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HUMAN RIGHTS AUTHORITY-NORTHWEST REGION

REPORT 08-080-9003
SWEDISHAMERICAN HOSPTIAL

Case Summary: the Authority found violations in three of the four complaints presented; the public record on this investigation is found below. The facility's response is not included in the public record.

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation of possible rights violations in the treatment of a mental health recipient within the emergency department at SwedishAmerican Hospital. It was alleged that the hospital:

1. Detained the recipient for fourteen hours without cause and authority.
2. Forcibly stripped her of her clothing, restrained her with excessive force without cause, and made her lie in urine for hours.
3. Forced her to provide urine and blood samples without cause.
4. Searched her purse without cause or her permission.

Substantiated findings would violate rights protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5) and under the Code of Federal Regulations for Medicare/Medicaid participation (42 C.F.R 482).

The hospital is a subsidiary of the SwedishAmerican Health System in Rockford. It has nearly 400 beds and a thirty-room emergency department, four of which are designated for patients with special needs. Crisis workers from the hospital's assessment and referral division meet with mental health recipients in that area to determine courses and locations for treatment as evaluations are completed. The emergency department employs about twenty physicians from Infinity HealthCare, a group headquartered in Mequon, Wisconsin that provides expertise in emergency medicine in addition to other medical practice and management services.

We visited the hospital and interviewed representatives from administration, risk management and the emergency department in order to pursue the issues. Hospital policies were reviewed as were relevant sections of the recipient's record upon written authorization. A policeman and two friends of the recipient's were interviewed separately, and records from a hospital where the recipient was transferred after her evaluation at SwedishAmerican were reviewed with additional authorization.

The recipient in this case is an adult who maintains her legal rights.

COMPLAINT SUMMARY

Allegations state that the recipient had been taken by police to the emergency department for a psychiatric evaluation. She waited in a special needs exam room while a nurse tried to conduct an assessment. After about five minutes the recipient decided she did not need to be there and refused to cooperate with assessments or provide blood and urine samples. Eventually three or more men reportedly came in and grabbed her. She went limp on the floor as the men began to move her over to the cart and lift her. She began to urinate right there without control as one of the men started taking off her clothes. The complaint states that because the staff were being brutal the recipient started to strike at them. The men were said to enjoy looking at her, laughing and snickering while one man held one leg and another man held the other as she was restrained with a lot of force. Her right knee was allegedly pushed sideways very forcefully into the mat in a "gyno position" as another man held her upper body down, his elbow pressing into her neck and a hand on her jaw forcing her face sideways into the mat. Her right arm was held flat and her left arm was held back with her hand up by her head. She was reportedly catheterized at that point and forced to give urine and blood before she was left for hours with only a urine-soaked sheet over her. The complaint concludes by stating that some time later a nurse came in the room and took the recipient's purse without asking and rummaged through it. She signed an emergency department consent form on the following morning after allegedly feeling coerced and battered, and was discharged after being there for about fourteen hours.

FINDINGS

Record reviews:

According to the record, the recipient arrived on May 22nd, 2007 at 4:35 p.m. by police escort. An accompanying petition for involuntary admission was completed by the police officer at 4:20 p.m. and entered in the record; it asserted that the recipient made suicidal statements while the officer was checking on her at home. The initial psychiatric assessment conducted by a nurse at 4:54 p.m. stated that the recipient denied having any suicidal or homicidal thoughts and that she was alert, oriented, appropriate, and cooperative, but agitated, angry and hostile. She was a potential harm to herself and others and in need of a crisis evaluation.

A crisis worker began a full evaluation almost immediately at 4:50 p.m., entered it two days later at 3:27 on the 24th, and wrote that the recipient was extremely agitated and non-cooperative, refusing to give any information. She was described as being "gamey", as in playing games, and when asked if she would harm herself said it did not matter and that the inevitable could not be stopped. She was asked to provide urine and blood samples but flatly refused, and an exchange carried on between the two over being held involuntarily. The recipient made numerous attempts to leave in the meantime and ended up being put into 4-point restraints. She swung at one of the staff and kicked a nurse. The assessment stated that once the recipient calmed down she was released from the restraints and placed into a clean gown since she had urinated on herself and the staff while being catheterized.

The next set of documentation came from a nurse at 6:54 p.m. The recipient was said to be combative, refusing to follow commands and that she was trying to leave and needed to be restrained per the attending physician. She noted four minutes later that leather restraints were applied to her ankles and wrists. There were no details of the events that transpired including how the recipient's clothes and belongings were removed or if and how urine and blood were

taken.

Security reports referenced the incident as well. According to one guard's report, he was on standby with the recipient at 6:35 p.m. when she tried to leave, and he called two additional guards for back up. The guard and a technician placed her on the bed; the recipient reportedly said she wanted to do it the hard way, and she began screaming, kicking and swinging her arms, hitting the technician. The guard wrote that she attempted to bite so he put his forearm over her cheek until the rubber locking restraints were on. A second guard reported in more detail that she was called to the scene and found the recipient yelling and swearing while arguing with the other guard about getting a catheter put in because she was refusing to give urine. The guard located the recipient's nurse, advised him of the situation and confirmed that he wanted her restrained. The recipient was then escorted to the bed and was hitting and kicking at them. She was held down as a straight catheter was done, after which the guard put a rubber locking restraint on her right leg. A third guard reported that he arrived to find two guards, two nurses and a technician trying to restrain the recipient. He restrained her left ankle using a hard rubber restraint, and then left the room once the others were on. These reports listed about seven staff members involved including the three guards, one of whom is female, a male nurse and a female nurse, a male technician, and a male physician.

The record showed orders for blood, alcohol and drug tests at 6:30 p.m. and a urinalysis at 9:29 p.m., but there was no order to use a catheter. Laboratory results were provided between 7:00 and 10:05 p.m. A restraint justification flowsheet was completed at 6:50 p.m. and signed by the physician at the same time. It called for leather restraints to wrists and ankles, and it noted that the recipient was unresponsive to various alternative measures and was combative and refusing to follow commands. The flowsheet included 15-minute observations throughout the restraint duration of just over three hours, but there was no statement as to whether they posed an undue risk to the recipient in light of her physical and medical condition. There was also no accompanying rights restriction notice.

The physician filled out a certificate for emergency admission but did not include the time his examination was done. The physician's report stated that he could not rely on the recipient's statements about her health and situation since she had lied to him. He described her as being extremely combative and stated that she was writhing around, fighting them, screaming, and had to be restrained.

The third guard added to his reports at 8:04 p.m. that the crisis worker asked him to shift the recipient's left arm from above her head. He moved the arm down and restrained it to the bed. At 10:05 p.m. he wrote that a nurse asked him to stand by with the recipient as she was now out of restraints. The guard explained in his report how he had to tell the recipient to get back in her room repeatedly as she tried to leave. He was relieved by another guard at midnight.

A nurse entered in patient notes that the restraints were removed at 10:00 p.m. The recipient remained angry but cooperative, and she went to the bathroom and was put in a gown. It was noted at 11:30 p.m. that a screener from a community mental health clinic had arrived and asked the nurse to find identification in the recipient's purse to verify whether she was a veteran. The next note at 12:15 a.m. stated that the nurse was going through the recipient's purse while being witnessed by a police officer, a security guard and the screener. Copies of her veteran's identification card were made, and then the purse was returned as the recipient swore at the nurse and accused her of stealing. There was no indication of whether the recipient was in view of the search. The last two nursing entries were made at 2:30 a.m. when the recipient complained of neck pain caused by staff while being restrained, and at 5:24 a.m. when the nurse stated that the

recipient would not get off the phone to offer medication, presumably the pain medication, Toradol, ordered a few hours earlier.

The physician also documented in his report that the recipient was cleared medically but that she complained of having neck pain and left knee pain from being restrained by the security guards. Her neck and knee were reevaluated, and there were no signs of injuries.

At some point in the morning of May 23rd the recipient signed a consent form for general treatment and information disclosure, but the time of signing was not included. Above her signature the recipient added, "Physically abused here". Another crisis worker also accepted her signature on a voluntary application to a veterans' hospital in another city at 2:20 a.m. Per the physician's report and the nurse's final notation, she was transferred to that hospital by ambulance at 5:45 a.m.

Records from the admitting hospital stated that the recipient complained of neck pain on arrival and that she was given Motrin for it. On the next day there were five small, old and faint brown skin discolorations observed on her right upper arm, and when she was asked about her neck pain she said someone at the other hospital put his elbow in her neck when trying to control her and that it still hurt. On her third and final day in the hospital she was noted to have a bruise on her right inner thigh and four bruises on her right upper arm.

Statements:

We spoke with the police officer who escorted the recipient to the hospital. He recounted what took place at the recipient's home and restated her need for evaluation. He also verified that the information he included on the petition was accurate.

During interviews at SwedishAmerican, the first attending emergency department nurse told us that the recipient was very angry and agitated from the start, claiming that no one wanted to help her. He tried to sit with her and talk for a while, and he said she was not physically violent up to the point of being restrained.

According to the crisis worker, she spent most of the time with the recipient. She recalled how the recipient was really manic, depressed and spoke in a loud voice. She went over the Code's involuntary process with her and told her that no one wanted to hurt her. Regarding the need for restraints, the crisis worker said that the recipient tried pushing by her a few times when she wanted to leave. Security was there too, but when they moved her into the room is when she became physically aggressive.

The physician stated that he had seen the recipient and believed she needed the restraints too and that he never orders them unless patients are harmful. He said that the lab orders were done to medically clear her, but probably not all of them were necessary; they tend to be a reflex when someone is suicidal, and admitting hospitals want them done. He said he did not get the recipient's consent for the tests and added that he was not able to trust her given that she denied being a veteran. He felt he could not get a straight answer from her.

We were also told that the recipient tried to spit while being restrained, and one of the men held her head to the side with his hand to prevent her from reaching anyone. The hospital usually uses a spit hood in these cases, which is made of a fine mesh. It was also explained that the recipient's arm was positioned up by her head as a safety measure to prevent her from flipping over the cart.

On the issue of being left in urine-soaked linens for hours, the nurse who inserted the catheter said that the recipient was in a gown while she was restrained and that there was no

urine spilled at that time. Another nurse who was with the recipient later on said that she helped her to the bathroom after the restraints were removed and that soiled linens were changed at that time.

Regarding the need to rummage through the recipient's purse, a nurse said that it was not done while she was restrained, and, there were three witnesses present in the meantime. The purse was searched outside her door, and it was necessary to confirm her veteran's status in order to get her the help she needed. The screener would also not be able to help her if she was in fact a veteran, which turned out to be the case.

We asked about the emergency department consent form on which the recipient wrote that she had been physically abused. None of the staff we interviewed seemed to be aware of the written statement and did not know if anything was done about it other than the attending physician having reevaluated his patient after hearing about her neck and knee pain. One administrator commented that it would have been most appropriate to notify a caregiver of the recipient's or the guest relations department--we agree.

Two friends of the recipient's were interviewed separately. One recalled how the recipient reached her by telephone while still at SwedishAmerican: "She was extremely upset over how she was being treated, saying the staff had grabbed at her and her clothes; they choked her and were laughing at her. She wanted to know how she could get out of there. There was commotion in the background and someone told the recipient she had to get off the phone." The friend said that she picked up the recipient from another hospital a few days later and noticed black and blue marks on her legs and underarms. Another friend said he saw her about the same time and observed bruises on her legs and arms. He said the bruises under her arms looked like fingerprints and that the recipient told him they were caused by people who wanted a urine specimen.

CONCLUSIONS

Complaint #1: The emergency department's policy on involuntary detention for psychiatric evaluation states that a petition must be completed in order to hold a patient for a mental status exam (Policy #20-6780.038.0). The Mental Health Code provides for the same and adds that petitions must list observed reasons as to why the recipient may be in need of hospitalization and that no one may be held longer than 24 hours unless a certificate is completed (405 ILCS 5/3-600 et seq.). In this case a policeman who was summoned to the recipient's home believed she needed help and took her to the emergency department where he promptly filled out a petition complete with his observations. The attending physician filled out a certificate but left it incomplete without time verification. Still, she was transferred to another facility after spending just over 13 hours at SwedishAmerican under the authority of a completed petition. The complaint that the hospital detained the recipient for 14 hours without cause and authority is not substantiated.

Complaint #2: The emergency department's policy on the care of psychiatric patients states that patients will be asked to don a gown in order to facilitate medical screenings as well as for procedures and treatments. Patients who are determined to be at risk for harm will be asked to undress completely and can re-don their undergarments once no questionable personal effects are found. If the patient still refuses, and all efforts for cooperation fail, security will search the patient and any questionable personal effects will be removed. Female patients are to be searched by female staff with security present. Documentation is to be made in the nurses' notes.

Belongings and personal effects are removed from the patient's immediate area and placed in the personal effects area. When patients refuse to be searched or don a gown, a description of the interaction will be documented clearly and in detail in the nurses' notes. The patient's rights will be restricted during the stay in order to secure belongings (Policy #20-6780.034.2). Department restraint policies require a justification flow sheet to be filled out whenever restraints are used for behavioral purposes. A physician must sign the flowsheet, which constitutes an order. Restriction of rights forms are also completed in conjunction with behavioral restraints (Policy #20-678.409.8). The Mental Health Codes states that restraints may only be used therapeutically to prevent physical harm or abuse, in a humane manner, with periodic opportunities for toileting and taking fluids, and only upon written order and an accompanying restriction notice (405 ILCS 5/2-108). The Code of Federal Regulations adds that all patients have the right to be free from restraint of any form imposed as a means of coercion, discipline or convenience and may only be imposed to ensure immediate physical safety (42 C.F.R. 482.13). The Mental Health Code also prohibits negligence, which is the failure to provide personal maintenance resulting in physical or mental injury or deterioration, and requires that all care be adequate and humane (405 ILCS 5/2-112, 5/1-117.1, and 5/2-102).

This part of the complaint states that the recipient was forcibly stripped of her clothing, restrained with excessive force without cause, and made to lie in urine for hours. There are multiple record entries describing how uncooperative she was even to the point of making attempts to leave, but nothing on how she became unclothed in order to be catheterized and nothing by way of hospital policy on what happened to her clothes and personal effects in the meantime. Although a few of the staff persons we interviewed said that the recipient was physically aggressive before she was approached to be restrained, their documentation is conflicting and unsupportive. Even with the physician's report stating that she was writhing around, fighting them, screaming, having to be restrained, the indication is this happened when she faced the prospect of being catheterized unwillingly while being rushed upon by a lot of people. To make the point, the nurse who initiated the restraints made no corresponding patient notes even remotely describing the need to prevent physical harm; instead, he filled out the order/flowsheet by saying the recipient was combative and refused to follow commands, neither of which without explanation of potential physical harm are allowable reasons to restrain someone under the Mental Health Code and the Code of Federal Regulations. One note was entered by another nurse who merely cited the same reasons but added that the recipient tried to leave. Restraints might have been appropriate in that case if she started writhing and fighting the guards before they moved in to restrain, but what was clearly detailed by three security guards and the crisis worker is only that she was uncooperative, loud and profane at the time. According to their documentations, the recipient and a technician were arguing about getting a catheter. One guard proceeded to search out the nurse; he said to put her in restraints, and the group moved in. At that point the recipient became physically aggressive. Another guard wrote that he held his forearm over her cheek as she was restrained, which was likely the reason she complained of neck pain afterwards. The order called for leather restraints although all security reports state that rubber locking ones were applied. She was also not given a restriction notice, which would have provided her a rightful opportunity to have any person or agency of her choice be notified of what was happening to her--another violation of hospital policy and the Mental Health Code. There was no documentation about the manner in which she remained in restraints for three hours, except that fifteen-minute observations listed circulation, motor and sensory checks ok, offers for toileting and fluids unchecked. Although the nurse who inserted the

catheter said that no urine was spilled, the charting provides more contradiction. The crisis worker wrote that once the recipient calmed down she was placed in a clean gown and that she had urinated all over herself and the staff while being catheterized. A nurse followed up by noting likewise that on release nearly three hours later the recipient was taken to the bathroom and put in a gown. Both entries suggest that she was left in soiled linens for the duration, which corroborates with the complaint. That could be negligence although we have no way of knowing if it caused physical or mental injury or deterioration; it certainly is not humane. The complaints in #2 are substantiated.

Complaint #3: The hospital's informed consent policy states that if a patient is physically or mentally incapacitated so that she does not understand the significance of medical treatment and cannot give meaningful consent, and if her health or life might be seriously impaired, consent will not be necessary provided that the nature and details of the medical emergency are specifically outlined in the patient's record by the physician (Policy #500.075.5). Per the Mental Health Code, a medical emergency exists when delay for obtaining consent would endanger or substantially affect the recipient's health. Essential medical procedures may be performed without consent when the physician determines that the recipient is not capable of giving informed consent, and recipients have the right to refuse services absent an emergency (405 ILCS 5/2-111 and 5/2-107). According to the hospital's patient rights and responsibilities notice, all patients have the right to receive respectful care that promotes dignity, privacy, safety and comfort and to accept or refuse recommended tests or treatments and to be informed of the medical consequences of their choices (SHMS-2010). The hospital's code of conduct states that all employees are expected to conduct themselves in a respectful, caring and accountable manner and to comply with department policies (Policy #10-951.008.3).

This recipient's physician told us he did not seek his patient's consent before ordering laboratory tests and that he believed she was untrustworthy, having lied about her mental health history and being a veteran. He also said that some of the tests were probably unnecessary; they tend to be a reflex for suicidal patients, and admitting hospitals want them done. Nonetheless, this record's documentation seems to fall short of the policies and regulations listed above that outlines specific requirements about her decisional capacity, the need to forego her consent, the reasons her health and life were seriously impaired while being there, and whether she was informed of the consequences for refusing recommended tests and treatments. It also seems that her capacity to make her own decisions about recommended tests might have been appropriate to accept since it was accepted a few hours later when the hospital asked her to sign a voluntary admission application. Based on the documentation and statements, the complaint that the hospital forced the recipient to provide urine and blood samples without cause is substantiated.

Complaint #4: The last matter is whether the hospital searched the recipient's purse without cause or her permission. As mentioned under the conclusions of complaint #s 2 and 3, SwedishAmerican has specific policy for searching a psychiatric patient's belongings. Such interactions are to be documented clearly, and the patient's rights are to be restricted during her stay in order to secure the belongings (Policy #20-6780.034.2). And, the hospital's patients' rights and the code of conduct state that all care promotes dignity and is respectful (SHMS-2010 and Policy #10-951.008.3). Although the nurse documented that she and three witnesses were going through the recipient's purse, we take issue with the disrespectful and uncaring manner in which it was handled. First, the search was being done to find proof of veteran identification, not questionable personal effects. Second, two of the three witnesses were not hospital employees; one was from a community clinic and the other was a police officer who happened to be there

with another patient. Third, the nurse told us that the search was done outside the exam room door and that the recipient was no longer restrained at the time. That means she was no longer a physical threat, and, we think she should have been dignified by at least being able to directly view the search if the search was truly an absolute necessity in the first place. Finally, there was no evidence of a proper restricted right as required. The complaint is a substantiated rights violation.

RECOMMENDATIONS

1. Follow policy and document searches and removals of patients' personal effects (Policy #20-6780.034.2). All appropriate emergency department personnel should be periodically reminded of this requirement.
2. Stop the practice of using restraints for reasons other than documented potential physical harm. Restraining for "refusing to follow commands" implies discipline and coercion. Reinforce this with all staff including emergency department physicians. (405 ILCS 5/2-108 and 42 C.F.R 482.13).
3. Monitor restraint use for assurance that in all instances they are applied in a therapeutic and humane manner. Review the appropriateness of pressing a person's head into the mat and the need to maintain dignity and change soiled linens during restraint episodes (All hospital restraint policies, 405 ILCS 5/2-108, and 42 C.F.R. 482.13).
4. Require all appropriate personnel to complete rights restriction notices whenever behavioral restraints are used for a mental health recipient, to ask in every instance if anyone is to be contacted about the restriction and to follow through with making requested contacts per the Mental Health Code (405 ILCS 5/2-108 and 5/2-201).
5. Be sure that nurses and security staff communicate properly when following physicians' orders for restraints. This order called for leathers while all of the security staff reported that rubber locking restraints were applied (Policy #20-678.409.8 and 405 ILCS 5/2-108).
6. Instruct all emergency department physicians to secure informed consent or specifically outline the nature and details of why it is necessary to proceed with tests and treatments without consent and to inform patients of the consequences for refusing them (Policy #500.075.5; SHMS-2010, 405 ILCS 5/2-111, and 405 ILCS 5/2-107).
7. Require staff to conduct all searches in discreet, respectful and caring manners by hospital employees only. Always inspect purses and other personal effects in patient rooms with them and in their full views. If staff safety is still a concern in the meantime, make some space, perhaps with security in between, but never preventing the patient's view. The search policy should be revisited to address this issue (Policy #20-6780.034.2).

SUGGESTIONS

1. Staff should not rely on words like combative when documenting and justifying the need for restraints in patient notes and restraint orders or flowsheets. Combative is vague and arguable and does not reflect what took place. Terms like motioning to strike, hitting, kicking, pushing and shoving, or other phrases that clearly indicate the need to prevent physical harm are dead-on descriptions of events as they occur and leave no questions for any reviewer.

2. Use spit hoods!
3. Get a physician's order whenever using catheters.
4. In general, petitions for involuntary hospitalization are merely that--petitions, which may be filled out by anyone who is 18 years old. That means the information within is speculative until the hospital makes its own determinations for medical and mental health needs based on current observations. Just for assurance sake, the hospital should be certain that all physicians and emergency department personnel understand this and do not reflex to tests and treatments based on petitions alone.
5. It is imperative that all emergency department physicians at SwedishAmerican undergo training on Illinois' mental health due process, in particular, filling out legal documents thoroughly, including essential time requirements, and reciting any required admonishments that are to be made during certification (405 ILCS 5/3-208 and 5/3-600 et seq.).
6. Stop the practice of having recipients sign voluntary admission applications to other facilities (405 ILCS 5/3-400 et seq.).
7. The security reports suggest that the guards were present while this woman was being catheterized, locking the restraints and leaving when the procedure was done. The third guard, a male, wrote that he was holding down her left ankle in the meantime. We understand that nude patients are seen by males and females every day in the hospital setting, but we question the appropriateness of security staff being present for this type of procedure, particularly of the opposite sex, and because they are not treatment personnel. They had the opportunity to lock the restraints and leave before the procedure was done, and there were several nurses, techs and a physician present at the same time to help out. We strongly urge the hospital to review this practice, particularly in relation to mental health patients who are already in a crisis and do not need what they perceive to be more trauma from uniformed security guards seeing them in that position.

COMMENTS

SwedishAmerican has recently added Psychiatric Technicians to the emergency department to help ensure the best of individualized care for mental health recipients. Orientation materials provided to us show that the technicians as well as other department staff are going through extensive training on psychiatric emergencies, overall care, mental health policies and procedures, required legal documents, patient rights, medication and restraint use, and the handling of personal belongings; case studies are part of the training. We take an opportunity to say that this is a brilliant addition and that it would be even better to see physicians listed on these training rosters.

There have been two recent cases in which patients at SwedishAmerican's emergency department complained of neck pain after being restrained in similar manners (HRA #s 07-080-9014 and 08-080-9003), and two recent cases in which patients at the emergency department complained of being humiliated by loosing control of their bodies and possessions in similar manners (HRA #s 08-080-9003 and 08-080-9004). Regardless of medical or mental needs, their experiences in the hospital should never be as traumatic as the ones that got them there. The policy revisions, added staff and trainings are sure to help, but we implore the hospital to make sure there is measured success from them and an observed commitment by all staff on the floor to promote respect and dignity as called for in the hospital's bylaws and regulations.