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REPORT OF FINDINGS
FRANCISCAN ST. JAMES HOSPITAL and HEALTH CENTERS —– 12-040-9012
HUMAN RIGHTS AUTHORITY—– South Suburban Region

[Case Summary— The Authority made corrective recommendations regarding two 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 complaint stated that recipients are routinely placed in seclusion and restrained for the convenience of the Emergency Department staff. Additionally, it was reported that the staff failed to follow the Mental Health Code's requirements concerning admonishment of rights prior to examination and preparing certificates. If substantiated, these allegations would be violations of the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.) and the Centers for Medicare and Medicaid Services, (CMS) Conditions of Participation for Hospitals (42 CFR Part 482).

Located in Chicago Heights this general hospital and health centers is affiliated with the Sisters of Saint Francis Health Services, Incorporated. The hospital does not have a psychiatric unit but employs certain mental health professionals.

METHODOLOGY

To pursue the investigation, the HRA conducted two site visits and interviewed the hospital's Counsel, the Director of Clinical Integration/Quality/Regulation, the Director of Risk Management, the Director of Security, the Manager of the Emergency Department, an Emergency Department Physician, five Registered Nurses, a Mental Health Technician, a Certified Nursing Assistant, two technicians/paramedics and a case manager. The complaint was discussed with a third paramedic employed by the hospital by phone. The allegations were discussed with the complainant several times. Sections of recipient A and B's records with personally identifiable material deleted were reviewed. Relevant hospital policies were also reviewed.

At the second site visit, the HRA interviewed eight staff members separately.

COMPLAINT STATEMENT

The complaint stated that recipients who present with psychiatric problems are routinely locked in a room and restrained because sitters are not ordered unless the individual will be

admitted to the hospital's medical unit. Once there, it was reported that recipients are not properly monitored, but nurses are required to document that 15-minute safety checks are done. The complaint provided two examples of recipients who were allegedly secluded and restrained without cause in February 2012. It stated that a male recipient was petitioned for emergency hospital admission and was placed in 4-point restraints. It was reported that a staff person who sustained bruises during the alleged incident said that the recipient was "tough [and that] he wasn't crazy after all…." Also, the staff person allegedly said that the recipient was not doing anything when restraints were applied, but the physician said "do it." It was reported that the recipient had bruising on his face on that next morning. He insisted that his family should be called and was discharged after the Emergency Department physician spoke to a family member.

The second example stated that an elderly female recipient was restrained without justification. It was reported that the recipient had no previous psychiatric history and that a family member was at her bedside. The complaint alleged that the recipient became upset after she was informed that the hospital's security would be called, that the door would be locked, and that her family member had to leave the room. It was reported that the local police came to the hospital in response to her family member's call for help, but restraints were continued until the physician was informed that a staff person who was not qualified had ordered them.

The complaint stated that certificates for emergency involuntary hospitalization are completed by staff who are not qualified under the Code. It was alleged that rights are not admonished prior to examination, but physicians certify that this is done.

After the complaint was filed with the HRA, it was alleged that the Manager of the Emergency Department sent the staff an email stating that "I am working with the Nursing Office to identify a process for the ED to have sitters for those low risk psych patients [who] would benefit from a sitter… thus, eliminating the pink papers… yea!" Also, the email allegedly said that the Ancillary Department\In-Patient Units would be engaged under the hospital's "Surge Policy" to manage the increase in patients seen in the Emergency Department.

FINDINGS

Recipient A's record indicated that he was transported by ambulance to the hospital's Emergency Department on February 29th, 2012 around 1:00 a.m. According to the triage notes, the recipient was found sleeping in his car, which had rolled into a gas station and hit the wall, and was awakened by the police. He had abrasions on his chest and arm. He reportedly smelled of alcohol beverages and was not sure why he had been transported to the hospital. A form recorded that the recipient verbally consented to general treatment. He was initially placed in room #2, fluids intravenously (IV) were administered and blood was drawn. A Computed Tomography Scan (CT) of the brain and other tests were ordered. At 1:30 a.m., the recipient pulled out his IV lines and refused to remove his clothing. He wanted to make a phone call, but he did not know the number. He was reassessed because of combativeness minutes later and was moved to room #5 for surveillance.

According to the record, the recipient was placed in seclusion at 1:45 a.m. and said that he was going to sue the staff. The hospital's security was called to assist with removing his

clothing and a contraband check was done. His belongings were removed from the room because the police were coming to the hospital to take custody of him. Ativan 1 mg and Benadryl 25 mg intramuscularly (IM) were administered for calming purposes around that same time. There was no indication whether he provided informed consent or was given the opportunity to refuse medication.

The record included an order signed by the Attending Physician at 1:45 a.m. for seclusion with audio and video surveillance for up to 4 fours, and 4-point restraints during transport for the CT scan were authorized from 2:10 a.m. to 2:15 a.m. The recipient was described as being agitated, a flight risk and verbally and physically threatening. The order reflected that alternative interventions such as medication and increased observation were attempted prior to seclusion and restraints. The physician declared on the order that he examined the recipient and that seclusion and restraints did not pose undue risk in light of his medical condition. On that same day, a mental health form indicated that his right to be free of seclusion was restricted, but there was no mention of restraints or restrictions on his rights to refuse medication and to retain personal property on the notice. There was no clear indication whether he wanted someone to be notified about the restrictions, but he reportedly was given a copy of the notice.

A Restraint and Seclusion form or flow sheet documented that the recipient was monitored and that his behaviors were recorded every 15 minutes. He reportedly was agitated or yelling from 1:45 a.m. to 2:30 a.m. His circulation, sensation and movement were within the normal limits. He was provided with a urinal container. The nurse wrote that restraints were discontinued at 2:25 a.m., which is ten minutes after the order for them had expired. It was recorded that the recipient was drowsy or sleeping from 2:30 a.m. until 3:45 a.m. Five minutes later, he was reassessed, and seclusion was discontinued. According to the record, the recipient was allowed to sober up because tests results showed that his blood alcohol level was extremely high. He was observed until 6:00 a.m. and his altered mental status was resolved. He was permitted to sign a recognizance bond and left the hospital with his wife.

Recipient B's record indicated that he was "combative" upon his arrival to the hospital's Emergency Department on February 27th, 2012 around 11:15 p.m. He had been transferred from a nursing home because his sodium and glucose levels were low. His history included Schizophrenia, seizures and other physical problems. He was placed in room #5 for monitoring, restraints were immediately applied, and a contraband check was done. Blood was drawn and tests such as an Electrocardiogram were ordered. A consent form for general treatment recorded that the recipient was very combative and was in restraints.

The record contained a physician's order signed at 11:15 p.m. for seclusion and 4-point restraints with audio and video surveillance for up to 4 fours. The recipient was described as being agitated, combative, a flight risk and verbally and physically threatening leading up to the order. It was documented that alternative measures such as verbal directions, reorientation and increased observation were attempted prior to the restrictive interventions. The order included a physician's determination that seclusion and restraints did not pose an undue risk to the recipient in light of his medical condition. On that same day, a form recorded that the recipient's right to be free of seclusion and restraints were restricted, but there was no indication whether he wanted

someone to be notified about them. The nurse recorded that the recipient was given a restriction of rights notice.

According to the flow sheet, the recipient was monitored, and his behaviors were recorded every 15 minutes. At 11:15 p.m., he reportedly was agitated or yelling. His circulation, sensation and movement were within the normal limits. Around 12:30 a.m., he "threw [a] urinal at security" and directed profane language at the staff while they were changing the linens soaked with urine on his bed. Documentation indicated that he was reassessed at 1:15 a.m. and 3:15 a.m. and was yelling during that time. He reportedly accepted a sandwich and coffee, and toileting was provided. He was cooperative or quiet from 3:15 a.m. to 6:30 a.m. and was released from restraints at 5:00 a.m. and seclusion at 6:30 a.m.

On the 28th, the recipient was admitted to the hospital's medical floor with diagnoses of Neutropenia (low white blood cells) and Hyponatremia (low blood sodium), and a sitter was assigned. On that same day, a petition and certificate for immediate involuntary hospitalization were completed by a social worker and a clinical psychologist at 2:40 p.m., respectively. The psychologist's signature on the certificate affirmed that he advised the recipient of his rights. We could not determine during the record review what time he was admitted to the unit because some of the dates were redacted in the record. However, the Director of Clinical Integration/Quality/Regulation placed the time around 6:30 a.m. on that morning. We noticed that the involuntary documents were completed more than 15 hours after his detention.

When the complaint was discussed with the hospital's staff, the Manager of the Emergency Department explained that there are five exam rooms with video surveillance in the department. She said that patients such as recipient A are not allowed to leave the department if they are under police arrest. Recipient A was moved to room #5 and placed in seclusion because he was a flight risk. She said that recipient B was restrained because he was combative upon his arrival. We mentioned that the flow sheet showed that restraints and seclusion were continued until 5:00 a.m. and 6:30 a.m., respectively. We asked why recipient B was not released sooner because the record showed that he was cooperative from 3:15 a.m. to 6:30 a.m. According to the Manager of the Emergency Department, patients are not restrained for the duration of the order if they can be released sooner. They are usually taken out of seclusion and restraints when they are calm and cooperative. We were informed that something might have happened in the department that prevented recipient B from being released from restraints sooner.

The staff interviewed did not remember the male recipient who the complaint alleged had bruising from being restrained in February 2012. They could not recall the elderly woman whose family member allegedly had called the local police after the recipient was placed in restraints. The paramedic, who was supposedly injured while restraining the male recipient, said he has participated in about ten or twenty restraint episodes in the past two years. However, he denied having received any injuries from applying restraints. He reported that his most recent training on dealing with aggressive individuals and restraints was about a year ago. This training is provided to staff annually. The HRA was informed that a written report would be completed if injuries are sustained during a restraint episode or whenever there is contact with the police. We were later told by the hospital's administration that there were no such reports.

The staff denied that sitters are only ordered if the recipient is admitted to the hospital as reported in the complaint. The first paramedic said that patients were previously locked in a room or supervised by the staff. He reported that the department started using more sitters in 2012 and that the Charge Nurse is responsible for ordering them. He said that sitters are assigned to psychiatric patients who present with low risk of harm or those who are intoxicated. We were told that there has been a reduction in the use of restraints. Patients who lack harm toward self or others probably would not be secluded or restrained.

The second paramedic told the investigation team that patients were restrained more frequently when he first started working in the department in 2011. He said that low risk patients were previously locked in a room and could not refuse certain things such as having their vitals taken and blood drawn. He said that "we get them sitters now" and that the department started using more sitters for non-threatening patients about six months prior to the HRA visit to the hospital in 2012. We were told that adult patients are not allowed to have family members at their bedside because they might have been involved in the petition process for involuntary emergency hospitalization. They are not allowed to use the phone, but staff will call the patient's family upon their requests. He said that patients are usually nervous and that restrictions such as a contraband check and taking their belongings escalate the situation. Patients who exhibit threatening behaviors or attempt to flee from the hospital are restrained. According to the paramedic, he believes that the hospital's security guards give patients too many chances to alter their behaviors before applying restraints.

The third paramedic reported that "seclusion orders were written when no one could sit with patients" who were at risk of self harm or physically violent or showed no signs of de-escalation. He said that patients would remain in seclusion with a "restriction of rights" notice. We were informed that there was a lot of discussion about sitters and caring for patients in anticipation that a local state-operated mental health facility would be closed. And, there has been an increase in sitters and a reduction in seclusion. We were told that technicians from other floors are being used to sit with patients and that changes in the department have allowed "locked doors and video monitoring to be set aside." It also eliminates paperwork for certain staff because sitters are required to complete sections on the restraint and seclusion form. We were informed that the above interventions are still used but less frequently and that the hospital's security is called for patients requiring restraints because of violent behaviors. According to the paramedic, who is also classified as a technician, they are supposed to help hold the patient while security guards apply the restraints. He reported that patients and staff have been injured during the process.

A Mental Health Technician said that sitters are being used more frequently to allow patients to have more freedom in the department. He said that patients are locked in a room if they are suicidal. They reportedly are informed that their belongings will be taken and that a contraband check will be done. Again, we were informed that family members are not allowed to stay in the room with the patient and that the staff will make a phone call for the patient if requested. He explained that the protocol for restraints is violent behavior such as hitting his or her head against a cart. We were told that a chemical restraint would be used first for aggression and that physical restraints are used only as the last resort. A physician's order is needed for

seclusion, restraints and restriction of personal property. According to the technician, he has not noticed either an increase or reduction in restraints use.

A nurse acknowledged that an email was sent to the staff regarding sitters as reported in the complaint. She said that this issue also has been discussed in memos and at staff meetings. She reported that sitters are used more often but seldom when restraints are applied. Patients who are intoxicated are assigned sitters, but this intervention would not be appropriate for individuals who attempt to hit others. She said that patients must be observed while in seclusion or restraints at all times. A second nurse said that sitters are being used more and that they have been a "godsend. She said that patients are locked in a room if they are dangerous to self or others or try to elope. And, restraints are used only to protect patients or staff. She reported that there has been an increase in patients being seen in the department, but restraints are seldom used.

A third nurse said that sitters are used frequently in the department, otherwise, patients would be locked in a room. He explained that the least restrictive intervention is preferred for patients with low risk of harm. Patients are restrained if they are dangerous to self or others. He said that verbal interaction is first attempted and that restraints are used only as the last resort. We were told that the hospital's security guards monitor the surveillance cameras and that they can do the 15-minute required safety checks on patients.

A fourth nurse reported that there has been an increase in psychiatric recipients seen in the department and that restraints are seldom applied. He said that sitters have made a big difference because they can explain to patients what is happening to them. The nurse was asked twice whether or not recipients who were previously secluded would be appropriate for a sitter now. And, he said "yes" both times. We were informed that rights are restricted when patients are in seclusion or restraints. The nursing staff was previously responsible for documenting the information required on the flowsheet but now sitters must do the same except for monitoring vitals and skin/circulation assessments. On questioning, three of the four nurses interviewed said that the Charge Nurse or floater or another staff person would monitor the patient if they had to leave the area to provide care to another patient. They reported that the staff person who actually provides the monitoring would sign the 15-minute safety checklist if this occurs. The Manager of the Emergency Department said that the Charge Nurse is always at the desk and observing recipients while in seclusion and restraints.

The Manager of the Emergency Department further reported that sitters are the least restrictive intervention for patients with low risk of harm and that they have always been used in the department. Patients are being held longer because of problems with finding alternative care for them. She said that the closing of a nearby mental health facility has resulted in more patients and sitters in the department. For fiscal years 2012 and 2013, the department reportedly has provided daily care to approximately 115 and 127 patients, respectively, which is an increase of 9%. The HRA was informed that the hospital might have three sitters available each day and that the float pool is now being used to manage the increase in patients. The hospital now has an agreement with an outside agency to evaluate and determine whether patients can be managed as an outpatient. According to the Manager of the Emergency Department, there has been a

decrease in restraint use, and the hospital's Quality Improvement Department tracks the use of restraints and seclusion.

According to a Certified Nursing Assistant, there have been no changes in sitters, but they are being used more often. She said that improving patients' visits is discussed at each staff meeting. Patients who are intoxicated are secluded. Those requiring mental health evaluations might be assigned a sitter instead of being locked in a room. We were told that patients are not allowed to leave the department, while pending the completion of a petition. A physician, who reportedly has been employed by the hospital for 3½ years, said that he sometimes uses seclusion to protect patients who have been subjected to domestic violence. He said that he admonishes rights upon entering the exam room and tries to engage the patient to complete the certificate. According to the physician, his last training on the Mental Health and Developmental Disabilities Code that included preparing certificates was in 2011.

According to the hospital's policy (#2001), restraints and seclusion may be used upon a physician's or Licensed Independent Practitioner's (LIP) written time limited order when recipients present with violent or self destructive behaviors. Restraints or seclusion should only be used after lesser restrictive measures have failed. The hospital's philosophy is to limit the use of restraints and seclusion to those situations with appropriate and adequate documentation and the use of the least restrictive method for the shortest possible duration. Restraints and seclusion must be discontinued at the earliest possible time regardless of the length of time on the order. They may not be employed concurrently unless the patient is continually monitored face-to-face or using both video and audio equipment monitored by trained staff. Only, a physician or LIP may order restraints prior to their application. In case of an emergency, the order must be obtained either during the application or immediately after the restraints have been applied. The physician or LIP must do a face to face evaluation within one hour and determine whether the interventions pose an undue risk to the recipient in light of his medical condition. The physician or a nurse must confirm in writing every two hours following a personal examination, that restraints and seclusion do not pose an undue risk to the recipient's health. The policy states that visitors are not allowed in the room unless the patient is a minor. A notice of restriction must be completed.

The hospital's policy (#2004) provides guidelines concerning restraints for managing non-violent and non-self destructive behaviors that jeopardize the immediate physical safety of the patient or others. It states that a physician order must be obtained within twelve hours following the application of two or three point soft restraints. The order must never be written as a standing order or as needed basis.

According to the hospital's "Patient Rights" policy, patients have the right to be free from all form of restraints that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.

The hospital's "Petition and Certificate for Mental Health Patients" policy states that a petition and certificate shall be completed in the Emergency Department for medical patients pending a mental health transfer only if the patient is determined to be at risk of harm to self or others and not solely because of the presence of psychiatric symptoms. It states that a 24-hour

sitter will be ordered until the behavioral health psychologist determines that the patient does need a mental health transfer because of lack of harm to self or others. The policy states that the restraint protocol will be implemented as needed.

According to the hospital's "Surge" policy, the hospital has a system in place to ensure that there are appropriate beds and resource utilization. It states that the hospital recognizes that situations will periodically occur when the number of patients seeking care exceeds the resources available and that patient's care will be adversely affected. The policy includes procedures for using resources in the Emergency Department and other resources to manage this problem.

The hospital reportedly has a policy concerning patients in police custody, but the document is part of a general policy.

CONCLUSION

According to the following Sections of the Code,

Section 5/1-122 states that,

> A qualified examiner means a person who is: (a) a Licensed Clinical Social Worker, a registered nurse with a master's degree in psychiatric nursing who has three years of clinical training in the evaluation and treatment of mental illness, and a licensed clinical professional counselor or marriage/family therapist who has at least three years of post-master's experience that includes the evaluation and treatment of mental and emotional disorders.

Section 5/1-125 of the Code states that restraint means direct restriction through mechanical or personal physical force of the limbs, head or body of a recipient.

Section 5/1-126 of the Code defines seclusion as sequestration by placement of a recipient alone in a room which he has no means of leaving.

Section 5/2-102 (a) of the Code states that,

> 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.

Section 5/2-108 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. (a) Restraint shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker,

> or registered nurse with supervisory responsibilities. In no event may restraint continue for longer than 2 hours unless a personal examination is done and it is determined that restraint do not pose an undue risk to the recipient's physical or medical condition…. the order shall state the events leading up to the need for restraint and the purposes employed. The order shall also state the length of time for restraint and give a clinical justification for the length of time…. (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 clinically appropriate but in no event less than once every 15 minutes…. the recipient shall be permitted to have regular meals and toilet privileges free from the restraints, except when freedom of action may result in physical harm to the recipient or others…. (i) Whenever a recipient is restrained, …staff shall remain with the recipient at all times unless the recipient has been secluded.

Section 5/2-109 of the Code states that,

> Seclusion may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others …. (a) Seclusion shall be employed only upon written the order of a physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities …. (e) A recipient who is restrained and secluded shall be observed by a qualified person as often as clinically appropriate but in no event less than once every 15 minutes.

Section 5/2-201 of the Code states that whenever any rights of a recipient of services are restricted, the recipient shall be promptly given a notice of the restriction and anyone he or she designates.

Section 5/3-208 of the Code states that,

> Whenever a petition has been executed …, and prior to this examination for the purpose of certification of a person 12 or over, the person conducting this examination shall inform the person being examined…the purpose of the examination [and his or her rights].

CMS' Conditions of Participation for Hospitals, (42 C.F.R. 482.13 e) states,

> All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the

patient, a staff member, or others and must be discontinued at the earliest possible time.

Documentation in recipient A and B's records indicated that seclusion and restraints were used because of agitation, a flight risk and verbal and physical threats. We noticed that there was no specific mention of any threats to inflict bodily harm, but recipient A was on police-hold because of driving under the influence of alcohol. According to the staff, recipients, who are intoxicated and/or under police arrest, are placed in seclusion. We noticed that 4-point restraints were applied to transport the recipient for a scan and that they discontinued ten minutes after the order had expired. It was documented that recipient B was restrained upon his arrival to the Emergency Department because he was combative. He reportedly threw a urinal container at the hospital's security while they were changing his bed linens soaked with urine. We noticed that restraints were continued following a noted absence of physical harm (more than a reasonable one hour and forty-five minutes period) and seclusion was continued for another forty-five minutes. The Manager of the Emergency Department speculated that something might have happened in the department that prevented the recipient from being released sooner. By documentation, recipient B clearly was not given the opportunity to have a person or agency notified about what was happening to them under Section 5/2-201.

When the complaint was discussed with the hospital, one nurse denied that patients are routinely secluded and restrained, two staff members said that patients were previously locked in a room; many of them said that patients are secluded if they are dangerous to self or others, a flight risk, intoxicated or under police arrest. One staff person said that patients were restrained more frequently in 2011; two staff members said that restraints are seldom used; three of them said that restraints are used only as the last resort; three staff members reported a decrease in the use of restraints. According to eight staff members, there has been an increase in the use of sitters. The staff interviewed denied that sitters are only ordered if the recipient is admitted to the hospital.

The Authority cannot substantiate the complaint stating that recipients are routinely placed in seclusion and restrained for the convenience of the Emergency Department staff. However, the investigation revealed that recipients who did not meet the requirement of physical harm were previously secluded and restrained because there was a shortage of sitters until the hospital's surge policy was implemented. A restriction notice suggests that recipient A was initially considered as a mental health patient, but it was later determined that his change in mental status was caused by alcohol intoxication. His record supports that seclusion and restraints were used without descriptive instances of potential physical harm to self or others in violation of CMS' Conditions of Participation for Hospitals 482.13 (e) and the hospital's policy. Recipient B's record also lacked indication of physical harm prior to the initiation of seclusion and restraints. This violates Sections 5/2-108 and 5/2-109 of the Code, CMS' Section 482.13 and the program policy. The Authority was informed that sitters are now being assigned to recipients who exhibit low risk of harm while seeking help in the hospital's Emergency Department.

The HRA cannot substantiate the complaint stating that the recipients are not properly monitored, but nurses are required to document that 15-minute safety checks are done. In

recipient A and B's records, the flow sheets documented that they were monitored and that their behaviors were recorded every 15 minutes. At the site visit, three nurses told the HRA that another staff person would monitor the patient if they had to leave the area to provide care to another patient. We were also informed that security personnel can do 15-minute checks.

Additionally, the Authority does not substantiate the complaint stating that the staff failed to follow the Code's requirements concerning admonishment of rights prior to examination and preparing certificates. It was specifically stated that staff who are not qualified were preparing certificates. A certificate was not completed for recipient B because his visit to the hospital was for medical reasons. His altered mental status was caused by his high blood alcohol level. We noticed that a clinical psychologist affirmed by signature on the certificate that rights were given to recipient B before the examination. We found no clear evidence to support the complaint or violations of Section 5/3-208.

RECOMMENDATIONS

1. The hospital must make certain that seclusion and restraints are only used to ensure physical safety pursuant to Sections 5/2-108 and 5/2-109 of the Code, Conditions of Participation for Hospitals 482.13 (e) and the hospital's policy.

2. Release recipients from restraints and seclusion when the threat of physical harm no longer exists under Sections 5/2-108, 5/2-109, 482.13 (e) and hospital's policy.

3. Ensure that recipients are provided with the opportunity to have any designated person or agencies notified, whenever restraints are applied for behavioral reasons under Sections 5/2-108, 5/2-201 and the hospital's policy.

SUGGESTIONS

1. Under state (405 ILCS 5/2-108 and 5/2-109) and federal (42 C.F.R. 482.12) laws restraints may only be used to ensure physical safety. Use exact language that describes what occurred. If a patient tries to hit a staff person, document that the patient tried to hit the staff person as opposed to "the patient was combative." Yelling and using profanity have nothing to do with physical harm and should never be reasons to seclude or restrain recipients.

2. When a restriction of medication, phone calls or visitors of choice are initiated in the hospital's Emergency Department, a restriction of rights notice should be issued pursuant to the Code's Section 5/2-201.

3. A staff person mentioned that chemical restraint versus physical restraint is always used first. The hospital is reminded that services shall be provided in the least restrictive environment and that the views of the recipient shall be considered, if any, concerning the treatment being provided pursuant to Section 5/2-102 (a) of the Code.

COMMENTS

The HRA reminds the hospital that Illinois law allows a recipient to be detained within a facility upon the initiation of a petition under Sections 5/3-601 and 5/3-606 of the Code. We noticed that the petition and first certificate regarding recipient B's detention were not completed until the 28th at 2:40 a.m., which more than 15 hours after his arrival to the hospital's Emergency Department and placement on the medical unit. The hospital must ensure that petitions are completed immediately whenever mental health recipients are prevented from leaving the Emergency Department under Section 5/3-601. Also, the hospital's policy states that a petition and certificate shall be completed in Emergency Department for mental health recipients who at risk of harm to self or others.

The HRA acknowledges that the complaint involved the hospital's Emergency Department, but we noticed that 4-point and soft wrist restraints were used during recipient's B's stay on the medical unit. Although dates on the physician's orders were redacted, one of them stated "restraints [as] needed." The hospital's policy (#2004) provides guidelines concerning restraints for managing non-violent and non-self destructive behaviors that jeopardize the immediate physical safety of the patient or others. It states that a physician order must be obtained within twelve hours following the application of two or three point soft restraints. The order must never be written as a standing order or as needed basis. The hospital is reminded to follow Section 5/2-108 of the Code, CMS' Conditions of Participation for Hospitals 482.13 (ii) (6) and program policy that prohibits these kinds of orders.