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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case #14-090-9002
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 visitation.
2. Inadequate assessment, a diagnosis was made on a patient without an assessment.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (MHDD Code).

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 complaints state that a patient was not allowed visits from family while staying at the facility. The complaint also alleges that a patient was diagnosed as developmentally disabled but there was no testing or assessments that lead to the diagnosis.

INTERVIEW WITH METHODIST MEDICAL CENTER STAFF (8/30/2013)

The staff began the interview by stating the patient did not have visitation rights restricted and that the patient had no visitors while at the facility. The patient said that she did not want

her mother to visit and the only contact that she had outside of the facility was with her grandmother. The patient said that she wanted to stay away from her mother. The patient was admitted on January 19th, 2013 and then discharged on January 30th, 2013 and then had a second overnight admission on February 14th, 2013.

Staff explained that the patient actually refused to release information to her mother but signed for her grandmother to know she was at the facility. The patient's grandmother never visited the patient because she lived out of state. There was nothing in the patient's record indicating the patient wanted a visitor or complained about visitation.

Staff stated that the facility visitation policy is in the patient handbook, which is provided to the patient and family. If a patient cannot read the handbook, they are provided a verbal explanation of the visiting hours. The visiting hours are daily from 6-8pm and on the weekends the times are 2-4pm and 6-8pm. Visiting hours are also based on circumstance and need, for example, if a visitor cannot visit during regular hours, staff will make exceptions and obtain a doctor's order for a patient to have visitors during non-visiting hours.

The patient was lucid while at the facility and was not experiencing hallucinations during her admission but she had some impairment. The patient was diagnosed on the first axis, clinical syndromes, with schizoaffective disorder and post traumatic stress disorder. The axis two diagnosis, developmental and personality disorders, was borderline intellectual functioning but not a diagnosis of a developmental disability. The facility had notes from 2008 stating they had performed an IQ test at the facility that made the physician pursue a Computed Tomography (CAT) scan. The CAT scan indicated significant atrophy, which means the patient's brain was smaller then it should be. The connection that the physician made was that this contributed to the patient's intellectual functioning rather than a psychotic process. The facility never received any documentation about a complaint regarding the patient's diagnosis.

Staff said that they would not diagnose a patient with a developmental disability but, to assist with the treatment, they may note that there is a cognitive impairment. Staff explained that they believe that it is clear in the patient's record that she is an unreliable historian. For example, the patient said that she graduated from Penn State but this was false. Everyone that is admitted into the facility has a history and physical completed. Depending on the psychiatrist's assessment, there may be an IQ or personality test completed. Sometimes a test like that is taken post discharge. The records of the two hospitalizations were similar but a diagnosis of borderline disorder was added to the February admission.

Staff were not sure how the patient would have even known about her diagnosis. They explained that the patient did not request her records while she was at the facility and if so, they would have reviewed her record with her. Staff also did not know if the patient requested the records after discharge. They explained that if a patient requests records after discharge, the request is processed by medical records or health information services. The treatment plan reflected that the patient participated in her treatment planning. Staff had no requests to amend records and if there was a request, they were not informed. If she disagreed with the record, she could complete a form to submit a modification.

FINDINGS (Including record review, mandates, and conclusion)

According to the records, the patient stayed at the facility on two occasions during the time frame mentioned in the complaint allegations. The dates were from 1.19.2013 until 1.30.2013 and then on a second occasion the patient stayed overnight on 2.14.2013.

Complaint #1 - Inadequate visitation.

In reviewing the record, the HRA found no documentation that the patient was not allowed visits. In the patient's treatment plan from the first admission, there were statements by the patient indicating issues with her relationship with her mother and documentation that there was no contact or attempts to contact her mother while at the facility. There was also no indication that the patient had visitors. On 1.21.2013, it is written in the treatment plan that the patient refused releasing information to her mother but did sign a release on 1.22.2013 to provide information to her grandmother who was contacted. The treatment plan for the patient's second admission at the facility did not indicate that the patient was not allowed to receive visitors and, there was also no indication that the patient had visitors.

The HRA reviewed the patient's application for voluntary admission which references the right to communicate with people "in private, without obstruction, or censorship by the staff at the facility. This right included mail, telephone calls, and visits." The patient also completed this form on her second admission. The HRA also reviewed, from the first admission, releases of information for the patient's grandmother (only to discuss treatment, progress, and discharge planning), a community mental health agency, a nursing home and a second mental health agency. For the second admission, there was a release for a nursing home and then two other releases that were signed under a fake name that, according to the treatment plan, the patient provided during admission. The first release was for an individual (who according to the document was a Power of Attorney agent) and the second was for a nursing home.

In the patient's admission history report, it reads that visiting hours were provided to the patient as a part of the patient education. The Methodist handbook that is provided to patients indicates that visiting hours are from 6pm - 8pm Monday through Friday and 2pm - 4pm and 6pm - 8pm on weekends and holidays. The handbook also states that "Exceptions may be ordered by your psychiatrist."

The Mental Health and Developmental Disabilities (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 #1 - Conclusion

Because the HRA found no evidence that the patient's visitation rights were restricted while at the facility, the complaint is found **unsubstantiated.**

Complaint #2 - Inadequate assessment, a diagnosis was made on a patient without an assessment.

In the patient's treatment plan from the first admission, it reads that the patient has had three prior hospitalizations and "Diagnosis has included Schizoaffective disorder, mood disorder NOS, mild mental retardation … Psychological testing was completed during a previous hospitalization in 2008 indicating full scale IQ of 61, performance IQ of 65, verbal IQ of 61. CAT scan in 2008 showed significant atrophy." The treatment plan from the second admission has similar verbiage regarding the testing. The patient's discharge progress note/continuing care plan reads that "Symptoms improved, but intellectual functioning makes symptoms difficult to assess." The patient's discharge assessment reads "At the time of discharge, the patient's symptoms had improved significantly, but her intellectual functioning does make it difficult to assess what symptoms are related to illness and symptoms are merely a reflection of her intellectual functioning." The axis of diagnoses on the discharge document has axis two as "Borderline intellectual functioning" and the discharge from the second reads that the second axis on the discharge document reads "Borderline personality disorder, borderline intellectual functioning." The patient's admission assessment reads "Unsure of validity of some pt responses as her IQ is in the moderate mental retardation range and she would not elaborate on some questions." Mentions of the patient's intellectual functioning appear in other areas throughout the record from the first admission. In the discharge document for the second admission, it reads "The patient is a 43-year-old Caucasian female with a significant past history of psychiatric problems and admissions as well as a history of low intellectual functioning … Her underlying personality disorder as well as intellectual functioning play a major role in her current symptomatology."

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 and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan." (405 ILCS 5/2-102).

Conclusion - Complaint #2

The HRA found no evidence that the patient was diagnosed as developmentally disabled without testing or assessment as stated in the complaint and, because of this, the HRA finds the complaint **unsubstantiated.**

Additional notes:

- In reviewing the patient's application and rights forms, the HRA saw that the contact information for several regional Authority offices is incorrect. The MHDD Code reads "Whenever a person is admitted or objects to admission, and whenever a recipient is

notified that his legal status is to be changed, the facility director of the mental health facility shall provide the person, if he is 12 or older, with the address and phone number of the Guardianship and Advocacy Commission. If the person requests, the facility director shall assist him in contacting the Commission" (405 ILCS 5/3-206). The addresses are now correct on the Illinois Department of Human Services website and the HRA asks that the new forms with correct addresses be used.