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Northwest Region
Report of Findings
Report: #20-080-9009
UW Health/SwedishAmerican Hospital– Rockford, IL

Introduction

The Human Rights Authority (HRA) opened an investigation into potential rights violations at UW Health/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 voluntary admission application, the discharge request was ignored 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 there is a special need unit (SNU) within the hospital's ED. Currently SwedishAmerican is the only hospital that offers inpatient mental health services in the city limits. 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

According to the complaint, the patient was unfairly treated regarding their care while on the specialized unit of the hospital and did not receive copies of admission documents timely nor advised of their rights. The patient reportedly felt pressured into signing a voluntary admission application and was not permitted a discharge form on request.

ED Record Review

The patient arrived in the ED at 8:10pm on September 18, 2019 via self-transport, due to experiencing delusions of being "bugged" by a significant other. During the initial contact with the patient at 8:49pm, the nurse practitioner (NP) obtained background information and the reasons for the visit to the ED, in which the patient explained "being bugged and wanting them removed, so the significant other cannot monitor her actions or

conversations". The patient also shared with the nurse that other family members can hear "the bugs when they talk to her". The preliminary diagnosis given by the NP in collaboration with the attending physician was that the patient "is actively hallucinating, thought content is paranoid and delusional, but cognition and memory are normal."

During the SNU psychiatric assessment, the attending nurse stated that the patient reported being a "prophet and sees many things" at 9:01pm. In the medical records, there is a notation that the patient was admitted voluntarily at 10:17pm, per the Assessment and Referral (A/R) Counselor, although a voluntary application was not completed at that time. Per the nursing notes, a meeting occurred between the attending physician, A/R counselor and the advanced practice registered nurse (APRN), in which a mutual determination was made to involuntarily admit the patient at 10:18pm, based on the following rationale " being a danger to self and in need of further observation and assessment." The A/R counselor completed the involuntary admission petition at 10:31pm, and the first in-patient certificate was completed and signed at 11:00pm.

Shortly thereafter the NP placed an order for psychotropic medications at 11:03pm to be intramuscularly administered between 11:30pm-11:44pm. At 11:10pm, according to the medical records, the patient consistently attempted to leave and come to the nurses' station. The patient received the first dosage of Haldol 5mg and Ativan 2mg by extending her arm to the nurse and stating, "I am not crazy, I want to go home" at 11:46pm. After the injection the patient appeared to sleep with a visitor by the bedside through the night and no incidents were reported. The next day at 5:41am, the ED staff was awaiting a urine sample collection and the patient's admission to the CFMH.

CFMH Record Review

Before the patient was transported to the unit at 3:05pm, the A&R staff went over the petition, provided a copy to the patient along with her belongings and with the assistance of hospital security escorted the patient via a wheelchair to the CFMH. Once the patient arrived at the CFMH, the unit staff got the patient situated in an assigned room. The patient met with a counselor to develop a treatment and service plan at 3:54pm, which included mood stabilization, medication management and therapy and determined the estimated length of stay to be between 3- 5 days. On the patient's first night on the unit, she did not participate in groups but did receive night medication dosages of Klonopin 0.5mg at 6:11pm and 9:56pm, respectively, and there were no incidents reported.

On the third day of admission at 6:19am, the patient refused to complete an EKG. The patient and counselor met to review the treatment plan, in which discharge goals were discussed, verbal consent was given to reach out to an out-of-state relative regarding placement and the patient reported being "not open to psychiatric medication at this time", due to a prior experience at 10:28am. A short time later a psychiatric exam was completed at 10:54am, during this exam the patient expressed a desire of "wanting to go home". During this visit, the unit psychiatrist, gave the patient time to ask questions; verbal consent was given for treatment and a plan was developed which included

medication monitoring, participating in unit activities and cognitive behavioral therapy sessions. While discussing the prescribed medication with the unit's psychiatrist, the patient stated her intentions that she "can't start medications but might refuse". Per the medical records, the second in-patient certificate was completed at 10:55am and noted that the patient was informed of her rights. There were various group sessions held throughout the day, in which the patient attended a few. The patient requested a medical exam; the complaint was for back pain, and she was seen at 4:58pm. During the evening shift, the patient requested juice, graham crackers, a sandwich and melatonin and Atarax to assist with sleeping which were given at 11:50pm.

On the fourth morning of admission, the patient again refused to complete an EKG. At 11:33am, the patient met with the unit psychiatrist in which she expressed her desire to go home and stated that she did not want Zoloft but was willing to sign a voluntary admission application. According to the nursing notes, the patient signed the voluntary admission application at 12:12pm; the signed application by the patient and the attending nurse is noted at 2:00pm. The application was certified that the patient had the capacity to consent for admission, rights were discussed, and a copy was provided to the patient and placed in the record. On the fifth day of admission, the patient expressed not being pleased with the day's menu offerings and put in an order for the next day. Periodically throughout the day, she attended and participated in group sessions. On the overnight shift, the patient spoke to staff about personal relationship issues and stated that her significant other "bugged" her. The patient asked the nurse on duty if she thought the "police would remove the tracking device" and she slept five hours.

On the sixth morning of admission, during a meeting with the unit psychiatrist, the patient continued to elude wanting to move out of state and feeling down due to not being able to visit family outside of visiting hours. The unit psychiatrist followed up on the patient's request of visiting with family outside of hours with a unit counselor. During a follow-up session the patient was able to get approval for visiting with family outside of the normal visiting hours approved. The patient agreed to increase Zyprexa and participated in services within the community before leaving the state. The patient's attendance and participation in group sessions on the unit continued to be sporadic. During the overnight shift, the patient complained of not being able to sleep and requested nicotine gum, which was denied by staff with the explanation that the gum is considered as a "stimulant". Staff offered melatonin, and the patient accepted it with graham crackers at 12:33am and slept five hours.

It was discovered on the seventh day of admission, by a nursing staff member, that the patient attempted to throw out the Zoloft dosage in the trash. On the same day the patient met with a counselor and further discussed discharge plans and signed a release to receive services through a community agency until the patient's moving plan was completed. The patient had a follow-up visit with the attending psychiatrist at 12:22pm and stated that she slept well the previous night. The patient provided the psychiatrist with contact information of a relative to discuss discharge plans. While meeting with the patient, the

attending physician stated there was a conversation with her attorney in which the patient reported having "felt pressured into signing the voluntary application", but the attending stated that the patient was provided with two options pertaining to admission, either involuntarily or voluntary and initially agreed to stay until Tuesday. While in the discussion, an updated treatment plan recommendation was shared that included that the patient's discharge was scheduled for the next day by noon. Throughout the remainder of the day, the patient was very active in participating in various group sessions. The patient signed a request for discharge at 3:40pm, while on the unit. During the overnight shift, she complained of back pain, nausea and received a dosage of Promethazine 12.5mg at 4:56 am and slept five hours.

The patient met with the attending psychiatrist at 7:59am on the final day of admission to complete discharge. The discharge order was confirmed, and notes stated that the patient would need to be driven home by another person and arrangements were made. Throughout the day the patient participated in various sessions and completed a closing counseling session at 2:28pm in which the patient was provided community resources and follow-up resources for the area. The patient was discharged at 3:48pm in the care of family members. During the patient's discharge session, after reviewing and agreeing to the plan, the patient took her belongings and declined a copy of the chart.

Interviews

Manager of Clinical Programming

The HRA team brought up the issue of the discharge procedures because the patient complained of not being able to request a discharge unless it was through the attending nurse. The HRA cited that this has been discussed in previous complaints surrounding the discharge request and noted the hospital completed a training for ED staff in September of 2019. The Manager stated that all CFMH unit staff have been trained on the proper process of completing appropriate discharge measures as well through an in-service training back in December 2019. Also, mentioned was that the case manager goes over the discharge policy with a patient once they are on the unit, which is part of the unit assessment.

CFMH Unit Nurse

The HRA team inquired about the number of patients being serviced for mental health needs due to the area's decreased capacity of providing services. The CFMH Unit Nurse stated that both the ED and the CFMH have seen an increase in patients since this is the only hospital in the community that provides this service. There was discussion around the issue of the patient reportedly being pressured to sign the voluntary admission application. The Unit Nurse stated that when the voluntary admission application is completed the staff and the patient discuss the admission and the process, their rights are read and explained to them and finally both parties sign the form. This is the process that happened with this patient. The CFMH Unit Nurse reiterated the decision is based on the

hospital personnel involved at that time. The benefits of an involuntary admission are explained to the patient. Also, the unit nurse stated that all documents that are completed on the unit, such as voluntary admission application and discharge request are provided to the patient immediately after signing.

Assessment/Referral (A/R) Counselor

In regard to the issue of the patient receiving a copy of her petition and rights while in the ED, the A/R counselor stated that all patients receive these documents and they are placed in the hospital bag containing their belongings that travels with them when transported to another unit. In the Assessment and Referral portion of the nursing notes, it is stated that the patient was admitted voluntarily, but an involuntary petition was completed and signed by the A/R counselor; the HRA committee inquired what occurred. Per the A/R counselor, initially the admission was voluntarily since the patient came to the hospital on her own for services; the patient displayed active psychosis and was assessed as delusional. The assessment and consultation with the attending psychiatrist and advanced nurse practitioner determined that this patient needed to be involuntarily admitted based on the behaviors that were exhibited and that route was taken.

Unit Physician

Per the Unit Physician, there was extensive conservation with the patient regarding being admitted voluntarily or involuntarily during individual sessions. It is noted that the physician stated informing the patient of her rights regarding admission on the unit and the patient understood the procedure. On the day of discharge the physician offered the patient to stay a few more days, but the patient flatly declined.

ED Inpatient Manager

The HRA questioned the usage of psychotropic medication intramuscularly and the ED Inpatient Manager stated that this method is preferred during a crisis. Patients are offered the choice of how they would like to receive medication, either orally or intramuscularly, and the situation that is evolving in the ED normally determines the track that is taken by staff. The ED Manager could not explain why a rights restriction notice for the emergency medications was not completed as required under the Mental Health and Developmental Disabilities Code.

Director of Center for Mental Health (CFMH)

The Director of the CFMH provided full disclosure of not being part of the mental health team during this patient's stay. The Director stated that the hospital staff prefer that all patients choose the method of medication that is best for them and provided the following choices (IM=intramuscularly or PO=taken by mouth), but sometimes the provider choses IM because it works quicker and it is what is needed at that time of interaction. The HRA stressed the need for restriction notices and the Director of the CFMH assured that a

discussion will be held with the ED manager about the appropriate procedure pertaining to the proper completion and usage of the restriction of rights form in the ED.

Policy Review

The "**Voluntary Inpatient Admissions"** policy states "a psychiatrist deems such a person clinically suitable and has the capacity to consent to voluntary admission". Per the medical records, the patient informed the psychiatrist on the fourth day of admission that she would sign a voluntary at 11:33am. According to the hospital policy "any person age 16 or older may be admitted as a voluntary patient for treatment of mental illness upon the filing of an application with a psychiatrist". The patient signed a voluntary admission application on that same day with a unit nurse at 2:00pm, although it was noted at 12:12pm that the application was signed.

The "**Discharge with Five-Day Request"** policy, states "after the patient gives his/her request, the facility must discharge the patient at the earliest appropriate time" which is line with the Code requirements set forth in Section 5/3-403. Per the medical records, there is a signed copy of a discharge request completed by the patient and a nurse on the seventh day of admission.

Conclusion

Complaint: The behavioral health patient's right to an appropriate voluntary admission process was ignored.

Per the Mental Health and Developmental Disabilities Code, a patient requesting and completing a voluntary admission application should be clinically appropriate, accepted by a facility director or appointee and can understand what the request entails (405ILCS 5/3-400). **A rights violation is substantiated**. In reviewing the medical records, the voluntary inpatient application was taken by nursing personnel at 12:12pm but not actually signed until 2:00pm; this process is not in accordance with hospital's policy. Per the policy "a patient may be admitted for treatment of mental illness upon filing an application with a psychiatrist, who deems the person clinically suitable". If the application procedure had followed the written policy, the unit psychiatrist would have taken the application and determined the patient's capacity.

Recommendation

The HRA offers the following recommendation:

1) Hospital personnel should follow the procedure that is spelled out in the policy or update the procedure to be inclusive of other members of the hospital staff being able to accept the voluntary admission application (IL 462-2202M, formerly MH-2).

Suggestion

The HRA offers the following suggestion:

1) Ensure that all information on admission and discharge documents are complete (time and date stamps) and align with the patient's nursing notation as a check and balance.

Complaint: The behavioral health patient's discharge request was ignored.

Per the Mental Health and Developmental Disabilities Code, a patient will be discharged at the earliest appropriate time, not to exceed 5 days, which excludes Saturdays, Sundays, and holidays, after staff has received written notification (405ILCS 5/3-403). **A rights violation is <u>not substantiated.</u>** In reviewing the medical records, the patient completed a discharge request on September 24th and was discharged the next day.

<u>Suggestion</u>

The HRA offers the following suggestion:

1) Hospital personnel should document appropriately in the patient's nursing notes when a request for a voluntary admission application or discharge is made, the time of request, the response and what action took place regarding the request.

<u>Complaint:</u> The patient was not provided with adequate and humane care.

Per the Mental Health and Developmental Disabilities Code, "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. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. 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" (405ILCS 5/2-102(a)). **A rights violation is <u>not substantiated</u>.** The patient on different occasions requested to be seen by a hospitalist for medical issues and follow-up was completed to address any medical issues that patient had. Also, the patient complained about the menu and the food that was provided and alterative options were provided. The patient was involved in services (such as counseling and recreational, wellness and life skills groups), medication monitoring and requested medication to address back pain which was provided. The patient had the option to attend and fully engage in or not participate in services. The patient, on a few occasions, expressed not being able to sleep and was provided snacks and sleep aids to make the patient comfortable.

<u>Complaint:</u> The patient's rights to receive a copy of the petition and voluntary application was disregarded.

Per the Mental Health and Developmental Disabilities Code, when a patient is admitted, within 12 hours, they must receive a copy of the petition (405ILCS 5/3-609). According to the medical records provided, the date and time on the petition shows that a copy was given to the patient on September 19, 20219 at 3:05pm. Although this is not noted in the nursing notes, it was certified by the Assessment and Referral counselor that a copy was provided. In reviewing if the patient received a copy of the voluntary application, per the Code when a patient signs a voluntary application and is admitted the patient is informed of their right to discharge orally, while receiving a copy of the application (405ILCS 5/3-401). The voluntary form was signed by patient and nursing staff on September 21, 2019 at 2:00pm, which notes there was a discussion regarding voluntary procedures and certified that the patient understood the form, the process and received a copy of the application. **A rights violation is <u>not substantiated</u>**, based on the signatures and interaction times displayed on the documents signed by all parties (hospital personnel and patient).

<u>Suggestion</u>

The HRA offers the following suggestion:

1) The hospital personnel develop a checklist that states the appropriate documents that are received by the patient and 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. This document should be part of the intake admission process when the patient arrives on the CFMH unit (a copy is kept with the patient chart and a copy is given to the patient).

2) The hospital personnel should always go over where the patient's documents and belongings are stored and the process for gaining access to these items while on the unit.

The HRA would like to thank the staff of UW Health/SwedishAmerican Hospital–Rockford, IL for their cooperation with this investigation.

RESPONSE

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