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North Suburban Human Rights Authority
Report of Findings
Elgin Mental Health Center
HRA #08-100-9001

Case Summary: The HRA substantiated the allegation that a STA used a consumer's personal possessions without the consumer's permission. The other allegations were unsubstantiated. The HRA's public record on this case is recorded below; the provider's response immediately follows the report.

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Elgin Mental Health Center (EMHC), Forensic Treatment Program, Hartman Unit. In August 2007, the HRA notified EMHC of its intent to conduct an investigation, pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The following complaints were investigated:

1. A staff member on the unit uses the consumer's personal possessions (straightening comb, fingernail products) without permission.
2. Staff members have attitudes and hold grudges.
3. A consumer was not allowed to wear her belt despite not being suicidal.
4. A consumer had enough of another consumer's constant harassing and provoking behavior which resulted in verbal aggression. The aggressor was subsequently unit-restricted. It was alleged that had staff intervened and made the other consumer stop her behavior, the aggressive behavior could have been avoided.
5. Africa American consumers get punished more severely than others.
6. The consumer's Physician is always too busy to speak to the consumer.
7. The consumer has to "beg" to get a copy of her treatment plan.
8. The telephones are not very private.
9. A consumer cannot attend scheduled off-unit activities because there are not enough staff available to provide an escort.

The rights of consumers receiving services at EMHC are protected by the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102, 5/2-112, 5/2-103, 5/2-104) and the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 10/4).

To pursue this investigation, the HRA reviewed, with written authority, a portion of the clinical record (April thru September 2007) of the consumer whose rights were alleged to have been violated. An on-site visit was conducted in September 2007, at which time the allegations were discussed with the consumer's Social Worker and the STA (Security Therapy Aid) that was identified as the staff member who used the consumer's personal products. The HRA also received a written

document from the unit's Nurse Manager that addressed some of the allegations. The consumer was also interviewed. The HRA acknowledges the full cooperation of unit personnel.

Background

Consumers receiving services at EMHC's Forensic Treatment Program have been remanded by Illinois County Courts to the Illinois Department of Human Services under statutes finding them Unfit to Stand Trial (UST) and Not Guilty by Reason of Insanity (NGRI). Placement evaluations determine the most appropriate inpatient or outpatient setting for forensic treatment based on a number of factors including age, gender, mental health diagnosis, and security need. Unless a person is specifically ordered to receive services in an outpatient setting, court ordered referrals under state forensic statutes call for placement in a secure inpatient setting. The Forensic Treatment Program has 315 beds.

Allegation #1: A staff member on the unit uses the consumer's personal possessions (straightening comb, fingernail products) without permission.

Findings

At the site visit, the STA reported that she did use the consumer's straightening comb on another consumer. The STA stated that the consumer (who wished to use the comb) told the STA that the she had gotten approval from the consumer to use the comb. The STA reported that she did not check to make sure that the consumer had approved this. The STA stated that when the consumer saw her comb being used, she became very irate and upset saying that they did not have permission to use her things. The STA reported to the HRA that she immediately apologized to the consumer and also reported that she will no longer use consumer belongings on another consumer. The STA reported that she had not used any of the consumer's nail products. The Nurse Manager addressed the allegation by saying that special arrangements have been made, in that the comb is now locked in the Case Worker's office.

The Center's Code of Ethics policy, the rights of patients, whether sanctioned by the application of moral principle, or by policy or law, are to be honored and respected. Among these rights (to abridge) are the right to respectful, competent treatment; the right to privacy; and the right to personal property.

Conclusion

Pursuant to Section 2-102 of the Mental Health and Developmental Disabilities Code, "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 STA acknowledged that she used the consumer's personal possessions without the consumer's permission; the allegation is substantiated. The matter has been addressed, thus no recommendations are made.

The HRA takes this opportunity to say that personal hygiene products should never be shared with others.

Allegation #2: Staff members have attitudes and hold grudges.

Findings

At the site visit, Center personnel described the consumer as paranoid and delusional, and that she often takes things very personally. It was stated that she has difficulty following rules and often states that staff members are unfair when they set limits. It was further offered that the consumer is very negative and expresses multiple complaints during each community meeting. The Nurse Manager wrote that the Hospital is actively working on changing the culture that will be more consumer friendly - specifically a coercion-free environment. It was also written that some patients

would not be satisfied even if staff responded in great kindness. The Manager further wrote that there is an expectation that staff members always speak respectfully to each consumer. Lastly, the Nurse Manager offered that staff members do not punish patients; rather there is a loss of privileges when it is warranted.

According to the clinical record, the consumer's diagnosis includes: Psychotic Disorder NOS (not otherwise specified), rule out Delusional Disorder, rule out Schizophrenia. The consumer was adjudicated NGRI on July 19, 2004; and was remanded to the DHS on July 18, 2004. A psychiatrist's note described the consumer as very paranoid and unreasonable. It was written that she interprets staff actions toward her as malicious, in that staff are trying to make the consumer's life at the Center unpleasant for her so that staff have job security. The consumer had indicated that she wanted the Center destroyed and staff members punished. An additional note relevant to this allegation was a nursing note that documented that the consumer had requested a PRN (as needed) medication because a staff member had given her a "dirty look". The staff member in question was transferred to another unit and the Office of the Inspector General was contacted.

The Center's Code of Ethics policy states that deliberate harm whether physical, psychological, or as a consequence of neglect must never be tolerated, or allowed to pass unreported. The Center's (7-page) Interpersonal Relations Between Staff and Patients policy states that staff shall at all times relate to patients in an objective, ethical, professional, and humane manner which demonstrates an awareness of the uniqueness of the formal positive interaction and helping relationship between the employee and the patient for which the employee receives monetary compensation. The Center's Prevention of Abuse and/or Neglect of Patients policy states that it is the policy of the Center to prevent the abuse and neglect of patients and to ensure a safe and secure environment for patients.

Conclusion

Pursuant to Section 2-112 of the Mental Health and Developmental Disabilities Code, "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect."

The HRA cannot discount the consumer's assertion that staff members have attitudes and hold grudges, however, no evidence was found to support the claim; the allegation is unsubstantiated.

Allegation #3: The consumer was not allowed to wear her belt despite not being suicidal.

Findings

At the site visit, hospital personnel stated that the consumer was, in fact, restricted from having her belt. However, it was due to being a danger to others. It was explained that when a consumer is placed on frequent observations, as this consumer was, certain restrictions are automatic. The restricted items would depend on why the frequent observation was imposed. For example, a consumer placed on frequent observations for suicidal ideation would have personal objects restricted that could cause harm (necklace, shoelaces, etc.). This consumer was placed on frequent observation (from July 3 through July 11, 2007) for unpredictable behavior due to aggression toward another consumer.

The Center's Special Observation policy states that whenever a patient is placed on special observation, a room search shall be conducted, including clothing that the patient is wearing. Potentially dangerous objects shall be removed; such items include shoelaces, belts, coins, scarves and other items that a patient could use to hurt self or others. The room and clothing search is to be documented in the progress notes. The HRA did not find chart documentation showing that the consumer's belt had been removed.

Conclusion

Pursuant to the Mental Health Code, Section 2-104, "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 therefore, except in the circumstances and under the conditions provided in this Section. (a) Possession and use of certain classes of property may be restricted by the facility director when necessary to protect the recipient or others from harm, provided that notice of such restriction shall be given to all recipients upon admission. (b) The professional responsible for overseeing the implementation of a recipient's services plan may, with the approval of the facility director, restrict the right to property when necessary to protect such recipient or others from harm."

The allegation that the consumer was not allowed to wear her belt despite not being suicidal is unsubstantiated. It is suggested that staff members be reminded to follow hospital policy and document when clothing is removed due to special precautions.

Allegation #4: A consumer had enough of another consumer's constant harassing and provoking behavior which resulted in verbal aggression. The aggressor was subsequently unit-restricted. It was alleged that had staff intervened and made the other consumer stop her behavior, the aggressive behavior could have been avoided.

Findings

At the site visit, Center personnel explained that on July 3, 2007, the consumer slapped another patient on the head. The consumer was restricted to the unit and she was monitored every 15 minutes (frequent observations) for unpredictable behavior. The restriction was discontinued on July 11, 2007. Center personnel relayed that the victim does in fact talk all day, and that this is a symptom of her illness. The other consumers are reminded to try to avoid that consumer if her constant chatter bothers them.

The chart documentation mirrors the above verbal information.

Conclusion

Pursuant to Section 2-102 of the Mental Health and Developmental Disabilities Code, "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."

Based on the information obtained, the HRA concludes that rights were not violated; the allegation is unsubstantiated.

Allegation #5: African American consumers get punished more severely than others.

Findings

At the site visit, it was offered that this is a reoccurring theme with the consumer. It was stated that while she was in the janitorial program, one duty was to take out the trash. The consumer subsequently complained that only the African American consumers were made to perform this task because of their race.

A psychiatrist's note documented that during a monthly staffing the consumer had many complaints about her treatment, medications and family problems/concerns. It was documented that the consumer remains oblivious to her paranoia and is very blaming and suspicious of staff. It was further documented that a workshop employee attended the staffing and praised the consumer's work and attitude, and that the consumer made no claims of being discriminated against or being treated unfairly as she had when in the janitorial services program. A progress note documented that the consumer reported that she was treated unfairly and differently from others in the Rehabilitation Services program (janitorial program) because she was late; her pay was subsequently docked and she had to perform trash disposal duties. A staff member from the Rehabilitation Services program met with the consumer and explained that all consumers are docked when they arrive late and that all consumers must perform trash disposal duties.

The Center has a Non-Discrimination in Service Delivery policy which defines "discrimination in the delivery of services" as the reporting of an investigation of alleged discriminatory treatment to patients wherein the patient complains of unequal delivery of services

(e.g., denial of goods or privileges otherwise given to all patients regardless of race, color, religion, sex, national origin, age or physical/mental disability). These occurrences are to be regarded as patient complaints, and the Incident Reporting procedure shall be followed.

Conclusion

Pursuant to Section 2-102 of the Mental Health and Developmental Disabilities Code, "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." Based on the information obtained, the HRA concludes that rights were not violated; the allegation is unsubstantiated.

Allegation #6: The consumer's Physician is always too busy to speak to the consumer.

Findings

At the site visit, it was stated that the consumer's Psychiatrist had been ill and that she might not have been as available as she should have been. The consumer was subsequently transferred to another Psychiatrist.

A review of the chart did not show that the consumer had difficulty getting her medical or mental health needs met. It is noted that during June and July 2007, the consumer met with her Psychiatrist five times and the Psychiatrist attended the consumer's service plan meetings. It is also noted that on July 5th and July 9th , the consumer was seen by a "covering" psychiatrist. The chart contained five additional psychiatric notes from July 19th through September 6th, 2007.

Conclusion

Pursuant to Section 2-102 of the Mental Health and Developmental Disabilities Code, "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." By staff members own admission, the consumer might have had, at times, difficulty seeing her Psychiatrist. However, nothing was found to indicate that the consumer's mental health or medical needs were not being addressed; the allegation is unsubstantiated.

Allegation #7: The consumer has to "beg" to get a copy of her treatment plan.

Findings

At the site visit, it was stated that the consumer does attend her staffings and will request a copy of the treatment plan. It was further stated that she requests the plan immediately after the meeting and that when changes need to be made, a copy is often not ready until the following day. The interviewees stated the consumer does get the plan, but she wants it immediately and does not want to wait.

Conclusion

Pursuant to the Mental Health and Developmental Disabilities Confidentiality Act, Section 4 (a) the recipient if he is 12 years of age or older, has the right upon request, to inspect and copy his record or any part thereof. Based on the information obtained, the HRA concludes that rights are not being denied; the allegation is unsubstantiated.

Allegation #8: The telephones are not very private.

Findings

At the site visit, Center personnel stated that the phones available on the unit are not completely private, as any consumer or staff member walking past a consumer on the phone could inadvertently hear a portion of the conversation. It was stated that the phones are not located near the nurses' station, but more centrally located in the open common area. A consumer could request to use his/her Caseworker's phone if the need for a more private conversation was necessary.

The HRA toured the unit to see the phones. Each phone area has a seat available and the phone is slightly encased with a steel partition.

The Center's Patient Phone Use policy mirrors the Mental Health Code, in that it states that patients shall be permitted unimpeded, private, and uncensored telephone communications with persons of their choice.

Conclusion

Pursuant to the Mental Health and Developmental Disabilities Code, Section 2-103, a recipient who resides in a mental health facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation. The HRA concludes that the telephones are as private as they can be on a mental health unit; the allegation is unsubstantiated.

Allegation #9: A consumer cannot attend scheduled off-unit activities because there is not enough staff available to provide an escort.

Findings

At the site visit, it was explained that this consumer has a building pass, meaning that she can attend off-unit programming without a staff escort. However, when she became aggressive, the pass was pulled and she was placed on frequent observations for unpredictable behavior. According to the chart, she was on frequent observation for about two weeks (7/3/07-7/11/07). It was explained that she was then not eligible for off-unit activities. It was explained that when the frequent observation is discontinued, the consumer needs to be observed for another week or two before the building pass is fully restored. During this time, the consumer can attend her off-unit programming activities, but she must be accompanied by a staff member. The STA stated that staff are very available to escort patients and that only sometimes on the weekend a patient may have to wait a bit.

Conclusion

Pursuant to the Mental Health Code, Section 2-102, 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 HRA found no evidence to support this claim; the allegation is unsubstantiated.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

Rod R. Blagojevich, *Governor*

Illinois Department of Human Services

Carol L. Adams, Ph.D., *Secretary*

Division of Mental Health - Region 2

Elgin Mental Health Center and Singer Mental Health Center

RECOVERY IS OUR VISION
Recovery is a Personal Journey of Hope, Healing, Growth, Choice, and Change

November 29, 2007

Ms. Kori Larson - Chairperson
North Suburban Regional Human Rights Authority
9511 Harrison Street, W-300
Des Plaines, IL 60016-1565

Re: HRA #08-100-9001

Dear Ms. Larson,

Thank you for your recent review. I am glad that only one of the nine allegations was substantiated. This substantiated complaint involved a staff member's admitted use of a consumer's comb on another consumer. The mistake was corrected when the staff became aware that the consumer did not give her permission to allow the other consumer to use her comb.

We agree that the staff member should never have allowed consumers to share personal hygiene products. We will ensure that the staff member involved is aware of this. We continue to strive to provide the best possible care for our consumers.

I would request that this response be attached to the report and be included with any public release of your Report of Findings.

Sincerely,

Raul Almazar, RN, MA
Hospital Administrator

RA/JP/pb

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