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HUMAN RIGHTS AUTHORITY – PEORIA REGION
REPORT OF FINDINGS

Case #19-090-9019
UnityPoint Health-Methodist/Proctor

INTRODUCTION:

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations involving services at UnityPoint Methodist/Proctor. The allegations are as follows:

1. **Improper use of restraints, resulting in physical injury.**
2. **Inadequate treatment while in seclusion.**
3. **Communication Violation.**

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-100). The facility receives patients statewide, excluding Cook County. There are 23 to 25 staff members, including nurses, mental health technicians, certified nursing assistants (CNA), a recreational therapist, and a psychiatrist. They provide medical and psychiatric services at the facility. Staff estimated between 1500 - 2000 patients present to the emergency department (ED) with mental health needs yearly, with 1700 to 1900 over the past three years. The emergency department has 30,000 overall patients that present yearly. The behavioral health unit is an inpatient mental health unit with sixty-seven beds. The HRA visited the facility and conducted a site visit interview with representatives involved with this patient's care. The HRA also reviewed, with authorized written consent, the patient's record.

Complaint Statement

The complaint alleges that an individual receiving treatment at Methodist Hospital Emergency Department (ED) was improperly restrained resulting in a physical injury. When the patient was transferred to the behavioral health unit, their patient rights were violated when the patient was in the "cool room" and hospital staff refused to give him water when he requested. The complaint also alleges that the patient's communication rights had been violated and that staff refused to allow the patient to visit with a friend

because this person uses a therapy dog which are not allowed on the Behavioral Health Unit.

Interview with staff (08-06-2019)

The hospital uses restraints based on behaviors being considered violent or nonviolent. Aggressive behavior is common due to many of the patients who receive care at the facility's mental health unit. Velcro restraints are used for a patient who is displaying violent behavior per Centers for Medicare and Medicaid Services (CMS) guidelines. An attending physician is the person who orders such a physical restraint. After staff have made efforts to use crisis prevention techniques, such as verbal de-escalation or 1:1 staffing, a physical restraint would be used. Staff also have a locked room that can be used as seclusion for a patient to deescalate. An example of physical restraints would be a two-person hold and Velcro restraints. If a patient's violent behavior is physically aggressive towards staff or their behaviors are considered a danger to themselves, and they are unable to be redirected, a physical restraint would be used. Before Velcro restraints are used on a patient, hospital staff in both the ED and on the Behavioral Health Unit have been certified in Crisis Prevention Institution (CPI) training to attempt to deescalate the patient. The CPI training is an eight-hour class required for all ED and Behavioral Health Unit staff. The hospital staff are also trained yearly on restraints and they know how to safely apply restraints.

The hospital also uses nonviolent restraints in cases in which a patient is struggling with receiving medical care. Nonviolent restraint is used, after being ordered by the physician, when a person is pulling out their intravenous fluid line or are excessively picking at their skin. Some interventions that hospital staff can use are Posey vests. This type of restraint is used to secure a patient to their bed if they are picking at their intravenous (IV) fluid line or ripping it out of their arm.

If a person is placed in a Velcro restraint, seclusion, or a Posey vest nursing staff continually monitor the person in restraints. The patient's circulation is checked where the restraint is attached on their body, usually arms and legs. They are offered fluids, an opportunity to use the restroom and their range of motion is checked and documented by nursing. A physical restraint would be removed after the patient is safe and has calmed down. Typically, after a restraint has been released the patient is provided with the rights restriction form and they may or may not sign.

If a patient's behavior is escalating and they are becoming physically aggressive the hospital has a team trained in CPI that are called to assist. The team is made up of employees from the ED, behavioral health and security. A patient can receive a physical injury during a physical restraint. These injuries are usually minimal. Commonly occurring physical injuries are scratches or bruises.

The hospital does have a safe room on the behavioral unit that can be used for patients who benefit from seclusion as an intervention. This is ordered by a licensed physician. A Lead Nurse can initiate a patient being placed into the seclusion room but

would still have to get an order from a physician for the patient. This space has extra padding to be protective. There are windows for staff to observe the patient directly for the first hour. There is also a camera in the room and then they watch the patient through a monitor. If a patient is in the safe room and needs the restroom, they would let the person use the bathroom. If a patient requests a drink of water and behaviors are still escalated, a team would assess and extra staff would be utilized to provide the patient with something to drink. The Lead Nurse determines if it is safe to be in the room with the patient and if someone is yelling or a loud talker, that would not deter them from being given water to drink. The hospital staff do not call the safe room a "cool room". To be released out of seclusion a patient will process the incident with staff, formulate a plan to address their behavior and follow staff directions.

Hospital staff who are involved with care of a patient, either in the ED or on the behavioral health floor, always provide the safest and least restrictive plan of care. If a patient is highly agitated and physically aggressive, a physical restraint can, often; be safer. If an individual has an IQ of less than 70, they are not allowed to go into seclusion per the Mental Health Code.

The hospital does not restrict a patient's communication unless ordered by a physician. In the ED and on the Behavioral Health Unit a patient always has access to two phones, one at the nurse's station and in a common area. The common area phone is turned off from ringing at 10:30pm for rest hours but the phone can still be used. The phone's ringers are turned off during group time, but there are exceptions to this practice. If a patient needs to use the telephone they would need to talk with nursing about this request. The use of the phone during group time is determined on a case by case basis. The nurse's station phone is not a community phone but patient's use it sometimes for long distance phone calls. A nurse can also transfer an incoming call from their phone to the community phone. In-person visits are often on 6W. The visiting hours are 6pm-8pm Monday - Friday and from 2pm-4pm and 6pm-8pm on the weekends. These usually take place on the Behavioral Health floor and anyone sixteen years old and older can visit. Some patients have different visits scheduled as ordered by their attending physician. The Behavioral Health Unit also ensures confidentiality by talking with a patient about whether they want their information released that they are inpatient. If a patient says they do not want people to know they are admitted to the floor, then staff are trained to respond to the caller with the statement, "Can't confirm or deny" that a patient is on the unit.

Methodist Policy does allow pets on the unit. They have had therapy dogs visit the floor on a regular basis. A patient could bring their service dog on the unit if the hospital is able to accommodate the animal. Staff involved in the site visit stated they have not refused a service dog visiting the unit and confirmed a therapy dog has visited the unit. This dog was brought on the floor by a family member of a patient.

The hospital also has a protocol for reporting any allegations of abuse. If a patient feels they have been the victim of abuse they should notify staff. The first report would be made to a nurse. Nursing staff would report to their supervisor and a patient advocate

would be contacted. The Guardianship and Advocacy Commission information is also posted on the unit for a patient to call if they need to. Each patient receives a copy of the Patient Handbook which also provides them with the details on how to address concerns while on the behavioral health unit. Staff do not put restrictions on patient complaints, they are addressed by staff on shift per hospital policy when the patient or staff brings them to staff's attention.

During the site visit staff explained that it was difficult to clearly locate much of the documentation that would answer a timeline of events due to how the paperwork displays in the hospital computer system. This patient had also had three inpatient hospitalizations in the last year with a different length of stay for each. Hospital staff were able to see that the individual involved with this complaint required seclusion as a CPI intervention during his mental health treatment on the behavioral health floor. For this instance, his behaviors started in the dining room. The patient was religiously preoccupied, sexually amped up, and made several sexualized comments towards staff. He was naked, refused to stop yelling, refused medications and was a danger to self or others. He was offered oral medications and he refused to take the medications or put on his clothes. Eventually he received an IM of Haldol 5mg and Ativan 2mg and he walked to seclusion and put on scrubs for clothing.

Hospital staff reviewed a progress note dated 4/13/19 that the patient thought he was physically abused and had bruises on his legs. He reported that he did not know where they came from and that he was "hog tied" and strapped down in the ED. The floor supervisor observed bruises green and yellow in color on his right and left upper leg. The patient was fixated on being abused and asked to call police. The patient continued to display behaviors and was reminded that the physician and patient advocate had met with him about his complaints. He was offered medications and he avoided seclusion.

Hospital staff reviewed a progress note under risk management dated 4/15/19 that the Patient Advocate was planning to meet with the patient. The patient called police on 4/16/19, using the nonemergent number to tell them about his injury. On this same day the patient signed consent to have his bruises photographed and wound care had to take pictures.

Hospital staff were unsure about refusing a visit to the patient due to the person having a service dog. There was a note in the computer system that a clinician had spoken with a member of the patient's family about a visit later that evening. It is unclear if that took place or if that person has a therapy dog.

FINDINGS

Complaint #1- Improper use of restraints, resulting in physical injury.

This individual was admitted to the Behavioral Health Unit on three different occasions as an Involuntary admission to the unit. His first involuntary admissions occurred 1/23/19-2/13/19, the second was 4/6/19-5/23/19, and the third is considered a re-admission as it took place on the same date as discharge from the second admission, those dates are 5/23/19-7/1/19. The HRA –reviewed chart documentation specific to physical and chemical restraints the patient underwent while receiving treatment in the emergency department and during admission to the behavioral health unit at UnityPoint Methodist-Proctor.

For the first admission reviewed by the HRA, the patient arrived at the hospital via ambulance with police escort on 1/23/19 at 1658 hours (4:58pm). He was displaying erratic behavior at his apartment and when he arrived to the Emergency Department (ED) note documents the patient was there for a psychiatric evaluation based on the criteria of patient being "off his meds and acting aggressive at apartment complex". He was initially assessed by an Advanced Registered Practice Nurse (APN) who ordered a 20mg dose of Geodon via intermuscular injection. The HRA was able to review the Medications-Clinical Order form and the Patient Care Timeline for treatment in the ED on 1/23/19 and confirms that a 20mg dose of Geodon was ordered by a UnityPoint APN and this medication was given to the patient at 1900 (7:00pm) hours in the "Right Ventrogluteal [part of the hip]." Psychotropic medications of Haldol and Ativan were ordered by the APN at 1912 (7:12pm) which, per the record, was given after the patient had already received Geodon. A PRN injection of Haldol 5mg was ordered by the APN and given to the patient by an RN on 1/23/19 at 1931 (7:31pm) in the "right anterior thigh". A PRN injection of Ativan 2mg was ordered by the same APN and given to the patient by an RN on 1/23/19 at 1931 (7:31pm) in the "right anterior thigh". On 1/23/19 at 20:06 (8:06pm) an ED note written by a hospital physician documents "Patient reassessed, calm at this time after chemical restraints. Lungs clear to auscultation, no indication for chest x-ray. Abdomen soft nontender, awaiting UA." The HRA can conclude that the patient arrived at the ED around 5pm and then received three psychotropic medications within 31 minutes beginning at 7:00pm and the last injection being received at 7:31pm. The HRA does not observe any documentation in this first ED treatment record that indicates the patient was physically restrained. The documentation is clear that psychotropic medication was ordered and given to the patient and is documented as a "chemical restraint". The HRA does not observe any communication with the patient by ED staff discussing medication side effects or a Notice of Rights Restriction for receiving the psychotropic medications in the ED on 1/23/19. There are two Notice of Rights Restrictions observed in the patient chart record that was completed from treatment with the ED dated 1/23/19 at 5:00pm and at 2236 (10:36pm) for elopement precautions due to involuntary status and the other was a restriction of personal possessions and due to being in a locked unit. The 5:00pm restriction notice was written by an RN and the box is checked that indicates a copy was given to the patient. The 10:36pm note is signed by a Mental Health Associate and the box is checked that indicates a copy was given to the patient. The HRA did note a brief note written by a Registered Nurse on the Patient Care Timeline from treatment in the ED that documented the patient resting in the room but the HRA was unable to find a Behavioral Health Flowsheet that documents consistent checks were made by the assigned hospital

staff. The HRA did not review documentation that determined the patient had the capacity to accept treatment, that the patient consented to the psychotropic emergency medication, or that the patient's emergency preferences were considered. The patient was involuntarily admitted to the Behavioral Health Floor on 1/23/19 at 9:52pm.

On 1/24/19 at 7:12am a University of Illinois College of Medicine at Peoria (UICOMP) Psychiatry Residency Teaching Service History and Physical Exam (H&P), which is completed with the patient and a medical doctor after being admitted to the Behavioral Health Unit, notes a discussion with the attending physician that the patient reported he should not take Geodon due to QTC prolongation (irregular heartbeat). His home medication list indicated that he was taking an 80 mg oral dose of Geodon but was discontinued by his primary care physician after a psychiatric stay at another hospital in November 2018. In the section of this H&P titled Psychiatric History it states the patient's Geodon and Zyprexa were discontinued due to weight gain. It is unclear to the HRA when the oral dose of Geodon was discontinued as a home medication by the primary care physician, but the record confirms that he was given Geodon in the ED on 1/23/19. An EKG was ordered and completed on 1/24/19 after the patient was admitted to the Behavioral Health Floor but the HRA is unclear as to the conclusion of the test. The HRA notes Geodon is not ordered for the patient for this admission or future admissions.

The HRA reviewed a Physical Assessment Supplemental Sheet dated 1/23/19 completed at 10:00pm by an RN. This form documents any special marks, injuries or other areas of concern for a patient. This form does not have any documentation of bruising being observed by medical staff upon admission to the behavioral health floor.

On 1/25/19 at 8:37am the patient was displaying sexually inappropriate behavior in the dining area. A nursing note documents the attending psychiatrist giving orders for a therapeutic escort and seclusion at 8:37am, documented at 8:57am. He required a therapeutic escort to seclusion by hospital security. He was placed in a therapeutic CPI approved hold, received IM medications, placed in the seclusion room, and locked. He was out of seclusion by 9:08am. He agreed to take Lithium at 9:12am and was given ice water and encouraged to drink fluids. The HRA reviewed the Notice of Restriction of Rights dated 1/25/19 documenting the incident of therapeutic hold, therapeutic escort and seclusion. This note documents that the patient refused to accept the rights restriction documentation.

On 2/3/19 a Plan of Care Encounter note completed by an RN documents "Patient continues to be agitated and erratic, even after multiple redirections. During safety rounds, patient was observed yelling and cussing in his room. When writer opened the door to obtain visual of patient, he was observed with no pants on. Patient started yelling 'Get out bitch', then slammed the door, almost smashing this writer's finger. Writer attempted to redirect patient, patient just slammed the door again and continued to yell and cuss. Security was called and patient was given as needed IM's for agitation. Will continue to monitor."

On 1/25/19 and 2/5/19 there is an order by a medical doctor for a therapeutic hold to be used when giving medication. On 1/25/19 there is an order from a medical doctor for a therapeutic escort due to "danger to others."

On 2/5/19 a Plan of Care Encounter note completed by an RN documents "Patient was verbally aggressive during medication administration. Patient refused oral medications and stated he was evoking his right to refuse medications. Patient was placed in therapeutic hold to give IM. Patient removed pant, bent over and stated, 'Give it up my ass', Patient was jumping up and down and began to masturbate in front of staff. Patient was given IM, calmed down, put his pants back on and became more respectful towards staff. Patient went to room and spent the rest of [sic] time in there during the shift. Interventions: calm approach, medication adherence. Response: Court ordered medication given IM." There is a Notice Regarding Restricted Rights of an Individual dated 2/5/19 observed in the chart that documents a therapeutic hold for court enforced medication. The box that indicates a copy of the form was given to the patient is marked.

The second admission began on 4/6/19 this same patient returned to the UnityPoint Methodist/Proctor ED for a psychiatric evaluation after starting a fire in his apartment. He was transported by ERS and local police. Police began the certification process. There is an order for "Restraint/Seclusion for Violent/Self-Destructive Behavioral Management" made at 4/6/19 at 5:03pm by an APN. A Progress Note written by the APN documents on 4/6/19 at 9:31pm "Upon arrival to the ED the patient had to be placed in 4-point restraints and received PRN medications." The HRA reviewed the ED Frequent Observation Flowsheet that documents the patient arrived at 5:02pm via police. Haldol/Ativan intermuscular injection (IM) was ordered at 5:06pm by the attending physician. At 5:19pm he was given "5mg IM Haldol in the left anterior thigh" and at 5:20pm he was given "2mg IM Ativan in his right thigh". There is a physician's order titled Restraint Seclusion for Violent Self-Destructive Behavioral Management Order/Renewal observed in the record dated 4/6/19 at 5:03pm. The areas checked on this form to indicate the need for restraint are: "Restraint for Violent/Self Destructive Behavioral Management, Type of Restraint locked [right and left] wrist and [right and left] ankle, Clinical justification to prevent harm to self and assaultive/aggressive behavior to others, the Restraint Time Frame was marked for four hours." At 11:05 pm he received a "peripheral Right Antecubital IV" due to a medical need. The HRA is unable to locate a Notice Regarding Restricted Rights of an Individual form available for the 4/6/19 locked restraint. Once he was medically cleared in the ED, he was voluntarily admitted to the Behavioral Health Unit on 4/7/19.

On 4/7/19 a Plan of Care note completed by an RN documents the patient was in physical restraints in the ED and received an IM psychotropic medication. A Physical Assessment Supplemental Sheet for this admission to the Behavioral Health unit completed at 0255 does not have any bruising of the patient noted on the form. There is a Notice Regarding Restricted Rights of an Individual for 4/7/19 that details the following restrictions for this patient "restriction to retain personal property and must wear scrubs; no shoes. Elopement precautions, involuntary admit." but this restriction notification is provided upon his admission to the Behavioral Health Unit on 4/7/19 and does not

document the ED locked restraint or emergency psychotropic medication the patient received in the ED.

The HRA reviewed the Behavioral Health Hand-off form titled SHARES which stands for "Situation, History, Assessment, Requirements, Evaluate and Safety" form that documents the patient's transfer from the ED to the Behavioral Unit on April 7, 2019. No bruises are documented on this form. ED Staff do document the use of locked restraints while in the ED and receiving emergency medication of Haldol and Ativan via inter-muscular injection. There is no indication in the patient record that a Notice Regarding Restricted Rights of an Individual for this treatment in the ED on 4/6/19 was provided to the patient. The UnityPoint Methodist Healthcare Behavioral Health Restraint/Seclusion progress note is observed in the chart to indicate staff were documenting the restraint of this patient during his treatment in the ED. The HRA was able to locate the Emergency Department Frequent Observation Flowsheet for the 4/6/19 day of ED treatment that indicates staff were completing fifteen-minute checks on the patient. The routine Consent to Treat release is noted in this patient's chart but has "unable to sign" documented for this 4/6/19 treatment in the ED.

The HRA reviewed a Physical Assessment Sheet completed on 4/7/19 at 2:55am and no bruises are documented.

On 4/12/19 he was given an IM of Haldol and he was walked to seclusion at 1:26pm and out of seclusion by 2:41pm. On 4/12/19 at 1:49pm a Notice Regarding Restricted Rights of an Individual was given to patient.

On 4/13/19 bruising is observed on the patient by the House Supervisor. On 4/13/19 there are three Plan of Care notes that document that an RN and House Supervisor observed the patient. The first is written at 9:31am: "Pt expressed belief that he has been physically abused. Pt stated that he doesn't know when, or by whom, and stated that this is because he was taking 'psych meds.' Pt stated that he has bruises on his leg, and that he doesn't know where they came from. Pt stated that he noticed them a couple of days ago. Pt stated, 'it might have been when they hog tied me or strapped me down in the ER.' Pt then expressed belief that he could have been sexually abused. Writer and [Nurse]. RN assessed bruises that patient was referring to on right and left upper legs. 0930: Dr. [Hospital Staff] notified of above information. 0934: [Hospital Nurse], covering nurse manager, notified. Per [Hospital Nurse], notify house supervisor and have her speak with patient. 0936: [Staff] house supervisor notified, stated that she will come up to see patient. He also discusses the bruises on a telephone call with his sister on 4/15/19." The second Plan of Care note written by an RN at 11:30am states "[Nurse], house supervisor, spoke with patient regarding patients' complaints of possible abuse. Dr. [Hospital Staff] and Dr. [Hospital Staff] updated that [Behavioral Health Staff] met with patient." Lastly, at 11:31am a staff Plan of Care note documents an RN "Went with house supervisor to exam patients bruises to bilateral legs. Bruises are green and yellow in color."

On 4/15/19, 4/16/19 and 4/20/19 the patient again speaks with staff about the bruises on his thighs that he thinks was from being restrained in the ED and 4/17/19 nursing staff requested a wound consult for the patient. On 4/17/19 the wound team arrived to take pictures of the patient's bruises with his consent. A Patient Advocate was also involved in this process. On 4/16/19, he spoke with the physician about the bruises when placed into restraint and the physician spoke with the UnityPoint Health Behavioral Health Director about the allegation of abuse. The HRA is unable to determine what the outcome of this line of communication was and if it was determined that the patient was indeed abused. On 4/17/19 a Progress Note written by a staff physician indicates the bruising did not require additional care. This note does not decide if the bruising is from improper restraint as the allegation alleges.

On 4/19/19, a Plan of Care note written by a mental health counselor discusses with the patient him being upset that he was on a phone restriction and states "Patient is preoccupied with being on a phone restriction. Patient also claiming he was abused last night. When asked more about this, the patient said, 'last night I was very angry about my phone privileges taken away and they told me to get away from the desk but freedom of speech.' Patient then said 'they got my arms like this (patient showed writer the positioning of his arms) and it kinda hurt my shoulder and they gave me an injection. That's abuse.' (RN notified). Patient then went back to talking about his phone restriction and said 'I have a freedom of speech. If I can't make calls, who am I going to tell about the abuse?' Patient said that, 'you all were cursed last night' and then went on a religious tangent. Patient not wanting to discuss anything else. Patient has not been physically aggressive thus far in the shift." On this same day there is a Plan of Care note written by an RN that the patient refused oral PRN medication due to escalating behavior but eventually agreed to take an intermuscular injection due to security being present on the floor.

The third and final admission under review for this HRA complaint began on 5/23/19 and was a readmission on the same day of discharge from the second admission. It does not appear that any physical restraints or therapeutic holds took place during this admission through the ED nor did the patient require seclusion. A Plan of Care note documents that on 5/27/19, the patient agreed to an IM medication due to his behaviors after security arrived on the unit.

UnityPoint Patient Handbook provides a list of Patient's Rights and explains that a patient has a right "To be free from restraint and/or seclusion of any form unless needed for the purpose of protecting you or others from injury or with critical medical treatment. Restraints are used while preserving patient's rights, dignity, and well-being. Patients will not be restrained as a means of coercion, discipline, convenience, or retaliation by staff." UnityPoint Health Policy #B-9.13 titled Patient Rights and Responsibilities dated 10/11/18 also states the same information regarding use of a restraint.

The HRA reviewed the UnityPoint Health Methodist/Proctor/Pekin Care Coordination Policy #BB-12 on Restraints dated 3/13/19 and last reviewed on 3/13/20. This policy explains "UnityPoint Health-Methodist/Proctor/Pekin is committed to

managing patients in the least restrictive environment. Restraint and seclusion, as defined below, are used only as emergency therapeutic measure and only where no other option is reasonably available to keep a patient from harming himself or others. Restraint/seclusion use is carefully documented, and patients are carefully monitored to ensure their safety."

The HRA reviewed the UnityPoint Health Methodist/Proctor/Pekin Care Coordination Policy #BB-12 on Restraints dated 3/13/19 and last reviewed on 3/13/20. This policy explains "UnityPoint Health-Methodist/Proctor/Pekin is committed to managing patients in the last restrictive environment. Restraint and seclusion, as defined below, are used only as emergency therapeutic measure and only where no other option is reasonably available to keep a patient from harming himself or others. Restraint/seclusion use is carefully documented, and patients are carefully monitored to ensure their safety." The section titled General Information defines... Restraint "1. Restraint consists of any physical restraint or chemical restraint used on a patient to reduce the risk that the patient will cause harm to himself or to others. A restraint can be any device utilized in order to control the patient's behavior or restrict the patient's freedom of movement or normal access to his own body whether the device was designed for that use. ... b. A chemical restraint is any drug or medication used as a restriction to manage the patient's movement and is not a standard treatment or dosage for the patient's condition. If the drug/medication used to treat the patient's condition is expected to enable the patient to more effectively or appropriately function in the world around them than would be possible without the use of the drug/medication, it is not considered a chemical restraint." This same policy also has a section titled Notification to Patient of Rights and states "a. Whenever restraint or seclusion is utilized on a Behavioral Health unit, the patient will be advised of his right pursuant to Section 5/2-109 of the Illinois Mental Health Code to have any person of his choosing, including the Guardianship and Advocacy Commission notified of the restraints. ... c. Behavioral Health units: a notice of restriction of rights will be given to the patient, with a copy to be placed in the patient's chart. A copy will also be sent to the patient's legal guardian or the designated Power of Attorney for Healthcare."

The Hospital Licensing Act (210 ILCS 85/9.6) Patient Protection from Abuse states: "(b) Any hospital administrator, agent, employee, or medical staff member who has reasonable cause to believe that any patient with whom he or she has direct contact has been subjected to abuse in the hospital shall promptly report or cause a report to be made to a designated hospital administrator responsible for providing such reports to the Department as required by this Section ... (d) Upon receiving a report under subsection (b) of this Section, the hospital shall submit the report to the Department within 24 hours of obtaining such report. In the event that the hospital receives multiple reports involving a single alleged instance of abuse, the hospital shall submit one report to the Department ... (e) Upon receiving a report under this Section, the hospital shall promptly conduct an internal review to ensure the alleged victim's safety."

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102). Care and services; psychotropic medication; religion states: "(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 Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107). Refusal of services; informing of risks states: "(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."

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-108). Use of restraint. requires that: "Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. 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. (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, advanced practice psychiatric nurse, or registered nurse with supervisory responsibilities. No restraint shall be ordered unless the physician, clinical psychologist, clinical social worker, clinical professional counselor, advanced practice psychiatric nurse, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of restraint is justified to prevent the recipient from causing physical harm to himself or others. In no event may restraint continue for longer than 2 hours unless within that time period a nurse with supervisory responsibilities, advanced practice psychiatric nurse, 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. (b) In the event there is an emergency requiring the immediate use of restraint, it may be ordered temporarily by a qualified person only where a physician, clinical psychologist, clinical social worker, clinical professional counselor, advanced practice psychiatric nurse, or registered nurse with supervisory responsibilities is not immediately available. In that event, an order by a nurse, clinical psychologist, clinical social worker, clinical professional counselor, advanced practice psychiatric nurse, or physician shall be obtained pursuant to the requirements of this Section as quickly as possible, and the recipient shall be examined by a physician or supervisory nurse within 2 hours after the initial employment of the emergency restraint. Whoever orders restraint in emergency

situations shall document its necessity and place that documentation in the recipient's record. (c) The person who orders restraint shall inform the facility director or his designee in writing of the use of restraint within 24 hours. (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. (e) Restraint may be employed during all or part of one 24 hour period, the period commencing with the initial application of the restraint. However, once restraint has been employed during one 24-hour period, it shall not be used again on the same recipient during the next 48 hours without the prior written authorization of the facility director. (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. (h) Whenever restraint is imposed upon any recipient whose primary mode of communication is sign language, the recipient shall be permitted to have his hands free from restraint for brief periods each hour, except when freedom may result in physical harm to the recipient or others. (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."

<u>The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-201)</u> Restrictions, restraints or seclusion; notice; records mandates 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, or the agency designated under "An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named", approved September 20, 1985,[1] if either is so designated; and (5) the recipient's substitute decision maker, if any. The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefor in the recipient's record."

COMPLAINT #1 CONCLUSION:

The HRA **substantiates** the allegation of improper use of restraints. This substantiation is based on the minimal documentation from this patient's treatment in the ED on 1/23/19 where he received a "chemical restraint" of IM Geodon, Haldol and Ativan but there is no indication that a Notice Regarding Rights Restriction of an Individual were provided to him during his treatment in the ED nor was there indication that a less restrictive alternative was attempted per the Code (405 ILCS 5/2-107). The HRA also substantiates based on the 4/6/19 ED order for a locked restraint but there was not a Notice Regarding Rights Restriction of an Individual provided to the patient after the use of locked restraints to treat the patient in the ED per the Code (405 ILCS 5/2-201) nor was the HRA able to locate an Emergency Department Frequent Observation Flowsheet for the April visit to the ED.

The HRA makes the following **recommendations:**

- Train UnityPoint Healthcare emergency department staff on the importance of clearly documenting the reason for a chemical restraint, physical restraint or seclusion order being used on a patient in their ED per the hospital's own Care Coordination policy.
- Provide evidence to the HRA that ED staff have been trained on appropriate documentation.
- Train UnityPoint Healthcare emergency department staff on when to provide a Notice of Rights Restriction to patients being treated in the ED per the Code (405 ILCS 5/2-201).
- Provide evidence to the HRA that the ED staff have been trained on when to provide a Notice of Rights Restriction to a patient.
- The medical record documentation reads that a Plan of Care note written by an RN that the patient refused oral PRN medication due to escalating behavior but eventually agreed to take an intermuscular injection due to security being present on the floor. There was another Plan of Care note that insinuated that he took medication after the security arrived. This is considered coercion and a violation of the patient's right to refuse medication per the Code (405 ILCS 5/2-107). The HRA suggests the facility review the practice of patients agreeing to take medication due to security being present and cease in this practice.

The HRA makes the following suggestion:

- The HRA observed in the medical record that the patient reported to the Behavioral Health Floor physician after the voluntary admission in January that he is unable to be treated with Geodon due to QTC prolongation which is a heart issue that contraindicates the use of Geodon as an appropriate psychotropic medication for this patient. Caution needs to be used before psychotropic medications are being ordered to treat on an emergency basis during a mental health crisis, especially for those who have medically indicated reason for nonuse due to adverse side effects of certain medications, as evidenced in this case by the use of Geodon being given in the ED in January 2019 without consulting with the patient prior to the medication being given.
- In reviewing the record, the HRA saw no evidence that the facility investigated the abuse allegations or reported the allegations per the Hospital Licensing Act, 210 ILCS 85/9.6. Going forward, assure that all abuse allegations are investigated to assure protection of the patient.
- The Mental Health Treatment Declaration is a type of advanced directive for individuals with mental health needs. The Declaration allows individuals to pre-define their choices and preferences in mental health treatment. The HRA suggests educating unit staff on this option and providing patients with related resource information, including the Commission's link to the topic:
  https://www2.illinois.gov/sites/gac/Forms/Documents/DMHTForm.pdf

Complaint #2- Inadequate treatment while in seclusion.

The first involuntary admission began on 1/23/19 in the ED documents that on 1/24/19 a Nursing Communication Note documents a UnityPoint Medical Doctor stating to "encourage the patient to take plenty of oral fluids." On 1/25/19, a Plan of Care Encounter note documents "... During breakfast Patient is aggressive getting in staff and peers faces. Patient is loud and threatening peers. Patient starts yelling, will not re-direct. Patient takes off clothes in dining room/hallway. Patient is escorted down the hallway, put in a therapeutic hold and goes into to seclusion. Patient is in seclusion now, see additional note for further details. ..." On this same day there is another Plan of Care note that documents "Therapeutic escort, therapeutic hold and seclusion orders obtained from Dr. [Staff Psychiatrist] at 0837." There is also another Plan of Care note written by a different RN on staff dated 1/25/19 that documents "... Patient was therapeutically escorted to seclusion by security (0825-0826). Patient then placed in a therapeutic CPI approved hold (0826-0827) where he received IM medications (at 0826). Seclusion locked (0827). ..." A Plan of Care Note dated 1/25/19 completed by an RN documents the following "Pt out of seclusion at 0908. [Physician] aware. Pt agreeable to taking Lithium 600mg at 0912. Pt given ice water, encouraged to drink oral fluids."

The second involuntary admission beginning on 4/6/19 an ED Flowsheet note documents under the section titled ED Intentional Rounding, patient "was provided with ice chips/water." Seclusion is not mentioned during treatment in the ED. Part of this record states the patient was an involuntary admission but then another part of the record

indicates the patient was a voluntary admission. The record reviewed by the HRA observed the patient's signature on voluntary admission documents on 4/6/19 after receiving two emergency psychotropic medications. On 4/15/19 a Plan of Care note completed by a medical doctor documents that the patient signed a 5-Day notice to discharge. On 4/17/19 the hospital filed petitions and certifications for an involuntary admission and the patient was provided with this information on the same day. Court was held on 4/23/19 and the patient attended. The patient was court ordered for involuntary admission and court enforced medications for up to 90 days. The chart record documents that the patient refused most all medications prior to the court hearing on 4/23/19. The patient discharged on 5/23/19 and returned to the ED on the same day. The hospital filed documents for another involuntary commitment on 5/23/19 and provided the patient with the documentation.

While the patient was admitted to the Behavioral Health Unit, on 4/12/19 documentation verifies that the patient was involved in a restraint and seclusion incident. A UnityPoint Methodist Proctor Medical Doctor ordered a "Restraints violent or self-destructive adults Type- Seclusion at 1521." The order frequency was "Continuous x 4 hours 4/12/19 1326-4hrs." On 4/12/19 a Plan of Care note written by an RN documents " ...RN administered injection (Haldol 5mg, Ativan 2mg). Patient then walked to seclusion and it was locked at 1326. ... Patient calmed enough to cooperate with putting on scrubs. Asked to be let out. States that he was angry that staff came into his bathroom. Talked about not threatening other peers, and patient replied, 'freedom of speech!' RN talked to him about threats against others not being appropriate or tolerated. Patient agreeable. States he will go to his room. Seclusion unlocked at 1441."

The third admission began on 5/23/19, after he was also discharged on this same day. A 6/5/19 Plan of Care Encounter note documents "Patient was in the dining room and arguing with a peer. Patient stripped his clothes off while in the dining room and then urinated on the dining room floor. Patient was waving his arms around and jumping around. Security was called to the unit. Patient was grabbing at security staff and throwing things. Patient was put in a therapeutic escort to seclusion. Patient was making threats toward staff. Patient was given as needed IM medications. Patient was locked in seclusion." There is also a corresponding UICOMP Psychiatry Residency Teaching Service Progress Note that is dated 6/5/19 that documents the behaviors that required seclusion and IM orders as the behavioral intervention. This information is also documented on an InterDisciplinary Team Note that was held on 6/7/19 and documents the 6/6/19 seclusion and PRN medication intervention due to behaviors.

On 6/5/19 a Plan of Care note written by an RN at 7:48pm documents "Patient woke up about 1930 and requested his dinner tray. Patient then began to clean up his room and pick up the trash. Patient was met with in his room where he was calm and cooperative. Patient stated, 'I threatened to put a car bomb in that judge's car. I meant it too. I don't want to stay here forever. And I got put in the cool room again today cause I took my clothes off in the dining room. I was abused in the cool room.' Patient was asked about his court ordered medications tonight and patient stated 'I will take the oral medications tonight.'"

On 6/3/19 a Plan of Care note documents the patient refusing to eat or drink that day and finally drinking a cup of water at 7:42pm

The HRA reviewed the UnityPoint Health Methodist/Proctor/Pekin Care Coordination Policy #BB-12 on Restraints/Seclusion dated 3/13/19 and last reviewed on 3/13/20. This policy explains "UnityPoint Health-Methodist/Proctor/Pekin is committed to managing patients in the last restrictive environment. Restraint and seclusion, as defined below, are used only as emergency therapeutic measure and only where no other option is reasonably available to keep a patient from harming himself or others. Restraint/seclusion use is carefully documented, and patients are carefully monitored to ensure their safety." The section titled General Information defines seclusion as "The involuntary confinement of a patient alone in a room or an area where the person is physically prevented from leaving. The door can be locked or unlocked. Seclusion is not just confining an individual to an area but involuntarily confining him or her alone in a room or area where s/he is physically prevented or has the perception of being prevented from leaving the area. Seclusion may be used only for the management of violent or self-destructive behaviors. Seclusion does not include confinement on a locked unit where the patient is with others."

The Mental Health and Developmental Disabilities Code (405 ILCS 5/1-126.) Seclusion defines: "'Seclusion' means the sequestration by placement of a recipient alone in a room which he has no means of leaving. The restriction of a recipient to a given area or room as part of a behavior modification program which has been authorized pursuant to his individual services plan shall not constitute seclusion, provided that such restriction does not exceed any continuous period in excess of two hours nor any periods which total more than four hours in any twenty-four hour period and that the duration, nature and purposes of each such restriction are promptly documented in the recipient's record."

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-109) Seclusion states: "Seclusion may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. In no event shall seclusion be utilized to punish or discipline a recipient, nor is seclusion to be used as a convenience for the staff. (a) Seclusion shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, clinical professional counselor, advanced practice psychiatric nurse, or registered nurse with supervisory responsibilities. No seclusion shall be ordered unless the physician, clinical psychologist, clinical social worker, clinical professional counselor, advanced practice psychiatric nurse, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of seclusion is justified to prevent the recipient from causing physical harm to himself or others. In no event may seclusion continue for longer than 2 hours unless within that time period a nurse with supervisory responsibilities, advanced practice psychiatric nurse, or a physician confirms in writing, following a personal examination of the recipient, that the seclusion 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 seclusion and the purposes for which seclusion is employed. The order shall also state the length of time seclusion is to be employed and the clinical justification for the length of time. No order for seclusion shall be valid for more than 16 hours. If further seclusion is required, a new order must be issued pursuant to the requirements provided in this Section. (b) The person who orders seclusion shall inform the facility director or his designee in writing of the use of seclusion within 24 hours. (c) The facility director shall review all seclusion orders daily and shall inquire into the reasons for the orders for seclusion by any person who routinely orders them. (d) Seclusion may be employed during all or part of one 16 hour period, that period commencing with the initial application of the seclusion. However, once seclusion has been employed during one 16 hour period, it shall not be used again on the same recipient during the next 48 hours without the prior written authorization of the facility director. (e) The person who ordered the seclusion shall assign a qualified person to observe the recipient at all times. 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 once every 15 minutes. (f) Safety precautions shall be followed to prevent injuries to the recipient in the seclusion room. Seclusion rooms shall be adequately lighted, heated, and furnished. If a door is locked, someone with a key shall be in constant attendance nearby. (g) Whenever seclusion 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 notified of the seclusion. A person who is under guardianship may request that any person of his choosing be notified of the seclusion whether or not the guardian approves of the notice. Whenever the Guardianship and Advocacy Commission is notified that a recipient has been secluded, it shall contact that recipient to determine the circumstances of the seclusion and whether further action is warranted."

COMPLAINT #2 CONCLUSION:

Unsubstantiated. The complaint alleged that the patient received inadequate treatment while in seclusion and was denied water upon his request. The HRA was unable to find any evidence in the chart record that indicated the patient requested water while in seclusion and was denied this request by staff. The HRA did see documented efforts by hospital staff to encourage the patient to drink water on 1/24/19, 1/25/19, and 4/6/19. There were also fifteen-minute check documents observed in the record to confirm staff were monitoring the patient during seclusion.

The HRA does suggest

- Behavioral interventions should always be attempted in the least restrictive manner. De-escalation attempts made through strength-based communication should always be the first tool used before seclusion.
- If psychotropic medication is required, always discuss with the patient medication choices and side effects that come with this type of medication. Also provide written documentation that explains the medication prescribed, no matter how many years an individual has been prescribed the medication.
- The HRA is concerned at the statement made by staff that a patient is a "Loud

Talker" then they may not receive water. Make sure that staff are differentiating between situations when they may be a threat versus situations of describing a patient's personality or how they present themselves socially, as in being a "Loud Talker".

Complaint #3- Communication Violation.

The complaint also alleges that patient was not allowed to visit with a friend due to this friend being accompanied by a service animal. Upon review of all three commitments, documentation provided shows that admission education was provided to the patient each time and included the following information "Hospitals are required to inform each patient (or the patient's support person, where appropriate) of his/her visitation rights. (1) Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, when he or she is informed of his or her other rights under this section. (2) Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time." This information was documented to be "accepted" by the patient on 1/23/19, 4/7/19, and 5/23/19 by UnityPoint Methodist admissions staff.

There were no documented incidents of in person visits on the unit for the 1/23/19-2/13/19 admission and patient was encouraged by UP staff to use the phone on 2/7/19 and 2/8/19 during the first admission.

During the second admission, the patient had access to the telephone either at the nurse's station or the common area. He is documented to be talking on the phone on 4/15/19. On 4/16/19, he wanted to call police. The nursing staff give him the phone to call. The local police department came to the mental health unit to meet with the patient. On 4/18/19 a Notice of Rights Restriction was provided to the patient to document the phone restriction. The form explains that the restriction was put in place due to "... misusing the phone repeatedly to call and harass the police and other government offices." The HRA observed a signature on this form of a UnityPoint Methodist RN.

On 4/7/19 the UnityPoint Methodist Proctor Illinois Department of Mental Health Rights of Individuals Receiving Mental Health and Developmental Disabilities Services form was observed in the patient chart. There is a box checked on this form that indicates the patient refused to sign. There are two hospital staff signatures noted on the form. One attesting to the following "I have explained these rights to the individual (or the guardian of the individual, if applicable) and have provided him or her a copy of it. A copy of this form has been filed in the individual's clinical record." The other signature is a witness to the staff signature.

On 4/16/19 a Plan of Care note written by an RN documents the patient's use of the telephone "Patient came up to the nurse's station and stated he was going to call the

police. Patient was informed that the phones were on and he could call. Patient made a phone call and stated that the police would be here soon. Patient stated that the FBI may come to the floor as well."

4/20/19 a Plan of Care note written by an RN documents the patient on the hall phone even though he was on phone restriction. The RN clarified with the patient that he is only allowed to use the "... phone at the desk, and patient was agreeable. ..."

On 4/26/19 a Plan of Care note written by a registered nurse documents a police meeting with the patient on the behavioral health floor and telling the patient he was on phone restriction.

On 4/27/19 there is a nursing note that documents that the patient was calling the state police making false allegations. A phone restriction was implemented.

On 4/30/19 at 9:28pm a Plan of Care note written by a nurse documents the patient asking to use the phone and being refused due to the phone restriction. The patient begins to escalate verbally and states, "...." Patient states that he is allowed for one hour per Dr. [Staff Physician] to make a phone call and his nurse on first shift allowed him to make a phone call. ..."

4/30/19 a clinician note documents the following "... Pt indicated he is aware of his rights and has been in contact with the Guardianship and Advocacy office. ..."

A Plan of Care note dated 5/28/19 written by a UnityPoint Clinician documents the following "... Pt was scheduled for involuntary commitment hearing today. The hearing was continued; but immediately following, pt signed voluntary admission. Pt's assigned attorney from Guardianship and Advocacy was present when voluntary admission and rights were discussed with pt. Pt then signed voluntary admission. Pt talked about interest in signing a 5 day request for discharge. Pt's attorney [Legal Advocacy Service Staff] asked for pt to call and discuss with him if pt is thinking about signing a request for discharge and to call before he signs the request for discharge. Family Response: Pt continues to refuse family involvement in treatment. Pt specifically said he does not want his sister contacted."

There is an order entered in the chart record by a UnityPoint Methodist Proctor attending psychiatrist on 4/18/19 placing the patient on a phone restriction due to frequent calling of the police and FBI.

In April 2019, there are two Plan of Care notes that document the patient is unhappy that a family member will not come and visit him.

On 5/18/20, 5/21/19, 5/27/19, 5/30/19, 6/2/19, 6/11/19, 6/16/19, and 6/19/19 Plan of Care notes document the patient had visitors on the unit visiting with him. Also, on 6/21/19 a Plan of Care note documents the patient "... Had a visit from 2 friends, including a friend who has a service dog. Patient was happy to see the dog, laughing and

petting it. His other visitor brought clippers and patient shaved off his beard. …" On 6/22/19 a Plan of Care note completed by a RN documents that "… Patient has a visit from friend with therapy dog. Patient was proud to show off his friend and companion. …"

The HRA did not see anything in the records provided that indicated the patient was refused a visit with a friend who uses a therapy dog.

On 6/12/19 a Plan of Care note documents a conversation between the patient and an RN about what will happen if the patient is placed on phone restriction again. A Plan of Care note dated 6/17/19 documents the patient using the phone.

The UnityPoint Patient Handbook revised 5/20/2020 communicates the following to behavioral health unit patients about visitation under the section titled Visitation Rights: "In concert with patient centered care, UnityPoint Health – Methodist | Proctor has an open policy regarding patient visitation. Exceptions are as follows: … As a patient*, you have the right to receive or restrict any visitors you designate, including, but not limited to, a spouse, a domestic partner (including a same sex domestic partner), another family member, clergy, and/or friend. The individual may or may not be the patient's surrogate decision maker or legally authorized representative. You may modify your visitation request at any time by communicating your wishes to the nursing staff." The UnityPoint Methodist Proctor Patient Advocacy number is also listed on this same page. UnityPoint Health Policy #B-9.13 titled Patient Rights and Responsibilities dated 10/11/18 also states the same information in section G. Visitation Rights.

The UnityPoint Patient Handbook revised on 5/20/2020 communicates the following to behavioral health unit patients about telephone access under the section titled Telephone "Telephones for your use are located in the hallways; two next to room 806 and 807 and two more in the hall next to 817 and 818. Patients are responsible for answering the patients' telephones and obtaining patients for incoming calls. Phone calls will be made and received from 7:30AM – 10:00PM, Sunday through Thursday and from 7:30AM – 10:00PM, Friday, Saturday, and holidays. Because groups are an important part of your program, the telephones will be shut off during group time so you will not be interrupted. Please dial "9" before you dial your number. Phone calls are limited to 10 minutes. Long distance calls can only be made collect or by using a calling card. The telephone numbers are: …"

The Mental Health and Developmental Disability Code 405 ILCS 5/2-103 - Mail; telephone; visits requires: "Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation."

The Mental Health and Developmental Disability Code (405 ILCS 5/2-201) Restrictions, restraints or seclusion; notice; records states: "(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:"

COMPLAINT #3 CONCLUSION:

Unsubstantiated.

The HRA was able to observe in the patient record several instances of the patient being able to use the telephone, have in-person visits, and clearly documented visits with a friend that required the use of a therapy dog. The facility permitted the dog to be brought to the unit on 6/21/19 and 6/22/19.
The HRA also reviewed documentation that restricted the patient's telephone use during the 5/23/19-7/1/19 admission due to using the phone to contact the police and other governmental officials such as the FBI. The police visited the patient on the unit and requested the hospital to restrict the patient's phone calls for non-emergency reasons.

The HRA suggests:

- Hospital staff continue to respect a patient's rights to privacy and unrestricted access to a telephone. If a phone or visit restriction is required due to behavioral concerns of a patient the physician should order this into effect, the patient should be notified verbally and have a Notice of Rights Restricted to an Individual form provided each time a restriction is required.
- The HRA saw that staff documented that the patient was in contact with the Illinois Guardianship and Advocacy Commission. Such documentation could suggest that staff are listening in on and then documenting private communications as guaranteed by the Code (405 ILCS 5/2-103). It is unclear if the patient reported this to staff or if staff impeded and then documented private communications. The HRA strongly urges the hospital to protect and respect the private communications of patients, including attorneys, and re-educate staff accordingly.

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. 19-090-90019

SERVICE PROVIDER: – UnityPoint Health- Methodist/Proctor

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:

X We request that our response to any recommendation/s, plus any comments and/or objections be included as part of the public record. Please do not include the lists of staff names as part of the posting

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

_____ No response is included.

DEAN STEINER
NAME

DIRECTOR
TITLE

12/3/20
DATE

221 Northeast Glen Oak Avenue
Peoria, Illinois 61636-0002
(309) 672-5522
www.unitypoint.org/peoria

December 3, 2020

Illinois Guardianship and Advocacy Commission
Peoria Regional Office
401 Main Street – Suite 620
Peoria, IL 61602

Re: HRA #19-090-9019

Dear Ms. Tucker:

Regarding the recommendations for the substantiated findings for the above case, we have educated our Emergency Department staff on documenting the reason for having to chemically or physically restrain or to seclude a patient. In addition, we have educated our Emergency Department staff on the when to provide a Notice of Rights Restriction to patients. As part of that education, we presented the issue that using our security staff as a coercive method to have someone take medication. A copy of the education log is enclosed.

Our Emergency Department leadership has made a commitment to providing quarterly education on the above topics to staff. Our intention is to keep these issues fresh and current for our staff and to allow for any questions or address any issues that need clarification.

Regarding HRA's suggestions on this case: we will work with the providers to consult with the patient about any history of allergies or adverse reactions to medications.

We recently completed education of our master's level staff (Inpatient, Outpatient and Emergency Behavioral Health areas) on the Mental Health Treatment Declaration. We are committed to educating our patients on this advanced directive and providing them with the necessary information they need to make a decision about having such a directive.

Finally, we want to address the item regarding HRA not seeing evidence that we investigated or reported allegations of abuse by this individual. An allegation of abuse was reported by the patient to our Patient Advocate on 4/16/19. That report was filed with IDPH through our Patient Safety Department on 4/16/19, and was subsequently investigated. Those findings were reported to IDPH on 4/18/19. We take such allegations very seriously and promptly investigate them.

We thank the HRA for providing us feedback so that we can continue our ongoing work to improve the care we provide to those we serve.

Sincerely,

Dean Steiner, LCPC
Director, Behavioral Health Services

cc: Karen Senger, IDPH
Keith Knepp, M.D.

enc