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Egyptian Human Rights Authority
Report of Findings
Union County Hospital
HRA# 16-110-9009
September, 2016

Introduction

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations in the care provided to a recipient at Union County Hospital (UCH) in Anna, IL. The specific allegations are as follows:

1. **Inadequate care and treatment of a patient**
2. **Inappropriate admission to a psychiatric hospital**
3. **Improper restraint of a patient**
4. **Breach of confidentiality**

If the allegations are substantiated, they would violate protections under: the Mental Health and Developmental Disabilities Code (405 ILCS 5); the Medical Patient Rights Act (410 ILCS 50/3; Hospital Regulations (77 IL ADC 250); the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110) and HIPAA regulations (45 CFR 164).

Union County Hospital emergency department (ED) currently has 6 beds to accommodate patients of all needs and the HRA was informed that it was very common for the hospital ED to serve people with mental illness. The allegations were discussed with staff involved in the recipient's care, administrative staff at the hospital, family members and the recipient involved. Relevant policies were also reviewed as were sections of the recipient's record with authorization.

Complaint Summary

The complaint alleged that Union County Hospital provided inadequate care and treatment by refusing to give a patient routine medication, administering a medication that a patient had an allergy to and not fully evaluating her by ruling out other possible causes for the patient's presenting symptoms other than mental illness. As a result, the patient was inappropriately admitted to a psychiatric hospital. The complaint also alleged that a patient was placed in restraints without meeting criteria and that the hospital breached the patient's confidentiality.

Findings

Interviews

A. Patient: The HRA team discussed the allegations with the patient involved in this complaint. The patient informed the HRA that she was a nurse and had worked in a state operated mental health facility before retiring. Therefore, she understood her rights and knew that the hospital did not follow legal requirements during her stay. The patient explained that she was in a car accident approximately 4 years ago which resulted in her being diagnosed with post-traumatic stress disorder (PTSD); Anxiety and traumatic brain injury (TBI). She had never had any other mental illness diagnoses prior to this admission to UCH where she was diagnosed with Schizophrenia, Alzheimer's disease and Dementia and the doctor also documented that she had Down Syndrome, which she does not. She was under the care of a psychiatrist for treatment for her TBI symptoms only. She is prescribed Adderall to help with lack of focus from her TBI. A few days prior to her admission at UCH, she had been admitted to another community hospital for back pain. While at that hospital, she did not receive her routine medications and as a result, she became confused. When her daughter brought home medications to this hospital, they played "catch up" with her Adderall and gave her 2 a day instead of 1 as her prescription was written. She stated they gave her another dose of Adderall on her way out the door and her daughter gave her another dose that evening. That night she had vivid dreams about her daughter in law running over her dog and sent a text to her asking why she did that. As a result, her family checked on her the next morning. She had already taken her daily medications when her family arrived; however, her daughter was demanding that she take more medication and that disagreement resulted in a physical altercation. She stated that her daughter threw her down, sat on her chest and tried to force medications down her throat. She kept telling her daughter to get off of her because she could not breathe. She scratched her daughter's neck while she was attempting to get her off of her. She was approximately 80 pounds at the time and her daughter weighs around 180 pounds. Her daughter threatened to take her to UCH to which the patient stated "I'd rather die than go to that hospital." Her daughter interpreted that as a suicidal reference and emergency services were called. Before the ambulance arrived, the patient had passed out due to her daughter sitting on her chest so long and her not being able to breathe. When the ambulance arrived she was unresponsive. When she woke up she was on the ambulance, scared and began fighting them and told them her daughter had tried to kill her. They placed her in restraints and explained to her where she was and then she calmed down. She heard the doctor on the radio giving orders for medication so she informed the drivers she has an allergy to Benadryl due to taking too many SSRI [selective serotonin reuptake inhibitor] medications. Therefore, they did not give her any medications.

After arriving at UCH she was evaluated by one doctor and automatically treated for mental illness rather than exploring the possibility that she was having a reaction to the Adderall medication due to the dosages being so irregular over the previous few days. She explained that she has tried in the past to go off of the Adderall but she noticed a decline in her mental status and began taking it again. She stated that it helps her with focus, finding words and memory recollection. When she quit taking it, she noticed a decline in those skills. Her son explained to the hospital that she needed her medications to stabilize her condition, but the hospital staff refused to give her regular medications because a psychiatric facility would not accept her if she was given any medications. The patient was evaluated by a crisis worker from a community counseling agency to determine if she met criteria for placement in a mental health treatment

facility. She told the crisis worker that she had vivid dreams the previous night. The crisis worker asked her to explain what she meant and when she described the dreams, the crisis worker documented the things in her dreams as active hallucinations. However, all of her paperwork stated that she was not a threat to harm herself or others but she was eventually sent to a psychiatric facility with an involuntary Petition and Certificate with a diagnosis of schizophrenia. She stated that she met with one crisis worker and then another crisis worker took over. She discovered this upon later review of her chart and stated that she never saw the second worker at all and that had her concerned that her involuntary commitment paperwork was based on "hearsay." Her son had told her that the crisis worker spoke with him and the doctor, but when she was able to review the Petition after discharge, she discovered that the only thing on the Petition was what her daughter had told the nurse that morning on the phone and that crisis worker passed information on to the next crisis worker. She explained that she was at the hospital from early morning to that evening and no one ever contacted her primary care physician to obtain her medical history

Later in the day, while still at UCH, she was looking for her family because they said they were going to eat and would be back but they had not returned for some time. She stated that she went outside to look to see if they or their cars were in the parking lot and the doctors came out and asked her to go back inside but before she could comply, a nurse grabbed her thumb and was bending it back to try and force her to the ground. The patient admitted to saying "someone get this lard ass off me" because she had no intention of not being compliant with the doctor's request. Once she was back inside, the hospital staff put her in a 4 point restraint even though she was being compliant. While in restraints, the same nurse she had difficulty with earlier came in and gave her an injection of what she was told was Haldol and Ativan. However, upon later review of her chart, she discovered that the doctor had charted that she was given Haldol and Benadryl, which she has an allergy to. The patient was concerned as to what was actually given to her and also stated that there was no need for her to be doubly restrained with restraints and medication when she was compliant. She stated that she was never given a restriction of rights form for the injections of Haldol and Ativan or Benadryl and the hospital did not have her sign consent to receive the medications.

She was later taken to a psychiatric hospital approximately 2 hours away from her home by a transportation company that is contracted by the hospital to transport mentally ill patients. When they arrived, she was told that she was going home. UCH staff took her outside and the drivers "got her from behind and put her in a van with a cage." When she noticed that she was going too far to be going home she began asking the drivers where she was going. She stated she was never told where she was going until she arrived and that the drivers made multiple stops along the way and smoked in the vehicle which made her feel sick. Once she arrived at the receiving psychiatric facility, they asked her to sign as a voluntary admit. She asked if she was safe there and when told that she was, she agreed to sign as a voluntary patient, so a Petition for Involuntary Admission was never filed with the court. She arrived on a Saturday afternoon and was discharged the following Wednesday.

Another concern was that the hospital breached her confidentiality. She explained that one of her daughter's friends works at the hospital and was the one who completed her CT scan. A relative of this hospital worker told her Sunday school class about this patient's admission to the psychiatric hospital and the patient knows this because her Aunt and ex mother-in-law attend her Sunday school class and told her about it. She also explained that after this ordeal was over and she was back at home, she requested copies of her medical records. When she received

them, there were pages of inaccurate information that was obviously about another patient, not her. She explained that it was her face sheet but the notes were not accurate for her. The notes stated that she was found at a school parking lot picking up her kids, which clearly was not the case and she discovered other inaccuracies in the diagnoses as well, Down Syndrome being one inaccuracy along with Alzheimer's, Dementia and Schizophrenia. She stated she even had an MRI done which showed she did not have Alzheimer's disease. She explained that she was given Aricept for her TBI and since that was in her medication regime; maybe that is why the hospital gave her the Alzheimer's diagnosis. She brought this to the hospital's attention and it was discovered that another person's medical records had been charted into her electronic record. In response the hospital staff made an entry that it was charted in the wrong chart and put a strike through editing line through all the inaccurate information. When she asked why it could not be taken completely out of her chart, she was told that they are not able to remove things from the chart once they have been documented. She began worrying if her records were in the other person's chart too and asked a friend at the hospital to see if she could find out who it was to see if her records were mixed in with hers as well. The worker at the hospital gave her the name but then the patient decided not to act on following up because she still has an active nursing license and thought that might jeopardize it. The patient did not tell the HRA the name of this staff person that was her friend because she did not want to get her in trouble.

She also discovered that a doctor other than the one who saw her did the charting in her records. She explained that the doctor doing the charting never saw her. She was also concerned because the doctor had charted that he was doing a physical exam during the same time she was meeting with the crisis worker. It was also documented that she was nonverbal and had no pain when in reality she was verbal and asking for pain medications for her back. She tried to reach out to several others within the hospital to follow a grievance process regarding the inaccurate charting and other issues but no one would help her. She spoke to the utilization review person at the hospital who stated she would look into it and get back to her but she never did hear back. She spoke to the secretary for the Hospital Administrator who instructed her to mail a letter to the Administrator and he would schedule a meeting with her. She did so, but a meeting was not scheduled, in return she received a letter that basically said he looked into the matters and concluded that the hospital did nothing wrong. She contacted the business office manager at the corporate office for the hospital who told her that she would receive a call from their compliance officer but that never happened. She did follow up to let them know she had never heard from anyone and was told that they are still looking into the matter and that person was not available at the moment, but she never heard back from anyone. She also spoke with the State's Attorney who referred her to the Attorney General. The Attorney General's office gave her forms to send back in and later informed her that they could not help with the matter because it would be medical malpractice which they do not handle. She called some local attorneys regarding a medical malpractice case and one told her she had a case and could possibly win, but that it would require more time and money to litigate than what she would get back from the lawsuit.

B. Crisis Workers: At the time of the HRA's interview, the first crisis worker had been employed with the community agency for approximately 1½ years. She vaguely remembered speaking with this patient on a crisis call and stated that it was one of her first cases on crisis that she had handled. She explained the process that is followed when the hospital contacts one of their case workers to conduct an evaluation. First, the patient is medically cleared and after that, the hospital contacts the counseling agency. Being medically cleared was described as having no "bad labs" which show drugs, urinary tract infection etc…The counseling agency cannot

evaluate a patient with "bad labs" for at least 24 hours. Once the labs are ok then the hospital can contact the agency. A patient must be medically cleared before the counseling agency can be contacted to conduct an assessment. Upon arrival, the worker completes an assessment form that is designed to determine criteria for admission to a psychiatric unit or hospital. If the patient cannot give the information needed to complete the form, the worker will contact family or an emergency room staff person and then will also speak to the treating physician to get the "whole picture." The physician will typically print off emergency nursing and physician notes and type out a summary for the crisis worker. The worker uses that information to help make a determination. The worker also has to determine if the family is giving accurate information and they look at previous history. If the patient is not giving the worker information, she might call the primary care physician or psychiatrist. However, it is not standard practice to automatically contact the primary care physician and crisis workers usually go off of the emergency room physician notes for information. If the patient does not agree to go as a voluntary patient and meets criteria for admission to a psychiatric hospital, the crisis worker completes a Petition for Involuntary commitment and a physician completes the certificate. The criteria for involuntary commitment is that the patient has to meet **one** of the following: Actively psychotic, danger to self or others or exhibiting an inability to care for self which was described as not taking medications which causes an exacerbation of symptoms, and not eating or being able to complete activities of daily living (ADL's). This case worker did not recall talking to the patient's daughter or son and just talked to the patient, nurse and the physician for information. She could not recall if the patient was given medication at the hospital or who the treating physician was but stated that typically it is the treating physician who signs the certificate. This worker was on call for this case from 1:00 p.m. to 5:05 p.m. then the second crisis worker took over and handled the case until the transportation to the receiving facility was scheduled. After transportation arrangements are made, the crisis worker is allowed to leave. The HRA questioned as to why the summary plan was left blank on the assessment form the HRA reviewed and she stated she had left it blank because she passed the case to her colleague who should have finished that section and told the patient where she was being transported to. The HRA questioned her regarding how the patient was presenting. It was explained that the report said she had attacked her daughter and the worker stated that she had active psychosis so she met criteria. She stated that the patient was nice to her and did not seem violent, but she was not the one who "dragged her into the ambulance." She does not remember the patient eloping while she was there. She knew she had been placed in restraints in the ambulance but was not sure if restraints were used at the hospital. When discussing this patient's case with staff at the hospital, they met behind the nurse's station through the doors and stated that nothing was discussed in a public area.

The second crisis worker was also interviewed by the HRA. This crisis worker was on call for this case from 5:30 p.m. until 7:03 p.m. She stated that she had spoken to the daughter and son and remembers the daughter stating to her that if her mother was given her Adderall medication, the hallucinations would stop as nothing else works for her. She stated that the patient did know that she was being admitted to a psychiatric facility. She stated that the hospital usually "stays out of it" once the crisis worker takes over and it is up to the crisis worker to notify the patient of placement intentions. She stated that the hospital has never told her to not tell a patient when they were being admitted to a psychiatric unit or hospital. She stated that the crisis worker does not typically stay until transportation arrives as they are free to go once copies of the crisis paperwork are made, therefore, she was not there when the driver picked up the patient. She does remember the patient being in a back brace when they met and described her

as “busy, getting in and out of bed.” She described the patient as being wrapped in EKG cords and stated that she did not like her back brace and was constantly up and down. She never saw the patient in restraints while she was at the hospital. The worker explained that crisis workers do not typically “cross check” what a physician says as they are not physicians therefore they go by what the emergency room staff and physicians report to them. If the patient seems coherent and states that they are not taking a medication, then the worker would cross check that information with her records.

C. Quality and Risk Management and Hospital CEO: It was explained that the hospital has 6 emergency room beds and it is very common to have patients with mental illness occupy those beds. Their treatment is based on their state at the time they are assessed which takes 15-30 minutes. If it is determined that the patient may be experiencing a mental health crisis, one of the community counseling centers is contacted. Placement in a psychiatric unit or hospital is determined by the crisis worker from the community agency with input and consultation with the hospital treating physician. This patient was brought in from an EMS call (emergency medical services). She was in UCH emergency room from 8:42 a.m. until around 8:00 p.m. Her daughter was with her; she was presenting as combative, homicidal, suicidal and there was a possibility of an overdose on her prescription medications. The patient was not answering questions and was restless and talking a lot. The emergency room staff placed her on continuous surveillance. Her daughter gave the hospital most of the information and stated that the patient had a significant psychiatric history. The patient was under psychiatric care and the hospital also had a “historical diagnosis” of schizophrenia. Therefore, the local counseling agency was contacted. The patient also spoke with the crisis worker. However, the patient could not focus and had an “altered state of mind.”

The physician is the one who determines if a patient’s condition is a psychiatric or a medical issue. In this case, they took labs to check for toxicity and completed a basic metabolic panel. She had some levels that were out of the normal range. Based on a basic drug panel, she tested positive for some due to the medications she was taking however it is not an overdose panel and only shows up as positive or negative. A computed tomography (CT) scan of the head without contrast was completed. It showed mild chronic age based deterioration but was negative for acute abnormalities.

It was explained that sometimes the hospital may hold certain medications and document why they are holding them (if it will affect the diagnosis etc…) otherwise, the hospital typically will give routine medications. In this case, the patient’s regular prescription medications were not given because she could not verify what she was currently taking and neither could her daughter. No known allergies were documented in her chart. The daughter did question as to whether or not the patient was doubling up on her medications. The hospital does not always call the primary care physician when a patient is being seen in the emergency room unless there is a question as to the mental health history. The treating physician is the one who sees and documents for the patient and if necessary, will sign the certificate that accompanies the Petition for Involuntary Admission.

When questioned about elopement, it was explained that the patient walked out the front door but was never left alone. Staff stayed with her so it was not a true elopement but she was described as being “on the move.” Staff brought her right back into the hospital. There were no documented incidents surrounding the “elopement” however a “nurse of color” stated that the patient had a problem with her and was upset anytime she was around the patient and this nurse was the one who was helping to bring her back inside. There was no documentation in the

hospital records indicating that the patient was placed in restraints. If she would have been placed in restraints, there would have been a physician's order for restraint. It was not possible that restraints could have been used and not documented because restraint use "generates significant paperwork." The procedure that is followed was described as 1. A physician has to order restraint use 2. A nurse acknowledges the order. 3. PYXIS pharmacy is accessed and 4. A locked door housing restraints is then opened. It was explained to the HRA that PYXIS pharmacy is a kiosk with drawers and employees scan their badge to pull medications or restraints from the kiosk. There is a way to override a restraint process but that also generates a report and no such report was in the patient's chart. The type of restraints used are "soft restraints" and nets that can wrap around the body. It was in the patient's chart that Haldol and Benadryl were given late, at 7:39 p.m., right before she was transferred to help calm her down. The HRA questioned about consent for treatment forms to give permission to administer the medication or provide other treatment. The HRA was told that consent is given on the admission paperwork when the patient signs consent to provide whatever treatment the physician deems necessary. However, this patient was not able to sign the consent forms upon admission or discharge. The hospital's policy in that situation is to document that the patient is unable to sign and two nurses witness it.

The patient did not want to be transferred, however an involuntary Petition was completed by the crisis worker with the physician's agreement and certificate. The patient was placed at a hospital psychiatric unit approximately 2 hours away because the local state operated facility and community hospital equipped with a psychiatric unit had no beds available. The crisis worker explained to the patient that she was going to a psychiatric hospital and it "was not well received" by the patient. Since the ambulance will not transport an involuntary patient, a contracted transportation company was contacted to provide the transport to the receiving facility.

As to the allegation of breach of confidentiality, it was explained that there was one or two sheets of someone else's records in this patient's chart. The hospital addressed that with medical records and the other person's chart was reviewed and none of this patient's records were in her chart. The hospital does not consider this a breach of confidentiality because even though inaccurate information was in her chart, the other patient's name did not accompany the notes that were in this patient's chart.

D. Family Members: One family member refused to meet with the HRA to discuss this case and stated that they "did not want to get involved." Another family member was contacted and agreed to meet with the HRA. This family member described the patient on the day of admission to UCH as having hallucinations and delusions of working for a government agency and was being combative with her daughter. The patient's daughter was sitting on her trying to keep her from hurting herself. The patient had stated that she wished she was dead not that she was going to kill herself. The patient had previously had another similar episode within the last year, but when the patient took her medications they helped. This time it did not therefore emergency services were called. The patient had been on psychiatric medications as long as this family member could remember, even prior to the automobile accident that resulted in her TBI. This family member was under the impression that the patient either did not take or was not given her medication during the previous hospital stay for back pain and that is what caused this episode. The family had communicated to UCH staff that the patient had been under the care of a psychiatrist and provided that psychiatrist's name to the hospital. The hospital was also made aware of the automobile accident resulting in a TBI. A history of the patient being in a hospital

for psychiatric care after her children were born was also reported. This family member was unaware of whether or not medication was given to the patient while at UCH but stated that the hospital staff had told the family that the patient could not take medications because if she did, the receiving facility would not accept her. The hospital staff told the family that the patient had tried to leave to catch a cat and stated that the patient had called a nurse some names. The family could tell that staff at the hospital were aggravated but did not think they treated the patient unfairly because of it. The second crisis worker did speak with family but that crisis worker did not have much information as she had taken over for another crisis worker. She stated that they would send her to a psychiatric hospital to get her medication straightened out and then the patient would be released. This family member did not know if the hospital or crisis worker had informed the patient as to where she was being transported but the family did not tell her because they were unsure as to how she would react. When family left the hospital, the patient was calm and they did not want to do anything that might possibly upset her further. Concerning the breach of confidentiality allegation, this family member stated that the family did feel at one time that staff at the hospital were talking about the patient amongst each other because they would look her way and snicker but the family could not hear what was being said. The family had heard "talk around town" that a hospital staff person had discussed this patient's hospital stay and eventual transfer to a psychiatric hospital without naming her name but being from a small community, people figured out who was being spoken of. This family member did not hear it directly however, so could not confirm or deny that it actually happened.

E. Transportation company: An interview was conducted with the driver who transported the patient to the psychiatric hospital. They left UCH at 8:47 p.m. and arrived at the receiving facility at 11:09 p.m. There was only one driver, not two as stated to the HRA by the patient. Having only one driver is standard procedure for this agency. It was explained that if a driver arrives to transport a patient and that patient is extremely combative, it is the driver's discretion whether or not they transport that patient. If the patient has to be restrained, then an ambulance has to transport them. They can transport patients if medications have been given and any prescription medications along with their personal belongings come with the patient. The driver stated that this patient did not know where she was going and when they got about a block away from the hospital, she asked the driver where she was taking her. The driver told her that she was going to a psychiatric hospital. The patient was calm when the driver told her where she was going but the patient did not understand why and stated "I don't know why they're sending me there." The driver explained to the patient that she did not make the decision or know why, just that she was contacted by the hospital that contracts their agency to provide transportation for patients. This driver did state to the HRA that she questioned psychiatric placement for the patient because typically, involuntary transports are combative and resistant. This patient was very "calm, polite and well-mannered" the entire time of transport; so much so that the driver trusted her to sit in the front seat rather than in the back seat behind the divider. They spoke a little during transport and the driver stated that the patient seemed coherent and had no "delusional talk;" she just did not understand why she was being sent to a psychiatric hospital.

F. Emergency Department (ED) Nurse: Due to the date the complaint was received by the HRA, the ED Nurse was interviewed approximately 12 to 18 months after the ED stay for this patient. For this reason, the nurse could not recall a lot of specifics regarding this patient and referred to her charting notes to answer most questions. She was questioned regarding whether or not routine medications or psychotropic medication could be given when a patient is going to be transferred to a psychiatric hospital. She explained that there is no problem giving these

medications on the receiving facility's side and they will usually accept patients if medication has been given. However, the ED physician has to also order these medications for them to be given in the ED. This patient was not able to tell what her regular medications were and neither were her family members so the nurse called the pharmacy with permission from the family to get a list of regular medications however, no orders were given by the ED physician for the routine medications to be given to this patient during her stay in the ED.

The process that is followed when a patient comes into the ED with a suspected mental illness is to do bloodwork to check for abnormalities and make sure nothing is out of the ordinary. After the physician sees the patient and he or she is cleared medically, then the community counseling agency is called to conduct a mental health assessment. When asked if the patient was assessed for other possible causes for her symptoms except mental illness, the nurse reiterated that lab work was done and the physician requested that counseling be called for a mental health assessment and at that point it is "out of the hospital's hands" because counseling takes over and makes the decision based on observation and consultation with the physician. The nurse's role during the ED stay is to ensure that the patient has a safe environment and does not cause harm to self or others while awaiting assessment or placement of the patient in another facility. Upon review of the chart, the nurse explained that the patient was brought in by ambulance at 8:42 a.m. and at 9:24 a.m. the nurse contacted the patient's daughter with permission from the patient and obtained a history and information about what brought her to the ED that day. The daughter provided a history of the patient being taken to multiple hospitals and no one knows what to do for her and stated that she was used to dealing with that and that her mother had been like that quite often. The daughter did report a car accident that occurred 2 years ago that resulted in her mother having a traumatic brain injury.

The HRA questioned why she was given a "Jane Doe" alias upon admission to the ED and the nurse stated that until a person's name is verified, they are assigned a Jane Doe alias so that medications or treatment can be ordered because without a name nothing can be entered into the computer system. The HRA asked if the ambulance driver provided the patient's name since the patient was brought from her home after family called emergency services. The nurse could not recall specifically for this case, but stated that they do not always give the hospital a name of the patient. She did remember this patient coming in "combative" and stated that she may have not been able to obtain the name from the ambulance drivers. She explained that it did not take long to identify the patient because the financial registration was completed at 9:55 a.m. with the patient's name.

The HRA also asked about the medication injections that were given to the patient. She looked at the chart and stated that she was given Haldol and Benadryl at 7:39 p.m. which would have been just prior to her transportation to the receiving facility. The nurse was not aware of any medication allergies as she did not see any notation in the medical records stating she had any allergies, and instead found a note stating there were no allergies. When asked if they issue a restriction of rights form when medication is given to calm a patient as was assumed in this case, she stated that patients sign a permission to treat form upon admission to the hospital which allows any treatment that the physician deems necessary. When reviewing when the medication was given, the nurse noticed that it was after her normal shift and stated that it was likely that she stayed over to assist the receiving nurse with the injections which sometimes is done if they suspect that they will have difficulty with a particular patient. The nurse did not recall any elopement attempt by this patient and did not see any reference to the same in her chart nor did she see any notes that would indicate that restraints were ever used on this patient during her ED

stay. She did note that she had a lot of charting on this patient which for her means she was worried about her and wanted to ensure she had thorough charting for the patient so that any receiving facility would have adequate information.

When questioned about any possible breach of confidentiality, the nurse noted that patients with mental illness are typically placed in rooms 1 and 2 because they have wider door frames with sliding glass doors that break way but do not lock. This protects confidentiality and allows continuous observation in case there is suspected harm to self. She never overheard anyone talking about this patient other than medical professionals in order to carry out their duties. She explained that most times the nurses in the ED do not even know why other nurses' patients are in the ED because they each have 1-3 patients and each nurse tends to their own patient unless they request assistance from another nurse. Even then, they would only know what is needed to assist the nurse and not necessarily all the information about their stay.

The treating physician for this patient is no longer with Union County Hospital and they did not know how to reach him so that he could be questioned for the HRA's investigation. It was also explained that this treating physician had difficulty with the electronic charting system and had a scribe appointed to him that would follow him when rounding patients and write down everything he stated and help enter data into the system, but the scribe only worked for a couple of hours each day so the physician still had to do his own charting into the computer system frequently which might explain why there were so many errors in this patient's chart. This might also explain why this patient was given a diagnosis of down syndrome because the electronic record is a "click system" and he could have clicked the wrong button or symptoms that would have generated that diagnosis.

G. The Compliance Officer: The compliance officer the HRA spoke with investigates breach of confidentiality complaints. She stated that during her investigation, she did find that another patient's information was included in this patient's record. However, the incorrect records had a strike through mark edit and there was a physician's note stating that these records were entered in error into this patient's electronic chart. The compliance officer explained that once errors are made in an electronic chart, they cannot be permanently removed because if the patient received treatment based on the incorrect information, the incorrect information would need to be in the chart to explain why certain treatment was given. She stated that the patient in this case did not receive any medications or treatment based on these notes as the error was caught right away and stricken from the electronic chart. This was not deemed as a breach of confidentiality because the other patient's name was not listed in this patient's chart therefore, no identifying information was disclosed to an unauthorized person. The compliance officer also ran a security audit of everyone who looked at this patient's electronic record and what screen they accessed. Everyone who viewed it were people who provided care or corporate office. She also interviewed every member of the emergency department that worked while this patient was in the emergency room. They were asked about any inappropriate disclosures or conversations and no one reported hearing any such disclosure or conversation. They elaborated that it is a noisy area but where they communicate during shift change reporting is surrounded by glass to help protect confidentiality.

The HRA questioned if another agency were to request these records in the future, if the incorrect "stricken through" records would be sent as well. She stated that yes they would but there is a note in the chart stating it was entered in error and should not be a problem. She reported her findings of the confidentiality breach investigation to the Quality Assurance staff person for the hospital who followed up on the other complaints that this patient had.

Record Review

A. Previous Community Hospital Records: The HRA reviewed the records from the previous hospital stay that occurred a few days prior to the patient's admission to Union County Hospital. The records show an admission date of 3/14/15 for back spasms. Allergies listed are as follows: Serotonin medications, Benadryl, Tramadol Hydrochloride, Seroquel and Strawberries. Her current medications were listed as Adderall XR 1 tab by mouth 2 times per day; Xanax 1 tab by mouth 3 times per day; Docusate Sodium 50 mg; Donepezil Hydrochloride (Aricept) 1 tab by mouth once daily; Cymbalta 1 tab by mouth once daily; Estradiol 1 tab by mouth daily at bedtime; Levothyroxine Sodium 1 tab once daily; Percodan (oxycodone and aspirin) 1 tab 3 times a day; and Propranolol Hydrochloride 1 tab 2 times per day. The records do not indicate whether or not those medications were continued during admission. Her psychiatric history is listed as having a history of anxiety and depression. Her neurological findings stated that she was oriented to person place and time. A consultation record dated 3/14/15 for pain control documented at home pain medications as Cymbalta 60 mg daily and Percodan 4/325 1 tablet three times a day. The In-patient pain medications are listed as Flexeril 10 mg every 8 hours, Cymbalta 60 mg daily and Morphine 2-4 mg IV push every four hours. A consultation record dated 3/14/15 for evaluation of altered mental status was also reviewed. It noted that she was scheduled for discharge when she developed acute change in mental status per the nursing staff. According to the patient, she said she developed "significant spinning sensation" when she stood up and this improved when she laid down flat. She denied any disorientation, headaches, new weakness or numbness. Her current medications on this form are documented as Senokot; Norflex; Miralax; Colace; Cymbalta; Milk of Magnesia; Magnesium Citrate; Estrace; Aricept; Synthroid; Zofran as needed; Phenergan as needed; Temazepam as needed; and Morphine as needed. Neither Adderall nor Xanax were listed as current medications. The mental status was described as "alert and oriented times three" and her psychiatric status was described as "her affect is flat." The plan/assessment documented that "*she was admitted for severe low back pain that has improved with the back brace and adjustment of her medications. However, on the day of consultation, she developed acute onset of vertigo with mild nausea, but no other brain stem symptoms, concerning for a possible benign paroxysmal positional vertigo. After discussion with the patient, she would like to be evaluated for vertigo prior to going home. So we will order vestibular testing. If there is evidence of BPPV or vestibulopathy, we will refer her to physical therapy for vestibular therapy. We will hold her anticholinergics as this can interfere with the study.*" The HRA tried to obtain a medication administration record from the hospital, but after 3 requests, was still unable to obtain the same to verify exactly which medications were considered anticholinergics and withheld from the patient during her stay.

B. Ambulance Service Records: The 3/18/15 records indicate that the 911 call was received at 7:23 a.m., and an ambulance was at the home by 7:41 a.m. and at the hospital at 8:29 a.m. The primary symptom is listed as mental/psychiatric and the medical history was obtained from family. The narrative of the call response documented that the local sheriff was also called to respond to the scene for "assistance trying to manage the patient." Upon arrival Emergency Medical Service (EMS) spoke with the patient's son who stated that it was "like a scene from the exorcist" and that his sister had arrived first to check on her and the patient attacked his sister. He said his sister was "sitting on the patient to hold her down and avoid being attacked" and that his mother was not mentally stable and that this was not the first occurrence. When EMS entered the residence, the patient was lying on her back facing up with her daughter sitting on her legs. It was noted that the patient "was not awake at that time but was instead responding only to

pain." She was moved to the cot "without incident" however, once in the ambulance she became combative and had to be restrained by EMS to avoid injuring herself and/or EMS. It was noted that she tried to bite EMS and talked about family trying to kill her. The patient was placed in soft restraints to aid in controlling her in case of future outbursts. The patient's family informed EMS that she had mentioned wanting to die and had possibly overdosed on one of her medications. EMS were also informed of her recent hospitalization for treatment of back pain and that she had been kept for an extended time due to noncompliance with medications. The patient was noted to have remained calm and responded only by looking around and would not verbalize. Due to her "altered mental status" it was noted that she was unable to sign paperwork. It was documented that she was allergic to Benadryl and Tramadol and that EMS provided a list of medications to the hospital.

C. The 3/18/15 emergency room documentation stated that there were no known drug allergies and indicated in social history that she was "nonverbal at this time patient nods head when ask [sic] a question." The presentation and reason for being at the emergency department is listed as *"The patient's problem is reported as altered mental status, confused, patient at home with family members and confusion and combative…not sure of the RX (prescriptions/medications) that the patient is currently taking or if the patient may be doubling on it…out of [name] hospital two days ago and was reportedly by family confused at that time. Seemingly much worse at this time of exam…Patient's baseline: Neuro: alert but confused. The patient has experienced a previous episode, family report prior similar problem when her medications got out of sequence. The patient has been recently seen by a physician: 2 day(s) ago, recently discharged from hospital."* Head/Face is described as *"minor changes with Downs [sic] syndrome and depressed communication skills."* Her Neuro is described as *"Orientation: Mentation is normal, Cranial nerves: grossly normal…Cerebellar function: is grossly normal, Motor: is normal, Sensation: is normal Gait: not tested."* Psych is described at 1:14 p.m. as *"Behavior/mood is anxious, aggressive, angry"* at 8:04 p.m. Psych is described as *"Affect is not oriented to person place, situation, Patient has no thoughts/intents to harm self or others."* A Jane Doe alias was given to the patient at 8:42 a.m. At 11:00 a.m. the course of treatment note stated that a CT scan without contrast was completed. The findings are *"No acute intracranial abnormality. Mild chronic ischemic disease of the white matter and mild cerebral volume loss…"* At 1:18 p.m. the differential diagnosis lists *"Dementia, Alzheimer disease, metabolic disorder, drug effects, aggressive behavior and confusion."* At 1:24 p.m. the ED Course states *"This patient is stable for mental health hospitalization and transport to an appropriate facility."* At 6:02 p.m. another ED course note states *"psych services here, have been evaluating patient….since approx. 13:30 for evaluation and possibly placement of pt."* A differential diagnosis entered at 8:05 p.m. listed diagnoses of *"psychosis, schitzophrenia [sic], bipolar."* Following these entries are *approximately* 4 pages of medical notes for the same date but with times of 9:02 a.m. through 1:03 p.m. that have a strikethrough correction/editing mark through the notes with an entry of "Delete reason: wrongful entry." The content could still be read but no other patient's name was mentioned. The pages contained this patient's name with the other patient's notes. The triage notes did say the patient denied pain and described her appearance as "distressed" and behavior as *"cooperative, crying, pt unable to speak, pt is communicating through non-verbal methods nodding head yes/no to answer questions. Neuro: oriented to person, situation, grips are weak on left full function in bilateral foot/feet Speech is absent…No drug allergies."* The patient was assessed to be a fall risk due to confusion and the suicide risk was deemed to be *"unable to obtain due to patient uncooperative."* Suicide interventions are

listed as *"de-escalation techniques used. Assessed for appropriate restraint or seclusion per policy. Room secured. Searched patient for dangerous items. Patient placed in hospital gown."* The ED Course stated that at 8:56 the patient was moved to CT and back at 9:02 then at 9:13 it was also noted that an EKG was done. A nursing note at 9:24 a.m. stated the nurse spoke with the patient's daughter per permission of patient. The daughter reported that her mother had been taken to another hospital recently for back pain. When the daughter went to visit her mother, she discussed her mother's confusion with the nurse who reported it to be withdrawal from Adderall. Upon discharge her mother still seemed confused and kept saying she was on a TV show. The daughter reported that she took her mother home and have her medication and she went to bed. That morning (of ED admission) the daughter reported that she had tried to get her mother to take her medications and she became combative saying she wanted to kill herself and the daughter had to physical restrain her. The mother was hitting and scratching her saying she wanted to kill her. The daughter reportedly stated that she was used to dealing with that and that her mother had been like that quite often and that she had been taken to multiple hospitals and no one knows what to do for her. The daughter did report a car accident that occurred 2 years ago that resulted in her mother having a TBI. The daughter did report that her mother had no psychiatric admissions since she was a small child. At 2:05 p.m. a nursing note documented that the patient was standing up talking with the counseling agency crisis worker. At 7:47 p.m. a nursing note documented that the transportation company was consulted for transportation of the patient to a psychiatric hospital. It was noted that the *"patient is a involuntary admission for psychiatric treatment."* Another nursing note at 8:22 p.m. stated *"discontinued lock no redness/swelling at site. Pt pulled IV out per self. Bleeding controlled with 2x2 and paper tape."* It was explained to the HRA that the lock described in this note refers to a saline lock on an IV not a restraint type lock. At 7:39 p.m. it was documented that the patient was given Haldol (as Decanoate) 5 mg IM (injection) and Benadryl 25 mg IM in the right deltoid. No reason for the medication was documented. It was documented at 8:57 p.m. that there was no adverse reaction. The patient left the ED at 8:56 p.m. and it was documented that the transfer was ordered by the physician. Upon further review, the HRA obtained a printout of the medication that the patient received during her ED stay which showed that Diphenhydramine (Benadryl) 50 mg was given not Ativan.

The HRA also reviewed the admission forms entitled inpatient/outpatient conditions of admission and consent to medical treatment. This document includes a paragraph on general consent for tests, treatment, photo, video and services. This consent paragraph states the following *"I hereby voluntarily consent for treatment/admission to the Facility. I permit the Facility and its employees, physicians, fellows, residents, interns, and others involved in my care to treat me in ways they judge to be beneficial to me, I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent for treatment or tests. I consent to examinations, blood tests…laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physicians, fellows, residents, interns, and their associates and assistants, or rendered by Facility personnel under the instructions, orders or direction of such physician(s), fellow(s), resident(s) or intern(s)…"* There was a note next to this paragraph where the patient was to initial that stated the patient was unable to sign which was initialed by a nurse. The final page of this form also stated that the patient was unable to sign and two nurses signed and dated the form with a time of 0851.

D. The crisis worker notes documented that there was no current risk of harm to self and no current risk of harm to others. The level of risk was marked as low. Past psychiatric care was listed as *"depression back in the 80's…ADHD from a brain injury."* Medication allergies are listed as *"none stated."* The patient's current presenting problem lists quotations from the patient stating she was time morphing, had a car accident in 2012 after which her and her daughter's relationship suffered, she stated she *"was attacked or could have been a helicopter."* The Petition for Involuntary Admission listed threats, behavior to support the complaint as *"patient was brought in by ambulance in restraints because she jumped her daughter while her daughter was making sure she took her medications. She has a history of being non-compliant with medications. She also has a history of being violent towards her daughter while in the ER. She was psychotic towards ER staff. Also she was trying to take off."* The crisis worker had another page of notes describing the patient's presentation. She stated that the patient was *"very delusional speaking about ER staff ganging up on her with family…denies mental health problems, she blames her problems on ADHD caused by a head injury she received in a wreck. Continuously speaks about time morphing and looping in and out of the past and future…speaks of dream jumping."* The worker did note that the patient's *"daughter seems to believe that if given Adderall XR the hallucinations would discontinue."* The physician's certificate attached to the Petition stated that his opinion was based on the following *"patient with schizophrenia and potential harm to herself or others."*

E. Psychiatric Hospital Records: The patient was admitted to the psychiatric hospital on 3/18/15 and discharged on 3/23/15. The history and physical form documented that the patient's chief complaint was *"my medication mess me up."* The form noted that the patient had a history of previous psychiatric admissions and that she has a history of having a motor vehicle accident in 2012 which caused her head injury. The form only lists an allergy to strawberries; nothing is mentioned about being allergic to Benadryl. The history of present illness stated that the patient *"was brought to the hospital after she had altercation with her daughter. According to the report, she beaten up, she was taken to the Union County Hospital in the ER. The patient was placed in restraints. She was also paranoia toward the staff there. She was restless. She was getting into the things. She reported that possibly she overdosed on prescription medications. The patient was having flight of ideas. She was having paranoia. [sic]"* The mental status examination documented that the patient *"is wearing braces on her chest. Her mood has been all right. Affect is constricted. She denies being suicidal or homicidal. She denies any voices. She is alert and oriented x3. Judgment and insight are limited. She is still disorganized, just kind of guarded and paranoid."* Her diagnosis is listed as Axis I Psychosis, not otherwise specified; Axis II Deferred; Axis III 1. History of head injury due to motor vehicle accident. 2. History of chronic back pain; Axis IV Physical problems; and Axis V Current global assessment of functioning is 30. Mental status exam at the time of intake showed a score of 17 and the form indicated that a score of 10 or greater indicates the need for consult with psychiatrist or Director of Resource Center. Her score was based on moderate distraction, impaired memory and hostility (hostile to hospital staff and daughter but not towards the agency worker) and severely impaired insight, hallucinating disorganized thinking and impaired judgment and impulse control problem along with bizarre or atypical speech. The treatment plan was described as: admission to the "closed psych unit;" observe behavior, sleep and appetite; provide education, support and therapy; discharge her when she is no longer a danger to herself or others. A 3/20/15 progress note stated that the patient *"is alert and oriented x3. She is cooperative. She denies being suicidal or homicidal. Her depression is better."* It was noted that the treatment was to

"continue the current medications. Supportive treatment was provided" but nothing was specified as to what medications she was on or what treatment was provided. The 3/21/15 progress note stated that the patient reported feeling better, her depression was better and she continued to deny homicidal or suicidal thoughts. The patient reported focusing better. The mental status note documented that her judgement and insight were improving. The 3/23/15 progress note stated that the patient reported feeling better, denied hearing any voices or seeing things, denied manic or hypomanic symptoms and denied any side effects to the medication; however the medication was not specified. The mental status examination portion stated that she was alert and oriented x3, pleasant and denied being suicidal or homicidal. The treatment was described as *"continue with current medications. Discharge home today with her daughter. Supportive treatment is provided. Follow up is arranged."* The discharge summary documented the history of her present illness and also stated that she *"has been taking Adderall, Xanax and trazodone. She is focused on the Adderall."* The course of hospitalization section documented her mood as *"euthymic"* and affect as *"restricted"*. It was noted that the patient *"adamantly denies any suicidal or homicidal ideation. She denies any symptoms of psychosis."* She was described as *"fully alert and oriented with limited insight and judgment…somewhat disorganized and somewhat guarded."* The patient reported that she had a reaction to being taken off the benzodiazepine medications and Adderall by the hospital which resulted in the behaviors and temporary psychosis that brought her to the psychiatric unit. Her discharge medications are listed as Levothyroxine (thyroid), Propranolol (beta blocker), Valacyclovir (antiviral) and Olanzapine (antipsychotic). Her condition at the time of discharge was described as *"fully alert and oriented. She is cooperative. She denies any suicidal or homicidal ideation. She denies any auditory or visual hallucinations or delusions. There are no symptoms of a mania. Her sleep and appetite are good. Her mood is stable. She does report feeling better, and she is looking forward to discharge."* The discharge instructions included the following in the substance abuse history *"Union County ER reports high levels of prescription medications in blood."* It was also noted that her medication was not being taken as prescribed.

The HRA reviewed Drugs.com to check for drug interactions on the medications the patient was prescribed by the regular treating psychiatrist. The results showed a "major" interaction between Flexeril and Cymbalta. The interaction was described as *"can increase the risk of a rare but serious condition called the serotonin syndrome, which may include symptoms such as confusion, hallucination, seizure, extreme changes in blood pressure, increased heart rate, fever, excessive sweating, shivering or shaking, blurred vision, muscle spasm or stiffness, tremor, incoordination, stomach cramp, nausea, vomiting and diarrhea. Severe cases may result in coma and even death. You should seek immediate medication attention if you experience these symptoms while taking the medications…"* Another "major" interaction was noted for Dexedrine and Cymbalta. This interaction was described as *"may increase the effects of dextroamphetamine, and side effects such as jitteriness, nervousness, anxiety, restlessness and racing thoughts have been reported. Combining these medications can also increase the risk of a rare but serious condition called the serotonin syndrome, which may include symptoms such as confusion, hallucination, seizure, extreme changes in blood pressure, increased heart rate, fever, excessive sweating, shivering or shaking, blurred vision, muscle spasm or stiff ness, tremor, incoordination, stomach cramp, nausea, vomiting and diarrhea. Severe cases may result in coma and even death…"* There were other interactions between some of her other medications that were listed as "moderate" which included symptoms such as confusion, difficulty

concentrating, mental impairment, impairment in thinking, altered judgment, motor coordination difficulties and changes in pulse rate or blood pressure.

E. Psychiatric Records: The HRA also reviewed records from the patient's regular treating psychiatrist. She was seen for a follow up appointment in February, 2016 for *"traumatic brain injury (TBI) unspecified intracranial injury without loss of consciousness, sequela, chronic recurrent major depressive disorder recurrent, unspecified, major depressive disorder, dementia unspecified without behavioral disturbance due to head injury, posttraumatic stress disorder (PTSD) unspecified and Obsessive-compulsive disorder.* For this particular visit from February, 2016 it was noted that the patient stated she had been having pain issues, feels depressed, receives Adderall from neurologist. The patient stated that she does not take this daily but admitted to not taking Synthroid as prescribed either. The patient admitted to not taking Xanax and Cymbalta appropriately, denied suicidal or homicidal ideation, denied hallucinations, and denied changes in her memory. The following is a list of medications reviewed by this psychiatrist that were recently filled (January, 2016 forward) and the common prescription reason according to WebMD:

- Xanax (anxiety) 1 tablet 3 times per day
- Flexeril (muscle relaxer) 10 mg tablet
- Dextroamphetamine ER (ADHD) 20 mg 24 hour capsule extended release
- Aricept (dementia/Alzheimer's) 10 mg tablet
- Cymbalta (Anxiety/Depression)
- Gabapentin (anti-epileptic, nerve pain) 100 mg capsule
- Oxycodone-aspirin (Pain) 325 mg tablet
- Propranolol (beta blocker) 20 mg tablet
- Propranolol ER 60 mg capsule 24 hour extended release
- Ambien (Sedative, Insomnia) 10 mg tablet

During this visit, the patient also complained of nightmares about her kids putting her in a psychiatric hospital. The records also noted an allergy to Benadryl. The assessment/plan documented that the physician discussed the importance of medication compliance and by not following the medication regimen, she is contributing to her symptoms. The patient agreed and stated she will start taking medication as prescribed.

Policy Review

The Union County Hospital's Patient Rights and Responsibilities policy addresses confidentiality by stating that patients have a right to *"personal privacy, privacy of your health information and to receive a notice of the hospital's privacy practices...access, request amendment to and obtain information on disclosures of your health information in accordance with law and regulation within a reasonable time frame."* This policy also states that patients have a right to care or services to be provided without discrimination related to physical or mental disability and that patients have a right to *"participate in decisions about your care, including development of your treatment plan, discharge planning and having your family and personal physician promptly notified of your admission."* The policy further states that patients have a right to *"receive information about the outcomes of your care, treatment and services, including unanticipated outcomes…receive information about benefits, risks, side effects to proposed care, treatment and services; the likelihood of achieving your goals and any potential problems that might occur during recuperation from proposed care, treatment and service and any reasonable alternatives to the care, treatment and services proposed."* The policy requires

that patients be *"free from neglect; exploitation; and verbal, mental, physical and sexual abuse [and be in] an environment that is safe, preserves dignity and contributes to a positive self-image. Be free from any forms of restraint or seclusion used as a means of conveniences, discipline, coercion or retaliation; and to have the least restrictive method of restraint or seclusion used only when necessary to ensure patient safety."* The policy also ensures a patient's right to *"lodge a concern with the state, whether you have used the hospital's grievance process or not."*

The hospital has a policy on outpatient registration. The section of this policy entitled Obtaining Preliminary Information (Non-Pre-Registered Patients) states the following *"4. The registration clerk should ask the patient (or his/her legal representative) to sign the Inpatient/Outpatient Conditions of Admission and Consent to Medical Treatment form. If the patient is unable to sign, the registrar should write in **UNABLE TO SIGN** and initial. The form will still need to be signed before the patient is discharged…"*

The UCH policy entitled patient/resident complaint/grievance states that the governing board has delegated the complaint and grievance process to the hospital quality improvement committee. The quality improvement committee has designated specific responsibilities to the following roles: 1. CEO: See that response letters are sent to the patient or family 2. Quality Director: aggregating and analyzing data to present to the quality improvement committee for review and recommendation. The hospital quality improvement committee ensures that the patient is provided written notice of its receipt, investigation and outcomes regarding the complaint or grievance within 7 days of the hospital's receipt of the same. However, the hospital's resolution does not need to be completed within the 7 day limit. The written notice should include: 1. The name of the hospital contact person 2. The steps taken on behalf of the patient to investigate the grievance 3. Results of the grievance process and 4. The date of completion. The policy continues to state *"If the grievance is not yet resolved within the initial, written response of 7 days, the written response will indicate that the hospital is working towards a resolution of the grievance and that a follow-up written response will be provided within a specified time period but not to exceed 30 days until the grievance is resolved. If the grievance remains unresolved after 30 days, additional written follow-up would be indicated within a specified time period but not to exceed an additional 30 days."*

The UCH policy on confidentiality requires that *"the use and disclosure of a patient's individually identifiable health information must be in compliance with existing federal and state regulations."* This policy also states that it *"applies to and will be distributed to all personnel, medical staff, clinical staff, volunteers, students and other members of the organization. Each facility should attempt to ensure that vendors are aware of and comply with federal and state laws and facility policies and procedures related to the protection of patient health information. Employees, volunteers and the medical staff are expected to exercise due care in any discussion, use or disclosure of PHI [protected health information.]"* The policy continues by stating *"The minimum necessary standard should be applied to all uses and disclosures of PHI. Use or disclosure should be made by limiting the information to the minimum amount required to fulfill the stated purpose. The minimum necessary standard applies when using or disclosing PHI, or when requesting PHI from another covered entity. Make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. The following requirements must be met:*

Uses (Internal access to PHI)

- *Identify the persons or classes of persons in the workforce who need access to PHI, the category or categories of PHI to which access is needed, and any conditions appropriate to such access*

- *Make reasonable efforts to limit the work force's access to PHI to only that information which is necessary to carry out their duties*

Disclosures (external releases of or access to PHI)

- *For any type of disclosure or access that occurs on a routine and recurring basis, limit the PHI disclosed to the amount reasonably necessary to achieve the purpose for the disclosure (Example: if a physician's summary of an inpatient admission is needed, provide only a copy of the discharge summary)*
- *For all other disclosures or access, limit the PHI disclosed or accessible to the information reasonably necessary to accomplish the purpose for which the disclosure or access is sought and review requests for disclosure or access on an individual basis in accordance with such criteria…*

- *To ensure compliance with federal and state privacy laws and regulations, PHI collected and/or generated within the facility will be maintained in a manner which restricts access to those with a need-to-know. The use and disclosure of PHI will be restricted in accordance with state and federal requirements."*

The hospital does have a <u>policy on amending the contents of a patient's medical record</u> which was reviewed by the HRA. This policy provides that *"patients who believe information within their designated record set is incomplete or incorrect may request an amendment to the information…the request to amend should be denied if the medical record in question is:*

- *Accurate and complete (as determined by the HIMD in conjunction with Facility Privacy Officer following an investigation of the alleged inaccurate/incorrect information)*
- *Not created by the facility receiving the request*
- *Not allowed to be disclosed per HIPAA privacy regulations…or state statutes or is not part of the patient's medical record…*

The Electronic Health Records (EHR) section states that *"B. The amendment must be made in the source system (where it was originally created) as well as in the long-term medical record or data repository system if applicable.* ***C. Maintain the original incorrect entry or documentation and add the corrected entry or companion document to it****…Exceptions: 2. Errors in charting identified by the author will be corrected in the body of previously charted text by using the single line, initials and current date with re-charting of corrected information at the bottom of the page using "Late Entry". Errors in charting identified by the author will be corrected in the source system, if functionality is available. If functionality does not exist, the above proper process will be utilized, as well as any other system in which the information is maintained. 3. The addition of information not documented at the time of the encounter shall be documented in a similar manner by the health care professional. "Late Entry", the current date and the information shall be documented at the bottom of the last page of documentation (i.e., last page of nursing notes, progress notes, etc.). For the electronic health record, the amendment*

shall be documented in the source system as a correction to the original, if functionality is available; otherwise the above proper process will be utilized."

The hospital policy on restraint and seclusion emphasizes the hospital's commitment to limit the use of restraints and seclusion to emergencies where there is a risk to the patient harming himself or others and includes a section of 11 approaches to use as interventions/alternatives when possible to help facilitate a limited amount of restraint and seclusion use. The policy defines what is and is not considered restraint and stated that *"drugs/medications used as a standard of treatment are not considered a restraint if the medication is used within the FDA guidelines (including dosing), follows national practice standards and is based on the patient's symptoms and overall condition. Medications used to enable (improve the patient's ability to effectively or appropriately interact with the world) and not disable the patient are not considered a restraint."* The policy while acknowledging a patient's right to refuse treatment stated that *"under certain circumstances, if serious bodily harm is judged to be imminent (e.g. violent patient) an RN, after assessment of the patient should institute the use of restraint, which he/she believes will protect the patient and/or others effectively, but alternatives must be considered."* The policy requires hospital staff to prevent, reduce and eliminate the use of restraints by basing use on the patient's assessed needs by: *"…Using the least restrictive method. Restraint use shall not be the first choice solution. The choice of device shall be the least restrictive restraint needed to accomplish this purpose and in consideration of the patient's condition when a restraint is used. All efforts should be made to avoid restraints if patient safety may be maintained without the use of restraints."* The policy requires that restraints not be used for punishment, coercion, discipline or retaliation of the patient, or for staff convenience. Situations in which restraints are clinically justified are listed as: Harmful to self or others and alternative measures have been attempted; threatens placement and/or patency of necessary therapeutic lines/tubes, interfering with necessary medical treatment and alternative measures have been attempted; patient is unable to follow directions to avoid self-injury and protective, alternative measures have been attempted. A physician or LIP (licensed independent practitioners) has to order every episode of restraints for a patient and orders cannot be for an unspecified future time or episode and cannot be written as a standing or PRN (as needed) order. The policy also requires each episode of restraint to be documented in the patient's medical record.

The HRA was informed that there is no formal policy that governs how to handle a patient with a suspected mental illness. However, the followed procedure is for the local community counseling agency to be contacted to provide a mental health assessment once a patient with a suspected mental illness has been cleared medically by the emergency department physician.

Statutes

Pursuant to the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102):

"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. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. In determining whether care and services are

being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided**...(a-5)** 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.*** 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. *If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only (i) pursuant to the provisions of Section 2-107 or 2-107.1 or (ii) pursuant to a power of attorney for health care under the Powers of Attorney for Health Care Law or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act.* ***A surrogate decision maker, other than a court appointed guardian, under the Health Care Surrogate Act may not consent to the administration of*** *electroconvulsive therapy or* ***psychotropic medication****. A surrogate may, however, petition for administration of such treatment pursuant to this Act.* If the recipient is under guardianship and the guardian is authorized to consent to the administration of electroconvulsive therapy or psychotropic medication pursuant to subsection (c) of Section 2-107.1 of this Code, the physician shall advise the guardian in writing of the side effects and risks of the treatment, alternatives to the proposed treatment, and the risks and benefits of the treatment. A qualified professional shall be responsible for overseeing the implementation of such plan. Such care and treatment shall make reasonable accommodation of any physical disability of the recipient, including but not limited to the regular use of sign language for any hearing impaired individual for whom sign language is a primary mode of communication. If the recipient is unable to communicate effectively in English, the facility shall make reasonable efforts to provide services to the recipient in a language that the recipient understands."

<u>The Code has guidelines that govern the use of psychotropic medications (405 ILCS 5/2-107):</u>

"(a) 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. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available. The facility director shall inform a recipient, guardian, or substitute decision maker, if any, who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services.

(b) Psychotropic medication or electroconvulsive therapy may be administered under this Section for up to 24 hours only if the circumstances leading up to the need for emergency treatment are set forth in writing in the recipient's record.

(c) Administration of medication or electroconvulsive therapy may not be continued unless the need for such treatment is redetermined at least every 24 hours based upon a personal examination of the recipient by a physician or a nurse under the supervision of a physician and the circumstances demonstrating that need are set forth in writing in the recipient's record.

(d) Neither psychotropic medication nor electroconvulsive therapy may be administered under this Section for a period in excess of 72 hours, excluding Saturdays, Sundays, and holidays, unless a petition is filed under Section 2-107.1 and the treatment continues to be necessary under subsection (a) of this Section. Once the petition has been filed, treatment may continue in compliance with subsections (a), (b), and (c) of this Section until the final outcome of the hearing on the petition.

(e) The Department shall issue rules designed to insure that in State-operated mental health facilities psychotropic medication and electroconvulsive therapy are administered in accordance with this Section and only when appropriately authorized and monitored by a physician or a nurse under the supervision of a physician in accordance with accepted medical practice. The facility director of each mental health facility not operated by the State shall issue rules designed to insure that in that facility psychotropic medication and electroconvulsive therapy are administered in accordance with this Section and only when appropriately authorized and monitored by a physician or a nurse under the supervision of a physician in accordance with accepted medical practice. Such rules shall be available for public inspection and copying during normal business hours.

(f) The provisions of this Section with respect to the emergency administration of psychotropic medication and electroconvulsive therapy do not apply to facilities licensed under the Nursing Home Care Act,1 the Specialized Mental Health Rehabilitation Act of 2013, the ID/DD Community Care Act, or the MC/DD Act.2

(g) Under no circumstances may long-acting psychotropic medications be administered under this Section.

(h) Whenever psychotropic medication or electroconvulsive therapy is refused pursuant to subsection (a) of this Section at least once that day, the physician shall determine and state in writing the reasons why the recipient did not meet the criteria for administration of medication or electroconvulsive therapy under subsection (a) and whether the recipient meets the standard for administration of psychotropic medication or electroconvulsive therapy under Section 2-107.1 of this Code. If the physician determines that the recipient meets the standard for administration of psychotropic medication or electroconvulsive therapy under Section 2-107.1, the facility director or his or her designee shall petition the court for administration of psychotropic medication or electroconvulsive therapy pursuant to that Section unless the facility director or his or her designee states in writing in the recipient's record why the filing of such a petition is not warranted. This subsection (h) applies only to State-operated mental health facilities.

(i) The Department shall conduct annual trainings for all physicians and registered nurses working in State-operated mental health facilities on the appropriate use of emergency administration of psychotropic medication and electroconvulsive therapy, standards for their use, and the methods of authorization under this Section."

Pursuant to the Mental Health and Developmental Disabilities Code (405 ILCS 5/3-600):

"3-600. A person 18 years of age or older who is subject to involuntary admission on an inpatient basis and in need of immediate hospitalization may be admitted to a mental health facility pursuant to this Article."

The Mental Health Code (405 ILCS 5/3-601) also provides that:

"(a) When a person is asserted to be subject to involuntary admission on an inpatient basis and in such a condition that immediate hospitalization is necessary for the protection of such person or others from physical harm, any person 18 years of age or older may present a petition to the

facility director of a mental health facility in the county where the respondent resides or is present. The petition may be prepared by the facility director of the facility.

(b) The petition shall include all of the following:

1. A detailed statement of the reason for the assertion that the respondent is subject to involuntary admission on an inpatient basis, including the signs and symptoms of a mental illness and a description of any acts, threats, or other behavior or pattern of behavior supporting the assertion and the time and place of their occurrence.

2. The name and address of the spouse, parent, guardian, substitute decision maker, if any, and close relative, or if none, the name and address of any known friend of the respondent whom the petitioner has reason to believe may know or have any of the other names and addresses. If the petitioner is unable to supply any such names and addresses, the petitioner shall state that diligent inquiry was made to learn this information and specify the steps taken.

3. The petitioner's relationship to the respondent and a statement as to whether the petitioner has legal or financial interest in the matter or is involved in litigation with the respondent. If the petitioner has a legal or financial interest in the matter or is involved in litigation with the respondent, a statement of why the petitioner believes it would not be practicable or possible for someone else to be the petitioner.

4. The names, addresses and phone numbers of the witnesses by which the facts asserted may be proved.

(c) Knowingly making a material false statement in the petition is a Class A misdemeanor."

According to the Mental Health Code (405 ILCS 5/3-602):

"The petition shall be accompanied by a certificate executed by a physician, **qualified examiner**, psychiatrist, or clinical psychologist which states that the respondent is subject to involuntary admission on an inpatient basis and requires immediate hospitalization. The certificate shall indicate that the physician, qualified examiner, psychiatrist, or clinical psychologist personally examined the respondent not more than 72 hours prior to admission. It shall also contain the physician's, qualified examiner's, psychiatrist's, or clinical psychologist's clinical observations, other factual information relied upon in reaching a diagnosis, and a statement as to whether the respondent was advised of his rights under Section 3-208."

Section 3-208 states "Whenever a petition has been executed pursuant to Section 3-507, 3-601 or 3-701, and prior to this examination for the purpose of certification of a person 12 or over, the person conducting this examination shall inform the person being examined in a simple comprehensible manner of the purpose of the examination; that he does not have to talk to the examiner; and that any statements he makes may be disclosed at a court hearing on the issue of whether he is subject to involuntary admission. If the person being examined has not been so informed, the examiner shall not be permitted to testify at any subsequent court hearing concerning the respondent's admission."

The Medical Patient Rights Act (410 ILCS 50/3) establishes the following rights *"(a) The right of each patient to care consistent with sound nursing and medical practices, to be informed of the name of the physician responsible for coordinating his or her care, to receive information concerning his or her condition and proposed treatment, to refuse any treatment to the extent permitted by law, and to privacy and confidentiality of records except as otherwise provided by law… (d) The right of each patient to privacy and confidentiality in health care. Each physician, health care provider, health services corporation and insurance company shall refrain from disclosing the nature or details of services provided to patients, except that such information*

may be disclosed: (1) to the patient, (2) to the party making treatment decisions if the patient is incapable of making decisions regarding the health services provided, (3) for treatment in accordance with 45 CFR 164.501 and 164.506, (4) for payment in accordance with 45 CFR 164.501 and 164.506, (5) to those parties responsible for peer review, utilization review, and quality assurance, (6) for health care operations in accordance with 45 CFR 164.501 and 164.506, (7) to those parties required to be notified under the Abused and Neglected Child Reporting Act1 or the Illinois Sexually Transmissible Disease Control Act,2 or (8) as otherwise permitted, authorized, or required by State or federal law. This right may be waived in writing by the patient or the patient's guardian or legal representative, but a physician or other health care provider may not condition the provision of services on the patient's, guardian's, or legal representative's agreement to sign such a waiver. In the interest of public health, safety, and welfare, patient information, including, but not limited to, health information, demographic information, and information about the services provided to patients, may be transmitted to or through a health information exchange, as that term is defined in Section 2 of the Mental Health and Developmental Disabilities Confidentiality Act, in accordance with the disclosures permitted pursuant to this Section. Patients shall be provided the opportunity to opt out of their health information being transmitted to or through a health information exchange in accordance with the regulations, standards, or contractual obligations adopted by the Illinois Health Information Exchange Authority in accordance with Section 9.6 of the Mental Health and Developmental Disabilities Confidentiality Act, Section 9.6 of the AIDS Confidentiality Act, or Section 31.8 of the Genetic Information Privacy Act, as applicable. In the case of a patient choosing to opt out of having his or her information available on an HIE, nothing in this Act shall cause the physician or health care provider to be liable for the release of a patient's health information by other entities that may possess such information, including, but not limited to, other health professionals, providers, laboratories, pharmacies, hospitals, ambulatory surgical centers, and nursing homes."

Hospital Regulations (77 IL ADC 250.1510) require that *"2) An adequate, accurate, timely, and complete medical record shall be maintained for each patient… 4) A committee of the organized medical staff shall be responsible for reviewing medical records to ensure adequate documentation, completeness, promptness, and clinical pertinence… e) Preservation 1) All original medical records or photographs of records shall be preserved in accordance with Section 6.17 of the Act. 2) The hospital shall have a policy for the preservation of patient medical records if the hospital closes."*

Hospital Regulations (77 IL ADC 250.2280) states that *"a) The "Mental Health and Developmental Disabilities Code" effective January l, l979, as hereafter amended - Public Act 80-l4l4 shall apply to the care of patients… c) Restraints and Seclusion Restraints and seclusion facilities shall be available and written policies shall be established for their use. Mechanical restraints and/or seclusion may be used only on the written order of a physician. This written order shall be valid for specific periods of time. In an Emergency, the person in charge may order restraints. Confirmation of the order by a physician shall be secured. Policies and procedures regarding use of restraints and seclusion will be reviewed annually. A log showing patient identification, justification for restraint, time applied and released and other pertinent information shall be maintained. (Refer to Public Act 80-l4l4 - the Mental Health and Developmental Disabilities Code.)"* Section 250.2290 further states that *"l) It is recommended that the unique confidentiality requirements of a psychiatric record be recognized and safeguarded in any unitized record keeping system of a general hospital."*

HIPAA regulations (45 CFR 164.502) state *"a) Standard. A covered entity or business associate may not use or disclose protected health information, except as permitted or required by this subpart or by subpart C of part 160 of this subchapter.*

(1) Covered entities: Permitted uses and disclosures. A covered entity is permitted to use or disclose protected health information as follows:

- *(i) To the individual;*
- *(ii) For treatment, payment, or health care operations, as permitted by and in compliance with § 164.506;*
- *(iii) Incident to a use or disclosure otherwise permitted or required by this subpart, provided that the covered entity has complied with the applicable requirements of §§ 164.502(b), 164.514(d), and 164.530(c) with respect to such otherwise permitted or required use or disclosure;*
- *(iv) Except for uses and disclosures prohibited under § 164.502(a)(5)(i), pursuant to and in compliance with a valid authorization under § 164.508;*
- *(v) Pursuant to an agreement under, or as otherwise permitted by, § 164.510; and*
- *(vi) As permitted by and in compliance with this section, § 164.512, § 164.514(e), (f), or (g).*

(2) Covered entities: Required disclosures. A covered entity is required to disclose protected health information:

- *(i) To an individual, when requested under, and required by § 164.524 or § 164.528; and*
- *(ii) When required by the Secretary under subpart C of part 160 of this subchapter to investigate or determine the covered entity's compliance with this subchapter.*

(3) Business associates: Permitted uses and disclosures. A business associate may use or disclose protected health information only as permitted or required by its business associate contract or other arrangement pursuant to § 164.504(e) or as required by law. The business associate may not use or disclose protected health information in a manner that would violate the requirements of this subpart, if done by the covered entity, except for the purposes specified under § 164.504(e)(2)(i)(A) or (B) if such uses or disclosures are permitted by its contract or other arrangement.

(4) Business associates: Required uses and disclosures. A business associate is required to disclose protected health information:

- *(i) When required by the Secretary under subpart C of part 160 of this subchapter to investigate or determine the business associate's compliance with this subchapter.*
- *(ii) To the covered entity, individual, or individual's designee, as necessary to satisfy a covered entity's obligations under § 164.524(c)(2)(ii) and (3)(ii) with respect to an individual's request for an electronic copy of protected health information."*

Pertaining to amending patient's medical records, 45 CFR 164.526 states that patients have a right to request an amendment to their records:

"(1) Right to amend. An individual has the right to have a covered entity amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.

(2) Denial of amendment. A covered entity may deny an individual's request for amendment, if it determines that the protected health information or record that is the subject of the request:

> *(i) Was not created by the covered entity, unless the individual provides a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment;*
>
> *(ii) Is not part of the designated record set;*
>
> *(iii) Would not be available for inspection under § 164.524; or*
>
> *(iv) Is accurate and complete…*

(c) Implementation specifications: Accepting the amendment. If the covered entity accepts the requested amendment, in whole or in part, the covered entity must comply with the following requirements.

(1) Making the amendment. The covered entity must make the appropriate amendment to the protected health information or record that is the subject of the request for amendment by, at a minimum, identifying the records in the designated record set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment.

(2) Informing the individual. In accordance with paragraph (b) of this section, the covered entity must timely inform the individual that the amendment is accepted and obtain the individual's identification of and agreement to have the covered entity notify the relevant persons with which the amendment needs to be shared in accordance with paragraph (c)(3) of this section.

(3) Informing others. The covered entity must make reasonable efforts to inform and provide the amendment within a reasonable time to:

(i) Persons identified by the individual as having received protected health information about the individual and needing the amendment; and

(ii) Persons, including business associates, that the covered entity knows have the protected health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to the detriment of the individual"

The Confidentiality Act (740 ILCS 110/4) requires that "*(c) Any person entitled to access to a record under this Section may submit a written statement concerning any disputed or new information, which statement shall be entered into the record. Whenever any disputed part of a record is disclosed, any submitted statement relating thereto shall accompany the disclosed part. Additionally, any person entitled to access may request modification of any part of the record which he believes is incorrect or misleading. If the request is refused, the person may seek a court order to compel modification. (d) Whenever access or modification is requested, the request and any action taken thereon shall be noted in the recipient's record."*

Conclusion

The first complaint alleged inadequate care and treatment of a patient due to refusing to give a patient routine medications, administering a medication which the patient has an allergy to and not fully evaluating the patient by ruling out other possible causes for presenting symptoms other than mental illness. The treating physician is no longer contracted by this hospital and could not be reached for an interview which made it difficult to decipher what options he explored before calling the crisis worker to conduct a psychiatric assessment of the patient. The physician did not chart that he was exploring overdose as an option for her symptoms, but he did order a CT scan to be completed which indicated he may have been exploring other possibilities or was at least trying to rule out other causes and clear the patient medically to determine if she needed to have a psychiatric assessment. The labs that were drawn showed that she tested positive for some drugs due to the medications she was taking, however an overdose panel was not drawn so it only shows up as positive or negative not the amount found in her system. It was also explained by hospital staff that once the community crisis worker is called to conduct an assessment, the issue of placement is "out of the hands" of the hospital and the crisis worker makes the determination based on assessment and discussions with the physician.

The second portion of this allegation involved the patient not being given her routine medications allegedly due to the hospital reporting to the family that those medications could not be given or the receiving facility would not accept her. Upon review with hospital staff, the HRA was informed that receiving facilities have no requirement that medications not be given whether routine or psychotropic for a patient to be admitted to their facility. However, the ED physician has to order routine medication before the ED can administer them. In this case, the physician did not order routine medications to be given. It was also documented in this patient's chart that when asked if she was in any pain or discomfort, she denied any pain so there was no reason to issue her pain medication for her back.

Another aspect of this first allegation was that a medication was given to the patient that she was allergic to. Upon review of the EMS documentation, the HRA found that the EMS report stated that after arrival at UCH ED the patient was moved to bed 2 and turned over to the nurse and that the patient "*had a history of back surgery and undiagnosed psychiatric issues. She was allergic to Benadryl and Tramadol and a list of medications was provided."* The hospital records documented that at 7:39 the patient was given Haldol Decanoate and Benadryl injections prior to her transfer to the psychiatric facility. Medication administration records also showed that Benadryl (Diphenhydramine) was issued for this patient. A review of the receiving psychiatric hospital's records also indicated that the patient's allergy to Benadryl was also not documented in the information provided by UCH to the receiving hospital. The Medical Patient Rights Act (410 ILCS 50/3) establishes the following rights: *"(a) The right of each patient to care consistent with sound nursing and medical practices…"* Hospital Regulations (77 IL ADC 250.2280) states that *"a) The "Mental Health and Developmental Disabilities Code" effective January l, l979, as hereafter amended - Public Act 80-l4l4 shall apply to the care of patients…"* The Mental Health Code (405 ILCS 5/2-102) requires that *"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."* For these reasons, this allegation is **substantiated.** The following **recommendation** is made.

1. **Quality Assurance and other pertinent hospital staff should review this admission and determine where the breakdown in communication occurred between the EMS workers and hospital staff that resulted in the patient's medication allergy not being documented and put corrective measures in place to ensure that this does not occur in the future.**

The HRA also offers the following suggestion:

1. It was documented in a nursing note at 9:24 a.m. that the nurse spoke with the patient's daughter per permission of patient. However, the admission consent form stated that the patient was unable to give consent for treatment. The HRA questioned why the patient was coherent enough to provide permission to speak with her daughter but not to sign consent forms for medication administration and other treatment which may have prevented the medication that she is allergic to being administered. Although there was no violation of the registration policy by staff who stated the patient was unable to sign and then provided nurses signatures to verify that, it was noted that this policy also states that when this procedure is followed, *"the form will still need to be signed before the patient is discharged."* In this case, a signature was never obtained. The HRA understands that in the ED this may not always be possible and standard of care is to provide treatment. However, for best practice the HRA suggests that the policy entitled Outpatient Registration Policy be revised to include a formal policy on the appropriate actions to be taken if, upon discharge, a patient is still unable to sign the consent forms and has no Power of Attorney in place to sign for him/her.

The second allegation alleged inappropriate admission to a psychiatric hospital due to the patient not being a threat to harm herself or others yet she was still discharged to a psychiatric hospital. The patient stated that upon review of her chart, she discovered that her psychiatric admission was based on a phone call and documented information that her daughter provided to the hospital which stated that she had an altercation with her daughter and was combative. However, she did state that the crisis worker met with her as well and completed an interview and assessment and the worker had documented that she was not a threat to harm herself or others. The patient was of the opinion that because she was not a threat to harm herself or others, she did not meet criteria for a psychiatric admission and contended that her symptoms were a result of receiving too much Adderall from a prior hospital admission for treatment of back pain. The hospital staff informed the HRA that there is no formal policy on how to treat patients arriving in the ED who are presenting with psychiatric symptoms however, the procedure was to clear the patient medically first by drawing labs and medically assessing the patient and then once cleared, they contact a community mental health provider to complete a psychiatric evaluation. In this case, a crisis worker was contacted and conducted the assessment and documented that the patient was experiencing psychosis because she was continuously speaking about time morphing and looping in and out of the past and future and dream jumping. When the HRA interviewed the crisis worker conducting the assessment, she stated that the criteria for involuntary commitment is that the patient has to meet **one** of the following criteria: Actively psychotic, danger to self or others or exhibiting an inability to care for self which was

described as not taking medications which causes an exacerbation of symptoms, not eating or being able to complete activities of daily living (ADL's). Since this patient, in the worker's opinion, was experiencing psychosis at the time of the assessment and the hospital reported the history of her being violent with her daughter, she did meet criteria even though while speaking with the worker the patient was calm and cooperative and did not appear to be a threat to harm herself or others. It was also documented in the EMS records that the patient had to be restrained due to becoming combative in order to prevent her injuring herself or EMS workers. For these reasons the hospital was within their legal authority under the Code (405 ILCS 5/3-601 and 602) to transfer the patient to a mental health treatment facility. Therefore, this allegation is **unsubstantiated.**

In this case, the family had notified the counseling agency and medical staff that the patient's medication had not been given properly during the previous hospital stay and mentioned that this might be a possible cause for her psychosis. The patient also did not have a psychiatric history of mental illness including Schizophrenia, Down Syndrome or Alzheimer's Disease which she was diagnosed with by the ED physician. Her psychiatric medical records included treatment for depression and TBI. Furthermore, once admitted to the psychiatric hospital, the patient was only there for a brief period of time before being discharged and their records documented that *"Union County ER reports high levels of prescription medications in blood."* Also, upon review of drugs.com drug interactions and the medications that this patient was given, the HRA discovered a "major" interaction between Flexeril and Cymbalta. The interaction was described as *"can increase the risk of a rare but serious condition called the serotonin syndrome, which may include symptoms such as confusion, hallucination…"* These factors suggest that the symptoms she was experiencing could have possibly been due to a medication error. The HRA offers the following suggestions:

1. When a patient who is being treated for possible mental illness or psychosis has lab work that tests positive for drugs, the hospital should follow up with a drug panel specific to overdose to also rule that out as a possible cause for the psychiatric symptoms prior to calling the community counseling agency for a mental health assessment.

2. When a patient is being seen in the ED for possible mental illness during regular business hours and the hospital is aware of psychiatric history and who the treating psychiatrist is, the nurse and/or physician should consider consulting with the regular treating psychiatrist to ensure accurate documentation of history, current medications and diagnoses.

The third allegation was that the patient was improperly restrained by being placed in 4 point restraints and given an injection of emergency medication when the patient was calm and compliant. The hospital records did not document that restraints were used on this patient during her ED stay. The crisis workers interviewed also stated that they never saw the patient in restraints during their assessment. The only documentation of restraint use was in the ambulance on the way to the ED where it was documented that she became combative and had to be restrained to avoid harm to herself or the EMS workers. The patient was given two injections (Haldol and Benadryl) while at the hospital but it was not documented why the medications were

given. Upon interview with the nurse and review of the time the medications were given, it was assumed that the medications were given to help calm the patient prior to transportation to the psychiatric hospital because the crisis worker had also documented that when told she was being transferred to the psychiatric hospital *"it was not well received."* The hospital's restraint and seclusion policy states that *"drugs/medications used as a standard of treatment are not considered a restraint if the medication is used within the FDA guidelines (including dosing), follows national practice standards and is based on the patient's symptoms and overall condition. Medications used to enable (improve the patient's ability to effectively or appropriately interact with the world) and not disable the patient are not considered a restraint."* Furthermore, the hospital informed the HRA that restraint access generates a significant amount of paperwork due to it being housed in the PYXIS pharmacy and is only accessed by scanning an identification badge. No such paperwork was generated and there was no documentation in her chart that restraints were ever used during her ED stay. Therefore, this allegation is **unsubstantiated.** The following suggestion is offered:

1. Given the length of time since this patient's treatment at UCH, it remains speculative whether she was given a choice for the injections while in the ED. The hospital is **strongly urged** to develop a Mental Health Code-compliant policy to direct ED treatment for patients with mental health needs as the Code is applicable whenever mental health treatment is provided there (405 ILCS 5/1-114), as it is when detaining a patient under evaluation and transfer (405 ILCS 5/3-600 et seq.) Unique informed consent requirements exist for treating patients with psychotropic medication (405 ILCS 5/2-102a-5) as do requirements for their use when there is an emergent need. These requirements specifically prohibit long acting medications such as decanoates (405 ILCS 5/2-107g). Restraint standards apply to the mental health patient as well (405 ILCS 5/2-108) as do unique steps for restricting any mental health patient's right to refuse treatment and to be free from restraints (405 ILCS 5/2-201). UCH is encouraged to create ED packets for staffs' quick reference wherein policy/procedure, consent materials, mental health-specific orders and restriction notices are readily available.

Finally, the complaint alleged that the hospital breached a patient's confidentiality by disclosing a patient's admission to a psychiatric hospital to community members and also by incorrectly placing another patient's information in this patient's chart. Upon review, the HRA discovered that there were several pages of incorrect information in this patient's chart with a line through it and a note indicating it was entered in error. The other patient's name was not listed in this patient's chart, only the case notes with this patient's name. The hospital's policy on amending the contents of a patient's medical record describes the proper procedure as *"maintain the original incorrect entry or documentation and add the corrected entry or companion document to it…Exceptions: 2. Errors in charting identified by the author will be corrected in the body of previously charted text by using the single line, initials and current date with re-charting of corrected information at the bottom of the page using "Late Entry."* The second aspect of this allegation was that family members of this patient were in the small community at a restaurant and someone approached them and stated that they heard the patient had been taken to a psychiatric hospital. Allegedly, a staff person at the hospital had disclosed

this information to another person outside of the hospital which lead to community members being made aware of the psychiatric hospitalization.

In conclusion, the incorrect charting information was stricken from the patient's chart according to policy and the other patient's name was not disclosed in this patient's records. Therefore the HRA determined that no breach of confidentiality occurred. The HRA was unable to verify that inappropriate disclosure of protected health information occurred because no one interviewed had heard any inappropriate discussion occur and had not disclosed protected information, therefore this allegation is **unsubstantiated.** The HRA offers the following suggestion:

1. The HRA suggests that staff be retrained on hospital confidentiality policies and HIPAA regulations (45 CFR 164.502) and reminded during training that even if a patient's name is not disclosed, describing specific situations to others especially in a small town, might lead to others being able to deduce who is being discussed. Staff should be reminded that any disclosure not described in HIPAA regulations is a breach of confidentiality.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

UNION COUNTY HOSPITAL

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October 20, 2016

Kim Conway, HRA Coordinator
Human Rights Authority
Egyptian Regional Office
#7 Cottage Drive
Anna, IL 62906-1669

RE: HRA Case#16-110-9009

Dear Ms. Conway:

Union County Hospital has completed its review of the recommendations made by the Egyptian Regional Human Rights Authority of Illinois Guardianship and Advocacy Commission regarding the case referenced above. We appreciate your assistance and recommendations in this matter. Union County Hospital is committed to providing high quality patient care. Along these lines, we submit the following:

We understand that of the four allegations, the HRA found one to be substantiated (Inadequate care and treatment of a patient). This involved a communication breakdown regarding patient allergies and administration of medication. The HRA recommendation was made, "QA and other pertinent hospital staff review this admission and… put corrective action measures in place to ensure that this does not occur in the future".

In response to this recommendation, Union County Hospital has developed the "Patient Allergy Assessment" policy. The policy will be put into effect October 21, 2016. All patients receiving care at Union County Hospital and affiliated clinics will complete allergy status assessments prior to the initiation of medication therapy. Sources of allergy information have been defined in the "Patient Allergy Assessment" policy to include Emergency Medical Staff (EMS, Ambulance crew members, police, etc.).

Union County Hospital has also reviewed the HRA suggestions with regards to three unsubstantiated allegations. We appreciate this information and will be taking each into consideration with our Medical Staff and Governing Board.

If you have further questions or concerns, please do not hesitate to let us know.

Sincerely,

Chief Executive Officer