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HUMAN RIGHTS AUTHORITY – PEORIA REGION
REPORT OF FINDINGS

Case #20-090-9001
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- **Inadequate treatment, including patient being restrained without cause and staff neglecting to tell patient if medication was given while being restrained. Lack of assistive device being provided for patient mobility which lead to injury. Lack of treatment for a hip injury and rude treatment by staff regarding mobility request.**

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 employed in the Emergency Department (ED), including nurses, mental health technicians, certified nursing assistants (CNA), a recreational therapist, and a psychiatrist. Staff estimated between 1500 - 2000 patients present to the emergency department 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 unit with sixty-seven beds. The HRA visited the facility and conducted a site visit with representatives involved with this patient's care. The HRA also reviewed, with authorized written consent, the patient's record.

Complaint Statement

The complaint states that a patient was voluntarily admitted to the hospital ED and was allegedly denied access to assistive devices to help him walk, both in the ED and behavioral unit. The complaint also alleges that while in the ED, a staff member told the patient he would be administered Haldol and the patient informed staff that he was

allergic and requested different medication. The allegations state that 6 people then restrained the patient by his neck, arms, and legs. Allegedly the patient was not even sure if he received a shot, he was never informed and there was no reason for the patient to be restrained. Additionally, the patient was bruised from being restrained. The patient also asked for an MRI to be completed on his injured hip and staff in the unit said that it was the physical therapy department who would examine his hip, but physical therapy would never examine. Allegedly, while on the unit, the patient had to walk holding the wall and fell, making an already present hip injury worsen. The allegations state that while on the behavioral unit, a staff member looked at him and said, "You can walk" and denied him a wheelchair or walker.

Interview with staff (10-21-2019)

A meeting was held at UnityPoint Methodist with HRA members and administrative staff from the hospital. The HRA provided a copy of the signed consent to the hospital staff to be able to discuss the patient that had received care at the hospital in the ED and the Behavioral Health Unit.

The hospital uses restraints based on behaviors being considered violent or nonviolent. Velcro restraints are used for a patient displaying violent behavior per Center for Medicaid and Medicare Services (CMS) guidelines. An attending physician is the person who orders a restraint. The hospital prefers verbal de-escalation or 1:1 staffing to prevent restraint. A patient's violent behavior can be physically violent towards staff or they are a danger to themselves. Before Velcro restraints are used on a patient, Crisis Prevention Institution (CPI) training is used to attempt to deescalate the patient. Hospital staff in both the ED and on the Behavioral Health Unit have been certified in CPI training. The hospital staff are trained yearly that they know how to apply restraints. This is an eight-hour class required for all ED and Behavioral Health Unit staff. Some of the steps utilized before a Velcro restraint could be verbal de-escalation as this is the main part of the process for CPI, but if that does not work a two-person hold or seclusion in a locked room on the behavioral health floor are other options.

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 having patient placed in a Posey vest. 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 by nursing. A physical restraint would be removed after the patient 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.

No behavior interventions can be implemented, such as a restraint, without a physician's order. 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 who are all trained in CPI. A patient can receive a physical injury during a physical restraint. These injuries are usually minimal. Commonly occurring physical injuries are scratches or bruises. Often the bruising to a patient happens before the physical restraint is applied to them. There is always the potential for a struggle between staff and the patient which could potentially result in a bruise. Sometimes a patient will take themselves to the floor and the momentum from this move could cause a bruising injury. Once a patient is released from a physical restraint they are assessed by staff for injuries and if there are any marks or redness, it is documented. If a patient continues to complain of pain in a certain area, then an x-ray could be ordered if a physician feels it is necessary. The hospital also does an internal investigation for physical injuries and would talk with ED and floor staff, risk management, and other regulatory staff within the hospital.

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 provide and permit mobility devices to be used while admitted to the behavioral health floor. Mobility devices such as walkers and wheelchair are used if ordered.

The Behavioral Health Unit also has call lights available in each patient's room. They can be pressed at any time. There is a computer screen at the nurse's desk that lights up when a call light is pressed. Nursing also makes four rounds per hour checking on patients and responding to call light requests. Any staff can respond to a call light and it is tracked in the computer that a light was on, but it does not document what response the patient received.

The patient involved with this complaint arrived at the ED in June for a psychiatric evaluation. He was brought to the ED by the Emergency Response Service (ERS) due to police being called to his home when he had barricaded himself in and his mom, who he lived with, was outside of the residence. He had also placed an order of protection against his mother. This individual was in restraint in the ED due to being verbally aggressive, kicking walls, and punching walls. There were no ED notes easily found during the site visit to indicate this individual was in restraints. He did receive a 5mg Haldol injection on 6/22/19 at 1:45am. There was no allergy listed in his patient chart at the time of receiving the injection. The allergy was then updated to his chart 7/15/19. The employees involved in the site visit confirmed that the patient received the

IM and were not sure if he suffered side effects of the medication. If an allergy is reported it would be screened at the ED. There are other alternatives to Haldol. The physician could order other medications if necessary. The only allergy listed in the patient's chart was to Sudafed at the time of this treatment. This individual required emergency medication due to pacing, spitting, punching and kicking walls. He received the psychotropic medication with staff assistance before a restraint that took place later. This patient was voluntarily admitted to the behavioral health unit. He was observed by staff and no adverse reactions were noted by staff such as stiff joints or clenched jaw. The nurse supervisor, who was part of the site visit, also met with this patient after he was transferred to the behavioral health unit. There is a rights restriction noted in the chart due to the emergency psychotropic medication being given on 6/22/19 but no record of a restraint was found. The patient did not report a fall on the day he was voluntarily admitted to the unit. Although this individual had received PRN medication prior to his admission, the attending physician determined he had decision-making capacity to voluntarily admit.

This patient did fall on 6/27/19 at 12:05am while he was being treated on the behavioral health unit. A note that was written by the lead nurse documents that this patient became irritable after voicing complaints of indigestion while they were making rounds. The patient became agitated when the nurse attempted to assess. The patient had a heat pack on his hip and cursed at the nurse. Patient said his hip "gave out" and he fell to the floor. Staff offered him assistance, he said he only came to the hospital for hip pain and wanted an MRI. Staff offered him milk. He declined assistance and ambulated back to his room with staff. They treated his hip with a heat pack and a topical pain cream. He was observed to ambulate without difficulty. Later this same morning around 1:32am, he complained of hip pain and demanded an MRI of his hip. He also wanted to transfer hospitals. He was asked to wait until the morning to speak with his physician. There is also a note written by a UnityPoint Methodist/Proctor Mental Health Associate that states when staff responded to a call light this patient was up and about, irritable and complaining of pain. He wanted a wheelchair or a walker. The staff attending to the patient let him know he would need to be assessed by physical therapy for that order. This employee documented that he was told, "We aren't gonna do that, you can walk." He was then evaluated by the hospitalist in the morning and no physical therapy was ordered. He was recommended to do some exercises, follow-up with his primary care physician, and had orders for a Voltarin topical and Tylenol as pain management medications. This patient was also seen by a medical doctor due to the pain concerns that he reported. He received PRN medications to manage the pain. He also received another psychotropic medication injection for his agitation during his behavioral health admission.

FINDINGS

#1- Inadequate treatment, including patient being restrained without cause and staff neglecting to tell patient if medication was given while being restrained. Lack of

assistive device being provided for patient mobility which lead to injury. Lack of treatment for a hip injury and rude treatment by staff regarding mobility request.

A review of patient records reveals this individual was taken to the hospital ED for a psychiatric evaluation by the local Emergency Response Services Specialist (ERS). The patient was in the ED voluntarily. A review of Emergency Department shows that the service recipient arrived at the ED on 6/21/19 at 1957. An ED Note written at 20:29 states the patient reported concerns to the attending physician of having a dislocated hip. An x-ray was ordered. On 6/21/19 at 2159 an ED note written by the attending Certified Physician's Assistant (PA-C) states "Patient is aggressive and is yelling profanities at staff at this time. ... Haldol ordered." At 00:41 the same staff wrote an updated ED note "Patient is requesting a Nicotine patch and food. Haldol was not given because the patient was being cooperative after being verbally abusive."

The HRA reviewed the ED Psychiatric Evaluation dated 6/21/2019 at 20:29 completed by the PA-C "[patient] is a 45 y.o. male presenting to the ED for a psychiatric evaluation. Pt states that he is scared that his mother is trying to kill him. He does not elaborate any further details after the initial statement. Pt confirms having occasional homicidal ideations. He states that he does not have a specific person or plan but thinks about harming people when they make him mad. Pt states, "I am not a violent person." He states that he has attempted suicide three times in the past. Pt mentions that his last suicide attempt was last August 2018 when he attempted to overdose on pills. Currently he has suicidal ideations however he will not disclose this information with me. Pt confirms that he has had trouble sleeping and is not eating well. He denies having any hallucinations at this time. No dysuria. Per pt, he believes that he may have a dislocated hip. Pt relays that he has been diagnosed with type 1 bipolar disorder and schizoaffective disorder. He confirms that he is compliant with his medications. He confirms being a smoker at four packs per day. Pt confirms copious use of marijuana, but denies the use of EtOH. No other complaints at this time."

At 6/22/19 at 1:35am there is an ED note written by a Registered Nurse (RN) that documents "... aggressive to staff" another ED note entered by another RN on shift at 1:37am states "BH staff called and notified patient is kicking the door. (Staff) RN went to bedside to speak with the patient. She states patient has been easily verbally redirected ...."

The HRA reviewed the Patient Care Timeline from treatment in the ED. This form documents on 6/22/19 at 1:45am patient received a 5mg Haldol injection to his "right anterior thigh" given by (Staff) RN. At 1:47am there is an UnityPoint Health (UPH) Progress note written by a Behavioral Health Counselor (BHC) that documents the following information "Due to patient's continued behavior of punching and kicking walls, medication is ordered for patient and patient is moved from BH3 to BH2. Patient observed to be pacing in room, sitting on the floor in the corner and sitting on the bed. Patient verbally aggressive towards staff. Patient given medication with staff assistance. Patient now sitting in corner, angry and pressured speech followed by sobbing." There are no progress notes that indicate the patient was given the choice to receive the

medication or notification that he would be receiving Haldol as a PRN medication. The HRA was unable to find a Rights Restriction in the chart record to document that hospital staff discussed with the patient that emergency PRN medications had been administered to him via intramuscular injection to his right anterior thigh while being treated in the ED. The HRA did not find documentation that the patient had been restrained in the ED. The HRA did see an order for a PRN medication for Haldol but did not see a physician's order for a restraint. The PRN order was ordered by a "PA-C". He was voluntarily admitted to the UnityPoint Methodist Behavioral Health Unit on 6/22/19 at 7:35am. The HRA does not observe a Rights Restriction in the chart record for emergency psychotropic medications. The HRA does observe a Master Interdisciplinary Treatment Plan dated 6/22/19 beginning at 11:40am and completed on the Behavioral Health Unit that has the patient's initials and arrow pointing down to indicate that medications and potential side effect was reviewed with him by a Registered Nurse (RN) and attending Psychiatrist. This document does not have Haldol listed as a medication reviewed.

The HRA reviewed the Behavioral Health Patient Hand-Off Form dated 6/22/19 that confirms the service recipient admitted to the behavioral health unit at 7:35am. This form does have a note that confirms the service recipient is a voluntary admission and received an intermuscular injection of Haldol in the ED.

6/23/19 a Plan of Care-Encounter Note completed by an RN documents a conversation with the service recipient regarding his treatment in the ED which states "Due to complaints of abuse by ED staff the night he got admitted, patient's bruising was evaluated by this RN. No bruising indicated on left side of rib cage/flank area where patient states he states he has pain. Patient also showed RN his left leg where there was bruising from about mid-calf to lateral upper thigh but states this is from fights with his mother (looked as though these were older), and the scratching on this leg (red blister on calf and old superficial scratching) from tripping over items in his house. On patient's right leg, bruising on calf and scratching is also noted during assessment. Patient also indicates that the posterior portion of his neck had mild redness that he does note is tender upon touch. Patient states that he did 'fight' staff a little bit when getting injection but states that while he was lying down, his head was held down by his forehead causing the neck pain, however no marks noted on patient's forehead. Patient also stated that he was mocked by ED staff when he asked for wheelchair due to severe pain due to his hip after getting an x-ray. Patient stated he was interested in getting these bruising sites documented, this was brought to attention of Amanda, nursing supervisor who explained that this would be handled by manager but to make a note about characteristics of bruising."

The HRA reviewed another Plan of Care Note completed by an RN on the Behavioral Health Unit on 6/23/19 that documents the following "Pt requesting Guardianship and Advocacy phone number because he felt like he was abused in the ER. Staff gave patient the phone number. Writer met with patient who stated that he was left in his underwear for hours. Pt later stated that he was given a blanket and gown. Pt reported that he has severe neck pain from someone's palm pushing down his head and neck when he was given a shot of Haldol. Pt stated that he did not want the shot and that

he told staff that last time he was given Haldol it made his tongue protrude. Pt stated he 'fought' staff a little. 0856: [Staff], nurse manager, notified of above information. 0900: [Staff], house supervisor, notified and stated that she will come to talk to patient. 0912: [Physician] notified of above information, notified of pt reporting severe neck pain. [Staff] house supervisor, met with patient. Patient stated that he knows that he can call Guardianship and Advocacy at any time, but that he is unsure that he wants to call at this time."

6/24/19 there is a Plan of Care- Encounter Note completed by a Behavioral Health Counselor that states the service recipient has a complaint with his treatment in the ED and stated "He did not remember much while down there, specifically whether or not if he received PRN medications. ...he was stuck in a tiny room for 3 hours." The documentation provides evidence that the staff "provided information to the patient advocacy line and the response was, 'make a claim when I leave.'"

A record review did not show any further discussion with the patient about receiving a PRN psychotropic medication in the ED. There was no corresponding rights restriction found in the ED records that documented the patient was notified by hospital staff that he received emergency psychotropic medication and no consent indicating that the patient allowed the medication.

On 6/25/19 a University of Illinois College of Medicine at Peoria (UICOMP) Psychiatry Residency Teaching Service Progress Note completed on day 5 of the voluntary admission to the Behavioral Health Unit documents a conversation between the Resident Psychiatrist and the service recipient. The note reads "... He reports that he had past medication trial of Wellbutrin, nortriptyline that made him feel worse and Haldol caused him possible allergic or dystonic reaction (tongue sticking out) in the past. ..."

On 6/26/19 there is a UnityPoint Methodist Plan of Care Note that documents a conversation between the service recipient and Mental Health Therapist regarding treatment in the ED. The note documents "... Patient endorses there is something wrong with the 'muscle' of his hip. Patient endorses that he wants an 'MRI' but the 'lady in the ER gave me the dirtiest look and said we aren't gonna do that. You can walk.' Patient endorsed becoming irritable and having to be 'pend down' and given Haldol. Patient states, 'There is no proof of me getting Haldol and my leg doesn't hurt. ...'"

A flowsheet reviewed by the HRA for 6/27/19 documents nursing evaluating the service recipient's activities of daily living and his mobility. His level of assistance is defined as "independent". On 6/26/19 his activity level is described as "Up (ad lib.) Ambulate in hall." On 6/25/19 his mobility is "up ad lib" and ambulates independently. 6/24/19 he ambulates independently with no assistance. 6/23/19 mobility section of the flowsheet indicates the service recipient ambulates independently with no assistance.

The service recipient's Activities of Daily Living Screening Flowsheet (ADL) screening completed on 6/22/19 on his admission to the behavioral health floor

documents his home use assistive devices are glasses/contacts. He reports "both legs are incredibly weak" and that he was independent with ambulation prior to hospitalization. He also reports difficulty walking and using stairs due to "back pain and torn ligaments in right foot. Old athletic injury." The section of the Flowsheet that would be marked if a patient needed therapy has nothing written by staff to indicate he needed a physical therapy evaluation. The discharge summary dated 6/28/19 completed by a resident physician references the service recipient requesting an MRI during the stay but "it was not clinically indicated" and he should follow-up with his outpatient doctor. He did receive an x-ray of his hip in the ED that was negative for a fracture. None of this documentation indicate that an assistive device, such as a wheelchair or walker, is needed for the service recipient.

The HRA did not find evidence that staff on the behavioral health floor failed to discuss the patient's request for an MRI due to a hip injury. There was also no documentation in the record provided that indicated behavioral health nursing spoke to the service recipient in a rude tone.

The HRA observed two Notice of Rights Restrictions forms within the service recipient record dated 6/21/19 and 6/22/19 but neither of these forms document the patient being provided a PRN medication on 6/22/19 at 1:45am. One was for restriction of personal property and the other was for elopement precautions.

The HRA reviewed the UnityPoint Health Methodist/Proctor Behavioral Health Services Patient Handbook - Adult/Geriatric and within this document, there is a Patient Rights and Responsibilities section. Under the section Access to Care, it informs the patient of their rights and states "4. Receiving a medical screening examination and stabilizing care, regardless of ability to pay." Under the section Respect/Dignity/Confidentiality/Safety it reads "you/your representative's rights include: … 5. To be free from mental, physical, and verbal abuse, neglect, exploitation, corporal punishment, and all forms of abuse or harassment. …9. 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." Under the section Involvement in Care/Informed Consent/Research You/Your Representative's rights Include: "3. Ability to make informed decisions regarding your care. This right includes being informed of your health status and diagnosis, prognosis (possible outcome), proposed procedures (including risks involved), being involved in development/implementation/management of your plan of care and treatment, and being able to request and refuse treatment and to know what may happen if you don't have this treatment."

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 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." Restraint is defined "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 or not 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 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 5/2-102) **Care and services; psychotropic medication; religion** (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. ... In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section

2-200 shall be noted in the recipient's treatment plan. (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. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only (i) pursuant to the provisions of Section 2-107 or 2-107.1 or (ii) pursuant to a power of attorney for health care under the Powers of Attorney for Health Care Law[1] or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act.[2] A surrogate decision maker, other than a court appointed guardian, under the Health Care Surrogate Act[3] may not consent to the administration of electroconvulsive therapy or psychotropic medication. A surrogate may, however, petition for administration of such treatment pursuant to this Act. If the recipient is under guardianship and the guardian is authorized to consent to the administration of electroconvulsive therapy or psychotropic medication pursuant to subsection (c) of Section 2-107.1 of this Code, the physician shall advise the guardian in writing of the side effects and risks of the treatment, alternatives to the proposed treatment, and the risks and benefits of the treatment. A qualified professional shall be responsible for overseeing the implementation of such plan. Such care and treatment shall make reasonable accommodation of any physical disability of the recipient, including but not limited to the regular use of sign language for any hearing impaired individual for whom sign language is a primary mode of communication. If the recipient is unable to communicate effectively in English, the facility shall make reasonable efforts to provide services to the recipient in a language that the recipient understands.

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-112)
Freedom from abuse and neglect. Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect.

The Mental Health and Developmental Disabilities Code (405 ILCS 5/1-125)
Restraint means direct restriction through mechanical means or personal physical force of the limbs, head or body of a recipient. The partial or total immobilization of a recipient for the purpose of performing a medical, surgical or dental procedure or as part of a medically prescribed procedure for the treatment of an existing physical disorder or the amelioration of a physical disability shall not constitute restraint, provided that the duration, nature and purposes of the procedures or immobilization are properly documented in the recipient's record and, that if the procedures or immobilization are applied continuously or regularly for a period in excess of 24 hours, and for every 24 hour period thereafter during which the immobilization may continue, they are authorized in writing by a physician or dentist; and provided further, that any such immobilization which extends for more than 30 days be reviewed by a physician or dentist other than the one who originally authorized the immobilization. Momentary periods of physical

restriction by direct person-to-person contact, without the aid of material or mechanical devices, accomplished with limited force, and that are designed to prevent a recipient from completing an act that would result in potential physical harm to himself or another shall not constitute restraint, but shall be documented in the recipient's clinical record.

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-108) Regarding restraints, the Code states, "Restraint 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 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, or registered nurse with supervisory responsibilities. No restraint shall be ordered unless the physician, clinical psychologist, clinical social worker, clinical professional counselor, 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 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."

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-201)
Restrictions, restraints or seclusion; notice; records (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. (b) The facility director shall maintain a file of all notices of restrictions of rights, or the use of restraint or seclusion for the past 3 years. The facility director shall allow the Guardianship and Advocacy Commission, the agency designated by the Governor under Section 1 of "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, and the Department to examine and copy such records upon request. Records

obtained under this Section shall not be further disclosed except pursuant to written authorization of the recipient under Section 5 of the Mental Health and Developmental Disabilities Confidentiality Act.[2]

COMPLAINT #1 CONCLUSION:

The information gathered during the site visit that the HRA conducted on 10/21/19 is conflicting compared to what the HRA was able to find documented in the chart. The hospital staff that participated in the site visit indicated that the patient did receive an emergency psychotropic medication and was involved in a restraint but the HRA was only able to find documentation confirming that a psychotropic medication, and it is unclear if it was voluntarily taken or given as a forced medication, was given to the patient and a "staff assist" was in the ED records provided. The part of the complaint alleging the patient was given medication without explanation is **SUBSTANTIATED**. The patient record review provides no evidence that staff in the Methodist ED provided the patient with information via a rights restriction that he had received a PRN medication of Haldol. The ED record does a poor job of documenting the situation as one nurse writes that on 6/22/19 the patient was "easily verbally redirected" at 1:37am and then suddenly at 1:45am he is being given an injection of 5mg Haldol "with staff assist". The HRA saw no documentation that the medication was willfully taken by the patient through MAR and also so no indication that the patient's capacity was determined by the physician and there is no documentation that the physician explained "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" (405 ILCS 5/2-102). There was also no documentation that the patient's rights were restricted and the medication was given in an emergent situation because the patient was "causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available" (405 ILCS 5/2-107 and 405 ILCS 5/2-201). Overall, the provision of psychotropic medication in the ED needs one of these situations to occur but the HRA saw no documentation of either. Additionally, staff said that the patient was involved in a restraint episode but the HRA did not see an order for the restraint or a rights restriction for the restraint (405 ILCS 5/2-201) Additionally, although the HRA was told there was a restraint put on the patient, there was no evidence of an order for the restraint (405 ILCS 5/2-108) or a rights restriction for the restraint (405 ILCS 5/2-201). Information disclosed during the site visit also indicates that the necessary rights restrictions were not given as the word "typically" was used to describe this process which makes the HRA suspect they were not provided in this case situation.

With regards to the part of the complaint specific to "Lack of assistive device being provided for patient mobility which lead to injury. Lack of treatment for a hip injury and rude treatment by staff regarding mobility request." the HRA did not see any documentation indicating the service recipient's medical needs were not addressed in the ED or while admitted to the Behavioral Health Unit. The patient did receive an x-ray of his hip while in the ED and based on chart record documentation reviewed, the patient

did have his mobility assessed daily as required during his admission to the Behavioral Health Unit. The HRA also did not find any grievance in the record that indicated the patient voiced concern of rude treatment by staff through the UnityPoint patient complaint process, although there were some comments on the record that the patient was "mocked" and told that he can walk.

RECOMMENDATIONS:

The overall issue is that the ED has failed to follow the Code for behavioral patients regarding restraints and emergency medication and staff must be in compliance with these regulations to assure a patient's rights. UnityPoint Methodist needs to educate and train their ED staff on the compliance with the Mental Health and Developmental Disabilities Code regarding restrictions, restraints or seclusion, emergency medications, and notice per 405 ILCS 5/2-102, 107, 108, and 201. The HRA requests evidence that this training is completed.

Additionally, during the interview, the staff discuss that a patient "may" receive a physical injury. The HRA does recognize that this is not common but there is also concern that the staff themselves believe that this could occur while the Code states that the restraint should be "employed in a humane and therapeutic manner" and those implementing restraints should be trained "in the safe and humane application of each type of restraint employed." (405 ILCS 5/2-108). The HRA request that the facility provide staff training in implementation of restraints with emphasis on safety and avoiding injury so that the use is as safe and humane as possible. Please provide evidence of the training

The HRA would suggest updating the service recipient's chart with the following:

- 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

- The HRA would also suggest that UnityPoint improve their paperwork process for behavioral health patients being treated in the ED, to include (put in the items that would add to improving the process)

- Staff describe during the interview that an internal investigation is completed regarding injury but there is no discussion about contacting the Illinois Department of Health hotline for abuse reporting or providing that number to the patient if they have complaints. If the facility is not already doing this, please provide that information to the patient if they feel as though they have been abused so that they have an outlet to investigate the situation and provide self advocacy. Actually, thanks to several HRA cases, the hospital is required to investigate and report patient claims of abuse, see 210 ILCS 85/9.6.

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. 20-090-9001

SERVICE PROVIDER: – UnityPoint Healthcare 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:

✓ 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 anything with staff names.

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

_____ No response is included.

DEAN STEINER
NAME

DIRECTOR
TITLE

11/13/20
DATE

UnityPoint Health
Methodist

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

May 17, 2021

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

Re: HRA #20-090-9001

Dear Ms. Tucker/Ms. Nowlan:

In response to your request to clarify staff education provided for the above case, I am writing to confirm that the education provided to staff did include education on the use of chemical restraints and rights notification. This education was pertinent to this case as well as to a similar case prior to this one.

Thank you for the opportunity to clear up any confusion. Should you have any additional questions or concerns, please contact me at 309-672-4653.

Sincerely,

Dean Steiner

Dean Steiner, LCPC
Director, Behavioral Health Services

UnityPoint Health
Methodist

221 Northeast Glen Oak Avenue
Peoria, Illinois 61636-0002
(309) 672-5522
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February 22, 2021

Human Rights Authority
Illinois Guardianship & Advocacy Commission
Peoria Regional Office
401 Main Street – Suite 620
Peoria, IL 61602

Re: HRA #20-090-9001

Dear Ms. Nowlan:
Per your request, I am enclosing content of the education provided to our staff for the above HRA case. The content that we used is labeled "Behavioral Health: Competency Skills Validation Instructor/Online Staff." Our educator reviewed the content of this sheet with Behavioral Health and Emergency Department staff. In addition, all Behavioral Health, Emergency Department and Security staff receive this training annually and they are required to physically demonstrate the application of restraints.

All Behavioral Health, Emergency Department and Security staff are trained annually in Crisis Prevention Intervention (CPI). We are committed to providing the safest interventions for our patients and our staff. The CPI certification course thoroughly explains the dynamics of a patient's escalating behavior and teaches staff appropriate non-violent ways to intervene, with the goal of avoiding the use of restraints.

I am also enclosing a copy of the power point presentation to our master's level clinical staff for the Mental Health Treatment Declaration, so that you have content of that component. This presentation included a group discussion and question and answer period.

Please note that we consider these documents proprietary and ask that they not be part of our response that may be included on your website.

Thank you for allowing us the opportunity to evaluate our services and to continue to work on improving the care we provide for our patients.

Sincerely,

Dean Steiner, LCPC
Director, Behavioral Health Services

UnityPoint Health
Methodist

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

November 13, 2020

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

Re: HRA #20-090-9001

Dear Ms. Tucker:

Regarding the substantiated findings for the above case, per HRA's recommendations, our Emergency Department staff was educated regarding restrictions, restraints/seclusions and emergency medications. Copies of our Learning Activity Record showing staff attendance are attached.

For HRA's suggestion related to the Mental Health Treatment Declaration, we recently educated our master's level clinicians about this document. They would be the most likely staff to discuss this with our consumers. We believe this will be of great help to those we serve.

Our culture is one that embraces continuous quality improvement, so we appreciate the opportunity to work with the Commission and value the recommendations.

Sincerely,

Dean Steiner, LCPC
Director, Behavioral Health Services

Cc: Sara Caruso
enclosures