located and the loss was the result of staff negligence, the manager will make arrangements to have it replaced (Chapter 900, Customer Service; #07). Under the Mental Health Code, when a recipient is discharged from a mental health facility, all of his personal property which is in the facility's custody shall be returned to him (405 ILCS 5/2-104).

In this case the patient's husband brought her a pillow sometime after her admission as reported by a unit staff member. The pillow was kept from her for safety reasons but not returned on her discharge. The hospital acknowledged the error and offered to reimburse if the patient would produce a receipt. Complaint #3, failing to return the patient's property, is not a violation of her rights given the reimbursement option. The complaint is not substantiated.

Hospital licensing requirements state that all persons admitted to the hospital shall be under the professional care of a member of the medical staff. No medication, treatment or diagnostics shall be administered except on written order of a member of the medical staff (77 Ill. Admin. Code 250.320, 330). Mental health patients are to be guaranteed adequate and humane care and services (405 ILCS 5/2-102).

Documentation from this patient's records showed that she presented to Rockford Memorial's Emergency Department with complaints of pain, for which she was given medication. Pain medications continued to be provided on the psychiatric unit as the patient needed; she took the medication sometimes and declined others. She was transferred to another unit where her complaints of additional pain and vomiting were treated and where she was given stronger pain medication, also as she needed. There was no indication that she ever had to "beg" for help with pain or that any care took too long. In short, within the first twenty-four hours of arrival she was seen by no less than four physicians from Emergency, Psychiatry, Internal Medicine and OB/GYN, all of whom prescribed her care as they determined appropriate. That is not a violation of her right to adequate and humane care, and Complaint #4, the hospital failed to provide adequate care for the patient's headache pain is not substantiated.

The hospital's patient grievance policy states that unit managers have the overall responsibility for processing unresolved grievances involving their service areas. On receipt of a verbal or written grievance, the manager will contact the patient and acknowledge receipt and the process to address it. Within seven calendar days, the manager will provide, in writing, findings of the investigation and any resolution or process to be taken. The written notice will contain the name and contact information of the manager, steps taken on behalf of the patient to investigate the grievance, the results and the date of completion (Chapter 900, Customer Service, #09), all of which is also required under CMS' hospital participation rules (42 C.F.R. 482.13).

Here Rockford Memorial reacted accordingly to the patient's grievances. Her complaints involved two units, and the managers from each were involved in addressing them. They conducted investigations and provided the patient with a timely letter. The letter cited results/resolutions to only one of the six complaints however, the missing pillow. It failed to

include specifics for the other five as required by hospital policy and CMS standards. Complaint #5, the hospital failed to provide the patient with a required grievance process is substantiated.

RECOMMENDATIONS

Cover the grievance policy and CMS requirements with department managers and with administrators who are responsible for reviewing and giving final approval for response letters.

SUGGESTIONS

Only one of the psychotropic medication consent forms in these records included a physician's written determination of the patient's decisional capacity. The medical staff should be reminded to carry out this important requirement. (405 ILCS 5/2-102 a-5).

The Mental Health Code no longer refers to "authorized involuntary treatment". The term is misleading, and the rights policy should be revised to include "electroconvulsive therapy and psychotropic medication" instead. (405 ILCS 5/2-102 a-5).

Because it remains the hospital's responsibility to return all patient properties, train the psychiatry unit staff to always add items to property or valuables logs as they come in so that items can be better tracked. (405 ILCS 5/2-104).