FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 20-090-9013
Carle BroMenn Hospital (previously known as Advocate BroMenn)

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at Carle BroMenn Hospital, formerly known as Advocate BroMenn Hospital. The complaints alleged the following:

1. **Inadequate involuntary admission process in that a patient's rights were violated when the patient was not provided rights notices, petition and certificates to notify of involuntary admission.**

2. **Patient rights were violated when the patient identified a friend to contact during their inpatient process, but hospital refused to involve this person due to Covid19 restrictions.**

If found substantiated, the allegations will violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/1). The Carle organization purchased Advocate BroMenn hospital on July 1, 2020. The facility primarily covers McLean County with eight surrounding communities. The hospital has 221 beds to serve medical patients, and 12 beds available on the inpatient behavioral health unit. There are plans by Carle hospital to expand the behavioral health unit by 6 beds. The hospital's behavioral health unit also treats individuals with a substance abuse diagnosis. The hospital has an average of 29,000 visits to the emergency department (ED) per year. The average length of treatment for an

Emergency Department patient in need of mental health treatment is 7 1/2 hours. The ED conducts approximately 300 mental health evaluations per month. The emergency department has 65 employees without including physicians. The HRA had a signed consent and was able to discuss patient specific details.

COMPLAINT STATEMENT

The allegations state, a patient was admitted on an involuntary basis to a behavioral health unit approximately hours away from her home. Her involuntary admission process began in Bloomington and the patient was eventually transferred to another hospital approximately three hours away. The complaint states the cause for presenting to the hospital was accidental overdose of prescribed sleeping medication and alcohol. The patient realized they had mistakenly taken the medication and drank alcohol and called 911 for an ambulance. The patient was transported to Carle BroMenn Hospital, previously known as Advocate BroMenn Hospital. The complaint alleges the patient was not provided with information from the hospital on the involuntary admission process. Allegedly, the patient had no recollection of treatment in the emergency department (ED) and has had to request medical records information twice. Allegedly, while in the hospital the patient was never tested for the prescription medication benzodiazepine and was actually prescribed more of this same classification of medication while being treated at the ED. Additionally the complaint alleges the involuntary admission process was never explained to the patient and the patient did not receive documentation on the admission, including patient rights. The complaint also alleges that patient had asked for a friend(s) to be called and the hospital refused. This patient was also denied a contact with a friend because of Covid19 precautions and felt this was unacceptable by the hospital.

Staff Interviews (8.19.20)

The HRA facilitated a site interview via WebEx videoconferencing platform with several administrative staff with the hospital. On July 1, 2020, Advocate BroMenn had been acquired by Carle Hospital. Staff participating in the site visit were employed when the hospital was managed by Advocate.

The Emergency Department (ED) sees approximately 72 patients a day. A patient can arrive to the ED several ways for treatment: transport

themselves, or transported by a friend, community service provider and ambulance. When a patient arrives to the ED, they are triaged and patients with mental health needs are considered high priority patients. When they arrive, the intake process involves taking vital signs, routine laboratory work, and a clinical assessment by a physician. If a patient is medically cleared by an attending physician and is determined to be having a mental health emergency, then they are put in their own room, personal items are secured, especially anything with a cord, and they are asked to remove their clothes and wear scrubs. There is then a collaborative process between either the hospital's attending physician, one mental health worker who is a Licensed Clinical Social Worker (LCSW) or a community mental health worker. There is an intake that involves questions related to substance abuse history, suicidal ideations and history of suicidal ideations. The attending physician makes the determination if a person has decision-making capacity. If a mental health patient is not willing to stay at the ED to be evaluated, then staff may implement a restriction of rights until a physician clears them. If a patient requires inpatient hospitalization to treat the mental health symptoms and their hospital's inpatient unit is not available or appropriate, the hospital has a list of Tier 1 and Tier 2 hospitals that they call to find an open bed for inpatient treatment. If a patient is refusing inpatient mental health treatment, then it is the physician's responsibility to make this determination. Often the hospital works with law enforcement, emergency medical services or individuals who know the patient to start the petition for the involuntary admission. The first certificate would be completed by the ED provider if admitted to Carle's behavioral health unit. Then the nurses on the behavioral unit complete the other certificate. If a patient requires transfer to another hospital for inpatient mental health care, then the receiving hospital would be responsible for the certificates and mental health court would happen in that county. A voluntary admission for inpatient treatment is also another option for treating patients experiencing mental health needs but this is strictly a voluntary process.

During the months of March 2020 through July 2020 the hospital did have heavier visitor restrictions due to the Covid-19 pandemic precautions that were in effect in the State of Illinois. All patients were asked to provide a contact person during their treatment; there were no in-person visits while a patient received treatment in the ED. The patients did have access to a telephone or an iPad to communicate with friends or family. Nurses also have Spectra link phones that are mobile and can be given to a patient for a private conversation. The hospital also has signage up making patients

aware of phone access. The hospital did not require a written consent for patients to sign for the hospital to communicate with whomever the patient identified. At the time of this site visit, August 19, 2020, the hospital had lifted restrictions on in-person visits in the ED and patients are allowed to have 1-2 support people with them during their treatment process.

The hospital staff the HRA interviewed were not familiar with this patient and their records indicated she has had few visits to the ED, the last one being in 2007. The patient arrived via ambulance to the ED while the hospital was still named Advocate BroMenn Hospital. The patient called the ambulance on her own due to being under the influence of drugs and alcohol. The patient arrived to the ED appearing very intoxicated per ambulance personnel. Emergency workers found the patient with access to a gun. The patient also contacted emergency personnel due to thoughts of suicide and ingesting prescription medication in the pharmaceutical classification of benzodiazepines. This case involved a lengthy medical clearance due to the prescription medication overdose and the patient's blood alcohol content being over the legal limit. The medical doctor contacted Poison Control about the medication overdose. The blood alcohol content required 8-12 hours observation before the patient was considered medically cleared. Routine treatment of this patient in the ED involved a standard laboratory panel completed, a toxicology report, and a urinalysis. The diagnosis was Polysubstance overdose and suicidal ideation. The ED Provider documented at 5:30am that the "patient currently intoxicated, able to talk, admitted to taking benzos." Poison control was contacted by the ED Physician.

This patient received emergency medication of Ativan (more than one dose) at 1:57am, fluids and was also ordered Zofran for nausea. This was due to the patient "flailing and yelling on the stretcher". The Physician could not examine her due to this behavior. The reason the hospital began the Involuntary Admission process was due to the patient having access to guns. There was no note observed in the patient record during the site visit that indicated this was the conversation staff had with the patient. The crisis worker did meet with the patient, but a psychiatrist was never consulted. The hospital would have used telepsychiatry in this instance. No substance abuse assessment was conducted with the patient but that is part of the intake process. Around 1pm the patient was clinically sober from alcohol and the primary concern at the time was the suicide attempt with access to a gun. Mental Health staff spoke with the patient about her alcohol use and the

patient admitted to drinking Crown Royale. The patient's rights were never restricted because she never refused treatment. She did not have a cellular phone with her.

The hospital did not admit the patient voluntarily out of concern that she would not stay at the hospital which is why they chose involuntary. This determination was based on the client having a strained relationship, feeling hopeless and making the statement "I am not sure if I won't hurt myself on Monday."

During this time of treatment in the ED the hospital did have visitor restrictions due to the Covid19 pandemic. All patients were asked to provide a person to contact. In person visits were not permitted in the ED. If a person asked to have a visit or contact with someone they would have been provided with a phone or the iPad to contact the requested individual. The facility has signage up to notify patients that visits were restricted due to Covid19. The hospital would not have made a call to a family member if the patient is over 18. The patient would have access to a telephone.

FINDINGS (Including record review, mandates, and conclusion)

1. **Complaint #1 – Inadequate involuntary admission process in that the patient's rights were violated when the patient was not provided rights notices, petition and certificates to notify of involuntary admission.**

The HRA reviewed an Emergency Room Note dated 5/10/20. The patient arrived to the hospital via ambulance and was first seen by primary ED physician #1 at 01:02 am, Physician #2 at 10:59am and Physician #3 at 4:26pm. The patient was in need of treatment in the hospital Emergency Department with the Trauma Categorization of "Triage Class II, Trauma Category Medical." At 0158 the Arrival Note explains "Pt. arrives for intoxication, suicidal ideation, and overdose." The Neuro check at this time has the patient orientation being unable to assess, level of consciousness "awake", comprehension "unable to comprehend", speech was "unclear", and behavior was "restless". The Opioid Sedation scale was marked as "1". It was determined by the Emergency Department Registered Nurse (EDRN) that the patient was awake/alert with no pain. Assessment 0300 by an EDRN of the patient documented "Pt complaining of overdose of benzos, threatened suicide

with guns. Suicidal/Homicidal Ideation admits Suicidal Ideation. ...behaviors 'Agitation'. Drug use, Poor concentration, ETOH, Pressured speech. Patient's affect Normal." "Suicidal. States drank 1/5 of Crown Royal, took benzos." The Chief Complaint was "Overdose Intentional". The ED Note comment section, completed by the ED Medical Physician, explained the following "[Patient] is a 37 year-old female who presents after an intentional overdose. Patient appears very intoxicated, and she is not making any intelligible sentences to provide a reliable history. According to EMS report, ... she was having thoughts of suicide. When they arrived on the scene, the patient was stating that she took too many benzodiazepines. She also had a loaded firearm at the scene. They were unable to locate the bottle for the benzodiazepines, but there are multiple prescription bottles for amphetamines. These prescriptions are old, and it is difficult to ascertain how many pills are actually missing. Patient appears to not be taking this medication properly. She also admitted to EMS that she had been drinking heavily. Upon arrival to the emergency department, she was calling out loudly and flailing about on the stretcher. She cannot verbalize whether she is having homicidal or suicidal thoughts. She does not appear to have any outward signs of trauma." There is another section of this form with further comments "This patient was taken in sign out from the prior shift pending placement. Patient is being held on a certificate. She is here with a suicide attempt with overdose on benzodiazepines with a loaded gun in the room. Additional risk factors is transsexual. Patient is medically cleared for psychiatric admission. Hemodynamically stable." Physician #3's name was listed on this part of the form, not the original ED doctor.

The same Emergency Room Note section titled "Medical Decision Making ED Course Discussion ED Course" written by the ED Physician #1 at 2230 documented "This is a 37 year-old female who presents with intoxication of unknown substances. She admitted to benzodiazepines and alcohol, but this does not entirely match the toxidrome. She was found to have an elevated alcohol level to account for the liquor she consumed. She also seemed to be more agitated than what I would expect with benzodiazepine overdose. I suspect that she took some of the prescription amphetamines in addition to the alcohol. She does not show any signs of opioid toxicity. Patient required multiple doses of Ativan to calm herself and keep herself safe while she continued to metabolize the substances. Poison control was called given the limited information.

Patient is currently too intoxicated to be evaluated by the crisis team. However she must be evaluated given these suicidal ideations expressed in the prehospital setting. Around 0530, the patient was able to answer more questions. She was still heavily intoxicated. She admits to taking 'a lot of benzodiazepines.' She cannot specifically name what benzodiazepine it is that she took. She states that she takes Ritalin twice a day. She will take benzodiazepine as needed to help with sleep. States that she had this prescription filled here in Illinois. She reports that the acetazolamide found at the scene was old and from a time that she needed it for altitude sickness. According to the records, patient had a prescription for 180 temazepam tablets filled in mid-April. All of these pills are unaccounted for. Poison control states that she will be medically cleared around 0700. However, she will not reach clinical sobriety in relation to her alcohol until later. Patient will be signed out to the day team at the end of my shift around 0600. Patient was signed out to me once again around 2000 pending disposition. ... Patient medically cleared but requiring crisis team evaluation. Crisis team did evaluate, and they will admit patient. ... She was accepted at [out of area provider] for admission for psychiatric treatment."

The HRA reviewed the ED Summary Report that provided a timeline of physician's orders and nursing follow-up for the patient's ED treatment. On page 7 and 12 the ED Suicide Risk Assessment completed by an ED RN on 5/10/20 at 0115, 0300, 0700, 1100, 1302, 2100, and 2330 indicated the patient had key factors to indicate she was at Level I-High Risk for Suicide/Self Harm and required Level II Observation. Based on the record reviewed the patient was observed for "Continual Observation for restrained level 1 and II" by the person documenting. The Level II observation consisted of 15 minute checks per the ED Summary Report until transfer to another facility. The HRA reviewed the data for this patient's observation status from 0115-0545 hours and the patient's behavior was described as "agitated, sleepy/drowsy" all being entered into the computer at 0555 hours by a Registered Nurse. Vitals were taken at throughout the first few hours of arrival to the ED at 0102, 0120, 0155, 0215, 0304, 0315, 0410, 0510, 0600, 0615 but were not recorded or data entered into the computer at the time of the EDRN treated the patient.

The medication Lorazepam injection 2mg was ordered by ED Physician #1 during the ED treatment at 0115, 0155 and 0159 with the

following noted: "Caution this medication increases patient fall risk. IV INJ 2mg or less over 2-5 minutes..." were ordered for this patient and were given 5/10/20 at 0125 and 0157. The 0159 order was not given. Zofran was also ordered and given to the patient at 0115. On page 40 notes were also entered on this document about the hospital staff's communication with poison control for an initial contact at 0510 which required "supportive care, monitoring 12-24 hours." At 0553 the EDRN noted on the ED Summary Note "...medication that the patient took too much off (of) (temazepam)...". The patient can now be medically cleared at 0700 (after 6 hours of monitoring) as long as there is no hypotension." The HRA researched the medication temazepam which is also known as Restoril which is a benzodiazepine and is considered a sedative, and should not be taken with alcohol and used to treat insomnia (medlineplus.gov).

The HRA reviewed a Petition for Involuntary/Judicial Admission that was started by a Registered Nurse on 5/10/20 at 0500 hours seeking involuntary emergency inpatient admission with the box marked correlating with the following statement "The Respondent is currently detained in a mental health facility or hospital; name of facility where detained: Advocate BroMenn Medical Center." The person completing the petition attested the patient as follows: "a person with mental illness who: because of his or her illness is reasonably expected, unless treated on an inpatient basis, to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed; ... in need of immediate hospitalization for the prevention of such harm." This petition explained the facility's reason for recommending involuntary inpatient treatment as "[Patient] ... stating that she wanted to kill herself and had already overdosed on a bottle of benzodiazepine, had several loaded guns, and drank a fifth of vodka." One Certificate of Examination was completed and attached to the petition signed by the ED Physician #1 on 5/10/20 at 5:10am. The HRA also observes the IL462-2005 in the chart record that is used to notify the patient of the hospital's petition for involuntary admission. This form is blank and does not have the patient's name documented on the form nor a patient signature indicating acknowledgement of the Involuntary Admission process or indicating why the patient did not sign.

The HRA reviewed a Crisis Intervention Note completed by a community based provider that the hospital contracts with to provide

crisis intervention to their ED patients. The Crisis Intervention Note was completed on 5/10/20 by an MSW level Crisis Counselor. The HRA was unable to observe a time on this form but based on an Emergency Room Note the Crisis Counselor was at the hospital at approximately 3:00pm on 5/10/20. Section D of this form titled "Presenting Problems (Describe sequence of events) Current behavioral status is marked as 'cooperative'." Further along this form described the reason for the mental health evaluation which documented: "client contacted EMS due to admitting to an intentional overdose while intoxicated. Upon EMS arrival, client had a gun next to her. …" The provider did not develop a safety plan with the patient due to being admitted to the hospital. Section H: Current Psychiatric/Chemical Dependency Treatment section documented: "client is prescribed ADHD medication by PCP, client has a psychiatrist, [Psychiatrist Name] whom client is unsure when the last time she has seen him was." Section I. Past Psychiatric/Chemical Dependency Treatment has "none reported." The QMHP checked a box next to the statement "History of using the following outpatient services over a one-year period either continuously or intermittently: Psychotropic medication management. Case Management, Outreach and engagement services (adult referrals only)…." Boxes are checked next to the statements: "Serious impairment in social, occupational, or school functions", "Does not seek appropriate supportive community services," "Lacks supportive social systems in the community," and "Exhibits inappropriate or dangerous social behavior resulting in demand for intervention by mental health and/or judicial legal system". The Current Client Status/Activity Description section documented the status/activity of the client as "Crisis Intervention Services (ECI) provided crisis intervention services at BroMenn ED due to client admitting to an intentional overdose. Clinical Intervention: Emergency Crisis Intervention (ECI) assessed client or risk of harm to self and others. Gathered information from hospital staff. Explored current stressors and triggers including an increase in work related stress and working from home. Explored risk and protective factors and client's ability to stay safe from harm. ECI educated client on in-patient hospitalization. Explored previous mental health treatment including previous hospitalizations and medication compliance. ECI consulted with the ED physician who is in agreement with in-patient treatment at this time to prevent further harm. ECI completed required involuntary paperwork. ECI to seek placement." The patient was given the DSM diagnosis of "Adjustment disorder with depressed symptoms." The section titled

"Client Response/Progress" has the following information "Client presented as cooperative but depressed, client reported that she had intentionally overdosed in an attempt to kill herself, but stated 'In hindsight that mixing alcohol with pills, was not a great idea." Client did admit to current suicidal ideation (SI) and stated " 'I am not sure that I would not try to harm myself come Monday again.' Client reports one previous attempt last week with pills but did not disclose this to anyone or seek out medical attention. ...limited supports..." The conclusion of this form provided the following recommendation from the MSW Qualified Mental Health Professional "At this time client is a high risk of harm to self and others as evidenced by client admitting to current SI and an intentional overdose. ECI to seek involuntary placement at this time."

The HRA reviewed a second Petition for Involuntary/Judicial Admission that was started by the Crisis Worker on 5/10/20 at 3:10pm. The petition was initiated for involuntary in-patient admission of the patient for "Emergency inpatient admission by certificate; (405 ILCS 5/3-600). The Respondent is currently detained in a mental health facility or hospital; name of facility where detained: Advocate BroMenn ED." The petition also explained why the involuntary admission was being sought for the patient by marking the following statement "a person with mental illness who; because of his or her illness is reasonably expected, unless treated on an inpatient basis, to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed;...in need of immediate hospitalization for the prevention of such harm. I based the foregoing assertion on the following ... On 5/10/20 ECI (Emergency Crisis Intervention) assessed client at Advocate BroMenn ED, client admits to current SI and is uncertain about intent or ability to stay safe. Client came into the ED today after admitting to an intentional overdose, missed with alcohol and having a loaded gun next to her in her home. Client admitted to overdosing on pills alone last week but did not disclose this to anyone or see medical attention. Client reports no previous mental health hospitalizations. Client is prescribed medication for ADHD and is not currently medication compliant. Client is in need of inpatient treatment at this time to prevent further harm. ..." There is an Inpatient Certificate that accompanied this second petition that was signed by ED Physician #2 at 1620pm that attested the patient was in need of involuntary admission based on the following opinion: "A person with mental illness who, because of his or her illness is reasonably expected,

unless treated on an inpatient basis, to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed;... is in need of immediate hospitalization for the prevention of such harm. I base my opinion on the following (including clinical observations, factual information): 'Patient with suicidal thoughts, she admitted to intentional overdose to kill herself. She took Benzodiazepines. She admits to drinking a large amount of alcohol additionally to harm herself. Patient was found to have a loaded handgun at the scene.' I believe that the individual is subject to (check one) ...Involuntary inpatient admission and is in need of immediate hospitalization." The HRA observed the ED Physician signature and printed name on this form. The second petition included the IL462-2005 which attested "Within 12 hours of admission to the facility under this status and/or completion of a new petition, I gave the respondent a copy of this Petition (IL462-2005). I have explained the Rights of Admittee to the respondent and have provided him or her with a copy of it. I have also provided him or her with a copy of Rights of Individuals Receiving Mental Health and Developmental Services (IL462-2001) and explained those rights to him or her (405 ILCS 5/3-609)." This document was blank with no patient name/signature written indicating she was provided with the Involuntary Admission paperwork from Advocate BroMenn.

The HRA reviewed Carle BroMenn Medical Center, Eureka Hospital Policy on Suicide Prevention with an effective date of 5/28/1995 reads "...7. Inpatients requiring suicide precautions are cared for on the Mental Health Unit or Intensive Care Unit Suicide Precautions, including level of observation, is found on the Behavior Documentation Record. Documentation of behavior is expected every 15 minutes while suicide precautions are in place. 12. A physician, PA, or APC order is required to discontinue or decrease the level of suicide precautions. If a patient is discharged to home, suicide precautions may be discontinued. Section III. Definitions/Abbreviations: ... 2. Continuous Patient Observation: Is defined as visual observation of the patient at all times. Family/friends may not be observers. Camera observation may be utilized. (Level II Observation) 3. Direct Observation Q 15 minutes Q 15 minutes: Is defined as visual observation of the patient at least every 15 minutes. Family/friends may not be observers. Camera observation may be utilized. (Level III Observations) ... Suicide Precautions a. Until evaluation of the patient's level of suicide risk is completed by a physician or qualified licensed clinician, suicide precautions are

implemented and maintained in keeping with the suicide risk assessment category (high, moderate, minimal, or low risk). 1) High Risk a. 1:1 continuous patient observation within arm's reach is required if the patient is not in a ligature-resistant environment. (Level I Observation). 1:1 continuous patient observation within a safe distance is required for volatile patients providing a threat to staff safety. b. Continuous patient observation is provided if the patient is in a ligature-resistant environment. (Level II Observation). ...2) Moderate Risk a. Patients with moderate risk of suicide are provided with continuous patient observation. (Level II Observation) ...3) Minimal Risk a. Patients with minimal risk of suicide are provided with q15 minute observation. (Level III Observation). ...b. Following physician or qualified licensed clinician assessment and determination of serious suicidal ideation 1) All high-risk patients not in a ligature-resistant environment will remain under 1:1 continuous observation within arm's reach (and those in a ligature-resistant environment will remain under continuous observation) until the physician or qualified licensed clinician provides documentation indicating they are not at serious suicidal risk in the current environment."

The HRA reviewed Carle BroMenn Medical Center Involuntary Admission policy in effect since 5/29/1984 last approved on 6/18/20: "**II Policy** A. Petition for Involuntary Admission states 1. Prior to, or at the time of admission, the petition is signed by any individual at least 18 years of age who wishes to initiate an examination and evaluation process regarding someone believed to be subject to involuntary admission. The petition may be executed by an 'interested person,' family member, police, or member of the hospital staff. 2. The petitioner must be able to provide as a result of personal observation: a) a description of any acts or significant threats that may assert to the patient's need for involuntary admission and provide times and places of their occurrences; b) the name and address of the spouse, parent, guardian, or friend of the respondent. If the petitioner is unable to supply any such names and addresses, he shall state that a diligent inquiry was made to learn this information and specify the steps taken. c) the petitioner's relationship to the respondent and a statement as to whether the petitioner has legal or financial interest in the matter or is involved in litigation with the respondents; d) the names, addresses, and phone numbers of the witnesses by which the facts asserted may be provided. B. Emergency Admission by Certificate ... 2. A certificate executed by a psychiatrist, another physician, a qualified examiner, or a clinical psychologist shall

accompany the petition. 3. Any patient subject to involuntary admission must have a petition and one certificate before being admitted to the Mental Health Unit. The Emergency Room physician can examine and execute the first certificate (IL 462-2006). 4. Within 24 hours of admission, a psychiatrist will examine the patient, subject to involuntary admission. This psychiatrist will not execute the first certificate. The admitting physician will make arrangements for the examination necessary for the second certificate. 5. If the respondent is not examined, or the psychiatrist does not find clinical evidence to execute a second certificate, the admitting physician will be asked to discharge the patient. 6. If, however, the psychiatrist does find clinical evidence that the patient would benefit from inpatient psychiatric treatment, the psychiatrist will document his/her clinical findings and his/her recommendation on a certificate to be forwarded to the court. 7. Upon completion of one certificate, treatment prescribed by the admitting physician or consulting psychiatrist beings. The patient is informed of his/her right to refuse medication. (See policy on Administration of Medication.) 8. All patients subject to involuntary admission receive a comprehensive physical and mental examination within 24 hours. A social investigation is done within 72 hours excluding weekends and holidays. There will be documentation in the electronic medical records notes if the patient refuses to cooperate with the physical and/or mental examination. 9. Within 24 hours of admission, a treatment plan is initiated for all patients subject to Involuntary Admission. 10. Once admitted, the patient is given the address and phone number of the Guardianship and Advocacy Commission. If the patient requests, a staff member at Carle BroMenn Medical Center will assist the patient in contacting the Commission. The patient can also contact the GAC without staff assistance. 11. Within 12 hours after admission, the patient is given a copy of the petition. 12. Within 24 hours after admission, excluding weekends and holidays, Carle BroMenn Medical Center deliver a copy of the petition to the patient's attorney and/or guardian if applicable. 13. If the patient chooses, a copy of the petition and/or statement concerning the Guardianship and Advocacy Commission is sent at least two people designated by the patient. 14. The patient is allowed at least two telephone calls at admission to anyone that he/she chooses. ... C. Certificate (IL 462-2006) 1. Any physician, qualified examiner, or clinical psychologist who has personally examined the patient up to 72 hours prior to admission may execute a first certificate. The certificate must contain the examiner's clinical observations, other factual information used to reach a diagnosis, and a statement as to whether the respondent was advised of his/her rights. 2. After a petition is executed, the

person conducting the certification examination informs the person being examined in a simple, comprehensible manner the purpose of the examination. The patient may choose whether or not to talk with the examiner. Any statement made during the examination may be disclosed at a court hearing regarding involuntary admission. If the examiner fails to inform the patient of the purpose of the examination, the examiner is not permitted to testify at any subsequent court hearings concerning the patient's admission. 3. Two certificates are needed for court commitment of involuntary patients. Within 24 hours after admission, a psychiatrist examines the patient for the purpose of the second certificate. The psychiatrist that executed the first certification cannot execute the second certificate. ... IV. **Procedure** A. If the patient presents with a certificate and petition already filled out, Patient Registration or Emergency Department will notify the Mental Health staff and the psychiatrist on-call of the possibility of an admission to the MHU. Medical Clearance is still required. B. As soon as the petition and certificate are completed and verified; after the patient's medical status is confirmed; and after the admitting psychiatrists has placed orders, the patient may be taken to the Mental Health Unit. C. The Rights of Recipients and Rights of Admittee are read to the voluntary patient on admission or involuntary patient within 12 hours of admission. Complete admission procedure per guidelines. D. Inform patient of right to make at least two phone calls and assist him/her as necessary. E. Notify Social Services of patient's admission. F. Give patient a copy of the petition and mail copies to the people designated by the patient. Director of Mental Health or designee will see that all forms are filed with the court at appropriate times. If requested, assist the patient in notifying the Guardianship and Advocacy Commission."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-129) Mental illness** states "Mental illness means a mental, or emotional disorder that substantially impairs a person's thought, perception of reality, emotional process, judgment, behavior, or ability to cope with the ordinary demands of life, but does not include a developmental disability, dementia or Alzheimer's disease absent psychosis, a substance use disorder, or an abnormality manifested only by repeated criminal or otherwise antisocial conduct."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/3-208) Examinations for certification; statement of rights** states "Whenever a petition has been executed pursuant to Section 3-507, 3-601 or

3-701, and prior to this examination for the purpose of certification of a person 12 or over, the person conducting this examination shall inform the person being examined in a simple comprehensible manner of the purpose of the examination; that he does not have to talk to the examiner; and that any statements he makes may be disclosed at a court hearing on the issue of whether he is subject to involuntary admission. If the person being examined has not been so informed, the examiner shall not be permitted to testify at any subsequent court hearing concerning the respondent's admission."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/3-600) Involuntary admission; immediate hospitalization** states "A person 18 years of age or older who is subject to involuntary admission on an inpatient basis and in need of immediate hospitalization may be admitted to a mental health facility pursuant to this Article."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/3-601) Involuntary admission; petition** states "(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. (b) The petition shall include all of the following: 1. A detailed statement of the reason for the assertion that the respondent is subject to involuntary admission on an inpatient basis, including the signs and symptoms of a mental illness and a description of any acts, threats, or other behavior or pattern of behavior supporting the assertion and the time and place of their occurrence. 2. The name and address of the spouse, parent, guardian, substitute decision maker, if any, and close relative, or if none, the name and address of any known friend of the respondent whom the petitioner has reason to believe may know or have any of the other names and addresses. If the petitioner is unable to supply any such names and addresses, the petitioner shall state that diligent inquiry was made to learn this information and specify the steps taken. 3. The petitioner's relationship to the respondent and a statement as to whether the petitioner has legal or financial interest in the matter or is involved in litigation with the respondent. If the petitioner has a legal or financial interest in the matter or is involved in litigation with the respondent, a statement of why the petitioner believes it would not be practicable or possible for someone else to be the petitioner. 4. The names,

addresses and phone numbers of the witnesses by which the facts asserted may be proved. (c) Knowingly making a material false statement in the petition is a Class A misdemeanor."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/3-602) Certificate of physician, qualified examiner, psychiatrist, or clinical psychologist** requires 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."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/3-608) Treatment; right to refuse; records** mandates that "Upon completion of one certificate, the facility may begin treatment of the respondent. However, the respondent shall be informed of his right to refuse medication and if he refuses, medication shall not be given unless it is necessary to prevent the respondent from causing serious harm to himself or others. The facility shall record what treatment is given to the respondent together with the reasons therefor."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/3-609) Right to copies of petition; telephone calls** states that "Within 12 hours after his admission, the respondent shall be given a copy of the petition and a statement as provided in Section 3-206. Not later than 24 hours, excluding Saturdays, Sundays and holidays, after admission, a copy of the petition and statement shall be given or sent to the respondent's attorney and guardian, if any. The respondent shall be asked if he desires such documents sent to any other persons, and at least 2 such persons designated by the respondent shall receive such documents. The respondent shall be allowed to complete no less than 2 telephone calls at the time of his admission to such persons as he chooses."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/3-610) Examination by psychiatrist; release** 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 personally 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, advanced practice psychiatric nurse, 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, advanced practice psychiatric nurse, or qualified examiner does not execute a certificate pursuant to Section 3-602, the respondent shall be released forthwith. For the purpose of this Section, a personal examination includes an examination performed in real time (synchronous examination) via an Interactive Telecommunication System as defined in 89 Ill. Adm. Code 140.403(a)(5). An examination via an Interactive Telecommunication System may only be used for certification under this Section when a psychiatrist is not on-site within the time period set forth in this Section. If the examination is performed via an Interactive Communication System, that fact shall be noted on the certificate."

CONCLUSION:

The HRA substantiates the allegation of *Inadequate involuntary admission process in that a patient's rights were violated when the patient was not provided rights notices, petition and certificates to notify of involuntary admission.* The patient's medical record for treatment in the ED provided evidence that the Involuntary Admission process was initially started for this patient on Sunday, 5/10/20, at two different times of the day 0500 hours and then later on the same day at 3:10pm. The patient transferred to another facility at 10:40pm on 5/10/20. Nothing in the petition paperwork documented the patient was informed of the plan to involuntarily admit her for inpatient treatment per **(405 ILCS 5/3-608).** Although the Crisis Intervention Note documented the patient was informed

of the Involuntary Admission process during the afternoon, there is no documentation within this note that indicated the patient was made aware of her rights in the Involuntary Admission process or how an inpatient placement would be sought to meet her level of care need. Also, the Code **(405 ILCS 5/3-609)** mandates that within 12 hours a respondent shall be given a copy of the petition and statement as provided in Section 3-206, and not later than 24 hours, excluding the weekend and holidays, after admission. A copy of the Involuntary Petition with form IL462-2005 that explains the Rights of the Admittee should also be reviewed. There was no signature on the petition indicating that these documents were provided to the patient within 12 hours and that area of the documentation was left blank for both petitions. Later during the treatment it was determined the patient had overdosed on her prescription medication Restoril which is prescribed for insomnia. The Physician evaluated her behavior and felt that behaviorally she did not appear to have misused benzodiazepines but possibly another amphetamine type medication.

The record provided by the hospital also conflicts with the hospital's own policy on how to treat a patient in their ED who has had a suicide attempt. There are no orders by Physician #1, #2, or #3 that show what level of supervision the patient required. There is a nurse note that indicated the patient was assessed to be "Level I: High Risk for Suicide Attempt" and required "Level II supervision" due to the suicide risk, which policy allows a registered nurse to begin suicide watch but there are no follow-up orders from the treating ED Physicians that indicated what type of patient monitoring was required to continue or when observation of the patient could have been less restrictive. The HRA also sees conflicting care from what hospital policy dictates and the practice that was actually implemented. Per the nursing notes reviewed this patient was being documented in alignment with Level III supervision which involves fifteen minute checks and was not under constant observation from a nurse as the documented Level II observation requires. The data entry for the Level II observation that was entered by a registered nurse is also inconsistent from the time of 0115-0545 the 15 minute observation data was all recorded in the computer at 0555. There were no handwritten observation logs provided in the patient record to indicate the patient was monitored every fifteen minutes. This same hospital policy also indicates that a patient requiring suicide precautions should be cared for on the Mental Health Unit or the Intensive Care Unit and this patient was never transferred to another floor within the hospital for unknown reasons although the medical record indicates the

patient was "admitted". The patient was held in the ED on 5/10/20 from 1:02am, medically cleared from the medication overdose at 0700 hours but still requiring medical observation due to alcohol intoxication (which the HRA is unable to determine when this person was medically cleared from the ETOH diagnosis) until discharge on 5/10/20 at 10:40pm which is approximately 22 hours after arrival to the ED. In the HRA's assessment of the documentation provided there was no compelling information provided by hospital personnel as to why this facility was used rather than admitting this patient to the hospital's own mental health unit, especially since the HRA did not see a Substance Abuse Evaluation/Assessment completed on the patient to establish their history of alcohol misuse and establish a dual diagnosis for this patient.

The HRA makes the following RECOMMENDATIONS:

- Train Carle BroMenn Hospital ED staff on the Involuntary Admission process policy, with an emphasis on the section titled Certificate that clearly explains how the physician should notify the patient in a "simple and comprehensible manner" the purpose of the exam and "C. The Rights of Recipients and Rights of Admittee are read to the voluntary patient on admission or involuntary patient within 12 hours of admission. Complete admission procedure per guidelines. D. Inform patient of right to make at least two phone calls and assist him/her as necessary." Provide evidence to the HRA that this has happened.

The HRA makes the following suggestions:

- When a patient is on suicide watch and requires 15 minute checks per hospital policy, the observation data should immediately be recorded in the patient's computer record to ensure compliance with this policy.

- Train Carle BroMenn Hospital ED staff on the hospital's own policy on Suicide Prevention.

- Individuals requiring treatment in the ED due to being under the influence of alcohol should have a Substance Abuse Assessment completed to determine the seriousness of the substance use and to care plan for further intervention.

- The HRA also suggests that Carle BroMenn Hospital review their Involuntary Admission policy and correct "... 4. Within 24 hours of admission, a psychiatrist will examine the patient, subject to involuntary admission. This psychiatrist will not execute the first certificate. The admitting physician will make arrangements for the examination necessary for the second certificate." Have it reflect who is able to complete the first certificate per The **Mental Health and Developmental Disabilities Code (405 ILCS 5/3-610) Examination by psychiatrist; release.** "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. 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, advanced practice psychiatric nurse, or qualified examiner...."

- During the site visit the staff involved reported to the HRA that if a patient is not allowed to leave the hospital before being seen by a physician they are provided with a Notice of Rights Restriction. This should not be the practice and the facility should start a petition to hold someone in the ED.

- The description of the petition and certificate process discussed in the interview sounds much like the process which was an issue in report 18-090-9022, where the facility said that they had to have the second certificate completed by the transferring facility. The HRA suggests the facility review the previous report and assure that this practice is not currently occurring.

Complaint #2- Patient rights were violated when the patient identified a friend to contact during their inpatient process, but hospital refused to involve this person due to Covid19 restrictions.

The HRA was unable to locate documentation between hospital staff and the patient discussing an emergency contact preference during the time the

patient was being treated for a behavioral health needs in the ED. The Suicide Assessment that was completed by the Crisis Worker in the 3pm hour on 5/10/20 indicated the patient lacked supportive social systems in the community. The patient reported to the QMHP during her assessment on 5/10/20 of "... Client has limited supports, and limited coping skills. Client does have a couple whom are her friends and are taking care of her cats. Client has strained relationships with Mom and Dad, as well as an estranged brother whom she has not spoken to in 10 years. Client is originally from [State] and if it were not for work, she would return. ...". Nothing in the record indicates the hospital contacting friends or family about the patient's treatment in the ED or involuntary admission to another hospital. The hospital registration has the patient's father who is Next of Kin listed as an emergency contact or "Person to Notify" as the form defines this person's role. But nothing indicates the Next of Kin was contacted.

The HRA reviewed an ED Summary Report entered at 2219 by an EDRN that documents a conversation with the patient about her medications "...Patient states she has a medication list on her phone, but she does not have her phone at this facility. ...".

The HRA reviewed a public statement from then Advocate BroMenn Hospital on their current No-Visitor Policy due to Covid-19 precautions. This information is dated April 27, 2020 and notifies the public of the following "To stem the spread of Covid-19 and help keep our patients, visitors and team members safe, Advocate Aurora Health implemented a no-visitor policy beginning March 16, 2020: No visitors, with few exceptions, will be allowed in any inpatient areas until further notice. All visitors who meet exclusion criteria must pass a health screening which will be administered at a central hospital checkpoint. Exclusion criteria includes: Pediatric caregivers (1), Companion of laboring mother (1) and if applicable a doula (1), End of life situations (number of visitors determined on a case-by-case basis) with family virtual visits/vigils encouraged as an alternative, Outpatient area companion (1): Parent(1) and siblings, if applicable, for children's office visits, Guardian (1) for adult patient, as needed, Support person (1) for adult patient to assist with complex medical decision-making discussions with the physician, In-person discharge instructions (1), Professionals assigned to assist with procedures (1). All potential visitors are being screened at a central hospital checkpoint, even if they are not in the exception category, including delivery personnel. All visitors who meet the above criteria must pass a health screening to enter the facility. In light of

new Centers for Disease Control and Prevention, we're encouraging all visitors to **bring and wear your own mask** to help keep all of our patients, team members and visitors safe. The patient had no restrictions on phone communication."

Public Health Title (77 Ill. Adm. Code 250.250) Visiting Rules states: "a) Each hospital shall establish, in the interest of the patient, policies regarding visitation on the various services and departments of the hospital. It is recommended that visitors be limited to two per patient at any one time. b) In times of increased incidence of communicable disease in the community, the hospital should consult with the local health officer regarding further restriction of visitors. c) No visitor shall knowingly be admitted who has a known infectious disease, who has recently recovered from such a disease, or who has recently had contact with such a disease. ..."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-103)** states "Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-103c)** states "Unimpeded, private and uncensored communication by mail, telephone, and visitation may be reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission."

CONCLUSION:

The HRA does not see any documentation in the patient chart record to indicate hospital staff contacted the patient's next of kin, who was listed as contact information on the hospital face sheet, to notify them of the patient's treatment in the ED. The HRA reviewed no documentation supporting the second allegation and part of the complaint alleging the patient was denied visitation or communication. There is no documentation in the patient record to indicate the patient made a request to contact a friend or that it was denied. Covid19 safety restrictions were in place during this

patient's treatment in the ED, which would have restricted an in-person visit to the ED but would have had no impact on telephone or videoconferencing communication.

The HRA offers the following **suggestions:**

- Because Covid19 precautions have dramatically changed the daily operation of the hospital processes, the HRA would encourage that in-person visits are provided to patients as safely as possible within the Covid19 safety guidelines of wearing a mask, maintaining social distancing, and using videoconferencing platforms when possible. Telephone communication should not be restricted.

RESPONSE

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

REGIONAL HUMAN RIGHTS AUTHORITY

HRA CASE NO. 20-090-9013

SERVICE PROVIDER: Carle BroMenn Hospital (previously known as Advocate BroMenn)

Pursuant to Section 23 of the Guardianship and Advocacy Act (20 ILCS 3955/1 *et seq.*), we have received the Human Rights Authority report of findings.

IMPORTANT NOTE

Human Rights Authority reports may be made a part of the public record. Reports voted public, along with any response you have provided and indicated you wish to be included in a public document will be posted on the Illinois Guardianship and Advocacy Commission Web Site. (Due to technical requirements, your response may be in a verbatim retyped format.) Reports are also provided to complainants and may be forwarded to regulatory agencies for their review.

We ask that the following action be taken:

X We request that our response to any recommendation/s, plus any comments and/or objections be included as part of the public record.

____ We do not wish to include our response in the public record.

____ No response is included.

Ellen Lee
NAME

President
TITLE

3-31-21
DATE

Carle
BROMENN MEDICAL CENTER

March 31, 2021

VIA FedEx Express and EMail

Meri Tucker, Chairperson
Illinois Guardianship and Advocacy Commission
Human Rights Authority
401 Main Street, Suite 620
Peoria, IL 61602

Re: Case # 20-090-9013

Dear Ms. Meri Tucker,

The purpose of this letter is to provide Carle BroMenn Medical Center's ("Carle BroMenn") formal written response to your letter dated January 26, 2021 and the Report of Findings enclosed therewith. Let us first thank you and the Illinois Guardianship and Advocacy Commission's Human Rights Authority (Authority) for providing Carle BroMenn with an opportunity to review and respond to the Report of Findings. The Report of Findings has been thoroughly reviewed by Carle BroMenn's leadership team, including the Medical Directors responsible for Mental Health and Emergency Medicine.

Based on Carle BroMenn's review of the Report of Findings, we would like to provide additional information regarding the allegation substantiated by the Authority and respond to the Authority's related recommendation.

Recommendation: "Train the Carle BroMenn Hospital ED staff on the Involuntary Admission process policy, with an emphasis on the section titled Certificate that clearly explains how the physician should notify the patient in a "Simple and comprehensible manner" the purpose of the exam and "C. The Rights of Recipients and Rights of Admittee are read to the voluntary patient on admission or involuntary patient within 12 hours of admission. Complete admission procedure per guidelines. D. Inform patient of right to make at least two phone calls and assist him/her as necessary." Provide evidence to the HRA that this has happened."

The Emergency Department nursing staff have reviewed the policy and procedure for Involuntary Admission and Suicide Prevention including required care and documentation. See the educational PowerPoint for content, attached hereto as Exhibit A. Additional training information includes, timing of Notice of Rights Restrictions, Petition, and Certificates, as well as suicide screening and prevention, and documentation requirements. Twenty-seven of thirty-three staff have completed this education as of March 30, 2021. The redacted list of staff members is attached hereto as Exhibit B.

The Emergency Services Director attended the March 2021 Department of Emergency Medicine meeting and reviewed the Authority's requirements as stated in above recommendation. There were ten providers and thirteen additional Emergency Department staff in attendance at the

Carle
BROMENN MEDICAL CENTER

meeting; minutes are distributed to those providers not in attendance. The redacted minutes attached hereto as Exhibit C. An opportunity to develop 'SmartPhrase" documentation within EPIC has allowed providers to add specific documentation to their dictation indicating the patient was notified of the examination in a "simple and comprehensible manner". The email informing physicians is attached hereto as Exhibit D.

The Involuntary Admission Policy has been revised to align language with the Mental Health and Disabilities Code (405 ILCS 5 3-610) language. The proposed revised policy and procedure is attached hereto as Exhibit E.

We welcome an opportunity to speak with you and or Erin Nowlan, Human Rights Authority Coordinator, about this response and the attached documents. It is our intent to finalize approval and publish the proposed policy in the coming days. Carle BroMenn continually strives to protect the rights of our patients while also protecting our staff and our community at large.

Should you have any questions regarding the content of this letter, please feel free to contact Janet Sutter directly at 309-268-5330 or Alicia Allen at 309-268-5503.

Respectfully,

Janet Sutter, MSN-ed, RN
Carle BroMenn Risk Manager

Alicia Allen, MSN, RN, BC
Director of Critical Care and Emergency Services

cc: Erin Nowlan
Coordinator
Illinois Guardianship and Advocacy Commission
Regional Human Rights Authority
401 Main Street
Suite 620
Peoria, IL 61602

Enclosures