FOR IMMEDIATE RELEASE

North Suburban Human Rights Authority
Report of Findings
Resurrection Westlake Community Hospital
HRA #13-100-9008

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Westlake Community Hospital. In October 2012, the HRA notified Westlake of its intent to conduct an investigation, pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The complaints accepted for investigation were that a consumer was held in the hospital's Emergency Department (ED) for an involuntary commitment; a petition and one certificate were completed but the second certificate was not completed within the mandated 24 hours. It was further alleged that the consumer had to sleep in the ED on an examination table without proper bedding, she was told she could not step outside of the room or she would be sedated and restrained, she could not make any telephone calls, she could not have any visitors, she was not offered food or fluids, and a security guard fondled himself in front of her.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/3-601, 5/3-602, 5/3-610, 5/2-112) and the Code of Federal Regulations (24 CFR 482).

To pursue this investigation, a site visit was conducted at which time the allegations were discussed with the hospital's Vice President of Patient Care Services, the Director of the ED Department and the hospital's Crisis Worker. The HRA reviewed, with written authority, the clinical record of the consumer whose rights were alleged to have been violated. Also reviewed were hospital policies relevant to the allegations.

Background

Westlake Hospital is a 282-bed facility located in Melrose Park. The hospital's Mental Health and Addiction services provide comprehensive care for children, adolescents, adults, and seniors in both inpatient and outpatient settings. The services include emergency/crisis care, a 25-bed inpatient treatment program, outpatient therapy, short- and long- term residential programs and home visits.

Findings

The clinical record revealed information on a female consumer that presented to the hospital from a local community healthcare center. The community healthcare center completed a petition for involuntary admission on September 20th, 2012 at 12:15 p.m. The petition noted that the consumer was extremely tearful, in distress and she reported feelings of hopelessness. The consumer had recently lost her mother which left the consumer with no support system and she had expressed suicidal ideation. The chart contained a certificate for involuntary admission that was

completed by hospital personnel about an hour later (1:16 p.m.). The consumer was then seen by the hospital's Crisis Worker and routine medical procedures were started. A few hours after admission, the consumer expressed wanting to go home, saying that it was a mistake coming to the hospital and she was asking to leave against medical advice. When told that she could not leave because of the petition and certificate, it was documented that the consumer became upset and agitated. The consumer was medically cleared at about 6:00 p.m. and the process began for admission to a state-operated facility.

At about 6:00 p.m., documentation noted that the consumer refused a dinner tray, saying it was too late and that no one asked her if she wanted anything to eat. The consumer reported she had been sitting there for hours and no one offered her anything and that she did not "want your food". Between 7:00 and approximately 8:00 p.m., the consumer was noted to be sleeping comfortably in bed. When she woke at 8:00 p.m. and asked how long she would be in the ED, she was told she might have to stay overnight depending on bed availability at the receiving hospital. The consumer then asked to call her therapist; the call was placed and the consumer talked to her therapist. According to documentation, the consumer for the most part slept throughout the evening/early morning hours and it was noted that she had a sitter at her bedside. The following day around 6:30 a.m. it was noted that the consumer had fluids; at 8:00 a.m. the consumer was offered breakfast but she refused. Food was again offered a few hours later but it was refused because (according to the consumer) no food was offered the previous evening except for the sandwich she had at 6:30 p.m. It was noted that she declined lunch, but about an hour later she accepted the tray. It was documented that she was also on the telephone this day.

That morning between about 8:00 a.m. and 10:30 a.m. the consumer wanted to leave and she was becoming increasingly upset that she could not leave. During this time, a nurse advised the consumer that if she did not stay in her room that "she may be given med [medication] to calm down or restrained."

ED documentation indicates that at 3:30 p.m., the consumer had not been evaluated by psychiatry though they were made aware that morning that she needed to be seen. The consumer reported feeling fine and saying things that she regretted. It was documented that the consumer was aware that the hospital could no longer legally detain her. The consumer was discharged at about 4:30 p.m. A second certificate was not completed.

At the site visit, hospital staff members recognized that the consumer was not evaluated for a second certificate within the mandated timeframe. It was stated that the psychiatrist was made aware that the consumer needed to be evaluated, but for whatever reason, the assessment did not happen.

Regarding the allegation that the consumer had to sleep on an examination table without proper bedding, it was stated that she slept on a gurney, as that is what is available in the ED. Hospital personnel offered that this might not be comparable to a bed on another floor, but they do have heated blankets available and they make every effort to ensure that the consumer is comfortable. The HRA observed a gurney and noted a thin mattress with hospital -issued bedding.

According to hospital personnel, consumers can and do make phone calls, and they can and do have visitors. As the chart noted, the consumer was on the telephone; there was nothing in the chart about visitors and staff members stated that no one came to see her.

Hospital personnel are to offer food and fluids as long as the consumer is medically able to consume these products.

When discussing the assertion that the consumer was told that she could not step outside of the room or she would be sedated and restrained, hospital personnel stated that this was an unacceptable statement that the nurse made to the consumer. They stated that the nurse no longer works at the hospital (although it was pointed out that this incident alone did not result in the nurse

leaving). And, as long as the consumer is not disruptive, he/she can walk around the department. The HRA reviewed a Crisis Prevention Institute Training manual and it states that "setting limits is the result of recognizing that you cannot force individuals to act appropriately. Trying to force a person to act in a certain way often results in a nonproductive power struggle. When you set limits, you are offering person choices, as well as stating the consequences of those choices. Limits are usually better received when the positive choice and consequence are stated first. Starting with a negative consequence may be perceived as a challenge or an ultimatum, and the individual may not even hear the positive choice."

Regarding the allegation that a security guard fondled himself in front of the consumer, it was stated that when security personnel are called to the ED, a report is generated and sent to the VP of Patient Care Services. The VP stated that upon receipt of this allegation, she checked all reports during the period in question and security guards were not called to the ED while this consumer was hospitalized. The HRA then asked if the sitter was male; we were advised that the sitter was female. Hospital personnel interviewed the sitter who had no recollection of a male guard being present during the consumer's time in the ED.

The hospital's 5-page Involuntary Admission Certificate/Court Order policy includes all Mental Health Code mandates. The hospital's telephone and visitation policy pertained to in-patient behavioral health programs. The hospital's restraint policy states that restraints are not to be used as a means of punishment, coercion, retaliation, discipline or for the convenience of the staff.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code (Code), Section 2-102 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." The consumer had to sleep in the ED on a gurney; the HRA found nothing to support the claim that the gurney was without proper bedding; the allegation is unsubstantiated. Based on chart documentation, the consumer was offered food and fluids; the allegation is unsubstantiated.

Pursuant to the Code of Federal Regulations Section 482.13, "A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation. A hospital must meet the following requirements: (1) Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, when he or she is informed of his or her other rights under this section. (2) Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time. (3) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. (4) Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences." According to the clinical record, the consumer requested to make telephone calls and these requests were honored; the allegation is unsubstantiated. Based on the information obtained, there was nothing to show that the consumer was denied visitors; the allegation is unsubstantiated.

Section 2-112 of the Code states that "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect." Section 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. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized. In no event shall

restraint be utilized to punish or discipline a recipient, nor is restraint to be used as a convenience for the staff." The consumer was told she could not step outside of the room or she would be sedated and restrained. The nurse started with a negative consequence which was perceived by the consumer as a threat; the allegation is substantiated. Based on the information obtained, the allegation that a security guard fondled himself in front of the consumer is unsubstantiated.

Section 3-601 of the Code states that, "a) When a person is asserted to be subject to involuntary admission on an inpatient basis and in such a condition that immediate hospitalization is necessary for the protection of such person or others from physical harm, any person 18 years of age or older may present a petition to the facility director of a mental health facility in the county where the respondent resides or is present. The petition may be prepared by the facility director of the facility. Sec. 3-602. The petition shall be accompanied by a certificate executed by a physician, qualified examiner, psychiatrist, or clinical psychologist which states that the respondent is subject to involuntary admission on an inpatient basis and requires immediate hospitalization. The certificate shall indicate that the physician, qualified examiner, psychiatrist, or clinical psychologist personally examined the respondent not more than 72 hours prior to admission." Section 3-610 states that "As soon as possible but not later than 24 hours, excluding Saturdays, Sundays and holidays, after admission of a respondent pursuant to this Article, the respondent shall be examined by a psychiatrist. The psychiatrist may be a member of the staff of the facility but shall not be the person who executed the first certificate. If a certificate has already been completed by a psychiatrist following the respondent's admission, the respondent shall be examined by another psychiatrist or by a physician, clinical psychologist, or qualified examiner. If the respondent is not examined or if the psychiatrist, physician, clinical psychologist, or qualified examiner does not execute a certificate pursuant to Section 3-602, the respondent shall be released forthwith." The consumer was held for commitment; a petition and one certificate were completed; the second certificate was not completed within the mandated 24 hours; the allegation is substantiated.

Recommendations

1. Hospital administration must ensure that limit setting is conducted according to crisis prevention standards.
2. Hospital administration must ensure that when a person is asserted to be subject to an involuntary admission, all mental health mandates regarding this process are completed within the mental health code parameters.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

VANGUARD | WESTLAKE HOSPITAL

WILLIAM A. BROWN, FACHE
Chief Executive Officer

March 28, 2013

Ms. Julie Sass, Rights Coordinator
Guardianship and Advocacy Commission
9511 Harrison Street, W-300
Des Plaines, IL 60016-1565

RE: HRA #13-100-9008

Dear Ms. Sass:

Westlake Hospital received the report of findings from the above case. I have met with the manager of the Emergency Department to create the action plan specific to the management of limit setting as a crisis prevention/intervention modality of treatment as well as the delineation of the process for ensuring that the patient has been assessed by the psychiatrist according to the timeframes established in the Illinois Mental Health Code.

The plan is for all of the Emergency Department clinical staff to attend crisis intervention classes provided by a mental health counselor who is a certified instructor through Crisis Prevention Intervention (CPI). These classes will also include an additional program that will verify their understanding of the use of restraints for behavioral reasons along with appropriate documentation, ensuring the rights of all patients are always met. Staff will attend one of the following training sessions to be held April 9th, April 23rd or May 2nd. The training program will become a part of the annual competency program for the Emergency Department staff.

A plan was immediately put in place to ensure that patients who presented to the Emergency Department and were held as a voluntary or involuntary admission were seen by the psychiatrist within the timeframes established in the Illinois Mental Health Code. This data is reported to the Director of Behavioral Health and the Chairman of the Department of Psychiatry. I want you to be aware that we have not had any noted deficiencies since your site visit. We will continue to monitor the findings and take appropriate actions.

Westlake Hospital requests that all findings be posted along with our response in the public record which may be posted on the Commission's Web Site.

If there is anything else you require, please contact Ruth Matthei at (708) 938-4982.

Sincerely,

William A. Brown

William A. Brown, FACHE
Chief Executive Officer

WAB/lll