FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 12-090-9017
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. Forced medication when a patient was told by staff that they would either hold the patient down and give medication or he could receive a shot.
2. Inhumane treatment, including a physician making abusive statements towards patients, patients not receiving adequate medical care, and a patient being misinformed about medication that he was receiving.
3. Inadequate treatment, including a patient signing a treatment consent while under the influence of medication and not understanding the document or the ramifications of signing the document
4. Inappropriate rights restriction, including a patient being strip searched without being given a reason for the search and patient being on unneeded suicide watch and not being able to access his property.
5. Inadequate communication of rights, including patients not being verbally informed of their right to refuse medication.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (MHDDC) (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 complaint alleges that a patient was overmedicated while completing paperwork for treatment consent and did not comprehend the ramifications of the paperwork. The complaint alleges that the medication made the patient groggy and a staff member was instructing a patient where to sign the documents even though the patient did not know what was being signed. Also, another staff member strip searched a patient and the patient could not remember a reason for the strip search because of the medication but does not believe a reason was ever given.

The complaint alleges that the patient was in the waiting room of the Emergency Department (ED) when the staff offered a pill for potassium because the patient's potassium levels were low. The patient refused the pill so staff responded by saying they were going to administer a potassium shot but the complaint states that staff lied and gave the patient a different medication. Also the staff stated that they would hold a patient down and make the patient take medication or the patient could cooperate and be injected so the patient agreed to the injection. Also, a patient was told by a nurse that they would go to court if they did not cooperate with taking medication. It was not determined in which department this statement was made.

The complaint also alleges that a unit psychiatrist was present while some patients were having behavior issues and said "What's happening? Dope them up I'm leaving." The complaint also states that patients are not receiving adequate medical care while on the unit, including one patient requesting a cane for a bad leg and being told by staff that he/she would have to see a therapist and another patient having the need for a new cast and that was not received until that patient was discharged. Another patient was reportedly told they were dreaming rather than having hallucinations when the patient complained of having the hallucinations.

The complaint also alleges that a patient was on suicide watch even though the patient did not need the restriction causing the patient to not have access to possessions.

The final complaint alleges that nurses do not verbally inform patients about their right to refuse medication. A patient only knows of one nurse having explained to a patient about this right.

INTERVIEW WITH METHODIST MEDICAL CENTER STAFF (7/10/2012)

The HRA begain the investigation by interviewing Methodist Medical Center staff about the incidents. Staff began the interview by stating it would be usual for a staff member to say that a patient needs to be examined by a therapist before providing them a cane. They also could not think of an instance where a patient would not recieve a cast if needed while at the facility. Staff explained that patients recieve a physical within 24 hours of admission and then physical needs would be determined. If a patient has other concerns after the physical, then they could recieve a consult. If a patient had a physical issue when entering the facililty, they would consult physical therapy upon admission. Staff explained that there is also a daily nursing assessment so if the patient did not have pain upon admission, there are opportunities for the nurse to catch any new issues. If a patient was in a cast, the facility would document the medical information about the cast. Also, the nursing assessment would involve checking the cast and checking for

damage. If a patient felt as though he/she needed a cast, the facility would perform an x-ray. If a patient was stating that they were having hallucinations, staff would try to determine if they are actually having a hallucination or if it was something else occurring. In that instance staff would assess the situation to determine if it was a dream or a hallucination.

Staff explained that documentation does not show evidence of the first complaint. Methodist staff explained that employees have been trained to not threaten. The staff stated the patient did recieve injections in the ED. The patient did not recieve an injection while in the psychiatric unit and also refused medication while on the unit. Staff explained that in the ED, the patient may have recieved emergency medication. The only medication that the patient signed consent for was for Zyprexa and this was signed upon admission. The staff explained that in the emergency room the patient recieved Zyprexa and Myrazapam. The staff explained that the only consents signed were on the inpaitent unit and the nurse who admitted the patient into the unit was the one that was named in the allegation. The patient's admission onto the behavioral health unit started at 5:12pm. The patient was recieved in the ED at 11:06am. The staff explained that because of his manic, psychotic state, they felt that they need to continually follow up with the patient to help him understand the process. The staff stated there was no documentation indicating that the patient was confused by the medication recieved. The staff explained that there is an Emergency Medical Transport (EMT) report that states the patient was showing volitale behavior, hostility, and he was delusional and aggressive. The ED report also stated he was delusional and experiencing psychosis. The patient's diagnosis was bipolar disorder.

The staff stated that the suicide precautions were based on an assessment scale and also his clinical behavior while on the floor. The staff also bases the suicide precautions on the level of stress due to incidents in the patient's life. Staff explained that they do often err on the side of safety with suicide precautions. The staff explained that this patient had suicide precautions ordered because of the patient's significant losses, such as job, foreclosure on a house, a friends suicide and his mother's death. Staff said his thinking was not clear and he was agitated. His significant loss, thinking and behavior made him a higher risk for suicide. Staff stated that the assessment tool is not the only determining factor for suicide precautions and staff are trained to use other factors when assessing the patient. The nurse educator checks periodically to see if staff have been scoring the assessments. Staff explained that they had issues in the past where new staff were not correctly scoring the assessments. Staff said that extensive time is spent on training staff regarding suicide.

Staff explained that when the patient comes to the unit, they are assessed by the nurse and asked to change into scrubs. In the admission process, staff look at the ED precautions they recieve as well as their own. After admission, the staff contact the physician for orders. If the physician orders suicide precautions, the patient's possessions are removed and they are only allowed to wear scrubs. The admission nurse also completes a restriciton of rights document. The admission and assessment paperwork is completed by one nurse. Staff explained that if the patient is not on suicide precautions, his/her clothes are given back. The patient's belongings are inspected for contraband and appropriateness upon admission. Even if they are on suicide precautions, patients can still use personal hygiene items, they just cannot have them in their

rooms. Staff explained that this patient had clothes that were taken away because of suicide precautions but he did not have any personal items aside from clothing.

Staff explained that the patient recieved a rights restriction for suicide precautions but not for medication. Staff also explained that there is not really a strip search for patients upon admission. The patient is asked to take off his/her clothes behind a screen in a closed room where staff check the patient's skin for any injuries or open wounds. Also, with a patient's permission, staff may check the patient's hair. Staff did state that they could see where a patient would describe the situation as a strip search but it is not like a prison strip search. Patients are briefly out of their clothes and this happens with every patient and the patient's are only touched when inspecting their hair and this is with the patient's permission. The entire process is explained to the patients and this includes why the situation is occurring. Staff said that it is probably not documented anywhere that the process is explained to them.

Staff said there is no documentation that the patient was agigated during the body check or that he did not comply. If a patient was agitated, the nursing staff would call a second person into the room and talk to the patient about the need for disrobing and inspection. The staff and patient would remain in the room with the staff until the body check was completed. Staff explained that they have never encountered a situation where they needed to physically disrobe a patient, even with aggressively delusional patients. In those incidents, staff took time to sit with them and talk to them about the process. Staff explained that the admission process often takes the facility some time. Staff said there is mention that the patient was unhappy about not having his property and said that if he did not recieve his property back, he was not going to eat. This occurred a day or two before he went to court.

Staff said that while in the ED, the patient did not sign for medication. The medication given was an emergency but they saw no evidence that the medication was forced. They speculated that he was feeling better once he got to the behavioral health unit because of the medication given in the ED. Staff also explained that he was involuntary admitted into the facility and he went to court where they dismissed the committment petition. When he was admitted, the patient rights were read to him but he refused to sign the document.

Staff explained that the only time the patient would have had medication that effected his mood or cognition was while in the ED. Once the patient was on the unit, he had a medication education sheet and he did consent to some medication. He took two doses of potassium on the unit but nothing else. Staff stated that at 12:41pm the patient was refusing medication while in the ED but then at 1pm he recieved a shot of psychotropic medication; they did not see that a rights restriction form was completed and given to the patient.

Staff explained that a physician has to authorize a shot and there is no mention in the ED documentation of the patient's capacity. The staff stated that there is a psychiatrist form that indicates that the patient was oriented "X4," which means the patient is aware of his name, where he was, the time, and the situation. There was a capacity statement once he was admitted into the psychiatriy unit which was completed by a psychiatrist. The staff stated that, in the admission statement, the psychiatrist noted that the patient said he was willing to take the medication.

The staff explained that, last fall, psychiatric unit staff recieved training based on another case with the HRA that dealt with forced medication. During the training, it was explained to staff that they could not make threats, coerce, or say to a patient that they will go to court if they do not take their medication. They have not had any issues since the training and they have not heard from any patients that there has been an issue. Staff said that there is no documentation that staff said the patient needs to take a pill or a shot. If an incident like that occurred, because they were educated, management would talk to them and provide coaching, counseling or possibly discipline.

As far as discussing a patient possibly being taken to court for medication, staff did feel as though it would be appropriate to talk to a patient about options regarding medication and explain that he could be taken to court for not taking medication. The staff said that conversation would be informative and not treated as a threat. Staff explained that the patient never made a complaint through the facility. There was a note that he wanted to contact the Guardianship and Advocacy Commission but not that he wanted to make a complaint through the facility.

In regard to the physician making abusive statements, staff stated that they would be surprised if statements like "dope them up" would have been made. Also, they explained the the psychiatric unit staff will inform management if they hear statements like what is alleged in the complaint. In that instance, the information would be relayed to the Psychiatric Director and the situation would be discussed with the individual who made the statements. There is no documentation that there were any conflicts with the physician and the patient or that an incident had occurred. The patient requested to see another physician but that would have been on an outpatient basis. The physician who was requested by the patient has admission privileges to the hospital but would not be the physician who would take care of the patient while at the hospital. The physician named in the allegation has never had a formal complaint raised against him. The physician is a psychiatrist so he would have had training in how to deal with patients and abuse. The staff explained that they were unaware of what the physician orientation entails but anything regarding abuse would be covered when a new physician begins at the hospital. Staff also explained that the physicians are aware of the mission and values of the facility and one of the values is that the hospital is patient driven.

Staff explained that patients are read their rights, and they are given a chance to sign the document and then be given a copy of the document. Staff document if they refuse to sign. The rights document states that the patient has the right to refuse medication. Staff explained that the patient should be given a copy of the rights in the ED. The psychiatric unit makes sure that patients recieve a copy of the rights document and have it read to them within 12 hours of the admission. Staff said that the rights are posted on the unit and in the ED. The rights are hung by the nurses' station in a central location (the HRA was taken to the nurses' station and saw that the rights were posted there). Staff also explained that the admission staff provide the patients a handbook and orientation after admission. Staff said part of orientation is providing the patients a telephone number for the hospital patient advocate. Staff explained there is a group orientation for new admissions and this is done typically the next day after admission. All new nurses or people who administer rights go through an orientation on administering the rights and then are observed for a certain time period to assure they are completing the task correctly. The staff

explained that the ED provides the patient with written rights but does not read the rights to the patient.

FINDINGS (Including record review, mandates, and conclusion)

The HRA reviewed documents and records pertinent to the complaints in this report. Upon reviewing documentation and speaking with staff, the HRA combines the first 3 complaints due to the narrative of the incidents that occurred and the relation to the documents that they share.

Complaint #1 - Forced medication when a patient was told by staff that they would either hold the patient down and give medication or he could receive a shot. Complaint #2 - Inhumane treatment, including a physician made abusive statements towards patients, patients not receiving adequate medical care, and a patient was misinformed about medication that he was receiving. Complaint #3 - Inadequate treatment, including a patient signing a treatment consent while under the influence of medication and did not understand the document or the ramifications of signing the document

According to the emergency department (ED) chart, the patient entered the department on 5/31/2012 at 11:06am. At 12:41pm, staff attempted to give the patient potassium and Zyprexa, both of which were refused. At 1:01pm it is stated that the patient received an injection in the right gluteal muscle of Olanzapine as ordered and, at 3:20pm, the patient received an injection of Lorazepam in the right deltoid muscle. There is no description as to any events or situation surrounding the injections and no rights restriction documented. According to the records, 3:20pm was the same time that the behavioral health admission information was provided. The ED chart is the only location where the Lorazepam was mentioned as being given to the patient. The patient's medication consent indicates that the patient signed consent for Zyprexa on 5/31 but there was no consent signed for Lorazepam on any date. The consent form indicated that on 6/1 and 6/3 the patient refused to sign consent for Carbamazepine. On 6/1 there is no signature (patient or registered nurse) for Trazadone, and it seems as though the patient signed a consent for Haldol and Congentin on 6/3, although the signature is difficult to read.

In reviewing the patient's medication administration record (MAR), which covers the date and times of 5/31/2012 at 11:17am to 6/6/2012 11:30am, it states that at 8:59pm,1:26am, and 6:01am the patient took Potassium Chloride, and other than that, the patient refused all other medication. According to the MAR, the times that the patient took the Potassium was when he was in the psychiatric unit and the medication was taken orally. According to the records, the patient did not take Potassium in the ED although it was offered. The Zyprexa and Lorazepam that was administered in the ED did not appear on the MAR that the HRA reviewed. There were no times given for when the patient signed the consent form for the Zyprexa (and no times are required) so there is no indication as to whether the patient was given a shot prior to consent or not, although the Lorazepam was given after the Zyprexa according to the ED chart. The patient signed consent for Zyprexa on 5/31 with no time, and the patient was given Zyprexa at 1:01pm on 5/31 and Lorazepam at 3:20pm on 5/31. There is no evidence of informed consent for the Lorazepam, which is not in compliance with the Mental Health Code. There is consent for general treatment and it is indicated that the patient refused to sign on 5/31/2012.

There are two other consent forms that the patient refused to sign on 5/31/12 and those are the Patient Financial, Information and Insurance Agreement, and a Consent for Treatment form. The Consent for Treatment form is not for specific medication but rather for overall treatment. Therefore, the only form that the patient could have signed while under the influence of medication would have been the consent for Zyprexa that he signed.

The HRA saw no evidence that the patient was, or was not told that he would be held down or staff would give him a shot. The HRA also saw no evidence that a nurse did or did not inform the patient that he would be taken to court if he did not take the medication. The HRA did not see or hear any evidence to prove or deny the fact that the facility told the patient he was receiving potassium but then gave him an injection of another medication.

The medical consent forms themselves state, in a section titled "Patient and Family Participation in the Plan of Recovery" that "I/We have discussed the problems and the goals outlined in this recovery plan …" This consent also is titled "Medications Explanation & Written Information On Side Effects Given."

In the physician's notes, which were dictated on 6/1, it states that the treatment recommendations are Carbamazepine and Trazodone and that the "risks, benefits and alternatives were discussed with the patient. The patient was able to give informed consent." This statement accounts for the patient's capacity although it does not directly state that the patient has the capacity to make an informed decision about treatment. The notes also say the patient is alert and oriented.. The HRA saw no capacity statement for the Lorazepam and Zyprexa that was given in the ED which is not in compliance with the Mental Health Code. While the HRA saw no evidence for or against the allegation that the patient was overmedicated while completing paperwork and did not understand the ramifications, the HRA saw no condition descriptions leading to a capacity determination for the medication taken in the ED.

From all of the interviews and the records reviewed, the HRA found no evidence that the physician named in this complaint made or did not make the statements that were alleged in the complaint. There was also no evidence for or against the allegation that a patient did not receive a cane, that another patient did not receive a new cast, or that another patient was told they were dreaming and not having hallucinations.

The HRA reviewed documentation of an education session that was provided by the facility regarding forced medication. The document reads "Do not use coercion when offering prn medications ('if you don't take your medication, I'll/you'll have to …..') - no threats."

The MHDDC reads "(a-5) If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated. 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 [an emergency]" (405 ILCS 5/2-102).

The Medical Patient Rights Act 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).

Compliant #1and #2 conclusion:

There is no record of the patient taking medication while in the psychiatric unit; therefore there is no record of medication being forced while in the unit. There is record of the patient refusing medication while in the ED but then receiving a shot. There was no evidence as to whether the medication was forced or not forced, therefore, the HRA has no findings that medication was forced on a patient or that the patient was coerced. There was also no evidence that misled the patient regarding medication. The HRA also found no evidence for or against the complaint that a physician made abusive statements towards patients.

It appears as though the psychiatric unit followed all necessary procedures for administering medication to the patient but the HRA has still discovered that there may be a gap in the hospital's procedure for administering psychotropic medication as required in the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) in the ED. The facility's ED did not have a written explanation of side effects for psychotropic medication that was signed by the patient nor was there a written determination of the patient's capacity to make reasoned decisions regarding treatment. When a facility provides mental health treatment, whether it is in a psychiatric unit or stabilizing through medication in the ED, the facility is required to adhere to the Mental Health and Development Disabilities Code. The HRA **substantiates** a violation of the Mental Health and Development Disabilities Code (405 ILCS 5/2-102) in regard to informed consent procedure for psychotropic medication. The HRA makes the following **recommendation:**

- When a patient with mental health needs enters the ED, the ED needs to be compliant with the MHDDC. The Methodist Medical Center ED must follow the MHDDC requirements for informed psychotropic medication consent, including the provision of written side effect information and a written physician's determination of decisional capacity. The HRA requests evidence in the hospital's response that the ED is in compliance with the Code including evidence that the ED staff is trained on the MHDDC.

Compliant #3 conclusion:

In reviewing the documentation, the HRA saw no evidence for or against the complaint that the patient was too medicated to understand signing the consent for treatment document or

the ramifications of the document because there is no time for when the document was signed. The patient also signed consents for medication on 5/31 but there was no timeframe in which the medication was taken and the consents were signed, therefore the HRA finds this complaint **unsubstantiated.**

Complaint #4 - Inappropriate rights restriction, patient was strip searched without being given a reason for the search and patient was on unneeded suicide watch and could not access his property.

The HRA reviewed the tool that the facility uses to assess patients who may have suicidal ideations. The tool is called "Suicide Clues and Behavior Rating Scale" and the patient scored "Moderately Low" on the assessment. The assessment reads that a score of 50 and below has a "low to moderate" probability of suicide.

The HRA also reviewed a rights restriction notice that was given to the patient on 5/31/12 and it stated that the individual had a restriction of the right to "Refuse search of person or living area" and the right "To retain personal property." The reason for the restriction was "Suicide precautions." The form states that the document was delivered in person to the patient on 5/31/12. This indicates that the patient did have a document stating that he had lost the right to refuse a search because of the rights restriction. On the restriction form, there is a statement as to whether the individual wishes for someone to be notified and, in this instance, there is no clarification whether the patient wanted someone to be notified of the restriction or not.

In reviewing the patient's behavioral health admission assessment, there is a belonging inventory on the date of 5/31 that the individual had only pants, long john underwear, shirts, hat, and shoes. In a later belonging inventory, dated 6/1/12, it reads that the patient had 2 pairs of jeans, 2 shirts, 5 pairs of underpants, 5 pairs of socks, and a sweatshirt. The same assessment indicates that there was a body check, the patient was gowned, and the patient's belongings were removed.

The HRA reviewed the documented process that Methodist staff follow for body checks. The HRA was informed that all staff are educated and orientated in the process. The process states to "be respectful and courteous" and to "Offer privacy and dignity." The document also states to "Be aware of past trauma for patient as to not traumatize again." Among other things, the process requires staff to take the patient to a private room, ask them to empty pockets, ask the patient to step behind a screen and take off all clothing and put on a gown, and staff is to "Look at all parts of patient's body." The process also states that the staff are to "Ask patient to lift hair as sometimes patients hide things under or in their hair" and also that "No invasive body searches of orifices are completed." The HRA also reviewed a document titled "Skin Checks" and one document dealing with nurses completing a skin assessment. None of the documents reviewed state that the staff member should discuss why the body checks or skin assessment are occurring.

The HRA did not see any evidence supporting that the patient could not remember the reason for the body check because of being over medicated or that the patient was told or not told why the check was occurring. Within the record, there is not enough documentation to make a judgment regarding the statement; the HRA could not confirm or deny the patient's statement.

The MHDDC 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" (405 ILCS 5/2-104). The Code also reads "(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 …"; the Code then lists individuals who should/could receive the restriction. The Code states that " The professional [involved in the recipient's care] shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefor in the recipient's record" (405 ILCS 5/2-201).

Compliant #4 conclusion:

The HRA reviewed the documentation and saw that the patient was supplied with a rights restriction form which explained that the patient did not have the right to refuse a search. The facility did take the patient's property from him because of the suicide precautions. The HRA does not have the capacity to determine whether or not an individual should have had suicide precautions because of the clinical nature of the suicide assessment. The HRA did determine that the facility completed an assessment and were aware of the patient's level of stressors, and the patient was presented with information regarding his situation with the rights restriction. Therefore, the HRA has found no evidence for or against the complaint that there was an inappropriate rights restriction and finds the complaint **unsubstantiated** but offers the following **suggestions:**

- The reason given for the restrictions was listed only as "Suicide precautions" but the HRA does not feel as though the reason is completely compliant with the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-201). The HRA suggests that the facility complete rights restriction forms in greater detail with regard to suicide precautions to comply with the Code.
- In the interview, staff stated that the only time a patient would be touched during the body check would be if his/her hair was checked. The training document indicates that the patient only needs to hold up hair for the staff to see and the patient would go untouched. Because there seems to be a discrepancy, the HRA suggests the staff review the process to assure that the procedure is being carried out correctly.
- Inform staff of the importance of documenting on the form whether or not the individual chooses to have someone notified of the restriction and remind staff to always ask the patient if they want someone notified of the restriction.

Complaint #5 - Inadequate communication of rights, including patients not being verbally informed of their right to refuse medication.

The HRA reviewed the rights document with the patient's record. The document reads "If you are over 18 and do not have a guardian, you have the right to refuse services, including medication or electroconvulsive therapy (ECT)." In the signature section of this document, it reads "I have explained these rights to the individual (or the guardian of the individual, if applicable) and have provided him or her a copy of it." The document is signed by the staff and it is written that the patient refused to sign the document.

The HRA also reviewed records from previous cases that they had investigated at the facility and discovered that all three had documentation that the rights restriction form was provided to the patient and explained. Two of the patients signed that the rights were explained and provided (11-090-9043 and 11-090-9022) and the third (11-090-9025) stated that the rights were explained but the patient refused to sign the documentation.

In touring the facility, the HRA saw that the patient's rights were posted in the window of the nurse's station, which is a central location to the rooms on the unit.

Also, in reviewing the patient's treatment plan, in a section titled "BH Admission Information," there is a section that indicates that the patient received rights information regarding mental health treatment, admission rights, and rights restrictions.

The HRA saw no evidence that a rights statement was read to the patient or provided to the patient by the ED. The HRA was not provided the ED rights statement that is given to patients but was told that the statement was not given orally. The MHDDC reads "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).

Compliant #5 conclusion:

The HRA saw no evidence indicating that rights are not verbalized to patients in the behavioral health unit. However, the HRA also finds no evidence that the individual was presented rights in the ED as required by the MHDDC (405 ILCS 5/2-200). The HRA finds this complaint **substantiated** and **recommends** that the facility comply with the MHDDC regarding the communication of rights statements and provide the HRA with evidence that the facility has adopted policy that finds them in compliance with the Code and trained staff on the policy.

Because the HRA did not investigate all ED policies to ensure compliance, the HRA cannot definitely state that the department is, or is not, in compliance with the MHDDC as a matter of practice. This report does provide evidence that suggests the department may not be in full compliance with the Code, at least in this case. As an overall suggestion, the HRA asks the facility to review the MHDDC to ensure the emergency department compliance with all aspects of the Code.

RESPONSE

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

Methodist

October 25, 2012

Mr. Gene Seaman
Human Rights Authority
Guardianship & Advocacy Commission
401 Main Street, Suite 620
Peoria, IL 61602

Re: Case #12-090-9017

Dear Mr. Seaman:

In response to substantiated complaint #1 and #2 in the above case, HRA concluded:

> When a facility provides mental health treatment, whether it is in a psychiatric unit or stabilizing through medication in the ED, the facility is required to adhere to the Mental Health and Developmental Disabilities Code.

Methodist disagrees with the above statement for the following reason.

The Federal District Court case of *Threlkeld v. White Castle Systems, Inc., et.al,* 210 F. Supp.2d 834 (2002) addressed the rights of patients undergoing mental health evaluations in emergency departments. In *Threlkeld,* the court held that a patient who had been brought to the Emergency Department of Jackson Park Hospital was a recipient of services and, therefore, entitled to the protections of the Mental Health and Developmental Disabilities Code (the MHDDC). The hospital claimed the MHDDC did not apply because the patient had not been admitted to the hospital at the time the services were rendered. The court held that whether the patient was actually admitted to the hospital was irrelevant as she was being evaluated for a mental illness.

However, in *Threlkeld,* the patient was being seen in the "psychiatric side" of the emergency department. In its discussion, the *Threlkeld* court acknowledged the 1998 Illinois Appellate Court case of *In re Moore,* 301Ill.App.3d 759 (1998) which held that an emergency department is not a mental health facility for purposes of involuntary admission procedures under the MHDDC (that same appellate court reached the same conclusion in 2010). The *Threlkeld* court distinguished in *In re Moore,* however, because the Jackson Park Hospital Emergency Department had a psychiatric side, the psychiatric side of the emergency department was considered to be a mental health facility and subject to the requirements of the MHDDC. Had *Threlkeld* not been on the psychiatric side of the emergency department, it follows that the rights of a recipient of mental health services under the MHDDC would not have attached.

Like the Jackson Park Hospital Emergency Department, Methodist's Emergency Department has both a "psychiatric side" and a "non-psychiatric side" within its emergency department. There is no authority for the proposition that the administration of psychotropic medication will in all cases implicate the MHDDC. We recognize that when a patient is on the "psychiatric side", the MHDDC applies. The purpose of having a psychiatric side of an emergency department is to have available staff trained to follow the MHDDC for recipients of mental health services. Our staff in that area report through our Behavioral Health Services, and therefore are expected to follow the MHDDC. That staff receive any/all ongoing training related to MHDDC issues.

Regarding Complaint #5:
Methodist repeats its response to Complaint #1 and #2 as its response to Complaint #5.

Sincerely,

Dean Steiner, LCPC
Director, Behavioral Health Services

cc: M. DeArmond
A. Howard