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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 13-090-9019
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. Inadequate communication, it was not explained why the patient was transferred to the facility.
2. Patient was told that if a medication was taken, the patient could be discharged but if it was not, facility would pursue a court order for medication.
3. Inadequate discharge process.
4. Communication violation.
5. Inadequate admission process.
6. Inadequate inventory process.
7. Inadequate treatment; patient was not allowed dental or chiropractic services.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (MHDD Code) (405 ILCS 5), the Medical Patient Rights Act (410 ILCS 50/3), and the Centers for Medicare and Medicaid hospital participation standards (42 CFR 482.43).

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 consist 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 allegations state that the patient was transferred to Methodist Medical Center from another hospital in the patient's hometown and it was not explained by Methodist staff why the patient was transferred. Another allegation states that the patient was told that if she did not take Risperdal then she would not be able to leave the facility. It was reportedly explained to the patient if she took the medication then she could be discharged, but if she did not, the facility would obtain a court order for medication. The third allegation states that a patient was not able to select a physician when being discharged from the facility and the patient was given a physician that did not have admitting privileges at the facility and was not located in the patient's hometown. The fourth allegation states that the patient was not explained the communication process, namely that long distance calls could be made. Another allegation states that the involuntary admission process was not explained to the patient and the patient was not given the option of voluntary admission. The complaints also state that while at Methodist Medical Center, patients are not included in the inventory process. The patient's possessions are handed to the patient in a bag when being discharged from the facility, and when you enter Methodist Medical Center, the emergency department (ED) simply takes the bag of possessions and puts it in a locker. While being transferred, the patient lost sunglasses. The final allegation states that the patient was not allowed dental or chiropractic services while at the facility.

INTERVIEW WITH METHODIST MEDICAL CENTER STAFF (3/14/2013)

The Methodist staff started the interview by explaining that they have no contact with patients prior to transfer from another facility. The staff stated that the patient had a diagnosis of chronic paranoid schizophrenia with a possibility for schizoaffective disorder and the patient was on the unit for 5 days. The patient's dates of admission were 12/14/2012 through 12/19/2012. The patient signed in voluntarily when being admitted to Methodist. The patient arrived at the facility at 2:40am and signed a voluntary admission application at 10:55am. Staff said that because the patient was a voluntary admission, her rights regarding the admission where explained to her at admission and the patient never requested a discharge while at the facility.

The Methodist staff explained that there are various reasons for transfer from one facility to another. Sometimes patients are transferred because other hospitals do not have room. Other times there are better services at the facility the patient is transferred to and sometimes facilities will not take patients who are aggressive. At the transferring facility, the patient was seen in the emergency department (ED) and they determined that they could not provide services and then transferred the patient to Methodist. The patient was not admitted at the other facility. The transferring facility did not give the patient a psychiatric diagnosis. The transferring facility had a petition and certificate for the patient.

Staff explained that in this case, the transfer was hospital-to-hospital. The transferring hospital makes the transportation arrangements and the staff speculated that they probably used a state contracted service. Staff said the patient came directly to the unit. The staff said that in reviewing the documents, the patient never asked why she was at the facility. Staff said there were many statements that the patient made indicating confusion. Staff said the patient was oriented to time, place and person but that was probably later that morning after admission. Staff also said there is no signed transfer statement and they are not aware of any hospital using a

transfer statement. Staff said the patient's insight to her mental illness was poor. They did not see any grievances regarding her stay. There was one comment in the records saying she was unhappy with the handling of her property.

Staff explained that if patients inquire as to why they are at the facility, staff will explain the reason to them. Staff explained that in this case, the patient could not even understand what was going on with her own illness. Staff stated that they orient new patients when they are admitted.

Concerning the inventory, staff explained that it is not uncommon for a patient to be confused about what they brought to the hospital. The staff said that they perform an inventory upon admission and in this case, the patient had not brought in sunglasses. Staff said patients are not included while conducting an inventory because of possible safety ramifications such as patients trying to grab items as the inventory is being conducted. The patients are only asked to sign an inventory for valuable items. Staff explained that they log all items and, in this case, they even have a log for a Livestrong bracelet. The patient's belongings are taken when they enter the unit. Staff take the items to a safe location where the property is inspected and then inventoried. The items that are allowable in accordance with the unit policy are given to the patient. Staff said that the patient never even contacted the facility about the missing sunglasses. Staff said that there is no written inventory policy but there is an inventory form that the staff complete upon admission. When a patient is discharged they are provided their property. Staff stated that many patients do not review their property when they leave. In this case, the patient only had the clothes she was wearing and the rest of her belongings were brought a day later by a friend. There was not an inventory sheet that the patient signed.

Staff said that the patient took Cymbalta for Fibromyalgia and Depression. Staff said she took Risperdal on 12/16/2012 and 12/19/2012. Staff explained that the medication was discontinued on the 16th and there was a new order the next day to increase the medication. Staff said the patient did not recieve any forced medication. The Methodist staff said that they did not seek a court order for medication because the patient's illness was not at the level where they felt like they could obtain a court order, so they discharged the patient. The facility felt that the patient was not a danger to herself and her Agent for Power of Attorney (POA) of healthcare agreed to discharge the patient. The staff explained that the psychiatrist would not feel comfortable pursuing a court order because the patient was not aggressive.

Staff explained that the patient's psychiatrist discussed medical compliance with the patient and they encouraged the patient to take medication. Staff explained that they could have possibly discussed legal action if the patient did not take the medciation. Staff said that each practioner would probably approach the situation differently, but if noncompliance is causing a concern, the practioner is expected to explain to the patient that he/she is deteriorating and there is a process to obtain court ordered medication. The staff explained that sometimes there is a problem with this discussion due to the patient's level of functioning and if the patient refuses medication, then the patient may see the conversation as coercive. There is no specific training about discussing court ordered medication with patients because it is assumed that physicians recieve this training during their residencies and also that the physicians should be familar with the laws. Staff explained that the physician would be the only staff member to have a discussion

about forced medication with the patient. Staff said that in this case, the patient told the Power of Attorney Agent during the family meeting that the patient would be medication compliant.

Regarding the complaint about discharge, staff said an appointment was made for a physician in the patient's hometown on 12/24/2012. Staff explained that one of the patient's complaints was that a particular psychiatrist did not have hospital privileges but the psychiatrist's offices were in the patient's home town and not in Peoria. The facility explained that they knew where the patient lived, and they even sent the patient's prescriptions to that town. Staff explained that when providing aftercare, sometimes there are limitations in available physicians based on which physicians are taking new patients and payer source. Staff explained that when setting up aftercare, they try to determine what physicians and services are available and then attempt to set an appointment for the patient. The aftercare process is done before the patient is discharged.

Staff stated that patients are allowed to make long distance calls. Methodist staff explained that they have patients from all over the state and they are not restricted by location. Methodist pays for the long distance calls. Staff did say that they would not allow patients to make long distance calls for no reason. Staff stated that they were not aware that this complaint was a problem. Staff said that the phones are in the hallway, and by attempting to dial out, the patient could have found out that long distance calls were available. Staff said that if for some reason a call would not go through, they would hope that the patient would alert a staff member. Staff said that the patient had no phone restrictions and filed no complaints about phone usage. The patients are given a handbook with the phone policy and they also have an orientation with newly admitted patients. Staff assumed that the patient did make long distance calls because a friend from her hometown brought her clothes.

Staff explained that the patient did not have dental pain. The only pain the patient reported were headaches, leg pain and foot pain. Staff said that there was one statement where the patient discussed a chiropractor but it dealt with a peer's needs. Staff said the only mention of dental work was wisdom teeth extractions. Staff explained that dental services are not normally provided unless there is an emergency. Staff said that there was no need for a chiropractor, the focus would be on pain control and it would be a medical physician that would examine and work with the patient. Staff explained that there is no policy dealing with dental services but they have staff caretakers if needed and they would consult the proper provider. Staff said that there are chiropractors who have privileges at the hospital but the treatment is not something that is usually done in an acute care setting at the hospital. The patient had other pain that was not in her back and was given Ibuprofen, which they were told relieved the pain.

FINDINGS (Including record review, mandates, and conclusion)

Complaint #1 - Inadequate communication, it was not explained why the patient was transferred to the facility & Complaint #5 - Inadequate admission process

Due to the relation between complaints #1 and #5, they have been combined within this report.

In the interview, the facility stated that the patient was confused upon arrival at the facility and also that they have no contact with the patient prior to their transfer to the facility, therefore indicating that the explanation for the transfer is the responsibility of the transferring facility. In reviewing the patient's treatment plan, the HRA read a section dated 12/14/2012 at 9:45 which reads "She has no insight why she is here." Later, on 12/18/2012 at 9:57 the treatment plan states "pt denies having any symptoms of her mental illness. She says she is here b/c 'they made her come in for no reason' pt thoughts and conversation are scattered and appear disorganized." On that same day at 10:03 the treatment plan reads "She says that her family doctor will be here later today to release her and let us know there is nothing wrong with her." Another section of the treatment plan, dated 12/14/2013 reads that "Pt believes she is here because 'it's not ok what's happening to my mother, my nieces, my nephews, and my brother.'" In the Behavioral Health Admission Assessment, dated 12/14/2012 Pt states that she is here to obtain the rest of her OTC [over the counter] medications. PT states that she did not receive all of the medications that she needed when she was discharged from [state operated mental health facility]. Pt states that she is here for medical purposes." On that same day at a later time, it states that her goals for hospitalization are "… to pursue the restoration of my smile and let's just leave it at that."

The HRA reviewed a voluntary application, a petition and one certificate. On the voluntary application, there is a statement that says the individual has the capacity to consent to voluntary admission. On the rights segment of the Petition, it states that the patient was admitted at 2:40am on 12/14/2012 and the application for voluntary admission that was completed and signed by the patient on 12/14/2012 was completed at 10:55am, which occurred before the 24 hours needed for the second certificate.

The HRA reviewed the facility admission policy which does not say that the patient must be allowed the opportunity to sign into the facility voluntarily. The policy does state that all patients must have their rights read to them. One section of the admission policy reads "A Power of Attorney for Healthcare may sign a patient in only if there is a copy of the Power of Attorney for Healthcare and this document has no exception or exemptions written for such admission."

On the petition, there is an explanation of patient's rights for involuntarily admissions and there is a signed statement which indicates that the rights have been explained to the patient and they have received a copy of the petition. The application for voluntary admission reads "I have been informed of the 'Rights of voluntary admittee' as explained on the back of this form. I have been given a copy of the 'Rights of individuals' which states in detail my rights as an individual receiving services." The voluntary admission form is signed by the patient and a psychiatrist.

In reviewing the patient's admission document, there is an indication that a specific individual is the healthcare power of attorney agent but, in reviewing the patient's admission history report, a statement from the patient reads "'I'm not sure that I am prepared to do a specific health care POA at this time. Can we save the information where we are at?'"

The MHDD Code reads "(a) Any person 16 or older, including a person adjudicated a disabled person, may be admitted to a mental health facility as a voluntary recipient for treatment of a mental illness upon the filing of an application with the facility director of the facility if the

facility director determines and documents in the recipient's medical record that the person (1) is clinically suitable for admission as a voluntary recipient and (2) has the capacity to consent to voluntary admission. (b) For purposes of consenting to voluntary admission, a person has the capacity to consent to voluntary admission if, in the professional judgment of the facility director or his or her designee, the person is able to understand that: (1) He or she is being admitted to a mental health facility. (2) He or she may request discharge at any time. The request must be in writing, and discharge is not automatic. (3) Within 5 business days after receipt of the written request for discharge, the facility must either discharge the person or initiate commitment proceedings" (405 ILCS 5/3-400). The Code also reads "§ 3-401. (a) The application for admission as a voluntary recipient may be executed by: 1. The person seeking admission, if 18 or older; or 2. Any interested person, 18 or older, at the request of the person seeking admission; or 3.A minor, 16 or older, as provided in Section 3-502". The application must state in large, bold-faced type the right and process for requesting discharge (405 ILCS 5/3-401).

The Medical Patient's Rights Act establishes "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).

Complaint #1 & #5 Conclusion

The HRA determined that the process for voluntary and involuntary admission was correctly followed by the facility and the patient actually signed voluntary admission documentation under Section 5/3-400 of the Code. In the documentation that was reviewed by the HRA, there was indication that the patient was very confused about why she was at the facility. Although the HRA saw no direct evidence that the staff attempted to explain to the patient why she was at the facility, a copy of the petition that provided an explanation was given to her and there was no further evidence that information regarding her transfer was kept from the patient. Because of these facts, the HRA finds this complaint **unsubstantiated** but makes the following **suggestion:**

- Assure facility compliance with the MHDD Code 405 ILCS 5/3-401 by updating the admission policy to clarify that any adult, at the request of the patient, can sign for a patient *if the patient has capacity and is seeking voluntary admission;* train staff on the policy clarification. The HRA also notes that when a Power of Attorney becomes effective, there is the implication that the patient no longer has capacity which is a requirement for voluntary admission. The HRA suggests that the POA reference in the policy be replaced by the exact Code verbiage and requirements as per 405 ILCS 5/3-401.
- Be sure to ask all patients if they have any questions when providing copies of admission documents.
- There seemed to be some discrepancies in the report as to wheither the patient actually had a POA for healthcare. Be sure to determine if the patient has a POA upon admission, if the POA is active and that this determination is consistent throughout the record.

Complaint # 2 - Patient was told that if a medication was taken, the patient could be discharged but if it was not, facility would pursue a court order for medication

The HRA reviewed the patient's treatment plan which, on 12/19/2012 at 16:07 reads "Pt has not been willing to follow psychiatrist recommendations regarding taking Risperdal. Pt has previously been informed by the doctor that if she did not comply, discharge would be considered. It was felt there would be no further benefit to inpatient treatment without pt taking medication as prescribed. With regard to the medication issue, pt does not meet criteria for involuntary hearing for medication." The treatment plan on the same day proceeds to state that there was a phone conference held with the patient and her friend who encouraged the patient to comply with treatment recommendations and the patient agreed. Later on in the treatment plan, it states that the patient is frustrated with the Risperdone dose. The next day, on 12/20/2012, the patient was discharged from the facility.

In reviewing the patient's medical administration record, Risperdal was taken once on 12/16/2012 and once on 12/19/2012. According to the psychiatric discharge dictation, dated 12/19/2012, it reads "The patient was started on Risperdal medication to address her symptoms of mania. In addition, she appeared to be exhibiting disorganized and tangential thought process. The patient did not take Risperdal for several days; however, following the second day she became noncompliant with the antipsychotic medication stating that 'I don't need this medication.' … By the time of discharge, the patient exhibited minimal disorganized thought process. Otherwise, there were no significant manic or psychotic symptoms that were reported or exhibited by the patient. In addition, she was observed to be able to take care of herself, during the hospital stay including eating meals, sleeping, and taking care of her hygiene. At this point, the patient does not meet criteria for continued admission, as she is not considered a risk or danger to either herself or others. The patient was discharged on December 19, 2012."

The daily physician assessment statement on 12/18/2012 states that the patient refused Risperdal but agreed to take a dosage that night. On 12/19/2012, the notes read "Pt. refused evening Risperdal for the 2nd night in a row. At this time she does not meet criteria for continued admission. She is not currently a danger to herself or others and able to take care of [illegible word]."

The MHDD 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).

Complaint #2 Conclusion

The HRA reviewed relevant documents that indicated the patient was told that if she was not medication compliant, then she could be discharged which is contrary to the complaint. The HRA finds this complaint **unsubstantiated.**

Complaint #3 - Inadequate discharge process

The HRA reviewed the psychiatric discharge documentation which stated that the patient was scheduled for follow-ups. The HRA also reviewed a release for behavioral health records for two separate physicians in the area that the patient lives and the reason for the release is continuity of care. In the treatment plan, on 12/14/2012, it also states "Family/significant other involvement encouraged. Linkage with outpatient mental health services."

According to the patient's discharge instructions, dated 12/20/2012, the patient was scheduled for a follow-up appointment with a physician that was located in the patient's hometown and the patient even had prescriptions sent to a pharmacy in the same city.

The HRA reviewed the facility discharge policy which reads that the facility should "Arrange for home medication, equipment, or treatments as ordered by the physician." The policy also states that the nurse may call prescriptions in to whichever pharmacy the patient would like and that "Other prescribed treatments, procedures, outpatient visits are arranged through the appropriate department."

The Centers for Medicare and Medicaid Services regulations state "The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing … (3) The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post- hospital services and of the availability of the services … (5) The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post- hospital care are made before discharge, and to avoid unnecessary delays in discharge" (42 CFR 482.43)

Complaint #3 Conclusion

Through reviewing the evidence, it was determined that the patient was provided aftercare by a physician that lived in the area where the patient lives. The HRA found no regulations that state a physician has to have admitting privileges to the hospital and, because the physician was in a different city, the physician would probably not have admitting privileges. The HRA finds this complaint **unsubstantiated.**

Compliant #4 - Communication violation

In reviewing patient records, the HRA saw no evidence that the patient was not aware that patients could make long distance calls nor was there evidence that the patient was aware.

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."

The patient handbook reads "Long distance calls can only be made collect or by using a calling card. You may call anywhere in '309' area code without it being long distance." The HRA requested clarification from staff considering this is different than what was stated in the interview and the HRA was told that the facility does pay for all long distance calls that pertain to the patient's treatment plan. Examples of long distance calls the facility would pay for are contact with family members, probation officers, discharge planning.

The MHDD Code reads "Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation" (405 ILCS 5/2-103).

Complaint #4 Conclusion

Because there is no evidence that it was not explained to a patient that she could make long distance calls from the facility, the HRA finds this complaint **unsubstantiated** but offers the following **suggestions:**

- Assure that patients are aware that they are able to make long distance calls if needed.
- Because there seems to be a discrepancy between the long-distance policy and what may actually be occurring, the HRA suggests that facility update their phone policy to prevent patient confusion.
- If staff is inquiring about long distance calls and their nature, the HRA is concerned about maintaining patient phone privacy. The HRA suggest the facility review current practice to ensure privacy.

Complaint #6 - Inadequate inventory process

The HRA reviewed a behavioral health admission assessment which had two belongings inventories. One inventory was dated 12/14/2012 at 6:34 and the other was dated 12/15/2012 at 13:41. No sunglasses appeared on either inventory. There is mention in the patient's treatment plan on 12/14/2012 that the patient's friend is going to bring her some clothes the next day and also on that same date it reads that the patient "Reports that she wants her valuables safe from her roommate's germs." On 12/18/2012 there is a section of the treatment plan that reads "She has made several requests of material items that the hospital does not carry. She asked if staff from the hospital could retrieve her belongings from [city]." Also, in the treatment plan on 12/20/2012 in the discharge plans section it reads that the patient was discharged with belongings.

In reviewing the admission and discharge process, it states that personal items brought into the facility are checked for contraband. The policy also reads "Patient is encouraged to send credit cards, cash, checkbook, keys, bankbook, or medication home with family, or it will be placed in hospital safe or secured on the unit (medication only). Items placed in the safe will be

documented on an inventory sheet with a copy placed in the charge. Home medication may be used only with physician order and verification through pharmacy." The policy reads that "appropriate patient belongings" are labeled and either given to the patient or placed in their basket because personal hygiene items or sharp items are not allowed in their rooms. The policy also states that a "Patient interview and documentation by the unit staff includes" a belongings inventory. The discharge plan reads that the patient's belongings are returned to them on discharge.

The MHDD 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 . . . (c) When a recipient is discharged from the mental health or developmental disabilities facility, all of his lawful personal property which is in the custody of the facility shall be returned to him" (405 ILCS 5/2-104).

Complaint #6 Conclusion

Because there is no evidence that the patient had sunglasses at the facility and no regulation stating that the patient must be involved in the inventory process, the HRA finds this complaint **unsubstantiated.**

Complaint #7 - Inadequate treatment, patient was not allowed dental or chiropractic services

In reviewing the medical assessment dated 12/14/2012, it does confirm that the patient has a history of Fibromyalgia but there were no significant pains at the time and a history of migraine headaches. The facility stated that they will provide pain management for both. Also, in the physician assessment on 12/15/2012 it reads that the patient has "poor dentition." In reviewing the nursing daily assessment, on 12/17/2013, in the pain section it reads "PT states 'well it's either my head or my foot' and then became distracted and switched subjects. Pt told that if she was in pain to notify staff, pt agreeable to this." In reviewing a flowsheet for pain, it does indicate that the patient had pain in the head, right foot, left foot and right leg. There is another section of the patient's treatment plan, on 12/16/2012, which reads "Thoughts are scattered. Difficult to follow what she is trying to tell staff. Talking about some chiropractor she has gone to then talking about the behavior of a peer and what they need." The HRA found no evidence that a chiropractor or dentist was actually requested and restricted by the facility.

The MHDD Code reads "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" (405 ILCS 5/2-102).

Complaint #7 Conclusion

Due to the fact that there was no evidence that dentistry and chiropractic services were requested, the HRA finds this compliant **unsubstantiated.**

- not.