FOR IMMEDIATE RELEASE

North Suburban Regional Human Rights Authority
Report of Findings
HRA #17-100-9009
Elgin Mental Health Center

Introduction

The North Suburban Regional Human Rights Authority (HRA) opened this investigation regarding Elgin Mental Health Center (EMHC), Forensic Treatment Program (FTP) after receiving a complaint of alleged rights violations. The complaint accepted for investigation was that a patient was given emergency medication without cause and no one was notified of the restriction. The rights of patients receiving services at EMHC are protected by the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5).

Patients 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 approximately 315 beds.

Methodology

To pursue this investigation, the HRA met with EMHC personnel to discuss the allegation. The HRA reviewed progress notes and physician's orders for the period in question (June 2016). After a review of the initial materials requested, the HRA reviewed documentation past the period in question. Also reviewed were facility policies relevant to the allegation.

Findings

According to the clinical record the female patient was admitted in early June 2016. During the first few weeks of the hospitalization, she was observed to be manic with pressured speech and racing thoughts. It was noted that sometimes she was difficult to redirect and other times she was able to be redirected. At the end of June 2016, it was documented that the patient became highly agitated, loud and she had a verbal altercation with a female peer. It was documented that the patient challenged the other peer to a fight and threatened to harm this peer. It was documented that staff members intervened and were unable to redirect her; emergency medication was subsequently given. The physician's order documented that the medication was needed for psychotic agitation. The Restriction of Rights Notice (ROR) showed that the reason for the restriction was because the patient was loud, highly agitated, challenging for a fight and threatening to harm a female peer and she was a risk of harm to self and others. The ROR indicated that the patient's individual preference

was not utilized because of the risk of harm to self and others, that the patient did not want anyone notified of the restriction, and that the form was given to the patient.

The HRA noted a progress note written on July 18, 2016, which documented that the patient approached an RN and asked if the incident regarding the emergency medication had been documented. The RN explained to the patient that whenever an intervention is performed, it is documented. The patient then requested a copy of the ROR Notice and the RN noted that when it was given to the patient, she stated that she had not previously received a copy. The chart contained a Designation of Emergency Treatment Preference and Emergency Notification form (signed by the patient on the day of admission) which showed that the patient preferred that seclusion be used in an emergency. In the section that designates the person(s) to be notified in a medical emergency or restriction, a family member and IGAC are listed; the patient signed-off on this section on July 18th, 2016. The form contained a note saying that the patient wanted the 6/29/16 ROR to be sent to the people listed on this sheet. The HRA notes that the numbers given for IGAC were a regional office number, the afterhours on-call telephone number and the general number (which is written incorrectly). The HRA could not prove or disprove that notification was made to the IGAC.

The HRA interviewed the Nurse that administered the emergency medication and she stated that she had been "pulled" to this unit and did not know the patient well. When the patient became upset, she relied on unit staff members to say whether they thought she could calm down on her own. Because this was unusual for this patient and she was not calming down, it was documented that the Medical Director on Duty was made aware of the patient's behavior and orders were given for medication. The Nurse stated that RORs are always completed and the patient is asked about notification.

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. It goes on to say that a rights restriction notice must be completed.

<u>Conclusion</u>

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.".

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 2-107, " Sec. 2-201. (a) Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to: (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian; (2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice…"

The complaint was that a consumer was given emergency medication without justification; observed behaviors showed the patient was threatening a peer and was at risk for harm to herself and others; it is concluded that rights were not violated.

On the day of the restriction the patient did not want any one notified. A few weeks later she requested that notifications be made. The HRA lacks substantiating evidence to support the allegation that no one was notified of the restriction; the allegation is unsubstantiated.

The HRA acknowledges the RN that addressed the patient's concerns on the 18th by documenting the patient's concerns regarding notification both for herself and outside parties. It is advised that unit staff members have the correct number(s) for IGAC. It is also suggested that when requested, RORs are mailed to the Guardianship and Advocacy Commission.

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*

James T. Dimas, *Secretary*

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

December 29, 2016

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

Re: HRA #17-100-9009

Dear Ms. Getchell:

Thank you for your recent thorough investigation of this patient concern. We are pleased to hear this allegation was unsubstantiated. We, at Elgin Mental Health Center, are proud of the quality of care we provide. In reference to our notifications to GAC, we plan to review our procedures with all staff to ensure they have the current GAC phone number and mailing address of your Des Plaines office.

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

Sincerely,

Brian Dawson, B.S.
Hospital Administrator

cc: Diana Hogan, Director of Nursing

BD/JP/aw