FOR IMMEDIATE RELEASE

North Suburban Human Rights Authority
Report of Findings
Centegra Health System
HRA #11-100-9016

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Centegra Health System. In June 2011, the HRA notified Centegra of its intent to conduct an investigation, pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The complaint alleged that a recipient was unjustly placed on a 24-hour psychiatric hold; he was threatened with restraints; a physician was not attentive to the recipient's medical needs, as medication was offered that was contraindicated to a previous diagnosis; a staff member made a false claim regarding the whereabouts of the recipient's electronic reader and the recipient was discharged without a discharge plan. The rights of mental health recipients are protected by the Mental Health and Developmental Disabilities Code (405 ILCS 5).

The HRA reviewed the clinical record of the recipient whose rights were alleged to have been violated, with written consent. A site visit was conducted in August 2011 at which time the allegations were discussed with the Emergency Department attending physician, the mental health crisis worker and a security officer. Also present at the meeting was a representative from risk management.

Background

According to the Centegra Health System web-site, "Centegra Health System was formed when Memorial Medical Center in Woodstock and Northern Illinois Medical Center in McHenry joined forces. Centegra serves the greater McHenry County region of northern Illinois and is the county's largest employer with over 3,100 Associates, 450 Physicians, and nearly 500 Volunteers. Centegra Health System has Level II Trauma Centers and Level II nurseries at both of its medical centers. In addition to Emergency Services and Obstetrics, Centegra has over 30 sites and is recognized for cardiac care, cancer care, rehabilitation services, occupational health, behavioral health services, and Centegra Health Bridge Fitness Center." The focus of this investigation was the hospital located in McHenry.

Allegation: unjustly placed on a 24-hour psychiatric hold.

Findings

According to the clinical record, the recipient went to the hospital on April 18, 2011 at about 1:00 p.m. requesting crisis intervention; he was discharged on April 19th, 2011. It is documented that he has a history of chronic hepatitis C undergoing interferon and ribavirin treatment for 48 weeks.

He reported that he was having problems with anxiety, anger, impulse control and sometimes suicidal thoughts. At approximately 4:00 p.m., he was assessed by the McHenry County Crisis Program. The clinical impression from this assessment was that the recipient met the criteria for in-patient hospitalization due to an increase in poor impulsive control and an increase in depression with increased suicidal thought and a plan to step in front of a train. It was noted that the disposition of in-patient hospitalization was discussed with the recipient and he agreed; it was also noted that he was motivated for treatment. The crisis worker contacted Centegra's central intake and learned that there were no beds available; she then contacted ten other hospitals and she was not able to secure a bed for the recipient. He was unable to contract for safety so he was placed on a 24-hour psychiatric hold and he was subsequently transferred to a medical floor. The chart contained a physician's "Hold Order" that documented the recipient could not leave the hospital because he was having suicidal thoughts, he was unable to contract for safety, and there were no beds available; the order was signed at 7:30 p.m. A psychiatric consultation was ordered and a petition for involuntary admission was completed; the recipient later signed an application for voluntary admission.

The McHenry County Crisis Center Program provides emergency mental health services, upon request, to all McHenry County residents. The Crisis Program's primary goals are to provide prompt, compassionate and effective mental health help during personal, family, or community emergencies. There are two main components to the program: a 24-hour crisis line and a 24-hour onsite response team.

The HRA interviewed the Crisis Worker who evaluated the recipient identified in this case investigation. She explained that she is part of the 24-hour onsite response team, meaning that the primary goals of the Onsite Crisis Team are to assess and stabilize the crisis situation and link individuals and/or families to the least restrictive level of care needed. The Worker stated that she begins the assessment by talking with hospital staff members and then the recipient. Once she has made her clinical assessment, she presents her recommendation to the physician. She stated that in this case, there was no doubt that the recipient needed inpatient services and that he willingly agreed to that treatment recommendation.

Conclusion

Pursuant to Section 3-400 of the Illinois Mental Health and Developmental Disabilities Code (Code), "Any person 16 or older, including a person adjudicated a disabled person, may be admitted to a mental health facility as a voluntary recipient for treatment of a mental illness upon the filing of an application with the facility director of the facility if the facility director determines and documents in the recipient's medical record that the person (1) is clinically suitable for admission as a voluntary recipient and (2) has the capacity to consent to voluntary admission.

Pursuant to Section 3-604 of the Code, "No person detained for examination under this Article on the basis of a petition alone may be held for more than 24 hours unless within that period a certificate is furnished to or by the mental health facility. If no certificate is furnished, the respondent shall be released forthwith."

Based on the information obtained, it is concluded that the recipient presented to the hospital with suicidal thoughts and a plan. The allegation that a recipient was unjustly placed on a psychiatric hold is unsubstantiated.

Allegation: the recipient was threatened with restraints

Findings

At the site visit, the Security Officer stated that he and another officer were called because the recipient was "Violent and Loud". The Officer said that when he entered the room the recipient used profanity and said he did not want the officers in his room. The Officer said that the recipient was upset because he had yet to been seen by a Psychiatric Physician. The Officer reported to the HRA that the recipient said something to the effect that "There is no way that you are going to keep me here." The Officer said that the recipient did not understand why he needed to be there and that everything made him upset. The Officer said that they tried to de-escalate the situation by offering the recipient food, a beverage and suggested that he watch TV. The Officer also said that he (the Officer) left the room because he felt that the recipient was upset because of his (the Officer's) young age and that he left the more senior Officer with the older recipient. He reported that the recipient became violent and slammed paperwork on the table. The one-to-one sitter became frightened and went to one corner of the room. The Officer did say that he told the recipient that they might have to use restraints if the recipient did not calm down.

The HRA requested and received a copy of the security report that was generated on this episode. The report, written by the Officer interviewed, mirrored the above verbal explanation of what happened; the report did say that the recipient said that he might do something they would all regret if they did not let him leave the hospital. The report documented that the Officer told the recipient that if he were to get violent, that security would have to restrain him to insure the safety of the staff and the recipient.

The only mention of the episode in the clinical record was an entry that simply said, "pt. frustrated pulling ID bands, 2 security guards at bedside with sitter." It is noted that the recipient was not placed in restraints.

The HRA reviewed the CPI Training manual and it states that "setting limits is the result of recognizing that you cannot force individuals to act appropriately. Trying to force a person to act in a certain way often results in a nonproductive power struggle. When you set limits, you are offering a person choices, as well as stating the consequences of those choices. Limits are usually better received when the positive choice and consequence are stated first. Starting with a negative consequence may be perceived as a challenge or an ultimatum, and the individual may not even hear the positive choice."

Conclusion

Section 2-108 of the Code states that "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."

According to the Security Officer, attempts were made to redirect the recipient without success. The recipient then made a verbal threat and he was told he might be placed in restraints. The Officer started with a negative consequence which was perceived by the recipient as a threat; the allegation is substantiated.

Recommendation

Hospital administration must ensure that limit setting is conducted according to CPI standards.

Comment

The HRA takes this opportunity to address the lack of nursing documentation regarding this event. The Officer explained the recipient as violent, yet there is nothing in the nursing progress notes to reflect this behavior. Hospital administration must instruct its employees to document all observed events, especially ones that are volatile in nature.

Allegation: a physician was not attentive to the recipient's medical needs, as medication was offered that was contraindicated to a previous diagnosis.

Findings

The complaint was that the physician ordered Ultram (Tramadol) for pain and that this medication is contraindicated because of the diagnosis of Cirrhosis. The recipient reported that he did not take the medication and stated that the physician would have known that medication was contraindicated had he read the chart and/or examined him before it was ordered.

According to medication literature, Ultram (Tramadol) is a narcotic-like pain reliever. Ultram is used to treat moderate to severe pain. Ultram extended-release is used to treat moderate to severe chronic pain when treatment is needed around the clock. Ultram is converted by the liver to several metabolites, one of which (referred to as M1) is pharmacologically active and a more potent analgesic than Ultram itself. The metabolism of both Ultram and M1 has been shown to decrease in patients with advanced cirrhosis of the liver, resulting in increased exposure to Tramadol as well as substantially prolonged elimination half-lives for both Tramadol and M1. Therapy with Tramadol should be administered cautiously in patients with impaired hepatic function. The recommended dosage for patients with cirrhosis is 50 mg. every 12 hours.

The recipient was assessed for neuropathy pain and reported a pain level of 8 (with 10 being the highest level of pain). A telephone order for Ultram 25 mg. (by mouth) every 8 hours PRN (as needed) was obtained at about 1:30 a.m. on the 19th. The chart showed that the recipient refused the medication and the order was later discontinued.

The physician explained to the HRA that he was the "On Call" medical attending physician and when the recipient was admitted on the Hold Order, the recipient was admitted to his service. The physician recalled the general details of the case and stated that he had reviewed and approved the medications that the recipient reported taking at home. He did not recall the telephone call regarding the recipient's request for pain medication or his order for the Ultram. He did not recall if he knew, or not, that the recipient was Cirrhotic when he prescribed the medication. He did say that the dose that was ordered was quite low and would not have been absolutely contradicted in a Cirrhotic patient. The physician said that he examined the recipient at about 7:30 a.m. on the 19th.

Conclusion

Pursuant to Section 2-112 of the Code, "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect." The Code defines neglect as "the failure to provide adequate medical or personal care or maintenance to a recipient of services, which failure results in physical or mental injury to a recipient or in the deterioration of a recipient's physical or mental condition."

The HRA acknowledges that when medication was ordered/offered that could have been contraindicated to a previous diagnosis, it would seem that the physician was not being attentive. However, a request for pain management medication was made and an order was obtained; the recipient was seen by the physician later that morning. It is concluded that rights were not violated; the allegation is unsubstantiated.

Allegation: a staff member made a false claim regarding the whereabouts of the recipient's electronic reader

Findings

The recipient reported that at the time of discharge, he was missing his electronic reader. He then went to hospital administration and when staff were questioned, they said they observed him placing the reader in his backpack. The recipient reported that the reader had not been placed in his backpack as he had later learned that a family member had already taken the reader home.

At the site visit it was explained that right after the recipient was discharged, he went to the lobby of the hospital and according to security documentation, he became unruly. The recipient reported that he was missing his electronic reader which he had prior to leaving his room. The recipient reported that when he checked his bag, the reader was not there. Security checked with the floor staff who reported they observed the reader being placed in the bag. Risk Management was subsequently contacted to address the matter. At the site visit, the HRA was told that the Risk Management representative was no longer employed at the hospital thus she could not be interviewed.

A review of the clinical record showed that the recipient did have an electronic reader while he was in the hospital.

Conclusion

Pursuant to Section 5/2-104 of the Illinois Mental Health and Developmental Disabilities Code, "Every consumer who resides in a mental health or developmental disabilities facility shall be permitted to receive, possess and use personal property and shall be provided with a reasonable amount of storage…When a consumer is discharged from the mental health or developmental disabilities facility, all of his lawful personal property which is in the custody of the facility shall be returned to him."

The recipient reported to the HRA that his reader had been taken home by a family member; hospital personnel reported to Security Officers that they observed the recipient placing the reader in his backpack. There are two versions of what happened to the reader, thus the HRA can neither confirm nor deny the allegation that a staff member made a false claim regarding the recipient's electronic reader.

Allegation: recipient was discharged without a discharge plan

Findings

The clinical record contained a "Discharge Instructions and Educational Summary" that the recipient received at the time of his discharge. The education summary included information regarding depression and pain management. He was instructed to continue his medications as previously prescribed and to schedule appointments as discussed with the psychiatrist; the recipient signed the instructions.

Conclusion

Pursuant to Section 5/ 2-102 of the Mental Health and Developmental Disabilities Code, "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 recipient was given discharge instructions that he acknowledged by signing the plan; the allegation is unsubstantiated.

RESPONSE

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

CentegraHealthSystem

4201 Medical Center Drive
McHenry, IL 60050

James Adamson
[redacted]

January 3, 2012

Julie Sass
Guardianship & Advocacy Commission
North Suburban Regional Office
9511 Harrison Street, W-300
Des Plaines, IL 60016-1565

Re: [redacted]
HRA # 11-100-9016

Dear Ms. Sass:

This letter is in response to correspondence from Kori Larson dated October 5, 2011. Thank you for conducting the investigation into the above referenced matter. There appears to be one allegation, that "the recipient was threatened with restraints", that resulted in a recommendation from the Authority that "Hospital administration must ensure that limit setting is conducted according to CPI standards." I can assure you and the Authority that Centegra associates understand the importance of caring for patients with respect, and minimizing the use of restraints according to applicable standards and regulations. As for security guards in particular, they have received CPI and/or MOAB training which stresses the importance of deescalating situations and setting limits. The security officers know to start with positive choices in addressing a disruptive or violent patient, and they do that. I believe that in fact occurred with [redacted]. The possible need for restraints was only made after other positive measures had failed. Nevertheless, we will use this situation as a learning opportunity for security and health care providers and reinforce the importance of initial positive approaches.

Finally, I do not believe this investigation report should be made a part of the public record as the allegations and findings do not warrant it. If the Authority votes to make the report part of the public record, I ask that this response be included in the record as well.

If you have any questions or require any further information, please contact me.

Very truly yours,

James Adamson
Director, Risk & Regulatory Matters
Centegra Health System

JCA/vlk