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Egyptian Regional Human Rights Authority
Report of Findings
08-110-9016
Chester Mental Health Center
April 29, 2008

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Chester Mental Health Center, the most restrictive state-operated mental health facility in the state. The facility, which is located in Chester, provides services for approximately 300 male residents. The specific allegations are as follows:

1. A recipient at Chester Mental Health Center does not have adequate clothing.
2. The recipient is not receiving an adequate amount of food.
3. Restraints were inappropriately applied.

Statutes

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/102, 405 ILCS 5/2-108, 405 ILCS 5/2-112 and 405 ILCS 5/2-201). Sections 5/1-101.1, 5/1-101.2 and 5/1-117.1 of the Code are pertinent to the allegations.

Section 5/2-102 of the Code states, "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."

Section 5/2-108 states, "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."

Section 5/2-108 (a) states, "Except as provided in this Section, restraint shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, or a registered nurse with supervisory responsibilities. No restraint shall be ordered unless the physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of restraint is justified to prevent the recipient from causing physical harm to himself or others. In no event may restraint continue for longer than 2 hours unless within that

time period a nurse with supervisory responsibilities or a physician confirms, in writing, following a personal examination of the recipient, that the restraint does not pose an undue risk to the recipient's health in light of the recipient's physical and medical condition. The order shall state the events leading up to the need for restraint and the purposes for which restraint is employed. The order shall also state the length of time restraint is to be employed and the clinical justification for that length of time. No order for restraint shall be valid for more than 16 hours. If further restraint is required, a new order must be issued pursuant to the requirements provided in this Section."

Section 5/2-108 (f) states, "Restraint shall be employed in a humane and therapeutic manner and the person being restrained shall be observed by a qualified person as often as is clinically appropriate but in no event less than once every 15 minutes. The qualified person shall maintain a record of the observations. Specifically, unless there is an immediate danger that the recipient will physically harm himself or others, restraint shall be loosely applied to permit freedom of movement. Further, the recipient shall be permitted to have regular meals and toilet privileges free from the restraint, except when freedom of action may result in physical harm to the recipient or others."

Section 5/2-112 states, "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect."

Section 5/2-201 states, "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 therefore 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, if either is so designated; and (5) the recipient's substitute decision maker, if any. The professional shall be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefore in the recipient's record."

Section 5/1-101.1 states, "'Abuse' means any physical injury, sexual abuse, or mental injury inflicted on a recipient of services."

Section 1-101.2 states, "'Adequate and humane care and services' means services reasonably calculated to result in a significant improvement of the condition of a recipient of services confined in an inpatient mental health facility so that he or she may be released or services reasonable calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self or others."

Section 117.1 states, "'Neglect' means the failure to provide adequate medical or personal care or maintenance to a recipient of services, which failure results in physical or mental injury to a recipient or in the deterioration of a recipient's physical or mental condition."

Investigation Information for Allegation 1

Allegation 1: A recipient at Chester Mental Health Center does not have adequate clothing. To investigate the allegation, the HRA Team (Team) consisting of two members and the HRA Coordinator (Coordinator), conducted a site visit at the facility. During the visit, the Team spoke with the recipient whose rights were alleged to have been violated and the Chairman of the facility's Human Rights Committee (Chairman). The Team reviewed the recipient's clinical chart with his written authorization. The facility's Patient Handbook was also reviewed.

Interviews:

Recipient:

When the Team spoke with the recipient, he stated that he did not have adequate clothing. He informed the Team that he does not have an adequate amount of changes of clothing and the clothing that he does have is not in good condition. He stated that he had requested additional clothing items; however, facility staff members have failed to provide those requested items.

During the interview, the Team noted that the recipient was appropriately dressed in a striped knit shirt and jeans. The Team noted that all of his clothing was in good repair, fit appropriately and was clean.

Chairman:

According to the Chairman, when a recipient arrives at the facility all of his clothing is inventoried, marked with his name, and sent to the facility laundry for washing. The Chairman informed the Team that if upon admission to the facility a recipient has less than six sets of clothing, the facility will provide the extra items to make certain that the recipient has the allotted amount in each category. This includes shirts, pants, socks, undershirts, and shorts. The Chairman stated that all shoes are examined to determine if they contain any metal that could potentially be used as a weapon. In the event that the shoes do not contain metal, they are given to the recipient. If it is discovered that metal is in the shoe, the recipient is provided with an acceptable pair, and the shoes that he brought to the facility are stored in the clothing room. The Chairman stated that laundry staff members ensure that a recipient's clothing are clean and in good repair

Record Review

Documentation in a 03/27/08 Treatment Plan Review (TPR) indicated that the 35 year old recipient was transferred to Chester Mental Health Center on 06/06/07 from another state-operated mental health facility. The recipient was sent to the facility after he injured four staff members at the transferring facility. According to documentation in the transfer report, the recipient displayed treatment resistant psychosis distinguished by auditory hallucinations, babbling to himself, disorganized thought process, paranoia and delusions. According to the record, the recipient had threatened to harm a high-ranking government official, and as a result of the threat, the United States Secret Service was contacted.

The recipient's diagnoses were listed as follows: AXIS I: Schizoaffective Disorder, (Bipolar Type); AXIS II: Personality Disorder NOS (Anti-social Traits); Axis III: Obesity, and Axis IV: Chronic Mental Illness Since Adolescent Years and History of Violent Crimes.

A facility Social Worker documented the following in a 06/08/07 Progress Note: "When the recipient arrived at the facility he displayed psychosis, his speech rambled and was fragmented, and his ideas were grandiose." The Social Worker recorded that the recipient had expressed concern about his checks from Social Security, his personal books and other belongings that were sent from the transferring facility. The Social Worker documented that the recipient requested items from his personal property; however, specific items were not indicated. According to the Progress Note, the Social Worker informed the recipient that she would inquire at Patient Resources about his Social Security checks.

According to documentation in the recipient's property inventory, the recipient arrived with four pairs of pants, five shirts, and shoes. Other items were added to his clothing inventory so that he might have six sets of clothing, a belt and a jacket.

The HRA did not observe documentation in the recipient's clinical chart that he was restricted from having any of the clothing items in his possession or that he had requested to purchase new items. Additionally, the Team did not view any recordings indicating that the recipient had expressed concerns about the condition of his clothing or concerns about not having enough clothing items.

Patient Handbook

The Authority reviewed the Clothing/Personal Property Section of the facility's Patient Handbook. Documentation in that Section is listed as follows: "Upon arrival, all of your clothing is inventoried and automatically sent to the facility laundry. The facility sends your dirty clothes to a commercial laundry that uses strong chemicals and very hot water to kill germs. If you have expensive clothing that might be harmed by the washing process, you should consider storing those clothes in the clothing room. The facility will pay for dry cleaning of non-washable clothing items, except for leather coats. Your shoes will be checked for metal before you receive them and if metal is found, those shoes will be stored in the clothing room. You will have at least six sets of clothing, one pair of shoes, one belt and one jacket (if needed). These may be facility clothing or your personal clothes. Any personal clothing that you would like to wear will be marked with your name so it will be given back to you after laundering. If you do not want your personal clothing marked, you should have those clothes stored in the clothing

room. You should direct all clothing requests to your therapist. When you are transferred, all state clothing in your possession must remain here at Chester Mental Health Center. Upon arrival all of your personal property is inventoried and sent to our property control supervisor for storage…."

Summary

According to the recipient, he did not have a sufficient number of clothing items that were in good repair. When the recipient met with the Team, it was noted that he was wearing clothing that fit appropriately and was in good condition. According to documentation, the recipient had the same number of clothing items that is allotted to other recipients and is in accordance with facility policy listed in the Patient Handbook. The HRA did not observe any documentation in the recipient's clinical chart indicating that he expressed a desire to purchase additional items or that items he owned were restricted from his possession.

Conclusion

Based on the information that was acquired during the course of our review, the Authority does not substantiate the allegation that a recipient at Chester Mental Health does not have adequate clothing. No recommendations are issued.

Investigation Information for Allegation 1

Allegation 2: The recipient is not receiving an adequate amount of food: To investigate the allegation, the Team spoke with the recipient and reviewed his clinical chart. The Team spoke with the Chairman about the allegation. During the site visit, the Team also observed the serving of a noon meal at the facility.

Interview:

Recipient:

During the site visit at the facility, the Team spoke with the recipient about the allegation. The recipient stated that he had requested double portions of food; however, the facility had failed to comply with his request.

Chairman:

According to the Chairman, a Registered Dietician reviews and approves meals that are served at the facility. Additionally, the Dietician will review each individual recipient to

determine if there are special needs that require a specific diet. Upon assessment a facility physician will review and complete an order for the diet.

Chart Review

According to the recipient's 03/27/08 TPR, the recipient is obese and has a goal to lose weight slowly and stabilize within his Ideal Body Weight (IBW). An objective was listed for the recipient to lose weight slowly and reach his goal by 06/08. The recipient's weight was listed as 279 lbs, a gain of 3 lbs from the previous month. Treatment interventions to assist the recipient in reaching the goal were listed as follows: 1) Nursing staff will ensure that the dietary recommendations are reviewed by the doctor and orders for diet are followed. 2) Nursing staff will weigh patient monthly and send a dietary referral if needed. 3) Activity therapy staff will encourage the recipient to attend and participate in off unit activities.

The second objective was listed as follows: The recipient will demonstrate a basic understanding of the five food groups and the importance of a balanced diet with exercise. The treatment intervention indicated that the nurse would educate the recipient on the complications of obesity such as cardiovascular disease, hypertension, and diabetes. Documentation indicated that due to the recipient's mental status at the time of the TPR, he was unable to comprehend information concerning obesity, hypertension, and diabetes. However, when the recipient was more mentally fit, the nurse documented that these issues would be discussed with him.

In a 08/09/07 Progress Note, the Dietician indicated that the recipient weighed 274 lbs, which was a loss of one lb from the previous month. However, the record indicated that the recipient remained well above the IBW. The Dietician indicated that she had attempted to discuss diet therapy with the recipient; however he did not respond well. She documented that the recipient was placed on a regular diet in order to produce a slow weight loss.

In a 11/19/07 Progress Note, the Dietician documented that a restriction in the recipient's diet might lead to dissatisfaction and that a regular diet should be maintained. The Dietician recommended an increase in the recipient's physical activities to assist in control of his weight.

Team Observation

During the site visit, the Team observed the serving of a noon meal. The Team noted that there was an ample serving of meat, vegetables, fruit/dessert, milk, and bread. Each recipient went to the serving area to obtain a food tray that was prepared in accordance with his specified diet.

Summary

According to the recipient, he is not receiving an adequate amount of food. He informed the Team that he had requested double portions; however, his request was not honored. According to documentation in the recipient's clinical chart, when a Registered Dietician evaluated the recipient's nutritional status a regular diet was prescribed. The Dietician documented that the recipient was above IBW; however, after speaking with him about diet therapy, he did not respond well and recorded that a restriction in his diet might lead to dissatisfaction. The Dietician recommended that the recipient's physical activities be increased to promote a slow weight loss.

Conclusion

The Authority determined that the facility did not restrict the recipient's rights when the recipient's request for double portions was not honored. Therefore, the allegation that the recipient did not have an adequate amount of food is unsubstantiated. No recommendations are issued.

Investigation for Allegation 3

Allegation 3: Restraints were inappropriately applied: To investigate the allegation, the Team spoke with the recipient and reviewed his clinical chart.

Interview:

When the Team spoke with the recipient regarding the allegation, he stated that facility staff placed him in restraints for no apparent reason and during the process he was injured when he was hit between his legs. The recipient could not provide the date of the restraint episode or names of witnesses to the restraint.

Record Review

According to the recipient's 03/27/08 TPR, the recipient had been informed of the circumstances under which the law permits the use of emergency forced medication, restraint or seclusion. The recipient stated that his first choice for emergency intervention was emergency medication and his second choice was placement in seclusion. Documentation indicated that he did not state a third choice.

When the HRA reviewed the recipient's clinical chart, the record indicated that the recipient was placed in restraints on 06/17/07 and in seclusion on 09/12/07.

Restraint:

According to a 06/16/07 Progress Note completed at 7:10 PM by a Security Therapy Aide (STA), the recipient was "demonstrating very bizarre behavior. He claimed to be seeing animals and insects in his room. He would not calm down and became combative with staff."

Additional documentation indicated that it was necessary to place the recipient in a physical hold and into restraint in accordance with a physician's order.

A facility physician documented at 7:15 PM on 06/16/07 that the recipient was delusional and verbally threatening, attempting to hit staff. He was placed in a five-minute physical hold initiated at 7:10 PM, and full leather restraints were initiated at 7:15 PM "for the safety of all'.

At 11:15 PM on 06/16/07, the physician documented in a Progress Note that the recipient remained unstable and extremely delusional and ordered continuation of the restraints for the recipient's safety, as well as others.

Additional recordings on 06/17/07 at 3:15 AM and 7:15 AM indicated that the physician had reviewed the recipient's continued need for restraints and documented that restraint was needed for the safety of all.

In a Nursing Progress Note at 09:15 AM on 06/17/07, documentation indicated that the recipient had met the criteria for release from restraint and debriefing was completed.

An Order for a Physical Hold (Order) was completed at 7:10 PM on 06/16/07 and extended for a five-minute period. Documentation in the Order indicated that the recipient had displayed bizarre ideations about his room and staff. Initially he was verbally aggressive with staff and those behaviors accelerated to physical aggression. According to the record, the recipient continued to be combative and would not calm down after the physical hold was implemented.

A facility physician completed an Order for Restraint at 7:15 PM. Verbal support and reassurance were listed as behavioral interventions attempted before the restraints were applied. The release criteria were documented as follows: 1) The recipient must be calm, cooperative, and agree to follow module rules. (Not cursing, arguing, spitting, or threatening others). 2) He should not be pulling or resisting restraints. 3) He must be awake to determine his ability to meet the criteria for release.

Documentation indicated that additional Orders for Restraint were issued on 06/16/07 at 11:15 PM and 06/17/07 at 03:15 AM, and 7:15 AM. Documentation in all of the Orders for Restraint indicated that the recipient continued to talk bizarrely, was unstable and delusional, and had not met the established criteria for release.

According to the Restraint/Seclusion Flowsheets for the restraint episode, the recipient's behaviors were recorded every 15 minutes. A RN reviewed his circulation, vital signs, mental status, and physical status. The recipient's limbs were released and he was offered toileting and fluids hourly. The recipient was offered a meal at 8:15 AM and documentation indicated that he ate 100% of the food.

A Restriction of Rights Notice (Notice) dated 06/16/07 was included in the recipient's clinical chart. The Notice indicated that the recipient's rights were restricted when he was placed in restraints at 7:15 PM on 06/16/07 and that the restraints were removed at 6/17/07 at 9:15 AM.

The reason for the restriction was listed as the recipient had attacked staff. Documentation indicated the recipient's preference for emergency intervention was not used because of the severity of his assault on the staff members. Additional recordings indicated that Notice was delivered in person, and the recipient had expressed that he did not want anyone notified of the restraint episode.

The Team did not observe any documentation in the recipient's chart indicating that he had reported any injury pertinent to the 06/16/07 incident. According to the Post-Episode Debriefing recording, when a RN examined the recipient at the end of the restraint process, no injuries were noted. Therefore, no injury report would be a part of the recipient's clinical record. The RN documented that the recipient's physical well-being had been addressed as well as his privacy needs.

Seclusion:

According to a 09/12/06 Progress Note completed by a RN at the facility, the recipient came out of his room very agitated and "ranting about someone putting sewer water in his room." The RN documented that the recipient's behaviors escalated leading to his unprovoked attack on staff. A physical hold was applied and the recipient continued to yell and curse at staff. As a result, the recipient was placed in seclusion.

A supervising RN on 09/12/07 completed a Physical Hold Order at 6:25 PM and the recipient was released from the hold at 6:30 PM. Documentation indicated that the recipient approached staff in a combative manor and attempted to attack a staff member. According to the Order, appropriate techniques were used to restrain and escort the recipient to ensure the safety of all involved. A Notice was given to the recipient pertinent to the physical hold.

Documentation indicated that an Order for Seclusion was implemented at 6:30 PM on 09/12/08 after the recipient was released from the physical hold. Documentation in the Order indicated that seclusion was implemented after empathic listening, verbal support and reassurance failed to cause the recipient's aggressive behaviors to cease. The recipient remained in seclusion until 10:30 PM on 09/12/08.

The Restraint/Seclusion Flowsheets indicated that the recipient was observed at least every 15 minutes and his behaviors recorded. An RN evaluated his status hourly, and he was offered toileting and fluids at the time of the evaluation.

An RN conducted a Post-Episode Debriefing and indicated that the recipient did not receive any physical injury during the event and his physical well-being was assessed. No injury report was completed.

A Notice was given to the recipient with the duration of the seclusion listed as 4 hours on 09/12/07. The reason for the restriction was recorded as an aggressive attack on staff. Documentation indicated that the Notice was delivered in person, and the recipient did not specify that the Notice be sent to other individuals.

Summary

According to the recipient, he was placed in restraints without an apparent reason and during the process facility staff caused him to be injured. He did not provide the date of the restraint or the names of the staff members who were involved in the restraint application. When the recipient's clinical chart was reviewed, documentation indicated that restraints were applied after the recipient became aggressive to staff on 06/16/07. The record indicated that an Order was issued for the 5-minute physical hold that occurred prior to the application of the restraints, and a facility physician issued Orders for Restraint every four hours for the restraint episode that continued for 14 hours. Review of the recipient's clinical condition and behaviors were in accordance with Code requirements. Restriction Notices were issued for the physical hold, as well as the restraint application. Debriefing was conducted at the end of the restraint. Documentation in the Post-Episode Debriefing Form indicated that when a facility RN examined the recipient no injuries were noted. Documentation in the Progress Notes indicated that the recipient did not receiving any injuries during the entire process. The HRA also reviewed information pertinent to the recipient's 09/12/06 seclusion, and found no indication of a Code violation or patient injury during the process.

Conclusion

Based on documentation in the recipient's clinical chart, the Authority does not substantiate the allegation that restraints were inappropriately applied. No recommendations are issued.