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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 10-030-9009
Kindred Hospital

Case summary: The HRA did not substantiate that the hospital did not follow Mental Health Code guidelines when it restrained a recipient.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Kindred Hospital. It was alleged that the hospital did not follow Mental Health Code procedures when it restrained a recipient. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Kindred is a long-term acute care hospital in Chicago which houses a 30-bed behavioral health unit.

To review this complaint, the HRA conducted a site visit and interviewed the Director of Risk Management and the Unit Manager. The HRA obtained the recipient's record with written consent. The recipient is an adult who maintains her legal rights.

COMPLAINT SUMMARY

The complaint indicates that the recipient went to the ladies' bathroom where someone had made a mess. The recipient then approached the nurses' station to request that the housekeeping department be notified. A confrontation allegedly occurred between the recipient and staff and two staff persons grabbed the recipient's arms and carried her to the quiet room. The recipient shouted that she wanted to speak with someone, however she was ignored and then as a means of getting attention, she tore the metal frame off of the window in the door. She was then removed from the quiet room and placed in restraints. One staff member reportedly put his arm and hand on the recipient's neck, causing her to believe that he was going to choke her. Another staff person reportedly used his leg to hold her arm down. The complaint was accompanied by photographs of what appeared to be the recipient's bruised arms, legs and wrist.

FINDINGS

The record shows that the recipient was petitioned for involuntary admission on 9/18/09 at 4:00 p.m. The section describing signs and symptoms of mental illness states, "Patient states she will harm herself or others. Patient is depressed and anxious. Has a history of self abuse/injury. Patient did indicate she 'cuts' herself to relieve stress." On the same day at 8:10 p.m. the recipient signed a voluntary application along with Rights documentation and the appropriate admission paperwork, and was then admitted to the behavioral health unit.

The Nursing Admission Assessment, completed on 9/18/09 at 9:00 p.m. states that the recipient had a scar on her left arm from "self-inflicted scratches" as well as self-inflicted burn scars on her leg from a butane lighter. There is no indication of bruising.

The first entry in the progress notes regarding a restraint episode is made at 5:45 p.m. on 9/19/09. The nursing note states, "Pt. has been placed in 4 pt. restraints after destroying a piece of window frame in the quiet room and refusing to comply with staff. She is verbally abusive and refused to sit down on bed when asked. Vital signs are stable. No distress noted." This entry is followed by a prn (as needed) medication stamp indicating that the recipient was given an IM (intramuscular) injection of Ativan 2 mg for "Agitation" at the same time and staff confirmed the injection was forced. The patient response to the medication is "increased agitation."

The Restraint and Seclusion Order offered the following justification for the restraint order: "Patient exhibited behavior potentially harmful to self although intent to harm may not be present." The description of the patient's behavior states, "Pt. tore a piece of door/window frame off while in quiet room- verbally threatened staff- refused to sit down." The order is given for 6 hours and indicates that it poses no undue risk to the patient's health and that the recipient will be examined by the physician within one hour of the restraint application. The physician certified that the recipient was examined within one hour. Additionally, the restraint observation record contains 15-minute checks of the recipient's condition.

The record contains a Restriction of Rights Notice for the restraint, seclusion and "other" meaning medication episode (as explained by staff). The stated reason is: "Pt. tore a piece of door/window frame in quiet room (exposing metal) verbally threatened staff. Refused to sit down, did not process for safety with staff." The restriction notice indicates that the recipient did not want anyone notified. The record does not contain a separate document for preferences for emergency treatment, however the Nursing Assessment contains a Psych./Spiritual/Cultural section in which the recipient indicated that her mechanism for coping with stressful situations is, "I like to crawl underneath my mattress."

The next entry in the notes is made by the nurse at 6:45 p.m. and states, "Pt. remains in restraints. She is irritable and refusing liquids offered. Vital signs are stable…no distress noted." At 7:15 p.m. another nurse's note states, "Pt. in restraints. She is complaining of pain in the left wrist. No swelling observed. Movement of fingers on left hand is good."

The next entry, made at 7:30 p.m. is made by the house physician and states, "Called by RN re: Pt. agitated and punched her hand in a window. Needed to be restrained. Pt. seen and examined. Complains of mild pain in right hand and arm…Ext [extremities]: R arm full ROM

[range of motion]. R hand full range of motion. R lateral hand 5th metacarpal tenderness (mild) to palpation. No bruises or open wounds no swelling no weakness…."

There is an electronic Change of Condition document in the record that was made at 7:36 p.m. that is written by the RN on duty at the time of the incident. In addition to the notation of vital signs and notification of the physician, it offers the following description of the episode: "Comment: pt. became agitated and verbally abusive to staff. Called him a nigger and struck window with hand. pt. was asked to go to quiet room. pt. given im shot 2 mg of ativan. was cooperative. Shortly afterwards pt was checked and it was noted that pt had ripped a piece of window frame off door. When questioned, pt became verbally abusive and threatening staff. pt. then placed in full 4 pt. restraints and was very combative. pt. stated right wrist was injured. This wrist was examined and no swelling or redness noted. Able to move all fingers and wrist but c/o [complained of] pain on movement. Tylenol offered but refused."

At 10:00 p.m. a nursing note describes the continued restraint: Pt. remains in restraints, continues to be hostile, irritable in mood. Vital signs stable. Has been examined by house physician and Tylenol order as given for R wrist pain." There is another stamp for prn medication (Ativan 2 mg IM) given at this time. The reason given is "agitated", and the patient response is listed as "less agitated".

At 11:00 p.m. the nursing note documents the end of the restraint episode: "pt. has contracted for safety and agreed to behave more civilly. She is alert and vital signs are normal. R wrist has some redness but no swelling. R fingers are moving well. Restraints are removed and pt. will be watched 1:1."

On 9/21/09 the progress notes contain an entry by the RN which states. "Pt. approached this staff and stated 'I would like to talk to the director of psych.' Explained Dir. Of Psych not available at this time and this staff would be available to assist. Stated 'I have a complaint on a couple staff and I am leaving today. I want to file a complaint.' Investigation initiated and pt. to file written complaint. Pt. would not explain to this staff but insisting on writing a written complaint." At 9:40 a.m. the RN added another entry which states, "This staff notified pt. to fill out written complaint. Per pt. 'I don't need to fill out the written complaint cause I already wrote it out on a piece of paper and handed it to the gentleman from IDPH (Illinois Department of Public Health).' Pt. was also asked if she had her x-ray done. Pt. 'I don't need it. I could get it done from my own doctor- I just want to go home.' "

The recipient was discharged on 9/21/09 at 10:00 a.m. with Tylenol given for pain to her right wrist.

Staff were interviewed about the restraint episode. They stated that the recipient went to the window area of the nurses' station to complain about a mess in the bathroom, and when she did not get the response she wanted, began to beat on the glass for attention. At the same time she was screaming obscenities. She was asked to quiet down or she would be sent to the quiet room. She continued to escalate, beating on the glass, until staff removed her to the quiet room where she continued to be loud and threatening, and at this time she was given the injection of medication. When she removed a piece of the frame of the window in the door, which could be

construed as a weapon, staff intervened and placed her in another room in restraints. Staff stated that the recipient is a large female and very strong and that she fought the restraints, and possibly could have been bruised at this time, however she had also been beating on the window of the nurses' station and this could also have caused her wrist pain. Staff confirmed that only those staff who have been officially trained in non-aggressive restraint are able to administer it and that they are given competency reassessment annually. Staff also stated that although the recipient's wrist had shown some redness, they did not observe any bruising or injury from the restraint.

Staff reported that the recipient wrote a letter of complaint about two staff persons the day before she was discharged. The staff persons involved in the incident were suspended three days while the internal investigation was completed by the Unit Manager and the Risk Manager. The recipient was then mailed a copy of the investigation resolution. The incident was also reported to the Illinois Department of Public Health (IDPH) by the recipient and by the Human Rights Authority and IDPH interviewed the recipient and the staff persons involved. They did not substantiate the allegations.

STATUTORY BASIS

Restraint is a therapeutic tool that the Mental Health Code carefully regulates. Although its use is to prevent physical harm, the Code outlines specific measures to ensure that it is safe 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….

(i) A recipient who is restrained may only be secluded at the same time pursuant to an explicit written authorization as provided in Section 2-109 of this Code. Whenever a recipient is restrained, a member of the facility shall remain with the recipient at all times unless the recipient has been secluded. A recipient who is restrained and secluded shall be observed by a qualified person as often as is clinically appropriate but in no event less than every 15 minutes.

(j) Whenever restraint is used, the recipient shall be advised of his right, pursuant to Sections 2-200 and 2-201 of this Code, to have any person of his choosing, including the Guardianship and Advocacy Commission or the agency designated pursuant to the Protection and Advocacy for Developmentally Disabled Persons Act notified of the restraint. A recipient who is under guardianship may request that any person of his choosing be notified of the restraint whether or not the guardian approves of the notice. Whenever the Guardianship and Advocacy Commission is notified that a recipient has been restrained, it shall contact that recipient to determine the circumstances of the restraint and whether further action is warranted" (405 ILCS 5/2-108).

The Mental Health Code mandates that facilities shall consider the views of the recipient in the services that are provided to them and states that "The recipient's preferences regarding emergency interventions shall be noted in the recipient's treatment plan (405 ILCS 5/2-102 a).

HOSPITAL POLICY

Kindred Hospital policy (H-PC 05-010) for restraint comports with all the requirements for restraint as detailed in the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-108). Additionally it states that the facility supports the patient's right to be free from restraints or seclusion and that the hospital utilizes the "Restraint Freedom" program to "systematically assess each patient's health and mental status, including the potential for restraint use, and uses interventions to prevent the use of restraints and eliminate their use at the earliest possible time." The policy also indicates that restraints are used only while an unsafe situation exists, and that once the unsafe condition ends, the use of restraints should be discontinued.

CONCLUSION

The restraint episode investigated herein was initiated because the recipient, who had been placed in a quiet room for hitting the nurses' station window, escalated to the point of tearing off a metal portion of the window, and this was judged by staff to be a threat of imminent physical danger. It is not possible to determine that she was injured as a result of this procedure, however the record shows she was examined by a physician and nurses who did not find any injuries and she was offered medication, which she refused. Additionally, the record indicates that the hospital staff followed all the Mental Health Code requirements for restraint and also initiated their own investigation of the incident.

The HRA does not substantiate the complaint that Kindred Hospital did not follow Mental Health Code procedures when it restrained a recipient.

SUGGESTIONS

1. Kindred should ensure that all treatment plans indicate whether a patient has designated an emergency intervention preference and that all preferences are considered for use as required by the Mental Health Code (405 ILCS 5/2-200 d and 5/2-102 a).

2. Train staff to indicate "medication" if it is added to other restrictions on a Notice of Rights Restrictions form as all rights under Chapter II of the Code that are restricted must be supported with proper notice (405 ILCS 5/2-201).