FOR IMMEDIATE RELEASE

Northwest Regional Human Rights Authority
Report of Findings
Case #20-080-9011
OSF Saint Anthony Medical Center

Introduction

The Human Rights Authority (HRA) opened an investigation into potential right violations at OSF Saint Anthony Medical Center. The complaints were that a patient was not free from restraints, was not allowed to refuse medication and treatment, not allowed telephone communication, not allowed to notify others of rights restrictions, and not assured the completion and timely filing of petition/certificates. Substantiated findings would violate rights protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

OSF Saint Anthony Medical Center in Rockford, Illinois is a 254-bed licensed facility that does not have an inpatient behavioral health unit. The hospital does have an on-site psychiatrist. Patients are assessed, stabilized, and transferred to other facilities for psychiatric inpatient services. The HRA discussed the case with representatives from the medical unit and administration. Relevant policies were reviewed as was the patient's record with authorization.

Complaint Summary

According to the complaint, the patient was forced to take psychotropic medication and was unable to leave the hospital without being met with threats of restraints and security involvement. The patient was also reportedly prevented from access to a telephone and when other various rights were restricted, he was not provided the opportunity to have anyone of his choosing notified. After careful review of the medical records, the HRA initiated an additional complaint that the hospital failed to file an involuntary admission petition according to Code requirements.

Record Review

The patient arrived at the hospital's emergency department (ED) on September 20, 2019 at 6:09am via emergency services, after being hit by a motor vehicle. Once arrived the patient repeatedly refused medical treatment and requested to leave, although he was physically unable given the severity of his injuries. The attending physician documented that the patient "refused spinal immobilization, EMS treatment, denied having an injury, was uncooperative and combative". Although the physician noted the patient " was intelligent and provided various reasons why he should refuse treatment", a decision was made that

based on the severity of the injuries sustained by the patient and his refusal of care, his rights needed to be restricted, which was the most appropriate medical decision at 7:21am. Per the patient care timeline at 8:40am, it was noted that restraints were ordered for daily usage and clinical the reason given was "disruption of critical medical care/equipment on cognitively impaired patient"(pulling of endotracheal tube2). Per the medical record, education would be given daily, monitoring would be every two hours and soft restraints would be used on the wrist and ankles. The restraints were discontinued at 11:05am by attending physician. The patient was intubated at 10:20 am during a trauma exam due to his uncooperativeness and the team's need to determine injury severity. The exam found that the patient suffered from blunt trauma, a broken pelvis, broken right leg and a fractured right elbow. On September 21, 2019 at 7:00pm, an inpatient behavioral consult was completed, and it was determined that patient was "capable of making his own medical decision and treatment, not supported, but he can leave AMA".

During the daily psychiatric consultation on September 23rd at 5:44pm, the attending psychiatrist reached out to the community mental health provider to get confirmation on the patient's current medication listing. On September 24, 2019, while seeing the hospital's psychiatrist, it was noted that patient was agitated, requesting to leave AMA, wavering back and forth regarding surgery and being verbally aggressive with personnel. In a conversation with the psychiatrist, the patient stated, "I would like the surgery today and if unable to be performed, would like to leave AMA". The psychiatrist noted that the patient "technically he is able to leave AMA as he has the ability to make medical decisions, however, does not have the physical means to do so." It was noted during the psychiatrist consultation at 8:25am on September 25th, that the patient hit the nurse manager and it was recommended that restraints be used. The attending psychiatrist completed the restriction of rights form at 8:34am which was dated from September 25th -October 25th, for administrating emergency medication and placing restraints on the patient, "who is danger to self and others". Per the nursing note, the attending psychiatrist provided the following reasons for the completion of the restriction of rights per observation and patient history: "*placing the patient in restraints and/or seclusion, admiration of emergency medications,, managing a patient's personal hygiene, searching of the patient's personal property or removing belongings, retaining personal property and completion of medical services the patient is refusing so as to complete establishing a diagnosis and formulating a treatment plan*". In reviewing the Restriction of Rights form, the checked boxed indicated that the patient did not wish anyone to be notified regarding the restriction notice.

Per the nursing note, the attending psychiatrist wrote, explaining the restriction of right to the patient, ensuring completion of the "Notice Regarding Restriction of Rights Individual Form" and gave the form to the patient While reviewing the medical records, the hospital noted orders restraining the patient daily on a monthly basis. The 'psych/suicide observation checklists dated from September 25th -September 30th "listed the hospital personnel completing the required 15-minute observation checks and indicating patient's behavior (which ranged from being restrained, cooperative, hostile, and sleeping). Per the

reviewed checklist the patient was restrained for 12 hours with 15 mins observation checks for behavior purposes from September 25th to September 26th, after hitting a nurse. The restriction of rights notice allowed the usage of restraints if needed throughout the month during admission but was not utilized during the entire time. The treatment plan that was put in place emphasized for "verbal and physical agitation; prn Haldol 2mg IM q6hr and Haldol 5mg q6hr oral tablet and Abilify 10mg at bedtime for mood stabilization and paranoia. The first **Petition for Involuntary Admission (IL462-2005**) was completed on the above date at 8:40am and never filed in Mental Health Court per the guidelines of the Code. The first inpatient certificate was completed by the attending psychiatrist at 12:00pm. During this session it was determined the "patient considered NOT decisional (inability to give consistent preference for treatment situation and plan)". In reviewing the medical records, the "psych/suicide observation checklists" dated from September 25th -September 30th listed the hospital personnel completing the required 15-minute observation checks and indicating patient's behavior (which ranged from being restrained, cooperative, hostile and sleeping. Per the reviewed checklist the patient was restrained for 12 hours with 15 mins observation checks for behavior purposes from September 25th to September 26th, after hitting a nurse. The restriction of rights notice allowed the usage of restraints if needed throughout the month during admission but was not utilized during the entire time

The hospital reached out to the Ethics Committee to get a recommendation regarding the decision to complete the surgery due to the indecisiveness of the patient on September 26th at 9:13am, needing to perform a medical emergency treatment in which the patient's life and limbs would need to be preserved. On the same day, the attending psychiatrist was informed by the nursing staff that patient had made inappropriate calls to local law enforcement and another hospital for transfer of care. The psychiatrist completed an a restriction of rights for the following reasons; "*placing the patient in restraints and/or seclusion, administration of emergency medications, managing a patient's personal hygiene, searching of the patient's personal property or removing belongings, retaining personal property and completion of medical services the patient is refusing so as to complete establishing a diagnosis and formulating a treatment plan. No telephone access or phone calls to be made outside the hospital* "at 9:41am from September 26-Ocotber 26, with no boxes checked to notify anyone per the patient's wishes. The second **Petition for Involuntary Admission (IL462-2005**) was completed at 9:45am and the inpatient certificate was completed by the attending psychiatrist at 10:00am.

Later that afternoon at 4:00pm, the assigned case manager sought out the assistance of the hospital's legal counsel to explore that avenue of seeking temporary guardianship for the purpose of the getting the medical procedure completed., and the committee advised that the patient's decisional capacity should be evaluated before moving forward. In a daily psychiatric consult on September 27th at 9:27am, a capacity evaluation was completed by attending psychiatrist due to the patient's verbal and physical aggressions toward staff and was "deemed not decisional to make medical decisions". During the evaluation there was discussion on the benefits and risks of the surgery and the patient stated "so the surgery, it is

supposed to fix me, so I can walk again and don't let them stop the surgery, because I can't think straight. At 3:32pm, a temporary guardian was assigned to make medical decisions, sign consents and authorizations, and make placement decisions on the patient's behalf. The court also assigned guardian ad litem for the patient to represent in court regarding best interest in the upcoming guardianship case scheduled for late October. Late that afternoon, a call was made to the guardian to discuss the urgency of this case and to get a medical determination. It was shared that two of the hospital's orthopedic surgeons agreed that the requested surgery is the best care option for the patient at this time. The guardian asked for an in-depth explanation of the procedure and the form of anesthesia that would be utilized, in which a follow-up call and gave temporary approval per follow-up from the attending surgeon. The guardian was consulted and advised of the consequences of the surgery and gave permission to move forward.

The next day the surgery was scheduled at 8:46am, the patient agreed to proceed and stated understanding of the surgery and the need to take anesthesia. The surgery addressed the following: right proximal humeral intramedullary nail, right humeral shaft intramedullary nail, closed reduction and laterally applied percutaneous skeletal fixation of right proximal tibia and push/pull examination. The third Petition **for Involuntary Admission (IL462-2005**) was completed on the September 28th at 5:30pm and the inpatient certificate was completed by the attending psychiatrist at 5:50pm. Per the nursing note, the attending psychiatrist documented completing an involuntary petition at 8:50am on September 29th and placed in the chart to be uploaded and scanned, in reviewing the medical records there was no Petition for Involuntary Admission form with this date. The fourth and final **Petition for Involuntary Admission (IL462-2005**) was completed on the September 30th at 9:33am, with no accompany inpatient certificate. None of the petitions and certificates were filed with Mental Health Court as per the Code. Per the attending psychiatrist, the involuntary admission would lapse at 4:08pm, "patient can be safe and not asking to leave AMA and an involuntary admission hinders placement". The patient was recovering from surgery and placed on a medical unit from September 30 through November 1st, with discharge occurring at 3:05pm on his own accord.

Medication

The patient was prescribed various medications ranging from psychotropic, pain and other medications associated with the surgery. Per the MAR, the patient began receiving emergency medications on September 21st with first dosage of Ativan 2mg given intramuscularly at 10:29am, for moderate agitation. The attending doctor reached out to a community mental health agency to verify psychiatric needs, but due to weekend hours, a message was left. Per a nursing note, on September 24th at 11:22am, patient was given 5mg of Haldol, due to "becoming paranoid and increasingly agitated" after consultation with hospital psychiatrist. In reviewing the restriction notice completed on September 25, 2019, the psychiatrist checked the box for administering psychotropic medication over the time

period from September 25th- October 25th at 8:43 am, but never specified or identified what psychotropic medication would be administered and the reason was "danger to self and others". In the medical records received, there were no Notice Regarding Restricted Rights of Individual forms completed for the dates of September 21st through September 24th in which the patient received emergency medication intravenously for anxiety, agitation, and verbal escalation. On September 24th, the patient hit a nurse and received a dosage intravenously shortly thereafter and was restrained. During the remainder of the patient's hospital stay the patient took numerous psychotropic and over the counter medication and occasionally refused the medication (all dosages were documented (refusal, acceptance, and delay).

Interviews

The HRA reviewed the following issues and concerns with the staff and administrators of the hospital: restraint usage, the reason psychotropic medications were given, restricting the patient's telephone usage, completion of restriction of rights and completing and filing petitions.

ED Attending Physician

The ED attending physician stated that the had extreme pelvic fractures, which needed to be addressed immediately. The patient also exhibited a flight of ideas and was unsure if this was because there was a head injury or not. So, the hospital wanted to ensure that was not an issue for this patient. It was determined to intubate the patient to safely manage and address the pelvic injury. The ED attending physician stressed that although the patient displayed some mental health issues and concerns, the ED personnel were trying to ensure that the patient would not succumb to the life-sustaining injuries. He stated the personnel were following the protocol as to address the trauma that the patient suffered from the accident.

Nurse Manager

The nurse manager backed up the ED physician regarding the patient needing emergency medication and restraints, due to the patient's ambivalence about the surgery. Per the nursing notes, it is documented that the patient on September 24th at 1:33pm, called outside emergency services number and then "grabbed nurse". This action led to the decision to restrain the patient, restrict phone calls, and give emergency medication to the patient. The nurse manager did confirm that the patient's right to make calls was restricted due to the inappropriate calls that were being made by the patient to outside entities. The HRA pointed out that being able to make calls is a right that patients have and there was no other documentation or options provided to the patient. The Nurse Manager stated direction from administration has been that involuntary petitions are only valid for 72 hours.

Risk Manager

Per the hospital system's director of risk management, the attending psychiatrist did complete capacity evaluations as a precautionary method.

Northern Region Director of Quality and Patient Safety

The Director explained that petitions are typically completed daily when holding a mental health patient awaiting transfer since St. Anthony's has no inpatient psychiatric unit. This patient was admitted for medical purposes primarily but was also suffering from mental health issues. Unfortunately, they were unable to transfer the patient, due to the outstanding medial issues. The patient could have left under AMA or elope, but since the patient was not medically cleared, the involuntarily petition was used to hold him and ensure that his medical needs could be addressed. The Director stated there is a gap in training on Code requirements like restriction of rights, intent of the petition, and she wants staff to truly understand using both. They are open to training that would benefit frontline staff.

Corporate Counsel

Corporate Counsel stated, "there was and has been some confusion regarding the usage of involuntary petitions within the hospital" and acknowledged that training is needed on the appropriateness of completing the petitions and filing procedures through Mental Health Court. The corporate counsel understands that in this case the mental health code applied in servicing the patient.

The administration interviewed stated they are open to training possibilities throughout the entire hospital. The administration wanted to ensure that it was noted the unique complications of this case given the patient's medical needs presented as well as mental health needs.

Policy Review

The "**Restraint and Seclusion Management**" policy states " to preserve the rights of patients and to protect the immediate physical safety of the patient, to minimize and or eliminate the use of restraint and seclusion at OSF, to provided clear guidance to all staff involved in the care and safety of patients that may require intervention of physical restraint for either non-violent, non-self-destructive purposes or for violent and self-destructive reasons and to successfully differentiate between the two categories of restraints, with a primary focus on the use of alternative measures". The hospital policy states, "emergency medical treatment is continuously available for patients in restraints or seclusion".

The "**Informed Consent"** policy states that " patients who are both legally and mentally competent have the right to make informed decisions regarding the health care treatment that they receive, which includes the right to accept or refuse medical treatment, including life-sustaining measures". Per the policy there are three exceptions to utilizing

informed consent: the patient is incapacitated or otherwise unable to give consent, obtaining consent is not reasonably feasible under the circumstances without adversely affecting the condition of the patient and the attending physician in an emergency documents the existence of such conditions in the patient's medical records as soon as it is reasonable feasible to do so".

The "**Patient Rights and Responsibilities"** policy states "to provide guidelines for patient rights and responsibilities". Per the interactions reflected in the medical records, the hospital personnel provided care to the patient that fell in line with the guidelines specified in the policy. Per the policy and medical records, the patient was constantly informed of diagnosis, treatment options, proposed producers and risk involved if patient choses to move forward or refuse treatment.

The "**Psychiatric Evaluation and Possible Admission to a Psychiatric Facility"** policy states "to assist patients who need psychiatric intervention". The intervention discussed in the policy range from reaching out to a patient's current provider with consent, in-hospital consult, or transfer to an available psychiatric facility. Per the policy if inpatient treatment is needed, the hospital will prepare an order of transfer, the attending psychiatrist will complete the inpatient certificate and the involuntary petition should be completed by the party that observed the behavior. The policy does address petition filing requirements and sending them to mental health court.

Findings

Complaint: The patient was unable to leave the hospital without being met with threats of restraints and security involvement.

Per the Mental Health and Developmental Disabilities Code, when a patient has been restrained, the rationale is for therapeutic purposes so they will not harm physically themselves or other and restraints should not surpass two hours unless required hospital personnel has observed the patient to ensure that an extension will not present undue risk to the patient (405ILCS 5/2-108 (a)). A rights violation is **not substantiated.** In reviewing the medical records, the 'psych/suicide observation checklists" dated from September 25th through September 30th listed that hospital personnel completed the required 15-minuteobservation checks and indicated what the patient's behavior exhibited (ranging from being restrained, cooperative, hostile and sleeping). Per the reviewed checklist the patient was restrained for 12 hours with 15-minute observation checks for behavior purposes from September 25th to September 26th, after hitting a nurse. The restriction of rights notice allowed the usage of restraints if needed throughout the month during admission but was not utilized during the entire time.

Complaint: The patient was forced to take psychotropic medication.

Per the Mental Health and Developmental Disabilities Code, "*The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication.... 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 (405 ILCS 5/2-107)*". A rights violation is **substantiated.** Per the medical records the patient received dosages of Ativan intravenously throughout the beginning of his admission, due to the patient being agitated and loud. Per the medical records the psychiatrist noted that patient should receive 2mg of Haldol intravenously for "verbal and physical agitation". On September 24th, the attending psychiatrist gave a one-time intravenous dosage of Haldol 5mg due to "acute agitation and verbal escalation." Although it is noted in the medical record by the psychiatrist that "if the patient refuses specific psychotropic medication, it is not court ordered and cannot be forcibly given but if patient is exhibiting agitation to inform the psychiatrist". Emergency medication is not used due to a patient being agitated, but to prevent serious and imminent physical harm and no less restrictive alternative is available.

Recommendation

Retrain all appropriate ED staff on the Code's requirements for emergency medication use (405 ILCS 5/2-107).

Complaint: The patient was not allowed to have others notified of rights restrictions.

Per the Mental Health and Developmental Disabilities Code, "*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: the recipient and, if such recipient is a minor or under guardianship, his parent or guardian; a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice; the facility director; the Guardianship and Advocacy Commission.... (405 ILCS 5/2-201)*". A rights violation is **substantiated,** restriction forms did not accompany initial emergency injections prescribed by the psychiatrist on September 21 and 24, and the patient therefor was not afforded his opportunity to receive written justification or to have others notified.

Recommendation

Retrain all appropriate ED staff to complete restriction notices *whenever* a right under Chapter II of the Code is restricted and provide to any person or agency the patient so chooses. (405 ILCS 5/2-201).

Suggestion

Stop allowing restriction notices to cover a range of rights over a month's period. The Code intends for a patient and anyone who is chosen to be notified of the justification *whenever* a right is restricted, that means each time. (405 ILCS 5/2-201).

Complaint: The patient was not allowed telephone communication.

Per the Mental Health and Developmental Disabilities Code, a recipient shall be provided unimpeded, private, and uncensored communication by telephone with persons of his or her choice unless necessary to prevent harm, harassment, or intimidation (405ILCS 5/2-103). Per the medical records it was noted that the patient was making unwarranted calls to the 911 emergency number on a consistent basis, and OSF cut him off from total phone access and communication outside the hospital instead of preventing him from just calling 911. A rights violation is **substantiated.**

Recommendation

All relevant OSF St. Anthony staff must be trained on the Code's involuntary detention and admission process and the completion of the required legal documents within. (405 ILCS 5/3-600).

Complaint: The patient was not provided with timely filed petitions and certificates.

Per the Mental Health and Developmental Disabilities Code, *"within 24 hours, excluding Saturdays, Sundays and holidays, after the respondent's admission under this Article, the facility director of the facility shall file 2 copies of the petition, the first certificate, and proof of service of the petition and statement of rights upon the respondent with the court in the county in which the facility is located. Upon completion of the second certificate, the facility director shall promptly file it with the court and provide a copy to the respondent (405ILCS 5-611)."* Reviewing the medical records and interviews with staff, the first petition and certificate were not filed accordingly and were followed by three more unnecessary petitions and two certificates. A rights violation is **substantiated.** The administrators of the hospital admitted this violation and stated wanting to develop a training curriculum with assistance from LAS on the Mental Health and Developmental Disabilities Code.

Recommendation

All relevant OSF St. Anthony staff must be trained on the Code's involuntary detention and admission process and the completion of the required legal documents within. (405 ILCS 5/3-600 et seq.).

Suggestion

Consult the hospital's legal resource for detention and admission qualification and filing requirements.

The HRA would like to thank the staff of OSF St. Anthony Hospital in Rockford, IL for their cooperation with this investigation.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider response appears verbatim in retyped format.

OSF HEALTHCARE

AUGUST 13TH, 2021
VIA CERTIFIED MAIL AND EMAIL

Kacie Terranova, Chair
Human Rights Authority
Illinois Guardianship and Advocacy Commission
4302 N. Main St., Ste. #108
Rockford, Illinois 61103-5202

Re: #20-080-9011

Dear Ms. Terranova:

This is in response to your letter dated July 15, 2021. Please accept our thanks to the Human Rights Authority for taking the time to meet with us to provide feedback and insight on ways we can improve services at OSF Saint Anthony Medical Center as it relates to patients who may be covered under the Illinois Mental Health and Developmental Disabilities Code. As part of our mission at OSF Saint Anthony Medical Center, we strive to provide quality, respectful care and comply with all applicable laws and regulations, including those pertaining to patients who receive mental health and developmental disabilities services.

Prior to receiving the report findings regard this case, OSF Saint Anthony Medical Center took the following steps to further understand the Mental Health and Development Disabilities Code.

> IGAC/ States Attorney Laurel Spawn gave a presentation to OSF Saint Anthony Medical Center Quality leadership, Emergency Department (ED) leadership, Case Management leadership, and Risk Management on April 29, 2021 to assist with developing training curriculum on the Mental Health and Developmental Disabilities Code.

In response to the recommendations and suggestions outlined in the report dated July 15, 2021 OSF Saint Anthony Medical Center has taken the following actions:

1. All eligible OSF Saint Anthony Medical Center ED and inpatient RNs were provided education on the OSF Patient Rights, Restraints, Seclusion and Restriction of Rights Policy in June 2021 via Health Stream with a completion due date of July 1, 2021. (Appendix A)
2. Re-education regarding Mental Health and Disabilities Code regarding the procedure for administering emergency medication utilizing the current Lippincott procedure titled Emergency psychotropic drug administration to Emergency Department RNs, and Inpatient RN's. Review of this module has been assigned to eligible Mission partners with a completion due date of September 30, 2021. (Appendix B)
3. An OSF HealthCare Clinical Education Specialist is creating an educational module regarding Mental Health and Disabilities Code section 405 ILCS 5/3-600, with emphasis on the procedure for voluntary and involuntary admission. Upon final approval, this module will be assigned to eligible OSF Saint Anthony Medical Center Inpatient Case Management staff, Emergency Department RNs, and Inpatient RN's with a completion due

OSF HEALTHCARE

date of September 30, 2021. SAMC will provide a copy of the module to the IGAC once it has received final approval at the system level.

4. Subsequent audits will be conducted on a random sample of patients with a mental health diagnosis to ensure compliance with the Mental Health and Disabilities code.

Please note that we take all complaints and concerns seriously and that we strive to improve the services we provide to our patients as it is our goal to "serve with the greatest care and love." We ask that our response be included as part of the public record.

Thank you again for this opportunity to respond to the recommendations and allowing us to make improvements to the care we provide. For any addition information or questions, please contact Victoria Kulavic, Manager of Patient Quality and Safety at Victoria.E.Kulavic@osfhealthcare.org office 815-227-2242.

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Enclosure: Appendix A
Appendix B

cc: Nicole Weathersby, Disablity Rights Manager
Liz Levi, Regional Director of Qualtiy and Safety, OSF Northern Region
Victoria Kulavic, Manager of Patient Quality and Safety, OSF Saint Anthony Medical Center
Brittany Nelson, Risk Manager, OSF Saint Anthony Medical Center
Barbara Frederickson, Corporate Legal Counsel, OSF Ministry Services