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Northwest Regional Human Rights Authority

Report of Findings

Case #20-080-9012

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, unable to use and retain personal property on the unit, unable to refuse services and medications and hospitalized under an inappropriate petition filing. 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 need unit (SNU) within the ED. The Assessment and Referral team 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 received two unwarranted Haldol shots, once in the ED and the other on the unit. The patient's personal property was reportedly taken without cause and he was told to undress without explanation during admission in the ED. The patient was hospitalized under an involuntary petition that reportedly did not state the reason for said hospitalization.

Record Review

ED Record Review

The patient was brought into the ED on October 3, 2019 at 10:37am, by local law enforcement who described the behavior being displayed as "manic". After arriving at the ED, the patient's belongings were placed at bedside, along with a completed belongings list at 11:00am. The attending physician briefly met with patient at 11:12am, who

reported “hearing lots of voices and not sleeping.” After meeting with the attending physician, the patient completed a physical exam, provided patient history, and was observed by the nurse practitioner, who recommended hospitalization for continued evaluation. Per the nursing notes at 11:16am. the nurse practitioner wrote “shared impression, prognosis, plan with patient who was agreeable, stated full understanding and denied further questions when asked.” One of the police officers who brought the patient to the ED completed the petition at 11:31 am and made the following assertation “*On 10-3-19, father went over to son’s residence to get his car running. Patient wanted his dad to smoke weed with him. While his dad was charging the battery, patient jumped down from the rafters into the garage and on the hood of the car. Patient and his dad struggled over the car keys. Patient pulled a ladder, umbrella and a snowblower from the garage. He put the umbrella on the hood of his dad’s truck. Patient got into the bed of the truck and took items. He also grabbed his dad’s mail, stuffed it into his pants and started dancing. His dad said patient was in a manic state form not taking his bi-polar meds*.” At 11:40am, the patient was transferred to the SNU, met with the nurse on duty and within a few minutes reported “hearing voices, which are nice”. While waiting in the SNU room, the patient attempted to leave at 11:57am, stating “he needs to go and penguins have happy feet”, but was redirected by the nursing staff and the petition was explained to patient. The patient responded, “a paper can’t hold me here”. The first inpatient certificate was completed at 2:52pm based on the following: *“ patient is manic, can’t remember the last time slept, exhibiting psychotic features, not making sense in somethings said, grandiose ideas that he owns a hospital, dancing and laughing inappropriately and confused thought process”* and the certificate did not have anything listed for the title of the person completing this form.

The patient attempted to elope from the assigned room numerous times throughout the day. At 3:16pm, during another attempt, the patient stated needing pants, “because I want to go now, this ain’t fun”, but was redirected by nursing staff back to the room. The patient attempted to leave again at 3:48pm and while being redirected, chest bumped the nursing staff and stated, “not going”, while hospital security escorted him back to the room. Per the nursing notes at 4:14pm, the patient was intramuscularly given 5mg of Haldol and 1mg of Ativan for pain/agitation and there was no restriction of rights included. While in the ED, the patient, garnered two security incident reports. The first report occurred on October 3, 2019 at 4:20pm; security was called while hospital personnel were trying to subdue the patient and all parties ended up on the floor. Per the report, security officers brought the patient to his feet and began escorting him to his assigned room. Shortly thereafter, the patient attempted to elope again at 4:36pm, and while being escorted to his room, he pushed staff, and was placed in a physical hold. While in the hold, the notes state, “the patient became more agitated and tried to grab staff wrist and twist it” and finally was returned to his assigned room. While in the room, the patient stood up and told the attending nurse “I will kick your ass, you better get the fuck out of here”. Per the incident report, when the patient was told of the next steps (which included being restrained), he complied without incident. The nursing notes state

that the patient "freely got on the bed and let security place restraints on without incident" at 4:45pm and remained in restraints until 6:40pm, in which there were periodic checks by hospital staff of the patient. On the second incident report, security was called to escort the patient to another room and standby, which occurred without incident at 6:45pm.

Medication

While reviewing the medication administration record (MAR), the patient initially was given Haldol and Ativan intramuscularly in the upper right arm on the first day in the ED. During an initial counseling session, the patient shared with the unit therapist "not interested in psych medications at this time." While hospitalized the patient was prescribed smoking cessation, psychotropic and over the counter medications, which were taken orally and intramuscularly by request. The patient did refuse dosages of Zyprexa 5mg two days in a row (October 4th & 5th), which the hospital honored during hospitalization stay.

CFMH Record Review

The patient was transferred to the CMFH unit at 7:10pm on October 3rd and once arrived, it was noted that the patient "was too tired to answer admission questions, uncooperative and slept through the night". The next morning, the patient woke at 5:25am, and requested Ativan for anxiety and refused Haldol, "just wanted to relax and discuss going home with the doctor" per the medical records. A little over and hour later, the patient requested Tylenol for pain in the rib area. The patient participated sporadically in groups throughout the day. The first certificate and petition were accepted at mental health court on October 4th at 7:45am. During the second day of admission, at 9:15am, while meeting with the attending psychiatrist, the second certificate was completed on the basis of a "history of schizoaffective disorder, aggressive behavior, struck father and delusional thinking" and noted the title of the person completing. Shortly after while meeting with a counselor in an initial session, the patient reported not being interested in psychotropic medication but did state wanting his mother involved in treatment while admitted. The patient shared with personnel during the evening shift that he wanted to go home. Most of the night the patient paced the halls, refused scheduled medication, which was honored, and requested nicotine gum, which was provided.

On the second day of admission, the patient sporadically attended sessions, refused medication, and attempted to elope. Security was called on stand-by on the unit. During the evening shift, the patient walked around the unit wrapped in a towel and was redirected to put on clothes. On the overnight shift, the patient continued to try and open the hospital doors, stated "hearing voices" and demanded to be released. Staff encouraged the patient to take medication for anxiety and auditory hallucinations, which the patient agreed via intramuscularly in the upper right arm (Haldol 5mg & Ativan 2mg) and the patient was able to sleep for four hours. During the third day of admission, the patient participated in various groups on the unit and reported improvement in mood to staff.

The patient slept part of the night, requested medication due to back pain and was provided with medication. The patient paced the halls the remaining of the night and no further incidents were reported. On day four, the patient met with his mental health team, which the patient reported that the only medications he needed was "marijuana, nicotine and water" and that he wasn't sure if he could return home after discharge. Discharge plans were discussed, and the patient was not in agreement with aftercare and possible resources.

On the fifth day, the patient slept in the soothing room and awoke at 3:56am requesting Tylenol for back pain. He paced the halls and met with the counselor and the attending psychiatrist who noted, "patient spoke with hands over face and presents with delusional thoughts". The patient participated in the recreational and life skills groups but did not attend evening groups. In the overnight hours of the fifth day, the patient stripped and wrapped himself with sheets and eventually put on a gown. According to medical records, "patient is responding to internal stimuli". Personnel were able to talk with the patient, but the patient's mood was changed. Staff gave the patient space, snacks and offered psychotropic medication and the patient refused. Staff continued to deescalate the patient and offered medication, which the patient finally accepted PRN (as needed) at 1:50am with another snack and eventually went to bed.

The patient was discharged on October 8th, via court order, although the therapist was not in agreement with order. The patient did not attend or participate in any groups on the sixth and final day of admission and previous medications were restarted due to lack of consistency. The patient declined all discharge documents and resources and was released on his own accord at 2:58pm.

Interviews

ED Nurse

Per the ED Nurse, there were extensive interactions with the patient during the night in question while in the ED. From the ED Nurse's recollection, the patient arrived at the hospital very manic, and he attempted to elope on more than one occasion. The ED Nurse stated that during an attempted elopement, the patient ran into the attending doctor in the hall and was escorted back to the room. While being escorted back to the room, the patient attempted to push this nurse and was put in a physical hold and tried to grab and twist the nurse's wrist. Once in the room, the patient stood up, challenged the nurse, and verbally threatened to kick the nurse and then was put in restraints. The ED Nurse reported, while the patient was in restraints, security personnel entered the room and the patient was given Haldol and stated, "go ahead". The HRA questioned the method used to administer psychotropic medication, because it was noted in the record, that it was completed intramuscularly and that a restriction of rights form was not completed. It was pointed out that anytime rights are restricted (chemically or physically), the patient should be informed verbally and in writing via the **Notice Regarding Restriction of Rights of an Induvial Form (IL 462-2004D).** According to the ED Nurse, the restriction

of rights was verbally given to the patient during this time. The ED Nurse stated the patient was swearing at security and was advised that he would be "given something to calm down" and stated the patient responded, "fine just give it to me.

Nurse Manager

The Nurse Manager followed up on the missing Restriction of Rights Form and stated "documentation in the chart regarding restriction notices is expected (as was here), but not having the completed form present is out of the normal" and could not explain why a notice regarding emergency medication was not completed as required under the Mental Health Code. The Nurse Manager stated that ED staff completed comprehensive training on topics ranging from discharge requests and restriction rights in December 2019 (which occurred after this admission).

Manger of Clinical Programming

Per the Manager of Clinical Programming there have been personnel changes, in which some staff that provided services for the patient during their admission are no longer with the hospital. The Manager of Clinical Programming agreed with the ED Nurse Manger regarding past training, which has occurred for hospital personnel in the ED and CFMH in one to two-hour restrictions of rights training in December of 2019, and at this time is unable to explain why the form was not completed.

Director of Center for Mental Health (CFMH)

The HRA inquired about the process and usage of restraints in the hospital and an explanation was provided by the Director of the CFMH. Per the Director's explanation, "it is a normal request from an attending Nurse Practitioner or Physician based on the behavior that is exhibited by a patient (harming self or posing a threat to others)." The restraints are placed on the patient for safety purposes first and then the order is completed. The HRA took note of the process and the reasoning but reiterated that per the Mental Health Code, the **Notice Regarding Restriction of Rights of an Induvial Form (IL 462-2004D)** is to be completed each time a right is restricted and there were none in the medical records provided. The Director stated from this discussion, this will be taken back immediately and addressed with nursing administration. The HRA discussed the issue of the completion of the certificates correctly (all spaces filled in with the appropriate information) and the Director stated internal controls are being put in place to address.

Policy Review

The "Proper Execution of Inpatient Certificate for Involuntary Admissions" Policy, states "all inpatient certificates are to be filled out appropriately when an adult is admitted to the inpatient unit" and "the examiner shall inform the person being admitted of his/her rights". The ED attending physician completed the inpatient certificate within the appropriate time frame in receiving involuntary admission application. Unfortunately,

the attending was not present during the interview and could not answer why their title was left off, which led to the certificate being deemed invalid in mental health court.

The "**Care of the Psychiatric Patient – ED" Policy,** states "patients will be asked to undress and don a patient gown to facilitate medical screening exam and mental health screening exam". Per the medical records, once the ED deemed that the patient was going to be admitted, the proper protocol was followed, and all belongings were placed in storage for the patient.

The **"Restraints – Violent" Policy,** requires the following: "optimizing the use of restraint and seclusion to the safest possible level and to provide guidelines for documentation that reflects attention to the rights of patients and adherence to regulatory standards". Per the medical records, the ED staff used restraints due to the patient attempting to leave, but the staff did not adhere to the Mental Health and Developmental Disabilities Code and complete a restriction of rights form.

Findings

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

Per the Mental Health and Developmental Disabilities Code, a patient will receive adequate and humane care and services and care in the least restrictive environment (405 ILCS 5/2-102). Once the patient arrived on the CFMH unit, the patient was provided with services and care when requested. The patient shared with the therapist that he would feel more comfortable in wearing his own clothes and not hospital gowns. The staff provided the patient with his own clothes to wear while on the unit, also whenever the patient requested food or medication to address nicotine issues and body aches, they were met. **A rights violation is not substantiated.**

Complaint: The patient was unable to use and retain personal property on the unit.

Per the Mental Health and Developmental Disabilities Code, particular possession and usage of property might be restricted to protect the patient and others (405 ILCS 5/2-104(a)). Per the hospital's policy on **"Care of the Psychiatric Patient – ED"**, it is noted that when an exam (medical or mental exam) is completed, the patient must be in a hospital gown. Once a patient is admitted to the CFMH Unit, all property for a patient is secured in their individual cubicle outside their room per the hospital. **A rights violation is not substantiated**.

Suggestion

1. Hospital personnel should go over the policy of the patient's property and note this in the medical records (i.e. where it is in the ED, on the unit and provide the patient with a checklist of what items were stored).

Complaint: The patient was unable to refuse services and medications.

Per the Mental Health and Developmental Disabilities Code, when an individual or his/her guardian is given the chance to decline mental health or developmental disability services, which include medication or electroconvulsive therapy, these services will not be provided unless there is a necessity to avoid serious and imminent physical harm to self or others (405 ILCS 5/2-107). **A rights violation is not substantiated.** During the patient's admission in the ED, the patient was injected with Ativan 1mg and Haldol 5mg in the upper right arm, although there was no documentation of completed restriction rights notices. The patient did per the medical records attempt to elope numerous times, got into physical altercations with personnel, was restrained and informed he would be provided with something to help "calm down", which otherwise could have led to imminent harm to self and others.

Suggestion

1. Hospital personnel must complete a **Notice Regarding Restriction of Rights of an Induvial Form (IL 462-2004D),** whenever a patient's rights are restricted via being placed in physical hold, using restraints, placed in seclusion and administering emergency medication, inform patient, provide a patient a copy and check if patient wants others to be notified. This form should be included in the record and documented in the nursing note.
2. Hospital personnel should per the "**Restraints – Violent" Policy** document any failed less restrictive alternative interventions (deselection, chemical or physical restraints) and justification of the use of any form of restraints.

Complaint: The patient was hospitalized under an inappropriate petition filing.

Per the Mental Health and Developmental Disabilities Code, any person 18 years of age or older may present a petition to a mental health facility that shall include, "A detailed statement of the reason for the assertion that the respondent is subject to involuntary admission on an inpatient basis, including the signs and symptoms of a mental illness and a description of any acts, threats, or other behavior or pattern of behavior supporting the assertion and the time and place of their occurrence." (405 ILCS 5/3-601). The involuntary admission petition that was submitted on behalf of this patient provided an explanation of what transpired that day, including what the patient's father believed were signs and symptoms of a mental illness along with descriptions of supportive behaviors. An appropriate petition filing includes a completed certificate however, which must be executed by a physician, qualified examiner, psychiatrist, advanced practice psychiatric nurse or clinical psychologist (405 ILCS 5/3-602; 3-611), and the person who completed the first certificate in this case did not include their qualifying credentials. **A rights violation is substantiated.**

Recommendation

1. Ensure that all petitions and certificates meet the requirements of the Code. That SwedishAmerican utilize the Health Unit Coordinator (HUC), to review all petitions and certificates for accuracy and appropriateness before they are submitted to mental health court. This individual will provide the hospital with a checks and balance system to ensure that all documents are completed appropriately and timely and will note in the medical records the actions taken (i.e. reviewing of the petitions/certificates and when submitted to Mental Health Court).

The HRA would like to thank the staff of SwedishAmerican Hospital in 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.