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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case #15-090-9021
OSF St. Francis Medical Center

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at the OSF St. Francis Medical Center. The complaints alleged the following:

1. **Inadequate treatment, including determinations made regarding care were based on minimal interaction with the patient and no counseling treatment provided.**
2. **The hospital detained a patient seeking discharge without due process.**
3. **Inappropriate restrictions, including only being allowed to use a spoon while eating and not being allowed cans.**
4. **Communication violation, including patient not allowed cell phone**.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (MHDD Code) (405 ILCS 5/1), hospital regulations (77 Il Admin Code 250), and the Healthcare Surrogate Act (755 ILCS 40/25).

The facility is not a licensed acute psychiatric facility and will only admit psychiatric patients when it is the secondary diagnosis. They provide no inpatient psychiatric care but have psychiatric staff for consults. The facility has 609 beds and services approximately 570 patients daily.

To investigate the allegations, HRA team members interviewed OSF Medical Center staff members and reviewed documentation that is pertinent to the investigation.

COMPLAINT STATEMENT

A patient was admitted February 1st for a suicide attempt and was in the Intensive Care Unit (ICU) for 3 days. The patient also was diagnosed with Methicillin-resistant Staphylococcus Aureus (MRSA) and was medically cleared mid-February but was not allowed to leave the hospital. The facility said that because of the severity of the suicide attempt, he needed transferred to a psychiatric unit so he was held until space was available in a unit. Many places that were contacted had no availability or said that the patient did not meet the criteria for admission. The patient said that he would transfer to another facility voluntarily. The facility

physician said explained to OSF was not qualified to keep patients like at a psychiatric unit. There was never any legal action and the patient never attended a commitment hearing or any other court hearing. The patient allegedly was kept at the facility for 32 days. The physician reportedly spoke to the patient for less than 5 minutes per day and never asked pertinent questions and the patient never received counseling while at the facility. Additionally, the patient was allegedly not allowed to use his cell phone and was only allowed spoons while eating. The patient was also not allowed cans as per the complaint. The patient was finally transferred to another facility and was discharged after 2 ½ days.

INTERVIEW WITH STAFF (5.12.15)

Staff began by explaining that the patient overdosed on Benadryl which caused kidney issues and led to admission. The patient was discovered at his home with two suicide notes and was transported to the hospital by Emergency Medical Services (EMS). Because the hospital is not a licensed psychiatric facility, they could only admit for the physical issues. Once the psychiatric needs were discovered psychiatric staff is contacted. The hospital may then transport the patient to a better suited facility. In this case, they made 45 referrals for transfer. It was discovered that that patient had MRSA which resulted in hospitals refusing to admit the patient. The patient also had a pending child sexual assault and drug charges which sometimes will cause facilities not to admit a patient for services. The hospital could not locate a psychiatric facility and the patient was not safe to be sent home. The patient was on suicide watch while at the facility.

The patient was seen by a psychiatrist and two other physicians. The psychiatrist was on a consultant basis. It was determined that the patient needed psychiatric help and he was seen by someone each day he was at the facility. Although they are not licensed for treatment, they attempt stabilizing the patients and provide treatment to keep them safe until they are transferred. What occurred is the usual procedure for a suicide attempt. The patient was at the facility from February 1st through March 4th. The patient was in the ICU from February 1st through February 4th and then moved to a medical surgery bed. The facility could not transfer until the patient was given medical clearance. On February 13th the patient was medically stable but was not stable enough to be discharged to home, so the facility is obligated to keep him at the facility.

The patient was admitted voluntarily and made the request to leave. The facility could not pursue a commitment because he was bonded on a felony charge and the Illinois does not allow commitments in that legal situation. The patient denied that he had attempted suicide even though there was medical and written evidence. A therapist, psychiatrist and social worker saw the patient daily. This is the general procedure with suicidal patients. The staff would see how the patient is proceeding and verify his status. Because they could not perform therapy, they would verify his status and that he was receiving appropriate care. Eventually the staff was able to transfer the patient to a psychiatric unit.

Staff said that the patient's inability to be transferred because of legal situations has occurred before. What they have tried before is to have the charges suspended. Because the charges included sexual assault and drugs, they did not attempt to have the charges dropped. They said if the charges involved something like a series of speeding tickets, they would have

attempted to have the charges dropped but not for this patient's charges. A number of the facilities they contacted said they did not feel that they could handle the patient's treatment as it was too acute. The patient had a behavioral health monitor that was with the patient constantly, which is part of the facility policy for patients who have attempted suicide. It was determined by staff daily if the patient needed psychiatry services. Staff review what has occurred which led to the decision that the patient still needed help. Staff did not believe the patient when he stated he was not suicidal and thought he was not credible because he had not admitted that he attempted suicide.

The staff stated that they never actually detained or restrained the patient. Staff explained that if the patient requests discharge, they would not have used physical or chemical restraints. Had the patient eloped, the police would be contacted which is standard for an individual with suicidal ideations. Because he was a danger to himself, had he eloped they would have called someone to try and have the patient return. Staff explained the options for discharge are regular discharge, leaving against medical advice (AMA), and elopement. If a patient wants discharge AMA, staff have to determine that the patient can appreciate the benefits and disadvantages of leaving, and then the patient must sign a form stating that he/she is leaving against medical advice. The medical physician must say that they disagree that the patient should go but understands that they have the capacity to make that decision. If the patient left without following procedure, it would be considered elopement. It was determined by staff that the patient did not have the capacity to leave against medical advice, because he never acknowledged the reason why he was there and staff said the patient did not appreciate the risks of leaving against medical advice.

Staff explained that the MHDD Code process for involuntary admission was never applicable because the patient was not involuntarily admitted but the Code does apply to the portions applicable to an acute care facility. Also they are not allowed to admit someone for acute psychiatric services so the Code would not apply in this case. The patient was annoyed that the process was not going faster but understood. He contacted patient relations several times and asked why the facility would discharge him. Patient relations reiterated what the staff were doing.

It is standard practice to not allow a patient who had attempted suicide to use a phone with a chord. The patient was aware that they removed the phone and it was explained to the patient why it was removed. A general patient room is used for patients who attempted suicide and they remove everything that a patient could not use to hurt themselves. Also, sometimes when a cell phone is not in use, they take it so the battery is not used for harm. The facility does not allow cords, sharp objects, silver wear, knives, forks and no real plates. The patient was allowed his cell phone and staff saw him using the phone. The phone was used frequently and staff speculated that he may not have been allowed to use his phone charger. They did request that he return the phone to the monitor when he was done using it. Staff said that the patient had lots of visitors while at the facility. The staff said that they did not ever completely take the patient's cell phone; they may have taken it to charge it. The only reason phone privileges may be restricted is if they were calling the police too often or making harassing calls. There were no telephone restrictions other than the suicide restrictions. If the cell phone battery would have died, they would provide the patient with a cordless phone. Staff explained that every patient at

the hospital can call patient relations. Every patient receives patient rights as a part of the admission folder. The patient had no restrictions on who he could call.

FINDINGS (Including record review, mandates, and conclusion)

Because of the relationship between complaint #1 & #2 and the similarities between complaint #3 and #4, the complaints were combined below.

Complaint #1 - Inadequate treatment, including determinations made regarding care were based on minimal interaction with the patient and no counseling treatment provided & Complaint #2 - The hospital detained a patient seeking discharge without due process.

According to the record, the patient was admitted to the facility on 2/1/2015 and discharged on 3/4/2015. The patient was medically cleared on 2/19/2015 or 2/20/2015 (the records indicate two possible dates of medical clearance). In reviewing the documentation, a physician spent time with the patient at the facility. Initially, on the date of 2/2/2015, the physician had an 123 minute consultation with the patient that included "… examination of a patient - history, mental status, and disposition - and exchange of information with the primary physician and other informants such as nurses or family members or other sources and preparation of a report." There was also a 40 minute consult with the patient on 2/3/2015 and it was stated that the session had more than 50% of the time dedicated to counseling or coordination of care. From that time forward, a physician saw the patient every day during the stay except for 2/8/2015, 2/9/2015 and 2/11/2015. Those sessions were generally 15 or 20 minutes and it was again documented that more than 50% of the time was dedicated to counseling or coordination of care. The HRA also saw documentation in the record that the patient was seen by a licensed clinical professional counselor, a licensed clinical social worker, and a registered nurse (RN) at separate times between 2/12/2015 and 3/3. The registered nurse (RN) notes list no time spent with the patient and RN progress notes are not completed daily. The therapist progress notes are not documented daily, with the dates 2/22/2015, 2/25/2015, 2/26/2015, and 2/29/2015 not accounted for in the notes. The time spent by the social work staff, range from 17 minutes as the longest amount of time, to 2 minutes as the shortest amount of time. The notes state that the times include individual psychotherapy, insight orientation, behavior modifying and/or supportive counseling. The HRA also reviewed the patient monitor notes. On 2/4/2015 it reads "[Physician] in room to talk to patient about policy and procedures with being on suicide precautions. Patient understands that we have to have sight on him for his safety so we have to leave the door open and be in the bathroom when he showers." The monitor's notes indicate that from 2/12/2015 until the last day of the patient's stay, staff met with the patient. For example, on 2/12/2015 the hospital manager came as well as the physician. On 2/13/2015 the physician and a therapist came as well as patient relations. On 2/14/2015 the physician and staff came to inform the patient that they were still trying to find placement. According to the monitor notes, the only day the patient was not seen by a physician or therapist was 2/15/2015 and 2/25/2015, and often the patient was seen by both.

The psychiatry consult service progress notes from the therapist, document attempts to find placement. On 2/12/2015, there is a note that one hospital had no beds available, another could not accept the patient because of assault charges and another facility stated they would

contact administration to see if they could accept the patient. On 2/13/2015 there are a list of facilities contacted with reasons why the patient could not be placed that included; MRSA, assault charges, and the lack of a room. On 2/20/2015 there are examples of two lists, one by the licensed social worker and one by the licensed clinical professional counselor that lists facilities and reasons for not admitting the patient. Another list is documented on 2/22/2015 and 2/23/2015. On 2/26/2015 there is a note that another facility denied the patient because of lack of acuity. On 2/27/2015 another facility was contacted and declined the patient and another said they may be able to accept but then on 2/28/2015 the referral had still not been processed because of the volume of intakes. Staff followed up with that facility later on 2/28/2015 and then again on 3/1/2015. On 3/1/2015 they were told that they did not know if the referral had been reviewed but the facility did not have beds at that time. Finally, on 3/3/2015 a facility accepted the patient. In reviewing the psychiatry progress notes, from 2/5/2015 until the end of the documented notes, the patient was willing to sign in voluntarily. The only exceptions are notes from 2/21 and 2/22 but those notes do not state that the patient is not willing.

In each set of psychiatry progress notes on the record for the patient's stay it declared that the patient is not to leave AMA. The behavioral monitor notes from 2/4/2015 read "Pt states he is going home tonight and can bet $1,000 on it. Wife and patient mom asked why he says that and he stated because this is ridiculous and has gone too far. Wife said why do you say this and patient state you'll see." Later on the same day the record states that "Pt mom and Pt wife stated they will be right back and are going to get lunch. Pt. replied 'If I'm not here I'll be at home.' Pt mom tried to [illegible] pt and pt hollered. Pt. also stated 'I'm not threatening to leave; I'm telling you someone is going to help me get out of here. I have friends who are attorneys.'" On 2/12/2015 the behavioral monitor notes read "Pt crying and frustrated over all this. Pt upset that Dr's have kept him here this long." A passage from 2/16/2015 reads "Pt wife and son left Pt very tearful and crying" and 15 minutes later it reads "Pt is very irritated that he might have to be here in St. Francis for another three days." Forty-five minutes later the notes read "Called therapist to come talk to Pt about the Pt concerns. Pt very irritated about certain things he's been told." On 2/21/2015, the notes state that the "Therapist and psych here to see pt. Pt. states he is frustrated about placement. Pt. explaining to therapist about why he tried to kill himself and what lead up to his suicide attempt." Later that day the record documents that "Doc into talk with pt about plan of care and what's been going on. Pt stated he will never be coming back to OSF for anything because of the care he has received. Stated that OSF has lost a customer." On 2/26/2015 the notes read "Pt received a call from [facility] psychiatrist and the therapist asked him if he was voluntarily wanting to go. Pt says yes he was and therapist says Pt was not suicidal and Pt could get out Pt help and there was no reason for OSF to keep him and the therapist at OSF were supposed to evaluate Pt to see if he had thoughts of harming himself and again after 72 hours and if no signs of thought he could leave, and therapist is going to call [OSF Staff] to let her know and therapist from [facility] told Pt to call Pt relations." Another note relating to the allegations states that the "Pt feels like there's a contradiction between many people he spoke to about being here. He's waiting on pt. relations to call him back." In the psychiatry progress notes for the patient, dated 2/17/2015, it reads "Pt seen today in follow up. Pt is very frustrated today about situation and length of stay. Discussed limitations of what our hospital can provide, and that his medical situation mixed with legal situation has definitely prolonged things. MRSA swab expected to be done in 2 days, which should with a negative allow pt to be accepted to an open bed if available at 2 facilities." On 2/13/2015 the notes state

"Aware that hold up yesterday was positive MRSA swab, and pt is slightly irritated with medical team that this wasn't addressed fully earlier and that it's holding up his progress." In the psychiatry consult notes on 2/27/2015 it reads "Visited patient at bedside. Extremely frustrated with the process of sitting and waiting for inpatient admission. Feels like a 'caged animal' and unable to care for his family the way he needs to. Explained that because of his SA the physicians feel this is the safest approach. Understands but remains frustrated." Another RN note in the psychiatry consult portion of the record and dated 2/13/2015 reads "Called to patient room regarding issues with stay. Feels as though sitting in a room without a purpose. Explained the reason for not being able to go home before placement. Understood but remains frustrated" and another note with the therapist on 2/13/2015 reads "LCSW met with pt in room for f/u, pt reports he is feeling well and eager to transfer to inpt psych as soon as possible. Pt voice frustration with continued positive MRSA as this may be hold up for transfer …".

The patient's psychiatric progress notes for 2/20/2015, which were written by the patient's primary physician at the hospital, reads that the "Pt states he didn't try to kill himself, but doesn't remember anything about what did happen, says he doesn't remember writing the notes (wife says they were clearly in his hand writing). Pt was quite irritable and was uncooperative with attempt to interview him further, but did allow me to speak with wife and mother. Mother does report that 4 bottles of OTC sleeping medication were found in the trash empty, and that they had been purchased over the weekend. Wife still very certain that this was an attempt." The progress notes for 2/21/2015, written by another physician, reads "Pt admits today he indeed intend to kill himself. States the reason for this attempt was 'feeling hurt' after his house was raided by the police and he was arrested as a result of a charge of sexual assault of a 15 yo. to whom he provided cannabis … The pt states he cannot remember whether he bought the Benadryl or whether it was in the house. States he does not remember what happened, first memory is being in the hospital … Nevertheless he states that at the time he took the OD he truly intended to kill himself and that at the point in time he became acutely depressed." The progress note also reads "My impression is the pt intended to kill himself and may try it again as he is facing the possibility of incarceration and losing his life as they were until now. The pt decisional capacity is intact and he understands the charges against him." The recommendations still state that the patient should not be allowed to leave AMA. On 2/22/2015 the same physician stated to refer to his more detailed notes from the previous day but also states that the patient's decisional capacity is intact. On 2/23/2015 the main attending physician has noted in the assessment that the "Pt states he didn't try to kill himself, but doesn't remember anything about what did happen, says he doesn't remember writing the notes." The rest of the notes are similar to the notation on 2/20/2015. The note still states that the patient should not leave the facility AMA. Notes from the main physician on 3/2/2015 again state that the patient states that he did not attempt to kill himself and also states that "Pt has been agreed to require inpatient psychiatry by both [first physician] and [second physician] as additional opinions" and also "Need for inpatient has been agreed on by [first physician] over weekend in coverage and was agreed with by [second physician] as well in prior weekend coverage."

Part of the psychiatry consult service progress notes, dated 2/28/2015, from the therapist reads "LCSW met with pt alongside [physician] for follow up. Pt continues to report minimal memory of events leading up to suicide attempt. Pt shares that he had just gotten home from jail after posting bond and was 'shocked and hurt' by legal charges. Pt reports overdose was 'spur of

the moment' reaction and states he did not know what else to do. Pt's continues to minimize and rationalize severity of attempt and ongoing, unchanged stressors leading up to attempt. Pt reports attempt was spontaneous, however evidence shows deliberate and planned attempt. Pt bought four boxes of Benadryl, locked bedroom door, left two suicide notes, and was found unresponsive the next day." In the assessment part of the notes, it still states that the "Pt denied that he was trying to kill himself, and stated 'that is just not me'".

In the RN progress notes, dated 2/27/2015, it reads "Pt seen as follow-up and for re-petition/certification with [physician] and BH monitor present … Petition completed, will continue to seek placement." On 2/25/2015 there was another statement in the RN notes that make the same statement. On 2/21/2015 in the therapist notes there is a statement that a petition has been completed. On 2/2/2015 there is a statement in the therapist notes that a petition needs to be completed when the patient is medically cleared. The HRA also reviewed a petition for involuntary admission that was dated 2/27/2015 and signed by an RN and has the address of OSF St. Francis Medical Center. When asked for clarification, the facility stated that the petition was not filed by them, but by the admitting facility and they could not answer whether the other facility filed the document.

The HRA reviewed a facility policy titled "Behavioral Health (BH) Psychiatry Consult Service (PCS) Continuity of Care and Coordination of Services" which has the purpose "To define and coordinate the appropriate assessment, treatment and disposition of care, and ensure clinical continuity for patients who present to the Emergency Department (ED) and In-House with behavioral health concerns." The policy states that "BH PCS therapist assesses, diagnoses, and refers patients to appropriate services and collaborates with other disciplines within SFMC [St. Francis Medical Center] to ensure continuity for the patient care process." The policy lines up a process and staff actions for care. The attending physician is to place an order for PCS assessment/evaluation. Physical tests are run if it is believed that the patient is impaired or in need of inpatient psychiatric treatment. The PCS receives the physician's findings, communicates them and makes recommendations for disposition. The nursing staff interacts on exchanging information on the patient's health and history, ascertains if search and secure procedures have been implemented, facilitates continuity and collaborative care and facilitates patient transfer. The psychiatrist confers on the psychological assessment, reports on patients, and confers when deciding the disposition of patient. Social services offer patient substance abuse treatment referral and referrals other than psychological." Another policy titled "Patients at Risk of Suicide/Homicide" states that the purpose is "To provide process to care for suicide/homicide patients when entering the medical care setting for SFMC personal and to promote safety and protection for patients, SFMC personnel, and others when patient is verbalizing and/or demonstrating self-harming behaviors and/or threatening harm to others." The policy illustrates the responsibilities of the psychiatry consult service, nursing staff, and emergency department. Among the PCS responsibilities, "Counseling/psychotherapy services are provided upon request or as follow-up for existing in-house patients" and the PCS Therapist/Psychiatrist responsibilities include the need to follow the patient as necessary throughout hospitalization.

The facility admission, discharge, transfer planning policy reads that a "Patient leaving without an authorized discharge signs an Against Medical Advice form" and that a "Parent or

legal guardian signs if the patient is a minor" and "If patient leaves without signing a form, two nurses sign form." The policy also states "Every effort is made to assist the patient in understanding implications of their particular case if they choose to leave against medical advice" and the occurrence is documented in the record.

The facility policy regarding discharge against medical advice reads that AMA is "Defined as a competent patient entitled to make decisions concerning their healthcare including whether or not to remain hospitalized." The HRA also reviewed the facility elopement policy which states that there is an alert when an elopement occurs, including overhead announcement and security is contacted as a part of that alert. Security performs a grounds search while unit staff members search rooms, walkways, stairwells, and elevators on their units for no longer than 10 minutes. It is assessed as to whether the patient who has eloped has "demonstrated any suicidal ideation, homicidal ideation, or psychoses." Then it is determined whether police involvement is needed and then security may make a call to the police. The patient is discharged if not discovered within two hours of elopement.

The Hospital regulations state "3) The hospital shall provide basic and effective care to each patient. No person seeking necessary medical care from the hospital shall be denied such care for reasons not based on sound medical practice or the hospital's charter, and, particularly, no such person shall be denied such care on account of race, creed, color, religion, gender, or sexual preference" (77 Il Admin Code 250.240). The requirements also state "The hospital shall have written policies for the admission, discharge, and referral of all patients who present themselves for care … 4) When the hospital does not provide the services required by a patient or a person seeking necessary medical care, an appropriate referral shall be made … 5)" (77 Il Admin Code 250.240). The requirements also read "All admissions to and discharges from psychiatric hospitals and the psychiatric department or service of a general hospital shall be in accordance with the Mental Health and Developmental Disabilities Code" (77 Il Admin Code 250.2270). Additionally, the requirements also state "c) In licensed general hospitals without an approved psychiatric service, psychiatric care to patients with a primary diagnosis of mental illness may be rendered on an emergency basis by appropriate members of the medical staff as determined by the hospital. Psychiatric consultation shall be available and utilized appropriately as determined by the hospital. Adequate and acceptable sources for transfer of psychiatric patients shall be documented and arranged within 72 hours unless the determination by a psychiatrist is such that the patient's condition no longer requires transfer to a licensed psychiatric unit or hospital" (77 Il Admin Code 250.2220).

The Health Care Surrogate Act reads "(a) When a patient lacks decisional capacity, the health care provider must make a reasonable inquiry as to the availability and authority of a health care agent under the Powers of Attorney for Health Care Law. When no health care agent is authorized and available, the health care provider must make a reasonable inquiry as to the availability of possible surrogates listed in items (1) through (4) of this subsection" (755 ILCS 40/25). The same section of the Act also reads "With respect to a patient, a diagnosis of mental illness or an intellectual disability, of itself, is not a bar to a determination of decisional capacity. A determination that an adult patient lacks decisional capacity shall be made by the attending physician to a reasonable degree of medical certainty. The determination shall be in writing in the patient's medical record and shall set forth the attending physician's opinion regarding the cause, nature, and duration of the patient's lack of decisional capacity."

The MHDD Code also reads "When, as a result of personal observation and testimony in open court, any court has reasonable grounds to believe that a person appearing before it is subject to involuntary admission on an inpatient basis and in need of immediate hospitalization to protect such person or others from physical harm, the court may enter an order for the temporary detention and examination of such person. The order shall set forth in detail the facts which are the basis for its conclusion. The court may order a peace officer to take the person into custody and transport him to a mental health facility. The person may be detained for examination for no more than 24 hours to determine whether or not she or he is subject to involuntary admission and in need of immediate hospitalization. If a petition and certificate are executed within the 24 hours, the person may be admitted provided that the certificate states that the person is both subject to involuntary admission and in need of immediate hospitalization. If the certificate states that the person is subject to involuntary admission but not in need of immediate hospitalization, the person may remain in his or her place of residence pending a hearing on the petition unless he or she voluntarily agrees to inpatient treatment. The provisions of this Article shall apply to all petitions and certificates executed pursuant to this Section. If no petition or certificate is executed, the person shall be released" (405 ILCS 5/3-607). The Code also states that "The circuit court has jurisdiction under this Chapter over persons not charged with a felony who are subject to involuntary admission" (405 ILCS 5/3-100). The Code also reads "A person 18 years of age or older who is subject to involuntary admission on an inpatient basis and in need of immediate hospitalization may be admitted to a mental health facility pursuant to this Article" (405 ILCS5/3-600).

Compliant #1 & #2 – Conclusion

The patient's records indicate that the patient was willing to be placed in an inpatient unit, which the facility actively worked on during the patient's admission. There was a long wait for the patient to be transferred, but the lack of placements was documented. It appears that the facility was not detaining the patient but there was an elongated wait for the patient to transfer, for which the patient was willing to wait. Additionally, documentation appeared to show that the staff spent time with the patient and documented reasoning for the patient transferring to another facility. Because it appears that the patient was willing to transfer and because it was documented that the patient spent time with the patient, the HRA finds these complaints **unsubstantiated** but the HRA has strong concerns about the patient's stay at the facility. The records indicated that, at times, the patient did not have capacity and could not leave AMA, but at other times, it was documented that the patient did have capacity, which is alarming considering facility policy allows patients with decisional capacity to leave AMA. The HRA **strongly suggests** that the facility staff assure adequate communication regarding patient capacity and assure that the AMA policy is understood, especially considering the importance of the policy. An additional concern is the facility's lack of compliance with the Healthcare Surrogate Act which states that a facility needs to find a decision maker for a patient in the absence of capacity (755 ILCS 40/25). The HRA saw no evidence of this occurring and **strongly suggests** the facility review its practice regarding obtaining a surrogate for decision making when it is determined that patient decisional capacity is lacking.

There were also statements made in the record about re-petitioning the patient although there was no direct evidence indicating that this did occur. There was a petition that appeared to be completed by the facility (although staff denied that this occurred) even though a commitment is out of the jurisdiction of the courts due to the felony. The HRA is concerned about the lack of coordination and disconnect as well as the fact that staff possibly re-petitioned the patient which is not in compliance with the Code. The HRA **strongly suggests** the facility review the commitment process (405 ILCS 5/3-601 – 607) to assure compliance and discontinue re-petitioning if that is the facility practice.

Complaint #3 - Inappropriate restrictions, including only being allowed to use a spoon while eating and not being allowed cans & Complaint #4 - Communication violation, including patient not allowed cell phone.

The patient had a monitor due to the suicide precautions and the HRA reviewed the patient monitor notes dated 2/3/2015 through 3/4/205. In the notes, there were instances where the patient was provided a meal and the monitor documented that all silverware was accounted for after the meal was provided. The monitor also occasionally documented that the silverware consisted of one, metal spoon. The HRA also saw an instance where it was documented that the patient specifically received a call on the room phone, and two other occasions where it was documented that the patient was talking on a phone. The HRA never saw documentation that the patient's cell phone was or was not taken away from the patient. It was also indicated that "search and secures" where done in the room and on one occasion it was documented that food brought for the patient was also searched. It was also indicated in the documentation that the patient could not be in a room with the door closed and, at one point in the stay, could not shower without someone in the bathroom with him.

The HRA reviewed the facility policy titled "Search and Secure of Personal Belongings and Contraband" which reads "Safety of patients is the highest priority, and any patient who exhibits any self-mutilation, suicidal ideation, suicide attempt, or homicidal ideation is searched for any objects that may potentially be harmful to self or others (medications, sharp objects, lighters, safety pins, etc.)." The policy indicates when to perform the search, when behavioral health consultants should be contacted, how to perform the search and where to search on the individual. The policy reads "Search all patient belongings and inventory of any other personal belongings (non-contraband)." The policy states to remove from the room any objects which are identified as potentially harmful to the patient and then provides a list that includes sharp items, breakable items, items that can be used to strangle (including cellular phone and computer electrical cords), purse, wallets, and more items. The policy also states "Remove belongings (including medications) from patient's room" and to "Keep items in secured area on units; send home with family or send to Security" and also that "No items are permitted in patient's room."

The facility provided the HRA with an excerpt of the patient rights/responsibilities packet which explains that there are telephones in most rooms, how to make outgoing calls, where to locate the room number; the policy also states that cell phones may be used in patient rooms but if it is an intensive care unit, the call must be made outside the room.

The facility has a document titled "Suicide/Homicide Precaution Protocol" which reads

“Interventions for safety are of primary importance for patients whose behavior may be destructive to themselves or others. The goal is to provide protection for the patient in the least restrictive environment that allows for necessary level of observation and/or physiologic monitoring. Interventions range from regular and periodic observation to 1:1 contact observation in an observation or secluded area.” The protocol states that there is a level of precaution that is ordered by staff and the level is assigned after assessing the patient. The precaution levels are low and high. The high level descriptions read “Indications: patients admitted for medical stabilization following suicide attempt; active suicide ideation; verbalizes intent to harm self; has concrete/specific plan for self-harm; exhibits disorganized and/or psychotic behavior.” Part of the high level interventions is to remove room objects and the list mirrors the list from the search and secure policy from above. In addition, there are dietary tray restrictions which include no plastic silverware, no forks or knives, no aluminum cans, and the patient can only have a metal spoon that must be accounted for before and after every meal. Throughout the psychiatry notes in the patient’s record, it is recorded that the patient needs precautions. Sometimes it is documented that the patient is at high risk, other times it is documented to continue precautions, and other times it is documented that the patient still requires precautions. An initial psychiatric note dated 2/3/2015 stated that the patient is at high risk. There is documentation regarding his precautions every 24 hours.

The MHDD Code reads “2-104. Every recipient who resides in a mental health or developmental disabilities facility shall be permitted to receive, possess and use personal property and shall be provided with a reasonable amount of storage space therefor, except in the circumstances and under the conditions provided in this Section. (a) Possession and use of certain classes of property may be restricted by the facility director when necessary to protect the recipient or others from harm, provided that notice of such restriction shall be given to all recipients upon admission” (405 ILCS 5/2-104). The Code also reads “a) 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 therefor to …” and the Code lists individuals who are to receive copies of the restriction notices (405 ILCS 5/2-201). The Code does not specify cell phones or specific food items as being a right in the chapter. Additionally the Code reads “Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation” (405 ILCS 5/2-103). The Code also states that “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 (i) 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" (405 ILCS 5/2-102). Section 2-107 of the Code states "(a) An adult recipient of services or the recipient's guardian, 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."

Compliant #3 & #4 – Conclusion

Through reviewing documentation, the HRA concluded that the patient was under suicide preventions while at the facility and the MHDD Code specifically states certain classes of property can be restricted if necessary to keep the recipient safe from harm (405 ILCS 5/2-104). Also, the MHDD Code does not recognize cell phones and silverware as rights by a patient (405 ILCS 5/2-201) but it does recognize the right to communicate (405 ILCS 5/2-103) and the record indicates that the patient was allowed to use the telephone, although it was unclear whether the patient was allowed to use the cell phone. Because the HRA discovered no evidence indicating that the facility was not in compliance with the regulations, the HRA finds the complaint **unsubstantiated** but offers the following **suggestions**:

- The record indicates that the patient was provided Lorazepam as a medication but the HRA saw no consent or court order for psychotropic medication. It was explained by the facility that the patient came through the emergency department but did not have decisional capacity, thus consent was deemed under the emergency presumed consent doctrine for medication administered during this stay determined most appropriate by the attending physicians. In accordance with the MHDD Code psychotropic medication is only allowed with patient consent, to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available, or with a court order (405 ILCS 5/2-102 and 5/2-107). Although the patient may have had suicidal ideations according to the facility, he was being physically kept safe and was not, at the time, in imminent physical harm. The HRA **strongly suggests** the facility discontinue this practice to assure compliance with the MHDD Code.
- In reviewing the patient's record, the HRA saw that the record narrative changed from the patient's narrative to another patient's narrative in the record. The record did return to the correct patient but the HRA is concerned for the integrity of patient records and **strongly suggests** that the facility enact some form of quality assurance for current patients to ensure that the correct patient information is being recorded in the correct patient record. The HRA also **strongly suggests** the issue be investigated internally by the hospital to discover how it occurred and how the hospital can ensure that this does not happen again.

RESPONSE

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

OSF
SAINT FRANCIS MEDICAL CENTER

November 9, 2015

Debra Goodwin, Chairperson
Guardianship & Advocacy Commission
Human Rights Authority
401 Main Street, Ste 620
Peoria, IL 61602

Re: Case#15-090-9021

Dear Ms. Goodwin,

OSF Saint Francis Medical Center received the Commission's final report with recommendations pertaining to the case referenced above. We will take those recommendations under advisement as we continually strive to improve our policies and procedures.

We thank the Commission for its work on this matter.

If you should have any questions, please contact me at 655-2402.

Sincerely,

Michael Henderson
Corporate Counsel

MH: rh

cc: Gene Seaman