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Egyptian Regional Human Rights Authority
Chester Mental Health
Report of Findings
Case #24-110-9009
July 31, 2024

The Egyptian Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission voted to pursue an investigation of Chester Mental Health Center after receiving the following complaints of possible rights violations:

1. **Inappropriate Restraint Use**

2. **Inappropriate Restriction of Rights**

If the allegations are substantiated, they would violate protections under The Mental Health and Disabilities Code (405 Ill. Comp. Stat. Ann. 5/2-102 and 405 ILCS 5/2-201).

Complaint Summary: The complaint alleges the facility is inappropriately restraining the individual. The complaint alleges staff withholds food from the individual while in restraints. Allegedly, the individual is given emergency medication excessively.

Investigation:

The HRA proceeded with the investigation after having received proper consent. To pursue the matter, the HRA met with staff and the program representatives were interviewed. Relevant practices, policies and sections of the consumer's record were reviewed.

Interviews:

The social worker for the individual was interviewed. The social worker stated the individual was reluctant to participate in treatment in the beginning. However, after some time the individual came around and participated. The individual took medication voluntarily but did voice his objection to medication at first. The social worker stated the individual did need to be in restraints sometimes during the early stages of treatment. The social worker stated food was never withheld from the individual. At times, the individual would refuse a food tray because the individual did not like the food. The individual would state the food was not up to his dietary needs.

Policy Review:

A review of the "Patient Rights" policy states "a patient shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual treatment plan. … Individuals and the individual's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or ECT (Electro-Convulsive Therapy). Individuals shall have the right to not be restrained or secluded except as specified in sections 2-108 and 2-109 of the Mental Health and Developmental Disabilities Code. Individuals shall not be subject to treatment by unusual, hazardous, or experimental therapies without the individual's consent. Such treatment shall follow applicable federal or State statues or regulations. … Emergency Restriction of Rights: A restriction of a patient's rights should be based on an assessment of the patient and/or the situation affecting the

safety of the patient or others by clinical staff on duty who oversees the patient's treatment plan. A Notice Regarding Restricted Rights of Individuals (IL462-2004M) will be issued to temporarily restrict the patient's rights. A progress note will be documented in the patient's record showing justification for the restriction of rights and explanation of actions taken."

The HRA reviewed Chester's "Use of Restraint and Seclusion" policy. The policy states "Neither Restraint nor Seclusion may ever be used as a means of coercion, discipline, punishment, convenience or staff retaliation. The least restrictive intervention that is safe and effective for a given individual will be used. Restraint or Seclusion will be discontinued at the earliest possible time, regardless of the scheduled expiration of the order. … Only Qualified Staff Members may apply Physical Hold, Restraint, or implement Seclusion. No fewer than three staff persons shall be present to apply Restraints including Physical Hold. If insufficient staff are available to safely control and restrain an individual during a crisis, staff should remove others from harm's way and get help before attempting Restraint. At no time is pressure to be placed upon the patient's back while the patient is in the prone (face down) position. Patient arms, shoulders, and legs are to be immobilized. Staff body weight is not to be applied to the torso or above the upper thighs. Unless specifically ordered by the treating psychiatrist, an individual will be restrained in the supine (face up) position. The nurse should ensure that the individual's head is free to rotate … An individual who is restrained, including Physical Hold or secluded must be continuously observed by 1:1 supervision from a Qualified Staff Member whose only responsibility is to monitor the individual in Restraint or Seclusion. An individual in mechanical Restraint must be continuously observed by a Qualified Staff Member who is no further away than the door to the Restraint Room. At no time shall the door to the Restraint Room be locked or left unattended. An individual in Seclusion must be continuously monitored by a Qualified Staff Member stationed outside of the door to the Seclusion Room who observes the individual through the window that provides visual access to the Room. If an individual remains in Seclusion for more than one-hour, constant audio and video simultaneous monitoring may be used. The staff providing Continuous Observation must be immediately available and prepared to intervene should the individual appear to be at risk. Video monitors may be used only when the entire Seclusion Room is viewable through the monitor. Each facility that uses video cameras for Continuous Observation shall have detailed procedures for such use that have been approved by the Chief of Clinical Services. While the Individual is Restrained including Physical Hold, or secluded, the individual must be placed in a location where he or she will be safe … If an individual remains in Restraint or Seclusion for more than 12 hours, the Facility Director or his or her designee (i.e., Medical Director or physician designee) must be immediately notified. The designee is not to be the physician who ordered the restraint or seclusion. If an individual experiences two or more separate Episodes of Physical Hold, Restraint, or Seclusion of any duration within 12 hours, the Facility Director or his or her designee (i.e. Medical Director or physician designee) must be immediately notified. The designee is not to be the physician who ordered the Physical Hold, Restraint, or Seclusion. The Facility Director or his or her designee (i.e., Medical Director or physician designee) must be immediately notified every 24 hours if either of the conditions in Procedures (II) (G) (6) or (7) above persists. The designee is not to be the physician who ordered the Physical Hold, Restraint, or Seclusion."

Records Review:

The HRA reviewed a "Notice Regarding Restricted Rights of Individual" dated 7/1/2023 at 11:05am/11:10am and another one at 11:15am. Both forms state "Pt [patient] attacked peer, refused to stop. Placed in PH [physical hold], continued to fight, placed in metal cuffs, continued to struggle, placed in FLR [full leather restraints] for safety of all." The form indicates the individual did not wish for anybody to be notified of the restriction.

The HRA reviewed an "Order for Physical Hold, Mechanical Restraint, or Seclusion" for the individual. The start time of the restraint is at 11:05am and end time is 11:15am. The order states "Pt attacked peer, unprovoked, redirected x 3, refused to stop, placed in PH, continued placed in metal cuffs, pt continued to fight, placed in FLR for safety for all. Behavioral Response to interventions: unsuccessful. Clinical justification for length of time authorized: to allow pt time to meet release criteria. Seclusion/Restraint release criteria: calm, cooperative, follow module rules, no aggression to staff/peers." The order was signed by a registered nurse and

physician on 7/1/23 at 11:05am. Another "Order for Physical Hold, Mechanical Restraint, or Seclusion" for the individual dated 7/1/23 from 11:15am to 5:15pm. The order states "Pt attacked peer, unprovoked, redirected x 3, refused to stop, placed in PH, continued to fight, placed in metal cuffs then FLR for safety for all. Behavioral Response to interventions: unsuccessful. Clinical justification for length of time authorized: to allow pt time to meet release criteria. Seclusion/Restraint release criteria: calm, cooperative, follow module rules, no aggression to staff/peers." The order was signed by both a registered nurse and physician. A third "Order for Physical Hold, Mechanical Restraint, or Seclusion" for the individual was reviewed. The start time of the restraint is at 3:15pm and end time is 5:15pm. The order states "Pt remains argumentative and verbally threatening in FLRs – release criteria not met – pt continues to pose an imminent risk of danger to all if released. Behavioral Response to Intervention: unsuccessful – verbal aggression and threats of physical aggression continue. Length of time authorized: to allow pt time to meet release criteria. Seclusion/Restraint Release Criteria: Pt will be calm and cooperative – no longer threatening – will deny thoughts of harming self or others and agree to comply with facility rules." The order was signed by a registered nurse and physician on 7/1/23 at 3:15pm.

There was a "Restraint/Seclusion Flow Chart" reviewed by the HRA. The chart indicated the individual had circulation checks done every 15 minutes on 7/1/23 from 11:30am to 3:15pm while the individual was in restraints. Another flow chart shows the individual had circulation checks every 15 minutes from 3:15pm - 5:15pm.

The HRA reviewed documentation showing Chester staff reviewed the individual's restraint hourly until the individual was removed from restraints on 7/1/23.

The HRA reviewed the "Notice Regarding Restricted Rights of Individual" dated 6/30/23 that states "Pt approached STA staff with fists clinched and being verbally aggressive, was unable to redirect pt, he took a fighting stance and was placed in a physical hold. Pt continued to struggle and was placed in 5 pt [point] FLR's for safety of all."

On 6/30/23 from 7:53pm – 10:40pm there was another order for restraint on the individual. The order states "pt was verbally threatening staff, came up from behind them with clinched fists and took a fighting stance, refusing redirection, was placed in PH and escorted to room 902 and placed in 5-point FLRs for safety of all. Length of time order is authorized: to allow patient time to meet release criteria. Seclusion/Restraint Release Criteria: Pt must be calm, cooperative willing to follow unit rules and staff direction." The order was signed by the registered nurse and physician at 7:55pm. There was a flow chart reviewed for the individual's restriction on 6/30/23. The individual had circulation checks every 15 minutes from 7:55pm to 10:40pm on 6/30/23. Additionally, staff reviewed the individual's restraint hourly on 6/30/23.

Progress Report Review:

The HRA reviewed progress notes for the individual. The progress note dated 6/29/23 states "0800: pt [patient] is requesting a PRN [as needed medication] at this time. C/O [complaint of] increased agitation/anxiety. Offered and accepted Lorazepam 1mg po per order." Later on, the note states "2000: pt refusing meds … pt cont. [continues] to refuse." Another note on 6/29/23 states "Pt requesting PRN for anxiety. Lorazepam 1mg PO [by mouth] PRN offered and accepted." An hour later the note states "PRN follow up. Pt continues to be agitated but denies anxiety. PRN partially effective."

On 6/30/23 the note states "Pt requests a PRN at this time. Pt states 'I don't want my morning meds, but I want my Ativan.' Offered and accepted Lorazepam 1mg PO per order. Pt refuses to say why he wants Lorazepam, but demanding medication." Another note on 6/30/23 states "Pt approached STA [security therapy aide] staff with fists clinched and being verbally aggressive, was unable to redirect pt, he took a fighting stance and was placed in a physical hold. Pt continued to struggle and was placed in 5 pt [point] FLR's for safety of all. Circulation x4, proper body alignment, ROR [restriction of rights] given and informed of release criteria …".

On 7/1/23 at 0740 the note states “Pt up on module pacing, angry demeanor, verbally aggressive -offered and accepted Lorazepam 1mg PO per order, will monitor.” Later the note states “Pt appears much calmer PRN effective.” A few hours later a note states “At 1105 pt was involved in a physical altercation with peer. Swinging closed fists - refused redirection, placed in a physical hold at 1105 where [sic] aggression continued and escalated. At 1110 metal cuffs were applied for safe transportation to restraint room- at 1115 pt was placed in 4-point FLR in room 927 for safety of all as pt poses an imminent risk of danger to all - pt made aware of release criteria and ROR completed- circulation check x 4- pt in proper alignment- [physician] notified …”. At 1515 hours the note states “The patient remains argumentative and verbally threatening in FLRs - his release criteria has been explained to him and he verbalized understanding, however criteria has not been met – the patient is making statements continuing to threaten the safety of staff and the patient he [sic] was involved in the physical altercation with stating ‘when I get out of here its round 2’ and ‘I’m a high profiled rapper and if you make me agitated I will be aggressive.’ Security, nurses and [physician] met with pt during his 4-hour review at this time and determined [individual] to pose an imminent risk of danger to all if released. Restraint renewal order signed by [physician] – notification email sent and [staff] signed prior auth [authorization].” “Pt refused lunch tray x 3 attempts …”.

The note on 7/2/23 states “Pt refused his lunch tray x 3 offers per [staff] with no reason given.”

On 7/5/23 the notes state “Social worker note: Patient continues to make complaints that are incongruent with treatment and purpose of receiving treatment. He remains manic with grandiose delusions and disorganized thoughts that hinder his ability to effectively communicate with others. Staff will continue to closely monitor for any maladaptive behaviors. Medication is being monitored by psychiatrist in regards to [sic] symptoms.”

Conclusion:

Complaint 1: Inappropriate Restraint Use **Complaint 2: Inappropriate Restriction of Rights**

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) states “(a) 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 Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan.”

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-201) states that “(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; (3) The facility director; (4) the Guardianship and Advocacy Commission, or the agency designated under “An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named”, approved September 20, 1985,1 if either is so designated; and (5) The recipient's substitute decision maker, if any.”

The complaint alleges the facility is inappropriately restraining the individual. The HRA reviewed documentation showing the individual was placed in restraints on 6/30/23 and again on 7/1/23. On 6/30/23 the

individual was placed in restraints due to the individual approaching staff in a threatening manner. Staff attempted to deescalate the situation, but the individual had clenched fists and took a fighting stance with staff. On 7/1/23, the individual attacked a peer and was a danger to himself and others. Documentation shows the individual was given a restriction of rights form for both restrictions on 6/30/23 and 7/1/23. The complaint alleges staff withhold food from the individual while in restraints. The HRA reviewed progress notes that documented the individual refused food trays while in restraints in addition to refusing to food trays when not in restraints. Staff stated the individual would refuse a tray if he did not like the food. The complaint further alleges that the individual is given emergency medication excessively. Staff stated the individual took his medication voluntarily. The HRA reviewed progress notes that documented the individual would request PRN medication several times to help with anxiety. Based on the findings above as documented in the individual's record, the Egyptian Human Rights Authority concludes that the consumer's rights were not violated, and the complaint is **unsubstantiated.**