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Peoria Human Rights Authority
Report of Findings
Case #15-090-9011
UnityPoint Health – Methodist | Proctor Hospital

The Peoria Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation allegations concerning rights violations within the behavioral health services program at UnityPoint Health – Methodist| Proctor Hospital located in Peoria, Illinois. The complaints alleged the following:

1. Forced medication. (A patient was told that if she did not take her medication, she would receive a shot and when the medication was refused, a shot was administered.)
2. A communication violation.
3. Inadequate discharge.

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5).

The complaint states that the patient refused medication on 3 instances and was told that if she did not take the medication, she would be given forced medication. When the patient continued to refuse, she was forcefully given the medication. Allegedly, nothing led up to the shots other than the patient refusing the medication. The complaint stated that the patient was not having dangerous behaviors prior to receiving the shots and was not a danger to herself or others. Per the complaint, the patient was calm prior to receiving the medication, although the patient acted up after the shot was given. The patient was reportedly given the shots between October 28, 2014 and November 6, 2014 and was always given them during the night shift.

Additionally, the complaint alleges that between 10:30 p.m. and 7:30 a.m. the patient's cell phone was taken away, and this patient asked to make a call during that time and it was refused.

Finally, the patient was at the hospital voluntarily and wanted to be released, but the facility would not give her the paperwork for being released voluntarily. The hospital did not petition the court for an emergency admission.

FINDINGS

Per the website: "UnityPoint Health - Methodist offers the most comprehensive mental health services in Central Illinois. We work together with patients, families and agencies to

develop coordinated care plans so people with emotional and behavioral problems can get the help they need. Programs are available for children, adolescents, adults and seniors, with inpatient, outpatient and partial hospitalization care. Individuals and families who may not qualify financially for other behavioral health services in the community may benefit from our Outpatient Behavioral Health Services program."

Interviews:

Per discussion with staff it was explained that the hospital mental health unit can house 67 patients in three different units. The mental health unit is designed to meet the needs of those with very disorganized thinking and is equipped to assist with comorbidities that are not acute. The average length of stay for a patient is 8 to 9 days. The two units that serve adults report that the average age of a patient is approximately 40 years old. The units will serve adults age 18 and up. On the child and adolescent floor, the hospital will work with children from the age of 4 until they are 18 or 19. If the patient is still in high school, then they will most likely be placed on the adolescent floor.

The majority of the hospital's patients come from Peoria, Tazewell, Woodford, and Fulton Counties. If there are beds available, then the mental health unit will accept patients from 22 counties across central Illinois.

During the day, the patient to staff ratio is approximately 5 to 1. At night, the ratio dips down to 1 to 11. There are registered nurses, Mental Health Associates (MHA), and Certified Nursing Assistants (CNA) at night.

Per the administrator, staff receive training on how to administer forced medication by means of a PowerPoint and also Crisis Prevention Institute (CPI) classes. Additionally, Advanced Physical Training (APT) is also taught to all new hires. One of the techniques taught is how to safely hold a patient who is experiencing behaviors. The hospital is currently searching for different specialized trainings in how to safely restrain people with autism and individuals in the gerontology unit. The trainers additionally discussed with the staff the best way to assist someone when they are feeling triggered. The manner in which the hospital prefers the staff to interact with patients is to discuss how the patient copes when they feel triggered. The training teaches them how to recognize and respond to behaviors with an individualized plan based on what the patient finds most useful. For some, this could include listening to music when they start to become agitated, redirecting the patient with a different activity, such as a quiet place, giving them a snack, talking through what the patient is experiencing, using medication, or a physical restraint. The facility management does not want anyone to feel coerced and so they try to teach staff ways to avoid coercing patients. The director of nursing stated that unless the patient is in danger, they have the right to refuse medication. Staff are trained to offer medication at these times out of concern for the patient's safety. The director of nursing (DON) stated that usually the patients consent to taking the medication. In the hospital, there is also a trainer and a person with resources when an incident occurs in order to resolve the situation in the best way for everyone. All staff receive annual training in order to refresh them on restraint techniques.

Patients are first informed of their rights in the Emergency Department, as was the patient in this case, according to the DON. Per the interview, the patient signed a statement of voluntary

admission to the hospital. While in the intake center, the patient donned a gown and her belongings were secured. The patient was also reportedly informed that not all of her possessions were permitted on the unit; a physician determines what items a patient may bring on the unit. All electronics are locked away on admission. The hospital issued her a rights restriction form at the time of admission, according to the DON. The hospital staff also administer the Columbia-Suicide Severity Rating Scale (C-SSRS) to determine the level of suicidal ideation at the time of admission and at discharge.

According to the interview process, there are 2 telephones on the wall are available to the patients from 7 AM until 10:30 PM. The staff cited that the hours were enforced in order to promote sleeping and to find a balance in the different aspects of life. In the case of an emergency, a patient could call their family or the police. Also, the patient would be able to receive a phone call in the event of a crisis.

The staff are also trained that patients have equal rights and that everyone has to respect the patients and their rights, including confidentiality and privacy rights. Rights restrictions are considered if the unit is aware that a patient is harassing someone; physicians are contacted to make the final decision to issue a restriction. Management provides a quarterly safety training update which, according to their records, receives almost 100% compliance. The 2 hour training covers topics that arise from day to day experiences. The trainer answers any questions that may come up. There are refreshers and updates in how to restrain a client. If there is an urgent concern in the middle of the quarter, it will be addressed immediately and then refreshed in the quarterly meeting.

If someone wants to leave at any time of the day after they have been voluntarily admitted to the hospital, then a 5-Day request would be submitted, per the Mental Health Code. A 5-Day request means that the patient can decide that they want to leave the hospital and the facility has 5 business days to discharge the patient. The psychiatrists are contacted in order to allow them to consider the merits of the plan of care.

For the patient, according to the interview she was explained her rights at the time of admission and the patient did not sign a 5-Day request. Should a patient request to leave, a nurse will offer to process those feelings. If the patient still wishes to be discharged, they are encouraged to discuss that decision with their psychiatrist. The next step is to file for a 5-Day request to leave the facility after a consultation with the psychiatric department.

The patient was admitted to the emergency department on 10/28/14. She was diagnosed with Schizophrenia and Bipolar Disorder with Psychotic features. In accordance with hospital policy, the patient saw a hospitalist within the first 24 hours of her stay. The patient had a treatment plan. Patients have treatment plan meetings and they start at the time of admission. The patient did not make any grievances during her stay at the hospital.

Unless a physician is on call, the nursing department makes the decision to administer forced medication. According to a quote read by the DON from the patient's file, the preference for emergency intervention was "drinking beer and smoking cigarettes." The facility offered a prescription for nicotine treatment of a patch and gum.

The hospital has a policy on medication administration, which they would follow. Staff are taught to offer options “You’re getting upset, would you like this type of medication.” They look in the notes to see what soothes a patient.

During her stay on the unit, the patient on 4 occasions received emergency medication. On one incident on 11/1/14 at 1:30 am, the patient was restrained in her room and held for medication. While a patient was in restraints, observations were completed every 15 minutes, as was done with this patient. A rights restriction was given. Emergency medication (intramuscular or IM injection, pro re nata or PRN of Zyprexa) was given 3 other times without restrains. The first time was on 10/30/14 slightly after midnight. The second incident of emergency medication occurred on 10/30/14 at 11:58 pm. The fourth and final emergency medication incident happened a little after 3:30 am on 11/4/14.

The patient was discharged 11/6/14 because her treatment goals were completed, per the documentation.

Before the interviews, the HRA toured the facility. Each patient room had its own mural. There were murals that spanned the entire behavioral health unit and there was plenty of natural light.

Records Review:

According to the clinician notes on the first day of her stay, the patient had previously been diagnosed with Major Depression, Recurrent with Psychotic features. The patient had reportedly been exhibiting paranoid delusions before admission, under the impression that the pharmaceutical companies that manufacture her medication were poisoning people, so the patient stopped taking her medication.

The patient met with her medical team and psychiatrist 8 times during her stay at the hospital on 10/30/14, 10/31/14, 11/1/14, 11/2/14, 11/3/14, 11/4/14, 11/5/14, 11/5/14, and 11/6/14. During these sessions, the patient and the physician would review the patient’s mental status, medication compliance, sleep schedule, physical health, vital signs, assessment of the patient, and plan. At the end of each entry in the patient’s medical records, it states, “Unless otherwise noted, patient understands burdens and benefits of recommended and current care, including common and serious medication risks, has had any questions and concerns addressed, and consents to the plan as outlined above.”

A rights restriction notice documented at 12:23 am on 10/30/14 that the patient was placed in a physical hold and given emergency medication because she was not able to be redirected and was going into multiple patients’ rooms and attempting to wake them up. The patient had indicated “No preference” for emergency treatment. Per the nursing records, the patient vacated her room on the unit and took to the hallway in order to wake up the other patients and inform them that "no one has rights on this unit: it's a prison! Prisoners wake up!" The patient attempted to use the phone at the nurses' station. Additionally, the patient was offered medication "to help calm her down" and, per the nurse's report, the patient refused. According to the nurse's notes, the patient was administered emergency medication. There was

no documentation that waking up patients rises to the need to prevent serious and imminent physical harm. (Per a later discussion with the DON, this right's restriction was filled out in error, that the patient had taken the emergency medication willingly except on 11/1/14. That right's restriction notice was legitimate)

Per the psychiatrist notes 10/30/14 at 10:08 am, compliance was noted most of the time with medication. The plan was to continue medications, activity and therapy. Abilify, 10mg at twice daily, was prescribed for the patient.

Per nursing notes on 10/30/14 at 2:13 pm, the patient stated that because she inquired about descriptions on her chart, the patient is under the impression that staff believe she is paranoid. Also per the nurse's records, the patient is quoted as saying she would like to be "discharged today. I will be out of here today. Call the doctor or I will take people out of here with me."

The nursing record states that the patient refused to comply with medication on 10/30/14 at 11:34 pm. According to the patient, the nursing staff were trying to administer a higher dose than her (the patient's) psychiatrist prescribed. The patient also reportedly had difficult behavior, which included being demanding of the nursing staff, making claims about the quality of the unit like "You have more rights in jail than you do here," and the patient also made allegations that staff were abusing other patients on the unit. The intervention in the notes states "Calm approach. Talking with patient. Redirection as needed. Medications as ordered."

The medication administration record (MAR) documented that emergency medication was given at on 10/30/14 at 11:58. There is no further documentation by staff that she accepted the medication, that a rights restriction notice was given and/or that the patient was informed of the right to refuse.

As written in the nursing notes on 10/31/14 at 1:25 pm, the patient reportedly has been "demanding" to be discharged from the unit periodically during the day. The patient stated that "I checked myself in and I'm checking myself out."

Per the psychiatrist notes on 10/31/14 at 2:41 pm the patient remained grandiose and irritable. She had required PRN Zyprexa overnight and she had refused Abilify. Abilify was discontinued and Risperidone was prescribed for agitation and to help with sleep. It was documented in the notes that the "Patient understands burdens and benefits of recommended and current care including common and serious medications risks, has had any questions and concerns addressed, and consents to the plan as outlined above."

The patient is reportedly worse than the patient's sister has ever seen her, according to what the sister said to a nurse in her note on 10/31/14 at 5:37 pm. The nurse's report also states that the patient is speaking with nurses at their station asking one of them to page the on-call doctor in order to ascertain whether or not the patient can be discharged.

The patient left her room in the middle of the night on 11/1/14 and began harassing other patients on the unit according to the nurse's notes at 2:06 am. Requesting the key to leave the

floor, the patient also stated that she "will make a phone call." The staff informed the patient that the phones "are off until 7 am per unit policy." Reportedly, the patient also began following another patient on the floor claiming that he was "the devil." The patient also claimed "I am the almighty god. I will get the devil out of you." The patient was unable to be redirected. Subsequently, the patient then disrupted other patients on the floor, pounding on their doors, opening them up, and calling for everyone to wake up. Notes document that the patient was unable to be redirected. The staff then administered 10 milligrams of Zyprexa as emergency IM medication. The patient was escorted down to her room and fell asleep. Restraints were documented at 1:30 am; a physical hold and medication were administered. Less restrictive measures used prior to the restraint were redirection, orientation to reality, removal from stimuli, verbal de-escalation, distraction/diversional activities and comfort measures. In response, the patient response remained agitated, continued to be a safety risk, and was non-receptive. A rights restriction notice was given.

Per the psychiatrist's notes on 11/1/14 at 10:16 am, the patient continued to be grandiose. She had been disruptive overnight and required a Zyprexa injection. There was documentation that the patient had taken the Risperidone and did not notice any side effects of the medication. It was also noted the patient had agreed to the safety plan. Risperidone was increased to 3mg.

Psychiatrist notes document on 11/2/14 at 10:20 am that the patient shows signs of improvement. The patient stated she was not going to take the increased Risperidone, but then ended up taking it.

While meeting with a counselor on 11/3/14 at 11:38 am, the patient revealed that she spoke to the doctors earlier in her stay and would like to be discharged. The patient also expressed a desire to know more about her discharge plan. Per the counselor's notes, there is not an update as to what information she received about her discharge plan.

The nurse's notes on 11/3/14 at 12:01 pm stated that the patient was at their station demanding that she [the patient] wanted to be discharged from the facility that morning. The patient reportedly was upset that she was not able to leave the unit without the permission of a physician.

The patient was overheard speaking with someone on the phone on 11/3/14 at 7:36 pm saying, "I'm not going to stay here! Do whatever you have to; get me out of here!" According to the notes of a Certified Medical Assistant (CMA), the staff informed the patient that it was up to the physicians to begin the discharge paperwork, to which the patient responded that "They make the decisions after the sh*t you guys write down on paper." Additionally, the patient also claimed, "The shots didn't work." The patient also said "You forced me to take the shots because I wouldn't take my medicine, which you can legally refuse, then put me in that concrete room." The CMA did not provide a response in the progress notes.

According to the MAR and the nurse's report on 11/4/14 at 3:35 am, the patient awoke in the early hours of the night and created a commotion. The patient was reportedly suggested oral medication, which she refused, and was escorted back to her room. After being asked to stay in her room, the patient exited and proceeded to call upon the other residents of the unit to "come

save the children!" After this, the patient attempted to make a phone call at the nurses' station. The staff administered emergency medication (Zyprexa) due to an inability to redirect the patient. There was no evidence of a rights restriction notice or that the patient was given the right to refuse.

While speaking with a registered nurse on 11/4/14 at 12:15 pm, the patient revealed some of her wishes, which were recorded in the nurse's notes. Reportedly, the patient is "preoccupied with discharge." The patient is said to have proclaimed, "I signed myself in; I can sign myself out." Also, the patient believed that she was being treated unfairly because the other patients on the unit have unrestricted phone privileges, while the patient has restricted access to the telephones per the beliefs of the patient. The patient additionally stated she understands that last night she had an "outburst" and claims that she "got medication shots against her will for the third time." Per the documentation in the nurse's notes, the patient does not believe that she has caused much trouble except for her single incident earlier on 11/4/14. The patient also requested that her Bipolar Disorder medication dosage is not increased because she would like to speak about that with her physician.

The patient was discharged on 11/6/14 after receiving information about her medication and a Discharge Recovery Plan booklet. The discharge book contains various reminders about the coping mechanisms discussed with the patient in therapy, the patient's identified support system, and a plan of how to stay safe when the patient feels triggered. According to a note from the patient's physician regarding her discharge plan, the patient has responded well to changes in her prescription medication, the patient participated in group therapy sessions, and the patient, her family, and her treatment team were comfortable with the patient's plan of discharge.

Policy Review:

The HRA reviewed the Administration of Medications (1/14), Medication Administration training and Medication Enforcement Training which lists the following:

- " Patients have the right to refuse medications,
- We must always use least restrictive measures,
- PO [by mouth] is less restrictive than IM medication,
- We need to offer and consider least restrictive measure,
- Team decision may be to take patient concerns regarding medication enforcement needs to court for their ruling."#
- "Whenever medications are given in an enforced fashion a restriction of rights is given to the patient,
- Court ordered medications are covered under the court order."

The HRA did not receive emergency medication administration policy.

The HRA reviewed the telephone policy as it is outlined in the Patient Handbook. There are two main telephones available to patients near the nurse's station. When one of the phones rings, another patient is responsible for answering it and finding the recipient of the call. However, these telephone calls can only be received during the hours of 7:30 am to 10:30 pm,

except during group therapy sessions. Phone calls may also only last a duration of 10 minutes, according to the Handbook.

In the Admission and Discharge (03/14) criteria that the HRA reviewed, there are 14 pages of information on the rights of patients in the hospital. Of note are the following criteria:

"Discharge Criteria:

1. Patient no longer presents a danger to self and others.
2. Patient demonstrates ability to provide for his or her safety as indicated in the interdisciplinary treatment/discharge safety plan.
3. Patient demonstrates an ability to provide for one's own needs and/or with no expectation that the patient will be able to improve any further with inpatient treatment.
4. Patient meets criteria for discharge to an alternative level of care/provider. Adequate discharge plan in place.
5. Patient is psychiatrically stable and/or has been identified as receiving maximum benefit from inpatient Behavioral Health stay but continues to have active co-morbid medical condition. Patient is discharged for medical management to the appropriate medical care setting.
6. Discharge recovery/safety plan has been developed with the patient (and family as appropriate).
7. Patient is free of symptoms of acute substance withdrawal.
8. Problems have been alleviated to the extent that patient is able to minimally function in family/social setting and can safely continue treatment in an outpatient setting…."

Under the Admission and Discharge Criteria (03/14), the definition of a voluntarily admitted patient is listed as follows: "A voluntary admission is defined in Article V of the Mental Health Code. A 16-year old or older may be admitted voluntarily if he/she makes the application for admission. Parents of a minor will be informed and the patient will be treated as an adult." The HRA did not observe the policy that addresses the right to request discharge and when staff should give a discharge form or advise the patient to request discharge in writing.

The HRA also reviewed the education policy on restraints (03/14). This section details the level of training that staff must receive and what the training encompasses. "The training will include information on minimizing the use of restraints and seclusions, appropriate method for applying the restraint to patients, on the need for discussion of the use of restraint with patients/families, and on monitoring patients while in restraint, including first aid techniques and CPR." There is additional information detailing the specifics of the training in the interview portion of this report.

Also in the Patient Handbook is a section entitled 'Speak Up' where patients are encouraged to report any issues or concerns to a nurse and also for patients to voice their opinions. The number for the patient advocacy line is listed as well.

CONCLUSIONS

Regarding the forced medication complaint and based on the evidence from the interview with staff, the documentation in the MAR and the evidence in the record, the HRA finds this complaint <u>substantiated.</u> The Mental Health Code in section 405 ILCS 5/2-107 states "An adult recipient of services, must be informed of the recipient's right to refuse medication….The recipient shall be given the opportunity to refuse generally accepted mental health, including, but not limited to medication….If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available." There were two rights restrictions in the record regarding emergency medication on two occasions when the patient was given forced emergency medication on 10/30/14 and on 11/1/14. Supposedly the first one was completed by staff in error, however the evidence points that it was given against the patient's wishes. There is no documentation by staff that the patient willingly agreed to take the medication. There were two other occasions where emergency medication was given without rights restriction notices and without documentation that the patient was given the right to refuse on those occasions. On all 4 occasions it involved waking up other patients, which, without more supportive documentation, may not rise to the need to prevent "serious and imminent physical harm…and no less restrictive alternative is available" per the Code in section 2-107. The HRA does acknowledge how disruptive and uncomfortable this might have been for staff and other patients, but the criteria for forced emergency medication is to prevent serious and imminent physical harm.

On 11/1/14 the patient stated she was almighty God and was going to get the devil out of that other patient. Documentation showed the patient began to follow a peer on the floor yelling that the peer was the devil and that she would get the devil out of him. This was the one incident when the patient was given forced medication, restrained and issued a rights restriction. The notice did indicate she was asked if anyone was to be notified and she replied that she did not. The documentation was completed by a registered nurse with supervisory responsibilities, after personally observing and examining the patient. The record showed the use of restraint was justified to prevent the patient from causing physical harm to herself or others.

The patient met with her medical team 8 times during her stay at the hospital. At the end of each entry in the patient's medical records, the record stated, "Unless otherwise noted, patient understands burdens and benefits of recommended and current care, including common and serious medication risks, has had any questions and concerns addressed, and consents to the plan as outlined above." It was noted the patient did understand the recommended course of treatment including medication.

The Code, in 405 ILCS 5/2-102 (a-5), states that "If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment." Stating a patient understands medication may not mean the same as having the capacity to make a reasoned decision or that the patient had been given the opportunity to refuse.

The HRA makes the following recommendation:

1. **Follow the Mental Health Code, Section 405 ILCS 5/2-107, including the recipient's right to refuse medication unless such medication is necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available"**
2. **If a patient willingly agrees to take emergency medication it should be documented in the patient's record.**

The HRA takes this opportunity to make the following suggestion: during the third shift, the ratio of staff to patients, dips down to 1 staff per 11 patients. The HRA strongly suggests that the hospital consider increasing the staffing to provide services during the late evening or third shift to assist with recipient needs.

2. Regarding the communication violation, **the HRA finds that the complaint is substantiated.** The Mental Health Code, Section 405 ILCS 5/2-103, states that, "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." The primary phones that are accessible to the patients are two phones mounted on the wall side by side in a hallway off the main corridor of the unit in front of the nurse's station. This does not allow for any privacy. Imagine there are two patients using the phones at the same time: one is trying to make arrangements after discharge and the other was recently admitted, still exhibiting symptomatic behaviors. It would be very difficult and distracting for both patients while they complete their phone calls, which would not be private and probably impeded because of being mounted closely to each other. It is also not private if too close to the nurses who can "overhear" conversations.

The HRA makes the following recommendations:

1. Follow the Mental Health Code, Section 405 ILCS 5/2-103, which requires that "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"

2. Complete rights restriction notices and issue them to anyone designated (405 ILCS 5/2-201) whenever telephone communication or any right under the Code is restricted and be sure that all rights related policies may amplify or expand, but not restrict or limit these rights (405 ILCS 5/2-202).

The HRA takes this opportunity to make a **suggestion.** The HRA has observed that some facilities have cubicles where patients may make a private phone call. A cubicle or other barrier would allow for privacy for an individual making a phone call and also somewhere to sit and take notes, as needed.

Regarding the complaint of inadequate discharge, during the course of the patient's stay, it was documented in the staff notes that the patient requested discharge on 10 occasions: 10/30/14 at 2:13 pm; 10/30/14 at 11:34 pm; 10/31/14 at 1:25 pm; 10/30/14 at 5:37 pm; 11/3/14 at 11:38 am; 11/3/14 at 12:01 pm; 11/3/14 at 7:36 pm; 11/4/14 at 12:15 pm; 11/4/14 at 4:15 pm; and 11/5/14 at 3:04 pm. Section 405 ILCS 5/3-403 of the Mental Health 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." Upon review of the record it appears that no staff explained to the patient that she could request in writing to be discharged or that she would either be discharged or commitment proceedings would take place if she did sign the request. It was documented on the application for voluntary admission which is included per the Code that "She may request discharge at any time. The request must be in writing, and discharge is not automatic." At this time the patient may have not had the capacity to understand or remember she could complete her request in writing. There was no evidence that the patient was advised that she could complete the 5 day request to leave the facility in the record. The record shows her repeated requests for discharge without staff giving her a form to sign, which must be done regardless of whether any counselor or psychiatrist is alerted first. **The complaint of inadequate discharge is substantiated.**

The HRA makes the following recommendations:

1. Follow the Mental Health Code, Section 405 ILCS 5/3- 403. It is the voluntary patient who decides when she wants to request discharge and she can request discharge at any time. Because of a patient's capacity staff should remind her/him of this right to request discharge in writing. It should also be explained to the patient again that discharge is not automatic, and that within 5 days of receiving the request the hospital will either discharge or initiate civil commitment proceedings. The right to request discharge should proceed before the hospital's practice of having the patient wait to discuss exercising the right with a counselor and then a psychiatrist.

The HRA appreciates the full cooperation of UnityPoint Health (Methodist) during the course of the investigation. It is commendable for UnityPoint to create an atmosphere of warmth and comfort for the patients with murals on the walls and in the patient rooms.