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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 13-090-9022
CHOICES - OSF Saint Elizabeth Medical Center

INTRODUCTION

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

1. Inadequate explanation of rights to patient
2. Inadequate discharge process
3. Inadequate treatment process
4. Inhumane treatment
5. Violation of patient's right to vote in general election
6. Inadequate involuntary commitment process
7. Inadequate patient safety
8. Communication violation

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (MHDD Code) (405 ILCS 5), the Hospital Licensing Act (210 ILCS 85/2) and the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4).

The CHOICES is a behavioral health program through OSF Saint Elizabeth Medical Center that has inpatient, outpatient, and partial hospital services. The program covered a 30 mile radius but is now contracted as part of Illinois' Community Hospital Inpatient Psychiatric Services Program (CHIPS). The facility now covers the northern one-third of Illinois. The inpatient program consists of 22 beds that are split into 2 identical units (14 beds in one unit, 8 in the other) with an average daily census of 14 patients. The facility has a staff of 35 employees.

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

COMPLAINT STATEMENT

The complaints allege that the facility attempted to transfer the patient to another facility without informing the patient of his rights. The complaint alleges that a patient demanded to see

an attorney and a judge and the facility denied that the patient had such rights. Also the patient demanded to sign a 5-day discharge document but the facility hesitated in letting the patient sign to be discharged, but eventually allowed the patient to sign. A physician at the facility told the patient that the patient did not have to speak with the him, which the patient did not want to do, but it was alleged that then the physician would provoke the patient by speaking with the patient daily. The allegation states that the patient felt that the physician was trying to provoke the patient into a violent act so that the physician could transfer the patient to a jail or criminal psychiatric facility.

An allegation states that a patient demanded the right to vote in the general election but was continuously denied. The patient requested to be taken to early voting but was refused numerous times. Eventually the facility allowed the patient to vote but told the patient not to tell any other patients he was the only patient permitted. The allegations state that a certificate of involuntary admission was falsified by a therapist because the therapist that completed the form had never interviewed the patient that was being committed. The facility also reportedly would not give the patient a copy of the commitment certificate in an attempt to cover for the fact that the therapist had never interviewed the patient. The patient was also allegedly threatened with violence by another patient and nothing was done by the facility to protect the patient. Staff told the patient that he was imagining the confrontation as per the complaint. The allegations also state that the patient was denied anti-anxiety medication while at the facility. The final allegation is that the facility violated the patient's communication rights by opening a patient's letter from the Illinois Guardianship and Advocacy Commission and did not give the patient the letter until several days after his court hearing.

INTERVIEW WITH CHOICES STAFF (4/3/2013)

Staff began the interview by explaining that the patient has received services at the facility for years. The patient was diagnosed with Bipolar Disorder, alcohol dependence, Borderline Personality Disorder and Narcissistic Personality Disorder. The patient had 10 hospitalizations in 2012. The facility stated that the patient often came into the emergency department with suicidal ideations and has attempted suicide in the past. Staff said that because of the patient's multiple hospitalizations, the patient has a special treatment plan that contains extra outpatient services. The staff said the patient receives partial hospitalization services continuously as well as psychiatric services. Staff explained that partial hospitalization is a day program at the hospital that occurs Monday through Friday. The staff took this approach because standard treatment approach was not working. Staff stated that they even called the patient at home in an attempt to try and keep the patient sober and attending appointments regularly. Staff said they would call the patient and the patient would be intoxicated and threaten suicide, so they would have him brought to the facility. Staff said that with regard to the admission allegations in this complaint, the patient was brought to the facility and they decided that a transfer to a state operated facility would be the best way to help the patient. This decision made the patient angry and the patient felt as though he was abandoned. Staff said that the patient was taken to court and committed, but was granted an independent psychiatric evaluation and a jury trial, which was at the patient's request. In court, the judge ordered the patient to cooperate with treatment and the patient was released prior to the actual jury trial. The admission pertaining to the allegations lasted twenty eight days total.

Staff explained that the patient's rights were read to him upon admission. The patient also requested a discharge and the patient's rights were discussed at that time as well. Staff said the patient originally was a voluntary admission but was later petitioned for commitment. After the patient was at the facility for several weeks, he requested discharge which led to the commitment. Staff explained that when the transfer was originally discussed, the patient became upset and demanded to leave. According to staff, the patient also became uncooperative at that time because the patient was upset. Staff said they discussed the frequent hospitalizations with the patient and the patient's failure within the program. Staff said they discussed solutions with the patient. Staff explained that when there was discussion about transfer the patient began to say that he no longer had suicidal ideations. Staff explained that when a patient requests a discharge they usually provide a printed copy of the documentation immediately. Staff said the patient definitely received the discharge form the same day of the request and they often provide the document to the patient within the hour of the request. The 5-Day discharge form also lists patient rights but the patient stated that he did not want to hear those rights and covered his ears.

Regarding the complaint about violence with another patient, staff said that they were unaware of any incident. Staff said there was no physical altercation. If there was an incident, staff explained there would be a written report. Staff explained that the patient argued with other patients and staff and could be intimidating because of the patient's size. Staff said that they have no knowledge of policy regarding patient safety. Staff explained that if there were two patients that were agitating and threatening each other, they would move one patient to one side of the unit, and move the other patient to the other side of the unit. Staff explained that patients do tend to provoke each other and it is not an odd occurrence. They stated that if they are aware of it, then they would intervene immediately and document the situation. Staff explained that they complete rounds on the unit every 15 minutes so they probably would have seen an altercation. They explained that counselors and other staff are always on the unit so they would also possibly see an altercation. The staff also explained that nothing was reported to them about any altercations.

Concerning the allegations that patients were not allowed to vote, staff explained that they contacted the local police who escorted the patient to the polling place. The patient was court committed at the time that he wanted to leave to vote, so the facility did not feel comfortable allowing the patient to leave alone. They originally offered the patient an absentee ballet but the patient did not believe that his vote would be counted if it was absentee. Staff said that they never told the patient that other patients could not know that he was allowed to vote and, in fact, the patient was talking about voting so often that they felt everyone in the unit was aware that there was an election. Staff said that no other patient wanted to vote and that the patient involved in this complaint was the only patient who took interest in the election. Staff explained that voting rights are a part of the admission rights so all the patients see the statement about voting. Staff stated that most patients are there for a short length of stay so elections are generally not an issue. If there were other patients who wanted to vote, they may be taken to the polling place in the hospital van depending on their medical condition. Staff said that when there were longer admissions, it seemed like patients were more interested in voting.

Staff stated that they do not open patients' mail, but in this case, a social services staff member received a letter that was accidentally opened and the patient was given the mail immediately. Staff explained that the staff who deals with mail probably did not know who was to receive the mail. The staff investigated the incident but could not figure out what occurred. Staff said that if mail was ever intentionally opened, it would be with the patient present. The letter that was mistakenly opened was from the Illinois Guardianship and Advocacy Commission. Although it was never determined exactly why the envelope was opened, staff speculated that it may have only been addressed with the patient's name and did not identify that he was a patient or have the patient's code on the envelope. The hospital explained that when there is a new admission on the unit, they are given a code that they can give to individuals outside of the facility. If someone calls for the patient, they can give the code and the facility knows it was shared by the patient and that the individual has consent to know the patient is in the facility. The patient can also sign a consent form. The inpatient list is kept confidential, even from staff within the hospital, so they would not have known that the patient is at the facility. Staff also speculated that the letter may not have been addressed to CHOICES. Staff said that most cards or flowers that come to the patients are addressed to CHOICES. Staff said that if the letter only has an individual's name, and hospital, and they are not on the list or an employee, then staff would not know to whom to send it. Staff explained that there is a communication policy, and there is a phone on the unit for patients to use. Staff also said that sometimes the patient will alert staff that someone wants to send flowers and then they instruct them in the best manner to address the letter. Staff said that the patient wanted to speak with an attorney so the staff assisted him in locating an attorney. Staff also explained that the patient received the mail the same day that it was discovered accidentally opened. The staff did not know if the incident occurred before or after the court date.

Staff explained that all employees are orientated on rights and communication. The patients' rights are posted on the unit and also posted off the unit. Once the orientation is completed, training is ongoing. Staff have an annual evaluation but it is not specific to patient rights. Staff check the patients' charts daily as part of their routine to assure that patients' rights are communicated to them and processes are being completed correctly. The Nurse Manager, Social Services Supervision and Administrative Director are the staff members who review charts on a daily basis. Staff explained that they have patients who are involuntary admissions that convert to voluntary, which is also part of the reason why the records are reviewed over and over again.

Staff explained that when completing certificates, both staff members perform a full examination. In this case, a social worker completed the first certificate and a physician completed the second. Staff said the social worker is a qualified examiner and did interview the patient. Staff said that the examination begins with an interview, then staff review the patient's records, and then they review the patient's history. Staff said that they would be presenting to the court that the patient being received is a danger to themselves or others and the interview would cover what this person has potentially done to meet the criteria for commitment. Staff stated that there is no quality control procedure to assure that the examination was completed.

The staff explained that patients are asked to sign a treatment plan which this patient did. Staff did say that sometimes the patient would participate in the treatment planning and

sometimes he would not. They stated that towards the end of the stay, the patient would not sign the plan. Staff said the patient would also leave group and, for part of the stay, the patient refused medication. Staff said the patient was given non-addictive medications. The patient wanted Valium continued, which was given to the patient early in the hospital stay for detoxification, but because of the patient's addiction history, staff did not want to continue the medication. In the patient's own notes it was written that the patient still wanted the drug. The patient was receiving anti-depression medications and mood stabilizers. BuSpar was the anti-anxiety medication that was given. Staff explained that the patient was on anti-anxiety medication just not the medication that the patient wanted. Staff said that the patient knew that the medication was anti-anxiety, and the patient was given written and verbal explanations of the medication.

Staff explained that they discussed the transfer with the patient and they would never transfer a patient against his/her will unless there was a court order. If a patient was transferred he/she would receive discharge instructions. Staff said that in this case, the patient was beginning to approach time to discharge but then began talking about suicide. Staff discussed the need for long-term care with the patient but, as stated previously, this angered the patient. The patient actually asked for another psychiatrist to take over the patient's care but the other psychiatrist did not accept the patient because he felt as though the patient was being manipulative.

Regarding the complaint that a physician was bothering the patient, the staff explained that the patient does not have to talk to the physician, but they did need to inquire with the patient if he wanted to speak to the physician daily to check and see if the patient had changed his mind and did need to speak to the physician. Staff said they would ask the patient if he wanted to speak to the physician, and if he did not, then they would leave him alone and if the patient did want to talk, then they would talk. Staff said the patient was always given the opportunity. Staff said the patient's documentation said he stopped calling the physician "doctor" and said that the doctor was trying to "bait" him. Staff said that the patient was angry and even threatened the physician. Staff said that as soon as the patient did not agree with the physician, the patient would walk away.

FINDINGS (Including record review, mandates, and conclusion)

With the proper consent, the HRA reviewed patient records and facility policy that pertain to the allegations in this case.

Complaint #1 - Inadequate explanation of rights to patient

The HRA began its review of the allegations by reading the patient's admission summary which indicates that the patient was admitted on 10/16/2012 at 1007 and was discharged on 11/13/2012 at 10:45am. The HRA reviewed the patient's multidisciplinary progress notes which stated that on 10/16/2012 at 1100 the patient refused reading of rights in lieu of receiving copies and then later verbally indicated that the rights were understood. The admission document does appear to be signed by the patient.

The HRA reviewed the facility involuntary admission policy which states that within 12 hours of admission, the patient must be given a copy of the petition and be read his/her rights. It also states later in the policy that the patient must be informed of his/her rights and this must be documented in his/her medical record. The HRA also reviewed the voluntary admission procedure which also states that the patients "shall be informed orally and in writing of his/her rights." In a later entry in the patient's progress notes on 10/30/2012 at 1330, it states "MHC [Mental Health Clinician] attempted to read pt his rights. Pt. became very irritable, got up and walked away from MHC. He was yelling 'don't read me anything, I can't understand it without a lawyer or proper representation. Leave me alone.' Pt. then placed his hands over his ears and yelled 'lah, lah, lah.' Pt. was given a copy of his rights." There is an entry 30 minutes later stating that the necessary paperwork for a mental health commitment was filed with the State's Attorney.

The HRA also reviewed the patient's application for voluntary admission which states that the patient's rights were explained and the patient was provided a copy of the rights. On the admission form, there is a note stating that the patient refused the reading of the rights and the actual rights document includes that statement. On the rights form, it states that communication from a licensed attorney will be forwarded to the patient without examination, even if communication is restricted. The rights also state that no facility will prevent any attorney from visiting during normal business hours. The HRA also reviewed the rights forms that are with the petition dated 10/29/2012 which reads "You have the right to be present during your court hearing" and "You have the right to be represented by an attorney."

The HRA saw an instance in the patient's reflections group worksheet, which was written on 11/1/2012, stating that the patient felt as though his rights had been violated and he also has no legal counsel. In another reflections group worksheet, which is written by the patient on 11/2/2012, it is stated that he wanted an attorney because he was not being allowed to vote. There was another note written by the patient making a similar statement about wanting an attorney that was dated 11/4/12. Another personal note on 11/1/2012 written to the physician states that the physician is violating the patient's right to counsel.

The HRA also read in the voluntary admission policy that "A substitute decision maker means a person who possesses the authority to make decisions under the Powers of Attorney for Health Care Law or under the Mental Health Treatment Preference Declaration Act. A substitute decision maker for Healthcare and/or Mental Health Power of Attorney may consent to the admission of a person who lacks decision making capacity provided that a copy of the Power of Attorney form is presented and is deemed to be valid." Additionally, the Inpatient Status Certification form has a section (checkbox area) where the staff can detail the status of the patient. The prewritten status section notes whether the patient has the capacity to consent to voluntary admission, does not have the capacity to consent to voluntary admission and the guardian/POA has consented to treatment or that involuntary admission papers have been filed with court.

The MHDD Code 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 … Upon commencement of services, or as soon thereafter as the condition of the recipient permits, the facility shall ask the adult recipient or minor recipient admitted pursuant to Section 3-502 whether the recipient wants the facility to contact the recipient's spouse, parents, guardian, close relatives, friends, attorney, advocate from the Guardianship and Advocacy Commission or the agency designated by the Governor under Section 1 of '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, or others and inform them of the recipient's presence at the facility. The facility shall by phone or by mail contact at least two of those people designated by the recipient and shall inform them of the recipient's location. If the recipient so requests, the facility shall also inform them of how to contact the recipient" (405 ILCS 5/2-200). The Code also reads "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. 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" (405 ILCS 5/2-108).

The MHDD Code states that "§ 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. 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" (405 ILCS 5/3-401). The Code also states that "A surrogate decision maker under the Health Care Surrogate Act may not consent to the admission to a mental health facility of a person who lacks decision making capacity. A surrogate may, however, petition for involuntary admission pursuant to this Code. This Section does not affect the authority of a court appointed guardian" (405 ILCS 5/3-601.2).

Complaint #1 Conclusion

Because the HRA found no evidence that the patient did not have rights explained or was denied access to an attorney or judge, the HRA finds this complaint **unsubstantiated** but offers the following **suggestions:**

- In reviewing the admission process, the HRA saw that the facility allows patients to be admitted by substitute decision makers which is in violation of the MHDD Code 405 ILCS 5/3-401 without stipulating that it must be *at the request of the person seeking admission*. The HRA **strongly** suggests that the facility adjust policy to comply with the Code.
- There did seem to be documented instances in which the patient wanted to speak with an attorney and although there was no evidence that the facility blocked the patient from

communication, the HRA still suggests that the facility discuss patient and attorney relationships with staff to assure patients are being allowed to speak with attorneys.

Complaint # 2 - Inadequate discharge process

The HRA reviewed the facility's policy regarding patients requesting discharges. The policy reads "In accordance with Illinois statutes, each patient and family are informed upon admission that consent for treatment may be revoked in writing during the treatment period. If a patient requests their own discharge, the hospital has five days, excluding weekends and holidays to evaluate the patient and respond to the request." The procedure states that a patient may submit a written request for discharge to any professional member of the staff and any staff person receiving the request will notify the attending psychiatrist and managers and make the request part of the medical record. The procedure states that if the psychiatrist determines that the patient represents a danger to self or others, the procedure for involuntary admission will be instituted. The policy states that "The patient should utilize the Request for Discharge Form." The policy also states that "The patient may retract his/her request by completing the 'Retraction of Discharge Request' Form." The facility voluntary admission policy also states that "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/she 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 'involuntary admission' procedures are executed."

The HRA reviewed a copy of the patient's voluntary admission application which matches the above mentioned discharge policy. This is the document which, as stated in complaint #1, the patient refused to hear read to him but received the paperwork. The HRA reviewed the request for discharge document that was signed by the individual on 10/29/2012.

In reviewing the patient's record, the HRA found no evidence of the facility being hesitant in allowing the patient to request discharge.

The MHDD Code reads "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). The Code also 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).

Complaint #2 Conclusion

The HRA saw no evidence that the patient requested to be discharged prior to the 10/29/2012 date when the 5-Day Discharge documentation was actually signed by the patient. The HRA also saw no evidence indicating that the facility hesitated in letting a patient sign to be discharged. Because of this the HRA finds the complaint **unsubstantiated** but offers the following **suggestion:**

- The facility policy indicates that the patient should sign a specific request for discharge form and specific retraction of discharge form that is by the facility but the MHDD Code does not dictate that the patient must complete a form, only that the request and retraction must be in writing. Assure that patients are being allowed to give other written notice if they choose and that staff are accepting these requests and not forcing them to complete the facility forms. Also assure that the procedure is not being delayed because the staff are retrieving the proper forms for the individual.
- Choices' policy on requesting discharge states that the hospital has 5 days, excluding weekends and holidays to evaluate and respond to a patient's discharge request. This is a misrepresentation of the Code's mandate that "…the recipient may be discharged from the facility *at the earliest appropriate time, not to exceed 5 days…."* (405 ILCS 5/3-401) and the policy should be revised to reflect the Code's intentions and avoid conflict with the voluntary admission policy, which is more accurate.

Complaint #3 - Inadequate treatment process & **Compliant #4 -** Inhumane treatment

Because the complaints are so closely aligned, the HRA combined complaint number 3 and number 4 within this report. The HRA began by reviewing the complaint regarding the physician speaking with the patient. In the patient progress notes, on 10/31/2012, the patient states that he would like a new physician and this was also documented in the group therapy notes on the same day. In the adult reflections group worksheet, on 11/1/2012, for the questions "Did you have any visitors or a family meeting today" it reads "No. I was too anxious to telephone anyone as I was baited by [physician], yet again." On that same date, in the progress notes, the patient states that the physician is not his physician. A progress note on 11/2/2012 reads "States he will not take any medication ordered because he would be saying [physician] was his doctor and admitting he was wrong." There are other instances throughout the record in which the patient states that the physician is no longer his physician and he states his displeasure with the physician. The patient also wrote a series of notes, one of which, dated 10/31/2012, states the physician is not his physician any longer and one on 11/1/2012 which reads "[Physician] You are no longer my doctor. You read me my 'Miranda Rights.' Please never speak to me again as you are repeatedly attempting to provoke me and are violating my rights to counsel." The HRA never saw an instance in the documentation where the physician might have provoked the patient.

In regard to the complaint that the patient was denied anti-anxiety medication while at the facility, the HRA began by reading the patient's discharge summary. The discharge summary read "He [the patient] was detoxed from alcohol. He was detoxed with Valium. He was also prescribed Paxil and Tegretol for his mood, BuSpar for anxiety, and melatonin for sleep." The

website Drugs.com states that BuSpar is an anti-anxiety medication. On 10/31/12 in the patient's progress notes, the patient states that he was cut off his Valium and on other occasions in the progress notes, he states that he wants to be on Valium and he was cut off. On 11/5/12 there is a progress note that reads that the patient was feeling very anxious and requested Valium. This request was made by the nurse to the patient's psychiatrist and medical doctor who declined ordering the Valium for the patient.

According to the patient's physician's orders, Valium was discontinued on 10/30/12. It does state that the patient was ordered Paxil, which according to the online Physician's Desk Reference is used in the treatment of "… social anxiety disorder (SAD), generalized anxiety disorder (GAD), and post-traumatic stress disorder (PTSD)." The HRA saw no evidence in the physician's orders that the patient was prescribed BuSpar. However, in the patient's admission assessment, it indicates that the patient uses Buspar as a home medication for anxiety. The HRA also reviewed an education sheet for Buspar dated 10/16/2012 which stated that the patient received copies and understood the medication. In reading the patient's discharge instructions, on the Activity for All Days sheet, BuSpar was a medication that was a part of the instructions.

In reviewing the medication administration record, the Diazempam (Valium) was discontinued on 10/30/2012 but the patient was scheduled to have BusPIRone (BuSpar) twice a day. The patient refused the BuSpar for several days after 10/31/2012 but started taking it again fairly regularly on 11/5/2012.

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. The plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible…." (405 ILCS 5/2-102). The Medical Patient Rights Act reads "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 #3 Conclusion & Complaint #4 Conclusion

The HRA saw no evidence that the physician was provoking the patient and understands that the physician must ask the patient if he/she wants to talk on any given day. The HRA also saw no evidence that the patient was denied anti-anxiety medication. We did see that Valium was discontinued but there was another anti-anxiety medication in place. The HRA contends that decisions regardin appropriate prescriptions are based on clinical judgement and beyond the HRA's scope. Because of this, the HRA finds the complaint **unsubstantiated** but offers the following **suggestions:**

- Although the HRA understands that a physician can deny service to a patient with reason, the HRA suggests that the facility keep the thought of a patient switching physicians open in future instances such as this since the Code intends for patients to be included in their treatment planning.

Complaint #5 - Violation of patient's right to vote in general election

The rights document provided by the facility for voluntary admissions states that the patient does not lose any rights as a general rule. The rights provided to an involuntary patient also reads that, as a general rule, you do not lose any rights. Both reference the "Rights of Individuals" which is given to all patients and reads that they do not lose the right to vote. As stated previously in the report, these are the rights that the client refused to hear verbally but signed and accepted copies.

On 11/2/2012 in the progress notes, it states that the patient said that he wants to vote. In the patient's adult reflections group worksheet dated 11/2/2012, which are completed by the patient, the complaint section states, "Yes, early voting ended today. No one took me to vote. My civil rights are being violated. I want an attorney." Another reflections worksheet dated 11/3/2012 states the patient told staff that he wants to vote. In a group documentation form dated 11/4/2012, notes on the patient's behavior in group therapy state that the "Pt is upset that he isn't being allowed to vote and feels that his rights are being violated." In a note by the patient, dated 11/4/2012, it reads "I want to vote on election day or I will bring a civil rights law suit against [staff member] for personally preventing me to do so." In another reflections group document dated 11/4/2012, it reads "I want to vote and [staff member] says I can't." In a progress note, which is written by staff on 11/4/12, it states "Patient had opportunity to obtain absentee ballet to vote." Progress notes from 11/6/2012 read that the patient was allowed to vote and given his ID so that he could go vote. The notes state that the patient was escorted by local police and returned to the facility. A physician's order dated 11/5/2012 states that the patient "May go vote tomorrow escorted by [local police department] if behavior is appropriate."

The MHDD Code reads "No recipient of services shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the receipt of such services" (405 ILCS 5/3-601.2).

Complaint #5 Conclusion

The records that the HRA reviewed are unclear, in one instance there is a statement that the patient is upset that he is not being allowed to vote but in another instance, the patient was offered an absentee ballot and was allowed to vote on Election Day. The HRA did not review any information stating that the patient was not to inform other patients that he was allowed to vote. Based on the documentation, the HRA feels as though the process definitely needs review by the facility, but there is also not enough evidence to substantiate the allegation. Because of this, the HRA finds the complaint **unsubstantiated** but offers the following **suggestions:**

- Because of the importance of voting, the HRA suggests that the facility communicates more with patients regarding their voting rights and upcoming elections.
- The physician's order makes the statement that the patient **may** vote if his behavior is appropriate but the patient is afforded the right to vote by law. Assure that the facility is compliant and allow recipients the opportunity to vote.

Complaint #6 - Inadequate involuntary commitment process

The HRA reviewed the facility involuntary commitment policy. The policy states that a patient can be petitioned for involuntary admission and "The petition shall be accompanied by a certificate executed by a physician, qualified examiner, or clinical psychologist which states that the respondent is subject to involuntary admission that requires immediate hospitalization. The certificate shall indicate that the physician, qualified examiner, or clinical psychologist personally examined the respondent not more than 72 hours prior to admission." The policy proceeds to say that within 24 hours of admission, there needs to be an examination by a psychiatrist and a second certificate needs completed. The policy also states that within 12 hours of admission, the patient will be given a copy of the admission and read their rights. The policy does not state if the patient is to receive a copy of the certificate.

In reviewing the two certificates, both were completed on 10/30/2012. One was completed at 10:20am by a Mental Health Therapist and the certificate states that the therapist, by signature, advised the patient of his rights and personally examined him. The second certificate has a time of 10:30am and states that the psychiatrist, by signature, advised the patient of his rights and personally examined him. In reviewing the patient rights form, the facility states that a copy of the petition and certificates will be filed with the court and a copy of the petition will be given to the patient. The fourth page of the petition reads "Within 12 hours of admission to the facility under this status I gave the respondent a copy of this Petition (MHDD-5). I have explained the Rights of Admittee to the respondent and have provided him or her with a copy of it. I have also provided him or her with a copy of the Rights of Individuals Receiving Mental Health and Developmental Services (MHDD-1) and explained those rights to him or her." This is signed by a mental health counselor.

In the patient's reflections worksheet, the patient states that he was not examined by a second psychiatrist 24 hours from involuntary admission. In another worksheet, dated 11/3/12, it stated that the physician, mental health therapist (MHT), and another staff member reportedly lied on the certificate and petition. In the above mentioned note, the patient stated that the facility did not allow the patient to see a psychiatrist within 24 hours of involuntary admission and that the mental health therapist did not speak to the patient regarding a reference the patient made about suicide. The patient accused the therapist of never communicating with him about the matter. The certificate does say that the patient has a history of dangerous behaviors which include suicide attempts. The Certificate was dated 10/30/2012 and the patient wrote the statement that the MHT lied in this note on 11/4/2012. According to the progress notes, the patient went to court on 11/5/2012. In reviewing progress notes and group therapy notes, the HRA saw no documentation that the patient was examined and did not see documentation that the facility was withholding the certificate from the patient.

Under the MHDD Code, a petition must be completed in order to hold any adult for evaluation and potential involuntary admission (405 ILCS 5/3-601).

The MHDD Code reads "The petition shall be accompanied by a certificate executed by a physician, qualified examiner, psychiatrist, or clinical psychologist which states that the

respondent is subject to involuntary admission on an inpatient basis and requires immediate hospitalization. The certificate shall indicate that the physician, qualified examiner, psychiatrist, or clinical psychologist personally examined the respondent not more than 72 hours prior to admission. It shall also contain the physician's, qualified examiner's, psychiatrist's, or clinical psychologist's clinical observations, other factual information relied upon in reaching a diagnosis, and a statement as to whether the respondent was advised of his rights under Section 3-208" (405 ILCS 5/3-602).

The Mental Health and Developmental Disabilities Confidentiality Act states that "(a) The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof . . . (2) the recipient if he is 12 years of age or older" (740 ILCS 110/4).

Complaint #6 Conclusion

In reviewing the documentation, the facility has a procedure in the place for involuntary commitment that is compliant with the MHDD Code. There was no documentation that the patient was examined in any of the record other than the certificates. A required petition was completed and a copy provided, and on 10/30/2012, there is a section in the progress notes that state that the patient had his "Miranda" rights read to him per the certificate, which we assume is in reference to his rights according to 5/3-208. Because there is no direct evidence that staff lied or that the patient was not provided copies of the certificate, the HRA finds this complaint **unsubstantiated** but would like to offer the following **suggestion:**

- Assure that the facility is compliant with the MHDD Code 405 ILCS 5/3-610 and also assure that patients are allowed copies of the record for their review upon request per 740 ILCS 110/4.

Complaint #7 - Inadequate patient safety

In reviewing the patient's discharge summary, it states that "He had some conflicts on the unit with staff and other patients." In a progress note on 10/18/2012, it reads that the patient "Can't control himself gets in an argument." On 10/27/2012 group therapy note, it reads "Clt [client] joined in group therapy this afternoon; did not identify any goals as he left group early. He related poorly to peers. Disagreed with a peer and left the room as an avoidance of conflict as he is unable to move past or let go of issues. Clt is argumentative." In a group therapy note on 11/1/2012 it reads "Pt needed to be redirected multiple times before having to be asked to leave group for upsetting other pts." On 11/2/2012 progress notes there is an incident where the patient knocked over a chair and on the same date the patient was verbally aggressive in group therapy. Throughout the record, there are other incidents where the patient was verbally aggressive, upset and angry.

On 11/12/2012, a progress note reads "Pt irritable and obsessive before breakfast. Pt. making unfounded complaints about a peer and other complaints about his [word omitted by writer] being opened." The patient's group documentation form reads "A male peer was making aggressive gestures at patient and he became agitated and upset. Support and suggestions were given." In an adult community meeting sheet, which is completed by the patient, under the

question "Do you have any safety concerns, questions or complaints that staff should be aware of" it reads "Yes, [other patient] was threatening me yesterday."

The Hospital Liscensing Act states "§ 9.6. Patient protection from abuse. (a) No administrator, agent, or employee of a hospital or a member of its medical staff may abuse a patient in the hospital. (b) Any hospital administrator, agent, employee, or medical staff member who has reasonable cause to believe that any patient with whom he or she has direct contact has been subjected to abuse in the hospital shall promptly report or cause a report to be made to a designated hospital administrator responsible for providing such reports to the Department as required by this Section … (d) Upon receiving a report under subsection (b) of this Section, the hospital shall submit the report to the Department within 24 hours of obtaining such report. In the event that the hospital receives multiple reports involving a single alleged instance of abuse, the hospital shall submit one report to the Department. (e) Upon receiving a report under this Section, the hospital shall promptly conduct an internal review to ensure the alleged victim's safety. Measures to protect the alleged victim shall be taken as deemed necessary by the hospital's administrator and may include, but are not limited to, removing suspected violators from further patient contact during the hospital's internal review" (210 ILCS 85/9.6).

The Hospital Licensing Act also reads "The purpose of this Act is to provide for the better protection of the public health through the development, establishment, and enforcement of standards (1) for the care of individuals in hospitals, (2) for the construction, maintenance, and operation of hospitals which, in light of advancing knowledge, will promote safe and adequate treatment of such individuals in hospital, and (3) that will have regard to the necessity of determining that a person establishing a hospital have the qualifications, background, character and financial resources to adequately provide a proper standard of hospital service for the community" (210 ILCS 85/2).

The MHDD Code reads "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect" (405 ILCS 5/2-112) and also "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). The Code also reads "Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a recipient of services indicates, based upon credible evidence, that another recipient of services in a mental health or developmental disability facility is the perpetrator of the abuse, the condition of the recipient suspected of being the perpetrator shall be immediately evaluated to determine the most suitable therapy and placement, considering the safety of that recipient as well as the safety of other recipients of services and employees of the facility" (405 ILCS 5/3-211).

Complaint #7 Conclusion

In reviewing the complaint, there appears to be parts of the record that state the complaint is unfounded, yet another section indicates that the patient was receiving threats from another patient. The patient had even written down that he was threatened, including the name of the patient who threatened him. The HRA found no evidence of an investigation being completed or

any action being taken other than support and suggestions given to the patient by staff. Because there was some action taken in staff providing support and suggestions, and the HRA does not have enough evidence to state that nothing was done by the staff nor resident-to-resident abuse, the HRA finds this complaint **unsubstantiated** but offers the following **suggestions:**

- The HRA suggests creating a patient-on-patient abuse policy that defines what abuse may be and what actions to take should abuse occur in order to keep patients safe while on the unit. In creating this policy, reference the MHDD Code 405 ILCS 5/3-211.

- The HRA suggests reviewing the Hospital Licensing Act 210 ILCS 85/9.6 and 210 ILCS 85/2 with the staff as well as the MHDD Code 405 ILCS 5/3-211 to assure compliance and to promote the safety of patients and staff.

Complaint #8 - Communication violation

The communication policy that was sent by the facility did not include mention of communication by mail. The rights statement that has been referenced throughout this report states that "You have a 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."

The patient's progress notes on 11/11/2012 is the first mention of the patient's mail being opened. The note states that the facility opened the patient's mail and the patient requested to speak with the police, which the facility contacted. The patient spoke with an officer on the unit. The patient's adult community meeting worksheet reads "Letter from atty. [attorney] Opened and not given to me before court. It's interference with the mail, privacy, and obstruction of justice."

The HRA notes that the first letter that was sent to the patient from the Illinois Guardianship and Advocacy Commission was sent on 10/30/2012 and the first mention that someone had opened the patient's mail was 11/11/2012. According to the record, the patient was in court on 11/5/2012.

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" and that all letters to and from the Guardianship and Advocacy Commission shall be delivered without examination (405 ILCS 5/2-103).

Complaint #8 Conclusion

The facility staff admitted to mail from the Guardianship and Advocacy Commission being opened accidentally prior to being delivered to the patient. The MHDD Code states that the the patient has a right to unimpeded and private communication via mail and for mail to and from this agency to be delivered without examination (405 ILCS 5/2-103). Because the mail was opened, the HRA finds the complaint **substantiated** and gives the following **recommendations:**

- Create a mail policy that ensures compliance with the MHDD Code 405 ILCS 5/2-103.

- The facility staff stated that the letter may not have been addressed CHOICES or did not have the patient's code, so there could have been an issue on that front, but the HRA contends that the family or whoever is trying to contact the patient should be able to have their mail reach the patient even if a step is left from the process. The HRA recommends that whatever process is chosen does not add burden on the sender or patient to label the envelope as instructed by the hospital but rather that the envelope is addressed as it usually would to reach the patient.
- Retrain staff that mail from the Illinois Guardianship and Advocacy Commission, attorneys, government agencies, etc. is not to be opened per 405 ILCS 5/2-103.

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

- Include written correspondence in the facility communication policy.
- Choices is using outdated rights forms that have incorrect addresses. We suggest that they are replaced with newly revised forms downloaded from the Dept. of Human Services library.
- Assure patients are recieving their mail in a timely manner.