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HUMAN RIGHTS AUTHORITY – PEORIA REGION
REPORT OF FINDINGS

Case #23-090-9011
OSF Healthcare

INTRODUCTION:

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations involving mental health services at OSF Healthcare Emergency Department (ED). The allegation(s) are as follows:

1- Improper physical restraint

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-100). OSF Healthcare Peoria is the largest hospital in the OSF Healthcare system. The hospital serves the tri-county area and beyond. The ED treats 86,000 patients per year. Of this 86,000 approximately 1,000 patients require behavioral health treatment. The hospital does not have a behavioral health unit. The ED is staffed with 12-13 nurses during the day shift 7am-7pm. Shifts overlap and at peak time could have up to 23 nurses on the shift. Staffing for the night shift is lower and same on the weekend when census is lower. The hospital staffs one Medical Director focused on psychiatry and has two other physicians who specialize in psychiatric consultations when necessary. The hospital does not employ psychiatric nurses. The hospital has 2 psychotherapists on staff, each assigned to 1st or 2nd shift. The psychotherapists have an LCPC or LCSW. The hospital also staff Behavioral Health Monitors, which are nurses who would be assigned as 1:1 for a patient. The ED does have Security on staff and 1-2 are assigned to the hospital ED. The hospital is fully accredited by The Joint Commission (JC).

Complaint Statement

The complaint alleges that a patient was transported to a local hospital by ambulance and required emergency treatment in the emergency department (ED). Allegedly the patient was placed in four-point restraints and not given a clear reason why restraint was used nor was the patient given a notice of rights restriction for the use of physical restraint.

Interview with staff (3.2.23)

Several OSF Healthcare administrative staff and direct care staff attended the site visit. The definition of physical restraint was read verbatim from OSF Healthcare policy. The HRA was provided with a copy of this policy. Per the policy, physical restraint is defined as "Any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely." The hospital differentiates the use of restraint for non-violent vs. violent behaviors. An example of using physical restraint is if a patient is violent and has acute self-harm to themselves or others. Non-violent restraints could be used for medical care such as preventing an IV from being pulled out of a patient's arm. A restraint would not occur without an order. The process for charting on a restraint for violence is obtaining a physician's order, completing flowsheets, monitoring every 15 minutes, and checking for comfort. If a person is in a non-violent restraint, they are checked every 2 hours.

The hospital does call Security to implement a physical restraint if a patient is at risk to be violent. The Security staff are usually holding the patient while nursing staff apply the restraints. The hospital has access to two types of physical restraints described as "soft-restraint" and "hard restraints". The use of one or other is determined on patient need. Patient need also determines how it would be applied to the body. Staff are trained on the use of restraints during orientation and there is a yearly competency training that also discusses how physical restraints are documented. A physical restraint would only be ordered for a behavioral health patient if they were considered a danger to themselves or others. A physician would write an order and the nurse's chart and restraint flowchart are used to document the restraint use. If trained Security staff are involved, they would write a report documenting their involvement. The Security report is not kept in the patient's chart record. Restraint is ordered on a case by case basis and the goal is for a patient to be out of restraint as soon as possible. A physician's order for physical restraint is good for up to 4 hours.

Security is often needed in the ED and is used to ensure safety of staff and patients. The hospital uses a situational- team approach with Security staff. Security staff usually stand outside of the patient's door and can be an effective part of the de-escalation process. Before the use of a physical restraint, staff make attempts to verbally de-escalate if possible. The hospital trains staff in "Workplace Violence" de-escalation techniques. Specifics of this de-escalation program were not provided during the site visit. If a restraint is ordered, the patient would be communicated with by staff and provided a Notice of Restricted Rights of Individual form to document the use of physical restraint as a treatment intervention.

Hospital staff also explained that since the hospital does not have a behavioral health unit, a patient who had been medically cleared and assessed to need further mental health care would stay in the ED until placement was found at a hospital outside of OSF. Psychiatric services would be called to complete an evaluation and determine if the patient is a harm to self or others and make recommendations for treatment. A

Behavioral Health Monitor would be assigned to the person for 1:1 supervision/observation and a psychosocial assessment would be completed.

The service recipient involved in this case was confirmed to have been a patient in November 2022. The service recipient's chart record was referenced a few times during the site visit. There were two registered nurses who had provided direct service care to this service recipient on first shift 7am-7pm and second shift 7pm-7am, each nurse working 12-hour shifts. The first shift (7am-7:00pm) nurse had difficulty remembering the chain of events but did know that the ED had received a call from EMS that they were transporting a "combative patient" to the hospital. The medics were asking for "physical and chemical restraints". When the service recipient arrived at the ED, they were triaged but were "destatting", meaning they had altered mental status and not breathing well with low oxygen stats. The patient had to have emergency ventilation by EMS staff due to respiratory failure. The service recipient was also treated with Ketamine by emergency personnel while en route to the hospital. The hospital is unable to give information pertaining to EMS care provided to the patient. The first shift nurse explained she prepped the room for a psychiatric patient. When the service recipient arrived EMS provided her name but it was not easily found in the system due to a unique spelling. The first shift nurse identified her as "Jane Doe" to get orders entered. The service recipient was not alert and not able to be asked questions. This nurse could not recall how and when restraints were ordered without looking at the chart. It took approximately ten minutes for registration to identify the service recipient but she was found in their system and the patient record was merged. The service recipient was not combative at first but was unresponsive upon arrival. EMS gave the chemical restraint first and not the hospital emergency department. The medication Droperidol was also given to the service recipient during treatment in the ED. The service recipient was treated for altered mental status, behavioral health patient, and abnormal behavior. The service recipient was described as having a manic episode. ED staff treated the service recipient with Narcan due to concerns that some type of substance was misused by the service recipient which caused the service recipient's decline when Ketamine was administered. It is not uncommon for a patient to become aggressive once Narcan is given and they come to. The Medical Director did verify in the site visit that the ethanol screen and urinalysis was negative for illegal substances. Laboratory blood work was not confirmed at the site visit.

The third shift nurse (7pm-7am) explained that when she arrived on shift around 7pm the service recipient was in physical restraints. When asked to describe the service recipient's violent behavior she explained the service recipient had, "waxed and waned" upon admission to the ED. Upon further exploration of that meaning she shared, "Like those patients do." The nurse clarified the use of the term "those patients" and it was explained patients diagnosed with altered mental status. The service recipient was agitated and aggressive; upset about home life, yelling, and hitting head against bed, and also was speaking in tongues or a language unable to be recognized by treating staff.

One of the two nurses involved in the service recipient's care explained that EMS called the hospital to notify them of the service recipient's arrival and recommended that

physical restraints be ordered upon arrival to the hospital on 11/22/22 at approximately 7pm. The physical restraints were removed at 2am. The service recipient's behavior during the ED care and reason for physical restraint was documented as "uncooperative-acute altered mental status with confusion restraints ordered for patient and staff safety". On 11/22/22 at 10:31pm there was an order entered for a psychiatric consult. On 11/23/22 at 1:27am a psychosocial assessment occurred. The Administrative staff that was speaking to the psychiatric care provider explained that she is unsure about the length of time to complete the psychotherapy assessment stating it could have been a variety of reasons: waiting for her to be medically cleared, busy night in the ED or psychiatric staff waiting to make sure she was able to communicate. The service recipient was ambulatory at discharge, did receive their copy of a Notice of Restricted Rights of Individual form and was discharged from the hospital to a family member on 11/23/23 at 11:26am.

FINDINGS

1-Improper physical restraint

The HRA reviewed the ED chart record for this service recipient. The service recipient arrived to the OSF emergency department (ED) on 11/22/22 via ambulance at approximately 6:30pm. The "Clinical Impression" is documented as "Altered Mental Status Acute, Agitation Acute, and Episode of Abnormal Behavior Acute" and the "Chief Complaint" noted by the medical provider to be "Respiratory Distress and Psychiatric Evaluation." The History of Physical Illness (HPI) explains the following reason for emergency treatment "35-year-old female presenting to the ED after EMS was called for patient. Unsure on events leading to EMS arrival however patient was found to be acutely agitated for unknown reason requiring ketamine. In route they noted after the IM ketamine the patient began to desaturate and become bradycardic and they started to bag the patient. On arrival the patient was minimally responsive however did have non-purposeful movement and miotic pupils. She was given Narcan and had more purposeful movement she was otherwise protecting her airway. Her subjective history otherwise is limited secondary to the patient's status." The HRA reviewed a "Patient Care Report" from the ambulance provider that documents this service recipient receiving 300mg of Ketamine via intramuscular injection ordered as a "pharmacological restraint" and physical soft restraints due to being combative and yelling.

On 11/22/22 at 6:45pm the treating physician documents "Narcan was administered" and the resident physician documents "After Narcan the patient was commanding, able to grip my hands and move all of her extremities." The resident physician had a face-to-face contact with the service recipient at 6:45pm.

On 11/22/22 at 7:06pm a "Face to Face Restraint order," was entered by the Resident Physician #1 as "Restraints placed onto pt. Immediate situation (Medical and Behavioral Condition): **Patient has exhibited violent/self-destructive behavior which jeopardizes the immediate safety of patients, staff, or others (emphasis added)** Pertinent patient history: See HPI for details." I have directly observed, and/or obtained the history from

the **other (emphasis added)**, who directly observed the following behaviors exhibited by [Service Recipient]. Patient behaviors: **Patient attempting to harm others (emphasis added)** Because of these behaviors, I have ordered the restriction of rights to include **Placing the patient in a physical hold. Administration of emergency medications. Retaining personal property." (emphasis added)**

On 11/22/22 at 7:08pm, the Attending/Teaching Physician documented on an "ED Provider Note" the following "I examined pt. with Dr. [Resident Physician #1] on arrival, Pt. with acute altered mental status, seen by paramedics / EMS, Pt with history of (unknown) Drug ingestion uncertain type, given, ketamine IM due to acute agitation, and alt mental status, Has pinpoint pupils, and was more responsive to Narcan, Patient with increased resp efforts and no hypoxia in our ED, Restraint policy started / pt. restrained for pt. / staff safety, CT scan arranged Priority 1, pending, Pt with blood testing sent, pending, Has acute altered mental status with confusion / alt mental status at her home, will obtain testing / CT results /and re-assess, …".

On 11/22/22 at 6:45pm Resident Physician #1 completed an "ED Provider Note" documenting "A 35-year-old female presenting to the ED for altered mental status. She received ketamine en route and en route the patient became hypoxic and bradycardic and required bag-valve-mask ventilation. On arrival here she was minimally responsive however having some nonpurposeful movement her pupils were miotic she was given Narcan and responded to this and was commanding afterwards however still unable to get much history from the patient. EMS further reported that the patient was acutely agitated when they arrived, and she required ketamine. Given the acuity of the patient's condition and altered mental status priority 1 head CT was obtained. Patient's CBC was reassuring. CMP was reassuring. Troponin was normal. TSH was normal. Ethanol was negative. CT head was negative for bleed. CT C-spine was negative for acute fracture. EKG was normal. Re-evaluated the patient she was more alert however not oriented. Asked her about the events of today leading her to be here and she was not sure she kept repeating today over and over again. More chart review was obtained it appears the patient sees Behavioral Health as an outpatient. She does have a history of acute psychosis. Patient began to scream and yell in the ED droperidol was ordered. Care was transferred to [Resident Physician #2] pending re-evaluation. Coding" It was signed off on by the attending/teaching physician at 11:41pm. Resident Physician #2 was assigned at 10:11pm and entered a "Consult with Psych" order at 10:31pm.

On 11/22/22 at 7:32pm the night shift nurse entered/started an order for a physical restraint explained as, "Physical- 'DO' (doctor's order) and 'MD (medical doctor) ordered'". The reason for the physical restraint order is noted as "Due to violent behavior". The order for a physical restraint was discontinued on 11/23/22 at 4:34am.

On 11/22/22 at 7:39pm the HRA reviewed an "ED Note" written by the day shift RN, entered at 7:59pm due to patient care, documenting physical restraints being ordered and prior care given by EMS as "Pt to ED via EMS from home for manic episode. Per EMS pt was uncooperative and manic. Pt was holding onto children and not letting them go. EMS gave 300mg ketamine IM prior to arrival. EMS stated pt began to destat en route.

Upon arrival, EMS was bagging pt, pt noted to be in a c-collar. Pt met in room this RN, [Staff] RN, [Staff] RN, [Staff] RN, [Staff] MD. Pt placed onto monitor, IV access, blood sugar, labs and vitals obtained. GCS 3. 2mg Narcan IV administered. Obtained verbal order for restraints by [Resident] MD. Restraints placed onto pt. …".

The HRA reviewed an OSF document titled "1:1 Observation Checklist" dated 11/22/22-11/23/22. This form documents the service recipient's behavior during a physical restraint. There is one RN who charted the checklist based on initials. The checklist was then signed by the Night Shift RN who also entered the observations on the Flowsheet. Based on this observation checklist, from 7-8:45pm the service recipient is documented as a "6" defined as "Appears to be sleeping. Chest rising and falling" and "10" for being in a physical restraint. From 9pm-9:45pm the behavior code is documented as a "9" which is defined as "Hostile, agitated" and continues to be "10" in physical restraint. She falls back to sleep for approximately fifteen minutes. Then from 10:00pm-10:30pm she is again described as "hostile and agitated". At 10:45pm, the behavior code then changes to a "4" defined as "Cooperative" and as a "10" being in physical restraint until 11:45pm. At midnight, on 11/23/22 the service recipient is still coded as a "10" and being in a physical restraint. The service recipient's behavior is coded as a "6" to indicate they appear to be sleeping until 12:45am. At 12:45am-1:45am the service recipient is still coded as being in a physical restraint and the behavior is coded as "4" meaning, they were cooperative. They were released from the physical restraint around 1:45am. The service recipient was in a physical restraint in the hospital's ED for 6 hours and 45 minutes.

On 11/22/22 at 7:11pm the HRA reviewed a "Flowsheet" for a timeline of care and treatment for "Restraint Monitoring" specific to the service recipient's monitoring in the ED. Their Violence Assessment Tool (VAT Risk) score completed at the same time was a 6. The only comment observed on this screening tool is from the doctor's order (DO) and states "Statement or behaviors that could reasonably be interpreted as threatening to exercise physical force, in any setting, against any person including a caregiver that could cause injury." At 11:46pm, several entries are entered into the electronic medical record. This is where the HRA notes the first behavior change being charted on the flowsheet as "agitated, excitable, sad, restless, hyperactive" since 7:34pm. This same document has the Restriction of Rights form as being scanned at approximately 8:39pm and being given to the patient at the same time.

On 11/22/22, The ED Notes document a 2mg injection of Narcan given at 7:35pm. At 9:00pm, the night shift RN #1 gives a 1.25 mg injection of Droperidol. Then again at 10:26pm the assigned night shift RN #2 gives a 1.25mg injection of Droperidol. The HRA does not find a corresponding Notice of Restricted Rights of Individual that documents the use of Droperidol as an emergency medication.

The HRA reviewed the DHS "Notice Regarding Restricted Rights of Individual" that was completed on 11/22/22 at 7:00pm. Section I of this form is used to document what type of restriction was implemented. This section the box next to "physical restraint" is marked. This same section offers a space for staff to explain the reason for the rights

restriction. There is nothing written in this section. It is blank. Further along in Section I the form states, "In accordance with the Mental Health and Developmental Disabilities Code, the individual designated his/her preference for emergency intervention if circumstances arise as indicated below:" Staff responsible for completing out the form would then mark one of the following statements "The individual indicated no preference for emergency treatment. The individual preference was utilized (see Treatment Plan). The individual preference was not utilized for the following reason." No boxes are marked next to those three statements.

Section II of the form documents "Other Restrictions" and documents the length of time the restrictions will be in place, dated "11/22/22" through "Discharge". This same section then has a list of restrictions that can be implemented. Those restrictions are listed as "To refuse medical services- x-ray, to refuse other medical services, to manage personal hygiene, to refuse medical services-laboratory, To refuse search of person or living area, To refuse dental services, To be allowed to communication via: telephone, mail, visitation, other". Every box next to those restrictions were marked with an "X" except for "Other". The service recipient was even restricted from using the telephone and having visits. There is then a section to document "Reason(s) for the identified restriction(s) include" and the HRA reads the following "Pt. was in restraints due to being uncooperative and a safety risk to staff and self."

Section III of this form is where the individual responsible for completing the form documents that a copy was given to the service recipient in English. Nothing is marked next to the following statements "Individual wished no one to be notified of this notice (Exception: Guardian must always be notified) and Individual wished Guardian and/or designee notified as indicated below." This area is blank. A Registered Nurse's printed first name and illegible signature is observed on the form attesting to "I certify I have completed this form. Copies of this notice were given to the individual, mailed to all individuals, and placed in his/her medical file."

On 11/22/22 at 7:42pm, an ED Note entered by the night shift RN documents "This RN assumed care of patient. Pt is alert and able to answer questions. Pt is confused to situation. Pt is alert to self and time. Pt respirations are unlabored and at a normal rate on room air. Pt denies any pain or other needs currently. Pts vitals obtained and pt has call light within reach." At 10:41pm, "This RN and [Staff Name] RN preformed a bladder scan after pt was unable to use a bedpan x2 pt had 669 mL of urine in her bladder. This RN told Dr. [Staff Name] and orders placed for straight cath. Pt had 700 mLs of urine out." On 11/23/22 at 1:45am, "Pt. attempting to use bedpan at this time and unable to." At 2:00am she was "bladder scanned for 587 ml of urine." At 6:49am, "Psych at bedside." At 7:04am "Patient ambulating in the hallway."

The HRA reviewed a document titled "ED Hand Off Note" completed on 11/23/22 at 8:15am by a Medical Doctor that documents "[Service Recipient] is a 35 y.o. female presenting to the emergency department with a chief complaint of mania, agitation. Notable findings in the history and physical include patient needed IM ketamine with EMS for agitation, required bagging afterwards. Received Narcan on arrival to ED. Woke

up and didn't remember today's events. Reportedly tried to take a child from a stranger. No known PMH (prior mental health), no known drug use. UDS (urine drug screen) pending. CT head negative."

On 11/23/22 at 2:20am, an "OSF Saint Francis Medical Center Behavioral Health Psychiatry Consult Service Initial Evaluation" completed by an LCSW documents the reason for the consult was "Acute Psychosis" and the Psychiatry Consult Service was consulted for an evaluation and recommendations. The therapist introduced self to the patient and patient agreed to an evaluation. The Brief Narrative of recent issues/concerns included: "Patient is 35-year-old female presenting to emergency department for evaluation of agitation and possible psychosis. EMS was called to the home by patient's son for 'a pt who was not responding'. Son reported to EMS that patient was 'thrashing around' and related to EMS that 'this happens sometimes. Per EMS report, 'Other sons on scene relate that pt has 'been called crazy in the past'. The EMS report indicates that the patient was making delusional statements and was telling her son 'You are a king, you have royalty in your blood, and you are from Nigeria' and stating 'Kate William and Diana are her cousins from Wales'. When EMS attempted to assess patient, she would become agitated and was combative and yelling. Patient's children had difficulty staying away from patient on scene and patient would grab her children and not let them go. Patient received 300mg of Ketamine around 6pm by EMS. In route to SFMC, patient began to desaturate and become bradycardic, and patient was being bagged by EMS on arrival to ED. Per ED resident, [Resident #1] DO, report, 'On arrival the patient was minimally responsive however did have nonpurposeful movement and miotic pupils. She was given Narcan and had more purposeful movement she was otherwise protecting her airway'. Patient continued to thrash/scream on stretcher and was administered droperidol 1.25mg at 2100 and 1.25mg at 2226.' When approached for assessment, patient is resting calmly on stretcher. RN and other ED staff removed restraints. Patient was pleasant and cooperative. Patient talks in various accents depending on which staff she is talking to. When asked if she recalled what occurred earlier in the day, patient states she had a seizure and fell. Patient then states she was walking to her car with her children when she slipped and fell. Patient had her son call '988 not 911' when she fell. When informed that the EMS report indicated that patient's son had called 911 due to her not being responsive patient seemed a little surprised. Confronted patient regarding other details in the EMS report that she was agitated, combative and not making sense at times. Patient recalls this and states she was upset that DCFS had conducted a home visit earlier in the day. Patient states that this type of episode occurs when she is under extreme stress. When asked about statements regarding being royalty, patient recalls stating this and states she is religious and believes that we all come from God who is king, and that she tells her sons that they are kings to help with their self-esteem. Patient denies suicidal thoughts or homicidal thoughts. Patient denies auditory/visual hallucinations or feelings of paranoia. Patient adamantly denies using substances."

The HRA reviewed OSF Healthcare policy "Restraint and Seclusion Management" approved on 12/19/2022. There is a section titled "Definitions" that defines the following "1. Restraint: a. Physical restraint: Any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or

her arms, legs, body or head freely. b. Chemical Restraint: A medication used as a restriction to manage a patient's behavior or restrict the patient's freedom of movement, which requires adherence to all ordering, monitoring, and documentation requirements of a physical restraint. Note: the use of a standard drug in a standard dose used for emergency purposes for treatment of a patient's medical condition is not considered a chemical restraint." Further along, the policy explains "3. Restraint for Violent and/or Self-destructive behavior: Safe and therapeutic restraint is used for the management of patients whose violent or self-destructive behavior jeopardizes the immediate physical safety of patients, staff, or others. Refer to Attachment: Examples of the Use of Restraints". The section titled "Purpose:" explains "To preserve the rights of the patient and protect the immediate physical safety of the patient, family and staff, by providing standard guidelines for the care of patients that require use of physical or chemical restraint, or seclusion." The section titled "Policy" explains "1. Restraint or seclusion is never used as a means of coercion, discipline, convenience, or staff retaliation. It is used only when less restrictive interventions are ineffective. Restraints shall be employed in a safe and therapeutic manner. 2. When a patient's violence or self-destructive behavior jeopardizes the immediate physical safety of the patient, staff and others, use of Restraint or Seclusion for Violent and/or Self-Destructive Behavior may be warranted. a. In Illinois, requires initiation of Notice Regarding Restricted Rights of Individuals form. ...b. Restraint and seclusion are reviewed daily by the facility director or designee. ... 6. Restraints or seclusion are ordered by licensed physicians, or if authorized by the medical staff, advance practice registered nurses or physician assistants trained in the application and evaluation of restraints and seclusion practice and permitted to order restraints or seclusion under a written policy or supervisory or collaborative agreement. ... 8. In an emergency, a Registered Nurse (RN) may apply a restraint or initiate seclusion prior to receiving an order. An order is obtained immediately (within a few minutes) following restraint application. 9. Training: a. Physicians, authorized advanced practice registered nurses and physician assistants, that order and/or evaluate for restraints, have working knowledge about the hospital policy for restraint use. Training occurs during orientation, every 2 years, and if significant policy revisions occur. B. Authorized supervisory registered nurses (HMMC and SHMC only) who conduct face to face assessments for violent restraints and seclusion receive additional training for evaluation of the patient's condition and contributing factors requiring restraints. Training occurs during orientation, every 2 years, and if significant policy revisions occur. c. Staff with direct patient care restraint responsibilities are trained and competent in the application of restraints, implementation of seclusion, monitoring, assessment and care for patients prior to providing patient care. Training occurs during orientation and annually. D. Staff who apply restraint or seclusion, monitor, access or provide care for a patient in restraint or seclusion are trained and competent in providing first aid techniques as well as training and certification in the use of cardiopulmonary resuscitation. 10. The use of restraints is periodically reviewed. When restraints are used for violent and/or self-destructive behavior, clinical leadership is informed within 24 hours." The section titled "Process" explains "1. Obtain initial order and renewal orders for restraint or seclusion based on patient assessment, and according to the following: Initial and Renewal Orders for 'Violent/Self-Destructive Behavior Restraint and/or Seclusion' the order renewal frequency is "Adults 18 years or older: Every 4 hours ...Order includes: Events leading

up to the need for restraints, Reason for Restraint (e.g. danger to self or others), Type of restraint, Duration of restraint order." Further along the policy explains the following: "2. Ensure face-to-face evaluation is performed within one hour of initiation of a restraint for violent and/or self-destructive behavior. 3. If the order is not received from the physician who is primarily responsible for the care of the patient during the episode of restraint use, inform the physician of the order as soon as possible, based on the needs of the patient. 4. Employ and document interventions and less restrictive alternatives that may prevent the patient from needing restraints. 5. RN assesses the clinical justification or reason why restraint is needed, as listed in the restraint order; and continuously assesses for discontinuation. 6. RN completes an immediate assessment to ensure proper and safe application at the time restraints are applied. RN documents any concerns regarding safety risks to the patient, staff or others. 7. Educate the patient and family regarding the need for restraint. Document education within the EHR. 8. RN and designated, trained staff, monitor the following for Violent/Self-Destructive Behavior Restraint (Physical or Chemical) and/or Seclusion. Frequency: continuous. Monitoring and Documentation Includes: Visual check of patient in restraint and/or seclusion for level of distress and agitation. Performed by: RN or designated trained staff. Frequency: Every 15 minutes or more often as needed. Monitoring and Documentation Includes: Circulation and skin integrity at the site of the restraint, and any possible injury. Performed by: RN or designated trained staff. Frequency: Every 2 hours or more often as needed. Monitoring and Documentation Includes: mental status assessment, range of motion to extremities, fluids and foods as appropriate, elimination needs. Performed by: RN. Frequency: Per licensed provider order. Monitoring and Documentation Includes: vital signs. Performed by: RN or designated trained staff. Frequency: Within 1 hour of initiation. Monitoring and Documentation Includes: face to face assessment. Performed by: Licensed provider; or Licensed independent practitioner; or Authorized supervisory RN who has received additional training … Frequency: Once (Illinois only). Monitoring and Documentation Includes: Provide patient with Restriction of Rights form (refer to Restriction of Rights" Illinois Policy). Performed by: Professional responsible for the care of the patient. 9. Update the patient's plan of care (POC) to address restraints. If temporary release of the restraints should occur for patient care needs, the patient remains under direct staff supervision (i.e., staff member is present and serves the same purpose as restraint or seclusion) and documents the release of the restraint and the re-application. 11. Discontinue the restraint when the behavior or condition that was the basis for the restraint order is resolved, when the initial behavior is no longer evident or alternatives are effective (decreased agitation, demonstrates understanding or instructions and is able to comply) regardless of the duration of the order. a. Licensed physician, advanced practice registered nurse, physician assistant, or RN determines that restraints are no longer clinically justified. b. Restraints are discontinued at the earliest possible time. c. Document discontinuation in the electronic health record (HER). d. Discontinue restraint order in the HER. e. Notify the physician of the restraint discontinuation. …".

This same policy also has a section titled "Face to Face Assessment of Restraint for Violent and/or Self-Destructive Behavior and/or Seclusion: 1. When a restraint is used for the management of violent or self-destructive behavior, ensure the patient is seen face to face within 1 hour after the initiation of the intervention: a. By a physician or

authorized advanced practice registered nurse, physician assistant or supervisory registered nurse (HMMC and SHMC only) who has received additional training. b. When the face-to-face assessment is conducted by an authorized advanced practice registered nurse or physician assistant, or authorized supervisor registered nurse (HMMC and SHMC only), the physician who is primarily responsible for the care of the patient during the episode of restraint use, is consulted as soon as possible. … d. The evaluation is documented. 2. Unless there is an immediate danger that the patient will harm himself or others, restraints will be applied to permit freedom of movement. The patient should be permitted to have regular meals and toilet privileges free from restraint, except when freedom of action may result in physical harm to the patient or others. …". The HRA reviewed a grid within this policy that explains the actions to be taken for a face-to-face assessment as "Restraints for: Violent/Self-Destructive Behavior and/or seclusion. Content: Patient's reaction to the intervention. Patient's immediate situation. Patient's medical and behavioral condition. Plan to continue or terminate restraints/seclusion. Focus/information includes Reaction to restraints/seclusion. Immediate presentation of the patient. Assessment/documentation of systems, behavioral assessment, patient history including drugs and medications, lab reports, therapy/medication interactions, any other contributing factors including environmental factors. Rationale for continuing or discontinuing restraint/seclusion."

The HRA reviewed OSF Healthcare's Code of Conduct approved in August of 2019 which reads … "commitment to serving our patients with the greatest care and love" and on page 20 of this handbook explains how the hospital would involve a patient in their care as "Shared Decision-Making, Informed consent is an ongoing process of communication between the physician or other-licensed provider and the patient … that provides adequate information to ensure shared decision-making about a patient's care. The process typically results in a signed confirmation of the patient's understanding of the procedure …".

The HRA reviewed OSF Healthcare's Patients Rights and Responsibilities brochure that communicates the following to a patient receiving care at this hospital "We want to treat all our patients with dignity. This is very important to us. We focus on the needs of each patient within the means of OSF HealthCare. We give considerate and respectful care to our patients. We follow the OSF HealthCare Mission and the law. We also follow the Ethical and Religious Directives for Catholic Health Care Services. We are committed to honoring your rights as a patient. We want you to be an active partner in your care so you can help us meet your needs. That is why we ask you to share in some responsibilities. Your rights and responsibilities are explained in this brochure. 4. Receive care without being restrained. We will use restraints only to keep you and others safe. You will be restrained only if other methods do not protect you or others. Restraints will not be used as punishment." The section titled "Safety and Respect" communicates to a patient "You are responsible for: 1. Following the requests made by your health care providers about your care, behavior and safety." The last section of this brochure applicable to this complaint is the section titled "Receiving or Refusing Care" and communicates "You are responsible for: 1. Asking questions if you do not understand your agreed plan of care."

The HRA reviewed OSF Healthcare's policy titled "Aberrant Drug Use Behaviors Procedure" and page 7 of this policy guides staff to "Keep up to date on the organization's practices for working with persons exhibiting aberrant drug use behaviors, including colleagues and organization team members. Focus on reducing stigma while creating an environment that supports harm reduction. Rationale: A focus on reducing stigma that often accompanies SUDs and mental illness while creating an environment that supports a harm reduction model is the most effective and supportive approach to patient care."

The HRA reviewed OSF Healthcare's policy titled "Behavioral Health (BH) Psychiatry Consult Services (PCS) Continuity of Care and Coordination of Services" in effect since March 2022. The section titled "Purpose" explains "To define and coordinate the appropriate assessment, treatment, and disposition of care, and ensure clinical continuity for patients who present to the Emergency Department (ED) and In-House with behavioral health concerns." The section titled "Policy" further explains "BH (Behavioral Health) PCS (Psychiatry Consult Service) therapist assesses, diagnoses, and refers patients to appropriate services and collaborates with other disciplines within SFMC to ensure continuity for the patient care process." The section titled "Process" guides the employee to "BH PCS therapist collaborates with multiple disciplines, as necessary, to provide continuity of care for the behavioral health patient in the ED and the In-House setting. 2. Attending Provider, ED / In-House perform the following in collaboration with BH PCS personnel: a. Places order for PCS assessment in EPIC, 'IP Consult to Psychiatry'. b. Provider or other medical staff in the ED or In-House contacts PCS therapist when patient is appropriate to participate in full psychosocial evaluation. c. Patient cannot be evaluated by PCS therapist if patient is sedated or impaired. … c. Once patient is appropriate for evaluation contact PCS therapist through PALS at [Phone Number]. d. If provider believes it is likely that patient is impaired or may be in need of inpatient psychiatric treatment the following labs / tests may be needed for medical clearance to a treatment facility. CBC; CMP; TSH; Serum Alcohol Level; UA; Urine Tox Screen; Urine Pregnancy; EKG; Magnesium; Poison Control Clearance (when appropriate). e. PCS receives order for assessment f. Receives provider's findings, input and recommendations g. Communicates findings of assessment h. Makes recommendation for disposition i. Helps facilitate provider-to-provider call in case of transfer. j. Helps social services to facilitate providers signatures on appropriate documents, if needed. 3. Nursing Staff/ED / In-House personnel perform the following in collaboration with BH PCS personnel: a. Takes report from nurse on basis for need assessment. b. Interacts with nursing staff to exchange information on symptoms, history, medications, current symptoms and emerging issues. c. Ascertains when appropriate, if 'search and secure' procedures have been implemented by the nurse or BH monitor. Facilitates continuity and collaborative care for patient by providing nurse with information concerning findings from assessment, such as suicide assessment/risk. Facilitates transfer of patient, when diagnosis, referral and disposition is made. Collaborates in obtaining copy of patient's electronic health record (EHR), including discharge instructions and recommendations. 4. Psychiatrist, ED / In-House personnel perform the following in collaboration with BH PCS personnel: a. Confers with questions concerning psychological assessment regarding symptoms, diagnosis and medications. b.

Reports on patients in the Emergency Department, c. As appropriate reports on patients being assessed and admitted to medical floor. d. Reports on patients needing assessment in-house. e. Confers when deciding on disposition of patient. f. Confers when discharging BH monitors. …".

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102)** Care and Services; religious objection" 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 recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 [405 ILCS 5/2-200] shall be noted in the recipient's treatment plan…."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107)** Refusal of services; informing of risks mandates the following "**(a)** An adult recipient of services … must be informed of the recipient's right to refuse medication … . The recipient … 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 facility director shall inform a recipient, guardian, or substitute decision maker, if any, who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services. **(b)** Psychotropic medication … may be administered under this Section for up to 24 hours only if the circumstances leading up to the need for emergency treatment are set forth in writing in the recipient's record. … **(g)** Under no circumstances may long-acting psychotropic medications be administered under this Section. **(h)** Whenever psychotropic medication or electroconvulsive therapy is refused pursuant to subsection (a) of this Section at least once that day, the physician shall determine and state in writing the reasons why the recipient did not meet the criteria for administration of medication or electroconvulsive therapy under subsection (a) and whether the recipient meets the standard for administration of psychotropic medication or electroconvulsive therapy under Section 2-107.1 of this Code. If the physician determines that the recipient meets the standard for administration of psychotropic medication or electroconvulsive therapy under Section 2-107.1, the facility director or his or her designee shall petition the court for administration of psychotropic medication or electroconvulsive therapy pursuant to that Section unless the facility director or his or her designee states in writing in the recipient's record why the filing of such a petition is not warranted.

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-108)** 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. 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. ... **(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. ...".

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-201) 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 ... 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 Physical Restraint" which violates **(405 ILCS 5/2-108), (405 ILCS 5/2-107), (405 ILCS 5/2-201) and (405 ILCS 5/2-102)**. This substantiation is based on evidence in the service recipient's chart record for treatment that the recipient received from 11/22/22-11/23/22 in the hospital ED. The service recipient was assessed to need emergency behavioral health care for "mania, agitation", "altered mental status acute", "respiratory distress" and "psychiatric evaluation", yet immediately upon arrival to the ED the patient was recommended by paramedics to have ED staff place the service recipient into a physical restraint for alleged violent behaviors that occurred prior to arrival at the ED. The only "behavior" documented in an ED Progress Note to explain the order for physical restraint, and later emergency medications, was the service recipient noted to be "screaming and yelling" while on the stretcher. After reviewing the patient record, the HRA questions why this was the plan of care for this service recipient when they were documented on the 1:1 Observation Checklist as "appears to be sleeping" as early at 7:00pm. Additionally, the HRA questions this decision because the service recipient received a 300mg dose of Ketamine, as an emergency pharmacological restraint, prior to their arrival to the ED which may have caused respiratory distress. The Initial Psychiatric Evaluation also documents the Resident Physician stating in the chart, "On arrival the patient was minimally responsive however did have nonpurposeful movement and miotic pupils. She was given Narcan and had more purposeful movement she was otherwise protecting her airway". Other details in the record that corroborate the substantiation of improper physical restraint are: the service recipient not being released from restraint after 2 hours; not being permitted to use the restroom free from restraint; the order placed by the resident physician and the treatment that followed by the RN; the failure to enter another face to face order at the 4 hour mark to justify the continued use of physical restraint per OSF policy, the documentation on the Notice of Rights Restriction form that aligns with **(405 ILCS 5/2-201);** and, no informed consent or clinical plan of care discussion with the service recipient to de-escalate behaviors prior to being administered Dropodril as an emergency medication at 9:00pm and again at 10:46pm while in the physical restraint.

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-108)** mandates restraint can only be used when a service recipient is "causing physical harm to himself or physical abuse to others". The Code mandates how providers are to implement an order for a restraint as an intervention: "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". The

restraint timeline established by the HRA, based on the record provided, documents a "Face to Face" order being implemented by the Resident Physician at approximately 7:06pm. The order entered and corroborated by the attending/teaching physician does not clearly order a "physical restraint" only agrees with the Resident Physician. This resident physician's order reads "restraints placed on person" with the following orders: "Placing the patient in a physical hold. Administration of emergency medications. Retaining personal property." A physical hold is not the same intervention as a physical restraint. There should have been a clearly written ED note or more detailed order by a qualified person to indicate the justification for the use of restraint to occur other than "screaming and yelling." At two hours she should have been released per the Mental Health Code. Per OSF policy, at the four-hour mark, the order would have ended requiring another face-to-face order. At 10:11pm another Resident Physician was assigned to the service recipient and ordered the initial psych consult. If the service recipient still met criteria to be a danger to self or others, then there needs to have been another "Face-to-Face" order entered after a personal examination of the service recipient. After the resident physician ordered the initial restraint at 7:06pm, no other orders pertaining to the four-point physical restraint were found in the medical record provided. It is not even clear as to when the service recipient was again examined by a physician after this initial order. At 9:00pm, the service recipient is documented as "hostile, agitated" and administered a 1.25mg injection of Droperidol. The patient slept for fifteen minutes. According to the chart, the patient woke up again around 10:00pm, and continued to be charted as "hostile, agitated" until 10:30pm. At this point in time, the service recipient was in a four-point physical restraint for three hours and thirty minutes. There is no discussion documented with the patient about their right to be free from restraints to use the bathroom, which should have been documented at 9pm. At 10:41pm, the recipient was offered and unable to use a bedpan, so the assigned night shift RN sought an order to straight catheter the service recipient to eliminate their bladder need versus a less restrictive/invasive treatment intervention. The service recipient is given the second dose of Droperidol at 10:46pm. They are charted as cooperative for the remainder of the restraint 1:1 observation checklist. However, the patient was not released from a physical restraint until 11/23/22 at 2:00am when assessed for an Initial Psychiatric Evaluation by an LCSW. The Mental Health Code **(405 ILCS 5/2-108)** clearly mandates that "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," and "the recipient shall be permitted to have regular… toilet privileges free from the restraint." The hospital's own policy on Restraint and Seclusion Management provides policy guidance to the employee that an order is not to last more than 4 hours for those over age 18. "The order is to include events leading up to the need for restraints, document the Reason for Restraint (e.g., danger to self or others) … staff should Employ and document interventions and less restrictive alternatives that may prevent the patient from needing restraints. 5. RN assesses the clinical justification or reason why restraint is needed, as listed in the restraint order; and continuously assesses for discontinuation. … b. Restraints are discontinued at the earliest possible time."

Although this issue is not part of the complaint allegation, the HRA is incredibly concerned about the practice and documentation of emergency medication by OSF ED staff. In this case, the service recipient received two intramuscular injections of Droperidol at 9:00pm and 10:36pm without informed consent or the use of emergency medication being documented on the Notice of Restricted Rights of Individual form. This is evidence of a direct violation of the Mental Health Code **(405 ILCS 5/2-107)** which gives the patient the right to choose to refuse emergency medications and be informed of the risks of refusing a medication. It also conflicts with the OSF Healthcare's Code of Conduct reviewed by the HRA. If the treating physician still feels the individual requires an order for emergency medication due to being assessed as "causing physical harm to himself or physical abuse to others" an emergency medication could be used in a clinical behavioral health emergency. If such medication is used to mitigate unsafe behaviors, it needs to be documented on the Notice Regarding Restricted Rights of Individual form as such and further communicated to the patient. Although there was a vague physician's order for "emergency medications" it did not specify what type of antipsychotic would be used and what diagnosis/behavior it was treating.

To conclude, during the site visit, hospital staff reported that they could not speak to the treatment received by the service recipient in the ambulance, yet they used information from paramedics to administer Narcan and place the service recipient in a physical restraint immediately upon arrival to the ED. This decision resulted in the recipient being in a physical restraint for six hours and forty-five minutes as part of their behavioral health emergency treatment. The service recipient arrived to OSF ED in respiratory distress at 6:36pm, caused by an adverse reaction to an emergency dose of Ketamine given by paramedics during transport to the hospital. According to the medical records, the service recipient had been sedated in the ambulance when given Ketamine, mixing with unknown home medications or substances used; this emergency medication then triggered the service recipient's vitals to decline requiring emergency resuscitation interventions. The service recipient's only documented ED behaviors found in the chart are "screaming and yelling" when they arrived at the ED. The service recipient was charted on the 1:1 Observation Checklist as "appears to be sleeping" at 7:00pm.

RECOMMENDATIONS:

- Update OSF's Restraint and Seclusion Management policy, #8, on page 3, to align with the Mental Health Code (405 ILCS 5/2/-108) to clearly state an RN may only apply restraint or seclusion prior to receiving an order if the "…person who has been trained in the application of the particular type of restraint to be utilized."

- Update OSF's Restraint and Seclusion Management policy, #11 beginning on page 6, to align with the Mental Health Code **(405 ILCS 5/2-108)** to clearly state restraint is not to last longer than 2 hours unless properly examined by a qualified individual defined as "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".

- Train ED staff on OSF's Restraint and Seclusion Management policy on Face to Face Assessment of Restraint for Violent and/or Self-Destructive Behavior and/or Seclusion policy "that a service recipient has a right to toilet privileges free from restraint, except when freedom of action may result in physical harm to the patient or others."

- Provide evidence to the HRA of the updated policy and educational curriculum used for training.

- Provide evidence to the HRA of ED staff being trained evidenced by staff training log or attendance sheet.

- Train ED staff on how to properly complete a Notice of Restricted Rights of Individual form for Physical Restraint.

- Train ED staff on how to properly complete a Notice of Restricted Rights of Individual form for emergency medications as mandated by **(405 ILCS 5/2-107)**. Provide evidence of all ED staff being trained on the use of the Notice of Restricted Rights of Individual form evidenced by staff training log or attendance roster.

- Provide educational curriculum used to re-train staff on the Notice of Restricted Rights of Individual form.

- Train all ED Resident Physicians on how to correctly enter a "Face to Face" order when treating a behavioral health patient in crisis. Provide educational curriculum used to train ED Resident Physician's on how to correctly enter a "Face to Face" order for a behavioral health patient in crisis. Provide evidence of all ED Resident Physician's being trained on how to correctly enter a "Face to Face" order for a behavioral health patient in crisis evidenced by staff training log or attendance sheet.

The HRA also strongly suggests:

- Update OSF's Restraint Utilization policy on page 6 of 10 within the grid used for the section titled "Violent/Self-Destructive Behavior Restraint (Physical or Chemical) and/or Seclusion" with clear details on how to complete the Restriction of Rights form. Currently, there is a hyperlink in the policy to take staff to another area of policy.

- The rough data provided by hospital staff during the site visit, indicates that the hospital treats approximately 1000 patients in the ED, per year, that have a clear behavioral health need yet do not have any psychiatric nurses on staff. The HRA

strongly suggests the hospital staff their ED team, each shift, with a certified psychiatric nurse(s) to improve emergency care outcomes for this demographic of patient.

- Train staff on a trauma-informed care approach to emergency treatment for all patients, particularly those with a co-occurring disorders or dual diagnoses.

- Improve chart record documentation. The HRA noted that the 1:1 Observation Checklist, Flowsheets, and ED Notes did not document the same or even similar details to warrant behavioral health care interventions provided.

- Improve communication amongst the ED treatment team: physicians, residents, nurses, 1:1 aides and patients.

- 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: Forms (illinois.gov)

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. 23-090-9011

SERVICE PROVIDER: – OSF Healthcare

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

IMPORTANT NOTE

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

We ask that the following action be taken:

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

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

_____ No response is included.

Shelby Rowatt
NAME

Regulatory Coordinator
TITLE

11/22/2023
DATE

OSF HEALTHCARE

To: Erin Nowlan, Disability Rights Manager, Human Rights Authority of the Illinois Guardianship and Advocacy Commission

From: Regulatory/Quality & Safety, OSF HealthCare Saint Francis Medical Center

Date: November 22, 2023

Subject: Case #23-090-9011 Response to Recommendations

We thank you for presenting the recommendations as a result of the investigation of the case listed above. We take the safety and care of our patients with high standing and have addressed these recommendations with high severity and consideration. Please find our response and our requested public action enclosed.

Recommendation #1:

Update OSF's Restraint and Seclusion Management policy, #8, on page 3, to align with the Mental Health Code (405 ILCS 5/2-108) to clearly state an RN may only apply restraint or seclusion prior to receiving an order if the "…person who has been trained in the application of the particular type of restraint to be utilized."

Response:
We would like to provide clarification that this is currently already stated in our policy:

a. Staff with direct patient care restraint responsibilities are trained and competent in the application of restraints, implementation of seclusion, monitoring, assessment and care for patients prior to providing patient care. Training occurs during orientation and annually.

Recommendation #2:

Update OSF's Restraint and Seclusion Management policy, #11 beginning on page 6, to align with the Mental Health Code (405 ILCS 5/2-108) to clearly state restraint is not to last longer than 2 hours unless properly examined by a qualified individual defined as "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 heath in light of the recipient's physical or medical condition."

Response:
We would like to provide clarification that this is currently already stated in our policy. Our OSF policy is more stringent than the Mental Health Code.

a. For violent/self-destructive behavior restraints, patients are examined/assessed at the following intervals:

- Every 15 minutes or more often as needed: circulation, skin integrity, and possible injury by registered nurse or designated trained staff
- Every 2 hours or more often as needed: mental status, range of motion, fluid/foods, and elimination needs by registered nurse or designated trained staff
- Within 1 hour of initiation: face-to-face assessment by licensed provider

Recommendation #3:

Train ED staff on OSF's Restraint and Seclusion Management policy on Face to Face Assessment of Restraint for Violent and/or Self-Destructive Behavior and/or Seclusion policy "that a service recipient has a right to toilet privileges free from restraint, except when freedom of action may result in physical harm to the patient or others."

Response:
All clinical staff at OSF HealthCare Saint Francis Medical Center are trained annually on Patient Rights, Restraints, Seclusion, and Restriction of Rights. This training was assigned to all clinical staff in May 2023. See training module attached (page 27) which includes toileting as an example of reason to allow and document a temporary release from restraints.

Recommendation #4:

Provide evidence to the HRA of the updated policy and educational curriculum used for training.

Response:
See response to Recommendation #1 and #2.

Recommendation #5:

Provide evidence to the HRA of ED staff being trained evidenced by staff training log or attendance sheet.

Response:
The training module has been completed at a rate of 87.8% as of November 22, 2023. See attached training module transcript report. We have several employees on a leave of absence. Those that have not completed the required training yet have been instructed to do so upon their return.

Recommendation #6:

Train ED staff on how to properly complete a Notice of Restricted Rights of Individual form for Physical Restraint.

Response:
All clinical staff at OSF HealthCare Saint Francis Medical Center are trained annually on Patient Rights, Restraints, Seclusion, and Restriction of Rights. This training was assigned to all clinical staff in May 2023. See training module attached (page 74) which includes a step-by-step breakdown of how to complete the form accurately for each part of the Notice Regarding Restricted Rights of Individuals form.

To additionally support enforcement and understanding of this training, dedicated Emergency Department education professionals are completing in-person rounding and simulations for clinical staff in the Emergency Department throughout the month of November.

Recommendation #7 & 8:

Train ED staff on how to properly complete a Notice of Restricted Rights of Individual form for emergency medications as mandated by (405 ILCS 5/2-107). Provide evidence of all ED staff being trained on the use of the Notice of Restricted Rights of Individual form evidenced by staff training log or attendance roster. Provide educational curriculum used to re-train staff on the Notice of Restricted Rights of Individual form.

Response:
All clinical staff at OSF HealthCare Saint Francis Medical Center are trained annually on Patient Rights, Restraints, Seclusion, and Restriction of Rights. This training was assigned to all clinical staff in May 2023. See training module attached (page 74) which includes a step-by-step breakdown of how to complete the form accurately for each part of the Notice Regarding Restricted Rights of Individuals form. The training module also includes administering emergency medication as an example of a situation in which patient's rights are restricted.

In addition, OSF HealthCare has added the definition of "emergency medication" to the Restriction of Rights: Illinois policy. See definition below. The policy, with new definition, is currently going through the internal approval process. This policy is reviewed annually.

a. Emergency Medication: In the context of this policy, means psychotropic medication that is given in an emergency when necessary to prevent the patient from causing serious and imminent physical harm to themself or others with the intention of treating the cause.

The training module has been completed at a rate of 87.8% as of November 22, 2023. See attached training module transcript report. We have several employees on a leave of absence. Those that have not completed the required training yet have been instructed to do so upon their return.

To additionally support enforcement and understanding of this training, dedicated Emergency Department education professionals are completing in-person rounding and simulations for clinical staff in the Emergency Department throughout the month of November.

Recommendation #9:

Train all ED Resident Physicians on how to correctly enter a "Face to Face" order when treating a behavioral health patient in crisis. Provide educational curriculum used to train ED Resident Physicians on how to correctly enter a "Face to Face" order for a behavioral health patient in crisis. Provide evidence of all ED Resident Physicians being trained on how to correctly enter a "Face to Face" order for a behavioral health patient in crisis evidenced by staff training log or attendance sheet.

Response:
All clinical staff, including ED resident physicians, at OSF HealthCare Saint Francis Medical Center are trained annually on Patient Rights, Restraints, Seclusion, and Restriction of Rights. This training was assigned to all clinical staff in May 2023. See training module attached (page 65) which includes the content and focus items to be included in a face-to-face assessment. The face-to-face assessment is a provider note rather than an order which was completed for this patient case.

The training module has been completed at a rate of 95.2% as of November 22, 2023. See attached training module transcript report.

Please address any additional questions or needs to our OSF HealthCare Saint Francis Medical Center Regulatory division.

Shelby Passwater - (309) 655-6328 Shelby.D.Passwater@osfhealthcare.org
Jamie Tosh – (309) 655-7872 Jamie.J.Tosh@osfhealthcare.org
Mary Beth Fiedler – (309) 624-5849 MaryBeth.B.Fiedler@osfhealthcare.org

Thank you,

X Shelby Passwater

Shelby Passwater
Regulatory Coordinator