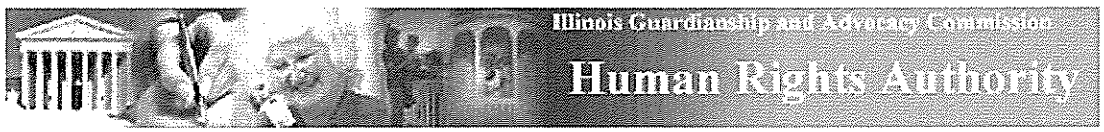

FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY-PEORIA REGION
REPORT OF FINDINGS

Case # 19-090-9017
Illinois Valley Community Hospital (IVCH)

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations at Illinois Valley Community Hospital (IVCH) in Peru, Illinois. The complaints alleged the following:

1- Inadequate Guardian Notification
2- Inadequate Guardian Participation in Treatment.

Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5), the Medical Patient Rights Act (410 ILCS 5/3) and other federal regulations. The hospital covers LaSalle and Bureau Counties. The Emergency Department (ED) serves approximately 13,000 patients per year. The hospital does not have an inpatient behavioral health unit. The hospital uses a tele-psychiatry program in the ED when a patient is in need of a mental health evaluation. The hospital has 600 employees with 30 full time employees in the ED. The registration department of the ED employs approximately nine registration staff: four on first shift, three on second shift and two on third shift. They evaluate approximately 441 patients with mental health needs on a yearly basis in the hospital ED.

COMPLAINT SUMMARY

The complaint states that in early March, a patient with a legal guardian whose psychotropic medications were discontinued and resulted in behaviors at the group home and day program he attended. On or around March 21, 2019 the patient was sent to the ED at IVCH which resulted in a transfer to a Chicago area hospital for involuntary admission due to behavioral health needs. The complaint alleges that the legal guardian was not notified by IVC Hospital that they were treating the patient in the ED and that there was a plan to transfer him to a hospital outside of the local area. The only way the legal guardian was notified of the patient's involuntary admission was when the Chicago area hospital called to discuss the admission. The HRA did verify that the involved patient has a legal guardian and received the Letters of Office to confirm this.

Interview with Staff (8.28.19)

The HRA met with staff at IVC Hospital in Peru, Illinois for a scheduled site visit. Several staff from the hospital participated in the meeting. The HRA started the meeting discussing policy that the hospital uses when treating patients in their ED. When a patient arrives at the ED, nursing staff and the attending physician decide if a person requires medical treatment or behavioral health treatment. The hospital employs three social service staff that are on call twenty-four hours a day and seven days a week. If a patient's behavior is escalated, then nursing staff would contact social services to request their assistance. If a patient is medically cleared and needs mental health treatment but is physically aggressive or agitated, the ED has a safe room. If further intervention is needed to control behaviors due to safety concerns of the patient or others, a "code white" would be announced over the intercom system and ED staff that are trained in a de-escalation program would come to assist. All hospital staff are trained in the hospital's de-escalation program but the ED staff's training is more in-depth.

A patient can arrive at the ED in a variety of ways such as: by ambulance, transported by a friend/family, and on their own. If a person needs a wheelchair due to difficulty walking, a volunteer would greet this person and take them to preregistration where a nurse starts to triage their level of need. When a person is assigned to a room, registration would gather patient demographic information. The hospital registration employee does not specifically ask about a legal guardian for an adult. The registration paperwork does require an emergency contact, if a person has a Power of Attorney (POA), and/or a Living Will. If someone presents to the ED from a nursing home, with altered mental status, the ambulance team usually brings paperwork from the sending facility with the patient's contact information. This should also be the practice of patients who arrive to the ED from a group home or other community living situation. This information should then be entered into the computer system. If a patient has a POA, Living Will or has a Do Not Resuscitate (DNR) order, then there would be an alert in the computer system of this patient information. Registration prints this information from the patient's computer record and places a paper copy in the patient's chart. It was unclear to the HRA during the interview process who is responsible for entering this legal information.

When a patient has a POA or legal guardian the hospital assumes that the sending facility (nursing home, group home, supported living program, etc.) notifies the necessary people that their client was being sent to the hospital. Once the patient arrives at the ED, and if the assigned nurse notes a guardian or POA, they should call this individual to communicate the patient's status. The registration employee is responsible for documenting the consent to treat. Often times a patient arrives with a face sheet and a medication list from the sending facility and this information should be placed in the computer system and paper chart.

If a patient is being evaluated at the ED for a behavioral health need, and requires voluntary or involuntary admission, then the assigned nurse is responsible for coordinating this care. The nurse starts contact with other providers. For an involuntary admission, such as this case, the nurse and attending physician complete the petition and first certification and the second certificate is completed by the facility receiving the

patient. The tele-psychiatrist would also be consulted about the plan of care. The nurse tries to locate another hospital that is as close as possible to the patient's home. The referred patient is then screened over the phone by the out of area provider and can either deny or accept the patient. This can be a lengthy process and nursing staff should notify the emergency contact listed of the plan for discharge. Social Services could also become involved and reach out to the listed patient contacts. If a patient is suicidal or homicidal, then they would be admitted to the Intensive Care Unit (ICU) for observation and would have a staff assigned as a 1:1. The attending physician decides when a patient is admitted to the ICU. The hospital often uses this for patients who are under the influence of unknown substances or are in need of inpatient behavioral health treatment but are awaiting transfer to another facility to meet their needs.

The HRA has a consent to review the records of the patient involved in this HRA complaint. This patient arrived at the hospital ED with a police escort and via ambulance. He did arrive with documentation and he was sent to the ED for a psychiatric examination. The agency who sent the patient refused to accept the patient back without a psychiatric examination being completed. The patient was accompanied by agency staff who stayed with him for several hours. The hospital is familiar with the patient due to previous ED contact. Staff explained that during this visit in March 2019, the records reviewed in the computer system do not document staff contacting the patient's legal guardian at any time. When IVCH located a hospital to transfer the patient to, there is no documented contact with the legal guardian of the patient noted in the computer record. It is unclear if the sending facility had an emergency consent form signed by the legal guardian to receive treatment in their ED.

The hospital had contact with the patient in February 2019 and they did not discontinue medications. The patient was not admitted to the hospital. In March 2019, the patient arrived at the ED at approximately 9:11am and was accepted at the Chicago area hospital on this same day at 4:42pm. IVCH had difficulty finding transportation for the patient as the original ambulance company refused to transport him to the Chicago hospital. The hospital was able to work with another area ambulance provider to transport him to Chicago. The patient transferred to the Chicago hospital around 8:43pm with a copy of the petition and certification. There is nothing listed in nursing notes, registration or social services that indicate hospital staff called the legal guardian. This patient did not require any restraints, psychotropic medications or "Code white" calls during his treatment in the ED. The hospital did not discontinue medications at this visit.

FINDINGS (Including record review, mandates, and conclusion)

Complaint #1- Inadequate Guardian Notification

The HRA reviewed records and documents pertinent to the complaints alleged in this case. The first document reviewed, titled Emergency Record, has identifying information for the patient and lists the emergency contact as the patient's father with a telephone number as a contact. The General Consent and Financial Agreement form documents "unable to sign PT is very confused". This form has initials for a witness signature and is dated 3/21/19 at 9:19am. The HRA reviewed the document titled Petition for Involuntary Judicial Admission and a section of the petition lists the patient's

mother and father, with an address and phone number but there is no documentation that IVCH ED staff attempted to contact the people listed in this section.

The HRA reviewed a document titled Illinois Valley Community Hospital Patient Profile report. This document has demographic information for the patient. The patient's father is listed as an emergency contact with a phone number. This form also has the option to answer yes or no to Guardian for this contact information. Underneath the word guardian is the letter "N" for no.

The HRA reviewed a faxed form from the Chicago Hospital that was completed by IVCH staff in February 2019. This form is titled Advance Directive/Healthcare Proxy Acknowledgement. A section on this form documented and marked with a star that the patient has a legal guardian, and the parents of the patient are listed with a phone number. This section also has the statement "If yes, a copy of Guardianship provided?" This question is not answered with a yes or no, it is left blank.

The hospital provided a copy of the patient's community integrated living arrangement (CILA) provider's medical information document that was included in the patient's record. This form has the question "Does Individual Have a Guardian?" There is a yes response to this answer. Another area asks to specify the type of guardianship which indicated the patient has a guardian of person and estate. Again, the legal guardians are listed as the patient's parents with contact information included.

The HRA reviewed a letter sent by IVCH with the requested hospital documentation dated August 29, 2019. This letter acknowledges that during the treatment of the patient in IVCH ED the hospital staff did not contact the legal guardian to get consent for treatment for his services in March. The hospital verifies in this same letter that they had communication with the father on 2/11/19 and 5/7/19 for consent to treat.

The HRA reviewed IVCH policy titled Consent that was last reviewed by hospital administration in July 2018. This policy provides the definition of an Incompetent Adult-Adjudged Incompetent. The definition reads "An adult who has been adjudged incompetent by the Court cannot give a valid consent. That consent must be given in writing by the duly appointed legal guardian."

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) states: "A recipient of services shall be provided with adequate and humane care in the least restrictive environment, 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 Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107 a) states: "(a) An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy."

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-201 a) requires that "(a) Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to: (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian"

The Probate Act of 1975 (755 ILCS 5/11a-17) Duties of personal guardian states: "(a) To the extent ordered by the court and under the direction of the court, the guardian of the person shall have custody of the ward and the ward's minor and adult dependent children and shall procure for them and shall make provision for their support, care, comfort, health, education and maintenance, and professional services as are appropriate"

The Probate Act of 1975 (755 ILCS 5/11a-23) Duties of personal guardian states: "Every health care provider...has the right to rely on any decision or direction made by the guardian...that is not clearly contrary to the law, to the same extent and with the same effect as though the decision or direction had been made or given by the ward"

The Medical Patient's Rights Act (410 ILCS 50/5) Statement of hospital patient's rights states "(a) Each patient admitted to a hospital, and the guardian or authorized representative or parent of a minor patient, shall be given a written statement of all the rights enumerated in this Act, or a similar statement of patients' rights required of the hospital by the Joint Commission on Accreditation of Healthcare Organizations or a similar accrediting organization. The statement shall be given at the time of admission or as soon thereafter as the condition of the patient permits. (b) If a patient is unable to read the written statement, a hospital shall make a reasonable effort to provide it to the guardian or authorized representative of the patient."

Federal Regulation 42 C.F.R. 482.13 Condition of participation: "A hospital must protect and promote each patient's rights. (a) Standard: Notice of rights— (1) *A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.* b) Standard: Exercise of rights. (1) The patient has the right to participate in the development and implementation of his or her plan of care. (2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate."

Conclusion - Complaint #1

Based upon the review of evidence provided to the HRA by the Illinois Valley Community Hospital the allegation of Inadequate Guardian Notification is **SUBSTANTIATED.** In accordance with the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102), the guardian should be allowed to participate in

the patient's treatment, including the right to refuse treatment (405 ILCS 5/2-107 a), and have been notified of rights restrictions (405 ILCS 5/2-201 a) when the restriction occurred during the patient's stay. Additionally, the Probate Act of 1975 states that the guardian should procure care and the health care provider has the right to rely on the decision of the guardian (755 ILCS 5/11a-17, 755 ILCS 5/11a-23). These are also supported by the federal regulations (42 CFR 482.13) and the Medical Patient Rights Act (410 ILCS 50/5). These regulations support the fact that the guardian must be notified. Due to the lack of notification the HRA finds the complaint **substantiated** and makes the following **recommendation:**

- Assure that when a patient has a guardian, the guardian is contacted as to be allowed to participate in the patient's treatment in accordance with the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102, 5/2-107, 5/2-201a). Provide the HRA with evidence that this is occurring at the facility and that staff have been trained on these mandates and its own policy.

The HRA suggests the following:

- Communicate with community service providers who support adults with disabilities in the LaSalle county area to ensure appropriate documentation is sent to the hospital when IVCH is serving the medical or mental health needs of their clients.
- For the patient involved in this case, update his computer chart to identify his legal guardian(s) and clearly note the need for staff to call his legal guardians prior to treatment.
- For the patient involved in this case, add the Letters of Office into the computer chart and paper chart in a spot easily seen by attending staff.
- Review with their staff other patients from other community facilities that could potentially have a legal guardian, such as those living in a nursing home or CILA, to ensure the legal guardian is contacted upon arrival to the ED.
- Train their registration and emergency department staff on their own policy focusing on who can consent to treatment in the ED. Specifically, consent should be received from a patient's legal guardian or patient representative under the Medical Patient's Rights Act 410 ILCS 50/5. With emphasis on consent being signed before treatment in the ED.
- Provide documentation to the HRA that the recommended training has been completed with an attached list of employees that participated and the date(s) of the staff training.
- Assure that the facility is not holding a patient in the ED without filing a petition and certificates with the court and is in compliance with the Mental Health and Developmental Disabilities Code for involuntary commitment and discharge (405 ILCS 5/3-403, 601, 602, 610, and 611 and 405 ILCS 5/3-403).

Complaint #2 - Inadequate Guardian Participation in Treatment

The HRA reviewed a letter sent with the requested hospital documentation dated August 29, 2019. This letter acknowledges that the hospital did not communicate with the patient's legal guardian during his treatment in their ED in March 2019. The hospital does state that they had contact with the guardian in February 2019 when the patient was at their ED and he was transferred to a Chicago Hospital. This letter also states that in May 2019 the ED staff contacted the patient's mother who came to the hospital and took him home because she did not want him transferred to another hospital. This letter also states that the legal guardians of this patient were not contacted in March 2019 when he was involuntarily admitted to a Chicago area hospital.

The HRA reviewed the IVCH Authorization to transfer form dated 2/11/19 that shows the signature of the patient's father who is his legal guardian. On 5/17/19 the HRA reviewed an IVCH document titled Psychiatric Complaint and a note is written in red that the patient's mother, who is also his legal guardian, was at the ED and the patient was discharged "home with POA".

IVCH provided the HRA a copy of the Patient Rights and Responsibilities which was last revised by hospital administration in November 2018, but has not been reviewed since March 2013. The "Plan of Care" section states "1. The patient has the right to participate in the development and implementation of his or her plan of care. 2. The patient has the right to designate a healthcare surrogate to assume these responsibilities. 3. When the patient cannot make decisions, a family member or Proxy is identified to participate in the patient's care decisions." Section E, Informed Consent, states " ... c. The patient shall not be subjected to any procedure without his or her voluntary, competent, and informed consent or that of his or her legally authorized guardian. ..." Section O, Transfer and Continuity of Care, states " 1. A patient shall not be transferred to another facility unless he or she has received a complete explanation of the risks, benefits and alternative to such a transfer and the transfer is acceptable to the receiving facility. 2. The patient or his or her legally authorized representative has the right to be informed by the practitioner responsible for his or her care of any continuing health care requirements following discharge from the hospital. ..."

The HRA also reviewed IVCH hospital policy titled Emergency Medical Treatment and Labor Act (EMTALA) last reviewed by hospital administration in August 2019. The purpose of this policy addresses the guidelines for providing the appropriate setting (department) for conducting medical screening and requirements for the emergency medical screening. This policy defines Emergency Medical Condition to mean "A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that in the absence of immediate medical attention could reasonably be expected to result in...". This IVCH policy also defines Emergency Medical Log and what minimal data the emergency medical log should record "Patient identification information. Disposition, categorized as applicable: a. Was treated, admitted, stabilized, and/or transferred or discharged, as applicable; b. Refused treatment; or c. Was denied treatment." This policy references an attachment for an IVCH form titled Refusal of Care Against Medical Advice and lists a Criteria for Refusing Care. In this section it states "The patient/parent/guardian meets all of the following. 1. Is at least 18 years old or an emancipated minor. ... 3. Understands the nature of their medical condition and the potential risks and consequences of refusing care, including disability and death." This

form does not have any signature line for a legal guardian or space that identifies the patient's legal guardian. It does have a space for a caregiver to initial when the patient refuses to sign and would then have this person sign as a witness.

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) Care and services; psychotropic medication; religion states "(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, 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 recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan."

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107 a) states: "(a) An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy."

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-201 a) requires that "(a) Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to: (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian."

The Probate Act of 1975 (755 ILCS 5/11a-17) Duties of personal guardian states: "(a) To the extent ordered by the court and under the direction of the court, the guardian of the person shall have custody of the ward and the ward's minor and adult dependent children and shall procure for them and shall make provision for their support, care, comfort, health, education and maintenance, and professional services as are appropriate"

The Probate Act of 1975 (755 ILCS 5/11a-23) Duties of personal guardian states: "Every health care provider...has the right to rely on any decision or direction made by the guardian...that is not clearly contrary to the law, to the same extent and with the same effect as though the decision or direction had been made or given by the ward"

Conclusion - Complaint #2

After reviewing the information provided, the HRA has determined the second allegation is **SUBSTANTIATED**. The hospital has acknowledged via the site visit on August 28, 2019 and letter dated August 29, 2019 that their emergency department staff did not make contact with the patient's legal guardian at registration, during the ED assessment, or at the time of hospital transfer although the hospital did have medical record information that showed a legal guardian listed for this individual.

The HRA makes the following **recommendations**:

- Assure that the guardian is allowed to participate in treatment, including decision making such as transfer to another facility per Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102, 5/2-107, 5/2-201a). Provide the HRA with evidence that this is occurring at the facility and that staff have been trained on the mandated requirements, including applicable hospital policies.

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. 19-090-9017

SERVICE PROVIDER: – Illinois Valley Community Hospital (IVCH)

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.

Tommy Hobbs
NAME

Chief Executive Officer
TITLE

12/21/2019
DATE

Illinois Valley Community Hospital
925 West Street, Peru, Illinois 61354
Phone 815-223-3300 • Fax 815-223-3394
www.ivch.org

December 21, 2019

Meri Tucker, Chairperson
Regional Human Rights Authority
Peoria Regional Office
401 Main Street, Suite 620
Peoria, IL 61602

Dear Ms. Tucker,

Illinois Valley Community Hospital (IVCH) is committed to consistently improving the care and service we provide our patients. The recommendations received from the Illinois Guardianship and Advocacy Commission have been addressed per the following actions.

Please see the following as the actions taken and planned to address Complaint # 1, Inadequate Guardian Notification.

IVCH has responded by implementing the following internal actions: Communicate with community service providers. Letters were sent to area nursing homes and Horizon House. See the information below:

> "In an effort to improve our patient care and ensure all patients requiring /having guardianships have adequate representation when seeking assistance at IVCH, we ask for a copy of any and all legal Letters of Guardianship, Letters of Office or other legal documentation be copied and sent with the individual. This will assist IVCH in ensuring appropriate contact can be made prior to treatment in the Emergency Department or Hospital. Please contact, Tina's Wawerski, Quality Director with any questions. "

Actions 2 & 3: To ensure staff are informed of guardianship:

a. Patient Access (registration) - "Guardian" has been added to the emergency contact information that included Power of Attorney and/or Living Will.
b. Letter of Office (guardianship papers) will be added into the computer chart and a copy placed on paper chart to ensure attending staff see it.

To ensure IVCH staff are aware of requirements and expectations regarding Guardian Notification the following education and training has been developed and provided that includes:

a. Community facilities that may have clients with guardianships; nursing homes, assisted living facilities, horizon house and any other Community Integrated Living Arrangements (CILA).
b. Review on policies and process for consent to treatment in the ED, including role of legal guardian or patient representative.

c. Importance of contacting the guardians and including them in decision making and treatment options.
d. Review of Medical Patients Right Act/ Mental Health and Developmental Disabilities Code for involuntary commitment and discharge.
e. Emphasis on obtaining consent prior to treatment.
f. Education initiated 12/20/19 for ER staff. Completion of education by current staff by 12/30. Supplemental staff will complete as assigned to work in Emergency Department.
g. Assignment will be provided in a packet for review, and an electronic education course in HealthStream.
h. A list of completions will be sent by 12/30/19 to the Human Rights Authority.

Please see the following as the actions taken and planned to address Complaint # 2, Inadequate Guardian Participation in Treatment.

To ensure IVCH staff are aware of requirements and expectations regarding Guardian Participation in Treatment the education and training actions of Complaint # 1, with specific emphasis on "Importance of contacting the guardians and including them in decision making and treatment options" (Section c), will serve to effectively address Complaint #2.

IVCH appreciates the opportunity to serve our community and consistently work to improve the care and service provided.

Sincerely,

Tommy Hobbs
Chief Executive Officer
Illinois Valley Community Hospital