FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY – PEORIA REGION
REPORT OF FINDINGS

Case #21-090-9009
UnityPoint Health-Methodist/Proctor

INTRODUCTION:

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations involving services at UnityPoint Methodist/Proctor. The allegations are as follows:

1- Improper use of physical restraint.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-100). This hospital has a primary service area of four counties. They have a secondary service area of seventeen counties. The hospital's emergency department (ED) sees approximately 5,000 patients per year. Approximately 45% of these patients are admitted in one year. There has been an increase in admissions since the Covid-19 pandemic began.

Complaint Statement

The complaint alleges that a patient was being treated in the ED for mental health care and was left "waiting" in one of the patient rooms with no communication from the staff about his plan of care. Allegedly the patient attempted to leave to the waiting room, raised his voice and was taken down by 5 security guards. The allegations state the guards squeezed his left knee, dragged the patient across the floor and placed him in four-point restraints.

Interview with staff (02-23-2021)

A site visit took place at UnityPoint Methodist Hospital with several management staff and security personnel. The HRA also had two volunteer board members in attendance. The HRA had a signed and witnessed consent to release information.

This situation took place in the hospital emergency department (ED). When a patient arrives at the hospital ED they are seen by security upon entry to the hospital. Next is the triage desk and their level of care is determined. Once the level of care is determined, a patient may be asked to wait in the ED waiting room. If a patient is there for a behavioral health need, then efforts are made to have the person wait in one of the assigned behavioral health rooms. Once they are assigned to a room they meet with a nurse and are asked to place on a gown. Their belongings are secured and a safety monitor sheet is started. A nurse asks questions of the patient about their symptoms. An ED provider would complete a medical screening, order any necessary laboratory blood work and a Behavioral Health Crisis Evaluation is ordered. Once this evaluation has been formally entered, a masters level clinician or social worker would then arrive within a few minutes to complete the evaluation. It could take a bit longer based on the census of patient's in the ED.

Security would become involved only if requested by attending medical staff. A Patient Care Technician could request assistance from Security personnel if they feel that a behavioral health patient is a safety risk to self or others. They would not just arrive at a patient's ED room without a request from staff. The Security desk is the patient's first point of contact when they arrive at the ED. Covid-19 precautions are in place and there is a process if someone is symptomatic and presumed positive. The patient would be asked to wear a mask by Security if they were not already doing so. Security has plexiglass between them and the patient. If a patient, reports symptoms of Covid-19, then the on duty security staff would notify medical staff and make every effort to maintain social distancing.

The Service Recipient involved in this case did not have a physical restraint that involved security personnel in the ED. A situation that occurred on 3rd shift did involve a physical restraint. This patient is known to have multiple encounters with the ED and security. This patient has presented to the ED as verbally aggressive and confrontational in past experiences. This patient carries a notebook with him during the treatment process and writes everything down. He has been known to leave his assigned ED room and will try to walk around the Behavioral Health section of the ED and walk the hallways. This is not permitted due to HIPPAA.

Security attending the site visit reviewed a timeline of camera footage and provided the following information. On 12/27/20 (a Sunday) at 7:05pm, this patient walked into the ED and was assigned to room #3. The patient was in street clothing and had personal property. He was asked to change into a gown and property was locked up per procedure. At 11:11pm the patient left the assigned ED room and was "barely out of his room" in the hallway and walking with staff. A staff member walked out of the patient's room. At 11:17pm the patient began pulling property out of his locker and had a green bag with a guitar case. At 11:18pm staff walked into the room and then security walked into the room after being called by staff. Security stood by and staff and security tried to have the patient move to restraint room #2. The patient resisted, "going to the floor" outside room #2. The HRA inquired as to the reason for the changing of room and staff reported that room #3 only has a chair, room #1 has a bed that can be used for soft

restraints. This patient is described as a "very big man" and the bed is used for physically aggressive patients and the room doors can lock if necessary. At 11:20pm staff were able to get the patient onto the bed and a soft restraint was applied to both wrists and ankles. At 11:27pm the patient received 2 injections, one in the right leg and one in the left arm. At 11:45pm the left arm/right leg restraint was removed. At 12:02am the left leg and right arm was unrestrained. A staff member was in the room and the patient was calm. At 12:03am the patient walked to another room with a blanket and was transferred at 6:09am by wheelchair to another floor. This patient did not have any involvement with security while being treated on the Behavioral Health Unit.

Another hospital staff attending the site visit who was the MSW Clinician, involved with the meeting explained her interaction with the patient. She was passing through the ED on her lunch break and observed the patient in the ED waiting room. He had arrived agitated and had previously been making calls to the hospital to come to the hospital. The patient wanted to be a direct admit to the Behavioral Health Unit and bypass triage. This is not the policy and procedure of the hospital. She is familiar with him. This was explained to him by the clinician who interacted with him for an hour. At some point, the patient came out of the assigned room for an unknown reason, was getting impatient, and staff were behind the desk. A male staff stayed down the hall away from the patient. The patient pulled open a locked cabinet pulling out his guitar case. The patient began to threaten to punch staff; the patient was "agitated and threatening staff". Efforts were made to talk him down. The patient wanted his stuff. The staff were trying to move him to a different room but the patient did not want to move. While the patient was waiting he had a mental health assessment completed. The ED had to wait for him to be medically cleared. This entailed waiting for his Covid-19 test result and laboratory work. It takes three hours for these test results. The patient was given attention and updates during this time. Around 9:51pm psychiatry was contacted because placement had to be sought outside of the facility as there were no open inpatient beds.

The plan of care was to admit the patient for an Unspecified Mood Disorder after the medical screen had been completed. The patient was positive for marijuana based on the urinalysis laboratory work completed. The patient admitted to using marijuana. Security was not involved with this patient until he required a restraint. When the patient arrived in the ED he did not have to wait, and went directly to a room since he was agitated upon arrival.

On the day of this person's treatment, the ED had six behavioral health evaluations occurring between 3-10pm. Check-in during that time does not reflect what level of triage was in place for other patients. The staff explained that six evaluations is a "fair amount" of behavioral health patients to be seen in the ED. Staff are trained on crisis prevention. Due to the Covid-19 pandemic, there is a delay for admitting patients, at least 3 hours because this is the length of time it takes to have the Covid-19 test returned. The behavioral health unit will accept positive Covid-19 patients and the unit has been organized to meet this need.

An Emergency Severity Index (ESI) score is used to triage patients in the ED. This score varies and begins at check-in and establishes priority of care. The ED Supervising Nurse that attended the site visit was unsure how long he waited but was triaged at 5:38pm, and triage was completed by 5:40pm. The patient was in a room by 6:00pm. This patient would call the ED and expect immediate care. The HRA inquired as to how phone calls such as this are handled by ED staff. The Charge Nurse would handle the calls and they do not give the patient a wait time to expect. They could notify ERS to perform a screening to determine his need level. Once a behavioral health patient arrives the ED, staff would incorporate a variety of communication approaches to deescalate behavior risk. Some of those approaches would be: verbal de-escalation, offering food, talking, changing patient rooms, television, making sure the patient knows where the remote control is, coloring books, etc. The patient will continually be evaluated through the stages of the crisis continuum. If behavior escalates during the treatment process, then the patient would be involved in a recovery/debriefing and they would be highlighting the behaviors that led up to whatever outcome. If a patient is unable to deescalate and is identified to be a safety risk to themselves or others, than a physical restraint, locked seclusion, unlocked seclusion, or chemical restraints (medications order outside of the realm of diagnosis) would be considered.

An involuntary admission for this patient began in the ED at 9:51pm and a physical restraint began at 11:32pm. The patient had been verbally notified of the involuntary admission and behavior escalated after that. The involuntary admission paperwork would not be filled out until it was determined the patient was being admitted. The patient demanded to speak with a psychiatrist and wanted to go home after being notified of the involuntary admission. The patient had medications offered to him before the physical restraint based on a chart review. The patient had Zyprexa ordered at 8:43pm. Then, 2mg Valium was given in the left arm at 11:29pm and 5mg of Inapsine was given at 11:29pm in the right arm due to agitation. Staff explained the patient was provided with a restriction of rights notice and the chart record should reflect documentation of the medications being given. The HRA asked if the patient sustained a physical injury during the restraint. There were no notes that indicated an injury had been reported by the patient and the patient was calm/cooperative. The patient was unsteady after the chemical restraint but no pain was reported. The HRA was able to confirm that a particular Registered Nurse (RN) was involved with this patient's care. The hospital also reiterated that even if the patient contacted the hospital ED and spoke directly with Intake Staff for the Behavioral Health Unit, the patient would still need to admit through the ED. The patient was discharged on 12/29/21.

The hospital also acknowledges that the ED required the assistance of local police on 1/10/21 and 1/16/21 to have the patient removed from the ED after being assessed for medical needs.

On 6/4/21 the HRA followed-up with the hospital's Release of Information department to verify that all of the patient chart records had been received. The hospital staff confirmed that the patient's record provided to the HRA with consent to release information was 754 pages.

FINDINGS

1- Improper use of physical restraint.

The HRA reviewed the chart record provided by UnityPoint Methodist. This patient's treatment began in the emergency department on 12/27/20. The patient arrived to registration at the ED on 12/27/20 at 5:37pm. The patient was admitted to room B3 at 6:00pm moved to B1 at 7pm and back to B3 at 10:00pm.

The HRA reviewed ED Progress Notes that provide further details of treatment.

On 12/27/20 at 7:51pm a document titled Chief Complaint & History of Present Illness documents contact with a Physician for a Psychiatric Evaluation "[Patient] is a 64 y.o. male presenting to the emergency department for psychiatric evaluation. Patient is a difficult historian. Patient endorses vague suicidal ideation and describes that he seeks situations in which he could be in danger, such as confronting police officers or 'gang bangers.' Patient also describes auditory hallucinations that tell him that he is 'fucked.' Patient states that he has a 'perception problem' and states that what he feels is the truth is not accepted by others. Patient states he is currently participating in the [Local Provider] 90 day program. Patient states that his goal is to become 'closer to Jesus' as well as to his son, and he states that his son had urged him to enroll in the program. Patient states that he is being abused at the [Local Provider], but he has a difficult time elaborating on this further. Patient states that he is estranged from his brother, sister, and son. Patient also states that he was recently divorced. Patient denies visual hallucinations. Patient states he is uncertain of his present psychiatric diagnoses, but he states that he has been diagnosed with PTSD and personality disorder in the past. Patient reports compliance to all prescribed medications. Patient reports marijuana use and denies alcohol or other recreational drug use. Patient reports additional history of hyperlipidemia and a-fib, for which he is anticoagulated with coumadin. Patient provides an account of various grievances against the [Local Provider]. Patient names various individuals, who are presumably staff members, that have harassed him about having his phone... and not giving him his sweatshirt. Patient states that he is abused by the staff there. Patient states he has tried making police and media outlet reports, but he states that he is not believed. Patient makes various other claims about events in Peoria. Patient states that 'Black Lives Matters is taking over Peoria from underground,' and he states that no one will listen to his opinions because he is a republican. The history is provided by the patient. No language interpreter was used. ... Review of Systems Psychiatric/Behavioral: Positive for agitation, dysphoric mood, hallucinations and suicidal ideas (passive). All other systems reviewed and are negative. ... Neurological: Mental Status: He is alert and oriented to person, place, and time. Psychiatric: Attention and Perception: He perceives auditory hallucinations. He does not perceive visual hallucinations. Thought Content: Thought content is paranoid and delusional. Comments: conspiratorial thought process"

An ED Course and Progress Notes and Physician Consultations written on 12/27/20 at 8:18pm document the following "The HPI (History of Present Illness) and ROS (Review of Systems) have been obtained, and physical exam has been completed. Treatment plan has been discussed with the patient. No further questions have been provided at this time. Patient has agreed to take an oral medication for his agitation and anxiety..." Further along on this document a new Physician takes over the case at 10:30pm "Received pt case from [Physician #1] . Labs reassuring. Await BH [Behavioral Health] eval. BH recommends admission. Orders placed. DIAGNOSIS: After the evaluation in the Emergency Department, my clinical impression is 1. Unspecified mood (affective) disorder (HCC). Given this patient's current condition and after appropriate tests were ordered and interpreted this patient's conditions was discussed with BH staff at 10:41 PM who agreed that the patient should be admitted for further management and treatment. Will continue to monitor the patient during the remainder of their stay in the Emergency Department prior to transfer for inpatient services. Patient condition remained stable during the remainder of their stay in the Emergency Department."

The ED Mental Health Clinician (MHC) on 12/27/20 at 7:45pm documents on the ED MHC/RN Impressions "64 year old male presented to the Emergency Department (ED) for a psychiatric evaluation. Patient (pt) reports that he believes that everyone hates him and that 'everyone says to ignore the truth so I don't know the truth'. Pt reports that he can't seem to have a life where he is accepted and that he is cast out because he is a demon. Pt reports that he was abused by people who work at the [Local Provider] and that is why he was kicked out and cannot return. Pt denies having suicidal thoughts but reports that he puts himself in dangerous situations 'messes around with gang bangers' and 'challenges black lives matter members. Pt denies wanting to hurt others but reports that others hurt him but would not elaborate on anything specific. Pt denies any past or present self-harm. Pt denies having any supports and reports that his family does not talk to him because they think he is a liar. Pt denies any past suicide attempts but reports that he was hospitalized earlier this year on 8 Hamilton. Pt reports that he does have a primary care provider, [Physician], and a psychiatrist, [Psychiatrist], and has two counselors whom he sees regularly. Pt provided a medication log and reports that he is compliant with his medications. Pt reports that he does smoke marijuana but denies other substances including alcohol. Pt denies any hallucinations or delusions but does appear to have slight paranoia. ED MHC/RN Recommendations: Admission [the BH floor]."

The Progress Note-Attending Note dated 12/27/21 at 10:31pm documents the Attending Physician and Resident/Attending Psychiatrist recommended the patient for inpatient admission. The HRA reviewed a Rights of Individuals Receiving Mental Health and Developmental Disabilities Services form reviewed with the patient by the Behavioral Health Clinician on 12/27/20 at 10:30pm. The form indicates that the patient refused to sign the document. The Involuntary petition began at 10:42pm by the Behavioral Health Clinician. The first Inpatient Certificate was completed at 10:50pm.

The HRA reviewed the Patient Care Timeline for this patient's treatment in the ED and observes the medical doctor was notified/ordered physical restraint for unsafe behaviors on 12/27/20 at approximately 11:00pm. The Clinical Justification is

documented as "Imminent risk of harm to self or others." The section titled Restraint Note documents "Patient attempted to elope. Broke open closet and would not return belongings. Patient threatening force."

An ED Progress Note written on 12/27/20 at 11:15pm by the Behavioral Health Counselor documents "Patient stating 'you fucking lied to me this is bullshit, it's against my will. Call security you're gunna have to take me down. Call them.'" Patient also states 'better call security I'm not staying.'"

An ED Progress Note written on 12/27/20 at 11:22pm by a Behavioral Health Counselor documents "11:17pm: Patient demanding to speak with psychiatrist- advised he will speak with psychiatry tomorrow. Patient went back into room and broke open the closet door. Patient was advised he could not have his belongings and refused to give them up- MHA [Staff] notified RN and security. Patient continues to tell us to 'call security because I'm going home.' and continued to refuse to let go of personal belongings. Patient was asked multiple times to move to BH1 and patient refused and again stated 'call security.' Security arrived and patient was escorted to BH1 and restrained. 11:21: ED Provider notified."

An ED Progress Note written 12/27/20 at 11:25pm by an MSW Clinician documents "Patient forced open locker that was locked and started to get belongings out. Patient was told to give belongings to clinician and patient refused and continued to get belongings. Clinician took belongings and patient began to get angry and agitated with clinician and other staff. Patient refused to listen to staff and made threats which resulted in security being called and patient being restrained in B1."

An ED Progress Note written on 12/27/21 at 11:38pm by a Behavioral Health Therapist documents "After forcing open belongings locker and insisting on eloping from the unit, the patient remained agitated and was unable to verbally redirect. Patient reported that we were going to have to 'force him to stay' because he was leaving. Patient stated 'you're going to need security to stop me from leaving'. Security was notified and patient was told to move to BH1 for need of seclusion or restraints. Patient then thrashed and attempted to break free from security. Patient was eventually placed into restraints to ensure safety to self and staff."

The HRA is able to verify based on the 12/27/20 ED Progress Notes and Behavior Health Precautions Flowsheet documentation in the patient chart that this individual was on 15 minute checks and placed in four point soft restraints of the left and right wrist and left and right ankle on 12/27/20 at approximately 11:30pm. The reason for the restraint is described as "violent or self-destructive". This patient also received emergency medication on 12/27/20 at 11:29pm. The medication administered by an RN was Inapsine IM 5mg in the right anterior thigh and 2mg Valium in the left deltoid. There is an ED Medication Order entered by an attending Physician for these two medications to be given. The Valium and Inapsine was ordered on 12/27/20 at 11:21pm by the ED Physician. The patient was released from the soft restraints at 11:49pm and the left wrist and right ankle was freed. On 12/28/20 at midnight the right wrist and left ankle were

freed. An ED Physician entered the formal order for the use of restraints due to "Assault and Suicide Precautions" on 12/28/20 at 12:50am. The patient was eventually admitted to the Behavioral Health Unit on 12/28/20 at 6:20am

The HRA does not observe a Notice Regarding Rights Restriction of Individuals in the file that documents the soft restraints or emergency medications being administered to the patient during treatment in the ED on 12/27/20. There are two Notice Regarding Rights Restriction of Individuals in the chart record that were completed by staff on the Behavioral Health Unit upon admission but neither one of these forms indicate the patient was placed in four-point restraint and received emergency medication while being treated in the hospital's ED.

UnityPoint Health Care Coordination policy titled Care Coordination, dated 11/2020 focused on Non-Violent/Self-Destructive Restraints which states "I. UnityPoint Health- Methodist/Proctor/Pekin is committed to managing patients in the least restrictive environment. Restraint, as defined below, is used only to ensure the immediate physical safety of the patient, staff member or others and will be discontinued at the earliest possible time. Restraint will never be used as a means of coercion, discipline, convenience, or retaliation by staff. Restraint use is documented, and patients are monitored to ensure their safety. ... IV. Definitions A. Restraint- any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, hands, legs, body or head freely. B. Least restrictive interventions: Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, staff, or others from harm. Focus on prevention measures, including ongoing milieu management and individualization of the plan of care. Least restrictive measures include, but are not limited to: 1. Ventilation of feelings 2. Separating patients 3. Use of substitute activities or distraction 4. One-to-one session 5. Limit setting; offer choices 6. Offering privacy 7. Use of a quiet room or area 8. Offering medication."

The HRA reviewed UnityPoint Health-Methodist/Proctor/Pekin Patient Rights and Responsibilities form that communicates the following to a patient "While you are a patient of UnityPoint Health-Methodist/Proctor/Pekin, we will do our best to protect and promote your personal rights in accordance will all relevant state and federal laws and the standards of the Join Commission. ...Access to Care You/Your Representative's Rights Include ... 9. To be free from restraint and/or seclusion of any form unless needed for the purpose of protecting you or others from injury or with critical medical treatment. Restraints are used while preserving patient's rights, dignity, and well-being. Patients will not be restrained as a means of coercion, discipline, convenience or retaliation by staff."

The **Mental Health and Developmental Disabilities Code 405 ILCS 5/2-108 Use of restraint** mandates that "... restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized. In no event shall restraint be utilized to punish

or discipline a recipient, nor is restraint to be used as a convenience for the staff. (a) Except as provided in this Section, restraint shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, clinical professional counselor, advanced practice psychiatric nurse, or registered nurse with supervisory responsibilities. No restraint shall be ordered unless the physician, clinical psychologist, clinical social worker, clinical professional counselor, advanced practice psychiatric nurse, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of restraint is justified to prevent the recipient from causing physical harm to himself or others. ... (b) 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, advanced practice psychiatric nurse, 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, advanced practice psychiatric nurse, 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. (c) The person who orders restraint shall inform the facility director or his designee in writing of the use of restraint within 24 hours. ...(j) Whenever restraint is used, the recipient shall be advised of his right, pursuant to Sections 2-200 and 2-201 of this Code, to have any person of his choosing, including the Guardianship and Advocacy Commission or the agency designated pursuant to the Protection and Advocacy for Persons with Developmental Disabilities Act[1] notified of the restraint. A recipient who is under guardianship may request that any person of his choosing be notified of the restraint whether or not the guardian approves of the notice. Whenever the Guardianship and Advocacy Commission is notified that a recipient has been restrained, it shall contact that recipient to determine the circumstances of the restraint and whether further action is warranted."

The **Mental Health and Developmental Disabilities Code 405 ILCS 5/2-201 Restrictions, restraints or seclusion; notice; records** expects 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 therefor to: (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian; (2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice; (3) the facility director; (4) the Guardianship and Advocacy Commission, or the agency designated under "An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named", approved September 20, 1985,[1] if either is so designated; and (5) the recipient's substitute decision maker, if any. 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. (b) The facility director shall maintain a file of all notices of restrictions of rights, or the

use of restraint or seclusion for the past 3 years. The facility director shall allow the Guardianship and Advocacy Commission, the agency designated by the Governor under Section 1 of "An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named," approved September 20, 1985, and the Department to examine and copy such records upon request. Records obtained under this Section shall not be further disclosed except pursuant to written authorization of the recipient under Section 5 of the Mental Health and Developmental Disabilities Confidentiality Act."

The **Mental Health and Developmental Disabilities Code 5/3-608. Treatment; right to refuse; records** mandates that "Upon completion of one certificate, the facility may begin treatment of the respondent. However, the respondent shall be informed of his right to refuse medication and if he refuses, medication shall not be given unless it is necessary to prevent the respondent from causing serious harm to himself or others. The facility shall record what treatment is given to the respondent together with the reasons therefor."

COMPLAINT #1 CONCLUSION:

The HRA **substantiates** the allegation of improper physical restraint. Although the patient was not involved in a physical restraint by security personnel during his treatment in the ED, on 12/27/20 he was escorted to another ED behavioral health room in the presence of security personnel and placed in four point restraints by ED staff. The patient also received two emergency medications to treat his unsafe behaviors. The patient record does not provide the appropriate documentation to indicate that the patient's rights were ensured nor was the Notice of Restricted Rights of Individual form reviewed or provided to the patient after treatment in the ED as mandated by **Mental Health and Developmental Disabilities Code 405 ILCS 5/2-201 Restrictions, restraints or seclusion; notice; records** which reads "... (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 therefor to: (1) the recipient and, ..."

Regarding the allegations that the patient was left waiting for treatment in the ED without communication, the HRA reviewed the patient record provided. The patient arrived on 12/27/20 and was admitted to a room at 6pm. The patient met with a Behavioral Health Clinician around 7:45pm and was assessed by two ED Physicians at 7:51pm and again around 8:40pm. At approximately 8pm the ED progress notes reflect the Physician statement that the "Treatment plan has been discussed with the patient. No further questions have been provided at this time. Patient has agreed to take an oral medication for his agitation and anxiety...". The hospital also reported during the site visit that they did not have an open bed available and had to seek placement outside of the hospital. Although this information is not reflected in the chart record. Eventually, the patient was able to be admitted to this hospital on 12/28/21 at approximately 6:15am.

Lastly, the HRA has concern with the hospital's use of emergency psychotropic medications while this patient was in four point restraints. Although orders were adequate and the emergency involuntary admission paperwork had been started. The physician ordered the use of Valium and Inapsine before the patient was in restraint but it was administered while the patient was restrained. The HRA would strongly suggest that the hospital train ED staff on **Mental Health and Developmental Disabilities Code 5/3-608. Treatment; right to refuse; records** mandates that "Upon completion of one certificate, the facility may begin treatment of the respondent. However, the respondent shall be informed of his right to refuse **medication** and if he refuses, **medication** shall not be given unless it is necessary to prevent the respondent from causing serious harm to himself or others. The facility shall record what treatment is given to the respondent together with the reasons therefor."

The HRA makes the following recommendations:

- Train ED staff on the Mental Health and Developmental Disabilities Code **405 ILCS 5/2-201 Restrictions, restraints or seclusion; notice; records** section "... (b) 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, advanced practice psychiatric nurse, 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, advanced practice psychiatric nurse, 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 hospital must follow the Mental Health and Developmental Disabilities Code **405 ILCS 5/2-201. Restrictions, restraints or seclusion; notice; records** pertaining to section one of the Notice of Restricted Rights of Individual forms. The form needs to be completed in its entirety and provided to the patient after the use of emergency psychotropic medication. It would also be best practice to include a corresponding nursing or behavioral health progress note to document this occurring. Retrain staff accordingly.

- Provide training curriculum used, staff sign-in sheet, and verification of completed training for all ED staff.

The HRA makes the following suggestion:

- When reviewing the patient chart record, the HRA noted that although staff

assessed the patient to be in need of a psychiatric evaluation in the ED, the notes do not reflect a clear conversation with the patient asking about the treatment he was seeking. If this conversation would have occurred it potentially could have thwarted the escalating of behaviors which resulted in physical restraint and emergency medications being given.

- The HRA also strongly suggests that the hospital review the use of emergency medication when a patient is in four point restraints.

- Train staff on the **Mental Health and Developmental Disabilities Code 405 5/3-608. Treatment; right to refuse;** records mandates that "Upon completion of one certificate, the facility may begin treatment of the respondent. However, the respondent shall be informed of his right to refuse medication and if he refuses, medication shall not be given unless it is necessary to prevent the respondent from causing serious harm to himself or others. The facility shall record what treatment is given to the respondent together with the reasons therefor."

- Update the patient's chart with The Mental Health Treatment Declaration which 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. 21-090-9009

SERVICE PROVIDER: UnityPoint Healthcare Methodist/Proctor

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:

X 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.

Education provided per recommendations. Please do DOT include staff names.

DEAN STEINER
NAME

INTERIM COO - UNITYPLACE
TITLE

3/2/22
DATE

Guardianship & Advocacy

- Clearly document necessity of restraints in EMR
- Notice of Restriction of Rights completed, and patient is given a copy – Documented in EMR (pt VU/Ref…)
- Rights of the Individual completed, and patient is given a copy – Documented in EMR
- Clearly document conversations regarding the treatment the patient is seeking (pt perspective)
- Emergency medications when in 4-point restraints
  - Indication/justification
  - Included in ROR or another form completed
  - Documentation in EMR
- Offer Mental Health Treatment Declaration