REPORT OF FINDINGS- 20-040-9004
PALOS COMMMUNITY HOSPITAL
HUMAN RIGHTS AUTHORITY- South Suburban Region

INTRODUCTION

The complaint stated that the hospital's Emergency Department staff did not provide a copy of the petition, certificate, and rights information, 2) the recipient was handcuffed for refusing to put on a hospital gown and was disrobed by a male security employee, 3) the recipient was not allow to keep her belongings at her bedside, 4) the recipient was informed that she would be discharged from the hospital's emergency department once the petition had expired and later was told that she would be transferred to a state-mental health hospital, 5) the recipient's request for an adult diaper was not honored and a nurse yelled at her for wetting the bed, 6) the hospital's Patient Advocate did not return the recipient's phone call, 7) the recipient's medication for seizures was not timely administered, and, 8) the recipient was not allowed to keep her service dog when she was detained in the hospital's emergency department.

If substantiated, these allegations would be violations of the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.) and the Americans with Disabilities Act (ADA) Title II (State and local government services) and Title III (Public accommodations and commercial facilities).

Located in Palos Heights, this general hospital has a behavioral health unit with 34 beds and due to the covid-19 virus only 18 beds were reportedly being used when the complaint was discussed with the staff.

METHODOLOGY

To pursue the investigation, the hospital's Vice President of Clinical Services, the Medical Director of the Emergency Department, the Director of Emergency Services, a physician of Emergency Services, the Director of Public Safety, a Public Safety Officer, and two nurses were interviewed. A letter written by the hospital's former Director of Emergency Services concerning the complaint issues was reviewed. The complaint was discussed with the adult recipient, who maintains her legal rights, and sections of her record were reviewed with consent. Relevant hospital policies were also reviewed.

COMPLAINT SUMMARY

The complaint stated that the recipient was detained in the hospital's emergency department for more than 24 hours and alleged that copies of the petition, certificate, and rights information were not provided. She was reportedly placed in handcuffs for refusing to put on a hospital gown and was disrobed by a male security employee. She was not allowed to keep her belongings at her bedside as per the complaint. She was allegedly informed that she would be discharged from the hospital's emergency department upon the expiration of the petition. Later, she was reportedly informed that she would be transferred to a state-mental health hospital. She was not provided with an adult diaper as requested and a nurse yelled at her for wetting the bed, according to the complaint. She called the hospital's Patient Advocate, but her call was allegedly

not returned. The complaint stated that Gabapentin medication for seizures was not timely administered. It was reported the medication should have been administered every three hours due to possible severe withdrawal symptoms. Additionally, the complaint stated that the recipient's service dog was not allowed in the hospital's emergency department.

FINDINGS

Information from the record, interviews, and program policy

An HRA record review revealed that the recipient was transported by ambulance to the hospital's emergency department for a psychiatric evaluation on Tuesday, October 29th, 2019 around 10:20 a.m. She was not cooperative with the staff and initially had refused to put on a hospital gown and a hospital's Public Safety Officer was at her bedside. She called her daughter to pick her up and was informed that she could not leave the hospital due to suicidal ideations. Her belongings were given to the Public Safety Officer. The Attending Physician documented that the recipient has a history of depression, anxiety, and physical medical problems. She had denied ingesting or abusing alcoholic beverages and later acknowledged drinking alcoholic beverages earlier on that same day. The physician documented that the recipient was shouting and agitated during the examination and lacked decisional capacity to give consent for psychotropic medication and emergency medication to prevent harm to self and others was ordered. According to the medication record, the emergency forced medication was not administered on the 29th.

A nursing note documented that the recipient had refused to return to her assigned room, and a Public Safety Officer helped to escort her back to her room at 11:30 a.m. The "pt did not fight or argue" as she voluntarily walked back to her room. A corresponding Public Safety Incident Report documented that the hospital's procedures were explained to the recipient after she was "physically escorted" back to her room by the Public Safety Officer and a nurse and that no further action was required by the officer. A certificate, completed by the Attending Physician on October 29th, 2019 at 11:35 a.m., documented that the recipient was having thoughts about ingesting an overdose of medication pills because she did not have money for her medications and to pay her bills. A nursing note indicated that the recipient had refused to comply with blood work and tried to leave the hospital's emergency department at 11:59 a.m. She reportedly was educated on why blood work was needed and why she could not leave the emergency department. She told the nurse that she would need to be restrained for blood work and the hospital's Public Safety Department was called. A corresponding Public Safety Incident Report documented that five officers had presented to the hospital's emergency department to place the recipient in a physical hold due to her refusal to comply with medical procedures. According to the Public Safety Incident Report, the recipient complied with the requested medical procedures, and no further action was required of the officers other than standing nearby.

A petition, completed by a nurse on October 29th, 2019 at 8:00 p.m., documented that the recipient had verbalized feelings of depression and possibly harming herself. The HRA noticed that the petition that allows for a recipient to be detained for a mental health assessment was completed more than eight hours after the first certificate and some nine hours after being prevented from leaving. According to the petition, the recipient had received a letter from her medical health insurance provider stating that her insurance coverage had been cancelled. She told a representative from her medical health insurance provider during a phone call that she would harm herself by taking an overdose. Her record indicated that multiple urine samples were

provided and that toileting options were offered. She told the intake nurse that she uses a service dog as a coping mechanism. There was no more documentation concerning this issue found in her record. She was medically cleared for a psychiatric evaluation at 3:40 p.m. She told a nurse that she had been without her medications including her seizure medication for three months due to her financial problems. Gabapentin was ordered due to her history of chronic leg pain and paresthesia and per her request. This medication had been previously prescribed twice daily. The medication record documented that Cymbalta was administered one time and Gabapentin was administered twice on that same day. The HRA notes that Cymbalta is used to treat depression.

A second certificate was completed by another physician on October 30th, 2019 at 11:30 a.m. and repeated the information documented on the first certificate. According to the progress notes, the recipient was allowed to review the petition and certificate upon her requests on that same day at 9:39 a.m. and 3:29 p.m. She reportedly gave the involuntary hospital admission documents to the staff after she had reviewed them. A clinical nurse, who served as the hospital's Patient Advocate, had a meeting with the recipient about her concerns at 3:15 p.m. She reportedly was upset about the length of stay in the hospital's emergency department. She said that she did not give consent for treatment and was not examined by the physician as declared on the certificate. She said that the intake nurse had told her that she could leave the hospital upon the expiration of the "certificate." She said that she was not suicidal and wanted to go home and would sign a Leave Against Medical Advice form. She told the clinical nurse that she should not be transferred to a named state operated mental health facility because she has medical health insurance. She requested to talk to the intake nurse and the physician was informed about the recipient's concerns. At 4:37 p.m., the physician, the recipient's mother, and the same clinical nurse were present when she was informed that she needed to be evaluated by a psychiatrist before she could leave the hospital. She was told that a psychiatrist was coming to evaluate her on that same evening. She was allowed to review the petition and certificate for a third time upon her request and said that she understood that she could not keep the involuntary hospital document but could review them.

A nursing note stated that the recipient had requested morning medication and orders were received from the physician. The medication record documented that Cymbalta and Gabapentin were administered twice on the 30th. Elavil and Celebrex were administered one time on that same day. Elavil and Celebrex medications are used to treat depression. She was evaluated by a psychiatrist on the 30th around 8:00 p.m. and denied having any thoughts about harming herself. The psychiatrist recorded that the recipient's family did not have any concerns about her safety if she was discharged from the hospital's emergency department on that same night. Her discharge plan recommended that she should call a crisis hotline if she was having suicidal thoughts and to participate in psychotherapy sessions to learn better coping skills.

The recipient told the investigation team that she was placed in handcuffs and was escorted to an examination room. She said that her clothing was removed by a male security employee for refusing to disrobe as requested by the staff. She said that a male nurse was also in the examination room when the incident had occurred. She said that she had initially refused to give blood for testing as requested. However, she did agree to cooperate with the blood draw if her daughter was allowed access to her cell phone to make calls for her. She said that a behavioral health nurse asked her a few questions and told her that she was not suicidal around 6:00 p.m. The nurse told her that she did not have medical health insurance and that she could leave when the "petition" expired. Then, she was told that she would be transported to a state mental health hospital. She

was awakened around 3:00 a.m. on that next morning and was told that she would know where she was going when she got there and was moved to another room in the emergency department.

The recipient told the HRA that rights information was not provided and that her parents came to pick up her because she thought that the petition had expired. She was not informed that she did not have to talk to the physician, but this was affirmed on the certificate. An Administrator told her that she could not give her a copy of the petition and certificate. She reported that she had called her attorney and was told to contact the Illinois Guardianship and Advocacy Commission. The hospital's Patient Advocate did not return her call and later she was informed that the hospital does not have a Patient Advocate. She said that the Director of the Emergency Department and the physician who signed the second certificate asked her some questions on the 30th around 6:00 p.m. And, the physician told her that she could go home, but she needed to be seen by a psychiatrist before she could leave the hospital. She said that she was moved to another room in the emergency department and was allowed access to her computer and cell phone. She told the investigation team that her service dog was not allowed in the hospital's emergency department. Her service dog can push her medical alert response device and is trained to go for help. She reportedly was evaluated by a psychiatrist on the 30th around 8:00 p.m. and was discharged on that same night.

The Director of Emergency Services told the HRA that the recipient was transported by ambulance to the hospital for a psychiatric evaluation. She said that a representative from the recipient's medical health insurance provider had called 9ll because the individual had said that would harm herself. The Attending Physician told the HRA that the recipient initially denied having suicidal and homicidal ideations. However, she told a nurse that she had a plan to overdose on pills. She initially had denied using or abusing alcoholic beverages and later reported having consumed one alcoholic beverage earlier on that same day. Her history includes depression and anxiety. She was agitated, shouting, argumentative, and oriented times three on October 29th. The Attending Physician told the investigation team that emergency medication was ordered but the medication was not administered because she was able to calm herself. He said that the recipient was informed of her rights as he had affirmed on the certificate prior to examination.

The staff reported that the recipient was allowed to review the petition and certificate several times as documented in her record and the hospital's letter. The hospital's behavioral department staff had told them that recipients can review the petition and certificate and that a copy of the documents should not be provided. The HRA informed the staff that the hospital's emergency department is a mental health facility as defined under the Code. The recipient was detained for more than eight hours before the petition was completed. The petition should have been prepared around 10:20 a.m. on the 29th when she was detained for a psychiatric evaluation and before the certificate was completed. She should have been provided with a copy of the petition because of her lengthy stay in the hospital's emergency department, which totaled more than 24 hours, as she waited to be transferred to an inpatient state-operated facility on a petition and certificate. And she was evaluated by a psychiatrist on the evening of the 30th and was released. The staff reported that mental health recipients are not allowed to keep their belongings with them for safety reasons. They said that the recipient would have been provided with an adult diaper upon her request and that her record lacked documentation concerning this issue. The investigation team was informed that the hospital does not have a Patient Advocate and that staff

members will fulfill this role as needed. The recipient did not have a service dog when she had presented to the hospital's emergency department.

The hospital's letter documented that the recipient was allowed to review the petition and certificate three times per her requests on October 30th, 2019. Her record indicated that she was initially not cooperative and had refused to change into a hospital gown. However, she did comply with this after a nurse had provided education. She was not restrained during her hospital visit and handcuffs are not utilized even if the application of restraints is appropriate. The hospital's Public Safety Department told the HRA that the local police department would be called for recipients requiring handcuffs. The hospital's Public Safety Officer involved in the incident on the 29th at 11:30 a.m. said that he had "grabbed" the recipient's arm to get her to return to her room. Then, he said that he had "guided" her back to her room with the help of a nurse. The hospital's letter stated that the hospital adheres to its policy on recipient's belongings. According to the hospital's letter, the record does not support that the recipient was informed that she would be discharged from the hospital's emergency department once the petition had expired and later was told that she would be transferred to a state operated mental health hospital. And, this reportedly is not the hospital's practice.

The hospital's letter stated that multiple urine samples were provided, and toileting options were offered during the recipient's hospital visit. Her concerns were addressed by a staff person who served as the hospital's Patient Advocate on October 30th, 2019. The physician made a determination that medication could be safely administered after her blood alcohol level had shown improvement. Gabapentin was ordered per the recipient's request and physical medical history. Additionally, the hospital's letter stated that the emergency medical services transport report does not mention a service dog, but the recipient told the intake nurse that she uses a service dog as a positive coping mechanism. The hospital's letter documented that the recipient's record does not reflect that she or her family had requested her service dog.

The hospital's Safety Screening of Behavioral Health Patients in the Emergency Department policy states that a visual physical safety screening is completed in a manner supportive to the patient's dignity and right to privacy. The patient is provided with an explanation and rationale for this procedure and will be asked to change into a hospital gown in the presence of two staff members and one of them must be a nurse with the hospital's Public Safety on standby. As the patient removes his or her belongings the items will be passed to a Public Safety Officer and will be inventoried and placed in secure bags. A patient's belongings will be given to a nurse upon the patient's disposition from the emergency department.

The hospital's Involuntary Admission To A Psychiatric Unit policy states that a petition and certificate must completed for any involuntary admission. The petition should be completed immediately when a patient is involuntarily detained for a mental health examination. A psychiatrist or physician will examine the patient to determine the need for involuntary admission and complete a certificate. A patient will be informed of his or her rights if the evaluation is solely for the purpose of certification prior to the examination. A patient will be examined by a psychiatrist as soon as possible but not later than 24 hours, excluding Saturdays, Sundays and holidays. The Rights of Admittee and the Rights of Individuals Receiving Mental Health and

Developmental Disabilities Services shall be explained, and a copy shall be provided. The hospital's policy does not direct that a copy of the petition shall be provided.

The hospital's Service Animals (Guide Dogs) policy states that the hospital and its facilities support the American Disabilities Act (ADA) concerning the use of service animals by a disabled person unless doing so would create a fundamental alteration or a direct threat to the safety of others or the facility. Service animals will be prohibited in isolation rooms, operating rooms, food preparation and food service areas, and may be prohibited in specialized units such as critical care units.

CONCLUSION

According to Section 5/1-114 of the Mental Health Code,

> A mental health facility is defined as any licensed private hospital, institution or facility **… or section thereof**, … for the treatment of persons with mental illness **and includes all hospitals**, institutions, clinics, evaluation facilities and mental health centers which provide treatment for such persons.

According to Section 5/1-123, "a recipient of services" or "recipient" is defined as a person who has received or is receiving treatment or habilitation.

According to Section 5/1-128, treatment includes, but is not limited to hospitalization, partial hospitalization, outpatient services, examination, diagnosis, evaluation, care, training, psychotherapy, pharmaceuticals, and other services provided for recipient by mental health facilities.

Section 5/2-102 states that,

> a) All recipients of services shall be provided with adequate and humane care and services, pursuant to an individual services plan. The plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipients' substitute decision maker, if any, or any other individual designated in writing by the recipient.

According to Section 5/2-201 of the Code, whenever any rights of a recipient of services are restricted, the recipient shall be promptly given a notice of the restriction.

Section 5/3-205 states that,

> 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.

Section 5/3-601 states that,

> 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. The petition may be prepared by the facility director of the facility.

Section 5/3-602 states that,

> The petition shall be accompanied by a certificate executed by a physician, qualified examiner, psychiatrist, advanced practice psychiatric nurse, 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, advanced practice psychiatric nurse, or clinical psychologist personally examined the respondent not more than 72 hours prior to admission. It shall also contain the physician's, qualified examiner's, psychiatrist's, advanced practice psychiatric nurse's, or clinical psychologist's clinical observations, other factual information relied upon in reaching a diagnosis, and a statement as to whether the respondent was advised of his rights under Section 3-208.

Section 5/3-610 states 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 personally examined by a psychiatrist…. If the respondent is not examined or if the psychiatrist, physician, clinical psychologist, advanced practice psychiatric nurse, or qualified examiner does not execute a certificate pursuant to Section 3-602, the respondent shall be released forthwith.

According to Title II (State and local government services) and Title III (Public accommodations and commercial facilities) of the Americans with Disabilities Act (ADA),

> Service animals are defined as dogs that are individually trained to do work or perform tasks for people with disabilities. Examples of such work or tasks include guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting and protecting a person who is having a seizure, reminding a person with mental illness to take prescribed medications, calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack, or performing other duties. Service animals are working animals, not pets. The work or task a dog has been trained to provide must be directly related to the person's disability. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.
>
> Businesses, and nonprofit organizations that serve the public generally must allow service animals to accompany people with disabilities in all areas of the facility where the public is allowed to go. For example, in a hospital it usually would be inappropriate to exclude a service animal from areas such as patient rooms, clinics, cafeterias, or examination rooms. However, it may be appropriate to exclude a service animal from operating rooms or burn units where the animal's presence may compromise a sterile environment.

Complaint #1

The complaint stated that the hospital's Emergency Department staff did not provide a copy of the petition, certificate, and rights information. According to the record, the recipient was transported to the hospital's emergency department on October 29th, around 10:20 a.m. A certificate was completed by the physician on the 29th at 11:35 a.m. Petitions authorize detention, and this one was completed by a nurse on the 29th at 8:00 p.m., which was more than eight hours after her detention had started. A second certificate was completed by another physician on the 30th at 11:30 a.m. Her record and the hospital's letter documented that she was allowed to review the petition and certificate three times as requested on the 30th. She reportedly gave the involuntary hospital admission documents to the staff after she had reviewed them. She was evaluated by a psychiatrist on the 30th around 8:00 p.m. and was discharged from the hospital's emergency department on that same evening.

Although the recipient was not admitted to the hospital's behavioral unit but was to the emergency department, she should have been provided with a copy of the petition and rights

information because of her lengthy stay in the hospital's emergency department, which totaled more than 24 hours, while she waited to be transferred to an inpatient state-operated facility. The hospital's emergency department is a "mental health facility" as defined in the Code's Section 5/1-114. The complaint is substantiated only in regard to the petition and rights information. The HRA notes that the hospital is not required to provide a copy of the certificate, however one should be given upon request.

Complaint # 2, 3 and 4

The complaint stated that the recipient was handcuffed for refusing to put on a hospital gown and was disrobed by a male security employee. The recipient was not allowed to keep her belongings at her bedside. Additionally, the complaint stated that the recipient was informed that she would be discharged from the hospital's emergency department once the petition had expired and later was told that she would be transferred to a state-mental health hospital. The record contained supportive documentation that the recipient had refused to put on a hospital gown as requested by the staff. However, she reportedly complied with this request after the hospital's Public Safety Department was called for help. A Public Safety Officer told the HRA that the hospital does not use handcuffs to restrain recipients. Her record lacked documentation that she was disrobed by a male security officer. The hospital's policy on safety states that behavioral health recipients' belongings will be given to the hospital's Public Safety Department and will be inventoried and placed in secure bags. The recipient's record documented that the recipient was informed that she would be discharged from the hospital's emergency department once the petition had expired and later was told that she would be transferred to a state-mental health hospital. However, the hospital denied the complaint and said that the recipient was updated on her plan of care. The Authority does not substantiate a rights violation concerning complaint #2, 3, and 4.

Complaint #5, 6, 7 and 8

The complaint stated that the recipient's request for an adult diaper was not honored and a nurse yelled at her for wetting the bed. The hospital's Patient Advocate did not return the recipient's phone call. The recipient's medication for seizures was reportedly not timely administered. Additionally, the complaint stated the recipient was not allowed to keep her service dog when she was detained in the hospital's emergency department. There was no documentation of the recipient's request for an adult diaper or that a nurse was verbally abusive found in her record. The staff reported that the recipient would have been provided with an adult diaper upon her request. According to the progress notes, a clinical nurse served as the hospital's Patient Advocate and met with the recipient about her concerns on October 30th, 2019 at 3:15 p.m. The clinical nurse informed the physician about her concerns such as she wanted to go home. At 4:37 p.m., the physician, the recipient's mother, and the same clinical nurse were at her bedside when she was informed that she would be evaluated by a psychiatrist on that same evening. Her record documented that she had been transported by ambulance to the hospital, and she told the intake nurse that she uses a service dog as a coping mechanism. However, her record lacked documentation that she had requested the use of her service dog during her detention in the hospital's emergency department. The Authority does not substantiate a rights violation concerning complaint # 5, 6, 7, and 8.

RECOMMENDATION

1. The hospital shall follow Section 5/3-601 and 3-205 of the Code and the hospital's policy directing that a petition should be completed immediately when a patient is involuntarily detained for a mental health examination.

SUGGESTIONS

1. Consider revising the hospital's Involuntary Admission To A Psychiatric Unit policy to direct staff to provide a copy of the petition within 12 hours of admission.

2. The hospital's "Service Animals" policy prohibits service animals in its hospital and facilities' food service areas. Consider revising the hospital's policy to comply with the ADA that allows service animals in food service areas such as the hospital's cafeteria.

3. The hospital is reminded that all mental health patients, as a blanket rule, do not need to put on a gown however preferred and that a safety need for them should be individually determined.

4. In this case, there should have been a restriction notice for the lab work since the recipient really was not allowed to refuse it, given the five security personnel who presented to the hospital's emergency department to "hold" her.