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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 13-030-9006
Swedish Covenant Hospital

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 Swedish Covenant Hospital (Swedish) in Chicago. It was alleged that the facility staff administered forced psychotropic medication in violation of the Mental Health Code, used bodily force for no adequate reason, and refused the recipient food that was required for her special diet. If substantiated, these allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Swedish Covenant Hospital is an independent, nonprofit teaching hospital under the auspices of the Evangelical Covenant Church, and it incorporates a 25-bed Behavioral Health Unit.

To review these complaints, the HRA conducted a site visit and interviewed the Associate General Counsel, the Behavioral Health Nurse Manager, the Clinical Director of Behavioral Health, and the Unit Registered Nurse. Relevant program policies were reviewed as were the adult recipient's records upon written consent.

COMPLAINT SUMMARY

The complaint in this case involves the admission of a recipient into the Swedish Covenant Hospital Behavioral Health Unit (AP2). The recipient had gone to an emergency department of another hospital because of suicidal behavior. From that hospital the recipient was transferred on an involuntary petition and certificate to Swedish. The complaint indicates that at Swedish, the recipient noted that the nurses were working in the nurses' station and then approached her for a body search, without changing their gloves. When the recipient requested that they change their gloves before attending to her, they allegedly became angry and threatened her. Later the recipient allegedly requested the food that her mother had brought for her dietary requirements and staff would not allow it. When the recipient began arguing with staff, the complaint alleges that a staff person threw her against the wall and she hit her head.

Additionally, the complaint indicates that the recipient was then held down by 6 staff persons while she was injected with psychotropic medication.

FINDINGS

The clinical record indicates that the recipient was admitted to Swedish Covenant Hospital on 8/18/12 at 8:26 p.m. on a petition for involuntary admission along with a certificate completed after her psychiatric evaluation in the emergency department of another hospital. The psychiatric assessment, completed on 8/18/12 at 11:30 a.m. states, "Pt. brought in by CFD, per CFD pt called 911 after taking 32 pills of clonazepam, a box of wine, and a bottle of Nyquil. Pt arrives with slurred speech, drowsy, unable to stand without assistance. 'I took all of it because I wanted to die, I have depression.' Pt states SI [suicidal ideation], denies HI [homicidal ideation],. Pt intermittently cooperative. Pt alert to self and can state, 'I am in hospital.' Pt states history of bipolar and depression. Per ed attending: 'I attempted to get a history from the patient. She indicates that she probably took the medicine between midnight and 2:00 a.m. Pt wants to go home and states, 'You don't care that I took the medicine. You're pretending to care.' Appears to exhibit some paranoid ideation. Pt very concerned that I did not wash my hands despite using the alcohol gel, then wanted me to use the alcohol gel after I washed my hands with soap and water… Pt is medically clear for crisis evaluation and admission." Upon arrival at Swedish the recipient signed an application for voluntary admission at 10:30 p.m. and then immediately completed a Request for Discharge (also signed at 10:30 p.m.).

Progress notes written on 8/18/12 at 10:14 p.m. indicate that the recipient is "Agitated and uncooperative" and with "violent thoughts." When given the option for alternatives should the recipient become violent, the notes indicate that the recipient preferred the use of emergency medication but would not want either seclusion or restraint. The notes then indicate that at 11:21 p.m. "Pt agitated and hostile. Argumentative and Demanding. Banging on nursing station door. Pushed staff. Loud and verbally threatening. Escalating and intrusive. Coming into nursing station and refusing to leave despite multiple verbal redirection by staff. Pt accepted Ativan 2 mg IM willingly". The clinical record indicates that the recipient gave informed consent for the administration of two psychotropic medications: Topamax and Trazodone and on this document the physician recorded that she had decisional capacity. There is no indication of informed consent for Ativan. There is no Restriction of Rights document in the clinical record.

Progress Notes from 8/19/12 at 7:22 a.m. state that the recipient was given food that her mother brought to accommodate her special diet (lactose free, gluten free and vegetarian). The record does not indicate at what time the mother initially brought food for her daughter, however staff reported that they requested a physician order for a special diet when the recipient requested it.

On 8/19/12 at 3:15 p.m. the recipient was seen by her attending physician and he determined that she would not benefit from extended treatment within the behavioral health unit and she was discharged at 4:30p.m. There is no indication from the clinical record that the recipient had a physical altercation with staff at any time.

The hospital provided the administrative response to complaints filed by the recipient after her hospitalization. Included in this packet is an Investigation Report developed by the Clinical Director of the Unit:

"AP2 staff brought to my attention that patient made following accusation against AP2 staff

1. Body search was conducted by 2 male staff upon admission
2. Gave medication against her will
3. Slammed her against the wall by a male staff and has scratches on her neck.

AP2 clinical Director performed an investigation based on the above accusations. Patient was admitted 8/18/12 at 1940. Patient came from …hospital ED. Patient was a voluntary admission and signed request for discharge on the admission day. Patient was admitted for depression and suicidal attempt by overdosing on medication. Patient claimed that she was overdosed on klonopin 32 tablets, alcohol, and Nyquil. ED faxed report from Northwestern also indicates that patient is paranoid and demanded the ED resident to wash hands frequently.

[RN], who was the admitting RN, documented that body/belonging search was done. According to [Attending RN], 2 female staff … performed body search for the patient. [RN] mentioned to me that patient was paranoid and demanded them to remove gloves and wash hands again. Both [RN's] explained to her the reason of body search. Staff changed gloves per patient's request. Patient demanded to have her clothes back and was questioned about skin check. [Attending RN] documented that both arms of patient were slightly reddened and per patient it is from 'yeast infection.'

Patient received Ativan 2mg I/M [intramuscularly] at 2321 stat. Documentation under EMAR comment section indicates that patient was agitated, hostile, banging on nurses' station door, argumentative, demanding, pushed staff, loud, escalating, verbally threatening, and refused to leave nurses' station. Staff also documented that verbal redirection given, Ativan 2 mg I/M given and patient accepted medication willingly. There was no evidence in the document and staff verbal report to me that the patient was given medication against her will or any force applied.

Patient claimed that the male counselor slammed her against the wall. I spoke with him and he denied this accusation and reported that he did not touch her physically at all. According to the RN, she worked with patient on 8/18/12 and did not witness anyone slamming her against the wall. Documentation in the EMAR (Under comment section) shows that verbal redirection was given to the patient. No evidence of force applied per record and also per RN. Patient was seen and examined by Dr. on 8/19/12 and the report shows no skin breakdown or wounds.

Patient continues to be demanding, agitated, angry, paranoid, and uncooperative since admission according to patient record. There is consistency in documentation that emotional support and allowed her to verbalize feelings in multiple shifts by different staff members. Patient demanded to be discharged. Dr. … documented that patient has borderline personality. Patient is not certifiable and would not benefit from extended stay. Patient was discharged AMA on 8/19/12. Patient reported to police her accusations and police talked to RN. According to

Dr… psych assessment, patient reported having difficulty with [referring hospital] ED staff and got into altercations with staff there. Dr… mentioned in his report that she is forced on her mother as being 'evil incarnate'. At this point, writer has not found any evidence to support patient's accusations".

Hospital Representatives' Response

Hospital staff were interviewed regarding the complaints. They stated that the recipient was very uncooperative and threatening from the time that she arrived at AP2. They indicated that she was fixated on the cleanliness of the staff and that she asked them to change their gloves which they did. At one point the recipient entered the nurses' station and when asked to leave, began banging on the window. Staff then asked her to stop, however the recipient responded in a way which suggested that she was recalling events from the previous hospital emergency department, and she could not comply. The nurse then asked the recipient if she wanted an injection and she went to her room and was given the Ativan. Staff indicated that no security officers were called to the scene and the recipient was never subdued- she insisted that she did not want any pills and the staff respected this preference. Staff noted that in their interactions with the recipient she continued to ask the same questions repeatedly, as if she was not able to understand what was happening. Staff were asked if a Restriction of Rights form was completed and issued for the event and they said that when medication is administered against the recipient's refusal, then a Notice is issued, however in this case it was accepted.

Staff were asked about the allegation that a staff member threw the recipient against the wall. They indicated that the alleged staff person is a counselor on the unit who the recipient had been focused on, asking staff his name and what he was doing there, however this counselor was not assigned to the recipient and had no interaction with her. The nurse on duty at the time of the recipient's admission indicated that she was attending to the recipient throughout this time and was certain that she was not attacked by a staff member. Staff also believe that the recipient may be recalling events which happened at the emergency department of the referring hospital. They also noted that the recipient called the police and they responded, however they did not find any wrongdoing. The hospital, however, did not report the alleged abuse to the Department of Public Health.

Staff were asked about the recipient's ability to eat the food her mother brought for her special diet. The nurse on duty on the evening the recipient arrived indicated that the mother had not been there while she was on duty, so she had not arrived by 11:00 p.m. The entry in the progress notes was then made by the following day shift nurse, referring to food that was brought in some time before 7:22 a.m. Staff indicated that family are allowed to visit at any time during the admission process and they indicated that staff would not deny the recipient her mother's food, especially for a special diet. Staff also indicated that the special diet was immediately requested for the recipient during the admission process and would have then been ordered by the physician the same morning.

Staff were questioned about the policy and practice of completing body or strip searches on new admittees. Staff indicated that recipients are asked to remove their clothing (everything but their underwear) and are given a gown so that they can be visually inspected for any

contraband, injuries, or medical issues. They indicated that they explain the necessity of the search to the recipient and if the recipient refuses, they will be given a pat down search. The entire process usually takes 3-5 minutes however in the case of this recipient it took almost a half hour. The recipient did not refuse the search, however she continued to ask the same questions repeatedly, as if she could not understand, and she requested her clothing, which is generally not returned until after the recipient is evaluated by the attending physician, but within 24 hours.

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 also provides guidelines for the administration of psychotropic medication:

"(a-5) If the services include the administration of…psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment. …. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only (i) pursuant to the provisions of Section 2- 107 [below]…." (405 ILCS 5/2-102).

Additionally, 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 Hospital Licensing Act (210 ILCS 85/9.6) sets mandatory standards for hospitals' response to alleged abuse. The Act prohibits any act of abuse by any hospital staff (a), and mandates that any staff member who has reasonable cause to believe that any patient with whom they have direct contact has been subjected to abuse in the hospital must promptly report or cause a report to be made to a designated hospital administrator responsible for providing these reports to the Illinois Department of Public Health (b). Additionally the Act outlines the mandatory response elements:

"Retaliation against a person who lawfully and in good faith makes a report under this Section is prohibited.

Upon receiving a report under subsection (b) of this Section, the hospital shall submit the report to the Department within 24 hours of obtaining such report. In the event that the hospital

receives multiple reports involving a single alleged instance of abuse, the hospital shall submit one report to the Department.

Upon receiving a report under this Section, the hospital shall promptly conduct an internal review to ensure the alleged victim's safety. Measures to protect the alleged victim shall be taken as deemed necessary by the hospital's administrator and may include, but are not limited to, removing suspected violators from further patient contact during the hospital's internal review. If the alleged victim lacks decision-making capacity under the Health Care Surrogate Act and no health care surrogate is available, the hospital may contact the Illinois Guardianship and Advocacy Commission to determine the need for a temporary guardian of that person.

All internal hospital reviews shall be conducted by a designated hospital employee or agent who is qualified to detect abuse and is not involved in the alleged victim's treatment. All internal review findings must be documented and filed according to hospital procedures and shall be made available to the Department upon request.

Any other person may make a report of patient abuse to the Department if that person has reasonable cause to believe that a patient has been abused in the hospital.

The report required under this Section shall include: the name of the patient; the name and address of the hospital treating the patient; the age of the patient; the nature of the patient's condition; including any evidence of previous injuries or disabilities, and any other information that the reporter believes might be helpful in establishing the cause of the reported abuse and the identity of the person believed to have caused the abuse.

Except for willful or wanton misconduct, any individual, person, institution, or agency participating in good faith in the making of a report under this Section, or in the investigation of such a report or in making a disclosure of information concerning reports of abuse under this Section, shall have immunity from any liability, whether civil, professional, or criminal, that otherwise might result by reason of such actions. For the purpose of any proceedings, whether civil, professional, or criminal, the good faith of any persons required to report cases of suspected abuse under this Section or who disclose information concerning reports of abuse in compliance with this Section, shall be presumed.

No administrator, agent, or employee of a hospital shall adopt or employ practices or procedures designed to discourage good faith reporting of patient abuse under this Section.

Every hospital shall ensure that all new and existing employees are trained in the detection and reporting of abuse of patients and retrained at least every 2 years thereafter.

The Department shall investigate each report of patient abuse made under this Section according to the procedures of the Department, except that a report of abuse which indicates that a patient's life or safety is in imminent danger shall be investigated within 24 hours of such report. Under no circumstances may a hospital's internal review of an allegation of abuse replace an investigation of the allegation by the Department. …"

<u>HOSPITAL POLICY</u>

Swedish Covenant Hospital policy and procedure states that the hospital maintains patients' dignity and rights while protecting the rights and safety of all patients and staff. A patient's right to refuse psychotropic medication may be restricted only in order to prevent a patient from causing "serious and imminent physical harm to self and or others and no other less restrictive alternative is available."

The hospital does not have policy and procedure which addresses the Hospital Licensing Act (210 ILCS 85/9.6) requirements for reporting alleged abuse.

CONCLUSION

The complaint alleges that the recipient received forced emergency medication in violation of the Mental Health Code. The notes for the event state that the recipient was agitated, hostile, that she was going into the nursing station and refused to leave while escalating in her negative behaviors, and she then pushed staff. This documentation suggests that medication was administered on an emergency basis, however there is no Restriction of Rights Notice, which staff indicate would signify a forced administration. Also, notes as well as staff report indicate that the recipient accepted the medication which was given to her after she willingly returned to her room. If the medication was accepted and not forced, the record contains no documented evidence of the patient's informed consent for this medication, thus violating informed consent requirements under the Code. The HRA substantiates that the hospital administered forced emergency medication in violation of the Code.

The complaint alleges that hospital staff used bodily force for no adequate reason. The clinical record as well as the report that was issued in response to this allegation indicate that the nurse on duty at the time of the alleged incident as well as the accused staff person were questioned about this event and both denied that the recipient was physically touched, and the recipient was subsequently examined by a physician who reported that she had no injuries. Although the HRA cannot substantiate that the hospital staff used bodily force, we did find that the hospital does not have policy and procedure which adequately addresses the Hospital Licensing Act requirements for responding to allegations of patient abuse. Some of these requirements are that the Illinois Department of Public Health must be notified, that measures are taken to ensure the recipient's safety while the incident is being investigated, and that the internal review is completed by a person who is not part of the recipient's treatment. Not only did the hospital response fail to meet these requirements, but the hospital does not have the policy or procedure necessary to comply with this law. The HRA strongly recommends that the hospital immediately develop this policy and train all staff in its implementation.

With regard to the complaint that the recipient was refused the food that was required for her special diet, the record shows, and staff confirm, that the staff immediately requested an order for a special diet upon the recipient's admission, and that the recipient was given the food her mother provided shortly thereafter. The HRA does not substantiate that the hospital refused the recipient the food that was required for her special diet.

RECOMMENDATION

1. Review with staff the Mental Health Code requirements for the administration of psychotropic medication and ensure that the record reflects that the recipient gave informed consent for all psychotropic medication.

2. Review the Hospital Licensing Act requirements for responding to allegations of patient abuse and develop policy and procedure for the implementation of its requirements. Train all staff in these mandatory requirements.

SUGGESTION

Although it was not part of the extant case but was addressed administratively in the hospital investigation, the HRA is compelled, as advocates for mental health recipients, to request that Swedish Covenant Hospital cease their blanket practice of body or "strip" searches for mental health patients. The hospital feels that strip searches are necessary to guarantee the safety of the unit, and feel that insurance or funding sources require these measures. The HRA strongly disagrees and feels that this practice supports the widespread prejudice that mental health recipients are more dangerous than medical patients, which they are not. Additionally, the damage to the dignity, personal safety and modesty of these patients, who may have clinical issues surrounding their bodies, overrides the benefit of the safety of the unit. The Mental Health Code mandates that all care and services be administered in the least restrictive environment and based on individual need, and this blanket policy for all mental health recipients, who may already be fragile and vulnerable, is excessive at best. Consider the use of the "pat down" search for those recipients who are assessed as a safety threat, and discontinue the humiliating practice of making patients strip and stand before an investigator at a time when they are most in need of safety and help.