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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case #18-090-9023
OSF St. Joseph Hospital

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations involving services at OSF St. Joseph Hospital. The allegations were as follows:

1. Inadequate restraint procedure.
2. Lack of guardian notification.
3. Inadequate care and treatment, including contacting the police rather than providing treatment and violating patient's right to refuse.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-100). The facility estimates that between 2500 and 3000 people present to the emergency department (ED) per year, and this includes patients with a mental health diagnosis that present with health issues as well. The facility has no psychiatric unit but does have a transfer agreement for psychiatric services. They have 80 ED staff that include nurses, physicians, patient care technicians, unit secretaries and RNs. McLean County is the facility's primary service area.

Complaint Statement

The complaint states that on June 12th, emergency medical services (EMS) took a patient to OSF St. Joseph and the guardian was never notified. While at the hospital emergency room, the recipient reportedly received several bruises on her arms and body from being placed in restraints and the staff attempting to remove her pants to catharize her for a urine sample. The patient's right arm was restrained over her head and the left arm was restrained as well. It is alleged that the resident had a full palm print on her arm and bruises on her arms and back from the restraint. While at the ED, the recipient allegedly struck a nurse and security guard, so the hospital contacted the police which led to an arrest. The hospital never notified the guardian, who was finally informed by the county jail of the patient's location and the incident.

On June 25th, the patient was apprehended by police, and the patient's guardian requested the patient be transported to a different hospital, but the patient was still transported to OSF St. Joseph. After discovering the patient was not in the requested location, the guardian travelled to OSF St. Joseph and was told the patient was not there. She contacted the police who said that they were not supposed to divulge the patient's location and she would be contacted when the patient was discharged. Another agency that serves as a crisis facility contacted the guardian and stated the patient was at OSF St. Joseph. The guardian went to OSF and they explained that they were not required to provide the patient's location due to the Health Insurance Portability and Accountability Act (HIPAA) even if she is guardian and said this as a policy.

Interview with staff (9/6/2018 and 10/4/2018)

Staff began by explaining that if a patient presents with behavioral health symptoms, they perform a risk screening questionnaire. The risk screening questionnaire is a standardized tool that is evidence based and is performed as a collaboration between the physician and the nurse. Depending on the how the patient scores, the staff will initiate a treatment plan. The hospital has a contract with a local mental health provider and if a patient presents with a specific score, the provider is contacted. The patient must be cleared of alcohol before the provider examines. The patient is always housed in the ED.

In this specific patient's case, the EMS team stated that the patient had suicidal ideations. The patient arrived calm at 1:50pm. At 2:05pm the patient made the statement that "she doesn't matter anymore." At 2:15pm the facility began the psychiatric observation. The physician began a restriction of rights stating that the patient could not leave the room and they contacted the mental health provider. Around 4pm the patient began punching and kicking at staff and she was placed in restraints. Because the patient was violent, the police were contacted. The police arrived at the facility and were in the patient's room at 5pm.

Staff explained that employees are trained by security for aggressive behaviors. The course is similar to Crisis Prevention Institute (CPI) training but they have now modified. Staff stated that the restraints are documented in the chart and they are applied by staff trained in restraint. The restraints were applied on June 12th, with an order that discontinued later. The restraint was ordered for 1630 for self-destructive behavior because the patient was violent. She became hostile and was swinging and kicking at the nurse. The patient was held to the floor, then hit security and was put into restraints. The patient had 4-point restraints applied to all her limbs. Checks were completed and documented in the record. According to the chart, the patient was cooperative but became agitated again later. The police were then contacted and took over the situation, including the restraints. The mental health provider was in transit while this was occurring.

Police are contacted when someone is struck because the behavior is considered an assault. Staff said they have an obligation to protect the other patients and the staff. Staff said that if they were aware of a guardian, then it would be standard to contact the guardian. They stated in this case, there was no evidence in the record of guardian contact. Staff said that the patient was brought to the ED by the fire department, but the

patient presents to the ED repeatedly. She had presented prior to June 12th and the staff are familiar with the patient. Staff said that they would know if there was a guardian on file and in this case, the patient did have a power of attorney in her file. If a patient is new to the ED, the guardianship is determined during registration. If the patient is presented by another facility, then the facility would inform them that the patient has a guardian and the guardian would be contacted.

Staff said that in this case, there was no a consent to treat on the record and it is documented that the patient was unable to sign for the consent, but the staff did not know why she was unable to sign. That was at 1629 and the patient was hostile. Staff said they attempted to have her sign, but she was in restraints, so she was unable, and they completed the registration. The patient is listed as her own guarantor on the account, for Medicaid and Medicare, which is not uncommon. Staff discovered that there was a legal guardianship in the patient's file during the interview with the HRA. They stated that it was from 2008 and questioned the validity but an HRA board member explained that it would be considered valid unless ruled invalid by a court. Staff said that guardianship is not a standard question asked of adults. If it is apparent that the patient could not make decisions, then staff ask. They said in this case, there was no alert that there was a legal guardian. There was no function for alerting that a guardianship was on file.

Staff said that if a guardian asked to speak to the patient, they would escort them unless the patient is a "Do Not Announce," then they will not inform the guardian about the patient. This would occur if someone contacted the hospital over the telephone as well. They would not divulge their care regardless of the guardianship. The physician would be involved in determining capacity, and if the patient had capacity, then they would not allow guardian notification. In this case, the patient was not on "Do Not Announce" status. During the 6/12 treatment, the laboratory was contacted to draw blood. It was not documented that they were unable to obtain a urine sample and the chart indicates that the specimen was provided. There was also no mention of a catheter.

Staff explained that the situation had to be severe for them to contact the police. If the security is unable to handle the situation, then the police are contacted. The police are not contacted every time a patient swings at staff, only if the situation is out of control or if security is unable to handle the situation. If police are contacted, it is because staff were assaulted but they do not think that an assault charge has ever been pressed by staff. The employee must make that decision on his/her own.

The HRA spoke specifically to a nurse that was involved in the patient's care during this incident. The nurse stated that all the blood and urine samples provided were voluntary. The nurse stated she was around when the EMS brought in the patient and they started the assessment as usual. The patient gave the staff her belongings and was dressed in a paper scrub. The belongings were placed in a locker. They received the results from the patient's specimen and a nurse petitioned for involuntary commitment. The nurse heard a commotion and saw that a physical altercation had begun. The patient was saying that she wanted to leave. The patient initiated the first physical act and was taken to the ground. Staff completed a full body lift onto the bed and secured the patient with hard restraints. The police were notified that a caretaker was assaulted. The nurse said that the situation escalated quickly. The patient said that she wanted to leave, and the other nurse asked her to sit down, so there was verbal redirection. The nurse was aware of the patient's family. She said she had never met the family member, but the family member

was involved and aware that the patient was at the hospital, although this was not documented. She believed the family member/guardian was made aware that the person was at the hospital. The HRA board member stated that there were some concerns because staff went to the ground with the recipient. Staff explained that the primary intervention is verbalization and redirection, and if that does not resolve the situation, there is voluntary medication. If the medication does not work, they would restrain the patient.

The next incident regarding the patient was said to have occurred on June 25th but according to staff the next documentation of the patient at the facility was June 21st. Staff said that they were also unable to obtain a consent from the patient at that time either. The patient presented to the facility via ambulance and there was a restriction of rights ordered. The patient had been in public making suicidal remarks and the community mental health provider was contacted. The patient's flow sheets indicated that there was a drug screen performed, vitals were refused, and the patient was discharged to the individual who is her guardian. The patient was not administered medication and staff said they would provide emergency care whether there was a guardian or not.

The HRA met with a second nurse that was involved with the patient on June 21st. The nurse stated that he works at multiple hospitals, so he is less familiar with repeat patients. He remembers that the patient presented, and he interviewed her, but she did not want treatment. She denied suicidal and homicidal thoughts. The physician wanted a crisis evaluation, but it took a long time to convince the patient to allow blood work. Staff explained that if someone was to contact the hospital and if the patient is categorized as a "do not announce" and the person was a family member, they would take them to the room or check with the nurse to see the procedure. If the patient was not a "do not announce", then there is no reason why they would restrict contact with that family member. The nurse is "pretty sure" he walked with the patient to the waiting room door and the family member was there.

If someone inquired about the patient at the triage desk, the staff there would be able to provide information on the patient. The triage staff would escort them to the room. The family is involved in the plan of care. Staff did not remember a family member trying to contact the patient and nothing was documented. They would not know how the outside community mental health clinic would have contacted the family member as well. There was a physician's note, on 6/21 that the community mental health agency consulted with the family member. Staff said that the note indicated that the agency spoke with the guardian and client while discussing treatment.

When the HRA asked the nurse and staff about interaction with aggressive patients they stated that every nurse uses de-escalation as a standardized tool. They receive various training techniques on de-escalating situations. They attempt to verbally de-escalate first before anything is done physically. There is a core competency training and then a supplemental training for nurses. Now the training is called MOAB which stands for Modification of Aggressive Behavior.

FINDINGS

Complaint #1 – Inadequate restraint procedure.

The "Security Officer Incident Report" reads "On June 12, 2018 while checking on Patient Care Tech [Name] who was watching [Patient], [Patient] was in room 4 on a psych hold. I started to hear [Patient] start to scream stating that she was about to leave the facility. I Security Officer (SO) [Name] and Tech [Name] stood in front of the door as [Patient] tried to exit the door. As I was attempting to get control of [Patient's] arm she struck me in my arm twice. I then gained control of one of her left arms while Tech [Name] gained control of the right arm. [Patient] started to say that she wanted to punch anyone so that she could go to jail. [Patient] stated since she couldn't make it to her unknown appointment that she rather go to jail than to stay here at Saint Joseph Medical Center (OSF). Once gaining control of [Patient] I radioed for SO [Name] to help assist me getting her into bed. Once I, Tech [Name], RN [Name], SO [Name] attempted to get [Patient] into the bed that is when [Patient] kicked [Staff] in her breast. [Patient] was then restrained to the hospital bed ..." According to the report, this occurred from 1630 until 1654. The HRA reviewed the police report which documented that the facility security guard was assisting in restraining the patient.

The HRA reviewed the order for the restraint. The order was written for "Continuous 4 hours 016/12/108 1645 – 4 hours," there were alternative interventions, and the justification for the restraint was "Imminent risk of harm to self and others." The HRA reviewed the rights restriction for the incident on 6/12/2018. The rights restriction is one document that has all the rights restrictions for that day separated into two parts; part one documents physical holds, restraints, seclusions, and emergency medication restrictions and part two documents other restrictions. The first section does not document an actual rights restriction for a restraint, only a restriction for "placed in a physical hold." The reasons identified for the hold were "I just don't matter anymore, no one cares." There is a section that reads "In accordance with the Mental Health and Developmental Disabilities Code, the individual designated his or her preference for emergency intervention if circumstances arise as indicated below (check one)" and no options were selected. There is a "Psych/Suicide Observation Checklist" and the patient was checked every 15 minutes from 1415 until 1715.

In the ED notes, written by the physician, it reads "30-year-old female presenting with suicidal ideations. I do not believe she is actively suicidal she was simply acting out and she was upset that she was not getting what she wanted. During her ED stay she became violent with staff. Police were called. Patient was taken away in police custody." There is a restriction of rights section of the notes that reads the physician observed the patient's behaviors and obtained a history from the patient, as well as suicidal statements. The physician notes that, because of the behaviors, he ordered rights restrictions that include "Place the patient in a physical hold, Placing the patient in restraint and/or seclusion."

The facility "Restraint and Seclusion Management" policy reads "When a patient's violence or self-destructive behavior jeopardizes the Immediate physical safety of the patient, staff and others, use of Restraint or Seclusion for Violent and/or Self-Destructive Behavior may be warranted." The policy states that the restraint warrants a Notice Regarding Restricted Rights of Individual's form and "... may be applied during all or part of a 24 hour period" but "... once this restraint has been applied and discontinued during a 24 hour period, it is not used again on the same patient during the next 48 hours without the prior written authorization of the facility director or designee."

The policy states that restraints and seclusions are ordered "by licensed physicians, or if authorized by the medical staff, advance practice nurses or physician assistants trained in the application and evaluation of restraints and seclusion practice and permitted to order restraints or seclusion under a written policy or supervisory or collaborative agreement." The policy also states that in an emergency situation, an RN may apply a restraint or initiate seclusion prior to receiving an order. There is a section on who receives training which reads "a. Physicians, and authorized advanced practice nurses and physician assistants, that order and/or evaluate for restraints, have knowledge about the policy for restraint use. B. Authorized advanced practice nurses and physician assistants, and authorized supervisory registered nurses who conduct fact to fact assessments for violent restraints and seclusion receive additional training for evaluation of the patient's condition and contributing factors requiring restraints. c. Staff with direct patient care restraint responsibilities are trained and competent in the application of restraints, implementation of seclusion, monitoring, assessment and care for patients prior to providing patient care." The policy also illustrates that renewal order frequency required for restraint or seclusion for non-violent patients is once a daily, every calendar day and for violent/self-destructive behavior is every 4 hours for adults, every 2 hours of adolescents 9-17 and children under 9 is every 1 hour.

The process states to obtain an order, and then employ interventions using less restrictive alternatives first; an RN is to assess and document the reason for the restraint along with a continual assessment of discontinuation. Also. there is an immediate assessment to ensure proper and safe application and patients and family are educated regarding the need for restraints. The policy then reads that if the patient is in restraint for "Non-violent/Non-self-destructive behavior" there is a check every two hours for elimination needs, circulation, physical comfort, etc. and every 4 hours for vital signs. For patients who are restrained for "Violent/Self-Destructive Behavior" check every 15 minutes for mental status, level of distress and agitation, circulation, skin integrity and/or injury. There is also a check every 2 hours for range of motion to extremities in restraints, fluids and food, and elimination needs, then every 4 hours for vital signs. The HRA asked if the security guard assisting with the restraint had received training and was told that evidence of specific restraint/seclusion training was not found but since, restraint training had occurred.

The Mental Health and Developmental Disabilities Code states that "Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized. In no event shall restraint be utilized to punish or discipline a recipient, nor is restraint to be used as a convenience for the staff" (405 ILCS 5/2-108). The Code also reads "(a) Except as provided in this Section, restraint shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, clinical professional counselor, or registered nurse with supervisory responsibilities ... In no event may restraint continue for longer than 2 hours unless within that time period a nurse with supervisory responsibilities or a physician confirms, in writing, following a personal examination of the recipient, that the restraint does not pose an undue risk to the recipient's health in light of the recipient's physical or medical condition. The order shall state the events leading up to the need for restraint and the purposes for which restraint is employed. The order shall also state the length of time restraint is to be employed and the clinical justification for that length of time. No order

for restraint shall be valid for more than 16 hours. If further restraint is required, a new order must be issued pursuant to the requirements provided in this Section … (d) The facility director shall review all restraint orders daily and shall inquire into the reasons for the orders for restraint by any person who routinely orders them … (f) Restraint shall be employed in a humane and therapeutic manner and the person being restrained shall be observed by a qualified person as often as is clinically appropriate but in no event less than once every 15 minutes. The qualified person shall maintain a record of the observations. Specifically, unless there is an immediate danger that the recipient will physically harm himself or others, restraint shall be loosely applied to permit freedom of movement. Further, the recipient shall be permitted to have regular meals and toilet privileges free from the restraint, except when freedom of action may result in physical harm to the recipient or others … (g) Every facility that employs restraint shall provide training in the safe and humane application of each type of restraint employed. The facility shall not authorize the use of any type of restraint by an employee who has not received training in the safe and humane application of that type of restraint. Each facility in which restraint is used shall maintain records detailing which employees have been trained and are authorized to apply restraint, the date of the training and the type of restraint that the employee was trained to use … (i) A recipient who is restrained may only be secluded at the same time pursuant to an explicit written authorization as provided in Section 2-109 of this Code. Whenever a recipient is restrained, a member of the facility staff shall remain with the recipient at all times unless the recipient has been secluded. A recipient who is restrained and secluded shall be observed by a qualified person as often as is clinically appropriate but in no event less than every 15 minutes. (j) Whenever restraint is used, the recipient shall be advised of his right, pursuant to Sections 2-200 and 2-201 of this Code, to have any person of his choosing, including the Guardianship and Advocacy Commission or the agency designated pursuant to the Protection and Advocacy for Persons with Developmental Disabilities Act[1] notified of the restraint. A recipient who is under guardianship may request that any person of his choosing be notified of the restraint whether or not the guardian approves of the notice. Whenever the Guardianship and Advocacy Commission is notified that a recipient has been restrained, it shall contact that recipient to determine the circumstances of the restraint and whether further action is warranted" (405 ILCS 5/2-108).

The Code also requires that "(a) Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to …" (405 ILCS 5/2-201).

Compliant #1 Conclusion

In reviewing the facility policy, interviews and the Code regarding restraints, the HRA has found inconsistencies between the regulations and the facility policy and practices. The Code states that the facility "shall not authorize the use of any type of restraint by an employee who has not received training in the safe and humane application of that type of restraint" (405 ILCS 5/2-108) but it was stated by facility staff that they could not produce training for the security staff who assisted in the restraint

application. Although the facility said the guard has had training since, the HRA does not know that this includes "safe and humane" application. The order for the restraint was "Continuous 4 hours 016/12/108 1645 – 4 hours" when, according to the Code, "In no event may restraint continue for longer than 2 hours." The order also needs to document the "... events leading up to the need for restraint and the purpose and the clinical justification for that length of time" but all that was written justifying the restriction states "Imminent risk of harm to self and others." There is also a statement in the Code (405 ILCS 5/2-108) that the order for restraint should not be valid for longer than 16 hours but this does not appear in the policy. Neither does 405 ILCS 5/2-108 which states that the facility director should review all the restraint orders daily. The policy differentiates between types of restraints and has different monitoring times for different actions while the Code states that the patient should be observed "as often as clinically appropriate but in no event less that once every 15 minutes" (405 ILCS 5/2-108 f). Also, from the same section of the Code, unless there is "immediate danger" the "restraint shall be loosely applied to permit freedom of movement" and the recipient should have regular meals and toilet privileges unless it may cause physical harm. The policy also does not mention that the patient can have any person of his/her choosing informed of the restraint, including the Guardianship and Advocacy Commission or the agency designated to be notified of the restraint. Lastly, the policy overall differentiates between nonviolent and violent behavior while the Code does not make this differentiation.

Additionally, the restriction notification should.include a reason for the restriction (405 ILCS 5/2-201) but in this case, the reasoning states "I just don't matter anymore, no one cares" and the patient was "placed in a physical hold" rather than restraints. According to the rights restriction notification, it does not appear as though the preference for emergency intervention was completed. Because of this, the HRA finds the complaint **substantiated** and offers the following **recommendations:**

- Update the facility restraint and seclusion policy to include compliance with the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-108) and train staff on this policy and procedure. Provide the HRA of evidence of the updated policy and training.
- Assure that rights restriction notification is in compliance with the Mental Health and Developmental Disability Code 405 ILCS 5/2-201 and provide a reason for the restriction within the notice. Provide HRA evidence of this occurring.

Complaint #2 – Lack of guardian notification.

The HRA reviewed an encounter sheet, from the emergency department, dated 6/12/2018, which states that the patient has a legal guardian and provides that individual's name, home phone number, and relationship. On the facility facesheet, the guardian is listed as the individual's emergency contact but there is no statement that the person is the patient's guardian. In the ED provider notes from that date, it states that the patient's "[Guardian] states 'tick and lock jaw' when pt took this med" but does not indicate the source of this communication. This statement appears elsewhere in the record. The HRA reviewed a rights restriction for the individual dated 6/12/18 and there was no name or address of a guardian or designee. The form does read "Guardian must

always be notified" in bold. The document was unsigned by the guardian. The rights restriction notification form, dated 6/21/2018, also lacks the guardian information. The HRA read the confidential patient information worksheet for 6/12/108 which contains an emergency contact but does not state that the emergency contact is the patient's guardian.

On 6/21/2018 the "[Patient] was brought here again for suicidal remarks her history from EMS. Labs performed for medical clearance for crisis evaluation. Crisis worker came to evaluation the patient and it was deemed that patient was no longer suicidal and is stable to be discharged to her [guardian] after safety plans were made after consultation of the crisis worker with the patient's [guardian]." The HRA reviewed a "Crisis Intervention Notice" that was in the St. Joseph record but was completed by the community mental health facility, which indicates that the individual has a guardian and provides the guardian's name and telephone number. Another assessment summary from the same community mental health facility, about the 6/21 visit, indicates that there were discussions with the patient and guardian.

The patient rights and responsibilities policy states that the purpose is "To ensure patients and/or patients' personal representatives are aware of and understand patients' rights and responsibilities during care." The definition of "Personal representative" is "A person authorized to act on behalf of the individual making health care related decisions." The policy also reads "OSF facilities and operating units inform each patient and/or the patient's personal representative (which appropriate) of the patient's rights and responsibilities, prior to providing or discontinuing patient care whenever possible." The HRA also reviewed a pamphlet for the hospital which outlines the patient's rights and responsibilities. In the handbook, a section states: "A parent or guardian who is authorized by law has these rights for the patient. The parent or guardian must carry out these responsibilities for the patient." The HRA reviewed the restriction of rights policy which reads "Explain the restriction to the patient and the patient's representative (i.e. individual(s) identified to receive the 'Notice Regarding Restricted Rights of Individuals'(MHDD4) from)." The form also reads "Complete pertinent sections of the form and provide to the patient/guardian the original 'Notice Regarding Restricted Rights of Individuals'(MHDD4) form." The policy also requires notification of the restriction to the guardian.

The Mental Health and Developmental Disabilities Code provides for the inclusion of the guardian in all aspects of treatment from the time that services begin: "A recipient of services shall be provided with adequate and humane care in the least restrictive environment, pursuant to an individual services plan. The plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian...."(405 ILCS 5/2-102). The Mental Health Code also allows the guardian to refuse treatment for the recipient (405 ILCS 5/2-107 a). And, whenever a guaranteed right of the recipient is restricted, the recipient and his/her guardian must be given prompt notice of the restriction and the reason therefore. (405 ILCS 5/2-201 a). The Probate Act of 1975 reads "To the extent ordered by the court...the guardian of the person shall have custody of the ward and...shall procure for them and shall make provision for their support, care, comfort, health...and maintenance...." (755 ILCS 5/11a-17). Also, "Every health care provider...has the right to rely on any decision or direction made by the guardian...that is not clearly contrary to the law, to the same

extent and with the same effect as though the decision or direction had been made or given by the ward" (755 ILCS 5/11a-23).

Conclusion - Complaint #2

In reviewing the records, the HRA saw no documentation that the guardian was contacted on 6/12/2018 and, although there is documentation that the guardian was involved on 6/21/2018, there is no documentation that the guardian was actually contacted. There was no sign of contact even though it was documented that the patient has a guardian on the encounter sheet from the emergency department. In accordance with the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102), the guardian should be allowed to participate in the patient's treatment, including the right to refuse treatment (405 ILCS 5/2-107 a), and have been notified of rights restrictions (405 ILCS 5/2-201 a) when the restriction occurred during the patient's stay. Additionally, the Probate Act of 1975 states that the guardian should procure care and the health care provider has the right to rely on the decision of the guardian (755 ILCS 5/11a-17, 755 ILCS 5/11a-23). Due to the lack of notification the HRA finds the complaint **substantiated** and makes the following **recommendation:**

- Assure that when a patient has a guardian, the guardian is contacted and allowed to participate in the patient's treatment, including being notified of rights restrictions per the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102, 5/2-107, 5/2-201a). Provide the HRA with evidence that this is occurring at the facility and that staff have been trained in this policy.

The HRA also offers the following **suggestion:**

- During the interview, one staff was not aware that guardianship lasted indefinitely, and another staff member kept referring to Power of Attorney only and never referenced guardianships. The HRA **suggests** that staff receive education on the types of representation that people receive so they have a knowledge base for dealing with patients.

Complaint #3 - Inadequate care and treatment, including contacting the police rather than providing treatment and violating patient's right to refuse.

The HRA reviewed the ED record which reads "30-year-old female presenting with suicidal ideations. I do not believe she is actively suicidal she was simply acting out and she was upset that she was not getting what she wanted. During her ED stay she became violent with staff. Police were called. Patient was arrested and taken away in police custody." A physician's note on restriction of rights includes "...Completion of medical services the patient is refusing so as to complete establishing a diagnosis and formulating a treatment plan." And ED note reads "Police given patient discharge instructions. The patient is medically cleared for jail. Patient moved to police custody. Patient refused discharge vitals. Police escorted patient from facility. Crisis notified of patient transfer of care. No signs of distress noted."

As stated in the first complaint, the HRA reviewed the security officer incident report which read that the patient struck the security guard and technicians. The security guard's report reads that one of the RNs involved "informed myself and [Technician] that we should file charges. Bloomington Police (BPD) was then called to take the report of battery. I spoke with Bloomington PD and they then took my statement, [Patient] was medically cleared then Bloomington arrested [Patient] and was now in their custody." The HRA also reviewed the police report regarding the incident which read that after the Rescue and Bloomington Police Department left the patient in the ED the first time, the patient "... tried to leave the hospital. [Staff] said when [Patient] was advised she could not leave, due to being involuntary admitted, [Patient] became combative. [Staff] Said she was trying to restrain [Patient] to prevent her from leaving and fighting. [Staff] said [Patient] tried hitting her a few times, but did not make contact. [Staff] stated [Patient] then kicked her twice in the chest. [Staff] said the kicks were a little painful, but she was okay. There were not any marks on [Staff] body from [Patient] battering her." The report states that the security officer was trying to help restrain the patient and was "also battered." The security guard said the patient hit him in the arm twice and it did not hurt and there were no marks. Both staff agreed to be listed as victims of "Batter and Disorderly Conduct." The HRA requested records for 6/21/2018 but was told that there were no records available.

The HRA reviewed a "Patient Relations Worksheet" which read that staff "... received a call from [Guardian] first. She was very upset her [Relation to Patient] was mishandled by security and the nurses. [Guardian] said we are very familiar with her daughter and her behavior and questions why things went so far [Patient's] last ED visit." The statement reads that the patient was restrained and had bruises "all over her body" along with swelling. The statement then reads "[Guardian] said [Patient] got so upset because she did not want her pants removed. [Guardian] said we were going to cath [Patient] to get a urine sample to test for street drugs. [Guardian] said we have tested [Patient] many times in the past and we are fully aware [Patient] does not do street drugs. [Guardian] said [Patient] was raped in the past and that is why she reacted so violently to having her pants removed." The HRA reviewed a response to the allegations written by the Medical Director of Emergency Medicine which read "[Patient] presented for a psychiatric evaluation, specifically asking to be provided with a new counselor. Crisis was contacted to evaluate her. They require screening blood work, urinalysis and urine drug screen before they will evaluate. These were ordered. During her visit [Patient] became agitated and violent toward staff, striking and spitting at nurses/techs/etc. Security/Police were contacted and restrained [Patient]. She was treated with Haldol/Ativan IM for agitated delirium. She was arrested by police and taken to jail. [Patient] has 'anxiety' listed as her reaction to Haldol. This is not an allergy, but potentially an intolerance. She was provided the medication as I believed the benefit outweighed the intolerance. She in fact calmed after being provided the medication and did not suffer any anxiety. Her chart will be duly updated."

In the ED notes, there is a section titled "Medications" and which reads that Haldol and Ativan were not administered. Another section in the ED medication administration notes state that both drugs were "Not Given" and it reads "Attempting discharge in to Jail's custody – patient no longer experiencing aggressive behavior." In the patient HPI (History of Present Illness), Haldol and Ativan are both listed as "current

facility-administered medications" but neither actually have documentation that they were administered. The HRA saw no evidence of any consent for the medication or consent from the guardian. The HRA also reviewed two physician's orders for Haldol and Ativan but it was stated that both drugs were discontinued.

The HRA reviewed the patient's rights restriction document, on 6/12/2018, which reads that the patient had restrictions on certain rights which included "To refuse medical services – laboratory specimens." Other medical services were not restricted. The restriction was scheduled for 24 hours (6/12/18 at 1422 until 6/13/18 at 1422). There was also a restriction for the right "to refuse search of person or living area", and "To retain personal property." The reason listed for the restrictions are "I just don't matter anymore, no one cares." As stated on the previous complaint, there is no indication whether the patient wanted or did not want someone notified or a guardian/designee notified, and there was no guardian or designee signature. In the ED notes, on 6/12/2018, there is another section written by the physician which reads "I have directly observed, and/or obtained history from [Patient] who directly observed, the following behaviors exhibited by [Patient]. Suicidal statements. Because of these behaviors, I have ordered the restriction of rights to include (LIST ALL) Searching of the patient's personal property or removing belongings and retaining personal property. Searching of the patient's personal property or removing belongings and retaining personal property. 1. Type of Right(s) being restricted (List all): Placing the patient in a physical hold, Placing the patient in restraint and/or seclusion, Restriction of visitors, Administration of emergency medications, Managing patient's person hygiene, Searching of the patient's personal property or removing belongings, Retaining person property, Restricting access to phone, mail, or other outside communication and Completion of medical services the patient is refusing so as to complete establishing a diagnosis and formulating a treatment plan. I have explained the restriction of right to the patient, ensured completion of the 'Notice Regarding Restriction of Rights of Individual Form,' and given the form to the Patient."

Regarding the 6/21/2018 ED examination, the ED provider notes state that "On arrival patient was not cooperative to the staff the but I was able to convince her to allow the staff to get blood samples and urine patient was not cooperative earlier with history taking but was able to talk later after the crisis worker talked with her." In the current facility-administered medications section it reads Haldol and Ativan (as well as Benadryl) but it does not state if the medication was given. Another ED provider note reads "[Patient] was brought here again for suicidal remakes per history from EMS. Labs performed for medical clearance for crisis evaluation. Crisis worker came to evaluate the patient and it was deemed that the patient was no longer suicidal and is stable to be discharged to her [Guardian] after safety plans were made after consultation of the crisis worker with the patient's [Guardian]. The patient was also seen by me and claims that she is not suicidal at all. Patient seemed comfortable. I initially offered Ativan for anxiety, declined and the changed her mind, was then given Ativan 1 mg p.o. before discharge. Patient stable and not suicidal on DC." Another ED note from that date states: "Pt initially refusing all care and denying suicidal/homicidal ideation. After multiple staff members and attempts of care pt agreeable to plan of care." Another ED medication administration form states that the Ativan was the only medication given. The HRA again found no consent for anything from the patient. The ED events section of the record reads there was a urinalysis ordered on 1422 and later, at 1658, it is noted that there was a final

result of the urinalysis. Also, in the records, there was a narrative of the urinalysis. Additionally a urine drug screen was ordered on 1422 and the results were received at 1715. The HRA saw no consent for the urinalysis documented in the record.

In reviewing the rights restriction for 6/21/18, it reads that the patient's has the following rights restricted: "To refuse medical services – x-ray," "To refuse other medical services," "To refuse medical services – laboratory service," "To retain personal property," "To refuse search of person or living area." There is no written reason associated with the restriction, no guardian signature, and no documentation of an individual being made aware of the notice or notification of Guardian or designee documented. There was no restriction of rights statement written into the ED notes like the 6/12/18 stay.

The HRA reviewed the facility "Refusal of Treatment, Test, or Procedure" policy which reads "OSF St. Joseph Medical Center recognizes the right of every patient to refuse medical care or treatment to the extent permitted by law and the Ethical and Religious Directives (ERDs), and to be informed of the consequences of the refusal." The policy states "A patient or their Power of Attorney for Health Care (POA) may refuse care, services, or treatment at any time." The policy states that "In the case of a competent adult refusing a treatment, test, or procedure (hereafter called 'treatment') which the physician has requested, the physician is contacted for further orders. The appropriate director or supervisor will also be notified of the refusal of treatment." The policy states the refusal will be reviewed to determine if it is in compliance with "existing law or the ERDs," and if the refusal is not in compliance with the ERDs, then a referral to the Ethics Committee will be made. All actions with the refusal will be documented on the medical record.

The facility restriction of rights policy reads that the purpose is "To ensure initiation and completion of the 'Notice Regarding Restricted Rights of Individuals' form when right(s) are restricted for a patient (age 12 and over) with a behavioral health condition who is exhibiting behaviors which are a danger to themselves or others." The policy states that a rights form is provided when a patient is 12 or over, has a behavioral health condition, rights are restricted, and the "Patient is exhibiting behavior which is a danger to themselves or others." The examples of situations when a patient's rights are restricted include: placing a patient in a physical hold, restraints or seclusion for violent or self-destructive behavior, emergency medication, managing patient's personal hygiene when refused, searching a patient or their living area, retaining personal property, restriction of communication, and "Completion of medical services when a patient refuses (i.e. x-ray, laboratory specimens, dental service, or other)." The rights restriction is to go to the patient, patient's parent or guardian, patient's surrogate or legal decision maker, or any other person that patient selects to receive it. The rights restriction form is to document the reason for the rights restriction and behaviors exhibited. The policy also states that the restriction is to be explained to the patient and the patient's representative.

The patient rights and responsibilities policy states "OSF Healthcare supports independent expression and decision-making consistent with the *Ethical and Religious Directives for Catholic Health Care Services*, applicable law, and regulatory agencies." The policy also reads "OSF facilities and operating units protect the rights of patients and promote an active role in their own care by asking patients to share in some responsibilities to help us meet their needs."

The Code requires that "(a) An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The, recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available" (405 ILCS 5/2-107). The Code also requires that "(d) Upon commencement of services, or as soon thereafter as the condition of the recipient permits, the facility shall advise the recipient as to the circumstances under which the law permits the use of emergency forced medication or electroconvulsive therapy under subsection (a) of Section 2-107, restraint under Section 2-108, or seclusion under Section 2-109. At the same time, the facility shall inquire of the recipient which form of intervention the recipient would prefer if any of these circumstances should arise. The recipient's preference shall be noted in the recipient's record and communicated by the facility to the recipient's guardian or substitute decision maker, if any, and any other individual designated by the recipient. If any such circumstances subsequently do arise, the facility shall give due consideration to the preferences of the recipient regarding which form of intervention to use as communicated to the facility by the recipient or as stated in the recipient's advance directive" (405 ILCS 5/2-200). According to the Probate Act of 1975, "every health care provider and other person (reliant) has the right to rely on any decision or direction made by the guardian" (755 ILCS 5/11a-23) The Mental Health and Disabilities Code states that "(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment ... (a-5) If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment. The physician or the physician's designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing" (405 ILCS 5/2-102). Regarding the restriction of property, the Code states: "(b) The professional responsible for overseeing the implementation of a recipient's services plan may, with the approval of the facility director, restrict the right to property when necessary to protect such recipient or others from harm" (405 ILCS 5/2-104). Regarding restrictions of communication, the Code mandates: "(c) Unimpeded, private and uncensored communication by mail, telephone, and visitation may be

reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission. When communications are restricted, the facility shall advise the recipient that he has the right to require the facility to notify the affected parties of the restriction, and to notify such affected party when the restrictions are no longer in effect" (405 ILCS 5/2-103).

Another section of the Code states: "A medical...emergency exists when delay for the purpose of obtaining consent would endanger the life or adversely and substantially affect the health of a recipient of services. When a medical or dental emergency exists, if a physician or licensed dentist who examines a recipient determines that the recipient is not capable of giving informed consent, essential medical...procedures may be performed without consent. No physician nor licensed dentist shall be liable for a nonnegligent good faith determination that a medical or dental emergency exists or a non-negligent good faith determination that the recipient is not capable of giving informed consent" (405 ILCS 5/2-111). Additionally, regarding rights restrictions, the Code requires that: "(a) Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to: (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian; (2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice; (3) the facility director; (4) the Guardianship and Advocacy Commission...." (405 ILCS 5/2-201).

Complaint #3

There is no documentation as to whether the patient provided consent to a urinalysis in the ED, and in the grievance, the patient states that it was not agreed upon. The physician did not deny the accusation about the urinalysis, but that does not provide the HRA with conclusive evidence that the patient was forced to provide a urinalysis against her will. The HRA does not substantiate that aspect of the complaint. In reviewing the records regarding the patient's treatment in the ED on 6/12 and 6/21, the HRA saw that there was an order for Haldol and Ativan that, according to the records, were not administered but in the grievance investigation, it was stated that the medications were administered. On 6/21, it is documented that Ativan was provided to the patient, but the Mental Health and Developmental Disabilities Code states that the recipient and guardian must be advised, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment. Also, the patient's capacity to make a reasonable decision about treatment must be determined (405 ILCS 5/2-102). Additionally, the HRA is concerned about the rights restriction process used by the facility. The patient entered the facility on two separate occasions and there was a rights restriction document completed for the patient. The restriction for 6/12 used quotes from the patient as the reasoning for the restrictions and the 6/21 restrictions included no reasoning for the restrictions. The 6/12 restrictions had some documentation in the ED records stating the patient had rights restricted because of "Suicidal Statements" but the ED notes states that a "30-year-old female presenting with suicidal ideations. I do not

believe she is actively suicidal she was simply acting out and she was upset that she was not getting what she wanted." On the 6/21 record, there is a statement that a "Crisis worker came to evaluate the patient and it was deemed that the patient was no longer suicidal and is stable to be discharged to her [Guardian] after safety plans were made after consultation of the crisis worker with the patient's [Guardian]. The patient was also seen by me and claims that she is not suicidal at all. Patient seemed comfortable." Prior to that, the facility had been able to talk the patient into getting bloodwork and a urinalysis. The time on the 6/12 rights restriction was 1422 and the patient was at the facility at 1355. The time on the 6/21 rights restriction was 2020 and according to the ED records the patient was at the facility at 2014. As seen by the Code (405 ILCS 5/2-107, 5/2-104 & 103), restricting rights are to protect the patient themselves and others from causing serious and imminent physical harm but, it appears that the rights restrictions for medication (and other rights) are done in mass with minimal reason given for the restrictions. Additionally, there was no indication that the guardian was provided either restriction. Finally, the facility states that the right to refuse is to be reviewed to see if it complies with the facility Ethical and Religious Directives with no mention of any regulations.

Because of this, the HRA finds the complaint **substantiated** and **recommends** the following:

- The facility begin following the Mental Health and Developmental Disabilities Code requirements for refusing medications and then for administering emergency medications if the Code's standards are met (405 ILCS 5/2-107, 5/2-102 and 5/2-200), including eliminating the review of Ethical and Religious Directives. The HRA asks that policy and training be updated as evidence of this change and the evidence be provided to the HRA.
- The facility must provide guardian copies of the restrictions (405 ILCS 5/2-201) and restrictions must include specific justification to prevent serious and imminent physical harm towards the resident or others (405 ILCS 5/2-201, 5/2-104 and 5/2-103). The facility must cease in the practice of providing groups of rights restrictions upon admission to the ED and only provide restrictions when a patient is in danger of harm to self or others per the Code. The HRA asks that policy and training be updated as evidence of this change and the evidence is provided to the HRA.

The HRA also offers the following **suggestions:**

- The HRA **strongly suggests** that if there is a situation where a patient does not want to provide specimens or bloodwork, assure that the ED is not forcing the samples to occur.
- Also, the HRA is concerned that the facility is not following the Mental Health Code for psychotropic medication and rights restrictions as previously stated and **strongly suggests** the facility begin following those regulations while the patient is in the ED.
- Additionally, the HRA is concerned because the police were contacted when there was a violent behavior rather than the facility attempting to treat the behavior,

which borders on non-compliance with the Code which states that the patient should receive adequate and humane services according to the patient's treatment plan (405 ILCS 5/2-102). The HRA would like to point out that after the patient was relinquished to the police, the patient returned to the facility 10 days later in need of services. The HRA cannot tell a facility to not contact the police and dissuade them from care towards staff, but the HRA would like to **strongly suggest** that the facility make every possible attempt to treat a patient whose behaviors may be due to the diagnosis and contacting the police for a suicidal patient should be a last resort for safety of the staff.

- The physician wrote a list of rights restrictions for the patient in the record, but those restrictions were different than what was added to the patient's rights restriction notification. It appears the restrictions were not transcribed over to the record and the HRA **suggests** better record keeping for restrictions in the future.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, provider responses appear verbatim in retyped format.

REGIONAL HUMAN RIGHTS AUTHORITY

HRA CASE NO. 18-090-9023

SERVICE PROVIDER: OSF St. Joseph Medical Center

Pursuant to Section 23 of the Guardianship and Advocacy Act (20 ILCS 3955/1 *et seq.*), we have received the Human Rights Authority report of findings.

IMPORTANT NOTE

Human Rights Authority reports may be made a part of the public record. Reports voted public, along with any response you have provided and indicated you wish to be included in a public document will be posted on the Illinois Guardianship and Advocacy Commission Web Site. (Due to technical requirements, your response may be in a verbatim retyped format.) Reports are also provided to complainants and may be forwarded to regulatory agencies for their review.

We ask that the following action be taken:

_✓_ We request that our response to any recommendation/s, plus any comments and/or objections be included as part of the public record.

____ We do not wish to include our response in the public record.

____ No response is included.

Lynn A Fulton
NAME

President
TITLE

May 8, 2019
DATE

OSF HEALTHCARE

October 25, 2019

Meri Tucker, Chairperson
Regional Human Rights Authority
401 Main Street Suite 620
Peoria, IL 61602

Re: OSF HealthCare St. Joseph Medical Center
2200 East Washington Street
Bloomington, IL 61701

Dear Ms. Tucker,

I would like to express our appreciation to the IGAC for their time and attention to this complaint. OSF HealthCare St. Joseph Medical Center (SJMC) has embraced the recommendations and suggestions to better care for all patients.

In regard to correspondence on September 23, 2019, surrounding Human Rights Authority Case #18-090-9023 SJMC offers this response: OSF HealthCare St. Joseph Medical Center appreciates the request to add specific verbiage from the Mental Health and Developmental Disabilities Code to the Patient Rights and Responsibilities policy. However, the organization considers the intent behind the additional verbiage is already captured. The Patient Rights & Responsibilities brochure allows for the patient, guardian or legal decision maker the right to refuse treatment and services. This refusal would include the administration of medications and electroconvulsive therapy as outlined in the code. Although, it should be noted that the facility does not offer electroconvulsive therapy. When a situation occurs where the patient requires emergency administration of psychotropic medications, the staff would rely upon the procedure which has been provided to the HRA for review.

If you have any questions, please do not hesitate to call me at 309-665-5784 or via email at Lynn.A.Fulton@osfhealthcare.org.

Sincerely,

Lynn Fulton
President

May 8, 2019

Meri Tucker, Chairperson
Regional Human Rights Authority
401 Main Street Suite 620
Peoria, IL 61602

Re: OSF Healthcare St. Joseph Medical Center
2200 East Washington Street
Bloomington, IL 61701

Dear Ms. Tucker,

Please find the enclosed response to the recommendations and suggestions from the letter dated March 25, 2019. My sincere appreciation to the IGAC for your time and attention to this case as well as to each person you serve.

If you have any questions, please do not hesitate to call me at 309-665-5784 or via cell 309-854-3639.

Kind regards,

Lynn A. Fulton
President
OSF Healthcare St. Joseph Medical Center
lynn.a.fulton@osfhealthcare.org

OSF HealthCare St. Joseph Medical Center's Response to

Regional Human Rights Authority Report of Findings

Case No. 18-090-9023

OSF HealthCare St. Joseph Medical Center (SJMC) would like to express its gratitude to the Regional Human Rights Authority of the Illinois Guardianship and Advocacy Commission (HRA) for its time and attention to this complaint. SJMC appreciates the opportunity to address the concerns raised in the March 25, 2019 Report of Findings by the Regional Human Rights Authority of the Illinois Guardianship and Advocacy Commission. SJMC has embraced the recommendations and suggestions to better care for all patients.

It is important to note that we have cared for this patient extensively over the last two plus years. In order to better meet her needs; SJMC has worked with the patient and her guardian to develop a care plan that is followed whenever she seeks care at SJMC. Since that development; her care has gone smoothly and communication between the hospital and her guardian has improved.

Complaint #1: Inadequate Restraint Procedure

SJMC Response:

1. Only employees from SJMC that have been trained in the safe and humane/therapeutic application/removal of restraints will apply or remove the devices. SJMC did extensive re-education of all nurses in the Emergency Department using In-the-Seat Training. This training was completed by October 21, 2018. Evidence of this training is attached as Attachment A.

   The security officers employed by SJMC were also trained to assist nursing should restraints become a necessity. These employees do not apply the restraint, but assist nursing when the situation requires it to ensure adequate and humane services are provided. Evidence of training is attached as Attachment B.

   SJMC will revise the restraint and seclusion policy to clarify points raised by the HRA, and employees will be educated on those changes. Specifically, the policy makes the following clear: (a) no patient will remain in restraints for more than two hours until a physician has personally observed and examined the restrained patient within two hours of the restraint application; (b) the physician must document that the restraint does not pose an undue risk to the patient's health; (c) no order for restraint will be valid for more than 16 hours; (d) all behavioral health patients in restraints for violent or self-destructive behavior will have a behavioral health monitor/sitter in the room, and the monitor/sitter will document the patient's condition at least every 15 minutes; (e) the Facility Director or designee will review all orders of restraints daily; and (f) the restrained patient has the right to have any person notified of their restraint including the Guardianship and Advocacy Committee.

2. Education was updated and provided to employees regarding proper completion of the restriction of rights notice and that a patient over 12 years of age or the patient's guardian or legal decision maker will also receive a copy of the restriction of rights document (this

requirement currently exists in the policy). This training was completed using In-the-Seat Training. All employees completed this training by October 21, 2018. See Attachment A.

The policy in regard to the restriction of rights will be updated as indicated to include HRA's recommendations regarding the Mental and Developmental Disabilities Code (MHDDC). SJMC employees will be re-educated on the policy updates.

Complaint #2: Lack of Guardian Notification

SJMC Response:

1. An updated process has been put in place, via the patient registration department which will notify the employees if the patient has a legal representative or guardian. Employees have been re-educated regarding the requirement that the guardian shall be notified about all aspects of the treatment that is being provided to the patient. This also includes the guardian's right to refuse treatment for the patient and that the guardian must be given prompt notice of the restriction of rights. Education was also provided to the employees regarding the types of legal representatives for patients including guardians. See Attachment A.

2. Re-education of employees will be completed in regard to guardians and other legal decision makers as well as duration of these documented relationships.

Complaint #3: Inadequate care and treatment, including contacting the police rather than providing treatment and violating patient's right to refuse

SJMC Response:

1. SJMC uses the Ethical and Religious Directives for Catholic Health Care Services (ERDs) to align with our mission, vision, and values. The ERDs are not in conflict with the Mental and Developmental Disabilities Code. Nursing employees have been educated on the patient's rights including, but not limited to the refusal of medications and treatment. The policy, "Refusal of Treatment, Test or Procedure," was retired. The policy, "Patient Rights and Responsibilities," is now used. Employees will be re-educated on the content of the document which allows for refusal of treatment, tests or procedures.

2. Education was updated and provided to employees regarding proper completion of the restriction of rights notice and that a patient over 12 years of age or the patient's guardian or legal decision maker will also receive a copy of the restriction of rights document (this requirement currently exists in the policy). This training was completed using In-the-Seat Training. All employees completed this training by October 21, 2018. See Attachment A.

   The policy in regard to the restriction of rights will be updated as indicated to include HRA's recommendations regarding the Mental and Developmental Disabilities Code (MHDDC). SJMC employees will be re-educated on the policy updates.

3. SJMC makes all attempts in cooperation with patients to obtain the specimens necessary to develop the plan of care. The patient does have the right to refuse any of the treatments provided including the collection of laboratory specimens. It is important to note this patient was cooperative prior to becoming agitated. She willingly provided a urine specimen and allowed a laboratory employee to collect her blood.

4. Education was updated and provided to employees regarding proper completion of the restriction of rights notice and that a patient over 12 years of age or the patient's guardian or legal decision maker will also receive a copy of the restriction of rights document (this requirement currently exists in the policy). This training was completed using In-the-Seat Training. All employees completed this training by October 21, 2018. See Attachment A.

   The policy in regard to the restriction of rights will be updated as indicated to include HRA's recommendations regarding the Mental and Developmental Disabilities Code (MHDDC). SJMC employees will be re-educated on the policy updates.

5. SJMC employees contacted the local police in response to the extreme violence of the patient against multiple staff members. Contacting of law enforcement is used as a last resort for the safety of the employees and the patients. SJMC employed security officers assist nursing when the situation requires to ensure adequate and humane services are provided. SJMC has worked with the patient and her guardian to develop an agreeable plan of care to be implemented whenever she presents for treatment at SJMC.

6. Education was updated and provided to employees regarding proper completion of the restriction of rights notice and that a patient over 12 years of age or the patient's guardian or legal decision maker will also receive a copy of the restriction of rights document (this requirement currently exists in the policy). This training was completed using In-the-Seat Training. All employees completed this training by October 21, 2018. See Attachment A.

   The policy in regard to the restriction of rights will be updated as indicated to include HRA's recommendations regarding the Mental and Developmental Disabilities Code (MHDDC). SJMC employees will be re-educated on the policy updates.