Community Grievance Decision Digest

Decisions

This document is available for viewing or printing at the Client Rights office website

http://dhs.wisconsin.gov/clientrights/index.htm

This document has been updated through January 2009

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General Information:

This document contains decision summaries that were made at Level III and Level IV of the DHS 94 grievance procedure. These "precedents" are summarized in this document.

These decisions were made via the State Grievance Examiner in the Client Rights office and the Administrator of the Division of Mental Health and Substance Abuse Services.

The purpose of setting forth the summary of decision "precedents" is to provide guidance for the interpretation of the patient rights laws and rules.

Given a particular fact situation, the Client Rights office (CRO) finds that it is helpful to allow both service providers and consumers to see what interpretations have been made in the past.

If a Level III decision is cited, that means the Level III decision was not appealed to Level IV by either party. Thus, it stands as precedent on that issue.

It does not contain the summaries of decisions for patients receiving services from state-operated facilities. Please contact the Client Rights office with requests for information concerning patients in state-operated facilities.

It does not contain any summaries of decisions saved at the following levels:

- Provider level (Level I)
- County level (Level II)

This document is organized alphabetically by topic, and then chronologically by the date of the decision, with the latest decisions being added to the end. This shows the progression of the earliest decisions to the present as the decisions are read.

For further information please visit the Community Grievance Decision Digest website http://dhs.wisconsin.gov/clientrights/CGDD/index.htm

What does 'Emphasis Added' mean?

Emphasis has been added to exact quotes from laws and rules in this document by **bolding** to draw attention to them. "[Emphasis added]" means the original text was not highlighted. Key words in decision summaries are also bolded to allow the reader to quickly find decisions that are relevant to their interest.

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When the 'Print Properties' window opens, look for the 'Print Range' menu and choose 'Pages From' and enter the range of pages to print.

Errors and Omissions

Please send errors and omissions to the Client Rights office (CRO) by US Mail.
Please use the following address:

Client Rights office (CRO)
Division of Mental Health and Substance Abuse Services (DMHSAS)
1 West Wilson Street, Room 850
P.O. Box 7851
Madison, WI 53707-7851

Contact the client rights office:

The Client Rights office (CRO) oversees the grievance procedures for the state operated facilities and the grievance process for the community.

Client Rights website
http://dhs.wisconsin.gov/clientrights/index.htm

Community Grievance Decision Digest website
http://dhs.wisconsin.gov/clientrights/CGDD/index.htm

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1 West Wilson Street, Room 850
P.O. Box 7851
Madison, WI 53707-7851

Telephone: (608) 266-2000

The Client Rights office (CRO) staff hopes that both client rights personnel, patients and their advocates will all find these precedents helpful. Any questions about them from clients should be addressed to the service provider's Client Rights staff. We would like the community client rights specialists to be the first line of response. The community client rights staff can always ask the Client Rights office for further clarification if necessary.

Abuse, Freedom From

Decisions:

12/26/2003
(Level III Decision in Case No. 03-SGE-02)
A mother complained that **her daughter's therapist reported sexual abuse** to the county social worker. The therapist learned that a teacher at her daughter's home school had touched the young woman inappropriately. The therapist reported the allegations to the county social worker. The county Social Services department then got the police involved. The police came to the home school to arrest the teacher. This situation was stressful for both mother and daughter. The incident met the legal definition of sexual abuse. **Since she was a minor, law mandates the reporting** of the allegation. The therapist's actions were professional and appropriate.

6/15/2004
(Level III Decision in Case No. 03-SGE-04)
The **sister/guardian** of a woman filed a grievance about the care the woman had received while she was living in her own apartment. She had been receiving supportive home care services from an independent service provider under a general contract with the county. The guardian alleged **"abuse of a vulnerable adult"** because the woman's apartment was not kept clean by the contractor and was "unlivable due to filth". The contract contained no specific requirements, but there was a list of duties for the staff who visited her apartment. One duty was to clean the apartment weekly. During one particular period, the contractor's employees did not complete many of the required items and the apartment became very dirty. Instead, they spent the time **providing companionship** to the woman. Regardless of her desire for companionship, **the employees were responsible for keeping the apartment clean**. Whenever possible the caregivers should be making sure the task list is completed while working with the client to model those skills, and to create a social situation where tasks can be completed together and in a way that is therapeutic for her by reinforcing daily living skills. While it **did not rise to the level of being "abuse"**, the contractor **violated her right** to a **humane environment.**

Access to Grievance Procedure[1]

Decisions:

07/02/2004
(Level III decision in Case No. 04-SGE-01)
An **ex-patient** attempted to file a complaint with a county mental health center on behalf of some of their current patients. The center asked the county's Corporation Counsel for advice. They were told that they did not have to accept the complaint since the individual filing it was no longer a patient. However, the law says "A patient or **any person acting on behalf** of a patient..." so the center was required to accept the complaint. Failure to timely reply to the complaint was a technical violation of the complainant's rights. That failure was remedied by the center's acceptance and investigation of the complaint.

03/29/2005
(Level IV decision in Case No. 04-SGE-06)
An individual who **had never been in, toured** or **otherwise** had **any connection** whatsoever with the residents of a nursing home for elderly and developmentally disabled clients **tried to file a complaint** on their behalf. He claimed they should have been paid wages for the volunteer work they did. This individual was **not** affiliated with any advocacy group. It was ruled that the individual was not a "**person acting on behalf of a patient**" under DHS 94.28(1), Wis. Admin. Code, and, therefore the **facility did not violate his rights** by **refusing to accept his grievance** filed on behalf of the residents of that facility.

04/18/2005
(Level III decision in Case No. 05-SGE-03)
Where a client **did not receive a timely response** to her grievance her rights were violated. The service provider was required to establish a policy outlining the required steps that must be taken when a client raises a concern and expresses a desire to file a formal grievance under DHS 94. The State Grievance Examiner also required that a copy of that policy and documentation that staff have been trained in how to respond to grievances be sent to the Client Rights office in order to resolve this violation.

04/18/2005
(Level III Decision in Case No. 05-SGE-03)
Where an investigation was conducted into a client complaint, but where **the client did not receive a response** to the grievance, **her right** of access to the grievance process **was violated**. The service provider was **required to remedy** the violation by **establishing a policy** outlining the required steps that must be taken when a client files a formal grievance under DHS 94. A copy of that policy and **documentation** that **staff had been trained** in how to respond to grievances, was **required to be filed** with the DHS Client Rights office

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[1] A person under guardianship may still file his or her own patient rights complaints. The guardian's consent is not required. The guardian should, however, be informed of any complaint involving the guardian's ward.

04/03/2006
(Level IV decision in Case No. 06-SGE-01)
A client complained about **lack of access to the DHS 94 grievance procedure** at a clinic. The grievance was filed directly at Level III because the State Grievance Examiner has jurisdiction over issues related to access to the grievance procedure. It was determined that the **clinic does have a Client Rights brochure**, which the client was able to get a copy of. The brochure outlines the DHS 94 grievance procedure. The **clinic was reminded** that they need to **put the name** and contact information of the clinic's **Client Rights Specialist on all their brochures**.

05/02/2006
(Level III decision in Case No. 06-SGE-06)
A client alleged a **lack of response** to his grievances. The SGE accepted the case under his **original jurisdiction** over access to the grievance procedure. Investigation revealed that the client had **multiple pending complaints** that were being individually addressed by the service provider. It was concluded that the client's right of access to the grievance process was not violated.

08/18/2006
(Level IV decision in Case No. 06-SGE-04)
A complaint was filed about a **facility refusing to accept** a patient rights grievance **on behalf of some unnamed, unspecified clients**. The facility's Counsel advised the facility not to accept the grievance unless the complainant could name at least one client of theirs whose rights had been violated. The complainant, himself, was receiving physical health treatment at the facility, not mental health treatment. **There is nothing inherently wrong** with a facility Client Rights Specialist (CRS) **conferring with the facility's attorneys** on issues pertaining to patient rights. The patient rights laws and rules are complex. Seeking the advice of counsel is often a good way to ensure that the facility is in full compliance with those rights. The decision of the CRS, even if that decision is not to accept a complaint, is still appealable. The four-stage grievance process ensures due process of law for persons seeking to file complaints. The complainant's **rights were not violated**.

09/25/2006
(Level IV decision in Case No. 06-SGE-07)
A father filed a complaint about **restrictions on his visiting** with his **son**, who was in treatment foster care. The county had imposed limitations on his visits with his son as part of the child welfare system. The DHS 94 **grievance procedure** has **no jurisdiction over child welfare matters**. After exhausting the county's grievance process regarding child welfare issues, the next step available to the father was to contact the office of Strategic Finance[2] (OSF) Regional office.

11/30/2006
(Level III decision in Case No. 06-SGE-13)
An ex-patient **filed a complaint 80 days after her discharge** from a Methadone clinic. The Client Rights Specialist for the clinic informally considered the concerns and determined that no rights violations occurred. Since th**e 45 day time frame to file a complaint was exceeded**, the patient's **right to file** a grievance was **not violated** by the clinic's refusal to formally process the complaint.

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[2] Office of Policy Initiatives and Budget, http://dhs.wisconsin.gov/aboutdhs/OPIB/index.htm

06/26/2008
(Level IV decision in Case No. 08-SGE-04)
DHS 94.41(5)(a)1 sets a **45-day time limit on filing complaints** to ensure that the **facts are not too stale to be investigated**. One client's **complaint was filed** with the county **214 days after the incident**. That was 4¾ months later and it was 169 days after the 45-day time limit expired. The county **could have accepted his late grievance "for good cause"** per DHS 94.41(5)(a)2, but **they opted not to**. The question then became **whether or not they "abused their discretion"** by not accepting his late complaint. The client stated that he was "not thinking correctly" during that 45-day period. But that does not constitute "good cause" for him to wait an additional 169 days after that to complain. There was **no "abuse of discretion"** by the county's refusal to accept his very late complaint.

Aesthetics, Hygiene and Sanitation

No decisions at this time.

Arbitrary Decisions, Right to Be Free From

Decisions:

11/10/1998
(Level III decision in Case No. 98-SGE-03)
A county **found a 17-year old ineligible for developmental disabilities services**. She had been **diagnosed** as having a developmental disability **at the age of 6 months**. At the age of 12, she was **diagnosed as autistic** by a multi-disciplinary team of professionals. **Autism is developmental disability** that is a **life-long condition**. The question was whether or not she met the eligibility threshold of a 30% or more functional limitation in at least two of five areas of skills. The county conceded she met that threshold in the area of "self-direction and independence". The records indicate that she also meets the threshold in the area of "self care". Thus, **she should have been eligible for the county's programs**. Her right to prompt and adequate treatment was violated by the county's denial of her eligibility.

07/28/2000
(Level III decision in Case No. 00-SGE-08, upheld at Level IV)
A mother complained that her **son's condition was worsening** since his **medications were discontinued**. Her son's **doctor was on maternity leave** and the service provider would not temporarily assign him to another doctor. She was instructed to call back when the doctor may have returned. But they never attempted to ascertain exactly when the doctor would come back. The **service provider violated the son's right** be free from **arbitrary decisions** being made about him.

06/06/2001
(Level III decision in Case No. 01-SGE-02)
Financial assistance for **housing** is **not an issue covered by client rights** and such decisions cannot be challenged in the grievance process in DHS 94.

03/27/2002
(Level III decision in Case No. 01-SGE-09)
A patient **wanted to continue the individual therapy** she had received for 9 years, but the service provider shifted to **only doing group therapy** with her. She had been made aware months in advance of the upcoming change in services. The **treatment team agreed** that this **change was appropriate** for her treatment needs. Thus, her right to treatment and **her right to be free from arbitrary decision-making** were **not violated**.

03/10/2004
(Level IV decision in Case No. 02-SGE-07, reversing the Level III decision)
A man complained on his wife's behalf that she was **given a new therapist without consulting her first**. A treating facility has the **right to change therapists** for business **management reasons**. It is **good practice** to **consult with the patient first**, but it **does not rise** to the level of a rights violation **not to do so**.

12/20/2004
(Level III decision in Case No. 04-SGE-02)

A **methadone clinic** took away a client's **Sunday take-home privileges** after some incidents. The client had a positive breathalyzer test result for alcohol, had lost her take-home bottle, and had taken an overdose of another medication. She was **informed in writing** of the **requirements** for restoring her Sunday take-home privilege, which included having no positive breathalyzers for alcohol and obtaining a letter from her psychiatrist stating that in his/her best clinical judgment that she was responsible and could handle her Sunday take home bottle. Her **right to be treated fairly** was **not violated** because the clinic had **significant, appropriately documented reasons** to take away her Sunday take-home dose. The Sunday take-home dose was eventually restored in an individualized and appropriate manner.

12/20/2004
(Level III decision in Case No. 04-SGE-02)
A client of a **methadone clinic** had difficulties receiving psychiatric treatment for anxiety that was accessible and affordable to her and which was also acceptable to the clinic. She found one she liked, but **was told to quit seeing him** by the clinic or her services would be terminated. The psychiatrist in question **does not have a good reputation in the field of substance abuse treatment** because he has a reputation for **prescribing medications that may not be appropriate**. She then found a new psychiatrist who charged more and was less accessible for her to visit. Her right to choose her own psychiatrist was not violated because the clinic had good reasons to ask her to see a different psychiatrist. It was **not an arbitrary decision** by the clinic in these circumstances.

04/11/2005
(Level III decision in Case No. 03-SGE-09)
The primary rationale for the **proposed change in vocational services** for a client was **economic**. The county Health and Human Services (HHS) program faced **increasing waiting lists** for people who need services while having **less fiscal support** to provide those services. In the face of a decreasing budget, the HHS was looking at areas where money could be saved. The **costs** of continuing this client's current vocational service provider were **considerably more** than other, **similar providers** in the area. It was **reasonable** for the county to **consider cutting costs without cutting programs**. The client rights question was whether or not the other providers would be able to offer **like services** that **adequately met** the client's **individualized needs** and supported her right to receive **prompt and adequate treatment** appropriate to her condition. It was found that the support services the other vocational provides could offer would be **comparable**. The client would continue working in the same settings at the same times, and with a support person available for the same amount of time. The changes would necessarily include different persons providing those services and doing so under a different organizational structure. However, the vocational services would essentially be the same under the county's proposal. The county's request that the client choose between two other, less expensive, vocational services providers was reasonable and fair. The **need to serve as many clients as possible outweighs** the **potential benefits of one individual** to continue receiving services from a **more costly service provider** than is necessary to provide support services in a similar manner that other agencies may provide in the same setting. Thus, requiring the client to choose between the two less expensive of three possible providers was not a violation of her rights.

12/19/2007
(Level III decision in Case No. 07-SGE-03)

A client had used an **enclosed canopy bed** (manufactured and labeled as a "Vail 1000" bed[3]) for several years for sleeping at night, occasional naps during the day, and as a platform for some personal cares. After an extensive review of the client's situation, it was concluded that **this particular canopy bed was appropriate and safe** for her use. Though technically a **restrictive measure**, it was found that the bed was the **least restrictive alternative to ensure her safety** while allowing her to get the sleep she needed. Therefore, the state and county decisions to discontinue their approval of the use of her Vail 1000 bed was a **violation** of the client's right to a **safe and humane environment** and an **arbitrary decision** because it **was not individualized** to this client's **exceptional safety needs and her unique situation**. This decision **does not set precedent for all Vail beds** or other canopy beds, but only for the bed as it was being used in this specific instance. Thus, the precedent is not binding for other provider agencies or other clients.

[3] Trademarked by Vail Products Inc, 235 first Street, Toledo, OH , 43605-2041

Assistance in the Exercise of Rights

Decisions:

06/29/2001
(Level III decision in Case No. 00-SGE-01)
The **notification of rights** is a **very important task** as it is intended to convey to clients that, indeed, **they have many rights** while receiving services, and that there are **mechanisms designed to protect their rights** – such as the DHS 94 **grievance resolution procedure**. Yet, as clients begin receiving services, they may be at various **functioning levels** in terms of their **ability to process** this information and understand their rights. The law emphasizes the **need for flexibility and follow-up** by providers as may be warranted in any given situation. For example, if a client is admitted to an inpatient setting in an **acutely psychotic state**, that may be a **time when the rights are the least meaningful or understandable**. Thus, someone will need to **follow up** with the rights notification at a later time when the client is **more likely to understand** them. There are creative and effective ways in which information can be shared, explained, and discussed to make it meaningful. Usually some combination of oral notification (unless a client states that is not wanted) **and written notification** followed by an **opportunity to ask questions**, **discuss** what the rights mean, ensure the client **knows who the Client Rights Specialist is**, etc., is effective. The key part of this entire process is **documentation**. Having a patient **sign an acknowledgement** of receipt of rights information is always a **good idea** but, **without more**, **this alone is not always meaningful.** If there is a question later, additional and **contemporaneous documentation** about what the rights notification process entailed is **a good protective measure** for both a client and agency. It is always positive to include such documentation in the client's record. Documentation of **annual re-notification** of rights is **also necessary**. Who does the follow-up in up to the provider, but logically the Client Rights Specialists should have some role.

Burden of Proof

Decisions:

09/19/2003
(Level IV decision in Case No. 02-SGE-04, overturning the Level III)
There must be **sufficient evidence** to show it was **more probable than not** that a **doctor departed from professional judgment** in his prescribing medication to a patient after a phone call with her. Such evidence would have to come in the form of a second opinion from a professional of equal or greater standing than the doctor. Where there was **no such evidence** presented, the finding of a **rights violation** will be **overturned**.

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
The sister/guardian of a woman filed a grievance about **the care the woman** had received while she was **living in her own apartment**. She had been receiving supportive home care services from an independent service provider under a general contract with the county. The **guardian alleged abuse and neglect** because of failure to report theft of monies and possessions and fraud and/or misrepresentation of funds. These issues were properly referred to other authorities. **To criminally convict a person of abuse**, **neglect, or criminal misconduct, there must be proof beyond a reasonable doubt**. A **patient rights violation only requires** a finding that the allegations are proved "**more probable than not**" true.

Civil Rights

No decisions at this time.

Client Choices, Respecting

Decisions:

11/03/1999
(Level IV decision in Case No. 99-SGE-03, reversing the Level III decision)
A client was placed in a **more restrictive setting** than necessary under an **emergency detention**. She was **advised** to **execute an Advance Directive** to **identify her hospital preference** and her treating physician and to provide a copy to the county, too. That would assist the county to appropriately place her if she ever needed emergency detention again.

02/16/2001
(Level III decision in Case No. 00-SGE-05)
A client who was about to be discharged from an inpatient facility **felt she was not being given enough input or choices** in terms of to **where she would be discharged**. She **wanted to be placed in an apartment** in the community. Facility staff were considering placement at other inpatient settings or a CBRF[4] (group home) setting. Ultimately, she was transferred to a community **supported living arrangement** in an apartment. Since this was what she wanted, the grievance was dismissed at Level III as being "**resolved**".

02/05/2001
(Level III decision in Case No. 00-SGE-06)
A client was denied **CIP 1-B funding** for an **addition to her house**. The county followed all applicable laws and policies in denying the request, so the client's **rights were not violated**. However, the county and the department worked together to find **another way to pay** for the remodeling project.

03/23/2001
(Level III decision in Case No. 99-SGE-08)

An inpatient complained about **lack of interactions with staff** during her six-day stay. Each patient's needs and perceptions are unique, and staff cannot use a "one size fits all" approach. There is a **thin line between respect** for a patient's privacy and **choices** (e.g. to not have many interactions with others and to be given personal space), **and going too far in the other direction** (e.g., in trying to probe for interaction with many questions). In the latter instance, the patient could have complained that she was not respected and not given reasonable space or privacy. Here, the record reflects a **reasonable degree of staff attentiveness** and vigilance and, in the latter part of the stay, more discussion with her about issues. It was concluded that the patient's **right** to a humane psychological and physical environment was **not violated** in this circumstance.

04/09/2001
(Level III decision in Case No. 00-SGE-04)
A man made several statements about **wanting to take his own life**. His wife called the police and he was **emergency detained**. He **wanted** to be detained at a **local hospital**, but the police

[4] Community Based Residential Facility

made the decision to detain him at a state mental health facility, over his objections. Since **other, less-restrictive options were available** and he adamantly did not want to go to the state facility, **his right to the least restrictive conditions was violated**.

08/06/2001
(Level III decision in Case No. 00-SGE-12)
A client complained that a **Community Service Provider** (CSP) had not done enough to get him **re-involved** in a **local community center**. This was considered part of his right to **reasonable access to community activities**. The grievance was resolved by an agreement between the CSP and the client that the CSP would assist him with an inter-personal problem-solving protocol that would hopefully enable him to return to the community center.

10/18/2001
(Level III decision in Case No. 01-SGE-06)
A patient **threatened to kill his wife**, **her boyfriend** and his **therapist**. The transitional living facility he had been in was **justified** in **not allowing** him to be **re-admitted**.

11/29/2001
(Level III decision in Case No. 01-SGE-05)
A service recipient felt her **case manager was too controlling** of her life. She usually **accompanied** the individual to her **doctor appointments**, but did most of the talking. However, the doctor had ordered the case manager to monitor the individual's psychotropic medications and to visit her weekly. Thus, it was appropriate for the case manager to accompany her and report to the doctor. The individual also had private appointments with her doctor, so her right to treatment was not violated.

03/27/2002
(Level III decision in Case No. 01-SGE-09)
A patient wanted to **continue the individual therapy** she had received for 9 years, but the service provider shifted to **only doing group therapy** with her. She had been made aware months in advance of the upcoming change in services. The treatment team agreed that **this change was appropriate** for her treatment needs. Thus, her rights to treatment and her right to be free from arbitrary decision-making were not violated.

03/27/2002
(Level III decision in Case No. 01-SGE-09)
A patient **wanted to choose a new psychiatrist** after her case was transferred from a doctor she had been seeing to another doctor. The service provider **tried to accommodate** her request, but the two psychiatrists she asked for declined to accept her on their caseloads. The **accommodation attempts were reasonable**. **No violation** of her rights was found.

02/18/2004
(Level III Decision in Case No. 03-SGE-06)
A father/guardian **wanted to choose a different county case manager** for his son. He noted that the **Medical Assistance Waivers Manual**[5] emphasizes a **choice of providers**. The father **wanted to choose a specific case manager** who worked for the county. The county **had only five case managers** and had a **solid rationale** for why they were not willing to reassign the son

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[5] See the Wisconsin Department of Health Services, Bureau of Long-Term Support webpage, Medicaid Home and Community-Based Waivers Manual: http://dhs.wisconsin.gov/bdds/waivermanual/index.htm

to the case manager the father requested. They **gave him the option** of choosing **either** the **county** as a provider **or** an **outside agency**. Thus, the **county was providing him with a choice** of provider. The county was **not mandated** to provide him with a **choice amongst their own case managers**. The counties still maintain final decision-making authority in how they manage their staff and the workload that is assigned to those staff. No rights violation occurred.

03/10/2004
(Level IV decision in Case No. 02-SGE-07, reversing the Level III decision)
A man complained on his wife's behalf that she was **given a new therapist without consulting her first**. A treating facility has the right to change therapists for business management reasons. It is **good practice** to **consult with the patient first**, but it **does not rise** to the level of a rights violation **not to do so**.

12/20/2004
(Level III decision in Case No. 04-SGE-02)
A client of a **methadone clinic** had difficulties receiving psychiatric treatment for anxiety that was accessible and affordable to her and which was also acceptable to the clinic. She found one she liked, but **was told to quit seeing him** by the clinic or her services would be terminated. The psychiatrist in question **does not have a good reputation in the field of substance abuse treatment** because he has a reputation for **prescribing medications that may not be appropriate**. She then found a new psychiatrist who charged more and was less accessible for her to visit. Her right to choose her own psychiatrist was not violated because the clinic had good reasons to ask her to see a different psychiatrist. It was not an arbitrary decision by the clinic in these circumstances.

04/11/2005
(Level III decision in Case No. 03-SGE-09)
The primary rationale for the **proposed change in vocational services** for a client was **economic**. The county Health and Human Services (HHS) program faced **increasing waiting lists** for people who need services while having **less fiscal support** to provide those services. In the face of a decreasing budget, the HHS was looking at areas where money could be saved. The **costs** of continuing this client's current vocational service provider were **considerably more** than other, **similar providers** in the area. It was **reasonable** for the county to **consider cutting costs without cutting programs**. The client rights question was whether or not the other providers would be able to offer **like services** that **adequately met** the client's **individualized needs** and supported her right to receive **prompt and adequate treatment** appropriate to her condition. It was found that the support services the other vocational provides could offer would be **comparable**. The client would continue working in the same settings at the same times, and with a support person available for the same amount of time. The changes would necessarily include different persons providing those services and doing so under a different organizational structure. However, the vocational services would essentially be the same under the county's proposal. The county's request that the client choose between two other, less expensive, vocational services providers was reasonable and fair. The **need to serve as many clients as possible outweighs** the **potential benefits of one individual** to continue receiving services from a **more costly service provider** than is necessary to provide support services in a similar manner that other agencies may provide in the same setting. Thus, requiring the client to choose between the two less expensive of three possible providers was not a violation of her rights.

Clothing and Laundry

No decisions at this time.

Conflicts between Patients

No decisions at this time.

Consent, Must be informed

Decisions:

03/37/2002
(Level III decision in Case No. 01-SGE-09)
A patient wanted to **continue the individual therapy** she had received for 9 years, but the service provider shifted to only doing group therapy with her. She had been made aware months in advance of the upcoming change in services. But her **interim plan for transitioning** to group therapy **was not** documented or **consented to** by the patient. Thus, her right to treatment and her **right to informed consent** were **violated**. It was recommended that the service provider create a space on its treatment plans for the patient's signature and that they fully document all services received by the patient.

03/29/2002
(Level IV decision in Case No. 01-SGE-07, reversing the Level III decision.)

A therapist did not present his written assessment and treatment plan to the patient prior to beginning treatment. The **treatment plan** was developed after the first session but **not signed** by the patient **until after the third session**. The plan should have been provided to the patient prior to his second session. This **was a violation** of the patient's rights to participate in his treatment planning and **to provide informed consent** for treatment.

09/19/2003
(Level IV decision in Case No. 02-SGE-04)
Where a **doctor knew or should have known** that his patient was **seeing other professionals** involved in her care, the **doctor has a duty** to at least **attempt to inform** the other therapist involved of a change in medication. **If the patient's consent is required**, the **doctor should ask for it**. Where no such attempt was made here, the doctor violated the patient's rights.

04/22/2004
(Level III Decision in Case No. 03-SGE-07)
An ex-patient complained about a **lack of billing information** about the cost of his stay at a psychiatric hospital. At the time of admission to the hospital, the patient and his wife spoke with staff in the Business office about the cost of care. The couple expressed concerns that their insurance would only cover psychiatric care for a limited time. They requested to be informed by the Business office when he had reached the limit the insurance would pay, and the hospital assured them that they would do so. Later, during his stay, a facility representative informed the patient that he was close to exhausting his insurance benefits. At that time, **he signed a form** called the "Beneficiary Notification of Noncovered Care: Disclosure and Acknowledgement statement of Noncovered Services." The signed form acknowledged that he wished to stay at the hospital to receive services and that he was solely liable for payment of the services that would not be covered by his insurance benefits. The ex-patient said that he did not recall seeing or signing this form but his signature on it appears to be on it. One important question is **whether or not** the form is **legally valid as an informed consent document**. Since he was a **legally competent adult**, the hospital presented this form to him in good faith, as he requested.

However, **his inability to recall signing the form** begs the question of "**capacity**" rather than competence during his hospitalization. Certain diagnostic factors indicated that he may not have had a reliable functional capacity to understand the implications of the form he signed, and may account for his inability to recall signing it. The hospital should have gotten his consent on admission to share his billing information with his wife so that they could inform her, too, when the insurance funds were running out.

06/08/2006
(Level III Decision in Case No. 05-SGE-03)

Where a client **participated in a mental health assessment**, her right to provide **informed consent to treatment** was **not violated** because she was not yet in treatment. By her cooperation, she gave her **implied consent** to participate in the evaluation and assessment. This was adequate to begin that assessment process.

Cost of Care, right to be informed of

Decisions:

10/13/1998
(Level III decision in Case No. 98-SGE-02, upheld at Level IV)
An individual was convicted of his 5th Operating While Intoxicated (OWI) got involved in Rational Recovery[6], a non-traditional treatment alternative. He then **demanded reimbursement for all costs of his prior treatments** for the OWIs. He was **properly informed of the costs of his care** at the time of admission to those treatment programs, so **he was not entitled to any refund** of costs he already paid. .

11/03/1999
(Level IV decision in Case No. 99-SGE-03, reversing the Level III decision)
A county human services department (HSD) **did not have a policy** in place for **contacting clients who are emergency detained**. Having such a policy is **not mandated by law**, but is a **good risk-management practice**. Had the HSD had such a policy, they would have found out that **this particular client had insurance** that **would have covered her stay in another facility**, where her treating physician also happened to work. This resulted in her staying at the original place of detention longer than necessary and costing her money from her own pocket. It **violated her right** to the least restrictive setting. Also, **the client should not be held personally responsible** for the **increased cost of care**.

04/06/2000
(Level III decision in Case No. 00-SGE-02)
A patient complained that the facility **did not properly inform her** of the **increase in the charges** for her cost of care. The Level II grievance decision found that she was **not properly informed** of the increased costs and her **billing was adjusted to reduce the fees** to the original costs. This was a **fair resolution** of the grievance.

04/14/2000
(Level III decision in Case No. 00-SGE-06)
A patient's **ex-husband attempted to file a grievance** on his ex-wife's behalf about the **fees charged for her mental health services**. He had been ordered by the divorce court to pay that bill. He **lacked standing** to bring the complaint or appeal it through the grievance process without his ex-wife's consent. **Patient rights attached to her, not her ex-husband**, since she was the one receiving the treatment.

04/20/2004
(Level III Decision in Case No. 03-SGE-07)
An ex-patient complained about a **lack of billing information** about the cost of his stay at a psychiatric hospital. At the time of admission to the hospital, the patient and his wife spoke with staff in the Business office about the cost of care. The couple expressed concerns that **their insurance would only cover psychiatric care for a limited time**. They **requested to be informed** by the Business office **when he had reached the limit the insurance would pay**, and

[6] Rational Recovery, http://www.rational.org/

the hospital assured them that they would do so. Later, during his stay, a facility representative **informed the patient** that he was close to exhausting his insurance benefits. At that time, he signed a form called the "Beneficiary Notification of Noncovered Care: Disclosure and Acknowledgement statement of Noncovered Services." The signed form acknowledged that he wished to stay at the hospital to receive services and that he was solely liable for payment of the services that would not be covered by his insurance benefits. The law states that, "A patient, **a patient's relative who may be liable for the cost of the patient's care and treatment** or a patient's guardian may request information about charges... (Emphasis added). The **patient was given written notice** of the cost of his care. However, **his wife also requested information** about charges for care and treatment services. The hospital policy with competent adults is to only inform the patient receiving services about the cost of the care. However, his wife was also eligible to receive the same information because **she** was his relative, **was also liable for the cost of care**, **and had requested that information**. It is very reasonable for the spouse to request be kept informed about the cost of care for which she is also liable. Furthermore, since the patient was receiving psychiatric services at that time, it would also be reasonable for the spouse to monitor the insurance and billing aspects of care so that the patient could focus more on the psychiatric treatment that he was there to receive. Since the **wife was not informed** nor presented with a release form, she did not become aware of the bill until it had already exceeded the insurance limit and the patient had been discharged. Thus the **patient's right to be informed of costs of his care was inadvertently violated** by the hospital. At the time of admission, the hospital should have presented him with a Release of Confidential Information to release his specific billing information to his wife. **Without the signed consent**, his **wife** would only be eligible to receive **general billing information** that is not specific to the patient, such as the daily cost of inpatient care and any policies about how costs for care are billed at the hospital.

04/22/2004
(Level III Decision in Case No. 03-SGE-07)

A psychiatric **hospital erred** by **not also informing the patient's wife** when his cost of care exceeded his insurance coverage, as she requested. The **hospital needed to revise its admissions policies and procedures** to **cover release of billing information** to those who may be responsible for it. The couple requested that the remainder of their outstanding bill for psychiatric care be waived. While it is concluded that his rights were violated, the **remedial action requested exceeds the scope of the grievance process**. If the couple wants to pursue that resolution independently, they would need to contact the facility to request a settlement or a private attorney for civil litigation.

04/02/2008
(Level III decision in Case No. 07-SGE-02)
When multiple services are to be provided, such as a combination of outpatient individual psychotherapy and family therapy, the **informed consent** process should give clear notification for the proposed costs for each type of service, so the clients may make an **informed choice** in the services they choose to receive. Here, it was determined that the right to **meaningful notification of the cost of care** was **violated** by the **lack of documentation** and the **ambiguity of the consent** to treatment. The family would not have consented had they realized that their insurance would not cover one of the two types of services provided.

04/02/2008
(Level III decision in Case No. 07-SGE-07)

A patient's mother felt that the outpatient drug treatment program "failed" her son by **not promptly diagnosing his depression**. The son ended up requiring inpatient treatment. The mother wanted the outpatient program to **pay for her son's inpatient stay.** This was **not within the purview** of the grievance procedure.

Credibility of Witnesses

No decisions at this time.

Client Rights Limitation or Denial Documentation (CRLD) Process

No decisions at this time.

Dayroom Activities - TV, Radio, etc.

No decisions at this time.

Dignity and Respect

Decisions:

06/17/2000
(Level III decision in Case No. 00-SGE-02, upheld at Level IV)
A therapist's supervisor correctly **referred** a client to the facility's **Client Rights Specialist** when she wanted to **file a complaint about the therapist**. The client felt the supervisor did not care about her concerns. However, the **referral was appropriate** and did not violate the client's right to be treated with dignity and respect.

03/23/2001
(Level III decision in Case No. 99-SGE-08)
An inpatient complained about **lack of interactions with staff** during her six-day stay. Each patient's needs and perceptions are unique, and staff cannot use a "one size fits all" approach. There is a **thin line between respect** for a patient's privacy and choices (e.g. to not have many interactions with others and to be given personal space), **and going too far in the other direction** (e.g., in trying to probe for interaction with many questions). In the latter instance, the patient could have complained that she was not respected and not given reasonable space or privacy. Here, the record reflects a **reasonable degree of staff attentiveness** and vigilance and, in the latter part of the stay, more discussion with her about issues. It was concluded that the patient's **right** to a humane psychological and physical environment was **not violated** in this circumstance.

08/14/2001
(Level IV decision in Case No. 00-SGE-16, upholding the Level III)
A patient was a **recovering alcoholic** who experienced a **relapse** after six months of sobriety. He visited a pastor while he was intoxicated. He ended up in detox[7] that night. Upon intake, he **alleged** that the **pastor had sexually assaulted him**. He made those allegations while he was **still intoxicated**. The staff at the detox facility **took no actions** on the allegations. It is normal procedure to **wait until a patient is no longer intoxicated** to address such issues. Later, when he was no longer under the influence of alcohol, he denied that any assault had occurred. It was reasonable for the staff to accept the later, sober, statements over the prior intoxicated ones. He was released the day after being admitted and did not pursue criminal charges against the priest. No rights violation was found in the manner in which the staff dealt with his allegation of assault.

11/29/2001
(Level III decision in Case No. 01-SGE-05)
A service recipient complained about her **case manager yelling at her** and pounding her fist on the table during a home visit. The case manager admits doing this but said it was a demonstration of how she would act if she were, in fact, the type of controlling person that the service recipient described her to be. This was an isolated incident, but the **effect** on the service

[7] A detoxification facility

recipient was **very negative**. **Even though it only happened once**, **it was a violation** of the individual's right to be treated with dignity and respect.

12/10/2001
(Level III decision in Case No. 01-SGE-02)
Her daughter's therapist told her mother, in a rather public place, that she (the mother) was the one who needed treatment. This remark was **insensitive**, but the **mother was not a patient** at the time and the **right** to dignity and respect **did not apply to her**.

08/27/2002
(Level IV decision in Case No. 01-SGE-08, modifying the Level III finding)
On the day before her discharge, an Occupational Therapist (OT) **made a comment** to the patient to the effect that, "You won't be embarrassed about walking into the dayroom naked and sitting down." She followed it up by saying, "**Just kidding**". There was no further discussion between the OT and patient regarding the comment. The patient did not tell the OT she found the comment distressing in any way, and the OT did not have any other indication that the patient had not accepted it in a humorous way. In retrospect, the OT said she never would have used this comment or any reference to the word "naked" had she been aware of the sensitive connotation that may have had with the patient. The OT wished that the patient had stated her concerns at the time so they could have discussed them in a positive and solution-oriented way. The OT **felt comfortable about using humor** with this patient since she had responded well to humor being used in a therapeutic setting on prior occasions. **Staff are not expected to interact only in a formal or robot-like manner with patients**. There is **ample room for humor** in the course of mental health treatment. Had the OT known that the patient would find the comment distressing or demeaning rather than humorous, it would have been a rights violation to say it. **Some comments are so egregious** that, as a matter of law, **they are rights violations** – such as cursing at a patient, or making racial or ethnic slurs. This comment does not fit that category. Under these circumstances, the comment **did not rise** to the level of a rights violation.

03/10/2004
(Level IV decision in Case No. 02-SGE-07, reversing the Level III decision)
The Level III decision found a violation of a complainant's wife's rights when **her therapist called her at work** to say she was discontinuing the therapy. However, there was **no evidence** in the record that his **wife told the therapist not to call her at work**. This was a **business call**, rather than a personal call, and therefore it was **not necessarily inappropriate** for the therapist to **call his wife at work**. The **finding of a rights violation** was **reversed**.

03/10/2004
(Level IV decision in Case No. 02-SGE-07, upholding the Level III decision)
A complainant accused his wife's therapist of **verbally accosting him** in a public parking lot. The record shows he attempted to obtain a restraining order against the therapist in court, but was unsuccessful. Since he was **unable to prove the matter in court**, he **failed to show** that the therapist had **violated his rights** in those circumstances.

04/22/2004
(Level III Decision in Case No. 03-SGE-07)
An ex-patient complained about a **lack of individualized treatment** at a psychiatric hospital. These concerns were **meaningfully addressed** when the **hospital responded** to his observations and concerns about the manner in which patients are assessed and treated. The hospital was

planning a specific **training session** for staff to address indicators, features, and treatment approaches for Post Traumatic Stress Disorder and Parkinson's Disease. The training will also address the variables that could arise with men's issues during treatment. This staff training should lead to an improved awareness and create a better standard of care, **greater dignity and respect** for patients, and more individualized treatment decision-making. Given the training initiatives planned, this issue was **considered resolved**.

12/20 2004
(Level III decision in Case No. 04-SGE-02)
A client's right to be treated with dignity and respect were **violated** at a methadone clinic when her **psychiatrist made a remark** about her lack of treatment progress **in front of other clients** in the waiting room. That remark should not have been made in front of others.

06/08/2006
(Level III Decision in Case No. 05-SGE-03)
A client's right to be treated with **dignity and respect was violated** by the **lack of shared decision-making and collaborative planning** during the **evaluation and assessment phase** of services. While the service provider does maintain the right to choose which clients they will or will not see, their assessment and evaluation of a client's treatment needs should also recognize and respond to a client's request for more frequent visits. They need to clearly define the purpose of the assessment and set reasonable expectations for the client.

Discharge of Voluntary Patients

Decisions:

01/27/2003
(Level III decision in Case No. 02-SGE-06)
A father claimed that his **son's discharge** from treatment at a medical center **was in retaliation** for his filing a complaint about his own mother's care there. It was determined that **other factors led to the son's discharge** and that the father had been told that it was going to occur soon. This occurred several months prior to the complainant filing a grievance about his mother's care. No retaliation for filing a complaint was found.

Discrimination, Right to be Free From

No decisions at this time.

Documentation Requirements

Decisions:

06/17/2000
(Level III decision in Case No. 00-SGE-02, upheld at Level IV)
A patient **claimed a breach of confidentiality** by her therapist in a phone conversation with her mother. It was found that the mother initiated the call because of her concerns for her daughter and that the therapist was careful not to divulge any information about the daughter's treatment. The mother asked the therapist not to tell the daughter about the phone call. The therapist could not promise that she would not divulge that the mother called, but eventually decided not to inform the daughter. Her **reasons for making** that **decision were documented**. No breach of the daughter's confidentiality was found.

07/28/2000
(Level III decision in Case No. 00-SGE-08, upheld at Level IV)
A mother complained that her **son's condition was worsening** since his **medications were discontinued**. Her son's doctor was on maternity leave and the service provider would not temporarily assign him to another doctor. She called the service provider several times, explaining her son's condition and asking to have another doctor assigned. These **requests were never documented** in the son's records. The service provider **violated** the son's right to **proper documentation** in his records.

03/23/2001
(Level III decision in Case No. 99-SGE-08)
An inpatient, admitted to county hospital via an "**Emergency Detention**" due to suicidal ideation, felt staff did not provide her enough time and attention in dealing with her concerns - especially, why she was **not eating meals**. She was depressed during much of her six days there. She refused several meals. She wanted her meals served to her in her own room so she would not have to sit near a certain male peer. There was considerable charting as to the staff's plan to encourage the patient to eat meals and have proper nutrition and food intake. But two days passed with the patient not coming out for meals, and staff seemed to not be doing anything more to explore why she was not eating, and/or in what circumstances she would be able or willing to eat meals. Patients have a right to refuse meals. But, in this instance there were medical reasons why proper food intake was important, and the charting also stressed that eating meals was to be encouraged. That being the case, one might reasonably expect staff to do more than simply observe that a patient was not coming out to eat. They let her eat one meal in her room, then gave her a "take it or leave it" ultimatum. What really was the goal? Was it to encourage nutritional intake? Or to try to force compliance with the unit expectation that patients come out of their rooms to eat in the congregate setting? There was **no documentation** as to **why** they took that stance. No other approaches to encourage her to eat were made. Under these circumstances, the **lack of any documented team discussion** or decision **was a violation** of the patient's **right to specific and objective documentation** of the reasons and rationale for the decision that was made.

05/25/2001
(Level IV decision in Case No. 01-SGE-01, upholding the Level III)
A doctor filed a **late entry** in a patient's chart **clearing up some confusion** over when a specific medication was given to a patient. While this entry was **not timely,** it **did not mean** the original records were **falsified**.

06/29/2001
(Level III decision in Case No. 00-SGE-01)
The **notification of rights** is a **very important** task as it is intended to convey to clients that, indeed, they have many rights while receiving services, and that there are mechanisms designed to protect their rights – such as the DHS 94 grievance resolution procedure. Yet, as clients begin receiving services, they may be at various functioning levels in terms of their ability to process this information and understand their rights. The law emphasizes the need for flexibility and follow-up by providers as may be warranted in any given situation. For example, if a client is admitted to an inpatient setting in an acutely psychotic state, that may be a time when the rights are the least meaningful or understandable. Thus, someone will need to follow up with the rights notification at a later time when the client is more likely to understand them. There are creative and effective ways in which information can be shared, explained, and discussed to make it meaningful. Usually some combination of oral notification (unless a client states that is not wanted) and written notification followed by an opportunity to ask questions, discuss what the rights mean, ensure the client knows who the Client Rights Specialist is, etc., is effective. The **key part of this entire process is documentation**. Having a patient **sign an acknowledgement** of receipt of rights information is always a good idea but, without more, this **alone is not always meaningful**. If there is a question later, additional and **contemporaneous documentation** about what the **rights notification** process entailed is a good protective measure for both a client and agency. It is always positive to include such documentation in the client's record. **Documentation** of the annual **re-notification** of rights is also necessary. Who does the follow-up in up to the provider, but logically the Client Rights Specialists should have some role.

03/27/2002
(Level III decision in Case No. 01-SGE-09)
A patient **wanted to continue the individual therapy** she had received for 9 years, but the service provider shifted to **only** doing **group therapy** with her. She had been made aware months in advance of the upcoming change in services. But her **interim plan for transitioning** to group therapy was **not documented** or consented to by the patient. Thus, her right to treatment and her right to informed consent were violated. It was recommended that the service provider create a space on its treatment plans for the patient's signature and that they **fully document all services** received by the patient.

03/29/2002
(Level IV decision in Case No. 01-SGE-07)
A therapist **mis-dated some entries** about when he saw a client. He also documented one entry twice. These discrepancies were **ordinary human error** and they did **not amount to a violation** of the client's rights.

09/19/2003
(Level IV decision in Case No. 02-SGE-04)
Patients have the **right** to have their **care and treatment coordinated** with **other treatment staff** who are involved in their care and treatment. A **doctor ordering a change** in a patient's

medication must ensure that **other members** of the patient's treatment team are **informed** about the new medication and the expected benefits and potential adverse side effects which may affect the patient's overall treatment. This should be **documented**.

09/19/2003
(Level IV decision in Case No. 02-SGE-04)
A Level III decision **described** a doctor's **progress notes as being** "**inadequate**", but found no rights violation. This issue was not addressed on appeal because, **no matter how the notes were characterized**, the **outcome** (no rights violation) was **not affected**.

09/19/2003
(Level IV decision in Case No. 02-SGE-04)
In general, the **treatment decisions of professionals** are afforded "**due deference**" by peers and by the courts. However, if a treatment decision "departs from professional judgment", the patient's right to treatment may have been violated. A "departure from professional judgment" may be evinced[8] in any of three ways:

- where the evidence suggests that the professional exercised no judgment at all;
- where the individual was not qualified to make the judgment; or
- where a decision was made on an impermissible basis (e.g., as "punishment").

Documentation by the decision-maker is **key to ensuring** professionals are **not departing** from professional judgment.

09/19/2003
(Level IV decision in Case No. 02-SGE-04)
In a situation where a **suicidal patient** has been put on a **new medication**, then **cancels her next appointment** with the doctor, the **clinic has a duty** to at least have someone **review** the situation to see if follow-up contact with the patient is necessary. There was no evidence that this was done here. While it could be assumed that, as a voluntary patient, she was exercising her right to discontinue treatment, there should have been some determination made as to whether or not to contact her. The clinic thus **violated the patient's right** to prompt and adequate treatment by **not making** and **properly documenting** that determination.

09/19/2003
(Level IV decision in Case No. 02-SGE-04, overturning the Level III)
Where a **service provider** asserted that the **facts** in the Level III decision were **incorrect**, the **file records** were **re-reviewed** in the **Level IV** process. The **facts** of the Level III decision regarding **documentation** were found to be **incorrect**. However, the **documentation had been made in margin notes** rather than in some clearer form. This **poor documentation** resulted in the finding of a **rights violation** at Level III. There was sufficient evidence, on closer inspection, to indicate that the violation did not occur.

09/19/2003
(Level IV decision in Case No. 02-SGE-04, overturning the Level III)
Sec. 51.30(4)(e), Stats., requires that, when **records are released**, "a **notation shall be made** in the records by the custodian thereof that includes the following: the name of the person to whom the information is released; the identification of the information released; the purpose of the release; and the date of the release". **Handwritten notes in the margin** of records request

[8] (1.) To show clearly; make evident or manifest; prove. (2.) To reveal the possession of (a quality, trait, etc.).

documents, due to their brief nature, are **unlikely to satisfy** all the **documentation requirements** of this statute. Subsequent to April 14, 2003, entities releasing records must also comply with the even more stringent federal Health Information Portability and Accountability Act (**HIPAA**[9]).

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
An independent agency working on a contract with the county **did not have any documentation** regarding services they provided because they moved offices and, apparently, those **files were lost** during the move. The missing files should have been retained for a minimum of seven years. offices and agencies move locations or may close one of their offices over time, but their records must be retained. The **loss of these records is inexcusable**. The **rights** of the client **were violated** because the agency did not retain documentation as to the care and treatment of the client.

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
The **contract** between an **independent service agency** and a **county** should have been **more precise**. The treatment plan and the expectations of care protocols should have been as specific as possible to reflect the client's individual needs and the tasks required in the contracted agreement with the agency. **Documentation** of the expectations, and their implementation, is **essential**.

[9] The Health Insurance Portability and Accountability Act of 1996, http://www.hhs.gov/ocr/hipaa/

Drastic Treatment Procedures, Right to Refuse

No decisions at this time

Drug Testing

Note: drug testing, including random urinalyses (UA's) are considered "**Searches**".

See "Searches of Person and Possessions" in this document.

No decisions at this time.

Due Process of Law

Decisions:

09/13/2003
(Level IV decision in Case No. 02-SGE-04)
A hospital noted on appeal of findings of rights violations that the **State Grievance Examiner (SGE) had not contacted the patient's doctor directly** during the Level III review. The **hospital asserted** that this **evinced[10] a lack of professional courtesy** and **constituted a violation of due process**. The SGE should probably have contacted the doctor to **provide him with a sense of fairness**. But the SGE has **broad discretion** in **how to conduct Level III reviews**. Where the SGE felt he could rely on the written records available to him, **failure to contact the doctor** was **not** an abuse of that discretion or a **violation of due process**.

08/18/2006
(Level IV decision in Case No. 06-SGE-04)
There is **nothing inherently wrong** with a facility Client Rights Specialist (CRS) **conferring with the facility's attorneys** on issues pertaining to patient rights. The patient rights laws and rules are complex. Seeking the advice of counsel is often a good way to ensure that the facility is in full compliance with those rights. The decision of the CRS, even if that decision is not to accept a complaint, is still appealable. The **four-stage grievance process ensures due process** of law for persons seeking to file complaints.

[10] (1.) To show clearly; make evident or manifest; prove. (2.) To reveal the possession of (a quality, trait, etc.).

Equal Protection of the Law

No decisions at this time.

Evidence

Decisions:

02/21/2001
(Level IV decision in Case No. 00-SGE-08)
The complainant wanted the State Grievance Examiner to conduct personal interviews of all staff involved in a grievance issue. **State Grievance Examiner (SGE) has the discretion** whether to conduct a **field investigation** or rely on documentation submitted in the grievance process. Where **sufficient documentation exists**, **personal interviews** of staff are **not necessary**, either.

06/19/2001
(Level III decision in Case No. 00-SGE-16, upheld at Level IV)
A grievance was filed on well past the 45-day timeframe in DHS 94.41(5)(a). However, the county reviewed it at Level I and II. It is within the client rights specialist's discretion to accept complaints that are filed after the timeframes. **A long delay** in **filing a grievance** after an event **significantly compromises the quality of the investigation** that may be conducted. Individuals often do not recall all the details of what happened or what was said after such a lengthy period of time. In this case, since it was accepted at Level I and II, it was also accepted at Level III. The Level III review was **limited to a desk review** of this case based on the available documents. The ability to conduct a thorough investigation was limited by the delay in the filing of the grievance.

08/27/2002
(Level IV decision in Case No. 01-SGE-08, modifying the Level III finding)
On the day before her discharge, an Occupational Therapist (**OT**) **made a certain comment to the patient**. The **OT had not been personally interviewed** during the Level III review. Much more information about the OT's role and perspective was provided during the Level IV review. This **additional evidence** was found to be **relevant and credible** information **bearing on the appeal**.

09/19/2003
(Level IV decision in Case No. 02-SGE-04)
A hospital noted on appeal of findings of rights violations that the **State Grievance Examiner (SGE) had not contacted the patient's doctor directly** during the Level III review. The hospital asserted that this evinced[11] a lack of professional courtesy and constituted a violation of due process. The SGE should probably have contacted the doctor to provide him with a sense of fairness. But the **SGE has broad discretion** in how to conduct Level III reviews. Where the SGE **felt he could rely on the written records** available to him, **failure to contact the doctor** was **not an abuse** of that **discretion** or a violation of due process.

09/19/2003
(Level IV decision in Case No. 02-SGE-04, overturning the Level III)
There must be **sufficient evidence** to show it was **more probable than not** that a **doctor departed from professional judgment** in his prescribing medication to a patient after a phone

[11] (1.) To show clearly; make evident or manifest; prove. (2.) To reveal the possession of (a quality, trait, etc.).

call with her. Such **evidence would have to come in the form of a second opinion from a professional of equal or greater standing than the doctor**. Where there was **no such evidence** presented, the finding of a rights violation will be overturned.

09/19/2003
(Level IV decision in Case No. 02-SGE-04, overturning the Level III)
Where a service provider asserted that the facts in the Level III decision were incorrect, the **file records were re-reviewed in the Level IV process**. The **facts** of the Level III decision regarding documentation **were found to be incorrect**. However, the **documentation had been made in margin notes** rather than in some clearer form. This **poor documentation** resulted in the finding of a rights violation at Level III. There was **sufficient evidence**, on closer inspection, to indicate that **the violation did not occur**.

03/10/2004
(Level IV decision in Case No. 02-SGE-07)
There is **insufficient evidence** to conclude that a **facility's Chief Legal Counsel discouraged someone from filing a complaint**. The facts indicate he **merely informed** the individual that **he did not believe he had a malpractice claim that would be upheld in court**. The fact that the individual was able to bring this complaint and appeal it up through the grievance process to Level IV indicates that his right to complain was not violated.

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
The sister/guardian of a woman filed a grievance about the care the woman had received while she was living in her own apartment. She had been receiving supportive home care services from an independent service provider under a general contract with the county. The **guardian alleged abuse and neglect** because of failure to report theft of monies and possessions and fraud and/or misrepresentation of funds. These issues were **properly referred** to **other authorities**. To **criminally convict** a person of abuse, neglect, or criminal misconduct, there must be **proof beyond a reasonable doubt**. A **patient rights violation** only requires a finding that the allegations are proved "**more probable than not**" true.

12/20/2004
(Level III decision in Case No. 04-SGE-02)
A client of a **methadone clinic** was also undergoing **treatment for hepatitis** and liver cancer. The clinic had some concerns about a small amount of **alcohol** in her system, which she claimed was a **byproduct** of her **hepatitis treatment**. From the **limited facts** at hand, it was not possible to determine if any violation of her rights occurred.

08/15/2005
(Level IV decision in Case No. 04-SGE-07)
The Level III decision **thoroughly addressed** all of the complainant's issues. In her appeal to Stage 4, the complainant provided **no new evidence** sufficient to justify reversing the Level III decision. The Level III decision was therefore affirmed.

Exercise and Recreation

No decisions at this time

Filming or Taping, Consent Required[12]

Decisions:

07/17/2003
(Level III decision in Case No. 03-SGE-03)
A father **wanted to audio-tape staff's meetings** where they discussed his son's treatment. The **facility refused to allow this**. This is **not a patient rights issue**. The only relevant patient right is the **right not to be filmed or taped**. The **facility offered** to **write up the outcomes** of the meetings for the father. This was a **reasonable resolution,** but the father refused to accept it.

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[12] The Division of Quality Assurance has issued a memo entitled, "Electronic Video Monitoring and Filming in BAL Regulated Facilities". It applies to all facilities regulated by the Bureau of Assisted Living and covers filming and taping of residents of those facilities.
The memo can be found at: http://dhs.wisconsin.gov/rl_DSL/Publications/08-023.htm

The Bureau of Assisted Living (BAL) is now part of the Wisconsin Division of Quality Assurance (DQA). Additional information can be found on the DQA web homepage: http://dhs.wisconsin.gov/rl_DSL/bqa.htm

Food, Meals and Diets

Decisions:

03/23/2001
(Level III decision in Case No. 99-SGE-08)
An inpatient, admitted to county hospital via an "**Emergency Detention**" due to suicidal ideation, felt **staff did not provide her enough time and attention** in dealing with her concerns **- especially, why she was not eating meals**. She was depressed during much of her six days there. **She refused several meals**. She **wanted her meals served to her in her own room** so she would not have to sit near a certain male peer. There was considerable charting as to the staff's plan to encourage the patient to eat meals and have proper nutrition and food intake. But two days passed with the patient not coming out for meals, and staff seemed to not be doing anything more to explore why she was not eating, and/or in what circumstances she would be able or willing to eat meals. **Patients have a right to refuse meals**. But, in this instance there were medical reasons why proper food intake was important, and the charting also stressed that eating meals was to be encouraged. That being the case, one might reasonably expect staff to do more than simply observe that a patient was not coming out to eat. They let her eat one meal in her room, then **gave her a "take it or leave it" ultimatum**. What really was the goal? Was it to encourage nutritional intake? Or to try to force compliance with the unit expectation that patients come out of their rooms to eat in the congregate setting? There was **no documentation** as to **why** they took that stance. No other approaches to encourage her to eat were made. Under these circumstances, the **lack of any documented team discussion or decision** was a **violation** of the patient's right to specific and objective documentation of the reasons and rationale for the decision that was made.

Funds and Indigence

Decisions:

02/05/2001
(Level III decision in Case No. 00-SGE-06)
A client was **denied CIP 1-B funding for an addition to her house**. The county followed all applicable laws and policies in denying the request, so the client's **rights were not violated**. However, the county and the department **worked together** to **find another way to pay for the remodeling project**.

06/06/2001
(Level III decision in Case No. 01-SGE-02)
Financial assistance for housing is **not an issue covered by client rights** and such decisions **cannot be challenged in the grievance process** in DHS 94.

03/19/2003
(Level III decision in Case No. 02-SGE-05)
An ex-patient complained that an inpatient treatment facility **overcharged him for some smoking materials**. **County funds paid for those materials**, rather than the patient. The issue was **thus between the county and the facility** and the issue was **not appropriate for the grievance process**.

Grievability

Decisions:

02/06/1998
(Level III decision in Case No. 98-SGE-01)
The DHS 94 grievance process has **no jurisdiction over issues raised by an individual under the control of the Department of Corrections (DOC)**[13]. The individual who brought the complaint was redirected to appeal through the DOC inmate complaint system.

04/14/2000
(Level III decision in Case No. 00-SGE-06)
A patient's **ex-husband attempted to file a grievance** on his ex-wife's behalf about the **fees charged for her mental health services**. He had been ordered by the divorce court to pay that bill. He **lacked standing to bring the complaint or appeal it through the grievance process without his ex-wife's consent**. **Patient rights attached to her**, **not her ex-husband**, since she was the one receiving the treatment.

04/09/2001
(Level III decision in Case No. 00-SGE-04)
A patient being **emergency detained** complained about **being shackled** by the **sheriff officers during transport**. This is their standard practice. The **grievance process has no jurisdiction over the actions of law enforcement agencies**.

06/06/2001
(Level III decision in Case No. 01-SGE-02)
Financial assistance for housing is **not an issue covered by client rights** and such decisions **cannot be challenged in the grievance process** in DHS 94.

08/26/2002
(Level IV decision in Case No. 00-SGE-11, upholding the Level III decision)
A client **also filed a complaint** with the Department of Health Services[14], **Bureau of Quality Assurance** (BQA)[15], which certifies providers and clinics. The issues raised in that context were reviewed as part of a separate process. The **grievance procedure reviews complaints in the context of DHS 94 rights**, and **does not deal with licensing or certification issues**. Thus, **there is no standing to raise licensing and certification issues in the grievance process**, too.

03/19/2003
(Level III decision in Case No. 02-SGE-05)
An ex-patient complained that an inpatient treatment facility **overcharged** him for some smoking materials. **County funds paid for those materials**, rather than the patient. The issue was thus between the county and the facility and the issue was **not appropriate for the grievance process**.

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[13] http://www.wi-doc.com/
[14] http://dhs.wisconsin.gov/
[15] Division of Quality Assurance, http://dhs.wisconsin.gov/rl_dsl/bqa.htm

07/17/2003
(Level III decision in Case No. 03-SGE-03)
A father **wanted to audio-tape staff's meetings** where they discussed his son's treatment. The **facility refused to allow this**. This is **not a patient rights issue**. The only relevant patient right is the right **not** to be filmed or taped. The facility offered to write up the outcomes of the meetings for the father. This was a reasonable resolution, but the father refused to accept it.

10/23/2003
(Level III decision in Case No. 03-SGE-10)
A **court decision** to **order medications cannot be challenged in the grievance process**.

11/11/2004
(Level IV decision in Case No. 04-SGE-04)
Sheltered workshops that have been **approved by DWD**[16] [or the federal Department of Labor[17]] to **pay sub-minimum wages** are, by such approval, deemed in compliance with the client wage requirements of § 51.61(1)(b), Stats. The DHS 94 grievance procedure has **no jurisdiction** over issues of **compliance** with the **federal Fair Labor Standards Act**[18].

09/27/2006
(Level IV decision in Case No. 06-SGE-09)
A **diagnosis** made by an independent, outpatient clinician was that **clinician's opinion**, which **cannot be challenged** in the **grievance process**. The client has the right to get a second opinion if she disagrees with the diagnosis.

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[16] Department of Workforce Development, http://www.dwd.state.wi.us/
[17] U.S. Department of Labor, http://www.dol.gov/
[18] U.S. Department of Labor, Employment Standards Administration, http://www.dol.gov/esa/whd/flsa/

Grievances, Right to File

The following sections in this document refer to definitions and decisions concerning the following aspects of the Grievance Procedure:

- Access to Grievance Procedure
- Burden of Proof
- Credibility of Witnesses
- Evidence
- Grievability
- Mootness
- Procedural Issues
- Resolutions and Remedies
- Retaliation for Use of Grievance Procedure Prohibited

Guardianship[19]

Decisions:

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
The individual's right to treatment includes specific protocols as necessary to ensure health and sanitary living conditions. The treatment needs of the client need to be considered and clearly documented in the contract between the county and any contract agencies, with a plan for monitoring and updating those treatment goals. Any barriers to achieving these needs must be documented, the guardian must be informed, and a plan to resolve such issues needs to be implemented. These treatment protocols are an essential feature for the treatment and management of the client, and they are an integral part of the client's right to prompt and adequate treatment.

[19] A person under guardianship may still file his or her own patient rights complaints. The guardian's consent is not required. The guardian should, however, be informed of any complaint involving the guardian's ward.

Humane Environment

Decisions:

03/23/2001
(Level III decision in Case No. 99-SGE-08)
An inpatient complained about **lack of interactions with staff** during her six-day stay. Each patient's needs and perceptions are unique, and staff cannot use a "one size fits all" approach. There is a thin line between respect for a patient's privacy and choices (e.g. to not have many interactions with others and to be given personal space), and going too far in the other direction (e.g., in trying to probe for interaction with many questions). In the latter instance, the patient could have complained that she was not respected and not given reasonable space or privacy. Here, the record reflects a **reasonable degree of staff attentiveness** and vigilance and, in the latter part of the stay, more discussion with her about issues. It was concluded that the patient's right to a humane psychological and physical environment was **not violated** in this circumstance.

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
The individual's **right to treatment** includes specific **protocols** as necessary to **ensure health and sanitary living conditions**. The treatment needs of the client need to be considered and clearly documented in the contract between the county and any contract agencies, with a plan for monitoring and updating those treatment goals. Any barriers to achieving these needs must be documented, the guardian must be informed, and a plan to resolve such issues needs to be implemented. These **treatment protocols** are an **essential feature** for the treatment and management of the client, and they are an **integral part of the client's right to prompt and adequate treatment**.

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
The sister/guardian of a woman filed a grievance about the **care** the woman had received while she was **living in her own apartment**. She had been receiving supportive home care services from an independent service provider under a general contract with the county. The guardian alleged "abuse of a vulnerable adult" because the woman's apartment was not kept clean by the contractor and was "unlivable due to filth". The contract contained no specific requirements, but there was a list of duties for the staff who visited her apartment. One duty was to clean the apartment weekly. During one particular period, the contractor's employees did not complete many of the required items and the apartment became very dirty. Instead, they spent the time **providing companionship** to the woman. Regardless of her desire for companionship, the **employees were responsible** for keeping the **apartment clean**. Whenever possible the caregivers should be making sure the task list is completed while working with the client to model those skills, and to create a social situation where tasks can be completed together and in a way that is therapeutic for her by reinforcing daily living skills. The **contractor violated** her right to a **humane environment**.

06/15/2004
(Level III Decision in Case No. 03-SGE-04)

The **county** is **ultimately responsible** for the **health and safety** of a client to whom they provide services. Even though they have a **contract** for an **independent service provider** to do the hands-on services, the **contracted agency's failure** to perform its duties **is also the county's failure**. The county must monitor the providers it contracts with in order to ensure that vital services are provided for their clients.

7/23/2008
(Level IV decision in Case No. 08-SGE-01)
A patient complained about the manner in which facility staff treated her **during an Emergency Detention (ED)**. She focused her complaint on staff shining laser-pointers and lights in her eyes, especially at night. **Patients on ED require frequent monitoring** as they are usually in a crisis situation. That means **staff must continuously check on their welfare, even at night**. In the dark, it requires shining a light on them to make sure they are OK. Lights are also used by clinical staff to check the patient's eyes for dilation. While **this can be very irritating** to the patient, it is **often necessary** for their welfare. There is insufficient evidence to conclude that a laser pointer was used on her. It could also have been a small, focused light. The blurred vision she experienced could have been caused by many different factors, including the stress or her ED and medications she may have taken. No rights violations were established.

Informed of Rights, Right to Be

Decisions:

10/13/1998
(Level III decision in Case No. 98-SGE-02, upheld at Level IV)
An intense **inpatient AODA[20] program** requires 24-hour, 7-day a week involvement of the patient for up to 30 days. Where this is **explained to all patients upon intake**, the patients' right to **notification** of their rights is **not violated**.

05/17/2000
(Level III decision in Case No. 99-SGE-02, Appeal to Level IV by the patient was dismissed since the Level III decision was in his favor)
Where a **methadone clinic did not ensure that all clinic employees were aware of patient rights and the grievance process**, they **violated** the patients' rights.

06/29/2001
(Level III decision in Case No. 00-SGE-01)
A patient received services from an **agency contracted by the county**. He felt he was **not adequately informed** of his patient rights because his rights were provided in a **perfunctory way**, **without dialog or the ability on his part to ask questions** or seek **further clarification**. He wanted clarification of the notification requirements and expectations. Given his requested relief, there was **no conclusion** made that the provider was out of compliance, but recommendations were made for **further review** of the agency's rights **notification process**.

06/29/2001
(Level III decision in Case No. 00-SGE-01)
The **notification of rights** is a **very important task** as it is intended to convey to clients that, indeed, **they have many rights** while receiving services, and that there are **mechanisms designed to protect their rights** – such as the DHS 94 **grievance resolution procedure**. Yet, as clients begin receiving services, they may be at various **functioning levels** in terms of their **ability to process** this information and understand their rights. The law emphasizes the **need for flexibility and follow-up** by providers as may be warranted in any given situation. For example, if a client is admitted to an inpatient setting in an **acutely psychotic state**, that may be a **time when the rights are the least meaningful or understandable**. Thus, someone will need to **follow up** with the rights notification at a later time when the client is **more likely to understand** them. There are creative and effective ways in which information can be shared, explained, and discussed to make it meaningful. Usually some combination of oral notification (unless a client states that is not wanted) **and written notification** followed by an **opportunity to ask questions**, **discuss** what the rights mean, ensure the client **knows who the Client Rights Specialist is**, etc., is effective. The key part of this entire process is **documentation**. Having a patient **sign an acknowledgement** of receipt of rights information is always a **good idea** but, **without more**, **this alone is not always meaningful.** If there is a question later, additional and **contemporaneous documentation** about what the rights notification process entailed is **a good**

[20] Alcohol and Other Drug Abuse

protective measure for both a client and agency. It is always positive to include such documentation in the client's record. Documentation of **annual re-notification** of rights is **also necessary**. Who does the follow-up in up to the provider, but logically the Client Rights Specialists should have some role.

07/16/2003
(Level III decision in Case No. 03-SGE-01)
It is **not necessary** for each treatment **staff person** of a clinic, hospital or treatment program to **notify a client of his or her rights** and the grievance process. **One timely notification** prior to the patient beginning his or her treatment is **sufficient**.

07/16/2003
(Level III decision in Case No. 03-SGE-01)
Even though the DHS 94 grievance process has **no jurisdiction** over an **independent physician** delivering services through an office that is not part of a program, the **physician was still obligated to inform his patients of their rights** under Sec. 51.61, Wis. Stats. And, **when the physician became part of an organized service corporation**, he was **also obliged to inform his patients** that the **DHS 94 grievance process** applied as of that time.

04/03/2006
(Level IV decision in Case No. 06-SGE-01)
A client complained about lack of access to the DHS 94 grievance procedure at a clinic. It was determined that the clinic does have a Client Rights brochure, which the client was able to get a copy of. The brochure outlines the DHS 94 grievance procedure. The clinic was reminded that they **need to put the name and contact information** of the clinic's **Client Rights Specialist** on **all their brochures**.

Least Restrictive Conditions Necessary, Right to

Decisions:

10/13/1998
(Level III decision in Case No. 98-SGE-02, upheld at Level IV)
An individual was convicted of his **5th Operating While Intoxicated** (OWI) and received an assessment. His **assessment recommended inpatient** treatment. The individual **tried a voluntary admission**, but **left after five days**. He was **offered outpatient counseling** as an alternative, but **never accepted it**. His **right** to the least restrictive setting was **not violated**.

11/03/1999
(Level IV decision in Case No. 99-SGE-03, reversing the Level III decision)
A county human services department (HSD) **did not have a policy** in place for **contacting clients who are emergency detained**. Having such a policy is **not mandated by law**, but is a **good risk-management practice**. Had the HSD had such a policy, they would have found out that **this particular client had insurance** that would have covered her stay in another facility, where her treating physician also happened to work. This **resulted in her staying at the original place of detention longer** than necessary and costing her money from her own pocket. It **violated** her **right to the least restrictive setting**. Also, the client should not be held personally responsible for the increased cost of care.

11/03/1999
(Level IV decision in Case No. 99-SGE-03, reversing the Level III decision)
A client was placed in a **more restrictive setting than necessary** under an **emergency detention (ED)**. She was **advised to execute an Advance Directive** to identify her **hospital preference** and her treating physician and to provide a copy to the county, too. That would assist the county to **appropriately place her** if she ever needed emergency detention again.

05/16/2000
(Level IV decision in Case No. 99-SGE-01)
Methadone is a **nationally recognized treatment modality** for **heroin addiction**. Where a patient has done well on a methadone program, staying drug-free for a period of 18 months, the **continuation of outpatient treatment for her is appropriate**. It is also the **least restrictive alternative to inpatient treatment**.

05/24/2000
(Level IV decision in Case No. 99-SGE-02, upholding the Level III)
A patient in an **outpatient methadone treatment program** was observed "**splitting his dose**" in a bathroom at the clinic. The clinic subsequently **increased his "monitoring level"** for a six-month probationary period. This **did not violate** his right to the least restrictive treatment.

01/03/2001
(Level III decision in Case No. 99-SGE-07)
Where a developmentally disabled young woman ended up in an **acute inpatient mental health setting**, it was appropriate for the Level I Client Rights Specialist to recommend a potential

“**crisis intervention plan**” for her in case the situation arose again. Such an approach is an element of ongoing quality assurance on the part of the county program, too.

02/05/2001
(Level III decision in Case No. 00-SGE-06)
A client was **denied CIP 1-B funding for an addition to her house**. The county followed all applicable laws and policies in denying the request, so the client’s **rights were not violated**. However, the county and the department **worked together to find another way to pay for** the remodeling project.

02/16/2001
(Level III decision in Case No. 00-SGE-05)
A client who was about to be discharged from an inpatient facility **felt she was not being given enough input or choices** in terms of to **where she would be discharged**. She **wanted to be placed in an apartment** in the community. Facility staff were considering placement at other inpatient settings or a CBRF[21] (group home) setting. Ultimately, she was transferred to a community **supported living arrangement** in an apartment. Since this was what she wanted, the grievance was dismissed at Level III as being “**resolved**”.

04/09/2001
(Level III decision in Case No. 00-SGE-04)
A man made several statements about **wanting to take his own life**. His wife called the police and he was **emergency detained**. He wanted to be detained at a local hospital, but the police made the decision to detain him at a state mental health facility, over his objections. Since **other, less-restrictive options were available** and he adamantly did not want to go to the state facility, **his right to the least restrictive conditions was violated**.

10/15/2007
(Level IV decision in Case No. 05-SGE-13)
A civil patient complained about his county not placing him in the **least restrictive** setting. Since he had a **pending criminal charge**, the matter was **placed on hold** until a final disposition was made about the charge. As part of his criminal commitment, he was **placed on Conditional Release** through the department’s Community Forensic Services Program and his **Ch. 51 proceedings were terminated** by the court. Thus, the county whose actions he had originally complained about had no further involvement in his care and treatment. **As a “forensic” (criminal) client**, he **no longer had the right to the least restrictive conditions** as set forth in §51.61(1)(e), Wis. Stats. All decisions about his placement or living arrangements had to be approved by his agent and the Conditional Release program. The matter was considered resolved and the complaint dismissed.

[21] Community Based Residential Facility

Legal System, Courts and Petitions for Review, Access to

Decisions:

08/15/2005
(Level III Grievance Decision in Case No. 04-SGE-07 affirmed at Level IV on 8/15/05)
The **treatment professionals and the courts** are the **final decision-making authorities** on mental health commitments. A county department of community programming (DCP) does not have the primary decision making capacity about a commitment. The role of the DCP is to file the petition. However the court retains jurisdiction over the petition. The DCP is simply the responsible entity for monitoring and coordinating the commitment once it is adjudicated.

11/30/2006
(Level III decision in Case No. 06-SGE-13)
A patient who had been **discharged from a Methadone clinic** requested our department to assign an attorney to her assist her. The department does not assign attorneys to individuals. If she wanted to sue the clinic, she would have to hire a private attorney.

Liberty and Level Issues

No decisions at this time

Mail, Legal

No decisions at this time

Mail, Personal

No decisions at this time.

Medications, Free From Unnecessary or Excessive

Decisions:

04/17/2000
(Level III referral in Case No. 00-SGE-07)
Where a hospital patient complained about an **error in medication administration**, the State Grievance Examiner **referred** the matter to the **Bureau of Quality Assurance**[22] for investigation. [BQA subsequently issued the hospital a citation for violation of state and federal regulations.]

06/17/2000
(Level III decision in Case No. 00-SGE-02, upheld at Level IV)
A client was **deprived of one of her medications** just prior to taking a long trip, due to a series of **errors and omissions** on the service provider's part. This was a **violation** of her right to prompt and adequate treatment.

07/28/2000
(Level III decision in Case No. 00-SGE-08, upheld at Level IV)
A mother complained that her **son's condition was worsening** since his medications were discontinued. Her son's **doctor was on maternity leave** and the service provider would not temporarily assign him to another doctor. She was instructed to call back the next month when the doctor was scheduled to return. The **desperate mother** put her son back on the discontinued medication, without any medical assistance. The service provider **violated** the son's right to prompt and adequate treatment.

05/25/2001(Level IV decision in Case No. 01-SGE-01, upholding the Level III)
A doctor filed a **late entry** in a patient's chart **clearing up some confusion** over when a specific medication was given to a patient. While this **entry was not timely**, it **did not** mean the original **records were falsified**.

09/12/2001
(Level III decision in Case No. 00-SGE-03)
A woman complained about her doctor, alleging that the **medications he prescribed** for her may have **caused an adverse heart reaction** leading to an emergency visit to the hospital. This allegation was reviewed by the **Bureau of Regulation and Licensing**[23] (BRL), which reviews medical allegations of malpractice or injury to others. BRL did not find that the heart reaction and emergency room visit were necessarily caused by the medication. The **grievance process defers to BRL's medical expertise** on such issues and thus there was **no finding** of any rights violation.

03/29/2002
(Level IV decision in Case No. 99-SGE-05 on 3/29/02, upholding the Level III)

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[22] Wisconsin Division of Quality Assurance, http://dhs.wisconsin.gov/rl_dsl/bqa.htm
[23] Department of Regulation & Licensing, http://drl.wi.gov/index.htm

A **PRN**[24] ("as indicated") **order** does **not mean** the patient will receive the medication **upon demand**. A qualified medical professional, such as an RN, must make the **clinical decision** as to whether or not it is appropriate for the patient, based on an **assessment** of the **patient's condition** at the time.

03/29/2002
(Level IV decision in Case No. 99-SGE-05, upholding the Level III)
An RN assessed a patient and denied his request for a **PRN**[25] **for Xanax**, which he requested to help him sleep. The records indicate he **was asleep within an hour**, which supported the RN's decision. The patient, on appeal to Level IV, stated he was **faking being asleep**. However, the decision to deny him the medications was appropriately **based on the facts available** to them at the time. **No violation** of his rights was found.

08/27/2002
(Level IV decision in Case No. 01-SGE-08)
Where a patient received medications in dosages that made her **over-sedated** and caused her **blood pressure and pulse rate to drop** substantially, her right to be free from unnecessary or excessive medication was **violated**. However, the facility **mitigated** this violation by **recognizing the over sedation** and **taking steps** to reduce her medications.

09/19/2003
(Level IV decision in Case No. 02-SGE-04, overturning the Level III)
There must be **sufficient evidence** to show it was **more probable than not** that a doctor **departed from professional judgment** in his prescribing medication to a patient **after a phone call** with her. Such evidence would have to come in the form of a **second opinion** from a **professional of equal or greater standing** than the doctor. Where there was no such evidence presented during the Level III review, the **finding of a rights** violation will be **overturned**.

09/19/2003
(Level IV decision in Case No. 02-SGE-04)
In a situation where a **suicidal patient** has been **put on a new medication**, then **cancels her next appointment** with the doctor, the **clinic has a duty** to at least have someone **review** the situation to **see if follow-up contact** with the patient is necessary. There was **no evidence** that this was done here. While it could be assumed that, as a voluntary patient, she was exercising her right to discontinue treatment, there should have been **some determination** made as to whether or not to contact her. The **clinic** thus **violated the patient's right** to prompt and adequate treatment by not making that determination

09/19/2003
(Level IV decision in Case No. 02-SGE-04)
Patients have the **right** to have their **care and treatment coordinated** with **other treatment staff** who are involved in their care and treatment. A **doctor** ordering a change in a patient's medication **must ensure** that other members of the patient's **treatment team** are **informed** about the **new medication** and the **expected benefits** and **potential adverse side effects** which may affect the patient's overall treatment.

[24] According to need (physicians use PRN in writing prescriptions)
[25] according to need (physicians use PRN in writing prescriptions)

09/19/2003
(Level IV decision in Case No. 02-SGE-04)
Where a **doctor knew** or should have known that his patient was seeing other professionals involved in her care, the doctor has a **duty** to at least **attempt to inform** the **other therapist** involved of a **change in medication**. If the patient's consent is required, the doctor should ask for it. Where no such attempt was made here, the doctor violated the patient's rights.

10/23/2003
(Level III decision in Case No. 03-SGE-10)
A **court decision** to **order medications cannot be challenged** in the **grievance process.**

07/14/2004
(Level III Decision in Case No. 03-SGE-08)
A **service provider** where the individual picked up his medications has **inadequate parking**, making it inconvenient for him at times. The service provider attempted to resolve this by offering him alternative times in which he could pick up his medication when the parking lot would be less crowded. These accommodations included:

- Suggesting he pick up his medication on a Friday when the parking lot is less busy;
- Picking up his medication in the afternoon when the staff parking lot is less full; or
- Speaking with his case manager to arrange picking up his medication at a different time than the set times.

They were also willing to arrange for him to pick up his medication when he meets with his psychiatrist every three months for his psychiatric medication check up, thus saving him four trips a year. These **accommodations were reasonable** and **sufficient**.

07/14/2004
(Level III Decision in Case No. 03-SGE-08)
The service recipient wanted to **receive his medications** in the **exact form** the pharmaceutical company sends it and as soon as they send it. However, his service provider had the **need to double-check all medications** being given to patients through a Patient Assistance Program[26] (PAP). They do so through a local pharmacy. When they receive medications from any drug company they immediately send it to the pharmacy where it is checked, repackaged and dispensed. The pharmacy does not mix lot numbers or expiration dates, therefore each patient receives the same medication (with regards to freshness and lot number) as was sent from the drug company. The individual's desire to receive his medication just as it was sent from the drug company is understandable; however, so is the service provider's liability to make sure that he is getting exactly what medication he was prescribed from the drug company. The service provider agreed to have their professional staff open the medication, check its content, and dispense the medication as prescribed by his psychiatrist in order to avoid his medications having to go through the pharmacy, as requested. This **resolved** his complaint.

07/14/2004
(Level III Decision in Case No. 03-SGE-08)
The service provider was concerned that a patient did not have a strong family/friend support network that would report unusual behavior. So they **required** him to come in to **pick up his medications** every **28 days**. This was required **in order to assess** him for abnormal psychiatric

[26] Aditional information is avalible on the DHS webpage: Consumer Guide to Health Care - Prescription Drug Assistance Programs: http://dhs.wisconsin.gov/guide/spec/freeprescr.htm

symptoms, adverse side effects, and the effectiveness of the medications he was receiving. While this assessment may seem very basic or even inadequate to the recipient, the **nurse** who dispenses the medication is **qualified** to be conducting this assessment and, if unusual behavior were present, they would extend the assessment. Since he was clear and present when he came to pick up his medications, the assessment was very brief. However, if he were not well, the assessment would be much more thorough and he would be asked to come into another room to speak privately with nursing staff for a more thorough interview. This issue was **referred to his psychiatric**. His psychiatrist can decide if they have developed a reliable history with him, sufficient to extend the amount of medication given to him at one time and thus lengthen the time between pick-ups.

07/14/2004
(Level III Decision in Case No. 03-SGE-08)
The **psychiatrist prescribing** the medications has the **ultimate authority** to make **individualized decisions** for each patient. Individualized decision-making is a key element for providing prompt and adequate treatment services appropriate to each individual patient's condition. While the majority of patients may not be suitable for a full disbursement of their medications, psychiatrists and treatment providers need to recognize individuals who are stable and consistent with their treatment programs and accommodate their request for dispensing increased amounts of medications at one time accordingly.

03/20/2007
(Level IV decision in Case No. 06-SGE-10)
A client objected to the **medications she was given** during an **Emergency Detention**. Patients have a **right to refuse** medications in most situations. There is an **exception**, however, that **allows medications to be administered in an "emergency"** situation without the patient's consent. The hospital was relying on that exception when they gave her medications without her consent.

Medications, Refusal on Religious Grounds

No decisions at this time

Management of Facilities

Decisions:

03/10/2004
(Level IV decision in Case No. 02-SGE-07, reversing the Level III decision)
A man complained on his wife's behalf that **she was given a new therapist without consulting her first**. A treating **facility has the right to change therapists** for **business management reasons**. It is **good practice** to **consult with the patient** first, but it **does not rise to the level** of a rights violation **not to do so**.

Mootness

Decisions:

09/25/2004
(Level III decision in Case No. 04-SGE-03)
A client complained about being on 1:1 supervision. During the Level III investigation, the client was **discharged** to her parents' home. It appeared that the facility had handled her grievance properly during her stay. **No further relief could be provided** and the allegations appeared unfounded. The matter was dismissed as being **moot**.

Notification of Rights

No decisions at this time

Patient Defined (to Whom Patient Rights Apply)

Decisions:

04/14/2000
(Level III decision in Case No. 00-SGE-06)
A patient's **ex-husband attempted to file a grievance** on his ex-wife's behalf about the **fees charged for her mental health services**. He had been ordered by the divorce court to pay that bill. He **lacked standing** to bring the complaint or appeal it through the grievance process without his ex-wife's consent. **Patient rights attached to her, not her ex-husband**, since she was the one receiving the treatment.

05/16/2000[27]
(Level IV decision in Case No. 99-SGE-01)
The rights and grievance procedure in DHS 94 **do not apply** to the **Intoxicated Driver Program[28]** (IDP) or the **driver's safety program plans**.

05/16/2000
(Level IV decision in Case No. 99-SGE-01)
Even though the patient rights and grievance procedure in DHS 94 do not apply to the Intoxicated Driver Program (IDP) or the driver's safety program plans, where an individual is **also in a methadone treatment program**, she **has patient rights** and access to the grievance process regarding that treatment.

04/09/2001[29]
(Level III decision in Case No. 00-SGE-04)
A patient being emergency detained complained about **being shackled** by the **sheriff officers during transport**. This is their standard practice. The grievance process has **no jurisdiction over the actions of law enforcement agencies**.

06/06/2001
(Level III decision in Case No. 01-SGE-02)
Financial assistance for **housing** is **not an issue covered by client rights** and such decisions cannot be challenged in the grievance process in DHS 94.

12/10/2001
(Level III decision in Case No. 01-SGE-02)
Her daughter's therapist told her mother, in a rather public place, by that she (the mother) was

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[27] See DSL Memo Series 2000-04 on 4/25/00, http://dhs.wisconsin.gov/dsl_info/InfoMemos/DSL/CY_2000/InfoMem2000-04.htm
[28] See the Intoxicated Driver Program (IDP) website, http://dhs.wisconsin.gov/substabuse/idp/index.htm
[29] The legislature subsequently modified DHS 62, "Assessment of Drivers with Alcohol or Controlled Substance Problems", effective December 1, 2006. DHS 62.24(1) states, "Any client may file a grievance under ch. DHS 94 or s. 51.61, Stats., if the client believes that the client rights specified under ch. DHS 94 or s. 51.61, Stats., have been violated." Thus, the DHS 94 grievance process now applies to that program. DSL Memo Series 2000-04 noted in the decision dated 05/16/2000, (Level IV decision in Case No. 99-SGE-01) above, has been repealed.

the one who needed treatment. This remark was **insensitive**, but the **mother was not a patient** at the time and the **right** to dignity and respect **did not apply to her**.

04/30/2002
(Level III decision in Case No. 00-SGE-11, dismissed at Level IV for lack of standing to appeal because the ruling was in his favor at Level III)
A complainant raised issues regarding the "**couples therapy**" he and his wife received. **At Level II** of the grievance process, it was concluded that the complainant **was not a client**, in the context of therapy that was provided, and thus did not have access to the grievance process. At Level III, it was concluded that the **complainant was a patient** by definition since he was **referred to as such numerous times** in the treatment records, **had his own diagnosis**, and had a **joint "treatment plan" with his wife**. Thus, he had access to the grievance process like any other "patient".

03/10/04
(Level IV decision in Case No. 02-SGE-07)
A complainant claimed he was not allowed to participate in the planning of his treatment with regard to **joint marriage counseling**. It was found that these were **individual sessions for his wife in which he was invited** to be present. No rights violation was found since it **was not *his* treatment** that was involved. It was conclude that **joint marriage counseling, *per se*[30], is not mental health treatment to which "patient rights" apply**. There was no violation of his rights, even if it was joint marriage counseling.

09/27/2006
(Level IV decision in Case No. 06-SGE-09)
The purpose of an **independent outpatient evaluation** is to determine whether or not the individual is experiencing a mental illness and is in need of treatment. **It is the provision** of **treatment** that **makes the individual a "patient".** The full panoply of patient rights did not attach to such an evaluation. However, the complainant still had rights in regard to access to the records generated by the evaluation.

[30] A Latin phrase used in English arguments for "by itself" or "by themselves"

Patient Run Businesses

No decisions at this time.

Petition for Review of Commitment, Right to

No decisions at this time.

Physical Health Treatment

Decisions:

03/23/2001
(Level III decision in Case No. 99-SGE-08)
An inpatient at a county hospital had a pre-existing **blood clotting condition** for which she was taking a **blood thinning medication**, coumadin. She felt staff delayed a medical assessment by not promptly arranging for a pro-thrombin time test (PT) reported as International Normalized Ratio (INR) that shows the blood level of the blood thinning medication. It is necessary that **blood tests** be done at **regular intervals** to **monitor** the level of this medication within one's system. It must remain within a certain therapeutic range in order to ease the risk of blood clotting (if the medication level is too low) or the risk of undue bleeding (if it is too high). She was given the PT/INR test **four days after her admission**. It was noted that her coumadin level was much higher than the recommended therapeutic level. Once levels are stabilized, the PT/INR tests should be done up to a month apart. Here, staff had no reason to believe a PT/INR had not been done for as long as a month, so they could justifiably have believed that waiting several days was not a major medical concern. Given these facts, **failure to conduct the blood tests** sooner than four days after admission does **not constitute a violation** of "prompt and adequate" treatment. The fact that the results were very high in this situation does not automatically make it a rights violation.

03/29/2002
(Level IV decision in Case No. 99-SGE-05, upholding the Level III)
An RN **assessed** a patient and **denied** his **request for a PRN[31] for Xanax**, which he requested to help him sleep. The records indicate he was asleep within an hour, which supported the RN's decision. The patient, on appeal to Level IV, **stated he was faking being asleep**. However, the decision to deny him the medications was appropriately **based on the facts available** to them at the time. **No violation** of his rights was found.

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
The **county** is **ultimately responsible** for the **health** and safety of a client to whom they provide services. **Even though they have a contract** for an **independent service provider** to do the hands-on services, the contracted agency's failure to perform its duties is also the county's failure. The **county must monitor** the providers it contracts with in order to ensure that vital services are provided for their clients.

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
The **sister/guardian** of a woman filed a grievance about the **care** the woman had received while she was living in her own apartment. She had been receiving supportive home care services from an independent service provider under a general **contract with the county**. The guardian alleged lack of care causing deterioration in health to the point of needing immediate medical

[31] According to need (physicians use PRN in writing prescriptions)

attention. Staff's tasks included providing "acu-checks," monitoring her bathing three times a week and providing medical treatment for her hands and legs with sores. It was found that the **woman's rights were violated** when the **contract agency** did **not complete the assigned tasks** during a period of time and the woman's **health deteriorated** as a result.

Possessions, Limits on

No decisions at this time.

Possessions, Lost or Damaged

Decisions:

10/18/2001
(Level III decision in Case No. 01-SGE-06)
A discharged patient asked the hospital to **return his personal journal**. It **should be returned to him** since **it is his property**, whether or not the hospital considered it part of his treatment record.

Privacy, Other

Decisions:

03/23/2001
(Level III decision in Case No. 99-SGE-08)
An inpatient complained about **lack of interactions with staff** during her six-day stay. Each patient's needs and perceptions are unique, and staff cannot use a "one size fits all" approach. There is a **thin line between respect** for a **patient's privacy** and choices (e.g. to not have many interactions with others and to be given personal space), **and going too far in the other direction** (e.g., in trying to probe for interaction with many questions). In the latter instance, the patient could have complained that she was not respected and not given reasonable space or privacy. Here, the record reflects a **reasonable degree of staff attentiveness** and vigilance and, in the latter part of the stay, more discussion with her about issues. It was concluded that the patient's **right** to a humane psychological and physical environment was **not violated** in this circumstance.

Privacy in toileting and Bathing

No decisions at this time

Procedural Issues

Decisions:

02/06/1998
(Level III decision in Case No. 98-SGE-01)
The DHS 94 grievance process has **no jurisdiction over issues raised by an individual under the control of the Department of Corrections**[32] **(DOC)**. The individual who brought the complaint was redirected to appeal through the DOC inmate complaint system.

11/10/1998
(Level III decision in Case No. 98-SGE-03)
A county received a **complaint about denial of services**. The county **treated the complaint as a reapplication** for services and thus **did not follow the DHS 94 grievance process rules**. Since the complainants clearly identified it as a grievance and asked that a Client Rights Specialist investigate it, this was a **violation** of the complainants' right of access to the grievance process.

01/22/1999
(Level IV decision in Case No. 98-SGE-02)
Subsection 51.30(4)(b)5 allows **access without consent** "...to **qualified staff members of the department**... as is necessary to determine progress and adequacy of treatment..." Thus the **State Grievance Examiner is allowed to obtain otherwise confidential records without the informed consent** of the complainant.

04/06/2000
(Level III decision in Case No. 00-SGE-02)
The **grievance procedure** under DHS 94 has **no authority to award damages**. Monetary damages can be pursued and **awarded only by a court of law**.

04/14/2000
(Level III decision in Case No. 00-SGE-06)
A patient's **ex-husband attempted to file a grievance** on his ex-wife's behalf about the **fees charged for her mental health services**. He had been ordered by the divorce court to pay that bill. He **lacked standing to bring the complaint or appeal it through the grievance process without his ex-wife's consent**. **Patient rights attached to her**, **not her ex-husband**, since she was the one receiving the treatment.

05/16/2000
(Level IV decision in Case No. 99-SGE-01)
The rights and grievance procedure in DHS 94 do not apply to the Intoxicated Driver

[32] http://www.wi-doc.com/

Program[33] (IDP) or the driver's safety program plans. [See DSL Memo Series 2000-04 on 4/25/00[34].]

05/16/2000
(Level IV decision in Case No. 99-SGE-01)
Even though the patient rights and grievance procedure in DHS 94 do not apply to the Intoxicated Driver Program[35] (IDP) or the driver's safety program plans, where an **individual is also in a methadone treatment program**, **she has patient rights** and **access to the grievance process** regarding that treatment.

05/17/2000
(Level III decision in Case No. 99-SGE-02, appeal to Level IV by the patient was dismissed since the Level III decision was in his favor)
Where a **methadone clinic discouraged a patient from bringing an advocate with him to a team meeting**, the clinic **violated** his right to bring a grievance without fear of retaliation or discrimination.

05/17/2000
(Level III decision in Case No. 99-SGE-02, appeal to Level IV by the patient was dismissed since the Level III decision was in his favor)
Where a **Level II grievance decision did not advise the complainant of his right to a state-level review,** his **rights were violated**.

07/17/2000
(Level III decision in Case No. 99-SGE-02, appeal to Level IV by the patient was dismissed since the Level III decision was in his favor)
Where **a methadone clinic did not ensure that all clinic employees were aware of patient rights and the grievance process**, they **violated the patients' rights.**

05/24/2000
(Level IV decision in Case No. 99-SGE-02)
The DHS 94 **grievance procedure does not include a "fair hearing"**.

05/24/2000
(Level IV decision in Case No. 99-SGE-02)
Someone in a **methadone treatment program can ask for a "fair hearing"** only when they have been **involuntarily terminated from the program**.

06/17/2000
(Level III decision in Case No. 00-SGE-02, upheld at Level IV)
A **therapist's supervisor correctly referred** a client to the facility's Client Rights Specialist to file a complaint about the therapist. The client felt the supervisor did not care about her concerns. However, the **referral was appropriate** and did not violate the client's right to be treated with dignity and respect.

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[33] See the Intoxicated Driver Program (IDP) website, http://dhs.wisconsin.gov/substabuse/idp/index.htm
[34] The legislature subsequently modified DHS 62, "Assessment of Drivers with Alcohol or Controlled Substance Problems", effective December 1, 2006. DHS 62.24(1) states, "Any client may file a grievance under ch. DHS 94 or s. 51.61, Stats., if the client believes that the client rights specified under ch. DHS 94 or s. 51.61, Stats., have been violated." Thus, the DHS 94 grievance process now applies to that program. DSL Memo Series 2000-04 noted in the decision dated 05/16/2000, (Level IV decision in Case No. 99-SGE-01) above, has been repealed.
[35] See the Intoxicated Driver Program (IDP) website, http://dhs.wisconsin.gov/substabuse/idp/index.htm

06/17/2000
(Level IV decision in Case No. 00-SGE-02)
A **favorable grievance decision cannot be appealed by the prevailing party**.

06/17/2000
(Level IV decision in Case No. 00-SGE-02)
The meaning and applicability of the section of DHS 94.24(3) regarding "**redress through the grievance procedure**" is to assure that no one is deprived of using the grievance procedure to seek redress for an alleged violation of his or her rights. It **does not allow for the award of punitive monetary damages** in the grievance process. **Only a court can award damages**. The individual whose rights were allegedly violated must initiate any court action.

08/02/2000
(Level III decision in Case No. 00-SGE-13)
A patient at a county psychiatric hospital **complained about a seclusion incident**. He raised issue about whether there was justification for the initial use of seclusion and whether he was released in a prompt and timely manner. There was a discrepancy between a verbal report of one staff and the documentation form that was completed while he was in seclusion. In the Level I grievance decision, the **Client Rights Specialist (CRS) made a suggestion** that staff **more carefully document** anything of concern that may be displayed while a patient is in seclusion. The **improvements in documentation** made by the hospital in response to his complaint were noted. The **patient withdrew** his complaint at Level III.

01/03/2001
(Level III decision in Case No. 99-SGE-07)
Where **the county's Client Rights Specialist was also the case manager** of a woman bringing a complaint, **a conflict of interest arose**. In that case, the CRS **had the discretion to skip the county stage of the process** and forward the grievance to the State Grievance Examiner[36].

01/03/2001
(Level III decision in Case No. 99-SGE-07)
The Level I **Client Rights Specialist has the discretion** to **look beyond** the **original complaint** to **identify related client rights issues**, even if they are not articulated as such.

01/03/2001
(Level III decision in Case No. 99-SGE-07)
Where a complainant had **already initiated a civil lawsuit** on the issues raised in the grievance, the **State Grievance Examiner has the discretion to not issue a decision** in the patient rights grievance procedure. A **court decision takes precedence** over a grievance decision.

01/03/2001
(Level III decision in Case No. 99-SGE-12)
The **State Grievance Examiner is responsible** for **ensuring compliance** with the **grievance procedure** on behalf of **all patients** protected by DHS 94 client rights. As such, the **SGE has a role in providing technical assistance** to **Client Rights Specialists** who issue Level I and II decisions.

01/03/2001
(Level III decision in Case No. 99-SGE-12)

[36] Another option would have been to have another county staff member act as the alternate CRS for that case.

The **Client Rights Specialist's is expected to be objective and neutral** in regard to a complaint. The CRS is **expected to investigate all allegations** raised in a complaint.

01/03/2001
(Level III decision in Case No. 99-SGE-12)
When a patient raises treatment issues, it is **not sufficient** for the Client Rights Specialist to **simply note the response of the patient's attending physician**. **Further investigation may be required**.

02/21/2001
(Level IV decision in Case No. 00-SGE-08)
The **State Grievance Examiner has the discretion** whether to **conduct a field investigation or rely on documentation** submitted in the grievance process. Where sufficient documentation exists, **personal interviews of staff are not necessary**.

02/21/2001
(Level IV decision in Case No. 00-SGE-08)
A **client's mother filed a written complaint** on his behalf about the treatment he was receiving from his doctor. She was **referred to the doctor**, instead of the Client Rights Specialist. Since **this was a formal complaint**, the **doctor had a conflict of interest** and it was **inappropriate to refer the matter to him**.

02/21/2001
(Level IV decision in Case No. 00-SGE-08)
Where violations of client rights are found, the matter **may be referred to the Bureau of Quality Assurance Certification Unit**[37] to determine if **any violations of certification requirements occurred**.

06/06/2001
(Level III decision in Case No. 01-SGE-02)
Financial assistance for housing is not an issue covered by client rights and such decisions **cannot be challenged in the grievance process** in DHS 94.

06/19/2001
(Level III decision in Case No. 00-SGE-16, upheld at Level IV)
A grievance was **filed on well past the 45-day timeframe** in DHS 94.41(5)(a). However the county reviewed it at Level I and II. **It is within the client rights specialist's discretion to accept complaints that are filed after the timeframes**. A **long delay** in filing a grievance after an event **significantly compromises** the **quality of the investigation** that may be conducted. Individuals often do not recall all the details of what happened or what was said after such a lengthy period of time. In this case, since it was accepted at Level I and II, it was also accepted at Level III. The Level III review was limited to **a desk review** of this case based on the available documents. The ability to conduct a thorough investigation was limited by the delay in the filing of the grievance.

08/14/2001
(Level IV decision in Case No. 00-SGE-16)
A complainant questioned **whether a county Client Rights Specialist** (CRS), by **virtue of employment** by the county, **could conduct an impartial investigation** into his grievance. **CRSs**

[37] Division of Quality Assurance, http://dhs.wisconsin.gov/aboutdhs/DQA/index.htm

are required to be impartial to the issues of a specific grievance. **Merely working for the county does not create a conflict of interest for a CRS.** The **many levels of appeal**, including **two levels of state review**, **ensure that the grievance process as a whole is free from bias**.

09/12/2001
(Level III decision in Case No. 00-SGE-03)
A woman **complained about her doctor**, alleging that the **medications** he prescribed for her **may have caused an adverse heart reaction** leading to an emergency visit to the hospital. This allegation was **reviewed by the Bureau of Regulation and Licensing**[38] **(BRL),** which reviews medical allegations of malpractice or injury to others. BRL did not find that the heart reaction and emergency room visit was necessarily caused by the medication. The **grievance process defers to BRL's medical expertise** on such issues and thus there was no finding of any rights violation.

10/18/2001
(Level III decision in Case No. 01-SGE-06)
A patient complained that **his grievance about his therapist** was **not promptly investigated**. It was noted that he had **threatened to kill his wife, her boyfriend and his therapist** and the **police delayed the investigation** by requiring a waiting period for further action, allowing each party time to seek an injunction against the other. The police also required signed releases from both spouses. **The delay in processing his complaint was reasonable** under the circumstances.

10/18/2001
(Level III decision in Case No. 01-SGE-06)
Where a Level II grievance **decision did not state that the grievance was unfounded** and **did not advise the complainant of his right to appeal**, the complainant's **right to the grievance procedure was violated**. It was thus appropriate to allow him additional time to appeal to Level III.

10/18/2001
(Level III decision in Case No. 01-SGE-06)
Where the complainant was **not provided a copy of the Level I decision** and given the opportunity to provide additional input prior to issuance of the Level II decision, his rights were violated. The issue of the hospital's grievance system being in compliance with the DHS 94 requirements was **referred to the Bureau of Quality Assurance**[39]**.**

11/29/2001
(Level III decision in Case No. 01-SGE-05)
A service recipient **asked a temporary receptionist for a grievance form**. The **temp asked other staff where the forms were**. The case manager heard about the request and asked the individual to come to her office to discuss her concerns. The grievance she wanted to file, however, was about her case manager. There was **no evidence** that **anyone tried to talk her out of filing a complaint**, nor any indication of reprisal, retaliation or discrimination because of her grievance. There was **no violation of her right to file a complaint**. The temp asking other staff where the grievance forms were did not violate her right to confidentiality.

[38] Department of Regulation & Licensing, http://drl.wi.gov/index.htm
[39] Division of Quality Assurance, http://dhs.wisconsin.gov/aboutdhs/DQA/index.htm

12/10/2001
(Level III decision in Case No. 01-SGE-02)
A patient's mother complained that her **daughter's doctor** violated her daughter's confidentiality. The Level I **Client Rights Specialist did not address this issue** in his written response. The **failure to address this issue was a violation** of the right to have the grievance fully investigated.

12/10/2001
(Level III decision in Case No. 01-SGE-02)
The law states that, "A patient *or a person acting on behalf of a patient*" may file a complaint. It was **a violation** of the complainant's rights when a Level I Client Rights Specialist **refused to investigate her allegation that her ex-husband's right to confidentiality had been violated**.

12/10/2001
(Level III decision in Case No. 01-SGE-02)
A facility was **under the impression** that a mother's complaint on behalf of her daughter **could be handled informally and internally**. The complaint itself stated that she wished to file "a formal grievance". **The informal resolution process can only be used if all parties agree to it.** The **facility violated** the mother's right to bring a complaint by not handling it as a formal grievance.

12/10/2001
(Level III decision in Case No. 01-SGE-02)
A facility **issued what amounted to a Level II decision without** first **providing the complainant a copy of the Level I decision**. The purpose of requiring the facility to provide a copy of the Level I decision is to **allow the complainant the opportunity to review the decision and provide any additional input** to the person making the Level II decision. This **was a violation** of the complainant's rights. The facility was requested to revise its grievance process to comply with DHS 94.

03/29/2002
(Level IV decision in Case No. 99-SGE-05)
Level IV reviews are limited to consideration of factual information that was not available for the Level III review.

03/29/2002
(Level IV decision in Case No. 99-SGE-05)
Where a **Level III decision found** that the patient's **right** to make and receive a reasonable amount of phone calls **was violated**, the **complainant's appeal** to Level IV on that issue was **dismissed**.

03/29/2002
(Level IV decision in Case No. 01-SGE-07)
A complainant was out of state for an extended period of time and **did not receive his Level III grievance decision** until his return. This was **sufficient justification** for the Administrator to **allow a late appeal** of that decision.

04/30/2002
(Level III decision in Case No. 00-SGE-11, dismissed at Level IV for lack of standing to appeal because the ruling was in his favor at Level III)

A complainant raised issues regarding the "**couples therapy**" he and his wife received. At Level II of the grievance process, it was concluded that the complainant was not a client, in the context of therapy that was provided, and thus did not have access to the grievance process. At Level III, it was concluded that the complainant **was a patient** by definition since he was referred to as such numerous times in the treatment records, had his own diagnosis, and had a **joint "treatment plan**" with his wife. Thus, **he had access to the grievance process** like any other "patient".

05/02/2002
(Level III decision in Case No. 02-SGE-01)
A parent filed a **complaint about a doctor giving the wrong pills to her minor children**. But she **refused to sign a consent form** allowing the Level I Client Rights Specialist (CRS) access to the children's treatment records. **This limited the CRS to trying to resolve the matter informally.** Although it was the parent's right to refuse access to the treatment records, it **prevented the CRS from conduct a complete, formal grievance investigation.** Given the **lack of a formal grievance**, **the appeal to Level III was denied**.

08/26/2002
(Level IV decision in Case No. 00-SGE-11, upholding the Level III decision)
A complainant **wanted to expand his original complaint at Level III** of the process to include several other issues regarding his treatment. The **State Grievance Examiner rightfully refused to allow the expansion** of the original complaint and **correctly referred the complainant to Level I** to **raise those additional issues**. **New issues must go through the entire grievance process, starting at the first level**.

08/26/2002
(Level IV decision in Case No. 00-SGE-11)
Where the **Level III decision found in favor of the complainant** on the two issues he raised, the **complainant was without standing to appeal** the decision to Level IV.

08/26/2002
(Level IV decision in Case No. 00-SGE-11, upholding the Level III decision)
A client **also filed a complaint** with the Department of Health Services **Bureau of Quality Assurance**[40] (BQA), which certifies providers and clinics. The issues raised in that context were reviewed as part of a separate process. The **grievance procedure reviews complaints in the context of DHS 94 rights**, and **does not deal with licensing or certification issues**. Thus, **there is no standing to raise licensing and certification issues in the grievance process**, too.

08/27/2002
(Level IV decision in Case No. 01-SGE-08, modifying the Level III finding)
The **Client Rights Specialist** at Level I **must attempt to resolve matters** to the satisfaction of the patient **whenever possible**. But the CRS **must also be prepared** for the more tedious, potentially adversarial, **process of gathering facts** from parties that may have quite different perspectives.

08/27/2002
(Level IV decision in Case No. 01-SGE-08, upholding the Level III finding)
Where a patient filed a **detailed complaint about her medications**, the Client Rights Specialist

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[40] Wisconsin Division of Quality Assurance, http://dhs.wisconsin.gov/rl_dsl/bqa.htm

at Level I referred the matter for a medical review. The Level I decision acknowledged there had been difficulties with medication adjustments but said there were "no major findings of inadequate medical practice. He found no violation of the patient's right to be free from unnecessary or excessive medications. The **CRS provided few details or facts to support his conclusion**. This **was a violation of the patient's right to an adequate investigation** in the grievance procedure.

03/19/2003
(Level III decision in Case No. 02-SGE-05)
An ex-patient complained that an inpatient treatment facility **overcharged** him for some smoking materials. **County funds paid for those materials**, rather than the patient. The issue was thus between the county and the facility and the issue was **not appropriate for the grievance process**.

07/16/2003
(Level III decision in Case No. 03-SGE-01)
The **45-day time limit** for filing a complaint was **not followed** when a complaint was **filed 7 months after the alleged mis-diagnosis**. **Case** was **dismissed** as untimely filed.

07/16/2003
(Level III decision in Case No. 03-SGE-01)
A **grievance must be filed within 45 days** of the occurrence of the event or circumstances or of the time when the event or circumstances "should reasonably have been discovered" or whichever comes last. Here, a minor's prior physician apparently **misdiagnosed** him. The minor was later correctly diagnosed and appropriately treated during a stay at a state mental health facility. His parents filed a grievance about his original misdiagnosis seven months after his discharge from the state facility. **The grievance was not timely filed**. The program director's **refusal to accept this late complaint was an exercise of his discretion**. He could have accepted the complaint, but chose not to. He **did not abuse his discretion.** In fact, there **would have been little point in accepting it** since the **doctor in question was no longer working for the program**.

07/16/2003
(Level III decision in Case No. 03-SGE-01)
The DHS 94 grievance process has **no jurisdiction over an independent physician** delivering services through an office that is not part of a program. Patient rights still apply, but **violations must be dealt with through the licensing process.**

07/16/2003
(Level III decision in Case No. 03-SGE-01)
Even though the DHS 94 grievance process has no jurisdiction over an independent physician delivering services through an office that is not part of a program, the **physician was still obligated to inform his patients of their rights** under Sec. 51.61, Wis. Stats. And, **when the physician became part of an organized service corporation**, he was also **obliged to inform his patients** that the DHS 94 **grievance process applied as of that time**.

09/19/2003
(Level IV decision in Case No. 02-SGE-04)
A hospital noted on appeal of findings of rights violations that **the State Grievance Examiner (SGE) had not contacted the patient's doctor directly** during the Level III review. The

hospital asserted that this evinced[41] a lack of professional courtesy and constituted a violation of due process. The SGE should probably have contacted the doctor to provide him with a sense of fairness. But **the SGE has broad discretion in how to conduct Level III reviews**. Where the SGE felt he could rely on the written records available to him, **failure to contact the doctor** was **not an abuse of that discretion or a violation of due process**.

09/19/2003
(Level IV decision in Case No. 02-SGE-04)
A Level III decision **described a doctor's progress notes as being "inadequate**", but **found no rights violation**. This issue was not addressed on appeal because, **no matter how the notes were characterized, the outcome** (no rights violation) **was not affected**.

10/23/2003
(Level III decision in Case No. 03-SGE-10)
A **court decision to order medications cannot be challenged in the grievance process**.

01/23/2004
(Level III Decision in Case No. 03-SGE-05)
A complaint alleged that a **county did not properly allow access to the Grievance Procedure appeal process** as described in DHS 94. Per DHS 94.51, regarding **complaints** that are **related to the existence or operation of grievance resolution systems**, the **State Grievance Examiner** has **original jurisdiction** over this issue.

01/23/2004
(Level III Decision in Case No. 03-SGE-05)
The **Division of Hearings and Appeals**[42], as described in the Medical Assistance Waivers Manual[43], is **only available** for the purpose of **addressing issue of denials of eligibility, terminations of eligibility, and reductions in waiver services**. They are **not the proper referral agency** for someone **appealing a client rights grievance** about **other issues** in the DHS 94 grievance procedure.

01/23/2004
(Level III Decision in Case No. 03-SGE-05)
A complainant wanted to appeal the county's Level II grievance decision made under DHS 94. He was **incorrectly referred to the Division of Hearings and Appeals** instead of the State Grievance Examiner. **Since this appeal information was incorrect**, his **rights were technically violated**.

01/23/2004
(Level III Decision in Case No. 03-SGE-05)
A complainant wanted to appeal the county's Level II grievance decision made under DHS 94. He was **incorrectly referred to the Division of Hearings and Appeals** instead of the State Grievance Examiner. The **county agreed that a mistake had occurred** in this process. They **revised the county manual** and added the correct standard appeal language to the end of the grievance decisions that the county issues. Thus, the **violation of rights was remedied** and the issue was **considered resolved**.

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[41] (1.) To show clearly; make evident or manifest; prove. (2.) To reveal the possession of (a quality, trait, etc.).
[42] Division of Hearings and Appeals, http://dha.state.wi.us/home/
[43] See the Wisconsin Department of Health Services, Bureau of Long-Term Support webpage, *Medicaid Home and Community-Based Waivers Manual*: http://dhs.wisconsin.gov/bdds/waivermanual/index.htm

03/10/2004
(Level IV decision in Case No. 02-SGE-07)
There is insufficient evidence to conclude that a **facility's Chief Legal Counsel discouraged someone from filing a complaint**. The facts indicate he merely **informed the individual that he did not believe he had a malpractice claim that would be upheld in court.** The fact that the individual was able to bring this complaint and appeal it up through the grievance process to Level IV indicates that his right to complain was not violated.

03/10/2004
(Level IV decision in Case No. 02-SGE-07)
A man complained on his wife's behalf that **her original complaint was not responded to**. There was evidence in the record to indicate **the facility may not have received the original complaint**. But they did receive the copy provided by the husband later. **They responded to the issues involved as if there was one combined complaint from the two of them**. **No rights violation** was found.

03/10/2004
(Level IV decision in Case No. 02-SGE-07, modifying the Level III decision)
A complainant alleged that **the facility's Client Rights Specialist (CRS) did not identify himself as such to him in a timely manner**. There was evidence in the record that the **CRS's name and title were provided to all patients at the facility**. If the individual was not re-informed of his title as CRS when discussing his issues with him, this was a **technical violation** of his rights.

04/22/2004
(Level III Decision in Case No. 03-SGE-07)
A psychiatric **hospital erred** by not also informing the patient's wife when his cost of care exceeded his insurance coverage, as she requested. The hospital needed to revise its admissions policies and procedures to cover release of billing information to those who may be responsible for it. The **couple request that the remainder of their outstanding bill for psychiatric care be waived**. While it is concluded that his rights were violated, the **remedial action requested exceeds the scope of the grievance process**. If the couple wants to pursue that resolution independently, they would need to contact the facility to request a settlement or a private attorney for civil litigation.

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
The sister/guardian of a woman filed a grievance about the care the woman had received while she was living in her own apartment. She **asked for $500 per year replacement of the ward's homestead money**[44], which she previously received because she was in an apartment instead of an Adult Family Home, where she now resides, and **$300 for moving expenses** because the county did not move her. The **grievance procedure does not have authority to award monetary damages**.

07/02/2004
(Level III decision in Case No. 04-SGE-01)
The law states that "**any person** who is aware of a possible violation of client rights" [emphasis

[44] Wisconsin Department of Revenue webpage: *Homestead Credit Frequently Asked Questions*: http://www.dor.state.wi.us/faqs/ise/home.html

added] **may file a complaint on behalf** of a client. Where a facility **refused to accept an ex-patient's complaint** on behalf of current patients, **his right to file a complaint was violated**.

07/02/2004
(Level III decision in Case No. 04-SGE-01)
Where an **ex-patient filed a complaint on behalf of current patients**, all of whom **had guardians**, the **facility was obligated to check with the guardians** to **see if they wished to pursue** the complaint.

07/02/2004
(Level III decision in Case No. 04-SGE-01)
Where a **facility initially refused to accept a complaint** from an ex-patient, but then, **after receiving advice** from the Client Rights office, **did accept the complaint**, the **rights violation was remedied**.

08/15/2005
(Level IV decision in Case No. 04-SGE-07)
The Level III decision **thoroughly addressed** all of the complainant's issues. In her appeal to Stage 4, the complainant provided **no new evidence** sufficient to justify reversing the Level III decision. The Level III decision was therefore affirmed.

04/03/2006
(Level IV decision in Case No. 05-SGE-09)
A Level III decision found that a service provider had addressed all ten of the concerns a client raised and that the matter was considered resolved. The client was **given notice of his right to appeal** the Level III **within 14 days**. He **appealed 45 days** after the Level III was issued. The client was asked to show good cause why he had not appealed within the time frame. He did not respond. His **lack of response** lead to the conclusion that he was **no longer interested** in pursuing the matter. The complaint was therefore **dismissed**.

06/08/2006
(Level III Decision in Case No. 05-SGE-03)
The information contained in response to a client's grievance **included personal and subjective observations** that were **not appropriate**. Here, the provider was informed of the appropriate information to include in the program level review of a grievance and this concern was considered **resolved**.

08/18/2006
(Level IV decision in Case No. 06-SGE-04)
There is **nothing inherently wrong** with a facility Client Rights Specialist (CRS) **conferring with the facility's attorneys** on issues pertaining to patient rights. The patient rights laws and rules are complex. Seeking the advice of counsel is often a good way to ensure that the facility is in full compliance with those rights.

03/20/2007
(Level IV decision in Case No. 06-SGE-10)
By **signing a Settlement Agreement** with the court, a client had **agreed to her inpatient placement** under an **Emergency Detention**. She **could not subsequently challenge** that placement **through the grievance process**, only through the courts.

Records, Access by Patients

Decisions:

01/22/1999
(Level IV decision in Case No. 98-SGE-02)
Subsection 51.30(4)(b)5 **allows access without consent** "...to qualified **staff members of the department**... as is necessary to determine progress and adequacy of treatment..." Thus **the State Grievance Examiner is allowed to obtain otherwise confidential records without the informed consent** of the complainant.

10/18/2001
(Level III decision in Case No. 01-SGE-06)
A discharged patient **asked** the hospital to **return his personal journal**. It should be returned to him since **it is his property**, whether or not the hospital considered it part of his treatment record.

05/02/2002
(Level III decision in Case No. 02-SGE-01)
A parent filed a **complaint about a doctor giving the wrong pills to her minor children**. But she **refused to sign a consent** form allowing the Level I Client Rights Specialist (CRS) access to the children's treatment records. This limited the CRS to trying to resolve the matter informally. Although it was the parent's right to refuse access to the treatment records, it **prevented the CRS from conduct a complete**, **formal grievance investigation**. Given the lack of a formal grievance, **the appeal to Level III was denied**.

09/19/2003
(Level IV decision in Case No. 02-SGE-04, overturning the Level III)
Sec. 51.30(4)(e), Stats., requires that, **when records are released**, "a **notation** shall be made in the records by the custodian thereof that includes the following: the name of the person to whom the information is released; the identification of the information released; the purpose of the release; and the date of the release". **Handwritten notes in the margin** of records request documents, due to their brief nature, are **unlikely to satisfy** all the requirements of this statute. Subsequent to April 14, 2003, entities releasing records must also comply with the even more stringent federal Health Information Portability and Accountability Act (**HIPAA**[45]).

03/10/2004
(Level IV decision in Case No. 02-SGE-07)
A complainant was **denied access to the records of his joint meetings with his wife and her therapist**. There was no rights violation because **these were individual sessions with his wife in which he was invited to be present**. If his wife wants access to those records, **she has the right request copies from the facility**.

08/15/2005
(Level III Grievance Decision in Case No. 04-SGE-07, affirmed at Level IV on 8/15/05)

[45] The Health Insurance Portability and Accountability Act of 1996, http://www.hhs.gov/ocr/hipaa/

A client wanted copies of all of her records, including the **private psychotherapy notes** that her therapist made during the course of her treatment. Those notes were not part of her **treatment record** as defined in § 51.30(1)(b), Wis. Stats., because they were **maintained for personal use** during the provision of therapy and they **were not shared** with others.

09/27/2006
(Level IV decision in Case No. 06-SGE-09)
The full panoply of patient rights did not attach to an independent outpatient evaluation. However, the complainant still had rights in regard to access to the records generated by that evaluation.

11/30/2006
(Level III decision in Case No. 06-SGE-13)
A patient who had been discharged from a Methadone clinic requested access to two federal forms from our department[46]. The forms she request were **internal operations forms** between methadone treatment provider agencies and the **federal government**. Clients **do not have a right to either of those forms**.

[46] Wisconsin Department of Health Services, http://dhs.wisconsin.gov/

Records, Confidentiality of Treatment

Decisions:

05/27/1997
(Level III decision in Case No. 97-SGE-01)
A hospital had a **release of information** allowing them to share information about the patient's care **with her family**. However, **they released records** to the family that the **patient did not want released**. The **hospital acknowledged** they had exceeded the scope of the release of information they had and **implemented a procedure** to ensure that this **error did not occur again**. **Nothing can undo the error**, but the hospital's **actions were the proper remedy** under the circumstances. That is all the grievance process can do. The **patient could still take the hospital to court if she wished**. This matter was considered resolved.

01/22/1999
(Level IV decision in Case No. 98-SGE-02)
Subsection 51.30(4)(b)5 allows **access without consent** "...to qualified staff members of the department... as is necessary to determine progress and adequacy of treatment..." Thus the **State Grievance Examiner** is allowed to **obtain otherwise confidential records** without the informed consent of the complainant.

05/17/2000
(Level III decision in Case No. 99-SGE-02, appeal to Level IV by the patient was dismissed since the Level III decision was in his favor)
A **methadone clinic** involved **17 different staff** members in a **multi-disciplinary team** meeting to discuss a patient's alleged dose-splitting. This team meeting **included staff** who had **no involvement** with the patient and had **no "need to know"** the treatment information about this client. The patient provided no release of information. This process **violated the patient's right to confidentiality** of his treatment information

06/17/2000
(Level III decision in Case No. 00-SGE-02, upheld at Level IV)
A patient **claimed** a **breach of confidentiality** by her therapist in a phone conversation with her mother. It was found that the **mother initiated the call** because of her concerns for her daughter and that the **therapist was careful not to divulge** any information about the daughter's treatment. The mother asked the therapist not to tell the daughter about the phone call. The therapist could not promise that she would not divulge that the mother called, but eventually decided not to inform the daughter. Her reasons for making that decision were documented. **No breach** of the daughter's **confidentiality** was found.

06/29/2001
(Level III decision in Case No. 00-SGE-01)
A client received services from an agency contracted by the county. He felt that the **provider releasing information**, **without his consent**, to an **evaluator** who was completing a vocational assessment **violated his confidentiality**. The evaluator was from a local university who had no official connection to the county's service delivery system. However, by mutual agreement all

the parties, including the client, he was to do a comprehensive vocational evaluation the client. At a later meeting with the parties, the client found out that county staff had shared specific information about his mental health history but had not obtained a release from him to do so. Other "consents to disclose confidential information" were on file, but there was **no release** of information relative to the staff's involvement in the evaluation process. Was the verbal sharing of any information with the evaluator was permissible? Any information about the client's mental health history and treatment would constitute "treatment record" information within the meaning of confidentiality laws. But the staff's very presence at the meeting was an identification of sorts that the client was receiving services from the county. Did the presence of the staff at the meeting and the client's lack of objection at the time to any information shared provide an implied consent on his part? Was any information shared covered by some other exception to the requirement for an informed written consent? It was concluded that this evaluation was akin to a "second consultation" and not provided as a routine "purchase of service" resource for county staff. Thus, it did not readily fit into one of the exceptions to the confidentiality law wherein there would is a pre-existing purchase of services contract between the county and a provider. Further, the section of DHS 94 that addresses a "second consultation" notes that the person doing the consultation can review the client's treatment record. By the **staff member's un-objected-to presence**, the client may have provided an **implied consent**, but that this was a **"close call"** in terms of the technical confidentiality requirements. Since the vocational evaluation was set up by mutual agreement of all parties, there likely was an expectation of open sharing of treatment information to assist the evaluation process. Nonetheless, it would have been **best practice** for the service providers to have a **clearly written release of information** from the client that would specify who all could be part of the information sharing process. There was insufficient evidence to find a rights violation. When **outside evaluations** occur, there should be **clear documentation** of the evaluator's legal status in terms of that person's right to access treatment information. For example, is it being done under a purchase of services agreement, as a second opinion or consultation, or via a specific release of information that clarifies who can provide treatment information, and what type, to the evaluator.

08/06/2001
(Level III decision in Case No. 00-SGE-12)
Generally, **information** from a patient's treatment records **cannot be released** without the client's **written informed consent**. But there are **exceptions** to confidentiality laws allowing for release of information without a patient's consent. One such exception stems from a 1988 Wisconsin Supreme Court[47] decision in the **Schuster**[48] case. In that case, the Wisconsin Supreme Court said that mental health therapists had a **"duty to warn"** any person who may be the specific target of a threat of harm. The patient was angry with a particular person and expressed that anger to his therapist. He did not think that he had specifically threatened to harm that person. However, if anger is expressed in a way that is assessed as threatening toward another person, there is little choice on the part of a mental health therapist but to share that information with a person who may be the target of potential harm. In this situation the **threat** was **passed on,** but no other treatment information was shared. That **disclosure** was **not a violation** of the client's right to confidentiality of his records.

[47] Wisconsin court system, http://www.wicourts.gov/
[48] See the Wisconsin Supreme Court case: Schuster v. Altenberg, 144 Wis.2d 223 (1988)

09/12/2001
(Level III decision in Case No. 00-SGE-03)
A patient, who had complained about her therapist and physician, expressed concerns about the **confidentiality** of her involvement in the **grievance procedure** and any follow-through that had occurred with her provider. She alleged that the entire staff of the service provider knew about her complaints. The director of the service provider noted that the record keeping system for grievances was entirely separate and that **only staff with a "need to know"** are **given access** to or information about the filing of grievances. Only a select group of management and treatment staff were aware of this patient's grievances and information about them was not available to others. It was found that the **confidentiality** of this grievance **was honored** and no rights violation occurred.

09/12/2001
(Level III decision in Case No. 00-SGE-03)
A patient wanted to **bring a friend** to her **therapy sessions**. The service provider agreed that there are times that it may be appropriate, especially if the person is a primary support person for the client. Bringing another person to a therapy session **requires a signed release** from the patient. Since the requested remedy was provided, this issue was considered resolved.

10/18/2001
(Level III decision in Case No. 01-SGE-06)
A patient complained that his **therapist** allegedly **asked him if his wife was having an affair**. He **responded** that **he would kill her and her boyfriend**. He also threatened to kill the therapist. The therapist discussed this with her supervisor and was instructed that she **had a duty to warn the wife of the threat**. The therapist informed the wife and the police. When the police questioned the husband, he threatened to harm them, too. These threats led to his emergency detention. The therapist's actions were appropriate under the circumstances. She **did have a duty to warn** where **threats were made about immediate harm to specific people**.

11/29/2001
(Level III decision in Case No. 01-SGE-05)
A service recipient asked a **temporary receptionist** for a grievance form. The temp **asked other staff** where the **complaint forms** were. The case manager heard about the request and asked the individual to come to her office to discuss her concerns. The grievance she wanted to file, however, was about her case manager. There was no evidence that anyone tried to talk her out of filing a complaint, nor any indication of reprisal, retaliation or discrimination because of her grievance. There was no violation of her right to file a complaint. The **temp** asking other staff where the grievance forms were **did not violate her right to confidentiality**.

12/10/2001
(Level III decision in Case No. 01-SGE-02)
A patient's mother complained that her **daughter's doctor** violated her daughter's confidentiality. The Level I Client Rights Specialist did not address this issue in his written response. The **failure to address** this issue was a **violation of the right** to have the **grievance fully investigated**.

12/10/2001
(Level III decision in Case No. 01-SGE-02)
A patient's mother complained that her daughter's doctor violated her daughter's confidentiality

by **reading things from her records** during a **meeting** between the doctor, the **patient and her parents**. The parents had the **same right of access** to her records **as the daughter** had under §51.30(5)(b), Stats. Therefore there was **no violation** of confidentiality.

12/10/2001
(Level III decision in Case No. 01-SGE-02)
The law states that, "A **patient** *or a* ***person acting on behalf of a patient***" may **file a complaint**. It was a violation of the complainant's rights when a Level I Client Rights Specialist **refused to investigate** her allegation that her **ex-husband's right** to confidentiality **had been violated**.

12/10/2001
(Level III decision in Case No. 01-SGE-02)
A **therapist informed a woman** that her **former husband was in counseling**. She had been unaware of that. The **disclosure violated** her ex-husband's **right to confidentiality**.

03/27/2002
(Level III decision in Case No. 01-SGE-09)
Patients have the **right to involve their spouses** in their **home-visit treatment sessions** unless their participation is contraindicated for treatment reasons. The service provider should either allow such participation or explain to the patient why it is contraindicated. The patient would have to **sign a release of information** to allow the **spouse to be present** during treatment sessions.

09/19/2003
(Level IV decision in Case No. 02-SGE-04, overturning the Level III)
Sec. 51.30(4)(e), Stats., **requires** that, when **records are released**, "a **notation** shall be made in the records by the custodian thereof that includes the following: the name of the person to whom the information is released; the identification of the information released; the purpose of the release; and the date of the release". **Handwritten notes in the margin** of records request documents, due to their brief nature, are **unlikely** to satisfy all the requirements of this statute. Subsequent to April 14, 2003, entities releasing records must also comply with the even more stringent federal Health Information Portability and Accountability Act (**HIPAA**[49]).

12/26/2003
(Level III Decision in Case No. 03-SGE-02)
A mother believed a **therapist acted unprofessionally** in working with her daughter by **not reporting** various **risky behaviors** in which her daughter was engaged. The therapist was aware that her daughter tried to commit suicide, purposely cut herself many times, used illegal drugs, and engaged in underage sex with multiple partners. The mother thought the therapist should have reported all these incidents to proper authorities. She requested disciplining the therapist – including possible license revocation. The records indicated that the suicidal ideation expressed by the daughter was taken seriously. Appropriate referral resources were immediately offered to her parents. The daughter was also placed on a medication for depression. For the next seven subsequent sessions the therapist inquired about and documented the daughter's present mental status and thoughts of suicide or dying. Each entry includes some statement indicating that she was asked if she was seriously contemplating suicide or hurting herself. She responded that she was not having thoughts about suicide or hurting herself over the following months. Therefore,

[49] The Health Insurance Portability and Accountability Act of 1996, http://www.hhs.gov/ocr/hipaa/

her right to prompt and adequate treatment was met. The therapist was **not obligated** to initiate social services **intervention** into her family life, **or** to **notify any other authorities**.

12/26/2003
(Level III Decision in Case No. 03-SGE-02)
A mother complained that her **daughter's therapist reported sexual abuse** to the county **social worker**. The therapist learned that a teacher at her daughter's home school had touched the young woman inappropriately. The therapist reported the allegations to the county social worker. The county Social Services department then got the **police involved**. The police came to the home school to arrest the teacher. This situation was stressful for both mother and daughter. The incident met the legal definition of **sexual abuse**. Since she was a **minor**, law **mandates** the **reporting** of the allegation. The therapist's actions were professional and appropriate.

12/26/2003
(Level III Decision in Case No. 03-SGE-02)
There is legal precedence for the "**duty to warn** or protect," though in Wisconsin it is not defined by statute. The precedent is from the courts, and is outlined in the 1988 Wisconsin Supreme Court case ***Schuster** v. Altenberg*[50], and in subsequent literature. This case, similar to many that preceded it, establishes a **duty** on the part of **psychotherapists** to take "some **reasonable" action** to prevent **foreseeable harm** to third parties who are injured by those being treated by the psychotherapists. This state precedent parallels federal precedent, ***Tarasoff** v. Regents of the University of California*[51], which was a 1976 California case decided by the U.S. Supreme Court.

12/26/2003
(Level III Decision in Case No. 03-SGE-02)
A mother was concerned about the way her **daughter's underage sexual activity** was handled in treatment. The therapist learned she had engaged in sexual activity with multiple partners. While it is true that a minor cannot legally consent to sexual activity, the relationships the minor was engaged in were not against her will, the relationships were with other minors who she was dating, and thus were not considered to be abuse. There was thus **no cause to violate** the **daughter's confidentiality** by reporting this matter to outside authorities.

07/14/2004
(Level III Decision in Case No. 03-SGE-08)
A form called "**Consent for Release** of Information – Patient Assistance Program" is used by a service provider and is presented to all patients who **receive medications** through the Patient Assistance Program[52] (PAP). This form is to aid patients in filling out the paperwork necessary to receive medications through the Patient Assistance Programs offered by pharmaceutical companies. The release allows service provider staff to help patients fill out all the information required on the application, and it allows staff to send the applications to the pharmaceutical companies (or their contracted agencies) for the patients. Without this consent, patients would need to fill out and mail the application form themselves. This is not possible in its entirety, as their physicians prescribing number is not available to be known by patients and must come from

[50] See the Wisconsin Supreme Court case: Schuster v. Altenberg, 144 Wis.2d 223 (1988)
[51] See the Supreme Court of California case: Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (Cal. 1976)
[52] Aditional information is avalible on the DHS webpage: *Consumer Guide to Health Care - Prescription Drug Assistance Programs*: http://dhs.wisconsin.gov/guide/spec/freeprescr.htm

the service provider. **If a patient refuses to sign** this consent form, the individual **may not be denied services** by the provider, and patients may elect to fill out and send the application to the Patient Assistance Program on their own. In this case, the service recipient chose not to sign the release, and this did not negatively affect his treatment because he was able to handle the paperwork himself. This resolved the concern as it applied to him. However, he expressed concern about the form for other patients' confidentiality. Over 700 patients receive medications from this provider and approximately 75% of those patients receive their medications through a Patient Assistance Program, which resulted in over $300,000 worth of medications being disbursed to patients at no cost to them in the last year through that agency. **Many of these clients do need assistance** in filling out the paperwork to maintain these free medication services. It was determined that the **consent form** in question is a **useful** and **important tool** for those individuals to maintain their psychiatric treatment services. While this person's concern for their confidentiality is admirable, the allegation that this form violates their confidentiality is unfounded, and the limitations on the types of information that can be released does protect patients' confidentiality and allows the provider to facilitate their clients' participation in the PAP.

12/20/2004
(Level III decision in Case No. 04-SGE-02)
The **confidentiality rights** of a client at a methadone clinic were **violated** when she was **called by her first and last name in the waiting room**. The appropriate and professional way to address her would be to only use her first name when other clients are present. The clinic **remedied** this confidentiality breach by conducting a staff **In-service[53] on confidentiality**.

08/15/2005
(Level III Grievance Decision in Case No. 04-SGE-07, affirmed at Level IV on 8/15/05)
In order to **protect** a client's **confidentiality**, it is **not appropriate** to **discuss** confidential or personal matters **on a speakerphone** in a **cubicle workplace environment**. Speakerphone use during conference calls should be restricted to constructed office space or conference rooms that offer reasonable degrees of privacy. Here, the speakerphone use in question was appropriately conducted in a constructed office with a closed door.

08/15/2005
(Level III Grievance Decision in Case No. 04-SGE-07, affirmed at Level IV on 8/15/05)
If a county is **contracting with a mental health center** to provide inpatient treatment for a client, **they can share confidential client information** they have with the center **without the client's consent**. It did not violate the client's confidentiality here where the information shared was something the client had objected to as being inaccurate. The client had other means of trying to correct the information at issue.

04/02/2008
(Level III decision in Case No. 07-SGE-02)
An **informed consent** document for treatment planning should **clearly set forth the information necessary** for the patient/guardian **to make a clear and informed decision** regarding the services they consent to receive. This should **include a clear indication of the types and specific costs for those services.** Here, the provider did not specifically document or

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[53] Definition of in-service: Training, as in special courses, workshops, etc., given to employees in connection with their work to help them develop skills, etc.

clarify the types of services recommended and the billing codes that would apply. The consent to treatment listed two conditions and two treatment modalities, but did not explicitly link either of them to one another, making the quality of the information provided by the consent ambiguous. This did not provide a clear expectation for the family, and thus the consent was not truly informed.

Records, Correction of Information in

Decisions:

08/15/2005
(Level III Grievance Decision in Case No. 04-SGE-07, affirmed at Level IV on 8/15/05)
A client **objected to an entry** in her chart which raised the possibility that the client was **stalking her therapist**. She was informed of her **right to enter a correction** of information into the treatment record per § 51.30(4)(f), Stats. She did enter an addendum in the record and it is now attached to the reference about possible stalking concerns and will be released whenever the related record is released. This was the **appropriate remedy** for her objection.

05/16/2006
(Level III Grievance Decision in Case No. 05-SGE-12)
An outpatient client **disagreed with** her therapist assigning her an Axis II Borderline Personality Disorder **diagnosis**. A diagnosis is ultimately a professional opinion and given "due deference". However, the professional opinion of the therapist did not take into account the physiological factors that the client later became aware of, post-therapy. It was **recommended** that she **submit a clarification** of her treatment record that included her experiences and the **medical information** from her **physician**.

Refusing Medications and Treatment, Consent Required

No decisions at this time

Religious Worship, Right to

Decisions:

10/13/1998
(Level III decision in Case No. 98-SGE-02, upheld at Level IV)
The **alcohol treatment program** did **not require** the individual to **attend Alcoholics Anonymous**[54] **(AA) or the steps that have religious aspects**. Thus, his **right** to be freedom of religious worship was **not violated**.

06/26/2008
(Level IV decision in Case No. 07-SGE-04)
A client in the community complained about her **telephone conversation with a crisis worker on a suicide hotline**. She felt that the crisis worker was disrespectful and offensive, especially when it came to the topic of spiritual support since the client was not a spiritual or religious person. The conversation was not recorded, so it was difficult to establish exactly what the crisis worker said to her. But it was obvious that the client was in despair and that the **crisis worker was trying every approach she knew to try to reach out to her**. The crisis worker asked her about family, friends, religious, spiritual or other supports she could turn to. **It is not, *per se*[55], inappropriate** to ask a caller on a crisis line **if they have any spiritual or religious beliefs that might help them** through a very trying time. For some, such support can be a comfort.

[54] Alcoholics Anonymous, http://www.aa.org/
[55] A Latin phrase used in English arguments for "by itself" or "by themselves"

Research, Experimental, Consent Required

No decisions at this time.

Resolutions and Remedies

Decisions:

05/27/1997
(Level III decision in Case No. 97-SGE-01)
A hospital had a **release of information** allowing them to share information about the patient's care with her family. However, **they released records** to the family that **the patient did not want released**. The hospital **acknowledged they had exceeded the scope of the release** of information they had and **implemented a procedure to ensure that this error did not occur again**. **Nothing can undo the error**, but the **hospital's actions were the proper remedy** under the circumstances. That is all the grievance process can do. The patient could still take the hospital to court if she wished. This matter was **considered resolved**.

04/06/2000
(Level III decision in Case No. 00-SGE-02)
A patient complained that the facility **did not properly inform her of the increase** in the **charges** for her cost of care. The Level II grievance decision found that she was not properly informed of the increased costs and **her billing was adjusted to reduce the fees to the original costs**. This was a **fair resolution** of the grievance.

04/06/2000
(Level III decision in Case No. 00-SGE-02)
The **grievance procedure** under DHS 94 has **no authority to award damages**. **Monetary damages** can be pursued in and awarded **only by a court of law**.

04/17/2000
(Level III referral in Case No. 00-SGE-07)
Where a hospital patient complained about an **error in medication administration**, the State Grievance Examiner **referred** the matter to the **Bureau of Quality Assurance**[56] for investigation. [BQA subsequently issued the hospital a citation for violation of state and federal regulations.]

06/17/2000
(Level IV decision in Case No. 00-SGE-02)
The meaning and applicability of the section of DHS 94.24(3) regarding "redress through the **grievance procedure**" is to assure that no one is deprived of using the grievance procedure to seek redress for an alleged violation of his or her rights. It **does not allow for the award of punitive monetary damages** in the grievance process. Only a court can award damages. The individual whose rights were allegedly violated must initiate any court action.

06/17/2000
(Level IV decision in Case No. 00-SGE-02)
A **favorable grievance decision cannot be appealed** by the **prevailing party**.

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[56] Division of Quality Assurance, http://dhs.wisconsin.gov/rl_dsl/bqa.htm

08/02/2000
(Level III decision in Case No. 00-SGE-13)
A patient at a county psychiatric hospital complained about a **seclusion incident**. He raised issue about whether there was justification for the initial use of seclusion and whether he was released in a prompt and timely manner. There was a discrepancy between a verbal report of one staff and the documentation form that was completed while he was in seclusion. In the Level I grievance decision, the Client Rights Specialist (CRS) **made a suggestion** that staff **more carefully document** anything of concern that may be displayed while a patient is in seclusion. The improvements in documentation made by the hospital in response to his complaint were noted. The **patient withdrew his complaint** at Level III.

01/03/2001
(Level III decision in Case No. 99-SGE-07)
Where a **developmentally disabled young woman** ended up in an acute inpatient mental health setting, it **was appropriate** for the Level I Client Rights Specialist to recommend a potential "**crisis intervention plan**" for her in case the situation arose again. Such an approach is an element of ongoing quality assurance on the part of the county program, too.

02/16/2001
(Level III decision in Case No. 00-SGE-05)
A client who was **about to be discharged** from an inpatient facility felt she was not **being given enough input or choices** in terms of to where she would be discharged. She **wanted** to be placed in an **apartment** in the community. Facility staff were considering placement at other inpatient settings or a CBRF[57] (group home) setting. Ultimately, she was **transferred to a community supported living arrangement in an apartment**. Since this was what she wanted, the grievance was dismissed at Level III as being "**resolved**".

02/21/2001
(Level IV decision in Case No. 00-SGE-08)
Where **violations** of client rights are found, the **matter may be referred** to the **Bureau of Quality Assurance[58] Certification Unit** to determine if any violations of certification requirements occurred.

06/29/2001
(Level III decision in Case No. 00-SGE-01)
A patient received **services from an agency contracted by the county**. He felt he was **not adequately informed of his patient rights** because his rights were provided in a perfunctory way, without dialog or the ability on his part to ask questions or seek further clarification. He **wanted clarification** of the notification requirements and expectations. Given his requested relief, there was no conclusion made that the provider was out of compliance, but **recommendations** were made for **further review** of the service provider's rights notification process.

09/12/2001
(Level III decision in Case No. 00-SGE-03)
A woman **complained about her therapist** because of **cancelled appointments**. The Level I decision found that **her right** to receive prompt treatment **was violated** by the high number of

[57] Community Based Residential Facility
[58] Division of Quality Assurance, http://dhs.wisconsin.gov/rl_dsl/bqa.htm

cancellations. The service **provider implemented a formal plan and consistently followed up on it to reduce the number of cancellations**. It was found at Level III that the frequency of cancellations did rise to the level of a patient rights violation and the Level I finding was upheld. The **actions taken** by the service provider **remedied** the rights violation.

09/12/2001
(Level III decision in Case No. 00-SGE-03)
A patient wanted to **bring a friend to her therapy sessions**. The service provider agreed that there are times that it may be appropriate, especially if the person is a primary support person for the client. Bringing another person to a therapy session requires a signed release from the patient. Since the **requested remedy** was **provided**, this issue was **considered resolved**.

01/23/2004
(Level III Decision in Case No. 03-SGE-05)
A complainant **wanted to appeal** the county's Level II grievance decision made under DHS 94. He was **incorrectly referred** to the **Division of Hearings and Appeals**[59] instead of the **State Grievance Examiner**. The **county agreed that a mistake had occurred** in this process. They **revised the county manual** and added the correct standard appeal language to the end of the grievance decisions that the county issues. Thus, the **violation of rights was remedied** and the issue was **considered resolved**.

04/22/2004
(Level III Decision in Case No. 03-SGE-07)
An ex-patient complained about a **lack of individualized treatment** at a psychiatric hospital. These concerns were **meaningfully addressed** when the hospital responded to his observations and concerns about the manner in which patients are assessed and treated. The hospital was planning a **specific training session** for staff to address indicators, features, and treatment approaches for Post Traumatic Stress Disorder and Parkinson's Disease. The training would also address the variables that could arise with men's issues during treatment. This staff training should lead to an improved awareness and create a better standard of care, greater dignity and respect for patients, and more individualized treatment decision-making. Given **the training initiatives** planned, this issue was **considered resolved**.

04/22/2004
(Level III Decision in Case No. 03-SGE-07)
A psychiatric **hospital erred** by **not also informing the patient's wife** when his **cost of care exceeded his insurance coverage**, as she requested. The hospital needed to revise its admissions policies and procedures to cover release of billing information to those who may be responsible for it. The couple **requested** that the **remainder of their outstanding bill for psychiatric care be waived**. While it is concluded that his rights were violated, **the remedial action requested exceeds the scope of the grievance process.** If the couple wants to pursue that resolution independently, they would need to contact the facility to request a settlement or a private attorney for civil litigation.

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
The sister/guardian of a woman filed a **grievance about the care** the woman had received while

[59] Division of Hearings and Appeals, http://dha.state.wi.us/home/

she was living in her **own apartment**. She had been receiving supportive home care services from an independent service provider under a general contract with the county. The guardian **alleged abuse and neglect** because of failure to report **theft of monies** and possessions and fraud and/or misrepresentation of funds. These issues were **properly referred** to other authorities.

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
The sister / guardian of a woman filed a grievance about the care the woman had received while she was living in her own apartment. She **asked for $500 per year replacement of the ward's homestead money**[60], which she previously received because she was in an apartment instead of an Adult Family Home, where she now resides, and **$300 for moving expenses** because the county did not move her. The **grievance procedure does not have authority to award monetary damages**.

07/14/2004
(Level III Decision in Case No. 03-SGE-08)
A service provider where the individual picks up his medications has **inadequate parking**, making it inconvenient for him at times. The service provider **attempted to resolve** this by **offering him alternative times** in which he could pick up his medication when the parking lot would be less crowded. These **accommodations** included:

- Suggesting he pick up his medication on a Friday when the parking lot is less busy;
- Picking up his medication in the afternoon when the staff parking lot is less full; or
- Speaking with his case manager to arrange picking up his medication at a different time than the set times.

They were also willing to arrange for him to pick up his medication when he meets with his psychiatrist every three months for his psychiatric medication check up, thus saving him four trips a year. These **accommodations were reasonable and sufficient**.

07/14/2004
(Level III Decision in Case No. 03-SGE-08)
The service recipient **wanted to receive his medications in the exact form** the **pharmaceutical company** sends it and as soon as they send it. However, the service provider has the need to double-check all medications being given to patients through the Patient Assistance Program[61] (PAP). They do so through a local pharmacy. When they receive medications from any drug company they immediately send it to the pharmacy where it is checked, repackaged and dispensed. The pharmacy does not mix lot numbers or expiration dates, therefore each patient receives the same medication (with regards to freshness and lot number) as was sent from the drug company. The **individual's desire** to receive his medication just as it was sent from the drug company is **understandable**; however, **so is the service provider's liability** to make sure that he is getting exactly what medication he was prescribed from the drug company. The service provider **agreed to have their professional staff open the medication**, check its content, and dispense the medication as prescribed by his psychiatrist in order to avoid his medications having to go through the pharmacy, as requested.

[60] Wisconsin Department of Revenue webpage: Homestead Credit Frequently Asked Questions: http://www.dor.state.wi.us/faqs/ise/home.html
[61] Aditional information is avalible on the DHS webpage: Consumer Guide to Health Care - Prescription Drug Assistance Programs: http://dhs.wisconsin.gov/guide/spec/freeprescr.htm

12/20/2004
(Level III decision in Case No. 04-SGE-02)
The **confidentiality rights** of a client at a methadone clinic were **violated** when she was **called by her first and last name in the waiting room**. The appropriate and professional way to address her would be to only use her first name when other clients are present. The clinic **remedied** this confidentiality breach by conducting a staff **In-service on confidentiality**.

06/08/2006
(Level III Decision in Case No. 05-SGE-03)

The information contained in response to a client's grievance **included personal and subjective observations** that were **not appropriate**. Here, the provider was **informed of the appropriate information** to include in the program level review of a grievance and this concern was considered **resolved**.

06/08/2006
(Level III Decision in Case No. 05-SGE-003)
The information contained in response to a client's grievance **included personal and subjective observations** that were **not appropriate**. Here, the provider was **informed of the appropriate information** to include in the program level review of a grievance and this concern was considered **resolved**.

04/02/2008
(Level III decision in Case No. 07-SGE-07)
A patient's mother felt that the outpatient drug treatment program "failed" her son by **not promptly diagnosing his depression**. The son ended up requiring inpatient treatment. The mother wanted the outpatient program to **pay for her son's inpatient stay.** This was **not within the purview** of the grievance procedure.

06/26/2008
(Level IV decision in Case No. 07-SGE-04)
A client in the community complained about her **telephone conversation with a crisis worker** on a suicide hotline. She felt that the crisis worker was disrespectful and offensive, especially when it came to the topic of spiritual support since the client was not a spiritual or religious person. At a reconciliation meeting the crisis worker apologized to the client for anything that disturbed or offended her. The conversation was not recorded, so it was difficult to establish exactly what the crisis worker said to her. But it was obvious that the client was in despair and that the crisis worker was trying every approach she knew to try to reach out to her. The crisis worker asked her about family, friends, religious, spiritual or other supports she could turn to. It is not, *per se*[62], inappropriate to ask a caller on a crisis line if they have any spiritual or religious beliefs that might help them through a very trying time. For some, such support can be a comfort. The **crisis worker had already apologized**. Even if a rights violation had been established here, there was **nothing more that the grievance procedure could offer her** by way of an outcome. The grievance process **cannot award monetary or other damages or impose disciplinary actions** on staff who violate patients' rights. Any such action could only be taken by the courts or by the staff member's employer.

[62] A Latin phrase used in English arguments for "by itself" or "by themselves"

Restraint and Seclusion, Right to be Free From

This topic has been renamed to "Restrictive Measures – Right to be Free From"

Restrictive Measures, Right to be Free From

Decisions:

08/02/2000
(Level III decision in Case No. 00-SGE-13)
A patient at a county psychiatric hospital **complained about a seclusion incident**. He raised issue about whether there was **justification for the initial use of seclusion** and whether he was **released in a prompt and timely manner**. There was a discrepancy between a verbal report of one staff and the documentation form that was completed while he was in seclusion. In the Level I grievance decision, the Client Rights Specialist (CRS) made a suggestion that staff more carefully document anything of concern that may be displayed while a patient is in seclusion. The **improvements in documentation** made by the hospital in response to his complaint were noted. The patient **withdrew his complaint** at Level III.

04/09/2001
(Level III decision in Case No. 00-SGE-04)
A patient being emergency detained complained about **being shackled by the sheriff officers during transport**. This is their standard practice. The grievance process has **no jurisdiction over the actions of law enforcement agencies**.

12/19/2007
(Level III decision in Case No. 07-SGE-03)
A client had used an **enclosed canopy bed** (manufactured and labeled as a "Vail 1000" bed[63]) for several years for sleeping at night, occasional naps during the day, and as a platform for some personal cares. After an extensive review of the client's situation, it was concluded that **this particular canopy bed was appropriate and safe** for her use. Though technically a **restrictive measure**, it was found that the bed was the **least restrictive alternative to ensure her safety** while allowing her to get the sleep she needed. Therefore, the state and county decisions to discontinue their approval of the use of her Vail 1000 bed was a **violation** of the client's right to a **safe and humane environment** and an **arbitrary decision** because it **was not individualized** to this client's **exceptional safety needs and her unique situation**. This decision **does not set precedent for all Vail beds** or other canopy beds, but only for the bed as it was being used in this specific instance. Thus, the precedent is not binding for other provider agencies or other clients.

[63] Trademarked by Vail Products Inc, 235 first Street, Toledo, OH , 43605-2041

Retaliation for Use of Grievance Procedure Prohibited

Decisions:

05/17/2000
(Level III decision in Case No. 99-SGE-02, appeal to Level IV by the patient was dismissed since the Level III decision was in his favor)
Where a **methadone clinic discouraged a patient from bringing an advocate with him to a team meeting**, the clinic **violated** his right to bring a grievance without fear of retaliation or discrimination.

09/12/2001
(Level III decision in Case No. 00-SGE-03)
A patient who had **complained about her therapist** and physician expressed **concerns about the confidentiality of her involvement in the grievance procedure** and any follow through that had occurred with her provider. She alleged that the **entire staff of the service provider knew about her complaints**. The director of the service provider noted that the **record keeping system for grievances was entirely separate** and that **only staff with a "need to know"** are given access to or information about the filing of grievances. **Only a select group** of management and treatment staff **were aware of this patient's grievances** and information about them was not available to others. It was found that the **confidentiality of this grievance was honored** and no rights violation occurred.

01/27/2003
(Level III decision in Case No. 02-SGE-06)
A father claimed that his **son's discharge from treatment** at a medical center was in **retaliation for his filing a complaint** about his own mother's care there. It was determined that **other factors led to the son's discharge** and that the father had been told that it was going to occur soon. This **occurred several months prior** to the complainant filing a grievance about his mother's care. **No retaliation** for filing a complaint was found.

03/19/2003
(Level III decision in Case No. 02-SGE-05)
There is **no limit to the number of grievances a patient may file**. But where an inpatient filed **many, many complaints** while in a treatment facility, without any attempts to resolve his issues first, he **should not be surprised** when **both the staff and his peers became very frustrated with him**. The county **transitioned him to a smaller home** with fewer residents where he would have less opportunity for confrontation with others. This was **not done in retaliation** for his use of the grievance process.

03/10/2004
(Level IV decision in Case No. 02-SGE-07)
There is **insufficient evidence** to conclude that a **facility's Chief Legal Counsel discouraged someone from filing a complaint**. The facts indicate he merely **informed the individual** that he did **not believe he had a malpractice claim that would be upheld in court**. The fact that the

individual was able to bring this complaint and appeal it up through the grievance process to Level IV indicates that his right to complain was not violated.

12/15/2006
(Level IV decision in Case No. 05-SGE-06)
A psychiatrist determined that the **therapeutic rapport** between himself and one of his clients had been **irrevocably damaged**. That presented a valid treatment reason for **discontinuing** his **services** to that client. There was **no indication** that a psychiatrist's services to a particular client were **terminated in retaliation** for his **use of the grievance procedure**.

12/15/2006
(Level IV decision in Case No. 05-SGE-08)
A psychiatrist determined that the **therapeutic rapport** between himself and one of his clients had been **irrevocably damaged**. That presented a valid treatment reason for **discontinuing** his **services** to that client. There was **no indication** that a psychiatrist's services to a particular client were **terminated in retaliation** for his **use of the grievance procedure**.

Risk Reduction Measures

No decisions at this time

Rules and Sanctions

No decisions at this time

Safety, Right to

Decisions:

09/12/2001
(Level III decision in Case No. 00-SGE-03)
A woman **complained about her doctor**, alleging that the **medications** he prescribed for her may have **caused an adverse heart reaction** leading to an **emergency visit** to the hospital. This allegation was **reviewed** by the **Bureau of Regulation and Licensing**[64] **(BRL),** which reviews medical allegations of malpractice or injury to others. BRL did not find that the heart reaction and emergency room visit was necessarily caused by the medication. The **grievance process defers to BRL's medical expertise** on such issues and thus there was **no finding** of any rights violation.

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
The **county** is **ultimately responsible** for the health and **safety** of a client to whom they provide services. **Even though they have a contract** for an independent **service provider** to do the hands-on services, the **contracted agency's failure** to perform its duties **is also the county's failure**. The **county must monitor** the providers it **contracts** with in order to **ensure that vital services are provided for their clients**.

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
The sister/guardian of a woman filed a grievance about the **care** the woman had received while she was **living in her own apartment**. She had been receiving supportive home care services from an independent service provider under a general contract with the county. The guardian alleged lack of care **causing deterioration** in health to the point of **needing immediate medical attention**. Staff's tasks included providing "acu-checks," monitoring her bathing three times a week and providing medical treatment for her hands and legs with sores. It was found that the woman's **rights were violated** when the contract agency **did not complete** the **assigned tasks** during a period of time and the woman's health deteriorated as a result.

12/19/2007
(Level III decision in Case No. 07-SGE-03)
A client had used an **enclosed canopy bed** (manufactured and labeled as a "Vail 1000" bed[65]) for several years for sleeping at night, occasional naps during the day, and as a platform for some personal cares. After an extensive review of the client's situation, it was concluded that **this particular canopy bed was appropriate and safe** for her use. Though technically a **restrictive measure**, it was found that the bed was the **least restrictive alternative to ensure her safety** while allowing her to get the sleep she needed. Therefore, the state and county decisions to discontinue their approval of the use of her Vail 1000 bed was a **violation** of the client's right to a **safe and humane environment** and an **arbitrary decision** because it **was not individualized**

[64] Department of Regulation & Licensing, http://drl.wi.gov/index.htm
[65] Trademarked by Vail Products Inc, 235 first Street, Toledo, OH , 43605-2041

to this client's **exceptional safety needs and her unique situation**. This decision **does not set precedent for all Vail beds** or other canopy beds, but only for the bed as it was being used in this specific instance. Thus, the precedent is not binding for other provider agencies or other clients.

Searches of Person and Possessions

No decisions at this time.

Security Measures

No decisions at this time.

Sexual Harassment, Right to be Free From

Decisions:

08/14/2001
(Level IV decision in Case No. 00-SGE-16, upholding the Level III)
A patient was a **recovering alcoholic** who experienced a **relapse** after six months of sobriety. He visited a priest while he was intoxicated. He ended up in detox[66] that night. Upon intake, he **alleged that the priest had sexual assaulted him**. He made those allegations while he was **still intoxicated**. The staff at the detox facility took no actions on the allegations. It is **normal procedure** to **wait** until a patient is **no longer intoxicated** to address such issues. Later, when he was no longer under the influence of alcohol, **he denied** that any assault had occurred. It was reasonable for the staff to accept the later, sober, statements over the prior intoxicated ones. He was released the day after being admitted and did not pursue criminal charges against the priest. **No rights violation** was found in the manner in which the staff dealt with his allegation of assault.

12/26/2003
(Level III Decision in Case No. 03-SGE-02)
A mother complained that her **daughter's therapist reported sexual abuse** to the county social worker. The therapist learned that a teacher at her daughter's home school had touched the young woman inappropriately. The therapist reported the allegations to the county social worker. The county Social Services department then got the police involved. The police came to the home school to arrest the teacher. This situation was stressful for both mother and daughter. The incident met the legal definition of sexual abuse. Since she was a **minor**, law **mandates** the **reporting** of the allegation. The therapist's actions were professional and appropriate.

[66] A detoxification facility

Sleep Issues

No decisions at this time.

Smoking and Non-Smoking Issues

No decisions at this time.

Social Contacts, Right to

No decisions at this time.

Staff and Patient Conflicts

Decisions:

03/23/2001
(Level III decision in Case No. 99-SGE-08)
An inpatient complained about **lack of interactions with staff** during her six-day stay. Each patient's needs and perceptions are unique, and **staff cannot use a "one size fits all" approach**. There is a thin line between respect for a patient's privacy and choices (e.g. to not have many interactions with others and to be given personal space), and going too far in the other direction (e.g., in trying to probe for interaction with many questions). In the latter instance, the patient could have complained that she was not respected and not given reasonable space or privacy. Here, the record reflects a **reasonable degree of staff attentiveness and vigilance** and, in the latter part of the stay, more discussion with her about issues. It was concluded that the patient's right to a humane psychological and physical environment was not violated in this circumstance.

11/29/2001
(Level III decision in Case No. 01-SGE-05)
A service recipient complained about her **case manager yelling at her** and pounding her fist on the table during a home visit. The case manager admits doing this but said it was a demonstration of how she would act if she were, in fact, the type of controlling person that the service recipient described her to be. This was an **isolated incident**, but the **effect** on the service recipient was **very negative**. **Even though it only happened once**, **it was a violation** of the individual's right to be treated with dignity and respect.

08/27/2002
(Level IV decision in Case No. 01-SGE-08, modifying the Level III finding)
On the day before her discharge, an Occupational Therapist (**OT**) **made a comment** to the patient to the effect that, "You won't be embarrassed about walking into the dayroom naked and sitting down." She followed it up by saying, "**Just kidding**". There was no further discussion between the OT and patient regarding the comment. The patient did not tell the OT she found the comment distressing in any way, and the OT did not have any other indication that the patient had not accepted it in a humorous way. In retrospect, the OT said she never would have used this comment or any reference to the word "naked" had she been aware of the sensitive connotation that may have had with the patient. The OT wished that the patient had stated her concerns at the time so they could have discussed them in a positive and solution-oriented way. The OT felt comfortable about using humor with this patient since she had responded well to humor being used in a therapeutic manner on prior occasions. **Staff are not expected to interact only in a formal or robot-like manner with patients.** There is **ample room for humor** in the course of mental health treatment. Had the OT known that the patient would find the comment distressing or demeaning rather than humorous, it would have been a rights violation to say it. **Some comments are so egregious** that, as a matter of law, **they are rights violations** – such as **cursing** at a patient, or **making racial or ethnic slurs**. This comment does not fit that category. Under these circumstances, the comment **did not rise** to the level of a rights violation.

03/10/2004
(Level IV decision in Case No. 02-SGE-07, reversing the Level III decision)
The Level III decision found a violation of a complainant's wife's rights when her **therapist called her at work** to say she was discontinuing the therapy. However, there was **no evidence** in the record that his **wife told the therapist not to call her at work**. This was a **business call**, rather than a personal call, and therefore it was **not necessarily inappropriate** for the therapist to call his wife at work. The **finding** of a **rights violation** was **reversed**.

03/10/2004
(Level IV decision in Case No. 02-SGE-07, upholding the Level III decision)
A complainant accused his wife's therapist of **verbally accosting him** in a public parking lot. The record shows he **attempted to obtain a restraining order** against the therapist in court, but was **unsuccessful**. Since he was unable to prove the matter in court, he failed to show that the therapist had violated his rights in those circumstances.

03/10/2004
(Level IV decision in Case No. 02-SGE-07, reversing the Level III decision)
A man complained on his wife's behalf that she was **given a new therapist without consulting her first**. A treating facility has the right to change therapists for business management reasons. It is **good practice** to **consult with the patient first**, but it **does not rise** to the level of a rights violation **not to do so**.

03/10/2004
(Level IV decision in Case No. 02-SGE-07, modifying the Level III decision)
A complainant alleged that the facility's **Client Rights Specialist** (CRS) **did not identify himself as such** to him in a timely manner. There was evidence in the record that the CRS's name and title were provided to all patients at the facility. If the individual was not re-informed of his title as CRS when discussing his issues with him, this was a **technical violation** of his rights.

04/22/2004
(Level III Decision in Case No. 03-SGE-07)
An ex-patient complained about a **lack of individualized treatment** at a psychiatric hospital. These concerns were **meaningfully addressed** when the hospital responded to his observations and concerns about the manner in which patients are assessed and treated. The hospital was planning a specific **training session for staff** to address indicators, features, and treatment approaches for Post Traumatic Stress Disorder and Parkinson's Disease. The training will also address the variables that could arise with men's issues during treatment. This staff training should lead to an improved awareness and create a better standard of care, greater dignity and respect for patients, and more individualized treatment decision-making. Given the training initiatives planned, this issue was **considered resolved**.

06/26/2008
(Level IV decision in Case No. 07-SGE-04)
A client in the community complained about **her telephone conversation with a crisis worker on a suicide hotline**. She **felt that the crisis worker was disrespectful** and offensive, especially when it came to the topic of spiritual support since the client was not a spiritual or religious person. At a reconciliation meeting the crisis worker apologized to the client for anything that disturbed or offended her. The conversation was not recorded, so it was difficult to establish

exactly what the crisis worker said to her. But it was obvious that the client was in despair and that **the crisis worker was trying every approach she knew to try to reach out to her**. The crisis worker asked her about family, friends, religious, spiritual or other supports she could turn to. **It is not, *per se*[67], inappropriate to ask a caller on a crisis line if they have any spiritual or religious beliefs that might help them** through a very trying time. For some, such support can be a comfort. The **crisis worker had already apologized**. Even if a rights violation had been established here, **there was nothing more that the grievance procedure could offer her by way of an outcome**. The grievance process cannot award monetary or other damages or impose disciplinary actions on staff who violate patients' rights. Any such action could only be taken by the courts or by the staff member's employer.

07/23/2008
(Level IV decision in Case No. 08-SGE-01)
A patient complained about the manner in which facility staff treated her **during an Emergency Detention (ED)**. She said staff shined laser-pointers and lights in her eyes, especially at night. Patients on ED require frequent monitoring as they are usually in a crisis situation, so staff must continuously check on their welfare, even at night. In the dark, it requires shining a light on them to make sure they are OK. Lights are also used by clinical staff to check the patient's eyes for dilation. While this can be very irritating to the patient, it is often necessary for their welfare. There is insufficient evidence to conclude that a laser pointer was used. It could also have been a small, focused light. The blurred vision she experienced could have been caused by many different factors, including the stress or her ED and medications she may have taken. No rights violations were established.

[67] A Latin phrase used in English arguments for "by itself" or "by themselves"

Storage Space, Right to

No decisions at this time.

Telephone Calls, Rights to Make and Receive

Decisions:

10/04/2000[68]
(Level III decision in Case No. 99-SGE-05, appeal dismissed at Level IV)
An inpatient was in a meeting with staff when his mother called. Staff who answered the phone told her to call back later. The patient was **never informed** of the **phone call** from his mother. To inpatients, calls from family and friends are an important link to the outside world. **Patients should be informed of all calls**. The failure to so inform the patient here, even if it was unintentional, was a **violation** of his rights.

03/29/2002
(Level IV decision in Case No. 99-SGE-05)
Where a Level III decision found that the patient's **right** to make and receive a reasonable amount of phone calls **was violated**, the complainant's **appeal** to Level IV on that issue was **dismissed**.

[68] See the Level IV decision in Case No. 99-SGE-05 on 3/29/2002.

Toilets and Grooming, Access to

No decisions at this time.

Transfers

Decisions:

02/16/2001
(Level III decision in Case No. 00-SGE-05)
A client who was about to be **discharged** from an inpatient facility felt she was not being **given enough input or choices** in terms of **to where she would be discharged**. She **wanted** to be placed in an **apartment** in the community. Facility staff were considering placement at other inpatient settings or a CBRF[69] (group home) setting. Ultimately, she was transferred to a **community supported living arrangement** in an apartment. Since this was what she wanted, the grievance was dismissed at Level III as being "**resolved**".

[69] Community Based Residential Facility

Treatment, Evaluation and Monitoring of

Decisions:

05/24/2000
(Level IV decision in Case No. 99-SGE-02, upholding the Level III decision)
A patient in an **outpatient methadone treatment program** was observed, "**splitting his dose**" in a bathroom at the clinic. The clinic subsequently **increased** his "**monitoring level**" for a six-month probationary period. This did **not violate** his right to the least restrictive treatment.

03/23/2001
(Level III decision in Case No. 99-SGE-08)
An **inpatient**, admitted to county hospital via an "**Emergency Detention (ED)**" due to **suicidal ideation**, felt staff did not provide her enough time and attention in dealing with her concerns - especially, **why she was not eating meals**. She was depressed during much of her six days there. She refused several meals. She wanted her meals served to her in her own room so she would not have to sit near a certain male peer. There was considerable charting as to the staff's plan to encourage the patient to eat meals and have proper nutrition and food intake. But two days passed with the patient not coming out for meals, and staff seemed to not be doing anything more to explore why she was not eating, and/or in what circumstances she would be able or willing to eat meals. Patients have a right to refuse meals. But, in this instance there were medical reasons why proper food intake was important, and the charting also stressed that eating meals was to be encouraged. That being the case, one might reasonably expect staff to do more than simply observe that a patient was not coming out to eat. They let her eat one meal in her room, then gave her a "take it or leave it" ultimatum. What really was the goal? Was it to encourage nutritional intake? Or to try to force compliance with the unit expectation that patients come out of their rooms to eat in the congregate setting? There was **no documentation** as to why they took that stance. No other approaches to encourage her to eat were made. Under these circumstances, the **lack of any documented team discussion** or decision was a **violation** of the patient's right to specific and objective documentation of the reasons and rationale for the decision that was made.

09/19/2003
(Level IV decision in Case No. 02-SGE-04)
In a situation where a **suicidal patient** has been put on a **new medication**, then **cancels her next appointment** with the doctor, the **clinic** has a **duty** to at least have someone **review** the situation to **see if follow-up contact** with the patient is necessary. There was **no evidence** that this was done here. While it could be assumed that, as a voluntary patient, she was exercising her right to discontinue treatment, there should have been some determination made as to whether or not to contact her. The clinic thus **violated** the patient's right to prompt and adequate treatment by not making that determination.

09/19/2003
(Level IV decision in Case No. 02-SGE-04)
Patients have the **right** to have their **care and treatment coordinated** with other treatment staff who are involved in their care and treatment. A **doctor ordering a change** in a patient's **medication** must ensure that other members of the patient's **treatment team** are **informed** about

the new medication and the **expected benefits** and **potential adverse side effects** which may affect the patient's overall treatment.

09/19/2003
(Level IV decision in Case No. 02-SGE-04)
Where a **doctor knew or should have known** that his patient was seeing **other professionals** involved in her care, the doctor has a **duty** to at least **attempt to inform** the **other therapist** involved of a **change in medication**. If the patient's consent is required, the doctor should ask for it. Where **no such attempt** was made here, the doctor **violated** the patient's rights.

02/18/2004
(Level III Decision in Case No. 03-SGE-06)
A father/guardian wanted to **choose** a different county **case manager** for his son. He noted that the Medical Assistance Waivers Manual[70] emphasizes a choice of providers. The father wanted to choose a specific case manager who worked for the county. The county had only five case managers and had a solid rationale for why they were not willing to reassign the son to the case manager the father requested. They gave him the option of choosing either the county as a provider or an outside agency. Thus, the **county** was **providing** him with a **choice of provider**. The county was **not mandated** to provide him with a **choice amongst their own case managers**. The counties still maintain final decision-making authority in how they manage their staff and the workload that is assigned to those staff. No rights violation occurred.

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
The **county** is **ultimately responsible** for the health and safety of a client to whom they provide services. Even though they may have a **contract** for an **independent service provider** to do the hands-on services, the contracted **agency's failure** to perform its duties **is also the county's failure**. The **county must monitor** the **providers it contracts with** in order to ensure that vital services are provided for their clients.

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
An independent agency working on a contract with the county did not have any documentation regarding services they provided because they moved offices and, apparently, those **files were lost during the move**. The missing files should have been retained for a minimum of seven years. Offices and agencies move locations or may close one of their offices over time, but their records must be retained. The **loss of these records is inexcusable**. The rights of the client were violated because the agency did not retain documentation as to the care and treatment of the client.

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
The **contract** between an independent service agency and a county **should have also been more precise**. The treatment plan and the expectations of care protocols should have been as specific as possible to reflect the client's individual needs and the tasks required in the contracted agreement with the agency. **Documentation** of the expectations, and their **implementation**, is **essential**.

[70] See the Wisconsin Department of Health Services, Bureau of Long-Term Support webpage, Medicaid Home and Community-Based Waivers Manual: http://dhs.wisconsin.gov/bdds/waivermanual/index.htm

07/14/2004
(Level III Decision in Case No. 03-SGE-08)
The **psychiatrist prescribing the medications** has the **ultimate authority** to **make individualized decisions** for each patient. Individualized decision making is a key element for providing prompt and adequate treatment services appropriate to each individual patient's condition. While the majority of patients may not be suitable for a full disbursement of their medications, psychiatrists and treatment providers need to recognize individuals who are stable and consistent with their treatment programs and accommodate their request for dispensing increased amounts of medications at one time accordingly.

Treatment Participation

Decisions:

09/12/2001
(Level III decision in Case No. 00-SGE-03)
A patient wanted to **bring a friend** to her **therapy sessions**. The service provider agreed that there are times that it may be appropriate, especially if the person is a primary support person for the client. Bringing another person to a therapy session **requires a signed release** from the patient. Since the requested remedy was provided here, this issue was considered resolved.

11/29/2001
(Level III decision in Case No. 01-SGE-05)
A service recipient felt her **case manager** was **too controlling** of her life. She usually **accompanied** the individual to her **doctor appointments**, but **did most of the talking**. However, the doctor had ordered the case manager to monitor the individual's psychotropic medications and to visit her weekly. Thus, it was appropriate for the case manager to accompany her and report to the doctor. The individual also had private appointments with her doctor, so her right to treatment was **not violated**.

03/27/2002
(Level III decision in Case No. 01-SGE-09)
A patient wanted to **continue the individual therapy** she had received for 9 years, but the service provider **shifted** to only doing **group therapy** with her. She had been made aware months in advance of the upcoming change in services. But her **interim plan** for transitioning to group therapy was **not documented** or consented to by the patient. Thus, her **right to treatment** and her right to informed consent were **violated**. It was recommended that the service provider create a space on its treatment plans for the patient's signature and that they fully document all services received by the patient.

03/27/2002
(Level III decision in Case No. 01-SGE-09)
A patient **wanted** to **choose** a **new psychiatrist** after her case was transferred from a doctor she had been seeing to another doctor. The service provider tried to accommodate her request, but the two psychiatrists she asked for declined to accept her on their caseloads. The accommodation **attempts were reasonable**. No violation of her rights was found.

03/27/2002
(Level III decision in Case No. 01-SGE-09)
Patients have the **right to involve** their **spouses** in **home-visit** treatment sessions unless their participation is contraindicated for treatment reasons. The service provider should either allow such participation or explain to the patient why it is contraindicated. The patient would have to **sign a release** of information to allow the spouse to be present during treatment sessions.

03/29/2002
(Level IV decision in Case No. 99-SGE-05, upholding the Level III)
A patient's **treatment plan** focused on the patient's **suicidal ideation** and safety. His doctor

developed the plan based on the information he had at the time. Where the patient claimed, at a much later dated, that **he lied** to the doctor, his right to prompt and adequate treatment was **not violated.**

03/29/2002
(Level IV decision in Case No. 01-SGE-07, reversing the Level III decision)
A therapist did not present his written assessment and treatment plan to the patient prior to beginning treatment. The **treatment plan** was developed after the first session but not signed by the patient until after the third session. The plan **should have been provided** to the patient **prior to his second session**. This was a violation of the patient's rights to participate in his treatment planning and to provide informed consent for treatment.

03/10/2004
(Level IV decision in Case No. 02-SGE-07)
A complainant claimed he was not allowed to participate in the planning of his treatment with regard to **joint marriage counseling**. It was found that these **were individual sessions for his wife** in which **he was invited** to be present. No rights violation was found since it was **not *his* treatment** that was involved. It was conclude that **joint marriage counseling, *per se*[71], is not mental health treatment** to which "patient rights" apply. There was no violation of his rights, even if it was joint marriage counseling.

12/20/2004
(Level III decision in Case No. 04-SGE-02)
A **methadone clinic** took away a client's **Sunday take-home privileges** after some incidents. The client had a positive breathalyzer test result for alcohol, had lost her take-home bottle, and had taken an overdose of another medication. She was informed in writing of the requirements to restore her Sunday take-home privilege, which included having no positive breathalyzers for alcohol and obtaining a letter from her psychiatrist stating that in his/her best clinical judgment that she was responsible and could handle her Sunday take home bottle. Her **right to be treated fairly was not violated** because the clinic had **significant, appropriately documented reasons** to take away her Sunday take-home dose. The Sunday take-home dose was eventually restored in an individualized and appropriate manner.

05/16/2006
(Level III Grievance Decision in Case No. 05-SGE-12)
An outpatient client alleged that her right to **ongoing participation** in her treatment planning was violated. The **right to participate** in the planning of treatment interventions and modalities is **continuous** and ongoing throughout the course of treatment. But it is **limited** by both the **therapist's abilities** and the **therapist's professional decision-making**. That is to say, clients do not have the right to direct their therapy, but rather to offer insight and feedback about what they believe is effective treatment for them.

06/08/2006
(Level III Decision in Case No. 05-SGE-03)
A client's right to be treated with dignity and respect was **violated** by the **lack of shared decision-making** and **collaborative planning** during the **evaluation and assessment phase** of her services. While the service provider does maintain the right to choose which clients they will

[71] A Latin phrase used in English arguments for "by itself" or "by themselves"

or will not see, their assessment and evaluation of a client's treatment needs should also **recognize and respond to** a **client's request** for more frequent visits. They need to **clearly define** the **purpose of the assessment** and set **reasonable expectations** for the client.

Treatment, Right to Prompt and Adequate

Decisions:

10/13/1998
(Level III decision in Case No. 98-SGE-02, upheld at Level IV)
The **alcohol treatment program** did **not require** the individuals to **attend Alcoholics Anonymous**[72] (AA) or the steps that have religious aspects. Thus, his right to be freedom of religious worship was not violated.

11/10/1998
(Level III decision in Case No. 98-SGE-03)
A **county found** a 17-year old **ineligible for developmental disabilities services**. She had been diagnosed as having a developmental disability at the age of 6 months. At the age of 12, she was diagnosed as autistic by a multi-disciplinary team of professionals. **Autism is developmental disability** that is a **life-long condition**. The question was whether or not she met the eligibility threshold of a 30% or more functional limitation in at least two of five areas of skills. The county conceded she met that threshold in the area of "self-direction and independence". The records indicate that she also meets the threshold in the area of "self care". Thus, she should have been eligible for the county's programs. Her **right** to prompt and adequate treatment **was violated** by the county's denial of her eligibility.

01/22/1999
(Level IV decision in Case No. 98-SGE-02)
A complainant **claimed** on appeal that "**alcoholism is not a disease** and that there is not treatment for it." The Level IV decision pointed out that the state Bureau of Substance Abuse Services[73] developed a paper titled, "**Disease concept of Alcoholism**" and that numerous national and international organizations and associations define and classify alcoholism as a disease. The decision also pointed to statistics showing that, although no form of treatment can guarantee 100% success, there is a **high rate of success** for post-treatment abstinence with **post-discharge support group** utilization.

06/17/2000
(Level III decision in Case No. 00-SGE-02, upheld at Level IV)
A client was **deprived of one of her medications** just prior to taking a long trip, due to a series of **errors and omissions** on the service provider's part. This was a **violation** of her right to prompt and adequate treatment.

07/28/2000
(Level III decision in Case No. 00-SGE-08, upheld at Level IV)
A mother complained that her **son's condition was worsening** since his medications were discontinued. Her son's **doctor was on maternity leave** and the service provider would not temporarily assign him to another doctor. She was instructed to call back the next month when the doctor was scheduled to return. The desperate mother put her son back on the discontinued

[72] Alcoholics Anonymous, http://www.aa.org/
[73] Bureau of Prevention, Treatment and Recovery, http://dhs.wisconsin.gov/SubstAbuse/

medication, without any medical assistance. The service provider **violated** the son's **right to prompt and adequate treatment**.

01/03/2001
(Level III decision in Case No. 99-SGE-07)
Where a developmentally disabled young woman ended up in an acute inpatient mental health setting, it was **appropriate** for the Level I Client Rights Specialist to **recommend** a potential "**crisis intervention plan**" for her in case the situation arose again. Such an approach is an element of ongoing quality assurance on the part of the County program, too.

01/03/2001
(Level III decision in Case No. 99-SGE-12)
When a patient raises treatment issues, it is **not sufficient** for the Client Rights Specialist to **simply note** the **response** of the patient's attending **physician**. Further investigation may be required.

02/21/2001
(Level IV decision in Case No. 00-SGE-08)
A client's mother filed a **written complaint** on his behalf about the treatment he was receiving from his doctor. She was **referred to the doctor**, instead of the Client Rights Specialist. Since this was a formal complaint, the **doctor had a conflict of interest** and it was inappropriate to refer the matter to him.

08/06/2001
(Level III decision in Case No. 00-SGE-12)
A client complained that a Community Service Provider (CSP) had not done enough to get him **re-involved** in a local **community center**. This was considered part of his right to reasonable access to community activities. The grievance was resolved by an agreement between the CSP and the client that the CSP would assist him with an inter-personal problem-solving protocol that would hopefully enable him to return to the community center.

09/12/2001
(Level III decision in Case No. 00-SGE-03)
A woman complained about her therapist and the **quality of services** she received. The allegations included concerns about the therapist's professionalism, timeliness, and the large amount of personal information and opinions that were communicated to her during therapy sessions. In a non-secure treatment setting, a therapist's sharing personal information with the client can help to build the relationship by allowing the therapist and client to relate to one another. However, the therapist and patient here seemed to have divergent opinions on social, political, and religious issues. Thus, in this case the **sharing of personal information** may have **compromised** the quality of the **therapeutic relationship**. It seems to have detracted from the client's ability to relate to her therapist or discuss details of her treatment issues with the therapist. This seems to have occurred both because of the content of the information and the frequency with which it was shared, leaving the client less time to address treatment needs during the therapy sessions. The client did not verbally express her disagreeable response to the sharing of this information to the therapist during sessions. This is unfortunate because the nature of their dialog may have changed if this concern had been clearly stated early in the relationship. However, this is more of a **personality conflict** rather than a patient rights issue. Thus, this **does not rise** to the level of a patient rights violation.

09/12/2001
(Level III decision in Case No. 00-SGE-03)
A woman complained about her therapist because of **cancelled appointments**. The Level I decision found that her right to receive prompt treatment was violated by the high number of cancellations. The service provider implemented a formal plan and consistently followed up on it to reduce the number of cancellations. It was found at Level III that the frequency of cancellations did rise to the level of a patient rights violation and the Level I finding was upheld. The **actions taken** by the service provider remedied the rights violation.

09/12/2001
(Level III decision in Case No. 00-SGE-03)
A patient wanted to **bring a friend** to her **therapy sessions**. The service provider agreed that there are times that it may be appropriate, especially if the person is a primary support person for the client. Bringing another person to a therapy session **requires a signed release** from the patient. Since the requested remedy was provided, this issue was considered resolved.

10/18/2001
(Level III decision in Case No. 01-SGE-06)
A patient **threatened to kill** his wife, her boyfriend and his **therapist**. The transitional living facility he was in was justified in not allowing him to be re-admitted.

03/27/2002
(Level III decision in Case No. 01-SGE-09)
A patient wanted to continue the individual therapy she had received for 9 years, but the service provider shifted to only doing **group therapy** with her. She had been made aware months in advance of the upcoming change in services. The treatment team agreed that this change was appropriate for her treatment needs. Thus, her right to treatment and her right to be free from arbitrary decision-making were not violated.

03/29/2002
(Level IV decision in Case No. 99-SGE-05, upholding the Level III)
A patient's treatment plan focused on the **patient's suicidal ideation** and safety. His doctor developed the plan based on the information he had at the time. Where the patient claimed, at a much later dated, that he lied to the doctor, his right to prompt and adequate treatment was not violated.

03/29/2002
(Level IV decision in Case No. 99-SGE-05, upholding the Level III)
A **PRN**[74] ("as indicated") order **does not mean** the patient will receive the medication **upon demand**. A **qualified medical professional**, such as an RN, must make the **clinical decision** as to whether or not it is appropriate for the patient, based on an assessment of the patient's condition at the time.

04/30/2002
(Level III decision in Case No. 00-SGE-11, dismissed at Level IV for lack of standing to appeal because the ruling was in his favor at Level III)
A complainant raised issues regarding the "**couples therapy**" he and his wife received. At **Level II** of the grievance process, it was concluded that the **complainant was not a client,** in the

[74] According to need (physicians use PRN in writing prescriptions)

context of therapy that was provided, and thus did not have access to the grievance process. At Level III, it was concluded that the complainant was a patient by definition since he was referred to as such numerous times in the treatment records, **had his own diagnosis**, and had a **joint "treatment plan" with his wife**. Thus, he had access to the grievance process like any other "patient".

07/16/2003
(Level III decision in Case No. 03-SGE-01)
A grievance must be filed within 45 days of the occurrence of the event or circumstances or of the time when the event or circumstances "should reasonably have been discovered" or whichever comes last. Here, a minor's prior physician apparently **misdiagnosed** him. The minor was **later correctly diagnosed** and **appropriately treated** during a stay at a state mental health facility. His parents filed a grievance about his original misdiagnosis seven months after his discharge from the state facility. The grievance was not timely filed. The program director's refusal to accept this late complaint was an exercise of his discretion. He could have accepted the complaint, but chose not to. He did not abuse his discretion. In fact, there would have been little point in accepting it since the doctor in question was no longer working for the program.

09/19/2003
(Level IV decision in Case No. 02-SGE-04)
In general, the treatment decisions of professionals are afforded "**due deference**" by peers and by the courts. However, if a treatment decision "**departs from professional judgment**", the patient's right to treatment may have been violated. A "departure from professional judgment" may be evinced[75] in any of three ways:

- Where the evidence suggests that the professional exorcised **no judgment** at all;
- Where the individual was **not qualified** to make the judgment; or
- Where a decision was made on an **impermissible basis** (e.g., as "punishment").

09/19/2003
(Level IV decision in Case No. 02-SGE-04, overturning the Level III)
There must be **sufficient evidence** to show it was **more probable than not** that a **doctor departed from professional judgment** in his prescribing medication to a patient after a phone call with her. Such evidence would have to come in the form of a **second opinion** from a professional of equal or greater standing than the doctor. Where there was **no such evidence** presented, the finding of a **rights violation** at Level III will be **overturned**.

09/19/2003
(Level IV decision in Case No. 02-SGE-04)
In a situation where a **suicidal patient** has been put on a **new medication**, then **cancels her next appointment** with the doctor, the **clinic has a duty** to at least have someone review the situation to see if follow-up contact with the patient is necessary. There was **no evidence** that this was done here. While it could be assumed that, as a voluntary patient, she was exercising her right to discontinue treatment, there should have been some determination made as to whether or not to contact her. The clinic thus **violated** the patient's **right** to prompt and adequate treatment by not making that determination.

[75] (1.) to show clearly; make evident or manifest; prove. (2.) to reveal the possession of (a quality, trait, etc.).

09/19/2003
(Level IV decision in Case No. 02-SGE-04)
Patients have the right to have their **care and treatment coordinated** with **other treatment staff** who are involved in their care and treatment. A doctor ordering a change in a patient's medication must ensure that other members of the patient's treatment team are **informed about the new medication** and the **expected benefits** and **potential adverse side effects** which may affect the patient's overall treatment.

09/19/2003
(Level IV decision in Case No. 02-SGE-04)
Where a **doctor knew or should have known** that his patient was **seeing other professionals** involved in her care, the doctor has a **duty** to at least **attempt to inform** the other therapist involved of a change in medication. If the patient's consent is required, the doctor should ask for it. Where no such attempt was made here, the doctor violated the patient's rights.

12/26/2003
(Level III Decision in Case No. 03-SGE-02)
A mother believed a **therapist acted unprofessionally** in working with her daughter by **not reporting various risky behaviors** in which her daughter was engaged. The therapist was aware that her daughter tried to commit suicide, purposely cut herself many times, used illegal drugs, and engaged in underage sex with multiple partners. The mother thought the therapist should have reported all these incidents to proper authorities. She requested disciplining the therapist – including possible license revocation. The records indicated that the suicidal ideation expressed by the daughter was taken seriously. **Appropriate referral resources** were immediately **offered** to her parents. The daughter was also placed on a medication for depression. For the next seven subsequent sessions the therapist inquired about and documented the daughter's present mental status and thoughts of suicide or dying. Each entry includes some statement indicating that she was asked if she was seriously contemplating suicide or hurting herself. She responded that she was not having thoughts about suicide or hurting herself over the following months. Therefore, her **right** to prompt and adequate treatment **was met**. The therapist was **not obligated** to initiate social services intervention into her family life, **or to notify any other authorities**.

04/22/2004
(Level III Decision in Case No. 03-SGE-07)
An ex-patient complained about a **lack of individualized treatment** at a psychiatric hospital. These concerns were meaningfully addressed when the hospital responded to his observations and concerns about the manner in which patients are assessed and treated. The hospital was planning a specific training session for staff to address indicators, features, and treatment approaches for Post Traumatic Stress Disorder and Parkinson's Disease. The training will also address the variables that could arise with men's issues during treatment. This **staff training** should lead to an improved awareness and create a better standard of care, greater dignity and respect for patients, and more individualized treatment decision-making. Given the training initiatives planned, this issue was **considered resolved**.

05/16/2004
(Level IV decision in Case No. 99-SGE-01)
Methadone is a **nationally recognized treatment modality** for **heroin addiction**. Where a patient has done well on a methadone program, staying drug-free for a period of 18 months, the

continuation of outpatient treatment for her is **appropriate**. It is also the least restrictive alternative to inpatient treatment.

05/24/2004
(Level IV decision in Case No. 99-SGE-02)
Someone in a **methadone treatment program** can ask for a "**fair hearing**" **only** when they have been **involuntarily terminated** from the program.

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
The individual's right to treatment **includes specific protocols** as necessary to ensure health and sanitary living conditions. The treatment needs of the client need to be considered and clearly documented in the contract between the county and any contract agencies, with a plan for monitoring and updating those treatment goals. Any **barriers** to achieving these needs **must be documented**, the guardian must be informed, and a **plan to resolve** such issues needs to be **implemented**. These treatment protocols are an essential feature for the treatment and management of the client, and they are an **integral part** of the client's right to prompt and adequate treatment.

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
The sister/guardian of a woman filed a grievance about the care the woman had received while she was living in her own apartment. She had been receiving supportive **home care services** from an **independent service provider** under a general **contract with** the **county**. The guardian alleged "abuse of a vulnerable adult" because the woman's apartment was not kept clean by the contractor and was "unlivable due to filth". The contract contained no specific requirements, but there was a list of duties for the staff who visited her apartment. One duty was to clean the apartment weekly. During one particular period, the contractor's employees did not complete many of the required items and the apartment became very dirty. Instead, they spent the time **providing companionship** to the woman. Regardless of her desire for companionship, the employees were responsible for keeping the apartment clean. Whenever possible the caregivers should be making sure the task list is completed while working with the client to model those skills, and to create a social situation where tasks can be completed together and in a way that is therapeutic for her by reinforcing daily living skills. The contractor violated her right to a humane environment.

06/15/2004
(Level III Decision in Case No. 03-SGE-04)
The individual's **right to treatment** includes specific **protocols** as necessary to **ensure health and sanitary living conditions**. The treatment needs of the client need to be considered and clearly documented in the **contract** between the county and any contract agencies, with a **plan for monitoring and updating** those treatment goals. Any barriers to achieving these needs must be documented, the guardian must be informed, and a plan to resolve such issues needs to be implemented. These **treatment protocols** are an **essential feature** for the treatment and management of the client, and they are an **integral part of the client's right to prompt and adequate treatment**.

07/14/2004
(Level III Decision in Case No. 03-SGE-08)

A **psychiatrist** prescribing the medications has the **ultimate authority** to make **individualized decisions** for each patient. Individualized decision-making is a key element for providing prompt and adequate treatment services appropriate to each individual patient's condition. While the majority of patients may not be suitable for a full disbursement of their medications, psychiatrists and treatment providers need to recognize individuals who are stable and consistent with their treatment programs and accommodate their request for dispensing increased amounts of medications at one time accordingly.

04/11/2005
(Level III decision in Case No. 03-SGE-09)
The primary rationale for the **proposed change in vocational services** for a client was **economic**. The county Health and Human Services program faced **increasing waiting lists** for people who need services while having **less fiscal support** to provide those services. In the face of a decreasing budget, the HHS was looking at areas where money could be saved. The **costs** of continuing this client's current vocational service provider were **considerably more** than other, **similar providers** in the area. It was **reasonable** for the county to **consider cutting costs without cutting programs**. The client rights question was whether or not the other providers would be able to offer **like services** that **adequately met** the client's **individualized needs** and supported her right to receive **prompt and adequate treatment** appropriate to her condition. It was found that the support services the other vocational provides could offer would be **comparable**. The client would continue working in the same settings at the same times, and with a support person available for the same amount of time. The changes would necessarily include different persons providing those services and doing so under a different organizational structure. However, the vocational services would essentially be the same under the county's proposal. The county's request that the client choose between two other, less expensive, vocational services providers was reasonable and fair. The **need to serve as many clients as possible outweighs** the **potential benefits of one individual** to continue receiving services from a **more costly service provider** than is necessary to provide support services in a similar manner that other agencies may provide in the same setting. Thus, requiring the client to choose between the two less expensive of three possible providers was not a violation of her rights.

04/11/2005
(Level III decision in Case No. 03-SGE-09)
Clients throughout the state receive **different services** from **different providers** who work together as parts of the service delivery system. The key to **maintaining quality services** and an **effective continuity of care and treatment** is the use of effective **communication protocols** between agencies. All agencies involved are expected to communicate and cooperate for the benefit of their clients and in accord with the right to provide prompt and adequate treatment and excellent continuity and coordination of services.

08/15/2005
(Level III Grievance Decision in Case No. 04-SGE-07, affirmed at Level IV on 8/15/05)
A client in need of a **very specific type of therapist** alleged that the county department of community programming was not coordinating her services adequately. While some of their correspondence and efforts to assist her could have been more timely, **she was receiving** treatment during the time she allege the lack of coordinated services. This situation **did not rise** to the level of a patient rights violation.

12/15/2005
(Level IV decision in Case No. 05-SGE-06)
A psychiatrist determined that the **therapeutic rapport** between himself and one of his clients had been **irrevocably damaged**. That presented a **valid treatment reason** for **discontinuing his services** to that client. The agency the psychiatrist worked for gave the client adequate notice and time to find a replacement psychiatrist and also suggested possible alternatives. The client was also appropriately referred back to his own county. The client's rights were not violated.

12/15/2005
(Level IV decision in Case No. 05-SGE-08)
A psychiatrist determined that the **therapeutic rapport** between himself and one of his clients had been **irrevocably damaged**. That presented a **valid treatment reason** for **discontinuing his services** to that client. The agency the psychiatrist worked for gave the client adequate notice and time to find a replacement psychiatrist and also suggested possible alternatives. The client was also appropriately referred back to his own county. The client's rights were not violated.

05/16/2006
(Level III Grievance Decision in Case No. 05-SGE-12)
An outpatient mental health client believed **she needed financial counseling** and that this should have been brought to her attention by her therapist. While it is recognized that clients in the midst of stressful situation often lack the insight to identify these kinds of needs on their own, this allegation **does not rise** to the level of a patient rights violation. The treatment she was receiving was for psychological issues. It was **reasonable** for her therapist to believe that the **client could identify** and address her **financial concerns** without explicit direction from her therapist.

05/16/2006
(Level III Grievance Decision in Case No. 05-SGE-12)
The **adequacy** of the treatment a client received during the last six months of treatment was difficult to ascertain. Treatment records were minimal, the treatment occurred years ago in the past, and there are some differences of recollection between the client and the therapist. However, based on all available information, it seemed **likely** that the therapist was providing adequate treatment based on **her perception** of the client's treatment needs. While it is carefully considered that the **client did not agree** with the therapist's perception of her treatment needs nor the manner in which treatment was provided, it is difficult to prove that the treatment was not adequate based on the available facts. While it was recognized that the treatment she received was **not optimal**, there was **insufficient evidence** to **substantiate** the allegation that the treatment was **not adequate**.

05/16/2006
(Level III Grievance Decision in Case No. 05-SGE-12)
Ideally, **treatment** should be provided in the most **integrated** and **comprehensive** manner possible. While each treatment professional may only act within the scope of their own professional capacity, communication between professionals (with the client's consent) is an option. **Professional collaboration** can help provide an i**ntegrated mind/body perspective**. In a situation where a client is in a state of emotional or psychological distress, it may be appropriate for a therapist to request the client's consent to communicate with her other treatment professionals, such as her gynecologist. This is particularly pertinent when the client may lack insight or the ability to process all facets of medical or psychological information at the

time. However, it did not rise to the level of a rights violation where there were indicators that the client's physical health care needs were being met and the client desired confidential services. In this situation, it was **not necessary or appropriate** for the therapist to request a release to **talk** with the client's **other medical professionals**. Identifying a client's physiological health care needs is not an expectation or responsibility of a psychotherapist.

09/27/2006
(Level IV decision in Case No. 06-SGE-09)
A diagnosis made by an independent, outpatient clinician was that **clinician's opinion**, which **cannot be challenged** in the **grievance process**. The client has the right to get a **second opinion** if she disagrees with the diagnosis.

08/16/2007
(Level IV decision in Case No. 06-SGE-14)
A client complained about **being refused services** by the **psychiatrist in her small home town**. She was being provided those services in a larger, nearby city, but she had transportation problems. Records indicated that she had originally requested that her services be transferred to the provider's outpatient department in the city, **blaming her local psychiatrist for all of her problems**. Later, she wanted to return to that psychiatrist, but **he refused to take her back** as a client. Considering the history between them, **it was appropriate** for the psychiatrist to refer her to another service provider. When the **psychiatrist/client rapport was irretrievably broken**, **referral** to **another psychiatrist was warranted**, even if that meant the client had to find transportation to the new provider a few miles away.

04/02/2008
(Level III decision in Case No. 07-SGE-07)
A patient's mother felt that the **outpatient drug treatment program "failed" her son** by **failing to diagnose his depression**. The son ended up requiring inpatient treatment. However, according to his outpatient treatment records, the son **did not appear to present with any depressive or mood disorder** at the time. By his own account, **he did not report feeling depressed, tired, or sad**, as evidenced by the questionnaire he completed on admission. Although the clinic did not diagnose him with depression during his first year of outpatient treatment, the evidence indicated that **a thorough assessment was conducted**. Based on the documentation, the **lack of diagnosis did not constitute a violation** of his right to receive adequate treatment appropriate to his condition.

Treatment, Second Opinions, Right to

Decisions:

06/29/2001
(Level III decision in Case No. 00-SGE-01)
A client received services from an agency contracted by the county. He felt that the provider releasing information, without his consent, to an evaluator who was completing a vocational assessment violated his confidentiality. The evaluator was from a local university who had no official connection to the county's service delivery system. However, by mutual agreement all the parties, including the client, he was to do a comprehensive vocational evaluation of the client. At a later meeting with the parties, the client found out that county staff had shared specific information about his mental health history but had not obtained a release from him to do so. Other "consents to disclose confidential information" were on file, but there was no release of information relative to the staff's involvement in the evaluation process. Was the verbal sharing of any information with the evaluator permissible? Any information about the client's mental health history and treatment would constitute "treatment record" information within the meaning of confidentiality laws. But the staff's very presence at the meeting was an identification of sorts that the client was receiving services from the county. Did the presence of the staff at the meeting and the client's lack of objection at the time to any information shared provide an implied consent on his part? Was any information shared covered by some other exception to the requirement for an informed written consent? It was concluded that this evaluation was akin to a "second consultation" and not provided as a routine "purchase of service" resource for county staff. Thus, it did not readily fit into one of the exceptions to the confidentiality law wherein there is a pre-existing purchase of services contract between the county and a provider. Further, the section of DHS 94 that addresses a "second consultation" notes that the person doing the consultation can review the client's treatment record. By the staff member's un-objected-to presence, the client may have provided an implied consent, but that this was a "close call" in terms of the technical confidentiality requirements. Since the vocational evaluation was set up by mutual agreement of all parties, there likely was an expectation of open sharing of treatment information to assist the evaluation process. Nonetheless, it would have been best for the service providers to have a clearly written release of information from the client that would specify who all could be part of the information sharing process. There was insufficient evidence to find a rights violation. When outside evaluations occur, there should be clear documentation of the evaluator's legal status in terms of that person's right to access treatment information. For example, is it being done under a purchase of services agreement, as a second opinion or consultation, or via a specific release of information that clarifies who can provide treatment information, and what type, to the evaluator.

09/19/2003
(Level IV decision in Case No. 02-SGE-04)
In general, the treatment decisions of professionals are afforded "due deference" by peers and by the courts. However, if a treatment decision "departs from professional judgment", the patient's right to treatment may have been violated. A second opinion is usually necessary to see if a

professional exercised his or her judgment in a professional manner. A “departure from professional judgment” may be evinced[76] in any of three ways:

- Where the evidence suggests that the professional exercised no judgment at all
- Where the individual was not qualified to make the judgment;
- Where a decision was made on an impermissible basis (e.g., as “punishment”).

09/19/2003
(Level IV decision in Case No. 02-SGE-04, overturning the Level III)
There must be sufficient evidence to show it was more probable than not that a doctor departed from professional judgment in his prescribing medication to a patient after a phone call with her. Such evidence would have to come in the form of a second opinion from a professional of equal or greater standing than the doctor. Where there was no such evidence presented during the Level III review, the finding of a rights violation will be overturned.

05/16/2006
(Level III Grievance Decision in Case No. 05-SGE-12)
An outpatient client disagreed with her therapist assigning her an Axis II Borderline Personality Disorder diagnosis. A diagnosis is ultimately a professional opinion and given “due deference”. The client had the right to obtain a second opinion from a different therapist.

09/27/2006
(Level IV decision in Case No. 06-SGE-09)
A complainant had the opportunity to challenge the diagnosis reached by an independent outpatient clinician in the ongoing legal proceedings where that diagnosis was presented in court. She could have obtained a second opinion from a different psychologist and presented that as a rebuttal. The diagnosis was the clinician’s opinion, which cannot be challenged in the grievance process.

[76] (1.) To show clearly; make evident or manifest; prove. (2.) To reveal the possession of (a quality, trait, etc.).

Treatment, Security Issues

No decisions at this time.

Treatment, Termination of Outpatient Treatment

Decisions:

05/16/2006
(Level III Grievance Decision in Case No. 05-SGE-12)
A client **felt** her **termination** from **outpatient** therapy constituted "**abandonment**" which left her without mental health services and without options for a smooth transition into other services. Both she and her therapist agreed that the **attainment of measurable objectives was not being met** and that she was **no longer making progress in treatment**. The personalities involved were not meshing together in a productive fashion and the kind of therapeutic work and progress that the client really wanted was not getting done. This could have led to voluntary discharge, rather than termination, by encouraging joint decision making and agreement by both the client and the therapist. The **termination** of a client's outpatient therapy **did not rise to the level of a violation** based on the rights and rules that are currently in place. However, the **best practice** would be to **achieve consensus** that treatment goals were not being met and to **mutually agree** to **discontinue therapy**.

08/16/2007
(Level IV decision in Case No. 06-SGE-14)
A client complained about **being refused services** by the **psychiatrist in her small home town**. She was being provided those services in a larger, nearby city, but she had transportation problems. Records indicated that she had originally requested that her services be transferred to the provider's outpatient department in the city, **blaming her local psychiatrist for all of her problems**. Later, **she wanted to return** to that psychiatrist, **but he refused to take her back** as a client. Considering the history between them, **it was appropriate** for the psychiatrist to refer her to another service provider. When the **psychiatrist/client rapport was irretrievably broken**, **referral to another psychiatrist was warranted**, even if that meant that the client had to find transportation to the new provider a few miles away.

Visitors, Right to Receive

Decisions:

09/25/2006
(Level IV decision in Case No. 06-SGE-07)
A father filed a complaint about **restrictions on his visiting with his son**, who was in treatment foster care. The county had imposed limitations on his visits with his son as part of the **child welfare system**. The DHS 94 grievance procedure has no jurisdiction over child welfare matters. After exhausting the county's grievance process regarding child welfare issues, the next step available to the father was to contact the Office of Strategic Finance[77] (OSF) Regional office.

[77] Office of Policy Initiatives and Budget, http://dhs.wisconsin.gov/aboutdhs/OPIB/index.htm

Wages for Work and Patient Work Programs

Decisions:

03/19/2003
(Level III decision in Case No. 02-SGE-05)
A patient was **encouraged** by his treatment plan to **seek employment**. This **was not "forced employment"** as the patient later claimed. He had, in fact, agreed to his treatment plan.

11/11/2004
(Level IV decision in Case No. 04-SGE-04)
An ex-patient of a mental health complex complained about current **developmentally disabled residents** being **paid less than minimum wages** for their work in a sheltered workshop. The Department of Workforce Development[78] (DWD) had **licensed and certified** that **sheltered workshop to pay sub-minimum wages**. Sheltered workshops that have been approved by DWD [or the federal Department of Labor[79]] to pay sub-minimum wages are, by such approval, deemed in compliance with the client wage requirements of § 51.61(1)(b), Stats. The DHS 94 grievance procedure has no jurisdiction over issues of compliance with the federal Fair Labor Standards Act[80].

03/29/2005
(Level IV decision in Case No. 04-SGE-06)
The **geriatric residents** of a **nursing home** for elderly and developmentally disabled clients who **occasionally volunteer** to assist staff in **simple tasks** for **short periods** of time are **not doing work that is of financial benefit** to the facility. They are volunteering to do those tasks in order to have something to do. The facility is **not obligated to pay them wages** under those circumstances.

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[78] Department of Workforce Development, http://www.dwd.state.wi.us/
[79] U.S. Department of Labor, http://www.dol.gov/
[80] U.S. Department of Labor, Employment Standards Administration, http://www.dol.gov/esa/whd/flsa/

Waiver of Rights Prohibited

No decisions at this time.

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