FOR IMMEDIATE RELEASE

North Suburban Regional Human Rights Authority
Draft Report of Findings
HRA #20-100-9007
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) N after receiving a complaint of alleged rights violations. The complaint accepted for investigation alleged that a patient was placed in restraints without justification. 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 several 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 requested Physician's orders, Restriction of Rights Notices and progress note documentation specific to the allegation for the patient identified in this complaint, with written consent. The allegation was discussed with the unit Nursing Manager.

Findings

According to the clinical data reviewed, the female patient was remanded to the Center in June 2019. Progress note documentation (June 2019 through August 2019) showed that the patient was placed in restraints on three separate occasions. On June 20th, she was placed in restraints for about three hours. Documentation indicated that she was highly agitated, aggressive, running around the unit without clothing, pushing staff and posturing at peers; she was unable to calm down or be redirected. The chart contained the physician's order for the restriction which indicated that the patient had no preference regarding her personal safety plan, a Restriction of Rights Notice and a completed 15-minutes Restraint/Seclusion Flowsheet.
On July 1st, the patient was placed in restraints for about an hour. It was documented that the patient was running in the unit naked, she was going into peers' rooms and invading their personal space, she was agitated, threatening staff, aggressive toward staff and posturing at staff members. The chart contained the physician's order for the restriction which indicated that the

patient had no preference regarding her personal safety plan, a Restriction of Rights Notice and a completed 15-minutes Restraint/Seclusion Flowsheet.
On July 19th, the patient was placed in restraints for about two hours. It was documented that the patient became extremely aggressive toward a staff member; she struck the staff member in the face with her fist without provocation. The chart contained the physician's order for the restriction which indicated that the patient had no preference regarding her personal safety plan, a Restriction of Rights Notice and a completed 15-minute Restraint/Seclusion Flowsheet. The Restriction of Rights Notices for each of the above noted restraint restriction indicated that the patient wished that no one be notified of the restriction.
At the site visit, the Nursing Manager stated that staff members are trained annually via the Crisis Prevention Institute, which specializes in the safe management of disruptive and assaultive behavior. Staff members are instructed to provide the least restrictive intervention before restraints are used. When asked about the emergency treatment preference, it was offered that when possible, staff will try to use the patient's preference. However, there are times that behavior might not allow for the preference.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 5/2-108, "Use of restraint. Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized. In no event shall restraint be utilized to punish or discipline a recipient, nor is restraint to be used as a convenience for the staff."

The findings do not support the assertion that a patient was placed in restraints without justification; 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.

IDHS
Illinois Department of Human Services

JB Pritzker, *Governor*

Grace B. Hou, *Secretary*

Elgin Mental Health Center
750 South State Street • Elgin, IL 60123

March 5, 2020

Ms. Kim Larson, Chair Pro Tem
North Suburban Regional Human Rights Authority
9511 Harrison Street, W-300
Des Plaines, IL 60016-1565

HRA# 20-100-9007

Dear Ms. Larson:

Thank you for your thorough review. We are happy to hear these allegations are unsubstantiated. EMHC takes great care and consideration before enforcing any Restriction of Rights on patients and only uses restraints as a last resort. We are moving to adopt the Joint Commission standard of Zero-Harm and we are striving to make Elgin MHC a Zero-Harm facility. We believe this will further reduce the rate of restraints.

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

Respectfully,

Michelle Evans, DSW
Hospital Administrator