FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
PALOS COMMUNITY HOSPITAL— 10-040-9010
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary— The Authority made corrective recommendations regarding all three allegations that were accepted by the service provider. The public record on this case is recorded below; the provider's response immediately follows the report.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA), the investigative division of the Illinois Guardianship & Advocacy Commission has completed its investigation into allegations concerning Palos Community Hospital. This general hospital located in Palos Heights has a behavioral health unit with 38 beds. According to the complaint, the Emergency Department staff failed to follow the Mental Health Code in detaining, restraining and treating a recipient. If substantiated, these allegations would violate the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.).

METHODOLOGY

To pursue the investigation, the complaint was discussed with the hospital's Counsel, the Assistant Vice President of Nursing, three Emergency Department Physicians, the Manager of Nursing, a Registered Nurse and a Certified Nursing Assistant. The recipient's record was reviewed with written consent. Relevant hospital policies were also reviewed.

COMPLAINT STATEMENT

The recipient was transported to the hospital's Emergency Department from a local jail after having an episode of laryngospasm and loss of consciousness. Laryngospasm is a vocal cord dysfunction which temporarily interrupts a person's ability to breathe. She was allegedly placed in restraints for an excessive period of time without justification and in contraindication to her many medical problems such as severe asthma with Laryngospasm. She reportedly has severe asthma; she suffers from flashbacks and becomes increasingly terrified when forced to lie on her back. The complaint alleged that psychotropic medications were administered which caused increased breathing problems and prolonged confusion. Additionally, it was reported that the recipient was overmedicated.

Information from record, interviews and program policies

The hospital's Emergency Department Record documented that the recipient was in handcuffs upon her arrival on October 21st, 2009 around 4:14 p.m. It was recorded that paramedics had been called to a local jail because the recipient was acting irrationally and breathing fast. She refused to talk to the paramedics and became combative. She was restrained and transported to the hospital for a psychiatric evaluation. A form indicated that the recipient gave verbal consent for general treatment, but she refused to sign the form. At triage, the recipient was described as agitated, paranoid, yelling and grabbing at the hospital's staff. She accused them of trying to strangle her and was unable to follow simple commands.

According to the record, three physicians were involved at some level in the recipient's care, and she was diagnosed with Acute Psychosis. Her medical history included Supraventricular Tachycardia, which produces a rapid heart beat. A Physician Report, dictated on October 21st and written by the clinician who provided the most care, documented that the recipient was uncooperative, screaming and threatening others upon her arrival. There were many law enforcement officers at her bedside because she was under arrest. She accused everyone around her of hurting her, but there was no one touching her. She was "immediately" placed in 4 point restraints because she continued to grab at the hospital staff when the handcuffs were removed. A chest restraint was also applied to keep her flat on the cart.

A Behavioral Management Restraint Observation Record or flow sheet corroborates that the restraint process was started at 4:19 p.m., and the recipient was in 5 point restraints at 4:30 p.m. The record contained a physician's order for restraints up to 4 fours because of unpredictable behavior. According to the order, restraints were warranted because of extreme paranoia, flight of ideas, yelling, inability to follow commands and trying to get off the cart. It was documented that alternatives such as verbal limits setting, offering choices, and directives were attempted prior to the use of restraints. The physician declared on the order that she examined the recipient at 5:25 p.m. and that the restraints did not pose undue risk in light of her medical condition. A notice, dated from the 21st to the 22nd, indicated that her right to be free of restraints, to refuse medication and medical services, to communication, and to retain personal property were restricted for 24 hours. There was no indication whether the recipient wanted someone to be notified of the restriction, but the form suggests that she was given a copy of the notice. The record does not indicate how the notice was delivered.

According to the flowsheet, the recipient was monitored while in restraints, and her behaviors were recorded every 15 minutes. A nurse wrote that the recipient screamed that she was claustrophobic and was having flashbacks after the restraints were applied. Also, she screamed "pour water on me … I do not want to be tied down… this is torture, and [I am] trying real hard." The nursing entry stated that the recipient was unable to calm down and to "negotiate" with the staff. Ativan 2 mg and Benadryl 50 mg Intramuscularly (IM) were given around 5:45 p.m., and the recipient stopped screaming about 30 minutes later. She was placed on an oxygen and pulse oximetry. Her saturations continued to remain at 99%, and she was resting.

The record states that at 6:45 p.m., the recipient was angry; she threatened a nurse and was pulling on the restraints. Whether she was threatening to inflict physical harm is unclear. She refused to use a bed pan or offer for a foley catheter. And, there was no indication that her

objections were overruled. The physician documented that the recipient was reassessed at 7:30 p.m. An order indicated that restraints were continued at 8:19 p.m. for up to 4 hours because of verbal aggression, yelling, profanity and attempting to make physical contact with the staff by using her upper body (chest). However, the restraint record and nursing notes documented that the recipient was sleeping from 7:00 p.m. to 10:00 p.m. and woke up screaming. She then threatened a nurse; she was rocking the cart and pulling on the restraints. The nurse attempted to massage the recipient's right leg because she complained of having pain but was unable to calm her in spite of redirections. At 10:30 p.m., Ativan 2 mg IM was administered for agitation. She was repositioned, and all restraints were readjusted. Her circulation, sensation and movement were checked hourly between 8:30 p.m. and 11:30 p.m. She refused offers for food, fluids and toileting at 11:15 p.m.

At 12:00 a.m. on the 22nd restraints were continued for up to 4 hours because the recipient was screaming and trying to hit the staff. The physician certified that the restraints did not pose undue risk to the recipient's medical condition upon a personal examination at the time. Her airway was reportedly open, respirations full and even, extremities were warm and pink, and she was able to move her hands and feet within limits of the restraints. According to the flow sheet, the recipient woke up screaming that she needed to get out of the restraints. She managed to get her right wrist out of the restraint about thirty minutes later. The hospital security was called to reinforce the cart to the floor and reposition the recipient in 5 point restraints. Ativan 2 mg and Benadryl 25 mg IM were administered at 12:30 a.m. A notice documented that all rights mentioned on the first notice were restricted on the 22nd at 12:00 a.m. for eight hours.

The recipient was mainly noted to be sleeping or calm between 1:15 a.m. and 2:00 a.m. She refused offers for food, fluids and toileting fifteen minutes later. Also, she was calm or sleeping from 2:30 a.m. to 3:30 a.m. She then was described as restless, screaming and anxious. An order reflected that restraints were continued at 4:00 a.m. for up to 4 fours because of yelling and rocking the cart. Ativan 1 mg and Benadryl 25 mg IM were administered ten minutes later. According to the flow sheet, the recipient was calm and sleeping from 4:45 a.m. until 6:00 a.m. She then exhibited anger and violent behavior. It was documented that the physician attempted to release the recipient from the restraints at 6:45 a.m., but she could not follow commands and was spitting water on the sitter minutes later.

A petition and a certificate for immediate involuntary hospitalization were completed on the 22nd at 7:00 a.m. and 7:30 a.m. respectively. According to the involuntary documents, the recipient was acutely psychotic, agitated, combative, paranoid, kicking, spitting water at others and trying to get out of the bed. She was reasonably expected to engage in dangerous conduct because of her mental illness. The physician did not affirm on the certificate that he advised the recipient of her rights prior to the examination for certification. The flow sheet showed that the recipient was sleeping between 7:45 a.m. and 8:15 a.m. and there was a shift change among the law enforcement officers at her bedside. A nurse wrote that the officers requested that the recipient should not be awakened. An order indicated that restraints were continued at 8:00 a.m. for up to 4 fours because of rocking the cart and spitting water at the staff. The physician documented that he examined the recipient and that the restraints did not pose undue risk to her medical condition at the time. A third notice stated that the recipient's rights to be free of

restraints, to refuse medication and medical services and to retain personal property were restricted on the 22nd at 8:00 a.m. for eight hours.

According to the restraint record, the recipient was mainly angry, anxious and crying from 8:30 a.m. to 10:00 a.m. She refused nourishment and toileting at the time. She was later described as angry, screaming, and banging her arms against the cart. Ativan 2 mg IM was administered at 11:00 a.m. An order indicated that restraints were continued at 12:00 p.m. for up to 4 fours because of yelling, rocking the cart, spitting and threats. Again, the physician documented that the recipient's respiratory status, circulation and mobility were good upon examination at 12:00 p.m. The space on the order where the prescribing clinician certifies whether the restraints pose an undue risk to the recipient in light of her medical condition was left blank. A notice mirrored that all rights mentioned on the third notice were restricted on the 22nd at 12:00 p.m. There was no end time found on the notice. Also, the HRA observed that the second, third and fourth notices indicated that the recipient did not want anyone to be notified of the restrictions, and a copy was given to her.

The flowsheet further referenced that the recipient refused nourishment and toileting at 12:45 p.m. Her right hand was released from the restraint fifteen minutes later, and all restraints were discontinued at 1:15 p.m. after having been in place for about 21 hours. She complained of having discomfort in her right wrist, and she was examined by a physician. Valium 5 mg and Baclofen 10 mg were given by mouth. An X-ray report showed no evidence of acute fracture or dislocation but additional films of her entire wrist for further evaluation were recommended. Shortly afterwards, the recipient was released to law enforcement personnel for transfer to the county jail mental health facility for further psychiatric evaluation upon a court order.

The complaint was discussed with the hospital staff during our site visit. According to the triage nurse, the recipient was verbally and physically aggressive upon her arrival to the Emergency Department. She was informed that she had been transported to the hospital for an evaluation. She refused to answer questions and was grabbing at the nurse's arms. She accused people of trying to hurt her and was more paranoid of men. She tried to calm down the recipient but was unsuccessful. The HRA pointed out that the petition that allows a recipient to be detained under Illinois law for a mental health evaluation was not completed until the 22nd. The staff said that the Emergency Department's nurses are responsible for completing petitions when appropriate. The triaged nurse reported that she is familiar with completing petitions. The Assistant Vice President of Nursing stated that there was some confusion about the need for a petition because the recipient was in police custody.

According to the primary Attending Physician and the triage nurse, restraints were needed because the recipient was grabbing at the staff. The physician reported that she tried to talk to the recipient, but she could not follow commands such as lying back on the cart. Medications were administered for combativeness and agitation. They were given to help relax the recipient and to get her out of the restraints. There was much discussion about the need to continue restraints at 8:19 p.m. because the flowsheet and nursing entries indicated that the recipient was sleeping from 7:00 p.m. to 10:00 p.m. According to the hospital staff, recipients are continually assessed by the physician to determine if the restraints can be removed. Recipients are told what behaviors they would need to exhibit for discontinuation of restraints.

A trial period or release is done for maybe 15 minutes or longer. According to the Manager of Nursing, the recipient's behavior of thrashing her chest at the staff could have been harmful to self and others. This behavior was recorded on the 21st at 8:19 p.m. The Assistant Vice President of Nursing said that releasing recipients from restraints while they are sleeping is not clinically sound practice.

According to the Certified Nursing Assistant (the sitter), who monitored the recipient on the 22nd from 1:45 a.m. to 7:00 a.m., law enforcement officers never left the recipient's bedside, and two hospital staff members were present most of the time. The recipient was extremely agitated and disruptive to the milieu. She continually tried to free herself from the restraints. She refused to use the bed pan when offered. She tried to bite the sitter and spit water in the staff person's face. On questioning, the sitter said that she did not specifically document the biting behavior in the record but recorded that the recipient was violent. Also, the sitter reported that the second physician told the recipient many times that the restraints would be removed if the recipient could assure her safety.

The second physician who authorized the restraints and medication around 4:00 a.m. and restraints at 8:00 a.m. said that he was asked to evaluate the recipient to see if she could have water. According to the record, the physician was at the recipient's bedside at 6:45 a.m. The physician explained that he usually tries to reason with a recipient before medication is given. The medication can take up to two hours for effectiveness. He told the recipient that the restraints might be removed if she could stop yelling and trying to get off the cart. On questioning, the physician said that the recipient would need to refrain from these behaviors for maybe one or two hours, but she was unable to do so. The third physician who signed the restraint order at 12:00 p.m. did not remember the recipient. He said that he must have believed that the restraints were needed based on information from the staff. He evaluated the recipient's right wrist because of abrasions. Her wrist was x-rayed, and a bandage was applied.

According to the Assistant Vice President of Nursing, de-escalation and verbal interventions training is a component of orientation. Restraint training is provided annually, and the staff must be competent in this area. On questioning, the triage nurse did not recall whether she asked the recipient if she wanted someone to be notified when her rights were initially restricted. She agreed that it would have been appropriate to document the recipient's response on the notice if she had asked. Also, she could not explain why the first notice reflected that rights were restricted for 24 hours although restraints were initially ordered for up to 4 hours.

Palos' "Involuntary Admission to a Psychiatric Unit" policy states that in the event that the recipient is transported to the hospital by a peace officer, the peace officer may complete the petition. If the petition is not completed by the peace officer, the transporting officer's name, badge number, and employer shall be included on the petition as a potential witness. The petition can also be completed by a hospital employee who can describe acts or threats supporting the need for involuntary admission. The petition should be completed immediately when a recipient is detained involuntarily for a mental health examination. When a psychiatrist or physician evaluates a recipient solely for the purpose of certification for involuntary admission, the recipient will be informed of his or her rights prior to examination.

According to the hospital's policy, restraints will be used when a recipient's violent or aggressive behavior presents an immediate and serious danger to the individual or others. The least restrictive, safest, and most effective type of restraint will be used. Five-point restraints will be used when the recipient's level of agitation and/or physical strength require a high level of security and protection if possible. A physician's order must be obtained for restraints; the physician must conduct a face-to-face assessment within one hour of restraint application. When a physician is not available, the Director of Nursing or Clinical Nurse Manager will evaluate the recipient within one hour of restraint application and consult with the attending physician as soon as possible. The policy states that recipients will be monitored and reevaluated while in restraints.

The policy further directs that restraints should be discontinued as soon as the recipient's behavior is safe. The decision to remove restraints for behavioral management is a collaborative decision in the Emergency Department. Examples of criteria for discontinuation include: 1) The recipient's ability to participate in the plan to maintain his/her safety, 2) Whether the person is oriented to the environment, and, 3) Cessation of verbal threats. If an emergency health situation occurs, the recipient shall be released from restraints as dictated by the emergency. Injuries sustained from restraints shall be reported to the Nursing Director and the appropriate report will be completed.

Palos' "Psychiatric Patients in Police Custody" policy states that a patient who is suicidal or at risk for other destructive behaviors shall not be allowed to leave the Emergency Department unless he or she is admitted to the hospital's psychiatric unit or another inpatient facility. If the police are not able to contact a judge and the patient's condition requires inpatient treatment at the county jail mental health facility, the individual must be held in the Emergency Department until a judge is available. A patient cannot be sent back to jail if they are suicidal or at risk for other destructive behaviors.

The hospital's "Patient Rights" policy mirrors Sections 5/2-102 (a-5), 5/2-107 and 5/2-201 below.

CONCLUSION

According to the following Sections of the Code,

> Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. (a) Restraint shall be employed only upon the written order of a physician…. in no event may restraint continue for longer that 2 hours unless a personal examination is done and it is determined that the restraint does not pose an undue risk to the recipient's physical or medical condition…. the order shall state the events leading up to the need for the restraint and the purposes employed. The order shall also state the length of time for the restraint and give a clinical justification for the length of time…. (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 clinically appropriate but in no event less than once every 15 minutes…. the recipient shall be permitted to have regular meals and toilet privileges free from the restraints, except when freedom of action may result in physical harm to the recipient or others…. (405 ILCS 5/2-108).

Whenever any rights of a recipient of services are restricted, the recipient shall be promptly given a notice of the restriction and anyone he or she designates. (405 ILCS 5/2-201).

Whenever a petition has been executed …, 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 statement he makes may be disclosed at a court hearing on the issue of whether he is subject to involuntary admission. …. (405 ILCS 5/3-208).

When a recipient is asserted to be subject to involuntary admission and in such a condition that immediate hospitalization is necessary for the protection of such person or others from physical harm, any person 18 years of age or older may present a petition … (b) The petition shall include a detailed statement of the reason for the assertion that the recipient is subject to involuntary admission, including the signs and symptoms of a mental illness and a description of any acts, threats, or other behavior or pattern of behavior supporting the assertion and the time and place of their occurrence. (405 ILCS 5/3-601).

A peace officer may take a person into custody and transport him to a mental health facility when, as a result of his personal observation, the peace officer has reasonable grounds to believe that the person is subject to involuntary admission and in need of immediate hospitalization to protect such person or others from physical harm. Upon arrival at the facility, the peace officer may complete the petition…. under Section 3-601. (405 ILCS 5/3-606).

Upon completion of one certificate, the facility may begin treatment of the respondent. However, the respondent shall be informed of his right to refuse medication, and if he refuses, medication shall not be given unless it is necessary to prevent the respondent from causing serious harm to himself or others. The facility shall record what treatment is given to the respondent together with the reasons therefore. (405 ILCS 5/3-608).

> An adult recipient of services…must be informed of the recipient's rights to refuse medication ….If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent harm to the recipient or others and no less restrictive alternative is available….psychotropic medication or electroconvulsive therapy may be given under this Section for up to 24 hours only if the circumstances leading up to the need for emergency treatment are set forth in writing in the recipient's record. (405 ILCS 5/2-107).

It was clearly documented that the recipient was in the custody of law enforcement officers upon her arrival to the hospital on October 21st, 2009 around 4:14 p.m. Her visit to the hospital for a psychiatric evaluation was involuntary because she was in handcuffs. Although the recipient was not free to leave the hospital, a petition was not completed until the 22nd at 7:00 a.m. Illinois law allows a recipient to be detained within a facility upon the initiation of a petition under Sections 5/3-601 and 5/3-606 of the Code. The Authority finds the contents of the petition meet the requirements of Section 5/3-601, but Palos Community Hospital violates the Section and its policy because the petition was completed about 15 hours after the recipient's arrival to the hospital's Emergency Department.

The hospital had no authority to detain the recipient until the petition was completed on the 22nd. However, the recipient was placed in 5 point restraints upon her arrival on the 21st and restrained until she was released to law enforcement officers on the 22nd around 1:30 p.m. The HRA is very concerned because the Restraint Observation Record and nursing entries clearly indicated that the recipient was sleeping on the 21st from 7:00 p.m. to 10:00 p.m. But, restraints were continued at 8:19 p.m. for verbal aggression and attempting to make physical contact with the staff by using her upper body (chest), while in restraints. There were many restraint orders for up to 4 hours because of unpredictable behaviors found in the record. An order indicated that restraints were continued at 12:00 a.m. for rocking the cart and trying to hit the staff. Restraints were continued at 4:00 a.m. for yelling and rocking the cart. It was recorded that the recipient exhibited violent behavior at 6:00 a.m., and the sitter reported to us that the recipient tried to bite her. An attempt was made to discontinue the restraints at 6:45 a.m. but, according to the physician, the patient could not follow directions. Restraints were continued at 8:00 a.m. and 12:00 p.m. for rocking the cart, spitting water on the staff and threats.

The restraint record documented that the recipient was assessed for undue risk in light of her medical condition by physicians at 5:25 p.m. and 7:30 p.m. on the 21st and 12:00 a.m., 8:00 a.m. and 12:00 p.m. on the 22nd. The physician who assessed the recipient at 12:00 p.m. checked on the form that her recipient's respiratory status, circulation and mobility were good upon examination. Although the clinician failed to check that the restraints did not pose undue risk to the recipient's medical condition, the restraint episode did not exceed the 2 hours protocol that requires a declaration. The flowsheet indicated that the recipient was offered nourishment and toileting regularly but refused. The hospital violates Section 5/2-108 because the record does not clearly support physical harm or physical abuse when the restraints were continued at 8:19 p.m. on the 21st.

A certificate was completed on the 22nd at 7:30 a.m. Whether the recipient was overly medicated as alleged in the complaint cannot be determined by the HRA. The physician acknowledged that he did not personally inform the recipient of her rights before the certification exam. Rights restrictions notices were found in the record for all instances of restraints and emergency medications, but the first notice lacked any indication of whether the recipient wanted someone to be notified of the restriction.

The hospital violates Sections 5/2-201, 5/3-208, 5/3-601 of the Code, and its involuntary admission policy regarding petitions and admonishment of rights for certification. The Authority substantiates that the Emergency Department staff failed to follow the Mental Health Code in detaining, restraining and treating a recipient.

RECOMMENDATIONS:

1. Ensure that petitions are completed immediately whenever mental health recipients are prevented from leaving the Emergency Department under Section 5/3-601 and the hospital's policy.

2. Ensure that the events leading up to restraints on the order and the flowsheet correspond regarding potential physical harm under Section 5/2-108.

3. Instruct all appropriate staff to complete restriction of rights notices in their entirety, and that recipients should be asked if anyone is to be contacted about the restriction in all instances according to Section 5/2-201.

4. Require all qualified examiners to admonish each person under examination for immediate hospitalization of their full rights *before* examinations begin as required by Section 5/3-208 and policy.

SUGGESTIONS

1. Use exact language that describes what occurred. If a patient tries to bite a staff person, document that the patient tried to bite the staff person as opposed to "the patient was violent."

2. Under state (405 ILCS 5/2-108) and federal (42 C.F.R. 482.13) laws restraints may only be used to ensure physical safety. Extreme paranoia, flight of ideas, unable to follow commands, yelling and using profanity have nothing to do with the physical and should not be listed as reasons to restrain on any order.

COMMENT

The hospital is reminded that the Code's process for involuntary administrations of psychotropic medication and electroconvulsive therapy is governed by Section 5/2-107 and that recipients must still be provided with written educational information under the following Section, which states,

> (a-5) If the services include the administration of psychotropic medication and electroconvulsive therapy, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment …. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only (i) pursuant to Section 5/2-107 …. (405 ILCS 5/2-102).

The HRA is unclear whether the hospital staff met the written medication information requirement mentioned above.

RESPONSE

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

Palos Community Hospital

12251 S. 80th Avenue Palos Heights, Illinois 60463 (708) 923-4000

February 28, 2011

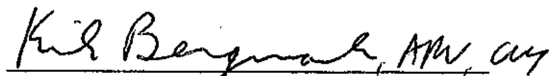
Ms. Judith Rauls, Chairperson
Regional Human Rights Authority
Guardianship & Advocacy Commission
P.O. Box 7009
Hines, IL 60141-7009

Re: HRA No. 10-040-9010

Dear Ms. Rauls:

The requirements of the Illinois Mental Health and Developmental Disabilities Code are regularly reviewed with staff as part of our ongoing commitment to provide compassionate and humane care to patients in need of mental health services. The specific Human Rights Authority recommendations and suggestions were shared and discussed with the Emergency Department leadership and staff following receipt of the report of findings. Per your request, please see the attached staff training materials. The Emergency Department physicians and nursing staff have each received a copy. The information will be reviewed and discussed at the Emergency Department Nursing Meeting on March 3, 2011 and at the Emergency Department Physicians Meeting on May 20, 2011.

Sincerely,



Kirk Bergmark, APN, CNS
Assistant Vice President of Nursing,
Psychiatry/Chemical Dependency

KB:bjg

Attachments

Palos Community Hospital

12251 S. 80th Avenue Palos Heights, Illinois 60463 (708) 923-4000

Executive Offices

December 14, 2010

Ms. Judith Rauls, Chairperson
Regional Human Rights Authority
Guardianship & Advocacy Commission
P.O. Box 7009
Hines, IL 60141-7009

Re: HRA No. 10-040-9010

Dear Ms. Rauls:

Please accept this letter as the response of Palos Community Hospital to the above-sited report of the Human Rights Authority. We have reviewed the Human Rights Authority Report, including all recommendations and suggestions, as well as the care provided to the patient in our Emergency Department. We will assure that our Policy and Procedures and the requirements of the Illinois Mental Health and Developmental Disabilities Code are consistently followed.

Palos Community Hospital's Policy and Procedures are consistent with the recommendations of the Human Rights Authority. The recommendations will be reviewed with staff and discussed at an Emergency Department meeting.

Palos Community Hospital remains committed to providing compassionate and humane care to patients in need of mental health services.

Sincerely,

Sister Margaret Wright

Sister Margaret Wright
President

SMW:mkb