FOR IMMEDIATE RELEASE

Report of Findings
Report: #20-080-9018
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 complaints are that a patient's rights were not adequately explained, and the patient's voluntary admit was not based on consent or capacity**. Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

UW Health/SwedishAmerican's Emergency Department (ED) sees about 70,000 patients each year, in which 14,000 of the patients seen are for mental health reasons/purposes. The hospital has a special need unit (SNU) within the hospital's ED. Currently UW Health/SwedishAmerican is the only hospital that offers inpatient mental health services in the city limits. The hospital's Assessment and Referral (A/R) team is made up of counselors 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), and has capacity for 46 patients (adults and children). The HRA discussed the case with representatives from the CFMH, ED personnel and administrators.

Complaint Summary

Per the complaint, after arriving in the ED for assistance, the patient was given a voluntary admission application to complete but the patient was not coherent. The patient also reported that during the hospitalization, their rights were not adequately explained verbally or in writing.

Record Review

The patient arrived at the ED via ambulance on January 4, 2020, at 5:02am after calling the emergency number for assistance. Shortly after arriving per the nursing notes, it was reported that the patient was "experiencing hallucinations, very anxious and unable to keep tasks on tract", calm, and cooperative with staff at 5:09am. The patient's belongings, which consisted of shoes, socks, a pair of jeans, a coat, and two shirts were placed in a bedside locker at 5:15am. The patient met with the attending ED physician at 5:47am, and per the nursing notes it was reported that the patient was not trying to hurt himself but was experiencing hallucinations. Per the ED physician, "patient is requesting admission to the hospital and denies any suicidal ideations, homicidal ideations or any medical complaints". Per the diagnosis made by the attending, "the patient was positive for self-injury and once

clinically cleared, will have a crisis evaluation". Later that morning, an order was placed by the attending physician for an intramuscularly (IM) dosage of 5mg of Haldol at 6:09am. Per the ED care timeline at 6:33am, the attending nurse gave the IM dosage of Haldol to the patient. In the nursing note, the attending nurse provided the following statement indicating that at 6:40 a.m. the nurse, "reviewed and agreed with the MD assessment, followed hospital policy and protocol for patient care and procedures". The remainder of the morning, the patient rested quietly on a cart and then at 12:10pm was transferred to the SNU. At 12:43pm, the SNU Nurse began a psychological assessment and per the nursing notes, "patient was asked if still had suicidal thoughts and answered yes". The patient met shortly thereafter with the Assessment and Referral Counselor at 1:00pm and during the assessment, the patient began to cry and provided the following statements "without help, may do something to hurt self on impulse" and "if discharged not sure what I will do." At this time, a voluntary admission application that include rights information (IL 462-2202M) and the rights of individual receiving mental health and developmental disability services (IL 462-2001) form were reviewed and signed by the patient. The A/R counselor acknowledged that the patient's rights were explained, and the patient was deemed to have the capacity to request a voluntary admission. After meeting with the patient, the A&R counselor consulted and reviewed the assessment outcomes with the on-call psychiatrist and attending ED physician, who agreed with the assessment and accepted the patient's voluntary admission application for further evaluation through the CFMH. Per the nursing notes, at 1:33pm, the patient was read his rights, signed them, and was provided a copy by the A&R counselor.

While hospitalized the patient requested on two occasions to be discharged against medical advice (AMA). During the first instance which occurred overnight on January 6, 2020, staff redirected patient to discuss discharge with the unit psychiatrist during next session. On January 7, 2020, during a therapeutic staffing with the unit therapist and Nurse Practitioner (NP), the patient requested discharge and it was explained that the staff wanted to monitor patient's reaction to medication dosages and discharge could occur the next day. Later that same day, a meeting was called with unit therapist, NP and a Legal Advocate in which the patient stated "not knowing what he was doing, when signed the voluntary admission, someone brought it to him in his sleep and wanting to leave". The hospital staff discussed that discharge could occur the next day after the case manager put community services in place, spoke with family about relocation the patient was agreeable to this plan. On January 8, 2020, the patient woke early and was excited for the scheduled discharge, which occurred at 11:30am to a waiting taxicab.

Interviews

Assessment/Referral (A/R) Counselor

When questioned if the A/R Counselor covered rights with this patient, the counselor stated, "normally a note would be documented in the record of this type of interaction with all patients" and referred back to the patient's medical record, in which there was a note reflecting this type of interaction. The HRA Committee raised the question of when ~~is~~ it is determined if an admission would be involuntary or voluntarily, and the A/R Counselor

stated that an admission is based on the issues that brought the patient to the attention of the ED and what the patient does or does not express regarding needing services during assessment. The A/R Counselor reiterated that the admission process, usually starts as a conversation with each patient individually, discussing the situation or issues that brought them to the ED ,the available options and then consultation occurs with on-call psychiatrist and the attending. The HRA questioned for this admission, if there was an in-depth conversation with patient about the signing of the voluntary admission application. The A/R Counselor stated not being able to directly recall the specific conversation, but referred back to the nursing notes, in which it was documented that the patient was tearful, reported hearing voices and stated "without help may do something to hurt self on impulse". Per the A/R Counselor assessment notes, a consultation for admission was sought from the on-call psychiatrist, the patient's rights were read to him and a copy of the application and rights were given to him. There was no other communication or interaction between the A/R Counselor and patient, after the signing of the voluntary admission application.

CFMH Unit Nurse

The HRA inquired upon reviewing the notes, that the patient requested to be discharged and wondered why that did not happen. Per the CFMH Unit Nurse, it was written in the nursing notes that the patient needed to let the medication dosage work (observation by nursing staff) and the patient was not keen to accepting that information or directive. Also, the HRA questioned if discharge options were discussed with the patient and a CFMH nurse stated that she did not discuss completing a 5-day discharge request. The HRA pointed out that when a patient signs a voluntary admission application, they have the right to request a discharge and those options should be discussed with the patient.

Unit Psychiatrist

When discussing discharge options, the Unit psychiatrist stated when a patient is admitted voluntarily and submits a discharge request, the provider will assess if the patient needs continued services or if discharge is the best option for them. Regarding this patient, the unit psychiatrist per the medical records deemed the patient was stable enough to discharge, his mood had improved and the risk to harm self or others was not imminent.

Director of Center for Mental Health (CFMH)

The Director of the CFMH stated this patient per the notes requested a voluntary admission, once he arrived at the ED. The Director stated when a patient normally comes to the ED willingly and requests a voluntarily admission, it is accepted by the ED team. Per the Director this patient was assessed in the ED upon arrival, continually assessed throughout the day and the patient's chosen admission was agreed upon by all involved.

Hospital Policy Review

The hospital's **"Voluntary Inpatient Admission"** policy dated June 14, 2018, 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 records provided, as well as the site visit interview, proved that the patient signed and submitted a voluntary admission application on the same day of admission with an A/R Counselor, which is not in line with this policy. As of October 4, 2021, this policy was updated to include the following wording "*any person age 16 or older may consent to a voluntary admission, if that person has the capacity to consent to a voluntary admission according to the professional judgement of the Facility Director or his or her designee".*

Conclusion

Complaint: The patient's voluntary admit was not based on consent or capacity.

Per the Mental Health and Developmental Disabilities Code, a patient aged 16 or older must meet the following guidelines to consent for a voluntary admission: "is clinically suitable for admission as a voluntary recipient and has the capacity to consent to voluntary admission" (405 ILCS 5/3-400). Based on the nursing notes and the site visit interviews, the patient needed services and treatment, because he posed a danger to himself based on his reactions and conversations with staff. It is documented in the nursing note, that the attending physician met with patient at 5:47am on the day of admission and the patient was requesting admission to the hospital. At 1:00pm, the patient signed a voluntary admission form with the A/R counselor which the patient gave consent to the admission, and it was certified that the patient had the capacity to consent. **A rights violation is not substantiated.** The hospital has already taken precautions by updating their "Voluntary Inpatient Admissions-CFMH" policy, effective October 2021 to include a designee of the Facility Director to complete the Voluntary Admission Application with a patient and/or guardian .

Suggestion

The HRA offers the following suggestion:

1. All information on admissions and discharges documents (time and date stamps), align with the patient's nursing notations as a check and balance.

2. Consider a policy revision that when a patient verbalizes a discharge request that a request for discharge form be provided, the verbalized request be documented and the requested followed up on per the Code and its required time frames.

<u>Complaint:</u> The patient's rights patient's rights were not adequately explained.

Per the Mental Health and Developmental Disabilities Code, it is noted that when a patient is beginning to receive services "every recipient who is 12 years of age or older and the parent or guardian of a minor or person under guardianship shall be informed orally and in writing of the rights"(405 ILCS 5/2-200). In reviewing the nursing notes and the interviews, the patient was informed of his rights and signed **the Rights of Individual Receiving Mental Health and Developmental Disability Services (IL 462-2001), which states "*I have explained these rights to the individual (or the guardian of the individual, if applicable) and have provided him or her a copy of it. A copy of this form has been filed in the individual's clinical record*"**. This form was signed by the patient and the A/R Counselor that verified the patient's rights were explained and he received a copy of them**. A rights violation is <u>not substantiated.</u>**

The HRA would like to thank the staff of UW Health/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.