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North Suburban Regional Human Rights Authority
Report of Findings
HRA #14-100-9027
Adventist Hinsdale Hospital

Introduction

In May 2014, the North Suburban Regional Human Rights Authority (HRA) opened this investigation regarding Adventist Hinsdale Hospital. A complaint was received that alleged that upon entering the Emergency Department (ED), a consumer of mental health services was not given the opportunity to willingly remove her clothing as staff members physically and aggressively removed the clothing. Before a gown was given to cover up, a security guard stared at the consumer's exposed body. The consumer was placed in restraints incorrectly; the restraint was very tight on one wrist, while she was able to easily get out of the other wrist restraint. It was also alleged that while receiving services in the behavioral health program, emergency medication was presented before less restrictive measures were offered. The rights of consumers are protected by the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102 & 5/2-108).

According to the hospital's web-site, the hospital is committed to delivering whole-person care by creating an environment that promotes comfort and healing. Adventist Hinsdale Hospital is the only teaching hospital in DuPage County. The website states that many of the medical staff members hold teaching positions at Chicago's premier medical schools and academic medical centers, and participate in medical research studies and clinical trials. The 276-bed hospital is recognized as a leader in a wide range of medical fields, where university-level care and medical breakthroughs are achieved each day per the website description.

Adventist Hinsdale Hospital's Behavioral Medicine 17-bed inpatient program provides collaborative care for adolescents and adults experiencing acute distress related to emotional, physical, and behavioral and addiction disorders.

Methodology

To pursue this investigation the HRA reviewed a consumer's clinical record, with written consent. Also reviewed were hospital policies specific to the allegations. The HRA conducted site visits in June & July 2014, at which time the allegation was discussed with the hospital's Risk Manager, the Directors for the Emergency Department and the Behavioral Health program, and two Security Officers present during the consumer's ED admission.

Findings

According to the clinical record, the consumer presented to the hospital with a history of Bipolar Disorder and suicidal ideation. The ED physician documented that upon arrival the consumer was agitated and threatened to leave despite being redirected by a female RN staff member and the Physician. The Physician documented that the consumer was asked to remove her clothes which she adamantly refused. The consumer was "assisted to remove her clothes by female

RN and myself, gown placed on her." It was noted that the consumer was asked to remain calm however she continued to argue with staff and attempted to get off the cart and walk out saying – "let me die". The consumer was then placed in restraints for her safety. It was documented that within less than an hour, the consumer became calmer and agreed to remain cooperative; the restraints were removed. The chart contained documentation showing that while in restraints, every fifteen minutes an observed behavior was noted. Documentation indicated that the consumer's skin and circulation were assessed and nothing was shown to be unusual; there was nothing in the record that indicated that the restraints were applied incorrectly. A Restriction of Rights Notice was not completed for the restraint intervention.

The chart contained a Department of Safety and Security Activity Report which stated that security personnel had been alerted by ED staff members that a consumer with suicidal ideation was arriving via ambulance. When the consumer arrived, it was documented that the consumer was escorted to a room with security personnel remaining outside of the room. The Report documented that the ED staff told the consumer that she would need to change into a hospital gown to which the consumer was initially uncooperative and began using profanity towards ED staff. It was documented that eventually the consumer agreed to change into a gown without incident. The Report indicated that all male staff exited the room and pulled the patient privacy curtain closed. The consumer then became uncooperative with staff while changing into the gown and became "extremely aggressive" toward the RN. The Report noted that multiple attempts to verbally deescalate the consumer were attempted without success. The Security Officers attached the 4-point behavioral restraints.

At the site visit, it was stated that all behavioral health consumers must remove their clothing for safety reasons. When consumer refuses this process, staff will intervene. It was stated that the ED has both male and female staff members, so if possible, they will try to have same gender staff assist with the removal of the clothes (if needed). But, this is not always possible and should the behavior of a female consumer require a male presence, a male would be asked to assist with a female consumer. Hospital personnel explained that Security personnel receive annual CPI training (Crisis Prevention Institute) from an employee from the behavioral health department. It was offered that restraints are not used much in the ED and staff prefer not to use this intervention. It was also offered that once on, the restraints are checked to ensure that restraints are neither too tight nor too loose and that no male staff member would look at an exposed patient in any way other than to ensure that the patient is safe.

In discussing the allegation with the Security Officers, they stated that they receive CPI training and restraints are applied pursuant to that training. The training consists of an initial 8-hours, and then 4-hour training annually. The Officers did somewhat recall the consumer identified in this investigation. They recalled her saying that she did not want any males in the room so they left the room and closed the curtain (as indicated in the Department of Safety and Security Activity Report). The Officers stated that they are asked to be in a patient room for safety and even during the disrobing process if safety is of concern. It was stated that there are usually two officers present when applying restraints on a patient. Once the restraints are applied, the devices are checked to ensure proper fit. When asked, they stated that just they recently started to debrief with ED personnel after restraint episodes.

In discussing the allegation that while receiving services in the behavioral health program, emergency medication was presented before less restrictive measures were offered, it was stated that this would not be a process used in the program. It was stated that when addressing an unstable consumer, personnel are trained to provide 1-to-1 redirection, talking to the consumer, offering a quiet area, etc., before any measure such as emergency medication is considered.

A review of the clinical record showed one possible entry that might pertain to this allegation. The Behavioral Health Therapeutic Activity Note documented that the consumer became upset with a peer in group session and left angry; it was documented that a staff member processed with the consumer after group and discussed assertive strategies to utilize when feeling this way. There was nothing in the clinical record to indicate that staff members were considering emergency medication for this consumer.

The hospital's restraint policy states (in part) that clinically and developmentally appropriate alternatives to restraint are to be attempted, documented and found to be ineffective prior to use of restraint if possible, when restraint is necessary, the patient's safety, privacy, and dignity are of paramount importance and shall be maintained at all times. Restraint may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others based on an individual patient assessment; as ordered by a physician or licensed independent practitioner; and must be discontinued at the earliest possible time once the unsafe situation ends regardless of the scheduled expiration of the order. The policy states that monitoring and assessment will consist of safety checks to include hydration, circulation, level of distress/agitation, and skin integrity as well as the patient's need for nutrition, hygiene, elimination, and range of motion at an interval appropriate to the patient's condition and the type of restraint used.

The hospital's Patient Rights/Inpatient Psychiatry policy for Refusal of Medication/Treatment policy quotes the Illinois Mental Health and Developmental Disabilities Code, in that medication may be refused and will not be given unless the medication is necessary to prevent physical harm to the patient or others.

Conclusion

Pursuant to Section 2-102 (a) of the Illinois Mental Health and Developmental Disabilities Code (Code), "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."

Pursuant to Section 2-108 (g) of the Code, 'Every facility that employs restraint shall provide training in the safe and humane application of each type of restraint employed. The facility shall not authorize the use of any type of restraint by an employee who has not received training in the safe and humane application of that type of restraint. Each facility in which restraint is used shall maintain records detailing which employees have been trained and are authorized to apply restraint, the date of the training and the type of restraint that the employee was trained to use". Section (f) of the Code states that "Restraint shall be employed in a humane and therapeutic manner and the person being restrained shall be observed by a qualified person as often as is clinically appropriate but in no event less than once every 15 minutes. The qualified person shall maintain a record of the observations. Specifically, unless there is an immediate danger that the recipient will physically harm himself or others, restraint shall be loosely applied to permit freedom of movement. Further, the recipient shall be permitted to have regular meals and toilet privileges free from the restraint, except when freedom of action may result in physical harm to the recipient or others."

Based on the information obtained, it is concluded that the consumer was given the opportunity to willingly remove her clothing. Documentation indicated that the clothing was physically removed by staff members. Although the HRA cannot discount the consumer's assertion that staff members aggressively removed her clothing, nothing was found to support the claim. The allegation that the consumer was not given the opportunity to willingly remove her clothing as staff members physically and aggressively removed the clothing is unsubstantiated.

The consumer's perception that a security officer stared at her exposed body cannot be discounted. However, the officers recalled that the consumer did not want males in the room and according to the Security Report, this request was honored. The allegation is unsubstantiated.

Documentation does not show that the consumer was placed in restraints incorrectly; the allegation that the restraint was very tight on one wrist while loose on the other wrist is unsubstantiated. The clinical record did not show that emergency medication was considered for this consumer; the allegation that while receiving services in the behavioral health program, emergency medication was presented before less restrictive measures were offered is unsubstantiated.

Suggestions

1. Revise Refusal of Medication/Treatment policy to ensure that the policy quotes the Mental Health Code accurately by stating that medication will not be given unless the medication is necessary to prevent serious and imminent physical harm to the patient or others.
2. Whenever any rights of a recipient of services are restricted, staff members must promptly giving notice of the restriction pursuant to Sections 5/2-200 and 201 of the Code.

Comment

Hospital practice indicates that all mental health patients must disrobe. The HRA realizes that safety is an understandable need and when a patient is assessed as dangerous then this practice is warranted. However, not all mental health patients are dangerous, and, as with all hospital patients, care and treatment are determined on an individual basis. We offer that being forced to remove street clothing can be extremely disturbing and feel very unsafe for individuals who have a history of sexual abuse and trauma. These individuals may refuse to remove their clothing and ultimately engage in physical struggles as security guards attempt to disrobe them, reenacting their former abuse and greatly exacerbating the emotional crisis that brought them to the emergency department in the first place. ED staff must be sensitive to all these issues and halt blanket disrobing practices.