

GRIEVANCE PROCESS - EVIDENCE

[NOTE: These are cases where questions about the use of evidence in the grievance process arose. See also the "BURDEN OF PROOF" and "CREDIBILITY" sections of this Digest for more specific issues related to evidence.]

DECISIONS

1. 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**, either. (Level IV decision in Case No. 00-SGE-08 on 2/21/01.)
2. 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. (Level III decision in Case No. 00-SGE-16 on 6/19/01, upheld at Level IV.)
3. 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**. (Level IV decision in Case No. 01-SGE-08 on 8/27/02, modifying the Level III finding.)
4. 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 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. (Level IV decision in Case No. 02-SGE-04 on 9/19/03.)
5. 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. (Level IV decision in Case No. 02-SGE-04 on 9/19/03, overturning the Level III.)

6. 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**. (Level IV decision in Case No. 02-SGE-04 on 9/19/03, overturning the Level III.)
7. 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. (Level IV decision in Case No. 02-SGE-07 on 3/10/04.)
8. 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. (Level III Decision in Case No. 03-SGE-04 on 6/15/04.)
9. 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. (Level III decision in Case No. 04-SGE-02 on 12/20/04)
10. The Level III decision **thoroughly addressed** all of the complainant's issues. In her appeal to Level 4, the complainant provided **no new evidence** sufficient to justify reversing the Level III decision. The Level III decision was therefore affirmed. (Level IV decision in Case No. 04-SGE-07 on 8/15/05)

11. A patient **felt she was treated disrespectfully** by group leaders in sessions. **Statements by treatment staff** to a patient regarding normal procedure for responding to homework, regarding saving matters for future sessions due to time constraints, and regarding the processing of disability claims, **generally, do not amount to violations of the patient's rights without proof of exacerbating circumstances**. Provider staff must communicate directly regarding how matters are generally handled and there was **no evidence that the group leaders were personally deriding this patient** by discussing procedural issues in response to her questions and requests. (Level III decision in Case No. 11-SGE-01 on 6/28/11)
12. While program staff may be capable of disrespectful, passive-aggressive behavior towards patients, in such cases it is **essential that grieving parties provide more than hearsay evidence** for a rights violation to be found. (Level III decision in Case No. 11-SGE-01 on 6/28/11)
13. A patient claimed a staff member did not treat her with **dignity and respect**. However, she **did not provide the staff person's specific statement** that she alleged caused her to almost leave the premises in tears. Also, the **staff person in denied making any offensive statement**. The waiting room activity had been recorded on **video**, but the **videos are not preserved** for longer than three months and observed only the seats, not the assistance windows in the waiting room. In addition, complainant **could not provide any contact information for the witness** she mentioned. Her **complaint could not be substantiated** because it amounted to a "he said – she said" argument. The complainant had the burden of proof of the alleged staff wrongdoing. This called for the **weighing of the two parties' credibility**. Based on the written materials she provided, it was found that **complainant's description of events was credible**, but, if true, it did not rise to the level of a rights violation because it did not describe what the staff did to upset her, nor did it describe proof of that occurrence. Thus, she had not met her burden of proof and no violation of her right to respect and dignity was found. (Level III decision in Case No. Case No. 11-SGE-07 on 06/22/12)
14. A patient had several complaints that stemmed from her alleged misdiagnosis by one of the provider's doctors. The patient was diagnosed with bi-polar II, which allegedly caused severe problems for her. The **patient alleged that the complaint that she filed was not processed in a timely manner**. There was a dispute as to when the grievance was received by the provider. The patient provided inconsistent information regarding when the grievance was originally filed. The State Grievance Examiner determined that the patient had probably unintentionally attempted to circumvent the first two levels of review by requesting a level III investigation. **It was concluded that provider's Client Rights Specialist and Chief Medical Officer responded in a timely manner to the patient's grievance and no violation was found**. (Level III decision in 12-SGE-0006 decided on 11/14/2012)
15. A patient claimed that the provider violated her rights to adequate treatment and to be treated with dignity and respect. The patient found that the topics discussed in

group therapy, including many disturbing past and present psychological problems, were extremely upsetting. The patient alleged that this experience traumatized her and caused her anxiety, stress and depression. The **patient has the burden of proof to show that his or her allegations are more likely than not (more than 50% likely) to be true in order to prove wrongdoing.** Thus, the patient had to prove that it was more likely than not that the client's right to adequate treatment was violated when the group therapist discussed personal matters in therapy. The client claimed that a nurse stated that the provider's services were inadequate, but this was not corroborated by any documents provided or by the provider's staff. **Even if the nurse's statement corroborated the grievant's claims, it would not prove that it is more probable than not that the group session was inadequate treatment or that other aspects of the services received by the client were so poor as to rise to the level of inadequate treatment.** Similarly, the patient provided no supporting evidence that the group therapist directly caused her problems or that the alleged mental or physical problems existed. Self-reported evidence standing alone is not generally sufficient to meet the patient's burden of proof to show wrong doing by staff. (Level III decision in 13-SGE-0006 decided on 12/18/2013)

16. A patient alleged that her right to dignity and respect was violated when staff allegedly stared at her in an inappropriate and disrespectful manner on several occasions and staff from the hospital's bariatric program shamed her and lectured to her when she complained. The patient also claimed that staff of the bariatric clinic and the mental health clinic gossiped with each other about her with the result that she was denied bariatric surgery. The **patient failed to provide evidence that it was more likely than not that the staff stared at, shamed, lectured to or gossiped about her.** The patient did provide a great deal of information about her understanding of what occurred while she was receiving services, but she did not provide any corroborating evidence that the allegations were more likely true than not. **The patient was credible, but without more evidence, no violation of the patient's right to dignity and respect was found.** (Level III decision in 13-SGE-0006 decided on 12/18/2013)

17. A patient filed a grievance stemming from a disagreement between the patient and the therapist about whether the client should be tested for PTSD. When a grievant makes an allegation against a staff member the burden of proof is on the grievant to prove that it is more likely than not that his allegations are true. In this case the parties were alone together in a therapy session. **The client alleged that the therapist told the client that he was not giving him a PTSD test because he thought that the client was trying to get on SSDI, which was causing the patient to be ambivalent about getting better. The therapist's notes reflect similar content. The allegations were likely to be true. However, no rights violation was found because this decision was within the therapist's professional discretion. Further, different psychologists can arrive at different determinations of whether the same person meets the DSM diagnostic criteria for a given disorder.** (Level III decision in 14-SGE-0002 decided on 11/19/2014)

18. A patient indicated that he would be willing to provide evidence to back up his claims upon request from the State Grievance Examiner. A **deadline for providing evidence was imposed on the patient so that the patient would have the opportunity to submit everything that he felt would support his grievance without further extending the decision making process.** (Level III decision in 14-SGE-0003 decided on 6/26/2015)
19. A patient alleged that his rights to adequate treatment and to be free from arbitrary decisions were violated when his therapist failed to provide medication that he requested. Due deference must be given to treatment professionals in making decisions regarding a patient's treatment plan. Such decisions will not be found to violate a patient's rights unless it is more probable than not that the determination was inappropriate. **In order to meet this burden of proof a patient must show that it was more likely than not that the treatment team failed to meet established professional standards of psychiatry when determining the patient's treatment recommendations.** The patient did not meet this burden. There was insufficient evidence to show it was more likely than not that the grievant's treatment team failed to meet established professional standards. In fact, evidence in the grievant's treatment record shows that the medical staff made a considered professional judgement to deny pain medications to the grievant. No violation of the patient's right to adequate treatment was found. (Level III decision in 14-SGE-0003 decided on 6/26/2015)
20. A patient claimed that her right to be treated with dignity and respect was violated when a strip search was conducted without warning upon her admission to an inpatient psychiatric hospital. The grievant alleged that at an informal grievance meeting **staff told her that she would not want to know what would have happened if she had refused the strip search. Actual or threatened retaliation is not allowed when a patient refuses to give or withdraws informed consent.** All staff persons present at the meeting denied that the statement was made. The grievant offered only her own testimony as proof of wrongdoing. The grievant had the burden to show that it was more likely than not that staff violated her rights. Further, the grievant's credibility was compromised because of the inconsistency arising when she initially characterized the search as a rectal cavity search and then characterized it as a visual search. Therefore, there was no violation to the patient's right to be treated with dignity and respect as a result. **However, if the patient had been able to offer more evidence that the statements were made it would have been a violation of her right to be treated with dignity and respect.** (Level III decision in Case No. 15-SGE-0008 on 6/16/2016)
21. The grievant's claim that he was blocked from grieving was unsupported by evidence other than his claims. The grievant's claim that staff made obstructive statements to him was **hearsay**, which is a statement introduced to prove the matter asserted. When evaluating hearsay the **credibility of the declarants can be considered.** The client told the State Grievance Examiner that he wished to grieve,

changed his mind, and then changed his mind again. The Client Rights Specialist reported the same phenomena. **The patient's credibility was diminished by his waffling as to whether or not he wanted to file a grievance.** (Level III decision in Case No. 15-SGE-0006 on 7/11/2016)

22. A patient was receiving services at a Community Based Residential Facility (CBRF) under a commitment order and an involuntary medication order. The **patient alleged that she was poisoned at the CBRF.** The grievant's only evidence was her claim that staff tried to poison her with tainted hamburger. No violation of the grievant's right to adequate treatment or her right to a safe environment was found because **the grievant's allegation was the only evidence presented that staff served the grievant poisoned hamburger.** (Level IV decision in Case No. 15-SGE-0001 on 10/17/2016)
23. A patient alleged that a provider violated her client rights when she called to complain about adverse side effects that she was experiencing after changing her medication. The patient claimed that provider staff: spoke rudely to her over the telephone; inaccurately claimed that staff did not need to respond to her inquiry for 48 hours; hung up on her and accused her of using foul language when she was unable to speak clearly. The grievant produced evidence in the form of a letter provided by her speech therapist to the effect that the patient would not have been able to speak clearly enough to have a person understand the nature or content of her verbalizations, which weighed against the patient using profanity. Contemporaneous nursing notes show that the patient was stuttering and speaking very fast, but that the nurse was able to understand about a page worth of dialogue in which the patient swore at staff. The State Grievance Examiner decided that **the detailed and contemporaneous progress notes that the nurse made at the time of the telephone call were the most persuasive evidence. This case would not have risen to a violation of the patient's right to be treated with dignity and respect even if this portion of the complaint had not been dismissed as moot.** (Level IV decision in 14-SGE-0005 decided on 10/17/2016)
24. A patient claimed that her former therapist, who retired during the pendency of the grievance, lied in her progress notes, behaved inappropriately towards her and was not properly credentialed to provide services to her. All that the grievant provided to support her claims were annotated copies of the progress notes prepared by the provider. The annotations were made by the grievant. The grievant did not submit any other evidence. **The case had to be dismissed for failure to provide evidence that the grievant's claims were valid.** (Level III decision in Case No. 16-SGE-03 on 11/3/2016)
25. A patient claimed that her former therapist lied in her progress notes. The patient alleged that the misrepresentations in her treatment record were a violation of her right to have non arbitrary treatment decisions made about her. Among the therapist's alleged lies included in her treatment record were: that she had no previous history of memory loss; that he had not previously known the patient to be

so upset; that her symptoms had been worsening and etc. It could be an arbitrary decision if a therapist wrote inaccurate information in progress notes. **There was no legitimate reason for the therapist to lie in the client's progress notes.** Here, there was **no evidence that the therapist's notes were inaccurate.** **The main problem with the grievant's claim was that she did not support her grievance with evidence of the veracity of her allegations.** No violation was found because the progress notes did not appear on their face to be based on arbitrary rationalization. (Level III decision in Case No. 16-SGE-03 on 11/3/2016)

26. A patient claimed that her therapist violated her right to be treated with dignity and respect and treated her poorly in therapy. **The evidence that the patient provided consisted of her own annotations to the therapist's progress notes.** However, the annotations were opinions on the accuracy of the statements made in the progress notes. They were not facts or evidence that supported the grievant's opinions. **The claim was dismissed because there was not enough evidence to show that a violation occurred. No violation of the grievant's right to be treated with dignity and respect was found.** (Level III decision in Case No. 16-SGE-03 on 11/3/2016)

27. A patient complained that her drug test samples were dated incorrectly, were analyzed by staff with an incorrect professional title (Doctor) and were submitted to the lab 4 days after they were given. However, **no evidence** was submitted that **demonstrated that the delay would cause the results to be less accurate.** Further, **no evidence** was submitted that **tended to support that a mis-dated sample, or one that was collected by staff with an incorrect title would effect the results of the lab test.** Such **evidence would have supported an argument that the lab and provider testing standards were substandard,** and thus a potential violation of the patient's right to adequate treatment, but the argument was not adequately supported. (Level IV decision in Case No. 16-SGE-0006 on 10/23/2017)

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