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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 11-090-9022
Methodist Medical Center

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at Methodist Medical Center. Complaints alleged the following:

1. Inadequate care, including patients not receiving proper medication to relieve pain, not discussing treatments and discharge dates with patients or allowing patients to participate in their treatment, misleading patients regarding treatment, not caring for patient hygiene, giving a patient a one-on-one when patient is not suicidal, stealing personal belongings, and sending patients home when they are not prepared to be discharged.
2. Communication rights violations, including lack of privacy, impeded phone calls, lack of communication with individuals outside of the hospital.

If found substantiated, the allegations would violate the Medical Patient Rights Act (410 ILCS 50/3) and the Mental Health and Developmental Disabilities Code (405 ILCS 5/2).

The Methodist Medical Center covers a 22-county area, with Peoria, Tazwell, Woodford, and Fulton being patients' primary counties of residence Behavioral Health Unit has 2 adult units consisting of 44 beds and an adolescent unit which consists of 23 beds. The Behavioral Health Unit employs approximately 120 staff which consists of nurses, Masters level clinicians, mental health associates, nurses' aides, activity therapists, and psychiatrist. The Methodist Medical Center also offers other mental health programs such as partial hospitalization and an outpatient mental health clinic for children and adolescents.

To investigate the allegations, HRA team members met and interviewed Methodist Medical Center staff members and reviewed documentation that is pertinent to the investigation.

COMPLAINT STATEMENT

The complaint states that a patient in the behavioral health unit was not given medication for a headache and the staff would not help with the pain. The complaint alleges the patient was not allowed to communicate with her doctor; staff say they ordered medication but then the patient never got medication for pain, and staff would tell a patient that they would contact her physician but never did. The patient finally received pain medication after talking to the facility patient advocate. The complaint also alleges that a patient broke her tooth and the staff would not give her pain medication or call the physician regarding the broken tooth.

Another allegation is that, in general, the staff would not listen to a patient regarding her care. A patient was put on one-on-one suicide watch but was not suicidal. Another aspect of the complaint is that the facility would not give the patient antidepressant medication. The complaint states that staff would not tell the patient about her treatment for the first 2 days and would not tell the patient when she was going home. They would only tell the patient that she was paranoid because she is pregnant. Reportedly, no one would give the patient any answers. Also when a patient spoke with her doctor, she allegedly was lied to about her medication and the doctor wanted to put her on Haldol. The complaint states that the staff lies about specific treatments and when medication is supposed to be prescribed. According to the complaint, staff also cannot give answers about simple questions that were asked and staff were harassing and intimidating when asked questions about treatment.

The complaint alleges that patient rooms have not been cleaned and the patients' hygiene is not being taken care of, including a patient urinating and not being cleaned up. The complaint states that the patients smell like urine and feces. Patients are also reportedly being discharged that are not ready to leave and patients are being told that they will be discharged when they are not actually being discharged. The complaint also states that patients are being ignored when they ask questions.

The complaint states that there is not a way for people outside of the hospital to know a patient is in the hospital or communicate with that patient. A patient was reportedly not allowed to talk to her husband and phones where shut down during group time. The complaint alleges a patient also stated that a phone cord will fall out of the phone and interrupt the patient's calls and that staff watched her and listened as she made phone calls. A patient said the nurse was telling her that she only had two minutes and the patient said that they were to turn the phones off while she was talking to the HRA (specifically this writer). Also, another call was interrupted on another occasion (a partial message was left on this writer's voicemail and then a second message saying that the first call had been interrupted by the phone cord). A nurse paged a patient to the front desk and then told the patient not to talk about other patients over the phone (this was overheard by this writer over the phone). The complaint states that the nurse also used threatening facial expressions.

The complaint also states staff moved a patient from one room to another because she was crying while talking to the patient referenced in this complaint and the patient was told that she was not allowed to speak with the other patient. The complaint alleges that the staff made threatening remarks about a patient informing another patient about services for persons with disabilities

There is also an allegation that staff stole personal belongings from a patient.

FINDINGS

Interviews with Methodist Medical Center Staff (3/3/2011)

The Methodist Medical Center staff explained that the individual involved in the complaint was admitted because she said that her husband put a mind control device in her head and because of this she hears voices that tell her to do things. They said that she was diagnosed with Bipolar Disorder. She was involuntarily admitted and was brought to the hospital via East Peoria ambulance.

The staff stated that the patient made grievances while admitted to the behavioral health unit. She called the Guardianship and Advocacy Commission (GAC) several times. The staff explained that she was in a manic state. She was also hyper vigilant about other patients. Staff were not aware in one instance that she was calling the GAC and intervened because of hearing her say other patients' names. They told the staff that the patients can call GAC with complaints regarding themselves and others but, sometimes, such as when a patient is talking to friends or family, the staff will intervene if they hear confidential information given over the phone. They stated that the patient never had phone restrictions but the phones on the floor are shut down during group and also shut down at 10 pm and available again at 7:30am. Even with the phone being shut down in those situations, family members can contact the unit and patients know they can contact family in an emergency.

The staff explained that the patient was in the facility for 8 days. She was there involuntarily but was discharged before her court hearing because the physician felt that she was safe. The Methodist Medical Center staff said that the average length of stay for a patient in their facility is 8 or 9 days. They also explained that the patient was pregnant. The gynecologist consult was very clear on authorized medication that the patient could take because of the pregnancy. The patient did not trust the staff with the medication that they brought and that is the reason why she wanted to speak with the doctor.

The patient called the Methodist patient advocate, who contacted the unit manager. The unit manager tried to work with the patient by having her point out which staff members she trusted for that day and those staff members would be the ones taking care of her on that day. The patient was on suicide precautions while she was at the facility. She had a one-on-one staff member. The patient stated she did not want the baby so the facility was worried that she may do harm to herself. The patient was also on a mood stabilizer. The only psychotropic medication that was given to her was Seroquel because of her pregnancy. The patient was focused on pain meds that would be bad for her baby. She felt staff was not contacting the physician but they had been. She blamed staff and then would tell them to leave her alone. She would also state that she did not want to be at the hospital and believed to be mistreated because she was being kept against her will. The staff stated that they never received complaints from the patient about items stolen. The staff explained that when patients are on suicide watch, staff remove items away from the patient so maybe she thought that was stealing.

When the patient asked for pain medication, she received non-narcotic pain medication because of the baby and a prior drug dependency and she constantly requested pain medication. The staff explained that she was positive for drugs when she was admitted. She reported that she had inpatient treatment for substance abuse. She was manic during her stay at the hospital. The only medication that she wanted was Tramadol and she received that medication.

In regard to the complaint that no one was told that the patient was in the hospital, the Methodist staff explained that they do not disclose the admission of individuals to the Behavioral Health Unit. They had verbal consent that her husband could know her location and a signed release but the patient later rescinded the release. The patient had no phone restrictions, so she could call her husband whenever she wanted. With the release, they could call him for up to 3 days. The hospital authorizes long distance calls once a day if she needed to call out of state. The staff explained that the patient's ex-husband was contacted and he had been talking to her and visiting regularly. She received Tylenol 3 times and then started Tramadol. The patient received pain medications on admission and received them everyday after that for the duration of her stay. She used the Tramadol on the 15th and she was at the facility between the 14th and the 22nd, so she received the Tramadol immediately.

The Methodist staff explained that they have a daily housekeeper on the unit but patients disorganize their rooms quickly and sometimes they look messy. They have a daily group in the morning that discusses topics such as complaints and cleanliness. Some complaints are not documented, such as complaints that rooms are messy.

The staff stated that they would never coerce a patient to bathe. Some patients are incontinent because of disorganized thinking and they try to help them with bathing and grooming. Showering can be a goal because it shows they are improving. There are two shower times per day but they can shower anytime based on their needs.

The staff stated that while the patient was at the facility, she became very involved with the other patients. They said there was a possibility that in one instance they considered moving her because she was upsetting a patient but they were not sure if this happened or not. They said that the patient even had a notebook where she kept track of all her thoughts and what was happening around her. They stated that the patient received a tremendous amount of staff time. When she was discharged, she was discharged to her home with her husband.

The patient was allowed to speak with the physician but did not trust the staff. The staff documented talking to her about why she was there. The patient also refused to sign a treatment plan, but the plan also explained why the patient was there. When a patient is discharged, the facility gives 24 hours notice prior to discharge. It was difficult to talk to her about discharge because of her emotional state. The Methodist staff said that patients are never given a date for discharge but they may give them a general idea of when they may be discharged. They said they are cautious to not make promises that they cannot keep.

The Methodist Medical Center staff stated that patients are in constant assessment of their progress by the staff and they attempt to help patients recover and be released. They also set them up with community resources. Sometimes with Medicaid the facility loses money on extra

unpaid days to keep the patients there until they are ready to be discharged. The interdisciplinary team discussed discharge dates on the 17th with the patient and the clinician talked with her on day 3 of her stay. On the 20th they met with her again regarding discharge dates.

The staff explained that they have regular plastic wall mount phones on the walls in the unit. If a phone breaks, then they replace the phone. The facility is in the process of obtaining stainless steel phones for the unit. They said she could have stretched the cord and pulled it out of the phone on the wall. Staff noticed that she was using other patients' names when they interrupted her on the phone. They overheard because she was not very quiet while on the phone. The staff explained that staff members are in and out of the telephone area all of the time and the phones are not far from the nursing station. If it is requested, they can have a private phone call and, the staff stated, they can also be quieter while on the phone. They stated that patients do receive private calls that way. They stated that if a patient was making threatening or harassing phone calls, or calling 911 often, they would restrict their phone rights. They have also restricted phone access if an individual just randomly dials phone numbers often.

There was no one else that the patient wanted to be in contact with other than the physician. She wanted to talk to the physician several times a day but no physician would talk to her as often as she wanted. The staff ended by saying that they try to give as much control and freedom to the patients as possible regarding their stay and their treatment.

Tour of the facility to see telephones

The HRA toured the facility to see the telephones. There are two telephones in a public hallway around the corner from the nurse's station. The phones are not that far away from the nursing station. The HRA picked up the phones and there were no loose cords on the phone. There was an individual on the phone when the HRA started the tour, and the person could be heard from the middle of the unit where the hallways merge which is close to the nurses' station.

Record Review

The HRA reviewed documents pertinent to the complaints in this case. According to the patient's treatment plan, the patient was brought to the facility by a local fire department. The plan states that the patient was "manic, labile, delusional; states her husband and the government have a mind control device in her head making her a prostitute and making her take drugs. Hearing voices of people she claims are family." A physician's medical report/history in the documentation (dated 12/14/2010) states that the patient's urine pregnancy test came back positive and also her urine drug screen was positive for opioids, which "she attributes to getting an injection of morphine when she went to [hospital] 2 or 3 days ago."

There are several aspects to the first complaint that the HRA reviewed; the first being the allegation that a patient was not given medication for a headache, the staff would not do anything to help the patient with the pain, and the patient was not allowed to communicate with her doctor. This part of the complaint also states that the staff would order medication but the patient would not receive the medication, that the staff would tell the patient that they would contact her physician but never did, and also that the staff would not inform the patient about her

treatment for the first two days and would not tell the patient when she was going home. The complaint also states that the patient finally received pain medication only after talking to the facility patient advocate. The HRA reviewed physician consultation notes (with a consultation date of 12/14/2010) which reads, in the assessment and plan area "Headaches. The patient says she gets headaches often. I think it is mostly stress headaches. I would avoid giving any medications unless it is absolutely necessary because of her possible pregnancy. I would use Tylenol as needed for pain." The patient arrived in the ER on 12/13/2010 and was admitted into the adult psychiatric unit at 10:53 pm that day. An admission medication reconciliation (dated 12/14/2010 at 1:15am) form shows that Tramadol (pain medication) was ordered for the patient with a frequency of "once now." The HRA reviewed a medical administration record for the duration of the patient's hospitalization (12/13/2010 - 12/22/2010) and the patient was given a one time order of Tramadol the first day and second day of her stay (12/13 and 12/14), then took Acetominophen on the third day (12/15), and most of the fourth day but was switched to Tramadol by the end of the fourth day (12/16). The patient only took Tramadol for the rest of the time spent on the unit.

The HRA also reviewed a document titled "Daily MD Assessment/Integrated Progress Note." These notes were filled out every day from 12/14/2010 until 12/21/2010, indicating that the patient had contact with a physician almost daily throughout her stay at the facility (she was admitted late on 12/13/10 and 12/22/2010 was her discharge). The assessment does not exactly state that the patient was told about her treatment but it does indicate that the patient communicated with her physician.

In the patient's treatment plan, there is a section titled "Discharge Plan" which reads that the patient will probably be discharged to her home but the facility needs more information about her living arrangements and also that the facility may refer her to a mental health clinic. There is no indication in the discharge plan when she was going home and there was also no indication throughout the treatment plan that the patient was told when she could return home. Also, on 12/20/2010, there is a note in the "Staffing" section that reads "Continue safety precautions. Continue medication. Group as appropriate. Build rapport. Anger management. Discharge planning."

There are also areas of the patient's treatment plan that indicate the patient did not completely understand the treatment or did not listen to explanations. One entry into the notes of the treatment plan read "Patient unable to fully understand explanations about her medications." Another section reads "Patient became upset when RN tried to explain when patient's PRN meds are due. Patient walked off,"

In the emergency department chart, it reads "Give 50mg Benadryl for agitation per psychiatrist. D/W [staff name] about telling patient she is pregnant. Concern is that it may make her even more agitated and difficult to calm, especially since we are limited as far as meds that are safe to give her since she is pregnant. [Staff name] agrees that with her acute psychosis it is better not to tell her at this time." This section was dated 12/13/2010 10:51pm. In the patient's treatment plan, it reads "This staff was present with [physician] and patient's nurse when [physician] informed patient about her pregnancy test being positive." The time and date for this note was at 2:28pm on 12/14/2010, which indicates that the facility waited approximately 15 ½

hours before telling the patient that she was pregnant. Also, in that time, the patient was given medication, without being informed that she was pregnant.

On top of receiving the Benadryl without knowing she was pregnant, the patient's MAR shows that she took Tramadol at 1:45am on 12/13, Geodon at 1:45am on 12/13. Both were given before the patient knew that she was pregnant.

The HRA saw no evidence that the patient was told that she was paranoid because she was pregnant.

Also in the treatment plan, there is a note on 12/14/2010 which states "Labile. Demanding at times when requests aren't immediately met." Another note on 12/15/2010 reads "Patient is mostly uncooperative and argumentative. Patient has numerous requests and becomes angry when her needs aren't immediately met. But patient requests are immediately after a Dr. has been paged for our prior request. Demanding to call the Patient Advocate, which she was given the phone number to." Another note also on 12/15/2010 reads "Feels like no one is meeting her medical needs. Wants to take Tramadol as frequently as she can. Patient doesn't have any other PRN's. Patient advised staff that [gynecologist] was her gynecologist. [Physician] paged and received Tylenol orders. Also advices [staff physician] about [gynecologist]. [Staff physician] advised staff to call [gynecologist]. Patient much calmer after [gynecologist] saw the patient." On the same date of 12/15/2010, the treatment plan states "Irritable. Sarcastic with staff. Suspicious of staff when opening her medication" and another on the same date reads "Patient irritable when she believes that her requests aren't being made." On 12/16/2010 it reads "Patient is very sarcastic and rude. Demanding that [gynecologist] be called constantly for pain medications" and on the same day "Patient is constantly asking for pain medications and demanding [gynecologist] be called to order more pain medications." The treatment plan also reads "Angry at staff who she feels are mistreating her. Unable to discuss other possible realities, including that [gynecologist] has only ordered Tylenol #3 and not Tramadol, she claims he wanted her on. Feels staff are not contacting [gynecologist] regarding her pain." And also "If staff doesn't agree with her perception about something, they are lying. Example, 'my medications are between me and [gynecologist] and he ordered Tramadol regularly for me … the staff are lying about it being a one time order.'" In another section of the treatment plan (dated 12/18/2010), it states "Patient states her head still hurts, 'like at least an 8'; however, behavior and affect not congruent with stated pain experience. Patient laughing and joking with peers." These statements also connect with the complaint that the staff lies about specific treatments and when medication is to be prescribed as well as that staff cannot give answers about simple questions that were asked and staff were intimidating when asked questions about treatment. The HRA saw no evidence of the staff lying or being intimidating when asked questions.

At one point in the treatment plan, the patient is quoted as saying "… don't care about if the safety is unknown, I am in pain and Tramadol is the only thing that will work!" In an order confirmation report, dated 12/16/2010, it states "[gynecologist] specified that the patient be told that safety in pregnancy is unknown before medication is given and this has been done." This same statement is on the patient's discharge medication reconciliation form. In the patient's

treatment plan, a section reads "Patient signed her med education sheet on her tx plan to indicate that she understands that the safety of Tramadol is unknown for use in pregnancy."

Regarding the patient's complaint that she did not receive pain medication until after talking to the facility patient advocate, the patient's treatment plan, on 12/15/2010, states "Demanding to call the Patient Advocate, which she was given the phone number to." According to the above dates, she received pain medication prior to contacting the advocate.

Part of the complaint states that the patient broke her tooth and the staff would not give her pain medication for the broken tooth. In the patient's treatment plan, on 12/17/2010, it states under the "Pain" heading that patient said she has a broken tooth. The pain scale was at 10 and the description was a sharp ache in her head. The pain intervention documentation states that there was pain scale education, emotional support and medication. The time states that this occurred at 7:06 am or pm. The patient's MAR corroborates that she was given Tramadol at 7:06 am or pm on 12/17/2010. There was no indication in the treatment plan that the individual requested that her physician be called. The HRA saw no other mention of the broken tooth within the documentation.

Regarding the allegation that the patient was put on one-on-one suicide watch but was not suicidal, the HRA reviewed the behavioral health unit safety plan, dated 12/14/2010, which states "Patient is on suicide precautions and will have belongings removed until order is changed." It also states that the patient is on 15 minute checks. In a medical document which gives a brief history and course of hospitalization, dated 2/17/2011, it states "She did not have any suicidal thoughts or homicidal thoughts." This document was written by a physician. In another physician's document, it states "She denies any thoughts of wanting to harm herself or others." In the emergency department chart, which was written at 9:13 pm on 12/13/2010, it reads that the patient "states she is not suicidal or homicidal" and that she denies suicidal thoughts and thoughts of doing harm to others. An order confirmation report from 12/14, states "Precautions: room/patient search every shift, scrubs, restrict to unit, 1:1 precautions, elopement precautions, suicide precautions, aggression." Another order confirmation report adds the following precaution: "potential for sexual acting out, in staff sight." A MD assessment note from 12/16/10 states that the patient denies all thoughts of wanting to harm self or others." The HRA reviewed documents titled "Suicide Clues and Behavior Rating Scale." One dated 12/13/2010, at 11:18 am, scored the patient as a 53 which was considered "Moderately High." The description on the form states "A score of 50 is an arbitrary division point where suicidal behavior is probable." Another form, filled out on 12/16/2010 scores the patient at a 55 and another on 12/19 scores the patient at a 53. On 12/22, when the patient was released, her score was 44. The HRA also reviewed the patient's rights notice which states she has a rights restriction on 12/14/10 at 2 am and was being placed on suicide precautions. The specific restrictions were the right to refuse search of person or living area and the right to retain personal property. In the treatment plan, the first mention of a 1:1 is on 12/15/2010, but it does state that there are suicide precautions on 12/14/2010 which is the first date associated with the treatment plan. In the daily Behavioral assessment flow sheets, it is mentioned on 12/16/2010 (early morning) about the patient's 1:1. Later in the treatment plan, there is a note which states "Patient advised per [physician] that she was going to remain on 1:1 observation and in staff sight until she can change her behavior and stop being so argumentative and uncooperative."

The HRA also reviewed a rights restriction for the patient which stated that the patient was "placed on suicide precautions" and this would occur until "discharge or change in orders." There is no detail as to what the suicide precautions were.

In regard to the complaint that the facility would not give the patient antidepressant medication, according to the MAR the patient was given Geodon at 1:45 am on 12/13/2010, then was not given any mood changing medication on 12/14/2010, only Levothroid and Tramadol: on the 15th the patient was given Seroquel.

Another part of the allegations state that a patient was lied too about her medication and the doctor wanted to put her on Haldol. The HRA began with reviewing the complaint regarding Haldol. According to an order confirmation report, dated 12/14/2010, Haldol was ordered as a PRN and stated that the drug was for "agitation if patient is in danger of harming self or others." Another order for the drug was filled on 12/15/2010 for the same reasons. According to the patients MAR, the drug was never given to the patient. In the patient's treatment plan, on 12/16/2010, the patient states that she does not believe she needs to take Haldol because she is not hearing voices any longer, but it does not state that a physician was asking her to take Haldol.

In regard to the complaint that patient rooms are not being cleaned, the patients' hygiene is not being taken care of and the patients are smelling like urine and feces, there is a section of the patient handbook titled "Self Care" which states that the patients are to do their laundry (and gives laundry hours) unless they are unable to do their own laundry and also gives times for patients to take showers. The section also reads "Clean bed linen will be distributed every Tuesday morning. You need additional sheets, etc., at other times, please ask a staff person. If physically able, you will be expected to make your own bed and maintain the orderly appearance of your unit." One section of the treatment plan states that the patient "refuses to go to groups as she says her peers stink and being in the same room with them makes her sick." There is another occasion in the treatment plan where the patient says the peers smell. This writer has toured the facility on several occasions and never saw any issues with the cleanliness of the unit.

Regarding the complaint that patient's questions were being ignored, in reviewing documentation and records from previous and current cases involving Methodist Medical Center, including this case, the HRA saw no evidence that patient's questions were being ignored or that they were being told a date when they could go home at all (cases referenced are 10-090-9026 and 11-090-9025). From these reviews the HRA also saw no evidence that individuals were being sent home before they were ready.

The HRA reviewed the behavioral health unit's discharge policy and procedure. The document does state that "Discharge planning begins at admission when goals are identified and projected length of stay is anticipated." The policy does not state that patients are told the projected length of stay. Some of the general guidelines for determining discharge include consideration of "symptom reduction in patient and stabilization of family situation," "likelihood of having reached maximum benefit from inpatient treatment," and "completion of all assessment and evaluations." Specific goals for admission include the patients' dangerousness to self or

others, the extent that goals and objectives have been reached from treatment, adequacy of post-discharge placement, and potential for treatment in a less restrictive environment to name a few.

The HRA also reviewed other parts of the patient's treatment plan that is related to the above complaints. One section reads "Patient irritable with staff on the unit and states that she feels her rights are being violated up here as well as other peers on the unit … Patient calling patient advocacy on several occasions in regards to self and other peers. Irritable with staff." Another section reads "Feels that her rights and other peer's rights are being violated. Patient pacing the halls and calling people on the phone on several occasions throughout the day regarding her rights as well as other patient's rights. Irritable and abrasive with staff."

Another complaint deals with communication rights violations. The section above not only deals with the patient interacting with peers but it also deals with communication violations because the staff note what is being spoken about on the telephone, indicating that the conversation is not private. Another indication of this in the treatment plan reads "Patient has called the patient advocacy commission numerous times. She has a notebook and is writing most of the patients' first and last names down and calling the advocacy commission and telling them that staff are not treating the patients right. Patient is advising all of the patients to call the advocacy commission to report the hospital. Patient advised this was not appropriate but patient is refusing to listen and is trying to build an alliance with peers against staff. Stands at the desk and smirks at staff and is very confrontational and demanding. Patient unwilling to listen to staff. [Staff member] notified of situation and he was going to seek legal advice."

The unit handbook has a telephone policy which reads "Telephones for patients are located near the nurse's station. Patients are responsible for answering the patients' telephones and obtaining patients for incoming calls. Phone calls may be made and received from 7:00AM - 10:00PM. Because groups are an important part of your program, the telephones may be shut off during group time so you will not be interrupted … Phone calls are limited to 10 minutes." This passage also refers to the complaint that phones are shut off during group time.

Another area of the rights violations regarding communications, states that there is no record of disclosure for people to know about a patient's situation at the hospital and a patient was not allowed to talk to her husband. In the patient's treatment plan, on 12/14/2010, it reads "Patient very agitated upon arrival to unit; was allowed to call husband (left message on answering machine)." There is another statement that reads "Patients ex-husband came to the unit and was also very confrontational with staff and wanted on the unit. Advised there needed to be a Dr. order, ex-husband not real accepting of this. Patients ex-husband brought a bag of clothes and had a bottle of Tramadol wrapped up in panties. Advised ex-husband this was not allowed and advised patient this was not allowed." From the note it is not known whether the husband was allowed on floor but it indicates that he knew she was there and had been talking to her.

The HRA reviewed authorizations to release information. One was dated 12/13/10 and signed by the patient to release information to another individual with the patient's last name. The purpose of the release was for continuity of care. There is a note on the release stating that the patient rescinded the release on 12/17/10 which was also signed by the patient. The second

release was for the same individual but there was no date on the release and there is a note that states the patient refused to sign the release. In the patient's treatment plan, it states on 12/16/10 that the staff "met with patient and her visitor to explain what items visitors could and could not bring patient" and the patient is "visiting with '1st husband' in day room."

The HRA explored the allegation that staff stole personal belongings from the patient. In the patient's treatment plan, on 12/16/2010 at 4:37 am or pm it reads "Loud and agitated. Accusing staff of stealing her patient advocacy paperwork that patient left in the dayroom (a peer turned the paperwork and staff returned it to patient except a peer who had kept patient's notebook). Later in the document, on the same day at 6:09 am or pm, a note reads "States that she believes staff is discriminating against her and violating her rights. Suspicious and irritable. Pacing, using phone, loudly accusing staff of refusing to help and of stealing her patient right's paperwork." Later that same day it reads "Patient has been very agitated and irritable despite staff's attention 7 prompt response with pain meds, contacting her doctors, searching for her papers." The HRA saw no other mention of items being stolen in the documentation.

The final allegation states that another patient was moved from one room to another because she was crying from the patient involved in the complaint talking to her and the patient involved in the complaint was told to not speak with the other patient. Also the staff allegedly made threatening remarks to a patient for informing other patients about services for persons with disabilities. In the patient's treatment plan, the HRA read the following "Patient has to be constantly reminded that peers are not allowed in her room, but patient does not listen and continues to try to get peers alone to try to convince them to go against staff and try to get the hospital in trouble." Another passage reads "Defiant-instigates problems for other patients." There are other occasions in the treatment plan where it is noted that the patient felt that her peers' rights are also being violated. The HRA saw no evidence that the staff made threatening remarks to the patient.

The HRA also reviewed the 5 Day Request in the patient's record. The request was dated 12/15/2010. In reviewing the treatment plan, the first time the patient stated that she wanted to be discharged was 12/14/2010 at 2:28pm.

MANDATES

The HRA reviewed regulations related to the complaints in this case. For the first complaint, the HRA reviewed the Medical Patient Rights Act, which reads "(a) The right of each patient to care consistent with sound nursing and medical practices, to be informed of the name of the physician responsible for coordinating 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" (410 ILCS 50/3). The Federal regulations also state "(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).

The Mental Health and Developmental Disabilities Code also states "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" (405 ILCS 5/2-102).

The Mental Health and Developmental Disabilities Codes states that "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect" (405 ILCS 5/2-112).

Regarding the second complaint in this case, the Mental Health and Developmental Disabilities Code states "§ 2-113. (a) Upon admission, the facility shall inquire of the recipient if a spouse, family member, friend or an agency is to be notified of his admission to the facility. If the recipient consents to release of information concerning his admission, the facility shall immediately attempt to make phone contact with at least two designated persons or agencies or by mail within 24 hours" (405 ILCS 5/2-113). The Code also states "Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation" (405 ILCS 5/2-103). The Code also reads "The respondent shall be allowed to complete no less than 2 telephone calls at the time of his admission to such persons as he chooses" (405 ILCS 5/3-609).

The Mental Health Code also reads "The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment. The physician or the physician's designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only (i) pursuant to the provisions of Section 2-107 or 2-107.1 or (ii) pursuant to a power of attorney for health care under the Powers of Attorney for Health Care Law or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act" (405 ILCS 5/2-102).

The HRA found no regulations stating that the facility must inform patients of a date of discharge while they are on a unit.

CONCLUSION

Complaint #1 - Inadequate care, including not giving patients proper medication to relieve pain, not discussing treatments and discharge dates with patients or allowing patients to participate in their treatment, misleading patients regarding treatment, not caring for patient hygiene, giving a patient a one-on-one when patient is not suicidal, stealing personal belongings, and sending patients home when they are not prepared to be discharged.

The complaint states that a patient in the Behavioral Health Unit at Methodist Medical Center received inadequate care, including not being allowed to participate in treatment, being lied to about treatment, and having a one-on-one when patient was not suicidal among others. The hospital staff maintained that the patient was very suspicious and untrusting of the staff. The documentation that the HRA reviewed supports this statement and the HRA found no evidence that supported the complaints, except in the complaint that the staff would not tell the patient about her treatment. According to the complaint, the patient was not told about her treatment for two days, which the HRA cannot substantiate, but the staff did not tell the patient that she was pregnant for approximately 14 ½ hours from the time that they discovered the pregnancy and treated the patient with medication during that timeframe. The staff made this decision because of the patient's emotional state when she entered the ER as they did not want to agitate her further, but at the same time, the patient was not allowed to make an informed decision about treatment based on her condition. Also, the patient was given medication during that time frame that she may have refused knowing she was pregnant. The Medical Patient Rights Act states that it is the patient's right to receive information about his/her condition and proposed treatment and be able to refuse that treatment (410 ILCS 50/3) and the Federal code states that a patient has the right to participate in the implementation of their care (42 C.F.R. § 482.13). Because of the delay in fully informing the patient of her condition which subsequently impacted her rights related to informed consent, treatment planning participation and treatment refusal, the HRA **substantiates** the complaint. The HRA only substantiates the aspect of the complaint that a patient was not allowed to participate in her treatment because she was not informed of her pregnancy. The HRA offers the following **recommendations:**

- Follow the Medical Patient Rights Act and fully inform patients of their conditions in a timely manner to ensure rights associated with informed consent, treatment planning participation and treatment refusal

- Create policy and procedure that assures patients the opportunity to be completely informed of their condition before treatment begins so that they may have the opportunity to refuse treatments based on their condition. Educate staff regarding requirements and policy/procedure.

The HRA also offers the following **suggestions:**

- There seemed to be mixed messages and confusion in the documentation as to why the one-on-one was used and when the one-on-one was implemented. The HRA reviewed a suicide assessment document that stated the individual was a high suicide risk but in the treatment plan, it is noted that the patient was going to remain on one-on-one observation until she could change her behavior, not be so argumentative and learn to cooperate with the staff. The quote in the treatment plan sounds as though the one-on-one is possibly not being used as a suicide precaution. Also, the patient's rights restriction notice only has the sentence "placed on suicide precautions" but does not state that a one-on-one is part of those precautions. The document gives no detail as to the reason for the suicide precautions The HRA strongly suggests adding exact detail to the rights restriction form regarding what actions are being taken to restrict the patient's rights. The HRA feels that, according to the documentation, the one-on-one was possibly being used in response to

the patient's argumentative and noncompliant behavior and interactions; if so, this approach could be considered punitive and contradictive to the right to treatment in the least restrictive environment. The HRA strongly suggests that this practice be eliminated and the staff be educated on not using the one-on-one supervision in this manner.

- The one-on-one did not seem to be a part of the original suicide precaution and was added later. Because the rights restriction notice is vague, the one-on-one looks as though it was added to that rights restriction when it probably should have been its own rights restriction. The HRA strongly suggests that when there is an additional rights restriction added, a new document be completed for that restriction.
- In reviewing the 5 Day Discharge document and the treatment plan, the HRA saw that the discharge document was signed a day after the patient first requested to be discharged. The HRA suggests that the facility educate staff in starting the requested discharge process for a patient immediately upon request.
- The HRA is concerned by the statement made in the treatment plan that the patient is unable to fully understand explanations about her medications. The HRA questions the patient's capacity to understand the medication based on the statement. Although the HRA did not request documentation regarding capacity, there was also no capacity statement reviewed in the documents that were reviewed. The HRA suggests that the facility ensure that they are following the Mental Health Code and Developmental Disability regulations requiring decisional capacity statements by physicians when administering psychotropic medication (405 ILCS 5/2-102).

Complaint #2 -Communication rights violations, including lack of privacy, impeded phone calls, lack of communication with individuals outside of the hospital.

The complaint states that there is no record of disclosure for people to know about the patient's situation in the hospital, a patient was not allowed to talk to her husband and phones were shut down during group time. The facility does have phone rules, such as phones being shut down during group and phone calls will last only 10 minutes. The complaint also stated that a phone cord will fall out of the phone and interrupt calls and staff watched and listened as the patient made phone calls. Even though an interruption was witnessed by this writer, there is no evidence that the phone cord fell out of the phone, just that the call was interrupted somehow, and when the HRA toured the facility, the phone cords were not loose. The call could have even been interrupted by the patient's actions. This writer did hear a nurse speaking to the patient while she was on the phone and there is documentation that the nurses knew about the patient calling the patient advocate and the Guardianship and Advocacy Commission, which indicates that the phone calls being made are not private. During the staff interview, it was said that the patient was loud when talking and could have been quieter if she wanted privacy. With that being said, it is the patient's choice to be loud and, if a nurse accidentally overheard a conversation, it could have been ignored and not documented in the patient's treatment plan, which in and of itself makes the conversation public due to the hospital staff viewing the document. Additionally the proximity of the phones to the nursing station and phones being in a highly trafficked area do not lend to the conversation being private. The staff stated that the patient can have a private phone call if requested, but the HRA would like to point out that privacy is a guarantee in the Mental Health and Developmental Disabilities Code without having to make requests for privacy. Regardless. The HRA also saw that the patient was able to communicate with individuals outside

the hospital via phone and even had visitors at the hospital. The patient also rescinded a release to give individual information and did not sign a second form; therefore some communication was blocked because of the patient's actions. The impeded phone call and lack of communication with individuals outside of the hospital parts of the complaint are not substantiated but the lack of privacy aspect of the complaint is **substantiated** due to the fact that there is evidence that the staff knew at times knew who was being called and what was being said. The HRA offers the following **recommendations:**

- During the interview with staff, it was said that patients are allowed to use a private phone when requested. In accordance with the Mental Health and Developmental Disabilities Code, privacy is already a guarantee and should not have to be requested. The HRA recommends that the facility assure that patients are allowed private communications per the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-103).
- The HRA would also like to remind the facility that the hospital is regulated by the Health Insurance Portability and Accountability Act (HIPPA) but the patients are not regulated by the Act. Although it is understood the hospital does not want the patients to indentify that individuals are patients on the unit, the facility also needs to understand that the patients are not healthcare providers and censoring their phone conversations for patient names is verging on excessive controlling and also an additional responsibility for the facility staff.

RESPONSE

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

Methodist

January 24, 2012

Ms. Meri Tucker
Guardianship & Advocacy Commission
Peoria Regional Office
401 Main St., Suite 620
Peoria, IL 61602

Re: Case # 11-090-9022

Dear Ms. Tucker:

Thank you for giving us the opportunity to respond to the above listed complaint filed with the Guardianship & Advocacy Commission. We have thoroughly reviewed the report, and we appreciate the thoroughness in which the commission's evaluation was done.

Please be advised that we take all complaints and grievances very seriously, and that we work to improve the services we provide. We would ask that our response be made part of the public record.

In response to the substantiated part of the above mentioned case, we have completed the following steps:

- Behavioral Health staff and psychiatrists have been educated on the need to inform patients of their conditions in a timely manner. Staff was educated in October 2011; psychiatrists were educated in December 2011. In addition, the Emergency Department physicians were educated in January 2012.
- Staff was also educated in October 2011, about the need to allow private conversations for our patients. Please note that there may be some cases that we cannot allow this due to requests from law enforcement agencies, to ensure compliance with a restraining order, or for patient safety purposes. In those cases, we would discuss this with the patient and issue a restriction of rights.
- Regarding the concern about HIPAA (Health Insurance Portability and Accountability Act) regulations: all staff members receive training about confidentiality (HIPAA and the Confidentiality Act as it applies to behavioral health patients). In this particular case, they were being overly cautious in trying to protect other patients' right to confidentiality. While good intentioned for the other patients, the manager and I clarified for the staff at the time this occurred, that the hospital staff was not responsible for the individual patient's behavior in giving out other patients' names. We subsequently reviewed this with all staff in October 2011.

We also appreciate your suggestions, and we are working to improve these points. As you noted, there was some confusion in the documentation as to why the one-on-one was used. Please be assured that one-on-ones are not used for patients who are argumentative or uncooperative, so that did not occur with this individual. We use case examples to help staff learn ways to improve their documentation, so it is helpful to have this example. We continue to educate staff on the need for specific documentation on all forms and in their general charting. Staff was also reminded to start the requested discharge process upon the patient's request. We continue to address the decisional capacity statements as well.

Again, thank you for this opportunity to address your concerns and to make improvements in the care we provide. Please do not hesitate to contact me if you have any questions or need any additional information.

Sincerely,

Dean Steiner, LCPC
Director, Behavioral Health Services