FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
PALOS COMMUNITY HOSPITAL— 08-040-9001
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary— The Authority substantiated that the hospital did not follow the Code's requirements concerning petitions, psychotropic medication, rights restriction notices and admonishment of rights. The HRA has reconsidered its findings regarding the restraint issue in response to the provider's response. The public record on this case is recorded below; the provider's response immediately follows the report.]

INTRODUCTION

The Human Rights Authority (HRA) opened this investigation concerning Palos Community Hospital in August 2007. This general hospital located in Palos Heights has a behavioral health unit with 38 beds. The complaint alleged that the Emergency Department failed to follow the Code's requirements when it: 1) Detained a recipient and based her detention upon false information, 2) restrained and administered psychotropic medications, 3) did not provide appropriate rights restriction notices, and, 4) did not allow the recipient to contact her family or the Illinois Guardianship and Advocacy Commission.

If substantiated, these allegations would violate the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.).

METHODOLOGY

To pursue the investigation, the complaint was discussed with the hospital's Assistant Vice President of Nursing during closed sessions at the South Suburban Regional Authority's public meetings on September 13th and October 11th, 2007. The HRA conducted a site visit, and interviewed the Assistant Vice President of Nursing, the Director of the Emergency Services, the Attending Physician and three nurses. The police officer who prepared the petition and a college employee were interviewed separately. The recipient's record was reviewed with consent. Relevant hospital polices were also reviewed.

FINDINGS
Complaint # 1 The facility detained a recipient and based her detention upon false information.

The Emergency Hospital Record indicated that the recipient was involuntarily taken to Palos Community Hospital's Emergency Department for a mental health assessment on November 30th, 2006. An ambulance report reflected that the recipient was sitting in an office

building located on a college campus when paramedics arrived. They were informed on the scene by the police that the recipient was suicidal. According to the report, the recipient became combative, and she started to hyperventilate when placed on a stretcher to be taken to the hospital. She had an asthma attack and Albuterol (breathing treatment) 2.5 mg via inhalation was administered twice. Her breathing reportedly improved, and she was transported in a sitting position without further documented incident.

According to the record, the recipient was in handcuffs when she arrived at 3:30 p.m., and the paramedics informed a nurse that the recipient had threatened to harm herself according to the campus security officers. A petition was completed by a police officer at 4:21 p.m., which allows for a recipient's involuntary detention for a mental health assessment under the Code. According to the petition, the recipient said that she was depressed over her son leaving home and that she was suicidal. She reportedly had a typed letter in her possession stating that "she [was] distraught and not expecting to endure long." The petition stated that the recipient had refused counseling services or to provide any medical information such as her primary physician's name. She started screaming as she thrashed her arms and legs about when informed that she would be taken to the hospital.

The record contained a certificate for immediate hospitalization completed by the Attending Physician at 7:30 p.m. It asserted that the recipient was imminently dangerous to herself and others because of her unpredictable behavior. She was described as very agitated and combative. The certificate stated that the recipient might not survive, but she did want her son to know what she had planned, according to the recipient's typed letter. The space where the physician was to certify that rights were admonished prior to examination was left blank.

On questioning, the police lieutenant who completed the petition informed the HRA that a college employee had called the police on November 30th, 2006 because the recipient was distraught. The police lieutenant said that two police officers were dispatched to assist the employee while he tried to contact a relative. He said that the recipient was crying when he arrived at the incident location. She reportedly said that she was a witness for the federal government. According to the police lieutenant, the counseling employee who called the police told him that the recipient was suicidal. He explained that the recipient would not talk to the psychologist at the college. He was concerned that she might kill herself if she was allowed to leave the campus grounds. Upon questioning, the police lieutenant could not clearly recall how access to the recipient's typed alleged suicide letter was obtained. He said that the recipient might have had the letter in her hand when paramedics placed her on the stretcher.

The employee confirmed that she called the police after talking with the recipient who had written several letters to a relative because he refused to talk with her. According to the employee, the recipient had shared thoughts about suicide in one of her letters. She stated that the recipient was talking "erratic," and she was crying when the police arrived. The HRA was informed that the recipient either showed or mentioned the alleged suicide letter to the police. The employee said that she also called the college's psychologist for assistance, but the recipient reportedly seemed uncomfortable with that, and they tried to explain to the recipient that she needed to be assessed for possible risk of harm including their obligation concerning this issue.

A copy of the alleged suicide letter was included in the hospital record. The letter's first paragraph states that "I am very distraught over your actions [unclear] and will suffer greatly. There are many [people] who have suffered much more than you and still act responsibly…. there is a possibility that I will not survive what I shortly will be forced to endure. I [do not] want you [not to] know what I have planned, what I had hoped and what has actually happened." The letter then essentially talks about the writer's family discord including her legal problems.

Palos Community Hospital first responded to the complaint in a letter dated August 29th, 2007. According to the hospital's letter, the petition clearly described the recipient as distraught, suicidal and "not expecting to endure long." It also listed four police officers, the paramedics and other fire department members as witnesses to the above information. Subsequently, the Attending Physician and the police lieutenant told the HRA that they both read the recipient's entire alleged suicide letter, which consisted of 4½ pages. They reportedly were concerned for the recipient's personal safety. According to the Attending Physician, he tried to talk to the recipient at intake, but she was thrashing all over the room.

The Attending Physician acknowledged that he did not inform the recipient of her rights prior to the examination. Palos Community Hospital's involuntary admission policy states that recipients are informed of their right to a court hearing and counsel upon certification. The psychiatrist who completes the second certificate will inform the recipient of the examination purpose.

Additionally, the hospital's policy reflects rights under Sections 5/3-601 (b) and 5/3-602 of the Code below.

CONCLUSION

According to the following Sections of the Code,

> A peace officer may take a person into custody and transport him to a mental health facility when, as a result of his personal observation, the peace officer has reasonable grounds to believe that the person is subject to involuntary admission and in need of immediate hospitalization to protect such person or others from physical harm. Upon arrival at the facility, the peace officer shall complete the petition…. under Section 3-601. (405 ILCS 5/3-606).
>
> (b) The petition shall include a detailed statement of the reason for the assertion that the recipient is subject to involuntary admission, including the signs and symptoms of a mental illness and a description of any acts, threats, or other behavior or pattern of behavior supporting the assertion and the time and place of their occurrence. (405 ILCS 5/3-601).

> The petition shall be accompanied by a certificate [and] … shall indicate that the physician, qualified examiner, or clinical psychologist personally examined the respondent not more than 72 hours prior to admission. It shall also contain the physician's…clinical observations, other factual information relied upon in reaching a diagnosis, and a statement as to whether the respondent was advised of his rights under Section 3-208. (405 ILCS 5/3-602).
>
> Whenever a petition has been executed …, and prior to this examination for the purpose of certification of a person 12 or over, the person conducting this examination shall inform the person being examined in a simple comprehensible manner of the purpose of the examination; that he does not have to talk to the examiner; and that any statement he makes may be disclosed at a court hearing on the issue of whether he is subject to involuntary admission. (405 ILCS 5/3-208).

The recipient was taken into custody by a peace officer under Section 5/3-606, and she was transported to Palos Community Hospital's Emergency Department for a mental health assessment on November 30th, 2006. The authority to detain a recipient involuntarily within a facility is initiated by a petition. The peace officer completed a petition at the facility at 4:21 p.m. under Section 5/3-601, an hour after her arrival when her detention began. According to the petition the recipient was depressed and suicidal based upon the petitioner's observations and a letter in her possession stating that "she was distraught and not expecting to endure long"; we cannot prove that the information was false. The HRA finds a violation in that the petition was completed late, but not in the contents of the petition which meet the requirements of Section 5/3-601 (b).

The Code requires that a petition be accompanied by a certificate for immediate hospitalization. A first certificate was completed by the Attending Physician at 7:30 p.m. well within the 72-hour timeframe pursuant to Section 5/3-602. The Attending Physician acknowledged that rights were not admonished to the recipient prior to her examination, which the Mental Health Code guarantees for all involuntary recipients under Section 5/3-208. Additionally, the Authority finds that the hospital's involuntary admission policy does not meet the requirements of Section 5/3-208 in that it separates key elements of the recipient's rights which must be admonished in full before *both* certificates are executed. The HRA substantiates rights violations related to the recipient's detention.

RECOMMENDATIONS

1. Follow the Code and ensure that petitions are completed immediately whenever recipients are detained involuntarily for mental health examinations per Section 5/3-601 and 5/3-606.

2. Require all qualified examiners to admonish each person under examination for immediate hospitalization of their full rights before examinations begin as required by Section 5/3-208.

3. Revise the hospital's involuntary admission policy to reflect that all recipients shall be informed of their full rights, including the examination purpose, upon examination for certification in accordance with Section 5/3-208.

4. Train physicians and all appropriate personnel in the hospital's Emergency Department on Sections 5/3-208, 5/3-601 and 5/3-606.

Complaint # 2 A recipient was restrained and administered psychotropic medication. She reportedly sustained injuries from the restraints.

According to nursing entries, the recipient was very angry when she arrived at 3:30 p.m., and she refused to answer questions. A nurse recorded that the recipient was given many chances to cooperate with the assessment process, but she remained "combative." Documentation indicated that the recipient was placed into five-point restraints for her safety at 4:15 p.m. The record included an order signed by the Attending Physician at 4:00 p.m. authorizing the use of restraints for up to four hours and describing the recipient's behavior as "combative." It also reflected that alternative interventions such as verbal limit setting and reduced stimuli had been attempted prior to restraints.

The physician verified on the order that the restraints did not pose an undue risk to the recipient's medical condition based on his personal examination. He also noted that restraints were needed because of the recipient's combative and unpredictable behavior, which included throwing a "mayo stand." The hospital's staff later told the investigation team that a mayo stand is a small table.

Subsequent nursing notes indicated that the recipient informed a nurse that she had many allergies within minutes after restraints were ordered but still refused to disclose her medication information. There were notes describing the recipient's behaviors and the staff's attempts to release her from restraints. A note written at 4:20 p.m. stated that the recipient struggled to take off the chest restraint by thrashing about on the cart as she screamed. The nurse also recorded that she refused to answer simple questions. Documentation indicated that the chest restraint was removed at 5:05 p.m.; the Attending Physician was in the exam room and the recipient continued to cry. She then informed the staff that [restraints] would cause her to have a flash back and that they were contraindicated to her condition.

Valium, 5 mg intravenously (IV), was administered five minutes later, and the medication was noted to be somewhat effective. There was no clear written justification for the medication or evidence that the recipient was informed of her right to refuse or given the opportunity to refuse it. According to the hospital's August 29th letter to the HRA, the recipient did not refuse medication. However, we found no evidence that her decisional capacity was established in writing or that her informed consent was provided before the medication was administered, and, the record documented that the recipient told the hospital's staff that her rights were being violated after the medication was administered.

According to the Restraint Flow Sheets, the recipient was monitored while in restraints and her behaviors were recorded every 15 minutes. Her skin, circulation, and range of motion were checked every two hours. She was offered nourishment and toileting more frequently than the two-hour requirement under the Code. At 5:25 p.m., a nursing note stated that the recipient reported that she was feeling better after two restraints were removed. She was given fluids, and at 5:45 p.m., she was placed back into five-point restraints for safety reasons. One nurse recorded that the recipient became agitated when asked if she was willing to cooperate for restraints release. She repeated that her rights were being violated, and she threw a bedside table as the physician entered the exam room. A second nurse wrote that the recipient kicked the metal table; she grabbed a nurse by her wrist and verbally abused staff members. The physician's report also documented that a nurse was struck when the recipient kicked the table.

The hospital's August 29th letter suggests that the above two incidents were separate. However, the physician later clarified that the recipient kicked the table, and the HRA determined that they were the same. Upon questioning, a nurse reported that the nurse who was struck did not have any injuries.

Further nursing entries revealed that the recipient was "quiet" around 6:15 p.m., and she refused offers for food, fluid and toileting. At 6:30 p.m., the recipient was reportedly screaming and agitated as the restraints were loosened; her right hand was also released. She complained of having back spasms as she repositioned herself on the cart and stretched her back. The recipient resisted restraint application, digging her fingernails in a nurse's hand, and the hospital's security applied four-point restraints. Valium, 5 mg IV, was administered for agitation at 6:45 p.m. As before, there was no indication as to whether she provided informed consent first or was given the opportunity to refuse.

Documentation on the flow sheets indicated that the recipient was angry, hostile and aggressive throughout most of the first restraint order. The Attending Physician ordered that restraints be continued at 8:00 p.m. up to four hours because of "verbal abuse [and] trying to crawl off cart." A flow sheet revealed that the recipient was calm from 8:15 p.m. to 8:45 p.m., and she was released from restraints for a toilet break at 9:45 p.m. The recipient reportedly requested that all male officers be removed from the exam room as she screamed "don't let them hurt me." A nurse documented that the recipient was informed that there were no male officers present at the time, and restraints were discontinued. There was no documentation that injuries resulted from the restraints or that the recipient complained of injuries from the restraints.

According to the record, the recipient had an asthma attack around 11:00 p.m. and vomited a small amount of thick clear mucus. She requested Atrovent and saline treatment. Atrovent and Xopenex (breathing treatment) were administered as ordered. A nursing entry reflected that the recipient did not exhibit any respiratory distress after the breathing treatments were given. She was offered medication to help her relax more because of randomly yelling and cursing at the staff. The recipient refused the medication, and there was no evidence that the medication was administered over her objection.

When the complaint was discussed with the hospital staff, the nurse who met the recipient upon her hospital's arrival told the HRA that the paramedics reported that she was

suicidal. She informed the recipient that there was a concern about her safety and that an evaluation would be done. The recipient reportedly was not receptive to the nurse's attempts to decrease her anger, and restraints were needed because she became combative. She said that the recipient reported having allergies, but she would not give any other information. The Attending Physician stated that the recipient was thrashing all over the room when restraints were initiated.

Upon questioning, the Assistant Vice President of Nursing and the nurse who first saw the recipient defined combative as "striking out at the staff." The nurse further explained that the recipient was hitting at the staff, and restraints were ordered because she could not be calmed. According to the Assistant Vice President of Nursing, all staff receive training in dealing with aggressive recipients during orientation, and they also receive annual restraint training. Subsequent to the site visit, the Assistant Vice President of Nursing said that rights restrictions notices are not used in the hospital's Emergency Department. He said that the hospital will be reviewing service delivery regarding behavioral health recipients in its emergency room.

Section 5/1-114 defines a mental health facility as any licensed private hospital, institution or facility … **or section thereof**, … for the treatment of persons with mental illness **and includes all hospitals**, institutions, clinics, evaluation facilities and mental health centers which provide treatment for such persons.

According to the hospital's policy, restraints will be used when a recipient's violent or aggressive behavior presents an immediate and serious danger to the individual or others. The least restrictive, safest, and most effective type of restraint will be used. Five-point restraints will be used when the recipient's level of agitation and/or physical strength require a high level of security and protection if possible. A physician's order must be obtained for restraints; the physician must conduct a face-to-face assessment within one hour of restraint application. The policy states that recipients will be monitored and reevaluated while in restraints.

The policy further directs that restraints should be discontinued as soon the recipient's behavior is safe. The decision to remove restraints for behavioral management is a collaborative decision in the Emergency Department. Examples of criteria for discontinuation include: 1) The recipient's ability to participate in the plan to maintain his/her safety, 2) Whether the person is oriented to the environment, and, 3) Cessation of verbal threats. If an emergency health situation occurs, the recipient shall be released from restraints as dictated by the emergency. Injuries sustained from restraints shall be reported to the Nursing Director and the appropriate report will be completed.

The hospital's "Patient Rights" policy mirrors Sections 5/2-102 (a-5) and 5/2-107 below.

CONCLUSION

According to the following Sections of the Code,

> If the services include the administration of authorized involuntary treatment [psychotropic medication and ECT], 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 …. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only (i) pursuant to Section 5/2-107 …. (405 ILCS 5/2-102 [a-5]).
>
> An adult recipient of services … must be informed of the recipient's rights to refuse 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 harm to the recipient or others and no less restrictive alternative is available…. (405 ILCS 5/2-107 [a]).
>
> Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. (a) Restraint shall be employed only upon the written order of a physician…. in no event may restraint continue for longer that 2 hours unless a personal examination is done and it is determined that the restraint does not pose an undue risk to the recipient's physical or medical condition…. the order shall state the events leading up to the need for the restraint and the purposes employed. The order shall also state the length of time for the restraint and give a clinical justification for the length of time…. (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 clinically appropriate but in no event less than once every 15 minutes…. the recipient shall be permitted to have regular meals and toilet privileges free from the restraints, except when freedom of action may result in physical harm to the recipient or others…. (j) Whenever restraint is used, the recipient shall be advised of his right, to have any person or his choosing including the Guardianship and Advocacy Commission notified of the restraint under Sections 5/2-200 and 5/2-201. (405 ILCS 5/2-108).

The recipient's record contained two restraint orders signed by the Attending Physician. The first order leading up to the need for restraints described the recipient's behaviors as combative, agitated and unpredictable, which, without further description of potential physical harm, would not rise to the Code's standard for restraint use. A nurse told the investigation team that the recipient was hitting at the staff and less restrictive interventions to calm her failed. We think her documentation in the record should have described the same. However, according to

the order the recipient also threw a small table, although the Attending Physician later said that she kicked the table.

Restraints were continued because the recipient was verbally abusive and she was trying to crawl off the cart. According to the restraint flow sheet, there was a thirty-minute period that the recipient was calm, and restraints were continued. Section 5/2-108 requires a threat of physical harm and when the threat no longer exists that restraints should be discontinued. The hospital's policy gives three examples of criteria for restraint discontinuation that includes the cessation of verbal threats. Being verbally abusive without documented implication of imminent physical harm does not meet the standards for the use of restraints.

The Authority does not substantiate that the hospital's staff failed to follow the Code's restraint requirements. Restraints were applied upon a physician's order; the recipient was assessed for undue risk; and, she was continuously monitored for safety, offered nourishments and allowed use of the toilet. As previously mentioned, the documentation on the first restraint order was not thoroughly descriptive, but kicking the table could have potentially caused physical harm to the recipient or other people. However, the hospital violates Section 5/2-108 because restraints were continued following a noted absence of physical harm (a reasonable thirty-minute period). There is no documented evidence to suggest that injuries may have resulted from the restraints.

Nursing documentation indicated that the recipient was given psychotropic medication intravenously twice while in restraints. Although the hospital said that the recipient did not refuse the medication, we believe it would be difficult for anyone in restraints and with IVs to feel there is much choice. The Code requires informed consent, based upon documented decisional capacity, whenever a recipient accepts the medication, all of which was missing for the first dose that the recipient was said to not refuse. The second dose reportedly was given because of agitation. A nurse documented that the recipient was fighting with the staff who were trying to put her back into restraints and that the hospital's security was called to help; there was no indication that the recipient was given her rightful opportunity to refuse as required by the Code.

The Authority substantiates that the hospital staff did not follow the Code's requirement in both medication instances.

RECOMMENDATIONS

1. Release recipients from restraints when the threat of physical harm no longer exists under Section 5/2-108.

2. Follow Code requirements and document whether a recipient has the capacity to give inform consent about the proposed treatment and ensure that informed consent is obtained before administering psychotropic medication under Section 5/2-102 (a-5).

3. Ensure that recipients are given the opportunity to refuse the treatment in absence of a documented emergency pursuant to Section 5/2-107 (a).

4. Train or retrain all emergency room staff regarding the Code's treatment process regarding restraints, medication and capacity determinations.

SUGGESTIONS

1. The hospital should instruct its emergency room staff to provide better record documentation that more accurately reflects the need to prevent physical harm whenever restraints are used for mental health recipients.

2. The hospital should be aware that amendments to Section 5/2-102 (a-5) were effective in August 2007 that reworded "authorized involuntary treatment" to "psychotropic medication and ECT".

Complaint #'s 3 and 4 The hospital failed to issue rights restriction notices. The staff also did not allow a recipient to contact her family or the Illinois Guardianship and Advocacy Commission.

Although the recipient was restrained and administered medication against her will, the record lacked rights restriction notices. The restraint order also does not indicate whether the recipient wanted someone of her choice to be notified about the restrictions. According to the hospital's restraint policy, recipients admitted to the hospital's psychiatry department shall receive additional rights protection under the Code when restraints are ordered. A rights restriction notice will be given. Recipients will be informed of their right to have someone of their choosing notified including the Guardianship and Advocacy Commission.

The record contained a nursing note written at 7:15 p.m. stating that the recipient requested that her father and her private psychiatrist be called. One nurse recorded that the Attending Physician spoke with both of them shortly after she wrote the note. At 10:15 p.m., a second nurse documented that the recipient's private psychiatrist did not returned the hospital's call. There was no documentation that the recipient requested to call the Guardianship and Advocacy Commission as stated in the complaint, and no reference as to whether she was asked if she wanted the Commission or any other agency contacted.

Upon questioning, the Attending Physician clearly remembered talking to the recipient's father. The family member reportedly told the physician that the recipient had been diagnosed with Post Traumatic Stress Disorder. The physician also said that he asked the recipient's father to come to the hospital. However, the recipient's father's physical health would not allow this.

Contrary to the complaint, at 10:00 p.m., the recipient reportedly refused to talk with her father. She told the staff that, "I will speak to him when I get home." Documentation indicated that the recipient became agitated about thirty minutes later; she requested the phone and started screaming again that her rights were being violated. At 10:45 p.m., the hospital's security was called because the recipient started swinging at the staff, and she pulled out her IV line when informed that she would be transferred to another hospital. A nurse recorded that the recipient

was also kicking and trying to bite the staff. She started screaming "get them out of here [and] don't let them hurt me," and the hospital's security was removed from the exam room.

According to the record, the recipient was involuntarily transferred to another hospital for admission on December 1st, 2006 after she was medically cleared. The recipient reportedly was given a copy of the petition which included her rights, and she verbalized an understanding of them.

The hospital "Patient Rights" policy mirrors 5/2-200 of the Code below.

CONCLUSION

According to the Section,

> Upon commencement of services, or as soon thereafter as the condition of the recipient permits, every adult recipient, as well as the recipient's guardian or substitute decision maker, and every recipient 12 year of age or older and the parent or guardian of a minor or person under guardianship shall be informed orally and in writing of the right to designate, a person or agency to receive notice under Section 2-201 or to direct that no information about the recipient be disclosed to any person or agency. (405 ILCS 5/2-200).

Pursuant to Section 5/2-201 of the Code, whenever any rights of a recipient of services are restricted, a notice of the restriction shall be promptly given to the recipient and to any person or agency she designates including the Guardianship and Advocacy Commission.

The Authority substantiates that the hospital did not provide appropriate rights restriction notices when the recipient was restrained and administered psychotropic medication. This violates Section 5/2-201. In addition, the hospital's restraint policy referenced that recipients admitted to its psychiatry department are issued rights restriction notices. The policy does not include issuing restriction notices to recipients who receive care in its Emergency Department.

The HRA does not substantiate the complaint that a recipient was not allowed to contact family. Documentation in the record states that the recipient refused to talk with her father by phone. Although there is no documented indication that the recipient wanted to call the Guardianship and Advocacy Commission, under program policy and Sections 5/2-108 and 5/2-201 of the Code, the facility is responsibility for asking a recipient whether she wants any person or agency contacted as her rights are being restricted. Based on this record, there is no evidence of that occurring, and the Authority substantiates that the hospital did not allow the recipient her right to contact any person or agency including the Guardianship and Advocacy Commission when she was restrained and administered involuntary psychotropic medications.

RECOMMENDATIONS

1. Complete restriction of rights notices whenever guaranteed rights within the Code are restricted, including the requirement to note if the recipient was asked if any person or agency is to be contacted per Sections 5/2-108 and 5/2-201.

2. Revise the restraint policy to include issuing notices to all mental health recipients when rights are restricted.

3. Follow Section 5/2-200 regarding admonishment of rights.

4. Train all emergency room staff regarding issuing of rights restriction notices and admonishment of rights under Section 5/2-200 and 5/2-201.

RESPONSE

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

Palos Community Hospital
12251 S. 80th Avenue Palos Heights, Illinois 60463 (708) 923-4000

February 13, 2008

Ms. Theresa Buell, Chairperson
Regional Human Rights Authority
Guardianship & Advocacy Commission
P.O. Box 7009
Hines, IL 60141-7009

Re: HRA No. 08-040-9001

Dear Ms. Buell:

Please accept this letter as the response of Palos Community Hospital to the above-sited report of the Human Rights Authority. We have reviewed the Human Rights Authority Report, including all recommendations and suggestions, as well as the care provided to the patient in our Emergency Department. While it is clear that the patient received compassionate, respectful and clinically appropriate care, clearly there are opportunities for us to assure that all requirements of the Illinois Mental Health and Developmental Disabilities Code are consistently followed.

While we agree that the authority to detain a recipient involuntarily is initiated by a Petition and that the Petition should be completed as soon as is reasonably possible, the Mental Health Code states that the Peace Officer transporting the patient to a mental health facility shall complete the Petition. We will continue our efforts to obtain the cooperation of Peace Officers to complete Petitions upon presenting patients to our Emergency Department. We are also revising our policy and procedure for Involuntary Admission to clearly state that each person under examination for immediate hospitalization should be advised of their full rights, including the examination's purpose, before the examination begins, and that failure of the examiner to do so will result in the examiner not being permitted to testify at any subsequent court hearing concerning the admission. These changes to our Involuntary Admission policy and procedure will be reviewed with the Emergency Department physicians at one of the regular Emergency Department meetings.

While we agree that recipients should be released from restraints when the threat of physical harm no longer exists, we disagree that the patient's thirty-minute period of calm constituted such a situation. This patient was brought into the Emergency Department due to concerns that she was at imminent risk of self-harm. She was, in fact, violent in the Emergency Department and remained labile throughout her Emergency Department stay. Furthermore, while we make every effort to

provide a safe environment for psychiatric patients in the Emergency Department, it is not possible to provide the same level of safety in that environment as afforded to patients on a locked psychiatric unit.

The documentation in the record clearly indicates that the circumstances leading up to the need for psychotropic medication administration met the emergency criteria set forth in the Illinois Mental Health and Developmental Disabilities Code. Prior to the first administration of medication, the patient was pulling at the restraints and thrashing around on the cart, placing her at risk for imminent physical harm. Prior to the second administration of medication, the patient had dug her finger nail into the hand of a nurse who was adjusting the patient's restraints to allow for greater movement in response to the patient's complaint of discomfort.

We agree that when psychotropic medications are to be given, the physician will document whether the recipient had the capacity to make reasoned decisions about the treatment, and, if not, the medications will be given only if it is determined to be an emergency situation. We will revise our policy to insure that recipients are given the opportunity to refuse treatment in the absence of a documented emergency, and that a Restriction of Rights will be completed and provided to the patient when emergency medication is indicated. Policies and procedures will also be revised to reflect the recent changes in the Illinois Mental Health and Developmental Disabilities Code that re-word "authorized involuntary treatment" to "psychotropic medications and ECT.". The Emergency Department staff, including physicians, will be instructed on all of these changes regarding restraints, medications and patients' rights to refuse treatment.

Restriction of Rights notices will be completed whenever guaranteed rights within the Code are restricted. Restriction of Rights notices will be issued whenever behavioral management restraints are applied to a mental health recipient, regardless of his/her location in the Hospital.

Thank you for your review of this case as well as recommendations and suggestions for assuring that the rights of our patients are respected and protected. Palos Community Hospital remains committed to providing compassionate and humane care to patients in need of mental health services, while at the same time assuring that all the rights under the Illinois Department of Mental Health and Developmental Disabilities Code are afforded to all recipients of mental health services.

Sincerely,

Kirk Bergmark, APN, CNS

Kirk Bergmark, APN, CNS
Assistant Vice President of Nursing,
Psychiatry/Chemical Dependency

KB/jk
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