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Northwest Region
Report 20-080-9028
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 was not provided with adequate and humane care, their rights were not appropriately rendered, and they did not receive a copy of their petition or medical records, when requested.** Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110).

UW Health/SwedishAmerican Hospital's Emergency Department (ED) sees about 70,000 patients each year, some 14,000 of the patients seen are for mental health purposes and the hospital has a special need unit (SNU) within the ED. The Assessment and Referral (A/R) team are staff members that are available for screening the 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) which has capacity for 26 patients. The HRA discussed the case with representatives from the CFMH, ED and administration. Relevant policies and the patient's record with authorization were reviewed.

Complaint Summary

According to the complaint, after voluntarily arriving at the ED for assistance, the patient had to wait thirteen hours without being seen. The patient briefly spoke with a physician before being involuntarily admitted without any rights advisement. The patient was prevented from accessing and reviewing medical records while in the hospital. The allegations also state the patient felt detained on the hospital's mental health unit and felt obligated to sign a voluntary admission application, when asked. The patient also reported that services were not adequately provided while on the unit, by only offering one group session per day.

Record Review

Emergency Department

The patient arrived at the hospital's ED on March 7, 2020 via self-transport, after ingesting a large amount of prescribed medication and stating, "I have no family and I want to kill myself". Shortly after arriving, the patient was assessed, and the attending physician contacted the statewide poison control hotline and was advised to monitor for

six hours at 4:15am. At 6:28am, an ED nurse followed up with poison control hotline and was advised to run an IV with fluids to the patient and continue observation. The poison control hotline called the hospital and determined based on the labs that the patient was not in danger and to close the case at 10:16am.The patient was moved to the SNU for continued observation and crisis evaluation and at 11:50am the patient completed a Columbia Suicide Severity Rating Scale (C-SSRS) which produced a score of high risk. It was determined through information obtained via the assessment and referral (A/R) counselor and consultation with the on-call provider that the patient would be admitted involuntarily at 11:54am. The hospital offered the patient a transfer to a veterans' hospital in another state for services and the patient declined. The A/R counselor and the attending provider completed the involuntary petition and 1st certificate, which the physician signed and acknowledged providing patient his rights at 11:57am for admission to the Center for Mental Health (CFMH) unit. Per the nursing note, the attending physician, while meeting with the patient explained that due to the suicide attempt, it was currently unsafe to send the patient home. The attending reported that the patient "was not happy with this and still wishes to go home" and it was determined that admission was the most appropriate decision. While waiting for an available bed the patient slept in the SNU and at 3:54pm was escorted to the unit by a crisis worker and security. At 4:00pm, the patient was given a copy of his petition and rights were shared before arriving on the CFMH unit ten minutes later, with all his belongings and placed on 1:1 observation.

Center for Mental Health (CFMH)

After arriving at the CFMH the unit, the staff got the patient situated in an assigned room and completed a voluntary admission application at 4:25pm with the attending nurse. The application stated the patient "needed further evaluation, suicide attempt" and confirmed that the patient was clinically suitable for voluntary admission and had the capacity to consent. The patient met with the hospitalist shortly after arriving on the unit at 5:13pm, during which there were no reported issues, and the hospitalist's recommendations were for the patient to meet with a primary physician after discharge. On the unit the first night, the patient ate dinner, refused a dosage of gabapentin, and stated, he "had not taken this medication in over two months" and slept through the night. On the second day of admission, the patient met with the unit psychiatrist to develop a treatment plan at 8:40am. The treatment plan included the following tasks: "medication monitoring, attendance at unit activities, and participation in groups and in supportive cognitive behavioral therapy ". During the session, the patient "gave verbal consent for treatment and understands the risk and benefits of proposed treatment plan" to the unit psychiatrist. There were various group sessions held throughout the day, in which the patient attended a few. During the evening shift, the medical records note that the patient was socializing with peers, reporting a positive effect, and politely declined dosages of Neurontin and stated he would discuss with the provider tomorrow.

On the third day of admission, the patient met with a unit psychiatrist and discussed discharge planning at 9:33am. Later in the morning the patient had his first therapy

session with a unit counselor at 11:32am and reported following the treatment plan as developed with the psychiatrist although "mood and coping skills have increased" since admission. There were various group sessions held throughout the day, in which the patient attended a few. During the evening and overnight shifts, there were no issues reported and the patient slept through the night. On the final day of admission, the patient met with the psychiatrist at 8:59am and discussed ongoing treatment recommendations of appropriate medication dosages, and follow-up with the primary physician for any medial reasons. Per the medical records, the patient attended and participated in two group sessions. The interdisciplinary team agreed based on a recently completed Suicide Assessment Five-Step Evaluation and Triage (Safe-T) that the patient was deemed a low risk and that discharge was best. The final counseling session occurred at 9:31am and it was documented that the patient refused to sign release of information forms to the local VA, the patient's mood improved and was stabilized, the patient did not sign releases for outside providers to receive records and follow-up appointments were made to an outside clinic. During this session it was noted that patient's outside therapist left a message for the counselor and per the nursing note, the patient did not want the counselor to contact his therapist but would contact the therapist on his own. Throughout the patient's admission there was nothing noted that the patient requested records during any interactions with hospital staff. The patient was discharged at 1:12pm; the unit nurse explained the discharge papers and the patient left via private transportation.

Interviews

Clinical Manager for the Center for Mental Health

Per the Clinical Manager, the process of the physician giving patient's rights advisement typically occurs when completing the certificate in the presence of an A/R Counselor, but the manager was unable to state what occurred in this situation.

A/R Counselor

Per the A/R Counselor, this patient was upset that he was going to be hospitalized, and although a transfer to an out-of-state hospital was offered, the patient declined. The A/R Counselor stated from her interaction, there seemed to be a level of understanding by the patient on why the hospitalization was occurring.

The HRA pointed out that the involuntary admission petition and inpatient certificate were completed at the same time. The A/R Counselor explained being a newer employee at the time of this admission and this was her second time completing the form. While reviewing the inpatient certificate, the HRA asked if the A/R counselor recalled if the attending physician explained the rights and admission reason to the patient and the A/R did not recall. The A/R Counselor stated that per the training received, the A/R counselor consults with the on-call psychiatrist and then with the

attending physician and together they come to a decision regarding the type of admission to pursue.

Manager of the Inpatient Unit for the Center for Mental Health

The Manager clarified that when patients come into the ED for attempted suicide and there was ingestion, the hospital observes patients for 6 hours per poison control before being medically cleared to move forward with admission to the unit, if they are to be admitted. The HRA reiterated part of the complaint was that the patient waited 12 hours without receiving treatment. The Manager, reviewed the notes and stated that the patient arrived in the ED at 2:50am, monitoring of patient began at 4:15am, the patient was cleared by poison control at 10:16am and then the crisis evaluation was completed. After the crisis evaluation was complete, the outcome garnered an inpatient stay and the patient had to wait until a bed was available on the CFMH unit.

The Manager explained that on the units, the nurses or staff usually review the patients' rights and the voluntary application when the patient arrives on the unit. The HRA pointed out this is a good measure to have, but in this instance, it was not documented and difficult to tell if this action occurred.

The Manager stated that when monitoring patients that are admitted with suicidal tendencies or attempted suicide, the staff must complete a Columbia Suicide Severity Rating Scale upon admission and agreed that the **Suicide Assessment Five-Step Evaluation and Triage (Safe-T)** must be completed daily.

Manager of the Emergency Department

The ED Manager stated that when a patient arrives in the ED, an admission is not automatic. The determination is generated from completing a clinical assessment of the patient and observation. This patient reported wanting to harm himself, which equates into a safety risk, and leads to an admission and a deeper assessment by the hospital staff.

The HRA questioned the statement that was made by the attending physician in the nursing notes, which stated, "**will restrict the patient's rights and admit to the CFMH**" and there were no restriction of rights forms included in the medical record. The ED Manager spoke on the behalf of the provider who was not present and stated, "the physician meant that the patient was restricted to an involuntary admission in the ED and admitted on a petition and certificate".

CFMH Nurse

The HRA inquired about the voluntary admission application that was taken shortly after the patient arrived on the CFMH unit; there is no supporting documentation of the interaction in the nursing notes. The CFMH Nurse stated that there was a discussion with the patient, after he requested the application, going over the details with a level of understanding.

CFMH Counselor

The HRA asked if the patient ever discussed dissatisfaction with the group sessions that were offered, the CFMH Counselor stated, “the patient only had one session with them and did not voice dissatisfaction with counseling/therapy being offered.”

Also, the Counselor stated that the unit conducts daily multidisciplinary meetings which include the psychiatrist, counselor, and nursing staff to discuss the safety of all the patients on the unit and if pattient’s risk factors have changed from the previous day.

Director for the Center for Mental Health

The HRA pointed out that in the complaint summary, the patient stated he was told an admission would not occur. The HRA inquired if this type of conversation would occur before an assessment was completed. The Director of CFMH stated typically “a discharge plan might be discussed, but the staff would not state if a patient did or did not need to be at the facility”.

The Director agreed with the CFMH Counselor that the purpose of the multidisciplinary meeting is to discuss each patient and their level of safety. The Suicide Assessment Five-Step Evaluation and Triage (Safe-T) has been in place since March 2020 and is completed daily to monitor and track the pattient’s level of safety, which is part of the hospital’s “suicide prevention” policy.

Policy Review

“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 patient completed the voluntary application shortly after arriving on the CFMH unit with the attending nurse on the day of admission.

The **“Suicide Prevention”** policy updated March 13,2020 states “to provide a standard of care and procedure for the assessment of a patient’s suicide risk and to provide protective interventions for the potentially suicidal patient”. The policy provides a standard procedure for admission to the CFMH based on a moderate to high risk rating by the patient on the (Safe-T). Per the policy, if a patient agrees with receiving continuous treatment, the patient will be admitted voluntarily and if the patient is not in agreement, the patient is admitted on an involuntarily basis. According to the records received, the patient was offered treatment elsewhere but declined to transfer and was involuntarily admitted. The Safe-T used in conjunction with the patient’s inpatient admission did not denote a rating, but the Columbia Suicide Assessment which was also completed produced a high-risk score.

“The Involuntary Inpatient Admission” policy’s purpose is “To secure a consistent approach to the involuntary admission of persons according to the Illinois Mental Health and Developmental Disabilities Code, January 2011”. The policy points out that there will be “clear documentation in the chart of all the above steps is extremely important

and should be very promptly accomplished." The steps include: the patient receiving a copy of the petition and a statement within 12 hours; the patient completing at least 2 phone calls; within 24hrs (excluding the weekend & holiday) the patient receiving the petition, statement of rights, contact information of Guardianship and Advocacy and/or copies provided to person of patient's choice, and inquiring if patient has others that they would like to receive the information. In reviewing the records provided, it is not clearly documented if these steps had taken place.

Conclusion

Complaint: 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 not substantiated**. Throughout the medical records, there are references to the patient giving verbal consent to the treatment plan that was developed, documentation of the patient declining or refusing certain medications and group sessions in which the patient chose whether to attend.

Complaint: The patient was not given a copy of their petition or medical records timely.

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). Per the medical records reviewed, the patient was provided a copy of the petition and certificate at 4:00pm on March 7th, once transferred to the CFMH unit, which was within 12 hours of their admission. According to the signed involuntary petition and inpatient certificate, both were completed at 11:57am. Also, in reviewing the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4), patients that are aged 12 years or older are "entitled to inspect and receive a copy of their records upon request". **A rights violation is not substantiated**, based on the acknowledgement on the petition for involuntary admission form (**IL 462-2005)** which states that the respondent (patient) was provided with a copy of the petition. There is nothing noted in the record that the patient requested records, but there is a notation that upon discharge, the patient received a discharge packet and requested not wanting any documents mailed out to current providers.

Complaint: The patient's rights were not appropriately rendered.

Per the Mental Health and Developmental Disabilities Code, at the start of services, individuals aged 12 and above will be told of their rights verbally and orally within 12 hours of their admission and will be provided a copy of the petition (405 ILCS 5/2-200). **A rights violation is not substantiated,** in reviewing the medical records received, the attending physician noted that the patient was informed of moving forward with an admission and not being happy with that decision. The **Petition for Involuntary Admission (IL 462-2005)** was completed shortly after the physician met with the patient at 11:55am and told the patient of being admitted. This document has a certifying statement that was signed and dated by the attending, which states that the rights and responsibilities were explained to the patient. During the patient's involuntary admission, an offer was made to transfer to a specialty hospital and the patient declined. The patient received a copy of the petition at 4:00pm in route to the unit, which was done in under 12 hours.

Overall Suggestions

The HRA offers the following suggestions:

1) UW Health/SwedishAmerican Hospital should revise the discharge packet for all patients seeking service and treatment through the following action: include in the pathways to recovery packet, a signature line for the patient to acknowledge receiving discharge records. The rationale will ensure the patients are part of their treatment planning and will ensure that it has been documented that patients either received or refused their medical records. This is a safeguard for the hospital as well and eliminates the confusion if the patient was in receipt of their medical file.

2) In adhering to hospital policy, regarding the **"**the involuntary inpatient admission", include a signature line for the patient and staff to sign-off that the noted required steps in this policy had been followed and documented as required.

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