FOR IMMEDIATE RELEASE

North Suburban Human Rights Authority
Report of Findings
Northwest Community Healthcare
HRA #18-100-9022

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 inappropriate discharge of a minor patient. It was asserted that a minor patient was assessed in the Emergency Department (ED) and it was determined that the patient was a danger to self and others. After being in the ED for around 44 hours, the parents were advised that an in-patient bed could not be located so the patient was discharged.

The rights of mental health patients receiving services at NCH 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.

Background

According to its website, Northwest Community Healthcare is a 489-bed facility located in Arlington Heights. NCH's Emergency Department 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 clinical record revealed data on a 9-year-old male with autism and no prior psychiatric hospitalizations. He was admitted due to aggressive behaviors; he had threatened his younger brother with a knife and had made threats toward his mother. He entered the ED on April 8, 2018 at about 6:00 p.m.; he was discharged on April 10, 2018 at about 2:00 p.m. The assessing

Psychiatrist recommended that staff members proceed with efforts to place the patient on an inpatient psychiatric unit due to the aggressive behavior. It was also noted that the mother felt unsafe for him to be home. It was noted that the psychiatric liaison began working on placement. The mother was advised that placement might be challenging that night and it was noted that she understood the challenge. On the 9th, it was documented that the patient unintentionally hit his arm on a cart and then started punching himself because he was upset about hitting his arm. His brother visited this day and the mother reported that the patient ran up to him and "flicked" him in the eye. Other than these behaviors, the patient was observed to be calm, cooperative, resting, no distress noted, ate well, sleeping, etc.

The clinical record contained a Behavioral Health Placement chart that showed what shift called for placement (day, evening), the name of the facility contacted, the time of the call, the status of the call, and comments. The chart showed that numerous contacts were made on both shifts to numerous hospitals within the state, all without success as no beds were available.

On April 10th, a Psychiatric Nurse Liaison met with the patient and his father. It was noted that per staff and the patient's father, the patient's behavior had been more appropriate that day. The father reported his frustration that appropriate placement had not been secured. The father reported that he had made an appointment for an outpatient Psychiatrist for May 24, 2018. It was then documented that the patient and his father met with the Physician who recommended medication and provided a prescription. The father reported that he felt safe taking the patient home. The patient denied suicidal or homicidal ideation and no symptoms of psychosis were noted. It was documented that the patient's Pediatrician was updated with the plan of care and the Physician ordered discharge.

The Physician discharge summary documented that "initially, inpatient psychiatric admission was recommended, yet the placement on the inpatient unit is difficult to accomplish and the boy is getting more restless in waiting for the placement in the ED room. Parents are also uncomfortable with this situation and now they believe that they would be able to care for him at home with medication, Abilify, that he used to be in the past, awaiting an appointment with a pediatric psychiatrist on May 24. No aggressive behaviors here in the ED. The patient is interacting well with parents and does not threaten them".

At the site visit, the HRA meet with the Psychiatric Nurse Liaison – the Physician was also scheduled to attend the meeting but she was running late. The Liaison firstly stressed that she does not have the authority to discharge a patient-this decision can only be made by a Physician. She did say that all efforts were made to find placement for this patient and she can certainly understand the frustration of the parents. She stated that while in the ED, the patient never required any behavioral intervention and she was concerned if he remained in the ED, his behavior might become worse. When asked if anything would have been done differently, it was stated that the patient was well cared for and repeated contacts were made for placement. It was felt that they did everything they could for this patient.

Conclusion

Pursuant to Section 3-503 of the Illinois Mental Health and Developmental Disabilities Code, "a) Any minor may be admitted to a mental health facility for inpatient treatment upon application to the facility director, if the facility director finds that the minor has a mental illness or emotional disturbance of such severity that hospitalization is necessary and that the minor is likely to benefit from inpatient treatment. Except in cases of admission under Section 3-504, prior to admission, a psychiatrist, clinical social worker, clinical professional counselor, or clinical psychologist who has personally examined the minor shall state in writing that the minor meets the

standard for admission. The statement shall set forth in detail the reasons for that conclusion and shall indicate what alternatives to hospitalization have been explored."

Based on the information obtained, the HRA does not find that rights were violated. The minor was initially assessed as a danger to self and others. Although placement in fact had not been located, no aggressive behavior was noted during the ED stay and the parents stated they could care for him at home. The HRA recognizes the parents' frustration with the time the child spent in the ED, however, it was not due to lack of trying to find placement by hospital personnel.