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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 11-090-9043
Methodist Medical Center

INTRODUCTION

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

1. Communication rights violations
2. Inadequate discharge process regarding 5 day discharge procedure
3. Forced medication without cause and without a rights restriction
4. Right to personal funds violation, patient was not allowed to have money in wallet
5. Patient was told he could review a copy of the Mental Health and Developmental Disabilities Code (MHDDC) to review rights and requirements and facility never provided a copy although they agreed to
6. As part of treatment and treatment planning, facility agreed to provide an interpreter for patient's wife during sessions but did not provide the interpreter
7. Confidentiality violation

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; most patients reside in Peoria, Tazwell, Woodford, and Fulton Counties. The Behavioral Health Program 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, nurse's aides, activity therapists, and psychiatrists. The Methodist Medical Center also offers other mental health programs such as a partial hospitalization program and an outpatient mental health clinic for children and adolescents.

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

COMPLAINT STATEMENT

The first allegation in the complaint is that a patient had restricted telephone rights and the facility did not follow through on the procedure for a rights restriction. The patient's rights were reportedly restricted for making inappropriate phone calls and his rights were restricted by a nurse. The facility states the [Sheriff's department] called the facility to ask the patient not to call again. The patient reportedly did not say anything rude to the Sheriff's department and the patient claims that they did not ask him to not call back. The restriction stated that the patient was to not use the phone indefinitely. The facility also did not tell the patient that he had an option to send the copy of the restriction to someone else. Beginning on the 30th of the June, the facility kept a phone log of calls that the patient was making and began telling him who he could or could not call. The patient could not receive any calls on the community phone and to make calls, he had to use the phone at the nurse's station. The nurse would dial out for the patient and listen while he was talking. There were times when he was not allowed to call his lawyer and there was a blanket statement that he could not call law enforcement. While the patient was talking to the HRA, hospital staff reportedly made the patient hang up and call back from the nurse's station.

The second allegation states that a patient entered a facility on a petition, but was allowed to admit himself voluntarily. In the process of admission, the facility did not speak to him about his voluntary rights. The patient requested a 5 day discharge and was allegedly told that the discharge was going to be a 13 day process. Staff said that he had to go to court which is only in session on Wednesdays. The 5 day discharge document was signed on the 28th, which was still only 8 days before the next Wednesday.

The third allegation is that the patient's right to refuse medication was restricted without a rights restriction notice. Late in the evening, staff woke the patient to take medication. The staff said that the physician wanted to give him Haldol and Ativan, and staff asked if he wanted a shot or a pill. The patient said that he didn't need them, but the staff persisted that he did. The patient then said that he had to call his attorney but then changed his mind and said that he would take the pill but the nurse explained that it was too late and staff had already decided to give him a shot. The patient was also told that if he did not want to take the medication, then he would be in the facility longer. Staff also allegedly attempted to physically threaten him to take the medication.

The fourth allegation is that the patient was not allowed to retain his personal property. The patient had five dollars in his wallet and he was made to put the money in a safe.

The fifth allegation states that the patient was told that he could read the Mental Health and Developmental Disabilities Code (MHDDC) and the facility never followed up on allowing the patient to read the Code. The patient requested the MHDDC on the 29th in the morning and still had not received it as of 2:30pm on the same day.

The sixth allegation states that the facility told a patient that there would be a Mandarin interpreter for the patient's wife but an interpreter was never provided. The patient's wife sat through two meetings without an interpreter. The complaint alleges that it was the hospital's idea that the patient's wife has the interpreter.

The final allegation is that the facility staff met with the patient's wife and mother without a release and would not tell the patient what was discussed, which is a violation of the patient's confidentiality.

INTERVIEW WITH METHODIST MEDICAL CENTER STAFF (9/30/2011)

The HRA began the review of the complaints by interviewing the Methodist Medical Center staff. He was brought to the facility involuntarily as far as transportation and once he was admitted into the facility, he signed into the facility voluntarily. The patient was brought to the facility because of delusions. His diagnoses were Bipolar Type 1 and Mania. The staff explained that hospitals will sometimes consider a patient as involuntary in order to be transported a distance and, when the patient arrives at the hospital, the patient's admission status can be changed which is what occurred in this situation. The facility also stated that the patient was given his rights and he signed them. The patient also signed the voluntary admission form listing all the voluntary rights on the back of the form.

The facility explained that the patient signed a 5-day request for discharge form around 11pm on the 28th and the patient was discharged on the 1st. The physician discharged the patient because he felt he had reached his maximum potential. The notice was acknowledged and the facility knew it had five days to go to court or discharge the patient; the hospital determined he was ready to go, so he was discharged. The staff stated that the discharge really did not have anything to do with the 5-day notice being signed. The staff did not know what the patient was told about the 13 day process. It is hard to tell where that information originated but they felt as though it was not from staff. They think maybe because he was there 8 days and had a 5 day, which equaled a total of 13 days, the patient could have thought that it was a 13 day process. There were no court orders other than the first petition. Commitment hearings do only happen on Wednesdays, when mental health court is held at the Methodist facility. When the papers are filed, the hearings always happen when they are supposed to happen and the court comes every Wednesday.

The facility staff explained that the patient's wife did speak English but not as fluently as he did, which is why they requested an interpreter. The patient made the request during a meeting. The clinician left to obtain an interpreter, and by the time he came back, the meeting was ending and the service was no longer needed. The patient's wife attended one family meeting with the patient's mother. The staff was not aware of the need because the patient's wife was speaking English.

On 6/28/2011 the patient used the hospital's Pride Line (hospital complaint number) regarding his confidentiality complaint. He had other concerns but did not want to discuss them on the line. The advocate called and decided the complaint was worth looking into. The complaint was the same as the complaint reported to the HRA. The facility informed the patient that it was investigating the matter, then after the investigation, the hospital's findings were sent to the patient. The patient's concern was a meeting on June 28th with the physician in which he felt that the physician shared confidential information with family members who were at the meeting. The patient had signed a release on the 27th allowing information to be shared with family members. The patient called because he thought he would have a private conversation

with the physician, but the physician only received information about the patient, he did not disclose any confidential patient information. The patient left the meeting with the family and there is no documentation about the patient questioning the meeting; he later spoke to the patient advocate which triggered the investigation.

In regard to the patient not being allowed to call his attorney, the staff were not sure if he had an attorney. They explained that sometimes a patient will say that he/she needs to call an attorney but then do not. Calling an attorney is never restricted unless the attorney asks that a patient not call, but this request is rare. The patient did have a restriction of rights document for not using the phone. In the patient's treatment plan it reads that he was calling the police station multiple times and he was even using both patient phones at once. With the rights restriction, he was allowed to call out, just not to the police. Staff did not monitor the calls but they did have to make sure that he was not calling the police. They would dial the phone and not listen, or dial and forward the call to the other phones. If he received an outgoing call from the wall phone, he could take the call from the wall phone. The staff explained he could have been at the nurse's desk when speaking with the HRA but they did not monitor the call. They can dial from the nurse's station and have the phone ring on the wall. Staff reported that they do not have documentation that he asked for more privacy. He was fixated on calling the police and upset that he could not. He had the delusion that he was a police officer as per staff. He wanted to call the police because he believed that his wife stole his wallet and he had evidence that she stole 4 million dollars from him. The police picked him up because he was saying that he was going to kill his wife, that he was a spy and that his wife needed to be eliminated. The restriction was written into the treatment plan documenting the reason. He saw the documentation for the restriction, according to staff. A physician ordered the restriction rather than a nurse as stated in the complaint. The staff explained that no log was kept of the patient's calls. The sheriff's department called to make the request that the patient stop calling. The staff did not know what he was saying to the sheriff, they just responded to the sheriff's request. The staff explained that the restriction of rights is not specific; it is just a telephone restriction. If he would have told staff that someone abused him or that he was in danger, they would have let him use the phone or would have helped him. The staff explained that the patient was aware of the advocacy telephone numbers which he utilized, so he did feel empowered to exercise his own advocacy. According to the staff, it was explained to the patient that others could be notified of the restriction, in fact the statement is on the form, but he stated that he did not want people to know about the restriction. Staff reported that the rights are explained to the patients. There is no documentation of the patient not being allowed to call his doctor.

The staff stated that when patients are admitted, they are encouraged to put money into a locked storage. The staff said that the patients can have their money and they are only encouraged to do this to prevent theft or loss. If the patients do not want to lock up money on the unit, they can keep it in the hospital safe. An inventory sheet documents when the patient gave the money to the staff and it is dated the day after admission. The inventory is done on admission and the money was inventoried the next day, which indicates to them that the patient decided to give the money to the nurse. There is no reason why they would need money while in the unit. The staff explained that when people are manic sometimes they want to take money, which is another reason why they would want to store money. The staff explained that the money was returned to the patient.

The staff explained that any item that may be considered dangerous would not be allowed on the unit, for example cologne in a glass container or a pocket knife would not be allowed. If there is something dangerous they try to send it home with the family. Deodorant and items like that are kept at the nursing station if they can be broken. If someone is on suicide precaution, they can have nothing. The items that can obviously do harm do not go in the room. If something was brought in and it was causing a problem and they had to take it, the staff would fill out a rights restriction notice. If a patient is on suicide precaution, and their clothes are taken away, staff complete a rights restriction notice.

The staff stated that on one occasion the patient was given forced medication and there was no restriction of rights form completed. Since the facility has discovered this, it has clarified to staff under what circumstances rights restriction forms need to be completed and an in-service about forced medication was held. The staff explained that they did not wake up the patient to take a shot. There was no documentation about oral medication versus intramuscular medication. Staff did not think that the situation described in the complaint occurred. They said if a patient is agitated and staff feel as though he needs a shot, they explain ~~it~~ to him that they are administering medications and provide an opportunity to take the medication. If a patient refuses then the medication may be forced if there are threats or physical assault. Staff offer oral medication for agitation early, and then if the agitation escalates, staff proceed to injections. Each restriction notice is completed on its own separate document. The staff explained that there is no documentation regarding a conversation between the nurse and the patient regarding the complaint.

The staff stated that they do a good job in negotiating and de-escalation with patients when agitated. Security staff are all trained on de-escalation and negotiation. The staff reiterated that, with emergency medication, they offer oral medication, and if refused the hospital has no choice, staff will give the medication intramuscularly. There is no documentation on whether the patient was told if he did not take the medications he would be there longer. If this occurred the staff explained that it would be considered a therapeutic conversation in which a physician may say medication will help the patient and if the patient does not take it, he/she may be there longer. The staff explained that the statement is not used as a threat, just as a general treatment statement. The staff explained that the patient was medication compliant and took Respiredol from the beginning of his time on the unit. The patient also took Depakote. The staff explained that it looked as though he took most of the psychotropic drugs he was given. The one intramuscular drug was the forced medication and it was Haldol and Ativan. The staff said they caught the lack of rights restriction notice when they were made aware of the HRA complaint. The staff said that forced medication is all part of the Crisis Prevention Institute (define acronym of CPI) training.

The staff explained that the patient's rights are posted in the unit. There is no documentation that the patient requested the entire Mental Health and Developmental Disabilities Code to review. The staff explained that there was no documentation of the request or the patient receiving the documentation. There is a signed rights document that was received. The staff explained that if someone did ask, they would make the documentation available.

The staff explained that the interpreter would be involved via a conference call. Depending on the language, it may take longer to find an interpreter but it never takes too long. On discharge, the patient's wife appeared to understand the discharge instructions and the patient even spoke privately with his wife and did not request an interpreter.

FINDINGS (Including record review, mandates, and conclusion)

Complaint #1 - Communication rights violations

The HRA reviewed records and policy dealing with each complaint in the investigation. The HRA began its record review with complaint #1. The HRA reviewed a notice regarding restricted rights, dated 6/27/11 at 21:30, which stated that the right to communicate via telephone was restricted for making inappropriate phone calls. The dates of the restriction are from 6/27/11 and were in place "until further orders." There are no details as to the specifics of the restriction, such as calls must be made from the nursing station. There is no documentation stating the call logs are being kept for the patient. There was also no documentation written within the rights restriction stating that the patient could not call his attorney or any law enforcement within the notice. The rights restriction document also indicates that the individual wished that no one be notified regarding the rights restriction. The rights restriction overall is very vague concerning the details around the restriction.

In reviewing the patient's treatment plan, on 6/24/11 at 10:51, it states "Has been using the phone a lot stating he's been calling his wife, mother and the federal government and everything is confidential. Whispering on the phone." On 6/24/2011 at 10:51 entry into the treatment plan states that the patient is "Angry that he was told to keep his phone calls to a minimum. Has been noted constantly on the phone and even using both phones at the same time. Refusing initially to listen when explained reason about other patients need to use the phone." On 6/25/11, an entry into the treatment plan at 13:30 reads "states that he needs to use the phone to call divorce lawyers, even though it is Saturday and the government. [sic] pt will not disclose what he needs to talk to them about only that it is top secret and confidential." On 6/26/11 at 14:01 the plan reads "remains on the phone a lot and is preoccupied with rules and does not like to be told no." At 6/27/11 at 14:24, which is the date of the phone restriction, an entry reads "Not happy that his phone calls are monitored and he can't be at the desk constantly." Another entry on that date at 20:24 reads "pt upset with the social worker, stating that she didn't meet him in an office and allow him to make a phone call to his attorney." At 22:28 on the 27th, it reads "Phone restriction explained, restriction of rights given." The time that the restriction was given was dated as 21:30.

On 6/28/11, there is a statement in the treatment plan at 13:59 that reads the patient is "Using of phones inappropriately [sic]." Another entry on 6/28/2011 at 17:11 reads "patient answered phone call for another patient and was speaking at length with caller, patient refused to get off phone despite instruction to do so from staff." On 6/29/2011 at 14:27 it reads "continue to monitor phone calls for inappropriateness." On 6/29/11, a note in the treatment plan at 17:55 reads "reinforced to pt phone privileges, restriction on calling police departments, and only one long distance phone call per shift." Another entry from that same day at the same time reads "Angry and argumentative with staff. Preoccupied with legal issues and wanting to call his

lawyer so that he can sue staff for violating his rights. Staff attempted to discuss the restrictions to his rights but he is unable to process limits at this time." The notes do not indicate exactly what restrictions are being discussed. Another note from the same day at 19:11 reads "Staff has explained his restrictions multiple times this evening, Patient advocate visited patient at staff and patient's request." Another note at that same time and date reads "Patient began asking to make many phone calls this shift including contacting the police because he believes that his wife stole his wallet. Staff explained that he was not allowed to call the police and that this in fact is the reason that he was placed on the phone restriction initially. He wanted to know why he cannot call the police. RN explained the police station called several times to request that he not be allowed to contact them any further. Patient became argumentative and irritable. Threatening to sue staff. Requested to contact the Equip for Equality office next, then called the VA hospital for records. At 5pm he requested to contact the patient advocate. RN contacted advocacy for patient." On 7/1/2011, at 12:11, there is another passage in the treatment plan which reads "Up to the desk every hr. requesting his hourly phone call."

The HRA reviewed an Order Confirmation report on 6/27/11 at 21:42 for phone restrictions and the instructions read "All calls to be made at the desk."

The HRA also reviewed a patient rights document, signed by the patient on 6/24/11, stating that "If your rights are restricted, the facility must notify …" and then proceeds to list the individuals that must be notified.

The patient rights and responsibilities policy for the facility reads, in the communication section, "The patient has the right to communicate either verbally or in writing with MMCI staff, visitors and others." The rights of individuals receiving mental health and developmental disabilities services, which was signed by the patient on 6/24/11 reads "You have the right to communicate with other people in private, without obstruction, or censorship by the staff at the facility. This right includes mail, telephone calls, and visits. There are limits to these rights. Communications by these means may be reasonably restricted by the director of the facility, but only to protect you or others from harm, harassment, or intimidation."

A discharge document completed by a physician and dated 7/26/2011 reads "He made multiple calls to the [police department] such that they requested that he no longer call. He was also calling the authorities such as FBI and CIA during his stay." It is noted that the police facility named in the discharge paperwork is different than the facility named in the complaint statement.

The Mental Health and Developmental Disabilities Code states that "(a) Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to . . ." and then the Code proceeds to list entities that would receive a copy of the document (405 ILCS 5/2-201).

The Mental Health and Developmental Disabilities 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" and "(c) Unimpeded, private and uncensored communication by mail, telephone, and visitation may be reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission. When communications are restricted, the facility shall advise the recipient that he has the right to require the facility to notify the affected parties of the restriction, and to notify such affected party when the restrictions are no longer in effect." The same section of the Code proceeds to state that "However, all letters addressed by a recipient to the Governor, members of the General Assembly, Attorney General, judges, state's attorneys, Guardianship and Advocacy Commission, or the Agency designated pursuant to 'An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named', approved September 20, 1985, officers of the Department, or licensed attorneys at law must be forwarded at once to the persons to whom they are addressed without examination by the facility authorities. Letters in reply from the officials and attorneys mentioned above must be delivered to the recipient without examination by the facility authorities" (405 ILCS 5/2-103).

The Code also states that "d) No facility shall prevent any attorney who represents a recipient or who has been requested to do so by any relative or family member of the recipient, from visiting a recipient during normal business hours, unless that recipient refuses to meet with the attorney" (405 ILCS 5/2-103).

Compliant #1 conclusion:

The patient did receive a rights restriction notice on 6/27/11 at 21:30 which stated that the patient's rights to telephone communication was restricted until further notice for making inappropriate phone calls, and there was no further description of what the restriction entailed on the document. As evidence shows, the restriction was not filed by a nurse but rather a physician and that a police department did call the facility requesting that the patient no longer call the department. The documentation indicated that the patient was aware that there was an option to send that copy of the restriction to others. Although the patient had made the allegation that he was prevented from communication with his lawyer, the HRA saw no evidence substantiating that aspect of the allegation. There where statements made that the patient's calls were "monitored" but there was no evidence reviewed by the HRA indicating that calls were logged by the facility. The HRA did witness the patient being told to hang up the community phone to be called back at the nurse's station, but other than the patient stating that the nurse was listening, and the patient's comfort level with the conversation that was being had with the HRA, there was no indication that the nurses were to listen to each call. Regardless, the restriction covers the loss of private phone conversations. What is not indicated in the restriction, and what seems to change throughout the documentation, is what exactly is being restricted. The document indicates that the patient is not allowed to use the telephone, but then there is evidence throughout the documentation of details to the restriction such as the patient using the phone at the nurse's station and the patient being allowed to use the phone once an hour. As written above, the Code states that whenever an individual's rights are restricted, the person responsible for overseeing the individual's service plan will be responsible for "promptly giving notice of the restriction or use of restraint or seclusion and the reason therefore …" (405 ILCS 5/2-201).

Because the actual restriction documented on the restriction notice does not match what was actually occurring with the description in the treatment plan, the HRA finds this complaint **substantiated** and offers the following **recommendations:**

- The Code indicates that the facility must give notice of the restriction and a reason for the restriction, when restricting a patient's rights. The restriction in this case is vague and does not reflect what the restriction actually was. To adhere with the Code, the HRA recommends that the restriction notices be detailed and state the exact restriction parameters. If the restriction changes, then the restriction documentation must reflect the change. The HRA recommends the facility create policy that is compliant with the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-201) and train facility staff in compliance with the Code.
- The Code also states that the documented reason for the restriction (405 ILCS 5/2-201) must "protect the recipient or others from harm, harassment or intimidation." (405 ILCS 5/2-103). The statement that the patient made inappropriate phone calls does not indicate that the facility was protecting the patient or others from harm, harassment or intimidation; although through reviewing the documentation there is indication that the patient was placing harassing phone calls. The HRA recommends that the facility detail a reason for each communication restriction and how it protects the recipient or others from harm, harassment or intimidation when completing rights restrictions forms to comply with the Mental Health and Developmental Code 405 ILCS 5/2-201 and 5/2-103. This issue should be addressed in any new policy developed.
- There is a statement made on 6/25/11 that the patient will not disclose as to why he needs to communicate with his divorce lawyers and possibly a government agency. It is stated that the patent will only state that it is top secret and confidential as to why he must speak with them. The patient is correct and he does not need to explain or disclose why he needs to speak to these individuals because he is afforded the right to private communication in compliance with the Mental Health and Developmental Disabilities Code. (405 ILCS 5/2-103). There is another instance where it is written in the treatment plan that the patient has been calling his wife, mother and the federal government and the patient was whispering on the phone. The fact that the staff knows that he is whispering into the phone is indicating that they are paying a lot of attention to him while he is having a phone conversation, which is violating the patient's communication privacy. The HRA recommends staff be reminded and reeducated that patients are awarded privacy and should not be listened to while communicating and also do not have to disclose reasons why they need to communicate as part of this privacy compliance.
- On 6/27/11, the treatment plan reads that, at 14:24 reads that the patient is "Not happy that his phone calls are monitored and he can't be at the desk constantly." and then later, at 22:28, it is written that the restriction is explained, which is 8 hours later. The time on the actual rights restriction is 21:30 and the time of the order confirmation of the rights restriction is 21:42. The time of 14:24 and the statement that the individual is not happy that his phone calls are monitored indicates that there was a restriction at least 8 hours prior to the actual restriction being in place and explained to the patient. The Code states that individual in charge of the of the patient's service plan shall be responsible for "promptly" giving notice of the restriction (405 ILCS 5/2-201). The HRA is concerned that 8 hours before the patient receives the restriction notice is bordering on violating the

Code requirements. The HRA recommends that the facility educate those responsible for rights restrictions in promptly giving restriction notices to comply with the Code.

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

- Although there is no evidence that the calls were logged, the HRA is concerned by the use of the term "monitored" by the staff. The calls should not be monitored if the person is restricted from communicating via the telephone. This term is dangerously close to the logging of calls that is discussed in the complaint statement. The HRA suggests that although this portion of the complaint was not substantiated, the facility still remind staff that in instances such as this, monitoring calls is not the action being taken but rather the patient is not being allowed to use the phone at all. The patient is not being watched or logged but rather only not allowed to carry out certain acts.
- If staff are to only dial out for recipients on telephone restrictions and then send calls to the patient phones, ensure that this is being carried out to help ensure private communications.
- Although it was not substantiated, the HRA feels that this is an excellent opportunity to review communication rights from the Code section 405 ILCS 5/2-103 regarding attorneys and government officials/agencies with behavioral health staff.

Complaint #2 - Inadequate discharge process regarding 5 day discharge procedure

The HRA viewed a 5 Day Request form that was signed by the patient and dated 6/28/11 at 23:20. According to the treatment plan, the patient was discharged on 7/1/11 which is 4 days later. The HRA saw no evidence that the patient was told that the discharge process was a 13 day process or discussion of the court process and petitions.

The HRA also reviewed the patient's application for voluntary admission, which was signed by the patient. The date of the application is 6/23/11. Part of the admission documentation that was signed reads "You have the right to request discharge from this facility. Your request must be in writing. After you give your request, the facility must discharge you at the earliest appropriate time. This time may never exceed 5 days, excluding Saturdays, Sundays, and holidays, unless it is expected that you are likely to inflict serious physical harm on yourself or others in the near future. If the facility director believes you are likely to harm yourself or others, he/she must file a petition and 2 certificates with the court within the same 5-day period. You will then have a hearing in a court and the court will determine if you must remain at the facility."

In reviewing the patient's treatment plan, on 6/23/11 at 16:26, there is a note that reads "Pt feels that he shouldn't be here." 6/24/11 at 15:16 there is a notation that the patient "Says that he's just ready to go home." Another note on 6/26/11 at 22:39 reads "States that he has been lied to because his doctor told him when he was admitted, he may be leaving in 3 days, and he has not left. When writer pointed out that was an estimate, not a statement of fact, patient still said 'but he lied'." On that same date, at 14:24, a note reads "Not happy to be here. Believes his doctor is a federal officer reason why he's being held here." Another note on the same date at

20:24 reads "upset about being in the hospital states that he was told that he would only be here for three days, upset b/c states he is being held here against his will … denies any racing thoughts or need to be here … demanding at times, upset he is still in the hospital and feels that he is been held against his will [sic]." On 6/28/11 at 13:59 a note reads "Angry with being in the hospital. Wanting to leave."

On 6/29/11 at 15:29, the treatment plan reads "Writer present for Family Meeting involving [physician], mother, wife, and [patient] at [patients] request. [Patient] expressed desire to 'discuss (his) 5 Day Request in the presence of (his) family.' Writer and [physician] explained this process, it was explained to him that court would most likely be scheduled for 6/13/11 [sic] if [physician] did not believe him ready for discharge." There are also examples in the rest of the treatment plan, after the date of 6/29/11 where the patient expresses that he should not be in the hospital, he should be able to leave, and he was lied to about only staying at the hospital for three days.

The Mental Health and Developmental Disabilities Codes reads "A voluntary recipient shall be allowed to be discharged from the facility at the earliest appropriate time, not to exceed 5 days, excluding Saturdays, Sundays and holidays, after he gives any treatment staff person written notice of his desire to be discharged unless he either withdraws the notice in writing or unless within the 5 day period a petition and 2 certificates conforming to the requirements of paragraph (b) of Section 3-601 and Section 3-602 are filed with the court" (405 ILCS 5/3-403). In reference to the voluntary admission form, the Code states " (b) The written application form shall contain in large, bold-face type a statement in simple nontechnical terms that the voluntary recipient may be discharged from the facility at the earliest appropriate time, not to exceed 5 days, excluding Saturdays, Sundays and holidays, after giving a written notice of his desire to be discharged, unless within that time, a petition and 2 certificates are filed with the court asserting that the recipient is subject to involuntary admission. Upon admission the right to be discharged shall be communicated orally to the recipient and a copy of the application form shall be given to the recipient and to any parent, guardian, relative, attorney, or friend who accompanied the recipient to the facility" (405 ILCS 5/3-401).

Complaint #2 Conclusion:

Due to the fact that the request for discharge procedure was stated on the voluntary application form per the Code (405 ILCS 5/3-401) and the patient did submit a written discharge statement which is also compliant with the Code (405 ILCS 5/3-403), and because the HRA saw no evidence that the patient was told the discharge was going to be a 13 day process, the HRA finds this complaint **unsubstantiated** but **suggests** the following:

- There was debate with the HRA on whether to substantiate this complaint due to the fact that the patient requested discharge and stated that he did not want to be in the facility multiple times before a 5 Day Discharge document was actually signed by the patient. Ultimately, the complaint was not substantiated due to the language of the Code only stating that the discharge request had to be in writing and vagueness regarding hospital staff's responsibility regarding providing the patient with the 5-day request for discharge documents or assistance with the documents. The HRA feels that, because the patient

may not be familiar with the process of discharge, it should be the responsibility of the staff to remind a patient that is making requests to be discharged or stating that they no longer want to be at the facility and that the process requires them to make the statement in writing. This does not appear to have immediately happened in this instance as the treatment plan has examples of the patient requesting discharge and stating that he no longer wanted to be at the facility. The HRA strongly suggests that Methodist Medical Center take the approach that, when a patient states that they want to leave the facility, the staff remind the patient of the discharge process and requirements.

The HRA also **suggests** the following:

- In this instance, the patient was given an estimated time of discharge of 3 days, which was not accurate and the patient focused on this estimate and was angered by the inaccuracy. The HRA by no means would suggest that the facility stop estimating discharge dates to the patients but, because of this instance and other situations that the HRA has reviewed regarding discharge estimates, the HRA feels that when discussing discharge times, it should be clearly explained to the patient that the dates are only estimates. The HRA suggests that this statement be provided to the patient in a written format so they have a point of reference regarding estimated discharge times.

Complaint #3 - Forced medication without cause and without a rights restriction

In the interviews, the Methodist staff stated that they did force medication in an emergency situation but did not follow protocol regarding rights restrictions. In reviewing the patient's medical administration record (MAR) the facility cited a situation on 6/27/11 at 11:32 when the patient was given Haloperidol and Lorazepam in the gluteal for being "loud agitated, not following direction" and "threatening remarks".

The HRA reviewed two rights restrictions documents; one was for telephone communication and one was for privacy due to elopement and aggression precautions.

The patient's treatment plan has no exact mention of the patient receiving forced medication or an incident when the patient was harmful to himself or others. The closest statement regarding the patient being forced medicated reads, on 6/27/11 at 20:24, "says he feels fine except for he states his rights have been violated b/c of him having to receive meds earlier in the day, claims he was only given meds b/c it was a powertrip by the nurses, 'they just want to control me.'" Another statement, as mentioned above, reads "phone restriction explained, restriction of rights given, med ed given & print out on Daxepin given to pt."

The HRA saw no other evidence of forced medication in the documentation that they reviewed and no evidence of an incident between the patient and staff as described in the complaint.

The Mental Health and Developmental Disabilities Code reads "The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited

to medication or electroconvulsive therapy. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available" (405 ILCS 5/2-107).

Also see 405 ILCS 5/2-201 cited in complaint #1 regarding rights restriction.

Complaint #3 Conclusion:

Due to the fact that the facility forced medication on a patient and did not follow protocol for the action that is cited in the Mental Health and Developmental Disabilities Code 405 ILCS 5/2-107 and 405 ILCS 5/2-201, the HRA finds this complaint **substantiated.** The HRA would like to state that in a previous report for case #11-090-9025, the following recommendation was made:

"Follow the Mental Health Code regarding emergency medication administration. In reviewing the documentation, the HRA feels that the process for restricting the right to refuse medication needs reviewed by the facility to comply with the Mental Health and Developmental Disabilities Code. As it stands on the documents, the reasoning for the 12/30 rights restriction is not clear and being threatening and agitated without further description does not indicate the need to prevent serious and imminent physical harm (405 ILCS 5/2-107 and 405 ILCS 5/2-201) and therefore is in violation of the Code. The HRA recommends that the facility create policy regarding rights restrictions and forced medication procedure that adheres to the guidelines of the Code and educate staff in these guidelines. The HRA also recommends when restricting rights, the facility document a very detailed description as to why the rights have been restricted on the rights restriction document not only for the hospital but also for the individuals or agency that the patient may want to receive the documentation."

On 11/15/11, the HRA received a response from Methodist Medical Center regarding the case which the HRA accepted at its 11/16/11 meeting but requested further evidence of staff attending an in-service. On 11/17/11, the HRA regional coordinator received the evidence and was told that they would receive a sheet of attendance for a future psychiatrist meeting dated 12/5. The incidents in this report occurred prior to the facility following the recommendations of report 11-090-9025 on the date of 6/27/11 and therefore, forced medication issues that occurred within this complaint were reviewed and resolved with that report (the in-service trainings occurred in the month of 10/11). Due to the fact that these issues have been addressed by the facility in a previous report, the HRA does not offer any further recommendations.

The HRA does offer the following **suggestion:**

- Aside from the lack of rights restriction, the HRA is concerned that there was an emergency incident but yet no real record of the incident even appeared in the patient's treatment plan or in any other documentation. The treatment plan is an important part of the patient's recovery and emergency incidents should be logged in the plan in some manner as a record to assist the patient and so that those involved in the patient's care know that an incident occurred. The HRA suggests that the facility review the

importance of logging and documenting emergency incidents with staff with emphasis of the importance of adding the documentation to the treatment plan.

Complaint #4 - Right to personal funds violation, patient was not allowed to have money in wallet

The HRA reviewed a valuables inventory that was filled out on 6/24/11 which stated that the patient had given $5 to the staff on that date at 22:45. The individual was admitted on 6/23/11. On the back of the form, it was stated that the individual received the money back on 7/1/11.

In a document titled BH Admit Assessment, it reads in the belonging inventory section that there was cash, a driver's license, and a wallet with the patient. At 16:31 on that same date it reads that the individual refused to give cash to staff.

In the legend charting section of a facility flowsheet, it reads that on 6/26/11 at 12:11 the "Patient at the desk requesting to have 10.00 from her money [sic]."

In the patient rights statement, that was signed by the patient on 6/24/11, it reads that with property, "You are entitled to receive, possess, and use personal property unless it is determined that certain items are harmful to you or others. When you are discharged, all lawful property must be returned to you." In the Money section, it reads "You may use your money as you choose, unless you are under the age 18 or prohibited from doing so under a court guardianship order." In the Banking section, it reads "You may deposit your money at a bank or place it for safekeeping with the facility."

The patient handbook for the behavioral health unit reads "The hospital will not assume responsibility for any money or valuables lost or stolen. For that reason, we ask that you deposit all valuables in the locked area on the unit or send them home with relatives. The receipt for your valuables will be kept in your chart." The section regarding property does not mention money. In the personal belongings section, it reads "MMCI can not be responsible for lost, misplaced, or stolen items." Money and property is not mentioned in the rights section of the handbook.

On 6/29/11 at 20:38, the treatment plan reads that staff asked a physician to "inform her that she needs to make sure every item she brings to the patient is given to staff at the desk for inventory before giving it to him …"

The Mental Health and Developmental Disabilities Code reads "A recipient of services may use his money as he chooses, unless he is a minor or prohibited from doing so under a court guardianship order. A recipient may deposit or cause to be deposited money in his name with a service provider or financial institution with the approval of the provider or financial institution" (405 ILCS 5/2-105).

Regarding personal property, the Code reads "Every recipient who resides in a mental health or developmental disabilities facility shall be permitted to receive, possess and use personal property and shall be provided with a reasonable amount of storage space therefor,

except in the circumstances and under the conditions provided in this Section. (a) Possession and use of certain classes of property may be restricted by the facility director when necessary to protect the recipient or others from harm, provided that notice of such restriction shall be given to all recipients upon admission. (b) The professional responsible for overseeing the implementation of a recipient's services plan may, with the approval of the facility director, restrict the right to property when necessary to protect such recipient or others from harm" (405 ILCS 5/2-104).

Complaint #4 Conclusion:

Although it looks as though the patient did give the facility money, there also seems to be some evidence at some point that the patient did have money and was allowed to refuse to have it inventoried. Due to a lack of evidence that the patient was not allowed to have money while on the unit, the HRA finds this complaint to be **unsubstantiated** but offers the following **suggestions:**

- It looks like an inventory was done and more items were brought into the facility by the patient's family that, even though there was discussion, never actually made it into an inventory. The HRA suggests that if items are taken from patients, the staff assures that the items are recorded in the patient's inventory, even if the items are only kept at the nurse's station for the patient's use. This ensures that if items are lost, the facility knows that they are lost and what exactly has been lost.

Complaint #5 - Patient was told he could review a copy of the Mental Health and Developmental Disabilities Code to review rights and requirements and facility never provided a copy although they agreed to

In reviewing documentation, the HRA saw no evidence that the patient requested a copy of the Mental Health and Developmental Disabilities Code to review. As stated in complaint #1, the patient signed a patient's rights document on 6/24/11, indicating that it was at least presented to him for review. The HRA found no evidence in the regulations that a facility must provide the patient with the entire Mental Health and Developmental Disabilities Code upon request. The Code does state "(a) Upon commencement of services, or as soon thereafter as the condition of the recipient permits, every adult recipient, as well as the recipient's guardian or substitute decision maker, and every recipient who is 12 years of age or older and the parent or guardian of a minor or person under guardianship shall be informed orally and in writing of the rights guaranteed by this Chapter which are relevant to the nature of the recipient's services program. Every facility shall also post conspicuously in public areas a summary of the rights which are relevant to the services delivered by that facility" (405 ILCS 5/2-200).

Complaint #5 Conclusion:

Due to the fact that there is no evidence that the patient requested and was denied the Code and because there are no requirements stating that the Code must be provided upon request, the HRA finds this complaint **unsubstantiated.** Regardless, the HRA encourages the unit to provide patients with the Code if requested.

Complaint #6 - As part of treatment and treatment planning, facility agreed to provide an interpreter for patient's wife during sessions but did not provide the interpreter

The HRA reviewed the patient's treatment plan which, on 6/29/2011 at 15:29 reads "[Patient] requested interpreter for his wife when she was asked for her input. Writer went out to obtain an interpreter, but when returned, the meeting was finishing and [patient] did not broach the subject again." Another passage, on 6/29/11 at 20:41 reads "Patient has requested a Mandarin interpreter for her [patient's wife] and [physician] agreed to relay messages to her for staff." There is also another passage on 7/1/11 at 15:14 which reads "Her [patient's wife] English was broken and difficult to understand at times." The HRA requested clarification from the facility regarding these passages and it was explained via email that in the 20:41 passage, the staff member documented the patient's earlier request for an interpreter and that it was not a second request. The staff also explained that a physician was able to speak in Chinese and communicate with the patient's wife about and the staff requested that he relay the process of bringing personal belongings to the patient.

The MHDDC reads "(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan" (405 ILCS 5/2-102 a). The Code also reads "A qualified professional shall be responsible for overseeing the implementation of such plan. Such care and treatment shall make reasonable accommodation of any physical disability of the recipient, including but not limited to the regular use of sign language for any hearing impaired individual for whom sign language is a primary mode of communication. If the recipient is unable to communicate effectively in English, the facility shall make reasonable efforts to provide services to the recipient in a language that the recipient understands" (405 ILCS 5/2-102 a-5).

Complaint #6 Conclusion:

The HRA found no evidence within the documentation that the patient was denied an interpreter and, because of this, finds the complaint **unsubstantiated** but offers the following **suggestion:**

- Prior to receiving clarification, the HRA thought that the 6/29/11 passage at 20:41 indicated that the patient made a second request for an interpreter. There was also some confusion and a lack of explanation regarding the physician speaking Chinese. The HRA feels that because this is the patient's treatment plan, which is an integral part of the patient's recovery, that the communication in the plan should be clear and concise. The HRA suggests the facility stress to staff members that the treatment plan be written clearly so that other staff are able to understand occurrences with no confusion and, thus, further the patient's treatment.

Complaint #7 - Confidentiality violation

The HRA reviewed a document titled "Authorization to Release and Request Information" that is signed by the patient and dated on 6/23/11 that authorizes an individual (who is later stated as his wife) to be authorized to know the patient's location. Another release form, dated 6/27/11 names the patient's parents as having access to records (intake data, psychiatric history/evaluation, treatment/discharge summary, etc.) for the purpose of family involvement. Another release, with the same date of 6/27/11 is signed by the patient for his wife to have access to the same information plus the patient's recovery plan for the purpose of family involvement and continuity of care. On the date of 6/29/11, there is another release signed by the patient for his mother for the purpose of family involvement. Another form is filled out for his father on the same date. There are no specific times when the consents were signed.

The patient's treatment plan, dated 6/27/11 at 14:37 states "Mother reported she, his father, and his wife, would be present for Family Meeting on Wed. 6/29/11 at 8:30 a.m. … He signed ROIs for parents, his wife and the VA." On 6/27/11 at 20:24 reads "Explained to pt that the social worker would set up a time for the family meeting when she contacted his family. Pt replied 'I rescinded my ROI's for my family b/c I want my care kept private and I am the pivot point I can set up everything.'" On 6/28/11 at 16:22 the treatment plan reads "Writer also talked to him about Family Meeting scheduled Wed 6/29/11 at 8:30 a.m. Writer explored him having rescinded his ROIs for parents, and how this would affect his family meeting. He reported that 'depending how (his) parents act tonight' he would decide if he wanted to redo an ROI for them." On 6/29/11 at 17:55 documentation reads "Called to floor for pt advocate, pt reports that his rights have been violated, that staff is talking to family in regards to his treatment. Had family conference today and permission for wife and mother to be present."

The HRA reviewed a letter from Methodist Medical Center to the patient regarding his privacy complaints. The letter reads "Per your request, one of Methodist's Patient Advocates did speak with you on 6/28/11 and she documented the concerns that you shared with her. It is our understanding that you informed her that you had collected data that would prove that there has been a violation of state and federal law regarding privacy laws. You stated that you heard [physician] speaking to your family (mother, father, and wife) without your permission. You also indicated that you wished to file a complaint regarding this matter." The letter proceeds to read "Your concerns were also discussed with [physician] regarding the incident that happened on the day of admission. [Physician] did talk with your family while you were present in order to obtain additional clinical information and to collaborate the information you had previously provided him. [Physician] was unaware of your concern as you did not deny him access to your family and allowed him to take each person into the interview room alone. [Physician] stated he had received your verbal permission to talk to your family members and that you did not voice any concerns or complaints at that time. The medical record documentation indicates that you had signed a 'release of information' document for your wife at that time to stat that you were a patient at Methodist. There are also signed releases of information by you in the medical record for your parents, wife which you also signed on 6/27/11." The letter proceeds to state that the facility did not believe there was an intentional breach of confidentiality and there were no violations.

In the admission document, that was dictated by the physician who saw the patient in the ER, there are multiple references to the patient's mother making statements about the patient to the physician, but no references to the physician sharing confidential information with the patient's mother.

The HRA saw no further evidence regarding staff discussing information with the patient's family.

The HRA reviewed a Methodist Medical Center policy titled "Use and Disclosure of Protected Health Information." The policy states "It is the policy of Methodist Health Services Corporation ('Methodist') that strict confidentiality of all Protected Health Information ('PHI') is maintained and that this information is only used and disclosed in accordance with federal and Illinois laws that protect such information." Another section of the policy reads "Methodist will only disclose PHI about the status of a patient to family members, other relatives, close friends, care givers and other individuals identified by the patient when: a. the patient is present and does not express an objection to the disclosure when given the opportunity to do so …" The policy also reads "Unless an exception applies, no PHI will be disclosed unless Methodist obtains the written authorization of the patient of the patient's Legally Authorized Representative." The policy also states "A patient may revoke an authorization at any time. To revoke an authorization, the patient must submit the revocation in writing that specifies the authorization to be revoked. A revocation will be effective immediately (unless the patient specifies another date)."

The HRA also reviewed the hospital's "Patient Rights and Responsibilities" policy. This policy states that the patient "can expect, within the law, personal and informational privacy, including the right to … Have his/her medical record read only by individuals directly involved in his/her treatment or who have a 'need to know' and by other individuals only on his/her authorization or that of his/her authorization representative … Expect all communications and other records pertaining to his/her care, including the source of payment for treatment, to be treated as confidential."

The MHDDC reads "(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient" (405 ILCS 5/2-102).

The Mental Health and Developmental Disabilities Confidentiality Act reads " Except as provided in Sections 6 through 12.2 of this Act, records and communications may be disclosed to someone other than those persons listed in Section 4 of this Act only with the written consent of those persons who are entitled to inspect and copy a recipient's record pursuant to Section 4 of this Act . . . The consent form shall be signed by the person entitled to give consent and the signature shall be witnessed by a person who can attest to the identity of the person so entitled. A copy of the consent and a notation as to any action taken thereon shall be entered in the recipient's record. Any revocation of consent shall be in writing, signed by the person who gave the consent and the signature shall be witnessed by a person who can attest to the identity of the

person so entitled. No written revocation of consent shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications" (740 ILCS 110/5).

Complaint #7 Conclusion:

Although there was indication that a physician did speak to the patient's family, first when the patient was admitted, and then later around the time of a family meeting, the HRA found no evidence that confidential information was disclosed from the physician to the family in either instance. Due to the fact that there was no evidence that a violation occurred, the HRA finds the complaint **unsubstantiated** but offers the following **suggestion:**

- In reviewing the documentation, the HRA had two concerns; the release signed for the patient's wife was for the purpose of allowing her to know her husband was at the facility and not a release to disclose information. The letter regarding the internal investigation states "The medical record documentation indicates that you had signed a 'release of information' document for your wife at that time to state that you were a patient at Methodist." The HRA suggests that the facility educate staff on the different types of releases and the corresponding patient information that can be disclosed.

RESPONSE

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

March 19, 2012

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

Re: Case # 11-090-9043

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.

In response to the substantiated parts of the above mentioned case, we are taking the following steps:

Complaint #1

- Restriction notices be detailed with exact parameters: In October 2011, we educated staff on the need for more detailed documentation related to any restriction of rights. HRA's specific note related to the confusing parameters is helpful and we can appreciate how this would cause confusion for recipient. Our next "all staff" meetings are scheduled for the first half of April. We have added this to our agenda, and we will send you a list of staff attendance after that education is completed.
- Detail reason for restriction and how it protects the recipient/others: We will include this in our education planned for April.
- Re-educate staff not to listen to phone calls: We have stressed this to staff in previous education, but will include this in April's education. We will also ensure that staff are aware that recipients of do not have to disclose reasons for their communication.
- In this education, we will also stress the expectation that rights restrictions be given promptly.

We appreciate HRA's suggestions and are reviewing them further., The staff education scheduled for April will provide us an opportunity to focus on communication rights in general. To provide some clarity to the HRA, we do not log our patients' telephone calls.

Complaint #2

A majority of the time, our patients may not be familiar with the process for a 5 Day Request for Discharge, staff is expected to explain that process to them. We used our all staff meetings in January this year to review the 5 Day process, based upon a previous HRA recommendation related to timing. We will use the April education sessions to remind staff that if a patient is talking about a request for discharge, that they should explain the process and offer the patient an opportunity to put that request in writing.

We are considering HRA's suggestion to provide an explanation of estimated lengths of stay to our patients. Currently, our staff consistently explains estimated lengths of stay, but many times, we experience individuals who hear an estimated date (or day of week) and they conclude that the date/day will, in fact, be their discharge date, even if they're not clinically ready for discharge. In those situations, staff helps patients better understand their readiness for discharge by referring to the goals they have established in their treatment plans vs. solely focusing on an actual date/day.

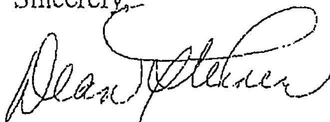
Complaint #3

- As noted above, staff will receive education in April about detailed descriptions for reasons of restricting a patient's rights. We will also re-educate staff to ensure individuals and/or agencies whom the patient has identified, receive this documentation.

We are in the process of creating policies related to restriction of rights as recommended in Complaints 1 and 3 above.

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 my office if you have any questions or need any additional information.

Sincerely,



Dean Steiner, LCPC
Director, Behavioral Health Services