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HUMAN RIGHTS AUTHORITY-CHICAGO REGION

REPORT 18-030-9004
UNIVERSITY OF ILLINOIS HOSPITAL

INTRODUCTION

The Human Rights Authority (HRA) reviewed inpatient behavioral health care and services at the University of Illinois Hospital in Chicago after receiving the following complaints:

1. A patient's phone rights were excessively restricted
2. The patient was not allowed private and confidential access to her attorney
3. She was denied meetings with her psychiatrist and refused a change in psychiatrists
4. She was not allowed contact with her private physician, and
5. She fell in the bathroom and the staff did not respond for twenty minutes

Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Centers for Medicare/Medicaid Conditions of Participation (42 CFR 482).

Part of the U of I Hospital and Health Sciences System, the inpatient behavioral health program includes a ten-bed adolescent unit and a thirty-seven-bed adult division of two units, one all-male acute and the other co-ed. The HRA met with representatives from administration and the program to discuss the issues. Relevant policies were reviewed as was the patient's medical record with authorization.

COMPLAINT SUMMARY

The patient was said to have been prohibited from placing calls and that for receiving calls she had to talk on the phone at the nurses' station just for calling 911. She had to meet with her attorney in a room with the door open even though she was not dangerous. The complaint goes on to say that the patient did not see her psychiatrist whenever requested; she felt there was

no trust in the relationship and the hospital would not consider her reasoning for another psychiatrist, and she was also not allowed to call her own doctor at any time. Finally, she allegedly fell in the bathroom and waited at least twenty minutes before help arrived.

FINDINGS

#1. Excessive phone restriction:

The record contained a single notice of restriction applied to the patient's phone access about one week into her stay: "No out-going calls, in-coming calls supervised at nurses station patient repeatedly called 911 reporting she is being held hostage." The patient wished for no one to be notified according to the form. Notes surrounding the restriction referenced the same, one nursing entry stating that per the physician, she could not make outgoing calls and incoming calls must be received at the nurses' station so she could be monitored during phone use. A couple days later she was reminded about not making phone calls, only receiving them, and then the nurse documented what she overheard the patient saying to a caller on her next phone conversation. Later, a second nurse did it as well, quoting verbatim what was said during a phone call. Only one entry hinted at allowing the patient an outgoing call, the note referring to a "supervised phone call to his [sic] son."

The staff explained how this patient screamed on the phone to 911 operators on several occasions, not just once, and that afterwards admitted to the fact. They also heard from her son around the same time who requested that she not be allowed to call him for a while. A phone restriction was quite necessary in this case, which lasted throughout her time there. They insisted that contrary to how the restriction was written, she was able to make outgoing calls provided the staff dialed the numbers, and so having her call from the nurses' desk accomplished that. Her calls were monitored for therapeutic value and to prevent her from hanging up and dialing 911. They had no explanation for the documented quotes from her phone conversations.

The HRA observed a unit and found patient phones situated in areas to accommodate privacy, away from the nurses' desk, and recipient rights and advocacy contact information was posted conspicuously.

CONCLUSION

U of I inpatient adult psychiatry policy states that communications will be restricted when deemed necessary to prevent harm, harassment or intimidation. Physicians' orders are required and a restriction form will be given to the patient and anyone designated. Restrictions are reevaluated by the treatment team during rounds and treatment planning.

The Mental Health Code lists the same reasons to restrict communications but adds that first they are to be unimpeded, private and uncensored. (405 ILCS 5/2-103).

In this case it was clear the staff needed to stop the patient from harassing 911 when she had no emergency for them, and dialing for her to avoid the targeted number is common practice although here there was no need to violate her right to privacy by monitoring and documenting her conversations. The complaint is substantiated.

RECOMMENDATIONS

Add to policy the Code's requirement to ensure that recipients are permitted unimpeded, private and uncensored communication with the persons of their choice. (405 ILCS 5/2-103).

All appropriate staff must be retrained on the right to unimpeded, private and uncensored communication and instructed to stop documenting private conversations unless there is an appropriate need. (405 ILCS 5/2-103).

SUGGESTION

Writing "staff to dial outgoing calls" would be more accurate than "no outgoing calls".

#2. The patient was not allowed private and confidential access to her attorney.
#3. She was denied meetings with her psychiatrist and refused a change in psychiatrists.
#4. She was not allowed contact with her private physician.

According to a social work note the patient was asked how a meeting with her attorney went the day before and whether there was anything from that meeting she wanted to bring up with the treatment team. The patient said "'no, it was private'" and that was the end of the subject. There was nothing else related in the record.

The staff we spoke with were puzzled at this complaint, saying there was no policy or practice of making attorneys meet with doors open unless a particular patient was dangerous. They have two conference rooms that can be used for privacy if available, which we were shown. One social worker recalled a time when the patient's attorney wanted to meet with her along with the patient and neither conference room was free. They met in the patient's bedroom instead and may have had the door open.

Regarding access to her psychiatrist or requests to change psychiatrists, the record is full of psychiatry notes of having seen, evaluated or conferred with the patient quite regularly and if not from the attending then from other physicians or residents. There were two references to the patient complaining about the treatment team or the present attending putting words in her mouth or twisting her words, but nothing resembling an outright request to see the doctor more or to make changes. Except that the idea seemed to be raised between the patient and her attorney

who relayed it to the social worker. According to the social worker's corresponding note, she approached the patient after speaking with the attorney and asked if she wanted to change psychiatrists. The patient said no, she did not, and went on to explain how dissatisfied she was with her outpatient doctors and was considering a change with them. She was asked a second time if she wanted to change her current inpatient psychiatrist specifically and again declined.

The patient's psychiatrist told us that she saw her on a daily basis on the milieu as rounds are done at about 3:30 p.m. She recalled a time when the patient wanted to see her and she was occupied but made sure to follow up with her. It was also offered there was likely a time when the patient's attorney arrived unannounced and wanted to see the psychiatrist who was not available at that time either. They try to be sure however to follow up or make someone else available.

The record contained numerous entries from staff who tried reaching the patient's private physician, leaving him or his office messages, and it seemed by the documentation that he was not the most reliable to respond. There were quite a few notations from nursing and social work alike of their attempts and of leaving what information the patient had requested throughout her stay at the hospital. In addition, discharge summaries referenced follow up appointments that the staff from the U of I made for the patient at her private physician's office.

The staff said that indeed, the private physician was difficult to reach but at no time was the patient prevented from trying herself; they would dial for her of course, but she repeatedly asked for them to call him which they did.

CONCLUSION

Pursuant to the Code, all recipients are permitted unimpeded, private and uncensored visits and no attorney who represents a recipient shall be prevented from such a visit. Every recipient subject to involuntary admission shall be represented by counsel who shall not be prevented from conferring with him during normal business hours. (405 ILCS 5/2-103, 3-805). A recipient shall be provided adequate and humane care and services pursuant to an individual services plan, which is to be formulated with the recipient whose views of the treatment being provided are to be considered. (405 ILCS 5/2-102a). And, under the Code and the CMS Participation Requirements, a recipient holds the right to have anyone of choice including his own physician notified promptly of his admission. (405 ILCS 5/2-113; 42 CFR 482.13).

Perhaps there were instances when the patient and her attorney were asked to leave a door open due to exceptional circumstances on the unit, but there is no evidence to suggest the patient's right to privacy with her attorney was violated, either in practice or policy. There is supportive documentation showing multiple encounters with her attending and other psychiatrists during her stay, and the record showed that she was asked twice whether she wanted a different psychiatrist, declining both times. While there were no examples of her attempts to call her own physician, there were also no examples of being denied, in fact, there is ample supportive evidence in the record of the staffs' tries at her request. Rights violations in complaints 2, 3 and 4 are unsubstantiated.

#5. The patient fell in the bathroom and the staff did not respond for twenty minutes.

One related incident was found in the record. A nurse wrote that he found the patient sitting in the shower one afternoon, saying she had fallen ten times. He checked her vitals and notified the physician on duty. She denied having any head injury, dizziness or shortness of breath and was helped to bed where she remained under monitoring for weakness and fall risk until the physician arrived a while later. According to the physician's note, the fall was unwitnessed and the patient reported some pain in her head and shoulder but denied loss of consciousness. He saw no signs of injury on exam and ordered a CT scan and a pain reliever. Observation sheets showed that she had been checked on every fifteen minutes around the time of her falls in the shower and she was noted to be in her room, agitated, restless and anxious at each interval and then asleep about hour after when she said the falls occurred. CT results were negative and over the next several days the patient was given pain relievers upon request as her complaints of pain changed from head and shoulder to a chronic lower back problem per the documentation. A social worker followed up with her days later and inquired about the fall. The patient claimed to have problems with the nursing staff in general and with the call button which she proceeded to push. A nurse responded right away; the patient told her to shut up and another staff person appeared moments later. She mentioned nothing of the ten falls or waiting twenty minutes for help, at least as recorded.

The staff expressed their concern about the patient's veracity given her accounts of the falls, the fact that they were unwitnessed and that she would sometimes put red marker on her arms. They referenced an earlier fall unrelated to this complaint where afterward they moved the patient to a room nearer the nurses' station, gave her a bell to ring for help and placed her on close observation, which is why she was being checked on every fifteen minutes, and we verified those events in the record. We also inquired with a patient services director who said he looked into the shower fall as well and found that the patient was not unattended for twenty minutes.

CONCLUSION

The program's observation levels policy allows for close monitoring of a patient at risk for harm due to health concerns or the inability to care for oneself. Fifteen-minute checks is one level, whereby the observation sheet is completed timely indicating a patient's location and behavior as viewed.

Under the Mental Health Code, a recipient shall be provided with adequate and humane care and services. (405 ILCS 5/2-102a).

Although the patient's claim of falling in the shower is not discredited, it is unlikely that she fell ten times without staff response for twenty minutes given the documentation, provided the completed observations are accurate. And, regardless of whether the falls occurred, the patient was treated adequately and humanely afterwards. The patient's right to adequate and humane care was not violated, and the complaint is unsubstantiated.