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HUMAN RIGHTS AUTHORITY - NORTHWEST REGION
REPORT 08-080-9004
SWEDISHAMERICAN HOSPITAL

Case Summary: The Authority found violations in all complaints presented; the public record on this investigation is found below. The facility's response is not included in the public record.

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation of possible rights violations in the treatment of a mental health recipient within the emergency and psychiatry departments at SwedishAmerican Hospital. It was alleged that the hospital:

1. Took the recipient's purse and inspected it without permission.
2. Detained and restrained her without cause and authority.
3. Inflicted physical and mental abuse by forcefully taking blood and urine specimens from her without consent.
4. Administered psychotropic medication without informed consent.
5. Did not provide adequate and humane care once her allegation of abuse was received.
6. Did not provide her with completed copies of her voluntary admission application and her rights information.
7. Did not allow her designated support person to attend her staffing or participate in treatment planning.
8. Did not have required advocate contact postings on the psychiatry unit.

Substantiated findings would violate rights protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5) and under the Code of Federal Regulations for Medicare/Medicaid participation (42 C.F.R 482).

The hospital is a subsidiary of the SwedishAmerican Health System in Rockford. It has nearly 400 beds and a 30-room emergency department, 4 of which are designated for patients with special needs. Crisis workers from an assessment and referral division meet with mental health recipients in that area to determine a course and location for treatment as evaluations are completed. The emergency department employs about 20 physicians from Infinity HealthCare, a group headquartered in Mequon, Wisconsin that provides expertise in emergency medicine in addition to other medical practice and management services. The psychiatry department is called the Center for Mental Health; it has an adolescent unit and a 20-bed adult unit for inpatient care.

To pursue the matter we visited the hospital and interviewed representatives from

administration, risk management and the two departments in question. Their policies were reviewed as were relevant sections of the recipient's record upon written authorization. The recipient in this case is an adult who maintains her legal rights.

COMPLAINT SUMMARY

The allegations state that the recipient was taken to the emergency department after police officers were called to her home following a domestic dispute. Her husband and the police were concerned about some missing pills, and she agreed to go for evaluation although she denied taking anything. It was said that at some point during her wait in the special needs area the recipient's purse went missing while she was in the bathroom changing into a gown. A security guard told her that it would be returned soon. She eventually got into verbal exchanges with the staff who were pressuring her to provide blood and urine samples, and she tried to leave twice but the guard stood in her way. She continued to refuse saying that she just wanted her purse back, and there was some back and forth until a nurse came in, pointed a walkie-talkie at the recipient's face and sternly told her that she would give the samples or be put in restraints. She refused once again and the nurse reportedly told the guard to get her "in all fours". Several men came in and restrained her as she cried for them to stop; they allegedly held her still as the nurse aggressively inserted a catheter causing the recipient to shriek in pain. The restraints were removed after about five minutes, and she crouched behind the bed sobbing and feeling like she had been raped. It was also said that at some point she was given two pills and told they would help her calm down. She thought she was taking Ambien but learned later that she had taken Ativan. Another woman came in and talked with her for a while until she agreed to sign a voluntary admission application.

The complaint further states that once admitted to the Center for Mental Health the recipient's claims of abuse were barely addressed, she was given blank copies of required admission documents, her husband was not permitted to attend or participate in treatment planning as she requested, and, there were no required postings on the unit for all recipients to review their rights or to make contact with advocacy groups.

FINDINGS

Complaint #s 1-4: the hospital took the recipient's purse and inspected it without permission, detained and restrained her without cause and authority, inflicted physical and mental abuse by forcefully taking blood and urine specimens from her without consent and authority, and administered psychotropic medication without informed consent.

Record review:

According to the recipient's clinical record, she arrived by ambulance at the emergency department on August 7th, 2007 at 9:43 p.m. with complaints of severe depression and domestic problems. It was noted that the ambulance had initially been called for a possible overdose but that the recipient denied taking any pills and the ambulance team's count of them seemed appropriate. A nurse charted at 10:00 p.m. that the recipient was alert, oriented, appropriate, calm and sober and that her speech was comprehensible; she was not a harm to herself or others, did not have security on standby; she denied suicidal or homicidal ideation although she was

tearful and in need of a crisis evaluation. The nurse entered at the same time that the recipient was placed in a gown while waiting for the attending physician who arrived about fifteen minutes later. He completed a physical examination and dictated in his report at 10:35 p.m. that the recipient did not have suicidal or homicidal thoughts, she had no medical problems, and she did not clinically appear to have overdosed or be intoxicated. He concluded that he and the crisis team agreed that she was a good candidate for outpatient counseling and advised that she return should any worsening or new symptoms occur. His depart order stated that the recipient was to be discharged to her home at 10:39 p.m. There is no documented reference to her purse being confiscated or to any struggle over her purse.

The crisis evaluation seemed to be ongoing in the meantime. The assessment stated that the recipient tried to kill herself by sitting in her car with the garage closed last evening and that she was homicidal toward her husband. Then, at 11:54 p.m., the physician ordered blood and urine tests. The nurse entered again around 12:10 a.m. that according to the physician, the recipient was now complaining of suicidal and homicidal ideation towards herself and her husband, that lab work and medications were to be given and that she was involuntary.

A security guard wrote in his incident report that he was called to stand by, and at approximately 12:20, the nurse said if the recipient did not cooperate with a blood draw she would need to be restrained per the doctor. The nurse gave her three chances to cooperate, and he and another guard went in the room to restrain her. His report stated that several minutes later the nurse and a technician, who was also female, left the room and asked him to remove the restraints. He removed them and then left the room. The other guard wrote in his report that he was called to the scene at about 12:10, and he observed the recipient refusing to give blood or urine. The nurse advised the guards to put her in four-point restraints, which they did, and then he left the room. He finished his report by saying that after about four minutes the nurse and the technician came out and advised them to remove the restraints.

We found no physician's order for these restraints. The next chart entry was from the nurse at 12:20 a.m. stating that the recipient was uncooperative, and, per the doctor, she was to be placed on a restriction of rights due to self harm; security remained on standby and the recipient on involuntary status. A rights restriction notice was entered at the same time, but it was not completed. It stated that for ten minutes the recipient's right to refuse medication and laboratory specimens was restricted because she was suicidal and homicidal, that she would not cooperate and was verbally abusive and aggressive toward staff. There was no name to indicate whose rights were being restricted, no indication of whether the recipient's preferences for emergency intervention were considered, and no confirmation by staff that a copy was provided to the recipient and to anyone she designated to be notified. Other than being uncooperative, there was also no correlating documentation in the record to the recipient being verbally abusive and aggressive toward staff at any time. The physician completed a certificate for involuntary admission at 12:20 as well. He asserted that the recipient was depressed, she attempted suicide the night before and wanted to kill her husband and that she was not taking her medication. There is no accompanying petition. According to the medicine administration record, the recipient was given two Ativan tablets by mouth around this same time; there is no documented indication that her informed consent was secured beforehand.

At 1:00 a.m. the nurse wrote that the recipient continued to cry in her room while sitting on the bed or the floor. She was still uncooperative and would not speak to the crisis worker. The physician entered his order for the recipient's admission at 1:17 a.m. He included an addendum to his report a short while later that the recipient had completely changed her story

and admitted to sitting in her car the night before while it was running in the garage and to wanting to kill her husband because they had been fighting.

At 1:48 a.m. the recipient signed a voluntary application for admission to the hospital's psychiatry unit. She was provided with written information about her rights, and was taken to that unit at 1:50 a.m. A subsequent physical was conducted there a few hours later, and there were no findings to suggest any physical injury.

Statements:

The nurse, the physician and one of the security guards who was on standby do not recall anything about the recipient's purse or other belongings.

The nurse explained to us that restraints were not used to draw blood and urine as was led to believe in the security reports. She said that the recipient was throwing herself about the room, and out of concern for her safety she had security restrain her. We asked her why this was not documented and she agreed that her documentation should have been better. She and the physician had no explanation as to why there was no order or flow sheet for the restraints, and it was confirmed that the recipient was catheterized for the urine draw although there was no order or documentation for that either. The nurse told us that she has never seen male security guards holding a woman's legs or feet so that she can be catheterized, as they had not done in this instance.

The physician said that based on the recipient's initial story that she was not suicidal or homicidal he was ready to discharge her following his medical clearance. But at some point her story changed completely. It was then he felt obligated to proceed with blood and urine tests to rule out an overdose even though he did not see any medical signs or symptoms of an overdose.

As far as physical or mental abuse, the nurse had no recollection of the recipient complaining about being hurt by the restraints or the catheter. We also spoke with the recipient's therapist from the Center for Mental Health and he said that he spent time talking with her about the incident later that morning. She told him that she had previously been raped. She was sobbing, was very upset, and said that she got a catheter earlier and that it was painful.

On the medication, we were told that even though the right to refuse medication was listed on the restriction notice the recipient took the Ativan willingly; informed consent however, was not provided first. The nurse said that the recipient definitely needed the medication following her abrupt change in behavior.

CONCLUSIONS

Complaint #1: SwedishAmerican's emergency department policy on the care of the psychiatric patient states that patients will be asked to don a gown in order to facilitate medical screenings as well as for procedures and treatments. Patients who are determined to be at risk for harm will be asked to undress completely and can re-don their undergarments once no questionable personal effects are found. If the patient still refuses, and all efforts for cooperation fail, security will search the patient and any questionable personal effects will be removed. Female patients are to be searched by female staff with security present. Documentation is to be made in the nurses' notes. Belongings and personal effects are removed from the patient's immediate area and placed in the personal effects area. When patients refuse to be searched or don a gown, a description of the interaction will be documented clearly and in detail in the

nurses' notes. The patient's rights will be restricted during the stay in order to secure the belongings (Policy #20-6780.034.2).

There is no documented reference to the recipient's purse or even other belongings or personal effects. But, given the fact that she was "placed in a gown", as the record states, and eventually catheterized, she must have been disrobed. And, according to policy, her belongings and personal effects were to be placed in the personal effects area and documentation was to be made in the nurses' notes, neither of which we saw evidence of in this record. The complaint that the recipient's purse, or personal effects otherwise, were inspected without permission is a substantiated violation of policy.

Complaint #2: The emergency department's policy on involuntary detention for psychiatric evaluation states that a petition must be completed in order to hold a patient for a mental status exam (Policy #20-6780.038.0). The Mental Health Code provides for the same (405 ILCS 5/3-600 et seq.). Department restraint policies require a justification flow sheet to be filled out whenever restraints are used for behavioral purposes. A physician must sign the sheet, which constitutes an order. Restriction of rights forms are also completed in conjunction with behavioral restraints (Policy #20-678.409.8). The Mental Health Codes states that restraints may only be used therapeutically to prevent physical harm or abuse and only upon written order and accompanying restriction notices (405 ILCS 5/2-108). The Code of Federal Regulations adds that all patients have the right to be free from restraint of any form imposed as a means of coercion, discipline or convenience and may only be imposed to ensure immediate physical safety (42 C.F.R. 482.13).

The record spells out how the recipient arrived at the emergency department voluntarily and remained there cooperatively to the point when her physician was ready to discharge her following his medical clearance. But sometime around midnight, perhaps before, she was no longer there willingly per the physician's and nurse's documentation. Until she signed the voluntary admission application, there needed to be a completed petition for involuntary admission on file. Although the nurse said that restraints were applied to prevent harm when the recipient was throwing herself about the room, we find no credibility without documentation or a physician's order to back that up. The only existing documentation is from two security guards, both of whom stated that they observed the recipient being threatened with restraints unless blood and urine were provided and that restraints were removed within minutes after samples were collected, statements that corroborate with the complaint. The complaint that the recipient was detained and restrained without cause and authority is substantiated.

Complaint #3: The hospital's informed consent policy states that if a patient is physically or mentally incapacitated so that she does not understand the significance of medical treatment and cannot give meaningful consent, and if her health or life might be seriously impaired, consent will not be necessary provided that the nature and details of the medical emergency are specifically outlined in the patient's record by the physician (Policy #500.075.5). Per the Mental Health Code, a medical emergency exists when delay for obtaining consent would endanger or substantially affect the recipient's health. Essential medical procedures may be performed without consent when the physician determines that the recipient is not capable of giving informed consent (405 ILCS 5/2-111). According to the hospital's patient rights and responsibilities notice, all patients have the right to receive respectful care that promotes dignity, privacy, safety and comfort and to accept or refuse recommended tests or treatments and to be informed of the medical consequences of their choices (SHMS-2010). The hospital's code of conduct states that all employees are expected to conduct themselves in a respectful, caring and

accountable manner and to comply with department policies (Policy #10-951.008.3). Abuse, which is any physical or mental injury inflicted on a recipient other than by accidental means, is prohibited under the Mental Health Code (405 ILCS 5/2-112, 5/1-101.1), and all forms of abuse or harassment are prohibited under the Code of Federal Regulations (42 C.F.R. 482.13).

We leave medical determinations in physicians' hands although in this case we question why the recipient was made to give blood and urine after spending hours in the emergency department without displaying threatening symptoms, already having been medically cleared, and when the physician said there were no medical signs or symptoms of overdose when the samples were taken. There is a policy violation in that while the record explicitly states that the recipient was suicidal, there were no physician notations specifically detailing the need to forego consent for the draws if she was unable to provide it, particularly when right afterwards her capacity to willingly take psychotropics and sign a voluntary admission application was accepted. We cannot prove that she sustained physical injuries from the incident although her claim that it was painful is not discredited. However, we think the manner in which it played out surely caused mental injury. There was nothing dignified, respectful, caring or comfortable in being told that you have to do something so personal or be restrained and catheterized, none of which was by accidental means. In addition, the signs of mental injury were obvious when the recipient's therapist and the HRA representative met with her later that morning and found her sobbing profusely as she recounted the ordeal. That part of the complaint is substantiated.

Complaint #4: The hospital has recently developed policy for the use of psychotropic medications in the emergency department; it was not in practice at the time of this recipient's visit. Consent forms are now being used as well. The new policy closely follows the Mental Health Code's requirements for using psychotropics, including the right to be apprised in writing of the drug's risks, benefits, side effects and alternatives, to have decisional capacity determinations made in order to provide consent, the right to refuse, and to be given them without consent only when necessary to prevent serious and imminent physical harm upon proper notification (Policy # 20-6780.041.0; 405 ILCS 5/2-102 a-5 and 5/2-201).

It seemed like the recipient was not going to be given a choice in taking the Ativan since her right to refuse was listed on the restriction form. The staff we interviewed said that that was not the case, which is good because there is no supportive documentation of the need to prevent serious and imminent physical harm by making her take the medication. The nurse and the physician said that she took the medication willingly and by mouth; in that case, there is no evidence of getting her informed consent beforehand as required by the Mental Health Code. The complaint is substantiated.

RECOMMENDATIONS

1. Follow policy and document searches and removals of patients' personal effects (Policy #20-6780.034.2). All appropriate emergency department personnel should be reminded of this requirement.
2. Comply with Mental Health Code and policy requirements by ensuring that all appropriate emergency department personnel complete petitions whenever a mental health recipient undergoing evaluation is prevented from leaving the hospital (405 ILCS 5/3-601 and Policy #20-6780.038.0). Physicians from Infinity HealthCare should be trained on these requirements.
3. Instruct all appropriate emergency department personnel, including physicians, to issue

restraints orders and flow sheets complete with appropriate justifications and accompanying rights restriction notices pursuant to the Mental Health Code, the Code of Federal Regulations and policy (405 ILCS 5/2-108, 42 C.F.R. 482.13, and Policy #20-678.409.8).

4. Instruct all emergency department physicians to specifically outline the nature and details of why it is necessary to proceed with treatment without consent (405 ILCS 5/2-111 and Policy #500.075.5).
5. Review the code of conduct policy with the staff members involved in this recipient's care (Policy #10-951.008.3).
6. Train staff on the new psychotropic medication policy. Require all appropriate staff to make written decisional capacity statements, to cover risks, benefits, side effects and alternatives, to provide that information in writing as the medications are proposed, and to secure informed consent absent an emergency (405 ILCS 5/2-102 a-5, 405 ILCS 5/2-107 and Policy #20-6780.041.0).

SUGGESTIONS

1. Be sure that inspection of personal property is always done in full view of the owner(s).
2. We recognize the need to ensure safety for everyone in today's hospitals. At the same time we encourage SwedishAmerican to revisit its care policy as written because it requires all mental health patients to undress for their exams--nowhere does it say that a patient who is not at risk for harm does not have to. Modesty may be at the heart of a patient's psychiatric crisis, and we think exceptions should be made for her particular, individual situation as required by the Mental Health Code (405 ILCS 5/2-102 a). Also, the practice of restricting a person's right to her personal effects without posing a threat is not justified by simply filling out a restriction form. Restriction forms serve to notify the patient and anyone she chooses of the reasons why her rights were restricted (405 ILCS 5/2-201).
3. We encourage SwedishAmerican Hospital to require its emergency department physicians to undergo periodic training on Illinois mental health due process.
4. If patient conditions do not allow for them to keep drug education materials with them during their wait in the emergency department, be sure that staff document the sharing of that information and also ensure that the materials leave or transfer with them if possible.

COMMENT

SwedishAmerican has recently added Psychiatric Technicians to the emergency department to help ensure the best of individualized care for mental health recipients. Orientation materials provided to us show that the technicians as well as other department staff are going through extensive training on psychiatric emergencies, overall care, mental health policies and procedures, required legal documents, patient rights, medication and restraint use, and the handling of personal belongings; case studies are part of the training. We take an opportunity to say that this is a brilliant addition.

Complaint #5: the hospital did not provide adequate and humane care once the recipient's allegation of abuse was received.

Record review:

A behavioral health specialist wrote in progress notes at 10:46 a.m. on the recipient's first morning that the recipient appeared frustrated, depressed and angry about how she was treated upon admission. There is no other related documentation in the record.

Statements:

The therapist said that once the allegations of abuse were given to him by the HRA representative on that first morning he met with the recipient, entered her concerns on an incident report, which is called a quality control report, informed his department's director of the complaint and then forwarded the report to risk management. He also said that he spent time with the recipient offering moral support since she was upset and stated that she wanted to complain. He provided her with contact information on sexual assault resources in the community for when she was discharged, which turned out to happen soon and before they were able to do anything else. It was suggested that the report traveled to the appropriate departments for review.

We contacted the recipient at the time of this writing. She said that no one from SwedishAmerican has ever contacted her, verbally or in writing, about her grievances and that she is afraid to ever go there again.

CONCLUSION

SwedishAmerican's patient complaint and grievance policy states that grievances are to be responded to in a timely manner and in collaboration with risk management, guest relations and the appropriate management and medical staff. A grievance is defined in correlation with federal standards to include any oral concern not resolved at the time of service regarding care, abuse, neglect or patient harm as made by the patient or his or her representative. A patient grievance form should be provided, and help will be offered to complete it if the patient is unable. Guest Relations will acknowledge all grievances received, and Risk Management maintains grievance information in a data base for quality improvement. A quality control report must be completed for all grievances with the health system. All grievances should be resolved within seven days. Complexities may extend that time, but in every case a written acknowledgment must be sent to the patient within seven days. All complaints and grievances are considered confidential (Policy #10-950.131.2).

The Mental Health Code requires all facilities to provide adequate and humane care and services (405 ILCS 5/2-102). For hospitals participating in Medicare/Medicaid, the Code of Federal Regulations state that,

> *The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. ... The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care…. At a minimum: (i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital. (ii) The grievance*

process must specify time frames for review of the grievance and the provision of a response. (iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision…contact person, the steps taken on behalf of the patient…results…and the date of completion. (42 C.F.R. 482.13).

The recipient formally notified SwedishAmerican about her complaints of abuse by hospital staff on August 8th, 2007. The hospital to date has provided her with no response or information of any kind regarding its handling of her grievance. This is not quality of care as described in policies and not adequate and humane care as required by the Mental Health Code. And, without respectfully demonstrating to the recipient that the hospital gave her grievance due consideration and resolution, it is a violation of federal standards. The complaint is substantiated.

The HRA reviewed an Illinois Department of Public Health report from an inspection conducted on September 4th and 5th, 2007 at SwedishAmerican. The report listed deficiencies involving a patient's care and grievances which closely resembled the same under our review. The Department found that the hospital failed to ensure a patient's August 8th grievances were recorded, investigated, and written notification was provided in a timely manner. A quality control report was forwarded to the emergency department manager on August 15th, and on September 4th the manager said that he was in the process of investigating. The report also mentioned that no response had been provided as of the survey date, 27 days from the date of the grievance and that Guest Relations had not previously seen the grievance and therefore, had not recorded, investigated or responded.

RECOMMENDATIONS

1. Comply with policy, the Mental Health Code and the Code of Federal Regulations and ensure that respect, quality, adequate care and timely resolution is provided to every formal patient grievance (Policy #10-950.131.2; 405 ILCS 5/2-102, and 42 C.F.R. 482.13).

Complaint #s 6-8: the facility did not provide the recipient with completed copies of her voluntary admission application and her rights information, did not allow her designated support person to attend her staffing or participate in treatment planning, and did not have required advocate contact postings on the psychiatry unit.

Record review:

An HRA representative visited the recipient on August 8th, the morning of her admission to the Center for Mental Health. She presented all documents that were provided to her on intake and had blank copies of a voluntary admission application and a rights information form. Her therapist was asked to furnish completed copies of each, and he got them from the record and gave her new copies.

The psychiatrist's admission note stated that the recipient would engage in individual, group and family therapies. She was described as having significant conflicts with her husband, and he was to be invited to family therapy. The treatment plan document was initiated on her first day. It included goals and interventions for family conflicts. The recipient's only staffing

with interdisciplinary team members was held on her second morning there. The recipient, her physician, her therapist and a recreational therapist were in attendance; her husband was not, although a day earlier she and the HRA representative requested that the husband be included. There is no reference to the husband being invited or declining to attend, and no accompanying rights restriction notice if it was decided that the husband's participation in the staffing was inappropriate. Results from the staffing were listed, and it noted that the recipient was upset about being mistreated in the emergency department and that she had conflicts with her husband. The group agreed on a plan for the recipient to be medication compliant, receive certain therapies and be linked with outpatient providers. The psychiatrist's discharge summary from August 10th stated that the husband was contacted to participate in family therapy and that he participated in a family meeting, during which time he reported that he was feeling safe with his wife going home.

Statements:

Representatives from the Center for Mental Health said they were not sure why the recipient was given blank copies of her documents. Intake personnel are to give them completed ones and recipients can ask for copies from the record at any time.

On the issue of the recipient's husband not being allowed to attend her staffing or participate in treatment planning, the unit's manager for inpatient services said that case managers inform treatment team members whenever patients have asked for someone to be involved. Designated people can attend staffings as they choose. It was not made clear whether this recipient's designated person was invited.

We followed up with the recipient's husband for his account, and he said that at no time did anyone from the hospital contact or invite him to a therapy or staffing, even when he was at the facility visiting his wife, and at no time did he attend a therapy or staffing. It was only on her day of discharge that he was approached. The psychiatrist came in the room for a few minutes and asked him if he was fine with the recipient coming home; he said he was; she was discharged, and he took her home.

There were no required rights postings on the adolescent or adult units at the time the HRA visited the recipient. Granted, the units were being painted at that time, but there were no temporary displays and an employee remarked that she had never seen postings on the adolescent side even before it was painted.

CONCLUSIONS

The program's policy on voluntary admissions outlines Mental Health Code requirements and includes the stipulation that *completed* copies of the application form shall be given to the patient and to any parent, guardian, relative, attorney or friend who accompanied the patient to the facility (Policy #613-II.206.0 and 405 ILCS 5/3-401). Under the Code, all recipients over the age of 12 must be informed orally and in writing of their rights which are relevant to the nature of their services programs (405 ILCS 5/2-200).

The voluntary admission application and the rights information form include sections that state by affirming signatures whether the recipient was provided with copies; those sections are completed on both documents. Given that this recipient's copies in hand were blank, the signed affirmations were not entirely accurate, and a violation of policy and the Mental Health Code is

substantiated.

Program policy on treatment team responsibilities calls for the interdisciplinary team to collectively develop the most patient-centered and appropriate treatment course possible to address targeted needs. The team is composed of a psychiatrist, a therapist, a nurse case manager, a recreational therapist and a chaplain. The patient and/or involved family member will be encouraged to attend and participate in weekly staffing meetings (Policy #613-I.110.1). According to the Mental Health Code,

> *The [treatment plan] shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible…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.* (405 ILCS 5/2-102 a).

There is no evidence from the record that the Center for Mental Health advised the recipient of her right to designate someone to participate in her treatment plan's formulation. There is also no evidence that once the facility was aware she had designated someone that it carried out its obligation to invite him or encourage him to attend. Based on the record and statements from the recipient's husband, the complaint is a substantiated rights violation.

Section 5/2-200 of the Mental Health Code requires facilities to post conspicuously all rights information as they relate to the services being delivered, which includes information on how to contact the Illinois Guardianship and Advocacy Commission. These required postings were not there during our initial visit, but were during a subsequent visit. A violation is substantiated, and has already been resolved.

RECOMMENDATIONS

1. Stop the practice of providing blank copies of required admonishments and legal documents to recipients. All Assessment and Referral and unit intake personnel must be retrained on this Mental Health Code and program policy requirement (405 ILCS 5/2-200; 5/3-401, and Policy #613-II.206.0).
2. Require all appropriate staff to advise every recipient of his or her right to designate a support person for treatment planning and to invite and encourage designated persons to attend staffings. Retrain all interdisciplinary team members on these Code and program policy requirements (405 ILCS 5/2-102 a and Policy #613-I.110.1).
3. Revise the treatment team responsibilities policy to include this requirement (Policy #613-I.110.1).
4. Document in the record whenever a recipient has designated a support person for treatment planning since the Code requires written designation (405 ILCS 5/2-102 a).

SUGGESTIONS

1. Make clear distinctions to all recipients between designating someone to be contacted about their admissions or for emergencies and the right to designate someone to

participate in the formulation of their treatment plans; each are different issues and can have different designations. In addition, family members are not the only options for treatment involvement as recipients have the right to designate anyone they please. Finally, should the treatment team not allow any designated person(s) to participate in treatment planning because of potential harm, harassment or intimidation, a restriction of rights notice must be completed and forwarded to the recipient and to anyone she requests (405 ILCS 5/2-102 a, 5/2-103, and 5/2-201).

2. The program's treatment team responsibilities policy should be revised to include recipients and their designated support person(s) as team members and not just encouraged attendees. It should also reflect that the designated person(s) chosen by the recipient may be someone other than family (405 ILCS 5/2-102a and Policy #613-I.110.1).
3. Complete and deliver rights restriction notices whenever it is necessary to prohibit a designated person from attending staffings or other treatment-related meetings for therapeutic or safety reasons (405 ILCS 5/2-201).