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HUMAN RIGHTS AUTHORITY-CHICAGO REGION

REPORT 22-030-9025
Ascension St. Mary's of Nazareth Hospital

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation due to a complaint of a potential rights violation in the treatment of a patient at Ascension St. Mary's of Nazareth Hospital (St. Mary's) previously known as AMITA Health St. Mary's. The investigated complaint is that the hospital improperly admitted, illegally detained, refused use of the phone and did not discharge a patient timely after the patient requested discharge.

Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

St. Mary's was founded in 1894. Per the website, the hospital was the City of Chicago's first Polish hospital and was opened to provide care for many Polish immigrants who settled in the area. In 2018 St. Mary's joined Ascension and has operated under AMITA Health. Currently, the hospital is a 495-bed medical center that provides comprehensive services including primary care, cancer care, behavioral health and more.

Per the quality director, the behavioral health department has 118 adult inpatient beds and sees over 5,800 inpatient admissions annually. The emergency department also treats over 4,000 patients annually.

The HRA met with the director of quality, two registered nurses, and the director of nursing on the unit at the hospital. Relevant policies were reviewed as was the recipient's record with proper authorization.

COMPLAINANT SUMMARY

A report indicated that a patient admitted themself into St. Mary's emergency department for a medical issue. The report furthered that the patient was transferred to a medical unit and not allowed any personal items, including a cell phone. The report then stated that the patient attempted to request discharge but was not allowed to. Finally, the report stated that the patient was attacked by several security personnel and placed back into their room without cause.

FINDINGS

"St. Mary's" Record Review

The HRA received a record that included progress notes, social worker and case management notes. The provided record also had an involuntary petition for admission, signed consents for surgery, privacy acknowledgements and consent for medical treatment. The record also had one restriction of rights notice.

From the record the patient entered the emergency department in mid-October of 2021 at roughly 7:00 A.M. The record also indicates the patient was discharged one day after admission. At admission the patient singed consent for billing, treatment, and privacy practices. Around 9:00 A.M. a CT scan of the patient's chest was ordered followed by another CT scan of the patient's abdomen. The record then illustrates that the patient was ordered an MRI test with the patient consenting to the order only under anesthesia.

The record then indicates that the patient was transferred to the tenth-floor medical unit. A progress note entered a few hours after the MRI states the following:

> At 2305 received patient from the [emergency room], patient oriented x4 … [patient] sleeping but arousable to do admission and assessment. [Patient] orientated to room and surroundings. During admission on Columbia screener, [patient] verbalized that in 2016, he tried to kill himself by hanging on a rope but the rope broke. [Patient] verbalized he doesn't have any thoughts or plan at this time … Instructed [patient] because of his history in 2016, he will need to be placed on 1:1 until evaluated by a psychiatrist, [patient] verbalized understanding.

The record then illustrates that a petition for involuntary admission was completed by the facility with one certificate. The initial certificate was completed by the patient's social worker. The petition and certificate indicate that the patient has a positive Columbia Suicide Screen and a history of suicide attempts, with the most recent being in 2016. The certificate states that there is a need for immediate hospitalization based on these factors.

Moreover, there is also a restriction of rights form completed along with the petition restricting patient's rights to have personal items. The record then indicates that the patient was given a copy and fell asleep with no distress noted. The next day the progress notes indicate that the

patient instructed staff that he was leaving the facility. The patient attempted to leave on his own accord but a 'code gray' was called.

Per the notes, the staff informed the patient of that he tested moderate on the Columbia Suicide Screener and was required to stay until a psychiatry evaluation was done. The patient stated, "he was being kidnapped" and proceeded to enter the elevator. The notes then indicate that once on the elevator two staff nurses held the elevator door and security officers assisted the patient back to the assigned room.

From this interaction it is noted in the record that the patient's Luer lock (leak protector) was found on the floor and that the patient was bleeding from an open IV. The notes then indicate that the patient requested his belongings to call his wife and take a picture. The notes further that the patient's request was granted by the primary nurse. The patient was then assessed by the psychiatrist a few hours after the initial certificate. The psychiatrist determined there was no need for psychiatric hospitalization and the 1:1 was removed.

Finally, the notes indicated that patient requested to leave Against Medical Advice (AMA) and the physician's assistant informed the patient of the risk and provided the AMA form. The patient was discharged a few hours after request, encouraged to seek follow up care for a gastric issue and given information on how to obtain medical records.

Site Visit and Interviews

In response to the complaint, the HRA conducted a site visit on September 12, 2022. The HRA opened the visit inquiring from the staff to explain the differences between the "Code Gray" and "Code Gold." The Director of Quality indicated that a "Code Gray" is when a patient is engaging in violent behavior. The director then indicated that a "Code Gold" is when a patient attempts to elope.

The HRA then asked the staff present how often they are trained on proper restraints and patient de-escalation. The nurses responded that every year they are required to take crisis prevention institute (CPI) training. The director of quality reported that all security is trained on CPI procedures. He furthered that all staff who need to be CPI trained must take refresher courses every two years. Finally, the director stated that most but not all nurses are required to be CPI trained.

Then the HRA asked all staff about what triggered the involuntary certificate for this patient. The director reported that the patient was fine but during the intake process the patient took a Columbia Suicide Screening. The director furthered that during the screening the patient self-reported a history of suicide attempts. He then indicated that it was hospital policy to complete a petition and certificate to have the patient evaluated by psychiatry as a precaution.

The director informed the HRA that because of the Columbia screening the patient was given a 1:1 sitter and moved to the unit. Finally, the nursing manager indicated that because of this

situation with this patient they have updated policy and made substantial changes to the intake triggers for involuntary petitions. The HRA requested the new policy and results of the implemented changes.

The HRA then asked the staff if patients are allowed cellphones in their rooms. The director stated that patients who are under petition were not allow personal items including cellphones. The director did also indicate that patients could retrieve numbers and information from personal devices to make calls from hospital phones. The director then reported that the patient did contact his wife as requested.

Finally, the HRA asked the staff about the restriction of rights notice. The HRA questioned the facility on why there is a missing description of the patient's behavior on the form. The staff reported that the facility never provided the patient with forced medication due to behavior but rather only restricted the patient's right to personal property.

Follow up questions

Following the site visit, the Chicago Disability Rights Manager (DRM) asked the director of quality several follow up questions about this patient's care. The initial question asked was whether unit staff received any additional training due to this incident. The director informed the DRM that it was determined that no additional training was necessary as staff operated according to protocol.

Next the DRM asked for clarification about the Columbia screening and petitioning. The quality director indicated that a positive Columbia screening does not "mean that patient will automatically get involuntary petition" but "the Columbia screen can be one of the tools that clinician[s] can use to determine if an involuntary petition is necessary."

Finally, the DRM asked the director of quality if the patient made any formal complaints about the treatment they received. The director of quality stated that the "patient never made a complaint to [St. Mary's] directly. If a patient were to submit a grievance, we have a protocol where we must send out a letter to the patient of any complaints/grievances. It looks like [the patient] submitted [their complaint] only to IGAC."

Follow up e-mail

On September 26, 2022, the DRM emailed the quality director to inquire about the changes implemented due this interaction with this patient. The quality director responded back that "there were no changes made from this event. We implemented a re-education process prior to [the HRA] case. During July to September 2022, hospital re-educated all the nursing team on the initial suicide screening and assessment process. That was what the manager was referring to when you were interviewing her."

Policy Review

The HRA reviewed St. Mary's "Initial Suicide Screening and Assessment Process (ED and Non-Behavioral Health Inpatients)." The policy originates from March of 2020 and was last reviewed and approved in April of 2022. The policy opens indicating it is hospital policy to "screen all patients 12 years of age and older for suicidal ideation who present to the Emergency Department and who are admitted to an inpatient unit, and at any time that suicidal ideation is suspected, or self-harm attempt is made."

The policy then indicates that a Columbia Suicide Severity Rating Scale, an evidence-based screening that incorporates clinical judgement, is utilized to determine the patient's overall level of risk for suicide. It continues that the scale is completed by the registered nurse or other trained professional during triage admission of the patient in the emergency department. Moreover, the policy indicates that patients who score positive on the screening with a moderate or high positive score will receive a physician's order for evaluation.

The policy then differentiates between moderate or high positive scores on the screening. For high positive scores, patients will receive a 1:1 monitoring, placed in gown/scrubs and patient's belongings will be placed in a secure area (with a restriction of rights form given to the patient). High positive patients will also receive an order for psychiatric consultation. Moderate scoring patients will only receive an order for a psychiatric consultation and hourly rounds. Therefore, this policy reflects Code section 5/2-201 which states that when "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[.]"

Next, the HRA reviewed St. Mary's "Involuntary Admission" policy. The policy was last reviewed and approved in March of 2022. The policy details all steps that are taken to secure an involuntary admission. The policy opens stating that "a person 16 years or older may be admitted as involuntary admission for immediate hospitalization for protection of self or others from physical harm." The policy furthers that such admission requires a detailed statement of the reason for the assertion that the person being admitted is subject to involuntary admission. The policy also indicates that this type of admission requires petition and certificates.

The policy then indicates that the individual under involuntary status must be seen within 24 hours, excluding Saturdays and Sunday, by a psychiatrist for the certification of inpatient need or the patient must be released. Lastly, the policy requires the hospital to submit all documentation to the Cook County court within 24 hours after admission excluding weekends and holidays. Thus, this policy meets most requirements set in 405 ILCS 5/3-600 et seq.

Finally, the HRA reviewed St. Mary's "Against Medical Advice" policy. The policy was last approved and reviewed in July of 2017. The policy opens stating that its purpose is to create a standardized format in documentation for when a patient requests to leave against medical advice. The policy then lists procedures for the staff to take to discharge the patient. The policy states that "the nurse shall notify the Charge Nurse and Attending Physician of the patient's

stated intent to leave the hospital Against Medical Advice. The nurse's actions shall be documented in the nursing notes."

Then "the Attending Physician should assess whether the patient understands and appreciates the risks of leaving, the benefits of remaining in the hospital and any alternatives in care or treatment. Where possible, the Attending Physician should determine whether the patient is danger to self or others or is otherwise incapable of understanding the risks and consequences of leaving the hospital AMA." Furthermore, the "attending physician must document a summary of the discussion(s) held with the patient" and a release of responsibility form is completed. Thus, this policy adheres to 405 ILCS 5/3-403 as it allows voluntary recipients to "be discharged from the facility at the earliest appropriate time."

CONCLUSION

The hospital improperly admitted and illegally detained.

From the information presented in the record and at the site visit the HRA can assert that the patient arrived at the facility voluntarily for medical reasons. During the intake process the patient was assessed and it was determined that the patient would be held pending psychiatric review. The facility filled out an involuntary petition with a timely certificate. The psychiatrist completed an assessment within Code time frames and determined that the patient did not meet the need for involuntary psychiatric care. The patient was then allowed to discharge upon request.

Although most of the Code was followed it is apparent that a completed petition and certification based on the "patient stated he attempted suicide in 2016 by hanging …[.]" This in an event that occurred five years prior and is not the intentions of the Code. The Code states that a "detailed statement of the reason for the assertion that the respondent is subject to involuntary admission on an inpatient basis, including the signs and symptoms of a mental illness and a description of any acts, threats, or other behavior or pattern of behavior supporting the assertion and the time and place of their occurrence." (405 ILCS 5/3-601) Therefore, a rights violation is ***substantiated***.

The hospital denied use of the phone to the patient.

The HRA toured the facility and noted that there are telephones in each medical room. The patient did have his rights to have personal items restricted, thus he did not have access to his own phone. Per the notes the patient was given a copy of the restriction of rights notice. However, the restriction of rights notice does not indicate why the patient's rights were being restricted. The form simply states, "until evaluated by psychiatrist."

When this was brought to the attention of the staff, they indicated that they did not fill out the top portion of the restriction of rights form as they never administered any forced medications.

The HRA agreed, however after further review the second section of the restriction of rights form also requires reasoning for why a recipient's rights would be restricted. Since the form is missing a reasoning, a rights violation is *substantiated.*

The patient was not discharged timely.

Per the record, the patient was discharged a few hours after the request. Therefore, a rights violation is *unsubstantiated.*

RECOMMENDATION

1. The HRA would recommend that the facility conduct a training on Code requirements on involuntary admissions.

2. The HRA would recommend that the facility conduct a training on Code requirements on restriction of rights. The HRA would recommend focusing on properly completing form IL462-2004M (R-05-20 - MHDD-4). The HRA would request documentation of completion with signatures of all emergency department nursing and social work staff.

SUGGESTION

1. The HRA would suggest that Updating the Involuntary Admission policy. It opens indicating that "a person 16 years or older may be admitted as involuntary admission for immediate hospitalization for protection of self or others from physical harm." However, the Code dictates that "a person 18 years of age or older who is subject to involuntary admission on an inpatient basis and in need of immediate hospitalization may be admitted to a mental health facility pursuant to this Article." (405 ILCS 5/3-603)

COMMENT

From the record the HRA discerned that this patient was injured during the struggle when attempting to leave the facility. The record gives no indication that the patient was ever verbally or physically threatening to any staff member. Thus, the HRA would caution the facility on its usage of force when conducting redirection efforts.