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HUMAN RIGHTS AUTHORITY – NORTHWEST REGION
REPORT 16-080-9001
ROCKFORD MEMORIAL HOSPITAL

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship & Advocacy Commission opened an investigation after receiving complaints of potential rights violations of a patient at Rockford Memorial Hospital. It was alleged that the patient received inadequate care, and the hospital failed to provide written information regarding patient rights. In addition, it was alleged that the patient was not allowed to use the telephone and was denied the right to file a grievance.

Substantiated findings would violate rights protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102(a), 103), Patient Rights under Hospital Licensing Requirements (77 Ill. Admin. 250.260) and the Centers for Medicare/Medicaid Services (CMS) Conditions of Participation for Hospitals (42 C.F.R. 482.13).

According to its website, Rockford Memorial Hospital is a 396-bed-licensed facility that first opened their doors in 1885. The Inpatient Behavioral Medicine Unit provides care and mental health treatment to men and women with severe depression, psychosis, suicidal ideations and other serious mental issues including people with both mental health and substance abuse issues. The unit has 14 adult beds and 10 private rooms. It is staffed by a care team of psychiatrists, nurses, social workers and mental health technicians.

To pursue the matter an HRA team met at the hospital and interviewed the following Inpatient Behavioral Medicine Unit staff: a director of risk management, a physician, a nurse manager and a

program director. In addition, legal representatives for the hospital were also interviewed. Policies as well as relevant sections of the resident's records were reviewed via written authorization.

COMPLAINT SUMMARY

The complaint alleges that for the period of 10/6/15 through 10/9/15, the patient went to the hospital emergency room and was later admitted to the Behavioral Health Unit. The patient explained to the staff that he had already been without his medications for a couple of months. It reportedly took the staff 15 hours to alleviate his pain and suffering from mood swings, agitation, irritability, anger, chest pain, anxiety and panic attacks with episodes of depression and suicidal ideations. No information regarding patient rights and responsibilities were reportedly provided to the patient in the emergency room, nor in the Behavioral Health Unit. The complaint goes on to allege that while on the unit, the patient was not allowed to use the telephone. He also requested to file a grievance, but was allegedly denied the right to do so.

FINDINGS

The attorney and hospital staff are in agreement that the patient received all of his medications in a timely manner from the time he was seen at the emergency room and during his voluntary admission to the hospital behavioral unit.

Per the nurse manager, patient rights were discussed at length with the patient in the emergency room as well as in the behavioral health unit. The patient signed an application for voluntary admission. The physician and social worker also signed the application. The nurse manager went on to expound that by signing the application, the patient is confirming that he received information regarding his rights and responsibilities and understood them. The attorney added that the patient also signed the DHS (Department of Human Services) rights form and was provided a copy of it. This form also contained the contact information for the HRA.

In regard to telephone usage, the nurse manager stated that the patient was allowed to use the phone anytime that he requested, but during the group sessions it was suggested to him that he wait until after the group session was finished. The patient then became angry and stated that his rights were being violated. The physician stated that although he had an appointment scheduled to see the patient later in the afternoon, at one point earlier in the day on 10/7/15, the patient became so agitated and frustrated that the nurse had to call him and he came and talked with the patient and calmed him down.

According to the attorney, on 10/7/15 the patient requested to file a complaint and was given pen and blank paper by the nurse to write his complaint down. The patient presented a written request dated 10/8/15 to the nurse. The nurse discussed the complaint with the patient in an attempt to help the patient understand that providing a TV in his room along with a closed circuit camera is not the policy of the unit, but the patient was not satisfied with the explanation. The nurse manager stated that also on 10/8/15, the patient put in a call to the HRA. The HRA came to see the patient per his request. The patient was provided more blank paper and he wrote another complaint.

RECORDS

The Emergency Room Report dated 10/6/15 depicts that the patient was seen at 12:02 p.m. for chest discomfort, panic attacks, hallucinations and suicidal ideations. At 3:38 p.m. the social worker notes that a behavior assessment was completed and discussed with the physician as well as the patient. The Application for Voluntary Admission was signed by the patient and the physician on 10/6/15 at 4:05 p.m.

Medication lists from the emergency room and the Behavioral Health Unit dated 10/6/15 denote the following: While in the emergency room, the patient was given the medication Zofran at 4:22 p.m. for nausea and vomiting. At 4:30 p.m. the patient was transferred to the Behavioral Health Unit and the nurse progress notes dated 10/6/15 at 4:30 p.m. state that the patient “was given Zofran in the emergency room and he will be re-evaluated and assessed”. At 5:34 p.m. on

10/6/15, the nurse progress notes state that "Patient states medication not helping, asking for physician, physician notified and at bedside". The Suicide Precaution Order was cancelled by the physician at 6:42 p.m. At 8:26 p.m. the patient was given another Zofran by the behavioral health nurse. The patient was re-evaluated at 9:28 p.m. per the progress note by the nurse. The assessment and plan of care included side effects of medications being reviewed with the patient who voiced understanding of the side effects and agreed to take the medications Zofran, Haldol, Ativan, Ambien, Wellbutrin, Adderall, Zyprexa, and Vistaril. The patient was encouraged to participate in 1:1 sessions and group therapy. Approximately 3 hours later at 12:42 a.m. on 10/7/15 the medication lists from the Behavioral Health Unit state that the patient was given the medication Vistaril, which is used as a sedative to treat anxiety and tension. At 12:58 a.m. the patient was administered Mylanta. At 2:05 a.m. the patient was given Lorazepam for an anxiety disorder. Lipitor was distributed at 3:00 a.m. and a chewable aspirin was given at 3:12 a.m. Another dosage of Zofran was administered at 4:28 a.m. including the following: Tylenol at 7:27 a.m., Vistaril at 9:50 a.m., Hydrocodone at 10:33 a.m., Zofran at 12:43 p.m. and Lipitor at 8:51 p.m.

According to the medication lists for 10/8/15, at 8:21 a.m. the medication Adderall, which is used for anxiety, was administered to the patient. To treat his depression, the patient was given Wellbutrin XL at 9:00 a.m. and Zofran at 9:29 a.m. Lipitor was dispensed to him at 8:22 p.m. and Zofran again at 8:26 p.m.

On 10/9/15 the medication records depict the following administrations: Zofran at 4:00 a.m., Adderall at 8:27 a.m. and a chewable aspirin at 8:27 a.m. According to the progress note by the recreational therapist dated 10/9/15, the only concern that the patient had was "receiving a prescription from the physician so that he can be discharged today". The recreational therapist records on 10/9/15 that: "This writer met individually with patient to cover material from community meeting. Follow community meeting agenda including concerns, unit reminders, goal setting. Patient response was receptive to reading through the agenda and did not have any questions. Patient's

stated goal: 'Talk to the doctor about writing a prescription, so I can go home today'". The social worker progress notes quote the patient as having said "Now that I have the medications back in my system, I am feeling more like myself and now I want to go home". The Request For Discharge form was explained and signed by the patient and nurse on 10/9/15, and per the Discharge Summary signed by the physician, the patient was discharged.

The Application For Voluntary Admission, the Psychotropic Medication Consent and the DHS Rights of Individuals form all dated 10/6/15, are signed by the patient, nurse and physician confirming that the patient was informed regarding his rights and responsibilities and understood them. The nurse progress notes dated 10/7/15 observed at 1:00 p.m. that "The patient presented to the nurse's station and requested the phone number of the CEO of the hospital. The patient was informed that he could call Guardianship & Advocacy and the phone number is on the back of his rights. The patient requested the telephone be turned on. This writer informed him group was currently going on and if he could call after group. The patient states 'You are interfering with my rights. Are you telling me you are going to deny my rights?' This writer informed the patient his rights were not being denied but in the future and if possible he should comply with the treatment services". At 1:30 p.m. the nurse progress notes report that "Patient returned to telephone to make more calls". And at 1:40 p.m. "Patient observed slamming telephone down and walking back to room".

The nurse progress notes infer that on 10/7/15 at 1:14 p.m. the "Patient presented to the nurse's station and states that he has legal counsel. The patient states that staff on the unit are violating his rights. He states he 'has serious complaints' to make". At 1:30 p.m. the nurse then records that the "Patient's complaint was filed according to hospital policy. Patient informed that this was done". At 2:00 p.m. the nurse notes depict the following: "Patient presented to the nurse's station and continues to verbalize anger and frustration. This writer contacted the physician and informed him the patient has escalated to contacting administration. Physician came and spoke with the patient and explained that he will be seeing the patient this afternoon. Patient

verbalized understanding but does not appear happy with this response. Patient returned to his room". The notes go on to state that around 3:00 p.m. "the patient has been observed pacing the halls and standing in front of the nurse's station. The patient appears angry, agitated and frustrated".

The handwritten complaint/grievance by the patient dated 10/8/15 specifies that he requested a closed circuit television to be installed in the room where group sessions are held, and in his room due to his panic disorder that makes it difficult for him to sit during the sessions in such a small room with several other patients.

On 10/8/15 at the request of the patient, the HRA visited him in the Behavioral Unit of the hospital. The patient signed a consent to release information and handwrote a letter on a blank piece of paper expressing his grievances of the inadequate care he felt that he had received along with the denials of an explanation of patient rights, telephone usage, and the right to file a grievance. Staff explained to the HRA that no formal complaint forms were available. The original complaint letter was provided to the hospital staff and a copy retained by the HRA.

The Psychiatrist Discharge Summary dated 10/9/15 makes lucid that "during his stay, the patient was very demanding and filed multiple complaints to the hospital administration. I discussed each and every complaint with the patient but he was not satisfied with the explanations".

In response to the grievances filed by the patient, a report was written on 10/15/15 by the nurse manager of the Behavioral Unit with a copy addressed to the patient stating the following: "In response to your formal complaints filed on October 8, 2015…I have undertaken an investigation which included interviews with staff and a review of your medical record". The report goes on to state that the medical records of the patient reveal that medications were found to have been administered in a timely manner as ordered by the physician. "You were provided with paper and pen and made the hospital aware of your concerns in letters dated 10/8/15. Contact information for Illinois Guardianship & Advocacy Commission was provided….Interviews with staff revealed that a phone was provided to you….Patient rights signage is displayed

on the unit; we are taking this opportunity to enhance our signage….In order to experience a beneficial therapy session, one needs to be physically present in the group sessions. Remote participation carries the risk of violating the privacy of other participants….I would like to thank you for making me aware of your concerns".

According to the Individual Plan Of Care For Patient/Recipient On The Behavioral Medicine Unit policy, "The treatment plan is initiated within the first 8 hours and completed within 48-72 hours following admission, and is based on information gathered from a variety of sources: information provided by admission data, nursing assessment, history and physical, psychosocial assessment, suicide risk assessment, psychiatric evaluation, recreational therapy assessment, direct observations and information provided by the patient/recipients, family members of significant others. The interdisciplinary treatment team is comprised of the psychiatrist, assigned nurse, social worker and recreational therapist of the patient on the Behavioral Health Unit, as well as the nurse manager and program director. The care plan identifies significant problems and intervention strategies to address the issues of the patient/recipient".

The Rights Of Patients On The Behavioral Medicine Unit policy specifies that "The rights of patients hospitalized on the inpatient Behavioral Medicine Unit at Rockford Memorial Hospital are assured and followed in accordance with Illinois state law. All patients shall be provided with adequate and humane care and services in the least restrictive environment. The views of the patient shall be considered in determining whether care is being delivered in the least restrictive environment".

The policy goes on to expound that "Patients have the right to have unimpeded, private, and uncensored communication with persons of his or her choosing by mail, telephone, and visitation. The unit Nurse Manager/Director will ensure that: 1. Mail can be conveniently sent and received. 2. Telephones are reasonably accessible. 3. Space for visits is available".

The purpose of the Rockford Memorial Hospital Patient Grievance policy is “To provide an effective method by which the patient may express any concern or complaint regarding care/service, have their concern/complaint received, addressed and resolved, when possible, in a professional, efficient and timely manner and in accordance with regulatory standards”.

The policy continues in that “A complaint is an expression of concern or dissatisfaction, whether verbal or written, provided by the patient/representative/customer regarding quality of care or service. A grievance is a formal or informal written or verbal complaint that is made to the hospital by a patient, or the patient’s representative, when the complaint is not resolved at the time of the complaint by staff present, is postponed for later resolution, requires investigation beyond the initial day the complaint is received, and/or requires actions for resolution….The guideline for the concern/complaint response model indicates that the timely and successful management of any concern/complaint is critical. The manager has the overall responsibility of managing the process for any unresolved service recovery or grievance involving their service area. Within 7 calendar days of receipt (day of receipt is day zero) of a grievance the Manager will acknowledge in writing the findings of the investigation and resolution or process to be taken to address/resolve the grievance. The manager will take detailed notes of the patient’s account of the issue. Enter the grievance in Riskmaster, if not done already. Complete an investigation and implement any necessary actions. In the resolution of the grievance the manager must provide the patient with written notice of its decision that contains the name/contact information of the manager, the steps taken on behalf of the patient to investigate the grievance, the results of the investigation and the date of completion. The director/immediate supervisor will review and approve the letter prior to sending it to the patient. A copy of the written notice is sent to Risk Management for Riskmaster filing”.

According to the Mental Health Code (ILCS 5/2-102) regarding care and services;

§ *2-102. (a) 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.*

According to hospital regulations (77 Ill. Admin. Code 250.260):

a) Policy on Patients' Rights

1) Hospitals shall adopt a written policy on patients' rights.

2) This policy shall be available to all patients and personnel upon request.

b) Patient Morale

1) Emotional and Attitudinal Support

Hospitals shall have a written plan for the provision of those components of total patient care that relate to the spiritual, emotional and attitudinal health of the patient, patients' families and hospital personnel.

According to the Mental Health Code (ILCS 5/2-103) regarding mail; telephone; visits:

§ *2-103. Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation. ….*

(b) Reasonable times and places for the use of telephones and for visits may be established in writing by the facility director.

(c) Unimpeded, private and uncensored communication by mail, telephone, and visitation may be reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation.…,

According to the CMS Conditions of Participation for Hospitals, Patient's Rights (42 C.F.R. 482.13):

A hospital must protect and promote each patient's rights.

(a) Standard: Notice of rights--

(1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.

(2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. ….
(i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital.

Complaint: The patient received inadequate care in regard to the facility taking 15 hours to alleviate his pain and suffering. From the time the patient arrived in the ED through his stay on the unit, he was seen by physicians who ordered treatment as determined. The patient was given several medications for chest discomfort, panic attacks, hallucinations and suicidal ideations per his record. According to the Mental Health Code (ILCS 5/2-102), a recipient of services shall be provided with adequate and humane care and services in the least restrictive environment. The hospital policy regarding the rights of patients on the behavioral unit denotes that "the rights of patients hospitalized on the inpatient Behavioral Medicine Unit at Rockford Memorial Hospital are assured and followed in accordance with Illinois state law. All patients shall be provided with adequate and humane care and services in the least restrictive environment". Based on sufficient evidence, the patient received adequate care and his pain was alleviated in a timely manner. The complaint is unsubstantiated.

Complaint: The hospital failed to provide the written information regarding patient rights and responsibilities. The following forms were signed by the patient on 10/6/15 confirming that he received written documents regarding patient rights and responsibilities: the Application for Voluntary Admission, the Psychotropic Medication Consent and the DHS Rights of Individuals form. In addition, the nurse progress notes dated 10/7/15 depict that there was a verbal discussion regarding the same. The Rights Of Patients On The Behavioral Medicine Unit policy specifies that all patients shall be provided with adequate and humane care and services in the least restrictive environment. According to regulations that govern the Department of Public Health, Policy on Patients' Rights (77 Ill. Admin. Code 250.260), "Hospitals shall adopt a

written policy on patients' rights. This policy shall be available to all patients and personnel upon request." Given the records containing the signature of the patient along with supportive documentation, the complaint is unsubstantiated.

Complaint: The patient was denied telephone usage. According to the nurse progress notes dated 10/7/15, the patient requested to use the telephone during a group session and he was informed by the nurse that his right to use the phone was not being denied, but "in the future and if possible he should comply with the treatment services". On this same day at 1:30 p.m. the nurse records that the patient made more phone calls and at 1:40 p.m. the patient was observed slamming the phone down. The hospital policy regarding the rights of patients on the Behavioral Unit explicates that patients have the right to have unimpeded, private, and uncensored communication with persons of his or her choosing by mail, telephone, and visitation. The unit nurse manager/director will ensure that telephones are reasonably accessible. The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-103(b) states that reasonable times and places for the use of telephones may be established by the facility director. From this the HRA concludes that the complaint is not substantiated.

Complaint: The patient was denied the right to file a grievance. The nurse progress notes dated 10/7/15 depict that the complaint made by the patient was filed according to the hospital policy and the patient was notified that this was done. In response to the grievances filed by the patient, a timely Riskmaster report was written on 10/15/15 by the nurse manager of the Behavioral Unit with a copy addressed to the patient stating that an investigation was conducted regarding his complaints which resulted in the following findings: his medications were administered timely, documents regarding patient rights along with contact information for the Illinois Guardianship & Advocacy Commission were provided, a telephone was made accessible and grievances were accepted and filed with explanations by the hospital staff. The Rockford Memorial Hospital Patient Grievance policy states

that “a grievance is a formal or informal written or verbal complaint that is made to the hospital by a patient, or the patient’s representative, when the complaint is not resolved at the time of the complaint by staff present, is postponed for later resolution, requires investigation beyond the initial day the complaint is received, and/or requires actions for resolution….The guideline for the concern/complaint response model indicates that the timely and successful management of any concern/complaint is critical. The manager has the overall responsibility of managing the process for any unresolved service recovery or grievance involving their service area. Within 7 calendar days of receipt (day of receipt is day zero) of a grievance the Manager will acknowledge in writing the findings of the investigation and resolution or process to be taken to address/resolve the grievance”. In review of patient rights according to the Code of Federal Regulations that governs the Conditions of Participation for Hospitals (42 C.F.R. 482.13), a hospital must inform, protect and promote the rights of each patient. The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital must establish a clearly explained procedure for the submission of a written or verbal grievance by the patient. It cannot therefore be concluded that the patient was denied the right to file a grievance. The complaint is <u>not substantiated.</u>

<u>SUGGESTION</u>

1. Rather than blank paper, have formal complaint forms available to the patients on the Behavioral Unit. This would ensure the patients that an official complaint or grievance is being filed.