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North Suburban Human Rights Authority Report of Findings Elmhurst Memorial Healthcare HRA #10-100-9017

Case Summary: the HRA did not substantiate the allegations presented. The HRA's public record on this case is recorded below.

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Elmhurst Memorial Healthcare. On April 6, 2010, the HRA notified Elmhurst Memorial Healthcare of its intent to conduct an investigation, pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The complaint investigated was that staff members were verbally abusive and that the program offers medication as the sole form of treatment.

If found substantiated the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102 and 5/2-112).

Provider Background

Elmhurst Memorial Healthcare is an independent not-for-profit hospital, governed by a volunteer board of trustees. Elmhurst Memorial Healthcare offers a range of programs and services designed to meet the needs of men, women, children and families. The hospital is accredited by the Joint Commission. The focus of this investigation will center on the 18-bed behavioral health program located within the hospital.

Method of Investigation

The HRA conducted an on-site visit in May 2010. While at Elmhurst Memorial Healthcare the HRA discussed the allegations with the program's Director and the Vice President of Patient Care Services. The complainant was interviewed by telephone. The HRA requested and reviewed the clinical record of a recipient of services with consent and hospital policy relevant to the allegations.

Findings

The recipient reported to the HRA that staff members are abusive, and sited the following example: because he refused all medical treatments including having staff members take his vitals, a staff member would not give him his meal tray - saying the recipient would get the tray after he had taken the vitals of all the other recipients. The recipient told the HRA that another staff member heard this exchange, and gave the recipient his meal tray.

The clinical record revealed data on a male recipient voluntarily admitted to the hospital on March 5, 2010 due to being dangerous to himself and others; he was discharged on March 10, 2010.

Regarding this allegation, hospital personnel stated that all meal trays are passed out and retrieved so that staff members can monitor the food consumed and ensure that the eating utensils are accounted for. The Director stated that she discussed the allegation with both staff members present during this meal. The RN stated that he was passing medications during a breakfast meal and he did tell the recipient that he needed to wait until the medications were passed before he could get his tray. The HRA was told that RNs typically do not pass out the food trays. It was relayed that the other staff member (who passes the trays) overheard this and stated she would get the tray; the tray was given to the recipient and the meal was not delayed. The Director stated that the RN's response was perfunctory and she did not believe it was said in a hostile or abusive manner and that the recipient had limits set which he did not like.

The hospital's Disruptive Behavior in the Workplace policy states that it is the policy of Elmhurst Memorial Healthcare to provide a professional and respectful work environment that is free of disruptive behaviors. Disruptive behavior includes unprofessional conduct of any kind, including but not limited to discourteous or abusive behavior, verbal or physical threats, attempted or actual assault or harassment of any form.

The recipient reported that the only treatment given at the hospital is medication and he does not take medication, thus no treatment. According to the clinical record, the recipient reported that he believes his religion "implied to him not to take any medications and have different type of treatment such as emotional treatment." The recipient advised his psychiatrist that it is his right to refuse medication and that he is not interested in wasting the psychiatrist's time about taking medication. The psychiatrist documented that the recipient has been informed about his rights [to refuse medication] and that his rights will not be taken away. According to the clinical record, the recipient did not take medication during the hospitalization.

In the materials reviewed, the program offers programming from morning until evening. Treatment groups noted on the schedule include: adjunctive therapy, process group, reflection time, medication education, coping skills, etc. It was stated that the schedule is posted on the unit and that each recipient is given a copy of the schedule. Recipients are encouraged to participate in all groups offered. The clinical record showed that the recipient would attend some groups, but he was described as argumentative and would often say that he knew more/was smarter than staff. The recipient had a Master Treatment Plan that included goals and interventions. Treatment goals included managing problematic impulses, focusing on productive activities, protect self from harm and take medications as ordered.

At the site visit, it was stated that the recipient is well-known to hospital staff members. He did not take medications during the hospitalization, and he never required emergency medication. The recipient was aware of and was encouraged to attend unit programming, and it was stated that he received one-on-one time with staff members.

The hospital's Treatment Planning policy states that its purpose is to develop a treatment plan for all patients receiving Behavioral Health Services based upon assessed needs and utilizing an interdisciplinary approach. The policy goes on to state that at a minimum the treatment plan will include presenting symptoms and precipitants and any barriers to treatment, problem identification, measurable goals/objectives, interventions which include frequency and services.

Conclusion

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

Based on the written and verbal information, the HRA concludes that recipient rights were not violated; the allegations are unsubstantiated.