FOR IMMEDIATE RELEASE

North Suburban Regional Human Rights Authority
Report of Findings
HRA #15-100-9003
Elgin Mental Health Center

Introduction

In August 2014, the North Suburban Regional Human Rights Authority (HRA) opened this investigation regarding Elgin Mental Health Center (hereafter referred to as Center), Forensic Treatment Program (FTP) Unit I. A complaint was received that alleged the following:

1. Physician/nursing personnel fabricate documentation –as an example it was stated that the initial 3-day admission report sent to the court was simply copied from jail documentation. The consumer had only been at the facility one day when the report was completed, thus the report was not based on any observation or examination. Another example was regarding the consumer receiving emergency medication in that what was documented about this intervention was untrue.
2. A consumer was given medication without consent; less restrictive measures were not initially attempted.
3. A consumer had severe sensitivity to light and noise – staff members insisted on keeping the door open and the light on.
4. A delay in addressing pain medication resulted in severe suffering to a consumer and staff members would not contact consumer's community physician for medical information.
5. The facility does not respond to consumer complaints.
6. The facility does not provide access to the medical record in a timely manner.
7. There are no provisions in the bathrooms for consumers with physical limitations.

The rights of consumers are protected by the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4).

Recipients receiving services at EMHC's Forensic Treatment Program have been remanded by Illinois County Courts to the Illinois Department of Human Services (DHS) 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.

Methodology

To pursue this investigation, the HRA made repeated requests for the clinical record of a consumer, with written consent. The Medical Records Department had been unable to locate the record in its entirety, thus the record "as available" was received in January 2015. The documentation received and reviewed included the consumer's discharge summary, a personal safety plan, a psychological assessment, a social assessment, the 30-day court report, a fitness evaluation and progress notes for the consumer's last two days of the hospitalization. The allegations were discussed with hospital personnel in February 2015.

Allegation #1: Physician/nursing personnel fabricate documentation –as an example it was stated that the initial 3-day admission report sent to the court was simply copied from jail documentation. The consumer had only been at facility one day when the report was completed thus the report was not based on any observation or examination. Another example was regarding the consumer receiving emergency medication in that what was documented about this intervention was untrue.

Findings

The documentation reviewed revealed data on a female consumer admitted to the Center on September 4, 2013; she was found fit to stand trial and was discharged from the Center on November 8, 2013. The psychological assessment dated September 16, 2013, noted that the consumer recognized and announced that she did not cooperate for a fitness examination by Forensic Clinical Services, and intended to do the same once she arrived at the Center. The consumer stated that she is "unquestionably fit", and that she will not be formally evaluated under any circumstances by staff. It was noted that she had refused to participate in any/all evaluations to date. The materials reviewed did not contain any documentation regarding emergency medication.

The Thirty-Day Report dated September 10, 2013, stated that in the Center's judgment, they would be able to provide an appropriate treatment program for the patient, that in their opinion the patient can be restored to fitness within one year of the date of the original finding of unfitness, and that a copy of the patient's treatment plan was enclosed.

Hospital personnel interviewed by the HRA advised that the court requires a 30-day report – not a 3-day as stated in the allegation- pursuant to state statutes and that this report is in fact completed on the day of admission. It was stated that the report verifies that the Center can provide the treatment needed for that consumer. The Director of Court Services explained that if the Center has a Rule to Show Cause as to why DHS should not be held in contempt for failure to comply with the Order of the Finding of Unfitness, as soon as that consumer hits the door he/she is assessed for fitness and a report generated, which then is used in court to defend whomever is named in contempt; otherwise there is no rush to do this.

Conclusion

The Code of Criminal Procedure(725 ILCS) Section 104-17(e) states that, "(e) Within 30 days of entry of an order to undergo treatment, the person supervising the defendant's treatment shall file with the court, the State, and the defense a report assessing the facility's or program's capacity to provide appropriate treatment for the defendant and indicating his opinion as to the

probability of the defendant's attaining fitness within a period of time from the date of the finding of unfitness. For a defendant charged with a felony, the period of time shall be one year. For a defendant charged with a misdemeanor, the period of time shall be no longer than the sentence if convicted of the most serious offense. If the report indicates that there is a substantial probability that the defendant will attain fitness within the time period, the treatment supervisor shall also file a treatment plan which shall include: (1) A diagnosis of the defendant's disability; (2) A description of treatment goals with respect to rendering the defendant fit, a specification of the proposed treatment modalities, and an estimated timetable for attainment of the goals; (3) An identification of the person in charge of supervising the defendant's treatment."

The 30-day report was completed on the day of admission and was completed based on observation of the consumer, verifying that the Center could provide the mandates as described in the Code of Criminal Procedure; the allegation is unsubstantiated. Since there was no documentation provided regarding the need for emergency medication, the HRA can neither confirm nor deny the allegation.

Allegation #2: A consumer was given medication without consent; less restrictive measures were not initially attempted.

Findings

An RN that worked on the day shift with this consumer was interviewed about this allegation; the consumer's attending psychiatrist has since retired from state employment. The RN recalled that once during her shift, the consumer did receive emergency medication. The RN recalled that the consumer was very agitated and she was banging her hands on the nurses' station. The RN stated that staff members tried to get her to calm down, suggesting she go to her room, asking her to calmly state what was wrong, but the consumer was unable to gain control. The RN stated that emergency medication was ordered at that time. The RN also stated that emergency medication is not freely given and the consumer must need the medication to help with the behavior.

The Center's Refusal of Services/Psychotropic Medication policy states that (to summarize) an adult patient is to be given the opportunity to refuse mental health services, including but not limited to medication, if such services are refused, they are not to be given unless such services are necessary to prevent the patient from causing serious and imminent physical harm to self or others or are court ordered.

The limited chart documentation did not contain any emergency medication events.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 2-107, "An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy".

According to the RN, the consumer was at least on one occasion given medication without consent as it was given in an emergency situation. Limited documentation cannot validate or invalidate the allegation that less restrictive measures were not initially attempted.

Allegation #3: A consumer has severe sensitivity to light and noise – staff members insisted on keeping the door open and the light on.

Findings

The RN interviewed confirmed that the consumer did have sensitivity to light and noise due to her migraines. However, her bedroom light needed to remain on because the consumer was on a

precaution and staff members needed to be able to readily see her for her safety. Also, it was stated that all consumers are monitored while sleeping and the overhead lighting is needed so that staff members can see that the consumer is breathing.

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." It is concluded that lights and doors need to remain on/open so that staff member have access to the consumer to maintain safety. Although the allegation that staff members insisted on keeping the door open and the light on even though a consumer had a severe sensitivity to light and noise indeed occurred, it does not constitute a rights violation. However the HRA takes this opportunity to suggest that exceptions and/or provisions be made when medically indicated.

Allegation #4: A delay in addressing pain medication resulted in severe suffering to a consumer and staff members would not contact consumer's community physician for medical information.

Findings

The Fitness Evaluation, dated October 31, 2013, noted that the consumer had signed release of information forms for her community medical physicians. The RN recalled that the consumer had back pain and the migraine pain and that she received medication for these symptoms.

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." The consumer did sign consent forms that would allow contact with her community physician's; however limited documentation cannot validate or invalidate the allegation that the physicians were not contacted. Limited documentation cannot prove or disprove the allegation that there was a delay in address the consumer's pain.

Allegation #5: The facility does not respond to consumer complaints.

Allegation #6: The facility does not provide access to the medical record in a timely manner.

Findings

The consumer's Social Worker stated that she recalled personally copying parts of the consumer's record for her and that all consumers have the right to review and copy their clinical record. The Social Worker also stated that the consumer had made numerous complaints during her stay and that all complaints were addressed by the appropriate person/department.

The Center's Patient/Family/Guardian Concerns & Grievances policy states that patients, families, significant others, and other interested parties have open recourse and opportunity to identify and resolve concerns and complaints concerning treatment, other services, or conditions at Elgin Mental Health Center. The policy goes on to say (in part) that for non- Office of Inspector General (OIG) complaints, staff receiving verbal complaints/concerns on the unit will attempt to satisfactorily resolve the complaint at the unit level, with the involvement of the treatment team or through the community meeting. Staff will hand forms completed by patients to the Nurse Manager or back-up for review and response. Verbal concerns/complaints on the unit that are not resolved

within 3 day can be called in to the Recovery Specialist or submitted in writing to the Nurse Manager. Within 2 working days of receipt of complaint, the Nurse Manager will deliver or send a written acknowledgement that the complaint was received. The Nurse Manager will attempt to resolve the complaint and will indicate the proposed solution on the form, as well as whether it was accepted, returning the response to the consumer within 2 working days.

The Center's Patient Access To Records policy states (in part) that a patient, guardian or authorized representative is entitled to inspect and request copies of the patient's medical record for as long as the record is maintained.

Conclusion

The Illinois Mental Health and Developmental Disabilities Confidentiality Act, Section 4 states that " (a) The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof (1) the parent or guardian of a recipient who is under 12 years of age; (2) the recipient if he is 12 years of age or older…" Limited documentation cannot validate or invalidate the allegation.

Allegation #7: There are no provisions in the bathrooms for consumers with physical limitations.

Findings

The HRA toured the unit's bathroom and shower area and found them both to be accessible for consumers with physical limitations.

Conclusion

The Americans with Disability Act (ADA) guidelines stipulate that restrooms must have grab bars, clear floor space and rotating space; both the bathroom and shower areas met these guidelines. The allegation is unsubstantiated.

Comment

The Director of Health Information Management stated that an extensive internal investigation was conducted to locate the missing clinical record. Staff members were interviewed and various areas within the hospital were searched; however the record could not be located.

The Illinois Department of Human Services Medical Records Security policy states the following: "Medical records are confidential and must be safeguarded against loss or use by unauthorized persons. All personnel, students, volunteers, auditors and program consultants and reviewers must execute a written confidentiality agreement before obtaining access to medical records. Refer also to Section 6.6 on training new or volunteer staff on confidentiality. Medical records must be kept locked in secure files unless they are under the supervision of an employee who has a business need to see the medical record. Medical records rooms will be locked after regular working hours. Medical records must be secured in locked cabinets during the time the janitorial service cleans the area where records are stored. Medical records being used by staff over a period of time must be kept in locked cabinets after regular working hours. Fax machines must be placed in an area where staff may supervise and safeguard the medical record information that is sent from other providers regarding clients. Records not filed after clinic hours, to be reviewed by employees the next day, must be kept in locked files." The Illinois Mental Health and Developmental Disabilities Confidentiality Act affords each consumer the right to review and/or obtain his/her clinical record.

Hospital administration must ensure that all records are safeguarded against loss or use by unauthorized persons.

RESPONSE

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

Bruce Rauner, *Governor*

Illinois Department of Human Services

James T. Dimas, *Secretary-designate*

Division of Mental Health – Region 2
Elgin Mental Health Center

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

June 30, 2015

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

Re: HRA #15-100-9003

Dear Ms. Larson:

Thank you for your thorough review. We are happy to hear these allegations were unsubstantiated.

Please feel free to include our response with any public release of your Report of Findings.

Sincerely,

Meredith Kiss, MA
Acting Hospital Administrator

MK/JP/aw