FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
ADVOCATE CHRIST MEDICAL CENTER– 11-040-9001
HUMAN RIGHTS AUTHORITY- South Suburban Region

[Case Summary— The Authority made corrective recommendations regarding one of four allegations that were accepted by the service provider. The public record on this case is recorded below; the provider did not request that its response be included as part of the public record.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA) has completed its investigation into allegations concerning Advocate Christ Medical Center in Oak Lawn. This general hospital with a psychiatric unit is part of Advocate Health Care. The specific allegations were as follows:

1) The hospital failed to provide a recipient with adequate supervision during the assessment process.
2) A staff person threw the recipient's eyeglasses at her.
3) Pain medication was delayed.
4) The recipient was transferred to another hospital because she tried to harm herself.

If substantiated, these allegations would be violations of the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.).

METHODOLOGY

To pursue the investigation, the Attending Emergency Department Physician, the Director of Medical Surgical and Psychiatric Services, the Manager of Outpatient Psychiatry, a Registered Nurse and a Crisis Intervention Worker were interviewed. The complaint was discussed with the adult recipient who maintains her legal rights. The recipient's record was reviewed with written consent. Relevant hospital policies were also reviewed.

COMPLAINT STATEMENT

According to the complaint, the recipient's private therapist had referred her to the hospital's Emergency Department (ED) because of suicidal ideations on June 16th, 2010. She told the triage nurse that she was suicidal upon her arrival and was placed unattended in a room. She started having a panic attack during a brief examination and the physician told her that he would be back in a few minutes. She removed the bed sheet from the cot, placed one end over the top

of the door, tied the other end around her neck, stood on a chair and tried to hang herself. A nurse heard the recipient screaming and removed the bed sheet from around her neck upon entering the room. She was allegedly placed on a cot in the hallway, and a nurse said "this is all that you will get" and threw the recipient's eyeglasses at her. Pain medication reportedly was delayed and a social worker said "that's what you get" when the recipient mentioned that her neck was hurting. A security officer asked "where is the crazy chick that was in room 14?" Additionally, the complaint alleged that recipient was transferred to another hospital because of her suicide attempt in the ED.

FINDINGS

The Advocate Christ Medical Center (ACMC) record indicated that the recipient was seen in the hospital's ED on June 16th, 2010 at 6:03 p.m., with complaints of suicidal ideations. Her condition was assigned an acuity rating of 2 (critical with stable vitals), and no pain was noted. She was asked to change into a gown and, according to the documentation, was placed alone in a room. At 6:26 p.m., a nurse wrote that the recipient was alert, cooperative, and that the physician was at her bedside. She reported having thoughts about killing herself by ingesting pills and alcoholic beverages. She told the physician that these thoughts had started about a week before her visit to the hospital. She was tearful as she talked about problems with her family. Her belongings were bagged and labeled with her name but were not inventoried.

At 6:31 p.m., the recipient was oriented to person, place and time upon examination by a Resident Physician. According to the physician's note, the recipient presented with increased depression and suicidal ideations. She reported having taken an overdose of medication about five days prior to her visit to the ED. She said that her therapist had encouraged her to seek help. She stated, "I want to kill myself and I [do not] like feeling this way." It was recorded that her history included psychosis and anxiety. At 6:34 p.m., the Attending Supervising Physician documented that he had personally examined the recipient and agreed with the management of her case. He also recorded that the recipient was "evaluated within fifteen minutes of sign up."

At 7:10 p.m., a nurse heard the recipient screaming and discovered upon entering her room that she had tried to hang herself. According to the nursing entry, the recipient was alert when the bed sheet was removed from around her neck. She was placed back on the cot; she was moved in front of the nursing station, and the physician was notified. The physician wrote that the recipient's neck was reddened, her voice was hoarse, but she was able to move all extremities after her suicide attempt. A Computed Tomography (CT) Scan of her cervical spine and CT Angiogram were ordered. There was no documentation found in the record that the recipient was wearing eyeglasses or that indicated whether the nurse was abusive toward the recipient. At 7:32 p.m., a Crisis Intervention Worker (CIW) completed a Psychiatric and Substance Abuse assessment and the recipient was recorded as saying "I just want to die." She reported having attempted suicide more times than she could remember. She was under the care of a psychiatrist and therapist in the community. The assessment also documented the recipient's suicide attempt and self harm plan previously mentioned. There was no mention in the record that the hospital's security was involved with the recipient.

Documentation indicated that the recipient was diagnosed with Depression and Suicidal Ideations. A determination was made that the recipient needed inpatient psychiatric care after the case was discussed with the medical physician and the psychiatrist on-call. The CIW recorded that the recipient would be transferred to another facility because there was no bed available for a female recipient on the hospital's psychiatric unit. At 8:15 p.m., a sitter was assigned to monitor the recipient who reportedly was comfortable on a cot in the hallway. Laboratory work was ordered around this time.

At 9:00 p.m., a certificate was completed by the Attending Physician, and a petition was prepared by the CIW at 9:30 p.m. But the record does not indicate that the recipient was refusing to be hospitalized. The CIW recorded that the recipient was informed about the plan to transfer her to another hospital for inpatient care. She also documented that there were no beds available at several named hospitals. At 9:07 p.m., the recipient's blood pressure and pulse rate were taken. At 9:32 p.m., Ibuprofen 600 mg was ordered and administered five minutes later. But, there was no documentation of the recipient's request for pain medication or why the medication was given. A CT Scan of her cervical spine and CT Angiogram of her neck were done around 11:00 p.m. All findings reportedly were within the normal limits. The CIW recorded that the recipient was given the receiving hospital's contact information and agreed to the transfer. Nursing entries indicated that the recipient's comfort was assessed and that she was given a blanket. She was stationed in the hallway and monitored by the sitter until she was transferred on June 17th at 2:15 a.m. A transfer form stated that "the patient was unable to sign" the document.

According to a note, the hospital conducted an investigation into the recipient's care and treatment in the ED. It stated that the recipient had complained of suicidal ideations at triage. She was escorted directly to the treatment area and was evaluated by a nurse and physician. She was placed in a room that has visual monitoring upon her arrival. A nurse checked on the recipient after she was evaluated by the physician. Ten minutes later, she heard the recipient yelling and observed a bed sheet around her neck upon entering her room. She was assigned a sitter after the incident. Tests results showed no signs of injury after the incident. She received pain medication five minutes after the medication was ordered. According to the note, the staff did not remember whether the recipient had eyeglasses and denied throwing them at her. The note was signed by the Manager of Clinical Operations but was not dated.

When the complaint was discussed with the hospital's staff, the HRA was informed that the most critical patients are assigned the highest acuity rating, which is level 1. Patients with suicidal ideations are escorted to the triage area and placed in one of the two treatment rooms that have a video monitor. They are assessed by a nurse. Their belongings are placed at the nursing station or given to the hospital's security staff. A recipient's items would be inventoried, and a restriction notice would be provided if they are given to security. Patients are seen by a physician. The recipient involved in the complaint reportedly went from the waiting area, to triage and then was placed in an examination room with video monitoring about four feet from the nursing station. According to the staff, the camera reportedly was working on the incident day. The monitor is located at the nurse's station, but patients are not monitored at all times.

The staff interviewed said that the recipient attempted to harm herself before the CIW was called. The nurse who found the recipient hanging from the bed sheet could not remember if her feet were touching the floor. The recipient was moved out of the exam room and placed within 2 to 3 feet of the nursing station. She reportedly apologized because she believed that the nurse might have been injured trying to help her. A sitter was assigned to monitor the recipient for the duration of her visit. According to the Director of Medical Surgical and Psychiatric Services, a new procedure was developed after the recipient's suicide attempt in the hospital's ED. All patients presenting with suicidal thoughts will be assigned a sitter even if they are placed in a treatment room with video monitoring.

The nurse and the CIW identified in the complaint denied making derogatory remarks to the recipient. They did not remember her wearing eyeglasses or asking for pain medication. The staff reported that pain medication was given within minutes after the medication was ordered as documented in the record.

The investigation team was informed that the hospital's adult psychiatric unit has eight rooms that consists of 16 general beds. Its Intensive Care Unit has five beds and two staff are usually assigned. According to the staff, the recipient would have been appropriate for either unit, but there was no bed available for a female patient on the incident day. The CIW said that she would have documented in the record if the recipient had refused the transfer plan. A petition and certificate are completed for all patients transferred to another facility for inpatient psychiatric care. On questioning, the staff were not sure whether the recipient had filed a grievance with the hospital regarding her care. They said that grievances are sent to the Patients Relations Department.

ACMC's "The Patient Care Process in the Emergency Department" policy (Revised on April 28th, 2004 and Reviewed on October 30th, 2009) states that every patient will be triaged to the appropriate area using the Emergency Severity Index - Five Level Triage System that matches the acuity of their presenting symptoms. The policy states that level 1 is assigned to patients who require immediate life-saving treatment. Levels 2 and 3 are for those whose conditions are acute but are not life threatening. And, levels 4 and 5 are for patients with non-urgent complaints. According to the policy, patients in the waiting areas will be reassessed and acuities updated as determined necessary by the nursing staff. The nurse will document the focused assessment of the patient at the minimum upon placement in the treatment room and assess those symptoms related to the presenting complaints.

According to the policy, all patients will be seen by the Attending Physician, and they also may be seen by a Resident Physician who is working under the supervision of the Attending Physician. Based on assessments and examinations, a treatment plan is developed and communicated to the patient. All pertinent laboratory and diagnostic/screening testing will be ordered, performed and documented in the medical record. The physician will determine a disposition and the patient and staff will be informed. Written instructions regarding the patient's condition and follow up information will be provided at discharge. The Attending Physician should be called concerning any questions about the patient's treatment.

The hospital's "Emergency Care of the Agitated Patient" policy (Revised on March 19th, 2010) states that patients will be treated with a non-judgmental, caring attitude in an environment most appropriate for their care. All treatment will be administered with consideration for safety and preservation of the patient's rights' and dignity. Agitated patients who are able to control their behavior will be triaged and a history will be obtained. Those who are suicidal or homicidal will be escorted directly to the department's treatment area. They will be placed in a gown for protection of self and others. Their belongings will be inventoried, placed in a sealed bag, and given to security. A restriction of rights notice will be provided if the patient is uncooperative during this process.

ACMC's "Clinical Assessment/Admission Level of Care Disposition" policy (Revised on November 10th, 2009) states that potential patients will receive a comprehensive assessment for the purpose of determining the appropriate treatment and level of care and/or follow up referrals. The CIW is responsible for periodically reassessing patients in the Emergency Department and this requirement cannot be substituted for those done by the physician or nurse.

The hospital's "Patient Rights and Responsibilities" policy (Revised on June 8th, 2010) includes the right to receive care in a safe setting, have pain management, to be free from all forms of abuse, and to file a complaint regarding services with the hospital or the Illinois Department of Public Health (IDPH) without fear. The policy includes the IDPH's telephone number and states that information will be provided regarding how to file a complaint with the hospital.

ACMC's "Resolving Patient/Family Complaints and Grievances" policy (Effective on August 1st, 2010) states that patients and their representatives are informed about its grievance process in many ways. For example, the Patient Rights and Responsibilities is reportedly provided upon admission and posted throughout the hospital. The policy states that a verbal or written complaint is considered a grievance if the complainant is not satisfied with the resolution provided by the receiving staff person. The hospital will try to resolve the grievance promptly, and that the majority will be resolved within 7 days upon receiving them. The complainant will be provided with an estimated date of completion if the investigation takes longer than 7 days. A resolution letter will be sent to the complainant that contains the steps taken to investigate the grievance and outcome, and the date completed.

CONCLUSION

> 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.

Based on the record and the staff interviewed, the recipient presented to ACMC Emergency Department because of suicidal ideations. She was placed alone in an exam room and tried to hang herself. A safe environment was not ensured until the recipient was moved to

the nursing station and then provided with a sitter. The Authority believes that putting her at the nurse's station and taking her sheet away was probably a good safety measure until the sitter arrived. The hospital took steps immediately following the incident to resolve the problem and have new procedures for suicidal patients. The complaint that the hospital staff failed to provide the recipient with adequate supervision during the assessment process is substantiated. The hospital violates Section 5/2-102 (a) of the Code only in regard to supervision and its policy and patient rights statement regarding care in a safe setting.

Documentation indicated that the recipient was provided with adequate medical evaluation based on assessments and medical screenings. She was given pain medication within minutes after the medication was ordered. There was no documented reason or request for the medication found in her record. The HRA found no evidence during the investigation to support the abuse allegations or that the recipient refused to be transferred to another hospital. The complaint that a staff person threw the recipient's eyeglasses at her, that pain medication was delayed and that the recipient was transferred to another hospital because she tried to harm self are unsubstantiated. No violations of Section 5/2-112 of the Code or the hospital's patient rights statement regarding abuse or grievance policy were found.

RECOMMENDATIONS

1. The hospital shall follow 5/2-102 (a) of the Code and its patient rights statement regarding care in a safe setting.

2. The Authority commends the hospital's Emergency Department for taking steps to prevent further occurrences by providing all suicidal patients with a 1:1 sitter. As a safeguard, ACMC shall include this newly established procedure in its policy.

SUGGESTIONS

1. Proper documentation in recipients' records such as the reason for prescribing medication should be discussed with physicians.

2. Use exact language to explain why the patient did not sign the transfer form. If a patient refuses to sign, document that he or she refuses as opposed to checking the box on the form that "the patient was unable to sign."

3. The hospital shall instruct all appropriate staff members about the importance of ensuring that recommendations #1 and 2 are followed.

COMMENT

Section 5/3-400 of the Mental Health and Developmental Disabilities Code states that any person 16 or older may be admitted as a voluntary recipient if the facility director determines that the person is clinically suitable for admission as a voluntary recipient.

According to the recipient's record, she was transferred to another hospital on a petition and certificate although she was not refusing to be hospitalized. The CIW told the investigation team that all patients who require inpatient care are transferred under the involuntary admission status. Although the hospital may determine that the recipient should get the treatment that he or she needs elsewhere, rights under Section 5/3-400 must also be respected without the threat of facing court action unless the person meets the Code's requirements for involuntary admission (405 ILCS 5/3-600 et seq.). The hospital is reminded that the safeguards of voluntary status cannot be removed unless a determination is made that the recipient lacks capacity to give informed consent for voluntary admission. Nowhere in the Code does it require a petition/certificate to be accepted at another facility as part of the transfer process.

ACMC policy states that patients who are suicidal or homicidal shall have their clothing removed. The hospital is also reminded that Section 5/2-102 (a) of the Code requires the provider to ensure that there are *individual* determinations and exceptions because all recipients with suicidal or homicidal thoughts might not 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.

Advocate
Christ Medical Center
Hope Children's Hospital
Powerful medicine. Compassionate care.

November 3rd, 2011

Judith Rauls, Chairperson Human Rights Authority
Human Rights Authority
P.O. Box 7009
Hines, IL 60141-7009

Re: Case # 11-040-9001

Dear Ms. Rauls,

We are in receipt of your report of findings for case number 11-040-9001 and seek to be in compliance with the recommendations as well as the three suggestions for improvement. We are responding with our immediate action plan to address the issues identified from this investigation.

Recommendations

1. Instruct all qualified examiners, including ED physicians, to always assert by signature and inform recipients under evaluation for emergency hospitalization of their rights under Section 5/3-208 of the Code and according to hospital policy.
2. The Authority commends the hospital's Emergency Department for taking steps to prevent further occurrences by providing all suicidal patient's with a 1:1 sitter. As a safeguard, ACMC shall include this newly established procedure in its policy.

Attached you will find the original version (attachment A) and new version (attachment B) of the suicide policy. While the one to one sitter practice was immediately initiated after the event, we have now, as recommended, put this into policy.

Suggestions

1. Proper documentation in recipients' records such as the reason for prescribing medication should be discussed with physicians.
2. Use exact language to explain why the patient did not sign the transfer form. If a patient refuses to sign, document that he or she refuses as opposed to checking the box on the form that "the patient was unable to sign".
3. The hospital shall instruct all appropriate staff members about the importance of ensuring recommendations #1 and #2 are followed.

A memorandum has been sent and a conversation held with the ED Chair regarding these findings. He has assured me he will relay these suggestions to his team at their next departmental meeting. Our Outpatient Psychiatry Manager of Clinical Operations is working with the Emergency Department's Manager of Clinical Operations to address suggestions to revise this form. As any potential revisions will still need to be forwarded to our forms committee, we can follow up as requested. Lastly, education around the change of practice in ensuring 1 to 1 monitoring for our suicide patients occurred immediately after the incident. As witnessed in the site visit, this practice has been hardwired.

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Upon review of this action plan, if any further or continued concerns remain from the Department of Human Services, we respectfully request written notification of any suggestions or amendments to this action plan. We thank you for your time and seek to continue the medical center's good standing with the Department of Human Services.

Sincerely,

Michael T. Moonan, RN, MBA
Director of Medical, Surgical and Psychiatric Services
Advocate Christ Medical Center

Harold McGrath, MD
Medical Director, Department of Psychiatry
Advocate Christ Medical Center