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HUMAN RIGHTS AUTHORITY- SOUTH SUBURBAN REGION

REPORT 11-040-9014
Franciscan St. James Health Center

[Case Summary— The Authority made corrective recommendations regarding the 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 Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Franciscan St. James Health Center (St. James). It was alleged that the facility did not follow Code procedure when it detained, treated, and denied adequate and humane care to a recipient. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107) and the Code of Federal Regulations (42 CFR 482.13).

St. James is a private community hospital owned by the Sisters of St. Francis Health Services, Inc. The hospital does not contain a behavioral health unit, so recipients with mental health needs are transferred to a state mental health facility.

To review these complaints, the HRA conducted a site visit and interviewed two Behavioral Health physicians, the Director of Nursing, the Director of Case Management, the Social Worker, three registered Nurses, the Patient Care Manager, the Emergency Department Registered Nurse Manager, and the Director of Quality Improvement. Hospital policies were reviewed, and the adult recipient's clinical records were reviewed with written consent.

COMPLAINT SUMMARY

The complaint indicates that the recipient went to the emergency department for dehydration on 5/20/11. It was determined that she had a urinary tract infection and she was admitted and held in the emergency department and placed in restraints when she resisted. She was later placed on a medical floor and was not given a copy of the petition which detained her. The recipient tried to elope however security was called and the recipient was handcuffed, restrained, and given forced psychotropic medication. Also, the complaint indicates that the recipient complained of chest pain as a result of the medication for her infection, and this issue was not immediately addressed by the staff.

FINDINGS

St. James emergency department notes indicate that the recipient was brought to the facility by ambulance at 11:20 p.m. on 5/20/11 due to complaints of dehydration, sleep deprivation, not feeling well, and experiencing hallucinations. When the physician attempted to examine the recipient she would not cooperate with the exam and was placed in seclusion due to the risk for elopement. At 11:45 p.m. the record indicates that the recipient was placed in restraints and given a Restriction of Rights Notice because she was "combative" when the physician attempted to take blood and place an IV in her arm. Physicians' Orders for 5/21/11 show that a behavioral health and neurological consultation were ordered at 4:45 a.m. that day and a sitter was recommended for the recipient's bedside to prevent elopement. Also on 5/21/11 the decision was made to contact social services for a transfer to an inpatient psychiatric program. The record indicates that the recipient was treated in the emergency department from 11:00 p.m. on 5/20/11 until approximately 4:00 a.m. on 5/21/11 at which time she was transferred to the medical/surgical floor. It is noted that emergency department notes are illegible and information from these notes was provided by staff and cannot be confirmed by the HRA.

A Restriction of Rights Notice is included in the record for the restraint episode (no mention of emergency medication) on 5/20/11. It indicates that it was delivered in person to the recipient, who did not want anyone else notified. It does not give the justification of the need for restraint, does not state the events leading up to the restraints, or the purpose for which the restraints were employed. A Physician Order for Violent and Self Destructive Behaviors form is included for this event. It orders restraint and seclusion due to the recipient's flight risk and states that the recipient's response to the intervention was "Calm and cooperative but continues to be a flight risk"- the form indicates that the physician evaluated the patient after one hour and the recipient continued to exhibit behaviors that necessitate continued restraint/seclusion. A Restraint and Seclusion flowchart is included for this episode and it indicates that the restraint was initiated at 11:00 p.m. on 5/20/11 and discontinued at 12:00 a.m. Separate emergency department notes indicate that the recipient also received "Ativan 2 mg IV push" at 11:30 p.m. on 5/20/11, however this is not included in the Restriction of Rights Notice.

A Behavioral Health Consultation was completed on 5/21/11 (time not noted). It states, "The patient was seen, examined, and the chart was reviewed. The patient was admitted to the hospital due to altered mental status, sleep deprivation, urinary tract infection, and dehydration. The patient's family was at bedside per the patient's request and provided much of the patient's history at this time. The patient appeared distracted and unwilling to participate in the exam at times. The patient would request behavioral health to leave and stop talking and then requested behavioral health to stay. The patient's mother reports that she has not been sleeping or eating for three days, which her mother reports is related to stress. She lives with family, attends online school and has been completing independent studies. The patient's family reports that the patient has been providing limited information. The patient was talking with a pastor who lives close to her family…. No psychotropic medications reported. The patient is familiar to behavioral health. The patient was last evaluated by behavioral health on November 8, 2011 [sic], due to 'bizarre' behavior and concerns about the devil running her life and needing to 'get it out of her.' "This report indicates that the recipient has been petitioned and certified (time not given) and a recommendation for a bedside sitter is included.

A Petition for Involuntary Admission, completed 5/21/11 at 3:30 p.m. is included in the record. It indicates that the recipient is in need of immediate hospitalization to prevent harm and is based on the following assertion: "The patient has not been sleeping or eating for the past three days. Thought process disorganized, paranoid and with evident thought reading. She was observed to be responding to internal stimuli and was infrequently and inconsistently responding to examiner questions. The patient's speech was minimal and perseverative at times repeatedly saying 'don't think like that' and 'don't talk like that.' She is in need of psychiatric hospitalization for stabilization and treatment." The petition indicates that a certificate is attached. The document does not indicate that the recipient was given a copy of the petition within 12 hours and does not indicate that the recipient was given rights information. The document does not indicate that the recipient was explained or given a copy of the Rights of Individuals Receiving Mental Health and Developmental Disabilities Services. The petition is accompanied by a certificate, completed on the same day at 3:30 p.m. The examiner has certified that the recipient was informed that she did not have to talk to him, that any of her statements could be used in court, and that she was entitled to an attorney. The certificate states that the recipient is in need of immediate hospitalization to prevent harm. This statement is based on the following clinical observation: "Patient with active thought disorder, struggling to follow conversation. Pt distractible with disorganized and confused thinking. Pt. easily agitated and has been hallucinating. Pt with a blunted affect. Pt has not slept for at least three days and has been eating poorly. Pt unable to described [sic] recent events and actions. Pt with prior similar episode several months ago. Pt has been under some stress as of late per family." Another certificate was completed on 5/22/11 at 11:45 a.m., 5/23/11 at 11:45 a.m., 5/24/11 at 12:15 a.m., 5/25/11 at 1:30 p.m., and 5/26/11 at 12:40 p.m. A second petition is included in the record which was completed on 5/25/11 at 7:40 p.m. The document does not indicate that the recipient was given a copy of the petition within 12 hours and does not indicate that the recipient was explained her Rights of Admittee or given a copy of the Rights of Individuals Receiving Mental Health and Developmental Disabilities Services.

The progress notes indicate only one episode of restraint, which occurred on 5/20/11 in the emergency department, and no incident of emergency medication is noted. The Nursing Discharge Report states that on 5/25/11 at 6:15 p.m., "Pt. noted running down hall trying to leave hospital. Pt. return to room screaming and agitated family at bedside gathering Pt. belonging. When family ask to leave room they began to yell and refuse to leave. Security at bedside. PRN given." There is no Restriction of Rights Notification issued for this event. This event appears to be mentioned in a behavioral health note made on 5/25/11 at 7:00 p.m. It states, "Upon arrival, [supposedly on the medical unit], the patient was observed to be escorted back to her room by security after attempting to elope." The record (Medication Administration Report) also shows several administrations of injected medication which were administered for "agitation" and appear to be "forced" medication, however this is not clarified in the record. On 5/22/11 at 10:19 a.m. the recipient received an injection of 9.75 mg Abilify in the left deltoid, on 5/24/11 at 8:22 p.m. she received an injection of 2 mg Lorazepam in the right deltoid, and on 5/25/11 at 6:41 p.m. she received an injection of 2 mg Lorazepam at 6:41 p.m. in the right deltoid.

The recipient was prescribed the following scheduled psychotropic medications: 50 mg Seroquel at bedtime and 10 mg Abilify daily. The recipient's prn (as needed) medications were

9.75 mg Abilify IM (intramuscularly) every 8 hours as needed, and 2 mg oral Lorazepam every 6 hours as needed and IM as needed. There is no informed consent for medication included in the clinical record. The record does include a Consent for Medical Treatment and it is signed by the recipient's representative, who is not the guardian.

The progress notes do not show when the recipient complained of chest pains. On 5/25/11 the notes indicate that at 1:25 a.m. the house physician was called to evaluate the recipient, and a cardiac consult was ordered. A Cardiac consultation was completed and these notes state, "This 21- year-old lady was brought to St. James Hospital after she complained of marked agitation, mental confusion, and sleep deprivation. The patient had a similar episode in the past, earlier in November of 2010, when the diagnosis of brief psychotic disorder was made with possible bipolar disorder. The patient also felt sensation of left anterior chest discomfort that occurred at rest [date and time not given]. It was short lived. It was not associated with diaphoresis, palpitations, or dizziness. It did not improve with rest. It was not worsened by deep inspiration. It does not radiate. She otherwise has no history of coronary artery disease, myocardial infarction, anginal pectoris, coronary heart disease, rheumatic fever, bacterial endocarditis…" The physician's plan is outlined in the report. It states that an echocardiogram, electrocardiogram, and holter monitor will be completed. An EKG was ordered for the morning of 5/26/11. The record shows that the recipient refused the echocardiogram. After the EKG, and Holter monitor were completed at 11:07 a.m., the recipient was cleared for discharge and then discharged to an inpatient psychiatric program on 5/26/11.

HOSPITAL REPRESENTATIVES' RESPONSE

Hospital representatives were interviewed regarding the complaint. They stated that the recipient came to the emergency room due to medical reasons and the mental health issues were secondary at that time. On examination, the recipient was found to have a urinary tract infection, and had not slept for three days. She was interviewed and showed some delusions and psychosis. Staff noted that at first the recipient was agreeable to treatment, however she then became aggressive and would not cooperate with testing or treatment. The emergency department staff requested several consultations, and one of these, from their behavioral health department, determined that the recipient was in need of mental health treatment, and the process began to have her transferred to a state mental health facility, which necessitated the petition and certificate. The staff contacted Madden Mental Health Center Intake Department and then Tinley Park Mental Health Center. Generally, staff reported, Tinley Park will not admit a patient unless they have a certificate completed with the last 24 hours before admission to the facility and for this reason the certificate is updated each day, in anticipation of the recipient's transfer. The recipient had originally been placed in seclusion in the emergency department when she became combative, and she was then moved to the medical/surgical floor where she continued to be treated for her urinary infection, and attempted to elope. Staff reported that they attempted to speak to the recipient and urge her to remain in the hospital, however when all attempts failed, they called security and the recipient was restrained. Staff also noted that the recipient's family was encouraging of the recipient's elopement, and even packed her belongings for her so she could leave. Staff stated that they always thought that the recipient, who remained delusional throughout her hospitalization, needed continued inpatient psychiatric treatment for her psychosis.

Staff were asked about the recipient's medication and her informed consent. They stated that the physician included a statement in the progress notes that the recipient was informed that she may require psychotropic medication, however there is no document which shows that the recipient was given verbal and written information on the risks, benefits and alternatives to the prescribed medications.

Staff were asked about their response to the recipient's chest pains. They stated that on 5/25/11 the recipient reported chest pain, which was evaluated and did not require immediate intervention. She was then checked at midnight at which time she had a rapid heart beat. They stated that the house doctor was called to the unit at 1:25 a.m. on 5/25/11 to address the recipient's chest pains. This physician evaluated the recipient and ordered a cardiac consult which resulted in an order for an echocardiogram, electrocardiogram, and holter monitor later in the morning of that day (the recipient later refused the echocardiogram). Staff felt that the notification of the physician was in direct and immediate response to the recipient's complaint.

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). Within 12 hours after his admission, the recipient must be given a copy of the petition (5/3-609). Also, within 24 hours, excluding Saturdays, Sundays and holidays, after the recipient's admission, the facility director must file 2 copies of the petition, the first certificate, and proof of service of the petition and statement of rights upon the recipient with the court in the county in which the facility is located. Upon completion of the second certificate, the facility director must promptly file it with the court. Upon the filing of the petition and first certificate, the court shall set a hearing to be held within 5 days, excluding weekends and holidays, after receipt of the petition (5/3-611).

The Mental Health Code allows for treatment without consent in the case of a mental or dental emergency, that is, when delay for the purpose of consent would "endanger the life or adversely affect the health of a recipient of services." A medical or dental emergency is determined by a physician after examining the recipient and determining that the recipient is not capable of giving informed consent (5/2-111).

The Mental Health Code guarantees all recipients adequate and humane care in the least restrictive environment. As a means to this end, it outlines how recipients are to be informed of their proposed treatments and provides for their participation in this process to the extent possible:

"(a) 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. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient…. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan. [Section 2-200 d states that recipients shall be asked for their emergency intervention preferences, which shall be noted in their treatment plans and considered for use should the need arise].

(a-5) If the services include the administration of…psychotropic medication, 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 the provisions of Section 2- 107 [to prevent harm]…." (405 ILCS 5/2-102).

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…must be informed of the recipient's right to refuse medication… The recipient…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).

HOSPITAL POLICY

St. James provided hospital policy regarding Patient Rights (Code 2005). It states that Patients Rights and Responsibilities are to be provided to patients in writing in the Patient Handouts, and distributed upon admission or as soon thereafter as the condition of the patient permits. The Rights include the right of patients to participate in the development and implementation of the care plan, and allows patients the right to consent to or refuse treatment after being adequately informed of the benefits, risks and alternatives to treatment. The Rights also include the right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.

St. James provided hospital policy regarding Informed Consent (Code 2018). It states, "The responsible physician for the patient must discuss with the patient (or his /her legally authorized health care agent or surrogate decision maker if the patient is a minor or lacks decisional capacity), the possible benefits, substantial risks, and alternative treatments of the proposed procedure or treatment. The patient (or his/her legal authorized health care agent or surrogate decision maker if the patient is a minor or lacks decisional capacity), will then provide a voluntary and informed consent prior to the initiation of such procedure or treatment. The initiation of psychotropic medications, compared to other medication classifications, places a special responsibility on the physician. After assessing the patient capacity to give consent for the use of psychotropic medications, the patient will be given medication information to allow for a competent decision to consent or refuse such medications…. The informed consent given by the patient shall be documented on the appropriate consent form, and documented in the progress notes by the responsible physician. The consent form shall be included in the patient's medical record…. If the informed consent discussion has occurred and the patient determines not to consent to the procedure or treatment, the consent form shall be placed in the patient's medical record with the notation 'Patient refused to sign this document.' Any exceptions to any elements of the consent must be noted on the form or in the patient's chart."

St. James provided hospital policy regarding Restraints (Code 2004). This policy states that all patients have the right to be free from restraints of any form. The policy states, "It is the hospital's philosophy to limit the use of restraints and assure all appropriate documentation including use of least restrictive methods. The use of restraint will only be used while the unsafe situation persists; restraints will immediately stop when the unsafe situation ends." Hospital policy outlines the restraint documentation that is required: Description of alternative interventions attempted prior to initiation of restraint and their effectiveness, updating of care plan, explanation of purpose given to patient and/or authorized representative at their level of understanding at the time the restraint is initiated, and clinical observations and documentation of restraint protocol. Although the hospital policy complies with the Mental Health and Developmental Disabilities' mandates regarding restraint, the policy is missing the completion of a Restriction of Rights Notice for each restraint event or whenever the rights of the recipient have been restricted.

CONCLUSION

The complaint in this case alleges that the facility did not follow Code procedure when it detained, treated, and denied adequate and humane care to a recipient. The investigation revealed that the detention, based upon the completion of two petitions and 5 certificates, was invalid due to the fact that these documents were not completed: there is no indication that the recipient or her representative were given Rights information, and there is no indication that the recipient or her representative were ever given copies of the petition. Additionally, the completion of a certificate each day that the recipient was hospitalized violates both the intent and the letter of the law. The Mental Health Code requires a petition and two certificates for an involuntary admission and mandates that these documents be filed with the court within a strict timeframe for the protection of the recipient's liberty interest- a new petition or repeated certificates do not reset the timeframe established in the completion of the original petition document. The HRA substantiates the complaint that the facility did not follow Code procedure when it detained the recipient.

The HRA also identified Code violations in the treatment of the recipient. The record is missing a physician statement of decisional capacity and documentation of informed consent for the prescribed treatment, both necessary for the administration of psychotropic medication. For the emergency medication, the record is missing the necessary Restriction of Rights Notices and documented evidence of the need for the intervention and the offer of less restrictive alternatives. There are two episodes of restraint referenced in the record. The first incident, occurring in the emergency department, is described in a Restriction of Rights Notice, however it does not give the justification for the restraints, the events leading up to the need for restraint, or the purpose for which it was employed. The second restraint episode is only vaguely suggested in the progress notes and there is no description of the event, no restraint flowchart or Restriction of Rights Notice issued for the event. The HRA substantiates the complaint that the facility did not follow Code procedures in its treatment of the recipient.

The HRA has investigated the complaint that the recipient complained of chest pain that was not addressed immediately. The progress notes do not describe an event in which the recipient complained of chest pain. However, they do indicate that on 5/25/11 the house physician was called at 1:25 a.m. to examine the recipient and a cardiac consult was ordered which resulted in several cardiac tests being completed the same morning. The HRA cannot evaluate the medical judgment of these professionals, and the time frame for their response appears to be reasonable. The HRA does not substantiate the complaint that the facility denied a recipient adequate and humane care.

RECOMMENDATIONS

1. Train all staff in the emergency department and on the medical floors on the Mental Health Code procedures for the admission of involuntary recipients and the procedure for completing the legal documents which authorize the facility to detain and treat mental health

recipients. Ensure that the facility develops policy and procedure which complies with the Code and which enables the legal processing of petitions and certificates with the court. Develop procedures to ensure that recipients are given a copy of the petition within 12 hours of admission.

2. Instruct staff to discontinue the practice of completing multiple petitions and certificates.

3. Train staff on the Mental Health Code and hospital policy regarding psychotropic medication. Ensure that the record contains a physician statement of decisional capacity, that the recipient has given informed consent, and that if the facility overrides the recipient's right to refuse treatment, that Restrictions of Rights Notices are completed and issued appropriately.

4. Train staff on the Mental Health Code requirements for restraint. Revise hospital policy to reflect the Code mandates and include the completion of a Restriction of Rights Notice for each restraint episode or whenever the rights of the recipient are restricted. Use current forms for Restriction of Rights Notices.

SUGGESTIONS

1. Remind staff to include the date and time on all entries in the clinical record. If reference is made to a procedure or event, train staff to include the date and time of the event when it is mentioned in the record.

2. Remind staff to write legibly when making entries into the clinical record.