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HUMAN RIGHTS AUTHORITY-NORTHWEST REGION

REPORT 10-080-9020
SWEDISHAMERICAN HOSPITAL

Case Summary: there were no violations found. The Authority's findings are recorded below, and there is no facility response.

## INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at SwedishAmerican Hospital. It was alleged that hospital staff physically abused a patient in the Emergency Department.

Substantiated findings would violate protections under the Medicare/Medicaid Conditions of Participation for Hospitals (42 C.F.R. 482), the Hospital Licensing Act (210 ILCS 85) and the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Located in Rockford, the hospital has an Emergency Department (ED) with over thirty treatment rooms, four of which are reserved in a secure location for patients with behavioral or substance abuse needs. The HRA visited the facility where hospital representatives including those involved in this patient's care were interviewed. Hospital policies were reviewed as were sections of the adult patient's medical record and related quality control reports, security reports, video recordings and photographs, with written authorization.

## COMPLAINT SUMMARY

The complaint states that a young man arrived by ambulance at the hospital's ED, agreeing to undergo evaluation. From inside the hospital he spotted his mother and sister and he ran outside toward them. Numerous people grabbed him, at least four or five security guards and a police officer. They pulled him around a corner, out of view from the family, as the mother reportedly heard them taunting the patient, saying, "Come on big guy. Show us what you got." The family went in the main entrance and got to the patient's exam room about ten minutes later to find him restrained, his face covered in blood. The police officer allegedly said that the patient was spitting at them and was banging his head on the concrete and that he was going to jail for the spitting.

FINDINGS

According to the ED record, the patient arrived at 18:16 one evening and was immediately triaged; chief complaints were that he needed a psychological evaluation. He reported having suicidal thoughts and had consumed alcohol. The summary report makes no mention of what transpired after that until a nurse entered at 18:42 that she assumed care of the patient whom security brought to the room in leather restraints. The nurse wrote that the patient was very aggressive, verbally abusive and that he was spitting, kicking, screaming and slamming his head on the bed. He had just been given Haldol, and his mother was in the room with him.

We asked the nurse for her recollection of what transpired. She explained that the patient was brought to a medical room after triage and was making threats to leave, which he eventually did out the main ED entrance. He ran over to the ambulance bay after staff attempted to redirect him. She heard a call for a bed outside, and on arrival she saw the patient struggling with security. He was trying to get away, thrashing about, fighting, and slamming his head on the ground. She remained a couple of feet away as several security staff tried to contain him. She could not see the patient's face but could see his arms and legs flailing around. The nurse said when she got there the patient was on the ground, but once he was in a standing position he would lean backwards and try to flee again, which caused an entanglement and everyone fell into the ED doors. The patient was able to be restrained on the bed soon after, and she did not see any of the staff being physically harmful to him. Regarding follow up on the matter, she said she was interviewed by her supervisors and a Department of Public Health inspector.

We looked to the nurse's quality control report for her documented account. She wrote that the patient was triaged; he was suicidal and walked out. Security was called to bring him back, and he was violent, aggressive, kicking, spitting, banging his head, struggling to get away. During the struggle the patient and security fell into the doors and landed on the ground where the struggle continued. The patient was still being aggressive and violent, and they had to put a spit mask on him. He was placed on a bed in restraints and was given a Haldol injection that had no immediate affect.

A second nurse on the scene was asked for what she witnessed. She said she remembered seeing the initial outburst when the patient was outside the main entrance trying to get in someone else's car. He was yelling at his family, being very abusive to them. She reported seeing or hearing nothing inappropriate in how security handled him.

The second nurse did not complete a quality control report, but we reviewed three more from other nurses and personnel who were there as well. Another nurse wrote that she followed the patient outside. His mother came out from the main lobby crying, trying to talk to him. Security was moving in as she tried to remove the mother and sister from the situation. Her report states that the family was worried for him, saying this was the only way to help him. A fourth nurse wrote that she was called to bring restraints outside where she found security holding the patient face-down on the ground. She described him as being aggressive, spitting at security, and she went for a spit mask. He was restrained to the bed but still tried to kick at them, getting one nurse on the hand. He was taken inside where the nurse ended her report by noting

that she applied an ice pack on his forehead injury. Another employee wrote much of the same, that he saw the patient shouting at a woman and security. He was swinging his arms and "attacked" security, spitting on them. They held him on the ground, put him in restraints and took him inside on a cart.

Six security guards helped with the patient, five of whom we interviewed as one is no longer employed at the hospital. Each offered similar accounts of what took place. To summarize all their statements, one said she arrived outside to find a couple nurses trying to calm and talk with the patient who was swearing and yelling. He lunged at her so she called for backup. Four additional guards came to assist, and she left to get a wheelchair. Everyone was moving toward the ambulance bay when she returned and the patient started fighting more. By "controlled take-down" they took him to the ground because he kept kicking, hitting, trying to get away. The guard said the patient flipped at some point from being on his back to being on his stomach. Even on the ground he was still fighting and banging his head on the pavement, and she tried to hold his head to stop him. A second guard said he saw her do that. He arrived to find the patient trying to get in a car as he was cursing at everyone around him; verbal cues were not working to redirect him. He and a third guard each held one of the patient's arms, one hand on the wrist and the other on the bicep. A fourth guard assisted closely on one side and a fifth followed from behind. They described a "slow take-down" to the ground on his stomach. The guard said the patient yelled, "Fuck you" and spat in his face. He said he never lost control of the patient or himself and left to clean off when the patient was being restrained. The patient was back in a hospital room when he returned. The fourth and fifth guards told us that the patient was aggressive and uncontrollable, that take-downs are done only to ensure everyone's safety as was the case here. They did not see him hitting his head as they were positioned behind the guards holding him, but they also did not recall anything inappropriate on security's behalf. One guard said he tried to hold the patient's legs during the take-down, during which time he fell against the doors and was unable to move or reposition for a while. He saw that once on the ground the patient continued to be frustrated and banged his head. Whoever was on top, one of the male guards, either the second or third guard, tried to stop him from banging his head but he was not sure which one. None of the guards recalled a police officer being present.

To summarize their documentation, security reports consistently noted the patient's increasing verbal and physical aggressions and that calming and redirections failed to stop him. They describe which guards held the patient's arms, which of them assisted or followed and how they took him down when it became impossible to escort him any farther. The first guard on the scene wrote that once on the ground he kept banging his head on the cement and moving it back and forth causing heavy bleeding. The two guards who held either arm wrote exactly the same as each other for the majority of their reports. Specifically on the banging, they wrote that once on the ground he "began to bang his head resulting in heavy bleeding from his nose and above. Once [the patient] stopped he began yelling and cursing and making threats." No one documented that they tried to stop his banging, although one guard wrote that he controlled the patient's head to stop him from spitting on him again.

We also reviewed video recordings of what occurred between the patient and security; there was no audio. It showed the patient standing by a car as two nurses tried talking to him. Security guards appeared as two take the patient's arms. The video showed the group going to

the ground, but it looked more like the group fell on top of the patient just as the nurse described as opposed to it being a slow, controlled take-down as security described. The video does not show the security team or any other employee beating the patient or being physically improper with him at any time. It does not show the patient banging his head because several guards standing around him were blocking camera view. It also therefore does not show anyone holding his head, although a female can be seen moving around to where his head would be. The video otherwise recorded the events as reported to us.

ED and security managers said they reviewed the reports and interviewed all the staff who completed them. They stated that no outside police officers were involved. They believed that everyone handled the patient accordingly. But we questioned one nurse's entry within her report. She wrote that once the patient was back in a room, "Security continued to exculate [sic, escalate] situation - verbally. This nurse re-directed security to decrease verbal agitation or remove himself from situation (pt was already restrained)." During our interviews the nurse could not remember what the guard said, but she described who he was. We spoke to that guard again, and he said at no time was he verbally aggressive with the patient. He was not angry with him, although he pressed charges because spitting is battery. He said the patient wanted him and another guard to leave, and he replied that he would not leave until staff told him to. Asked about his follow ups, the security manager said the nurse reported to him that it was more about security no longer doing any good at some point, not that they were doing anything wrong. We asked for something more concrete and were provided with a written statement from the manager. He stated that he visited two nurses recently to inquire again about what happened in the room. One nurse said she heard nothing inappropriate from the guards, but just their presence can sometimes escalate patients; this was one of those times. The nurse who wrote about the problem in her report said the guard and the patient were arguing back and forth but she could not remember the exact exchange of words. She asked both of them to calm down and stop the back and forth. After this failed, she asked security to leave the room. The manager said that based on this information, he has instructed his staff to follow caregiver directives and not to carry on conversations with patients unless ok'd by the caregiver.

The ED record demonstrated how the patient was cared for after the incident. The attending nurse entered that the patient had contusions or abrasions on his face, over his eyebrows and on his cheek and chin; the bleeding was controlled, and an ice pack was applied. He was examined by a physician who ordered CT scans of his face. Fractures were ruled out. Photographs taken at the hospital displayed the injuries as the nurse described.

We reviewed Department of Public Health survey findings for the month that followed the incident. There were four clinical records that showed patients restrained for violence were not given rights restriction notices, one showed that no alternative interventions were initiated prior to being restrained, six showed that restraint orders did not include time limits, and another showed the failure to discontinue restraints at the earliest possible time. There were no indications that the Department investigated abuse within this set of findings.

## CONCLUSION

SwedishAmerican policy (20-951.214.0) on patient interactions states that each patient receives respectful, quality care that promotes dignity, safety and comfort. Any incident of patient abuse will be reported immediately to the manager of the department, Human Resources and Risk Management. Any report of misconduct will be immediately investigated and steps will be taken for remediation. There is no circumstance that justifies mistreatment of patients and all complaints of patient abuse will be taken seriously. Incident reporting policy (10-950.053.8) calls for quality control reports to be completed and forwarded to Risk Management to facilitate follow up and investigation for occurrences that represent risk, injury or serious complaints regarding a patient's quality of care.

The Code of Federal Regulations prohibits all forms of patient abuse or harassment in hospitals (42 C.F.R. 482.13). Illinois' Hospital Licensing Act states that no administrator, agent, employee or medical staff of a hospital may abuse a patient (210 ILCS 85/9.6). Under the Mental Health Code, all recipients enjoy the right to be free from abuse and neglect (405 ILCS 5/2-112). Abuse is any physical injury, sexual abuse or mental injury inflicted other than by accidental means (405 ILCS 5/1-101.1). Neglect is the failure to provide adequate medical or personal care, which results in physical or mental injury (405 ILCS 5/1-117.1).

ED and security managers investigated the incident as required by policy and believed that this patient was handled appropriately under the circumstances he presented. Everyone directly involved completed reports as required by policy, nearly all of which attested to the patient banging his head on the ground. Based on those reports, the video recordings and staff statements, there is no factual evidence to say that the guards or any other hospital employee inflicted his wounds. The complaint is unsubstantiated.

## SUGGESTIONS

1. Medical records should reference and account for everything that happens with a patient in the hospital. This patient's ED progress notes document nothing between his arrival to a room after triage and his return to another room with facial injuries.
2. One security guard told us that she tried to hold the patient's head to prevent him from banging it on the ground, but her report does not reflect that. The second guard told us he remembered her doing so, but his report does not reflect that. Another guard told us one of the male guards on top of the patient tried to hold his head, but his report does not reflect that either. Undocumented events can suggest they never happened and the security team could have been negligent under the Mental Health Code without trying to stop the patient from harming himself. This kind of information is imperative and should be included so that documentation of physical altercations with patients is thorough, supportive and helps eliminate discrepancies.
3. Security reports made by the two guards who held the patient's arms are nearly identical. Clearly one copied the other. SwedishAmerican should review these reports and reaffirm with security staff that employees must document their own accounts of incidents.
4. Revise policies to reflect that all allegations of patient abuse must be reported to the Department of Public Health within twenty-four hours (210 ILCS 85/9.6).
5. When a mental health recipient is restrained in the ED, follow Mental Health Code provisions related to restraint use by issuing restriction notices, documenting attempts at

less restrictive alternatives, indicating time limits for restraint use and by releasing restraints as soon as release criteria are met.

6. This is the sixth complaint in the past five years alleging that SwedishAmerican security guards are injurious, too aggressive or inappropriate with patients in the ED (see HRA #06-080-9001, 07-080-9014, 08-080-9003, 08-080-9004, and 08-080-9011). While some have been substantiated and others have not, we are alarmed at the suggested pattern within one facility and implore the hospital to ensure it sees positive evidence of the training and improvements it has committed to providing, particularly in how security interacts with the mentally ill.