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**HUMAN RIGHTS AUTHORITY- CHICAGO REGION**

**REPORT #13-030-9001**

**Alexian Brothers Behavioral Health Hospital**

Case summary: The complaint alleged 14 Code violations. The HRA substantiated two of the complaints: That the recipient was not advised that she was being examined for certification purpose, and that the hospital breached confidentiality. The hospital has submitted a corrective action plan which is not included herein.

**INTRODUCTION**

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Alexian Brothers Behavioral Health Hospital (Alexian). It was alleged that the facility did not follow Mental Health and Developmental Disabilities Code requirements when:

1. A recipient was assessed for outpatient services and when she refused, the hospital Intake personnel then pursued an involuntary admission.
2. The petition contained an inaccurate reason for the involuntary admission that was obtained through manipulation.
3. The recipient did not receive a copy of the petition until she was discharged.
4. A recipient was not advised that she was being examined for certification purposes, was not informed that she did not have to speak with the examiner, and that any statements she made could be disclosed at an involuntary admission court hearing.
5. A certificate was completed by a person whom the recipient had never met or been interviewed by.
6. The record indicated that a recipient was admitted on a certificate when she was detained on a petition.
7. A recipient was assessed by an Intake staff unqualified to make psychiatric diagnoses and the Intake worker included errors, discrepancies and contradictions in the assessment.
8. A recipient was not allowed to make admission phone calls.
9. A recipient was threatened with security guards by Intake personnel when she indicated she wanted to leave.

10. Admitting times are inaccurate on some clinical documents.
11. A recipient was threatened with security guards by nursing personnel when she refused a strip search.
12. The clinical chart shows that blood/urine draws were taken when all draws were refused.
13. The requests made by a recipient for her clinical record were ignored by the facility.
14. The hospital breached confidentiality; data of another recipient was found in a recipient's clinical record.

If substantiated, this would violate the Mental Health and Developmental Disabilities Act (405 ILCS 5/100 et seq.).

Alexian is a 191-bed behavioral health hospital and part of the Alexian Brothers Health System, a comprehensive healthcare organization. It offers mental health and addictions treatment including inpatient, partial hospitalization, intensive outpatient and outpatient services for children, adolescents, and adults.

To review this complaint, the HRA conducted a site visit and interviewed the Director of Risk Management, Patient Advocacy and Patient Safety and the Intake Assessor. Relevant facility policies were reviewed, and records were obtained with the written consent of the recipient.

## COMPLAINT SUMMARY

The complaint indicates that the recipient was referred by her gynecologist to Alexian Brothers for outpatient counseling. She went, along with a friend, to the wrong building and an Intake worker in the inpatient behavioral health building then attempted to persuade the recipient to attend a 40-day hospital day program. Allegedly, when the recipient refused the day program, the Intake worker, who allegedly was not qualified to make psychiatric diagnoses, completed an inadequate and inaccurate diagnostic assessment, and while the recipient was in the restroom, the Intake person manipulated the recipient's friend into making statements regarding the recipient that implied that she was suicidal. The petition was completed on this information and the recipient never received a copy of it until she was discharged. The recipient then refused the admission and when she attempted to leave, she was threatened by the Intake worker that two male security guards would be called to have the recipient forcibly taken to the unit. Once on the unit, two female nurses asked the recipient to strip naked. When she refused, the nurses threatened to call the two male security guards to have them forcibly strip her if she did not cooperate. The complaint also alleges that the recipient requested but was denied admission phone calls to her family or attorney.

The complaint alleges that the certificate for involuntary admission was completed even though the recipient never met or spoke with the examiner. Additionally, it is alleged that the recipient was not advised that she was being examined for the purpose of certification, and she was not informed that she did not have to speak with the examiner. She was not told that any

statements she made could be disclosed at an involuntary admission court hearing. Additionally, admission times are incorrect on several clinical documents, and the clinical chart shows that blood/urine draws were taken when they were all refused.

The complaint indicates that the recipient requested her clinical record but these requests were ignored by the facility. Also it is alleged that the data from another patient's clinical record was included in the recipient's file.

## FINDINGS

The record contains a document entitled "Expected to Walk In." It is dated 6/07/11 at 4:21 p.m. and indicates that the recipient's physician had called the Intake Department and he described the recipient's symptoms as "Very depressed, cries a lot, wt loss, has been making SI [suicidal ideation] statements to her friend, recent miscarriage." The Possible Treatment Required section indicates Inpatient.

The record contains a Triage Appraisal document completed by the recipient on 6/07/11 at 5:45 p.m. before being assessed in Intake. The recipient answered "No" to all the following questions:

In the past 24 hours have you had thoughts about hurting or cutting yourself?  
Are you feeling like you want to hurt someone else?  
In the past 24 hours have you thought of ending your life?  
Are you feeling anxious, afraid, or worried?  
Have you taken more than your prescribed amount of medication in the past 24 hours?  
Have you taken more than the recommended dose of over-the-counter drugs in the past 24 hours?

The record contains the Level of Care Screening (EDM Assessments) completed on 6/07/11 at 5:52 p.m. by the Intake Assessor, a licensed social worker. The document contains a section entitled Patient's Own Complaint/Precipitating Event. It states, "'OBGYN recommended me here. I just really tired all the time, weight loss, dizziness, this has been going on for about a month. I have been isolating and crying and having a lot of depression. My ex threw me when I was having a miscarriage. This happened a month ago. Living with friend currently. I was eating a lot but was losing weight. And now the meds are making me have a huge loss of appetite. Over sleeping'. Patient not responding to a lot of questions and has a very flat affect. Patient never looked at assessor and had head down. Patient's friend petitioned patient based on a lack of functioning and stating she was suicidal last night." A section entitled Information from Additional Sources states, "The friend said that she has known her since she was 10 years old. She is constantly withdrawing, she is exhausted all the time. The relationship she was in was very bad. She was being abused verbally and mentally. She wants to work things out with him. He was very abusive. The friend said that she has sent me text messages saying she wishes that she was dead. Last night she said that if she could do suicide that she would do it." A section asking for descriptions of mood disorder behavior lists "Patient admits to passive SI [suicidal ideation] and not wanting to be in life." The document contains a section entitled Symptoms That Require Psychiatric Admission. It indicates that the patient is suicidal, unable to

care for herself, is a risk of harm to self/others due to "psychosis confusion, poor insight/judgment", and that the patient's psychiatric disorder "places physical health at risk/impairs daily functioning." The level of care that is recommended is inpatient and the Axis I diagnosis is listed as "Recurrent Depressive Disorder- Severe."

The recipient's Petition for Involuntary Admission, completed by her friend, is included in the record. It indicates that the petition is being initiated for emergency inpatient admission on the assertion that the recipient is a person with mental illness, who because of her illness is reasonably expected to engage in conduct which places her or others in physical harm or in reasonable expectation of being physically harmed, and that she is in need of immediate hospitalization for the prevention of this harm. This assertion is based on the following: "[Recipient] stated on 6/06/11 that if she thought she would be successful with Suicide she would do it. [Recipient] is severely depressed, not eating, risk to self and unable to thrive without help." The statement is witnessed by the recipient's friend and the friend is listed as the contact person. The recipient's friend signed as the petitioner and the petition is dated 6/07/11 at 6:36 p.m. The petition also contains a signed statement that the recipient was given a copy of the petition within 12 hours of admission and was explained the Rights of Admittee as well as given a copy of these rights. It also indicates that the recipient was given a copy of the Rights of Individuals Receiving Mental Health and Developmental Services.

The record contains the Nursing Assessment completed on 6/07/11. The Reason for Hospitalization stated, "Increased depressive symptoms, Suicidal Ideation yesterday. Patient is tearful, uncooperative during admission. Denies SI/HI [Suicidal Ideation/Homicidal Ideation] and wants to be d/c [discharged]." The Assessment indicates that the recipient refused to answer most of the Assessment questions. The Body Inspection section of the report notes that the recipient is "Uncompliant, cursing." The Rights and Responsibilities of Recipients document indicates that "Pt declines to participate- involuntary admission." The Designation of Emergency Treatment Preference and Emergency Notification document also has a notation which indicates, "Pt declines to participate." The record contains a Hematology report, but indicates that the recipient had not given a blood sample. The Chemistry Urines report indicates that the recipient did give a urine sample on 6/08/11. There is no indication from the record whether or not the specimen was given voluntarily.

The record contains the first Inpatient Certificate completed on 6/08/11 at 7:00 a.m. by the Director of Case Management/ Social Services, a licensed social worker. The section of the certificate that indicates that the recipient was informed of the purpose of the examination, that she did not have to speak with the examiner, and that any statements she made could be used in a court to determine the recipient's clinical condition or need for services is not signed. The document indicates that the recipient is in need of immediate hospitalization for the prevention of harm and this opinion is based on the statement, "Pt. increasingly depressed, suicidal ideations, Flat Affect, Poor sleep, Poor apatite. Pt. in need of hospitalization for safety and Stabilization." The second certificate, completed on the same day at 9:30 a.m. contains a signed certification that the examiner, a staff psychiatrist, has informed the recipient of her procedural rights, including the right to speak with a relative, friend or attorney before the examination, or to have an attorney appointed for her if she so desired. The certificate asserts that the recipient is in need

of immediate hospitalization for the prevention of physical harm and is based on the following statement, "Suicidal thoughts."

Progress Notes from 6/08/11 at 8:45 a.m. state, "Approached pt for H&P [history and physical]- refused. 'I'm not doing anything til I see the doctor and get the fuck out of here- this is a shithole. I don't belong here.' Staff attempted to explain process of evaluation to pt- she cont'd to curse and refused participate at this time. Dr... notified pt. would like to meet with him as soon as possible." At 11:50 a.m. an entry in the Progress Notes by the case manager states, "Met with pt to introduce self and case manager role. Pt. not wanting to meet with case manager. 'I wan to get out of here.' Pt irritable and short with case manager, interrupting. Pt claims she has outpatient in ... that she will follow-up with and that she already has appointments. Didn't want to discuss aftercare further. 'I don't need to be here, this isn't helping, I need to leave.'" The record shows that the History and Physical was then completed at 9:00 a.m.

The record contains a document entitled Inpatient Adult Criteria for Admission completed on 6/08/11 at 9:30 a.m. It presents 12 criteria and indicates that a person will be considered a candidate for acute inpatient psychiatric treatment who presents with at least one of the criteria. Five of the criteria are checked: 1) The patient expresses current suicidal ideation and is assumed to be in 'real and present danger'; 2) The patient is unable to maintain adequate nutrition, shelter, or other essentials of daily living due to a psychiatric disorder, and family/community support cannot be relied on to provide essential care; 3) The patient requires close and continuous skilled medical observation and supervision to make significant changes in psychotropic medication; 4) The patient requires continuous observation and control of behavior (e.g. isolations, restraining, other suicidal/homicidal precautions) to protect property, the patient and others; and 5) The patient requires close and continuous skilled medical observation due to side effects of psychotropic medication." A statement that the physician certifies that the patient meets medical necessity for inpatient psychiatric hospitalization and treatment is signed and certified by the attending physician.

The record contains the recipient's psychiatric evaluation completed on 6/08/11 at 9:49 a.m. It states, "Patient with a known history of major depressive disorder currently admitted to ABBHH through Access. Reportedly patient had a miscarriage in April. She went to see her gynecologist yesterday. During her appointment she expressed some depressive symptoms to her gynecologist who recommended that patient be assessed at our hospital for further treatment. Patient was brought to Access by one of her very close friends. During the assessment patient mentioned that she has been feeling depressed, repeated crying spells, lack of energy and motivation associated with weight loss. Patient went on to say during her Access assessment that she has been having some passive suicidal thoughts without any clear intent or plan. Collateral information was obtained from patient's close friend who was present at the time of the assessment revealed that patient has been functioning inadequately. She has been more isolated and withdrawn. Her friend reported that patient has been noted to be very depressed. Per friend did not endorse any symptoms of suicidal ideations or intent. However, patient could not contract for her safety and hence inpatient hospitalization was recommended. Reportedly patient became extremely agitated following that because she did not want to be admitted. Patient was verbally abusive to the staff at Access as well as in the inpatient unit. When I met with her, patient told me to 'Get the f\*\*\* out of here.' Patient is extremely angry and agitated at this time

because she mentioned that being locked up in the hospital is making her more anxious. She reported that she was tricked into coming into the hospital. She was noted to be extremely angry at her gynecologist who recommended psychiatric treatment. Patient has been swearing and was quite abusive towards me during the whole assessment. However, I was able to calm her down to a certain extent and explain to her about the treatment protocol here. Patient did not take it well. She remains angry at this time."

The evaluation describes the recipient's past psychiatric history: "Patient had a miscarriage in April following which she started having symptoms of depression. About three to four weeks back she was seen by a physician assistant from Carbondale and was started on Zoloft in combination with Klonopin and Xanax. Patient mentioned that she has not been taking her Xanax but was consistent with her other medications. She mentioned that she did not have any clear intention of abusing her medications or overdosing on them. This was her first psychiatric treatment. She denied any prior outpatient or inpatient psychiatric treatment prior to her miscarriage. She has never been on any psychotropic medications up until recently. Patient denies any prior history of suicide attempts. She also denies any history of substance abuse." The diagnostic impressions section shows an Axis I diagnosis of Major Depressive Disorder, Single Episode, Severe without Psychosis. On 6/08/11 the hospital filed the petition for involuntary admission with the Cook County Circuit Court.

The record contains an Inpatient Psychosocial Assessment completed on 6/09/11 at 9:00 a.m. by the recipient's case manager. The Assessment Summary states, "Pt. is a 25 y.o. S/W/F admitted due to SI statements made to a friend as well as being referred here by her OBGYN. Pt. reports she did not have SI and statements were a joke. Pt. currently resides with a friend but has an apartment of her own. Pt. reports current depressive sx's [symptoms] as depressed mood, decrease in appetite, and decreased energy. Pt. attributes symptom onset due to recent miscarriage in April. Pt. reports anxiety sx's of panic attacks which have been recently stabilized with medication. Pt. reports family hx of substance abuse (grandmother -ETOH) and mental illness (brother-anxiety and depression). Pt. reports hx of sexual abuse, being raped by a friend at age 14, but denies PTSD symptoms. Pt. denies substance abuse and a/v hallucinations. Pt.'s strengths include intelligence, family and friend support, and willingness to seek further treatment. Pt. limitations include poor insight and judgment. Pt. reports current stressors as 'here, I didn't have my friends and family, I was worried about how I had two miscarriages' as well as getting thrown out by my boyfriend. Pt. is in contemplative stage of change. Pt. reports to no known medical problems. Pt. presented with flat affect, little to no eye contact, slow to respond, and A&O x's 4 based on all the current and available data, pt.'s care will be addressed as follows: 1. risk of harm 2. increase in sx's 3. anxiety 4. cont care."

An entry in the Progress Notes on 6/09/11 at 9:00 a.m. entered by the recipient's psychiatrist states, "Pt. seen chart reviewed. Case discussed with staff. Pt. calm and cooperative. Requested to be discharged. No agitation, mood at baseline. Thought process/concentration WNL [within normal limits]. No psychosis. Cognition intact. Insight and judgment fair. No SI/HI. Assessment/plan- MDD recurrent severe without psychosis. Pt. medically/psychiatrically stable. Discharge today. F/U as arranged."

The recipient was then discharged on 6/09/11 at 1:25 p.m.

Information received from the HIM (Health Information Management) Department at Alexian shows that the recipient first requested her record on August 3, 2011. Since the form was missing some of the required information, the HIM staff member contacted the recipient by mail and informed her that she must complete the request and pay for the two copies (one for the recipient and another for her physician) of the record that she requested. The next correspondence from the recipient was a letter received on 1/19/12 and again the document was missing an expiration date and payment for half the cost of the record. On 1/30/12 HIM received the full payment and the clinical record was sent on 1/31/12. Additionally, information provided by the recipient to the HRA shows that she received two pages of notes from another recipient's hospital record along with her own record.

#### Hospital Representatives' Response

Hospital representatives were interviewed about the recipient's admission. They indicated that the recipient was recommended for inpatient treatment by her physician, who called the hospital prior to the recipient's arrival and described her as "very depressed" and "has been making SI statements to her friend." The recipient was brought to Alexian by this friend who then completed a petition for involuntary admission. Staff indicated that when recipients are being admitted involuntarily, and are adamantly objecting to admission, a staff person will meet with the petitioner in a separate room from the recipient. The petitioner may be aided in the completion of the petition by a staff member, as was the case in this admission. The recipient was then given her rights information and a copy of the petition by the Mental Health Counselor. Staff were very certain that the recipient received a copy of her petition after it was completed and that she was given her rights information, along with the information that she was being detained for examination. Staff indicated that there were no physicians available at the time the recipient requested to speak with a doctor- psychiatrists who are on call are consulted over the phone for admission orders. Staff indicated that the recipient was assured that the physician would be in the following morning after her admission to interview her.

Hospital representatives were interviewed about the recipient's first inpatient certificate. Staff indicated that the certificate was completed by the Director of Social Services, a licensed social worker, who is known to be meticulous about court documents. She indicated that the recipient was unable to contract for her safety and thus was appropriate for inpatient treatment. Staff were asked about the lack of a signature on the certificate to certify that the recipient was informed of the purpose of the examination, and that she did not have to speak with the examiner. They stated that the certifier stated, and the record shows, that the recipient was angry, cursing, and refusing to cooperate with any part of the admission, and this is the reason this section was not signed. After the complaint was lodged the facility staff discussed amongst themselves how they would document this section when patients are unable or unwilling to receive this information and it was determined that staff would document in the record why the patient was not provided the information and then try later to provide this when the patient is more stable.

Hospital representatives were interviewed about the recipient's admission to the behavioral health unit. They indicated that recipients are usually escorted from the Intake

Department to the floor on which they will be admitted. They indicated that there are no security guards on duty until 9:00 p.m. daily. They stated that the Intake is a locked unit and staff would not call security if an admittee wanted to leave, rather, a Code Green would be called which results in a large number of staff being a "presence" in order to aid the recipient in accepting his admission. In this case a Code Green was not called and the recipient went willingly to the unit. Staff reported that they do not conduct strip searches- recipients are observed by the Nurse for body view assessment and it is visualization only. If the recipient refuses, then the search is not conducted. Staff also indicated that there are 4-6 phones in the corridors of each unit and recipients are free to use them except during group, when the receivers are removed. Even when the receivers are removed the recipients may request to make a call and then they would have to ask for a receiver to complete a call. Staff reported that there is no indication from the record that the recipient requested to make a call or that she was denied a call. Additionally, staff reported that the initial complaint in this case did not include the denial of phone calls and this was added months after the complaints were filed.

Hospital representatives were interviewed about the record's indication that blood and urine samples were taken from the recipient when she refused them all. The HRA and hospital staff reviewed the recipient's chart and found that urine samples had been obtained but not blood samples. Staff indicated that if recipients refuse blood draws or urine samples they are not taken, so the recipient may have allowed the urine sample but when she refused the blood draw, it was not pursued. Staff were also asked about the times that are entered on clinical documents. They indicated that clocks from different rooms may indicate small discrepancies but that this is normal for most hospitals.

Hospital representatives were interviewed about the hospital response to the recipient's request for her clinical record. Staff indicated that the Medical Records Manager was asked about the timing of the response and she stated that the initial request was not completed correctly and a letter was sent to the recipient indicating the deficiencies, and this extended the response time.

Hospital representatives were interviewed about the recipient's record- data of another recipient was found in her copy. Staff reported that the Medical Records Department utilizes an independent copy service, whose staff come to the hospital and copy the appropriate records. Staff indicated that after receipt of the complaint the Medical Records Department was in-serviced on the handling of recipients' files and the copy service staff were also re-trained on the proper handling of files.

Hospital representatives indicated that the complaint in this case had originally centered around an objection to the hospital bill and that additional complaints were added over several months. They stated that many of the complaints in this case were investigated by the Illinois Department of Public Health as well as the Blue Cross/Blue Shield insurance association and there were no citations in either case.

## STATUTORY BASIS

The Mental Health Code states that when a person is asserted to be in such condition that immediate hospitalization is necessary for the protection of the person or others from physical harm, any person 18 years or older may present a petition (5/3-601a). The petition must contain a detailed statement of the reason for the involuntary admission, and include the signs and symptoms of a mental illness and a description of any acts, threats or other behaviors that support the assertion as well as the time and place of their occurrence (3-601 b). The petition must be accompanied by a certificate executed by a physician, qualified examiner, or clinical psychologist which states that the respondent is subject to involuntary admission and requires immediate hospitalization. The certificate must indicate that the physician or qualified examiner personally examined the respondent not more than 72 hours prior to admission. It shall also contain the physician or qualified examiner's clinical observations, other factual information relied upon in reaching a diagnosis, and a statement that the respondent was advised of his rights (3-602). If a physician, qualified examiner, or clinical psychologist is not immediately available or after diligent effort it is not possible to obtain a certificate, the respondent may be detained for examination in a mental health facility upon presentation of the petition alone, pending the obtaining of a certificate. If that is the case, in addition to the requirements outlined in 3-601, the petition must further specify that the petitioner believes, as a result of his personal observation, that the respondent is subject to involuntary admission, that a diligent effort was made to obtain a certificate, that no physician, qualified examiner, or clinical psychologist could be found who has examined or could examine the respondent, and that a diligent effort was made to convince the respondent to appear for examination, unless the petitioner reasonably believes that effort would endanger the respondent or others (3-603). No one detained for examination on the basis of a petition alone may be held for more than 24 hours unless within that time a certificate is furnished to or by the mental health facility. If no certificate is furnished, the respondent must be released (3-604).

The Mental Health Code states that whenever a petition has been executed, and prior to the examination for the purpose of certification, the person conducting the exam must inform the person being examined in a simple comprehensible manner the purpose of the examination, that the respondent does not have to talk to the examiner, and that any statements he makes may be disclosed in a court hearing to decide whether he is subject to involuntary admission. If the person being examined has not been so informed, the examiner must not be permitted to testify at any subsequent court hearing regarding the respondent's admission (3-208).

Within 12 hours after admission, the respondent must be given a copy of the petition and a statement as provided in 3-206 (whenever a person is admitted involuntarily or objects to admission, and whenever a recipient is notified that his legal status has changed, the facility director shall provide the person 12 years and older, with the address and phone number of the Guardianship and Advocacy Commission. If the person requests, the facility director must assist him in contacting them). No later than 24 hours, excluding weekends and holidays, after admission, a copy of the petition and statement must be given or sent to the respondent's attorney and guardian, if any. The respondent will be asked if he wants these documents sent to any other people, and at least 2 other people designated by the respondent can receive these documents. The respondent will be allowed to make no less than 2 phone calls at the time of admission to such people as he chooses (3-609).

As soon as possible but no later than 24 hours, excluding weekends and holidays, after admission, the respondent must be examined by a psychiatrist. The psychiatrist may be a member of the staff of the facility but not the person who executed the first certificate. If the respondent is not examined or if the psychiatrist does not execute a certificate, the respondent must be released.

Within 24 hours, excluding weekends and holidays, after admission, the facility director must file 2 copies of the petition, the first certificate, and proof of service of the petition and statement of rights upon the respondent with the court in the county in which the facility is located. Upon completion of the second certificate, the facility director must promptly file it with the court.... Upon the filing of the petition and first certificate, the court must set a hearing to be held within 5 days, excluding weekends and holidays, after receipt of the petition.

The Mental Health Code (5/1-122) defines "Qualified examiner" as "a person who is (a) a Clinical social worker as defined in this Act, (b) a registered nurse with a master's degree in psychiatric nursing who has 3 years of clinical training and expertise in the evaluation and treatment of mental illness which has been acquired subsequent to any training and experience which constituted a part of the degree program, or (c) a licensed professional counselor with a master's or doctoral degree in counseling or psychology or a similar master's or doctorate program from a regionally accredited institution who has at least 3 years of supervised postmaster's clinical professional counseling experience that includes the provision of mental health services for the evaluation, treatment, and prevention of mental and emotional disorders. A social worker who is a qualified examiner shall be a licensed clinical social worker under the Clinical Social Work Practice Act."

The Mental Health Code (5/1-121) defines "Psychiatrist" as "a physician as defined in the first sentence of Section 1-120 who has successfully completed a residency program in psychiatry accredited by either the Accreditation Council for Graduate Medical Education or the American Osteopathic Association." Section 5/1-120 defines "Physician" as "any person licensed by the State of Illinois to practice medicine in all its branches and includes any person holding a temporary license, as provided in the Medical Practice Act of 1987."

The Mental Health Code describes "clinical social worker" as "a person who has a master's or doctoral degree in social work from an accredited graduate school of social work and has at least 3 years of supervised postmaster's clinical social work practice which includes the provision of mental health services for the evaluation, treatment, and prevention of mental and emotional disorders" (1-122.1).

The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110 et seq.) states that "All records and communications shall be confidential and shall not be disclosed except as provided in the Act." The Act defines "recipient" as "a person who is receiving or has received mental health or developmental disabilities services." The Act requires that mental health records are to be made available to the recipient upon request, that the recipient can be charged a reasonable fee and that no fees are to be charged if the recipient is indigent (740 ILCS 110/4).

The Mental Health Code describes "Adequate and humane care" as "services reasonably calculated to result in a significant improvement of the condition of a recipient of services confined in an inpatient mental health facility so that he or she may be released or services reasonably calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not resent an imminent danger to self or others" (5/1-101.2).

## FACILITY POLICY

Alexian Brothers Hospital provided the policy and procedure manual for Involuntary Admission (No. PC 1500.006). The policy states that Alexian will accept an involuntary patient if the Admitting Psychiatrist finds the person clinically appropriate for such an admission. The person must be 18 years or older, mentally ill and because of his illness reasonably expected to inflict serious physical harm upon himself or another in the near future, and unable to provide for his basic physical needs so as to prevent harm to himself or others. A petition and certificate must accompany the patient who is presented for admission. If a certificate is unable to be obtained, the patient may be admitted for 24 hours during which time a certificate must be produced or the patient is discharged. Within 24 hours of the first certificate a second certificate must be obtained. The first certificate must be completed by a physician or Qualified Examiner and the second certificate must be completed by a Psychiatrist. The policy also indicates that an Assessment Specialist assist the petitioner in completing the petition. The Admission staff or Unit staff give the patient a copy of the petition and reads and gives the patient a copy of the Rights of Admittee no later than 12 hours after admission. The policy indicates that the first certifying examiner informs the patient of his rights prior to the certification examination, evaluates the patient, and completes the certificate. The second certificate must be completed within 24 hours of the first certificate.

Alexian Brothers Hospital provided the job description for the position of Assessment Specialist. The Assessment Specialist is responsible for Level of Care Screenings on patients and arranging appropriate admission into inpatient or outpatient programs. Following assessment, the Assessment Specialist consults with the physician, makes appropriate treatment recommendations to the patient, and coordinates admission procedures into inpatient care or partial hospitalization care. The minimum job requirements for this position are a Master's degree in Social Work or Psychology with a preference for a license in the area of education, a minimum of one year experience in mental health and/or addictions, and prior experience in a behavioral health hospital.

Alexian Brothers Hospital provided the policy and procedure for Contraband Checks of Person, Belongings and Room (No. RI 100.117). The purpose of contraband checks is to ensure a consistent process for identifying and confiscating dangerous substances or objects. Each patient receives a body and belongings inspection upon admission, when they return from passes, when placed on precautions, for self-injurious behavior and whenever there is a known or suspected contraband breach. Two same-gendered staff perform body checks and an RN is present for all checks. Inspections are conducted in a humane, non-threatening manner.

Alexian Brothers Hospital provided the policy and procedure for telephone usage (No. RI.100.118). All patients have the right to telephone communication both incoming and outgoing. On admission, the patient is asked if they wish to restrict their own phone use in any

way. Patients have the option of giving relatives and friends the direct numbers so that calls do not go through the nurses' station. Patients may call their attorney or the Guardianship and Advocacy Commission at any time.

Alexian Brothers Hospital provided the policy and procedure for Patient Privacy- Rights to Access Protected Health Information (No. IM 1000.003). Patients, parents, and/or legal /personal representatives are provided the right to inspect and obtain a paper copy of their protected health information (PHI) as required by the Health Insurance Portability and Accountability Act. The request for access is to be presented in writing by completing the Authorization to Disclose Protected Health Information. The facility must act on a request for access no later than 30 days after receipt. If the facility cannot/ is not able to provide access to the record in 30 days, the Privacy Officer or designee must provide the patient with a written statement outlining the reasons for the delay and the date by which the request will be fulfilled. If the request cannot be met within 60 days, the facility Risk Manager must be informed by the Privacy Officer of that facility of the delay no later than 5 business days prior to the deadline and must act to rectify the situation.

## **CONCLUSION**

1. Complaint: A recipient was assessed for outpatient services and when she refused, the hospital Intake personnel then pursued an involuntary admission. Conclusion: The record and staff report show that the decision to admit the patient for inpatient treatment was the report of suicidal ideation by her friend and the inability of the recipient to contract for safety. The HRA does not substantiate the complaint.

2. Complaint: The petition contained an inaccurate reason for the involuntary admission that was obtained through manipulation. Conclusion: The record shows that the recipient's friend petitioned the recipient on the same information that the friend had discussed with the recipient's physician earlier in the day. Whether or not this information was accurate, it was the information provided by the friend and would warrant an evaluation by a responsible mental health practitioner. Conclusion: The HRA does not substantiate the complaint.

3. Complaint: The recipient did not receive a copy of the petition until she was discharged. The petition contains a signed certification by a Mental Health Counselor that the recipient received a copy of the petition within 12 hours of admission. Conclusion: The HRA does not substantiate the complaint.

4. Complaint: A recipient was not advised that she was being examined for certification purposes, was not informed that she did not have to speak with the examiner, and that any statements she made could be disclosed at an involuntary admission court hearing. Conclusion: The section of the Inpatient Certificate which asks for a signature certifying these rights were recited was not signed by the examiner, therefore there is no documentation to support that they were given. Staff have stated that this section is not signed if the person completing the certificate cannot speak to the patient due to the patient's unwillingness to meet. Although the record shows that the recipient was angry and upset, it does not suggest that the recipient was in

such a state that she could not understand the purpose of her evaluation and her rights. Furthermore, the law requires that all examiners *shall* inform patients of what faces them and makes no mention of first determining their capacity. In other words, it's a mandate regarding the examiner, not the patient. Conclusion: The HRA substantiates the complaint.

5. Complaint: A certificate was completed by a person whom the recipient had never met or been interviewed by. Conclusion: The qualified examiner certified that she personally examined the recipient on 6/08/11 at 7:00 a.m. The HRA does not substantiate the complaint.

6. Complaint: The record indicated that the recipient was admitted on a certificate when she was detained on a petition. The purpose of the petition is to detain the person in need of immediate hospitalization so that they can be examined for certification. A certificate must accompany the petition and if it is unable to be obtained, the patient may be admitted for 24 hours during which time a certificate must be secured or the patient is discharged. The record shows that this process was followed for the extant case, however it is not clear if the recipient understood the petition process and the facility's power to detain her pending a psychiatric evaluation. Conclusion: The HRA does not substantiate the complaint.

7. Complaint: A recipient was assessed by an Intake clerical staff unqualified to make psychiatric diagnoses and the Intake worker included errors, discrepancies and contradictions in the assessment. The record shows that the assessment was completed by an Intake Assessor who is a licensed clinical social worker. Her job was to collect information but also to compile clinical impressions based on this information so she could then consult with a physician who determined the need for treatment. It appears from the record that this process was upheld and the order for inpatient treatment was issued based upon observed behaviors and collateral information which the HRA cannot judge at this point. Conclusion: The HRA does not substantiate the complaint.

8. Complaint: A recipient was not allowed to make admission phone calls. Facility staff reported that recipients are able to make phone calls at any time except during group therapy and even when phones are off a new admittee could request to make a phone call and they would be given a receiver. Although the recipient's right to make phone calls at admission is included in the hospital's admission documents, it is not clear from the record whether new admittees are informed of this right once they are admitted to the unit or whether they must request their guaranteed phone calls. Conclusion: There is no indication from the record that the recipient asked for or was denied a phone call and the HRA lacks sufficient information to substantiate this complaint.

9. Complaint: A recipient was threatened with security guards by Intake personnel when she indicated she wanted to leave. Staff report indicates that the Intake unit is a locked unit and security personnel are not present until 9:00 p.m. Staff indicated that if a recipient refuses to be admitted after being petitioned, a Code Green alert would be issued which brings staff members from throughout the building to provide a "presence" to encourage the recipient to comply. Staff indicated that a Code Green was not called for this recipient's admission. Conclusion: The HRA does not substantiate the complaint.

10. Complaint: Admitting times are inaccurate on some clinical documents. The HRA reviewed the documents related to the recipient's admission and found no deficiencies. The confusion surrounding the admission appears to be related to the power of the petition to detain a recipient pending an examination by a psychiatrist. The recipient in this case appears to have believed that the physician's order for treatment was the only authority on which she could be detained when this detention was initiated by the petition. Conclusion: The HRA does not substantiate the complaint.

11. Complaint: A recipient was threatened with security guards by nursing personnel when she refused a strip search. Facility staff indicated that strip searches are not performed, only body observation or visual inspection. Staff also indicated that if a recipient refuses the inspection, it is not done. Conclusion: The HRA does not substantiate the complaint.

12. Complaint: The clinical chart shows that blood/urine draws were taken when all draws were refused. The record shows that there were orders for blood and urine tests, however test results indicate that only the urine test was completed. Staff indicated that the recipient may have consented to the tests but then decided against the blood draws since she had recently had blood testing completed by her own physician. Staff reported that if recipients refuse the blood and urine tests, they are not performed unless there is a medical necessity, which there was not in this case. Conclusion: The HRA does not substantiate the complaint.

13. Complaint: The requests made by a recipient for her clinical record were ignored by the facility. The record shows that the recipient first requested her record on August 3, 2011. The form was not complete and returned to the recipient. The next correspondence from the recipient was a letter received on 1/19/12 and again the document was missing an expiration date and payment. On 1/30/12 the facility received the full payment and the clinical record was sent on 1/31/12. Conclusion: The HRA does not substantiate the complaint.

14. Complaint: The hospital breached confidentiality; data of another recipient was found in a recipient's clinical record. The recipient has provided information indicating that she received two pages from another recipient's record in her requested record, and hospital staff have acknowledged this deficiency. Conclusion: The HRA substantiates the complaint.

## RECOMMENDATIONS

1. Ensure that persons who are being certified for inpatient hospitalization are informed of the purpose of the examination, that they do not have to speak with the examiner, that any statements they make may be related in a mental health court hearing to determine their need for treatment, and that they may speak with a relative, friend or attorney before the examination. If the recipient is unable to understand their rights, note this in the clinical record and attempt to repeat and clarify the procedural rights when the recipient is stabilized.

2. Ensure that a process is in place to review clinical records before they are sent to recipients so that no patients' confidentiality is breached.

## SUGGESTION

1. Train staff to include their position and credentials along with their signature on record entries.
2. Ensure that the records department is aware that a copy charge is waived should a recipient claim indigence per the Confidentiality Act (See 740 ILCS 110/4b). Consider a policy revision to incorporate Confidentiality Act provisions for mental health records.
3. Ensure that new patients are informed of their right to make calls at admission.