HUMAN RIGHTS AUTHORITY-CHICAGO REGION

REPORT 18-030-9029
UNIVERSITY OF ILLINOIS HOSPITAL

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of potential rights violations in the care provided to a mental health patient in the Emergency and Behavioral Health Departments at the University of Illinois Hospital in Chicago. Allegations were that the patient was detained, restrained and treated in violation of the Code and that his claims of physical abuse by the staff were ignored.

Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Part of the U of I Hospital and Health Sciences System, the hospital's Emergency Department (ED) sees up to 1,500 mental health patients a year for assessment and care. The inpatient behavioral health program includes an adolescent unit and an adult division with two units, one all-male acute and the other co-ed. The HRA met with representatives from administration and both departments to discuss the issues. Relevant policies were reviewed as was the patient's medical record with authorization.

COMPLAINT SUMMARY

The complaint states that an individual was taken to the U of I Hospital's ED for heart trouble where he ended up detained for two days without a petition. He reportedly tried to leave when five security and police officers jumped him, and tackled him to the ground causing abrasions to his elbow and shoulder; he was then restrained and injected for no other reason. He later awoke on the psychiatric unit to find his petition lying next to him, signed by staff but without a personal explanation. It was also said that he told the unit staff about his injuries by the guards, and his complaints were ignored.

FINDINGS

According to the chart, the patient arrived via ambulance around 3 a.m. with complaints of chest pain, anxiety, panic attacks and of hearing children's voices. Medical assessments were carried out through the morning without apparent objection or incident, and no problems were noted. A psychiatry resident completed a petition at 6:22 a.m. claiming the patient exhibited

paranoia of conspiracies and of people running after him. It was followed minutes later with a certificate by an ED physician who referenced the patient's paranoid delusions and occasional outbursts about people in the building wanting to shoot him.

The patient waited throughout the day while various facilities were contacted for admission without much success, and he seemed to grow agitated in the meantime according to nursing flowsheets. By 11:30 a.m. he was asking to leave, and security was put on standby. Entries at about 6:30 p.m. stated that he became aggressive and tried to run away; security re-enforcements were called, and restraints and medications were ordered. Per the ordering physician's corresponding note, "Patient redirected multiple times, since uncooperative, attempted to leave despite [certificate] and assaulted officers/sitter, sedated and restrained for patient and staff safety." Orders and administration records showed that four-point restraints were applied and injections of Lorazepam and Haldol were given at about the same time at 6:33 p.m. There were no rights restriction notices to accompany the emergency interventions.

The restraint order form listed clinical justifications for them and stated that they were to be discontinued at the earliest appropriate time, not to exceed four hours. It also listed the attempted less restrictive alternatives that included reducing stimulations and redirections. The physician completed a face-to-face evaluation within one hour of their application and noted no undue risk in light of the patient's physical or medical condition. An assessment sheet was completed thoroughly every fifteen minutes until the restraints were removed exactly four hours later at 10:30 p.m. when the patient was sleeping.

The patient remained in the ED without further incident until he was transferred to the hospital's own psychiatry unit at 11:00 a.m. the following morning. There were continual nursing assessments and entries throughout, none reflecting any sustained injury from the scuffle with security.

The nurse who was involved with the patient did not remember him or the situation, however the ordering physician did. He recalled spending quite a lot of time with the patient and said he was walking around the emergency room presenting a security issue. He had to be asked repeatedly to stay in his room. He understood the patient's frustration but at some point he started throwing things at the trash can, ignored all redirections and he made a run for it when security was called. He said they held off on restraints and medications as long as they could but then he hit one of the officers on the head. He said the officers held him to get a stretcher but never took him to the ground as the patient continued to strike at them. Asked why the injections if he was being restrained, the physician said he was still so agitated and he wanted to avoid harming himself. He said that an injection is really a last resort and that in this case, less restrictives were not available at that point.

The HRA also met with treating staff from the behavioral health unit, including the attending psychiatrist who said she personally talked to the patient several times about his petition and the involuntary process, and, she knew without a doubt that other staff had as well. Regarding his alleged injuries at the hands of security, an RN said she remembered this patient distinctly and they would have documented and assessed any noted injuries or complaints of injuries. The staff said that at no time did the patient complain of abuse or injuries. They described a three-pronged

investigation process to engage if they had, which would include reviews by risk management, human resources and law enforcement if needed. Neither theirs nor the HRA's record review turned up evidence of any injuries.

Administration followed up on the injury claims after receiving our letter and met with the ED and psychiatry teams as well as the security staff involved. Nothing was discovered after their thorough review.

CONCLUSION

U of I Hospital involuntary admission policies state that the process may begin via evaluation from the ED and calls for the completion of petitions and certificates as Code-required but does not clearly address the need to complete petitions and certificates for the authority to detain anyone in the ED while under evaluation or awaiting admission/transfer. The policy continues to state that once admitted, the petition is to be covered with the patient and a copy given within twelve hours, in line with the Code.

Policies on restraints state that they are only imposed to ensure the immediate safety of the patient and staff. It outlines safety procedures and oversights according to related regulations and it includes a section to address forced medications while in a physical hold, but not while in full restraints.

Under the Mental Health Code, a patient may be detained for an evaluation for involuntary admission on the presentation of a petition which must be followed by a certificate completed within twenty-four hours. A copy of that petition and an explanation of its contents must be provided to the patient within twelve hours of admission. (405 ILCS 5/3-600 et seq.). A patient enjoys the right to refuse all services including medications unless it becomes necessary to prevent serious and imminent physical harm and no less restrictive alternative is available. A patient is free from restraint unless necessary to prevent physical harm and always free from physical abuse from staff. A restriction notice must be completed and provided to the patient and any person or agency he designates whenever his right to refuse medication is restricted or whenever he is restrained. (405 ILCS 5/2-107; 2-108; 2-112 and 2-201).

According to the record, the patient voluntarily entered the ED with medical complaints that were cared for without his objections, and when he was assessed for psychiatric problems he began to display, a petition and a certificate were appropriately completed to detain him for an admission. The documentation and the staffs' statements suggest that the petition and the rights and process detailed within were shared with him within twelve hours following his admission. After about sixteen hours waiting in the ED, he tried to leave while under a petition and became physically harmful striking at the security personnel who tried to stop him. He was appropriately restrained, and while that would seem to be enough to meet the emergency, his right to refuse medication was restricted at the same time. It is questionable whether the need to prevent serious and imminent physical harm and no less restrictive alternative was available, e.g, restraints, was still apparent, although the physician insisted to us that the patient's safety was still at risk. His

documentation however, does not support that. And, there were no restriction notices completed for the restraints and medications. A rights violation is substantiated.

U of I Hospital's policy on patient abuse by employees lists the types of potential abuse including any physical or mental injury intentionally inflicted. It states that no patient shall be mistreated or abused in any way by an employee and that any employee who learns of, witness or suspects such abuse must report to risk management. Employees are to be familiar with the policy, which outlines procedures for alerting the Chief Operating Officer, the police and legal counsel for appropriate reporting requirements as necessary, in compliance with Hospital Licensing Standards (210 ILCS 85/9.6 and 77 Ill. Admin. Code 250.260).

In this case there was no evidence of the patient lodging a complaint about abuse and injuries or recorded injuries that would have been spotted either on his complaints or observations when changing into his gown on admission. The hospital immediately conducted a review on learning of the allegation and came up with no reason to pursue. A violation is not substantiated.

RECOMMENDATIONS

Train prescribers to document the need to prevent serious and imminent physical harm whenever a patient's right to refuse medication is restricted, in and out of restraints. (405 ILCS 5/2-107).

Require ED staff to complete restriction notices and to promptly notify any designated persons or agencies whenever the right to refuse medication is restricted and whenever restraints are applied. (405 ILCS 5/2-107; 108 and 201).

Add the restriction notice requirement to mental health/behavioral related ED policies.

SUGGESTIONS

ED policies should include one dedicated to the detention of a mental health patient under evaluation for involuntary admission. (405 ILCS 5/3-600 et seq.).

ED policies should include one dedicated to the use of emergency forced medications under the Mental Health Code, whether in or out of restraints. (405 ILCS 5/2-107).