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HUMAN RIGHTS AUTHORITY-PEORIA REGION

REPORT 10-090-9007
METHODIST MEDICAL CENTER OF ILLINOIS

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at Methodist Medical Center of Illinois. It was alleged that a patient with mental health needs was verbally and physically assaulted by emergency room staff when he refused to disrobe and that he was not provided with mental health treatment following a suicide attempt.

Substantiated findings would violate protections under the Medicare/Medicaid Conditions of Participation for Hospitals (42 C.F.R. 482) and the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Located in Peoria, the hospital has just over 350 beds and an emergency department that treats more than 56,000 patients each year. The HRA visited the facility where hospital representatives including those involved in the patient's care were interviewed. Hospital policies were reviewed as were sections of the adult patient's medical record with written authorization.

COMPLAINT SUMMARY

The complaint states that the patient arrived at the emergency department with his parents one evening following a suicide attempt earlier in the day. Once settled in an exam room the patient said he preferred not to wear a gown. The nurse reportedly lost his temper and became aggressive, yelling, "I don't care what you want. Put the gown on now; you'll be lucky if you don't go to jail." The patient expressed his preference again, and the nurse bolted out of the room and called for security. Two guards responded and the team forced the patient to remove his clothes. At one point they allegedly held him on the floor, a knee pressed into his back. They pulled him off the ground and told him he was going to jail for hitting the nurse and that they did not have to treat him under law. The parents pleaded with the nurse to treat their son but were told, "No. He hit me and he's going to jail." It was said that the police arrived soon after, and the patient was paraded to a police vehicle, opened-gown, exposed to everyone in the waiting room. After a few exchanges between the family, hospital staff and the police, he was returned to the emergency department and was ultimately admitted for observation.

FINDINGS

The emergency department chart showed that the patient walked in just after 6:00 p.m. with complaints of overdosing on multiple drugs. He was seen by a nurse within ten minutes and was designated non-urgent. According to the nurse's assessment at 6:12 p.m., the patient was able to ambulate without difficulty; he was alert and oriented x3; his speech was clear and he responded to commands. He mentioned how he took all of his medication that morning to kill himself and that he vomited three times afterwards. He went to work and then left around noon and started drinking. His parents called 911 that evening. The nurse wrote that he asked the patient to disrobe and that he complied until it came time to remove his pants, "…started threatening violence if I tried to take them. I left room got 2 security. went into room with security, pt taunting youngest security officer, pt put on bed, he stated would comply. let pt stand to remove, pt then suddenly swung out punched me in low left chin, full force. pt then restrained until p.d. arrived at 1835. Alert. Oriented x3…. Combative. Cooperative. Fully verbal." (Verbatim).

A corresponding security report stated that two guards were called to assist the patient in taking off his clothes and putting on an exam gown. The guard noted that the patient refused to comply, became angry and punched the nurse in his face. As the documentation went, the guards "…then apprehended the patient and took him to the floor and held him in position until [the police] arrived and put handcuffs on pt. [The police] then took [pt.] out of the E.D. and placed [him] in his squad car." The report also referenced that a physician contacted the poison control center in the meantime and was advised that the patient should remain in the hospital for close observation. The patient was brought back in, and security was advised to notify the police at discharge so he could be taken into custody. One guard completed one report although two guards were involved, hands-on with the patient.

A police report completed by the responding officer detailed his account of the events, and according to him, he arrived to find officers already on the scene handcuffing the patient. The security guard who is referenced above explained the situation to him, and the officer took the patient to his squad car to calm down while he figured out what to do. The guard told him that the patient needed to remove his clothes and put on a gown to be treated; he refused to do so and became aggressive and threatening towards the nurse. They advised the patient to follow the procedure but he lunged toward them. The guards each grabbed an arm and held him up against the bed. The patient relaxed so they let him back up and he punched the nurse on the chin. The nurse verified the guard's account, and the officer wrote, "Both wanted [the patient] arrested and removed from Methodist." The officer added that before he would do that he asked the attending physician if medical attention was still needed. The physician said the overdose occurred eleven hours prior and the patient was not really showing affects. The physician said he would call the poison control center to find out and then he advised the officer that they would hang on to him for observation.

The attending physician documented his evaluation of the patient which started soon after the incident at 6:23 p.m., apparently while he was being held by the guards until the police

arrived. He described the patient as being intoxicated and stated that his reliability of history was questionable. He referred to the drug ingestion eleven hours earlier and wrote that it carried the possibility of a significant risk and that the patient admitted to active suicidal ideation. The psychiatric portion of the physical exam noted a flat affect and poor eye contact consistent with depression, and the review of symptoms was otherwise negative. The physician entered an update some thirty minutes later that said the patient had refused to cooperate and hit the staff, which was witnessed by security personnel, and that the police had come to arrest him. The physician discussed the matter with someone at a poison center who recommended a twenty-three-hour observation. Meanwhile various tests or monitors including blood work and an electrocardiograph were ordered. By 8:00 p.m. the physician had listed intentional overdose, suicidal ideation and alcohol intoxication as primary diagnoses and the patient was admitted to the intensive care unit.

Charting from the intensive care unit revealed that the patient was admitted clinically stable; he was to be monitored overnight and a psychiatric consult would be done in the morning. There were no documented indications on arrival of injuries or bruising from the incident with security and the emergency department nurse. A psychiatrist visited the patient at 1:00 p.m. the next day. Her report cited prior suicide attempts and a long-standing history of alcohol and substance abuse. The patient said he had been depressed for years, which was the cause for drinking, and his wife had just told him she wanted a divorce. He was alert and cooperative but seemed somewhat irritable, and he reluctantly agreed to voluntary psychiatric hospitalization. He was discharged from the unit that day with all diagnoses including drug overdose, hypertension and depression listed as stable; intoxication, resolving.

We followed up with interviews during our first site visit. Emergency department managers told us that the hospital has no written policy on disrobing and that all patients are expected to don a gown for an appropriate evaluation. They do not force absolutely everyone to disrobe, but they do want to make sure there are no concealed weapons. The nurse involved in the matter recalled what took place and said the patient smelled of alcohol, appeared intoxicated and mentioned suicide. The nurse said that patients have to be in a gown, and as a rule, they get them in gowns. This patient was a little verbally abusive and did not want to get undressed. He started complying but changed his mind and the nurse called security. Once security came in he got a little confrontational and taunted one guard's age and size. "He stood up, and out of the blue, he swung and hit me on the chin. We fell to the floor." He further explained how the guards were on the floor struggling with the patient who wrestled about. He could not remember how long they were on the floor, but the patient was thrashing and kicking; at no time did he see anyone press his knee into the patient's back. He also said that at no time did they force his clothes off, but the nurse removed his pants as he was being held. Regarding restraints, the nurse said they simply held the patient until the police arrived, which was within minutes, and that no mechanical restraints were used. All of the staff involved are CPI, or Crisis Prevention Institute, trained in safety management. On the issue of whether necessary mental health treatment was provided, the group told us that the patient's drug ingestion and intoxication were primary concerns and it would be typical to hold any full psychiatric evaluation until those were cleared. Such an evaluation in this case would have occurred in the intensive care unit some time later. Hospital administrators offered that a full root cause analysis had been conducted and they believe everything was done as needed. The hospital approached the police department and

talked to them about not taking patients away without medical clearance.

We attempted to meet with the security guards on three occasions. We requested their attendance at the first meeting but were told on arrival that one guard did not work that day and the other was no longer employed there. We set up another meeting with the guard who completed the security report and his supervisor. We were told on the day of our visit that the guard had a family emergency and would not be attending. We proceeded to interview the supervisor who said he had been in charge of security for about one and a half years. He described various issues that require a report, which included any violence, involvement with patients, routine assists and property damage; one guard will make a report. The supervisor told us that the guard who reported in this case is full-time, so he would be responsible for writing the report. The other guard is PRN, or as needed, although we note that the hospital said earlier he was no longer employed there. Reflecting on the incident at hand, he did not see how his team could have handled things differently and said that they were working under the direction of emergency department staff. After that visit we asked for the reporting guard's work schedule and offered to arrange either a visit or conference call with him. The hospital informed us that the guard was no longer employed at Methodist when we followed up for that.

CONCLUSION

Methodist policy (#Q-13) states that the rights of patients are respected by care, treatment and services provided in a way that respects and fosters dignity, autonomy, positive self-regard, civil rights and involvement. The patient has a right to personal dignity, to wear appropriate personal clothing as long as it does not interfere with diagnostic procedures or treatment, and to not remain disrobed any longer than is required for accomplishing medical purposes. The patient can expect to participate in decisions involving his/her health care, treatment and services, including the resolution of dilemmas about care, treatment and services. The patient may refuse care, treatment and services to the extent permitted by law and regulation. Consent policy (#Q-06) states that if an emergency exists, as defined by the physician in attendance, care should be initiated even without consent. The circumstances and measures taken should then be documented in the patient's medical record by the attending physician.

Under the federal Conditions of Participation for Hospitals, a hospital must protect and promote each patient's rights. The patient has the right to participate in the development and implementation of his or her plan of care. Rights include being able to refuse treatment. The patient has the right to personal privacy and to be free from all forms of abuse or harassment (42 C.F.R. 482.13). The Mental Health Code states the same and adds that services shall be adequate and humane, pursuant to individual plans (405 ILCS 5/2-102 and 5/2-107). Adequate and humane services is defined as those reasonably calculated to prevent further decline in the clinical condition of a recipient so that he does not present an imminent danger (405 ILCS 5/1-101.2).

Complaints stated that the patient was verbally and physically assaulted by emergency room staff when he refused to disrobe and that he was not provided with mental health treatment following a suicide attempt. In this case there are suggested provocations on behalf of each

involved, the patient, the nurse and the guards, but there is no factual evidence whether by documentation or statement that the nurse or the guards were verbally and physically assaultive. Examinations completed by a physician in the emergency department and in the intensive care unit after the incident revealed no injuries, marks or bruising as a result, at least by documentation throughout his stay at the hospital. That part of the complaint is not substantiated. Where Methodist erred is in how the nurse handled the situation and allowed it to become something completely unnecessary. Per the record the patient was there quite willingly to seek help after a suicide attempt, was designated non-urgent, which we were told means no apparent distress, was alert and oriented and was appropriate and cooperative until it came time to remove his pants. We agree with the hospital that given the patient's circumstances he was at high risk, and he certainly needed to be medically cleared and observed. But given the patient's circumstances is precisely why the nurse should not have insisted on forcing him to take his pants off, opting instead to alert the attending physician who could have made an appropriate determination on whether to proceed with or without the pants. That would have avoided the escalation and would have been acceptable according to the policies and regulations cited. As it turned out, the patient's right to refuse was hastily disrespected and the hospital's actions fostered patient humiliation, not dignity. That part of the complaint is substantiated. On the issue of not providing mental health treatment following a suicide attempt, there was compelling evidence in the patient's medical record that he was first provided with medical care and monitoring to ensure his health safety after taking in drugs and alcohol. It is very common to postpone psychiatric evaluations while a patient is intoxicated, and one was completed by a Methodist psychiatrist as soon as he was cleared. Determinations were made between the psychiatrist and the patient from there. That complaint is not substantiated.

RECOMMENDATIONS

1. Instruct all appropriate personnel to respect a patient's right to refuse treatment absent a physician-determined emergency.
2. Instruct all appropriate personnel to seek attending physician direction when a mental health patient refuses to disrobe.

SUGGESTIONS

Methodist told us that only one guard is required to complete a security report regardless of how many respond to a call. Here, one guard was a full-time employee while the other was part-time, so the full-time one was responsible for a report. Better practice and responsibility would call for everyone involved in a physical scuffle with a patient to be responsible for a detailed report of what occurred. The hospital should revise its security reporting requirements.

There is no data showing mental health patients as more dangerous than other patients in the emergency department setting. In fact, studies show that people with mental illness and other disabilities are more often victims, not perpetrators of abuse. Methodist is encouraged to stop blanket approaches to its mental health patients and treat each one individually, just as all medical care is prescribed individually. Instead of "as a rule, we get them in gowns" as stated by

the nurse, consider the crisis a patient may be under and that modesty might be an issue for him. When safety remains questionable, consider pat-downs as an alternative before stripping someone against his will.

An observation during this review has to do with the nurse's and the guard's insistence on having the patient arrested and removed from the hospital before he was medically cleared. The employees we spoke to seemed to assign blame on the police department, but the policeman's report provided a different story. He said that the guard and the nurse "Both wanted [the patient] arrested and removed from Methodist." The police officer, not the nurse nor the guard, said he would have to check with the physician first. Hospital administrators said they approached the police department, but obviously need to approach their own employees as well.

RESPONSE

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

Methodist
A MAGNET HOSPITAL

June 27, 2011

Ms. Meri Tucker
Guardianship & Advocacy Commission
Peoria Regional Office
401 Main Street, Suite 620
Peoria, IL 61602

Re: Case #10-090-9007

Dear Ms. Tucker:

Thank you for giving us the opportunity to respond to the above listed complaint filed with the Guardianship & Advocacy Commission. We have thoroughly reviewed the report, and we appreciate the thoroughness in which the commission's evaluation was done.

Please be advised that we take all complaints and grievances very seriously, and that we work to improve the services we provide.

In response to the substantiated part of the above mentioned case, we implemented those recommendations. Specifically, during the month of May, we completed staff education that instructs them to respect the patient's right to refuse treatment unless the physician has determined the treatment to be an emergency. Staff has been instructed to ask the emergency room physician for direction when a behavioral health patient refuses to disrobe. Evidence of that education is attached.

Thank you again for this opportunity to address your concerns and please do not hesitate to contact my office if you should have any questions or need any additional information.

Sincerely,

Julie Brown

Julie Brown
Manager, Emergency Department

Methodist

Date Entered_____

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LEARNING ACTIVITY RECORD

Upon completion of Steps 1-4, *PROMPTLY send this form to Human Resource Services (HRS).*
An employee may not receive credit for attendance *if* ID is incorrect or absent *OR* if the employee name is not printed legibly. *Please keep a copy for your records.*

STEP 1. Program Information

Course # _____ Date Completed: May 16-20, 2011 Course length: _____ ☐ Min ☐ Hrs

Program Title: Counning Pt's that Refuse

Coordinated by: J Brown Dept# 7600 Phone# /EXT _____

Presenter(s): _____

STEP 2. Needs Assessment (What prompted this presentation?) Check all that apply

✓	The patient population served, type and nature of care provided by the department and institution		Advances in health care management, health science and technology
	Identified staff needs/requests		Aggregate Data
	Department or individual performance appraisals		Organizational or Regulatory Requirement
	Performance Improvement Issue		Other (please specify):

STEP 3. Content Information

Learner's Objectives	Summary of Program Content or brief Program Outline	Teaching Method(s) Utilized (mark all that apply)	Evaluation Method(s) Planned (mark all that apply)
Following this presentation, the learner will be able to:		Knowledge based (cognitive) ☐ Lecture ☐ Self-paced learning Skill based (psychomotor) ☐ Demonstration ☐ Application practice Behavioral (effective) ☐ Discussion groups Others (please specify) ☐ _____	☐ Written test/quiz ☐ Return demonstration ☐ Competency check ☐ Reactive Survey or questionnaire ☐ 3, 6, or 12 month follow-up ☐ On-the-job observation ☐ Performance appraisal ☐ Outcome Indicator _____ _____ ☐ Others (please specify): _____ _____