FOR IMMEDIATE RELEASE

North Suburban Human Rights Authority
Report of Findings
Northwest Community Healthcare
HRA #17-100-9012

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Northwest Community Healthcare (NCH). The HRA notified NCH 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 was unjustly admitted to the behavioral health program and that staff members in this program did not pursue the reason for the admission and they were rude. It was also alleged that the patient's clinical records were sent to outside entities without the patient's acknowledge and/or consent.

The rights of mental health patients receiving services at NCH are protected by the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/2).

To pursue this investigation, the HRA interviewed hospital personnel. The HRA reviewed the patient's clinical record with written consent. Also reviewed were hospital policies relevant to the allegations.

Background

According to its website, Northwest Community Healthcare is a 489-bed facility located in Arlington Heights. NCH's Emergency Department (ED) is a Level II Trauma Center and sees about 120 patients needing mental health services per month. The NCH Emergency Department includes private rooms as well as specialty rooms for trauma, critical care, isolation and behavioral health. Behavioral Health Specialists are available 24/7 in the Emergency Department to provide patients with mental health assessments, crisis intervention, and referrals to inpatient and outpatient mental health services or community resources.

NCH provides outpatient and inpatient behavioral health, caring for a range of psychiatric, emotional, substance abuse and other behavioral or mental health issues, including: anxiety, substance abuse, Bipolar disorder, Dual diagnosis, age-related, eating disorders and self-injury. The facility serves the community by providing care for 52 inpatient and 30 residential beds, or any of the outpatient locations. Linden Oaks Behavioral Health manages the behavioral healthcare services at NCH.

Findings

The complaint was that a patient went to the hospital for hip and leg pain. When asked if she was suicidal, the patient reported that she and her husband had discussed a plan. It was stated that this comment was misunderstood in its context- meaning that yes they had discussed and developed a plan, but she did not mean that the plan would be used any time soon. It was also stated that the hospital had sent her records to her internist and "probably" to her rheumatologist without her consent.

A review of the clinical documentation showed that the adult female patient called 911 and arrived to the ED with complaints of severe leg pain. ED notes documented that during the triage screening, the patient admitted to suicidal ideations. She stated she had never done anything in the past to hurt herself. When asked if she had a plan, the patient stated that her ex-husband "knows how to do it" using helium and will assist her in suicide. The patient's medical needs were assessed, which included an ultrasound that showed the following: "there is no evidence of deep vein thrombosis within either lower imaging from the groin to the distal calf. There is normal compression and augmentation, no popliteal cyst or other abnormal fluid is seen. No solid soft tissue abnormalities are apparent. Unremarkable examination".

A behavioral health assessment was ordered and the assessment documented that the patient reported that she feels like she has been dying because she is so exhausted. She is not bathing, cleaning or taking care of her animals. She stated she did not want to kill herself but she just cannot stand the pain anymore. She reported that she did not want to end her life today but "some day". The patient reported to the assessor that she wanted pain medication – "the only thing that makes my depression better if I feel better. I am not here to discuss my depression." She stated that she thought the ED staff would run a test to find out what is wrong with her and relieve her pain. She further stated that she had gone to pain specialists in the past and tried multiple treatments and medications but nothing helped, and she does not want to risk addiction. The patient was medical cleared and documents were completed for an involuntary admission; the patient subsequently signed a voluntary application for admission to the behavioral health program.

At the site visit, the ED physician that called for the behavioral health assessment stated that the nurse initially conducts an assessment and if the patient mentions suicidal ideation, the nurse reports this to the physician. The physician stated that he then talks to the patient and asks a few questions, but he does not like to ask a lot of questions as he does not want the patient to have to repeat the same story again as that could be upsetting for the patient. As an example, he mentioned a sexual assault, saying that he does not want the patient to have to tell that story over and over. The Psychiatric Liaison is contacted as is the Psychiatrist on-call – both complete assessments. However neither professional determines the disposition of the patient. They both report their findings to the ED Physician who then makes the determination based on what they found and his own observations of the patient. In this case, he recalled (by reviewing the chart) that the patient had reported suicidal ideations to the nurse. He also stated that he was also very concerned about her inability to care for herself, saying that she had reported not taking care of her hygiene, pets, sleeping excessively, etc. He also mentioned that whenever any patient mentions a suicidal plan, they always want to err on the side of caution.

At the site visit, hospital personnel gave the HRA Joint Commission on Accreditation of Healthcare Organizations (JCAHO) sentinel event document that indicates who is at risk for suicide. To further demonstrate that the admission was just according to JCAHO standards, hospital personnel had highlighted this patient's following presenting observations: mental or emotional disorders, particularly depression, history of trauma or loss, chronic pain, social isolation, and access to lethal means coupled with suicidal thoughts.

In discussing the allegation about staff being rude and staff members not pursuing the reason for the admission, it was stated that an internal review did not reveal any indication that clinical professionals providing care to her were rude. They believed that the patient perceived the staff as rude because she was upset that she was being admitted to the hospital, that she did not like being told something that she did not want to hear, and she was mad at her psychiatrist. But again - this is all speculation on the part of hospital personnel. The HRA notes that while in the ED, the patient threatened to sue the hospital, and she threw her blankets out of the room, complaining that they smelled (after being replaced three times). While in the behavioral health program, she was observed to be angry, agitated, guarded, exit seeking and hostile. A progress note documented that the patient explained that she believed that everyone has a right to end their own life if they are in severe pain and said she wrote a thesis about this topic in law school. The patient continued to explain that she was currently not at that point and never intended to imply that she was at that point when she was in the ED.

In response to the allegation that the patient's clinical record was sent to outside entities without her acknowledge and/or consent, the chart showed that the patient identified her primary care physician (PCP) and signed a consent for the disclosure of information for the continuity of care. The chart also contained two additional signed consent forms that authorized the patient's ex-husband and her psychiatrist access to clinical information.

At the site visit, hospital personnel referenced the Illinois Mental Health and Developmental Disabilities Confidentiality Act, in that the patient's primary care physician is part of the Interdisciplinary team and because the patient's PCP is part of the Interdisciplinary Team, clinical records may be disclosed without the patient's consent for the purposes of care coordination. It was stated that limited clinical information was sent to this physician by the independent physician practitioners treating the patient. It was further stated that although statutes allow for this directive, signed consents are still obtained.

The hospital has policy and procedures in place for the Involuntary Admission of Adults and Minors that states (in part) that, "An adult who is subject to involuntary admission and who is in such a condition that immediate hospitalization is necessary to protect himself/herself or others from physical harm may be involuntary admitted to inpatient behavioral health services upon the completion of a Petition by any person eighteen (18) years or older."

Also in place are the Patients' Rights and Responsibilities document that shows that each patient has the right to be free of all forms of abuse or harassment. All employees receive training that includes (in part) occurrence reports, confidentiality/HIPAA documentation, and unit rounds/environment of care, patient rights, and therapeutic boundaries.

The hospital has policy and procedures for the Release of Information Concerning Mental Health and Developmental Disability Treatment that states (in part) that requires "confidentiality and privacy of all records and protected health information related to mental health and developmental disability treatment and to assure that such records are released only in accordance with state and Federal laws including the Federal Health Insurance Portability and Accountability Act Privacy Regulations (42 CFR part 160 and 164) and the Illinois Mental Health and Developmental Disabilities Confidentially Act (740 ILCS 110/et. seq.)."

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 2-102, "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment…"

Section 3-601 of the Code states that "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. The petition may be prepared by the facility director of the facility."

Pursuant to the Illinois Mental Health and Developmental Disabilities Confidentiality Act, Section 9, " In the course of providing services and after the conclusion of the provision of services, including for the purposes of treatment and care coordination, a therapist, integrated health system, or member of an interdisciplinary team may use, disclose, or re-disclose a record or communications without consent to: (1) the therapist's supervisor, a consulting therapist, members of a staff team participating in the provision of services, a record custodian, a business associate, an integrated health system, a member of an interdisciplinary team, or a person acting under the supervision and control of the therapist…"

Based on the information obtained, it is concluded that the allegation that a patient was unjustly admitted to the behavioral health program and that staff members did not pursue the reason for the admission is unsubstantiated. The HRA cannot dismiss the claim that the staff members were rude, but no evidence was found to support this claim; the allegation is unsubstantiated. Based on the information obtained, no evidence was found to support the allegation that the patient's clinical records were sent to outside entities without the patient's acknowledge and/or consent.

RESPONSE

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