FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY-NORTH SUBURBAN REGION

REPORT 21-100-9008
ADVOCATE LUTHERAN GENERAL HOSPITAL

Introduction
On 2/2/2021 the North Suburban Regional Human Rights Authority (HRA) opened an investigation of possible rights violations regarding the Emergency Department at Advocate Lutheran General Hospital. The complaint alleged that the Recipient of mental health services was treated rudely by medical staff after tripping and falling on the floor, and not offered any medical care for the fall. The complaint also alleged that the Recipient was coerced into signing a voluntary admission to a psychiatric hospital without an explanation of their rights. Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5), specifically the following sections of the statute:

> ***2-102a:*** *Adequate and humane care*
>
> ***3-402****: No physician, qualified examiner, or clinical psychologist shall state to any person that involuntary admission may result if such person does not voluntarily admit himself to a mental health facility*

Advocate Lutheran General Hospital is a 645-bed non-profit teaching hospital located in the Chicago suburb of Park Ridge, Illinois. For the purposes of this investigation, and in accordance with (405 ILCS 5/) the Mental Health and Developmental Disabilities Code, the Emergency Department is considered a "Mental health facility" in that it is a licensed private hospital providing ". . . treatment of persons with mental illness."

Method of Investigation
To proceed with this investigation, the HRA reviewed the Recipient's clinical record (with authorization) for the month of June 2020. The HRA obtained additional case information through an interview with the Recipient's attending doctors and nurses. The HRA also reviewed relevant hospital policies. The HRA acknowledges and appreciates the full cooperation of Advocate Lutheran General Hospital personnel in this investigation.

Summary
According to the complaint statement and the record, the Recipient brought herself to the Emergency Department (ED) at 10:30 am on 6/15/2020 for treatment of extreme anxiety and insomnia. Clinical staff reported to the HRA during the interview that the hospital filled out a

petition (the time of this is unknown) to detain the Recipient for a psychiatric assessment, after which a certificate for involuntary admission was completed and "filed in the chart". Neither the petition nor certificate were in the record, and neither could be produced by hospital administration upon further request.

Prior to receiving a psychiatric assessment, the Recipient was given a thorough medical examination (including an MRI), due to her medical history of brain tumors and recent brain surgery. According to the record, at approximately 7pm on 6/15/2020 the Recipient was told that her medical test results were normal and that she was cleared for a psychiatric assessment. According to the doctor's note in the record the falling incident occurred at this time. Interviewed for her account of the incident, the Recipient stated that the fall occurred because she:

> *". . . walked to the edge of the room and [the Doctor] aggressively came towards me and yelled 'get back in that room!' I was so startled I stumbled backwards and fell. Then he said, 'I didn't fucken push you, you're not having a seizure get back in bed.'"*

Notes in the record from the Doctor and the RN present a conflicting version of the Recipient's account of the fall. The Doctor wrote:

> *"Patient . . . was asked to go back into her room by myself. Patient went into the room lowered herself to the ground began shaking voluntarily and stated that she was having a seizure . . . I told her that she was not having a seizure and to stand up and she became verbally abusive to me and staff because she stated that I pushed her down when I never physically touched her . . . Patient suffered no acute injury when she lowered herself to the ground involuntarily picked herself up the ground and put herself back into bed."*

An RN note from 7:05 pm on 6/15/2020 provides a description of the falling incident that is similar to the Doctor's:

> *"Pt noted to be hovering in the doorway after having been instructed multiple times that all patients must be inside their room in the midst of a pandemic. [The Doctor] offered to instruct pt once again to sit back on her bed. RN witnessed patient raise her voice and begin to nonsense shake, lowering herself to the ground yelling 'you pushed me'. Pt spoke of having a seizure while verbalizing to MD. RN witnessed entire event and there was no physical contact between the patient and the MD. RN told the patient to get off the ground when she would not listen to the MD . . . Pt freely stood up . . . and then she sat on the bed.*

During the staff interview, the Doctor and RN reiterated the same versions of the falling events that were recorded in their case notes.

A psychiatric evaluation was performed by a doctor at 7:49 pm on 6/15/2020. A note in the psychiatric evaluation mentions that the certificate was placed in the chart, however the certificate was not found in the chart and could not be provided by hospital staff upon a later request. The

Recipient was discharged from the ED and taken by ambulance to a psychiatric hospital at 10:21 am on 6/16/10.

Case Findings

The complaint that the Recipient was treated rudely by medical staff after tripping and falling on the floor, and not offered any medical care for the fall is found to be ***unsubstantiated***. The complaint that the Recipient was coerced into signing a voluntary admission to a psychiatric hospital without an explanation of their rights is undetermined. Hospital staff told the HRA that the Recipient was admitted to Advocate Lutheran General Hospital involuntarily, but the record does not contain the legal forms required to detain the Recipient involuntarily. Since the record is *also* missing the legal forms required to admit the Recipient *voluntarily*, the hospital cannot demonstrate its authority to have detained the Recipient at all. Additionally, there is no documented proof that the hospital informed the Recipient of her applicable rights. Therefore, this investigation ***substantiates*** a violation of Illinois Mental Health and Developmental Disabilities Code statutes governing admissions and essential record keeping, specifically:

> ***405 ILCS 5/3-609:*** *Within 12 hours after admission, the respondent shall be given a copy of the petition and a statement [of how to contact the Guardianship and Advocacy Commission].*
>
> ***405 ILCS 5/3-202 (a)****: Every mental health facility shall maintain adequate records which shall include the Section of this Chapter under which the recipient was admitted, any subsequent change in the recipient's status, and requisite documentation for such admission and status.*

Analysis

The depiction of the falling incident as presented by the Recipient did not match the depiction of the incident as presented in the case notes. The HRA was convinced that the hospital version of the fall was the correct version of events because the hospital staff interviews reiterated the two case note versions of the falling incident. The case notes and staff interview also convinced the HRA that the Recipient had not needed medical attention after the falling incident.

There was no evidence in the record to support the allegation that the Recipient was coerced into signing a voluntary admission, and there was no voluntary application in the record. The hospital staff reported in the interview that the Recipient was an involuntary admittee to the hospital, but there were no petitions or certificates in the record. The only indication of this status in the record was found in a note from the Psychiatric assessment stating: “certificate placed in the chart”, and from an RN note at 10:11 pm on 6/15/2020 stating: “Pt wanting to leave, standing by door, sitter bedside”. Under 405 ILCS 5/3 Article VI, the petition and certificate documents are the *only* legal authority governing an involuntary admission to a psychiatric facility, and the hospital is unable to produce these required documents.

An HRA review of the Advocate Health Care policies and procedures governing psychiatric admissions and record keeping found that these policies do not sufficiently address protections to

psychiatric patient rights regarding emergency admission by certificate, and regarding record keeping. The "recommendations" section of this report contains the corrective action steps required to bring Advocate Lutheran General Hospital's psychiatric admissions policy and practices into full compliance with 405 ILCS 5/3.

Recommendations:

1. Revise *Advocate Health Care Policy: Admissions to the Department of Psychiatry* so that it reflects the following sections of the Code:

   ILCS 5/3-602: The petition shall be accompanied by a certificate executed by a . . . qualified examiner . . . which states that the respondent is subject to involuntary admission on an inpatient basis and requires immediate hospitalization. The certificate shall . . . contain a statement as to whether the respondent was advised of his rights under Section 3-208.

   ILCS 5/3-208: . . . prior to this examination for the purpose of certification . . . , 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.

2. Revise any relevant documentation or Psychiatric Admissions policies to reflect the documentation standards of the Code:

   5/3-202 (a): ...maintain adequate records which shall include the Section of this Chapter under which the recipient was admitted….

3. Retrain appropriate staff on the revised polices and Code-required documentation. Provide proof of completion.

4. Provide the HRA with drafts of revised Psychiatric Admissions and Record Keeping policies.

RESPONSE

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

Advocate Lutheran General Hospital

1775 Dempster Street || Park Ridge, IL 60068 || T 847.723.2210 || advocatehealth.com

October 13, 2021

Mariah Balaban
Disability Rights Manager, North Suburban Region
Human Rights Authority of the Illinois Guardianship and Advocacy Commission
9511 Harrison Avenue W-335
Des Plaines Illinois 60016

Re: HRA 21-200-9008

Dear Ms. Balaban,

Thank you for your letter dated September 1, 2021, with the findings of the investigation into the above referenced case. We appreciate the opportunity to review this matter, and to improve our processes and policies. This letter contains Advocate Lutheran General's response to the recommendations of the Human Rights Authority.

The recommendations made by HRA are:

1. Revise Advocate Health Care Policy: Admissions to the Department of Psychiatry so that it reflects the following sections of the Code: ILCS 5/3-602 and ILCS 5/3-208.
2. Revise any relevant documentation or Psychiatric Admissions policies to reflect the documentation standards of the Code: 5/3-202 (a).
3. Retrain appropriate staff on the revised polices and documentation.

As reflected in the HRA investigation report, interviews and chart review reflect the proper paperwork was completed to comply with the IL Mental Health Code. The deficiencies identified related to record keeping and opportunities to improve written policies. Advocate Lutheran General agrees the HRA recommendations will lead to improvements. Our goal is to have documentation that reflects the care team's compliance with all Illinois statutory requirements. A corrective action plan has been initiated to address the recommendations of the HRA.

The Advocate Lutheran General corrective action plan includes:

1. Policy updates to reflect copies of petitions and certificates related to involuntary admissions will be scanned into the medical record.
2. Policy updates to reflect proper documentation requirements for communication with patients related to involuntary admission.
3. Education plan for staff, including Emergency Department, Central Access Team, and Inpatient Behavioral Health Team.

An assessment process will be implemented to validate our actions have achieved sustained improvement. Thank you again for your review and recommendations. Your work helps us as we continuously improve the quality of care at Advocate Lutheran General Hospital.

Sincerely,

Kristie Johnson

Kristie Johnson, MBA, MSW, LCSW, CPHQ
Vice President of Clinical Excellence, LGH Clinical Excellence