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HUMAN RIGHTS AUTHORITY-NORTHWEST REGION

REPORT 08-080-9005
KISHWAUKEE COMMUNITY HOSPITAL

Case Summary: No violations were found. The Authority's record on the case is below; there is no facility response.

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations in the care provided to an adult mental health recipient at Kishwaukee Community Hospital. It was alleged that the recipient was not detained, treated and admitted under Code requirements. Substantiated findings would violate rights protected by the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

Located in DeKalb, the hospital provides comprehensive medical services including inpatient psychiatric care; it is an affiliate of the Kish*Health* System.

Representatives from administration and the emergency and social work departments were interviewed. Relevant program policies were reviewed as were sections of a recipient's medical records upon written authorization.

To summarize the complaint, it was stated that the recipient was held at the hospital involuntarily where he was restrained and force-treated without displaying physical harm. He was reportedly kept on a medical unit with an alarm on his bed and a sitter at his door to prevent him from leaving until the next day.

FINDINGS

Record review:

According to the records provided, the recipient visited Kishwaukee's emergency department on three occasions in September and October 2007. This review focuses on a September 16th visit, which involved an admission.

Records from the 16th stated that an ambulance was called to the recipient's home early that morning after policemen found him intoxicated, stating he had taken medications with alcohol. His speech was slurred, he was slow to respond and he had an unsteady gait; he was subsequently taken to the hospital without apparent objection. He signed a brief consent for treatment form on arrival, and he complained of severe hip pain from having several recent falls.

Ataxia, which is a central nervous system-related problem with coordination, drug ingestion and a mental status change were listed as presenting issues for which a series of laboratory tests and images were immediately ordered. There was no documented indication that he opposed being in the hospital at this point or that he opposed the tests although he was unable to sign a more comprehensive consent form because of his impaired condition. Nurses' notes stated in the meantime that he acted inappropriately by roaming about misguided, urinating in a garbage can and having to be redirected multiple times. By 11:15 a.m. he was described as confused, restless and uncooperative while attempting to remove various monitoring equipment. Four-point restraints were applied and a sitter was placed at his bedside for close observation. The corresponding order cited medical purposes for the restraints, that because of confusion they were needed to prevent falls, injury and the removal of necessary medical devices. They remained on as he was transferred at about 2:30 p.m. to a telemetry unit for further monitoring and hydration and for psychiatric and neurologic consults. The admitting physician's report stated that the recipient's mental status was still unclear and that admission and the consultations were needed for his unusual presentation. The recipient was given Benadryl and Thiamine but no psychotropic medications during his time in the emergency department, and he was never petitioned or certified for an involuntary psychiatric admission.

Nursing entries within the recipient's first hours on the unit described how he needed help moving from the bed to the bathroom since he walked unsteadily. His speech was garbled and he continued to appear confused at times although he knew where he was. A safety section in the notes stated that one-to-one supervision and a bed alarm were in place and that side bedrails were in the up position. The admitting physician called in at 7:30 p.m. to check his status and was told that he alternated between rest and periods of agitation. A nurse wrote that the physician did not want to order scheduled medications opting instead for a one-time dose of Klonopin, which medication administration reports showed that he took by mouth. The rest of the night was uneventful, but just after 6 a.m. he was noted to be agitated while screaming profanities. The physician was alerted, and the recipient accepted another dose of the medication. According to the chart, the physician visited him a few hours later and reported that the Ataxia was now resolved and was perhaps due to mixing alcohol with an extensive list of psychiatric medications. She suspected mild withdrawals from missed doses but that he had since improved medically. A psychiatrist followed up soon after and suspected withdrawals as well. The consultation report referenced a bipolar disorder, that hospitalization was recommended but refused and that Ativan was given to help the recipient calm down. The report concluded by stating that he was not committable.

A social worker visited him at 10:30 to discuss discharge plans. Her notes stated that he had a strong desire to leave against medical advice but that he agreed to stay until 3:00 p.m. to take medications and eat food. The psychiatrist provided a discharge order and a two-day supply of medications and the social worker gave him a bus schedule and fifty cents for fare. The recipient decided to leave just after noon, and he was escorted to the bus stop in front of the hospital.

Interviews:

Staff members said that the recipient was in an alert but disoriented state when he arrived at the emergency department. He got confused and agitated at times but did not fight with them or voice objections; it would be documented if he had, and, there were no police or security

personnel standing by his room. What was going on with him medically was such a mystery and it was difficult getting answers from him. He had no objections to providing blood and urine samples or going for diagnostic images, all of which were done before he was restrained. The restraints and the sitter were not used for behavioral purposes but for his medical safety because he continued to be so unsteady and disoriented. There was concern about him falling and pulling out attached monitoring equipment. A nurse stated that she made numerous attempts to redirect him beforehand without success and that he was not combative, just disoriented.

It was explained that the recipient was admitted to Telemetry where he could be on close cardiac monitoring, at which point he was still agreeable. A bed alarm and the sitter were used for safety measures and were not intended to prevent him from leaving as he chose. It was also explained that Klonopin, which was prescribed by a generalist, is used to ease panic attacks and seizures. The drug helped the recipient relax, and it was never forced on him. The social worker added that the recipient was asking for his medications during the psychiatrist's consultation and that medicine administration records suggest that only Klonopin was given, not the Ativan. She remembered having clarified with the recipient during her visits that he was not being kept against his will. She said that he agreed to stay for a while for observation and nourishment, but he changed his mind soon after and they discharged him at his request.

Two administrators stated that emergency department personnel typically know when mental health rights apply. They are trained on mental health processes, medication counseling, rights restrictions, petitioning and certifying, and on the use of behavioral restraints. They also undergo de-escalation training on an annual basis.

CONCLUSION

Kishwaukee's informed consent policy states that implied consent is that which is presumed to be given by an incompetent patient who has a medical emergency. Treatment to avoid loss or significant damage to any bodily function or system can be initiated since it is assumed that the patient would otherwise provide consent. In these circumstances when a patient cannot provide meaningful consent, whether permanently or temporarily due to intoxication for example, the nature and details of his condition must be specifically outlined in the record. If time permits, the physician should obtain consultations as necessary for rendering immediate care (Informed Consent Policy, Guidelines For Obtaining, pp. 2-3). Per the hospital's restraint policy, medical restraints may be imposed to ensure the immediate physical safety of the patient and to prevent the disruption of medically necessary treatment and/or falling or injury whenever alternative interventions have failed (Restraint: Medical, pg. 1).

Under the Mental Health Code, a recipient is anyone who receives treatment for the improvement of a mental condition including hospitalization, evaluation and care (405 ILCS 5/1-100 et seq.). The Code provides a system whereby an adult in apparent need of involuntary psychiatric hospitalization can be held for evaluation on petition and admitted on certification (405 ILCS 5/3-600 et seq.). Mental health recipients enjoy the right to refuse treatment including the use of medications unless it becomes necessary to prevent serious and imminent physical harm without available alternatives (405 ILCS 5/2-107). Likewise, restraints may only be used therapeutically to prevent serious harm (405 ILCS 5/2-108).

By all documented indications, this individual presented with medical concerns of hip pain, drug and alcohol ingestion, unsteadiness and disorientation. He signed an initial consent

statement but was unable to complete a full consent form because of his intoxicated condition. He was provided with immediate hospitalization, evaluation, consultation and care for medical purposes, the need for which was outlined specifically in his record as required by policy. He was restrained for medical safety, he took calming medications willingly, and he was discharged and helped out of the hospital within an hour of his request to go. Had he not been allowed to leave or had he been restrained and treated for a cited mental condition then the Code would have applied. A rights violation is therefor, not substantiated.