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HUMAN RIGHTS AUTHORITY-NORTH SUBURBAN REGION

REPORT 20-100-9008
AMITA ST. FRANCIS HOSPITAL

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of potential rights violations in the treatment provided to a mental health patient at Amita St. Francis Hospital in Evanston. Allegations were that the patient was restrained and given emergency medication without cause and was involuntarily detained without a petition and a certificate in place. Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Part of the Amita Health group, St. Francis' Emergency Department (ED) sees approximately one hundred patients per day, about eight percent of whom need mental health care. There is no psychiatry unit or staff on grounds, except for master's level crisis workers, although a telepsychiatry service is available for evaluation and disposition. ED physicians are contracted from an outside source. The HRA met with representatives from administration and the ED to discuss the matter. Relevant policies were reviewed as was the patient's medical record with authorization.

COMPLAINT SUMMARY

The complaint states that the patient went to St. Francis for back pain but soon found himself being accused of self-harm. Two guards reportedly jumped and choked him, and although he kept pleading that he could not breathe, they proceeded to restrain and inject him for no apparent reason. There were also no petitions or certificates completed to authorize holding him there for hours awaiting transfer to another facility.

FINDINGS

Restraints and emergency medication

According to the chart, the patient arrived on a Monday just after 10 p.m. with complaints of shoulder, back and abdominal pain all on the right side. A nurse conducted an initial triage

and screening within minutes and noted that the patient expressed suicidal thoughts and intentions following a series of specific questions. He was quoted as saying that his most recent attempt was within three months and that he stopped taking his medications. Various exams and lab tests were performed over the next couple hours and at 11:30 p.m. he was seen by a crisis worker who repeated the same concerns in more detail, "After reporting body pains pt. shared, 'I am suicidal and I want to kill my neighbor's dog for barking all day and night'. Per pt.- suicidal thoughts triggered from a car cutting in front of him and life flashing before his eyes. Pt. reports past suicide attempts (2/2019 cut wrist and 4/2019 ingested pills). Pt. reports irregular eating and sleeping…. Pt. would benefit from inpatient psychiatric hospitalization for stabilization and medication management."

The record showed regular monitoring by nurses and physicians through the night without incident. At about 7 a.m. the patient was described as more agitated than he had been, saying he did not want to see another psychiatry person. A nurse wrote that the patient complained of not getting treatment for left side pain, that he refused to acknowledge care from a resident and an attending physician and that he wanted to speak to an administrator. An ED manager met with him at 10 a.m. but he remained dissatisfied with the situation. "He continues to be belligerent and verbally aggressive toward staff. MD made aware." Medications to calm the patient were subsequently ordered and security was called when he refused to take them; he continued to be uncooperative and aggressive as they tried to medicate him, and he had to be restrained per the nursing entries. Restraints were applied and Ziprasidone/Ativan injections were given at 10:45 a.m. Fifteen-minute checks were completed through 1:30 p.m. when the restraints were removed. The nurse said that he checked a yes box in the computer software to show that he gave a restriction notice to the patient, however a copy of the completed notice was not included in the record.

A security report told of how the guards were approached for a show of force after the patient became aggressive with medical staff when they tried to medicate him. They explained his need to relax but the patient continued to refuse medication. One of the nurses then tried to give the injection and the patient "launched" towards the nurse. Two guards and five ED staff were able to control the patient's resistive behavior and get him back on the bed where he was medicated and restrained according to the documentation. The report stated that no one sustained injuries during the altercation.

There is nothing in the record or security report in reference to the patient's complaints of being choked, although the staff called the local police at the patient's request to file assault charges. He was monitored during the restraint episode and through the rest of the afternoon without any related concerns. The patient was medically cleared and transferred to another facility just after 6 p.m.

The HRA interviewed a number of staff persons who were directly involved with this case. The crisis worker recalled the patient and his condition, which she said was appropriate for hospitalization given his statements. She said it was also about his body language; he was fidgety and on edge. Regarding the need to restrain and medicate, the ED manager said she met with the patient after he requested to see someone from administration. He told her that he wanted to leave and did not need to be there. She explained the situation and went over the

petition and certificate information and he seemed to understand what was going although he grew more agitated. Asked to clarify his notation of the patient being belligerent and verbally aggressive at that time, the nurse said he was getting out of bed, pushing, shoving and swinging at staff, using vulgar language. The physician was consulted, and he ordered medication to help calm the patient although the patient adamantly refused. They tried talking with him and redirecting him without success until security was called for help. He then tried getting out of the room, pushing at the staff, calling them names. They had to hold him to try the injection while security was standing by; the patient started swinging and the guards moved in to get him back on the bed and in restraints.

At least three staff who were present during the restraining said they did not observe the patient being choked or unable to breathe. He called administration after his discharge and complained of being smothered and that he did not need to be restrained. A guest relations representative talked with him, and his temper seemed to escalate when referring to how the guards and nurses were on top of him. Although the patient did not file a formal grievance, the guest relations rep. and the ED manager investigated the restraint use and found all the staffs' handling to be appropriate. There is no documentation of the investigation.

CONCLUSION

St. Francis policies state that restraints are only to be used to ensure immediate physical safety, when less restrictive measure have failed. Patients are to be monitored every fifteen minutes and all initial orders are not to exceed four hours for adults. All components of the restraint policy comply with the Mental Health Code, except that in no event shall restraints exceed two hours unless within that time it is confirmed in writing that they pose no undue risk in light of the patient's medical condition (405 ILCS 5/2-108). The policy requires restriction notices to be given to patients and anyone designated, but only on inpatient behavioral health units, contrary to the Code's intention for all patients under mental health treatment to be given written notice whenever the right to be free from restraints and to refuse medication is restricted (405 ILCS 5/2-201). The hospital's psychotropic medication policy is also in line with the Code, calling for the emergency use only when necessary to prevent serious and imminent physical harm and no less restrictive alternative is available (405 ILCS 5/2-107), and for restriction notices to be given to patients and anyone so designated (405 ILCS 5/2-201).

The question is whether there was a need to restrain and medicate this patient, the standards for which respectively are to prevent physical harm and serious and imminent physical harm and no less restrictive alternative is available. The staffs' account of the events as described to the HRA was much more compelling than their unsupportive documentation, which states that the patient was belligerent, verbally aggressive and uncooperative, well short of meeting the standards. Only in the security report is there reference to preventing serious and imminent physical harm when the patient "launched" at the nurse, but by that time he had no choice and was getting the medication. A violation of the right to be free from restraints and to refuse medication is substantiated. Although the claim of being choked or feeling smothered is not discredited, there is no evidence to confirm either.

RECOMMENDATIONS

Train ED staff to thoroughly document the need to prevent physical harm whenever applying restraints to a mental health patient (policy; 405 ILCS 5/2-108).

Train ED staff to thoroughly document the need to prevent serious and imminent physical harm whenever giving involuntary, emergency psychotropic medications (policy; 405 ILCS 5/2-107).

SUGGESTIONS

St. Francis should review the practice of simply checking a yes box in software for proof of completing a rights restriction form and instead should place a copy in the record (405 ILCS 5/2-201).

Add the Code's requirement to include no undue risk statements whenever behavioral restraints exceed two hours.

Be sure to clarify in restraint policies that restriction notices apply to all mental health patients who are restrained in the ED (405 ILCS 5/2-201).

It seems the patient's complaints of being choked or smothered should have been handled as a formal grievance pursuant to CMS Rules (42 C.F.R. 482.13), and, since he complained of potential physical abuse by the staff, a formal in-house investigation by someone not involved, unlike the ED manager, should have handled the investigation to determine whether a report was to be made to the Illinois Department of Public Health (210 ILCS 85/9.6). Also, the HRA suggests that any investigation of such a complaint be documented and included in the patient's record.

Petition and certificate

The crisis worker completed a petition for involuntary admission at 1 a.m., about one hour after assessing the patient. She asserted the same information from her evaluation, that he expressed suicidal thoughts and that he reported detailed ways of trying suicide in the recent past. A certificate followed at 1:45 a.m., and it included a physician's signature of having advised the patient's rights and a clinical observation and statement of need.

Both documents were typed, and the certifier's clinical observation was a verbatim copy of his History and Physical. The crisis worker said they type these to make them more legible and to save time. The physician present for our meeting, although not the one who completed the certificate in question, said the they do make face-to-face observations and recite a patient's rights before any evaluation for involuntary admission. No one could say for sure exactly what those rights are.

Conclusion

Under the Mental Health Code, "When a person is asserted to be subject to involuntary admission on an inpatient basis and in such condition that immediate hospitalization is necessary for the protection of such persons or other from physical harm, any person 18 years of age or older may present a petition to the facility director of a mental health facility…." The petition must contain a detailed assertion that the person is subject to involuntary admission (405 ILCS 5/3-601). A certificate by a physician or qualified examiner that includes his or her clinical observations and other facts in reaching a diagnosis and a statement of whether the person was advised rights must be completed within twenty-four hours or the person is to be released (405 ILCS 5/3-602;604).

A petition and a certificate, each required to detain a person for involuntary admission, were completed thoroughly and timely in this case, and St. Francis had the authority to keep this patient safe in the facility until his transfer. A rights violation is not substantiated.

SUGGESTION

St. Francis should train all contracted ED physicians and any other qualified examiner on the Mental Health Code's requirement to advise patients of their rights before any certification exam begins, which includes the right not to talk and to know what they are facing (405 ILCS 5/3-208).

Of serious concern is the verbatim copy of the physician's H&P on the certificate, which implies that a face-to-face evaluation for the purpose of certifying following a rights advisement may not have been done. While typing for legibility seems ok, the hospital is implored to include the physician's or qualified examiner's actual certification note, which was not found anywhere in this record.

RESPONSE

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

AMITA HEALTH

April 30, 2020

To: Kori Larson
Human Rights Authority
Illinois Guardianship and Advocacy Commission
9511 Harrison Avenue
W-335
Des Plaines, Illinois 60616-1565

Re: HRA # 20-050-9008

Dear Kori Larson,

Thank you for your letter, dated March 5, 2020, of the findings of the investigation into the above referenced case. Our response to the recommendation by the Commission is explained below.

The recommendations made by HRA are:

1. Train ED staff to thoroughly document the need to prevent physical harm whenever applying restraints to a mental health patient;

2. Train ED staff to thoroughly document the need to prevent serious imminent physical harm whenever giving involuntary, emergency psychotropic medications.

Saint Francis Hospital and its staff provided the HRA with ample evidence to support the necessary decision to administer restraints to this patient (medical record, staff interviews, security reports, policy). The March 5, 2020 report confirms that this patient required the restraint that was administered due to aggressive behavior toward staff and expressed suicidal ideations. The deficiency identified was the lack of clear documentation by the treatment team and the lack of evidence in the record that the restriction of rights notification was given, although documented in the electronic record.

Saint Francis has developed a work group to address your recommendations. Initial education focusing on Restriction of Rights was conducted at Emergency Department huddles between February 4, 2020 and February 11, 2020 and at the Emergency Department Multidisciplinary Meeting on February 4, 2020.

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AMITA HEALTH

A comprehensive education plan addressing the issues raised in HRA's recommendations has been developed with an intent to begin implementation within the next 30 days. Due to necessary attention, focus and care of COVID-19 patients, Saint Francis has had to push back implementation of most education initiatives (including this one).

Emergency Department Leadership has developed an educational program for all staff focusing on the need to thoroughly document the need to prevent physical harm whenever applying restraints to a mental health patient. The educational program all focuses on documenting the need to prevent imminent physical harm whenever giving emergency psychotropic medications. The workgroup has also submitted a request to EPIC, (electronic health record) to enhance the existing flowsheet related to restraints to provide a clear depiction of the patient's behavior and less restrictive methods attempted. The Emergency Department Manager will audit restraint documentation and emergency medication administration to ensure that it addresses prevention of physical harm when applying restraint and or giving emergency medication to a psychiatric patient.

Also contained within HRA's March 5, 2020 letter were several suggestions that have been shared with AMITA system for review and consideration. Saint Francis is also evaluating the current petition and certification process to ensure that the information and papers are documented within the patient's medical record. The ED manager and medical records will be monitoring compliance and reporting their findings to the hospital Quality Committee.

Saint Francis strives to treat all our patients with respect and to ensure their safety. We continually strive to provide safe quality care to all of our patients. We will use your findings as an opportunity to focus on improving processes in our Emergency Department.

Sincerely,

Kenneth Jones
President, AMITA Health Saint Francis Hospital Evanston

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