FOR IMMEDIATE RELEASE

East Central Regional Human Rights Authority
Report of Findings
Case 11-060-9022
Provena Covenant Medical Center

The East Central Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning mental health services at Provena Covenant Medical Center located in Urbana, Illinois.

Complaint:

1. The hospital refused to provide treatment on the basis of an individual's disability.

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/1 et seq.).

Per its website: "Provena Covenant has the area's largest inpatient rehabilitation center, featuring facilities for physical, occupational and speech therapy. Also home to Provena is the Human Motion Institute, the Provena Center for Healthy Aging, and the area's only Adult Behavioral Health Unit in a hospital setting. The Behavioral Health Unit at Provena Covenant Medical Center is the area's only inpatient unit. We offer 24 adult beds for ages 18 years and up in a quiet environment, allowing for privacy and confidentiality."

COMPLAINT STATEMENT

The complaint alleges that the behavioral health unit does not serve persons with developmental disabilities. An individual with a dual diagnosis of mental illness and developmental disability was not admitted to the behavioral health unit even though he had reportedly aggressive and dangerous behaviors. Recently, when an elderly bus driver told him he could not go outside the bus and smoke a cigarette, he threw his lunch box at her and then he got out of his seat and started hitting her. He is a very large man. The police were called and intervened. The police had brought him to the Provena ER to be evaluated for possible admission to the behavioral health unit. The arresting police officer had completed the petition for involuntary admission due to the severity of the behavior and a history of these types of behaviors. Hospital staff called the qualified support professional (QSP) of the home, to come pick him up because he did not meet the criteria for admission. This individual has had a history of threatening to kill staff; he used racial slurs and profanity to provoke staff and peers. He has

repeatedly hit peers, which includes attacking a peer whose only mode of ambulation was a wheelchair. He has made false accusations against staff. Staff will not interact with him alone. He exhibits aggressive behaviors when asked to follow house rules regarding cigarettes, coffee, and pop.

The HRA proceeded with the investigation having received written authorization from the individual's guardian to review the consumer's record. The HRA visited the hospital where the hospital and behavioral health representatives were interviewed. Relevant practices, policies and sections of the patient's record were reviewed.

INVESTIGATIVE INFORMATION

Interviews

To pursue the matter the HRA investigation team visited the hospital where hospital representatives were interviewed. Relevant practices, policies and sections of the individual's record were reviewed. The HRA met with administrative, risk management and behavioral health staff, psychiatrists, nursing managers, and the crisis worker. Staff explained that the behavioral health unit is a 24 bed acute care facility. There have been several patients with dual diagnoses admitted, including those with developmental disabilities. The number of patients on the behavioral health unit averages about 12-13. Patients are triaged in the emergency room (ER). There are specialists on call. The behavioral health unit would be staffed with registered nurses, social workers, psychologists, patient care techs, and psychiatrists. Regarding the hospital's grievance process they follow the centers for Medicare & Medicaid (CMS) guidelines and hospital-based psychiatric quality assurance measures.

The typical process for admission to the behavioral health unit would be initiated when a patient comes to the ER where they are medically reviewed. There is a medical screening, and then the crisis team comes in. The local crisis team would consult with the ER physician and a psychiatrist to determine a plan of care. For the admission to be voluntary, the patient must be at imminent risk of harm to themselves or others. The same criteria is used for voluntary admission, because patients are in a locked unit. If an individual does not meet admission criteria there are referrals or resources provided. The local crisis team will make a referral depending on the individual's needs. It all depends on the evaluation and the physician.

At the ER there would be a medical screening exam and physician directed care. A medical exam is first completed by the physician who would rule out medical versus mental health concerns. The crisis team is a contracted service and they would do the evaluation if there were concerns for mental health. Once identified in need of mental health treatment individuals are given the opportunity to admit themselves voluntarily. When asked at what point does the hospital pursue involuntary admission, staff reported that if it is determined that the patient is at risk for being a danger to themselves or others; they do not take this lightly and want to be sure about proceeding, because that action would take this person's rights away.

Regarding information provided to recipients during the admission process, if the patient is in need of involuntary admission, the hospital provides status information, copies of all the paperwork, the petition, certificate, rights information and third party contact information. Forms are downloaded from the State's website. Rights are read to each patient. Nurses do an

extensive intact nutrition screening, mobility screening, and an assessment on arrival. Family history, current and past treatment, guardianship and power of attorney information would be collected. They would contact the guardian for needed information.

The HRA asked can the hospital accommodate a patient's developmental disability in the behavioral health unit; the response was yes, that they treat every patient individually. The patient is treated on their cognitive ability to participate. When asked what would need to change if they did accept this population into the unit, the response was nothing; they already do accept that population.

The circumstances that brought this patient to the ER were that he hit a bus driver and had a behavioral incident on the bus. He was diagnosed with a mood disorder. The ER physician had seen him to determine if it was a medical issue or more of a behavioral health unit issue. A crisis worker followed up on the behavioral health evaluation. The HRA asked if medication was assessed. The response was that the nurse obtained a list of the patient's medication. The physician would assess whether this be a reasonable medication for this person. The physician reviewed and considered if the medication would be the cause of the behavior. There are various medical evaluations conducted. There was RN assessment, a review of the history and physical, physician assessment, and labs were taken. The physician did assess the decisional capacity as part of his physical exam. When underlying medical issues were ruled out by the physician, the crisis team was contacted. Emergency medications were not given and the involuntary admission was not pursued because the crisis worker observed in the emergency room that he was very calm. The criterion for involuntary commitment has always been very strict. The judge wants to see detailed information, such as suicidal ideation before a patient is involuntarily admitted. They examine more than just aggression including if the patient shows eminent risk of harming himself or others.

When asked if the involuntary admission would have been pursued if the patient did not have a developmental disability, the response was in this case there would not have been any difference. The group home was contacted, his case manager, his therapist was contacted and his guardian was contacted.

With regard to the discharge arrangements, the recipient would have been returned to the community integrated living arrangement (CILA) home to review his medication with his current psychiatrist and physician. The discharge plan was to have the CILA staff pick him up and provide information about contacting his therapist and physician. Usually they give the provider the crisis team number.

There were no formal grievances or complaints registered by him or on his behalf regarding his treatment.

Interview with the Crisis Worker

In describing the role of the crisis team the representative explained that the physician drives the patient's care, and then the crisis worker would be called to assess the basis of care for mental health, to make recommendations, to assess for risk frequency of symptoms, and to determine underlying causes. Then the crisis worker discusses the plan for the patient with the

psychiatrist and the attending physician. The crisis worker would participate in the plan for care and help with setting up referrals. The crisis team would come into the ER and conduct a thorough evaluation to make recommendations.

This crisis team member has a BS in psychology; most crisis team members have a history in human services and have achieved a master's degree in psychology or social work. The crisis team consists of 5 people who work for a community mental health facility. It is a large entity that includes group homes, assisted living apartments; they have approximately 10 buildings overall.

When asked at what point would a crisis team member step into an admission, the response was that the ER will contact for a behavioral evaluation. The physician would contact the crisis team after the toxicology screen and the person is coherent enough to speak; they have had past interactions with this patient.

The HRA presented the scenario that this individual had just thrown a lunch box at an elderly bus driver and then got out of his seat and started hitting the bus driver, still the crisis assessment documented that he was a low risk of harm to others; the HRA questioned this. This crisis team member had spoken with a bus driver who stated she had sustained no injuries and the patient had this pattern of behavior. The bus driver stated that she had no concern for her own safety. This crisis team member also consulted with the individual's case manager. The patient was very remorseful; he was sorry that he had hurt anybody. He did not appear to be any threat to others.

The HRA inquired about the individual going to the ER for dangerous aggressive behaviors on 3/19, 4/9 and 5/4, yet still he was sent home after being assessed and not admitted; the HRA questioned if this would have been different if he did not have a cognitive impairment. The response was absolutely not.

The HRA inquired about documentation that his case manager believed his behaviors were escalating. The response was that past assessments were considered, the patient was involved in treatment and he had access to resources for support in the community, which was the least restrictive environment. If an admission was more appropriate it would have been recommended. There is no difference in how they would screen a patient regardless of his disability. The HRA asked again if he did not have a cognitive impairment and had three different incidents of aggression toward others in the community would anything have been different, and the response was nothing would have been different. The police who brought him in were only reacting to the call. They looked at the information provided by CILA home staff, the patient, the 3 different instances of the patient being brought to the ER, the environment and the staffing education. He had been there for 9 hours. There was no lack of knowledge on how to treat someone with this type of disability. The crisis worker along with the physician considered if he was remorseful of his behavior and if he was allowing treatment. There was a collaboration of care for this individual and the crisis clinician had a dialogue with his therapist before he left.

When asked why the staff think the complaint was filed, the response was that maybe it was out of frustration. This is an acute care behavioral health unit. The average stay is 4 days if medically cleared. A patient may be aggressive to another individual because there is a lack of resources. He was not denied care; he did not meet the criteria for admission and his medicine has evolved. Each component was reviewed. The behavior was not due to his mental illness. Staff examined how they can help control those behavioral symptoms.

The HRA inquired about the educational background or qualifications of the behavioral unit staff. There are psychologists, psychiatrists, and registered nurses; some are board certified. Health care techs are, at minimum, certified nursing assistants. All are certified for crisis prevention intervention (CPI).

Hospital staff explained that they have admitted individuals to the behavioral unit with a developmental disability for various lengths of time. There was no separate policy for a person with a developmental disability. Some individuals needing long term treatment have been referred to another local provider in the community. The hospital does have a policy against discrimination in service provision. The hospital has interpreters, is handicapped accessible and is in full compliance with the Americans with Disabilities Act (ADA) for patients, employees and clients.

The HRA team was provided a tour of the facility. Hallways were painted with beautiful murals. Third party advocacy information was posted. Rights are read to every patient and each individual is given a copy of their rights. The patient rights were not posted. The HRA team inquired about the posting of patient rights.

During the tour it was explained to the HRA that every day there is an interdisciplinary meeting between all staff, the psychologists, pastoral care, psychiatrists, and nursing. They strive to provide optimum care for each person served on the unit.

Records Reviews

The face sheet of the individual that travels with him to the emergency room (ER) documented that the patient has a mild mental impairment, schizoaffective disorder, and depression. Included with it are the physician orders.

This is the time line of ER treatment for the individual.
03/19/11 3:00 p.m. Ambulance records documented that the patient stated that he wanted to kill himself and others, but did not have a plan. The patient hit another resident of a group home today, but did not know why he was feeling like this. The patient had no plans of how to harm himself or others and wanted to go to the ER and get help.

5:28 p.m. The RN noted that the individual was sent to the ER after hitting another resident. He had been aggressive many times this year and the police department had been notified; there is nothing they can do. The group home staff sent the patient to the hospital to be evaluated for mental health reasons thinking his aggressions were from his Schizophrenia or Bi-polar Disorder diagnoses. The patient was not suicidal or homicidal and was cooperative.

8:05 p.m. The crisis team evaluated the patient and documented on the Crisis Screening form that the patient was unable to explain why he hit his roommate in the face. The client stated that "He felt sorry for it." The client reported that the staff were supportive of him and he would tell them if he felt like hurting anyone or himself. It was documented that the Crisis worker consulted with the physician and the psychiatrist who agreed that discharge was appropriate due to his current level of low risk.

04/09/11 1:45 p.m. Police department completed the emergency petition. It documented that the patient became violent when he could not get staff to give him a soda. He slammed cabinet doors and broke a telephone. He threatened to kill staff members. This was the second transport to the hospital this week.

3:45 p.m. Crisis Screening was completed. It was documented that the client regretted his actions and he did not want to do it again. The client reported that the staff have been supportive of him and that he would tell them if he felt like hurting anyone or himself. The writer verified that the last trip to the ER was on 3/19/11. Both the physician and the on call psychiatrist with the crisis team determined that he should return to the group home.

05/04/2011
The record showed that the patient got into an argument with another worker at his workshop and struck out at the bus driver. The local police department was called and brought him to the ER. The concern was that aggressive behavior was increasing.

The Crisis Screening Form documented that the patient threw his lunch box, hit, and pushed his bus driver. He displayed remorse over his behavior and denied any suicidal ideation or any desire to harm others. The patient was to receive psychiatric services from his psychiatrist and case manager. The writer consulted with the on-call psychiatrist who recommended that the patient follow up with his psychiatrist for medication management to help alleviate his symptoms. He did not meet the criteria for inpatient psychiatric admission due to his low risk of harm to self or others, without significant history of suicidal or homicidal behaviors as well as his current professional supports and supervised environment. It was recommended that he be discharged to his current group home. The physician concurred with this recommendation. The individual and his case manager were provided information regarding crisis services if symptoms persist.

05/05/11
The officer completed the petition for involuntary/judicial admission. Consent was given by the patient's guardian for treatment. The patient was discharged to his caseworker.

Alternate Redacted Record

The HRA requested to view a redacted record of any individual with a developmental disability who had been recently admitted to the behavioral health unit. The provider quickly provided a copy of a redacted record to show that there had been past admissions to the behavioral health unit by individuals with these types of disabilities. This record documented the admission and treatment of an individual who has a moderate mental impairment. The admission

was necessary to help stabilize the individual from harming himself and he was on the unit for 7 days of treatment.

Policy Reviews

The HRA reviewed the *Patient Grievance Complaint Policy dated 12/3/04, The Patient Complaint Form, (No Date,) Quality and Performance Improvement, Grievance Policy Procedure dated 8/3/10,* and *the PCMC Patient Grievance Process*. The HRA was also provided a packet that is given and explained to patients who are admitted to the Behavioral Health Unit. It included a statement of the Patient's Rights and Responsibilities. It listed the patient's rights and free hotline numbers for third party advocacy groups. It also listed contact information for customer relations. Included were the Behavioral Health Informational Handbook (*No Date)* that explains facility procedures and rules, including visiting hours, selecting a daily menu, a request to complete a patient satisfaction survey, safety issues, what to expect while you are there, and the staff who will assist the individual patient. There was information about the hospital's philosophy of limiting restraint/seclusion use. It states: "We consider restraint/seclusion an aspect of care that is high risk and problem prone. We acknowledge that restrictive measures are considered necessary last resorts to help patient reestablish control of their behavior. Provena Covenant Medical Center/Behavioral Health's commitment is to utilize the least restrictive alternative, thus limiting the use of restraint/seclusion. This is accomplished through patient/staff education and performance improvement measures."

MANDATES

The Mental Health Code under section 5/2-100. (a) states: "No recipient of services shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the receipt of such services.

(b) A person with a known or suspected mental illness or developmental disability shall not be denied mental health or developmental services because of age, sex, race, religious belief, ethnic origin, marital status, physical or mental disability or criminal record unrelated to present dangerousness."

Per the Mental Health Code, involuntary admission can be petitioned if a person who is 18 or older believes, as a result of his personal observation that the individual would be subject to involuntary admission on an inpatient basis because it is necessary to protect that person or others from physical harm. The person making the assertion completes the petition stating such and provides the name and address of the spouse, parent, guardian, substitute decision maker, if any, and close relative, or if none, the name and address of any known friend of the respondent whom the petitioner has reason to believe may know or have any of the other names and addresses. If that information could not be provided they would state it on the petition and their attempts to obtain it. The relationship of the petitioner to the individual would be documented as well as any financial or legal relationship with the individual. Anyone who could be a witness would be documented and a certificate by a physician, psychiatrist or a psychologist would

accompany it or be provided within 24 hours. Otherwise the individual would be released after a 24 hour period. In this case the peace officer had taken this person into custody and transported him to the hospital, because the peace officer had reasonable grounds to believe that the patient was subject to involuntary admission on an inpatient basis and in need of immediate hospitalization to protect him or others from physical harm. Upon arrival at the facility, this peace officer completed the petition pursuant to Section 3-601 of the Code.

If upon admission the certificate had been completed, the hospital could have begun treatment of the individual. The Code would have required that this individual be informed of his right to refuse medication and if he had refused, medication would not have been given unless it would have been necessary to prevent him from causing serious harm to himself or others. There would have been a record of what treatment was given and the reasons for it. In this case it was the general agreement by the crisis worker, the physician and the consulting psychiatrist that an involuntary admission was not necessary.

Regarding voluntary admission to a mental health facility, per the Code under section 5/3-400, any person age 16 or older, including a person adjudicated a disabled person, may be admitted to a mental health facility as a voluntary recipient for treatment of a mental illness upon the filing of an application with the facility director of the facility, if the director determines and documents in the recipient's medical record state that the person is clinically suitable for admission as a voluntary recipient and has the capacity to consent to voluntary admission. This person would have the capacity to consent to voluntary admission per the professional judgment of the facility director or their designee and would understand that he is being admitted to a mental health facility. This person could request to be discharged in writing, but discharge is not automatic. Within 5 business days after receipt of the written request for discharge, the facility must either discharge the person or initiate commitment proceedings.

In providing the notice of rights per the Code under section 2-200 (a), it states: "Upon commencement of services, or as soon thereafter as the condition of the recipient permits, every adult recipient, as well as the recipient's guardian or substitute decision maker, and every recipient who is 12 years of age or older and the parent or guardian of a minor or person under guardianship shall be informed orally and in writing of the rights guaranteed by this Chapter which are relevant to the nature of the recipient's services program. Every facility shall also post conspicuously in public areas a summary of the rights which are relevant to the services delivered by that facility."

CONCLUSIONS

Complaint:

1. The hospital refused to provide treatment on the basis of an individual's disability.

For this patient to be subject to involuntary admission on an inpatient basis, he would have had to be in a condition that immediate hospitalization was necessary to protect himself or others from physical harm. A petition had been initiated by a peace officer at the time of the incident when the patient had assaulted the bus driver, but after the patient was taken to the ER it was documented that the patient was calm and remorseful for his behavior and he denied any

suicidal ideation or any desire to harm others. It was also documented that he did not meet the criteria for inpatient psychiatric admission due to his low risk of harm to self or others, without significant history of suicidal or homicidal behaviors.

It was recommended that he be discharged to his current group home. The crisis worker consulted with the on-call psychiatrist who recommended that the patient follow-up with his psychiatrist for medication management to help alleviate his symptoms. The physician concurred with this recommendation. The individual and his case manager were provided information regarding crisis services if symptoms persisted.

The crisis evaluation documented that the patient was remorseful for his behavior, denied any suicidal ideation or any desire to harm others. He was evaluated by the physician, the crisis worker and the on-call psychiatrist was consulted. It was determined at that time that he was not a danger to himself or someone else. The HRA reviewed a redacted record of another individual with a developmental disability that showed that individuals with this type of disability have been admitted to the behavioral health unit. This individual spent 9 hours under evaluation before he was discharged. The record does not indicate that he was not dismissed because of his disability. Based on this evidence, the **Complaint: The hospital refused to provide treatment on the basis of an individual's disability, is <u>unsubstantiated</u>.**

The HRA offers the following suggestion:

Rights should be posted pursuant to section 2-200 (a), it states: "Upon commencement of services, or as soon thereafter as the condition of the recipient permits, every adult recipient, as well as the recipient's guardian or substitute decision maker, and every recipient who is 12 years of age or older and the parent or guardian of a minor or person under guardianship shall be informed orally and in writing of the rights guaranteed by this Chapter which are relevant to the nature of the recipient's services program. Every facility shall also post conspicuously in public areas a summary of the rights which are relevant to the services delivered by that facility." The HRA appreciates that rights are read and given to each recipient at admission, but these rights should be posted in the facility to protect the rights of individuals and as a reminder to the staff that serve them.

The HRA would like to thank Provena Covenant Medical Center for their cooperation with this investigation