FOR IMMEDIATE RELEASE

North Suburban Human Rights Authority
Report of Findings
Edward-Elmhurst Health
HRA #18-100-9016

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Edward-Elmhurst Health. In March 2018, the HRA notified Edward-Elmhurst of its intent to conduct an investigation pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The complaint accepted for investigation alleged while in the Emergency Department, a minor patient was not adequately assessed for the continued use of seclusion.

The rights of mental health patients receiving services at Edward-Elmhurst are protected by the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5).

Background

Edward-Elmhurst Health was created in 2013, when Edward Hospital & Health Services and Elmhurst Memorial Healthcare merged to become one of the larger integrated health systems in Illinois. Edward-Elmhurst Health is comprised of three hospitals — Edward Hospital, Elmhurst Hospital and Linden Oaks Behavioral Health Hospital and provides comprehensive healthcare to residents in the west and southwest suburbs of Chicago.

Methodology

To pursue this investigation, the HRA met with Emergency Department (ED) personnel to discuss the allegations raised in this complaint. The HRA reviewed the patient's clinical record with consent, and hospital policies relevant to the allegations were also reviewed.

Findings

The clinical record revealed data on a 14-year-old patient who had been transferred (after about 5 hours) from a nearby behavioral health hospital for medical clearance because the behavioral health hospital did not have a bed available. The patient arrived to the ED at about 10:00 p.m. on February 23, 2018. He was assessed for suicidal ideation at which time the patient noted to having thoughts of wanting to hurt himself. The ED documentation showed that he presented to the ED in no apparent distress and he was calm and cooperative. He remained in the ED until about 10 a.m. the following day at which time he was transferred to a behavioral health hospital.

The record contained a physician order for the seclusion, written at the time the patient entered the ED, citing imminent risk of harm to self as the clinical justification for the restriction. The order was renewed every two hours. The record contained a 15-minute flowsheet that documented the justification, discontinuation criteria, less restrictive alternative, psychological status, physical comfort, circulation, skin condition, range of motion, vitals, etc. During the 12-hour

period, the flowsheet showed that a less restrictive alternative was consistently documented as DA, meaning diversionary activities (per the flowsheet code chart). The patient's psychological status was consistently documented as QU (quiet) or SP (sleeping). The discontinuation criterion was documented as no imminent danger to self/others; follows directions; verbalizes alternative behaviors. The patient's response to this was VU (verbalized understanding). ED notes consistently documented the observed behaviors as sleeping, no distress, continues to rest on stretcher, sitting up on stretcher watching TV, remains cooperative with staff.

At the site visit, it was explained that the patient was referred to Edward Hospital from the on-campus behavioral health hospital to be medically cleared for a transfer to another facility once a bed became available. When the patient arrived at Edward, he was placed in a room in the Pediatric Emergency Department near the nursing station where he could be observed through a window. About a half-hour later when the Pediatric Emergency Department closed, he was transferred to the general Emergency Department. There, he was placed in a small room where he could be observed through the use of a camera at the nursing station, in addition to observation through a small window in the room door. It was stated that regulations call for continuous observation, but not necessarily a one-on-one person in the room.

Hospital personnel stated that seclusion is considered a "state", not a "place". Meaning, the patient could be in seclusion in various places within the hospital, as long as the patient receives the mandated observation and the inability to leave the assigned area. This patient was familiar to hospital personnel and it was stated that the restriction was necessary due to the suicidal ideation and his unpredictability.

The policy for Restraints and Seclusion states that restraint and seclusion use is limited to those situations where there is appropriate clinical justification, based on the assessed behavior needs of the patient, to protect the patient from harming himself/herself or others. Seclusion may be used only for the management of violent or self-destructive behavior. The policy states that seclusion is the involuntary confinement of a patient alone in a room or area from which the person is physically prevented from leaving. The policy further states that Emergency Department patients requiring seclusion are continuously observed in person for the 1st hour and assessed every 15 minutes or more frequently if needed. After the 1st hour, the patient monitoring is continued either in person or through use of video and audio equipment.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 2-109. "Seclusion may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. In no event shall seclusion be utilized to punish or discipline a recipient, nor is seclusion to be used as a convenience for the staff. (a) Seclusion shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, clinical professional counselor, or registered nurse with supervisory responsibilities. No seclusion shall be ordered unless the physician, clinical psychologist, clinical social worker, clinical professional counselor, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of seclusion is justified to prevent the recipient from causing physical harm to himself or others. In no event may seclusion 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 seclusion 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 seclusion and the purposes for which seclusion is employed. The order shall also state the length of time seclusion is to be employed and the clinical justification for the length of time. No order for seclusion shall be valid

for more than 16 hours. If further seclusion is required, a new order must be issued pursuant to the requirements provided in this Section. (e) The person who ordered the seclusion shall assign a qualified person to observe the recipient at all times. A recipient who is restrained and secluded shall be observed by a qualified person as often as is clinically appropriate but in no event less than once every 15 minutes."

The Mental Health Code mandates that seclusion be used as therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. Hospital policy states that seclusion may be used only for the management of violent or self-destructive behavior. The HRA found no document that staff members observed this patient causing physical harm to himself or physical abuse to others nor was he violent or self-destructive. And, being unpredictable is not a reason to impose a seclusion restriction. The allegation that while in the emergency department, a minor patient was not adequately assessed for the continued use of seclusion is substantiated.

Recommendation

Hospital administration must ensure that all staff members are aware of the mandates set by the Illinois Mental Health Code regarding the use of seclusion. This restriction may only be used when staff members have or are observing behaviors that would cause physical harm to the patient or physical abuse to others. Documentation must indicate the same.

RESPONSE

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

Healthy Driven
Edward-Elmhurst
HEALTH

December 11, 2018

Patricia Getchell-Chairperson
Illinois Guardianship and Advocacy Commission
North Suburban Regional Office
9511 Harrison Avenue, W-335
Des Plaines, IL 60016-1565

RE: HRA #18-100-9016

Dear Ms. Getchell:

Thank you for your Report of Findings in the above-referenced case. Edward Hospital recognizes the value of the Authority's investigative work on behalf of disabled persons and we welcome the opportunity to work with you. In the event the Authority votes to make any of its findings public, it may include this Response.

Edward Hospital is dedicated to its mission of providing premier care to its patients. Prior to February 23, 2018 and continuing through this submission, Edward Hospital has demonstrated its dedication to the requirements of The Illinois Mental Health and Developmental Disabilities Code, including but not limited to Section 2-109. By preparing, submitting and executing this Response, Edward Hospital does not admit the truth of facts alleged or that the cited deficiency exists and does not admit to the alleged statements, findings, facts or conclusions forming the basis of the cited deficiency and reserves any and all rights available to it under the law to challenge in any legal, regulatory or administrative proceedings all such matters.

The Report of Findings recommends that Administration ensure staff are aware of the Illinois Mental Health and Developmental Disabilities Code mandates regarding seclusion and that seclusion may only be used when staff have or are observing behaviors that would cause physical harm to the patient or physical abuse to others. Edward Hospital contends that this patient exhibited such behaviors at the time the care at issue was rendered. This patient was transferred to the Edward Hospital Emergency Department at approximately 10:00 p.m. for medical clearance to be transferred to a behavioral health hospital with bed availability. Upon presentation to the ED, staff observed behaviors putting the patient at risk for self-harm. Specifically, the patient demonstrated suicidal ideation including a plan to kill himself by hanging.

Cooperation, rest and sleeping do not remove the suicidality expressed by this patient. The Authority would have Edward Hospital wake or disturb the patient to remove him from seclusion, and potentially further agitate him or cause him greater harm. Respectfully, Edward Hospital errs on the side of caution given the volume of mental health patients cared for on a daily basis.

Edward Hospital's record contains the required documentation and clinical justification for the seclusion per the Illinois Mental Health and Developmental Disabilities Code. Edward Hospital provides regular staff education regarding the Illinois Mental Health and Developmental Disabilities Code requirements regarding the use of seclusion and documentation. Thank you for the opportunity to respond to the Report of Findings.

Sincerely,

Bill Kottmann
President and CEO
Edward Hospital