FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 19-090-9012
OSF St. Joseph Hospital

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at OSF St. Joseph Hospital. Complaints alleged the following:

1. Improper forced medication procedure.
2. Inadequate provision of prescribed medications while at hospital.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-100). The facility primarily covers McLean County. In 2018 the emergency department had admitted approximately 6000 patients. Of those admissions, 920 had a behavioral health diagnosis. The hospital has an average of 25,000 visits to the emergency department per year. The hospital does not have a behavioral health unit, so admissions to the hospital are based on a primary medical diagnosis. The average length of stay, for a patient, in the emergency department is 235 minutes. The facility has approximately 800 employees plus 200 ministry employees. The HRA has a signed consent and was able to discuss details about the patient's medical records.

COMPLAINT STATEMENT

A patient spent three days in the emergency department (ED) at St. Joseph Hospital. The patient was allegedly forcibly medicated solely because she refused to take the medications orally. She was reportedly held down by five or six nurses who forced medications and would not tell the patient what the medications were. The patient also did not receive her regular, prescribed medications for allergies, post-concussion syndrome, daytime drowsiness, and Attention Deficit/Hyperactivity Disorder (ADHD) while she was in the ED as per the complaint.

Staff Interviews (6.19.19)

The HRA facilitated a site visit at OSF St. Joseph Hospital in Bloomington, Illinois. The meeting was attended by hospital administrative and management staff. The site visit started with discussion of patient admissions to the hospital through the emergency department. All patients admitted to the hospital have a primary medical diagnosis. The hospital does not have a behavioral health unit so if a primary diagnosis is mental health related, they would not be able to be admitted. People are admitted to the hospital one of two ways, via triage or ambulatory through the emergency department. The patient would first be medically cleared to ensure that their behavioral health symptoms were not from an underlying medical condition. Part of the routine treatment a person receives in the ED is to have laboratory work completed such as blood work and a urinalysis. When a patient arrives at the ED, a licensed emergency provider diagnoses the patient after an assessment by nursing staff and/or crisis team. The hospital does not have an employed psychiatrist on staff. If a patient with mental health needs arrives at the emergency room, the licensed emergency room physician provides care. Typically, the hospital relies on a community based provider to assess a person in the emergency department to help determine what level of care the patient needs. The crisis team evaluates the behavior and risks of the presenting patient. If a patient needs hospitalization due to their behavioral health symptoms, the community crisis team would make that recommendation with the ED physician. The crisis team is responsible for the paperwork to admit to a behavioral health unit. They would complete and file the petition for an involuntary certification. The petition would then be filed in whatever county placement is located. Psychotropic medication could be ordered and given in the ED based on the level of risk, if it is medically appropriate, and if the patient's behavior warrants it. The hospital respects patients' rights when they refuse medications, but in case of an emergency the doctor will administer medications against the patient's will. The patient would need to be in a critical state and the medication would be strictly for treatment and given as a standard dose. During this time the hospital would offer the medication to the patient, temporarily hold them while administering it to prevent injury and the hold is released immediately after medication is administered. This situation does not happen very often. Often, individuals in need of a mental health admission would remain in the emergency department until a bed could be located on a behavioral health unit.

This particular patient had three separate visits to the ED with two admissions: December 2016, and August and October 2017. In December 2016, the patient was transported to the ED by emergency services due to the patient being hyperverbal/manic with paranoia and refusal to leave a local store. She was diagnosed by hospital staff of being in acute need. On this visit to the ED, the patient was not admitted but eventually discharged. The hospital reviewed the patient's medical history and the ED physician ordered psychotropic medications. The patient's routine medications for any medical diagnosis, such as allergies would also be given. This information is listed in the hospital computer system. During this visit the patient was given psychotropic medications orally and intramuscular (IM). The patient refused to participate in an EKG that was ordered as routine screening procedure. The individual was discharged on 1/2/17 after the patient's local psychologist assessed the patient as a courtesy to the patient. During this visit the patient did have a rights restriction and was in the hospital emergency department for

three days. A rights restriction in the emergency department could be having personal items placed in a safe spot if staff are concerned for patient/staff safety or have a 1:1 sitter to ensure safety.

In August 2017, this patient arrived at the emergency department from a jail. The jail began the involuntary petition on this individual due to her behaviors while detained. During this stay the patient was admitted for twenty-eight hours as the crisis team attempted to find a behavioral health bed opening for her to receive treatment. Placement was eventually found for her at a hospital in Chicago. During this visit the notes indicate the patient was not taking daily medications and did not understand her arrest. She was at risk of harm due to delusions which led to recommendations for psychotropic medications due to behaviors. The patient used her personal cell phone to call 911 during this visit to the emergency department. The patient was briefly restrained to receive the medication and the local police arrived at the ED during the administration of this medication. The medication was needed for patient safety and for safe transport to the other hospital. The records show the patient received routine medications.

In October 2017, this patient was brought to the ED by a private car driven by a friend. The friend reported to ED staff that the patient was delusional and in need of a psychiatric evaluation. This visit lasted one day before she was transferred to another facility on October 8, 2017. Records indicate the patient received all of her routine medications, but no IM or forced medications.

Lastly, when a patient arrives at the ED and in need of a behavioral health unit, the charge nurse is responsible for the communication of this. The charge nurse would call the local Crisis Response Team and work with them on facilitating this admission.

FINDINGS (Including record review, mandates, and conclusion)

Complaint #1 – Improper forced medication procedure.

The HRA was provided records of three ED visits. The first visit occurred in December. The patient arrived on 12/30/2016 at 10:12 PM and was discharged on 1/2/2017 at 10:57 AM. The patient was brought in due to manic behavior, delusions, and for refusal to leave a store. The ED Notes list a few occasions related to restriction of rights and forced medication procedure. On 12/30/2016 at 11:12 PM, the ED Notes state that a Restriction of Rights was placed on the patient including "Placing the patient in restraint and/or seclusion, Searching of the patient's personal property or removing belongings, Retaining person property and Completion of medical services the patient is refusing so as to complete establishing a diagnosis and formulating a treatment plan." It also states that this was communicated to the patient and the Restriction of Rights form was given. On 12/31/2016 at 10:57 AM, the ED Notes state that the patient's guardian was contacted and made aware of the restriction of rights. The ED Notes state that a second Restriction of Rights was placed on the patient on 12/31/2016 at 10:57 and included the same list as the previous restriction. On 1/2/2017 at 3:25 AM, the ED Notes state that the patient states "they did not have my permission to give me any medication."

The ED Orders section noted that a haloperidol injection was ordered on 1/01/2017 at 1:06 AM, a LORazepam injection was ordered on 1/01/2017 at 1:06 AM, and a LORazepam tablet was ordered on 12/31/2016 at 10:41 PM. The ED Medication Administration record indicated that two psychotropic medications were administered. LORazepam (ATIVAN) was administered via intramuscular injection on 1/01/2017 at 1:30 AM and haloperidol lactate (HALDOL) was administered via intramuscular injection on 1/01/2017 at 1:30 AM. The HRA saw no evidence of any consent for the medication or consent from the guardian. The HRA also found no record of a physician evaluating the patient's decision making ability or providing any written advice regarding the medication. The HRA reviewed the Notice Regarding Restricted Rights of Individuals which was issued on 12/30/2016 at 10:45 PM. Part I of the form noted that the individual was placed in seclusion for reason of "uncooperative with exam and treatment, expresses paranoid thought about people trying to harm her." Part II of the form noted other restrictions and listed restrictions on rights "to refuse medical services – laboratory specimens, to retain personal property, to refuse medical services." Part III of the form listed that a copy of the form was given to the patient in English and that the "Individual wished Guardian and/or Designee notified as indicated below." A second Notice Regarding Restricted Rights of Individuals was issued on 12/31/2016 at 10:00 AM. Part I of the form noted that the individual was placed in seclusion because "Pt has been brought in via EMS for refusing to leave Dollar Tree. Pt found paranoid with pressured speech. Pt refusing treatment." Part II of this form noted other restrictions and listed restrictions on rights "to refuse medical services – x-ray, to refuse medical services-laboratory specimens, to retain personal property, to refuse other medical services, to refuse search of person or living area, to be allowed communication via telephone". Part III of the form lists that a copy of the form was given to the patient in English and that the "Individual wished Guardian and/or Designee notified as indicated below." The form was signed by a registered nurse. The record of the December visit also listed a procedures section. This section noted that "Restraint for Violent/Self-Destructive D/T Behavioral Health Condition" was ordered on 12/30/2016 at 10:40 PM, on 1/01/2017 at 12:29 AM, and on 1/01/2017 at 5:29 AM. The section noted that each order was unscheduled and did not occur.

The second ED visit occurred on 8/15/2017. The patient arrived at 4:00 PM and was discharged on 8/17/2017, to an out of area hospital, at 12:00 AM. The patient was brought in for manic behavior and delusions after being arrested for trespassing. The patient was brought in and evaluated. It was determined that the patient needed to be transferred to a facility with a behavioral health unit. Transport was then arranged. The ED notes state that the ambulance arrived at 11:18 PM on 8/16/2017. The ED Orders section notes that a haloperidol injection was ordered on 8/16/2017 at 11:29 PM and a LORazepam injection was ordered on 8/16/2017 at 11:29 PM. The ED Medication Administration notes that two psychotropic medications were administered. Haloperidol was administered via intramuscular injection on 8/16/2017 at 11:47 PM and LORazepam was administered via intramuscular injection on 8/17/2017 at 12:00 AM. The patient was also prescribed an intermuscular injection of Benadryl 50mg dose that was given on 8/17/17 at midnight which is also the same time she transferred from the ED to an out of area hospital for involuntary admission. The HRA saw no evidence of any consent for

the medication or consent from the guardian. The HRA also found no record of a physician evaluating the patient's decision making ability or providing any written advice regarding the medication. The Ambulance service report on 8/16/2017 lists that the patient is a "danger to self/other", "medical attendant required", and that there is a "need or possible need for restraint". The HRA also reviewed the Notice Regarding Restricted Rights of Individuals dated 8/15/17 at 5:45. Part I of this form specific to Physical Hold/Restraint/Seclusion/Emergency Medication Restrictions noted that the patient was placed in seclusion for the reason of a "psych eval, hallucinations". Part II of this form titled "Other Restrictions" documents that the patient had a restriction placed on certain rights: "to refuse medical services-xray, to refuse other medical services, to refuse medical services-laboratory specimens, and to retain personal property". This same form is signed by a registered nurse and a copy was given to the individual in English and the form stated that the "Individual wished no one to be notified of this Notice."

The third ED visit occurred on 10/7/2017. The patient was brought in by a friend due to increasing delusions and paranoia at 5:31 PM and was discharged at 10:22 PM on 10/8/2017. The ED Notes on 10/7/2017 at 8:51 PM state that "The patient was given a copy of her restriction of rights". The ED Medication Administration record show that no psychotropic medications were administered. The HRA also reviewed the Notice Regarding Restricted Rights of Individuals that was issued on 10/7/2017 at 8:02 PM. Part I showed that no major restrictions occurred. Part II of the form lists other restrictions and notes restrictions on the right "to refuse medical services – laboratory specimens, to retain personal property, to refuse other medical services, to refuse search of person or living area, and use of a telephone". The reason for these restrictions was "experiencing paranoid and manic verbal and physical ideation and behaviors. Psychiatric evaluation for listed behaviors, inability to care for self, and risk of injury to self or others." Part III of the form states that the form was given to the patient in English and the form was signed by a Registered Nurse.

The HRA reviewed the hospital's policy for "Emergency Psychotropic Drug Administration." There policy is iterated upon regularly so there is a policy covering the December 2016 visit that was revised on April 3, 2015 and the August and October 2017 visits, which was revised May 12, 2017. The 2015 policy states "For example, when a patient becomes increasingly out of control verbally or physically or demonstrates threatening or aggressive behavior, a nurse may administer such medication as lorazepam, haloperidol, risperidone, or ziprasidone." The 2017 policy adds "OLANZapine" but remains identical besides that. Both the 2015 and 2017 versions state "In some instances, the patient may recognize the need for the medication and take it willingly; in other instances, he may refuse. The right of the patient or of the legally authorized representative to accept or refuse treatment with psychoactive medications may be upheld according to state law and your facility's guidelines, unless such a right is restricted by court order or superseded in an emergency. Certain instances may require an emergency order for administration without consent to prevent harm to the patient or others." Both iterations go on to state "Obtain a signed, verified informed consent to treat from the patient or a representative, as indicated and required by your facility; make sure that the consent is in the patient's medical record. If the patient consents but refuses to or

is unable to sign, obtain a witness and confirmation of verbal consent and document it, as required by your facility." In the documentation section of both the 2015 and 2017 versions it states "Document the name, dose, and route of the medication given and whether you had to restrain the patient."

The HRA also reviewed the hospital's rights restriction policy. The policy notes that "Examples of situations in which patient's rights are restricted include the following: a. Placing a patient in a physical hold b. Placing a patient in restraint and/or seclusion for violent and/or self-destructive behavior c. Administering an emergency medication... h. Completion of medical services when patient refuses (i.e. x-ray, laboratory specimens, dental services, or other). i. Note: Restriction of rights to refuse medical services is initiated only when the services is necessary to determine a diagnosis or to determine the necessary care of the patient." In the process section it states "2. Licensed provider documents reason for restriction and behavior(s) exhibited: a. Be specific as to the reason for the restriction, b. Describe the patient's behavior leading up to the restriction of rights in detail (i.e. stating that patient is exhibiting danger to self or others is not sufficient, nor are descriptions such as agitated or combative)"

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102a-5) states "If the services include the administration of electroconvulsive therapy or 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. The physician or the physician's designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing. 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 or 2-107.1 or (ii) pursuant to a power of attorney for health care under the Powers of Attorney for Health Care Law or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act."

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107a) states "An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. 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, guardian, or substitute decision maker, if any, 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."

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-108) states that "Sec. 2-108. Use of restraint. Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others....In the event there is an emergency requiring the immediate use of restraint, it may be ordered temporarily by a qualified person only where a physician, clinical psychologist, clinical social worker, clinical professional counselor, or registered nurse with supervisory responsibilities is not immediately available. In that event, an order by a nurse, clinical psychologist, clinical social worker, clinical professional counselor, or physician shall be obtained pursuant to the requirements of this Section as quickly as possible, and the recipient shall be examined by a physician or supervisory nurse within 2 hours after the initial employment of the emergency restraint. Whoever orders restraint in emergency situations shall document its necessity and place that documentation in the recipient's record."

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-201) requires that: "(a) Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason...."

CONCLUSION:

The HRA reviewed the records of the three ED visits and hospital policy. According to the Mental Health and Developmental Disabilities Code, if psychotropic medications are going to be administered the physician must provide the patient in writing of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment and must also evaluate and document the patient's ability to consent to the treatment. Psychotropic medication was administered on 1/01/2017 for the first visit and on 8/162017 and 8/17/2017 for the second visit. There are no records of physician advice being given or an evaluation of the patient's ability to consent being done for any of the psychotropic medication administrations. Additionally, the HRA looked at the rights restrictions. While there were rights restriction, there were none for "administered emergency medication". The patient did receive a rights restriction of "refusal of medical services" for each visit but minimal reason was given. The HRA has concerns about the rights restriction process. The patient received a rights restriction for each ED visit that seemed to provide a blanket restriction of rights with minimal reason given and each restriction included the right to refuse medical treatment. The Mental Health and Developmental Disability Code provides that rights can only be restricted to protect the patient and others from physical harm. Because of this, the HRA finds this complaint **substantiated**. The HRA investigated OSF St. Joseph Hospital (see report 18-090-9023) and made the following recommendations regarding rights restriction and forced medications "The facility begin following the Mental Health and Developmental Disabilities Code requirements for refusing medications and then for administering emergency medications if the Code's standards are met (405 ILCS 5/2-107, 5/2-102 and

5/2-200), including eliminating the review of Ethical and Religious Directives. The HRA asks that policy and training be updated as evidence of this change and the evidence be provided to the HRA." Also, "The facility must provide guardian copies of the restrictions (405 ILCS 5/2-201) and restrictions must include specific justification to prevent serious and imminent physical harm towards the resident or others (405 ILCS 5/2-201, 5/2-104 and 5/2-103). The facility must cease in the practice of providing groups of rights restrictions upon admission to the ED and only provide restrictions when a patient is in danger of harm to self or others per the Code. The HRA asks that policy and training be updated as evidence of this change and the evidence is provided to the HRA." The HRA determined that the facility complied with their recommendations within that report, and since the incidents represented in this current case occurred prior to the implementation of the HRA's recommendations in Case #18-090-9023, the HRA has no further recommendations.

As far as the administration of psychotropic medication, the HRA did not see evidence that the facility staff advised "...the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment" or that there was a determination that the recipient had the capacity to make decisions regarding the treatment per 405 ILCS 5/2-102a 5. Because of this, the HRA **strongly suggests** the facility assure that they are in compliance with the Code regarding psychotropic medication administration and train staff on psychotropic medication administration.

Complaint #2- Inadequate provision of prescribed medications while at the hospital.

The HRA was given records of ED visits on December 30, 2016, August 15, 2017 and October 7, 2017. Each record lists the patient's prescription list at the time. The December visit records list the prescriptions as acyclovir 800 mg tablet (take 1 tab by mouth 5 times daily for 7 days), diclofenac sodium 1% TD gel (apply by applicator 4 times daily), donepezil 10 mg PO tabs (take one tab by mouth nightly), fluticasone 50 MCG/ACT NA SOLN (1-2 sprays by nasal route daily), ipratropium 0.06% NA SOLN (2 sprays by nasal route 4 times daily), levothyroxine 50 MCG tablet (take 1 tab by mouth daily), montelukast 10 mg PO tabs (take 1 tab by mouth every evening), and SUMAtriptan 25 mg PO tabs (take 1 tab by mouth as needed for migraine). The records state that the patient has no known allergies. The ED Notes on 12/31/2016 at 4:16 PM state that "RN has looked for patient's medication list. RN has found prescriptions for patient at Osco Drug. Pt has had prescriptions filled by a physician based in Downers Grove for Provigil 200 mg, Dexadrine, and Aricept...ED provider has been notified." Aricept is the brand name for donepezil. The ED Medication Administration section lists haloperidol lactate, ibuprofen, and LORazepam as being administered to the patient. The medications on the prescription list were not noted as having been administered.

The August 15, 2017 visit records the patient's prescriptions as acyclovir 800 mg tablet (take 1 tab by mouth 5 times daily for 7 days), diclofenac sodium 1% TD gel (apply by applicator 4 times daily), donepezil 10 mg PO tabs (take one tab by mouth

nightly), fluticasone 50 MCG/ACT NA SOLN (1-2 sprays by nasal route daily), ipratropium 0.06% NA SOLN (2 sprays by nasal route 4 times daily), levothyroxine 50 MCG tablet (take 1 tab by mouth daily), montelukast 10 mg PO tabs (take 1 tab by mouth every evening), and SUMAtriptan 25 mg PO tabs (take 1 tab by mouth as needed for migraine). The records also state that the patient has no known allergies. The ED Medication Administration section lists levothyroxine, montelukast, and donepezil being administered all on 8/16/2017 at 6:20 PM. These are the only medications from the prescription list that are recorded as having been administered.

The October 7, 2017 visit records the patient's prescriptions as acyclovir 800 mg tablet (take 1 tab by mouth 5 times daily for 7 days), diclofenac sodium 1% TD gel (apply by applicator 4 times daily), donepezil 10 mg PO tabs (take one tab by mouth nightly), fluticasone 50 MCG/ACT NA SOLN (1-2 sprays by nasal route daily), ipratropium 0.06% NA SOLN (2 sprays by nasal route 4 times daily), levothyroxine 50 MCG tablet (take 1 tab by mouth daily), memantine 5 mg tablet (take 5 mg by mouth two times daily), montelukast 10 mg PO tabs (take 1 tab by mouth every evening), and SUMAtriptan 25 mg PO tabs (take 1 tab by mouth as needed for migraine). The record also states that the patient has no known allergies. The ED notes for 10/8/2017 at 8:45 AM states "Dr Smith notified of pt's request for her morning dose of levothyroxine". The ED notes for 10/8/2017 at 1:28 PM states "This RN called pharmacy to get a dose of namenda for pt". Namenda is the brand name for memantine. The ED Medication Administration lists levothyroxine as having been administered on 10/8/2017 at 9:00 AM and lists memantine as having been administered on 10/8/2017 at 1:30 PM. These are the only medications from the prescription list that are recorded as having been administered.

The HRA reviewed the Emergency Department Standards of Care policy in effect during the ED visits in review. The policy did not contain any mention of procedure regarding prescription medications.

The HRA reviewed the Medication Reconciliation policy in effect during the patient's hospital visits. The policy defines medication reconciliation as "The process of comparing the medications a patient is taking (and should be taking) with newly ordered medications. The comparison addresses duplications, omissions, and interactions, and the need to continue current medications." Within the process section under the "Hospice Home, Hospital" subsection it states "Licensed provider completes medication reconciliation by evaluating each medication on the medication list."

The Medical Patient Rights Act (410 ILCS 50/3) states that "The following rights are hereby established: (a) The right of each patient to care consistent with sound nursing and medical practices…"

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102a) states that "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan."

CONCLUSION:

The HRA reviewed records and policy regarding the three ED visits under review. While each visit does list the patient's current prescription list, the ED medication administration records do not record each prescription as being administered. The first 3-day visit records none of the patient's prescriptions as having been administered. The second 2-day visit notes a couple of prescriptions having been administered but not all. The third 1-day visit also notes a couple prescriptions having been administered but not all. The lack of administration of a patient's prescriptions is not in compliance with The Medical Patient Rights Act (410 ILCS 50) and The Mental Health and Developmental Disabilities Code (405 ILCS 5). Because of this, the HRA finds this complaint **substantiated** and offers the following **recommendations:**

- Administer a patient's medications as prescribed or document rationale for not administering.

The HRA also offers the following **suggestions:**

- Amend the Emergency Department Standards of Care policy to include a policy regarding administration of prescription medications that contains a clause for prescriptions to not be administered if they conflict with the current care plan.

The HRA would also **strongly suggest** the hospital complete a Mental Health Treatment Declaration with this patient to assist with case planning for potential future interactions the facility might have with this patient:

- The Mental Health Treatment Declaration is a type of advanced directive for individuals with mental health needs. The Declaration allows individuals to pre-define their choices and preferences in mental health treatment. The HRA suggests educating unit staff on this option and providing patients with related resource information, including the Commission's link to the topic: https://www2.illinois.gov/sites/gac/Forms/Documents/DMHTForm.pdf

RESPONSE

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

REGIONAL HUMAN RIGHTS AUTHORITY

HRA CASE NO. 19-090-9012

SERVICE PROVIDER: – OSF St. Joseph Hospital

Pursuant to Section 23 of the Guardianship and Advocacy Act (20 ILCS 3955/1 *et seq.*), we have received the Human Rights Authority report of findings.

IMPORTANT NOTE

Human Rights Authority reports may be made a part of the public record. Reports voted public, along with any response you have provided and indicated you wish to be included in a public document will be posted on the Illinois Guardianship and Advocacy Commission Web Site. (Due to technical requirements, your response may be in a verbatim retyped format.) Reports are also provided to complainants and may be forwarded to regulatory agencies for their review.

We ask that the following action be taken:

__✓__ We request that our response to any recommendation/s, plus any comments and/or objections be included as part of the public record.

_____ We do not wish to include our response in the public record.

_____ No response is included.

Lynnd Fulton
NAME

President
TITLE

May 25, 2020
DATE

OSF HEALTHCARE

March 6, 2020

Meri Tucker, Chairperson
Peoria Regional Human Rights Authority
401 Main Street, Suite 620
Peoria, IL 61602

RE: HRA No. #19-090-9012

Dear Ms. Tucker,

OSF HealthCare St. Joseph Medical Center (SJMC) would like to express its gratitude to the Regional Human Rights Authority of the Illinois Guardianship and Advocacy Commission (HRA) for its time and attention to this complaint. Thank you for the opportunity to address the recommendations and suggestions listed in the November 22, 2019 Report of Findings.

In response to the suggestion regarding Complaint #1; the hospital's policy "Medication Administration: General Policy" (Attachment A) addresses providing education to patients regarding safe and effective medication use. The Emergency Department nurses reviewed the policy and expectations to provide patient education for specific medications. The education was completed in February 2020 and the educational content (Attachment B) and the signature sheets (Attachment C) are enclosed for your records.

In response to the recommendation from Complaint #2, regarding the lack of administration of a patient's prescriptions; SJMC reviewed our existing "Boarded Patients" Policy (Attachment D). As stated in the section 4b, "Patient home medication list will be reviewed and orders obtained for patient to receive if deemed safe and appropriate by the ED physician." Pharmacy is available at all times for consultation. Education regarding home medication administration and documentation of rationale if medication is not administered was provided to the SJMC Emergency Department providers and nurses (Attachment E). The education was completed on March 6, 2020 and the signature sheets are enclosed for your records (Attachment F). ED providers completed education via email read receipt and those providers not completing will be educated prior to their next shift.

SJMC reviewed the suggestion of amending the Emergency Department Standards of Care policy to include information regarding administration of prescription medications that contains a clause for prescriptions to not be administered if they conflict with the current care plan. This policy will not be updated as our existing Boarded Patient Policy addresses administration of home medications as stated above.

OSF HEALTHCARE

Upon review of the strongly suggested completion of a Mental Health Treatment Declaration with this patient; we have determined that the patient has not been to SJMC since October 7, 2017. This patient's primary care physician (PCP) is an OSF HealthCare provider and a Patient Safety Contract has been established with the PCP. If the patient would present for treatment to SJMC Emergency Department, we would work with the patient to update the contract.

Thank you again for this opportunity to respond to the recommendations and allowing us to make improvements to the care we provide. If you have any questions, please do not hesitate to call me at 309-665-5784 or via email at Lynn.A.Fulton@osfhealthcare.org.

Sincerely,

Lynn A. Fulton
President
OSF HealthCare St. Joseph Medical Center
Lynn.A.Fulton@osfhealthcare.org

cc: Erin Nowlan