
**FOR IMMEDIATE RELEASE**

North Suburban Regional Human Rights Authority
Report of Findings
HRA #16-100-9001
Elgin Mental Health Center

**Introduction**

The North Suburban Regional Human Rights Authority (HRA) opened this investigation regarding Elgin Mental Health Center (hereafter referred to as Center), Forensic Treatment Program after receiving a complaint of alleged rights violations. The complaint accepted for investigation was that a consumer was given emergency medication without justification and that this same consumer had been unjustly restricted from visits with family members. The rights of consumers are protected by the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5).

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**

Relevant policies were reviewed as were sections of the consumer's record with authorization. The HRA met with nursing personnel and a Social Worker to discuss the allegations.

**Findings**

The consumer identified in this case was admitted in July 2014. A review of the chart showed that on three occasions in July 2015, he was medicated during the night shift (midnight-8:00 a.m.). Documented behaviors that incited the emergency medications were: 1)consumer getting close to staff and peers with closed fist in a threatening manner; 2) forceful hand gestures like shooting staff, loud, yelling; 3) spitting, pacing, loud, yelling, forceful hand gestures. It was noted by the HRA that during the day shift the consumer would display the same behaviors but emergency medication was not given. Because of the difference in treatment across shifts, the HRA interviewed the charge nurse from the night shift, and a randomly selected nurse from the day shift.

At the site visit, it was explained that this unit is for persons found "not guilty by reason of insanity". It is for long term consumers. The unit is mixed gender comprised of 31 male and 16 female consumers. It was stated that about 20% are violent (unpredictable) and about 90% are on medication. There are three shifts: the day shift has four nurses and eight Security Therapy Aids (STAs); the evening shift has two nurses and six STAs and the night shift has two nurses and four STAs.

The nurse that initiated one of the emergency medications during the night shift explained that the consumer needed the medication because he was a danger to others. She recalled the incident and described that she had prompted him several times to stop approaching staff with a

closed fist in a threatening manner but he did not comply with the prompts. When asked if he had been violent in the past, she stated that he had never physically made contact with a staff member or a peer when displaying this behavior. She went on to say that although he had never been physical in the past, there is a first time for everything and sometimes they cannot take that chance. When discussing this with the nurse on the day shift, we pointed out that at times the consumer received emergency medication for the same behaviors that would be observed during the day shift, but medication would not be given. He stated that when he observed the behaviors, his assessment of the behaviors did not rise to the level of harm to self or others; therefore emergency medication was not administered. The interviews did not reveal why the consumer was not medicated similarly in the two shifts.

Subsequent the visit, the HRA asked the Center for summary data on emergency medication issued. The data included medication administered for a six month period. Nineteen consumers received emergency medication; of those nineteen, fifteen consumers received the medication once or twice. One consumer received emergency medication three times in July; the HRA then requested and reviewed the Restriction of Rights Notices (ROR) for those incidents. The ROR Notices documented that the three emergency medications were given during the night shift. The observed behaviors were noted to be the following: running naked, going into a male peer's room and lied down; started hitting staff when redirected; aggression and yelling verbal threats to staff; extreme agitation, pounding on nurses station window multiple times, unresponsive to re-direction, screaming, cursing at staff, threating to kill RN.

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.

Regarding the allegation that the patient was restricted from visitation, the chart documented that he did have visits with his parents. The Social Worker stated that the consumer was not restricted from family visits.

The FTP's Visitation policy states that the visitation is to be "conducted in such a manner as to preserve the safety and security level of the environment. The restriction of any visitation shall be in conformance with the facility's policy for restriction of rights. The basis for the restriction shall be the patient's perceived dangerousness and/or elopement risk. In addition, visitation may be restricted to prevent harassment, intimidation, or deterioration of the clinical condition of the patient. Special treatment, restraints, or special precautions may also be a basis for restriction of visitation."

**Conclusion**

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section, 2-103, "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". Based on the information obtained, no evidence was found to support the claim that the consumer had been unjustly restricted from visits with family members; the allegation is unsubstantiated.

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. … 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.".

The complaint was that a consumer was given emergency medication without justification. The HRA, with hesitation, concludes that rights were not violated when the emergency medication was administered to the consumer identified in this case. The hesitation comes into play because of the concern that the consumer was not medicated similarly on the different unit shifts. The HRA questions if the medication was given during a time when less staff members were available to help the consumer gain control. There is also the concern that the inconsistently of the treatment provided might be confusing for the consumer.

Suggestion: Track the administration of emergency medication to ensure that the intervention is not being given during a time when less staff members are available to help the consumer gain control. Ensure that all staff members provide consistent treatment to each consumer pursuant to that consumer's treatment need and that emergency medication is administered consistent with the Code's requirement "…to prevent the recipient from causing serious and imminent physical harm…and no less restrictive alternative is available."

**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*

April 4, 2016

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

Re: HRA #16-100-9001

Dear Ms. Getchell:

Thank you for your recent thorough review of this consumer complaint. We take complaints very seriously. We agree that all emergency medication should be given with justification per the Illinois Mental Health and Developmental Disability code. We noted that HRA concluded that "rights were not violated." We have met with nursing staff to review the criteria for emergency medication and the importance of clear documentation justifying their use.

We request that our response be included in any public release of your Report of Findings.

Sincerely,

Meredith Kiss, MA
Hospital Administrator

MK/JP/aw

ELGIN MENTAL HEALTH CENTER MANUAL SYSTEM

| Manual Title | Focus | Vol. | Section No. and Title |
|---|---|---|---|
| POLICY & PROCEDURE MANUAL | CONTINUUM OF CARE | II | 1800 EMERGENCIES/SPECIAL TREATMENT |

| Policy/Procedure/Subject No. and Title | Page | Issued | Revised |
|---|---|---|---|
| 1864 SENTINEL EVENTS and CRITICAL CASE REVIEWS | 1 | 11/05/98 | 04/25/13 |

I. POLICY

It is the policy of the Elgin Mental Health Center (EMHC) to comply with the Illinois Department of Human Services (DHS) Office of Mental Health (OMH) Program Directive (PD) 02.02.06.010. EMHC also convenes Critical Case Reviews to gather facts, analyze and develop plans for systems improvements not individual performance, for adverse events that do not meet the threshold of Sentinel Events.

II. DEFINITIONS

Refer to Exhibit 1, page 2.
"Critical Case" is an incident resulting from a systemic failure that may be characterized as a "near-miss" in which a staff member or patient was injured or might have been injured but not permanently.

III. PROCEDURES

A. Refer to Exhibit 1.

B. At EMHC, the Director of Quality Strategies may call upon any staff member or group to assist in the review and/or Root Cause Analysis process.

C. Critical Case Review Procedures:

1. A Critical Case Review is convened by the Quality Director or designee at the earliest convenience of the involved staff and the Hospital Administrator, Medical Directors, Director of Nursing or designee, Program Administrator, Discipline Chiefs and Recovery Specialist(s). Attendance is by invitation of the Quality Director or designee.

2. A Critical Case Review is preceded by relevant Discipline Chief record reviews.

3. A Critical Case Review is convened under the provisions and protections of the Illinois Medical Studies Act (735 ILCS 5/8-2101).

4. Results of the Critical Case Review may include:

   a. Policy and/or procedure changes
   b. Improved practice recommendations and implementation plan
   c. Referrals to other committees or workgroups
   d. Commendations
   e. No action.

Attachment. PPM 1964



# 02.02.06.010 Sentinel Events

**Number: 02.02.06.010**

**Effective: 07/31/01**

**Section: Office of Mental Health**

**Subsection: Client Protection**

**Subject: Sentinel Events**

**Authority: (740 ILCS 110) Mental Health and Developmental Disabilities Confidentiality Act; (735 ILCS 5/8-2101) Medical Studies Act; and Joint Commission on Accreditation of Healthcare Organizations Standards.**

## Policy Statement

This Program Directive is the primary directive for responding to sentinel events in mental health facilities. It complies with the requirements of the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110), the Medical Studies Act (735 ILCS 5/8-2101), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Standards. For clinical and administrative reasons, the Office of Mental Health (OMH) may have chosen in this directive to exceed other requirements; therefore, this directive takes precedence.

The process of discovering, rectifying, and preventing problems is fundamental to improving organizational performance. The occurrence of an adverse, unexpected event signals an alert that an undesirable condition or a previously missed opportunity for improvement may exist. Although the provisions of this directive apply specifically to sentinel events as defined, it is the policy of OMH that all adverse, unexpected events, regardless of whether such events meet the definition of sentinel events, shall be reviewed for root cause and steps shall be taken to reduce the probability of future occurrences.

The "right thing to do" when such events occur is to search for underlying causes, which if eliminated or corrected, would prevent the adverse event from occurring again. In examining the underlying causes of sentinel events, staff are to use established methods for conducting thorough, credible, and objective root cause analyses.

Each State Hospital is expected to dedicate sufficient resources to the process of reviewing, analyzing, and reporting sentinel events. When the subsequent risk reduction strategies are within the hospital's control, the necessary resources will also be allocated to this process.

## Definitions

**"Action Plan."** The product of the root cause analysis that identifies the strategies that the organization intends to implement to reduce the risk of similar events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions.

(See attachment #1 Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event.)

**"Common cause."** A source of variation that is present in every process as a consequence of the way the process is designed to work. A process that varies only because of common causes is said to be "stable." Common cause variation can only be improved by redesigning the process.

**"Reviewable sentinel events."** A subcategory of sentinel events that are subject to review by the JCAHO in 45 calendar days of the event. These events are limited to the following occurrences:

- Suicide;
- Other unanticipated death while on the hospital books;
- A sentinel event that has resulted in major permanent loss of function; and/or
- Rape.

**"Risk points."** Specific points in a process that are susceptible to error or system breakdown. They

B. Each State Hospital will provide notification of the occurrence of a sentinel event via the required daily morning report. When feasible, the morning report will specify whether or not the event is a reviewable sentinel event. If further information is needed to make this determination, this should be noted.

C. The Quality Manager and/or the individual designated to oversee the tracking analysis of sentinel events will be promptly notified of all events included in the morning report.

D. Each State Hospital shall report all reviewable sentinel events to the Chief, Office of Mental Health, Bureau of Quality Improvement, within one business day of determination that it is a reviewable sentinel event. (Note: In some circumstances, it will not be possible to immediately determine if an event occurred, e.g. certain rape allegations. In these instances, judgement must enter the decision of whether it is a reviewable sentinel event. If there is reasonable certainty that the event occurred, it should be reported to the Chief, Office of Mental Health, Bureau of Quality Improvement. If not, report within one day of substantiating the occurrence of the event.)

E. In some circumstances (e.g. high media coverage of the event) it may be desirable to notify the JCAHO that the event occurred. In these cases, the Quality Manager or his or her designee will discuss the individual case with the Chief, Office of Mental Health, Bureau of Quality Improvement.

F. The Chief, Office of Mental Health, Bureau of Quality Improvement, will consult with the Office of Legal Services prior to notifying the JCAHO.

G. When indicated, the Quality Manager or his or her designee will notify the JCAHO via the form developed by JCAHO for this purpose. (See attachment #2, Accredited Organization Self-Reported Sentinel Event.)

**Conducting Root Cause Analyses**

A. If an occurrence has been determined to be a sentinel event, a root cause analysis is indicated whether it is a reviewable sentinel event or not.

B. When a reviewable sentinel event occurs, the root cause analysis process is to be given priority attention. A work group to begin the root cause analysis is to be convened within three working days.

C. Staff from the OMH Bureau of Quality Improvement are to be involved in the root cause analysis of all reviewable sentinel events and other sentinel events as indicated.

D. Because the analysis focuses primarily on systems, it is not always necessary to wait for collateral documentation, e.g. autopsy results, State Police reports, etc. to begin the root cause analysis. Judgement must be used to determine whether such documentation is essential to the analysis process.

E. Sentinel events must be subject to a root cause analysis that has the following characteristics:

1. The analysis focuses primarily on systems and processes, not individual performance.
2. The analysis progresses from special causes in clinical process to common causes in organizational processes.
3. The analysis repeatedly delves deeper by asking "why?"; then when answered, "why?" again, etc.
4. The analysis identifies changes that need to be made in systems and processes either through redesign or development of new systems and processes, that would reduce the risk of such events occurring in the future.

F. Within (45) calendar days after the occurrence of any sentinel event, full documentation of the root cause analysis is to be completed. In the case of a reviewable sentinel event, this documentation must be available for review by JCAHO within this time frame.

G. The root cause analysis must be thorough, i.e.:

1. A determination of the human and other factors most directly associated with the sentinel event and the process(es) and system(s) related to its occurrence are identified;
2. Underlying systems and processes are analyzed through a series of "Why?" questions to determine where redesign of a process or system might reduce risk;

## Table 2. Minimum Scope of Root Cause Analysis for Specific Types of Sentinel Events

Detailed inquiry into these areas is expected when conducting a root cause analysis for the specified type of sentinel event. Inquiry into areas not checked (or listed) should be conducted as appropriate to the specific event under review.

| | Suicide (24-Hour Care) | Medication Error | Procedural Complication | Wrong-Site Surgery | Treatment Delay | Restraint Death | Elopement Death | Assault/Rape/Homicide | Transfusion Death | Patient Abduction | Unanticipated Death of Full-Term Infant | Unintended Retention of Foreign Body | Fall Related |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Behavioral assessment process | X | | | | | X | X | X | | | | | |
| Physical assessment process | X | X | X | X | X | X | X | | | X | | | X |
| Patient identification process | | X | | X | | | | | X | | | | |
| Patient observation procedures | X | | | | X | X | X | X | X | X | | | X |
| Care planning process | X | | X | | | X | X | | | X | | | X |
| Continuum of care | X | X | | | X | X | | | | | | | X |
| Staffing levels | X | X | X | X | X | X | X | X | X | X | | X | X |

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