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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 12-030-9014

WESTLAKE HOSPITAL

Case summary: The HRA did not substantiate the complaint that the facility did not follow Code procedure when a recipient was held down by security guards and administered psychotropic medication after she asked to see a physician for stomach pain, when the facility did not clean the recipient's room after she vomited, and when the hospital denied the recipient her inhaler.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Westlake Hospital. It was alleged that the facility did not follow Code procedure when a recipient was held down by security guards and administered psychotropic medication after she asked to see a physician for stomach pain, when the facility did not clean the recipient's room after she vomited, and when the hospital denied the recipient her inhaler. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.) and the Illinois Administrative Code for hospitals (77 Ill. Admin. Code 250).

Westlake Hospital is a community hospital and a member of Vanguard Health System. The hospital incorporates a 31-bed Behavioral Health Unit.

To review these complaints, the HRA conducted a site visit and interviewed the Behavioral Health Director of Nursing and the Director of Risk Management. Relevant hospital policies were reviewed, and records were obtained with the consent of the recipient.

COMPLAINT SUMMARY

The complaint centers around an event that took place on 2/18/12 on the Behavioral Health Unit. The complaint indicates that the recipient requested to see her physician because she had been having stomach pain. Instead of calling the physician the staff called security who held the recipient down while a nurse administered forced psychotropic medication. After this event, the complaint indicates that the recipient vomited but could not get a staff person to help her clean the room. Additionally, the recipient requested, but did not receive, her inhaler for her asthma when she requested it after this incident.

FINDINGS

The record indicates that the recipient was admitted (2/17/12) as a voluntary recipient from the medical floor where she was treated for a medication overdose. In addition to a diagnosis of depression, the recipient's Psychiatric Evaluation and Initial Treatment Plan indicate that she suffers from Multiple Sclerosis, Fibromyalgia and back pain. The recipient's preferences for emergency treatment are included in the record and indicate that her preference for emergencies is seclusion or medication.

The record contains a medical note written at 5:00 pm on 2/18/12. It is written by the recipient's attending physician and states, "Refused exam, wants to be seen alone outpatient. Now wants a new medical doctor." The record then indicates that at 6:00 pm the doctor returned to examine the recipient and his notes state, "Patient is very upset- but did allow an exam. I assessed prognosis of the medical portion of this patient's care, and will be following her care. Continue inpatient treatment." At this time the Daily Nursing Assessment and Flow Record was completed on the recipient and it indicates "Denies complaints" on the genitourinary section of the assessment.

At 6:45 p.m. Progress Notes state, "Pt. loud, agitated, disruptive to unit, threatening, calling staff with profanities, not responding to verbal redirection, imminent danger to self and others. PRN [as needed] of Ativan 2 mg and Zyprexa 1 mg IM [intramuscularly] given with restriction of rights." The Restriction of Rights Notice issued for this event describes the reason for the restriction: "Loud, disruptive to unit, calling staff with profanities, threatening, not responding verbal redirection, imminent danger to self and others." The restriction notice indicates that the recipient did not want anyone notified. At 6:50 p.m. the notes state, "Pt. states, 'You gave me bruises on my arm.' Examined body, noted slight black dot at inner part of the arm. Continue to monitor." The record shows that two hours later the recipient's neurologist was consulted on the recipient's case. His notes state, "The review of systems is negative for chest pain, shortness of breath, and abdominal pain documented prior to admission."

Progress notes entered at 7:00 p.m. state, "Patient was yelling and screaming refused Vicodin and Spiriva [asthma inhaler]. She stated she doesn't want anything this time. Very disrespectful towards staff. She is also disruptive on the unit and loud."

Progress Notes from 2/20/12 indicate that staff met with the recipient regarding the incident on the 18th: "Met with pt. and social worker to review concerns re: intervention on 2/18 and use of forced meds. States staff didn't respond to her medical issues and assumed she was having a breakdown. Reports bruising in axillary areas, photos taken, and placed in record. Each axilla has 2-3 small dime-sized disclolored areas. Will follow up later with pt." Also on 2/20 the recipient's social worker met with her and notes state, "Social Worker informed patient that it is her right to transfer to another facility if she is interested in doing so. Social Worker explained this process and assisted pt. in weighing pros and cons of this decision and agreed to assist pt in obtaining phone numbers of other hospitals if needed. Pt. declined to be transferred to another facility. Social Worker also explained that nurse manager was conducting an investigation about patient's complaints." On 2/24/12 Progress Notes state, "Met with pt. to follow up on earlier complaint. Pt. states she is not sure how she wants to proceed with issue and

will discuss with husband after discharge. Apologized again for her experience and informed her that I provided her husband with my phone number."

The record includes a letter mailed to the recipient on 3/23/12 from the Director of Risk Management. It states:

"Following our conversation by telephone on 2/27/12, I have followed through on my promise to look into your concerns related to your inpatient hospital stay on the Behavioral Health unit, February 17, 2012 through February 25, 2012. I certainly apologize that Vanguard Westlake Hospital did not meet your expectations.

During our conversation I had made several notes regarding your concerns about the use of force in giving you medication on the evening of February 18. Specifically, you reported that you were having medical issues and pain, and felt that staff overreacted, forcing you onto the bed to give you an injection. You also stated that staff grabbed you, resulting in bruising to your arm. In addition, you reported that you became so ill after the incident that you vomited, urinated and defecated on your self.

In preparing to respond, I reviewed documentation of your stay in the Behavioral Health Unit. I also interviewed… Nurse Manager, Behavioral Health department.

Please allow me to review my findings. The staff reports that you were increasingly agitated and attempts to redirect you or calm you down only escalated your behaviors. A decision was made to administer medication pursuant to PRN medication and restriction of rights protocol. The nurse …, reports that she reminded staff assisting with the medication administration to handle you carefully because you were small. Following the medication administration, staff reports that you complained about a bruise to your arm. The counselor… reports that she helped you clean the vomit and to get more comfortable.

[The nurse manager] stated that she met with you on February 20, 2012 and February 24, 2012 to discuss your concerns and to apologize for your experience. You were given the option of transferring to another facility if you felt unsafe at Westlake, but you did not want to transfer.

[The nurse manager] has followed up with her plan to address your concerns with staff involved. We have a protocol for management of staff behaviors with the Human Resources department, which has occurred with both the Behavioral and Security staff. From working with [the Nurse Manager] on prior occasions, I can assure you her commitment to follow-through with her staff was fulfilled. In your ongoing treatment after discharge, I would hope you are discussing issues with your therapist or physician so you can get the support you need.

We take all patient concerns very seriously and plan to make changes in processes where we can, so that we can better serve you and other patients. I do appreciate your bringing your concerns to my attention, as it has allowed me to investigate and determine how to prevent this from occurring to other families in the future. Please accept my sincere apology for your stay here at Vanguard Westlake Hospital being anything but the best experience. If I may ever be of assistance to you in the future, I hope that you will call on me. My direct office line is…. If you

don't feel that your concerns have been resolved to your satisfaction, you may contact the Illinois Department of Public Health at 800-252-4343."

HOSPITAL REPRESENTATIVE RESPONSE

Hospital representatives were interviewed about the complaint. They stated that the recipient had become upset a short time before this incident when her attending physician had requested to examine her and she refused. He then returned at approximately 6:00 p.m. and the recipient agreed to the exam, however, as the doctor noted, she was very upset at that time. This anger continued to escalate until the recipient breached the staff's personal space and then the decision was made to administer forced medication. Staff stated that they were not aware that the recipient was having stomach pain, however they were later made aware that the recipient was constipated, because she was given milk of magnesia at 8:30 p.m. and this is noted in the chart. Staff also stated that the nurse who administered the medication had reminded the security staff to be careful with the recipient because she is very small. After the injection the recipient did vomit and defecate, however a nurse counselor was sent to assist her with whom she had a positive rapport and this nurse cleaned the room as well as aided the recipient in her personal care. The HRA asked if the hospital housekeeping was called after the event and they stated that there really wasn't a need since the recipient's counselor had intervened in this regard. After the injection event the recipient was seen by her own neurologist, who did not note any injuries as a result of the forced injection and did not note a report of stomach pain. Staff also noted that the record shows that the staff offered the recipient her inhaler but she refused it.

Hospital representatives stated that the recipient was offered a transfer to another hospital after the injection event, and she refused this offer. The recipient then met with the Director of Nursing (DON) on 2/20/12 and again on 2/24/12 to address the issues involved in the event. She stated that the recipient insisted that a staff member be discharged for the event, however the DON, who had initiated her own investigation, stated that she was not able to make that decision based on the information she had received. The DON indicated that an Incident Report was filed by the nurse on duty and the incident was reviewed by the Grievance Committee as well as the Physician Treatment Review and both concurred that the incident was handled appropriately. The DON stated that she interviewed all the staff involved in the incident and reported her findings back to the recipient and that the recipient seemed very upset that someone was not fired for the event. The recipient did return to the hospital later to speak with the Director of Risk Management in her office, and at this time she again became very upset stating that she had not received a written response and the Risk Manager copied the letter she had issued on 3/23/12 and gave it to the recipient.

STATUTORY BASIS

The Mental Health and Developmental Disabilities Code states, "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" (405 ILCS 5/2-102 a).

The Mental Health Code states, "An adult recipient of services…shall be given the opportunity to refuse generally accepted mental health or developmental disability services,

including but not limited to medication... If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available. The facility director shall inform a recipient…who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services" (405 ILCS 5/2-107).

The Illinois Administrative Code (Section 250.1710) directs hospitals and ambulatory facilities to have an organized housekeeping department under competent supervision, with a staff of supervisory and support personnel related to the size and complexity of the facility and to the scope of the services provided. With the goal of providing "a hygienic environment for patients and staff", it states, "….specific housekeeping procedures shall be developed and available for all departments and services."

HOSPITAL POLICY

Westlake Hospital policy for Patient's Refusal of Medication and Conditions for Emergency Use of Medication (#1308.75) indicates that upon admission to the inpatient psychiatric unit the patient is informed of his right to refuse medication and the circumstances in which emergency medications may be administered. The patient's preferences for emergency treatment are included in the patient's medical record and incorporated into the plan of care. The policy states that if the patient refuses medication, the patient may receive medication only if the patient demonstrates "behavior that causes serious and imminent physical harm to the patient and/or others and documentation in the medical record notes the need for emergency medication."

CONCLUSION

The complaint in this case alleges that the facility did not follow Code procedure when a recipient was held down by security guards and administered psychotropic medication after she asked to see a physician for stomach pain, when the facility did not clean the recipient's room after she vomited, and when the hospital denied the recipient her inhaler. The clinical record does not support the allegation that the recipient suffered stomach pain and then was refused her request to see her physician- rather it shows that the recipient was seen by her attending physician before the medication event and by her neurologist after the event, and neither time did the physician notes indicate a complaint of stomach pain. The decision to administer emergency medication is supported by documentation in the progress notes as well as the restriction of rights document which indicate that the recipient had become "threatening" and "an imminent threat of physical harm." The record, as well as staff report, show that a staff person very close to the recipient was sent to her room to aid in her care and clean-up after she vomited because staff felt that the recipient would feel more comfortable with staff with whom she had a rapport. And finally, the record indicates that the staff offered the recipient her inhaler shortly after the medication event and she refused it. The HRA does not substantiate the complaint that the facility did not follow Code procedure when a recipient was held down by security guards and administered psychotropic medication after she asked to see a physician for stomach pain, when the facility did not clean the recipient's room after she vomited, or that the hospital denied the recipient her inhaler.