FOR IMMEDIATE RELEASE

North Suburban Human Rights Authority
Report of Findings
Provena Mercy Center
HRA #09-100-9030

Case Summary: The HRA did not substantiate the allegations presented. The HRA's public record on this case is recorded below; the provider's response immediately follows the report.

Introduction

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Provena Mercy Center. In February 2009, the HRA notified Mercy Center of its intent to conduct an investigation, pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The following complaints were accepted for investigation:

1. A patient was made to sign admission papers even though she was too groggy to understand what she was signing.
2. A patient was given emergency medication without justification and without a physician's order.
3. A patient received a cold breakfast that was meant to be served hot; on one occasion she was not given lunch.
4. A patient was not allowed to review her clinical record.
5. After being found with contraband, a nurse lunged at a patient with such force it caused the patient's pajama top to be ripped open; the patient was subsequently made to remove all her clothing while the door to her bedroom was left open, exposing her to others on the unit. The patient was held down while a body cavity search was conducted; the patient was left bruised after the assault from the staff.
6. A patient's requests for medical attention were ignored.
7. A patient was over-medicated.

If found substantiated the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Hospital Licensing Standards (77 Ill. Admin.Code 250).

Background

According to its website, Provena Mercy Medical Center is a 356-bed hospital based in the western Chicago suburb of Aurora, Illinois. For more than 90 years, Provena Mercy Medical Center has been the area's leading provider of Behavioral Health Services. Those services include: Addiction, Attention Deficit Hyperactivity Disorder, adult, children/adolescent, and

older adult services. The focus of this investigation was the in-patient Behavioral Health program which has 70 beds and a nine-day average length of stay.

Investigative Methodology

The HRA conducted on-site visits in May and June 2009. At the visit in May, the HRA discussed the allegations with the Regional Director, the Risk Manager, the Unit Manager, a Registered Nurse and the Intake Manager. In June, the HRA interviewed two security officers and the Manager of the Security Department. The HRA requested and reviewed the entire clinical record of the adult whose rights were alleged violated, with written consent. Also reviewed were hospital policies specific to the allegations. The HRA acknowledges the full cooperation of all hospital personnel.

Allegation #1: A patient was made to sign admission papers even though she was too groggy to understand what she was signing.

Findings

The clinical record revealed data on a 44-year-old female patient who was admitted on November 18, 2008 from an area medical hospital at about 1:00 a.m. The admitting nursing note documented that the patient had been treated at the medical hospital for an apparent overdose on insulin and that she had written a 10-page suicide note. The note goes on to state that the patient was accompanied to the unit by her mother and that the patient was calm and cooperative; food and drink were offered and accepted. It was documented that the patient cooperated with the admission process with both the RN and the Intake Counselor. The Intake evaluation indicated her level of consciousness as "alert". She was noted to be very sleepy after the admission process and she retired to her bed without any problems.

The chart contained many admission forms: Application for Voluntary Admission (which showed that she was assessed and considered suitable for voluntary admission), Rights form, Consent to and Conditions for Treatment, Restraints and Seclusion, Release of Responsibility for Possessions, etc. that were signed by the patient at the time of admission.

At the site visit, the HRA was advised that triage and intake are done centrally and then the patient is brought to the applicable unit. At times when additional intake personnel are needed, the hospital contracts with an area community-based, not-for-profit organization that assesses the patient for disposition. In cases where intake is performed during the night when a patient may be groggy, it was stated that there is frequently a follow-up with the patient the next day to make sure that everything that was signed and explained during the intake process was understood. Intake training is a “hands on” experience that lasts approximately one month. In this case, the initial triage was done at a nearby medical hospital. The patient was subsequently taken to Mercy, where she was cooperative and signed in voluntarily.

The hospital's Admission of an Adult policy includes the admission process as mandated by the Mental Health Code; it does not say what to do if a patient seems too tired to understand what is going on.

Conclusion

Pursuant to the Mental Health and Developmental Disabilities Code Section, Section 3-400 "Any person 16 or older may be admitted to a mental health facility as a voluntary recipient for treatment of a mental illness upon the filing of an application with the facility director of the facility if the facility director deems such person clinically suitable for admission as a voluntary recipient."

The HRA does not dispute the assertion that the patient was too sleepy to understand what she was signing; yet the information found does not support the claim; the allegation is unsubstantiated.

Allegation #2: A patient was given emergency medication without justification and without a physician's order.

Findings

A review of the clinical record showed that the patient's room was noted to be smelling strongly of cigarette smoke. The patient refused to give up the lighter and cigarettes; she became combative and threatening so security was called for assistance with a body and room search. Subsequent the search, it was documented that the patient became more agitated and took off all her clothes and threw them at staff. Nursing notes documented that the Physician was called for orders which were received; she was given an injection of Geodon (antipsychotic agent used for acute manic and mixed episodes associated with bipolar disorder). The chart contained a physician's order for the single administration of the medication. Charting did not indicate whether the patient was given an opportunity to refuse the medication or that no less restrictive alternatives were tried; at the time of admission when asked about an emergency preference, the patient gave no response. It was noted that a restriction of rights notice was not located in the chart.

At the site visit, hospital personnel explained that emergency medications are administered if a staff member perceives that the patient may be harmful to himself or others. If a patient refuses and is still given medication, a Restriction of Rights form is completed.

The hospital's Consent for Medication Administration policy states that its purpose is to provide notification and achieve consent when psychiatric medications are ordered for patients in Behavioral Health Services. The policy states that "In the case of a patient able to give informed consent, a Restriction of Rights will be provided to the patient when a PRN medication has to be administered in an emergency and the physician has not previously notified the patient/legal guardian, or if the patient refuses a PRN medication which is deemed necessary if the patient is harmful to self or others."

Conclusion

Pursuant to the Mental Health Code, Section 2-107, "An adult patient of services or the patient's guardian, if the patient is under guardianship, and the patient's substitute decision maker, if any, must be informed of the patient's right to refuse medication. The patient and the patient'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. If such services are refused, they shall not be given unless such services are necessary to prevent the patient from causing serious and imminent physical harm to the patient or others and no less restrictive alternative is available." Section 2-200 of the Code states that "Upon commencement of services, or as soon thereafter as the condition of the recipient permits, the facility shall advise the recipient as to the circumstances under which the law permits the use of emergency forced medication… At the same time, the facility shall inquire of the recipient which form of intervention the recipient would prefer if any of these circumstances should arise. The recipient's preference shall be noted in the recipient's record and communicated by the facility to the recipient's guardian or substitute decision maker, if any, and any other individual designated by the recipient. If any such circumstances subsequently do arise, the facility shall give due consideration to the preferences of the recipient regarding which form of intervention to

use as communicated to the facility by the recipient or as stated in the recipient's advance directive." Section 2-201 of the Code states that "Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction…."

Based on the information received, it is concluded that the patient was given emergency medication with cause and the chart contained a physician's order for the medication; the allegation is unsubstantiated.

However, the HRA takes this opportunity to offer the following suggestions/reminders:

Suggestions:

- Hospital personnel must ensure that documentation supports the need for emergency medication as mandated by the Mental Health Code, in that the patient must be given the opportunity to refuse the medication, and if refused, only given to prevent serious and imminent physical harm to the patient and/or others and no less restrictive alternative is available.
- The hospital must ensure that when rights are restricted, that a Restriction of Rights Notice is completed and ensure that the patient is given the opportunity to have some one notified of the restriction.
- The hospital should revisit its Consent for Medication policy to ensure Code-compliance in that every adult, regardless of consent ability, has the right to refuse medication and to be given a restriction of rights notice with the opportunity to have some one notified of the restriction.

Allegation #3: A patient received a cold breakfast that was meant to be served hot; on one occasion she was not given lunch.

Findings

On the first day on the unit, progress notes indicated that the patient refused breakfast, lunch and she ate a dinner that was brought in by family. The next day progress notes documented that she was eating very minimal amounts and that she refused lunch. The following day progress notes documented that she refused breakfast. It is noted on the Main Standard Audit (a computerized assessment checklist) that the patient ate 100% of her meals on the 19th.

At the site visit, it was stated that there are microwaves on each unit if the food gets cold. If a patient refused a meal, the tray would probably be taken back to the kitchen with the cart. However, a patient always has the right to change his/her mind after refusing food. Should this occur, the Dietary Department can be called to have another tray sent to the unit. In addition, the unit has snacks (apples, crackers) that can be accessed during the day.

Conclusion

Pursuant to the Mental Health Code, Section 2-102, "A patient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan." The Hospital Licensing Standards (77 IL Adm. Code 250.1650) states that regarding meals, " To the extent medically possible, a minimum of three or their equivalent, shall be served daily, at regular hours with no more than a 14 hour span between a substantial evening meal and breakfast."

Based on the information obtained, it is concluded that rights were not violated.

Allegation #4: A patient was not allowed to review her clinical record.

Findings

There was nothing in the clinical record which indicated that the patient was allowed or not allowed to review her chart.

At the site visit, it was stated that patients always have the option to review their chart. If such a request were made it would be in the chart. In order to get a copy of the chart, patients must wait until discharge when the chart is complete.

The hospital's Request for Medical Record Review by Patient policy states that every patient of services has the right to review his or her medical record upon request.

Conclusion

Pursuant to the Mental Health and Developmental Disabilities Confidentiality Act, Section 4, "The following persons shall be entitled, upon request, to inspect and copy a patient's record or any part thereof: (1) the parent or guardian of a patient who is under 12 years of age; (2) the patient if he is 12 years of age or older…"

The HRA does not discount the assertion that the patient was not allowed to read her clinical record; yet the information found does not support the claim; the allegation is unsubstantiated.

The HRA takes this opportunity to remind the hospital that not only does the recipient have the right to review his/her chart upon request, that request extends to the right to have it copied upon request.

Allegation #5: After being found with contraband, a nurse lunged at a patient with such force it caused the patient's pajama top to be ripped open; the patient was subsequently made to remove all her clothing while the door to her bedroom was left open, exposing her to others on the unit, the patient was held down while a body cavity search was conducted, the patient was left bruised after the assault from the staff.

Findings

According to progress note documentation, on November 20th after midnight, the patient was noted to be awake and restless and complaining that she was unable to smoke. At 1:30 a.m., progress notes documented that the patient's room was noted to be smelling strongly of cigarette smoke. The patient refused to give up the lighter and cigarettes; she became combative and threatening so security was called for assistance with a body and room search. The note goes on to say that a "lighter was found at her waist and down her leg. One cigarette was wrapped in paper towel and tucked into her labia. A straightened paper clip was inserted into a bar of soap and hidden under her pillow…Patient became more agitated and took off all her clothes and threw them at staff." A physician was called for orders and received. The patient was medicated intramuscularly. She was discharged the following day.

At the site visit, the RN involved in the above incident recalled that smoke was detected in the patient's room. She stated that she called the physician and got permission to conduct a room and body search. The HRA notes that there are no orders for the room or body search. The RN went on to say that she conducted the search in the presence of two female staff members and two male security personnel. The patient was angry, agitated, and kicking out at the nurse. The nurse recalled that she sat the patient down on the bed and began patting her (patient's hospital gowns remained on) in a search for smoking contraband. During the pat-down, the nurse stated that she felt a lighter lodged in the back of patient's knee. The nurse stated that she pulled-out the waist band of the pants to search, as well as pulling-out the collar of the top to

search. While searching the patient's body, the nurse stated that she saw tissue between the patient's legs. The nurse removed the tissue without touching the patient. A cigarette was found wrapped in the tissue. The patient then tore off her own clothes saying something like - “You want to see? Look.” The nurse stated that she did not rip the patient's gown. When the nurse was asked, if on reflection she would have done anything differently in conducting the body search, she said no. She did say that a body cavity search was not done, and that cavity searches are not done at the hospital as a matter of policy.

The chart contained a Clothing and Possession Search Notification form signed by the patient which documented the patient's acknowledgement that in order to maintain a safe environment, possession and clothes will be searched for sharps, drugs, matches and other forms of contraband at the time of admission and/or when the patient returns to the hospital after a temporary release/pass.

In discussing this allegation with two of the three security officers that were present during the search, it was explained that they were called to the unit as stand-by assistance for a room and body search. When the patient refused to willingly give the nurse the suspected contraband and became combative, the officers then assisted in securing her to the bed by physical hold. It was explained that each officer held an arm while someone else controlled her legs. One officer said that the patient threatened to poke out their eyes with the bar of soap.

Hospital personnel told the HRA that Mercy Center security personnel are all male. This unit is a chronic unit and it is not uncommon for security personnel to be involved in such incidences. Staff safety is a concern for the hospital. In the past, patients frequently received contraband from visitors, and it had become an issue of serious concern. It was during the time of this patient's hospitalization that contraband on the unit became a problem. Since then, Mercy Center has experienced a significant decrease in visitor-delivered contraband because of new procedures for visitor education and visitor searches.

At the site visit, the HRA was told that after the incident identified above, and the subsequent allegations filed with the HRA led Mercy Center to conduct a Root Cause Analysis (RCA). The RCA (which the HRA was given a copy of) focused on training staff to conduct patient searches with dignity, conducting searches in a private room, using draping with patients, and having searches conducted by a member of the same sex, and if not possible having at least two persons present.

The hospital's Contraband Search/Removal policy states that when "contraband is suspected, a staff member may detain an inpatient and request that the patient submit to a possession search in order to remove an object that is potentially harmful to themselves or others. This search shall be done in a private room with two same gender staff members present, the patient shall be handed a gown to wear, for privacy, during the possession search."

Conclusion

Pursuant to the Mental Health and Developmental Disabilities Code, Section 2-102, "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan." Section 2-112 states that "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect." Section 2-104 states that "Possession and use of certain classes of property may be restricted by the facility director when necessary to protect the recipient or others from harm, provided that notice of such restriction shall be given to all recipients upon admission. The professional responsible for overseeing the implementation of a recipient's

services plan may, with the approval of the facility director, restrict the right to property when necessary to protect such recipient or others from harm."

The HRA found no evidence to substantiate the allegation that a nurse lunged at a patient with such force it caused the patient's pajama top to be ripped open or that the patient was subsequently made to remove all her clothing while the door to her bedroom was left open, exposing her to others on the unit. The patient was held down while a body search - not body cavity search - was conducted; however the search was needed to protect the patient from herself and others. There was nothing found to support the claim that the patient was left bruised after the assault from the staff. The allegation is unsubstantiated.

Comment

Curiously, the body search of the patient and the finding of a lighter on her person were not brought to the attention of the unit manager for a number of days after the incident occurred. Also found during the search was a bar of soap with a straightened paper clip coming out of the soap. This did not seem to raise any serious concern with the people met with during the first site visit. The RN even commented that no one spoke to the patient about that bar of soap. It is suggested that hospital management revisit this incident to see if appropriate measures were taken regarding management notification and patient safety. It is also suggested that hospital management revisit its Clothing and Possession Search Notification form to include that this might occur when contraband is suspected.

Allegation #6: A patient's requests for medical attention (yeast infection) were ignored.

Findings

According to the record, the patient complained of discomfort from a yeast infection and treatment was given (medication, external cream). When asked, she would report that she was not in any pain or discomfort and she was cooperative with vitals and Accucheck.

At the site visit, hospital personnel relayed that medical concerns would be addressed.

Conclusion

Pursuant to the Mental Health and Developmental Disabilities Code, Section 2-102, "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan." Section 2-112 of the Code states that "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect."

The findings do not support the claim; the allegation is unsubstantiated.

Allegation #7: A patient was over-medicated.

Findings

A review of the record showed that medications for both medical and mental health symptoms were ordered for the patient. For the most part, she refused the medications. She did accept Tylenol and small units of insulin.

Conclusion

Pursuant to the Mental Health and Developmental Disabilities Code, Section 2-102, "A patient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan." Section 2-112 of the Code states that "Every patient of services in a mental health or developmental disability facility shall be free from abuse and neglect." Section 2-107 of the Code states that "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 findings do not support the claim; the allegation is unsubstantiated.

RESPONSE

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

James D. Witt, FACHE, RN
President & CEO

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Aurora, IL 60506-1449
630 801-2616 Tel
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PROVENA
Mercy Medical Center

September 10, 2009

Via Federal Express

Mr. Dan Haligas
Chairperson
Guardianship & Advocacy Commission
North Suburban Regional Human Rights Authority
9511 Harrison Street, W-300
Des Plaines, IL 60016-1565

Re: HRA #09-100-9030

Dear Mr. Haligas,

Thank you for the report on the above-captioned case. I understand that the seven (7) allegations made by the patient have been found to be unsubstantiated, and the patient's rights were not violated.

I appreciate the suggestions you have made regarding documentation, restrictions of patient's rights, and the medication consent policy. These issues have been reviewed with staff, and our medication consent policy has been revised.

Once again, thank you for your response and feedback.

Sincerely,

James D. Witt, FACHE, RN
President & CEO

cc: D. McLaughlin, Director of Behavioral Health Services

LETTER FOR -

To: Governor, Legislatures, such as Senators, Congressman, and State Representatives of Illinois.

Also: The Congress of United States Who Made These Legal Services Prohibited.

Legislatures,

My name is Patrick C. Thornton #K66127 Incarcerated at Western Corr Center, Mt Sterling, Ill 62353.

I was writing a Legal Service to get help for a Situation that I have an Injury, while I'm Incarcerated, and have been Refused Medical Attention with the Reason There's Nothing Wrong. I have been here 17 Months To Date. I'm told that I must exhaust all remedies through Grievances, etc. Only to Rely on the same Persons, (Institution, Doctors Hired By Institution to Put my Health In Danger).

I've written everyone I have information from, and Legal Services to help me since I don't have money to even Legal through a Court Process to Resolve This!

(2) of 2

This is where I surprisingly found out that My Constitution Rights aren't to be used because I found the Reason that these Institutions Believe They Can Do what They Want is because of Grants Prohibited by the Congress (Letter dated 6/29/09 makes it Unable to even get Help Legally With Matters Of Concern such as Medical Attention to be Addressed.

By Prohibiting A Incarcerated Individual Assistance it creates a Gap. This gap is that by Prohibiting Access, makes an Infringement of Access to Equal Justice by these Restrictions.

Since Prisoners have limited Access to Law Firms, especially successful ones these Legal Services are an Intricate Part of the Checks and Balances of the Justice System.

This is just a Rough Draft of the Letter I intend to put Together; and I believe that Constitutional Rights are Governed By the Individuals who Get this Letter. Correctional Law Projects and Legal Assistance are Necessary. "Will Soon Become Too Expensive To REPRESENT —REPRESENT

Legal Services for Prisoners with Children

PATRICK C. THORNTON
K66127
WESTERN CORR CENTER
2500 RT. 99 SOUTH
MT. STERLING, IL 62353

L.S.P.C.,

I need help with my situation. I will send copies of letters sent to me by my 16 yr. old son, which distress me to say the least. The help I need is "how do I protect my son when I'm incarcerated.

I have written the Judge that gave custody to my Ex-Wife. But, I'm sure you see with the words of my son; she is doing a miserable job to say the least.

I am Married again and I had Jerome Lewis as my lawyer when I got my son to have Residence with me for the second time. The removal of my son from my house, where my other son and his Mother reside; I was told was illegal. And now I know something should be done; but I don't know how to proceed, since I can't get an answer from Judge.

When he was Residing on my house, he was going to school, was being taken care of, and he was happy!

Now, if you look also at his Internet Paper he is Running Wild and Mad at the World.

Well, if he's mad at me, it would be odd, since I talked to him on phone, about a year ago or more and he was Glad to hear from me.

But, if he hates me I wouldn't still not want him to be safe!

Please, let me know what's going on; the way I can find out how to Protect Him!

I would hope I can go to Court, please if this is possible let me know how.

Thank You,
Patrick C. Thornton