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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 11-030-9001
Provident Hospital of Cook County

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Provident Hospital of Cook County (Provident). It was alleged that the facility did not follow Code procedures when it detained, restrained, and then neglected a recipient. If substantiated, these allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Provident Hospital is a community teaching hospital and part of the Cook County Bureau of Health Services. The emergency department serves more than 50,000 persons per year.

To review these complaints, the HRA conducted a site visit and interviewed the Chairman of Emergency Medicine, the Nurse Manager of Emergency Medicine, the Associate Director of Nursing Administration, two Attending Physicians of Emergency Medicine, the Staff Nurse of Emergency Medicine, the Risk Manager, the Assistant Director of Quality Services, and the Interim Director of Quality Services. Relevant program policies were reviewed as were the recipient's records upon written consent. The recipient is an adult.

COMPLAINT SUMMARY

The complaint alleges that on 3/26/10 the recipient went to Provident Hospital for medication for stress, hypertension and constipation. Allegedly, after being examined, he stated to the nurse that after all he had been through in the past several days "God must have sent an angel to strengthen me to endure." The complaint then indicates that the nurse told the recipient he could not leave and that he had to be transported to another facility for psychiatric evaluation. The complaint indicates that the recipient attempted to leave at one point but security was called and he was placed in restraints and forced to remain in the hospital. The complaint states that the recipient was held from 7:00 am on Friday until 10:00 am on Saturday and other than one meal on Friday, he received no food or water. When he was placed in restraints, the complaint

indicates, he was given a urinal which he could not reach and he was forced to lay in his urine all night.

FINDINGS

The recipient's face sheet shows that he arrived at the emergency department on his own accord at 6:52 a.m. on 3/26/10. The chief complaint is listed as "anxious, paranoid, constipated." At 8:05 a.m. that day a History and Physical was completed which indicated visual hallucinations and paranoia. The Final Disposition recommends transfer to a state mental health facility and it also shows that another hospital was also contacted for possible transfer (this hospital later refused the recipient).

The record contains a Uniform Screening and Referral Form. It indicates an Axis I diagnosis of Psychosis. It describes the recipient as appropriate in dress, affect, and speech. His mood is described as euthymic (implying normal range), his cognition shows no deficits, and his thought process as "goal directed/linear." The recipient's thought process is "paranoid delusions and visual hallucinations." He is described as oriented to person, place, time and date, and his insight and judgment are described as "fair." The evaluator rated the recipient's level of dangerousness to self or others as low.

The record shows that the recipient signed a Consent for Physical Examination and Treatment on 3/26/10 (no time given). Emergency Nursing Patient Assessment Notes indicate that he underwent routine diagnostics throughout the morning of the 26th to include urinalysis, blood work and CT scan. He received Clonidine 0.1 mg orally at 11:45 a.m. on 3/26 and at 12:30 a.m. on 3/27. At 12:47 p.m. on 3/26/10 the recipient was transferred from his room into the adjacent hallway, while awaiting his transfer to either the state facility or hospital. It shows that he was given lunch at this same time. No other outstanding behaviors are noted. At 6:30 p.m. the record shows the recipient was given a dinner tray. The record shows that at 7:30 p.m. the recipient was "calm and cooperative" as he remained all evening, and the note entered at 11:10 p.m. indicates he was "on bed # 6 no complaint."

The record contains a petition for involuntary admission completed by an emergency department physician that is not dated and no time is given. The behaviors that are described to assert the need for involuntary commitment are, "Pt. complains of seeing people who he claims aren't there yesterday. Paranoia thinking people are poisoning his food. So won't eat." A checklist indicates that the recipient is reasonably expected to inflict serious harm on himself or another in the near future, is reasonably expected to engage in threatening behavior that places another person in reasonable expectation of being harmed, and is unable to understand his need for treatment because of his illness, and thus is in need of immediate hospitalization to protect himself and others from harm. An accompanying certificate, completed at 11:25 a.m. on 3/26/10 also indicates by checklist that the recipient, because of his mental illness is reasonably expected to inflict serious physical harm on himself or others, is unable to provide for his basic needs without outside help, is expected to engage in dangerous conduct which may place the recipient or others in harm, and is unable to understand his illness or his need for treatment to the extent that he is reasonably expected to engage in "dangerous conduct." The section of the document that offers the certifier's clinical observations and factual information on which to base these

assertions is blank. The section that indicates the recipient has been admonished of his rights is certified by the signature of a physician. The record includes a Rights of Admittee document and it certifies that the recipient received a copy of this document within 12 hours of its completion while at Provident. The record contains no physician's statement of decisional capacity.

At 11:11 p.m. the notes indicate that the recipient had attempted to abscond from the hospital and was brought back to the emergency unit by security and placed in restraints at 11:35 p.m. A physician's restraint order form is included in the record, however it is not completed except for the physician's signature and the date and time to discontinue restraints, which is 3/27/10 at 7:30 a.m.

The record contains a Nursing Alternatives to Restraint/Restraint Flowsheet. It shows that the restraint period began at 11:30 p.m. on 3/26/10 and continued until 7:30 a.m. on 3/27/10 with 15 minute checks. The form offers a legend for assessing the recipient's A) behavior, B) restraint alternatives, C) interventions and safety measures, and D) patient status. At 11:30 p.m. the notes indicate that the recipient was "anxious, agitated, crying, and restless ('other' is marked however nothing is indicated to describe this)." In the B section it indicates "provided constant supervision" and "other." In section C it states "spoke with patient in a calm/quiet manner" and "other". In section D it states, "Patient quieted" and "other." From midnight through 7:00 a.m. the flowsheet indicates at each 15 minute check that the patient is angry, that he received reduced environmental stimuli, that the recipient was spoken to in a calm/quiet manner, and that the recipient was "calm and able to control behavior for last 30 minutes."

The restraint flowsheet contains a section which indicates physical care that is offered to the recipient. It is difficult to tell on the sheet for the 26th, but the sheet for the 27th indicates that the recipient was "toileted," "food/fluid offered", and "hygiene measures provided" at midnight and again at 2:02 a.m. At these times the record shows that the skin and restraints were checked, the recipient's position changed, and circulation assessed. It is very difficult to tell from the restraint flowsheet if there was any additional care given to the recipient and the restraint episode is not described in the emergency department notes. There is an hourly nursing assessment that is part of the record, and it gives the patient's vital statistics. The record does not contain a statement that the restraints do not pose an undue risk to the health of the recipient. The record indicates that the recipient was released from restraints at 7:30 a.m. on 3/27/10.

The recipient was transferred to a state mental health facility at 10:30 a.m. on 3/27/10.

Hospital staff were interviewed regarding the complaint. They stated that although the recipient came to the hospital for medication for stress and constipation he was very delusional from the time he arrived in the emergency department. His attending physician evaluated him soon after his arrival and stated that he was so delusional he was probably unable to understand his treatment (actively hallucinating). His physician felt that the recipient could not be released back into the community in his condition and the decision was made for him to be transferred for psychiatric evaluation and treatment. The recipient had requested a hospital and the Provident staff attempted to get him transferred there, however that facility would not accept him. The Provident staff then contacted a state mental health facility and they began the process of transfer at 7:30 a.m. on the day the recipient arrived, however the receiving facility took until the

following day to approve the transfer, which facility staff stated is not unusual for recipients without insurance. The recipient's attending physician stated that the recipient became very anxious about the length of time he was waiting for his transfer and decided to leave the facility. Security was then called and the recipient was placed in restraints because he was a flight risk.

Hospital staff were interviewed regarding the restraint episode. They stated that patients are given the same nursing attention in restraints as for other patients in the emergency department and are monitored constantly. They stated that they see approximately 30-40 mental health recipients a month in the emergency department, but they very rarely use restraints. Generally they make sure that restrained individuals are safe and then they allow them to use the bathroom free from restraints. This recipient was given a urinal because it was determined that he was not safe to be removed from his restraints, which is the only condition under which a recipient in restraints would be given a urinal. Staff reported they would generally not allow a patient to remain on soiled linens and may not have been aware that the recipient was not able to use the urinal. The attending staff stated that the recipient received meals and water while in restraints and was checked according to the 15 minute mandate.

STATUTORY BASIS

The Mental Health Code describes a "mental health facility" as "...any licensed private hospital, institution, or facility or section thereof, and any facility, or section thereof, operated by the State or a political subdivision thereof for the treatment of persons with mental illness and includes all hospitals, institutions, clinics, evaluation facilities, and mental health centers which provide treatment for such persons" (405 ILCS 5/1-114).

The Mental Health Code states that when a person is asserted to be in need of immediate hospitalization, any person 18 years of age or older may complete a petition (5/3-600), which specifically lists the reasons (5/3-601). The petition is to be accompanied by the certificate of a qualified examiner stating that the recipient is in need of immediate hospitalization. It must also contain the examiner's clinical observations and other factual information that was relied upon in reaching a diagnosis, along with a statement that the recipient was advised of certain rights (3-602), including that before the examination for certification the recipient must be informed of the purpose of the examination, that he does not have to speak with the examiner, and that any statements he makes may be disclosed at a court hearing to determine whether he is subject to involuntary admission (5/3-208). Upon completion of one certificate, the facility may begin treatment, however at this time the recipient must be informed of his right to refuse medication (3-608). As soon as possible, but no later than 24 hours after admission, the recipient must be examined by a psychiatrist or released if a certificate is not executed (5/3-610).

Should the recipient wish to exercise the right to refuse treatment, the Mental Health Code guarantees this right unless the recipient threatens serious and imminent physical harm to himself or others:

"An adult recipient of services...shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to 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 physical harm to the recipient or others and no less restrictive alternative is available. The facility director shall inform a recipient...who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services" (405 ILCS 5/2-107).

Additionally, the Code states that whenever any rights of the recipient of services are restricted, notice must be given to the recipient, a designee, the facility director or a designated agency, and it must be recorded in the recipient's record (ILCS 405 5/2-201).

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

"Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized. In no event shall restraint be utilized to punish or discipline a recipient, nor is restraint to be used as a convenience for the staff.

(a) Except as provided in this Section, restraint shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities. No restraint shall be ordered unless the physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of restraint is justified to prevent the recipient from causing physical harm to himself or others. In no event may restraint continue for longer than 2 hours unless within that time period a nurse with supervisory responsibilities or a physician confirms, in writing, following a personal examination of the recipient, that the restraint does not pose an undue risk to the recipient's health in light of the recipient's physical or medical condition. The order shall state the events leading up to the need for restraint and the purposes for which restraint is employed. The order shall also state the length of time restraint is to be employed and the clinical justification for that length of time. No order for restraint shall be valid for more than 16 hours. If further restraint is required, a new order must be issued pursuant to the requirements provided in this Section....

(c) The person who orders restraint shall inform the facility director or his designee in writing of the use of restraint within 24 hours.

(d) The facility director shall review all restraint orders daily and shall inquire into the reasons for the orders for restraint by any person who routinely orders them.

(e) Restraint may be employed during all or part of one 24 hour period, the period commencing with the initial application of the restraint. However, once restraint has been employed during one 24 hour period, it shall not be used again on the same recipient during the next 48 hours without the prior written authorization of the facility director.

(f) Restraint shall be employed in a humane and therapeutic manner and the person being restrained shall be observed by a qualified person as often as is clinically appropriate but in no event less than once every 15 minutes. The qualified person shall maintain a record of the observations. Specifically, unless there is an immediate danger that the recipient will physically harm himself or others, restraint shall be loosely applied to permit freedom of movement. Further, the recipient shall be permitted to have regular meals and toilet privileges free from the restraint, except when freedom of action may result in physical harm to the recipient or others.... (405 ILCS 5/2-108)."

The Mental Health Code states that every recipient of services shall be free from abuse and neglect (405 ILCS 5/2-112). Neglect is the failure to provide adequate medical or personal care which results in physical or mental injury or the deterioration of physical or mental condition (405 ILCS 5/1-117.1).

HOSPITAL POLICY

Provident Hospital policy #06-03-25 states that persons presenting to the emergency department will be interviewed to determine if they have a medical or psychological complaint and assessed for priority for medical screening/treatment. Patients who are homicidal, suicidal or psychotic are listed as semi-urgent, meaning they require immediate medical attention and will be taken immediately to the treatment area. Treatment beds are assigned based on the patient's triage needs. Patients requiring psychiatric evaluation are immediately placed in a quiet area, if available, within the main emergency department. Policy #06-03-88 states that psychiatric patients will be evaluated by a physician and then when medically cleared, the patient may be transferred to a facility with psychiatric services after the physician called and discussed the case with the psychiatrist.

Provident Hospital policy #05-01-30 states that restraints are only applied when necessary to receive effective treatment and not as a means of "coercion, discipline, convenience or retaliation." Restraints are short-term therapeutic measures applied humanely in the least restrictive manner possible and discontinued as soon as it is safe to do so.

Behavior Management Restraints refer to restraints used in any treatment setting where the intervention is necessary for the management of violent or self-destructive behavior that jeopardizes the immediate safety of the patient, a staff member or others. Restraints for this purpose are used upon the written order of a physician, LIP, RN, or PA and must include an evaluation which includes at a minimum the patient's immediate situation, the patient's reaction to the intervention, the patient's medical /and or behavioral condition, and the need to continue or terminate the restraint. The time limit for restraint orders is four hours for patients 18 years and older.

Each physician's order must include:

- Assessment of behavior leading to restraint;
- Clinical justification of the use of restraints;
- Less restrictive measures implemented and are not effective;
- Type of restraints;
- Limited time period

The patient in restraints must be observed every 15 minutes and provision of care must be provided at least every two hours for inspection of skin under the restraints, range of motion, repositioning, offer of toilet, hydration and nutrition, and personal care.

On initiation of restraints the physician and nurse document in the progress notes/restraint order form: Assessment of the patient's behavior and /or events leading to the use of restraints, less restrictive measures tried prior to restraint and the patient's response to these measures, clinical justification for use, and type of restraint selected.

CONCLUSION

The recipient in this case presented to the emergency department for medication at 7:52 a.m. on 3/26/10. He was triaged in the emergency department and medically cleared at 7:30 a.m. at which time the state mental health facility was contacted for his transfer. At this time the hospital determined that the recipient was too delusional to be discharged and a petition and certificate were warranted to further detain and treat the recipient. The petition is not dated or timed, so it is unclear when this form was completed. The certificate was completed at 11:30 a.m., however it is missing the certifier's clinical observations and factual information on which to base assertions that the recipient was in need of immediate hospitalization, which does not follow the Code's required procedures.

The restraint episode was initiated when the recipient decided to leave the hospital. Security was enlisted to retrieve the recipient, and he was placed in restraints from 11:35 p.m. on 3/26/10 until 7:30 a.m. the following day. The record shows that the physician's restraint order is incomplete. There is no indication from the order of the events leading up to the need for restraints, no clinical justification for the restraints, no statement that the restraints do not pose a risk to the recipient's health, and no new physician's order after the four-hour limit. Although the emergency department nursing notes indicate vital sign checks every hour, the documentation indicating that the recipient was given chances for toileting and to have food and water shows only two entries, at midnight and two hours later (suggesting that he might have had to remain in soiled linens). This violates both the Code mandate for "regular toilet privileges" and the two-hour hospital policy for use of toilet. Even more troubling is the restraint flowsheet, which indicates that the recipient was "calm and able to control behavior for last 30 minutes" for the last seven hours of his restraint. Additionally, the flowsheet shows that the recipient was "quieted" from the onset of the restraint episode, calling into question the accuracy of any part of the document.

The HRA substantiates the complaint that the facility did not follow Code procedures when it detained and restrained the recipient. Although we are unable to substantiate neglect the documentation suggests that the recipient's care may not have been humane.

RECOMMENDATIONS

1. Once the determination has been made that a patient will be detained and treated as a mental health recipient, ensure that staff complete the necessary petition and certificate thoroughly which authorizes the hospital to involuntarily detain the recipient and provide treatment.

2. Review with staff the hospital and Mental Health Code requirements for restraint to include a physician's order stating the clinical justification for the restraint, that it is necessary to prevent the recipient from causing harm to himself or others, that it does not pose undue danger to the recipient's health in light of the recipient's physical or medical condition, that it states the events leading up to the need for restraint, and purposes for which it is employed, and that it states the length of time the restraints are to be applied and the clinical justification for that length of time. Ensure that the restraint is employed in a humane and therapeutic manner and that the recipient is observed every 15 minutes with documentation of these observations in the clinical record. Ensure that the recipient is permitted to have regular meals and toileting free

from restraint except when this may result in physical harm to the recipient or others. Ensure that recipients are released from restraints if the restraints are no longer clinically justified.

SUGGESTIONS

1. Make sure the hospital utilizes the latest version of the petition and certificate.