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Northwest Regional Human Rights Authority
Report of Findings
Report 20-080-9002
SwedishAmerican Hospital

Introduction

The Human Rights Authority (HRA) opened an investigation into potential rights violations at SwedishAmerican Hospital in Rockford. The complaint is that a patient was not provided with adequate and humane care, not given a copy of their petition or medical records, and voluntarily admission was not based on consent or capacity, but rather by using a threat. Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

A division of the University of Wisconsin Health system, SwedishAmerican's Emergency Department (ED) sees about 70,000 patients each year, some 14,000 of the patients seen are for mental health reasons/purposes and the hospital has a special needs unit (SNU) within the ED. The Assessment and Referral team has members that are available for screening mental health needs of patients on a twenty-four-hour basis. The hospital has an inpatient psychiatric program, referred to as the Center for Mental Health (CFMH). The HRA discussed the case with representatives from the CFMH, ED personnel and administrators. Relevant policies were reviewed as was the patient's record with authorization.

Complaint Summary

The complaint stated that the hospital completed an unfair involuntary admission when the patient was initially brought to the ED and the discharge was only allowed after agreeing to sign a voluntary admission application. The complaint also stated that the patient was not fully aware and informed of what forms were asked to be signed and only received copies of all signed forms during a discharge meeting.

Record Review

ED Record Review

The patient arrived at the ED at 9:22 a.m. after threatening suicide. Once in the ED, the patient reported to the registered nurse on duty of "hearing voices and having thoughts of wanting to hurt others". Based on the admission intake and the statement made to the nurse, the on-call physician transferred the patient to the SNU at 9:35am for additional observation and assessment. At 10:28am, the patient was providing history and discussing the current admission reasons with the Assessment and Referral (A/R) staff and on-call Nurse Practitioner (NP), who conferred with the attending physician that there was a need for intensive monitoring and recommended hospitalization. While the patient was meeting with the on-call physician, there

was discussion regarding the current care plan and needs. According to the records, "the patient was agreeable, had no further questions and stated having a full understanding".

An involuntary admission petition was completed at 10:44am by the A/R staff due to patient voicing a suicide threat and reporting hearing voices. By 11:00am the ED physician completed the first inpatient certificate after being briefed by the ED staff. After the certificate was completed, the on-call NP in meeting with the patient informed him of his rights. The patient displayed anxious behaviors, in which medication was ordered and hospital security was on stand-by at 11:06am. The NP noted in the records that the patient "is a risk to self and others". While completing the assessment and referral interview at 11:30am, the patient reported "homicidal ideations with no specific plan, always has them and has not slept in six days". At 11:44am, the NP spoke with the patient regarding the circumstances of being in the ED, the completion of the involuntarily petition for safety reasons and, the patient was advised of the administration of medication and restraints. Per the records "patient thoughts could not be redirected and displayed a fleeing mannerism", security was still on standby. There was discussion regarding suicidal ideations and the risk of harm to self and others; it was stated that the "patient did not disagree".

At 12:19pm, the on-call NP was called back to the bedside by the patient wanting to talk per the nurse on duty regarding the patient's status. The patient on numerous occasions was told of the decision to continue with the hospitalization out of concern for the patient's safety. By 12:45pm, the NP noted that the patient "had been redirected multiple times, no Haldol or Ativan was given, but provided with a nicotine patch". Per the signature on the petition at 12:56pm, the A/R counselor agreed that the patient was provided a copy of the petition, the Rights of Admittee and the Rights of Individuals Receiving Mental Health and Developmental Services with explanation of all forms having been provided.

CFMH Record Review

The patient arrived on the CFMH unit at 1:32pm from the ED and was admitted for suicidal ideations. During the unit admission transfer, nursing noted that the "patient was cooperative" but he refused to provide vitals, height, weight and refused to take any psychotropic medications, reporting that "meds don't work". Also, during the interview, the patient admitted to experiencing auditory hallucinations and homicidal ideation but said he could handle them. While getting adjusted on the unit, the patient did not initially participate in any groups, but had a first counseling session at 3:48pm and reported "hearing voices currently and have homicidal thoughts occasionally but doesn't have a plan". During the 3:00pm-11:00pm shift, it was charted that the patient agreed to sign a voluntary application. The shift nurse inquired how the patient was doing and the patient stated, "I'm here, I'm irritated that I'm here". The shift nurse documented in the medical records, that information was provided to the patient on the difference between involuntary admission and voluntary admission. After hearing this information, the patient claimed that he "did not want be here, therefore will not be signing in voluntarily". The on-call physician was contacted and spoke with the patient, who in the presence of the shift nurse, agreed, signed and received a copy of the voluntarily application at 4:20pm.

The first group that the patient participated in occurred at 7:06pm and the feedback was noted as "cooperative and pleasant". The patient met with the unit physician for a physical

exam at 7:44pm and was deemed medically stable. The next day at 9:47am, the patient met with the unit physician and explained "wanting to end the relationship and didn't say will end it". During the course of the physical exam, the patient refused psychotropic medications due to past encounters, but agreed to "take a low dosage of Seroquel 50mg" and a nightly nicotine patch. After meeting with the unit physician, the patient met with unit nursing staff and asked for a request for discharge form which was signed, filed and a copy was provided to the patient at 11:12am. At 12:17pm, the therapist and the patient met in which the patient was noted to say that he shouldn't be hospitalized and was not open to psychotropic medications. Later in the day at 2:00pm, the patient requested to see the unit physician and asked for a "copy of medical records"; according to the records there was no follow-up documented. There were various groups offered throughout the day and evening and the patient participated sporadically.

The patient met with hospital managerial personnel throughout the day about being held in the hospital, not having choices and withholding his medical records, according to the chart. Later that evening, the patient requested a dosage of Trazodone to assist in going to sleep. The next day the patient participated in one group session that was offered and he displayed positive interactions with peers. In the afternoon, the patient met with the therapist and displayed cooperative behaviors, shared that he had agreed to take psychotropic medications and had a positive outside visit. At 1:58pm, the patient met with the on-call physician and agreed to include outside involvement in his care plan, but there was no answer when call was placed. During the evening shift the patient informed staff that he did not want to take any medication moving forward but would take "to prove cooperation", but when offered the evening dosage of Seroquel, the patient refused.

The patient started off the third day at 6:52am by refusing any vitals to be taken, but he did provide a urine sample and requested a nicotine patch, which was provided. Later that morning, the patient had a tele-health video conference with the hospital physician for routine rounds and explained that since being in the hospital, he was diagnosed incorrectly and did not need to be hospitalized. After meeting with the patient, reviewing the records and speaking with staff, the physician assessed that "the patient has the capacity to make a reasoned decision about medication". During the evening shift at 9:45pm, the patient's disposition had radically changed due to participating in a family visit. When offered inquired "would it go against me if I do take my medication". The nursing staff provided the patient with the purpose of taking medication and the possible consequences if not taking. The patient participated in the majority of groups offered on the fourth day of admission, refused all medication dosages and slept for three hours.

On the fifth day of admission, per the overnight shift nurse, the patient only slept for three hours and spent most of the time communicating with the charge nurse. The patient participated in one group session but was very disruptive throughout. The patient had a closing counseling session at 11:21am, in which the therapist provided referrals to community services, which patient declined and provided follow-up contact information to an out of state psychiatrist the patient provided in first session. At 11:42am the patient had a final session with the onsite psychiatrist, in which the patient claimed that his current diagnosis was incorrect, and he wanted it changed. The patient did not accept any prescriptions. During discharge with the unit nursing staff, the discharge summary was reviewed, no follow-up appointments were made, and the staff ensured resource contact information was highlighted. The patient left at 1:45pm with all his belongings and hospital documentation when his family arrived to pick him up.

Interviews

Manager of Clinical Programming

The Manager of Clinical Programming provided the procedure summary that is followed on the CFMH unit in which patients are given their rights and responsibilities. During the time of this complaint, when a patient arrived on the unit, all belongings and medical documents (petition, rights/responsibilities and certificates) were locked in a closet in the patient's room. The HRA mentioned not knowing where the patient's documents were located and asked if a patient could possibly not be aware. It was stated when a patient arrives on the unit with their belongings and documents, these items are placed in the closet in their presence. Currently, the process includes each patient having a cubby that is located outside their room which can be accessed with the assistance of the nursing staff. In reviewing notes, it was mentioned that trying to locate information in the records was difficult due to information not being chronologically written. The Manager of Clinical Programming explained that the hospital medical records have been transitioned to a new system that is more user friendly since January 2020. For this particular case, the system that was used was not user-friendly and made the reading of the records not an easy flow of information. Around the discussion of this patient being "threatened" with signing a voluntary admission form, the director stated that, in general, unit staff will have a discussion with the patient of what voluntary admission entails. The new system allows the staff to include in detail within the nursing notes, when an admission occurs (voluntary or involuntary) and the patient's decisions about admission.

Director of Psychiatric Services

Per the Director of Psychiatric Services, patients receive copies of the admission documents which includes their rights and responsibilities immediately after signing the paperwork regardless if they are in the ED or on the unit. The HRA notes the prior issues of hospital staff not completing the "notice regarding restriction of rights of an individual form (IL 462-2004M)", which was not part of the medical records the HRA received, even though medication was given intramuscular on the date of admission. The Director stated that on the CFMH unit, the form should be included in all records after July 2019 and it was not completed in this case.

ED Inpatient Manager

Due to the ongoing issue of hospital staff not completing the notice regarding restriction of rights of an individual form (IL 462-2004M), the ED Inpatient Manager stated it became mandatory to be included in all charts effective December 2019 and could not answer why it was not completed on this complaint.

The question posed to the ED Inpatient Manager centered around if this patient was given the opportunity to refuse, have a least restrictive option offered and whether his preference for medication and services were considered. The ED Inpatient Manager could not speak directly to this patient's ED encounters, but provided insight on how the procedure should go. Per the manager "if a patient does not sign the documents, especially their rights, it is noted that there was refusal on the part of the patient. When the patient refuses medication, it is the job of the nursing staff to educate and reeducate the patient on the benefits, side effects of the proposed medication and what can occur if taken or not".

Assessment and Referral Coordinator

During the teleconference, the Assessment and Referral (A&R) Coordinator shed light on how a patient's admission status may change from involuntary to voluntary. The A&R Coordinator stated each admission is different and handled on a case-by-case scenario, in consideration of the reasons for admittance (overdose, behavior patterns, etc.). Observations in the ED and summaries of interactions before arriving can lead to an involuntary admission. Crisis team members talk with the patient, which usually includes a SNU nurse and the A&R coordinator to get historical background and the reasons for the visit from the patient.

The A&R coordinator will provide the patient with a disposition, the rights of admittee and discuss the options of being admitted. If the patient chooses the voluntary avenue and the application is signed, then, this choice is documented and placed in the file with the patient receiving a copy. There are instances when the crisis team meets with the attending physician who, based on the information gathered, the initial reasons for the patient being in the ED and the observed behavior, may determine that an involuntary admission is the best suited option. If this occurs, the patient is made aware of the decision and provided their rights by the attending physician.

Counselor

Per the therapist, when a patient refuses services or medication, that denial should always be documented in the medical record by the staff member who interacted with that particular patient.

Policy Review

The "**Informed Consent – Psychotropic Medications"** policy updated as of May 12, 2020 states," the patient in the ED has the right to refuse" and "if refused the Psychotropic Medication Consent Form is completed by the patient ". This was updated in the policy as of May 2020; previously, if a patient refused, the nurse would reinforce the education of the medication that was provided by the physician, inform the psychiatrist and denote in the record the refusal. The medical records indicated that while the patient was in the ED, an order was placed for psychotropic medication; the patient was advised of his rights, security was on standby, but no mediation was given during this time. Shortly after arriving on the CFMH unit, the patient , was given Haldol 5mg and Ativan 2mg intravenously at 1:53pm.

The **"Voluntary Inpatient Admission"** policy states " any person aged 16 or older may be admitted as a voluntary patient for treatment of mental illness upon the filing of an application with a psychiatrist, if deemed the person is clinically suitable for admission and has the capacity to consent". The medical record provided showed that the patient requested, signed and submitted a discharge request on the second day of admission at 11:12am and was officially discharged from the hospital on the fifth day of admission at 1:45pm.

The "**Patients' Rights and Responsibilities"** policy states "a patient is to be informed of the nature of their illness and treatment options, including potential risks, benefits, alternatives, costs, and to participate in those health care decisions". In reviewing the medical records there were numerous incidents in which the hospital staff informed the patient about his rights and the

next steps that were to take place, and although he countered or disagreed with those actions, he was informed.

Conclusion

Complaint: The patient was not provided with adequate and humane care.

Per the Mental Health and Developmental Disabilities Code, when a patient is receiving services based on their individual plan, the services provided by the facility must be adequate, humane and occasionally reviewed with the patient (405ILCS 5/2-102(a)). A rights violation is **not substantiated**. In reviewing the medical records, the hospital provided services(such as counseling and recreational, wellness and life skills groups), medication monitoring and added smoking cessation(which the patient requested and a nicotine patch provided).The patient had the option to attend and fully engage in or not participate in services. The patient, on a few occasions, got frustrated with staff and was redirected to use appropriate behavior.

Complaint: The patient's rights to receive a copy of petition and records was disregarded.

Per the Mental Health and Developmental Disabilities Code, an involuntary patient must receive a copy of the petition within twelve hours of admission (405ILCS 5/3-609). The patient was seen by the HRA Coordinator at the time of the complaint and asked to view documents surrounding admission; the patient stated not having a copy to review. Later that afternoon, the patient asked the attending doctor for a copy of his records and it seemed that there was no follow-up documented in the records on this request. During the site visits, hospital personnel stated that at the time of this admission all of patient's belongings were locked in a closet in the room; this procedure has changed. All the documents reviewed by the HRA noted that hospital personnel reviewed and provided the patient with signed copies of the petition, the voluntary application and the rights/responsibilities forms which included the time of the interactions. A rights violation is **not substantiated**, based on the signatures and interaction times displayed on the documents signed by all parties (hospital personnel and patient).

Suggestion

The HRA offers the following suggestion:

1) The hospital personnel should go over where the patient's documents and belongings are stored and the process for gaining access to the items in the locked cubby while on the unit.

Complaint: The patient's voluntary admit was not based on consent and capacity, but by threat.

Per the Mental Health and Developmental Disabilities Code, a patient must meet the following guidelines to consent for a voluntary admission: has the capacity to consent, meaning he understands he can request a discharge at any time in writing and after receiving the request the facility would need to make a determination regarding the discharge within five days (405ILCS 5/3-400). A rights violation is **not substantiated** per the medical records; the patient was educated on the different types of admission (involuntary or voluntary) and completed the application within the same day of arrival with the unit nursing staff and a witness. The application showed a valid signature by the patient, who acknowledged being informed of his rights as a voluntary admittee, designated a third party to be informed of his admission and

identified himself as an individual receiving service. The voluntary application also indicates that the patient "has the capacity to voluntary admission" which is signed by the unit nursing staff member with a time entered at 4:20pm.

Suggestion

The HRA offers the following suggestion:

1) Hospital personnel should document in the patient's nursing notes when a record request is made, the response and what action took place in regard to the request.

RESPONSE

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