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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 12-030-9010
Rush University Medical Center

Case Summary: The HRA did not substantiate the complaint that a nurse struck a recipient and then the recipient was restrained for no adequate reason.

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 Rush University Medical Center (Rush). It was alleged that a nurse struck a recipient and then the recipient was restrained for no adequate reason. If substantiated, these allegations would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

Rush University Medical Center is a not-for-profit medical center comprising Rush University Medical Center, Rush University, Rush Oak Park Hospital, and Rush Health. The Medical Center encompasses a 664-bed hospital along with a 16- bed behavioral health unit.

To review these complaints, the HRA conducted a site visit and interviewed two hospital Risk Managers, the Unit Director, the Psychiatry Department Associate Chair, and the Associate General Counsel. Hospital policies were reviewed, and the adult recipient's clinical records were reviewed with written consent.

COMPLAINT SUMMARY

The complaint alleges that a recipient approached the unit supervisor and requested a different nurse be assigned to her because she felt her assigned nurse had a problem with her. Later, the recipient wanted her blood pressure checked and when she asked the aforementioned nurse to take it, she was told by the nurse that she couldn't. The complaint alleges the recipient then asked for a supervisor and none was available. She then went to the nurses' station and took her own blood pressure (the complaint indicates she was behind the glass but still in the area where patients go). When she bent down to unplug the blood pressure machine, a nurse came from behind, pulled the recipient's arm down, and hit the recipient. A nearby male nurse told the recipient to go to her room, which she did. The recipient was lying on her bed in her room when 7-8 security officers came into her room and put the recipient in restraints. She was then injected with psychotropic medication. The nurse who allegedly hit the recipient came into the room and the recipient told her to get out. The supervisor came into the room and claimed that a nurse can use any force necessary if a patient goes into the nurses' station. Allegedly a medical student

told the recipient, "I saw her- she hit you." The recipient was then placed in restraints for 9 hours.

FINDINGS

The record shows that the recipient in this case was transferred to Rush from a hospital Emergency Department where she was evaluated for suicidal ideation. The petition for involuntary admission was completed before her arrival at Rush and at 11:30 a.m. on 10/10/11 an Inpatient Certificate was completed by the Rush Emergency Department physician, giving as the reason, "Depression, tearful, suicidal." The following day, on 10/11/11 at 1:30 a.m. the recipient completed an Application for Voluntary Admission and she was admitted to the Adult Psychiatry Unit at 1:30 a.m. The recipient's history and physical states, "52 year old female with history of CAD [coronary artery disease] and depression presents with depressed mood with passive SI [suicidal ideation] and paranoid delusions. Patient has history of depression, with periods of depressed mood, anhedonia, low energy, poor sleep, and SI. Patient denies history of suicide attempts, states no plan. Patient endorsing paranoid thoughts that an old ex, who she states is a high-profile political figure, is hiring people in the community to harm her. Patient states they have injected her with poison when she sleeps, and that they are following her and monitoring her movements. Denies history of AVH [auditory verbal hallucination]. Denies history of mania. Denies history of substance abuse. Socially, patient is currently homeless...." The recipient's diagnosis is listed as Major Depressive Disorder, single episode and severe and her past mental health care had been 1-5 outpatient treatment courses. The recipient has a complicated and serious medical history which includes neck, chest, and shoulder pain, hypertension, asthma, high cholesterol, congestive heart failure, coronary artery disease and she has a right coronary artery (RNC) stent. The recipient was prescribed a number of medications to treat her various medical conditions as well as Risperdal (a psychotropic medication), .5 mg nightly.

Resident Progress Notes from 10/12/11 indicate that although the recipient's mood began to improve overall, she continued with paranoid delusions, and began to extend her paranoia to the nursing staff, "...Patient moreover exhibits paranoia with nursing staff as she believes that nursing might have given her the 'wrong pills' and requested a print of her medication list so that she can verify her medicine intake independently...." On 10/13/11 a Progress Note Addendum states that, "Patient with bright affect on exam this morning, reporting improved mood, denying SI. Continues with fixed paranoid delusion, stating that it can involve people within the unit. Patient's affect noted to be somewhat labile and inappropriate by staff members." On 10/15/11 the recipient was given PRN (as needed) medication for increased irritability. The record states, "Patient increasingly irritable after lunch. Told RN, 'That cleaning lady is looking at me hard. If she keeps it up, I will have to confront her.' She demanded that MD order her an anti-itch cream, then was upset that 'It is not the right dose.' Patient was given Zyprexa 5 mg po [orally]. She was initially offered Zydis form, but asked to have it changed to a form she recognized. This was done."

There are two entries in the Progress Notes describing the restraint episode on 10/18/11. The first entry is made at 8:48 a.m. by the unit resident. It states, "Pt seen and examined this AM. Patient stating that her mood is a 6/10 with 10 being euthymic, but also a little anxious

about leaving. Pt. states that she is happy with her medication regimen and feels much better than before. Pt states she woke up last night with 2/2 pain but otherwise had uninterrupted sleep. Denies side effects of meds and denies SI/HI [suicidal/homicidal ideation], AVH. Pt states that she may have seen AH last night consisting of snake crawling on wall. Pt also states that she is going to inherit a lot of money and pay the nice doctors back for all their help here. Around 9:15 am pt came into nursing station and attempted to take blood pressure cuff stating 'it's time for my blood pressure to be checked. I want it checked now.' Pt was told by staff that she needed to leave nursing station. Pt angrily yelled 'don't touch me!' when staff attempted to get patient out of station, and pt was seen hitting staff member on arm. Pt then went to room and telephoned administrator on call stating that staff was touching pt inappropriately. Pt given zyprexa and put in restraints around 9:30 am."

A second entry made by an RN at 10:49 a.m. also describes the event: "Pt in dining area at breakfast, interacting with peers. Pt verbalized probable d/c today. When writer approached pt to introduce as RN for day, pt stated 'You will not be my nurse!' Pt unable to describe reason for concern, writer gently reminded pt of our positive relationship in past. Pt simply stated 'You are mean.' Pt refused vitals and all care from writer. Pt asked staff to meet with unit director and unit director contacted. Message relayed to pt that Unit Director was on way to meeting and would meet with her afterwards. Pt requested and given unit radio to listen in room. Five minutes later, pt noted walking quickly and forcefully down hall. Walked into nursing station and began to pull Dynamap out of nursing station. Encouraged verbalization of issues. Support provided. Monitored pt from distance while other staff interacting. Staff provided information regarding meeting with Unit Director. Writer approached pt while pt in Nursing Station and redirected that pts not allowed in station. Pt ignoring writer, loudly verbalizing 'I will take my own BP!' Pt attempting to pull Dynamap while still plugged to outlet. Writer went to Dynamap to stabilize Dynamap and pt hit writer's arm with hand clenched in fist. Pt returned to room after 6 staff present directing. Pt placed in 4 point locked restraints and receive Zyprexa 10 mg im [intramuscularly] at 9:30 for protection of self and others."

The record contains restraint documentation to include the physician order for restraints and emergency medication, statement of no harm to the recipient from the restraint episode, 15 minute checks of the recipient, and documentation of food, water and toileting opportunities. The criteria for discontinuation of restraints is listed as: "Verbalizes no intention to harm self, verbalizes no intention to harm others, and absence of behavior that requires restraints." The record contains a Restriction of Rights Notice issued for this event (to include restraint and medication) at 9:30 a.m. The reason listed for the restraint states, "Patient forcefully entered the Nurse's station and went to grab equipment. Nurse tried to intervene and redirect but the patient ignored the verbal redirection and struck staff hard on her wrist. Patient agitated shouting at nurse; again not following redirections to stay safe. Patient imminent danger to self and others. Alternatives tried and unsuccessful. Least restrictive alternative is 4 point restraints." The Notice indicates that a copy was given to the recipient and that she did not want anyone notified of the restriction.

A Progress Notes entry made at 12:48 p.m. on the same day states, "Pt maintained in locked 4 point restraints. Pt continues to demand writer leave the room, not allowing staff to talk to her. Pt partially sat up in bed telling writer that she was going to spit at her. Pt began to make

movements with mouth indicating the same. Pt demanding that writer 'better never come around me!' Pt refused ROM [range of motion], refused any po intake, nonverbal regarding use of bedpan. Fellow staff member present to administer medication and pt telling him that 'by you giving that to me, you are pushing me to get her.' Pt reported 'I am going to get my boys on you! It is not a threat! It is a promise!' Attempted to process situation with patient. Limits explained regarding being pt on unit and that there may be interaction and expectations of safety for all...."

A Progress Note made at 2:04 p.m. states, "Writer and another staff entered room at 1:15 p.m. Pt continues to demand writer leave and refusing interaction. Pt refused to process with staff members regarding concerns leading to restraints. Pt insisting that staff had 'hit her first.' Pt refusing all intervention including po intake... Safely maintained in restraints."

The record contains a second Restriction of Rights Notice for restraints issued at 1:30 p.m. on 10/18. The reason for the restriction is listed as, "Patient remains agitated; she was in restraints because she was hit by staff. Denied that other staff witnessed event. Started to yell at staff; threatened to harm staff and that would get her family to come after staff. Shouted that staff was agitating her; not following redirection. Imminent danger to self and others. Least restrictive alternative is 4 point restraint renewal." The Notice indicates that a copy was given to the recipient and that she did not want anyone notified of the restriction.

A Progress Note made at 3:30 p.m. states, "Staff approached patient with medication. Staff gave positive reinforcement for cooperating with ROM. Patient then yelled at writer 'I am not talking with you! Get the hell out of here! I am not talking to you so I am no where close to getting out of here!' Pt stated 'you nurses are the ones with psych problems. I can't help you with that!' Pt also stated 'You will be dealt with! I am going to end up in jail because of you.' Pt then turned head, refused to talk or acknowledge staff.... Pt continues to threaten staff. Continues with imminent safety towards others."

The record contains a third Restriction of Rights Notice for restraints issued at 5:30 p.m. The reason for the restriction is listed as, "Patient remains agitated. Patient has very little insight into the events leading up to or reason for restraints. Continues to state that 'she hit me first.' Patient denies ever making threats toward staff but continues to make vague threats, stating 'I'll just tell my sons what happened and have them take care of it.' Presents an imminent danger to self and others. Least restrictive...." The 15 minute checklist includes a statement that the restraints do not pose an undue risk to the patient. The Notice indicates that a copy was given to the recipient and that she did not want anyone notified of the restriction. The recipient was released from restraints at 6:30 p.m. on 10/18/11. Later, on 10/19/11 the recipient was seen by her attending physician and notes entered at this time state, "Pt seen in room, out of restraints, with security watch. Patient states she is apologetic, that she now understands that the nurse was not striking her but that she was trying to get her attention for wandering into the nurse's station. Patient denies any thoughts of harm to any staff members." The recipient was discharged on 10/20/11.

Hospital Representative Response

Hospital Representatives were interviewed about the complaint and the discrepancies in the two Progress Notes. The Staff person who was present at the time of the restraint episode stated that the resident was only peripherally involved in the situation and that the RN's account is more reflective of the event. She indicated that the recipient had entered the nursing station and had moved the blood pressure machine (which is an upright machine on wheels and is plugged into an electrical outlet). When the nurse attempted to secure the machine she was struck by the recipient and at that time the security was called. Staff were needed not only to stabilize the machine but also to help to physically remove the recipient from the nursing station and escort her to her room. The recipient continued to threaten staff and was then placed in restraints and administered psychotropic medication. Staff did not believe that the recipient had the opportunity to return to her room to call an Administrator and indicated that if a recipient requested to call the on duty Administrator they would be aided by staff in doing so. Staff were asked about the recipient's relationship with the nurse who was involved in the event and they stated that the recipient had not had a complaint about the nurse, had never requested that she be removed as the recipient's nurse and staff believed that the recipient had a very positive relationship with her, as is reflected in the Progress Notes. Staff also indicated that if a recipient requests a different nurse from the one assigned to them, the staff would discuss the options and make a decision on a case by case basis. Staff indicated that the recipient was placed in restraints because she was an imminent threat of physical harm, was periodically reevaluated for release and determined to be a danger to herself and others, necessitating her restraint. Staff reported that the recipient had not filed a complaint or grievance with the hospital regarding the event. Staff were asked if an Incident Report had been issued for the event since a staff person was struck and they indicated that this was not an unusual incident but rather it is part of ongoing patient care. The HRA also confirmed that there was not a Public Health investigation regarding this event.

STATUTORY RIGHTS

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)."

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).

HOSPITAL POLICY

Rush University Medical Center provided the hospital policy for Restraint which complies with the Mental Health Code requirements for its application.

CONCLUSION

Although the Progress Notes regarding the restraint episode are somewhat confusing, the report of staff who were present at the time of the event, along with the supporting documentation of the Restriction of Rights Notices indicate that the recipient was an imminent threat of physical harm to herself and others. Additionally, the restraint episode complies with all the requirements of the Mental Health Code. The HRA does not substantiate the complaint that a nurse struck a recipient and then the recipient was restrained for no adequate reason.

SUGGESTION

1. Review with staff the importance of the accuracy of documentation, especially the clinical justification for restrictions of recipients' rights.

2. The hospital has a statutory duty to report abuse/neglect regardless of a grievance or complaint as outlined in the Hospital Licensing Act (210 ILCS 85/9.6). Review this requirement, develop policy to comply with the statute, and require that staff are trained in its implementation.