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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 13-090-9029
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 discharge process, patient was coerced into signing a discharge request and not allowed to rescind the request.
2. Patient not being allowed access to chart and records, including petition and certificate.
3. Confidentiality violation.
4. Personal items were taken from patient and added to the patient's record.

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 patient, outpatient, and partial hospital services. The program covered a 30 mile radius but is now contracted as part of Illinois' Community Hospital Patient Psychiatric Services Program (CHIPS). The facility now covers the northern one-third of Illinois. The patient 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 complaint states that a patient was coerced into signing a discharge request by a staff member. A staff member allegedly entered the patient's room multiple times telling a patient that she needed to sign a discharge request to avoid admission at a state operated mental health

facility. Staff explained that if the patient signed the request, the facility would look into other hospitals, and if she did not, she would be admitted to a state hospital. Once signed, the patient asked to rescind the discharge request but was not allowed. At first, a staff member said that they shredded the discharge request but eventually said that they had the document and they were returning it to the chart. The patient was eventually allowed to rescind the request. Also the facility never explained that the patient could rescind the request, the process was explained by another party.

The complaint also states that a patient was not allowed access to her chart, including copies of petitions and certificates. The staff explained that the patient would have to be discharged to be able to review the record. Eventually, the patient was allowed her certificate but was continued to be denied the chart.

The third complaint states that a patient refused consent for the facility to speak to her mother but the physician and social services director spoke to the patient's mother anyway. The patient's mother told the patient that she was contacted by each staff member and they discussed all aspects of patient's treatment.

The complaint also states that pages from a patient's personal journal were taken and added to the patient's medical record for the patient's commitment hearing.

INTERVIEW WITH CHOICES STAFF (7/23/2013)

The patient involved with the complaint is a 38 year old female who was diagnosed with borderline personality disorder, antisocial personality disorder, and narcissistic disorder. The patient also has a history of self mutilation. Staff explained that the patient comes to the facility frequently for treatment.

Staff explained that along with the self-mutilation, the patient started showing homicidal tendencies and making statements about hurting staff. Staff explained that if the patient does not get what she wants; she becomes angry and says that she will commit suicide. She also has written letters with the staff member's name who made her upset. Staff explained that during the period where the allegations took place, the patient was angry and wanted discharged. Staff said that the reasons the patient wanted to leave the facility were not as important as her being healthy. Staff explained the patient was starting to decline and began inserting items into her body. Staff explained that they restricted phone rights because the patient was trying to remove a screw from the phone to insert into her body. They also had to restrict her access on the unit because she will break lights and use the shards to hurt herself and also find other objects to use in self mutilation. Staff explained that the patient was known to be manipulative and attempt to get her way. Staff said that throughout this behavior, the patient maintained that she was fine and wanted to be discharged. Staff explained that she was minimizing symptoms to get out of the facility.

Staff explained that the patient would request a discharge daily but never signed a discharge document. The patient that the physicians at the facility would not be able to help her because they do not specialize in self mutilation and they wanted her to pursue other treatment

programs. They explained that the patient had a history of noncompliance with treatment. Because of her relationship and history of incidents with her mother, the facility wanted to speak to the patient's mother in order to further her progress. The facility explained that when the patient's mother would contact the patient, the contact acted as a trigger because of their history, and the patient would have to be admitted to the hospital. The patient's mother was in denial of the situation and thought nothing was wrong with the patient. The staff thought that having the family involvement was essential for these reasons. The patient's mother also believed that the patient was healthy so the hospital was forcing the patient to be at the facility against her will.

Staff explained that they thought it was worse that the patient's mother did not know and realize the severity of the patient's condition. They thought this was hurting the patient and the facility came to the decision to talk to the patient's mother. The patient did give staff permission to speak with a friend. The staff wanted to have a family meeting to involve the patient's mother in long term care. The patient's mother was calling frantically because she thought that she should talk to the facility about her daughter's admission. The patient's mother even filed a complaint with the hospital's patient advocate.

Staff stated that the patient has a therapist outside of the hospital but does not attend sessions. They refer her to other services and the patient does not follow through with the referral. Staff said that they feel like they have run out of options because admitting the patient to their facility is not helpful.

Staff discussed committing the patient to a long term facility. The staff stated that the patient wanted one specific facility and refused all others. Staff said that they spoke with the patient about the programs and facilities that the patient wanted to participate in and staff told her that facilities would not accept her without an involuntary commitment. The staff explained that they are not able to transfer any patients from their facility to another without the involuntary commitment. The other facilities will not accept patients voluntarily and they think it's because the patients could arrive and change their minds. The staff also said that the patient did not want her information faxed to another facility. She did not want her records leaving the hospital. Staff said that they did not coerce her into signing a discharge, but rather only explained that the patient must be involuntary. They also said that they did not threaten the patient with sending her to a state operated facility and the patient did not want to be transferred to a state operated facility. Staff also stated that the patient came to them to discuss transfer to another facility, they did not approach her. The patient wanted to talk to social services and weigh the benefits of being transferred but it turned out that she only wanted to go to one facility. The staff said they eventually petitioned for the patient's commitment because she was so harmful to herself and the next day the patient requested discharge from the facility. The commitment went to court and, while in court, the patient requested a jury trail which was granted. The patient was discharged from the facility before the jury trail occurred. Staff stated that the patient refused a reading of rights at the facility.

Staff stated that the patient would have destructive behavior one day and then request discharge the next day. The patient would say that she was angry at a counselor, write the word "murder" on a piece of paper, and then turn that piece of paper into the counselor. The counselor would then show the physician the paper. The patient would then say the paper was taken from

her and put in her medical record. The staff also said that the patient once wrote that she will kill herself after discharge and gave the paper to a physician. The staff stated that the patient was under one-on-one observation.

Staff stated that they did deny patients access to records and have since changed their policy. They were not aware that they legally they had to provide them their record. They stated that they do not have a written policy for the new practice. Staff said that they denied this specific patient access to medical records because they were afraid that the patient would hurt herself after reading the chart. She made the request to see her record after 3-days of self mutilation. Staff stated that the patient did start to decompensate because of what she was reading and did end up hurting herself. Staff said that she was never told that the discharge document was shredded and it should currently be in her chart.

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. According to the documents reviewed, the patient was admitted on 4.15.13 and discharged on 5.7.13.

Complaint #1 - Inadequate discharge process, patient was coerced into signing a discharge request and not allowed to rescind the request.

The HRA began the record review by reviewing a portion of the progress notes. The notes state that on 4.15.13, the first day that the patient was admitted into the facility, the patient refused to review the patient rights document stating that she knew them and then signed into the facility voluntarily. In an adult community meeting sheet (which is completed by the patient), dated 4.17.2013, the patient stated that her goal for the day was to go home. On the same day, in the progress notes, there is a note from the physician which states "Explained to patient that given her emotional dysregulation, I will not discharge her unless a period of stability is seen. Also, given that she wants to change doctors, we will arrange for outpatient services at [facility - not state operated]." Later on the same day, it was written that the patient no longer wanted the physician and was offered assistance in calling the other facility. The patient refused to do this stating "I am being kicked out of Choices." The progress note reads "She was reminded she has chosen the stance of not wanting her doctor refusing meds prescribed by her. Clt asked about another Dr. and was advised that was not possible at this time." The patient proceeded to state she would stay with the current physician. In another situation on 4.18.2013, the patient had completed an act of harm to herself by inserting an object into her body. The patient stated that she would feel better if she could just go home. The progress note reads "Writer explained pt needs to cooperate with staff and [remove object] before she will be able to go home." On 4.19.2013 there is a statement made by the patient in the progress note that she was feeling worse because she needs out of the facility. Another entry in the progress notes on 4.20.2013, after the patient displayed injurious behaviors, states that "Pt made aware behavior won't get her discharged." A passage from the progress notes dated 4.21.13 at 9:38am written by the physician states "I discussed a plan with her, if she is able to stay calm till [illegible - maybe evening] we will contemplate discharge. If she decides to stay calm for 48 hours, I will offer her an in patient hour long therapy session." At 4.21.13 at 10:32am another note was written by the

physician stating that it was explained to the patient that given her past of homicidal ideation and fantasies of murdering the physician, the physician was not comfortable continuing therapy with her and the patient attempted self injurious behavior right after this was explained. The physician stated in this note that she did not believe the patient was appropriate for discharge.

On 4.22.2013, a passage in the progress notes states that the patient asked questions about providers that take her insurance and the patient was provided a specific provider intake number. The passages state "Clt stated she is fearful of leaving Choices, MHT (mental health therapist) discussed with Clt calling [facility] and asking questions about services they provide to gain knowledge of resources." Also, on 4.22.2013, there is a note written that reads "MHT me w/ pt and explained 5-day request for discharge paperwork. Pt. wanted to know 'pros/cons' of signing request. Pt. declined to sign at this time but verbally requested discharge." Later that day, another MHT met with the patient and the note reads "Clt was asking many legal questions such as if she has to sign a 5-day request for discharge in order to have a lateral transfer. MHT let Clt know that MHT was unsure of answer." The patient requested to meet with the patient advocate to ask rights questions. The passages states that they met and the advocate said that she would take the patient's questions to the hospital attorney. Later in the passage it reads "Clt discussed their feelings of betrayal in terms of being taken to court. MHT discussed Clt needing to be in an environment she can remain safe in and Clt stated she would like to remain on this unit but would be willing to go to another hospital such as [named facilities] … Clt stated she was fearful of state hospitalization [illegible] past sexual abuse at a state facility."

A passage on 4.22.2013 reads that staff met with the patient and "Clt was advised of their right not to speak to us and advised that such exchange could be used in court, she was advised that Court hearing was being pursued due to her inability to keep herself well and safe and that her actions were potentially lethal." Later, on 4.22.2013, the patient signed a 5-day discharge document and later on that same day, there is a passage indicating that staff took the patient's commitment papers to the States Attorney's office to be filed. On 4.23.2013 the patient requested and signed a retraction to the 5-day discharge which rescinded the request. The HRA reviewed both the Request for Discharge form, dated 4.22.2013 and the Withdrawal of Request for Discharge form which was dated 4.23.2013.

On the patient's application for admission, it reads that the patient has been informed of the "'Rights of a 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." This form is signed by the patient. The Rights of a Voluntary Admittee section explains that the patient has the right to request discharge from the facility and proceeds to illustrate the process of requesting discharge. There is also a statement in the rights that the patient has the right to withdraw his/her request to be discharged if he/she decide to stay. Although there is a statement that the patient refused to review the rights, the patient also signed the Rights of Individuals document.

We reviewed the facility discharge policy which states "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." This policy also states that patient can retract their request.

In reviewing the patient's Inpatient Status Certification, dated 4.15.2013, there is an area where it can be determined if the patient has the capacity to consent to admission and the patient's capacity is not documented. The patient's name and admission date are also not completed, only a signature certifying the form, the signature date and the completion date. Also, a re-certification of the patient's status is completed. There is a section on the application for voluntary admission document which reads that "I certify that the above person has been examined and is considered clinically suitable for voluntary admission." But it does not state that they have the capacity to consent to admission. In another document (which may have been intended to have been attached to the Petition for Commitment but this is unclear if it was), it states that "Given her longitudinal history as well as her current emotional state, I do not feel that she has the capacity to decide on discharge, as she displays severe insight/judgment."

The HRA reviewed the facility voluntary admission policy which states "…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 certifications conforming to the requirements of 'involuntary admission' procedures are executed."

The HRA reviewed mandates in accordance with the complaints. The Mental Health and Developmental Disabilities Code states "(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).

In regard to voluntary patient discharge, the Code states "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. Upon receipt of the petition, the court shall order a hearing to be held within 5 days, excluding Saturdays, Sundays and holidays, and to be conducted pursuant to Article IX of this Chapter. Hospitalization of the recipient may continue pending further order of the court" (405 ILCS 5/3-403).

The Code also states "(c) No mental health facility shall require the completion of a

petition or certificate as a condition of accepting the admission of a recipient who is being transported to that facility from any other patient or outpatient healthcare facility if the recipient has completed an application for voluntary admission to the receiving facility pursuant to this Section" (405 ILCS 5/3-400).

Complaint #1 Conclusion

The HRA saw no evidence that the allegations occurred, including the scenario that the patient was coerced into signing a discharge document and was not allowed to rescind the discharge. Additionally the HRA saw no evidence that the patient was unaware that the discharge could be rescinded. According to the record, she did in fact sign a rescindment. Because of this, the HRA finds the complaint **unsubstantiated** but offers the following **suggestions:**

- In reviewing the records, the HRA saw that the facility did not indicate that the patient had the capacity to consent to voluntary admission. Assure that the facility is in compliance with 405 ILCS 5/3-400 and following the regulations regarding capacity to consent.
- The facility indicated that receiving facilities are in violation of 405 ILCS 5/3-400 in that they are forcing patients to be petitioned prior to transfer. The HRA suggests that should this happen in the future with willing patients, Choices must reject the condition, contact the receiving facility's legal office and the Illinois Department of Public Health or appropriate licensing body. The Human Rights Authority can be another contact.
- The wording on the facility discharge policy is different than the wording on the voluntary admission policy regarding discharge requests, and the discharge request policy misrepresents 405 ILCS 5/3-403 as stated. The discharge request policy states that the hospital "has five days excluding weekends and holidays *to evaluate* the patient and respond to the request". More accurately, the patient shall be allowed to be discharged *at the earliest appropriate time, not to exceed five days*, meaning that evaluation begins immediately and is ongoing in order to honor the right to an earliest appropriate time. The HRA suggests the policy is updated to match the voluntary admission policy and to comply with the Code.

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

- It was indicated that the patient requested discharge daily but never signed a discharge document. Be sure that staff are offering discharge request forms at each and every request.

Complaint # 2 - Patient not being allowed access to chart and records, including petition and certificate.

In reviewing the patient's progress notes, on 4.22.2013 the patient was provided "multiple" copies of a rights restriction that was received while at the facility. On 4.23.2013, a passage in the progress notes, which was written by the physician, reads "Pt requested her chart to review the information we have put in for her. I do not think it is in her best interest to review

this chart." On 4.25.2013 there is a section which reads "Pt. requested copies of materials from her medical record. The following items were copied and given to pt …" and the section lists the items given to the patient which include a petition for involuntary admission and two certificates. Later in the passage, it reads "[Patient] said she received access to all the things she wanted from her record." According to HRA emails, this occurred after HRA intervention on 4.23.2013.

The HRA reviewed a policy titled Review of Medical Records which reads "Any person who has been treated at OSF Saint Elizabeth Medical Center shall be entitled to review of his medical record upon request." The procedure also states that there must be a written request for the review directed to the attention of the Health Information Management Director and the attending physician must be informed. The procedure also states that there must be a minimum fee of $15, someone from Health Information Management must be present and the physician has a right to be present and also the record must be complete, and, if not, the patient will have to wait for the review.

The Mental Health and Developmental Disabilities Confidentiality Act reads "§ 4. (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 … Assistance in interpreting the record may be provided without charge and shall be provided if the person inspecting the record is under 18 years of age. However, access may in no way be denied or limited if the person inspecting the record refuses the assistance. A reasonable fee may be charged for duplication of a record. However, when requested to do so in writing by any indigent recipient, the custodian of the records shall provide at no charge to the recipient, or to the Guardianship and Advocacy Commission, the agency designated by the Governor under Section 1 of the Protection and Advocacy for Developmentally Disabled Persons Act or to any other not-for-profit agency whose primary purpose is to provide free legal services or advocacy for the indigent and who has received written authorization from the recipient under Section 5 of this Act to receive his records, one copy of any records in its possession whose disclosure is authorized under this Act" (740 ILCS 110/4).

Under the Code of Federal Regulations, "The patient has the right to access information contained in his or her clinical records within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits." (42 C.F.R. 482.13 d, 2).

Complaint #2 Conclusion

In discussing this complaint and a second complaint regarding a patient not being allowed access to his/her records (see complaint 14-090-9026), it was determined that the facility was not in compliance with 740 ILCS 110/4 and 42 CFR 482.13 d. 2. Although there is a hospital policy stating that people receiving treatment at the hospital can review their medical record, the unit verbalized that their practice was not to allow the patient to review their medical record. Additionally, the policy that the HRA reviewed adds stipulations, such as stating that a physician has the right to be present and that there is a minimum fee of $15 to review the record, which are not provided for under the Act. The patient was also not initially allowed access to her

file until intervention by an outside agency. Because of this, the HRA **substantiates** the complaint and offers the same **recommendations** as 14-090-9026, which are:

- Create record-access policy that complies with the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4) and the CMS Conditions of Participatioin for Hospitals (42 C.F.R. 482.13) and educate staff on the policy. Provide the HRA with evidence of this policy and training. Should the recommendations for 14-090-9026 be satisfied, then the HRA will also consider this recommendation to be satisfied.

Suggestion:

- While it is reasonable to expect that a staff member would be present during a patient's review of his record to protect record integrity, there are no "physician rights" to be present or to grant access and Choices must be certain to avoid any delay or violation.

Complaint #3 - Confidentiality violation.

In reviewing the patient's psychiatric evaluation upon admission and some progress notes, the patient initially refused a family meeting but according to the patient's discharge summary, she did eventually participate in a family meeting. One progress note, written by the physician on 4.17.2013 reads "I am concerned about her safety and do not feel that she is appropriate for discharge especially as she refuses a family meeting. [illegible] we can not get family support to ensure safety.

In the patient's group documentation form, dated 4.24.2013, it reads "Clt then became upset when she found out that [physician] is planning on calling clt's mother. Clt ended one-to-one and went to contact her mother." On 4.24.2013, a progress note written by the physician reads "Spoke to patient's mother [name]. Explained reason for hospitalization including increasing self-injury, recent homicidal ideation which has decrease to anger but still remains and how she has articulated high distress with having no one to talk to. We explained that we have tried to provide the best treatment we can and she has failed treatment here." Another section written by another staff member reads "MHT spoke w/pt's mother and witnessed conversation between mother and [physician]. MHT explained legal outcome of paperwork filed with court. Mother verbalized concern about pt. being committed to SOF (state operated facility). MHT answered questions Mother had about [state operated facility]."

The HRA saw no consent signed that would allow the facility to discuss her treatment with her mother. The patient's admission application indicated that the patient's mother could be made aware that she was at the facility.

The HRA reviewed the facility confidentiality policy which reads "No staff member may release information of any nature without a signed consent form" and also "No staff member may release information unless the signed consent form meets Federal and State Regulations."

The Mental Health and Developmental Disabilities Confidentiality Act reads "All records and communications shall be confidential and shall not be disclosed except as provided in this Act" (740 ILCS 110/3) and "Except as provided in Sections 6 through 12.2 of this Act, records and communications may be disclosed to someone other than those persons listed in Section 4 of this Act only with the written consent of those persons who are entitled to inspect and copy a recipient's record pursuant to Section 4 of this Act" (740 ILCS 110/5). The Act also reads that a patient's records and communications can be disclosed "(ii) when, and to the extent, a therapist, in his or her sole discretion, determines that disclosure is necessary to initiate or continue civil commitment or involuntary treatment proceedings under the laws of this State or to otherwise protect the recipient or other person against a clear, imminent risk of serious physical or mental injury or disease or death being inflicted upon the recipient or by the recipient on himself or another" (740 ILCS 110/11).

Complaint #3 Conclusion

It is clear that the facility spoke with the patient's mother against her expressed wishes and without written consent from the patient, except for when she agreed to a family meeting. The facility stated that 740 ILCS 110/11 provides them the ability to speak to the patient's mother in this instance. We contend however that the patient was already admitted at the facility, which would be a safe environment, and the facility had already initiated the commitment process, which would negate the need to speak with the patient's mother. Furthermore, the staff told us that because of the patient's relationship and history with her mother, they wanted to speak with the mother to further progress and address the fact that her contact brought about observable triggers which the mother denied. None of these reasons have anything to do with initiating commitment proceedings under the Act. Because of this, the HRA finds the complaint **substantiated** and offers the following **recommendations:**

- Educate the staff in the facility policy and adherance to 740 ILCS 110/3 and 740 ILCS 110/11 and cease in the practice that staff can speak without consent in instances where there is no imminent danger to the patient or others. Provide evidence that these actions were taken.

Complaint #4 - Personal items were taken and added to patient's record.

The HRA reviewed documents, which appear to be handwritten on lined paper, which fit the description of what was discussed as being written by the patient in the staff interview. The writings read that the patient says she hates herself, is sick of the physician, wants to stab herself over and over, and if no physician will see the patient, then she will just die. The writings do make derogatory statements towards the physician and there is one that was reviewed which reads "Redrum" twice. The HRA reviewed a progress note which lists items that the patient requested from her record and received and one of the items was "personal notes written by pt."

The HRA reviewed a group documentation form dated 4.20.2013 which indicated that the patient could "journal" to help her deal with her emotions. In another group documentation form, dated 4.25.2013, it states that the patient requested to fill out a sheet and keep it for her own files, and did not turn them into the staff. The HRA also reviewed a reflections group sheet dated 5.1.2013 that indicates that the patient journaled.

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" (405 ILCS 5/2-104). The CMS Conditions of Participation for Hospitals reads "(c) Standard: Privacy and safety (1) The patient has the right to personal privacy" (42 CFR 482.13).

Complaint #4 Conclusion

The facility staff stated that the documents were handed by the patient to staff and included items that indicated the patient would injure herself as well as aggressive statements towards staff. Although it was shown that personal notes were added to the record, the HRA found no evidence contrary to the staff's statement that these items were provided to the staff by the patient or that the facility violated the patient's privacy or right to property in obtaining these documents, and therefore has no basis for findings with the complaint. The complaint is found **unsubstantiated** but the HRA offers the following **suggestion:**

- Regardless of how the staff discovers a patient's personal writings, instead of taking the writings, maybe make note of the writings and what was written in the patient's record rather then copying or taking the entire record. Along with this, it will assure that the patient has access to the original documents whenever wanted.

Additional comments -

- The HRA saw within the record that the patient was restricted to stay in her room in order to stay safe; a rights restriction form was completed but the procedure for seclusion was not followed. The HRA cautions the facility as the restriction seemed to border on seclusion which requires strict monitoring. The MHDD Code defines "Seclusion" as "… the sequestration by placement of a recipient alone in a room which he has no means of leaving. The restriction of a recipient to a given area or room as part of a behavior modification program which has been authorized pursuant to his individual services plan shall not constitute seclusion, provided that such restriction does not exceed any continuous period in excess of two hours nor any periods which total more than four hours in any twenty-four hour period and that the duration, nature and purposes of each such restriction are promptly documented in the recipient's record" (405 ILCS 5/1-126). The Code also has procedures for seclusion including 15 minute checks and other safety precautions (405 ILCS 5/2-109). Assure that the facility and staff are educated on what seclusion consists of and the regulations surrounding seclusion.
- The HRA reviewed a rights restriction, dated 4.16.2013 which indicates that the patient's right to communicate via the telephone was restricted because she was taking screws from the telephone. We propose that the right to communicate via telephone is separate, that the patient was using the phone to injure herself and, if something like this should happen in the future, the patient should still be allowed to communicate as the facility thinks of alternative protections such as using a phone without screws or detachable objects or periodic monitoring during the phone call.

- Another rights restriction, dated 4.21.2013, reads that the patient was placed in a physical hold and the note on the restriction notice reads "Pt was refusing meds prior to situation." The way the restriction was written suggests that the patient was placed in the hold because she was refusing medication. The HRA reminds the facility that according to the MHDD Code (405 ILCS 5/2-103) the patient does have the right to refuse treatment and cannot be forced unless there is need to prevent serious and imminent physical harm to themselves or others when no less restrictive alternative is available and suggests that the facility coordinate an education with staff regarding the right to refuse.