FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
SAINT JAMES HOSPITAL and HEALTH CENTERS— 10-040-9020
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary— The Authority made corrective recommendations regarding two of 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) has completed its investigation into allegations concerning Saint James Hospital and Health Centers. According to the complaint, the hospital did not follow the Mental Health Code in detaining, restraining and providing adequate and humane care to a recipient. If substantiated, these allegations would be violations of the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.), the Medical Patient Rights Act (410 ILCS 50/3 [a]) and the federal Conditions of Participation for Hospitals (42 C.F.R. 482).

Located in Chicago Heights this general hospital and health centers are affiliated with the Sisters of Saint Francis Health Services, Incorporated. The hospital does not have a psychiatric unit.

METHODOLOGY

To pursue the investigation, the hospital's Emergency Department Medical Director, the Director of Quality Improvement/Accreditation, the Director of Behavioral Health, the Director of Clinical Training/Behavioral Health, the Director of Nursing, the Director of Case Management, the Manager of the Emergency Department and a Clinical Psychologist were interviewed. The complaint was discussed with an Assistant State's Attorney from the Cook County Office by telephone. The complaint was discussed with the adult recipient who gave written consent to review his record. Relevant hospital policies were also reviewed.

The Attending Emergency Department Physician could not be interviewed because she is no longer employed by the hospital.

COMPLAINT STATEMENT

The complaint stated that the recipient was transported to the hospital's Emergency Department because he was having trouble breathing. It was reported that restraints were used without justification and that the recipient's hands and wrists were blue from restraints when he

awakened. He was allegedly admitted to a unit and held against his will, was not given a copy of the petition, had a sitter assigned to his room and was told that the hospital's security would tackle him to the ground if he tried to leave. The recipient was reportedly held for five days and transferred to a state-operated facility.

FINDINGS

The hospital's Emergency Department Record indicated that the recipient arrived by ambulance for a mental health evaluation on December 17th, 2009 at 2:40 a.m. During the ambulance ride, the recipient kept saying, "I'm going to die if I don't touch you." The paramedics also reported that the recipient believed that he was dead as well as his dog. He was described as hallucinating, uncooperative, combative, and agitated upon his arrival to the hospital. He was screaming that he was going to die, and that his girlfriend was dead. He was immediately placed in seclusion and 4 point restraints.

According to a nursing form, restraints were initiated because the recipient was a flight risk and potentially violent or destructive. An order for restraints and seclusion with direct observation signed by a physician at 3:00 a.m. documented that the recipient was examined at that same time. The justification for the order was that the recipient might leave the hospital. Included on the form is a statement that alternatives to restraints were considered and documented. However, this was not evident during the record review. The form also states that restraints and seclusion may be used for behavioral health recipients up to 24 hours, but the physician or Licensed Independent Practitioner must be contacted every four hours for adult recipients if they are continued. The record contained a notice stating that the recipient's right to be free of restraints and seclusion were restricted at 3:00 a.m. There was no end time written on the notice or indication that the recipient wanted someone to be informed of the restriction. Blood work, a urine sample, cardiac monitor and a Computed Tomography (CT) head scan were ordered around that same time. A form stated that the recipient was unable to give signed consent for general treatment "due to [his] mental condition."

A Restraint and Seclusion Observation Record documented that the recipient was monitored and that his behaviors were recorded every 15 minutes. He was kicking and biting from 2:40 a.m. to 4:00 a.m. He was quiet and cooperative from 4:00 a.m. to 6:00 a.m., and 4 point restraints were removed at 6:00 a.m. A nurse wrote that the recipient was aware of his surroundings. It was documented that restraints and seclusion did not pose undue risk to the recipient's medical condition at 4:40 a.m. and 6:40 a.m. His circulation, range of motion, skin, and vital signs were monitored. He was frequently offered toileting, but there was no mention of nourishment. He remained quiet and cooperative, but seclusion was continued at 6:40 a.m. There was a sitter in the recipient's room about forty minutes later. The flowsheet ends at 7:50 a.m., and there was no documented evidence of injuries from the restraints.

On December 17th, a petition was completed by the recipient's girlfriend, but it is unclear what time the document was prepared because the form used does not require this information. According to the petition, the recipient had awakened his girlfriend at 2:00 a.m. and reported having problems breathing. He had not been sleeping well before his visit to the hospital. He believed that dental x-rays had done something to his brain. A certificate for immediate

involuntary hospitalization was completed by the physician on that same day at 5:30 a.m. The physician certified that rights were admonished prior to examination. According to the certificate, the recipient believed that he was Judas and would save the world. He believed that his brain was detached because of radiation exposure from dental x-rays. The recipient was diagnosed with Altered Mental Status, Delusions, Hypertension and Hyponatremia (low blood sodium). He was admitted to the hospital's general medical floor and placed on 1:1 for suicide precaution. During the investigation, the recipient said that he did not realize that he was being admitted but was told that he was going upstairs. The record does not clearly indicate whether the decision to hospitalize him was explained but reflects that his girlfriend was given the telephone number to call regarding visiting hours.

According to the hospital's Inpatient Record, the recipient was oriented to the unit and his room around 9:00 a.m. The hospital visiting, smoking and telephone policy were explained. A History and Physical Report was completed on the admission day. The report stated that the recipient was awake but confused during the examination. The CT head scan results were negative. He was positive for marijuana, and his urinalysis was abnormal. Laboratory results also showed that he had Leukocytosis (a marked increase of white blood cells), Hypokalemia (low blood potassium) and Hyponatremia. The physician wrote that the recipient's lower levels were possibly caused by diuretics to control his blood pressure, but he was not able to confirm taking this medication. It was recorded that the recipient was diagnosed with Acute Psychosis. He would be treated for Deep Vein Thrombosis, and a urinary tract infection needed to be rule out. His blood pressure, diabetes, potassium and electrolytes would be monitored and treated. Physician's orders included Heparin a blood thinning medication, Norvasc for blood pressure, Novolin for diabetes and Klor-Con for potassium to be administered Intravenously (IV), and Levaquin an antibiotic by mouth, and that the recipient's IV port should be flushed with saline daily. A Complete Blood Count (CBC) and a Basic Metabolic Panel (BMP) was ordered for the following morning.

At 4:15 p.m., the recipient was seen by a Behavioral Health Resident Physician and a Clinical Psychologist. According to the Consultation Report, the recipient started vomiting within the first few minutes of the interview, and the report's information was obtained from the chart and staff. A nurse reported that the recipient had been drinking a lot of water and was forcibly vomiting after ingesting the water. According to the report, the recipient had become more delusional during the past week and believed that he was Judas. He was diagnosed with Brief Psychotic Disorder, and Schizophrenia needed to be rule out. A second certificate was prepared by the Clinical Psychologist at that same time and the information recorded on the document mirrored the first certificate.

On December 18th, the physician wrote that the recipient was feeling better but did not understand what had happened to him. On the 19th, the recipient was diagnosed with Psychogenic Polydipsia, which is a neurological disorder commonly associated with Schizophrenia and characterized by excessive thirst. A physician's order indicated that the recipient's fluid intake was restricted to 2.0 liters daily. There was no restriction order for this intervention found in the record. The physician recorded that the recipient's sodium and potassium blood levels had improved on the 20th and the 21st respectively. And, he could now be transferred to a psychiatric facility. The record contained multiple certificates stating that the

recipient's mental status had not changed on the 18th, 19th, 20th and the 22nd. Three of them were prepared by the Clinical Psychologist who completed the second certificate. One of the involuntary documents was prepared by another clinician of the same discipline. In all instances, the qualified examiners certified that rights were given prior to examinations including the second certificate completed on the 17th.

A second petition was prepared by a staff person on the 21st at 12:15 p.m. According to the new petition, the recipient presented with depression and delusional thoughts. It repeated that the recipient believed that he needed to save the world. There was no evidence that a copy of the petitions or rights information was given during his hospital stay. On that same day, a social worker wrote that the recipient was medically cleared for transfer to a psychiatric state-operated facility. The receiving facility confirmed that there was a bed available but requested a Basic Metabolic Panel be done on that next morning. On the 22nd, the recipient was transferred as planned by the hospital, and he refused to sign the transfer form. According to the Discharge Summary, there was an erroneous diagnosis of a urinary tract infection upon the recipient's admission to the hospital. The physician recommended that the fluid restriction should be continued until the recipient was psychiatrically stable.

A letter written on April 29th, 2010 from the hospital's Director of Quality Improvement/ Accreditation was reviewed. According to the letter, the hospital had recently formed a task force to review the petition and certificate process and to develop a comprehensive policy regarding this issue. The committee's meeting minutes for March 30th, April 7th and the 23rd were enclosed with the letter. They recorded that the hospital had been recently in-serviced on the petition and certificate process by an Assistant State's Attorney from the Cook County Office. This training was initiated by the hospital after learning that the involuntary documents for emergency hospitalization had been revised. The committee had agreed that each department would be responsible for using the correct forms. Also, the requirement to notify the court when medical patients are admitted on a petition and certificate would be included in the policy.

At the site visit, the HRA was informed that very few recipients who require psychiatric care present to the hospital's Emergency Department with the police. When this occurs, the police are asked to remove the restraints, and the hospital security would leave the room. The record does not support that the police were not involved in the recipient's transport to the hospital. In regard to seclusion and restraints, the staff were informed that documentation such as combative and agitation does not clearly indicate an emergency under the Code's standards. According to the Director of Quality Improvement/Accreditation, the word combative is more descriptive than agitation. There was some discussion concerning the need to continue restraints and seclusion from 4:00 a.m. to 6:00 a.m. because the flowsheet indicated that the recipient was quiet and cooperative. The HRA was told that the recipient needed to be evaluated by the physician. A nurse said that restraints were not removed sooner because the recipient was taken to the radiology department for a CT scan around 5:30 a.m. She explained that recipients are examined for injuries after they are released from restraints. All injuries observed are documented on the flowsheet, and post-restraint debriefings are done.

The staff person, who allegedly threatened to call the hospital's security if he tried to leave, was not clearly identified in the complaint. The staff interviewed explained that a sitter

was assigned to the recipient's room 24 hours according to the hospital protocol. The washroom door had to stay open while the recipient was toileting because of his close monitoring status. According to the staff, a restriction of rights notice was not required because the fluid restriction was a medical intervention. The primary Clinical Psychologist involved in the recipient's care told the HRA that rights were admonished before certifications. He recalled that the recipient was very delusional and believed that he was Judas. He saw the recipient multiple times to determine whether psychiatric hospitalization was still needed. He said that he usually tries to explain to recipients what is happening to them. And, the social worker talks to them about the specific hospital where he or she will be transferred. According to the Clinical Psychologist and the Director of Quality Improvement/Accreditation, the Assistant State's Attorney mentioned above told the hospital that certificates should be completed daily on the same recipient. The Assistant State's Attorney denied this during a follow up from the HRA.

Saint James Hospital Emergency Department policy states that patients who are psychotic or potentially suicidal shall be placed in a safe environment. Their clothing and belongings should be removed and kept at the nurse's station. Restraints may be used if a patient appears to be a danger to self or others and all calming efforts have failed. A petition for involuntary admission should be completed. The patient shall be evaluated, treated, and medically cleared by a physician. A certificate will be completed by the physician. The social worker will be called to help facilitate the transfer if the patient needs to be admitted to a psychiatric facility. The policy states that an outside agency will be called for assistance in evaluating and placement of all patients who lack funding.

According to the hospital's policy, restraint and seclusion may be used to manage violent or self-destructive behaviors that jeopardize the immediate physical safety of the patient or others. Restraints or seclusion should only be used after lesser restrictive measures have failed. The hospital's philosophy is to limit the use of restraints and seclusion to those situations with appropriate and adequate documentation and the use of the least restrictive method for the shortest possible duration. Restraints and seclusion must be discontinued at the earliest possible time regardless of the length of time on the order. They may not be employed concurrently unless the patient is continually monitored face-to-face or using both video and audio equipment monitored by trained staff. Only, a physician or Licensed Independent Practitioner may order restraints prior to their application. In case of an emergency, the order must be obtained either during the application or immediately after the restraints have been applied. A notice of restriction must be completed.

Saint James Hospital patient rights statement #1, guarantees that patients will be cared for with respect, dignity and receive impartial access to treatment regardless of race, sex, sexual orientation, religion, ethnicity, age, handicap or source of payment. The hospital patient rights statement #19, guarantees that patients will be free of restraint unless they are medically necessary. Restraint shall not be used as a means of coercion, discipline, convenience, or retaliation by the staff. All patients have the right and are encouraged to present any concerns to the hospital Guest Relations Department and the Illinois Department of Public Health.

CONCLUSION

According to the following Sections of the Mental Health Code,

> 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, and shall be free from abuse and neglect. (405 ILCS 5/2-102 [a] and 5/2-112). Abuse is defined in Section 5/1-101.1 as any physical injury, sexual abuse, or mental injury inflicted on a recipient of services other than by accidental means.

> Restraint and seclusion may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. In no event…is restraint to be used as a convenience for the staff. In no event may restraint and seclusion be continued for longer that 2 hours unless a personal examination is done, and it is determined that they do not pose an undue risk to the recipient's physical or medical condition. Restraint shall be employed in a humane and therapeutic manner. A recipient who is restrained and secluded shall be observed by a qualified person as clinically appropriate but in no event less than ever 15 minutes. (405 ILCS 5/2-108 and 5/2-109).

Federal standards add that all patients have the right to be free from restraint of any form imposed as a means of coercion and convenience. (42 C.F.R. 482.13).

> Whenever any rights of a recipient of services are restricted, the recipient shall be promptly given a notice of the restriction and to any person or agency he designates including the Guardianship and Advocacy Commission. (405 ILCS 5/2-201).

> The petition shall be accompanied by a certificate executed by a physician, qualified examiner, or clinical psychologist which states that the respondent is subject to involuntary admission and requires immediate hospitalization…. (405 ILCS 5/3-602).

> 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 of his or her rights. (405 ILCS 5/3-208).

> 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).

Within 12 hours after his admission, the respondent shall be given a copy of the petition and a statement as provided in Section 3-206. No later than 24 hours, excluding Saturdays, Sundays and holidays, after admission, a copy of the petition and statement shall be given or sent to the respondent's attorney and guardian, if any. The respondent shall be asked if he desires such documents sent to any other persons, and at least 2 such persons designated by the respondent shall receive such documents. The respondent shall be allowed to complete no less than 2 telephone calls at the time of his admission to such persons as he chooses. (405 ILCS 5/3-609).

Within 24 hours, excluding Saturdays, Sundays and holidays, after the respondent's admission under this Article, the director of the facility shall file 2 copies of the petition, the first certificate, and proof of service of the petition and statement of rights upon the respondent with the court in the county in which the facility is located. Upon completion of the second certificate, the facility director shall promptly file it with the court.... Upon filing of the petition and first certificate, the court shall set a hearing to be held within 5 days, excluding Saturdays, Sundays and holidays, after receipt of the petition. The court shall direct that notice of the time and place of the hearing be served upon the respondent, his responsible relatives and persons entitled to receive a copy of the petition pursuant to Section 3-609. (405 ILCS 5/3-611).

Under Section 50/3 (a) of the Medical Patient Rights Act,

Establishes the right of each patient to receive care consistent with sound nursing and medical practices, …, to receive information concerning his or her condition and proposed treatment, to refuse any treatment to the extent permitted by law, and to privacy and confidentiality of records except as otherwise provided by law.

In Illinois there is only one way to be detained involuntarily for psychiatric evaluation and that is via the Mental Health Code, under which a petition must be completed in order to start the involuntary process and have authority to hold any adult. The hospital's Emergency Department record indicated that the recipient arrived for a mental health evaluation on December 17th, 2009 at 2:40 a.m. On that same day, the recipient's girlfriend completed a petition under Section 5/3-601, but there was no time mentioned because the form used is outdated. According to the recipient's record, the first certificate for emergency psychiatric hospitalization was prepared by the physician on the 17th at 5:30 p.m. under Section 5/3-602. The physician affirmed on the certificate that rights were admonished prior to the examination pursuant to Section 5/3-208. The recipient was admitted to the hospital's medical unit because

he was not medically stable for transfer to a psychiatric facility. His low sodium and potassium blood levels were treated as indicated by the physician. His daily fluid intake was restricted to 2.0 liter as ordered because of excessive consumption of water that depleted his blood sodium level. There was no clear evidence that the recipient refused medical services.

The recipient's record contained five more certificates that recorded the same information. The Clinical Psychologist, who completed four certificates, told the HRA that rights were admonished prior to examinations. The Authority must emphasize that the Code requires one petition and two certificates for the same involuntary hospitalization. We take issue with the second petition prepared by the hospital on the 21st at 12:15 p.m. because the recipient's ordeal began hours earlier when the first petition was initiated. The hospital is reminded that the time at which the petition is initiated is vital as it sets strictly limited time protections and is a legal document that is intended to follow the patient and not be disregarded under Section 5/3-600 et seq. By documentation, the recipient was not given a copy of the petitions that include rights information under Section 5/3-609. The investigation further revealed that the hospital's previous practice did not include filing a petition and first certificate with the court within those strict time protections as required by Section 5/3-611. To correct the problem and to prevent further occurrences, the hospital reportedly will pursue policy development on the petition and certificate process. The hospital is also is planning on developing an educational program when the policy is completed.

The Authority substantiates that the hospital did not follow the Code in regard to detaining a recipient. The hospital violates rights under Sections 5/3-609 and 5/3-611. No violations of Sections 5/3-608 were found. The HRA cannot substantiate that the hospital did not provide adequate and sound medical care and services to the recipient. No clear violations of Sections 5/2-102 (a) and 50/3 (a) of the Medical Patient Rights Act were found.

Documentation leading up to the need for restraint and seclusion described the recipient as hallucinating, combative, agitated and uncooperative, which, without further description of potential physical harm, does not meet the Code's standards for their use. Also, the order stated that restraints were used to prevent him from leaving, which is not an acceptable reason under the Code, unless he had threatened physical harm while exercising his right to walk out of the hospital. There was no evidence of this found during the record review. The flowsheet further showed that the recipient was quiet and cooperative from 4:00 a.m. to 6:00 a.m., but seclusion and restraint were continued. The hospital policy states that the use of restraints and seclusion is limited to situations with adequate documentation and must be discontinued at the earliest possible time. The record contained a notice of the restriction under Section 5/2-201. According to the notice, the recipient did not want anyone notified of the emergency interventions employed. There was no evidence found in the record that the restraints resulted in bruises.

The Authority substantiates that the hospital did not follow the Code in regard to seclusion and restraints. The recipient's rights were violated under the Code's Sections 5/2-108 and 5/2-109. The hospital also violates its policy, and patient rights statement #19 which guarantee that patients will be free of restraint unless they are medically necessary. The HRA finds no clear violations of Sections 5/2-102 (a), 5/2-112 and 5/2-201.

RECOMMENDATIONS

1. Provide better record documentation that more accurately reflects the need to prevent physical harm, and not just to keep someone from leaving, whenever restraints and seclusion are used for mental health recipients pursuant to Sections 5/2-108, 5/2-109 of the Code, and the hospital's policy.

2. Release recipients from restraints when the threat of physical harm no longer exists according to Sections 5/2-108, 5/2-109, the hospital's policy and the patient rights statement #19.

3. Follow Section 5/3-609 of the Code and provide all involuntary recipients with copies of their petitions within 12 hours of admission.

4. Instruct all appropriate personnel to stop the practice of disregarding petitions that accompany recipients to the hospital's medical unit in favor of writing new ones under Section 5/3-600.

5. Instruct all appropriate personnel to stop the practice of preparing multiple certificates for the same hospitalization.

6. It is paramount that Saint James Hospital follows the requirements under Section 5/3-611 of the Code. Recipients who are held involuntarily have the right to a court hearing within 5 days, excluding Saturdays, Sundays and holidays, after receipt of the petition.

7. Provide the HRA with a copy of the hospital's revised policy on the petition and certificate process.

SUGGESTIONS

1. Be sure to use current petition forms that include the time of completion.

2. Regarding Recommendation #1, train staff to document exactly what occurred instead of generalizing with words like combative, agitated, threatening, etc.

COMMENT

Haldol was ordered during the recipient's inpatient stay, but there was no evidence that informed consent was obtained beforehand. Documentation indicated that Haldol 2 mg (IV) was administered on the 17th at 6:57 p.m. because of agitation, hostility and destruction of property. 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).

Based on the lack of documentation, the recipient was not given written medication information as required above. The record also suggests that he was not allowed to refuse the medication, but there was no restriction notice concerning this issue.

The record is unclear as to whether this recipient was agreeable to all of the medical treatment provided. St. James should be certain to recognize in all cases that mental health patients enjoy the right to consent to treatment as all other patients do unless otherwise determined:

> A medical…emergency exists when delay for the purpose of obtaining consent would endanger the life or adversely and substantially affect the health of a recipient of services. When a medical…emergency exists, if a physician…who examines a recipient determines that the recipient is not capable of giving informed consent, essential medical…procedures may be performed without consent. No physician…shall be liable for a non-negligent good faith determination that a medical…emergency exists or a non-negligent good faith determination that the recipient is not capable of giving informed consent. (405 ILCS 5/2-111).

St. James policy states that patients who are psychotic or potentially suicidal shall have their clothing removed. We implore the hospital to make sure that there are *individual* determinations and exceptions as not all people with psychosis or suicidal thoughts need to strip in order to maintain safety.

RESPONSE

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

CHICAGO HEIGHTS
1423 Chicago Road
Chicago Heights, IL 60411
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OLYMPIA FIELDS
20201 South Crawford Avenue
Olympia Fields, IL 60461
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July 14, 2011

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

Re: HRA #10-040-9020

Dear Ms. Rawls:

We are writing in response to the Commission's correspondence of May 12 requesting follow-up actions with the above investigation.

Upon receipt of the May 12 correspondence, I spoke with [redacted] about an extension beyond the 30 days and [redacted] was in agreement. The enclosed action plan summarizes steps that have have been taken as well as future activities that will occur to meet the Commission's recommendations. We have also included meeting minutes and education programs on restraints. The educational programs have started to be presented to the nursing staff. As you will note, a major agenda item at the various meetings has been developing a policy to meet the Commission's recommendations of court notification when a patient is admitted for medical care, but also has a Petition & Certificate completed. This notification process and the possible need to bring a patient for a court hearing within five days will be a major change in hospital practice and has far-reaching implications, so time will be needed to develop a realistic policy.

We would like to assure the Human Rights Authority that we are taking all recommendations very seriously and will continue to make a dedicated effort to full compliance. We will stay in contact with the Guardianship Commission and provide meeting attendance records as well as policy updates related to the Petition & Certificate process.

In the meantime, please let me know of any questions.

Sincerely,

William J. Dwyer

William J. Dwyer, MSW, MHA
Director, Quality Improvement

WJD:nh
Attach.

cc: Seth C. R. Warren, President, Franciscan St. James Health

St. James

Sisters of St. Francis Health Services

CHICAGO HEIGHTS
1423 Chicago Road, Chicago Heights, Illinois 60411-3483
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November 2, 2011

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

Re: Case #10-040-9020

Dear Ms. Rauls:

As a follow-up to the above complaint, we are providing the requested additional information and are hopeful this information will allow the closing of this complaint.

One of the enclosed documents is ED staff completion of restraint education for the year 2011. We already provided the educational materials. Our plan is to have all ED staff complete an educational session on restraint use by the end of the year.

We have also enclosed a draft copy of a new "Petition and Certificate" policy that will go through the designated approval process.

Please let me know of any questions.

Sincerely,

William J. Dwyer, MSW, MHA
Director, Quality Improvement/Accreditation/Regulatory Affairs

WJD:nh
Enc.

St. James
Sisters of St. Francis Health Services

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December 5, 2011

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

Re: Case #10-040-9020

Dear Ms. Rauls:

As a follow-up to the above complaint, we are providing the updated Petition & Certificate policy. We have tried to include all the Guardianship recommendations as stated in the November 21, 2011 correspondence.

Please let me know of any questions.

Sincerely,

William J. Dwyer

William J. Dwyer, MSW, MHA
Director, Quality Improvement/Accreditation/Regulatory Affairs

WJD:nh
Enc.