FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 10-090-9017
St. Margaret's Hospital

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at the St. Margaret's Hospital. The complaints alleged the following:

1. The hospital violated a patient's confidentiality.

2. The hospital did not honor a guardian's communication/visitation restriction.

3. The hospital discharged a patient still in need of care.

4. The hospital did not adequately notify or involve a patient's legal guardian.

If found substantiated, the allegations would violate the Medical Patient Rights Act (410 ILCS 50/3), the Hospital Licensing Act (210 ILCS 85/6.17), and Hospital Licensing Regulations (77 Il. Admin. Code 250) in regards to confidentiality, patient care, and visitation rights. Also, the Illinois Probate Act (755 ILCS 5/11a) and the federal Medicaid and Medicare participation standards (42 C.F.R. 482) were also reviewed.

St. Margaret's Hospital is an 83-bed hospital with 650 employees. Located in Spring Valley, the hospital serves four counties: Bureau, Putnam, LaSalle, and Marshall.

To investigate the allegations, HRA team members met and interviewed the hospital's staff and reviewed St. Margaret's privacy policy, the hospital authorization to release information documentation, the patient admission procedure, patient notes, guardianship documentation, nursing notes, discharge documentation, the patient's rights policy (which is located in the Patient Services Guide), notes and signs written by the hospital staff, and the admission questionnaire. All records were reviewed with the guardian's written consent; he is the patient's guardian of the person according to his Letters of Office.

The patient's discharge notes state that the patient was admitted on 10/24/2010 and discharged on 10/30/2010 during her first stay at St. Margaret's. The notes state that the patient was then transferred to a nursing home on 10/30/2010. Then, according to the notes, the patient

was readmitted to the hospital on 10/30/2010 on swing-bed status to "continue her rehabilitation while awaiting nursing home placement." The patient was finally discharged from St. Margaret's on 11/2/2010 and transferred to another nursing home.

COMPLAINT STATEMENT

According to the complaint, the hospital violated the patient's confidentiality by releasing the patient's information to anyone who inquired. The hospital explained to the guardian that the reason this information is available is because the patient's guardian failed to set a password on the patient's chart. The complaint states that the process of making medical records private was never completely explained to the guardian and that was the reason the password was not set. The complaint also states that the hospital did not honor the guardian's communication/visitation restriction. The guardian had asked the hospital to not allow visits from the patient's significant other but the hospital reportedly allowed those visits. The hospital allegedly explained to the guardian that a restraining order was needed to restrict the visits. Another complaint states that the hospital released the patient while the patient was still in an unsafe medical condition. The complaint states that the patient was still in need of medical treatment and also still under the influence of the medication given at the time of the patient's release. The complaint also states that the hospital did not adequately notify the guardian that the patient was being released and failed to discuss the patient's condition with the guardian prior to the patient's release. The complaint maintains that the hospital knew he was guardian, and treated him as though he was guardian in most cases, but at times ignored his guardian requests. The complaint states that the guardian faxed guardianship papers at the time of the patient's admission.

FINDINGS

INTERVIEWS

The HRA began its investigation by speaking to St. Margaret staff members regarding the the confidentiality complaint. The St. Margaret staff members explained that upon admission, the patient is asked to complete a Health Insurance Portability and Accountability Act (HIPAA) Confidentiality form. On this form, the patient is asked who can access his/her medical information. The patient is then asked to create a password to lock the medical information into the hospital's computer system. After admission, it is the patient's responsibility to communicate the password to anyone that they want allowed access to their medical records. The staff went on to explain that if the patient was not lucid, then the responsibility of completing the HIPAA form would go to whoever is the agent in a Power of Attorney or whoever is the guardian of the patient In this case, the staff stated they thought the patient was lucid enough to complete the form and create the password. From a previous visit, the staff pulled the patient's file and saw that the patient's son is the agent in the Power of Attorney for the patient. The staff stated in our interview that they did not know that the son was actually the patient's guardian because the Power of Attorney documentation was all they had on file. When a hospital staff member spoke to the guardian on the phone, the son stated that he was now legal guardian. The hospital needed proof of his guardianship and asked him to fax his guardianship papers. The staff stated the guardianship papers were not faxed until the day that the patient was finally released from the hospital (11/2/2009). Until the papers were faxed, the hospital was unsure as to whether he was

actually the guardian or not. The hospital staff stated that they would have let him pick the password for the HIPAA form and assist on the rest of the admittance process had they known he was the guardian. Without knowing about the legal guardianship, the hospital followed the patient's wishes regarding who had access to her medical records. The patient named two people who could have access, the guardian and her significant other. The guardian did not want the significant other to have access to the patient's medical records, but the hospital stated that they had to allow the access. The hospital's reasoning for allowing access was because the guardianship was not proven yet and the significant other was on the patient's list of people who were allowed access to the medical records. The hospital also stated that they now ask all patients if they have a legal guardian as a part of the admission process.

In regard to the complaint that the hospital did not honor the guardian's visitation/communication requests, the hospital restated that they did not have proof of guardianship until the day the patient was discharged from the hospital. The staff stated that the guardian had called asking that the significant other have limited visits with the patient. This was another situation where the hospital was unsure of guardianship status. The patient signed a handwritten document stating that it was okay for the significant other to visit her in the hospital. This document was signed on 11/1/09. Regardless of the signed note, the staff stated that they complied with the request from the guardian and limited the visits. The hospital staff created a sign that read "[the visitor] can only visit [patient] with someone in attendance. Visits need to be short." The hospital staff also said that the room was close to the nurse's station. Also, in regard to the fact that the hospital told the guardian that he needed a restraining order to restrict the visits, the hospital has written documentation in the patient's daily notes that the nurse informed the guardian that in order to restrict the patient's visitation rights at the nursing home she was being discharged to, that he would have to get a restraining order. This interaction occurred on 11/2/2009 before the hospital received guardianship papers. The hospital staff stated that they felt as though there were never threats surrounding the significant other visiting.

In regard to the complaint that the hospital discharged a patient still in need of care, the staff stated that the patient was hallucinating but still lucid. A staff member spoke to the patient and the patient made the statement that she saw herself in the parking lot but the patient indicated that she knew that the situation was not real and that she was only hallucinating. The staff member decided that because the patient knew that she was only hallucinating and knew that what she was seeing was not real, then it should not stop the discharge of the patient. The staff member thought that the patient was possibly seeing a reflection of herself in something in the parking lot. Also, the staff members indicated that the patient was being released to a skilled care nursing home to further rehabilitate from the surgery which also affected their decision to release the patient. The staff stated that the patient was released, but once she got to the nursing home, she became belligerent because she did not want to be at that specific nursing home. The nursing home brought the patient back to the hospital where she was admitted on "SWING bed status" where the hospital would admit her overnight and then send her to a different nursing home the next day. The staff stated that this nursing home was one with which the patient would be happier. The staff indicated that the patient was belligerent because she was placed in a nursing home that she did not want to be in rather than because she was not ready for hospital discharge.

In regard to the complaint concerning the hospital not informing the guardian of the patient's release or involving the guardian, the staff informed the HRA that they did attempt to contact the guardian at work. He did not answer so the staff member contacting the guardian left a message. The guardian was not at work that day and did not receive the message. The staff member thought that this method of contact would be the best way to contact the guardian because it had worked the day before. The staff member also states that she did not know that the guardian was not at work that day. When the guardian returned the call, the patient had already been discharged from the facility. The guardian did not want the patient to be discharged due to the hallucinating but she had already left. The staff member also stated that the guardian had been informed that the patient would be released from the hospital on Wednesday or Thursday of that week in a prior conversation.

RECORDS AND POLICIES REVIEW

According to the physician's notes, the patient in this case is an elderly woman who was brought to the emergency room via ambulance after falling at home and fracturing her hip, which she had surgery on after being admitted into the hospital. The patient lives in her own home with a significant other and the patient's guardian lives out of state. The patient's discharge notes state "She should progress with physical therapy but she may need a week or two to get her back on her feet totally so she will be transferred to the nursing home to complete her rehabilitation there. She was transferred in stable condition and she will follow-up with her family physician …Patient tolerated the surgery and is recovering well without any complications …" The discharge notes also state that the patient is "ambulating well with two people assisting her," that there is "no evidence of complications," that her "postop course was unremarkable," and that her "Pain was controlled." The discharge notes read that the patient's condition on discharge was "Stable." The patient's discharge notes also state that the patient was admitted on 10/24/2010 and discharged on 10/30/2010 during her first stay at St. Margaret's. The notes state that the patient was then transferred to a nursing home on 10/30/2010. The notes then state that the patient was readmitted to the hospital on 10/30/2010 on swing-bed status to "continue her rehabilitation while awaiting nursing home placement." The notes state on 11/2/2010 the patient was discharged and transferred to another nursing home.

The HRA obtained and reviewed copies of St. Margaret's privacy practices policy and the patients' rights policy (which is located in the Patient Services Guide), and with consent, the patient's hospital authorization to release information, patient admission procedure, patient notes, guardianship documentation, notes and signs written by the hospital staff, and the admission questionnaire. First, the HRA reviewed the hospital's policy on privacy. The privacy policy is located in the Patient Services Guide in the section titled "You Have the Right to Have Privacy and Confidentiality." Within that section, under a subheading titled "You can expect" there is a bullet point paragraph which reads "[You can expect] The hospital, your doctor and others caring for you will protect your privacy as much as possible." The second bullet point paragraph reads "[You can expect] That treatment records are confidential unless you give permission to release information, or reporting is required or permitted by law. When the hospital releases records to others, such as insurers, it emphasizes that the records are confidential." There is another signed document stating the patient received the Patient Service's Guide and was made aware of the sections regarding rights and also how to make grievances. There is also a document titled

"Authorization to Release Information" which is signed by the patient that explains that the patient will allow the hospital to release information regarding the patient's medical condition to anyone requesting the information who knows the chosen code word. The document also states that "It is the responsibility of myself or other family members to relay this code word to the persons listed below." The persons who are listed below are the patient's guardian and the patient's significant other, who the guardian did not want granted visitation rights to the patient.

The HRA also reviewed St. Margaret's discharge plan. In the plan, under the heading "Procedure," it states "If the patient develops any untoward symptoms, he/she should not be discharged until the physician has been notified." The Plan also states that "Discharge planning and education are done with cooperative efforts of the patient, family or Significant Other, physician, nursing staff, social services and any other services that are required."

The HRA also reviewed the guardianship papers that were faxed to the hospital. The guardianship papers are dated to have been received by the hospital on 11/02/2009, which is the date of the patient's final discharge from the hospital. The date coincides with the statement from the hospital staff that they did not have documentation proving guardianship until the day that the patient was discharged from the hospital. Also, there is a sheet of paper signed by the patient that states that her guardian "can call her at the hospital, but she doesn't want him for power of attorney anymore" and that the significant other "May come and see me [patient] here at the hospital anytime he wants." This sheet was signed on 11/1/2009 and indicates that the patient believed that the guardian was only legally the agent in the Power of Attorney on the day before the patient was released from the hospital. Also, in a hospital memo which the subject is "Advance Directive/Resuscitative Interventions" it states "Competent adults have the right to make decisions regarding their health care. The courts of this state have recognized that this right should not be lost when a person becomes unable to make his or her own decisions." The memo also states "In the absence of Advance Directives, and a patient is unable to make decisions regarding medical treatment, a health care surrogate may be chosen to make life-sustaining decisions for him/her. The surrogate who would act in such a case would be (in order of priority): guardian of the person, spouse, any adult children …" These statements corroborate the hospital's statements discovered in the Interviews section of this document regarding guardians and treatment of lucid patients.

The HRA also reviewed the List Patient Notes for the patient. The List Patient Notes are notes written that summarize the patient's hospital stay and care; from calls to family members to medical information about the patient. These notes are kept by the staff in St. Margaret's Patient and Family Services department. On 10/26/2009, it is written in the List Patient notes that "I [staff member] tried to discuss short term nursing home placement for skilled rehab with [the patient] but she insisted that she will not go to a nursing home and refused to discuss it. I will try again after surgery to discuss this with her. Her [guardian's name] will be involved in discharge plans. I will contact him once I have spoken with [patient] again." The notes for that day list the guardian's work, cell, and home phone numbers. The 10/30/2009 List Patient Notes state that "The contract [for SWING stay] was a phone consent with her [guardian's name]." Also there was a second notation on 10/30/2009 which states that "He [guardian] gave consent for SWING" at St. Margaret's hospital. There are also additional notes regarding a criminal situation

concerning the patient where there are notes stating the guardian was contacted and informed of situations on 10/30/2009 and 11/2/2009.

In regard to the complaint that the hospital discharged a patient still in need of care, the staff stated that the patient was hallucinating but still lucid. The List Patient Notes from 10/29/2009, states that "She [the patient] told me about seeing herself in the parking lot and that she knew she wasn't, but that it was okay that it was happening." The physician's discharge notes from 10/30/2009 state that "She [the patient] was transferred in stable condition …" The transfer mentioned is from the hospital to a skilled care nursing home for rehabilitation before returning home. The doctor's discharge notes do not mention the patient hallucinating. The doctor's discharge notes from 11/2/2009, which is the patient's second discharge from the hospital, reads "Her condition improved and she was able to be discharged to the nursing home, but apparently the patient has been having problems with dementia issues and when she arrived there she was very upset that she was there and immediately demanded that she be returned. Her son had been in touch with me and was also upset because he felt she was having some hallucinations prior to her discharge that I was not made aware of." Also in the List Patient Notes, on 10/28/2009 it is written that "[relationship with patient] and guardian, [guardian's name and work phone number] is aware of the referral [to a local nursing home] and is happy about it." This notation was dated 10/28 which is before the guardianship papers were faxed to the hospital on 11/2. The List Patient Notes from 10/30/09 also state that "A referral will be made to [another facility]. [The Guardian] said that his mother would 'not put up a stink' to go there because she has friends there. I asked why he did not tell us about this before. He said he didn't know why."

The List Patient Notes also read that, on 11/2/2009, "I did tell [guardian's name] that if he did not want [significant other] to see [patient] at the nursing home, he would need a Restraining Order." An excerpt from the List Patient Notes on 10/29/2009 read "Later, [guardian's name] called, the first call to PFS [Patient and Family Services] and said that he didn't want [patient] to leave today because she was hallucinating. After receiving the message, I discussed it with PFS group. When I called up to the floor, to talk to her nurse, [patient] was already discharged. She was to be picked up at 4:00 but was gone by 3:50. Later when I personally spoke to [guardian's name], he was upset that she had discharged to [nursing home] when he didn't want her to. I reminded him of our conversation yesterday that it could be Thursday or Friday as we were waiting for the post op BM and the negative Doppler." The passage goes on to read "I told him that I called him, the first one, once we got the okay, at work and got his voicemail. I left a message, as he was very easy to reach yesterday there and that since I was calling at lunchtime their time, that he would call me when he returned. He did not say that he would not be at work Thursday."

The HRA also reviewed a printed, computer screen image of the new admission procedure that was put in place by the hospital to ensure that the admission staff asks if the patient has a legal guardian. A masked, print screen image of a patient's admission indicates that there is a question asked when a patient is admitted which is "Do you have a Legal Guardian" and the patient can answer "Yes" or "No" and leave comments regarding the question. There is also a provision with the question that states "If this person has a Legal Guardian, SMH needs to

have a Copy of the Guardianship on Chart." This part of the admission procedure was put in place after the complaint incident occurred.

MANDATES

The HRA researched state and federal mandates in accordance with the complaints raised within this report. In regard to the complaint that the hospital violated the patient's confidentiality, the Hospital Licensing Act states that "No member of a hospital's medical staff and no agent or employee of a hospital shall disclose the nature or details of services provided to patients, except that the information may be disclosed to the patient, persons authorized by the patient, the party making treatment decisions, if the patient is incapable of making decisions regarding the health services provided, those parties directly involved with providing treatment to the patient or processing the payment for that treatment, those parties responsible for peer review, utilization review or quality assurance, risk management, or defense of claims brought against the hospital arising out of the care, and those parties required to be notified under the Abused and Neglected Child Reporting Act, the Illinois Sexually Transmissible Disease Control Act, or where otherwise authorized or required by law." (210 ILCS 85/6.17). Also, the Medical Patient Rights Act (410 ILCS 50/3) guarantees "The right of each patient to privacy and confidentiality in health care."

The Probate Act of 1975 calls for appointed guardians to secure and oversee appropriate care for their wards and to be assured that providers will rely on their directives:

> *To the extent ordered by the court…the guardian of the person shall have custody of the ward and…shall procure for them and shall make provision for their support, care, comfort, health…and maintenance….* (755 ILCS 5/11a-17).
>
> *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.* (755 ILCS 5/11a-23).

And, under federal Medicare/Medicaid participation standards:

> *(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. (42 C.F.R. 482.13).

Also, in accordance with the Medical Patient Rights Act (410 ILCS 50/3.2) it is stated that "Every health care facility in this State shall permit visitation by any person or persons designated by a patient who is 18 years or older and who is allowed the rights of visitation unless (1) the facility does not allow any visitation for a patient or patients, or (2) the facility or the patient's physician determines that visitation would endanger the physical health or safety of a patient or visitor, or would interfere with the operations of the facility."

In regard to the complaint that the hospital discharged a patient still in need or care, the Hospital Licensing Requirements (77 Il. Admin. Code 250.240) state that "At least 24 hours prior to discharge from the hospital, each patient who qualifies for the federal Medicare program shall be notified of the discharge. The notification shall be provided by, or at the direction of, a member of the hospital's medical staff." Due to the guardianship status listed above, the person who would need to be contacted in this situation would be the patient's legal guardian. The Code goes on to say that the discharge notification shall include the anticipated date and time of discharge and written information concerning the patient's right to appeal the discharge pursuant to the federal Medicare program. Also, the Medical Patient Rights Act (410 ILCS 50/3) states that patients have "The right … to care consistent with sound nursing and medical practices, to be informed of the name of the physician responsible for coordination his or her care, to receive information concerning his or her condition and proposed treatment, to refuse any treatment to the extent permitted by law, and to privacy and confidentiality of records except as otherwise provided by law." The Hospital Licensing Requirements (77 Il. Admin. Code 250.1070) also state that "The hospital shall provide basic and effective care to each patient."

CONCLUSION

1. **Complaint # 1 - The hospital violated a patient's confidentiality.**

The complaint states that the hospital violated the patient's confidentiality by allowing people access to the patient's medical records that the guardian restricted. As stated above, the hospital's procedure for individuals to receive medical records involves allowing the patient to create a password that protects the records and the patient gives the password to those that they would like to access the medical records. The guardian wanted a certain individual to be restricted from viewing the medical records. The fax of the guardianship papers has the date of 11/2/2009 which coincides with the hospital's statement that they did not receive the papers until the day that the patient was released. The hospital stated that, because they did not have the paperwork, and the patient was lucid, they followed the patient's preferences rather than the guardian's orders. Both the guardian and the restricted individual were listed on the "Authorization to Release Information" list, but it is clearly stated on the form that it is the patient's responsibility to relay the password to the people on the list. The hospital did look to the guardian for certain decisions but did not allow the guardian to make other decisions, such as restricting the patient's medical records, but due to the fact that the hospital's documentation shows that the guardianship papers were not faxed to the hospital until 11/2, the HRA finds the confidentiality complaint **unsubstantiated,** but offers the following suggestion:

- The information regarding passwords and the list of individuals who can review medical information that is in the "Authorization to Release Information" document needs to also appear in the "St. Margaret's Health Notice of Privacy Practices" document. Both the Health Notice of Privacy Practices and Authorization of Release Information forms should be given to decision makers.

2. **Complaint #2 - The hospital did not honor a guardian's communication/visitation restriction.**

The complaint states that the hospital did not honor the guardian's communication/visitation restriction. The guardian did not want a specific individual to visit with the patient due to a possible criminal issue with the individual. The hospital stated that the guardian did not want the visitor to be completely restricted from visitations but rather have limited visitations. The List Patient Notes on 10/30/2009 state that "At this time a sign is on [patient's] door requesting all visitors to report to the nurse's station before entering. She has a friend that may visit where there is cause for concern. I hung the sign and wrote the information regarding her visitor per request of [guardian's name]." The hospital also provided the HRA with a copy of the sign which is mentioned in the Record Review section of this document. As stated earlier in the report, hospital documentation shows that they did not receive a copy of the patient's guardianship paperwork until the day that the patient was released from the hospital (11/2), and was not obligated to follow the guardian's communication/visitation restriction. Even without the obligation to adhere to the guardian's wishes, the hospital still limited the visitations. It is also stated in the List Patient Notes that the staff member was speaking of the nursing home when she stated that the guardian would have to get a restraining order to stop the visit between the patient and visitor, not the hospital, which indicates that section of the complaint was a miscommunication and the hospital did not state that the guardian would have to get a restraining order to stop visitation at the hospital. Due to the fact that the hospital documentation showed that they did not receive that guardianship papers until 11/2, and the request was made on 10/30, and in accordance to the hospital documentation that the guardian's restriction was followed, the HRA finds this complaint **unsubstantiated,** but offers the following suggestion**:**

- Staff should note that the hospital policy dictates that a visitation restriction requires a physician's order and that a similar requirement governs visitation restrictions in nursing homes.

3. **Complaint #3 - The hospital discharged a patient still in need or care.**

The complaint states that the hospital discharged a patient who was still in need of care. The List Patient Notes do state that the patient was hallucinating on the day of her first discharge but the staff member reporting the information did not feel it was grounds for halting the discharge and the discharge notes stated that "She was transferred in stable condition." The second set of discharge notes state "Her condition improved and she was able to be discharged to the nursing home, but apparently the patient has been having problems with dementia issues and

when she arrived there she was very upset that she was there and immediately demanded that she be returned." The discharge notes documented by the physician state "Her son had been in touch with me and was also upset because he felt she was having some hallucinations prior to her discharge that I was not made aware of." The staff stated that the patient was belligerent at the nursing home due to the fact that she did not want to be at that specific nursing home rather than not being fit for discharge. Also, the patient was being transferred to a skilled care nursing home where she would still be under care and there would be a mental health screening prior to being placed in the nursing home. In the hospital's discharge policy, it states "If the patient develops any untoward symptoms, he/she should not be discharged until the physician has been notified." In this case, although the hallucinations were documented, the discharge notes state that the physician was unaware of the hallucinations. Due to the fact that HRA does not consider the hallucinations to be "untoward symptoms" and because the patient was released to a skilled care nursing home, where she would continue to be under medical care, the HRA finds this complaint **unsubstantiated,** but offers the following suggestion:

- Due to the fact that the physician did not know that the patient was hallucinating, but the nurse had mentioned this fact in her notes, there seems to be a disconnect in communication between the hospital staff. Consider developing a policy which directs a physician to read the nurse notes before discharging a patient and creating a system that ensures the physician has read the nurses notes before the patient is discharged (ex. An electronic signature, a checkbox that states "Notes have been read by the discharging physician").

4. **Complaint #4 - The hospital did not adequately notify or involve a patient's legal guardian.**

The complaint states that the hospital did not adequately notify or involve a patient's legal guardian. According to the List Patient Notes, the hospital had communication with the guardian on 10/26, 10/28, 10/30, 11/2. Also, the List Patient Notes stated that the guardian was contacted on 10/29 regarding the patient's discharge at the phone number at which the staff had been contacting him. The guardian did not answer and a message was left. Also, according to the List Patient Notes, the guardian was informed on the previous day that the patient would be leaving on Thursday or Friday. The hospital states in the List Notes on 10/26 that "[Guardian's name] will be involved in discharge plans." On 10/30, the List Notes state that "He [guardian] gave the phone consent for SWING." The guardian was not given 24 hour notice pursuant to Hospital Licensing Requirements (77 Il. Admin. Code 250.240) which states "At least 24 hours prior to discharge from the hospital, each patient who qualifies for the federal Medicare program shall be notified of the discharge. The notification shall be provided by, or at the direction of, a member of the hospital's medical staff." Also, the staff had three phone numbers provided to them by the identified decision maker in which they could contact him and they chose to only call one of the numbers to give the identified decision maker notice of the patient's discharge. Although the hospital did not contact the guardian and give 24 hours notice prior to discharge from the hospital, as stated previously in this report, the hospital documentation shows that they did not receive the guardianship papers until 11/2, which was the day that the patient was discharged from the hospital the final time, and the hospital was not obligated to contact the guardian or

involve the guardian in discharge plans. Due to the fact that the hospital did not receive the paperwork proving guardianship, the HRA finds the complaint **unsubstantiated,** but offers the following suggestions:

- Assure that an individual is within their legal rights to partake in a patient's discharge planning before indicating that the individual will participate in the planning process.
- When it is indicated that an individual is to be a part of discharge planning, and it is within that individual's legal right to participate in discharge planning decision making, assure that all telephone numbers given by that individual are called and that messages are left for the individual.

The HRA also offers the following suggestion based on the proof of guardianship issue involved in the above complaint. Although it is understood that it is the Guardian's responsibility to provide the hospital with proof of guardianship, the HRA makes the following suggestion for situations such as within this complaint:

- If there is a claim that someone is guardian but there is no paperwork available, due to the fact that guardianship papers are public record, the hospital could call the local Circuit Clerk's office where the guardianship papers are filed to obtain copies or to confirm guardianship status. The Bureau County Circuit Clerk's phone number is (815) 872-2001 and the Marshall County Circuit Clerk's phone number is (309) 246-6435. There is a $6 fee to obtain copies through the Marshall Circuit Clerk office and then a copy fee of $2 for the first page and 50 cents for each additional page. The Bureau County Circuit Clerk office charges 50 cents per copy up to 19 copies.

Although the HRA has unsubstantiated complaints due to the fact that the hospital did not have evidence that the guardian was the legal guardian until 11/2, the HRA does acknowledge that the hospital documentation shows evidence that the guardian was at times treated as legal guardian and decision maker by the hospital, but at times did not get treated in this manner. On 10/30/2009, the hospital received phone consent from the guardian for the patient's discharge to SWING (as documented on the List Patient Notes for that day). The hospital posted a note that the patient could only be visited with someone in attendance and that the visits much be short and stated at the bottom of the note that this was "Per request of [guardian's name]." On 10/28, the List Patient Notes directly called the individual "Guardian." Because the hospital treated the guardian as legal guardian at times, but at other times did not, the HRA asks that that the staff of St. Margaret's Hospital takes action to assure that this treatment of an individual does not occur in the future.

RESPONSE

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

St. Margaret's Health

St. Margaret's Hospital

SMP Health System

600 East First Street
Spring Valley, IL 61362
(815) 664-5311
(815) 223-5346
www.aboutsmh.org

March 21, 2011

Mr. Steven Watts, Chairperson
Regional Human Rights Authority
Guardianship & Advocacy Commission
5407 North University, Suite 7
Peoria, IL 61614

Re: Human Rights Authority Case #10-090-9017

Dear Mr. Watts:

St. Margaret's Hospital has reviewed the results of the Peoria Regional Human Rights Authority investigation of the case listed above. Our Hospital is pleased that the Authority found that all allegations were unsubstantiated.

We have closely reviewed the findings of the Authority's report and have reviewed the Hospital policies with respect to the release of information, visitation restrictions, physician-staff interaction and discharge planning. Thus far, we have implemented several suggestions raised by the Authority throughout its report. In addition, we are conducting a review of all policies related to guardianship and human rights to ensure our continued compliance with all laws and regulations.

St. Margaret's Hospital takes any and all complaints of human rights violations seriously. We wish to thank the Authority and its volunteers for their time and efforts in conducting a fair investigation of this case, and for the helpful suggestions, which will aid in our process of continuous quality improvement.

Sincerely,

Tim Muntz
President & CEO

cc Mr. Gene Seaman, Human Rights Authority Coordinator
Michael B. Henderson, Hinshaw & Culbertson