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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 09-030-9017
LORETTO HOSPITAL

Case summary: The HRA substantiated the complaint that the recipient was detained and administered psychotropic medication in violation of the Mental Health Code's established process. There was no evidence to suggest that restraints were used in violation of the Code's or the hospital's requirements or that staff struck the recipient in the face with a closed fist.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Loretto Hospital. It was alleged that the facility did not follow Mental Health Code procedures when it detained, restrained, and administered psychotropic medication absent an emergency and that staff struck the recipient in his face with a closed fist. If substantiated, these allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.), and hospital policies.

Loretto is a private medical facility located in Chicago. The hospital emergency department assesses approximately 1200 patients per year for mental health referral to the Loretto behavioral health unit, to a state mental health center or to another mental health facility.

To review these complaints, the HRA conducted a site visit and interviewed the Associate Vice President of Behavioral Health, the Assistant Nurse Manager of Behavioral Health, the Director of the Emergency Department and Cardio Pulmonary, the Medical Director of the Emergency Department, the Manager of Performance Improvement and Risk Management, and the attending nurse. Relevant program policies were reviewed as were the recipient's records upon written consent. The recipient is an adult who maintains his legal rights.

COMPLAINT SUMMARY

The complaint alleges that the recipient was working in an alley near his home when police, who were familiar to him, stopped the recipient to question him (he was using a hatchet). After some arguing, the police took the recipient in shackles to the Loretto Hospital emergency department. The complaint states that the recipient was taken to a side room and stripped of his clothing, after which his hands and feet were strapped to the bed. Staff then brought water in small cups, stating that he would be collecting urine for testing. The complaint alleges that a

staff person placed a catheter kit on the recipient's feet, at which time the recipient said, "Give me a while." He then shook his feet and the kit fell to the floor. The staff person then came to the recipient and hit the side of his face, saying "I don't want any of your shit." He then allegedly slammed the recipient's face against the rail and put the catheter in. The complaint then indicates that another staff person came in and the recipient asked him, "Who do I complain to- that guy just hit me." The staff person said that he was going to call the police and he left. The same staff person who had hit the recipient then re-entered the room and rolled up a sheet to place on the recipient's neck so that he could give him medication. The complaint states that the recipient was naked and taken to a state mental health facility, where he was denied admission, and then brought back to the emergency department for further tests. He was then taken back to the state facility where he was admitted for treatment.

FINDINGS

The Loretto Hospital Emergency Service Record shows that the recipient was admitted on 4/2/09 at 11:40 a.m. The chief complaint is: "Psych eval. Pt. found by [police department] w/a hatchet acting bizarre." Nursing Notes indicate that at 11:30 the recipient was placed in restraints and "….pt. very agitated, yelling, pt. threat to staff." At 11:45 a.m. the recipient received Zyprexa, 10 mg intramuscularly, and at 1:30 p.m. Ativan 2 mg intramuscularly. At 2:00 p.m. the record indicates "pt. sleeping. Out of restraints." The Emergency Treatment Record shows that the recipient was medically cleared at 4:20 p.m. At 6:00 p.m. an entry states, "[staff] from [state mental health facility] was called to give report. Report was given pt. sleeping well at this time NAD [no apparent distress]." At 9:10 p.m. the Notes state "[ambulance] here to transport pt. to [state hospital]. Pt's sleeping …." At 10:00 p.m. the Notes indicate, "Dr. from [state hospital] called states that pt. will have to come back to ER until pt.'s fully awake, able to stand, talk." At 2:30 a.m. the ambulance again arrived to transport the recipient back to the state mental health facility where he was admitted. The last entry of the Notes states, "Pt. verbally aggressive. [Ambulance attendant] advised to place pt. in restraints. Pt.'s unpredictable." There is no indication from the record that the recipient was catheterized.

Emergency Room diagnostics indicate that the recipient tested positive for cocaine and phencyclidine (blood and urine taken at 12:20 p.m.). The restraint order, included in the record, lists the behaviors that led to the decision for restraints as, "Pt. violent with [police] acting bizarre verbal threats to [police] and ER staff." The order indicates that the recipient is an imminent danger to himself and others, and orders full, hard restraints for two hours. A Restriction of Rights Notice is included with the restraint order, but there is no Restriction of Rights for the injection given earlier. The reason given for the restriction is "Pt. and staff safety." The restraint flow sheet indicates assessment checks in 15-minute increments beginning at 11:30 a.m. and ending at 2:00 p.m. with a physical risk assessment completed at 12:30 p.m. by the attending nurse.

The record shows that after the recipient was medically cleared at 4:20 p.m., a Crisis Intervention Assessment was completed on him (5:15 p.m.). The Presenting Problem is described therein: "Patient is a 57 year old, single male, ambulatory African-American with a history of mental illness, substance abuse and multiple psychiatric hospitalizations. Pt. was brought into Loretto Hospital ER by [police department] as a result of psychotic decompensation

and threatening behavior- Pt. was found in the alley talking to himself, cursing, yelling, and armed with a hatchet. Pt. was manic, he defecated on himself, disheveled, confused and delusional. He tested positive for cocaine and PCP." In the recipient's Background Information section it states, "pt. was significantly psychotic, and unable to provide any reasonable information." The Uniform Screening and Referral form (also completed at 5:15 p.m.) states that additionally, "Pt. is vulnerable to dangerous behavior to others."

The record shows that a petition for involuntary admission was completed by the crisis worker at 6:00 p.m. The statement of signs and symptoms states, "Pt. is a 57 year old male, ambulatory African American with hx [history] of mental illness, substance abuse and multiple psychiatric hospitalizations. Pt. was brought into Loretto Hospital ER by [police department] as a result of psychotic decompensation. Pt. was actively hallucinating, manic, confused, delusional, deficient in self care, armed with hatchet and threatening the civil population. Pt. was positive for cocaine and pcp." The petition includes the name, badge number and employer of the police officer. A certificate was completed at 4:15 p.m. by the emergency department physician which states, "Mr. [recipient] has a long history of psychosis associated with violence. Today he was brought in by police after he was acting bizarrely and wielding a hatchet."

Hospital representatives were interviewed about the HRA complaint and emergency department process. They stated that the recipient was so out of control on the day of his admission that he was carried into the department in shackles by the police. Even before the recipient reached the treatment area, his attending nurse reported that at least six state police officers were needed to subdue him to the ground in the hallway to control his extremely aggressive behavior. Although his nurse had cared for the recipient "countless" times in the past, and had a positive rapport with him, he stated that at this time the recipient was "extremely" out of control. He also stated that police reported that the recipient had been chasing people in the street with a hatchet and had become dangerous before he was brought to the hospital. After the recipient had been placed in restraints he was administered psychotropic medication due to his continued thrashing, shouting and threatening behavior.

Hospital staff reported that the recipient had his clothes removed when he arrived in the emergency department as is customary for patients (mental health recipients or others) who show harm to themselves or others. He was then placed in a hospital gown and remained in his gown until he was admitted to the state mental health facility. While in the emergency department the recipient was placed in one of two rooms dedicated to potential mental health recipients, however he was not considered a mental health recipient until he was medically cleared at 4:20 p.m. (the recipient had been treated medically, as well as behaviorally, at the hospital in the past).

Hospital staff reported that the recipient was not catheterized during his emergency department stay and there is no mention of the placement of a catheter or its removal in the hospital record. The attending nurse reported that the recipient was given a urinal for his urine sample and along with the aid of staff he was able to give a sample after receiving water several times, however he was not removed from the restraints. The restraint flowsheet indicates that the recipient was "agitated" and "yelling at staff" at the checkup made at 12:30 and the physician ordered the restraints to be continued, which they were, until 2:00 p.m.

The recipient's nurse and the treatment team did not receive a report of injury from the recipient at the time of the event and the hospital staff were not made aware of the alleged blow to his face until the HRA case opening. They also stated that reports of injury are considered very serious and would incur an Incident Report which would be forwarded to the Unit Manager and then to the Risk Manager. Staff reported that an injury to a patient would be fully investigated and all staff involved in the event would be questioned. The Risk Management Director stated that she did not receive a report of injury to the recipient while he was in the hospital, however she did speak with the attending nurse and his team regarding the HRA complaint. Staff reported that there was no Incident Report filed for this event and there is no documentation of an investigation after the receipt of the complaint from the HRA. Also, the recipient did not file a complaint with the hospital regarding the event. The HRA did report the allegation of patient injury to the Illinois Department of Public Health and an investigation was conducted which showed no evidence of physical abuse to the patient.

Hospital representatives were not sure why the recipient was returned from the state mental health facility. They stated that the state facility has a medical clearance sheet that was negotiated among emergency rooms, hospitals and state mental health facilities, and that a recipient being asleep is not an exclusionary condition. Also, they reported that it is possible that the doctor at the state facility evaluated the situation differently than they did.

Staff indicated that patients brought into the emergency department are treated by a physician and it is this physician who completes the first certificate, as was the case in this event. Crisis workers do not interview recipients until they are medically cleared and it is generally the crisis worker who completes the petition and informs the recipient of their rights. Psychiatrists from the hospital behavioral health unit are on-call for consultation in the emergency department but the emergency room physician makes the final determination for the need for mental health hospitalization. Hospital representatives indicated that emergency room staff are trained at least yearly on disability rights and due process.

STATUTORY BASIS

The Mental Health and Developmental Disabilities Code describes a "mental health facility" as "...any licensed private hospital, institution, or facility or section thereof, and any facility, or section thereof, operated by the State or a political subdivision thereof for the treatment of persons with mental illness and includes all hospitals, institutions, clinics, evaluation facilities, and mental health centers which provide treatment for such persons" (405 ILCS 5/1-114).

The Mental Health Code states that when a person is asserted to be in need of immediate hospitalization, any person 18 years of age or older may complete a petition (5/3-600), which specifically lists the reasons (5/3-601). A peace officer may take a person into custody and transport him to a mental health facility when the peace officer has reasonable grounds to believe that that the person is in need of immediate hospitalization to protect him from physically harming himself or others. In this case the officer may complete the petition and if it is not completed by the officer then the officers' name, badge number and employer shall be included on the petition (5/3-606). The petition is to be accompanied by the certificate of a qualified examiner stating that the recipient is in need of immediate hospitalization. It must also contain the examiner's clinical observations and other factual information that was relied upon in

reaching a diagnosis, along with a statement that the recipient was advised of his rights (3-602). Upon completion of one certificate, the facility may begin treatment, however at this time the recipient must be informed of his right to refuse medication (3-608).

The Mental Health Code mandates that recipients of services be provided with adequate and humane care in the least restrictive environment. Adult recipients of services must be informed of the right to refuse medication or electroconvulsive therapy. If these services are refused, they should not be given unless they are necessary to prevent the recipient from causing serious and imminent physical harm to themselves or others and no less restrictive alternative is available (405 ILCS 5/2-102 and 5/2-107). Additionally, the Code states that whenever any rights of the recipient of services are restricted, notice must be given to the recipient, a designee, the facility director or a designated agency, and it must be recorded in the recipient's record (ILCS 405 5/2-201).

Restraint is a therapeutic tool that the Mental Health Code carefully regulates. Although its use is to prevent harm, the Code outlines specific measures to ensure that it is safely and professionally applied:

> "Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized. In no event shall restraint be utilized to punish or discipline a recipient, nor is restraint to be used as a convenience for the staff.
>
> (a) Except as provided in this Section, restraint shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities. No restraint shall be ordered unless the physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of restraint is justified to prevent the recipient from causing physical harm to himself or others. In no event may restraint continue for longer than 2 hours unless within that time period a nurse with supervisory responsibilities or a physician confirms, in writing, following a personal examination of the recipient, that the restraint does not pose an undue risk to the recipient's health in light of the recipient's physical or medical condition. The order shall state the events leading up to the need for restraint and the purposes for which restraint is employed. The order shall also state the length of time restraint is to be employed and the clinical justification for that length of time. No order for restraint shall be valid for more than 16 hours. If further restraint is required, a new order must be issued pursuant to the requirements provided in this Section….
>
> (f) Restraint shall be employed in a humane and therapeutic manner and the person being restrained shall be observed by a qualified person as often as is clinically appropriate but in no event less than once every 15 minutes. The qualified person shall maintain a record of the observations. Specifically, unless there is an immediate danger that the recipient will physically harm himself or others, restraint shall be loosely applied to permit freedom of

> movement. Further, the recipient shall be permitted to have regular meals and toilet privileges free from the restraint, except when freedom of action may result in physical harm to the recipient or others…. (405 ILCS 5/2-108).

HOSPITAL POLICY

Loretto Hospital policy #IPU 1502.5 ensures that all patients are admitted within the guidelines of the Mental Health and Developmental Disabilities Code. It states that "An involuntary admission is any person … subject to involuntary admission status because that individual is in need of immediate hospitalization for the protection of self or others from physical harm." The policy does not address emergency room procedures for petitions and certificates apart from the Code requirements for these procedures.

Loretto Hospital policy #IPU-1500.1 states that "Loretto Hospital shall provide all rights to patients pursuant to the Illinois Mental Health Code and shall only restrict those rights to protect the patient or others from harm. All staff will know the rights and the procedures and standards for restricting those rights." The policy also states that upon commencement of services or as soon thereafter as the patient's condition permits, a staff nurse must orally review the rights with every patient or patient's guardian. Whenever any of the patient's rights is restricted, the policy requires written notice of the restriction be given to the patient, the guardian, the persons designated by the patient, an agency designated by the patient, the facility director, and any agency or attorney in fact under a Mental Health Preference Declaration or a Durable Power of Attorney for Health Care. Emergency medication may only be administered when such services are necessary to prevent the patient from causing serious and imminent physical harm to himself or others (#IPU- 1500.5).

Loretto Hospital policy #PCS-1325.18 states that, "It is the philosophy of Loretto Hospital that restraints are used only in emergency situations where there is an imminent risk of the patient harming himself/herself or others. Non-physical interventions are the first choice unless safety demands an immediate physical response." The hospital policy includes a lengthy description of policy and procedure for use of restraints that comports with Mental Health Code guidelines.

Loretto Hospital policy #2103 states that "An unusual occurrence (Any unusual occurrence, event, or situation that would not occur in the day-to-day operation of the facility, or an occurrence, event or situation that has, or has the potential to have, an unexpected outcome or the impairment of safety) will be reported to the Risk Management department and an unusual occurrence/incident report will be submitted to the Risk Management department in a timely manner." The hospital CEO is responsible for overseeing compliance with the hospital policy on incident reporting and the vice-president of Performance Improvement/Risk Management is responsible for tracking unusual occurrences and reporting the results to the appropriate committee.

CONCLUSION

The hospital record as well as the statements of staff who treated the recipient at the time of his hospitalization indicate that he was physically threatening to staff and others from the time that he arrived in the emergency department at 11:40 a.m. until he was subdued through the use of restraint and medication. Although the recipient's restraint documentation included a Restriction of Rights form, his forced injection did not. His restraints were removed at 2:00 p.m. and he was medically cleared at 4:20 p.m., at which time the doctor completed the first certificate. The crisis worker was called to complete her assessment after the recipient was medically cleared, and she assessed the recipient at 5:15 p.m., completing the petition at 6:00 p.m., thus the recipient was detained for over five hours before a petition was completed. Additionally, the certificate's clinical observation states, "[recipient] has a long history of psychosis associated with violence. Today he was brought in by police after he was acting bizarrely and wielding a hatchet." This description relies heavily upon the report of the police rather than the qualified examiner's clinical observation of the recipient's behavior and mental condition at the time of assessment.

Although there was some confusion about the recipient's readiness to be transported to the referring facility, the record does not show that he was placed in restraints without clothing, that he was catheterized, that he was injured by staff, or that he reported to staff that he had been injured (or that he filed a complaint with the hospital). The recipient had been subdued by at least six police officers before being admitted to the emergency department and in this interaction he might have incurred some injury, however the hospital staff who worked with the recipient on the day of his admission to the emergency department did not receive a report of his being struck, and the recipient did not file a complaint with the hospital. Additionally, the hospital has a process in place for the investigation of reports of injury to patients and their policy and procedure indicate that these reports are treated very seriously.

The HRA substantiates the complaint that the recipient was detained, and administered psychotropic medication in violation of the Mental Health Code's established process. There was no evidence to suggest that restraints were used in violation of the Code's or the hospital's requirements or that staff struck the recipient in the face with a closed fist.

RECOMMENDATIONS

1. Follow the Mental Health Code and ensure that when a recipient is detained for psychiatric evaluation a petition is completed in a timely manner (405 ILCS 5/3-600 et seq.).

2. Ensure that Restrictions of Rights documents are completed for all incidents of emergency medication (5/2-201).

3. Develop and implement policy specific to Code-compliant psychiatric treatment and evaluation within the emergency department.

SUGGESTIONS

1. Ensure that mental health recipients are recognized as such upon entry into the emergency department and apply the Mental Health Code accordingly.

2. Instruct staff to be specific in documenting the rationale for detention, restraint, and psychotropic medication; their recollections of the events were much more compelling than their documentation. Specific behaviors and factual information, rather than impressions, are more accurate in describing mental health status, should the question of the recipient's rights arise. For example, the emergency room documentation does not match the report of the staff who worked with the recipient on the day of his admission. The record states that the recipient was "agitated, yelling, pt. threat to staff" which does not match the description offered by the nurse, who described a very uncontrollable and violent individual who required the help of police, medication and restraint to subdue him. Although the restraint order indicates that the recipient was an imminent danger to himself and others, the reason for restraint is "Pt. and staff safety". Safety is an understandable need, but it does not specifically describe the imminent physical danger and could be clearer.

RESPONSE

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

Loretto Hospital
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January 29, 2010

Ray Hemphill
HRA Chairperson
Illinois Guardianship and advocacy Commission
1200 S. 1st Ave.
Box 7009
Hines, IL 60141

Re: #09-030-9017

Dear Mr. Hemphill,

Thank you for your letter of December 29, 2009 relating to case #09-030-9017. Due to the holidays, I did not receive this letter until January 4, 2010.

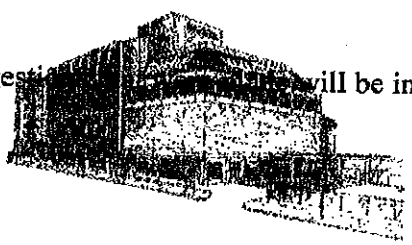
Loretto Hospital strives to be compliant with all regulations and thanks you and your team for the recommendations and suggestions. The feedback will help us develop a plan of action.

The Emergency Department, including nurses, physicians and PCTs and the Crisis Workers will be inserviced on the policy that has been developed for the completion of Restriction of Rights for any patient who receives Emergency Medications, Physical Hold and Mechanical Restraints. The completion of the training will be completed by February 28, 2010.

Staff will be educated on the timely completion of the petition and the certificate. A grid has been developed as a guideline for staff as a reference for who is responsible for what and a time line for completion of all forms. Education has begun and will be completed by February 18, 2010.

Electronic nursing documentation has been implemented since this patient was seen in the ED. When the electronic nursing documentation was implemented, a review of proper documentation was done.

The recommendations and suggest[illegible]ill be implemented and monitored for compliance at Loretto Hospital.



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