FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
Case 13-110-9024
Herrin Hospital

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Herrin Hospital, a 114 bed community hospital located in Herrin. The current census is approximately 80. The facility serves 5 to 6 counties in the surrounding area. The specific allegations are as follows:

1. **The hospital failed to communicate with a patient's guardian and care provider.**
2. **Emergency medication was inappropriately administered.**
3. **Restraints were inappropriately used.**

If found substantiated, the violations would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/1 et seq.), hospital regulations (42 C.F.R. 482.13), and the Illinois Probate Act of 1975 (755 ILCS 5/11a-23).

Statutes

The Mental Health Code (405 ILCS 5/2-102) 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 Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient.

Under section (a-5) of the Code, "If the services include the administration of electroconvulsive therapy or 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. The physician or the physician's designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only pursuant to the provisions of Section 2-107 or

2-107.1 or (ii) pursuant to a power of attorney for health care under the Powers of Attorney for Health Care Law or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act. If the recipient is under guardianship and the guardian is authorized to consent to the administration psychotropic medication pursuant to subsection (c) of Section 2-107.1 of this Code, the physician shall advise the guardian in writing of the side effects and risks of the treatment, alternatives to the proposed treatment, and the risks and benefits of the treatment." A qualified professional shall be responsible for overseeing the implementation of such plan. Such care and treatment shall make reasonable accommodation of any physical disability of the recipient, including but not limited to the regular use of sign language for any hearing impaired individual for whom sign language is a primary mode of communication. If the recipient is unable to communicate effectively in English, the facility shall make reasonable efforts to provide services to the recipient in a language that the recipient understands.

Furthermore under section 5/2-107 of the Code regarding the refusal of services and informing an adult recipient of services or the recipient's guardian of treatment risks: "If the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. 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, guardian, or substitute decision maker, if any, 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."

Section 5/2-201 of the Code states "whenever any rights of a recipient of services that are specified in this Chapter are restricted; the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefore to:(1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian; (2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice; (3) the facility director; (4) the Guardianship and Advocacy Commission, or the agency designated under 'An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named', approved September 20, 1985, [FN1] if either is so designated; and (5) the recipient's substitute decision maker, if any. The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefore in the recipient's record."

According to the Medicare/Medicaid Conditions of Participation for Hospitals pursuant to 42 C.F.R. 482.13, "(a)(1) A hospital must protect and promote each patient's rights. The hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible. (b)(1-2) the patient has the right to participate in the development and implementation of his or her plan of care. The patient or his representative has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or

her health status, being involved in care planning and treatment, and being able to request or refuse treatment. (c)(3) The patient has the right to be free from all forms of abuse or harassment. (e) Standard: Restraint or seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. 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."

The Probate Act of 1975 (755 ILCS 5/11a-23) states, " (a) For the purpose of this Section, "guardian", "standby guardian", and "short-term guardian" includes temporary, plenary, or limited guardians of all wards. (b) Every health care provider and other person (reliant) has the right to rely on any decision or direction made by the guardian, standby guardian, or short term guardian that is not clearly contrary to the law, to the same extent and with the same effect as though the decision or direction had been made or given by the ward. Any person dealing with the guardian, standby guardian, or short-term guardian may presume in the absence of actual knowledge to the contrary that the acts of the guardian, standby guardian, or short-term guardian conform to the provisions of the law. "

Complaint Information

According to the complaint, a person with a developmental disability was admitted to the hospital for treatment of pneumonia. During the overnight hours the patient became agitated and confused and was given two psychotropic medications within a one hour timeframe and was placed in restraints without notification to the guardian or care provider, even though hospital nurses were told to contact the care provider at any hour if a problem should arise and they would come to the hospital to provide assistance. The next morning, care providers arrived at the hospital to find the patient in restraints with his breakfast sitting next to him on a table and no hospital staff assisting him. The guardian was contacted who was also unaware of the events that had transpired.

Investigation Information

To conduct the investigation, the HRA coordinator spoke with the community integrated living arrangement (CILA) staff and the individual's legal guardian regarding the events surrounding this complaint. The team consisting of the HRA coordinator and 2 board members completed a site visit at Herrin Hospital where they met with the peer review coordinator, the accreditation compliance coordinator, the quality improvement manager, the IMCU/ICU nurse manager and the hospital administrator. Having received a signed release of information allowing records access, the team then reviewed the patient's records and toured the hospital. The nurses who were on shift the day of the alleged incident were unavailable for interviews during our visit so the HRA coordinator interviewed the 2 nurses at a later date and shared their responses with the HRA board.

Care Provider: The HRA coordinator interviewed the care provider from the patient's home who was on shift the day of the alleged incident. She told the HRA that on January 26th the patient was taken to the emergency room (ER) diagnosed with the flu and sent home. On January 28th he was again taken to the ER, when symptoms persisted, and he was admitted on

that day with pneumonia. Upon admission, the care provider gave her contact numbers to the ICU nurse and told the nurse to call if there are any questions or if any issues come up any time of the day. She stated to the nurse that they are less than 5 minutes away and could be there day or night to provide assistance if needed. The care provider also stated that on February 1st, the date of this incident, the house manager went to the hospital around 8:00 am to check on the patient and found him in bed with his wrists in restraints and his breakfast sitting next to him on a table, out of reach with no hospital staff there assisting him. The care provider was notified and she immediately sent out a text message to the patient's legal guardian. The guardian was also unaware that there were any incidents occurring overnight. The care provider then went to the hospital and spoke with their staff who told her the patient was given 5 mg Haldol at 1:30 am and 1 mg Ativan at 2:30 am. The care provider said the hospital staff did not notify them concerning the medication given or restraints used. According to the care provider, the hospital wanted to discharge the patient this day, but they explained to the hospital that they could not take him home due to his lethargy from the medication that was given and the hospital allowed him to stay another day.

The care provider also voiced concern to the HRA about the lack of communication from one shift to the next at this hospital. She said they frequently have to admit persons with disabilities, who are in their care, to this hospital and she has to repeat patients' information to the nurses on each shift. She also stated that it does not seem to her that there is good communication between the nursing staff.

Guardian: According to the Guardian, this person had been having problems off and on since the end of January with pneumonia and flu like symptoms and she was aware that he had been admitted to the hospital for treatment of pneumonia. She received a message shortly after 8:00 a.m. from the care provider advising that the house manager had gone to the hospital for morning check on this person and that he was found "out of it" with his arms in restraints and his breakfast next to him with no hospital staff there providing assistance. It was reported that he was very lethargic and he "couldn't function". The care provider said she was calling the Guardian to see if she had been notified or knew what was going on. The Guardian informed her that she had not received any notification from the hospital and was unaware of anything happening overnight. The care provider told her that she had given the nurse all of her contact numbers and told her to call anytime day or night if there were any issues and she or another staff would come to the hospital to provide assistance but the hospital did not contact them either. After going to the hospital to speak with hospital staff, the care provider called the Guardian and told her it was reported to her that he had gotten up in the middle of the night and had gone into another patient's room. Therefore, he was given two psychotropic medications, Haldol first then Ativan, to calm him down and they put him in soft limb restraints to keep him from pulling at his lines/tubes. The care provider told the Guardian that the hospital wanted to discharge him that day, but she refused to let them because he was so lethargic and she was concerned that they would not be able to provide the close supervision and level of care he required until some of the effects of the medication had time to wear off. The Guardian agreed with the care provider's decision. The Guardian also told the HRA that this person does get anxious and agitated at times, but can usually be reasoned with and redirected fairly easily. The Guardian was concerned that Haldol was given first because it takes longer to take effect but then lasts longer. She said in her experience, when someone is highly agitated to the point where

medication is required to calm him/her, typically the physician will order a fast acting medication like Ativan which is usually enough to provide some relief for the person. She felt like if that had been the case in this situation, he would not have needed a second medication and would not have been so lethargic and possibly could have been discharged that day. She was also concerned that he had a bed alarm that would have gone off when he got out of bed. She did not understand how he had time to get into another patient's room after the alarm went off.

Site Visit

During the HRA site visit, general hospital information was shared regarding the licensed beds and current census. The hospital serves 5-6 surrounding counties but there are 14 possible counties they can serve if needed. The staff to patient ratios in the IMCU is 1:4 or 1:5 and ICU is 1:2. Prior to hire, nursing staff must complete a background check, drug check, reference check, corporate orientation consisting of 1 day at the facility and 1 day of department orientation for units and 2 interviews, one with the manager and another with a peer. New graduate nurses complete the Versant training program and 18 weeks of orientation where they have someone with them all the time. A nurse with 1 or more years of RN experience is interviewed by the facility prior to hiring. A competency checklist is followed at different time intervals and if not met by the deadline, employment is terminated. Staff get a handbook at hire and also have access to an intranet for policies and payroll that is self serve. Hospital volunteers are only auxiliary and have no patient contact. They work in the shops, mail room, etc. and do not go through the hospital human resources process.

Ongoing training for staff is conducted yearly through the education department. Managers decide what topics are covered. Online classes are offered monthly. Anytime new equipment or services are acquired, new training is conducted to familiarize staff. The team questioned how often the topic of patients with mental illness and developmental disabilities (MI/DD) training is offered and was told that the emergency room department works with a community mental health/developmental disabilities agency 24 hours a day 7 days a week when patients with MI/DD come into the emergency room. The hospital pays for this agency to be a resource for their staff. The hospital also has a physician who specializes in psychiatry as its their medical director who provides updates on policies and new issues in the MI/DD population. If staff do not comply with mandatory continuing education, disciplinary action is taken and they are off the schedule until it is completed.

The hospital uses electronic records systems, Med-a-Tech and Chart Max, for patient information. They do have paper charts that have some information including contact information. The team was told that the nurses will normally contact a guardian when there is a condition change but it depends on the contact preferences of the family or guardian. Usually, they wait until regular business hours before calling unless the family has specifically asked to be contacted at any hour of the day. In emergency situations, they will notify the family once the situation is stabilized. In the case of restraints, they used to call the family/guardian for consent but now the policy states if appropriate, they may apply restraints with a doctor's order and contact the family/guardian after. The nurses try alternatives first before restraints are applied such as using the toilet, bed alarms, educating the patient on the situation and calling a nurse for a pain assessment. If the alternatives are unsuccessful, the nurses call the doctor to make a

determination based on an assessment of whether to use restraints, emergency medication, etc. They try the least restrictive measure first. Medication is considered less restrictive than restraint use normally, but it is always specific to the patient's needs. If emergency medication is the determination, the doctor will give an order, the nurses administer the medication and then call family. If it is in the middle of the night, as in this situation, the normal protocol is to wait until the next morning if it is not a life threatening situation.

The team inquired about the allegation regarding the patient's breakfast tray being next to him with no assistance and his wrists restrained. The hospital staff told the team that the dietary department delivers all trays on the unit and then notifies the nursing staff. The nurses will then go into the room and release restraints and/or provide assistance when necessary. In this case, the CILA home staff arrived at the hospital around 8:00 am which is when breakfast is normally served. The hospital staff stated that the nursing staff probably had not had time to go into his room to provide the assistance for feeding. The team questioned when security or room sitters might be brought in to provide assistance. The hospital staff told the team that if a patient is admitted and has a mental illness and is suicidal, etc. then they would use a sitter. If a patient is aggressive and cannot be controlled, they will call security. In this case, the medication and restraints allowed the patient to calm down and security was not necessary.

The team questioned the nursing staff about communication between shifts and was told that nursing staff pass along important information from one shift to the next by using a "shared tool" which the team was told comprises of a snap shot of the patient information. During a report, a nurse might handwrite additional information that was discussed to reference throughout her shift. At the end of shift, the shared tool is then discarded and not a part of the permanent record.

Records Review

The face sheet listed the patient information, physician information, employment information, contact information, guarantor information and reason for admission. Under the contact information, the guardian's name is listed as next of kin, with her home address and work phone number and lists "guard" under the relationship category. The person to notify is listed as the care provider's name with her home address and phone number and lists "othrel" under relationship.

The following is a timeline of the nursing notes from the Herrin hospital record of the patient on 2/1/13:

12:07 a.m. Side rails up x 3 bed alarm activated care giver at bedside
12:30 a.m. Patient trying to get up out of bed, offered toileting, incontinent care, patient repositioned for comfort.
1:00 a.m. The team found a doctor's telephone order for "Haldol 5 mg 1M x1 now". No reason was listed on the order and this is not listed in the nursing notes that the team reviewed
1:27 a.m. "Patient confused, up out of bed, pulled out IV & removed tele. reported."
2:10 a.m. "Patient trying to get up out of bed, reported to nurse (name)." Television is listed as play activity and pillow is listed as positioning aid

2:15 a.m. The team found a doctor's telephone order for "Ativan 1 mg IV Q4H PRN for anxiety". This wasn't listed on the nursing notes that the team reviewed
2:34 a.m. Pain assessment was done. Under pain "absent" is listed
2:36 a.m. Vital signs were taken
2:40 a.m.-2:43 a.m. "Restraint, non-violent order" is listed along with a note of "initial assess, safety check and reassessment" at 2:43 a.m.
2:44 a.m. a note is listed "soft limb restraint L Upper, R Upper & Safety Check"
2:45 a.m. a restraint reassessment note is listed stating reason requiring restraints as "pulling lines/tubes" restraints were continued
2:55 a.m. a shared tool note is listed that summarizes this visit and lists his CILA home under discharge planning
3:08 a.m. Restraint safety check - initial assessment is listed and notes restraint reason and safety education provided to patient and also lists ineffective alternatives that were attempted as toileting, diversion, reality orientation, modify environment, medication review, ambulation, verbal interventions, 1:1 intervention, safety alarm, pain/comfort measures, education sleeve/splint
3:30 a.m. BiPAP/CPAP Ventilatory Support - noted BIPAP as delivery type and "Full Face Mask" as delivery mode "FIO2 60%/O2 Sat by pulse oximetry 97%"
4:07 a.m. Critical Care shift assessment note summarizing current condition lists pupil reaction as sluggish, Glasgow coma scale verbal as confused, speech pattern as mumbled, patient behavior as restless, apprehensive, mood description as anxious and breath sounds as diminished
4:11 a.m.-4:13 a.m. Restraint safety check
4:14 a.m. a note stating that restraints continued
5:03 a.m. a shared tool note is listed summarizing this visit and lists his CILA under discharge planning
5:03 a.m. restraint safety check - and states "reason for restraints explained"
6:06 a.m. Patient care summary note is listed summarizing rounding performed and another Restraint safety check is noted listing "advised to not get out of bed on own-call for assistance" under general education comment
6:11 a.m. Vital signs were taken and another restraint safety check was done noting no skin problems related to restraints, no abnormal sensation, adequate circulation and patient's safety and dignity being maintained.
7:00 a.m. Restraint safety check - restraints continued
7:19 a.m. BiPAP/CPAP ventilatory support noted it was "off for day"
8:00 a.m. Critical Care shift assessment note summarizing this visit, listing no changes from the earlier critical care notes. Restraint safety check was done including a note stating the patient was released from restraints.

The HRA also reviewed the eMAR Medication Administration Report which shows that Haldol was given at 1:06 a.m. and Ativan was given at 2:34 a.m. on February 1st. No reason was listed on the eMAR for Haldol, but the PRN reason listed for Ativan was "anxiety."

The HRA reviewed the medication reconciliation as well as the discharge orders for medication which lists all of the regular medications this patient was given along with the reason for taking them. It was noted that Haldol and Ativan were not listed as regular medications.

Nurse Interviews

Nurse 1: This RN was on shift in the overnight hours of February 1st. She said the patient was pulling at his lines/tubes, pulled out his IV and walked into other patient rooms which lead to soft restraints and emergency medication being used. The reason for Haldol being given was not listed on the telephone order and when questioned if it is normally listed she said yes. When asked what the reason for Haldol being given was, the nurse said it was for anxiety and denied that it was given for restraint. She did not recall the time that Haldol was given but said it is usually documented on the EMAR. If a medication is being used as a restraint, the nurse said it is normally listed on the electronic chart. The order for Ativan was written at 2:15 a.m. and the nurse said that is when it was given. When questioned why a second medication was given, the nurse's response was "anxiety continued after Haldol 5 mg IM was given. He continued to pull at lines. This is to the best of my memory." When asked if this nurse was told by the ER or other nursing staff at shift change that the patient's caregivers from the CILA asked to be contacted anytime, she said no. When asked if there was a note to this effect on the chart's face sheet or otherwise documented in the chart, she replied no. The nurse stated that if someone asks to be contacted at any hour no matter what, that is usually communicated between nurses on the shift to shift communication, shared tools report.

The team was also provided with training verification for this nurse showing what training she had completed this past year. It appeared that she had completed approximately 37 online trainings as well as 21 trainings on the Versant program. The team could not find any that were specific to working with the MI/DD population. However, the Versant training on restraints and falls appeared to have a section that may have touched on this population in its section regarding chemical restraints.

Nurse 2: This nurse was on early morning shift on February 1st. The same questions the HRA asked Nurse 1 were also asked of this nurse. This nurse could not explain the events leading up to medication and restraints as it happened prior to her shift. When asked if the reason for emergency medication is usually listed on the telephone order she replied "sometimes it is and other times no." She did not recall what the reason for Haldol being given was or if it was given for restraint and stated that it was given prior to her shift. When asked if a medication is used as a restraint is it normally listed on the electronic chart or elsewhere, she replied that she was unsure. The order for Ativan was also written prior to her shift so she could not provide any reason as to why the second medication was given. When asked if this nurse was told by the ER or other nursing staff at shift change that the patient's caregivers from his CILA home asked to be contacted at any hour, she said she was not told this. She was also unsure if a note to this effect was documented on a face sheet or elsewhere in the chart. When the HRA asked her how it is normally documented when someone asks to be contacted at any hour no matter what, she replied that it could be documented in a nurse's note, passed on in report, or by a note on the chart. Prior to her shift, she did not know that the CILA home wanted to be contacted at any hour, but when a caregiver arrived she informed this nurse of that fact, and then it was passed on.

Conclusion

Allegation 1: Both nurses said that they did not contact the guardian or the CILA staff in the early morning hours to notify them of the events that had occurred and that emergency medication and restraints were used to stabilize the patient because they were not told to contact the care giver at any hour. Hospital staff confirmed that standard protocol would have been to wait until the next morning to notify unless they were told by the family/guardian to specifically call at any hour. Although the HRA understands that the nurses were following their standard protocol by not contacting the care provider or Guardian in the overnight hours, when speaking with the Guardian, she said she was never contacted by the hospital at all as is required by the Mental Health Code (405 ILCS 5/2-201) after her ward's right to refuse medication was restricted. The Team could not find any documentation in the hospital's chart indicating guardian notification of the administration of Haldol and Ativan. The care giver told the HRA that the CILA staff were not contacted overnight, even though they told the hospital they would be available, and that they were not informed of what happened until they asked the nurses directly the next morning after finding the patient in his room in restraints and lethargic. The Team could not find any documentation in the hospital's chart showing that the caregiver was notified of the incident and medication administration either the night before or the next morning. Therefore, the allegation that the hospital failed to communicate with a patient's guardian and care provider is **substantiated** and the following **recommendation** is made.

- The HRA recommends that the hospital follow the Mental Health and Developmental Disabilities Code, Medicaid/Medicare mandates and the Illinois Probate act and ensure guardian involvement in treatment. The HRA also recommends that staff be trained on guardian involvement. This hospital has an electronic record keeping system which allows caregivers to accurately record the care of their patients. Typically an electronic system might alert a caregiver that an individual has allergies, their blood type and when the last medication was given as documented in the EMAR. The HRA also suggests that this same system be used to alert staff that a patient has a guardian to make his or her medical decisions and that this same system be used to state what the contact preferences are for both the guardian and care provider when, in specific situations like this, they are two different people. This would ensure that important information is passed along from one shift to the next and would prevent miscommunication among the nursing staff. The patient has the right to have guardian participation for health services and notification for rights restrictions. This electronic record keeping system might facilitate the protection of patient's rights by reminding the staff to work with the patient's guardian and/or care provider and have them available to help formulate the plan for these services, which might also help the hospital staff provide the best quality of care for the individual.

Allegation 2: The nursing note at 12:30 am stated that the patient was "trying to get up out of bed". The doctor ordered Haldol 1:00 a.m. and per the medication administration report, it was given at 1:06 a.m. No reason for the Haldol being ordered was listed on either the order itself or the medication administration report. Per Nurse 1, the Haldol was ordered by the doctor for anxiety and not restraint. The next note is at 1:27 a.m. after medication was administered and states "Patient confused, up out of bed, pulled out IV & removed tele. Reported". At 2:10 a.m. the note states "Patient trying to get up out of bed, reported to nurse (name)." At 2:15 a.m. the doctor ordered Ativan for anxiety. Per the medication administration report, the Ativan was given at 2:34 a.m. PRN (as needed) reason is listed as anxiety. No other notes were found that

describe the situation as anything other than him trying to get up out of bed, pulling at lines and being confused, which do not meet the Code's standards for forced medication being administered.

The Code states that "the recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. 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" (405 ILCS 5/2-107).

Nursing notes show where some alternatives were tried first before the administration of Haldol and Ativan, however, the CILA staff were not contacted which may have been another alternative to try before medication. After speaking with the nurse, care giver and Guardian, the HRA was told he was also in other patients' rooms which could be determined as meeting the standard for giving medication to prevent imminent physical harm to others if the nursing staff determined he was indeed trying to harm other patients. However, no documentation could be found in his chart stating that he went into other patients' rooms or that staff felt that he was a danger to others. If the medication was given in an emergency situation, to prevent harm to self or others, then a restriction of rights should have been given to the patient and his guardian. Section 5/2-201 of the Code provides that if rights of a recipient of services are restricted; the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction and the reason therefore to the recipient or his guardian or another person designated to receive such notice. The HRA could not find a restriction of rights notice in the hospital chart and the guardian stated she did not receive one on his behalf. The Team also did not find any documentation in the hospital's chart showing that the guardian had given consent for the Haldol or Ativan.

Based on the lack of documentation of the events that led up to the medication administration, it is unclear if Haldol and Ativan were given on an emergency basis to prevent the patient from causing serious and imminent physical harm to himself by pulling at his lines, tubes and IV or if they were given just for anxiety and not due to any behavioral reasons. In order to be in compliance with the Mental Health Code, if the medications were given on an emergency basis then a restriction of rights notice should have been given to the patient and his guardian, and the patient should have been given the right to refuse the medication. Therefore, the allegation of inappropriate administration of emergency medication is **substantiated**. The HRA makes the following recommendations.

- Ensure that reasons for restrictions, including restricting the right to refuse medications, are more detailed and specific in the nursing notes and meet the Code's requirement of "serious and imminent physical harm." If medication is not being administered as an emergency, hospital staff should ensure that prior consent be obtained by the patient's Guardian before administering medication on a non-emergency basis.

- Haldol is without question a psychotropic medication and falls under the Mental Health Code's protections and must, therefore, be accompanied with written educational material

to the patient and any guardian *whenever* included in services (405 ILCS 5/2-102 a-5). Whether consented to or not, we suggest that Herrin Hospital provide drug information to patients and guardians as required so they are aware of what was put in the patient's body. Ativan is often used as a calming agent and not necessarily for psychiatric purposes, however, when administered along with Haldol for the same reasons we encourage the hospital to provide drug information for that as well (405 ILCS 5/1-121.1).

- Ensure that when PRN and/or emergency one time medications are ordered by a physician, that the reason for the medication being given is listed on the physician's order.

- Herrin Hospital should include more training relating to the mental illness and developmental disabilities population in their annual trainings for all hospital staff, not just those specific to the emergency room. This would allow the rest of the hospital staff to become more aware of the special needs of this population and how to best care for them when they are admitted to the hospital This would also allow hospital staff to become more familiar with the regulations of the mental health code as it relates to emergency administration of psychotropic medication.

- Herrin Hospital should commit to familiarizing its staff with the Mental Health Code's informed consent requirements since as in this case, there are reasons to provide mental health treatment. If psychotropic medications are being offered and ultimately accepted then a physician must make written decisional capacity determinations and drug information must be provided (405 ILCS 5/2-102 a-5). Familiarizing key staff with the Code's processes seems imperative since mental health treatment does occur at Herrin (405 ILCS 5/1-114).

- Ensure that patients who receive treatment with psychotropic medications are given opportunities to refuse them (405 ILCS 5/2-107).

Allegation 3: The documentation shows that the recipient was given medication first (at 1:06 & 2:34 a.m.) and was put in restraints later (between 2:40 & 2:44 a.m.) The HRA questions whether this is appropriate since action (medication use) was already taken that may have prevented harm to the recipient or others. However, the nursing note from 1:27 a.m. after the initial medication was given stated that the patient was pulling at his IV, and since the restraint order is for "non-violent" restraints, the HRA determined that the soft limb restraints were used to prevent him from pulling out his lines and not for behavioral reasons. Therefore, the allegation of inappropriate restraint use is **unsubstantiated,** but the HRA would like to offer the following suggestions:

- Ensure that reasons for restrictions of any kind are more detailed and specific in the nursing notes.

- Ensure that all less restrictive alternatives have been explored before resorting to more restrictive interventions such as soft limb restraints. In this case, less restrictive measures

such as enlisting a sitter to stay in his room may have been less restrictive than applying soft limb restraints especially since medication had also been given prior to restraint use.

The HRA commends the facility for its cooperation and assistance throughout the course of its investigation.

RESPONSE

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

HERRIN HOSPITAL

November 12, 2013

Clarence Russell, Chairperson
Egyptian Regional Human Rights Authority
#7 Cottage Drive
Anna, IL 62906

Dear Mr. Russell,

Thank you for the opportunity to respond to your concerns following your Human Rights investigation pertaining to HRA case number: 13-110-9024. Herrin Hospital/SIH is committed to providing excellent care to all patients we serve and have implemented the following actions to your recommendations:

Recommendation #1

Staff trained on guardian involvement; electronic system to accurately record care of patient; electronic system include contact preference for guardian.

Action: Newsletter sent to all SIH email users; mandatory LMS presentation & quiz for all hospital employees; hosted multiple nursing training sessions at various SIH locations led by the Guardian & Advocacy Commission representative; Guardian & Advocacy Commission representative presented to Herrin Hospital Medical Staff Committee. Electronic system currently in place for recording care of patient; tab placed in paper chart for state papers; IT developing interface on admission data base where guardian information and contact numbers will appear and carry through shift reports during stay. Completion expected by January, 2014.

Recommendation #2

Document in medical record the reason for restrictions, including restricting the right to refuse medications, and reflect in nursing notes justification that meets the Code's requirement of "serious & imminent physical harm".

Response: The reason for restrictions for this patient was documented in the medical record. These included frequently getting out of bed, pulling IV lines & telemetry leads out, & wandering into other patient's rooms. Effective alternatives were attempted but unsuccessful.

Psychotropic medication be accompanied with written educational material to patient & any guardian whenever included in services.

Response: Power Point presentation developed as a refresher for nursing to notify patients & guardian written material regarding medication, consents etc.

201 South 14th Street
Herrin, IL 62948
618-942-2171 www.sih.net

Ensure when PRN and/or emergency one time medications are ordered by physician, that the reason for this medication being given is listed on physician's order.

Response: There is an existing policy for physicians regarding documenting PRN indications. Physician caring for patient was counseled for not following policy.

Familiarize staff of Mental Health Code's informed consent requirements.

Response: Newsletter sent to all SIH email users; mandatory LMS presentation & quiz for all hospital employees; hosted multiple nursing training sessions at various SIH locations led by the Guardian & Advocacy Commission representative; Guardian & Advocacy Commission representative presented to Herrin Hospital Medical Staff Committee

Ensure that patients who receive treatment with psychotropic medications are given opportunity to refuse them.

Response: LMS presentation & quiz for all RN's educating on forms and rights.

Recommendation #3

Unsubstantiated

In review of this case, Herrin Hospital along with all of our SIH facilities believe the changes outlined in this letter will only enhance the delivery of services that are provided by our organization. We appreciate the opportunity to work with your organization and the patient population you serve. Please do not hesitate to contact me at 618-942-2171 should you have any questions regarding our plan.

Respectfully,

Terence F. Farrell, FACHE
VP/Administrator I Herrin Hospital

EGYPTIAN REGIONAL HUMAN RIGHTS AUTHORITY

HRA CASE NO: 13-110-9024

SERVICE PROVIDER: Herrin Hospital

Pursuant to Section 23 of the Guardianship and Advocacy Act (20 ILCS 3955/1 *et se.),* we have received the Human Rights Authority report of findings.

IMPORTANT NOTE

Human Rights Authority reports may be made a part of the public record. Reports voted public, along with any response you have provided and indicated you wish to be included in a public document will be posted on the Illinois Guardianship and Advocacy Commission Web Site. (Due to technical requirements, your response may be in a verbatim retyped format.} Reports are also provided to complainants and may be forwarded to regulatory agencies for their review.

We ask that the following action be taken:

✓ We request that our response to any recommendations/s, plus any comments and/or objections be included as part of the public record.

_____ We do not wish to include our response in the public record.

_____ No response is included.

Terence Farrell Terence Farrell
NAME

Administrator
TITLE

11-13-13
DATE