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Northwest Regional Human Rights Authority
Report of Findings
Case #20-080-9017
Mercyhealth Hospital – Rockton Avenue

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation into potential rights violations at Mercyhealth Hospital – Rockton Avenue. The complaint is that a patient was not provided with adequate and humane care and not treated in a way that protected the patient's right to be free from abuse and neglect while hospitalized. Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

The facility recently closed the mental health unit at this location in July 2020 and was recently approved through the State of Illinois on September 22, 2020. The 20-bed inpatient unit would typically serve 41 patients monthly, ages 18 years old and older. They have 30 staff including RNs, mental health technicians, and assessors. The hospital's psychiatrist departed from the hospital in July 2020. The emergency department (ED) has 30 stations, and 1 station is dedicated for trauma cases.

The HRA conducted interviews with representatives from the administration, legal counsel and ED personnel. Relevant policies were reviewed as was the patient's record with authorization.

Record Review

ED Record Review

The patient was brought to the ED by emergency personnel at 5:20 pm after getting into an altercation with another person**.** Once arrived, the patient was in a wheelchair and handcuffed, awaiting a bed with security and local law enforcement was present. While waiting for bed, a local officer completed a petition for involuntary admission at 5:35pm. The hospital staff completed an addendum which provided more in-depth petition information of interactions in the ED and noted that patient has a "person guardian", who needs to be contacted regarding hospitalizations. Once a bed was located, the patient was

assisted into a gown and on a bed by staff. During this time, the patient was uncooperative and yelling obscenities and threats, such as " F*** you, you aren't going to kill me by shooting me! Call my f***ing doctor, I am in cardiac arrest". Along with the statements that were made, the patient threatened to spit on staff and harm staff. A safety attendant was assigned to the patient. The certified nursing assistant (CNA) tried to obtain the patient's vitals and the patient began to yell; vitals were taken at 5:58pm. The patient was refusing to remain in the room or keep clothing on. According to the nursing note, the patient was naked in the bathroom, shaking and stated, "you can't f***ing touch me, I can be as naked as I want" The nurse was finally able to get the patient to put hospital gown and undergarments back on. At 6:20pm, the patient was resting and had calmed down, the hospital assigned a safety attendant to patient. Ten minutes later, the patient was up and moving around yelling for food and using obscenities. The ED Nurse informed the patient she would need to be cooperative in order to get food or drink. According to the medical record, the patient continued to yell obscenities, began to bang on hospital garage door and stated, "trying to kill me, by starving me" and refused to stop hitting the garage door. The nurse noted "tried many attempts to de-escalate by various staff members with no change in behavior". Security was called as well as the on-call physician. At 5:30pm, the ED nurse completed a restriction of rights form for administering emergency medication and the reasoning is "psychosis and agitation and threatening to patient and staff safety". The patient had no preference for intervention. According to the medication administration record at 6:55pm, the patient was given intramuscular dosages of Haloperidol 5mg (given IM) 2x, Ativan 1mg (given IV). At 7:04pm, according to the ED provider notes, the patient would not provide a medical history and stated nothing is wrong, but it was noted that the patient " will need medication for agitation for safety of self and staff"

The next day at 7:15am, the patient was requesting to see a doctor. Most of the day, the patient rested on a cart, ate breakfast at 8:50am, and lunch was available at 12:15pm; food was ordered periodically throughout the day. The inpatient certificate was completed at 11:00am. The patient met with a psychiatric assessor at 2:15pm to provide history. Based on assessment, the on-call psychiatrist was consulted, and it was stated "patient meets the standard criteria for inpatient psychiatric hospitalization". The guardian was contacted who suggested facilities outside of the current service area. The referrals were sent out to three hospitals and availability was found at one of the hospitals. At 2:58pm, the patient was shouting and claiming that she had not eaten and wanted to be returned to her residence. At 3:07pm, the patient yelled out loud she was "suing the hospital for illegal capture and holding". At 5:30pm, the EMS transport arrived to take to patient to approved hospital and the patient stated, " will kill all of you before you take me anywhere". The patient was transferred via EMS transport at 5:48pm that same day, which was the day after arriving to the ED.

Interviews

Hospital Legal Counsel

According to the hospital legal counsel, although the mental health unit is closed and awaiting final approval from the state regulators, the hospital is still servicing patients with mental health issues. The current services entail hospital transfers to providers for inpatient services and outpatient community referrals.

Senior Manager Inpatient Services/In-Patient Psychiatric Nurse Practitioner

The Senior Manager of Inpatient Services provided some background history on the psychiatric unit census before the closing and about guardians and hospital transfers. The hospital temporarily closed its psychiatric unit in July 2020. During this time there has been one transfer to an outside acute provider and before the closure the hospital psychiatric unit, on a monthly average, would see 41 patients aged 18 yrs. and older (no children). The ED would average one patient daily needing mental health services. It was stated if a patient has a guardian and it is known, they're contacted immediately and if a transfer is occurring, the patient would remain in the ED until the transfer is completed. With the temporary closure of the psychiatric unit, there was discussion on how the mental health needs are being met currently at the hospital. It was stated that the hospital still has psychiatric assessors and a psychiatrist on-call 24 hours for assessments and if in-patient services are warranted, the patient is transferred to a facility that can service the need or they can be referred to an outpatient provider.

The question was raised as to why there was no signature on page 4 of the petition for this particular complaint and whether this was normal procedure. According to the Senior Manager on this particular complaint, this missing signature must have been an oversight due to the process enacted in the ED. The process in the ED includes staff ensuring page 4 is signed once the patient arrives. The psychiatric assessor completes an addendum after reviewing the petition to ensure any missing information or added details are included.

Due to the nature and factors that brought this patient to the ED, the committee inquired of who makes the determination of admitting the patient for mental health services. According to the Senior Manager, the determination surrounding a patient being admitted is completed by an assessor and the on-call psychiatrist, who as a team, reviews the current symptoms, behaviors and the patient's admission concerns. A recommended treatment course of action (inpatient admission, outpatient referrals) is provided to the ED physician, who makes the final decision for the patient; that decision is usually in agreement with the assessments results. In previous HRA reports, it was noted that the

hospital staff uses medication as a last resort, but the record received showed that this patient did receive psychotropic medication. The Senior Manager stated, that the reason for medication should be distinguished in the patient record, an example would be " a patient is hearing voices" to "reduce their symptoms, provide the patient with antipsychotic medication".

The Senior Manager of Inpatient Admissions explained the process when a patient is requesting to have their primary physician contacted. Normally they are not contacted, the ED manages their care, but once they are admitted to the psych unit the primary may or may not be contacted if the patient has been following up with their primary. Also, they would hope that once transferred to another facility, that facility would reach out to their primary regrading medical issues/conditions.

ED Physician

The questions posed to the ED Physician in particular about this patient revolved around being handcuffed and the role of guardians. The physician stated that patients are admitted as they arrive the to the ED, which can be a walk-in on their own accord, police escort or wheeled in. This particular patient's admission was considered normal, because the patient was cuffed and escorted by the police. The physician stated that " according to the medical records, the on-call psycho-assessor and the nurse ensured that the guardian was contacted once the assessment started", which occurs before the physician and the patient interact.

ED Nurse

The issue of the patients being chemically restrained in the ED was posed to the ED Nurse and it was stressed that " in triage patients are not chemically restrained but can be physically restrained with the restriction of rights form completed". According to the notes and the restriction of rights forms, the patient in this case was chemically restrained twice during their time in the ED and the forms stated the patient had no preference. The committee inquired about the usage of chemical restraints on this patient and the ED nurse stated it depends on the situation. The ED Nurse pointed out there were varying forms of deescalating tactics used with the patient, which were ineffective, before the medication was administered. The issue of security being involved was discussed and the ED Nurse stated " a nurse should document in the patient medical record, if security is called and the overall purpose of security being present is to ensure all parties are safe (patient and staff). A follow-up question was asked as to why there was no signature on page 4 of the involuntary petition and the ED Nurse responded, "not sure why this page was not signed, it possibly was an oversight at the time of admission."

In this particular case, the question was raised if the patient was aware of their rights and responsibilities and how is that relayed to the patient and the ED Nurse stated, " the rights and responsibilities form is given to the patient and it is discussed with the patient as well". This discussion led to the ED Nurse explaining that the patient is briefed on what the next steps are in the ED process, which entails " what medications may or may not be used, the type of testing performed, why security might be called." If a patient's rights are restricted, they are given copies of the forms. Because this patient arrived in handcuffs, the committee inquired if this is part of the normal admittance procedure when local law enforcement transports patients, and the ED Nurse stated, "arriving handcuffed is not normal, that is under the police watch and they are the only people who can remove or place the cuffs on a patient. They remain with the patient until the cuffs are removed".

Policy Review

The "**Mental Health Recipient Rights in the Emergency Department"** policy states "the hospital recognizes that the emergency department is considered a mental health facility when procedural requirements of the Illinois Mental Health and Developmental Disabilities Code is adhered." This policy points out that medication should not be given just because a patient is "agitated" and that the reason for giving psychotropic medication needs to be explained to the recipient. There were two restriction right forms completed on this patient one for each day in the ED. The first administration shot of psychotropic medication was at 6:55pm on the day of arrival and the second dosage was later that same day at 5:44pm. In reviewing the medical records, which led to the discussion of the charting by the staff, the forms did not accurately/appropriately describe what occurred, but detail was given on the patient's imminent physical danger and behavior, which warranted the dosages.

The **"Restriction of Rights – Recipients of Mental Health Services"** policy states that **"** to assure that the rights of patients on the Behavioral Medicine Unit or who are in the Emergency Department and receive mental health services under the Code are appropriately maintained and when restricted, are done so in compliance with Illinois Law". Per the restriction notices that were completed in the record, it was indicated on the forms that the patient had no preference for emergency intervention. In reviewing the medical records, there was no mention of notifying the patient of restrictions being used which led to the discussion of the charting by the staff, and the forms that did not accurately or appropriately describe what occurred, especially when discussing de-escalating the patient (no specifics were given on the de-escalation technique, but detail was given on the patient's imminent physical danger).

The "**Physical Restraint Use for Violent /Self Destructive Behavior and Non-Violence/Non-Self-Destructive Behavior"** policy states "medication is used as a restraint

when it is given to control behavior or to restrict the patient's freedom of movement and is not standard treatment for the patient's medical or psychiatric condition and the four side rails on the bed are raised in order to immobilize or reduce the ability of patient to move his or her arms, legs, body and head freely". While in the ED, the medical records do state the rails were used, to prevent patient from walking around freely, it is noted that the patient did freely move around and bang on the garage and took clothes off.

Conclusion

Complaint: The behavioral health patient's right to receive adequate and humane care in the least restrictive environment.

Per the Mental Health and Developmental Disabilities Code, "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. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan" (405ILCS 5/2-102(a)). A rights violation is **not substantiated**. During the short time in the hospital, the staff provided care to the patient, including appropriate medical care as determined by a physician.

Suggestion

The HRA offers the following suggestion:

1) When using restriction forms, hospital personnel should document in the medical record; the type of restriction used, the reasoning for the restriction, the interaction with the patient regarding the restriction process and the outcome.

2) Javon Bea will train all medical unit staff on the usage of emergency medication and the Mental Health Code (405 ILCS 5) in accordance with hospital policies.

Complaint: The patient's involuntary admission was improper.

Per the Mental Health and Developmental Disabilities Code, "when a person is asserted to be subject to involuntary admission on an inpatient basis and in such a condition that immediate hospitalization is necessary for the protection of such person or others from physical harm, any person 18 years of age or older may present a petition to the facility director of a mental health facility in the county where the respondent resides or is present"(405ILCS 5/3-601). A rights violation is **not substantiated;** the patient presented with unpredictable behavior and delusions before being brought to the ED. Once arrived at the ED, the patient attempted to spit on staff members, threaten staff with bodily harm, used vulgarities towards personnel and refused to keep clothes on while waiting to be serviced. The admission was warranted for the safety of the patient and the staff members.

Complaint: The behavioral health patient's right to be free from abuse and neglect.

Per the Mental Health and Developmental Disabilities Code, when an individual is receiving services from a mental health facility, they will be free from abuse and neglect (405ILCS 5/2-112). When an individual is receiving services from a mental health facility, they will be free from abuse and neglect (405ILCS 5/2-112). A rights violation is **not substantiated,** there was no indication that the hospital personnel mistreated, ignored medical issues or unfairly treated the patient. According to the medical records, the patient inquired about seeing a doctor and stated being in "cardiac arrest". The attending physician prescribed a dosage of Atenolol of 12.5mg and medically cleared the patient before hospital transfer. The hospital ensured that all care including medical was provided pursuant to her care/treatment plan and there was no evidence of abuse or neglect, which is defined in the Code as: *abuse* "means any physical injury, sexual abuse, or mental injury inflicted on a recipient of services other than by accidental means" (405ILCS 5/1-101.1) and *neglect* " means the failure to provide adequate medical or personal care or maintenance to a recipient of services, which failure results in physical or mental injury to a recipient or in the deterioration of a recipient's physical or mental condition"(405ILCS 5/117.1).

RESPONSE

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