FOR IMMEDIATE RELEASE

North Suburban Human Rights Authority
Report of Findings
Edward-Elmhurst Health
HRA #17-100-9001

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Edward-Elmhurst Health. In August 2016, the HRA notified Edward-Elmhurst of its intent to conduct an investigation pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The complaint accepted for investigation alleged that a patient's rights were violated while receiving services in the Emergency Department (ED) in that the reason for admission was not accurate. It was further alleged that after receiving medical services, the patient was not advised that she was being sent to another hospital for behavioral health services; she was not advised that she was being examined for certification purposes, and she was not informed that she did not have to speak with the examiner. Lastly, she did not receive copies of the transfer petition and/or certificates.

The rights of mental health patients receiving services at Edward-Elmhurst are protected by the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5).

To pursue this investigation, the HRA interviewed hospital personnel. The HRA reviewed the patient's clinical record with written consent and discussed the allegations with a family member. Also reviewed were hospital policy relevant to the allegations.

Background

Edward-Elmhurst Health was created in 2013, when Edward Hospital & Health Services and Elmhurst Memorial Healthcare merged to become one of the larger integrated health systems in Illinois. Edward-Elmhurst Health is comprised of three hospitals — Edward Hospital, Elmhurst Hospital and Linden Oaks Behavioral Health and provides comprehensive healthcare to residents in the west and southwest suburbs of Chicago.

Findings

The complaint stated that the patient went to the Emergency Department for medical care only and later found out that ED documentation indicated that the patient was suicidal; it was stated that this was not an accurate diagnosis. The complaint also stated that when the patient was being examined by a psychiatrist, the patient was told about the petition process, but not that the patient had the right not to speak to the examiner.

According to the clinical record, the adult female presented in the ED on June 6, 2016 at about 2:30 p.m. after being found unresponsive at home. Her husband called paramedics and during the ED assessment she was found with three Fentanyl patches on her body; she was only prescribed one at a time. She was medically admitted for opiate intoxication and chronic pain managed via opiate medications, with a notation that an additional psychiatric consultation will be requested to determine the patient's presenting needs. The chart contained a petition and certificates completed

on June 7, 2016. The clinical record showed that the patient's husband was given a copy of the patient's petition and certificates. The certificate showed that the examiner advised the patient of the purpose of the examination and that she did not have to speak to the examiner. The chart also contained petitions and certificates that were completed on June 9 and 10th.

The Psychiatrist documented that in evaluating the patient today (6/8/16) she remembers their previous evaluation in April 2016. During that evaluation, the patient denied any suicidal attempt or ideation. The documentation indicated that the patient did offer that for the last six months she had been depressed with more crying and tearfulness, significant loss in weight, severe insomnia, hopelessness and helplessness. The patient expressed that she was upset that she was in the hospital and when confronted about the risky behavior, she became tearful talking about a family member whom she has not seen for the last two years. The patient also admitted to a decline in her overall functioning, and expressed that she did not care if she lived or died. It was documented that due to a *"significant change in emotion in the last six months indicate serious depressive episode with risky behavior indicating the patient put in serious position where she is not only unable to care for self, but she is in serious harm, direct harm to herself. At this point it was indicated that the patient would be treated in an inpatient setting with appropriate follow-up for inpatient rehab after the inpatient psych admission."* It was then noted that the patient was upset that she was being sent for inpatient services, and reported that she needed to be home to care for her 14 year-old son. The patient was confronted about the fact that she is really not there for him and this is a serious Illinois Department of Children and Family Services matter if anything happened to the son while she is physically there. It was documented that the patient *"agreed on treatment plan by the end of our discussion."* Further documentation noted that representation from the hospital's legal department were brought in due to the patient's and husband's dissatisfaction with the patient's need for inpatient services, but the recommendation for inpatient services was upheld.

At the site visit, hospital personnel reiterated the above noted clinical documentation. It was stated that when the patient was medically cleared and inpatient services were recommended, the husband and patient became upset. The Risk Manager stated that he was immediately called in to discuss the patient's disposition with both the patient and husband. It was offered that the Psychiatrist stood-by his recommendation that inpatient services were needed for the patient's safety. When asked, staff members stated that the patient and husband received a copy of the petition and certificate.

The hospital's Involuntary Psychiatric Hospitalization – Adult policy states (in part) that once a patient is identified as requiring inpatient services due to behavior that makes the patient a danger to safe, others or is unable to care for self, a petition and certificate process is initiated. Emergency Department staff member reads the patient his/her rights and signs and provides a copy of this to the patient. If the patient is to be admitted to a medical floor for medical stabilization, the Petition for Involuntary Admission and Certificate is then faxed to designated Behavioral Health staff. Behavioral health staff will fax the petition and certificate to the court within 24 hours of admission. The policy goes on to say that when on a med/surg unit, the consulting psychiatrist examines the patient and determines that the patient may be discharged or must be admitted to an inpatient psychiatric unit, once medically stable.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 3-205," Within 12 hours after the admission of a person to a mental health facility under Article VI or Article VII of this Chapter the facility director shall give the person a copy of the petition and a clear and concise written statement explaining the person's legal status and his right to counsel and to a court hearing. Following admission, any changes in the person's legal status shall be fully explained

to him. When an explanation required by this Chapter must be given in a language other than English or through the use of sign language, it shall be given within a reasonable time before any hearing is held." Section 3-611 of the Code states that, "Within 24 hours, excluding Saturdays, Sundays and holidays, after the respondent's admission under this Article, the facility director of the facility shall 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 shall promptly file it with the court and provide a copy to the respondent."

Based on the information obtained from the clinical record, nothing was found to support the allegation that the reason for admission was not accurate; patient rights were not violated. Clinical documentation showed that the patient was advised that she was being sent to another hospital for behavioral health services, that she was being examined for certification purposes, and that she was informed that she did not have to speak with the examiner; patient rights were not violated.

Documentation indicated that the husband was given a copy of the original petition and certificates. However, the documents should also be given directly to the patient. The HRA advises that hospital personnel be made aware of this requirement. It is noted that the petition/certificate completed on the day of discharge contained the same information as the original petition; no new information was added from the original assessment. The HRA concludes that patient rights were not violated.

The HRA suggests that the hospital review the practice of successive petitioning as it is not provided for in the Illinois Mental Health Code.