FOR IMMEDIATE RELEASE

North Suburban Human Rights Authority
Report of Findings
Evanston Northwest Healthcare
HRA #08-100-9021

Case Summary: The HRA did not substantiate the allegation that the consumer's presenting behavior did not justify in-patient hospitalization. The HRA found a rights violation when the ED failed to admonish the consumer, at least by documentation, of the purpose for the certification examination, which was to see if she should be admitted, which she was, against her will. The HRA substantiated the allegation that the consumer was given emergency medication without justification. It was concluded that the consumer was denied visitation with her children because she tried to leave the unit; the allegation was unsubstantiated. The HRA did not substantiate the allegation that staff members were unbending regarding the consumer's breast pump usage. The allegation that the consumer's medical symptoms were ignored was unsubstantiated. The allegation that the consumer was denied to request a room changed is a factual statement, however the denial did not violate her rights. The HRA's public record on this case is recorded below; the provider's response immediately follows the report.

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Evanston Northwest Healthcare (hereafter called Evanston). In February 2008, the HRA notified Evanston of its intent to conduct an investigation, pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The following complaints were investigated:

- A consumer went to the hospital on the advice of her psychiatrist due to sleep deprivation. Once at the hospital she was admitted to the behavioral health program without being seen by a physician in the Emergency Department (ED). She was admitted on a Petition and Certificate and her behavior did not indicate that she was a threat to herself or others.
- The consumer was not informed of her rights - in that she was told that she was not being held against her will, but yet she was unable to leave.
- The consumer was injected with medications unjustly.
- The consumer was denied visitation with her children (7 months and 3 years old) because she broke a unit rule - which was no calling the police.
- Staff members were unbending regarding the consumer's breast pump usage (a physician said she could use it about every 4 hours) and it was given only every 4 hours - despite her need to use it sooner.
- The consumer's reports of medical symptoms (mild blood sugar problem) were ignored-the following day her blood was drawn which confirmed her report.

- The consumer was approached by a male patient (co-ed unit) in a sexual manner which made her uncomfortable; his room was near hers and when she asked for a room change she was denied- she was allowed to sleep in the dayroom on a couch.

Background

Evanston Northwestern Healthcare is a not-for-profit corporation principally formed to provide quality healthcare services for the communities it serves. The delivery of healthcare services is provided in a wide range of inpatient and ambulatory healthcare settings, community-wide, employing modern technology and expertise. Support for qualified residents who may not be able to pay the entire cost of their care is a part of the organization's commitment. The organization's primary service area includes Chicago's "north shore," northern suburbs, and its environs. In support of its primary mission of patient care, the corporation engages in a wide range of academic activities in medical education and research, and does so largely by way of its affiliation with Northwestern University.

Investigative Process

The HRA conducted an on-site visit in April 2008. While at Evanston the HRA discussed the allegations with the Administrative Director, Department of Psychiatry, and the program's Director. The complainant was interviewed by telephone. The HRA requested the entire clinical record of the consumer whose rights were alleged violated, to include all progress notes, treatment plans, all admission documents, notification of rights forms and doctors orders, with written consent. Also reviewed were Evanston's policies specific to the allegations.

Allegation: A consumer went to the hospital on the advice of her psychiatrist due to sleep deprivation. Once at the hospital she was not seen by a physician in the ED but admitted to the behavioral health program. She was admitted on a Petition and Certificate and her behavior did not indicate that she was a threat to herself or others.

Findings

According to the clinical record, the consumer is a married female who was referred to the Emergency Department by her psychiatrist with a petition for involuntary admission. She entered the ED on November 9, 2007 at about 3:00 p.m. The triage notes documented that the consumer's psychiatrist had just seen the consumer and "prepared the paperwork which noted a break in reality." It was also noted that the husband had initiated the involuntary petition. The chart reviewed by the HRA did not contain the paperwork completed by the psychiatrist. The consumer was seen by a Physician at about 3:30 p.m.; she was medically cleared and was referred for a psychiatric evaluation. The psychiatric assessment documented that the consumer saw a psychiatrist two days ago and had been taking Seroquel for the past two days. Before this, the consumer had no treatment for her Bipolar Disorder for approximately 8-9 years. The assessment documented that the consumer was actively delusional, she was not oriented and

could not discern reality; and she was not oriented to the month or day. She presented with no insight into her ED visit. The consumer's husband was concerned because the consumer was having paranoid delusions (evil was coming and threatening the lives of her and her children), that there was a revolution occurring and she was part of a gang in which other members were threatening her life and her children's lives. It was further documented that the consumer was forgetting to eat - which put her baby at risk because she was breastfeeding, she had not slept in four days, she lost 12 pounds in one week, and she was cleaning excessively. The petition was completed around 5:00 p.m. by the consumer's husband and asserted that the consumer had been delusional and paranoid, she had significant impairment with judgment and insight, she was forgetting to eat, she had not slept in four days and she was not feeding the children on a regular basis. The certificate was completed around 5:15 p.m. by a Physician and asserted that the consumer was unable to care for herself, she was psychotic and delusional in the ED, she had a history of bipolar disorder and she was not on medications. The certificate does not contain the qualified examiner's signature documenting that the consumer was advised of the purpose of the exam or of her right not to speak to the examiner. At the site visit, hospital personnel stated that the consumer needed inpatient hospitalization as she was a danger to herself and her children.

The hospital's Emergency Department Evaluations policy states that the "Access Center's clinicians ("crisis") are available 24 hours a day, 7 days a week to evaluate all patients with psychiatric and/or chemical dependency complaints. The procedure is to conduct a psychological assessment, including a mental status examination, to determine whether or not a patient is at risk of harm to self or others or unable to care for his/her basic needs and is, therefore, in need of psychiatric hospitalization. In addition, the evaluating clinician/MD is responsible for determining whether or not a patient meets criteria for involuntary psychiatric hospitalization."

Conclusion

Under Sections 3-601 and 3-602, a person who is suspected of needing inpatient psychiatric care may be held for evaluation involuntarily by a completed petition that asserts the reasons why and may be admitted involuntarily by a completed certificate that includes clinical justifications.

Pursuant to the Mental Health and Developmental Disabilities Code, Section 3-604, "No person detained for examination under this Article on the basis of a petition alone may be held for more than 24 hours unless within that period a certificate is furnished to or by the mental health facility. If no certificate is furnished, the respondent shall be released forthwith." Based on documentation in this record, those required procedures were followed.

The Physician documented that the consumer was unable to care for herself and that she was psychotic and delusional; a petition and a certificate were subsequently completed. The HRA does not substantiate the allegation that the consumer's presenting behavior did not justify in-patient hospitalization.

Suggestion

It is suggested that the hospital's Emergency Department Evaluations policy include the mandates for completing petitions and certificates in reference to involuntary psychiatric hospitalizations, including specifics about having to complete petitions before a person can be held and about

informing a person of his rights before an examination begins (405 ILCS 5/3-600 et seq. and 5/3-208).

Allegation: The consumer was not informed of her rights - in that she was told that she was not being held against her will, but yet she was unable to leave.

Findings

The record contained a Rights of Admittee form, a Rights of Individuals Receiving Mental Health and Developmental Disabilities Services form (dated 11/9/07)-this form documented that the consumer was unable to sign the form. The Petition documented that the consumer was given a copy of the Petition within 12 hours of her admission and that the consumer's rights were explained to her verbally and in writing. As noted earlier, the certificate did not contain the qualified examiner's signature documenting that the consumer was advised of her right not to speak to the examiner. The initial nursing assessment (11/9/07- 7:00 p.m.) documented that the consumer was informed of her rights. The consumer signed a voluntary application on November 13th, and she then signed the Rights of Individuals Receiving Mental Health and Developmental Disabilities Services form indicating that she was informed of her rights. The voluntary application contained large, bold-face type a statement in simple terms that the voluntary recipient may be discharged from the facility after giving a written notice of his desire to be discharged.

On the 12th, the consumer met with a Mental Health Worker and it was documented that the consumer asked why she was involuntarily admitted. The Worker documented that he spent 10 minutes explaining her rights as a voluntary patient and that she asked appropriate questions. It was also documented that the consumer's memory continued to be impaired and that she declined to sign a voluntary application. On the 15th, the same Mental Health Worker documented that the consumer claimed that this Worker had not informed her of her rights. He documented that he did the best that he could, but it was clear that her memory was not good.

At the site visit, it was stated that consumers are advised of their rights at the time of admission or as soon as the condition warrants understanding. It was stated that random charts are checked to ensure that all admission forms are completed.

Conclusion

Pursuant to Section 3-609 of the Mental Health Code, within 12 hours after his admission, the respondent shall be given a copy of the petition and a statement as provided in Section 3-206, that the recipient at least 12 years old has been informed of the right to contact the Guardianship and Advocacy Commission and have assistance when requested. Section 3-401 requires voluntary applications to state in bold type a recipient's right to request discharge. According to Section 2-200, "(a) 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 who is 12 years 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 rights guaranteed by this Chapter which are relevant to the nature of the recipient's services program."

Based on the information reviewed in the clinical record, the HRA does not substantiate the allegation that the consumer was not advised of her rights. The consumer was, in fact, being held on a petition and certificates which

prevented her from leaving. The rights information that was shared with her in the meantime explained her situation thoroughly, once in the behavioral health unit, although documentation suggested that her condition made it necessary to review her rights several times. When she signed the application for voluntary admission, she signed a five-day notice of discharge and discharge proceedings occurred in accordance with the law.

Pursuant to Section 3-208 of the Mental Health and Developmental Disabilities Code, "Whenever a petition has been executed pursuant to Section 3-507, 3-601 or 3-701, 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 statements he makes may be disclosed at a court hearing on the issue of whether he is subject to involuntary admission. If the person being examined has not been so informed, the examiner shall not be permitted to testify at any subsequent court hearing concerning the respondent's admission."

The HRA does find a rights violation when the ED failed to admonish the consumer, at least by documentation, of the purpose for the certification examination, which was to see if she should be admitted, which she was, against her will. The rights admonishment requirement is the hospital's first required opportunity to inform a consumer about being held against his will.

Recommendation

The hospital must ensure that qualified examiners in all departments fulfill this important requirement and are trained on the new policy revisions from the Suggestion mention earlier in this Report.

Allegation: The consumer was injected with medications unjustly.

Findings

On November 11th, a Registered Nurse documented that the consumer was in a very agitated state - she was going from one staff member to another demanding to leave the unit, demanding that the police be called to rescue her, and she was threatening to legally punish the hospital for holding her against her will. The consumer was asked to go to her room as she was upsetting the other patients; she refused and she refused PRN (as needed) medication. It was documented that the consumer was escorted to her room and she resisted. A code was called and when Public Saftey arrived on the unit the consumer tried to run out of the unit. The consumer was then given psychotropic medication intramuscularly. The Restriction of Rights form, completed by a Mental Health Worker, documented that the consumer received emergency medication due to "noncompliance several times this shift". It is noted that the form did not indicate why the consumer's emergency preference was not used - this was simply left blank, as was the designated person notification section. Since the HRA was unsuccessful in finding the emergency preference documentation in the Care Plan, the Director was contacted to ask where this intervention preference is documented. It was stated that the nursing assessments asks the patient what is helpful in maintaining self-control. A review of the chart showed that the consumer responded to this question by saying "music".

The hospital's Administration of Psychotropic Medication policy states that emergency psychotropic medication may be given without the patient's consent only to protect a patient from imminent, direct, serious harm to self or others. Non-compliance with medication or preventative reasons for medicating are not valid reasons to administer without consent. The policy states that

staff are to document the threat of direct, serious, imminent harm to self/others and that a ROR is to be completed promptly.

At the site visit, hospital personnel stated that upon review of the clinical record for the emergency medication, the Director spoke to the Nurse about the event that required the intervention. The Nurse acknowledged that although the consumer's behavior warranted the medication, the documentation did not support the intervention. The Administration of Psychotropic Medication policy was subsequently amended to indicate that Registered Nurses are to complete the ROR forms. The Director gave the HRA a copy of the amended policy and stated that an official in-service for staff training was planned for the end of April, and the HRA was advised that staff members were informally made aware of the revision.

Conclusion

Pursuant to Section 2-107 of the Mental Health and Developmental Disabilities Code, "An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available." Under Section 5/2-201, notice of any restriction and the reasons must be delivered to the recipient and to anyone he or she designates.

Based on the lack of documentation, the HRA substantiates the allegation that the consumer was given emergency medication without justification. This matter has been addressed with personnel and a revised policy has been completed; thus no recommendations are issued.

However, pursuant to the Mental Health and Developmental Disabilities Code, Section 2-200 (d), a recipient must be informed of the circumstances when a facility may use medication, restraints or seclusion as emergency interventions and must be given an opportunity to select an intervention preference. And, per Section 2-102 (a) "In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan."

Recommendation

The hospital must ensure that the consumer's preference regarding emergency intervention is noted in the consumer's treatment plan.

Suggestion

Hospital personnel must ensure that appropriate staff always ask consumer's whose rights have been restricted whether they wish for anyone to be notified and that their responses are always documented on restriction forms pursuant to the Code's requirements in Sections 2-200 and 2-201.

Allegation: The consumer was denied visitation with her children (7 months and 3 years old) because she broke a unit rule - which was no calling the police.

Findings

According to the clinical record, on November 10th, the consumer was to be assessed to determine the appropriateness of having supervised visits with her 6 month old to breast feed; if appropriate the visit was to occur on November 12th. In the afternoon on the 10th, a RN documented that the consumer was calling the Evanston Police Department and telling them that she did not want to be at the hospital. A few hours after the RN note, the Director documented that she spoke with an Officer from the Police Department who stated that the consumer was making repeated phone calls to 911 and demanding their presence to release her. The PD asked that her outgoing calls be limited. The Director documented that she spoke with the consumer's Physician and it was decided that staff members would dial the number for all outgoing calls and the consumer was not allowed to call 911. A ROR Notice was completed for the communication restriction which documented that the consumer had "repeatedly called 911 and the police department requested calls be stopped." The restriction noted that the consumer wished no one to be notified of the restriction. The restriction was discontinued on the 13th; after agreeing to not call the police it was documented (on the 13th) that the consumer called the police. On this date the consumer also attempted to leave the unit.

The following day, a Social Worker documented that it was explained to the consumer that given what had transpired the previous day that a visit with her children would not be scheduled until approval was received from the consumer's psychiatrist. On the 15th, the consumer expressed that not being able to see her children after disregarding the rules is cruel and unusual punishment. The Social Worker documented (on the 15th) that he consulted with the consumer's psychiatrist and it was determined that a supervised family visit would be scheduled for November 16th. According to chart documentation, the visit occurred as scheduled. There is no accompanying ROR notice for the restricted visits in the record.

At the site visit, it was stated that due to Illinois Department of Public Health, no one under the age of 12 can visit the unit. The Director stated that however, exceptions are made on an individual basis. It was stated that an infant would be allowed on the unit, for example, should there be a bonding issue.

The hospital's Patient's Rights policy states that phone calls and visitation may be restricted, or observed, only to protect the patient or others from harm, harassment, or intimidation and restriction for these reasons must be documented on the chart and persons must be notified as specified in the MHDD Code. To provide for patient participation in treatment, phone calls and visitors would not conflict with scheduled activities, and quiet times are designated to provide for the comfort of all patients. The scheduled time for phone calls and visits are given to the patient upon admission and are posted on each unit. The patient Handbook states (in part) that visitors are limited to two people at a time and that children under 12 are not recommended to visit. Visit for young children may be arranged through discussion with the 5 East nursing staff.

Conclusion

Pursuant to Section 2-103 of the Mental Health and Developmental Disabilities Code, "A recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation. Unimpeded, private and uncensored communication by mail, telephone, and visitation may be reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction

shall be given to all recipients upon admission. When communications are restricted, the facility shall advise the recipient that he has the right to require the facility to notify the affected parties of the restriction, and to notify such affected party when the restrictions are no longer in effect".

Pursuant to (77 IL Adm. Code 250.250) Each hospital shall establish, in the interest of the patient, policies regarding visitation on the various services and departments of the hospital. It is recommended that visitors be limited to two per patient at any one time. Children under l2 years of age should not be admitted as visitors to the hospital except in the company of a responsible adult. Children under six years of age should be admitted as visitors only when the hospital has a special family visiting program or when requested in writing by the attending physician or chief executive officer of the hospital. Visiting facilities other than the patient's room shall be used for children under six years of age, unless that room is a private room.

Based on the information received, it is concluded that the consumer was denied visitation with her children because she tried to leave the unit; the allegation is unsubstantiated.

Suggestion

Because the superceding Mental Health Code's visitation mandates allow consumers to visit with persons of his choice and do not differentiate from an adult or minor visitor, when a minor's visit is denied, documentation must clearly state the reasons for the denial and a Restriction Notice must be completed.

The HRA takes this opportunity to remind the hospital that the IDPH simply suggests that those under 12 not be admitted unless accompanied by an adult.

Allegation: Staff members were unbending regarding the consumer's breast pump usage (physician said she could use it about every 4 hours) and it was given only every 4 hours - despite her need to use it sooner.

Findings

Documentation showed that the consumer was referred for a lactation consultation and she was seen for this consultation on November 10th. The consumer was referred to lactation services to set up a Lactina pump for breastfeeding; she was shown how to use the pump and it was recommended that the consumer use the pump about every 4 hours for 15-20 minutes. The expressed milk was to be stored in the refrigerator for the consumer's husband to take it home for the baby. During the morning hours on the 11th, a RN documented that she talked with the consumer about letting staff know when she needs to use the breast pump. About an hour later, the consumer requested the pump. Later that afternoon, it was documented that the consumer had been requesting the pump every 5-10 minutes for the last hour. It was documented that she was reminded that she should pump every 4-6 hours and that the last time she had pumped she was only able to sit long enough to pump less than 1 oz. Later that evening, the consumer began to escalate and demanded to pump every 5 or 10 minutes. It was documented that she was unable to remember that she had just asked and been told she could pump every 4 hours. The following morning the consumer was advised that she could use the pump within 3-4 hours apart from each time she does pump. Nursing notes documented that the consumer requested and used the pump once on the 12th - the chart contained no further documentation about the breast pump.

At the site visit, it was explained that the pump is considered "contraband" because of its wire, thus the machine needed be observed for safety. It was stated that they would not intentionally withhold the pump, and it was given when she requested it within the recommended time frame, they simply could not give her the pump every time she demanded it. At the site visit, the HRA learned that the hospital has a program for post-partum depression (PPD) - the staff expressed that

this consultation satisfied the question as to why this consumer was not sent for an evaluation of possible PPD.

Conclusion

Pursuant to Section 5/2-102 of the Mental Health and Developmental Disabilities Code, a recipient of services shall receive adequate and humane care. Based on the information obtained, the HRA does not substantiate the allegation that staff members were unbending regarding the consumer's breast pump usage.

Comment

The consumer was referred to lactation services by her request for questions about the medication that she had taken in the last 24 hours. The consumer was advised that the medications she had received - Haldol and Ativan - should be used with caution in nursing mothers. It was recommended that she pump prior to taking the medication and that she may want to dump the breast milk if she had pumped within 4-6 hours after the dose. The consumer asked the nurse to dump the breast milk that she had pumped the previous day. At the site visit, it was discussed about the advice regarding medication and nursing mothers. The Director responded that she has written a published article on this subject and this is not a concern. The HRA makes this comment to suggest that the hospital be more aggressive in their approach to this matter, by ensuring that each nursing mother is given both verbal and written documentation regarding the effects of medication and nursing mothers, ensuring that informed consent is obtained.

Even though the symptoms coincided with a recent birth, it seemed that the diagnosis treatment took the more expedient, less costly route based on the old diagnosis of MDI (Major Depressive Illiness) rather than doing a new work-up for Post-Partum Depression. Although it is realized that not all females should be evaluated for PPD, it might be prudent to document why the evaluation was not recommended.

Allegation: The consumer's reports of medical symptoms (mild blood sugar problem) were ignored-the following day her blood was drawn which confirmed her report.

Findings

On November 14th, nursing notes documented that the consumer complained of light headedness and she asked to have a chemstrip (chemical test strip) done as she was concerned about low blood sugar. The chemstrip read 180 and the consumer asked what the ranges should be; documentation did not show that this question was answered. A few minutes later a Mental Health Worker documented that the consumer was thinking that she had an elevated blood sugar. The Mental Health Worker asked why she thought the blood sugar was elevated and the consumer reported symptoms of light headedness, her feet hurt and the consumer reported that she had gestational diabetes during her first pregnancy. The consumer was refereed to her Medical Physician who was aware of and monitored her readings. On November 16th, a Mental Health Worker documented that when the consumer learned that her fasting blood sugar was 105, five points above normal, she insisted that the Mental Health Worker admit that he was wrong. The Mental Health Worker further documented that he did not have the opportunity to clarify much of the consumer's

concern - i.e. does this blood sugar mean to the consumer that the consumer is diabetic or does it only mean it is cause for concern. The Worker documented that it seemed important to the consumer that the Worker admit that he was wrong and the consumer was right - the Worker agreed that he was wrong in that it was five points above the new normal.

> The following was taken from the Mayo Clinic web site: *A random blood sugar test measures your blood sugar at any point in time, not necessarily a certain amount of time after a meal, snack or beverage. A normal random blood sugar level hasn't been clearly defined. However, even if you've recently eaten and your blood sugar level is at its peak, your random blood sugar level shouldn't be higher than 200 mg/dL. If your random blood sugar level is higher than 140 mg/dL but lower than 200 mg/dL, you may have prediabetes. A fasting blood sugar test measures the amount of sugar in your blood after you fast for at least eight hours or overnight. A normal fasting blood sugar result is lower than 100 milligrams of glucose per deciliter of blood (mg/dL). If your fasting blood sugar level is 100 mg/dL to 125 mg/dL, you have impaired fasting glucose — commonly known as prediabetes. To confirm the diagnosis, your doctor may repeat the fasting blood sugar test several days to a week later.*

At the site visit, it was stated that the consumer's medical concerns were addressed and not ignored. It was further stated that she seemed to be more focused on making the MHW admit that he was wrong than addressing the medical issues.

Conclusion

Pursuant to Section 5/2-102 of the Mental Health and Developmental Disabilities Code, a recipient of services shall receive adequate and humane care. The consumer reported symptoms of "light headed" which generally are indicative of low blood sugar - as the consumer pointed out. The symptom was addressed by the chemstrip and the blood sugar that was taken at that time was 180; this ruled out low blood sugar as a cause of her complaints. Because the Random reading was somewhat high - and because of her history of gestational diabetes - a Fasting Blood Sugar was completed which gave a more reliable base line reading of the blood sugar. The result was 105 - five points higher than the 100 normal level. The allegation that the consumer's medical symptoms were ignored is unsubstantiated.

Allegation: The consumer was approached by a male patient (co-ed unit) in a sexual manner which made her uncomfortable; his room was near hers and when she asked for a room change she was denied- she was allowed to sleep in the dayroom on a couch.

Findings

On November 13th, it was documented that the consumer was afraid of the peer across the hall and she was allowed to sleep in the dayroom; she was awake most of the night and was very suspicious. At a family meeting later that day, the consumer discussed her fears of being on the unit, saying she did not feel safe and wanted to be discharged. A short while later, it was documented that the consumer was given her clothes which the consumer reported made her feel safer sleeping in the hospital. It was documented that the consumer was provided support and reassurance that

she was safe. The consumer asked to be transferred to another room or to be discharged. Her physician stated that she needed a private room and she was to stay where she was. Of note, the consumer was clothed in hospital gowns due to an elopement precaution.

On November 16th, a MHW documented that the consumer was anxious/frightened because another peer was stalking her and using profanity. The consumer was reminded that staff are available 24/7 and to call staff if she felt threatened or needed staff intervention. The MHW documented that he and the consumer talked with this peer who was "inappropriate" even as the MHW set limits. The MHW documented that he reassured the consumer that this peer was not dangerous even though the peer could be inappropriate in terms if intrusiveness and inappropriate remarks.

At the site visit, it was stated that the consumer was in a bedroom closest to the nurses' station so that they could keep an eye on her. The treatment team, including her Physician, did not want to move her away from that area due to monitoring reasons.

Conclusion

Pursuant to Section 5/2-102 of the Mental Health and Developmental Disabilities Code, a recipient of services shall receive adequate and humane care. The consumer was placed in bedroom that allowed for maximum monitoring; her request to move from this room was denied for that reason. The allegation that she was denied to request a room changed is a factual statement, however the denial did not violate her rights.

Comment

The HRA does not support consumers sleeping in the dayroom; it seems that other more appropriate options could be explored. The HRA takes this opportunity to remind hospital personnel that when personal possessions are restricted (clothes due to a precaution) that are not considered contraband, a ROR is needed.

RESPONSE

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

EVANSTON NORTHWESTERN HEALTHCARE

Evanston Hospital

2650 Ridge Avenue
Evanston, Illinois 60201
(847) 570-2000

September 4, 2008

Julie Sass, Rights Coordinator
North Suburban Regional Human Rights Authority
9511 Harrison Street, W-300
Des Plaines, IL 60016-1565

RE: HRA #08-100-9021

Dear Ms. Sass,

We received the results of your investigation and appreciate your comprehensive assessment and recommendations. It is our mission to maintain and protect our patient's rights, and to ensure that they receive all information regarding those rights.

In response to your recommendations our plan is as follows:

- All qualified examiners (Emergency Room Physicians) will be trained in the requirement regarding informing a person of rights prior to the examination for purpose of a certificate (405 ILCS 5/3-600 et seq and 5/3-208). We will send you a copy of the education documents by October 31, 2008.

- Our nursing assessment electronic documentation currently includes information regarding patient stated alternatives to avoid restraints and our commitment to becoming restraint-free. We will enhance this information to include the patient's preference for emergency treatment. This information would then be displayed in the patient's Electronic Health Record on the Kardex. Once this enhancement is completed, we will send you screen shots of the process. This will automatically become a part of each patient's admission assessment and documentation.

- All nursing staff were trained in our policy on Restriction of Rights. A meeting was held with the Clinical Nurse Managers to review all requirements of the ROR and indications. The managers will review all ROR documentation for accurate completion. We will send you staff sign-off and training information.

We will send you an update regarding our progress on October 31, 2008. Thank you for your feedback. Please contact me should you have any additional comments or questions. I can be reached at [redacted].

Sincerely,

Deborah Taber, RN MS
Administrative Director, Department of Psychiatry
Evanston Northwestern Healthcare
2650 Ridge Avenue
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[redacted]