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HUMAN RIGHTS AUTHORITY - NORTHWEST REGION

REPORT 10-080-9012
ROCHELLE COMMUNITY HOSPITAL

Case Summary: findings were cited in the process of restraining and treating the individual but not in the need for the care. The facility's response immediately follows.

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation of possible rights violations in the treatment of a mental health patient at Rochelle Community Hospital. Complaints state that the patient was restrained and force-medicated without cause and due process and that the restraints were applied too aggressively. Substantiated findings would violate rights protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

The fifty-four-bed hospital has no mental health unit but does provide medical clearing and psychiatric evaluation in its emergency department. Counselors from an area mental health agency typically handle these evaluations. The intensive care unit is used when available to maintain a secure, calmer environment for patients in a prolonged stay.

To pursue the matter the HRA met with hospital personnel and toured the intensive care unit. Relevant policies were reviewed as were sections of a patient's medical record with consent.

COMPLAINT SUMMARY

According to the complaint, the patient arrived at the hospital after a night of heavy drinking and cutting on himself. He was there for over a day in the emergency department and then intensive care, during which a counselor visited him and asked him to go voluntarily to a psychiatric facility. He said no; the counselor insisted on him going, and the patient started yelling in opposition but did not become physical. Several staff along with policemen reportedly jumped him, restrained him and injected a drug. He pleaded them to stop but a nurse allegedly screamed at him that he was getting it anyway. The complaint states that in the meantime, his head was painfully pressed sideways into the bed with full body weight and the restraints were applied so tightly they caused bruising.

FINDINGS

We interviewed administrators and nurses who were involved in this patient's care. They explained that when suicide precautions are apparent they ensure constant observation, remove equipment from reach and contact the area mental health agency for evaluation. Precautions are determined on individual bases, the goal of which is to outline safety. There is no security staff in the small hospital so they call on local law enforcement who are minutes away if needed. Education on prescribed medicines is provided every time, although not always in writing. Psychiatric patients who pose danger and are on suicide precaution cannot leave. The staff are trained on completing petitions for involuntary admission, but they pretty much wait for the community agency to deal with that, rights information and restrictions. All staff who apply restraints are trained in the safe and effective use of them.

They said that this patient came to the emergency department on his own accord and was treated in the emergency department for lacerations on his wrists. Lab work was done as well, but he was never restrained or given medications there. The situation escalated however when he was in the intensive care unit and knew that his transfer to another facility was approaching. He grew more restless and aggressive. He kicked over a bedside table and was closing space between himself and the nurses. One nurse told us that she couldn't keep a safe distance and that he kept closing in; she felt they did all they could to calm and redirect him verbally. At some point the police came in and helped several staff restrain him; one person at all four limbs, and a policeman at his left hand. A towel was held near his mouth as a shield when he started spitting at them. An administrator who was on the scene did not recall an officer pressing the patient's face, rather, she said that the patient reached over to his left arm and the officer pushed his right shoulder back onto the bed.

Regarding the restraints being applied too tightly, we were told that nurses always make required checks. They usually document these checks on flow sheets, but failed in this case. The patient's mother was present the whole time and had no concerns about the restraints, just concern for his safety if he went home. And, on medications, the patient verbally consented to the Ativan that was used, even asking for more doses from time to time. One administrator remembered the nurse saying at every dose that Ativan would help him, explaining how, and that he was agreeable. We looked to the patient's medical record for support.

Emergency department records showed that the patient arrived just after noon on November 9th where he was diagnosed with intoxication, depression, suicidal ideation and bilateral wrist lacerations. Blood and urine work were done and his wounds were cleaned and bandaged. A consent for medical treatment form initialed by the patient was included in the chart. He is noted to be cooperative until 1:00 p.m. when a police officer was at his bedside. The note stated that he was briefly uncooperative, and we were told that he refused to exit the bathroom so the police were called to help coax him out. He eventually did and the police were able to leave. The patient was described as tearful, alert, refusing to talk but remaining cooperative; his mother was in the room with him. He was offered a Tetanus shot which he

refused, and there were no psychotropic medications prescribed or administered and no use of restraints before his admission to the intensive care unit according to the record.

Physician's orders entered at 3:40 p.m. admitted the patient to intensive care for intoxication, depression and suicidal ideation; he was placed on suicide precautions and waited for a psychiatric consult. Clonazepam, Cymbalta and Zyprexa were ordered at the onset as the patient was taking these medications at home, and Ativan as needed was added later that evening. There is no evidence of getting *informed* consent for these drugs, although the medicine administration records and progress notes suggest that he took most of them willingly, and no indication as to whether the patient had capacity to provide informed consent for them. His first dose of Ativan was given at 5:15 p.m. Corresponding progress notes stated he asked for the medication to help take the edge off his "jonesing" for a cigarette. Three more doses followed through midnight, all of which were given for agitation at the patient's request.

Progress notes documented the counselor's arrival at 3:15 a.m. By 4:45 a.m. he was noted to be at high risk for harming himself, saying he would be successful the next time he tried suicide. The involuntary admission process was started, a petition completed at 5:10 a.m. and a certificate at 10:00 a.m. At 3:20 p.m. the patient was informed he would be going to a psychiatric facility. The notes stated that he grew increasingly erratic and loud, pacing around refusing to go quietly. A code was called soon after as the staff felt threatened per the notes. Additional staff as well as the police arrived to help. The patient continued to escalate, yelling repeatedly that he would not go. At 4:00 p.m. the attending physician ordered more Ativan and 4-point restraints if needed. A nurse wrote at that time, "Pt. informed that he can willingly comply and allow us to give his Ativan or he will be restrained for his threatening behavior." Twenty minutes later, "Pt. consented to medication, Ativan 1mg given per IV. At [4:25 p.m.] an additional 1mg Ativan given per IV. [4:35 p.m.], pt. continues to escalate, not allowing restraints, IV noted to be infiltrated, site puffy. Pt. began to fight forcefully, 4 point restraints placed with police assistance. Second IV started." Another dose of Ativan was given at 4:40 p.m., and at 4:55, "Ativan 1mg IV given per Dr….order. Pt. thrashing about in bed, fighting against restraints….Attempted to talk patient down. He screams and yells, then will talk in quiet voice, then become irratic [sic] again, screaming and yelling." In all, the patient was given six doses of Ativan between 4:00 p.m. to 6:00 p.m. when he was transferred. He left the hospital restrained in an ambulance.

The chart contained no rights restriction notices to accompany medications or the restraints. An order for the restraints is included, but was rather incomplete. It only listed that four-point velcros were applied because of danger for harming self and others. It failed to note the events leading up to the need for restraints, less restrictive measures attempted and the duration for which they were ordered. Likewise, there were no observations documented while the patient was restrained for an hour and a half before leaving the hospital.

CONCLUSION

The hospital's policy for referring the emotionally ill states that should a patient be dangerous to himself or others, he is subject to involuntary hospitalization in accordance with the

Mental Health Code and that he has a right to accept or reject treatment under the same. Required petitions and certificates are to be completed. Policy (#600.006) says that restraints are used only for situations in which other less restrictive alternatives such as close observation and supportive staff interaction have been considered. A registered nurse will assess the situation, and a physician's order for the restraints must be obtained within eight hours. The order must specify a start and stop time and state the condition for requiring the use of restraints. Any patient requiring four-point restraints must be visible at all times and must be reassessed with documentation every fifteen minutes. Restraints will be loosened one limb at a time every two hours to check for circulation and skin condition, permit movement and reduce pressure. A restraint monitoring form must be completed.

The Mental Health Code calls any licensed hospital and any section thereof that provides mental health services a mental health facility (405 ILCS 5/1-114). Psychotropic medications are those administered for antipsychotic, antidepressant, antimanic, antianxiety, behavioral modification or behavioral management purposes (405 ILCS 5/1-121.1). To reach informed consent,

> *If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician…or designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as the alternatives to the proposed treatment…. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment. The physician or…designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only pursuant to the provisions of Section 2-107 [an emergency] or 2-107.1 [a court order].* (405 ILCS 5/2-102 a-5).
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> *An adult recipient of services, the recipient's guardian, if the recipient is under guardianship…must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian…shall be given the opportunity to refuse generally accepted mental health services…including but not limited to medication or electroconvulsive therapy. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm…and no less restrictive alternative is available.* (405 ILCS 5/2-107).

Under the Code, restraints may be used therapeutically, only to prevent a recipient from causing physical harm to himself or physical abuse to others. They must be applied by properly trained staff and never used as punishment, discipline or convenience. The order shall state the events leading up to the need for restraints, the purposes for which they are employed, the length

of time they may be used and the clinical justification for that length of time. They are to be used in humane and therapeutic manners. The person restrained must be observed as often as clinically appropriate but in no event less than once every fifteen minutes, a record of which must be maintained. Unless there is immediate danger, restraints are to be loosely applied to permit freedom of movement. Whenever restraint is used, the recipient is advised of his right to have any person of his choosing, including the Guardianship and Advocacy Commission, notified of the restraint (405 ILCS 5/2-108).

Finally, the Code states that whenever guaranteed rights under Chapter II are restricted, the service provider is responsible for promptly giving notice of the restriction or use of restraint to the recipient and to anyone he so designates (405 ILCS 5/2-201).

This patient presented voluntarily with thoughts of suicide and self-inflicted wounds. The charting suggests that during his wait for evaluation as he sobered, he was not opposed to the treatment being offered, even asking several times for more Ativan. The problem is a few missed steps in the due process. There is no evidence he was provided with thorough education on the medicine, including Clonazepam, Cymbalta and Zyprexa, and whether he had the capacity to provide informed consent given his condition, which is a violation of the Code. At question is if he was allowed to refuse or was given the opportunity to refuse Ativan after he learned he would be going to another facility and the situation escalated. New orders for Ativan were received at 4:00 p.m. A nurse wrote that the patient was told he could willingly comply with the medication or be restrained. He "consented" and received the dose twenty minutes later and was restrained anyway. At 4:55 the nurse wrote that Ativan was given again and that the patient was thrashing about in bed, fighting against the restraints. We were told his disposition about the medication at that time is not known. But, the documentation implies he had a qualified choice for one dose and no choice for the other, however necessary as he thrashed about in bed fighting, in which case he should have been provided with restriction notices and to have anyone he wanted notified of what was happening. These are Code violations. Likewise, the restraints seemed to be necessary although again, important steps in the process were missed. The order failed to include the events leading up to the need for restraints, alternatives attempted or considered and the time limits, all Code and program policy violations. It is difficult to tell if the restraints were aggressively applied or on so tightly they caused bruising, and, there were indications that the patient was thrashing about in them. Documented fifteen-minute checks were not done, which could have provided a more supportive answer. The failure to ensure safety through the required documentation is a violation of the Code and program policy. The complaints are <u>substantiated</u>, in part.

<u>RECOMMENDATIONS</u>

1. Train all physicians and appropriate staff to provide oral and *written* education and to document patients' decisional capacities whenever psychotropic medications are proposed and administered (405 ILCS 5/2-102 a-5).
2. Train all physicians and appropriate staff who order behavioral restraints to include the events leading up to the need for restraints, less restrictive alternatives attempted, and restraint duration times on all orders (405 ILCS 5/2-108 and hospital policy).

3. Retrain all appropriate staff to conduct and document fifteen-minute checks for the duration of a patient's restraint (405 ILCS 5/2-108 and hospital policy).
4. Train all appropriate staff to complete rights restriction notices and to promptly notify anyone designated whenever psychotropic medications and behavioral restraints are used over a patient's objections (405 ILCS 5/2-107, 2-108 and 2-201).
5. Develop policies specific to treating and restraining mental health patients under the Code's due process.

SUGGESTIONS

1. The only authority to detain a mental health patient is by a completed petition. The staff at Rochelle Community Hospital should be instructed to proceed with petitioning on their own observations and to provide timely rights advisements the moment a patient is not allowed to leave, instead of waiting for community counselors to arrive (405 ILCS 5/3-600 et seq.). The counselor will still be able to determine the patient's course (405 ILCS 5/3-602 et seq.).
2. This patient carried a pending felony charge while he was at the hospital. According to the documentation, the counselor talked with staff at the State's Attorney's office and was told the person overseeing his case was unavailable and unlikely to temporarily drop the charges. The receiving hospital initially refused to take him unless he went voluntarily, but later a physician there said he would admit him anyway. Since there is no authority to involuntarily admit patients with pending felonies (405 ILCS 5/3-100), we encourage Rochelle Community Hospital to open dialogue with the county's State's Attorney on how to proceed with any future instances.

RESPONSE

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

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August 25, 2010

Erin Wade, Ph.D., Chairman
Human Rights Authority
Illinois Guardianship and Advocacy Commission
4302 N. Main St., Ste. #108
Rockford, IL 61103-5202

RE: #10-080-9012

Dear Mr. Wade:

In your correspondence of August 5, 2010, the following recommendations were made:

1. Train all physicians and appropriate staff to provide oral and written education and to document patients' decisional capacities whenever psychotropic medications are proposed and administered (405 ILCS 5/2-102 a-5).
2. Train all physicians and appropriate staff who order behavioral restraints to include the events leading up to the need for restraints, less restrictive alternatives attempted, and restraint duration times on all orders (405 ILCS 5/2-108 and hospital policy).
3. Retrain all appropriate staff to conduct and document fifteen-minute checks for the duration of a patient's restraint (405 ILCS 5/2-108 and hospital policy).
4. Train all appropriate staff to complete rights restriction notices and to promptly notify anyone designated whenever psychotropic medications and behavioral restraints are used over a patient's objections (405 ILCS 5/2-107, 2-108 and 2-201).
5. Develop policies specific to treating and restraining mental health patients under the Code's due process.

In response to these recommendations, the following has occurred:

1. In-services were conducted for physicians and staff on the care of the mental health patient in the spring of 2010.
2. Policies pertaining to patients' rights and the use of restraints have been reviewed and are in the process of being updated to comply with the Mental Health Code.
3. Training of the policy revisions and documentation review will occur in the fall of 2010.

Respectfully submitted,

Betty O. Mortensen

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