FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY-NORTHWEST REGION
REPORT 09-080-9006
KATHERINE SHAW BETHEA HOSPITAL

Case Summary: the Authority found no evidence to support the complaint that the patient was handled roughly or that staff were rude, but substantiated process issues regarding the care provided. The public record follows; the facility's response is not part of the public record.

INTRODUCTION

The Human Rights Authority opened an investigation at Katherine Shaw Bethea Hospital (KSB) after receiving complaints of possible rights violations in the care of a mental health recipient within the facility's emergency and behavioral health departments. It was alleged that the patient was handled roughly during transfers, restrained without adequate cause, treated without consent and adequate cause and that nursing staff were rude and unhelpful. Substantiated findings would violate rights protected by the Mental Health and Developmental Disabilities Code (405 ILCS 5).

KSB provides comprehensive healthcare from various clinic locations in Lee and Ogle Counties; the 80-bed acute care hospital in Dixon is its main hub. We visited the facility where the matter was discussed with representatives from administration and both departments in question. Relevant policies were reviewed as were sections of the patient's medical record with her written authorization.

COMPLAINT SUMMARY

According to the allegations, the patient entered the hospital's emergency department on an ambulance stretcher and explained to nurses that she had recent knee surgery and could not easily transfer to an exam table. The nurses reportedly ignored her concerns, told her she was not cooperating and had four men grab the corners of her sheet and move her onto a table where she was put into "leg shackles". It was stated that the patient was not combative, and although she begged nurses to keep needles away from her, they proceeded to insert an I.V. anyway saying it was protocol in case doctors wanted to give medications. And, regardless of her numerous pleas that followed, the I.V. remained in until she was transferred to the psychiatry unit. The complaint concluded by saying that at some point on the psychiatry unit the patient asked another nurse for a blanket and was reportedly told to get it for herself; asked a second time, the nurse allegedly "tossed" one at her.

FINDINGS

Interviews:

Staff members whom we interviewed recalled the events differently and said they were careful with the patient and her knee. An emergency department nurse who was there explained that an ambulance team called to report that the patient was on her way in and that she was combative after having a family dispute. The patient arrived on a stretcher and in handcuffs soon after but she was kicking her legs around and it took numerous people including emergency, ambulance and law enforcement personnel to get her onto a cart. At no time did she complain of knee or leg pain or how the team handled her transfers. She said that the patient kept rambling, constantly trying to negotiate in the meantime. She proceeded to kick and push while refusing the I.V. and medications and made it clear that she was not taking anything, even after a physician tried to reason with her. Another nurse who was also present at the time agreed with the account, and both said that the patient was in obvious distress and needed to calm down. As her ankles were restrained the police and the ambulance team held her arms and shoulders down in order to get an I.V. and medications started. They said it took just a few minutes for her to relax and that once she did there were still no complaints of leg pain or careless handling during her time in the emergency department.

We met with the ambulance team as well in a separate interview. They reported that at the hospital they put a blanket over the patient's hands since they were cuffed and then took her on a cot to a room in the emergency department. The police removed the cuffs, and with the help of hospital staff the team transferred her to a bed by rolling up a blanket beneath her and lifting her over. Her care was turned over to a nurse at that time, but they stayed for a while as one of them held her hand until an I.V. was in place. There were no complaints of pain or mishandling.

We also talked with a nurse and an administrator from the psychiatry unit where the patient made her way after being medically cleared. They acknowledged via the record that the patient had special orders for knee care but neither recalled any troubling incidents in that regard. The nurse did not remember the patient at all and the administrator said that she heard of no complaints about her staff being rude or unhelpful while the patient was in the hospital.

Record Review:

Emergency Department records showed that the patient arrived with police escort at about 11 a.m. on June 18th for being combative and threatening suicide; it was noted that she had knee surgery a few weeks earlier. Nurses' notes stated that the patient was there with emergency personnel in addition to state and county police and that she had been combative en route to the hospital and on arrival. She was subsequently placed in restraints, but only on her ankles. She was given medication once an I.V. was in place and then again a short while later although by injection. A corresponding medication chart listed three doses of either Ativan or Haldol given between 11:08 and 11:30. An emergency physician's record indicated that the patient was

examined almost immediately. Complaints of depression and suicide were listed as moderate to severe and she was found to be angry, frustrated, agitated, hostile and paranoid although normally oriented without confusion or hallucination. There were no problems cited from the physical exam and no labs or others tests were carried out per the charting. The physician recommended admission, and nursing notes rounded out the emergency department's treatment by stating that the patient was now calm and cooperative. Her ankle restraints were removed as she was turned over to staff from the behavioral health program, the time at which was not noted.

Although a physician signed the emergency department record, there was no specific restraint order citing the need and length of time to restrain, no restraint flowsheet or other type of documented observation and restraint safety check, and no rights restriction notice for the restraints. There was no documented indication of having the patient's informed consent for the I.V. and the psychotropic medications although a general treatment consent form was signed by the patient's husband. There was also no documented reference to the patient having an opportunity to refuse the I.V. and medications or that she had no capacity to make treatment decisions, and, there was no rights restriction notice for the treatment.

The patient signed a voluntary admission application and a recipient rights information form at 12:32 p.m., an hour and a half after arriving. A corresponding entry from a psychiatric nurse stated that the restraints were removed at that time as the patient was transferred to the behavioral unit. Progress notes during her stay over the next two days reflected how special care and precautions were made for the leg, but there was nothing to suggest that the patient complained of being mistreated or that staff were rude and unhelpful. Regarding the alleged blanket incident specifically there was only one possible correlation in the record. A nurse wrote on the morning of the 20th that the patient was sitting in her chair with an ice pack on her knee. She asked for some flavored water and a blanket as she complained about not being able to keep the rules straight. The nurse wrote that the patient was "somewhat demanding with [a] sense of entitlement", but there was nothing to say that an exchange occurred or that the patient complained about the nurse being inappropriate.

CONCLUSION

KSB policy on treating the emotionally unstable in the emergency department states that appropriate measures will be taken to maintain the safety of the patient and staff at all times and that any immediate medical or surgical problems will be treated and stabilized (pg. 261). Hospital-wide restraint policies state that physical restraints may be used when needed to protect the patient from harming himself or others (pg. 1), and use for mental health patients specifically is outlined according to the requirements of the Mental Health Code (pp. 6-7). When considering the use of behavioral restraints, alternatives such as reorienting and calming approaches are to be attempted but deemed insufficient beforehand (pg. 7). Policy attachments include a restraint log that details the order, attempted alternatives, time, duration, physical assessments and 15-minute observations. According to informed consent policy, no treatment or procedure may commence without first obtaining informed consent of the patient or an appropriate surrogate for a patient who is unable to make or communicate an informed decision. The ordering physician is solely responsible for obtaining consent (p. 415). The physician shall

document a patient's refusal and reasons for refusing in the chart (pg. 420). The use of psychotropic medications is addressed in hospital policy, which also closely follows the Mental Health Code, and includes requirements to determine a patient's decisional capacity, to inform him of his right to refuse treatment and medications, to have the opportunity to refuse and be able to refuse unless it becomes necessary to prevent serious and imminent physical harm, and to notify a person of his choice should his right to refuse be restricted. A surrogate decision maker, other than a court-appointed guardian, may not consent to psychotropic medications. Attachments include a consent form that incorporates these rules (pp. 195-196). And finally, a policy on employee behavior calls for quality conduct that does not discredit the hospital or offends patients. Threatening or intimidating a patient constitutes grounds for termination (pp. 98-99).

Under the Mental Health Code, all recipients enjoy the right to adequate and humane care and freedom from abuse, which means any physical or mental injury inflicted by non-accidental means (405 ILCS 5/2-102 a, 5/2-112 and 5/1-101.1). Restraints may only be used as a therapeutic measure to prevent physical harm and upon written order that states the events leading up to the need for restraints, the purposes for them, the length of time they are to be used and clinical justification for that length of time. The person being restrained must be observed no less than every fifteen minutes and a record of the observations must be maintained. Whenever a recipient is restrained, a staff member shall remain with him at all times unless he is secluded, and he is to be afforded his right to have anyone of his choosing be notified (405 ILCS 5/2-108). In using psychotropic medications, a facility must first secure informed consent, based on shared written drug information and a physician's written determination that the recipient has the capacity to make a reasoned decision about the treatment; otherwise, the medications may only be given in an emergency in accordance with Section 5/2-107. Surrogate decision makers may not consent to the administration of psychotropic medications (405 ILCS 5/2-102 a-5). Recipients must be informed of the right to refuse medications and be given an opportunity to refuse them. When they are refused they may only be given to prevent serious and imminent physical harm and no less restrictive alternative is available (405 ILCS 5/2-107). A medical emergency exists when delay for the purpose of obtaining consent would endanger a recipient's life or substantially affect his health. If a physician determines that a recipient is not capable of giving informed consent then essential medical procedures may be performed without consent (405 ILCS 5/2-111). Whenever a guaranteed right under the Mental Health Code is restricted the facility must notify any person or agency the recipient chooses (405 ILCS 5/2-201).

The complaint alleged that the hospital handled this patient roughly during transfers, that she was restrained without adequate cause, treated without consent and adequate cause and that nursing staff were rude and unhelpful. In this case there is no supportive evidence whether by staff account or documentation that any of the staff were intentionally rough or harmful, rude or unhelpful; five people we interviewed including ambulance personnel agreed that she was handled appropriately. Although the patient's own recollection of her experience is not discredited, a rights violation for that part of the complaint is <u>not substantiated</u>.

On the restraint and treatment matters, KSB has the necessary Code-compliant policies in place but it seems they were not followed here, and, the documentation to justify restraints and forced treatment was not persuasive. Although the nurses said that the patient came in kicking

and that a physician tried to reason with her before being treated their charting is much less compelling. The record states only that she was combative and immediately restrained without explanation of the need to prevent physical harm, and there was no order citing the events leading up to the need and the purposes for the restraints, no indication of the length of time they were to be used, no documented checks for patient observation and safety and no accompanying rights restriction notice to further justify the restraints, all of which are violations of hospital policies and the Mental Health Code. Likewise, it seems by the emergency department record that administering Ativan and Haldol by I.V. was a reflex as opposed to a need to prevent serious and imminent physical harm. There was no documented indication that the patient was unable to make her own decisions or that there was an emergent medical need for the I.V. There was also no evidence from the record that she presented serious enough potential harm to warrant the forced treatment, that she was provided an opportunity to refuse, that less restrictive alternatives were considered or attempted prior, or that she was allowed to have anyone of her choice notified, which are also violations of hospital policies and the Mental Health Code. These parts of the complaint are substantiated.

We take this opportunity to say that KSB is already at work preventing similar circumstances. The hospital is developing a packet that will contain materials specific to mental health care issues so that nurses and physicians can refer to them quickly when needed. The packet will provide them with appropriate policies as well as education and consent forms, rights information, and restriction-related documents including those for restraint and treatment use.

RECOMMENDATIONS

1. Review behavioral restraint policies with all emergency department nurses and physicians and require them to use restraint logs, flow sheets and restriction notices (Restraint policies and 405 ILCS 5/2-108 and 5/2-201).
2. Instruct emergency department personnel to document the need to prevent serious and imminent physical harm by using accurate and descriptive language that clearly reflects events as they occur (405 ILCS 5/2-107 and 5/2-108).
3. Revise restraint logs and/or flow sheets that are attached to restraint policies, if they are to be used as orders, as they do not clearly provide space to list the specific events leading up to the need and the purposes for restraints 5/2-108.
4. Instruct all emergency department nurses and physicians to administer psychotropic medications without consent only to prevent serious and imminent physical harm, including when a patient lacks decisional capacity (405 ILCS 5/2-102 a-5 and 5/2-107).

SUGGESTIONS

1. KSB should engage emergency department personnel, local law enforcement and EMS teams to review the Mental Health Code's involuntary procedures.
2. Cover surrogate consent issues with emergency department personnel.
3. Consider revising the restraint policy. It states that in no event may restraints continue for longer than 1 hour unless it is determined in writing that they pose no undue risk (pg. 6, item B). This is a little stricter than the Mental Health Code which provides a 2-hour

limit (405 ILCS 5/2-108 a). Also, consider adding the requirement to have someone present at all times whenever a patient is restrained (405 ILCS 5/2-108 h).