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Northwest Regional Human Rights Authority
Report of Findings
Report 20-080-9001
SwedishAmerican Hospital

Introduction

The Human Rights Authority (HRA) opened an investigation into potential right 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 no rights advisement in violation of the Code. Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Mental Health and Developmental Confidentiality Act (740 ILCS 110).

A division of the University of Wisconsin Health system, SwedishAmerican Hospital has two locations in the Boone/Winnebago area. The Belvidere Emergency Department (ED), sees about 24 patients yearly who are treated for mental health issues and 2 patients per week, who are emergent, stabilized and transferred to the Rockford location. The Rockford ED sees about 70,000 patients each year, some 14,000 of whom are evaluated for mental health reasons/purposes and this location has a special need unit (SNU) within the emergency department. 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 met with representatives from the Center of Mental Health, emergency room personnel and administrators from Rockford and Belvidere. Relevant policies were reviewed as was the patient's record with authorization.

Complaint Summary

According to the complaint, the patient was unfairly and unnecessarily detained for two days on a specialized unit, was not given copies of her admission documents timely after requesting her medical records nor advised of their rights.

Record Review

ED Record Review

The patient arrived in the ED at 10:55pm on June 2, 2019 via ambulance due to an accidental overdose of taking 70 pills of various medication ranging from thyroid, anti-depressant and asthma. Once checked in and observed, the patient was deemed as being a

level 2 on the acuity chart, which translated into needing emergent care. The ED attending physician examined the patient at 11:01pm, who presented as being tired and had no other issues or symptoms. Due to the patient ingesting numerous pills, the attending ED physician reached out to the state poison control unit, which at 11:13pm suggested that the patient drink a container of 25g charcoal and complete an observation period, since the patient was under the poison level threshold before a final decision is made regarding full admittance. At 11:38pm, the patient was given the container of charcoal to drink and which assists in flushing the stomach of all pills. While the patient was drinking the charcoal, the local law enforcement agency completed an involuntary petition at 11:45pm, based on the patient leaving a note for family and a text to significant other with the following statement "wanting to be done and end it all".

On June 3, 2019 at 12:09am the ED physician received a call from the state poison control office with the following instructions: "Place the patient under observation for six hours, complete an EKG and drug screen to rule out any additional issues". The suggested observation period and various tests given, provided the medical personnel insight into the next step to move forward in the treatment of the patient and her admission or discharge. At 4:50am the ED nurse received a call from the state poison control hotline, in which the patient's condition/status was updated and the operator suggested case closure. After the case closure, the patient was moved from the medical side of the ED and admitted to the SNU at 5:03am. The first certificate was completed at 5:08am due to the ED physician believing that patient was still a danger to self. The inpatient certificate has the ED physician signature noting that the patient was advised of their rights (to not speak to physician and speak with an individual of the patient's choice), nothing was noted in the nursing records that hospital staff informed the patient or discussed in detail these rights.

The assessment and referral (A&R) counselor met with the patient shortly after the first certificate at 6:25am to get more of a detailed history of the patient and the events that led to current admission. During the assessment, the patient gave the following statement to the counselor "Yes, I got upset and I decided I was going to take pills because I didn't want to hurt anymore." Afterwards the counselor deliberated with the ED physician and the advanced practice nurse on duty of the results of the assessment, which led to a consensus of the appropriateness of pursuing an involuntary admission to the Center for Mental Health. On the involuntary petition pages 4 and 5, are signatures from the A&R counselor at 2:00pm stating that the rights of the admittee was given and certified that a copy of the petition was provided to the patient.

CFMH Record Review

Once the cooperative patient arrived on the unit at 2:42pm, the hand-off and transition to the unit went smoothly. The patient's first unit assessment was completed with the nursing staff at 4:00pm, in which community resources for substance abuse were provided. The unit's psychiatrist completed the second inpatient certificate on the patient at 4:30pm, which

was based off clinical observations and factual information. The inpatient certificate had the unit psychiatrist signature noting that the patient was advised of their rights (to not speak to physician and speak with an individual of the patient's choice). Later that evening at 11:12pm, the physical exam provided by the physician on the unit described that the patient would need to complete two nights stay on the unit and noted that the patient "denies suicide attempt". During the patient's initial counseling session on June 4, 2019 at 10:03am, the patient admitted "taking 15-20 pills to calm down and sleep for a longer period of time", after being on a call in which resulted in an argument developing. The therapist noted that the patient was obligatory in responses, but also crying during the interview in which the length of stay and treatment plan was determined. There was no documentation in the medical records of the patient receiving a copy of their petition or requesting a copy of the medical records. Later in the afternoon at 12:03pm, a physical exam was completed, the patient again denied a suicide attempt and instead reported "taking a make-up dosage". The patient attended and actively participated in various groups, medication monitoring and therapy sessions while on the unit. The patient's stay was issue free and the patient was discharged to family on June 5, 2019 at 12:00pm with discharge documents to follow up with primary physician and seek out therapeutic services.

Interviews

ED Manager Belvidere Location

The Belvidere ED manager provided an explanation of a patient being on acuity level two, which was documented on this patient's medical record. The meaning for is that the hospital considers them high risk and in need of emergent care and services. This descriptive coding is specifically used for mental health patients.

Attending ED Physician

During the site visit the attending ED physician stated recalling this patient and provided the process that is practiced in the ED when an individual attempts suicide or ingests substances. At this day and time, the hospital no longer pumps a patient's stomach, charcoal is provided for consumption. The pumping of the stomach can cause damage to the patient and the usage of charcoal is like swallowing a sponge to soak up the chemicals and pills. The charcoal method is advisable to initiate within an hour of the overdose to be successful and minimize damage. The doctor determines the level of need based on the summary provided by those involved (medical personnel, family, and patient). This particular patient gave conflicting pill amounts that was ingested (ranging from 20 to 70). When there is ingesting, the poison control hotline is contacted for direction and appropriate treatment options and then poison control gives the clearance when a patient is ready to leave or may need further services. The crisis counselor in the ED gages the person by completing an assessment and observes the patient. From the observations and assessment responses, the counselor shares this information with the doctor who determines the seriousness of the interaction ranging from discharge, further observation or admission. The

doctor stated for this particular case, due to information provided by law enforcement , the patient's self-report and not being able to guarantee the patient's personal safety led to the contributing factors of doctor's final decision of involuntary admission. This doctor said that he/she prefers to err on the side of safety and caution in occurrences such as attempted suicidal attempts and decides if the patient in question needs to be admitted for further follow-up.

Clinical Manager and Director of Psychiatric Services

The committee was made aware before the site visit that the counselor on this case was no longer employed by the hospital. During the site visit, the clinical manager and director of psychiatric services answered questions that covered the psychiatric clinical services department due to the employee change. There was discussion surrounding this patient's request for their medical records and neither could speak on this patient's particular request, due to not being involved in this patient care and not having any direct information or knowledge of a record request was made. Personnel provided the committee with an outline on the process when a patient makes a medical record request : 1) all records requests are handled by the medical records department after a patient is discharged, 2) during the discharge process, the patient will receive a copy of their discharge paperwork, and 3) during the admission process, the patient will receive a copy of their admission, patient rights and petition paperwork.

Policy Review

The "***Involuntary Inpatient Admission***" policy is a step-by-step procedure adopted by the hospital and used in the admitting of individuals to the psychiatric emergency unit (SNU) or the Center for Mental Health unit. Per the hospital's policy, which is modeled after the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5/3-206), the patient should receive a copy of their petition and certificate. In reviewing and reading the records there is nothing noted or documented that the patient received these documents during their stay. Although the policy particularly points out that there should be "clear documentation in the chart " that the patient was provided a copy for their records.

The "***Proper Execution of Inpatient Certificate for Involuntary Admissions***" policy ensures that the inpatient certificate is properly filed for an adult patient who has been involuntarily admitted to the inpatient unit. Reviewing the certificate and court documentation, the date and time stamp shows that the Health Unit Coordinator filed the certificate and petition timely with the mental health court.

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". Reviewing the medical records there does not seem to have been a discussion on her admission or the next steps, the

ED doctor on call determined that patient needed inpatient hospitalization and treatment options were discussed during the first counseling/therapy session.

Conclusion

Complaint: The behavioral health patient's right to receive adequate and humane care.

Necessary medical care is provided under the direction and supervision of medical staff per their orders (77 Ill. Admin. Code 250.320; 330), and, per the Mental Health and Developmental Disabilities Code, care is to be adequate and humane. (405ILCS 5/2-102). A rights violation is **unsubstantiated**, in reviewing the medical records, hospital personnel worked to ensure that the patient received the most appropriate care and to address the medical needs and well-being of the patient with continuous observation after case was closed by the state's poison control.

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

Per the Mental Health and Developmental Disabilities Code, a patient must receive a copy of their petition along with an explanation of admittee rights within 12 hours of their admission (405ILCS 5/3-609). On pages 4 and 5 of the petition form involuntary /judicial admission form the A/R counselor signed that the patient received a copy of the petition. Per the Mental Health and Developmental Disabilities Confidentiality Act (40 ILCS 110/4), patients 12 years and older are authorized to be provided a copy of their medical records when requested. Contrary to the complaint, there was no mention in the nursing notes or site visit interviews that a request was made or not made by the patient. A rights violation is **substantiated**, in reviewing the medical records and interviews from the site visit there was no indication or notation that the patient received copies during the appropriate time period

Recommendations

1) Follow the Mental Health and Developmental Disabilities Code (405 ILCS 5/3-609), and the hospital's' Involuntary Inpatient Admission policy regarding the patient receiving a copy of their petition and certificate within 12 hours and that nursing notes are reflective of this action.

Complaint: The behavioral health patient's right to receive their rights advisement was disregarded.

Per the Mental Health and Developmental Disabilities Code, a patient must be told the reason for the examination, the right to talk or not talk with the examiner and what is said can be used in court proceedings for the basis of the involuntary admission (405ILCS 5/3-208). A rights violation is **unsubstantiated,** in reviewing the medical records both certificates have signatures of medical personnel stating that they informed the patient of their rights.

Suggestion

1) Follow the Mental Health Code (405 ILCS 5/3-208), that the patient is advised of their rights orally and there is documentation in the patient's medical records to demonstrate that this was done.

RESPONSE

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