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HUMAN RIGHTS AUTHORITY – NORTHWEST REGION

REPORT 17-080-9003

ROCKFORD MEMORIAL HOSPITAL

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship & Advocacy Commission opened an investigation after receiving complaints of potential rights violations of a patient at Rockford Memorial Hospital. It was alleged that the patient was denied the right to view his medical records.

Substantiated findings would violate rights protected under the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4).

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

To pursue the matter an HRA team met at the hospital and interviewed the following Inpatient Behavioral Medicine Unit staff: a physician, a nurse manager and a recreational therapist. In addition, a legal representative for the hospital was also interviewed. Policies were reviewed as were relevant sections of the patient's records with written authorization.

COMPLAINT SUMMARY

The complaint alleges that for 3 days the patient repeatedly requested to view material contained in his medical records/medical charts and was told by the hospital staff that he could do so only after he was discharged from the facility.

FINDINGS

Reportedly, on 9/19/16 the patient was presented to the hospital emergency room with suicidal ideations with statements that he wanted to harm himself by walking into traffic or by hanging himself. The patient has had a history of suicidal attempts in the past with the most recent being approximately 6 months ago with an overdose of his medications.

According to the nurse manager, the patient was involuntarily admitted to the hospital behavioral unit the afternoon of 9/19/16. The patient was presented with a copy of the involuntary petition along with an explanation of the petition. In addition, the patient also was given an explanation and copies of the rights and responsibilities documents from the behavioral unit, although he refused to sign his portion of the forms.

The nurse manager and physician stated that whenever the patient asked to look at his records/charts, he was allowed to do so. When the

patient requested a copy of a document from his records, a copy was provided to him. Per the recreational therapist, there was an instance when the patient was late to his scheduled therapy group due to him reviewing his records with the physician and/or the nursing staff.

When asked what is the normal course of action a staff member should take when a patient requests to view their medical records, the nurse manager explicated that the patient can either ask the physician directly, or ask the nurse who will then inform the physician of the request. The physician added that he will have a consultation with the patient to determine if the patient wants to view their medical records overall, or if there is a specific concern they wish to address. After which, the patient is allowed to view and discuss their medical records with the physician. Completed progress notes may not always be available at the time of the request, but it is expounded to the patient that after discharge a formal request may be made to the hospital records department for a more detailed copy of their medical records as well as My Chart online access. The HRA apprised the physician that after receiving a call from the patient on 9/27/16, the HRA visited the behavioral unit at the request of the patient at approximately 1:00 p.m. During this visit, the patient asked a staff member at the reception window if he could view his medical chart and the staff member responded "I do not have your medical records. You will have to request them through another department". According to the nurse manager, staff may need to be re-trained in this area.

RECORDS

The Emergency Department Encounter dated 9/19/16 depicts that the patient "presents to the emergency room with the police department with ideations of suicide. Patient states he wants to hurt himself by jumping in front of traffic or trying to hang himself".

The 9/19/16 progress notes by the physician state that “Education provided regarding the legal process of the petition and certificate of involuntary admission. Explained a voluntary admission and the right to sign a 5-day. Reviewed patient rights”. Shortly after that, the hospital social worker composed the following note: “Offered patient a voluntary admission twice and he refused each time. He will be admitted to E-2 on an involuntary basis”.

The Petition For Involuntary Admission and the Inpatient Certificate on 9/19/16 delineate that the patient is reasonably expected, unless treated on an inpatient basis, to engage in conduct placing himself or another in physical harm and is in need of immediate hospitalization for the prevention of such harm. The patient was given a Mercyhealth Patient Care pamphlet along with the Rights Of Individuals Receiving Mental Health And Developmental Disability Services form dated 9/19/16 which was signed by the nurse and a witness, but the patient refused to sign, per the handwritten notation on the form by the nurse.

Progress notes written on 9/22/16 by the physician reveal that the “patient has completed a written contract for safety, provided with a copy per his request and a copy is placed on the chart”. According to the Plan Of Care notes by the nurse dated 9/26/16, the physician visited the patient and spent time in the recreation room, privately talking. At this time, the patient requested a copy of a note he had written to the physician that was in his file and a copy was provided to him. On 9/28/16, the Patient Care Conference–Encounter Notes written at 1:00 p.m. by the recreational therapist depict that “the patient arrived late after reviewing chart with staff”.

The Discharge Summary by the physician on 9/30/16 portrays that the “patient started attending the groups also, although he remained superficial, but his level of functioning got better”. “The Patient is scheduled for follow-up with his psychiatrist in 2 weeks. The patient was discharged home in stable condition”. The Patient Safety Plan was signed by the nurse and the patient on 9/30/16 indicating that the discharge instructions had been reviewed and the patient signed and

retained a printed copy of the document. In addition, the Rockford Health System My Chart information was also provided to the patient on this date. The My Chart System is the patient's online link to pertinent information from his medical record.

CONCLUSION

The Mercyhealth Patient Care Partnership information is posted in the emergency room, in the behavioral unit and in or near other various waiting areas of the hospital and is offered upon admission to patients. It states that "You can expect that all communication and records about your care are confidential, unless disclosure is permitted by law. You have the right to see or get a copy of your medical records. You may add information to your medical record by contacting the medical records department. You have the right to request a list of people to whom your personal health information was disclosed".

The Medical Records Management Policy depicts that records *may* be released upon request. Per Webster's Dictionary one of the definitions of the word *may* is: "shall, must – when it is used in law where the sense, purpose, or policy requires this interpretation". The policy goes on to expound that "Whenever a request is received, the request and the action taken shall be noted in the patient's medical record".

The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4) refers to persons entitled to inspect and copy the recipient's record.

4. (a) The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof:

(1) the parent or guardian of a recipient who is under 12 years of age;
(2) the recipient if he is 12 years of age or older;
(3) the parent or guardian of a recipient who is at least 12 but under 18 years, if the recipient is informed and does not object or if the therapist does not find that there are compelling reasons for denying the access. ;
(4) the guardian of a recipient who is 18 years or older;
(6) an agent appointed under a recipient's power of attorney for health care or for property, when the power of attorney authorizes the access;
(7) an attorney-in-fact appointed under the Mental Health Treatment Preference Declaration Act; or
(8) any person in whose care and custody the recipient has been placed pursuant to Section 3-811 of the Mental Health and Developmental Disabilities Code.

(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.

Complaint: The patient was denied the right to view his medical records. The Mercyhealth Patient Care Partnership information that informs the patient that he has the right to see or get a copy of his medical records was provided to the patient at admission. The Medical Records Management Policy states that medical records may (shall/must) be released upon request and noted in the patient's file.
The physician progress notes dated 9/22/16 confirmed that when the patient requested a copy of a written contract for safety, it was provided

to him. Nurse progress notes dated 9/26/16 state that the patient requested a copy of a note that he had written to the physician and a copy was given to the patient. Although the staff member at the reception desk informed the patient at the 9/27/16 HRA visit that he would have to request his records through another department, he was not told that he could not view his medical records and he was not told that he would have to wait until after his discharge date, as the complaint alleges. On 9/28/16 at 1:00 p.m., the recreational therapist wrote that the patient was late to group therapy due to reviewing his medical chart with the staff. Upon discharge on 9/30/16, the patient signed and was provided a copy of his safety plan. The Confidentiality Act (740 ILCS 110/4) establishes the standard in that a recipient 12 years of age or older shall be entitled, upon request, to inspect and copy any part of their medical record. The findings of the HRA are quite convincing, and thus the conclusion can be made, that the complaint is <u>not substantiated</u>.

<u>SUGGESTIONS</u>

1. Include in the Medical Records Policy and the Mercyhealth Patient Care Partnership that a request to view medical records should be made to the nurse or physician.

2. Require the training of all staff in the implementation of the Medical Records Policy and the Mercyhealth Patient Care Partnership.