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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 16-030-9011
South Shore Hospital

Case summary: The HRA substantiates the complaint that the facility restrained and administered forced emergency psychotropic medication in violation of the Mental Health Code. The HRA has received a non-public provider response.

## INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at South Shore Hospital. It was alleged that the facility restrained and administered forced emergency psychotropic medication in violation of the Mental Health Code. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.), the Centers for Medicare and Medicaid Administrative Rule (42 CFR 482.13 Patient's Rights), and the South Shore Hospital Bill of Rights.

South Shore Hospital is a non-profit organization serving the South Shore community. The Emergency Department serves approximately 16,000 patients per year and it is estimated that 5-7% of these patients have a mental illness. The hospital incorporates a 31- bed Geriatric Behavioral Health Unit.

To review these complaints, the HRA conducted a site visit and interviewed the Assistant Administrator, the Program Director, the Chief of Nursing, the Compliance and Risk Management Director, the Emergency Department Registered Nurse, and the Quality Management Director. Relevant hospital policies were reviewed, and records were obtained with the written consent of the recipient.

## COMPLAINT SUMMARY

The complaint alleges that a recipient was restrained and administered forced emergency psychotropic medication in the hospital emergency department (ED) because he refused to have his vitals taken and asked to be seen by a crisis worker. Reportedly the recipient's pants were removed to be placed in restraints, and he was given a catheter, as well as being placed in restraints. In the past the recipient had suffered third degree burns on 75% of his body, leaving his skin scared, very thin, and delicate. He is also blind, cannot walk, and his hands are

contracted so that he cannot ambulate his wheelchair or sign his name. The complaint alleges that a Program Director from the Geriatric Behavioral Health unit came to the ED and upon observing the recipient he told the staff to release his restraints, however staff refused to do so.

FINDINGS

The hospital record shows that the recipient was admitted to South Shore Hospital ED on 10/23/15 at 11:47 p.m. He had been transferred from a nursing facility where he had been petitioned at 10:47 a.m. that day for involuntary admission due to "increased agitation, intimidation, and physical aggression towards female staff and roommate." At 6:00 p.m. an emergency department physician at South Shore completed an Inpatient Certificate and the following day the recipient agreed to have an application for voluntary admission completed in his name. Included in the emergency department documentation is an Informed Consent for medication and it includes the medications Zyprexa and Paxil. None of the recipient's admission documents are signed- they state, "Unable to sign."

The Emergency Department Triage Assessment completed at 12:55 p.m. is included in the record. It states, "Pt presented to ED via [ambulance] with complaint of aggressive behavior. Per Life Line EMT, Pt was presenting aggressive behavior toward roommate last night, roommate was removed from Pt's room, Pt then directed aggressive behavior toward nursing staff at [nursing home]. Per EMT, Pt has refused psych meds for one month. Pt. stated, he is not a threat to himself/others, Pt refusing to answer any more questions. Upon assessment, Pt is alert/oriented x 3 [person, place and time], non-compliant, (Pt stated he will not allow vitals to be taken, and has been informed of the necessity of full completion of assessment), shouting out, scaring 75% of body (third degree burns), bilateral decrepit hands." Notes entered at 12:55 p.m. also indicate that the recipient is blind.

Emergency Department notes indicate that at 1:20 p.m. on 10/23/15 the recipient was placed in leather restraints. The behavior requiring restraints is described as, "Harm to self, harm to others, can't follow directions, decreased LOC [Level of Consciousness]." The less restrictive measures that were taken are described as, "limit setting/control, verbal intervention, reorient." At 2:20 p.m. a restraint/extremity check was completed at which time the restraints were removed and then reapplied. The less restrictive measures at this time state, "Limit setting/control, verbal intervention, medication, schedule position changes, place closer to station, reorient." At 3:01 p.m. the restraints were again removed and reapplied. At this time the behavior requiring restraints states, "Harm to self, harm to others, can't follow directions, decreased LOC, interferes with treatment, getting out of bed." The less restrictive measures then added an item, "Encourage family to sit" (there is no indication from recipient report or medical record that the family was present). At 3:30 p.m. the notes indicate that a urinary catheter was inserted. The next restraint check is entered at 4:05 p.m. when the record indicates the restraints were removed and reapplied. There are no changes made to the data for this application and those that followed- all checks involved the removal and reapplication of restraints. Restraint/extremity checks were completed at 5:05 p.m., 6:05 p.m., 7:06 p.m., 7:36 p.m., 7:51 p.m., 8:06 p.m., 8:21 p.m., 8:36 p.m., 8:51 p.m., and 9:06 p.m. These checks indicate that the recipient was offered comfort, nutrition, hydration, hygiene, circulation, range of motion, and

elimination assessments. There are no Restriction of Rights documents in the record. The recipient was released from restraints at 9:06 p.m.

Emergency Department notes indicate that the recipient was given a mental status assessment at 1:30 p.m. and 1:45 p.m. The recipient's thought process at the first assessment indicates that it was "logical, coherent, with clear judgement." The second assessment states that the recipient's thought process was "Intact, no delusions or hallucinations", and he was "well groomed." The record also indicates that the first set of vital signs was taken at 3:30 p.m. By 4:00 p.m. the recipient had been catheterized, his vitals monitored, an EKG completed, and blood and urine specimens taken.

RN notes are included in the record. Notes entered at 1:15 p.m on 10/23/15 state, "Pt presented to ED via Life Line with complaint of aggressive behavior non-compliant with medication. Per EMT and nursing facility staff the Pt is aggressive and displayed this behavior toward his roommate last night. Roommate was removed from Pt's room, the Pt then directed aggressive behavior toward nursing staff at [nursing home]. Per nursing facility staff the Pt has refused his psch meds for 1 month and Dr… is aware, and this is the second time this month being sent for a psych evaluation. Pt refuse to remove his clothes, give urine sample, blood specimen, take any medication or vital signs. Pt screaming and threatening staff. Pt explained policy and procedure, but the Pt refuses and states he only wants to see a crisis counselor. Pt has 75% of body (3rd degree burns), bilateral decrepit hands, and appears to be a threat to harm himself and others. Security and [staff] from Behavioral Health called for assistance."

Nursing Notes describe the restraint episode which coincides with the Emergency Department notes, except that at 7:25 p.m. the notes state, "Report from RN…; received patient in ER in 4 point restraints (bilateral leather wrist, bilateral LE [lower extremity] soft), sleeping and easily aroused by tactile stimuli; per report, patient was aggressive with staff; patient is currently cooperative, requesting update; patient repositioned for comfort; patient is legally blind, with old scars from burns to bilateral upper/lower extremity; patient alert/oriented x 3 in no acute distress; safety precautions maintained."

A Patient Complaint, prepared by the Patient Advocate, is included in the record. It states:

*On Monday, October 26, 2015, I received a call from …, the Nurse Manager in the GPU requesting my presence to take a patient's complaint. I went to the GPU and met with a patient by the name of … who is blind and has problems with the use of his hands. [The recipient] complained that a nurse filed a petition for him to be admitted.*

*[The recipient] alleged that [a nurse] was very indignant and 'snotty' toward him. He stated he told her he wanted to see someone over her. He stated he told her he was declining medical treatment. Pt. alleges she then strapped him down, forcefully (both arms and legs), removed his clothing, and inserted a catheter into his penis causing him to bleed. He kept telling her the whole time that he had the right to refuse treatment. He stated that there was no need for that and this happened in the Emergency Room. He stated he was left restrained there for a very*

*long time, approximately 2 hours until the shift changed and another nurse came in and removed the restraints. Patient stated you cannot force treatment on anyone.*

*Pt. stated he never struck anyone in the E.R. for him to be restrained. He stated the nurse was "cocky" and he is complaining about her and the staff. Pt. stated that no one has the right to take one's clothes off.*

*Please respond to this complaint to Administration, in writing, within 7 days as to the resolution to these accusations."*

A response to the above complaint is included in the record. It states:

*On Monday, October 26, 2015 a patient by the name of … presented to the ED with CFD [?] from a skilled nursing home with a petition. The patient was not cooperative with Life Line EMT's, who stated he did not allow them to obtain vital signs. RN … attempted to triage the patient who was not cooperative after several attempts of verbal communication. RN … intervened who was also the Charge nurse at the time was present, and the patient was not cooperative with her. I became the primary nurse for the patient because all of the staff members had a psych patient. I spoke with the patient calmly with Dr. … present, and the patient refused to remove his clothes, provide a urine sample, allow ED staff to obtain a blood specimen, nor did he allow ED staff to obtain vital signs. The Pt. became more agitated and requested a Crisis Intervention person. The patient was explained by several ED staff members that he has to be medically cleared before he can be admitted or cleared for our psych unit. The Pt continues to refuse all treatment. RN … from behavioral Health was called and notified of the Patient request and was also requested to come and speak with the Patient. The Patient became more anxious and agitated; the Patient attempted to hit RN … , spit and swing arms and kick ED staff members. Security was called for assistance, Dr. … was present along with [four RN's]. Per Dr. … orders that the Pt was restrained with leather restraints for the safety of the Patient and ED staff.*

*At 1345 RN … arrived in the ED, and spoke with the Patient. The Patient was not cooperative with RN … from Behavioral Health. [He] was notified that the Patient attempted to spit, hit, and kick ED staff and he was a threat to himself and ED staff. Rn … was notified that if he took the restraints off the Patient, the entire ED staff was requesting he resume responsibility of the Patient safety. The leather restraints were not removed from the patient upper extremities and the Patient did not have on any restraints to his lower extremities.*

*The Patient never calmed down with ED staff, the restraints were removed and reapplied, no injury noted to the Patient extremities each time they were removed and reapplied, the Patient was offered food, water, and a urinal for elimination but the Patient continue to refuse.*

*Between 1500-1530 writer along with ED Tech … removed leather restraints and ED Tech attempted to obtain blood specimen and complete EKG. The Patient 1st said it was OK, but then kicked ED Tech in his ear and attempted to hit RN … or myself. The Patient was then placed in leather restraints with soft restraints to the Patient ankles. The Patient was extremely aggressive Dr. … ordered a dose of 5 mg of Haldol because the Patient was not redirectable and*

*per Dr. … it was a safety issue. During this time with assist from ED staff RN [5 RN's] and ED Tech, blood specimen, foley cath was inserted for urine specimen, and EKG was completed. The Patient was agitated, threatening staff, while attempting to spit on staff.*

*I, [RN writer] never became indignant, snotty, or cocky with the patient. I tried along with all ED staff to make sure the Patient was safe, while explaining the procedure and protocols. The Patient stated he did not need medical treatment, and he has the right to refuse medical treatment. The Patient was explained he arrived to the ED with a petition from his nursing home residence and we could not allow him to make that decision at that time for his safety. The Patient did not agree and wanted a Crisis Intervention person. [Staff person] from Behavioral Health was notified. I would never intentionally [this is the end of the sentence- not completed].*

*I documented all my information, just as RN … regarding the patient not being compliant and cooperative.*

The record contains a response from the Patient Advocate to the recipient dated 12/14/15. It states:

*The complaint that you filed with South Shore Hospital's Patient Advocate on October 26, 2015 was investigated thoroughly and discussed at the Patient Satisfaction Committee meeting of November 25, 2015. The complaint was addressed and the person(s) involved and necessary action was taken immediately by obtaining detailed reports from the Emergency Room staff as to you forbidding them to have you treated, per the petition from the transferring facility. Your refusal to be treated resulted in necessary restraining from time to time while awaiting admittance to the Geriatric Unit. We apologize for any inconvenience this may have caused you and the necessity to restrain patients will once again be addressed within the E.R. staff….*

The petition and certificate for the involuntary detention were included in the clinical record. The petition was completed on 10/23/15 at 10:47 a.m. There are three assertions checked on the petition and they state:

*A person with mental illness who: refuses treatment or is not adhering adequately to prescribed treatment; because of the nature of his or her illness is unable to understand his or her need for treatment; and if not treated on an inpatient basis, is reasonably expected based on his or her behavior history, to suffer mental or emotional deterioration and is reasonably expected, after such deterioration, to meet the criteria of either paragraph one or two above.*

*An individual who: is developmentally disabled and unless treated on an in-patient basis is reasonably expected to inflict serious physical harm upon himself or herself or others in the near future, and/or*

*In need of immediate hospitalization for the prevention of such harm.* The recipient is not now nor has he ever been developmentally disabled.

The section of the petition that shows a certification that the recipient received a copy of the petition within 12 hours of admission, that he was explained the Rights of Admittee and was given a copy of it, and that he was provided with a copy of the Rights of Individuals Receiving Mental Health and Developmental Services is not signed by a staff person.

An Inpatient Certificate is included in the hospital record. The examiner has certified that the recipient was explained that he did not have to respond to the examiner and that information he provided could be used in a mental health hearing. The certificate is signed and dated 10/23/15 at 6:00 p.m.

HOSPITAL REPRESENTATIVE RESPONSE

Hospital representatives were interviewed about the complaint. They indicated that the recipient was brought to the hospital on a petition because he had been aggressive with staff at the nursing home where he lived. They indicated the recipient had been erratic from the moment he arrived in the ED. ED staff stated that they might not have known that the recipient was blind, even though it was recorded in the ED notes from the time the recipient was admitted. They indicated that they very rarely utilize restraint and that is the best indication that the recipient was acting dangerously. Also, security had to be called so staff felt that the recipient was able to impose harm on himself and others. The recipient was isolated in the ED and a staff person was called from the Behavioral Health unit. This staff person, the Program Director, spoke with the recipient for approximately a half hour. He then made a recommendation to the Primary Nurse requesting that the recipient's restraints be removed. He indicated that he didn't feel the recipient warranted restraints but he also added that the Primary Nurse and the ED physician are better able to make this determination because they know the recipient and the situation better. He also noted that it is also important for staff to listen to the patient. The Primary Nurse was asked about the behaviors the recipient was demonstrating and she indicated that he was able to kick, spit on staff and swing his arms even though he could not directly use his hands. She indicated that she is required to get certain information such as vital signs, etc. so that a physician can then medically clear the patient for transfer to the Behavioral Health unit, so the delay in obtaining the certificate is the direct result of the recipient's refusal to allow his medical information to be obtained.

The hospital administrator indicated that since the current complaint was filed the ED has added a separate room for patients presenting with mental illness and the HRA toured this room which allows for reduced stimulation and a quiet atmosphere.

STATUTES

The Mental Health Code describes a "mental health facility" as "…any licensed private hospital, institution, or facility or section thereof, and any facility, or section thereof, operated by the State or a political subdivision thereof for the treatment of persons with mental illness and includes all hospitals, institutions, clinics, evaluation facilities, and mental health centers which provide treatment for such persons" (405 ILCS 5/1-114).

The Mental Health Code defines medical emergency: “A medical or dental emergency exists when delay for the purpose of obtaining consent would endanger the life or adversely and substantially affect the health of a recipient of services. When a medical or dental emergency exists, if a physician or licensed dentist who examines a recipient determines that the recipient is not capable of giving informed consent, essential medical or dental procedures may be performed without consent…” (405 ILCS 5/2-111).

The Mental Health Code states that when a person is asserted to be in need of immediate hospitalization, any person 18 years of age or older may complete a petition (5/3-600), which specifically lists the reasons (5/3-601). The petition is to be accompanied by the certificate of a qualified examiner stating that the recipient is in need of immediate hospitalization. It must also indicate that that the qualified examiner "personally" examined the recipient not more than 72 hours prior to admission. It must contain the examiner’s clinical observations and other factual information that was relied upon in reaching a diagnosis, along with a statement that the recipient was advised of certain rights (3-602), including that before the examination for certification the recipient must be informed of the purpose of the examination, that he does not have to speak with the examiner, and that any statements he makes may be disclosed at a court hearing to determine whether he is subject to involuntary admission (5/3-208). Upon completion of one certificate, the facility may begin treatment, however at this time the recipient must be informed of his right to refuse medication (3-608). As soon as possible, but no later than 24 hours after admission, the recipient must be examined by a psychiatrist or released if a certificate is not executed (5/3-610). Within 12 hours after his admission, the recipient must be given a copy of the petition (5/3-609). Also, within 24 hours, excluding Saturdays, Sundays and holidays, after the recipient's admission, the facility director must file 2 copies of the petition, the first certificate, and proof of service of the petition and statement of rights upon the recipient with the court in the county in which the facility is located. Upon completion of the second certificate, the facility director must promptly file it with the court. Upon the filing of the petition and first certificate, the court shall set a hearing to be held within 5 days, excluding weekends and holidays, after receipt of the petition (5/3-611).

The Mental Health Code guarantees all recipients adequate and humane care in the least restrictive environment. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan. Section 2-200 d states:

"Upon commencement of services, or as soon thereafter as the condition of the recipient permits, the facility shall advise the recipient as to the circumstances under which the law permits the use of emergency forced medication under subsection (a) of Section 2-207, restraint under section 2-208, or seclusion under Section 2-109. At the same time, the facility shall inquire of the recipient which form of intervention the recipient would prefer if any of these circumstances should arise. The recipient's preference shall be noted in the recipient's record and communicated by the facility to the recipient's guardian or substitute decision maker, if any, and any other individual designated by the recipient. If any such circumstances subsequently do arise, the facility shall give due consideration to the preferences of the recipient regarding which

form of intervention to use as communicated to the facility by the recipient or as stated in the recipient's advance directive."

The Mental Health Code describes the requirements for the administration of psychotropic medication and its refusal:

"An adult recipient of services…must be informed of the recipient's right to refuse medication… The recipient…shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication... 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…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" (405 ILCS 5/2-107).

The Centers for Medicare and Medicaid Administrative Rules (42 CFR 482.13) outline Hospital Patient Rights. Section (b) states, "The patient or his or her representative (as allowed under State law) 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…."

Additionally, the Code states, "If the services include the administration of…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. …. 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 [to prevent harm]…." (405 ILCS 5/2-102 a-5).

Further, the Code states that whenever any rights of the recipient of services are restricted, notice must be given to the recipient, a designee, the facility director or a designated agency, and it must be recorded in the recipient's record (ILCS 405 5/2-201).

The Centers for Medicare and Medicaid Administrative Rules (42 CFR.13) describe a Patient's Rights concerning physical restraint. Section (e) states, "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 Mental Health Code states that restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. Restraint may only be applied by a person who has been trained in the application of the

particular type of restraint to be utilized. In no event shall restraint be utilized to punish or discipline a recipient, nor is restraint to be used as a convenience for the staff. In no event may restraint continue for longer than 2 hours unless within that time a nurse with supervisory responsibilities or a physician confirms in writing that the restraint does not pose an undue risk to the recipient's health in light of their medical condition. Orders for restraint must include the events leading up to the need for restraint and the length of time the restraint will be employed, not to exceed 16 hours.

Restraint is to be employed in a humane and therapeutic manner and the person restrained must be observed by a qualified person as often as is clinically appropriate but no less than once every 15 minutes. The person must maintain a record of the observations. Unless there is an immediate danger that the recipient will physically harm himself or others, restraint must be loosely applied to permit freedom of movement. Also, the recipient must 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. Every facility that employs restraint shall provide training in the safe and humane application of each type of restraint used. Whenever restraint is used, a member of the facility staff will remain with the recipient at all times unless the recipient has been secluded. A person who has been restrained and secluded shall be observed by a qualified person as often as is clinically appropriate but in no event less than every 15 minutes. Whenever restraint is used, the recipient shall be advised of his right to have any person, including the Guardianship and Advocacy Commission or the agency designated pursuant to the Protection and Advocacy for Developmentally Disabled Persons Act notified of the restraint.

HOSPITAL POLICY

South Shore Hospital provided the policy and procedure for Use of Restraint. It states, "It is the policy of South Shore Hospital to limit the use of restraint to only those situations that are clinically justified and only after all alternative measures have been considered. It is recognized that at times it is necessary to use protective restraint devices. It is our policy to utilize the least restrictive measure available at all times and to enforce guidelines that ensure the individual patient's rights, dignity and well-being are protected during use." The policy sets apart the use of restraint for violent or self- destructive behavior "that jeopardizes the immediate physical safety of the patient, a staff member, or others." Hard (leather) restraints are utilized "only in cases when the patient poses a threat to the safety of oneself or others (violent/self-disruptive behavior) and less restrictive measures have failed. A physician must evaluate the patient within one hour of application. Documentation of the behavior and all alternative measures attempted are to be entered into the initial progress note in the patient's medical record." The guidelines for the use of restraint and the procedures for its application all comply with the Mental Health Code, except that the policy does not mandate that a Restriction of Rights Notice is completed for the event.

South Shore Hospital provided their policy for the administration of medication. It states, "Patients have the right to refuse medication. Medications can only be administered involuntarily when there is legal documentation authorizing the use of involuntary medications.

In the event that a person is uncooperative, staff assistance may be necessary to ensure patient and staff safety during medication administration."

South Shore Hospital provided the Patient Bill of Rights. Included in these rights is the patient's right to be informed of his/her health status, to be involved in care planning and treatment, and to be able to request or refuse treatment." Additionally, these rights include, "The right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff." And finally, this document guarantees "The exercise of [the patient's] rights while receiving care or treatment in the hospital without coercion, discrimination or retaliation."

CONCLUSION

The Mental Health Code gives recipients of mental health services the right to refuse treatment. This right is upheld even if a recipient is detained upon a petition. Only when the recipient is an imminent threat of physical harm to himself or others may his right to refuse treatment be denied. In this case, not only the documentation, but the actual physical condition of the recipient contradicts the level of dangerousness that would require not only restraints, but also medication and the use of catheters. Even behaviors such as spitting and swinging arms, for a person who is blind, cannot walk, and cannot use his hands, are rendered a nuisance and an inconvenience since staff would only have to walk away to avert these behaviors. Additionally, it could be argued that restraints were contraindicated just for the condition of the recipient's skin alone. Even after a staff person asked to have the restraints removed they remained, even after the vitals were obtained, even after the EKG was completed, even when staff had to awaken the recipient to remove and reapply them. Additionally, many other Mental Health Code procedural mandates were neglected, such as the completion of Restriction of Rights documentation, or the Code mandated physician statement of decisional capacity, or the Code mandated 15-minute checks of persons in restraints. Finally, in addition to the restraints and forced medication there is the issue of forced blood and urine draws along with other medical procedures which the recipient refused but which were forced upon him without any indication of a medical emergency or his lack of the capacity to make decisions regarding his care.

The hospital stands on the fact that the recipient was dangerous, however their report, along with the documentation, suggests that the recipient's refusal of services prompted the severe treatment he received. The complaint response letter sent to the recipient from the Patient Advocate may more accurately describe the situation: "Your refusal to be treated resulted in necessary restraining from time to time while awaiting admittance to the Geriatric Unit." The HRA substantiates the complaint that the facility restrained and administered forced emergency psychotropic medication in violation of the Mental Health Code.

RECOMMENDATIONS

1. Train ED staff on the Mental Health Code. Ensure that all recipients receive adequate and humane care provided in the least restrictive environment, considering their preferences for treatment. Admonish all recipients of their rights, including the right to refuse generally accepted mental health services, and train staff that if such services are refused, they should not

be given unless they are necessary to prevent the recipient from causing serious and imminent physical harm and no less restrictive alternative is available.

2. Train staff to complete a Restriction of Rights Notice whenever any rights of the recipient are restricted and record this in the clinical record. Revise the restraint policy to include this Mental Health Code requirement.

3. Train staff that restraint may only be used as a therapeutic measure to prevent a recipient from causing harm to himself or others. Additionally, restraint may only continue for longer than 2 hours unless within that time a nurse with supervisory responsibilities or a physician confirms in writing that the restraint does not pose an undue risk to the recipient's health in light of their medical condition. Ensure that 15 minute checks of the patient are completed throughout their entire restraint episode.

4. The record shows that the recipient was admitted on a petition for involuntary treatment and this is the authority the hospital relied upon to treat the recipient. This document allows for the detention of a recipient so that he may be assessed for further treatment. The petition should be accompanied by the certificate completed by a qualified examiner who indicates that the recipient is in need of immediate hospitalization and provides the clinical observations and other factual information used to reach a diagnosis (this particular certificate said only: "Aggressive behavior"). In the extant case the petition was not completed- staff did not indicate that the recipient was apprised of his rights and there are no rights documents signed by (or for) the recipient. Additionally, the petition indicates that the recipient was developmentally disabled which is inaccurate. And finally, the certificate is completed approximately 5 hours after the recipient was admitted and 4 hours after he received forced emergency medication and restraint. Train staff that the petition only allows for the detention of the patient for examination and that the certificate provides the authority to treat. Ensure that the provision of rights information is documented.

5. Train staff to include a physician's statement of decisional capacity whenever psychotropic medications are part of the treatment protocol.