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HUMAN RIGHTS AUTHORITY - NORTHWEST REGION

REPORT 13-080-9001
OSF ST. ANTHONY MEDICAL CENTER

Case Summary: violations were found in the treatment provided to a patient without her consent. The facility's response is not part of the public record.

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving complaints of potential rights violations in the care provided to a mental health patient within the Emergency Department (ED) at OSF St. Anthony Medical Center in Rockford. Allegations were that the patient was detained, restrained and treated without consent, cause and authority.

Substantiated findings would violate rights protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5) and Medicare/Medicaid hospital participation standards (42 C.F.R. 482).

St. Anthony Medical Center is a 254-bed-licensed facility that does not include an inpatient behavioral health unit. The ED sees approximately 39,000 patients annually, less than five percent of whom may have mental health needs. Typically, they are medically cleared and assessed there where dispositions including transfers to appropriate facilities are made. The hospital has a psychiatrist on staff who provides expertise in the process.

To pursue the matter we visited the hospital where nurses and a physician involved with the patient's care, various management representatives and an attorney were interviewed. Policies were reviewed as were relevant sections from the patient's records with written authorization.

COMPLAINT SUMMARY

It was said that the patient went to St. Anthony's ED for help with pain from a kidney infection and dry socket from oral surgery. Recalling a previous admission, an ED physician allegedly saw the patient right away and said she was to have a blood draw for alcohol; the patient refused, and the physician proclaimed loudly that she was to be committed. Four men, presumably security guards, came in, put her over a gurney, yanked her pants down and gave her

a shot that turned out to be Haldol. By that time she grew hysterical as the men began cutting her clothes off. Nurses reportedly kept sticking her with needles for blood draws and she was on the gurney for hours, falling unconscious and waking up later naked and in four-point restraints while the guards were watching her. Despite her repeated objections to what occurred, she was eventually taken upstairs where she was held for about fifteen hours without a petition or certificate for involuntary admission. She was seen by a psychiatrist who told her she was being transferred out of town because there were no available beds in Rockford. The complaint concludes by saying that the same thing happened to her again during a subsequent visit two weeks later.

FINDINGS

Record reviews:

March 30th

According to records, this patient arrived at the ED at 3:08 in the afternoon. She was noted to have a mild distress level and her vitals were taken without incident. Triage was completed by 3:21 p.m., and she signed a consent for general treatment form. She was described as acting agitated and was yelling at a nurse when taken to a specific exam room, claiming that she previously received poor care but had no choice for another hospital. The attending physician and security were at her bedside within fifteen minutes, and blood work was ordered immediately.

Physician notes beginning at 3:50 p.m. referred to another admission a week earlier where the patient had mouth pain and alcohol on her breath; she was treated for the pain but did not require admission. The physician wrote that at this visit, the patient appeared with ear pain and was oriented to person, place and time. The psychiatric portion of the exam noted her as anxious, angry, labile and inappropriate with rapid and tangential speech. She was further described as being aggressive, hyperactive, paranoid and delusional, displaying poor judgment but no suicidal or homicidal plans. The physician called the patient's husband who said she was a danger to herself, threatening suicide. The entry stated how the patient refused blood draws except for a complete blood count specifically, to which the physician asserted that she wanted an alcohol level and possible tox screen. She documented her decision to seek an involuntary psychiatric admission. After several failed attempts at that, she was admitted to a telemetry floor where she would have a psychiatric consult after being sedated with Haldol and Ativan in the ED. Lab results showed a 131 alcohol level, and the entry concluded by saying that the husband and son agreed with care plans.

A nurse's notes at 3:52 p.m. reflected what the physician described: the nurse attempted to draw blood but the patient refused, saying she would only give blood if a complete count was done. The nurse reasserted what the physician said, that they were going to obtain an alcohol level "to which the pt. did agree", but in the very next sentence the patient was quoted otherwise as saying the only way they would get blood is to do it forcibly, which she considered assault and battery. She said they would have to restrain her to do it. No action was taken at that time and security remained at her bedside. At 4:03 p.m. the nurse repeated that the patient was

agitated, excitable, hostile, without explanation of how, and hyperactive. At 4:04 p.m. blood work orders were acknowledged, at 4:14 p.m. orders for Haldol and Ativan were placed, and at 4:30 p.m. injections were given. Entries at 5:07 p.m. explained what took place in detail, how another nurse tried completing a blood draw and how the patient continued to refuse, three more times. The note goes on to state how the patient was assisted to the bed, security at bedside, that Haldol was given in her right glut as she yelled and screamed. She was told to take her arm out of her sleeve for the blood draw; she refused and said they would have to cut her shirt off; they cut her shirt off and her left arm was restrained for the draw. She struggled enough that the draw was unsuccessful and the Ativan injection was given. Security was noted to be outside of the room at this point.

The physician's four-point restraint order was in place at 5:12 p.m., and continuous observations and other safety assessments carried on from there. Headings referred to them as violent, self-destructive restraints and there was no documented indication that the restraints, which continued beyond two hours, posed no undue risk. A modified dose of Ativan was given at 5:30 p.m. and blood was drawn from the patient's hand and sent to the lab about twenty minutes later. Notes at 6:15 p.m. suggested that she was not left naked in restraints as the nurse helped her remove her pants to urinate and then provided her with warm blankets. At 6:29 p.m. she asked why the restraints were continued; the nurse replied because they needed more blood. She cooperated with subsequent draws. The patient was quoted at 6:48 p.m. as saying she would avoid the hospital next time and that she did not want to be there. The restraints were discontinued one limb at a time with all limbs freed by 7:34 p.m. There were no accompanying rights restriction notices. At 8:53 p.m. she was reported to be angry but calm when she was taken along with a petition and certificate for involuntary admission to another floor as an "outpatient with observation services". Ziprasidone was ordered and administered on that floor the next day. As with the Haldol and Ativan, there is no documented indication of getting the patient's informed consent for these medications and no documented indication that the patient had an opportunity to refuse them, that it was otherwise necessary to give them in an emergency to prevent serious and imminent physical harm along with justifying rights restriction notices.

The record included a petition for involuntary/judicial admission completed at 3:35 p.m. on the 30th, about thirty minutes after the patient's arrival. The ED nurse asserted that the patient acted inappropriately and was aggressive, yelling, and had refused blood draws. The ED physician completed a certificate at 3:40 p.m. that same day, in which she stated that the patient was delusional and thought she had a brain abscess. Her husband reported that she threatened suicide. The requirement to signify that the physician explained the purpose for the certification exam and that the patient did not have to talk with her was not completed. A second set of petition/certificate was done twenty-four hours later before the patient was transferred to another hospital; the rights signification was completed on that one.

April 15th

The ED record for this next visit showed that the patient arrived by ambulance at 5:37 p.m. She was noted to have a moderate distress level and was in a c-collar and backboard, which were used as precaution for a possible fall and head injury. A Haldol injection was ordered within seven minutes and given in her left arm at 6:00 p.m. A corresponding note described her

behavior as agitated, combative and aggressive, but without further explanation of how. Neither the notes nor the administration records provided precise reasons for the injection, whether the patient gave informed consent, had an opportunity to refuse or was forced to have it in the face of an emergency along with a rights restriction notice. A physical exam, blood work, an electrocardiogram and a cat scan were completed and a foley catheter was inserted without reference to any incident or objection from the patient. There were also no references to security being present at any time. Lab results confirmed alcohol levels at 264.

The attending ED physician started her notations at 5:40 p.m. and described the patient who presented with complaints of chest pains as agitated, loudly repeating unintelligible statements. She stated further that the patient was disoriented and combative on arrival, and, that soft restraints were necessary but without detailed explanation of why or when. As with the previous visit, the husband provided history and implicated alcoholism, although here it was determined she was not in danger.

Order sheets reflected the restraint use. Headings referred to them as non-violent/non-self-destructive. They started at 10:30 p.m. and were discontinued when the patient was discharged the following day at 12:38 p.m. There was no clearly stated reason for their use.

Progress notes and medication administration records showed that another Haldol injection was given at 10:50 p.m. and that Ativan, given intravenously, followed at 3:48 a.m. after she was transferred to another unit. As before, there is no documented reason as to why, no evidence of getting informed consent, and no indication that she was provided an opportunity to refuse or was given them to prevent serious and imminent physical harm along with rights restriction notices.

A discharge summary stated that the patient had been admitted for acute intoxication and was seen by a psychiatrist the following morning. He saw no reasons for a psychiatric admission and she was sent home after saying she did not want to be there any longer. Other than being treated with psychotropic medications, we found nothing similar to the events of the first visit, at least according to this record.

Statements:

We spoke with the ED nurse who spent most of the time with this patient and the physician from the March 30th visit and with another ED nurse who spent most of the time with this patient on April 15th.

Regarding the first visit on March 30th, the nurse explained how the patient was yelling a lot from the onset and how she repeated that she did not like any of them. She said that the patient was not given a choice for the Haldol and Ativan, however, as in this case, she always approaches patients and tells them what the medication is and what it is for. Education materials on the drugs are not shared but verbal education is ongoing, at least within the ED. The written part might be done on another unit or on discharge. The nurse said that the meds and restraints were not used just to get blood draws but because they were necessary to prevent harm. She said the patient was verbally threatening and had thrown a cup at her and threw a bedside table. We

pointed out here that the documentation says nothing like that. She also said that the hospital provides yearly modules on training that includes mental health issues. Binders are available in the ED which contain various mental health related documents. These provide quick access when needed.

The physician told us that she had prior knowledge about the patient and knew early on that she needed inpatient psychiatric care. She thought she was manic and hostile. Asked to elaborate on being hostile, she said she was angry, agitated and was yelling. She said the patient remembered her from a previous visit. She was quite tangential, obsessed with a brain abscess and was not appropriate. The physician thought that blood draws were necessary to medically clear her. She did not smell alcohol on her but suspected alcohol use based on those past visits. She did not honor the patient's objections to treatment because she needed psychiatric admission: she did not understand her condition or that she was in danger, and, she drove herself to the hospital while intoxicated. Her husband reported that he thought she was dangerous as well. The physician did not think there was a dangerous medical condition. Regarding her failure to sign the certificate, signifying that she recited the patient's rights to her, she explained that she does talk to patients about her concerns and why the certification exams are necessary. In this case, she did not sign declaring she did that because the patient was so labile and upset with her.

We also inquired about the need for a second petition and certificate. A social services manager said that the hospital where the patient was transferred required updated ones to reflect the transfer date.

The nurse from the second visit on April 15th said he had no recollection of this patient or of anything that happened. But in reviewing the record, he said there would have been primary medical concerns since the patient arrived in a neck brace. At center were medical needs as opposed to mental health, which was agreed upon by the physician and the hospital's attorney. He too provides verbal explanations about medications before giving them but not written materials. He attends the annual trainings as well.

CONCLUSION

Complaint: the patient was detained, restrained and treated without consent, cause and authority.

Detention

St. Anthony's ED policy on psychiatric or suicidal patients states that if such a patient has immediate medical needs, the admitting physician admits him to a nursing unit and an involuntary admission form (a petition) is completed. A security guard is placed outside the patient's room for continual observation to ensure safety. If physical needs are met in the ED, the physician may decide to transfer to another facility for involuntary admission; the voluntary admission route is another option, which we applaud the hospital for acknowledging. For involuntary cases, a nurse is to complete a petition and a physician completes a certificate. Illinois' Mental Health Code provides for the same in that the authority to detain anyone begins with a petition, complete with asserting reasons, and adds that no one may be held for more than twenty-four hours on the petition alone unless there is an accompanying certificate that notes

clinical observations by a qualified examiner--observations from no longer than seventy-two hours prior (405 ILCS 5/3-600 et seq.). Qualified examiners must explain the purposes of certification exams and tell patients they do not have to talk to them before the exams begin (405 ILCS 5/3-208).

According to this patient's record from March 30th, she presented almost immediately while being delusional, labile, aggressive and displaying poor judgment, which were some of the compelling documented reasons to seek an involuntary psychiatric admission. And although she did not have suicidal or homicidal plans, her husband reported that she threatened suicide earlier that day. A petition and a certificate for involuntary admission were done within thirty minutes, well before she made it known that she preferred to leave. Obviously, consent is not considered for involuntary admissions, and St. Anthony demonstrated its cause and authority to detain her by securing the required legal documents. However, the physician who certified the patient left that document incomplete without declaring by signature that she recited the patient's rights to her. The complaint is substantiated only in regard to that missed step. We find no detention issues within the April 15th visit.

Restraints

Hospital policies on restraint management state that in general they are only used to protect the immediate physical safety of the patient, staff or others. Restraints are not used as a means of coercion, discipline, convenience or staff retaliation. Orders are made by physicians who are primarily responsible for a patient's care. Emergency medical treatments are continuously available for restrained patients. Non-violent/Non-Self-Destructive restraints are defined as those needed to prevent the pulling out or removing of vital equipment or the disruption of care and to ensure immobilization for a necessary procedure. Monitoring occurs and is documented every two hours or more often if clinically indicated. Violent/Self-Destructive restraints are defined as those used to manage a patient's behavior that jeopardizes immediate safety for everyone and alternatives have been unsuccessful. Monitoring occurs and is documented every fifteen minutes. The Code of Federal Regulations also states that all patients have the right to be free from restraint of any form imposed as a means of coercion, discipline or convenience and may only be imposed to ensure immediate physical safety (42 C.F.R. 482.13). The Mental Health Code provides for the same justifications and monitoring timelines but adds:

> *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 and undue risk to the recipient's health in light of the recipient's physical or medical condition* (405 ILCS 5/2-108).
>
> *Whenever any rights of a recipient of services that are specified in this Chapter [II] are restricted, the professional responsible for overseeing…the…services plan shall be responsible for promptly giving notice of the restriction or use of restraint…and the reason*

therefor to: the recipient [and anyone designated] (405 ILCS 5/2-201).

Although the nurse from March 30th said that the patient was restrained not to coerce blood draws but to prevent physical harm and that she had thrown objects at her, none of the documentation whether from the nurse or the physician supports it. Instead, notations failed to mention the throwing incidents at all and only referenced how the patient was yelling, verbally aggressive, agitated, excitable, hostile, hyperactive, delusional, tangential, etc., none of which implies the need to prevent physical harm without further explanation. Furthermore, per the record, when the patient was asked why restraints had to continue, the nurse told her that they needed more blood. And, there were no written statements that these restraints, used for behavioral purposes, posed no undue risk when exceeding two hours and no rights restrictions notices. Again, consent is not needed when considering restraint use and based on a physician's order the hospital had authority to apply them. But supportive documentation of cause is a must, and here, the documentation suggested that restraints were used when it became necessary to carry out blood draw orders. Because of the lack of supported cause, the complaint is substantiated. All indications from the April 15th record point to the need for medically-based, non-violent restraints.

Treatment

St. Anthony's rights and responsibilities policy and its informed consent policy state that patients have the right to accept or refuse treatment and to be informed of the medical consequences of refusing. They also have the right to give or withhold informed consent, although the informed consent policy states specifically that legally and mentally competent patients have the right to make informed decisions regarding their healthcare, including the right to accept or refuse any treatment or life-sustaining measures. The policy focuses on procedures and treatment considered invasive or manipulative, not routine such as blood draws. Exceptions to informed consent, for stated procedures, are outlined as when the patient is incapacitated or otherwise unable to give informed consent or when a physician documents conditions that make getting consent not reasonably feasible. A patient rights handout also lists the right to be treated with dignity and respect and to be involved in care planning and decision making, including refusing care, treatment and services. Under the Mental Health Code, a physician must determine and state in writing whether a patient has decisional capacity whenever psychotropic medications are proposed; the medications may only be given if they do. Written education materials must be shared to ensure consent is informed. Recipients have the right to refuse all services, including medications, unless it becomes necessary to prevent serious and imminent physical harm. A medical emergency exists when delay for obtaining consent would endanger or substantially affect the recipient's health. Essential medical procedures may be performed without consent when the physician determines that the recipient is not capable of giving informed consent (405 ILCS 5/2-102 a-5; 5/2-107; 5/2-111). As stated above, restriction notices must be issued to the patient and whoever he chooses when the right to refuse treatment, including medications, is restricted (405 ILCS 5/2-201).

The record from March 30th provided evidence of the need for psychiatric admission: a completed petition and certificate, and descriptions that the patient was delusional, displayed

poor judgment, was aggressive, agitated, hostile and combative. But admission and treatment are mutually exclusive; one does not guarantee the other and patients, regardless of admission status, enjoy the right to refuse treatment unless qualifying circumstances arise. Again, while the nurse and physician gave more compelling statements of what played out, the documentation provided nothing similar. No indications were documented that the patient was not "mentally competent" as provided in policy, no implications of the need to administer medications to prevent serious and imminent physical harm, no opportunity to refuse them, no justifying restriction notices and otherwise no evidence of getting her informed consent or that she even had the decisional capacity to give informed consent as provided in the Code. Same for when psychotropics were administered during the April 15th visit. There was also no indication of why it was necessary to ignore her repeatedly stated objections to blood draws. The record should have provided a separate account from the admission and given the physician's determination of the need to forego consent and save the patient's health from danger. Given the unsupportive documentation, there seemed to be no definite consent, cause and authority to treat the patient. The complaint is substantiated.

RECOMMENDATIONS

1. Reciting patient rights before certification exams is about the examiner's requirement, not the patient's condition. Train and require all qualified examiners to carry out this requirement and to sign in verification in all instances (405 ILCS 5/3-208; 5/3-602; 5/1-122).
2. To avoid question and ensure justification, retrain and require nursing and medical staff to document the need for restraints and emergency psychotropic medications in more descriptive detail. Say that the patient threw cups and bedside tables instead of leaving it to being aggressive or hostile without more qualifying descriptions to prevent physical harm or serious and imminent physical harm (Hospital policy; 42 C.F.R. 482.13; 405 ILCS 5/2-107; 5/2-108).
3. Complete rights restriction notices whenever restraints are used for mental health purposes and whenever patients are not allowed to refuse psychotropic medications (405 ILCS 5/2-201).
4. Provide written psychotropic drug information whenever they are used, voluntarily or involuntarily (405 ILCS 5/2-102 a-5).
5. Train and require prescribing physicians to determine and state in writing whether patients have decisional capacity whenever psychotropic medications are proposed (405 ILCS 5/2-102 a-5).

SUGGESTIONS

1. Consider adding to informed consent policies documentation directives for when physicians need to override objections for treatments, including those not necessarily invasive or manipulative (Hospital informed consent policy; 405 ILCS 5/2-111).
2. Keeping mental health related binders in the ED is an excellent idea. We suggest that all potentially needed materials are included, like written education materials about Haldol and Ativan, as they are typically used, petitions, certificates, rights forms, rights

restriction notices and behavioral (violent/self-destructive) restraint policies (405 ILCS 5/2-102 a-5; 5/2-107; 5/2-108; 5/2-200; 5/2-201; 5/3-600).

3. Develop hospital-wide policies for the use of psychotropic medications (5/2-102 a-5; 5/2-107; 5/2-201).
4. Stay away from terms like "mentally competent" opting for "capacity" instead. Competence is a legal determination while capacity is a medical one.
5. Seek formal Mental Health Code training for ED staff.