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HUMAN RIGHTS AUTHORITY – PEORIA REGION
REPORT OF FINDINGS

Case #22-090-9006
Carle Health Methodist Hospital

INTRODUCTION:

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

1- **Improper restraint resulting in injury.**

2- **Patient's rights were violated when hospital staff did not communicate the reason for a transfer to Proctor hospital (3W).**

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-100) and Emergency Medical Treatment and Active Labor Act (EMTALA) Sections 1866 and 1867 and the Social Security Act, 42 U.S.C 1395dd. The facility receives patients statewide, excluding Cook County, but primarily from the tri-county area around Peoria. The HRA visited the facility and conducted a site visit with representatives involved with this service recipient's care. The HRA also reviewed, with authorized written consent, the service recipient's record.

At the time of this complaint, the Covid-19 Executive Orders and mandates were still in effect. In 2021, the hospital had 14,021 discharges for medical patients. In 2021 the behavioral health units had 2,669 discharges. Beginning in April 2022, the hospital is now managed by Carle Healthcare.

Complaint Statement

The complaint alleges a patient was seeking treatment at Carle Health Methodist Hospital (Formerly UnityPoint Healthcare Hospital) for behavioral health care. The patient was physically restrained by five people after throwing a chair. The patient was in a room by themselves when the chair was thrown. The patient received an injury to their shoulder, which had been broken in the past. This occurred in August of 2021. The patient was

admitted to Carle Health Proctor Hospital (Formerly Proctor Hospital) hospital, which is a different hospital building, at some point in the admission/treatment process. The allegation states the patient did not know how they ended up admitted to a different hospital building location.

Interview with staff (6.22.22)

A site visit was facilitated by the HRA via Webex teleconference due to the ongoing State of Illinois Covid19 pandemic Executive Orders being in effect. Two administrative staff from the behavioral health unit attended the site visit, along with two Peoria HRA volunteer board members, and one HRA staff.

The hospital has two behavioral health floors, 6 West (6W) and 8 Hamilton (8H). 6W has a census of 22 beds. The 6W side provides inpatient treatment for patients assessed with chronic mental illness, more aggressive behaviors, and individuals with an intellectual disability. The other unit 8H also has a census of 22 beds and treats individuals with depression, anxiety, personality disorders, some elderly and those with nonintrusive psychosis. The hospital also offers a Geriatric Behavioral Health Unit (3W) for patients who meet criteria for admission. This unit is in another building. To be admitted to this unit one must be over the age of 62. This is considered a more therapeutic milieu and has less stimuli. If a patient enters the main hospital's Emergency Department (ED), they can be assessed and transferred to another building if needed. This transfer is done following Emergency Medical Treatment and Active Labor Act (EMTALA) requirements. It is not a formal transfer, as in to another hospital, it is still under Carle but a different building. It is considered an admission. The hospital would obtain consent from the patient before transferring to the other building via ambulance. The physician makes the bed request and the patient would need to be accepted by 3W.

The triage process to determine emergency level and the admission plan begins in the ED. A patient would check in at registration. It would be determined if they needed medical or behavioral health treatment in the triage process. If in need of behavioral health, and behavior is of concern, then they are assigned to a room on the ED behavioral health wing. Security would be able to watch over the environment for patient safety and staff safety. The Behavioral Health Intake unit of the ED has Intake Pod 1 and Intake Pod 2. Intake 1 has five beds. Intake 2 has 4 beds. The rooms are behind a main entry door that is locked. If a patient is assessed to be suicidal or homicidal then a patient safety companion would be assigned to observe them. If the intake beds are full, then a patient with behavioral health needs could be assigned as overflow to another bed in the ED but they must be ligature free.

The hospital has a physical restraint policy. If a patient's unsafe behaviors require a physical restraint, efforts would be made to de-escalate before restraint is used. The ED team would collaborate to determine what de-escalation techniques work for the patient and offer less restrictive interventions such as medications. Restraint is considered as a last resort. If physical restraint occurs, then a patient would be given a document that communicates they were notified of a rights restriction during treatment. Security can be

used to assist with a patient's behaviors. They are trained in Crisis Prevention Interventions (CPI). Security is common and work a lot with Emergency Response Services. There are always 2-3 Security Guards on duty who walk the area. The nurses' stations have emergency call buttons that can be pushed to alert security and/or other staff if they are in need of assistance. A patient would not be physically restrained for verbal aggression or yelling. Staff would make efforts to redirect and calm the person down. A physical restraint could occur after interventions failed and verbal aggression became physical aggression. Medications can be offered and given before a restraint or after. Medications are sometimes given when a person is in restraint. The ED will give PRN medications if ordered within a clinical dosing guideline while in restraints and not be considered an emergency medication. 1:1 supervision would also be used. All staff treatment and attempts to mitigate behaviors would be charted. Medications would be listed on the Electronic Medication Administration Record (EMAR), Restraint Notes, Flowsheets, and Nursing notes.

If an injury occurs to a patient during a physical restraint, then staff would debrief and discuss the injury. If the treating provider feels there needs to be further interventions ordered such as an x-ray that would be ordered. If a patient has an old injury, staff may not be aware of this at the time of care. The patient would need to disclose this information to the treatment team. It would then be documented and the inpatient treating team would be notified. If an injury occurred after a physical restraint, the patient could complain. They could tell a staff or report to the Patient Advocacy team. This would go through the manager or director of the unit. The hospital also gives rights forms after a physical restraint has occurred. Each staff person involved in a physical restraint intervention does not complete the same paperwork. For example, any staff would be able to document a physical restraint on the Restriction of Rights form. The practice in the ED and on the unit is that the person who initiates the intervention should be the responsible party completing the form. A restraint note would be created in the electronic medical record. This document has a timeline of the treatment interventions ordered and given by ED staff.

The CPI training does not specify how many staff should be involved in a physical restraint. An escort does involve two or more staff. The purpose of the escort is to try and secure a person's limbs to prevent injury and control the situation to keep all parties safe. More than two would be required if a person is kicking or demonstrating some other unsafe behavior during the escort.

The service recipient involved in this case had had numerous contacts with the hospital. In August 2021, the service recipient arrived at the hospital voluntarily. He was sent to the hospital by his doctor's office due to behavioral health needs. A triage note documents him reporting "I'm in a bad way." He was checked-in for a psychiatric admission. He was medically cleared before he had a behavioral health assessment. A Nurse Practitioner ordered a medical screen and crisis assessment. A Behavioral Health Clinician completed the assessments. The service recipient refused to answer the Columbia Suicide screening questions which assess suicidal ideation and risk. He denied homicidal ideation. Since this service recipient was examined in the hospital, the practice

has changed. In February 2022, when a patient with suicidal or homicidal ideation presents to the ED, they are immediately assigned to a patient safety companion. The service recipient was staffed for a plan of care with the 3W medical director for admission due to suicidal behavior with a plan of putting himself in dangerous situations. The example given during the site interview was, "wanting police to shoot him."

During treatment in the ED, the service recipient had a restraint ordered by a Nurse Practitioner (NP). The service recipient became violent, and seclusion and restraint were used as interventions. A quick review of the chart indicates, at 1:15am the service recipient was demanding to leave the hospital. The service recipient was refusing to follow staff directions. He was told by staff he would be escorted and required a two-person escort. Seclusion began at this time. The service recipient began to throw chairs in the room. The service recipient became physically aggressive towards staff, refused a staff escort and his momentum pushed staff. Security was called. The service recipient again "put up a fight" and was placed in 4-point restraints. PRN medications were also given. This physical restraint lasted from 1:15am until approximately 2:30am. The chart record documents the service recipient was agreeable to a transfer to the other building. There is no staff documentation of a new or old shoulder injury being reported by the service recipient. There is an injury noted and documented by staff in the debriefing section of the chart regarding a superficial scratch to the left arm of the service recipient.

The chart record does reflect the service recipient reporting left shoulder pain several days later on 8/10/21. The chart record note indicates the service recipient alleged this was due to the restraint. An x-ray was ordered and there were no acute findings for a fracture. The x-ray did indicate a healed midshaft fracture in the left shoulder and rod was intact. Staff treated the service recipient with pain assessments and was given Tylenol.

The service recipient needed a behavioral health admission. He arrived in the ED on 8/6/21 around 4:36pm. He was a voluntary admission patient at that point. A consent to transfer was signed by the service recipient on 8/6/21 at 11:48pm. He was assigned to a room in the ED at 5:24pm. The ED Nurse Practitioner (NP) evaluated the service recipient at 6:00pm. The clinician assessed at a similar time. From 6:30pm on 8/6/21 until 1:15am on 8/7/21, the service recipient was in the ED. He became increasingly agitated. The physical restraint occurred on 8/7/21 at 1:15am. The service recipient received: 5mg Haldol IM at 1:17am, and 2mg IM of Ativan at 1:41am. The service recipient was out of the physical restraint by 2:30am. The service recipient was transferred to 3W which is located in another building on 8/7/21 at 4:43am. According to staff at the site visit, nothing in the chart documents the service recipient asking to discharge or signing a Request for Discharge form. Additionally, nothing in the chart record documents the service recipient eating during his ED treatment. When the service recipient transferred to 3W due to the ambulance being used to transport him to the other building the Involuntary Admission forms were started. When the service recipient arrived at 3W he voluntarily signed himself in on 8/7/21. He was discharged on 8/12/21.

FINDINGS

1-Improper physical restraint resulting in injury

The HRA reviewed a Pain Clinic note dated 6/14/21, the service recipient had imaging completed at the hospital's Pain Clinic. The service recipient had an x-ray of his shoulder area. The findings are documented as "Well-aligned left humeral shaft fracture with intact hardware." On 6/29/21 an MRI test was completed, and the clinical history was documented by Radiology as the following "Neck pain that goes into his left shoulder and down his left arm at times. Two months ago, he was attacked being thrown down to the ground resulting in a fractured left shoulder." The MRI pre-screening assessment documents "bone/joint pin, screw, nail, wire, plate" in his shoulder. The MRI was done of his neck area only. With this information, the HRA established the shoulder injury occurring in April 2021 since it was documented that it occurred two months prior.

The HRA reviewed a document titled "ED-Carle Health Methodist Emergency Department" which documented the service recipient arrived at the ED. On 8/6/21 at 4:36pm, the service recipient arrived at the hospital on his own accord via taxi. His ED Referral documented the recipient as a "self-referral". The service recipient was placed on elopement and assault precautions. He was also care planned for the following "Attempt alternative methods initially. Avoid the use of physical intervention if at all possible. Use the least-restrictive restraint method possible and follow specific standards regarding physician orders and ongoing use."

On 8/6/21 at 4:57pm orders were placed by the Physician Assistant and acknowledged by an RN for 2mg Ativan via injection. The ED Care Timeline notes document: 8/6/21 2mg IM Ativan was given at 6:31pm at 10:12pm, the patient was medically cleared for admission by the medical provider; at 10:17pm notes document the service recipient's plan of care as "Transfer to Another Facility"

In the early morning on 8/7/2 at 1:17am, the ED Care Timeline documents an order for the patient to be given two intramuscular injections: 5mg of Haldol and 2mg injection of Ativan. At 1:33am the Physician's Assistant (PA) ordered a physical restraint for violent, and self-destructive adult; 2mg Ativan injection was given to the patient at 1:41am.

The HRA reviewed a "Petition for Involuntary Admission" that began on 8/6/21 at 9:30pm by an RN. The HRA reviewed the "Inpatient Certificate" that was completed by a Licensed Clinical Professional Counselor (LCPC) on 8/6/21 at 9:45pm. This clinician assessed that the service recipient met the standards for an involuntary admission and required immediate hospitalization. This was based on the service recipient having suicidal ideation and a plan "to put himself in dangerous situation to where people will kill him. Patient reported he would make the police angry so they will shoot and kill him. Patient reported that he needs to be admitted to protect himself from himself. Patient has a history of psychiatric hospitalization with a diagnosis of adjustment disorder, mixed disturbance of emotions and conduct." On 8/7/21 at 5:05am the service recipient signed himself into the geriatric behavioral health unit, located approximately ten minutes away from the main hospital campus, as a voluntary admission.

On 8/7/21 at 1:15am, the service recipient was placed into physical restraint in the ED. The HRA reviewed an ED "Restraint Note" written by a Behavioral Health Technician that documents this significant event as follows "Patient at the clinician window demanding to leave. Patient was asked to return to his room multiple times. Patient refused to follow direction. Patient was informed if he does not return to his room he will be escorted. In an attempt to escort the patient to his room he stated, 'don't fucking put your hands on me.' Patient was then put in a 2-person escort and he resisted the escort. After a physical attempt to get the patient into his room he finally began to walk. Seclusion began at this time in BH5. 1:20am: While in seclusion, the patient began to throw chairs in the room and at the door. Security personnel was called at this time. Door was opened and patient became physically aggressive with staff. Patient refused to follow direction of the staff at this time. Patient began to fight with staff in an attempt to escort him to another room. Patient's momentum pushed staff against the doors of other rooms. Patient's momentum took him to the floor. Medication was given while patient was on the floor. Patient was assisted to his feet. Upon getting to his feet, the patient again (began) to resist the escort. Patient was escorted to his room with assistance. Seclusion began at this time in BH2. (at) 1:25am: Patient was banging on the door. Patient was asked to stop banging on the door. Patient began to scream and bang harder on the door. At this time the patient's behaviors were being disruptive to the environment. Security personnel was called back to BH. Patient's room door was open. Patient immediately began to resist the instructions of the staff. Patient began to physically put up a fight to sit on his bed. The patient was then put into 4 point restraints at this time. 1:30am: Patient screaming and demanding to be released from restraints. 0145: Patient screaming and demanding to be released from restraints. 0200: Patient laying on the bed watching the staff asking to be released. 2:10am: Patient's left arm and right leg removed from restraints. Patient's right arm and left leg still restrained at this time. 2:15am: Patient asking to be released from remainder of restraints. Patient educated on behaviors that need to be demonstrated for restraints to be released. 2:30am: Patient agreed to follow staff direction. Patient agreeable to being transferred. Patient calm and cooperative at this time. All restraints removed at this time. Interventions utilized by staff to avoid Restraint/Seclusion: Patient asked to follow directions multiple times. PRN medications given. Restriction of rights is complete and in chart, copy given to patient or responsible party: YES Debriefing: Injury to patient: YES. Patient sustained a superficial scratch to the inside of his upper left arm."

The HRA reviewed a Notice of Restricted Rights of Individual dated 8/7/21 at 1:15am. The section of this document labeled Part 1 documents the following "Individual was placed in a physical hold, physical restraint, seclusion and administered emergency medications." The reason for the identified restrictions are documented as "Patient disruptive to unit environment. Patient refused to follow staff instructions. Patient aggressive and combative towards staff." This document is signed on the same date by a Mental Health Technician attesting to the statement "I certify that I have completed this form. Copies of this notice were given to the individual, mailed to all indicated individuals and placed in his or her medical record."

The ED Frequent Observation Flowsheet documents the service recipient being observed by two ED mental health technicians (MHT) from 1:00am-2:30am during the physical restraint.

On 8/7/21 at 2:50pm an RN on the Geriatric Behavioral Health Unit documents on a clinical note "Patient has several rectangular red marks on left upper arm in region of bicep approximately medially, 2 cm and identical in pattern. Patient reports pain from region and believes has a broken arm, uncertain from patient if report was before or after restraint prior to admission to this unit. Patient not showing evidence of pain on palpation, no crepitus or pain response."

The HRA reviewed a document titled "Psychiatry Initial Evaluation" dated 8/7/21 at 3:00pm. The History of Present Illness section explains "Emergency room note reviewed that patient was placed in seclusion. And as he began throwing chairs in the room became physically aggressive with the staff began to fight with the staff in an attempt while they are escorting him to another room patient was placed in seclusion in the room as he did not follow the instructions continue to be aggressive end up in four-point restraints because patient refused to follow the directions. After he is medically cleared the patient is transferred to 3 W." The section titled "Review of Systems" the following is documented "Musculoskeletal ROS says that he had a fracture in the upper arm and that is where they held and the put him in the restraints so it is hurting him."

The HRA reviewed a document titled "Hospital Consult" completed at Proctor Hospital on 8/7/21 at 5:00am. The reason for the consult is noted as "Evaluation of medical problems including hypertension, atrial fibrillation, type 2 diabetes". The section titled "History of Presenting Illness" documents "Patient is 65 y.o. male with known bipolar disorder and borderline personality disorder who was admitted to the geriatric psychiatry floor with increasing agitation and behavioral issues. States he has been under a lot of stress and is just not coping with them well. Has a history of aggressive behavior as well. Has had multiple psychiatry admissions in the past, but states that he has to feel comfortable in the setting in order to accomplish his goals. He does not trust Methodist Hospital, and thus asked to be admitted here for evaluation and treatment. I have been asked to see him to help manage his medical issues. Overall, the patient states he feels physically well. Is complaining of left upper arm pain after being 'grabbed' by a staff member prior to transfer to our hospital. States he has fractured that arm in the past and has a plate in it. Is able to move the arm per his baseline, however. No numbness or tingling reported. He denies any issues with his blood sugars at home. Admits to not watching his diet as closely as he should. Denies having any chest pain or difficulty breathing." The section of this document titled "Review of Systems" notes "Musculoskeletal: Positive for joint pain (left shoulder). Negative for myalgias."

On 8/9/21 at 2:54pm an RN documents on a clinical note "Patient alert and oriented x4. Patient presents in appropriate mood and affect. Patient denies SI/HI and A/V hallucinations. Patient interacts appropriately with peers and staff. Patient denies pain or further needs. Patient reports that staff at Methodist injured upper left arm. Patient has bruising and scratches on arm. Patient reports this is not painful to touch." The response

for this interaction is documented as "Response: Patient pleasant and cooperative with staff. Patient has good appetite. Patient attends groups. Patient takes medication as prescribed"

On 8/10/21 an RN on the inpatient behavioral health floor documents "Patient alert and orientated to person, place, time and events. Pt with many concerns, somatic complaints, and requests from staff. Encouraged independence by highlighting things that staff can do for himself. Pt verbalized understanding. Pt states that he would like an xray for a shoulder injury that he received in April. Telehospitalist deferred this request to the AM team. Pt verbalized understanding."

The service recipient had a pain assessment. On 8/10/21 at 5:21 he reports his pain as a 7 on a scale of 1-10. At 6:19am he notes pain of his left shoulder as a 5. An hour later at 7:15am he reports no pain. An RN also documents "Patient is complaining of left shoulder pain, stating it is caused from being placed in restraints. He is requesting to have the hospitalist assess his shoulder."

On 8/11/21 at 8:59am an inpatient Patient note written by a Behavioral Health Counselor documented "observed participating in morning groups. Patient denies suicidal ideation. Patient observed socializing appropriately. Patient continues to perseverate on wanting a shoulder x-ray due to an injury he received in April of this year. Patient reports, 'I want to make sure something gets done.' Attending meals. Medication compliant."

The HRA reviewed an "Inpatient Psych Note" dated 8/11/21 at 6:30pm completed by an attending Physician that documents the service recipient reporting "Today pt is in better mood, he says he just had Shoulder x-ray done" The HRA also observes in the chart record Radiology imaging results for an "x-ray humerus 2 results L" read by a physician on 8/11/21 at 11:15am. The narrative of the x-ray document reads "AP and lateral views left humerus were obtained. History is pain, prior surgery. FINDINGS: There is an intramedullary rod transfixed proximally and distally by screws. This transfixes a healed midshaft fracture. No acute findings". The Impression/Final Result is also noted as "No acute findings."

The HRA reviewed hospital policy B-12 titled Care Coordination on the subject of "Violent/Self Destructive Restraints;" the purpose of the policy is explained as "UnityPoint Health - Methodist I Proctor I Pekin is committed to managing patients in the least restrictive environment. Restraint and seclusion, as defined below, are used only to ensure the immediate physical safety of the patient, staff member, or others and will be discontinued at the earliest possible time. Restraint or seclusion will never be used as a means of coercion, discipline, convenience, or retaliation by staff. Restraint/seclusion use is documented, and patients are monitored to ensure their safety." Restraint is defined as "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, hands, legs, body or head freely. … g. Physical escort if the patient cannot easily remove or escape the grasp. Patients refusing services and emergency medication or treatment that is needed to

prevent serious and imminent harm to self or others and no less restrictive alternative is available. The LP must document giving the emergent medication and reasons for such use. A Notice of Restricted Rights of an Individual form must be completed in order to be in compliance with the IL Mental Health Code by the LP or designee and provided to the patient or guardian." Section D. of this policy explains "Least restrictive interventions: Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, staff, or others from harm. Focus on preventative measures, including ongoing milieu management and individualization of the plan of care. Least restrictive measures include, but are not limited to: 1. Ventilation of feelings 2. Separating patients 3. Use of substitute activities or distraction 4. One-to-one session 5. Limit setting; offer choices 6. Offering privacy 7. Use of a quiet room or area 8. Offering medication."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/1-101.2) Adequate and Humane Services** states: "'Adequate and humane care and services' means services reasonably calculated to result in a significant improvement of the condition of a recipient of services confined in an inpatient mental health facility so that he or she may be released or services reasonably calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self or others."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5//2-108) Use of Restraint** 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. … (f) Restraint shall be employed in a humane and therapeutic manner and the person being restrained shall be observed by a qualified person as often as is clinically appropriate but in no event less than once every 15 minutes. The qualified person shall maintain a record of the observations. Specifically, unless there is an immediate danger that the recipient will physically harm himself or others, restraint shall be loosely applied to permit freedom of movement. Further, the recipient shall be permitted to have regular meals and toilet privileges free from the restraint, except when freedom of action may result in physical harm to the recipient or others. (g) Every facility that employs restraint shall provide training in the safe and humane application of each type of restraint employed. The facility shall not authorize the use of any type of restraint by an employee who has not received training in the safe and humane application of that type of restraint. Each facility in which restraint is used shall maintain records detailing which employees have been trained and are authorized to apply restraint, the date of the training and the type of restraint that the employee was trained to use. … (i) A recipient who is restrained may only be secluded at the same time pursuant to an explicit written authorization as provided in Section 2-109 of this Code [405 ILCS 5/2-109]. Whenever a recipient is restrained, a member of the facility staff shall remain with the recipient at all times unless the recipient has been secluded. A recipient who is restrained and secluded shall be observed by a qualified person as often as is clinically appropriate but in no event less

than every 15 minutes. (j) Whenever restraint is used, the recipient shall be advised of his right, pursuant to Sections 2-200 and 2-201 of this Code [405 ILCS 5/2-200 and 405 ILCS 5/2-201], to have any person of his choosing, including the Guardianship and Advocacy Commission or the agency designated pursuant to the Protection and Advocacy for Persons with Developmental Disabilities Act [405 ILCS 40/0.01 et seq.] notified of the restraint. …"

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-201) Restrictions, restraints or seclusion; notice; records requires that: "(a) Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to: (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian; (2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice; (3) the facility director; (4) the Guardianship and Advocacy Commission, or the agency designated under "An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named", approved September 20, 1985,[1] if either is so designated; and (5) the recipient's substitute decision maker, if any. The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefor in the recipient's record."

COMPLAINT #1 CONCLUSION:

While the HRA has reviewed evidence that the service recipient experienced physical pain and discomfort of their shoulder, while restrained, due to a past injury to that area, the HRA finds the allegation of "Improper restraint resulting in injury" to be **unsubstantiated**. The complaint alleges the service recipient was physically restrained by five people after throwing a chair, although they were alone in a room, and the patient received injury to their shoulder during the restraint. The HRA can confirm the service recipient had a broken left humerus that required surgery in April 2021 prior to the August admission. On 8/7/21 upon admission to 3W, the service recipient did report shoulder pain after the physical restraint which was assessed for range of motion and treated by hospital staff with Tylenol. The hospital did x-ray the injured area and verified there was no fracture to the shoulder area from the restraint and treated the service recipient with pain medication. The HRA can confirm though documented evidence that the service recipient did throw a chair. The HRA can confirm through the documentation that the service recipient was ordered for a physical restraint by the Physician's Assistant on 8/7/21 at 1:33am due to escalating physical aggression by the service recipient. The documentation indicates the physical restraint was initiated when staff entered the patient's room after throwing a chair and he began to "fight" them. The Code **(405 ILCS 5//2-108)** mandates that "Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others." Hospital policy on "Violent/Self-Destructive Restraints" directs staff on how physical restraints are to be used: " … to ensure the immediate physical safety of the patient, staff member,

or others and will be discontinued at the earliest possible time. Restraint or seclusion will never be used as a means of coercion, discipline, convenience, or retaliation by staff. Restraint/seclusion use is documented, and patients are monitored to ensure their safety." Documentation is evidenced by the ED Frequent Observation Flowsheet found in the chart record. The service recipient was also provided with Notice of Restricted Rights of Individual per **(405 ILCS 5/2-201).**

The HRA would make the following suggestions:

- Update the ED chart that documents the patient's past history of a shoulder injury upon admission.

- Improve the treatment to admission/discharge time for all patients seeking behavioral health treatment in the ED.

- Offer a meal tray, snacks or beverages to all behavioral health patients during their treatment process to help mitigate behaviors that could be exacerbated due to nutritional needs.

- Staff should use a trauma-informed care approach for the service recipient when providing behavioral health care in the future.

- Work with the service recipient on a strong aftercare plan to prevent emergency behavioral health care crisis.

The HRA would also 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

FINDINGS COMPLAINT #2:

2- Patient's rights were violated when hospital staff did not communicate the reason for a transfer to Proctor.

The service recipient was an involuntarily admission that began in the main hospital ED on 8/6/21 due to suicidal ideation. Upon admission, the service recipient's plan of care was for him to be admitted to the Geriatric Behavioral Health Unit (3W) which is part of the hospital organization, however in a different location. On 8/7/21, he signed as a Voluntary admission for treatment on 3W.

On 8/7/21 at 8:50am a Registered Nurse documents the admission to the unit as "Patient arrived upon the unit at 5:00am escorted by security and EMS. Patient signed voluntary paperwork, but stated 'I don't have anyone to sign a Release Of Information (ROI) for.' Patient was compliant with assessment but was disorganized in conversation. Patient knew he was at Proctor hospital but due to falling asleep he would start mumbling about random things. Patient was very tired which only 2 set of vitals were obtained due to the patient being too tired to stand. kept falling asleep during admission. Patient told writer that 'He just wants to put himself in dangerous situation, and its a long story'. Patient denies suicidal thoughts upon admission but was very preoccupied talking about 'Fernando' but he was minimal in details due to falling asleep. Patient was in a recliner chair, intermittently sleeping in front of nurses' station. Patient at times was impulsive and restless requiring to be within staffs' sight to prevent falls. Patient's history shows: Closed fracture of left proximal humerus, Generalized anxiety disorder, Histrionic behavior, History of bipolar disorder, Adjustment disorder with mixed disturbance of emotions and conduct, Fatty liver, Centrilobular emphysema, Coronary arteriosclerosis, Diastolic heart failure, Atrial fibrillation, hypertension, Dilation of thoracic aorta, Bilateral leg edema, Bipolar 1 disorder, Borderline personality disorder, OSA (obstructive sleep apnea), Obesity is associated with physical deconditioning and dyspnea on exertion, Anticoagulant longterm use, Homicidal ideation, Chronic bipolar"

The HRA reviewed a Psychiatry Initial Consultation dated 8/7/21. During this consultation the service recipient is documented disclosing to the provider "Then he believes at Methodist he was placed in seclusion and restraints for no reason he was only trying to stand up for his right side and he believes everybody there mistreated him attacked his integrity. And then they sent me here. If they were going to send me here I would have brought myself here, so his perception is they kind of misinformed him."

The HRA reviewed a document titled "Patient Consent/Request to Transfer." This form communicates the following information to a patient: "You have the Right to: To receive medical examination or treatment, within the capabilities of the hospital staff and facilities, to stabilize an emergency medical condition or If necessary, to be transferred to another facility." The consent also communicates: "You have the right to be informed of: The risks of the examination and treatment. The benefits of the examination and treatment. You have the right to refuse the examination and treatment. This care and treatment is offered even if you cannot pay, do not have medical insurance or are not entitled to Medicare or Medicaid." The form further states under "Permission To Transfer: to be transferred to Proctor" the "Benefits of Transfer include but are not limited to: Need for a higher level of care. Benefits of Ambulance Transport: reduce delay or accident in transit, minimize pain or discomfort upon movement and provide medical assistance during transport in the event of a crisis. Risk of Private Vehicle Transport: delay related to traffic congestion or accident enroute, lack of medical assistance to assist with minimizing pain or discomfort or in the event of a crisis defined as a change in status that could put the patient or others at risk of injury. Risk and benefits of such transfer and the method of the transport have been explained to me. I authorized the hospital to release my health information to the receiving facility. As physician has recommended that I be transported by: Ambulance. I have elected to be

transported by: Ambulance. The reason for my transfer is: Age." The service recipient's signature is observed on this document on 8/6/21 at 10:49pm. The form is also witnessed by hospital staff.

The HRA reviewed hospital policy I-101 "Care Coordination" with the subject line "Transfer and Emergency Examination EMTALA" last reviewed April 2022. The purpose is: "This policy, in compliance with the EMTALA (Emergency Medical Treatment and Labor Act), outlines the procedure for the examination, stabilization, and transfer of individuals coming to a UnityPoint Health (UPH) Methodist, Proctor, and Pekin Emergency Departments requesting examination or treatment for a medical condition, including active labor, regardless of the individual's ability to pay." A psychiatric patient that qualifies for EMTALA is defined as "3. … individuals with symptoms of substance abuse, and individuals expressing suicidal or homicidal thoughts or gestures, if dangerous to self and/or others, may meet the definition of having an 'Emergency Medical Condition' because the absence of medical treatment may place their health in serious jeopardy, results in serious impairment of bodily functions, or serious dysfunction of a bodily organ." Section C. of the policy reads "To provide medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility; or with respect to a woman in labor, to deliver, including the placenta. 2. Stable for transfer A patient is stable for transfer from one hospital to a second hospital if the treating physician attending to the patient has determined, within reasonable clinical confidence, that the patient is expected to leave the hospital and be received at the second hospital, with no material deterioration in his/her medical condition. The receiving hospital must have the capability and capacity to manage the patient's medical condition and any reasonably foreseeable complications of that condition. If there is a disagreement between the treating physician or QMP and the off-site physician about whether a patient is stable for transfer, the medical judgment of the treating physician or QMP usually takes precedence over that of the off-site physician. 3. Stable for discharge." Section F. of this policy explains: "F. Transfer The movement, including discharge, of an individual outside the facility at the direction of any person employed by or directly or indirectly affiliated or associated with the UPH Methodist/Proctor/Pekin Hospital. This does not include such a movement of an individual who has been declared dead or leaves the facility without permission. Transfer does include the movement of an individual patient from UPH Methodist/Proctor/Pekin to another UPH hospital as the three are separately licensed and certified."

The HRA also reviewed UnityPoint Health Patient Rights and Responsibilities that communicates the following information to patients about their rights to access care: "4. Receiving a medical screening examination and stabilizing care, … 6. Receiving a consultation or second opinion from another physician as well as to change physicians."

The EMTALA regulations at (**42 CFR 489.24(b))** define "transfer" as " …the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the

hospital, but does not include such a movement of an individual who (i) has been declared dead, or (ii) leaves the facility without the permission of any such person."

The requirements in (**42 CFR 489.24(e)**) apply to transfers to another hospital. "These transfer requirements do not apply to an individual who is moved to another part of the hospital, because technically the patient has not been transferred. This is also the case when an individual who presents to an off-campus dedicated emergency department is found to have an EMC and is moved to the hospital's main campus for stabilizing treatment that cannot be provided at the off-campus site."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/3-400) Voluntary admission to mental health facility** directs the facility that: (a) Any person 16 or older, including a person adjudicated a person with a disability, may be admitted to a mental health facility as a voluntary recipient for treatment of a mental illness upon the filing of an application with the facility director of the facility if the facility director determines and documents in the recipient's medical record that the person (1) is clinically suitable for admission as a voluntary recipient and (2) has the capacity to consent to voluntary admission. (b) For purposes of consenting to voluntary admission, a person has the capacity to consent to voluntary admission if, in the professional judgement of the facility director or his or her designee, the person is able to understand that: (1) He or she is being admitted to a mental health facility. (2) He or she may request discharge at any time. The request must be in writing, and discharge is not automatic. …(c) No mental health facility shall require the completion of a petition of a certificate as a condition of accepting the admission of a recipient who is being transported to that facility from any other inpatient or outpatient healthcare facility if the recipient has completed an application for voluntary admission to the receiving facility pursuant to this section."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) Care and services; psychotropic medication; religion** requires that: "(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. … 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 [405 ILCS 5/2-200] shall be noted in the recipient's treatment plan."

COMPLAINT #2 CONCLUSION:

The HRA unsubstantiates complaint #2. The service recipient signed a consent at the ED and was informed on 8/6/21 that the plan of care was to transfer to 3W due to his age. The service recipient's signature is observed on the EMTALA consent form that is required before a patient transfer to another unit, outside of the main hospital campus.

This form was signed by the service recipient on 8/6/21 at 10:49pm, which is before his behaviors escalated. The HRA does assess that the involuntary petition and certificate was overly restrictive with regards to the transfer per **(405 ILCS 5/3-400)**. Although the involuntary petition began at approximately 9:30pm. The service recipient is documented by ED staff as communicating the following, "Patient reported that he needs to be admitted to protect himself from himself." Based on information provided in the site visit interview, the involuntary admission petition and first certificate was done due to needing emergency transportation to the other hospital location. The chart record also corroborates that the service recipient agreed to the transfer based on the 8/7/21 Initial Psych Evaluation at the Proctor hospital location that documents the patient knowing he was at this location, although he also reported feeling misinformed. The HRA observes documentation in the chart that provided evidence he voluntarily admitted to the Geriatric Behavioral Health unit. The HRA should also mention that the Emergency Medical Treatment and Labor Act is a federal law that prevents a hospital from discharging a person in crisis due to their inability to pay. The decision to transfer the service recipient was based on age and mental health need. The hospital policy provided for review by the HRA also distinctly separates that a person experiencing a behavioral health crisis qualifies for EMTALA as defined "individuals with symptoms of substance abuse, and individuals expressing suicidal or homicidal thoughts or gestures, if dangerous to self and/or others, may meet the definition of having an 'Emergency Medical Condition' because the absence of medical treatment may place their health in serious jeopardy, results in serious impairment of bodily functions, or serious dysfunction of a bodily organ." Based on information in the site visit and the HRA's review of **(42 CFR 489.24(e))**, the comment made that "These transfer requirements do not apply to an individual who is moved to another part of the hospital, because technically the patient has not been transferred," it is good practice for the hospital to treat the other hospital building location as a transfer. The hospital's "Care Coordination" policy is contrary to site visit staff's policy interpretation and makes the following expectation "Transfer does include the movement of an individual patient from UPH Methodist/Proctor/Pekin to another UPH hospital as the three are separately licensed and certified."

The HRA would suggest the following:

- Improve ED documentation discussing a care plan or transfer plan with a patient. Evidence was provided with signatures of the service recipient noted on the appropriate release of information but there were no corresponding ED timeline or progress notes detailing a formal discussion with the person about his plan of care and his response to the plan.

- Coordinate campus to campus transfer to align with **(405 ILCS 5/3-400).**