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HUMAN RIGHTS AUTHORITY-CHICAGO REGION

REPORT 18-030-9012
Community First Medical Center

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission reviewed the care and treatment provided to a mental health patient in the Emergency Department (ED) at Community First Medical Center in Chicago after receiving a complaint that the patient was detained, restrained and treated without cause, consent or authority and that her grievances were not responded to appropriately.

Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Centers for Medicare/Medicaid Conditions of Participation for Hospitals (42 CFR 482).

Community First is a 299-bed hospital that sees one to five mental health patients for evaluation in its ED every day; it has no psychiatric unit within the facility. The HRA met with the physician and the nurse who cared for this patient along with a patient coordinator and the hospital's attorney. Relevant policies were reviewed as was the patient's record with proper authorization.

COMPLAINT SUMMARY

It was reported that the patient was taken to the ED for a psychiatric evaluation during which the attending physician said he needed blood and urine samples. The patient refused and was allegedly held down by guards and a male nurse with "rope ties" and the blood was taken. The physician then proceeded with the urine sample by saying, "You either give it or I go in and get it", and the patient went in a bedpan. It was further reported that she then felt something stabbing her shoulder and the physician saying that it was something to shut her up. She filed a grievance with the hospital and has had no response.

FINDINGS

Record review

The patient arrived in the ED at 6:10 p.m. on 1/8/2017 by the fire department with complaints of agitation and suicidal ideation according to the record. The sixty-year-old reported being upset because her daughters would not celebrate her birthday and said to them that she could have taken all of her Xanax and no one would notice. She told the physician she was trying to make a point but had no suicidal or homicidal intentions. She complied with a physical exam, which, per the notations, appeared all negative. She was however, described as nervous, anxious, tearful and she was yelling. The attending nurse's entry stated around the same time that the patient denied harmful ideations as well but that she was noticeably agitated. He also wrote that the patient's daughter told ambulance personnel she had found a google search of lethal Ativan doses on her mother's computer, a statement repeated in the physician's notes.

At 7:15 p.m. a resident noted that the medical clearance was pending bloodwork, "Patient refusing bloodwork. Will give Haldol and Ativan." She also wrote that a crisis worker had evaluated the patient who met criteria for psychiatric admission in the meantime. The diagnosis was suicidal ideation, and the plan was to transfer to an inpatient facility. The nurse added at 7:20 p.m. that the patient remained uncooperative with medical personnel and that he would continue to monitor.

The crisis worker's evaluation referenced her determination for admission and her consults with the attending physician and resident who all agreed to the admission for the patient's safety and stability.

At 8:43 p.m. the nurse quoted the patient to say, "If I was hospitalized for 60 days and wanted to kill myself, day 61, I'd get out and just kill myself. How would you stop me?" He alerted the physician and the crisis worker. A petition for involuntary admission was completed at 9:00 p.m. by the crisis worker and a certificate followed right after from the physician, both asserting their observations, patient quotes and the need for safety. At 9:45 the nurse noted the patient to be sitting on her bed while being visibly agitated. At 10:21 he wrote that she was still agitated and continued to be uncooperative with medical personnel, and by 10:49 that she became increasingly agitated saying she would start "throwing shit around" and "set off explosives". Haldol and Ativan injections were given at 11:05 and 11:12 respectively. Blood and urine samples were then collected, and at 11:49 she was asleep.

Regarding physician orders, those for bloodwork and a urine toxicology were placed at 6:52 and those for the medications at 7:35. Urine was collected at 6:53, and there is nothing in the record to indicate any struggle or verbal exchange with the patient in doing so. The results were positive for opiates. The injections were given just after 11:00, and again there is no information about any exchange with the patient. The documentation showed that the nurse gave the injections, not the physician. An order for non-violent restraints was placed at 11:10 as the injections were being administered, but they were never applied according to the chart.

There is no documentation in the record provided to suggest that the patient asked to speak with someone or to file a grievance about her experience at Community First.

Statements

Asked to explain his documentation about the patient, the nurse recalled her being jittery, twitching, mostly uncooperative with her daughters at first and then with the staff and that she did not want to be there. She never got physically aggressive, but she was escalating for sure and at some point she threatened to throw shit around and said she would set off explosives. That was when they decided to give the injections after she was allowed to refuse and given quite a lot of time to relax on her own.

The physician said that the patient was very upset and agitated. Her behavior, anger and verbal abuse toward the staff caused him concern and that there could be something organic, medical. He wanted the labs to rule out and to review white blood counts. He insisted that while labs are preferred he would not force them on a patient if they showed no medical need. He also said that the restraints were ordered to make it safe to do the bloodwork but that he thought they were not used. We asked about reciting the patient's rights before the certification exam and the physician said he had not done that although he signed that he had. He was not aware of what the patient's related rights were exactly.

Neither the nurse nor the physician recalled guards holding the patient down or her being rope-tied and the physician could not recall saying the medications were to shut her up as claimed. They said it was hard to remember.

Regarding training on the Mental Health Code's processes, the physician and nurse offered examples of limited topics about filling out petitions and certificates and on maintaining safety and de-escalation techniques but nothing more specific to a patient's rights protections.

The patient coordinator was asked whether she met with or received a grievance from the patient. She said she had talked with her and that she went on and on about being in the ED and that she never asked to file a grievance. The coordinator said she thought the patient was a "nutty fruitcake." She reviewed the record and found nothing to pursue and said that an investigation and written response were not necessary.

CONCLUSION

Detention:

The hospital's Transfer of Adult or Minor to a Mental Health Facility policy requires the completion of a petition and certificate that includes the required supportive information outlined in the Code.

The Code allows a patient to be detained for evaluation for up to twenty-four hours upon presentation of a petition for involuntary admission, which shall assert the reasons and observations of the petitioner the admission (405 ILCS 5/3-600; 601). A certificate by a physician or other qualified examiner must follow the petition which includes a statement that the examiner discussed the patient's rights before the exam began (405 ILCS 5/3-602; 208). Under 3-208,

Whenever a petition has been executed pursuant to Section…3-601…, and prior to this examination for the purpose of certification of a person 12 or over, the person conducting this examination shall inform the person being examined in a simple and comprehensive manner of the purpose of the examination; that he does not have to talk to the examiner; and that any statements he makes may be disclosed at a court hearing on the issue of whether he is subject to involuntary admission.

In this case the crisis worker and the physician completed the petition and certificate within two hours of the patient's arrival, and each document included their assertions of the need for hospitalization for safety and stability. They physician however, failed to advise the patient of her rights before the examination and signed that he had. A rights violation is substantiated.

Restrained and treated:

Hospital restraints policy states that they are used only when clinically justified or when warranted by patient behavior that threatens safety. They are ordered by a physician and strict monitoring is to follow. The policy separates violent and non-violent uses.

Unless overlooked, the hospital has no policies for the treatment of mental health patients to include informed consent on capacity determinations, right to refuse, standards for emergency medications and rights restrictions.

The Code calls for restraints only when necessary to prevent harm and never for coercion or staff convenience (405 ILCS 5/2-108). An adult recipient shall be given the opportunity to refuse mental health services including medications, and if refused they shall not be given unless necessary to prevent serious and imminent physical harm and no less restrictive alternative is available (405 ILCS 5/2-107). Treatment may begin upon the completion of one certificate. The recipient shall be informed of his right to refuse medication and if he refuses, medication may not be given unless necessary to prevent serious harm to himself or others (405 ILCS 5/3-608). Whenever any right under Chapter II is restricted, a notice of the reasons why must be given to the recipient and any person or agency he so designates and must be entered in the record (405 ILCS 5/2-201).

Although a restraint order was written they were never used, at least according to the documentation. Questions remain about whether the injections were actually given to collect the

blood sample when the resident wrote that the patient was refusing so medications would be given and then the blood was drawn the moment after they were given. The Code allows a patient to continue refusing medication unless it becomes necessary to prevent serious physical harm, and since they staffs' documentation and statements about her escalation and threats to throw things, not the unlikely explosives, suggest a need to prevent harm, the HRA will defer to their decisions without more factual evidence otherwise. And, the nurse gave her multiple opportunities to refuse while attempting less restrictive alternatives at which point consent is not required. The only missed step was in not providing written notice of why her right to refuse medication was restricted or to have anyone of choice notified of the restriction, a substantiated rights violation.

Grievance:

Community First's Patient Grievances policy defines a grievance as any complaint regarding patient care, abuse or neglect. Whether received during or after an admission, *it is any complaint regarding patient care provided*. A grievance can be initiated by verbally contacting the designated hospital representative. A complaint that can be resolved promptly by staff present is not a grievance. A written response within seven days of acknowledgment must be provided that includes the necessary elements under the Conditions of Participation for Hospitals.

The Centers for Medicare/Medicaid Conditions of Participation for Hospitals requires an established process for prompt resolution of patient grievances, including a timely written response that reveals the hospital's decision, contact person, steps taken to investigate, results and the dates of completion (42 CFR 482.13).

The patient coordinator said that she spoke with the patient at her request and that she went on and on about being in the ED and that she never asked to file a grievance. Nowhere in the hospital's policies or CMS Rules is a patient required know the difference between a complaint and grievance or when to say the correct word to initiate one. She wanted to see the patient advocate about complaints regarding her care in the ED that certainly could not be resolved by staff present and the coordinator simply reviewed the chart and then ignored the patient. The HRA cannot imagine given the patient's alleged experience what was not necessary to follow up as stated by the coordinator and she offered no examples. A violation of policy and the Conditions of Participation is substantiated.

RECOMMENDATIONS

-Instruct all physicians and qualified examiners to advise patients under examination for certification of their rights prior to the examination. (405 ILCS 5/3-208; 602).

-Instruct all appropriate ED staff to complete restriction notices whenever a mental health patient's rights are restricted. (405 ILCS 5/2-201). Notices can be downloaded from the same Dept. of Human Services web library where petitions and certificates are found.

-Provide Mental Health Code-specific training to ED and risk management/patient coordinator staff.

-Retrain the patient coordination staff on the grievance policy and procedures and provide this patient a required, appropriate written response to her complaints.

SUGGESTIONS

The staff were unaware of the Code and asked what we kept referring to, and, they seemed surprised to learn that an involuntary mental health patient does not automatically lose the right to provide consent or whether their capacity can determine the course of treatment. In addition, the nurse said that he never completes petitions and that the crisis workers always do. Nurses and other staff should be trained on completing them in case of any significant delay in the crisis worker's arrival or evaluation. It is the presentation of a petition that gives the authority to detain and should be done when the patient is not allowed to leave. Ask EMS personnel and the police to complete petitions when they arrive with patients. They have the initial observations. Although the physician gave numerous examples of concerns for organic/medical reasons to pursue lab work on the patient, his record reflected nothing of the sort. These injections seem to be given for necessity under 2-107 and 3-608, but the hospital is encouraged to be sure that any treatment pursued for medical reasons over a patient's objections is appropriately documented and based on the patient's lack of capacity to give consent (405 ILCS 5/2-111). Consider policy development for the treatment of patients with mental health needs on such topics as informed consent, capacity determinations, right to refuse, emergency medication administration and rights restrictions; train staff accordingly.

The Code defines a mental health facility as "…any licensed private hospital, institution, or facility, or section 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). Treatment includes "…examination, diagnosis, evaluation, care…[and] pharmaceuticals…." (405 ILCS 5/1-128). So, the Code applies to Community First. Since the ED sees one to five mental health patients each day, the HRA suggests that the staff be trained on the Code's unique admission and treatment processes immediately.

The hospital should review restraint policies to ensure that Code requirements such as the following are included: In no event may restraint continue for longer than 2 hours unless within that time period a nurse with supervisory responsibilities or a physician confirms, in writing, following a personal examination of the recipient, that the restraint does not pose an undue risk to the recipient's health in light of the recipient's physical or medical condition. The order shall state the events leading up to the need for restraint and the purposes for which restraint is employed. The order shall also state the length of time restraint is to be employed and the clinical justification for that length of time. No order for restraint shall be valid for more than 16 hours. If

further restraint is required, a new order must be issued pursuant to the requirements provided in this Section. (405 ILCS 5/2-108).

The hospital's Abuse, Neglect and Assault policy covers those patients coming into the hospital and mentions nothing about when a patient already in the hospital has alleged to have been abused by hospital staff. 210 ILCS 85/9.6 should be reviewed and added or developed into policy.

COMMENT

We are appalled at the coordinator's remarkable insensitivity toward the patient and expect much better from a patient coordinator, particularly when "Community First remains committed to respecting the unique medical needs of the physically and mentally disabled patient" according to the attorney's introductory letter to the HRA. The "fruitcake" statement was heard by everyone in the room, including the physician, nurse and attorney, and we implore the hospital CEO to reprimand this person and retrain her on her role as a patient protector and caregiver.