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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 17-030-9026
Norwegian American Hospital

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Norwegian American Hospital (Norwegian). It was alleged that a 93 year old female patient was restrained and forced to lie in her own body fluids for no reason. The hospital then stopped the patient's physical therapy because she fainted in the hospital bathroom, and thus the recipient was not able to walk after being bedridden for 8 days. Also, the hospital did not address the written grievance that was submitted by the recipient's son/Agent under the Power of Attorney for Healthcare. If substantiated, this would violate the Center for Medicare and Medicaid Services, Department of Human Services' (CMS) Condition of Participation for Hospitals (42 CFR 482.13).

Norwegian is a 200-bed, acute care community hospital serving residents of the near northwest Chicago area.

To review these complaints, the HRA conducted a site visit and interviewed the Legal Counsel, the Director of Care Management, the Patient Experience Officer, the Associate Chief Nursing Officer (CNO), and the Vice President of Quality and Corporate Compliance. Policies were reviewed, and records were obtained with the consent of the Agent for Power of Attorney for Healthcare.

COMPLAINT SUMMARY

The complaint indicates that a 93 year old non-verbal dementia patient had a rash on her inner thigh. She was admitted to Norwegian (medical floor) on 1/18/17 at approximately 4:00 p.m. The patient's two sons (one being the Agent for Power of Attorney for Healthcare [henceforth the Agent]) remained with the patient until 10:00 p.m. The Agent informed staff that his mother needed help in getting to the bathroom, and staff said they would move her to a room near the nurse's station where they could easily monitor her. That night, the staff allegedly moved the patient to the 2nd floor. When the Agent arrived the following day, he was informed that his mother had been moved, and when he arrived in her room, she was allegedly tied to the

bed and could not move. She was allegedly lying in her own urine. The patient was crying and hysterical. When the Agent asked why she was restrained he was allegedly told that the patient was not eating. That night, the Agent went to the hospital CNO and complained. She allegedly indicated that a training meeting would be implemented to alert staff to proper procedures.

Two days later the patient was given assistance in walking down the hallway for "physical therapy." When she returned to her room, she fainted in the bathroom. As a result of this event, all the physical therapy allegedly ceased. Thus, the recipient remained bedridden for 8 days and could not walk by the time she left the hospital.

The Agent allegedly wrote a letter to the President and CEO of the hospital, and visited the hospital four times to get the administration to address his grievance. No one called or wrote to him in response. One day the Agent was allegedly in the President's office when the President walked in. The Agent asked him if he received the letter and he said that he had. Allegedly, the President then sent the hospital COO (Chief Operating Officer) out to speak with the Agent and he spoke with her for about 30 minutes. The Agent never received a written response to the complaint.

FINDINGS

According to the record, the patient in this case was treated on a medical floor for a rash and never experienced a fall. She had two incidents where she passed out while using the restroom and one incident where she became dizzy upon getting out of bed. The dates for events in the hospital record do not coincide with the dates offered by the complainant.

The record (Nursing Notes) indicates that the patient was admitted to Norwegian on 1/18/17 at 5:45 p.m. accompanied by her two sons. Her complaint was a rash on her left lower body. There are no notes entered for 1/19/17, and then, on 1/20/17 at 3:26 p.m. Nursing Notes indicate that the patient had walked for 60 feet that day with assistance from a physical therapist, "with no loss of balance or signs or increased fatigue noticed." The notes then state, "Pt was placed on toilet with reports of wanting to use the washroom. During toilet use, patient passed out. CNA present with patient during bathroom use. Code Blue was called by RN. Pt was immediately placed on bed with total assist x three people. Once in bed, patient became awake and aroused. Vitals were taken and were all stable. Patient will be discharged from Physical Therapy at this time until further notice from MD with an updated order to continue with Physical Therapy. Sons x 2 were present for today's initial evaluation."

Further Nursing Notes indicate that the patient remained stable on 1/21/17 and that her physician then spoke with her son regarding discharge: "…. Patient is confused and gets lightheaded when gets up. She has sitter for safety due to recent episode of syncope. Physical therapy is working with patient. She uses walker at home. She has dentures. Son [second son] states that she cannot go home now because she can't walk or sit up in a chair without lightheadedness. MD is aware and suggested to son that she go to skilled nursing for a couple weeks of rehab. Son [second] has agreed. Son [and Agent for Power of Attorney] is the decision maker for pt. Social worker spoke with [Agent] and he has not decided if he wants her to go to skilled care. Application was put in for Obra screen [mandatory needs assessment required for

nursing home admission] per social services. They are also pursuing home health in case [the Agent] decides he does not want skilled nursing." Later, on 1/22/17 the notes indicate another period of dizziness while the patient was using the restroom, however there is no mention in the Nursing Notes of restraints having been applied to the patient at any time.

On 1/24/17 the notes indicate that the Patient was moved: "Pt. endorsed to RN … on 2A. Pt. alert x1. Vitals stable. Pt sent with working IV to right forearm. Pt to go to either St. Joe's or St. Paul's for Physical Therapy. Pt is continent and getting up to bedside commode with 1 person assist…" A note entered at 3:50 p.m. the same day shows that the patient was accompanied to her new room by both of her sons.

The record shows that a sitter was assigned to the recipient beginning the same day that she was restrained and this record contains an Observation Record created by the sitters. These notes are entered on the dates of 1/19/17 from 7:00 p.m. until 12:00 p.m., on 1/20/17 from 1:00 p.m. until 11:00p.m., on 1/21/17 from 7:00 a.m. until 11:00 p.m., on 1/22/17 from midnight until 7:20 a.m., on 1/22/17 from 7:00 a.m. until 10:00 p.m. and on 1/23/17 from 7:00 a.m. until 3:00 p.m. Only the notes entered on 1/22/17 indicate that the patient was becoming uncooperative and agitated: "Pt uncooperative, will not allow vitals or blood drawn, trying to pinch, hit. Pt pulled off tele monitor and gown, tried to rip IV off arm. Becoming increasingly confused and agitated."

There is no mention of the restraint event in the nursing notes. There is a mention in a Hospital Discharge Report in an entry for 1/19/17 at 6:53 a.m. named "Fall". It states, "Pt alert orient to self only confused and high fall risk Pt on bed alarm but continue to try and climb out of bed order for soft wrist restraint and 1 to 1 sitter given per Dr. …" There is another entry in a Discharge Audit section of the record which indicates that at 7:00 a.m. the patient was placed in left and right soft leather restraints, with her behavior described as "confused; interfere with care unable to follow direction; uncooperative." A two hour re-assessment schedule is initiated. The entry for 900 a.m. in this section indicates that the patient's hygiene was checked, foods and fluids offered, toileting was offered, however "irritable" was added to the above behaviors for this entry. The patient's vitals (blood pressure, pulse, and respiration) are also included. Another later entry (time is not indicated) shows the same information as above, however by this time the behavior is described as "unable to follow direction." There is one other entry in this section and it indicates that the restraints remain in place because the patient is "unable to follow directions" and "uncooperative". It is not clear from this document when the recipient was released from restraints.

The record contains a Patient Assessment document. This three page record indicates that the patient was in restraints at 7:00 a.m. and re-assessed at 9:00 a.m. and 11:00 a.m. The descriptions of the patient's behaviors are the same as in the Discharge Audit and it shows that the patient was checked for safety, hygiene needs, offered fluids/food, and toileting. The patient's vitals are also included. This set of file entries also do not indicate when the patient was released from restraints.

The record does not contain any information regarding the patient's ability to walk when she left the hospital. It does indicate that the patient was mobile and able to walk with assistance

to the restroom and also to use a commode at her bedside. Sitter notes from 1/20/17 through 1/23/17 indicate that the patient was assisted to the bathroom and that when given the opportunity to ambulate to the restroom the patient attempted to leave down the hallway.

The record contains a letter from the hospital Patient Experience Officer to the patient dated 3/29/17 indicating that the hospital had received the patient's complaint as well as a complaint from the patient's son dated 3/19/17. The letter indicates that the patient's medical record was being reviewed and that the complaint was being fully investigated. The letter indicated that another letter would be forwarded with the conclusion of the investigation with an anticipated completion timeframe of 30 days. At the site visit the Patient Experience Officer explained that this letter was sent to the patient, however it was not sent to the patient's Agent because his contact information was not known at that time.

The record contains a letter dated 4/07/17 from the hospital Chief Medical Officer to a member of KEPRO, the hospital Quality Improvement Organization. It states, in part, "…. *We have been modeling our fall prevention program after the current Agency for Healthcare Research and Quality (AHRQ) Fall prevention toolkit. In addition, we have been heavily involved in fall prevention activities through the Illinois Hospital Association, the Great Lakes Hospital Improvement and Innovation Network (HIIN), the Midwest Alliance for Patient Safety (MAPS) Patient Safety Organization and the ECRI Institute so that we may implement best practices and clinical guidelines for fall prevention in the acute care setting.*

In the specific case of [the extant patient], the patient presented to the hospital on 1/18/17. The patient became extremely confused and was interfering with her care. In addition, the patient was an extremely high fall risk with a Morse Fall Risk Assessment of 110. This is 2.5 times higher than the Morse Fall Scale High Risk of greater than 45, which has been clinically validated in studies for over 30 years. The staff had done every other type of intervention including frequent monitoring, bed alarm, and placing the patient on all other high fall risk precautions. Unfortunately, the patient was only oriented to self and despite all of these fall reduction actions, the patient was still interfering with her care and at an extremely high risk for falls. An order was obtained and the patient was placed in soft wrist restraints at 0653 on 1/19/17. A second order was written at the same time for a 1:1 sitter. The family was asked if they could come in and sit with the patient. The patient was reassessed for restraint safety at 0700, 0900, and 1100 before additional staffing arrived and the patient provided a 1:1 sitter. The patient was then immediately taken out of restraints and the patient was provided with that additional 1:1 sitter for almost the entire duration of her stay until discharge on 1/26/17. We almost never restrain a patient for fall prevention; however, in this situation, the clinician believed the benefits of short-term restraints outweighed the extremely high risk of patient harm. Since there are no evidence based guidelines on restraints in fall prevention for this acutely at risk situation, we believe we acted in the highest regards for patient safety and well within the standard of care in a very complex situation…."

The record contains a letter dated 4/18/17 from KEPRO, the hospital Quality Improvement Organization. It indicates the Final Determination which resulted from their review of the complaint, the medical information, and any correspondence provided. For the complaint of the patient being restrained during her hospitalization, they indicated that

"According to 'Falls: Prevention in nursing care facilities and the hospital setting at UpToDate [an evidence-based clinical decision support resource to help practitioners make decisions at point of care]*, there is no evidence to support the use of physical restraints to reduce falls in the nursing home or inpatient setting."* In the Analysis and Findings section of the report it states, *"In the professional opinion of our peer reviewer, the services that were the subject of this concern did not meet all applicable professionally recognized standards of health care…"* The letter also addresses the complaint of the patient's lethargy during hospitalization. The Analysis and Findings section of the letter states, *"In the professional opinion of our peer reviewer, the services that were the subject of this concern did meet all applicable professionally recognized standards of health care."*

Norwegian provided a response to the opening letter of the HRA. The letter, dated 6/01/17, was submitted by the hospital's President and Chief Executive Officer. It reads:

"This is in response to your letter dated May 11, 2017 regarding an alleged violation of CMS Rule 42 CFR 482.13 against one of our patients.

As requested, I am enclosing all medical records regarding the patient's inpatient stay, the inquiry from KEPRO (our Quality Improvement Organization), our response to KEPRO, and their letters of determination. KEPRO agreed that there was no deviation from the standard of care although their opinion differed with our use of restraints regarding the referenced patient. We have revaluated our restraint process and enhanced our policy.

Norwegian American Hospital is modeling the fall prevention program after the current Agency for Health Care Research and Quality (AHRQ) and utilizes their fall prevention toolkit. In addition, we have been actively involved through the Illinois Hospital Association (IHA), the Great Lakes Hospital Improvement and Innovation network (HIIN), the Midwest Alliance for Patient Safety (MAPS), Patient Safety Organization (PSO), and the ECRI Institute [Emergency Care Research Institute]. By utilizing resources provided by these organizations, Norwegian American Hospital is able to implement best practices and clinical guidelines for fall prevention in the acute care setting.

In the specific case of [the extant patient], the patient presented to the hospital on 1/18/17. The patient was extremely confused and non-compliant with her care. The patient was extremely high fall risk, scoring greater than a 45 on the Morse Fall Scale, which is a tool that has been validated in clinical studies for over 30 years. The staff performed every type of intervention available to protect this this patient, including frequent monitoring, bed alarm, and placing her on high fall risk precautions and utilized a sitter to monitor her. Unfortunately, the patient was only oriented to herself, and despite all of our efforts, she remained non-compliant with her care and was continually assessed as a high risk for falls.

Based on the falls assessment and patient safety concerns, the nurse contacted the attending physician who placed an order for soft wrist restraints at 0653 on 1/19/17. A second order was written simultaneously for a sitter, but one was not immediately available. The family was notified and asked if they could come and sit with the patient. The patient was reassessed at 0700, 0900, and 1100 before additional staffing arrived and the patient was immediately

provided a 1:1 sitter. The restraints were removed from the patient the moment the sitter arrived, and the patient was provided with that 1:1 sitter for the majority of the duration of her stay until discharge on 1/26/17.

During her stay, [the patient] experienced an episode that was diagnosed by her neurologist as vasovagal syncope (non-cardiac syncope), which was likely precipitated by her use of the bathroom.

Physical therapy was discontinued based on the non-compliance of care. This is clinically indicated as there can be no benefit to the patient without active participation. Once the patient was stabilized, she was transferred to a nursing home with physical therapy services, and she began to participate and her sons reported that she was making good progress…."

The hospital record does not contain a response letter to the patient's Agent or a final response to the patient's initial complaint.

HOSPITAL REPRESENTATIVE RESPONSE

Hospital representatives were interviewed about the restraint episode. They reported that they try not to restrain patients, however, less restrictive measures had failed with this patient and their only other less restrictive option was to secure a safety sitter for the patient. A sitter was not available at the time, so staff asked the patient's sons if they could sit with the patient but neither one of the sons was available. Staff were asked if an Incident Report is generated when restraints are used and they indicated this is not the practice. HRA representatives were concerned that there is so little information in the record about the clinical rationale for the restraint and staff pulled additional information from the record that showed that the recipient had been unable to follow directions, uncooperative, confused, and interfering with her care. Staff were asked if a flow sheet is used to ensure that all safety measures are taken during the restraint and they indicated that this is not part of the protocol. HRA representatives mentioned that Norwegian hospital policy indicates that when a patient is restrained that they will be given a notice of this rights restriction, however staff were unaware of this (further review by the HRA revealed that this applies only to behavioral health patients). They did indicate that the record shows that the patient was informed of the reason why she was being placed in restraints. Hospital representatives also indicated that the hospital restraint policy had been enhanced since this event and that training in the area of restraint was modified.

Hospital representatives were interviewed about the hospital's response to the Agent's complaint. They reported that the Chief Nursing Officer met with the Agent on the day of the restraint event and then met with the patient's family and the patient nearly every day of the patient's hospitalization. At the same time an investigation was initiated by the hospital and was then elevated to the Hospital Executive Team for review. On 4/28/17 a meeting was held with the patient's sons and the Executive team members (COO and CMO) to review the complaint. On 6/06/17 the Agent again contacted the hospital stating that he had received some hospital bills that he did not understand and also he complained that some of his mother's clothing was not returned when she left the hospital. Another meeting was held on 7/13/17 with the hospital Chief Operating Officer, the Chief Nursing Officer, Assistant Chief Nursing Officer, the Vice

President of Quality, the Patient Experience Officer and others, to review the progress on the complaint and next steps. On 7/26/17 the Legal Counsel and the Patient Experience officer contacted the Agent informing him of the outcome of the inquiry. The hospital agreed to waive the charges for the hospitalization and a check was issued for reimbursement for the patient's lost clothing. The Agent signed for the check in person on 7/30/17. The record does not contain a formal written response to the complainant.

STATUTES

The Center for Medicare and Medicaid Services (CMS) Conditions for Participation (42 CFR 482.13) state, "*A hospital must inform each patient or when appropriate, the patient representative, of the patient rights, in advance of furnishing or discontinuing patient care whenever possible." Also, (2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. ... At a minimum:... (iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion."*

Section (e) of the CMS Conditions for Participation 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 and 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." Section (C) states, "Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff person, or others from harm."*

Other provisions of the CMS Rules for restraint include:

- It must be used in accordance with a written modification of the patient plan of care.
- It must be implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.
- It must be ordered by a physician or other licensed independent practitioner who is responsible for the care of the patient and authorized to order restraint and seclusion by hospital policy in accordance with State law.
- It must be ordered for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient or others.
- The record must include documentation of a face-to-face medical and behavioral evaluation one hour after the start of the restraint that includes a description of the patient behavior and the intervention used, alternatives or other less restrictive interventions attempted, the patient condition or symptoms that warranted the use of restraint, and the

patient response to the interventions used, including the rationale for continued use of the intervention.
- It must be applied by staff who are trained and able to demonstrate competency in the application of restraints.

The Illinois Power of Attorney Act (755 ILCS 45/) includes the Power of Attorney for Health Care Law (755 ILCS 45/4-3) which describes the general principles:

The health care powers that may be delegated to an agent include, without limitation, all powers an individual may have to be informed about and to consent to or refuse or withdraw any type of health care for the individual and all powers a parent may have to control or consent to health care for a minor child.

HOSPITAL POLICY

At the time of case opening for this investigation Norwegian provided the hospital policy and procedure for Restraint (#BM 3.050). During their response to the complaint and before the HRA site visit the policy was enhanced as indicated in the hospital response letter. The new policy (PC503) complies with all Federal and State mandates for the application of restraints and it includes the following enhancements:

1. The policy distinguishes between restraints used for violent and self-destructive behavior and restraint for non-violent or non-self-destructive behavior (Restraint initiated to control behavior that is non-violent or non-aggressive in nature. A restraint device may be used to protect the patient from accidental/intentional self-discontinuation of therapeutic interventions such as IV lines, catheters, ventilator, pacemaker, etc., when alternative interventions have failed to promote medical healing.). The policy states that restraints will be used in a manner to preserve patient rights, dignity, self-respect, and well-being. The new policy adds, "The least restrictive form of restraint shall be used that protects the physical safety of the patient, staff and others."
2. The policy offers recommended alternatives to restraint utilization and provides environmental conditions to address Fall Risk:

    - Utilize diversionary devises/activities such as playing cards for counting, towel folding, soft music
    - Provide a quiet, non-stimulating environment
    - Keep bed in low position with two side rails up
    - St bed exit and /or chair alarm
    - Relocate the patient near the nurses' station
    - Maintain appropriate lighting
    - Keep needed items in reach such as telephones and tissues
    - Insure patient uses proper footwear

3. The policy requires that an order from a physician must be obtained immediately or as soon as clinically appropriate to initiate restraint. The order must be documented on the appropriate order form and include the reason for the intervention. The physician must see and evaluate the individual in person within 24 hours of initial application. The policy

states that for all restraint, the RN will assess the patient at the time of initiation of restraint and at least every two hours thereafter while the patient remains in restraint.

4. The policy states that an RN or CNA will observe the patient as part of hourly rounds to assess for the continued safety, well-being, comfort, and dignity of the patient. At a minimum of every two hours, the RN or CNA will monitor circulation, (including skin integrity), movement, and sensation, and provide range of motion, hydration, toileting, vital signs, and other relevant care, as appropriate to the type of restraint and document all monitoring in the designated restraint forms.
5. As early as possible in the restraint process, the patient will be made aware of the rationale for restraint use and the behavioral criteria for release. If the patient has consented to have their family/significant others kept informed about their care, they will be informed of the need to use restraint as soon as practicable.

CONCLUSION

The CMS rules for the use of restraint in hospitals indicate that restraint is ordered for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient or others- it is not to be implemented for "convenience." Hospital policy states that the least restrictive form of restraint will be used that protects the physical safety of the patient. In this case the record shows that when this patient was admitted to the hospital it was known that she may require assistance to and from the bathroom. Additionally, this patient was documented as suffering from dementia, meaning that she might not remember to alert staff when she needed to use the restroom. What this suggests is, that unless the patient had an assigned sitter (the least restrictive form of restraint), she would remain in restraints throughout her hospitalization "for her safety." The fact that the hospital did not have a sitter is not justification for the patient being placed in restraints and there is no documentation in the record that she was a danger in any other way- "Uncooperative" and "interfering with her care" do not rise to a level of self- destructive behavior that would necessitate restraints. We can rely on the record (audit notes) to show that for her restraint episode the patient was given toileting (and thus did not have to lie in her own body fluids), however the HRA substantiates the complaint that a 93 year old female patient was restrained for no adequate reason and in violation of the CMS Rules and hospital policy.

The hospital record shows that although the patient's physical therapy was discontinued after an episode of fainting, the patient continued to ambulate throughout her hospitalization. If the patient was unable to walk when she was discharged from the hospital the HRA cannot determine that the patient's lessened mobility caused this condition. The HRA does not substantiate the complaint that the cessation of physical therapy caused the patient to remain bedridden, and thus the patient was not able to walk after being bedridden for 8 days.

The hospital staff acknowledged that although they met with the patient's Agent nearly every day while his mother was hospitalized, the letter which was sent to the patient indicating that the hospital would investigate the complaint was never sent to the substitute decision maker, who was the complainant. Additionally, it was not clear if a letter was sent to formally acknowledge the investigation results even though the substitute decision maker was reimbursed.

And finally, the investigation was opened on 3/29/17 and the reimbursement was made on 7/30/17. In the hospital's original acknowledgement of the investigation it stated that another letter would be forwarded with the conclusion of the investigation with an anticipated completion timeframe of 30 days. If circumstances had extended the time the hospital required to complete the investigation, another letter should have been forwarded to the Agent to inform him of the delay. However, the record shows that the Agent met frequently with the hospital staff and the hospital not only waived the cost of the patient's hospitalization but also reimbursed the patient for her missing possessions. The HRA does not substantiate the complaint that the hospital did not address the written grievance that was submitted by the patient's Agent.

RECOMMENDATION

1. Complete staff training on the use of restraint with specific focus on special needs patients, especially those with cognitive impairments.

2. Ensure that the restraint documentation reflects the clinical justification for the use of restraints. If the use of restraints is an unusual occurance, then it warrants the documentation to reflect what extraordinary events necessitated it.

3. Complete all documentation required under the law and hospital policy for the restraint episode and include it in the patient's record.

SUGGESTION

1. Alert family members and substitute decision makers when their loved one is placed in restraints.

2. Review the information that was included in the hospital Quality Improvement Organization's response which provides evidence-based data that "there is no evidence to support the use of physical restraints to reduce falls in the nursing home or inpatient setting."

3. Formalize all steps of complaint investigation by issuing the appropriate written correspondence to complainants as outlined in hospital policy.