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HUMAN RIGHTS AUTHORITY-NORTH SUBURBAN REGION

REPORT 21-100-9009
NORTHWESTERN MEDICINE DELNOR HOSPITAL

Introduction
On 3/4/2021 the North Suburban Regional Human Rights Authority (HRA) opened an investigation of possible rights violations regarding care for a recipient of mental health services in Northwestern Medicine Delnor Hospital's emergency department. The complaint alleged that the hospital denied the recipient's requests to view the petition for involuntary admission and improperly administered emergency medication. Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Northwestern Medicine Delnor Hospital is a 159 licensed bed acute-care facility in Geneva, Ill. For the purposes of this investigation, in accordance with (405 ILCS 5/1-114) Mental Health and Developmental Disabilities Code, this acute-care facility is considered a "Mental health facility" in that it is a licensed private hospital providing ". . . treatment of persons with mental illness."

Method of Investigation
To proceed with this investigation, the HRA reviewed the recipient's clinical record (with authorization) for services dates in November 2020. The HRA obtained additional case information through an interview with the recipient's psychiatrist, social worker, and a nurse. The HRA also reviewed relevant hospital policies, provided by the hospital. The HRA acknowledges and appreciates the full cooperation of Northwestern Medicine Delnor Hospital personnel in this investigation.

Case Summary
The recipient of services arrived in the emergency department on 11/23/2020 at 8:28pm and was provided with a transfer to a psychiatric hospital on 11/24/2020 at 6:59 pm. According to a case note, the recipient was brought into the ED by police. The original petition was completed by the Kane County Sherriff on 11/23/2020 at 8:06pm, in response to a domestic dispute in the home. A second petition was completed in the hospital by social work staff on 11/24/2020 at 12:17 am. The record contains copies of both petitions, which are *both* missing a name, signature, and date in the section of the petition requesting a signature to verify that "Within 12 hours of admission to the facility . . . I gave the respondent a copy of this Petition . . . I have explained the Rights of Admittee to the respondent and have provided him or her with a copy of it. I have also provided him or her with a copy of Rights of Individuals Receiving Mental Health and Developmental Services (IL462-2001) and explained those rights . . ."

When asked about the intake during the HRA interview, the social worker reported that she sat down with the recipient briefly in the evening to discuss his admission – the record indicates 11:30 pm although the social worker stated she couldn't remember the time. The social worker told HRA staff she explained to the recipient multiple times what the petition meant. When the HRA asked the social worker to demonstrate this explanation of "what the petition meant", the social worker said that it meant the recipient was being held in the hospital for a psychiatric evaluation, however the social worker could not elaborate on the Rights of Admittee under 405 ILCS 5/3-206. The social worker told the HRA that she did not provide the recipient with the address and phone number of the Guardianship and Advocacy Commission, and that she did not provide the recipient with a copy of the petition.

According to the record, the recipient received a medical examination and tests in his first few hours in the ED.

Social work and nursing case notes beginning at around 10:30 pm on the night of admission indicate that the recipient was in a hospital bed when he started to exhibit verbal aggression and a hostile demeanor. One such note reads: [recipient] is paranoid and yelling at staff here." Another emergency department note from an RN reads: "he is getting increasingly agitated . . . yelling and arguing, leaned forward and aggressively hit the bed."

The complaint presented this event differently from the hospital's account. According to the complaint, "[the recipient] laughed [at a joke the nurse told then] and slapped the bed a single time, a common habit of [theirs] when [they] are having a particularly hearty laugh. She said [the recipient] was being aggressive despite the fact [they were] sitting in bed and had not moved from that position. [The recipient's] response was to lie in a prone position on [their] face to demonstrate [they were] in no way a threat."

According to the written record, the recipient was ". . . asked numerous times to stop yelling and acting threatening, he continues. Physician aware, security called and order for Geodon given." A doctor's note for the same incident reads: . . . [recipient] started raising his voice, slamming things, yelling. Started becoming combative. Had to get Geodon and restrained."

When asked about this incident in the HRA interview, the doctor and social worker confirmed the accounts in the record, but could not recall what kinds of "things" the recipient had been slamming (as referenced in the record) and stated that the recipient was lying in a hospital bed at the time and did not have any kind of weapon or blunt object in his hand. The doctor was unable to provide behavioral examples to elaborate case notes that the recipient was "combative" and "acting threatening".

The doctor told the HRA that security was called at around 11:30pm, and the patient was given an emergency injection of ziprasidone. The recipient was not physically restrained – the doctor explained that the restraint mentioned in the record was the injection itself, a chemical restraint. A restriction notice for the chemical restraint was not found in the record. The doctor stated that he believed an emergency injection was the least restrictive method of treating the recipient available, due to the hospital's policies against physical restraint. The doctor told the HRA that he told the

recipient he was going to get an injection if he didn't calm down, although this is not mentioned in the record. The Doctor also told the HRA that he did not specifically inform the recipient of his right to refuse medication.

Due to the discrepancies between the stated complaint and the hospital's account of the same event, the HRA requested further explanation from hospital staff about the emergency injection. The doctor stated to the HRA that he could not clearly remember details of this event, but remembered that the patient was in bed and became verbally combative and aggressive. The nurse who had attended the patient at the time of the emergency injection no longer works for the hospital and could not be interviewed. The social worker on the case at the time told the HRA that she remembered the nurse telling her that the recipient " . . . lunged across the bed at [the nurse] with a closed fist", however this account does not appear in the record.

The doctor recalled that the nurse and the doctor made unsuccessful attempts to verbally redirect the recipient. The doctor confirmed that he felt the recipient posed an imminent danger because of reports that the recipient had displayed "spontaneous" and "volatile" behavior at home, and his record noted a history of mania and agitation.

The record contains a certificate of assessment signed by a doctor on 11/24/2020 at 12:30 am. The certificate is signed by the doctor to verify that he ". . . personally informed the above-named individual of the purpose of this examination and that he or she did not have to speak to me, and that any statements made might be related in court as to the individual's clinical condition or need for services." The doctor who completed the assessment and signed the certificate told the HRA that he was not aware of the recipient's right to refuse the assessment, and as such, did not inform the recipient of these rights before performing the assessment.

Policy Review

To satisfy the HRA request for all hospital policies regarding psychiatric intakes, mental health assessment, use of physical restraint, and forced medication, Northwestern Medicine Delnor Hospital furnished the hospital's standard patient rights brochure and the following Patient Care Services policies: Restraints and Seclusion; Psychiatric Care & Referral, Suicide Precautions For non-BHS Patients, and BHS Suicide Risk Assessment. The HRA found that *none* of these policies address the Mental Health and Developmental Disabilities Code (405 ILCS 5), and *all* of these policies are lacking provisions that would appropriately align them with corresponding sections of 405 ILCS 5.

Case Findings

The complaint that Northwestern Medicine Delnor Hospital (the Provider) did not provide the recipient with a copy of the petition and a statement of the right to contact the Guardianship and Advocacy Commission is ***substantiated***. The complaint that the Provider improperly administered emergency medication is also ***substantiated***.

Analysis

The section of the Mental Health Code governing admission by petition specifies that:

> *Within 12 hours after the admission of a person to a mental health facility . . . facility shall give the person a copy of the petition and a clear and concise written*

> *statement explaining the person's legal status and his right to counsel and to a court hearing.* (405 ILCS 5/3-205)
>
> *. . . the mental health facility shall provide the person . . . with the address and phone number of the Guardianship and Advocacy Commission.* (405 ILCS 5/3-206)
>
> *A recipient must be given a copy of the petition within 12 hours of admission, and a statement [of the right to contact the Guardianship and Advocacy Commission].* (405 ILCS 5/3-609).

The case record (which contained unsigned petitions) and the social worker's interview responses (which confirmed that she did not give the recipient a copy of the petition or information about the Guardianship and Advocacy Commission) corroborated violations of the above mentioned statutes. Additionally, the social worker was not able to demonstrate awareness of the recipient's admittee rights when questioned in the HRA interview, which further indicates that Mental Health Code statues governing involuntary admittee rights were violated. Without proof that the recipient was given the petition and explained his rights within 12 hours, the hospital cannot demonstrate its right to hold the recipient for over 20 hours.

Regarding the administration of an emergency injection, the "right to refuse" clause of the Mental Health Code states:

> *A . . . recipient of services . . . must be informed of [their] right to refuse medication. [And] . . . shall be given the opportunity to refuse . . . medication (405 ILCS 5/2-107)*

The doctor told the HRA that he did not specifically inform the recipient of the right to refuse medication, confirming a violation of this section of the statute. The Mental health code also states that emergency medication ". . . shall not be given unless such [medication is] . . . necessary to prevent the recipient from causing serious and imminent physical harm and no less restrictive alternative is available. (405 ILCS 5/2-107)"

The accounts of the incident that resulted in emergency medication told by the doctor, nurse, and social worker indicate that the recipient was "aggressively hitting the bed" and "slamming things", although the clinical team agreed in the HRA interview that the recipient was lying in a hospital bed and did not have any kind of weapon or blunt object in his hand. The doctor stated to the HRA that he believed the recipient posed an imminent danger because of reports that the recipient displayed "spontaneous" and "volatile" behavior at home and had a history of mania and agitation. None of the above descriptions provide sufficient evidence to prove a need to prevent serious and *imminent* physical harm. Assessing a threat based on an alleged history of volatile behavior in the past does not meet the standard of proof for an *imminent* threat. Additionally, having a "spontaneous" or "volatile" affect may be common symptoms of mental illness, and without specific behavioral descriptions, this explanation does not necessarily rise to a need for emergency medication under 405 ILCS 5/2-107.

The code also indicates that emergency medication may only be administered in the case that ". . . no less restrictive alternative is available." (405 ILCS 5/2-107). Although the doctor told the

HRA that the emergency injection *was* the least restrictive method available, due to the hospital's policies against physical restraint, a review of the hospital policies does *not* indicate that physical restraint is not allowed. Additionally, the lack of a restriction notice for the chemical restraint in the record is a violation of 405 ILCS 5 section 2-201:

> (*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 . . . to the recipient; . . . the facility director; the Guardianship and Advocacy Commission . . . The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefor in the recipient's record.*

Recommendations

1. Revise Northwestern Medicine Patient Care Services: Psychiatric Care & Referral policy so that it reflects recipient rights under the Mental Health and Developmental Disabilities Code (405 ILCS 5), specifically addressing the following chapters:
    a. Chapter II: Rights of Recipients of Mental Health and Developmental Disabilities Services
    b. Chapter III: Admission, Transfer and Discharge Procedures for the Mentally Ill

2. Revise Northwestern Medicine Patient Care Services: Restraints and Seclusion policy to indicate that restraints involving patients receiving mental health services must reflect recipient rights under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

3. Provide HRA with draft of revised Patient Care Services: Psychiatric Care & Referral and Restraints & Seclusion policy.

4. Retrain appropriate staff on the revised polices and Code-required documentation. Provide proof of completion.

Suggestions:

This investigation also found a **violation** of the recipient's right to be informed that he did not have to talk to the examiner when being assessed under a petition, and that anything he says when being assessed will be disclosed at his commitment court hearing **(405 ILCS 5/3-208)**.

The section of the Mental Health Code governing psychiatric assessment under a petition states:

> *Whenever a petition has been executed . . . the person conducting this examination shall inform the person being examined . . . 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.* (405 ILCS 5/3-208)

The HRA suggests that the hospital include the above section of the statute in any relevant hospital policies, retrain staff, and require all appropriate ED staff to recite certification exam rights per 3-208.

RESPONSE

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

Northwestern Medicine

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September 29, 2021

VIA FEDERAL EXPRESS

Mariah Balaban
Human Rights Authority-North Suburban Region
Illinois Guardianship and Advocacy Commission
9511 Harrison Avenue
W-335
Des Plaines, Illinois 60016-1565

Re: **#21-100-9009**

Dear Ms. Balaban:

Please accept this letter as Northwestern Memorial Hospital's response to the September 1, 2021, Report of the Human Rights Authority-North Suburban Region ("HRA").

Northwestern Medicine Delnor Hospital ("Delnor") respectfully disagrees with the conclusion that emergency department health care providers improperly administered emergency anti-psychotic medication. The records and statements of the providers clearly demonstrate an imminent risk of harm to the patient and staff based on the patient's physical violence and escalating behavior that could not be redirected by the reasonable actions of the experienced and highly skilled emergency medicine team at Delnor.

We highlight the documented evidence of attempts at less restrictive means to avoid harm and the specific behavior that demonstrate the need for emergency medication pursuant to 405 ILCS 5/2-107:

- The patient was taken by ambulance the Delnor emergency department following a physical altercation with his father to which the Kane County Sheriff's office responded. (See patient's parents' Petition for Involuntary Admission and p. 21 of Medical Records.) The patient's parents describe the patient pushing his father and their fear of his agitation, impulsivity and aggression.

- The patient arrived at Delnor on November 23, 2020 at 2028 hours. A second petition for involuntary admission was completed and the restriction of rights were given to the patient at 2037 hours by the emergency department nurse, who explained the contents of the form and what the next steps would be. (See second Petition for Involuntary Admission and Restriction of Rights.)

- At 2237 hours, the patient's agitation and threatening behavior are well documented. He was noted to be raising his voice, slamming things, yelling and arguing. At one point he is documented as leaning forward and aggressively hitting the bed. (See for example, pp. 6 and 20 of the Medical Records.) One of the witnesses stated that she was informed that his fist was closed when this occurred. The attempts to de-escalate and calm the patient are also well documented at 2237 to 2241 hours. Despite these attempts, the staff was unable to calm the patient, and he continued with yelling and threatening behavior. As is set forth in the Restraints policy provided to the HRA, the practice at Delnor is to take calming, de-escalating actions. These steps were taken in compliance with this policy, the standard of care, and Section 2-107 of the Code. For example, this patient was placed in a crisis room (18) designed to decrease stimuli and keep patients in crisis safe. Security staff was brought in for safety.

- The safety logs, which were produced to the HRA, also demonstrate the patient's escalating and threatening behavior. Security was present but the patient was not in restraints. Between 2230 and 2315, the safety logs reflect that security had to assist with the patient's care. During this time, the safety logs describe the patient as having the following behaviors: restless/agitated, yelling/calling out, attempts up/out, and hostile/threats. The patient's response during 2230 to 2300 was noted as uncooperative despite having staff in the room. He was cooperative (and de-escalation was possible) only after Geodon was administered at 2238 hours. The emergency department providers documented the patient's agitation, behavioral problems, self-injury (excoriation of arms), dysphoric mood, and his hyperactive and pressured speech. (See pp. 3-7 and 21 of the Medical Records).

It was the clinical team's assessment that the patient was an "imminent" threat of violence to himself or others, an assessment that is corroborated by the above referenced medical records. Comfortably after the fact, the HRA has interpreted events in a light most unfavorable to the experienced health care providers, replaced their professional judgment, and concluded essentially that the patient's behavior was not all that concerning. For example, the HRA's statement that "an alleged history of volatile behavior does not meet the standard of proof for an imminent threat" amounts to a criticism that the providers in assessing threat of harm should have ignored his past violent behavior earlier the same evening toward his own father. Ignoring that critical and recent historical information, however, would have been irresponsible and put the health and safety of the staff and the patient at risk. Further, the HRA report suggests that the emergency department physician acted only on the recent history of physical violence, but this is not the case. It was the patient's continued aggressive behavior and pressured demeanor, which were not responding to redirection and calming, along with the recent history of violence

that formed the basis of the physician's reasonable concern that the patient presented an imminent risk of harm to himself and others. Further, the HRA concludes that because the patient was lying in a hospital bed and lacking a blunt object or weapon in his hand, he did not pose a credible threat to the providers or himself. Any nurse or physician who has been punched, scratched, choked, pushed or slapped by a patient in a gurney would tell you that is ridiculous.

When emergency caregivers are assessing imminent threat of harm in the moment, they do not know with certainty how quickly a patient's aggressive behavior will escalate to the point of causing injury to himself or others. In real time, they must use their reasoned clinical judgment as to the measures needed to keep the patient and staff from harm. In this instance, the Delnor team exercised appropriate judgment in all respects.

Delnor emergency medicine professionals care for thousands of patients each year, many of whom require mental health services. The emergency medicine nurse, the social worker, and the attending physicians are outstanding examples of calm, mature emergency room providers, who are regularly confronted with hostile, intoxicated, or sometimes law-breaking patients. These professionals are also well-versed in caring for patients who present with mental health crises, some of whom are violent. The epidemic of violence against health care providers, particularly those in emergency medicine is well documented. There is no doubt, based upon the medical records and this particular team of health care providers, that all efforts were made to redirect this patient to keep him safe and the team safe. But when those efforts failed, the team correctly gave Geodon. Indeed, the patient remained safe and no health care providers or other patients were injured.

In conclusion, Delnor appreciates the opportunity to discuss these issues with the HRA and to use the information learned in the process to improve the quality of patient care in the emergency department. Delnor takes its obligation to all patients, including those with mental illness, very seriously. Delnor continues to train, monitor, and review its practices and procedures in order to provide the highest level of care.

While NMH disagrees that the HRA has provided grounds to demonstrate a material violation of the Mental Health Code, NMH will follow the HRA's Recommendations. The Recommendations were as follows:

1. Revise Northwestern Medicine Patient Care Services: Psychiatric Care & Referral policy so that it reflects recipient rights under the Mental Health and Developmental Disabilities Code (405 ILCS 5), specifically addressing the following chapters: a. Chapter II: Rights of Recipients of Mental Health and Developmental Disabilities Services and b. Chapter III: Admission, Transfer and Discharge Procedures for the Mentally Ill.

2. Revise Northwestern Medicine Patient Care Services: Restraints and Seclusion policy to indicate that restraints involving patients receiving mental health services must reflect recipient rights under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

3. Provide HRA with draft of revised Patient Care Services: Psychiatric Care & Referral and Restraints & Seclusion policy.

4. Retrain appropriate staff on the revised polices and Code-required documentation. Provide proof of completion.

NMH respectfully requests 120 days to update policies and provide training to the emergency room nurses regarding documentation of emergency administration of medications. I have enclosed the completed form regarding the public record.

Very Truly Yours,

Julia K. Lynch
Vice President and Senior Associate General Counsel

JKL/md
Enclosure