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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case #17-090-9001
Robert Young Center

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations involving services with Robert Young Center. The allegations were as follows:

1. Inadequate transfer process, including patients are transferred without consent or court order.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/1) and the Emergency Medical Treatment and Active Labor Act (42 USC 13955dd).

The Center provides mental health services for 5 hospitals in Iowa and 2 in Illinois, and both regions act as the catchment area. They are considered a community mental health center but have a collaborative agreement with Trinity Hospital for inpatient services. They provide adult, child and adolescent inpatient mental health services and adult inpatient substance abuse services, with 2 units for each. They have 54 licensed beds in the adult unit with filled beds flexing in number from 17 to 25 individuals and on the children's unit filled beds range between 14 and 6. There are 31 total beds for the mental health populations and 23 for substance abuse. The Center employs 330 staff members.

Complaint Statement

The complaint states that patients are transferred to other facilities and hospitals against their will without patient consent or court orders.

Interview with staff (8/25/2016)

Staff began the interview by stating that in their review of the complaint and search for records, they only found three instances when adult patients were not discharged home and went to a skilled care facility. They had one case when a patient was involuntarily transferred to an extended care facility and this was between 2010 and 2012; they had no other instances when an

adult patient was transferred to another facility. This was done because it was the least restrictive environment for the patient and he/she could see her children at the facility to which he/she was transferred.

Staff stated that they would not transfer an inpatient to another hospital. They said they would transfer a patient to a Veteran's Administration hospital so patients could use their benefits there but that would be voluntary. Staff said they do not even transfer to state facilities often. They said that a state-operated mental health facility within their catchment area closed so now they send patients to a state-operated facility downstate. Staff said they have not had a transfer there in 2 and ½ years. Staff said that they have had long lengths of stay because there was no place to transfer a patient. One patient was at the facility for over 90 days. They occasionally receive an involuntary patient but after a few days, they generally sign into the facility voluntarily. They said that it has roughly been 6 months since they have had a court hearing. They stated that sometimes when a patient lacks capacity they have extended stays at the facility; they try to find guardianship for such a patient.

Staff explained that if a patient is moved, it is not usually a transfer but rather the patient is discharged from their facility and then admitted to another which may sound like semantics. They said when discharge occurs, the case management staff talk to the patient about the discharge plan and obtain consent to contact the other facility. Once the patient is accepted at the facility, they would inform the patient, and if they are still agreeable, they arrange transportation and travel to the new facility. Sometimes they are able to provide the patient with more than one choice of facility, so they have to wait for the patient's decision. Sometimes patients have burned bridges at facilities and it's more difficult finding a facility.

The Robert Young Center provides mental health services for the 4 emergency departments at their hospitals, 2 in Iowa and 2 in Illinois. They have a 3.7 to 5.2 percent transfer rate but that is impacted by the Iowa hospitals. Iowa patients cannot be committed in Illinois and those are counted as being transferred. Iowa commits for substance abuse but Illinois does not which also affects the transfer rate. If a patient is in the Illinois emergency room, and has dementia or a developmental disability, then the patient must be transferred from the facility. Another reason why patients might be transferred is that they do not want to be at that facility. Sometimes they want to leave for insurance reasons or they just do not like the facility. They will also transfer from the emergency department if there is not an appropriate bed. Genders must be matched with the beds, so if there is an available female bed but a male patient is being considered for admission, they would not be able to admit. In those cases, they will start calling facilities that are closest geographically and then try calling facilities farther away. If the patient is voluntary, they will contact Iowa but if they are involuntary, they cannot. If they are in Illinois and present to the Moline complex, they transfer them to Rock Island to stay at the crisis stabilization unit while documents are being filed because it is safer there. Staff stated that they have a system Emergency Medical Treatment and Active Labor Act (EMTALA) policy but no direct inpatient transfer policy.

Staff said that they have a crisis stabilization unit that assists the hospital with new patients coming to the hospital. When patients enter the emergency department with mental health needs, they can go to the crisis stabilization unit for an evaluation and disposition. If the physician is unsure about the admission of the patients, they are able to stay at the crisis stabilization unit for 23 hours or they can go home. Staff explained that they performed a little less than 5,000 crisis evaluations and 71% were reconnected while only 3% returned to the emergency department in 3 days. Staff said that they were at 5.26 hours to transfer out of an

emergency room but that includes all four facilities and it could be 3 days to 1 hour. The minute they know someone will be transferred voluntarily or involuntarily, they start the transfer process.

Staff said that if an individual may not be capable of independent living and does not want to leave, they will work with the patient and the family to decide what to do. In the meantime, they still provide service and try to figure out what to do which can take time. Family will sometimes get guardianship and if someone is too violent for the Center, they will transfer to a state hospital. Generally, if a patient is too violent, the physician will determine this and not admit the patient. In those cases, they will keep them in the crisis stabilization unit until they are deescalated. Staff said that sometimes people think if the patient is in the crisis stabilization unit and not in the emergency department they are inpatient. Patients can always leave the crisis stabilization unit unless they are in danger and it may be determined that they need to be committed to the facility. If they are not deemed a risk, and want to leave then they do not hold them.

FINDINGS

The HRA reviewed redacted resident records and facility policy that pertain to the allegations in this case.

The HRA began by reviewing the facility "Transfer and Emergency Examination – EMTALA" policy. The purpose of the policy reads "To establish a procedure for the examination, stabilization, and transfer of individuals coming to a Trinity Medical Center (TMC) emergency department (ED) where a request has been made for examination or treatment for a medical condition, including active labor, regardless of the individual's ability to pay. This policy is also intended to assure appropriate treatment and transfer protocol in compliance with EMTALA (the Emergency Medical Treatment and Labor Act)." The policy defines "Transfer" as "The movement (including the discharge) of an individual outside the facility at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the particular Trinity Medical Center Hospital, but does not include such a movement of an individual who has been declared dead or leaves the facility without permission." The policy explains who is entitled to a medical screening, the medical screening procedures, and the medical screening examination in the emergency department. Within those sections, there is a subsection titled "Request for Transfer" which reads "If the individual or authorized representative requests to be transferred before a medical screening examination is completed, attempt to obtain the signature of the individual or the individual's authorized representative on the applicable Transfer request paragraph on the Transfer Record." Another section is titled "Transfer to Hospital with a psychiatric unit if Psych Indicators Present" and reads "Trinity Medical Center Emergency Departments are not staffed and equipped to handle the care of individuals exhibiting the following symptoms (the 'Psych' indicators): 1. Combative or agitated individuals. 2. Elopement risk combine with potential danger to self or others. 3. Potential danger to self or others." The procedure states "Individuals exhibiting psych indicators should be offered a medical screening examination and further treatment within the capability of the Emergency Department, as otherwise provided above. If the patient (who presented at the Trinity-Bettendorf ED) is determined to be in an emergency medical condition such as suicidal ideation and needs inpatient care and treatment, the ED physician will work with the Robert Young staff on appropriate placement. If the patient is to be involuntarily committed in Iowa, the commitment must be to an

Iowa hospital. The ED physician should call and speak with the psychiatrist at the hospital where the individual will be transferred. On a voluntary commitment, if the patient chooses to be transferred to … any other hospital versus the Robert Young Center, due to personal choice, the ED physician should call and speak with the psychiatrist [there] prior to the individual being transferred. On a voluntary commitment, if the patient chooses to be transferred to the inpatient unit at the Robert Young Center, the ED physician should call the Robert Young psychiatrist on call. If the patient poses a risk of harm to self or others, transport to a hospital with a psychiatric unit with appropriate facilities and staff should be arranged by ambulance or police squad car regardless of the individual's consent to such transfer. The medical record should reflect a determination by the examining physician that the patient was incompetent to refuse the transfer. The transfer record should be completed to the extent possible in the case of a transfer, recognizing that the Consent to Transfer will not be signed by an incompetent individual. Emergency Department personnel may attempt to contact an authorized representative for substitute consent by telephone, as time and circumstances permit. The ED physician is responsible for countersigning the Transfer Certification (for either a voluntary or involuntary transfer) which has been completed by the Robert Young mental health profession prior to the patient being transferred." The policy also describes a transfer for detoxification. The policy addresses the examination and transfer of pregnant women and medical screening in the Robert Young Center; the "Request to Transfer" section of that area reads "If the individual or the individual's authorized representative request transfer before a screening examination is completed, attempt to obtain the signature of the individual or the individual's authorized representative on the applicable Transfer Request paragraph on the Transfer Record Form."

There is a "General Procedures" section of the policy that includes a "Transfers" section. The section defines transfers again and then provides guidance for different areas of transfer. The first section is for "Appropriate Transfers" and reads "Transfer to another medical facility of an individual who comes to Trinity hospital with an emergency medical condition is appropriate only after the completion of a medical screening examination and under the following circumstances …" which include that the emergency medical condition has been stabilized or the condition has not been but the individual requests in writing for a transfer even though he/she is aware of the risks and the hospital's obligation to stabilize. The other circumstance for transfer reads "The individual's emergency medical condition has not been stabilized, but a physician (or Qualified Medical Person) has signed the certificate on the Transfer Record Form, stating that, based upon the information available to him or her at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment in another medical facility outweigh the increased risks to the individual and, in the case of labor to the unborn child, from effecting a transfer (the certification must include a description of the risks and benefits of transfer, including the risk of leaving Trinity – during the period of time necessary to effectuate the transfer)." The section states that another authorized staff will sign if the physician is not there.

Another section deals with transfer requests and states that if the individual requests a recommended transfer, all the steps must be taken to secure the individual's signature on a Transfer Record Form that includes a statement about the risk of transfer. The refusal section reads "If the individual or authorized representative refuses a recommended transfer after having been informed of the risks and benefits to the individual of the transfer, all reasonable steps must be taken to secure the individual's or authorized representative's written transfer refusal on the Refusal of Transfer Form. The form must be documented to indicate that the individual was

informed of the risks and benefits of transfer and state the reasons for the individual's refusal. The Refusal to Transfer Form shall also be documented with a description of the transfer refused by or on behalf of the individual. The individual shall continue to receive stabilizing treatment within the capabilities of the hospital. The Refusal of Transfer Form shall be completed." The section of the policy ends with requirements for transferring an individual in an unstable medical condition and the responsibilities in transferring an individual. The policy concludes with sections covering discharge, discharge against medical advice, the physician's roster, the central log, the maintenance of records, signage, the transfer record, mandatory reporting and non-retaliation.

The HRA reviewed the facility involuntary admission policy which has a review/revision date of 1/30/2015. The policy provides for the "Admission of a person 18 years or older who is mentally ill, utilizing the Robert Young Center Trauma Informed Care guiding principles and: A. Because of his/her illness is reasonably expected to inflict serious physical harm upon himself/herself or another in the near future which may include threatening behavior or conduct that places another individual in reasonable expectation of being harmed. B. Who, because of his/her illness, is unable to provide for his/her basic physical needs so as to guard himself/herself from serious harm, without the assistance of family or outside help." The policy also makes a statement regarding minors. The procedure for the policy states that a "Certificate should be completed by the physician, qualified examiner or clinical psychologist." The certificate "shall indicate that the patient was personally examined not more than 72 hours prior to admission" and that "Clinical observations and factual information on which diagnosis was based is to be recorded" and a "Statement as to whether the patient was advised of his rights." The policy also states that "Accompanying the certificate is the Petition for involuntary/Judicial Admission which should also be completed and signed by a relative, friend, police officer, who was a witness to the patient's behavior and/or the clinician who completed the crisis evaluation." The process states that the petition should include a reason why the patient is subject to involuntary admission, witnesses, name and address of a friend or family member, and indication as to whether the petitioner has legal, financial interest in the matter or is involved in litigation with the patient. The process states that within 12 hours after admission, the patient should be provided a copy of the petition, the patient rights should be read to the patient and the patient should be provided a copy of the rights. Within 24 hours, excluding Saturday, Sunday and holidays, "A second certificate is to be completed by a psychiatrist" and "Two copies of the Petition and Certificate shall be filed with the Clerk of the Court. The court shall set a hearing to be held within five (5) days, excluding Saturdays, Sundays and holidays." The process then describes the minor's process for admission. The HRA reviewed the facility voluntary admission policy which reads "A voluntary patient has the right to leave the unit and hospital against medical advice to the extent permitted by law." The procedure for leaving the facility reads that a "Patient must sign a 'Request for Discharge' notice and the physician must be informed of the patient request." Then the "Physician will decide if patient is appropriate for discharge and if not, will follow legal guidelines to assure patient safety." The next step reads "If the physician allows patient to leave the unit or hospital against medical advice, the hospital, unit and its physician will not be responsible for any harm that this action might cause him/her or others."

The Patients' Bill of Rights reads that "You as the patient, parent or representative of the patient determine what healthcare you get. You have the right to know who is doing what to you and why they are doing or not doing specific care. You have the right to an explanation you can

understand even if it's in another language. This right means you can refuse, within the limits of the law, any care you do not want and we will explain the risks and consequences to you." In the Bill of Rights as well as the hospital guide, the contact information for Illinois Guardianship and Advocacy is called "Robert Young Guardianship and Advocacy Commission," The hospital guide also has a "Safety and Comfort" section that reads "Participate in all decisions about your treatment." Also in that section there are statements that read "You and your doctor should agree on everything about your care….Be aware of who will care for you, how long the treatment should last and how you should feel….[and] More tests and medications may not always be better for you." There is a Physician Certification Statement for Non-Emergency Ambulance Services which has a general information section that reads "If hosp-hosp transfer, describe services needed at 2nd facility not available at the 1st facility."

The facility provided the HRA with a rights document provided by the Illinois Department of Human Services which reads "As a general rule, you lose none of your rights, benefits, or privileges simply because you are an individual receiving mental health or developmental disability services." The document also states that "If you are over 18 and do not have a guardian, you have the right to refuse services, including medication or electroconvulsive therapy (ECT)."

The HRA reviewed the facility "Discharge" policy which states that "It is the policy of the Robert Young Center to discharge patient's at the appropriate time, utilizing Robert Young Center Trauma Informed Care guiding principles, with any indicated follow-up arranged for and education done prior to discharge." The policy states that discharge planning starts at admission and the reason for discharge is documented; the policy then states that "Adult and adolescent inpatients are never discharged while on suicide precautions." The procedure states that patients will be scheduled or discharged against medical advice (AMA) dependent on the circumstances; and, if they are discharged AMA, they follow the AMA policy.

The HRA reviewed the facility voluntary admission process and its purpose is "To ensure appropriate steps for voluntary admission to inpatient mental health and chemical dependency services utilizing the Robert Young Center Trauma Informed Care guiding principles." The policy begins by stating "Admission to RYC/Riverside Inpatient Care require appropriate documentation, physician consultation and needed authorization documents." The policy provides a procedure for a psychiatrist initiated admission which states that if a private psychiatrist would like a patient admitted, they must contact the facility in advance, complete the appropriate paperwork (voluntary, involuntary) and be "responsible for obtaining 3rd party authorization or certification" prior to admission. Also, if a patient is from a nursing home, the psychiatrist must examine the patient 24 hours prior to admission and find the patient psychiatrically appropriate and medically stable for admission.

The HRA reviewed the facility discharge planning process which states that the facility has screened high risk patients upon admission, and that those patients may have more complex discharge needs and can request care coordination with discharge. The policy states that when a patient needs home care services, they will be informed of and provided a list of organizations. The policy reads "For home healthcare services and skilled nursing care facility's needs, the list shall include all Medicare certified and healthcare providers who provide the applicable service in the geographic area in which the patient resides." Managed care patients receive a list that deals with managed care and if the patient has no preferences, they will recommend services through a specific home health care agency. The procedure states that for low risk patients, the nursing units will place an order for home care and provide the family with a choice list for their

area, obtain the patient's preferred choice and make the referral. For high risk patients "Case management will follow patients identified as potentially needing a skilled nursing facility placement or other complex discharge planning needs." The next step is that "The Case Management staff will meet with the patient and/or family or caregiver of those identified by the high risk screening tool or a case management referral to complete an assessment and make recommendations regarding discharge plans. The Care Coordinator will provide the patient and/or family with a skilled facility choose sheet as appropriate and will obtain choice and make the referral." The last step in the procedure states that "The Care Coordinator will make referrals based on patient and/or patient's family choice and provide information as requested."

The HRA reviewed redacted records for 4 individuals who received services from the Robert Young Center psychiatric unit. The first patient's discharge summary reads "She was seen by me on Saturday and Sunday. On Sunday, she said she felt stable enough to go to [Addiction Treatment Center]. However, I recalled with the last admission, she was supposed to go to [Addiction Treatment Center] and did not go and she said that she wanted to go home as she was being kicked out of her apartment and that she wanted to do Suboxone. This was with the last admission, which was on 6/14/2016. She was discharged on 6/21/2016 and by 6/29/2016 she was back again. Now, she says that she is ready to go to [Addiction Treatment Center]." The paragraph also states that she was told she could go to the center and that the patient feels ready for the transfer. The progress notes, dated 7/4/2016 reads "Pt requested to leave AMA. Pt states 'I think I'm going to leave. My tooth hurts. It hurts when I sit up. I think I need to go to the Dentist.' All belongings returned intact. This writer explained to the pt the possible negative consequences of leaving AMA including possible relapse, legal issues, and financial issues. Pt reported good verbal understanding of possible negative consequences. Pt. denies any suicidal or homicidal ideations. Pt. left unit AMA with all belongings intact at 1052AM." The HRA reviewed a refusal of treatment or transfer document, signed by the patient stating that she wanted to leave to go to the dentist.

The progress notes for the second individual document that the individual was accepted at a long term care facility after at least 15 other facilities were contacted. The treatment plan states that the patient would like to go to a long-term facility once he stabilizes at Robert Young Center. There is also a mention of a case management consult pending. A crisis intervention plan reads that the "Patient was unable to contract for safety and is agreeable with transfer for voluntary psychiatric admission." The next page of the same document states that: "Consultation with [Physician] (psychiatrist on call) who gave orders to admit the patient for inpatient psychiatric care. Patient is currently a danger to himself and is unable to contract for safety. There are currently no beds available at RYC – 2N. Patient agreeable with transfer to the nearest psychiatric facility with a bed available."

The progress note for the third individual documents the following: "Spoke with [staff] from [Skilled Nursing Facility], pt was accepted. She asked if we could transport. Called transportation they can pick pt up in 30 mins. Trinity Case Management vouchered for transportation. Called pts RN on 2N and she stated a half an hour was enough time to get necessary discharge paperwork in place. Provided RN with phone number and location to call report. Informed [Staff] at [Skilled Nursing Facility] of time that pt will arrive." The patient encounter notes reads "He has had numerous visits to the ER intoxicated. He has gone to [Skilled Nursing Facility] numerous times. He was just there on 12/19 and he took off AMA. He got 2 DUIs in 1980. He denies any other drug use, but he has had problems with opiates and benzos in the past. He has been sober from marijuana and cocaine for about 10 years. He drank

prior to admission … Again, he usually comes to the ER intoxicated, goes to [Skilled Nursing Facility], leaves AMA and has been doing this since 2007."

The HRA reviewed the redacted record for the fourth individual whose care plan reads "Spoke with pts sister [Name]. Pt and family have agreed that pt will go to [Skilled Nursing Facility]. [Patient's Sister] would like to pick up pt between 1-2pm and then take her to [Skilled Nursing Facility]." Another section of the care plan states the following: "Call received from [Skilled Care Facility] that they would be able to take this pt. Informed pt and she does not want to accept until she has had a chance to speak with her sister. Spoke with sister [Name] and she is going to go and see the facility today." The passage also documents discussing other facilities with the patient's sister. Another part of the care plan has a plan A documented as the place that the individual ended up going to and then had a plan B in case she was not admitted. In another earlier section, they spoke with the individual's sister regarding discharge planning and it is documented that: "Pt is unable to transition to the assisted living area due to the suicidal attempts. Information given to them regarding going to a nursing home. Pt states that she is unable to contract for safety at this time if she returns to the [Facility that is not Robert Young]." The patient provided a list of facilities that she would like the Robert Young Center to pursue on her behalf. The note reads "Sister tried to get the pt to understand that it is very costly to go to the nursing home, as well as the limited space that is available at the nursing home. Pt continues to state that she doesn't know if she would be able to live along. [Sister] spoke to her other sister and gave her all of the information that we discussed. Pamphlets given to the family and she states that she will go visit the nursing homes."

According to the Emergency Medical Treatment and Labor Act: "(2) Refusal to consent to treatment. A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment" (42 USC 1395dd). The Act also states that: "If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless--(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility, (ii) a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or (iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and (B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility. A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based" (42 USC 1395dd).

According to the Mental Health and Developmental Disabilities Code, reads “(a) When a person is asserted to be subject to involuntary admission on an inpatient basis and in such a condition that immediate hospitalization is necessary for the protection of such person or others from physical harm, any person 18 years of age or older may present a petition to the facility director of a mental health facility in the county where the respondent resides or is present” (405 ILCS 5/3-601) and “The petition shall be accompanied by a certificate executed by a physician, qualified examiner, psychiatrist, or clinical psychologist which states that the respondent is subject to involuntary admission on an inpatient basis and requires immediate hospitalization. The certificate shall indicate that the physician, qualified examiner, psychiatrist, or clinical psychologist personally examined the respondent not more than 72 hours prior to admission” (405 ILCS 5/3-602). The Code also states that “(a) If no physician, qualified examiner, psychiatrist, or clinical psychologist is immediately available or it is not possible after a diligent effort to obtain the certificate provided for in Section 3-602, the respondent may be detained for examination in a mental health facility upon presentation of the petition alone pending the obtaining of such a certificate” (405 ILCS 5/3-603). Finally, the Code requires that “As soon as possible but not later than 24 hours, excluding Saturdays, Sundays and holidays, after admission of a respondent pursuant to this Article, the respondent shall be examined by a psychiatrist. The psychiatrist may be a member of the staff of the facility but shall not be the person who executed the first certificate. If a certificate has already been completed by a psychiatrist following the respondent's admission, the respondent shall be examined by another psychiatrist or by a physician, clinical psychologist, or qualified examiner. If, as a result of this second examination, a certificate is executed, the certificate shall be promptly filed with the court. If the certificate states that the respondent is subject to involuntary admission but not in need of immediate hospitalization, the respondent may remain in his or her place of residence pending a hearing on the petition unless he or she voluntarily agrees to inpatient treatment. If the respondent is not examined or if the psychiatrist, physician, clinical psychologist, or qualified examiner does not execute a certificate pursuant to Section 3-602, the respondent shall be released forthwith” (405 ILCS 5/3-610).

Regarding the Code’s discharge process, “A voluntary recipient shall be allowed to be discharged from the facility at the earliest appropriate time, not to exceed 5 days, excluding Saturdays, Sundays and holidays, after he gives any treatment staff person written notice of his desire to be discharged unless he either withdraws the notice in writing or unless within the 5 day period a petition and 2 certificates conforming to the requirements of paragraph (b) of Section 3-601 and Section 3-602 are filed with the court. Upon receipt of the petition, the court shall order a hearing to be held within 5 days, excluding Saturdays, Sundays and holidays, and to be conducted pursuant to Article IX of this Chapter. Hospitalization of the recipient may continue pending further order of the court” (405 ILCS 5/3-403). The Code states that “The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available” (405 ILCS 5/2-107).

Complaint #1 – Inadequate transfer process, including patients are transferred without consent or court order.

Conclusion #1

In reviewing the redacted records, the HRA found no evidence that the facility transferred a patient without consent or court order. Additionally, the staff stated that the psychiatric unit does not transfer patients from hospital to hospital and the HRA found no evidence that this type of transfer was occurring. The facility also has policy to execute petitions and certificates for involuntary commitments. Because of this, the HRA finds this complaint **unsubstantiated** but offers the following **suggestions:**

- The facility commitment policy states that the second certification must be completed by a psychiatrist, but the Code indicates that the second certificate can be completed by other staff if a certificate has already been completed by a psychiatrist upon admission (405 ILCS 5/3-610). The HRA **suggests** updating the policy for compliance.
- The facility Bill of Rights and Hospital Guide both have the Illinois Guardianship and Advocacy Commission titled as "Robert Young Guardianship and Advocacy Commission" which is misleading. The HRA **suggests** this be updated to the appropriate name for the agency.
- The policy regarding involuntary commitments has a list of individuals who can sign the petition but the list does not comply with the Mental Health Code (405 ILCS 5/3-601). The HRA **suggests** the facility update the policy to comply.