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REPORT OF FINDINGS
PROVENA SAINT JOSEPH MEDICAL CENTER — 08-040-9008
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary—— The Authority did not substantiate the complaint as presented; the public record on this case is recorded below. The provider requested that its response not be included as part of the public record.]

INTRODUCTION

The South Suburban Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission has completed its investigation into an allegation concerning Provena Saint Joseph Medical Center. This general hospital located in Joliet has an adult and adolescent psychiatric unit with a 34-bed total capacity. The complaint alleged that a recipient was threatened with restraints and a foley catheter because she refused to give a urine sample during a visit to the hospital's Emergency Department.

If substantiated, this allegation would violate the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.) and the Centers for Medicare and Medicaid Services, Department of Health and Human Services' (CMS) Conditions of Participation for Hospitals (42 CFR 482.13).

METHODOLOGY

To investigate the complaint, a site visit was conducted and the hospital's Counsel, the Director of Risk Management, the Risk Manager, the Patient Advocate, the Patient Care Manager of Emergency Services, an Emergency Room Assistant and a Licensed Clinical Social Worker were interviewed. The allegation was discussed with the Risk Manager at the South Suburban Regional Public Meeting. The complaint was discussed with the recipient who gave consent to review her record. Relevant hospital policies were also reviewed.

COMPLAINT STATEMENT

According to the complaint, the recipient voluntarily presented to the hospital's Emergency Department for a psychiatric evaluation because she was having problems sleeping. The recipient was examined by a physician, and a social worker informed her that she would be involuntarily admitted to the hospital. The social worker requested a urine specimen but the recipient refused to provide one. The staff person allegedly told her that mental health recipients do not have rights in the emergency room, and he reportedly threatened to call the hospital's security to assist with applying restraints and obtaining a urine specimen by catheterization. The

complaint stated that another staff person who was assigned to monitor the recipient brought the urine cup in the examination room and repeatedly asked her to cooperate with the social worker's request. Although the complaint acknowledged that the social worker did not follow through with his threat, the recipient was reportedly very traumatized by the incident. Finally, it was said that a grievance had been filed with the hospital but it was not handled appropriately.

FINDINGS

The April 29th, 2007 Emergency Department Record indicated that the adult recipient presented because of depression, anxiety and suicidal ideations around 5:30 p.m. She was examined by a physician, and a "sitter" monitored her from 7:15 p.m. to 9:45 p.m. The sitter recorded on a suicide precaution checklist that a social worker came into the exam room at 7:30 p.m. The form does not indicate that she left the exam room during the social worker's visit as later reported by the hospital's staff. There was also no indication of how long the social worker was with the recipient. The recipient's behaviors were recorded every 15 minutes on the form, and she was described as agitated, crying and calm throughout the above time frame. Blood work was done during the admission process, apparently without objection. A urine screening was also ordered but the word "err" was written next to the requested specimen. There were no orders for restraints and no documented indication that restraints were used or that urine was drawn during the recipient's stay in the emergency department.

A petition and first certificate were completed on April 29th because the recipient refused voluntary admission after she was informed that the hospital's behavioral health unit was non-smoking. The certificate was completed by the physician at 8:00 p.m., and the petition was prepared by the social worker named in the complaint at 9:05 p.m., about one hour after the certificate. The involuntary admission documents stated that the recipient was depressed; she was planning to hang herself with a cord and said she would rather kill herself than stop smoking. The recipient was diagnosed with suicidal ideations, and she was admitted to the hospital's behavioral health unit upon a physician's order. Additionally, the record contained a second certificate dated April 30th prepared by a psychiatrist, and a Voluntary Application signed on the following day.

On May 2nd, the Patient Care Manager wrote that the recipient had complained on May 1st, about her emergency room care on the previous day. According to the late entry, the recipient reported that the social worker said in reference to a urine sample, "We'll get one if we have to, security will come in and spread your legs apart and will stick a tube in there." Although it was documented that the hospital's Patient Advocate would be informed about the recipient's complaint, there was no indication that the Patient Care Manager notified the staff person. The HRA notes that the Patient Care Manager could not be interviewed because he is no longer employed at the hospital.

According to the hospital's "Patient Relations Worksheets," on May 2nd, the recipient called the Patient Advocate regarding the alleged abuse. She reported having problems sleeping and increased suicidal ideations, but no formal plans to achieve them. The recipient was quoted as saying, "I came to St. Joe because they allowed smoking and I was disappointed to learn that smoking is no longer allowed." The worksheet stated that she refused to cooperate with a social

worker's request for a urine specimen and that the social worker told her that security staff members would restrain her and force a catheter between her legs if she did not cooperate. She told the social worker that would be like rape to her, and the staff person said that behavioral health recipients do not have any rights in the emergency room. The recipient reported that urine was not taken because she told an emergency room nurse about the incident.

Two letters addressed to the recipient from the Patient Advocate after her discharge on May 2nd were reviewed. According to the May 9th letter, the Patient Care Manager of Emergency Services would investigate the recipient's complaint and provide a written response of her findings. The June 1st letter acknowledged the recipient's concerns and the right to refuse treatment. It stated that the hospital expected all healthcare providers to treat patients with respect. The Patient Care Manager of Emergency Services had discussed the recipient's concerns with the staff person involved and specific ways that her needs could have been better met. The letter further apologized for causing the recipient any unnecessary distress and stated that the problem would not occur in the future.

The Patient Advocate wrote (no date is given) that the recipient contacted the Patient Care Manager of Emergency Services by phone and requested a written apology from the social worker. The supervising staff person assured the recipient that she had appropriately followed up with the social worker, and a personal apology letter would not be sent. According to the entry, the Patient Care Manager of Emergency Services tried to bring closure to the grievance, but the recipient stood firm on her request. The Patient Advocate also documented that she spoke to the Director of Risk Management regarding the recipient's request, and that the Vice President of Nursing would be informed. Documentation on August 9th indicated that the hospital's administration was notified that the recipient continued to call regarding the status of her grievance. On that same day, the recipient complimented the emergency room nurse because he reportedly "helped smooth things over." On August 15th, the recipient was verbally informed that the hospital was still in the process of conducting a "thorough investigation," and follow up with all appropriate staff had not been completed because of scheduling conflicts.

On August 28th, the recipient was informed that she would receive a letter from the Director of Risk Management when she called again. An August 28th letter stated that all allegations involving a possible rights violation are taken seriously by the hospital. The letter documented that a second investigation was conducted, but the hospital was unable to reconcile the discrepancies between the recipient's recollections and the emergency room staff. According to the letter, the hospital wanted to bring closure to the recipient's grievance, but the provider could not comply with her specific request for a written apology from the social worker. The letter included a general apology to the recipient.

Documentation on September 4th revealed that the recipient was not satisfied with the August 28th resolution letter, and she informed the Director of Risk Management that a sitter was in the exam room. The recipient was told that the sitter would be interviewed, and she would receive a call on September 7th. The recipient was contacted on the above date, and a meeting was scheduled with her for September 25th. The Vice President of Nursing, the Director of Risk Management and the Risk Manager met with the recipient as planned, and she became upset when informed that the emergency room staff only remembered that she complained about not

being able to smoke. On October 11th, the Patient Advocate recorded that the recipient continued to be upset because she believed that the hospital's investigation was biased. There was no more grievance documentation found in the record.

The complaint was discussed with the hospital's staff. The Authority's members were informed by the Risk Manager that the recipient's grievance was referred to her on May 5th because the Patient Care Manager was unable to resolve it. The staff person reported that the social worker, the nurse and the sitter were interviewed during the hospital's investigation. She explained that the staff were asked first, what they remembered about the recipient in question. They all seemed to recall that the recipient was extremely upset that the hospital had changed its policy to non-smoking. She reported that the sitter did not stay in the exam room when the social worker came to talk to the recipient but returned as he was leaving. The Risk Manager said that the recipient did not voice any complaints upon the sitter's return to the exam room. Also, she said that the social worker denied the allegation but recalled that the recipient was angry about the hospital's new non-smoking policy.

On questioning, the Patient Care Manager of Emergency Services confirmed that she received a call from the recipient concerning the abuse allegation. This contact was recorded by the Patient Advocate, but the entry lacked a date. The supervisory staff person reported that she talked to the social worker, the sitter and the nurse no later than two days after receiving the call. She initially asked the staff about the recipient's care and then told them about the complaint issue. According to the Patient Care Manager of Emergency Services, the social worker denied the allegation. The nurse and the sitter did not witness the alleged incident. The assigned emergency room physician told her that obtaining a urine specimen was not important as implied in the complaint. The Patient Care Manager of Emergency Services told the HRA that she had no documentation of her investigation because there was nothing to record. According to the Director of Risk Management, the hospital is not required to document contents of investigations. She said that a second investigation was done because the recipient was not satisfied with the first grievance resolution.

The social worker and the sitter were interviewed separately by the HRA. The investigation team was informed that the social worker has been employed by the hospital for about four years. The social worker said that the recipient was alone when he entered the exam room and introduced himself. She reported having suicidal thoughts. She said that Provena was the only hospital that allowed patients to smoke when questioned about her three hour drive to the emergency room as noted on the intake form. According social worker, the recipient became agitated, profane, and she wanted to leave the hospital when informed about the hospital's no smoking policy. He tried to explain that she could not leave because she was a danger to self or others.

Upon questioning, the social worker could not remember whether he saw that a urine cup was in the exam room. He told the investigation team that there was no discussion about labs or a urine specimen. His only comment was "you know they are going to ask for routine labs." Once the staff person left the exam room he did not have direct contact with the recipient again. The social worker confirmed that the Patient Care Manager of Emergency Services had talked

with him about the abuse complaint. On questioning about rights, the staff person stated that rights begin the moment that a recipient is not allowed to leave the hospital.

Contrary to the social worker's statements, the sitter said that the staff person asked her to leave the exam room because he wanted to talk privately with the recipient. She said that the recipient was upset about the no smoking policy when she returned about 15-20 minutes later. According to the sitter, there was a urine cup in the exam room upon her return, and the social worker must have brought the cup in the room. The sitter told the recipient that a urine specimen was needed, and she replied, "I am not going in a cup." The sitter reported that she was interviewed by risk management regarding the grievance in October. The recipient's primary nurse did not recall the recipient in question or remember the Patient Care Manager of Emergency Services talking to him about the alleged incident. He stated that she might have brought up the subject while he was working. According to the nurse, he would have reported the incident to his supervisor if witnessed.

According to Provena's "Ethics" policy, a recipient or authorized agent has the right to refuse treatment. If such services are refused, they shall not be given except on the advice of counsel or court-ordered.

Provena's "Patient Grievance/Complaints" policy states that the hospital must have a process in place to document, resolve, track and trend patient's complaints and grievances. It directs all employees to accept complaints from patients or others on behalf of patients. The receiving employee will utilize the Service Recovery Process as follows: 1) Acknowledge and document receipt of the complaint, 2) Apologize to the complainant, and, 3) Provide resolution to the complaint. A member of the facility leadership team must be contacted, if the complainant is not satisfied with the resolution provided by the receiving staff person. The leadership representative must assess the complaint severity and determine if the above steps can be repeated for resolution. If the complainant continues to be unsatisfied, the complaint must be considered a grievance, and the grievance process will be initiated.

The leadership representative is responsible for providing the complainant with a written response within 7 days. A resolved grievance letter should include the contact person's name, the steps taken to investigate the grievance and outcome, and the date completed. A letter should be sent to the complainant indicating when he or she should expect another written response, if the grievance is not resolved within the above reasonable time frame. According to the policy, the risk management and/or patient relations representative should be contacted concerning any unresolved grievance. The risk management, the leadership representative and patient relations representative will work collaboratively to assure that the grievance steps are appropriately completed.

CONCLUSION

The Code's Sections 5/2-102 and 5/2-112 state that all provided mental health services are to be adequate and humane and that every recipient shall be free from abuse and neglect.

Abuse is defined in Section 5/1-101.1 as any physical injury, sexual abuse, or mental injury inflicted on a recipient of services other than by accidental means.

According to CMS' Conditions of Participation for Hospitals Section 482.13 (a-2), the hospital must establish a process for prompt resolution of grievances, including written notification on steps taken to review the matter, results, and contact information, which are also provided for in Provena's Patient Grievance/Complaints policy.

The complaint alleged that a recipient was threatened with restraints and a foley catheter because she refused to give a urine sample during a visit to the hospital's Emergency Department. Supportive documentation indicated that the recipient informed the Patient Care Manager and the Patient Advocate about the social worker's alleged threat on May 1st and May 2nd respectively. Although the Authority does not discredit the recipient's version of the alleged April 29th incident or that it was emotionally harmful, the investigation team could not determine whether the event occurred because of conflicting statements from the staff. The social worker said that the recipient was alone when he entered the exam room and that he did not threaten her. However, the sitter said that she left the exam room as requested by the social worker. Although the sitter reportedly took a 15-20 minute break, she documented on the checklist list sheet as though she was still in the exam room during the social's worker's visit. According to the sitter, the recipient was upset about the no smoking policy and there was a urine cup in the exam room when she returned from the break.

The HRA reviewed the hospital's written interactions and correspondences regarding the recipient's grievance. A letter dated May 9th acknowledged the recipient's concerns within the grievance policy's 7-day time frame. According to the letter, the recipient would receive a written response from the Patient Care Manager of Emergency Services after completion of the investigation. A June 1st resolution letter stated that the supervising staff person had discussed the recipient's concerns with the staff person involved and specific ways that her needs could have been better met. The letter was vague regarding how the social worker could have intervened more effectively with the recipient.

Documentation written in August reflected that the recipient was not satisfied with the grievance resolution. A second investigation was undertaken, but there were problems interviewing the staff because of their schedules. An August 28th letter from risk management stated that the hospital was unable to reconcile the discrepancies between the staff's and the recipient's recollections regarding her care. Although the letter included a general apology, the recipient remained unsatisfied with the grievance outcome. The hospital's administration met with her on September 25th, but they were not agreeable to providing a written apology from the social worker.

The Authority is concerned about conflicting statements of events between the social worker and the sitter, one of which leads to some indication that a urine sample was pursued or at least attempted. Without anything more factual, we cannot say that the recipient's treatment was inhumane or abusive; no violation of the Code's Sections 5/2-102 or 5/2-112 were found. The HRA finds that Provena's review and responses concerning the recipient's grievance conform to CMS' Section 482.13 (a-2) and the hospital's grievance policy.

SUGGESTION

1. In respect to the recipient, the Authority suggests that Provena's administration review this report with its quality assurance board because of the discrepancy in staff statements and documentation on the suicide precaution checklist made it difficult to determine whether the social worker was alone with the recipient. The sitter should also receive training regarding accurate documentation in recipients' records.

COMMENT

According to Section 5/3-601 (a) of the Code,

> When a recipient is asserted to be subjected to involuntary admission and in such a condition that immediate hospitalization is necessary for the protection of such person or others from physical harm, any person 18 years of age of older may present a petition …."

Based on the record, the recipient was not allowed to leave the hospital because she was suicidal. Once it was determined that the recipient should not be allowed to leave, a petition should have been completed, and then she could have been held for a psychiatric evaluation against her will. The social worker completed a petition at 9:05 p.m. under Section 5/3-601, an hour after the recipient's detention began. The hospital is reminded that petitions must be promptly completed when recipients are detained.