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Northwest Regional Human Rights Authority
Report of Findings
Case #23-080-9001
CGH Medical Center

Introduction

The Human Rights Authority (HRA) opened an investigation into potential rights violations at CGH Medical Center in Sterling, Illinois. **The complaints are that the patient's right to refuse medication and treatment was ignored, the right not to be subjected to restraints was ignored and the right to have sound nursing and medical practices was ignored.** Substantiated findings would violate protections under the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Medical Patients' Rights Act (410 ILCS 50).

CGH Medical Center is a 99 -bed facility in Sterling, Illinois which is located in the Sauk Valley region. The Emergency Department (ED) served approximately 24,656 patients during fiscal year 2022, and has 26 private rooms, 6 easy care areas and 2 trauma rooms. The Behavioral Health Unit (BHU) opened in April 2021 with 10 adult beds, which includes 4 semi-private rooms, 2 private rooms, seclusion room and offers the following services: inpatient therapy groups and symptom-management skills. The HRA discussed the case with representatives from the ED, BHU and administrators. Relevant policies were reviewed as was the patient's record with authorization.

Complaint Summary

Per the complaint, the patient while hospitalized was forcibly given a shot of Haldol, restraints were used unjustifiably and the right to sound and conventional medical practices was disregarded. The complaint stated that the patient hospital staff that the restraints hurt and there was no action taken to ease the pressure and the request to see a different physician was ignored and denied.

Record Review

Emergency Department

The patient was brought to the emergency department by emergency services without incident on June 29th at 10:50am. While waiting in the room for testing and evaluation to be completed, the patient removed her gown and began swinging it around the room at 12:01pm and a few minutes later was assisted with putting it back on. Around 12:57pm, the patient

initially came out the room and was redirected back. The patient continued to make numerous attempts to come out the room and began yelling at staff; security was called, and psychotropic medication was ordered. Around 1:14pm, security assisted in giving the patient 5mg of Haldol and Benadryl intramuscularly and the BHU was contacted to complete an assessment shortly thereafter. After the BHU assessor completed the assessment, the patient opened the door and "bulldozed" past staff without clothes on and ran out the room first towards the cafeteria and then towards the lobby. Once security was able to retrieve the patient and put a gown back onto her, they restrained her in a four-point restraint, which was ordered and executed at 1:45pm, by a signed physician order for soft restraints. Throughout this time, the patient was asking to be released so she can go home, and the nursing staff removed the leg restraints at 2:24pn. During the course of the removal, nursing staff told patient the following: "if patient remained calm and cooperative, we would talk about taking the wrist restraints off". Per the nursing notes, the patient laid in the bed quietly while waiting for the restraints to be removed. Finally, at 4:31pm, wrist restraints were removed, and the patient remained calm. While in the ED waiting for a bed on the BHU to become available the patient was provided food and a sitter in the room.

Orders w/ Restriction of Rights

The HRA reviewed the medication and restraint orders for the event described above. First, the staff ordered a shot of haloperidol and Benadryl to sedate and calm the patient, both were ordered by an MD at 1:10pm, and then both were administered by a nurse at 1:27pm. Both of those orders and executions line up with the events as they transpired. Then at 1:45pm, the MD used a "Physician Order Sheet – Patient Restraint" form to order four-point restraints and set their expiration for 4:45pm. The use of the restraints was justified as "Based on my examination of the patient, the patient requires Behavioral restraints because the patient is exhibiting violent or aggressive behavior that presents immediate and serious danger to the safety of the patient or others".

As far as the Restriction of Rights notices that the facility is required to provide, there is no record or indication the facility used the notice. Additionally, staff are recorded at the site visit as not being familiar with restriction notices to begin with.

Behavioral Health Unit

The patient arrived on the unit at 9:13pm without any incidences and during the admission intake process, the patient completed the voluntary admission application and rights were read and discussed. The admitting nurse inquired if the patient knew why she was being admitted and the patient stated "no". The second day on the unit the patient pulled her pants down and was reminded by nursing staff numerous times to have "appropriate behavior around others" and at times was very emotional in interactions with staff. The patient completed a hospitalist evaluation (medical exam), which recorded in the nursing notes, that the patient "generally is not in any acute distress". The patient completed a request for discharge on June 30th with BHU nursing staff. Throughout the patient's stay, she was provided continued observation due to inappropriate behavior, but was able to be redirected;

she remained on 15-minute checks, attended groups, received medication monitoring (patient refused numerous psychiatric medications) and attended daily psychiatric sessions. Per the written record, the patient is recorded on July 5 at 5:42pm demanding to be seen by a physician because the patient believes that she is growing a penis out of her vagina. The patient had been spending her stay at the emergency room and behavioral health unit having those hallucinations, but for July 5 she made the demand to be seen for it. The patient is recorded as saying " 'I can breath[e] water. …I [am] going to have perfect little mermaid babies,' 'I have not seen a physician! I need to see someone for this dick I am growing.'" The patient agreed with the proposed discharge plan and was discharged on July 6th.

Interviews

ED Provider

Per the attending MD that oversaw the patient, he could not specifically recall the patient nor could the attending MD attest to being familiar with restriction notices. The attending MD explained in the site visit that he was familiar with physical restraint order forms, and that he would sign such a form in order to ensure the safety of the staff and others around.

BHU Specialist

Per the Behavioral Health Specialist, the patient had refused to give information during the assessment and had her eyes closed. The patient is familiar with their particular emergency department and its staff. The patient had attempted to go through the ambulance bay, but a security guard and a room sitter were called.

ED Nurse

An ED Nurse corroborated the written record, recollecting that the patient was aggressive and "flinging the door" of her room. This particular ED nurse gave the patient the shot of haloperidol. This nurse claims that initially she tried to give the medication and the patient did not try to fight her on the shot but allowed the shot to occur. This nurse also claims that the patient was more relaxed after she had attempted to elope.

ED Nurse

Another ED nurse vividly remembered interacting with the patient, recounting how the patient was explaining her affliction to her. She recalled that the patient tried to run out of the ED and had ripped her gown off, leaving the patient in only socks. This ED nurse ran after the patient and eventually got a gown onto the patient. The patient was transferred to a bed and was handcuffed to the bed as she was being transported back to the emergency department.

BHU Nurse Practitioner (NP)

The nurse practitioner from the behavioral and mental health unit attested to the patient's hallucinations, explaining that the patient had shown the NP her genitals, trying to convey to the NP what she was witnessing. The NP explained to the HRA that performing a pelvic exam on the patient, when she presented to the ED with a behavioral health issue, would not have been protocol and it would not have been appropriate. The NP then explained that patients are evaluated by a process called the Head to Toe/History and Physical Exam. This exam collects information about the patient's past medical history, evaluates the chief reason why the patient is in the emergency room, and then they chart out the best possible avenues to address the chief complaint. Another MD corroborated this process, stating that this test has been protocol and is normal.

ED Director/Operations Director BHU

The HRA asked the Director to explained how mental health patients are treated in the ED, in which she provided the following: while in the ED, patients are asked to disrobe, and their belongings are taken to the nurses' station and held for either discharge or transfer (Dismissal, BH unit or another hospital). The ED has limited mental health providers, utilizes telehealth services and crisis workers are from a local community agency. There are three psychiatrists, a psychiatric nurse practitioner, and four crisis evaluators on site. The hospital transfers out psychiatric pediatric cases and uses an LCP (Licensed Clinical Psychologist). There are only two security guards (1 full-time who sits in the ED & the other is part-time) and the security cameras are monitored at the security guards' desk during the hours of 8am-4pm for assessments and after-hours telehealth through the local community agency.

Also, the director pointed out that the BHU has only been open since April 2021 and received training from an outside agency on the Illinois Mental Health and Developmental Disability Code in March 2021. The director pointed that the hospital uses a universal consent in the ED and other parts of the hospital and also confirmed that the hospital utilizes a physician order form for restraints, whenever restraints are used for when a patient is out of control and/or hurt staff.

Hospital Policy Review

The **"Restraint and Seclusion"** policy's purpose is to be "used when alternatives are not sufficient to protect the patient or others form injury, or to prevent serious disruption in the provision of care to the patient". During the site visit, the ED Director/Operations Director BHU stated that the hospital began utilizing this policy in the middle of August 2022 and seclusion or restraint is used "when a patient or staff are in imminent danger". Per the nursing note, it was written on the hospital-issued **"Physician Order Sheet – Patient Restraint"** form to restraint for up to 4 hours. In reviewing this policy, there was some confusion on the appropriate time frame for which behavioral restraints for adults will be

utilized; some sections state 4 hours and other sections state restraint use may not exceed 2 hours.

The **"Patients' Rights and Responsibilities**" policy's purpose is to "recognize and respect the patient rights as an important aspect of care and encourages the patient to become more involved and informed in their care". The hospital attempts to provide all patients the rights listed in the policy as well as displaying these rights throughout the hospital and views the patient as a partner in their care which includes being part of the treatment and discharge planning process. The hospital lists explicit, detailed instructions on their complaint policy that provides various entities the patient can contact to address any grievances or complaints, from locally to state-wide.

The **"Voluntary and Involuntary Admission Process of Medically Stable Patient" policy** purpose is to provide criteria and procedures for determining the involuntary and voluntary process for admission or transfer of behavioral health patients and ensures the rights of patients; the policy is complaint with the Illinois Mental Health and Developmental Disabilities Code. Per the policy, it is noted that the "voluntary application is completed with the patient prior to arriving on the behavioral health unit"; per the nursing notes, the patient arrived on the behavioral health unit at 9:13pm and signed the voluntary admission application at 10:05pm.

Conclusion

Complaint: The patient's right not to be subjected to restraints unjustly was ignored and the right to refuse medication and treatment was ignored.

Per the HRA investigation, several parts of the Illinois Mental Health and Developmental Disabilities code need to be invoked; (405 ILCS 5/2-107(a)); (405 ILCS 5/2-108); (405 ILCS 5/2-201(a)). Per the written record the medical facility did not demonstrate that there was a serious and imminent physical threat to anyone's safety, with no less restrictive alternative available (405 ILCS 5/2-107(a)) when using restrictions such as restraints or medications. The facility sedated the patient for being loud and obnoxious, which is not reason enough. Although, it is noted in the medical record that the patient requested and was agreeable to the dosages of psychotropic medication received, there was never an indication that the patient had the opportunity to refuse or the capacity to make the request or give verbal consent. Per the Mental Health and Developmental Disabilities Code, "if the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment" (405 ILCS 5/2-102(a)).

When the patient eloped from her room, and was brought back, the nursing staff applied restraints. Per the Mental Health and Developmental Disabilities Code, the facility is allowed

to use restraints as a therapeutic measure in order to prevent a recipient from causing physical harm to himself or physical abuse to others (405 ILCS 5/2-108), except it is not obvious that the patient presented as a threat to anyone or herself. The patient was certainly not being cooperative with the patient evaluation, and the patient was not being cooperative by evading hospital staff while exposing herself, but those reasons are not enough to restrain someone. Lastly while not initially part of the chief complaint, the facility failed to provide the patient with notices of Restriction of Rights forms for when they gave her emergency medications and restraints (405 ILCS 5/2-201(a)). This was evident when the MD, who was in charge of the patient in the emergency room, declared being unfamiliar with Restriction of Rights notices. For all the reasons described above, **a rights violation is substantiated**.

Recommendations

The HRA provides following recommendations:

1. Hospital personnel must complete a **Notice Regarding Restriction of Rights of Individual Form (IL 462-2004M),** whenever a patient's rights are restricted via being placed in a physical hold, using restraints, placed in seclusion and/or administering emergency medication. Also, personnel must inform the patient, provide the patient a copy of the form and check if the patient wants others to be notified. This form along with the hospital-issued **"Physician Order Sheet – Patient Restraint"** form should be included in the record and the usage of the medication should be adequately documented as a need to prevent serious and imminent physical harm.

2. CGH needs to update their **Restraint and Seclusion Policy** to follow the Code's mandates of patient notification, emergency intervention preference(405 ILCS 5/2-200) and maintain restriction notes for 3 years (405 ILCS 5/2-201). The HRA requests evidence that facility is in compliance with Code requirements and evidence of staff training on these mandates.

Suggestions

The HRA would offer the following suggestions:

1. Hospital personnel should per the hospital's "**Restraint and Seclusion" Policy,** document the patient's response to any failed less restrictive alternative interventions (de-escalation, chemical or physical restraints) and justification of the use of any form of restraints.

2. During the site visit interview the staff mentioned that since this patient's stay, they have trained staff on the usage of the **"Notice Regarding Restricted Rights of Individuals" (IL462-2004)** form. The HRA suggests that the facility provide the agency proof of the training, including how staff are shown to fill out and provide copies of the form to patients.

3. At a recent HRA meeting the facility shared that all ED physicians and nursing staff have received monthly trainings on the Illinois Mental Health and Developmental Disabilities Code, since Fall 2022 from the Emergency Department Director/Operations Director Behavioral Health Unit. The HRA suggests that the facility provide the agency proof of training.

Complaint: The patient was denied the right to sound and conventional medical practices.

Per the Illinois Medical Patient Rights Act, "The right of each patient to care consistent with sound nursing and medical practices, to be informed of the name of the physician responsible for coordinating his or her care, to receive information concerning his or her condition and proposed treatment, to refuse any treatment to the extent permitted by law, and to privacy confidentiality of records except as otherwise provided by law" (410 ILCS 50/3(a)). As evidenced in the written record, the patient received sound and conventional medical practices. The staff members that participated in the patient's care attested that the patient was hallucinating about growing different sex organs, of which services that were provided were part of the treatment plan (405 ILCS 5/2-102(a)), in which the chief issue was stabilizing the patient's behavioral health. **A rights violation is not substantiated**.

The HRA would like to thank the staff and administration of CGH Medical Center for their cooperation with this investigation