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Egyptian Regional Human Rights Authority
Report of Findings
08-110-9031
Chester Mental Health Center
May 27, 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 mental health facility in the state. The facility, which is located in Chester, provides services for approximately 300 male residents. The specific allegation is as follows:

A recipient at Chester Mental Health Center was inappropriately placed in restraints.

If substantiated, the allegation would be a violation of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/2-108 and 405 ILCS 5/2-201).

Statutes

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

Investigation Information

To investigate the allegation, the HRA Investigation Team (Team), consisting of one member and the HRA Coordinator (Coordinator), conducted a site visit at the facility. During the visit, the Team spoke with the recipient (Recipient I) whose rights were alleged to have been violated and reviewed his clinical chart. The Team also spoke with the Chairman of the facility Human Right Committee (Chairman) about the allegation. The facility's Policy/Procedure for Use of Restraints was reviewed.

Interviews:

When the Team spoke with Recipient I about the allegation, he stated that he had a fight with another recipient (Recipient II) in October 2007. Recipient I informed the Team that as a result of the altercation he was placed in restraints; however, Recipient II was not placed in restraints or seclusion. The recipient stated that he believed that both parties involved in the dispute should have been treated in the same manner.

Chairman:

The Chairman informed the Team that this particular issue had not been brought to the facility's Human Rights Committee for review. However, he was aware that facility staff members are provided with training in the Code's requirement pertinent to restraint application. The Chairman stated that the Security Therapy Aides (STAs), who provide direct care for the recipients, receive extensive training when initially employed and periodically thereafter. He informed the Team that the training includes the therapeutic application of restraints, appropriate application of various types of restraints and required documentation at various stages of the restraint process.

Chart Review

Treatment Plan Review (TPR)

According to Recipient I's 03/19/08 TPR, the recipient was discharged from a correctional facility on 09/10/04 and admitted to Chester Mental Health Center on the same day. The recipient was involuntarily committed to the facility after he reached his projected parole date and was deemed to be in need of immediate hospitalization for self-protection, as well as the protection of others.

Recipient I's diagnoses were listed as follows: AXIS I: Schizoaffective Disorder (Bipolar Type) and History of Alcohol Abuse; AXIS II: History of Gunshot Wound to the Abdomen and Left Humerus (08/98), Thrombocytopenia, History of Motor Vehicle Accident (MVA) with Loss of Consciousness (1991) and Sexual Dysfunction; and AXIS IV: Treatment Noncompliance.

Documentation in Behavior Data Reports written since the previous TPR indicated that Recipient I persisted in engaging in sexually inappropriate comments toward other recipients and female staff members. According to the record, the recipient continued to have grandiose and paranoid delusions, as well as auditory and tactile hallucinations. However, he had not been aggressive toward others or required restraints during the reporting period.

Progress Notes:

An STA, (STA I) recorded in a 10/28/07 Progress Note that Recipient I attacked Recipient II at 7:30 AM causing significant injury to Recipient II's face. According to the documentation, when staff attempted to intervene, Recipient I continued to fight with those around him. As a result, he was walked to the restraint room and placed in restraints. The record indicated that a physical hold was not necessary prior to Recipient I's placement in restraints. Additional documentation in the Progress Note indicated that a physician's order was obtained for the restraints, and Recipient I was provided with a Restriction of Rights Notice.

STA II documented his account of the events that led to Recipient I being placed in restraints. In a 7:30 AM, October 28, 2007 Progress Note, STA II documented that Recipient I hit Recipient II causing significant injury to Recipient II's face. When STA II asked Recipient I what had occurred to cause him to administer the blow, he replied "nothing". STA II recorded that Recipient I's attack was unprovoked by Recipient II.

At 11:30 AM on 10/28/07, STA II documented that Recipient I was calm and had met the criteria for release from restraints.

On 10/29/07, a facility psychiatrist recorded in a Progress Note that he had interviewed Recipient I after his attack on Recipient II. The psychiatrist documented that Recipient II's injury was severe enough that he required placement in the facility infirmary. The psychiatrist recorded that when he questioned Recipient I about the incident, he stated that he became upset with Recipient II because he attacked him 5 days prior to the 10/28/07 altercation. The psychiatrist documented that Recipient I denied having any thoughts of harming others or self, and he "appeared calm, not psychotic." After speaking with Recipient I, the psychiatrist recorded that he did not believe that a change in medication was warranted.

The HRA did not observe any documentation in Recipient I's chart that indicated Recipient II had attacked him prior to the 10/28/07 incident.

Order for Restraint or Seclusion (Order)

An Order for the placement of Recipient I in 4-point restraints was completed at 7:30 AM on 10/28/07 by a Registered Nurse (RN) and signed by a facility physician at 7:40 PM. The specific behavior requiring the use of restraints was listed as follows: "Recipient attacked another recipient, hitting him in the face causing injury". Documentation indicated that conflict resolution and counseling were used prior to the application of the restraints. The record

indicated that the Order was issued for up to 4 hours in order to allow the recipient time to regain control of his behaviors. The conditions for release were listed as follows: 1) The recipient will be calm and cooperative for 1 hour. 2) He will be non-threatening when the incident is discussed. 3) He will agree to module rules. 4) He will not curse, pull on restraints, spit, or express agitation or aggression for 1 hour prior to release. 5) The recipient must be awake to determine his ability to meet the release criterion.

Restraint/Seclusion Flowsheet (Flowsheet)

According to a 10/28/07 Flowsheet, Recipient I was placed in restraints from 7:30 AM until 11:30 AM. The Flowsheet indicated that a complete body search was completed when the restraints were applied. Documentation indicated that an RN reviewed the restraint process and that the restraints were properly applied. Additional documentation indicated the following: 1) The room environment was appropriate. 2) The recipient was wearing proper clothing. 3) The recipient was properly positioned. 4) The recipient was informed of the reason for the restraint and the criteria for release. 5) There were no medical contraindications. 6) The recipient was given a Restriction of Rights Notice.

The recipient was continually observed and his behaviors documented in the Flowsheet in fifteen-minute increments. An RN, on an hourly basis, reviewed his vital signs and circulation. His limbs were released, and he was offered toileting and fluids every hour. The record indicated that the recipient used the urinal twice and accepted 8 ounces of fluid during the 4-hour restraint episode. The RN recorded the hourly assessments and documented that the restraints caused no harm to the Recipient I.

Post-Episode Debriefing

Documentation indicated that an RN conducted a post–episode debriefing after the recipient was released from the restraints. The record indicated that Recipient I was able to identify stressor(s) occurring prior to the restraint. He was able to verbalize an understanding of the causes and consequences of his aggressive behavior. He was able to identify one or more methods to control his aggressive behavior, as well as verbalize that he could request assistance from staff prior to escalation of his anxiety and/or aggression. Documentation indicated that in the debriefing session the recipient was encouraged to discuss his feelings related to the restraint. Recipient I was examined by the RN to determine if he had received an injury during the process and to determine his overall physical well-being. His privacy needs were also addressed. The RN documented that the recipient was calm during the debriefing process.

Restriction of Rights Notice (Notice)

The record indicated that on 10/28/07 Recipient I was provided with a Notice pertinent to the restraints application. Documentation in the Notice indicated that the recipient's rights had been restricted when he was placed in restraints from 7:30 AM until 11:30 AM on 10/28/07. According to record, the Notice was delivered in person to Recipient I, and the recipient did not wish that anyone else be notified of the restriction.

Policy/Procedure for Use of Restraints (Policy/Procedure)

The HRA reviewed the facility Policy/Procedure regarding restraints. The following is included in the Policy/Procedure: definitions, types of restraint devices, specific exclusions, when restraints can be used, general requirements for restraint application, attention to a recipient while in restraints, time limits, review and documentation requirements, notification and reporting requirement, and staff training.

According to the Policy/Procedure, restraints may be used only as a therapeutic measure to prevent an individual from harming himself or others. Restraint may not be used until after other less restrictive procedures have been documented to be ineffective or inappropriate for the individual.

The specific requirements for Physician Orders, restraint application, procedures to follow during the restraint episode, time limits for Restraint Orders, documentation requirements, notification and reporting requirements and staff training listed in the facility's Policy/Procedure were in accordance with Code.

Summary

According to Recipient I, he was placed in restraints on 10/28/07 because he had a fight with Recipient II. Recipient I stated that is was unfair for his rights to be restricted when facility staff did not require Recipient II to be placed in restraints. According to documentation in Recipient I's clinical chart, he hit Recipient II in the face causing an injury that required Recipient II to be placed in the facility infirmary for medical treatment. The record indicated that Recipient II did not incite the attack. All of the information presented to the HRA indicated that Recipient I was placed in restraints for the protection of both recipients and that Recipient II was not placed in restraints because he did nothing to provoke the attack that led to his significant injury. The facility has a Policy/Procedure regarding restraints, and that policy is in accordance with Code requirements. All documentation reviewed by the HRA pertinent to the restraint episode indicated that the facility followed its own policy and the mandates of the Code.

Conclusion

Based on the information obtained during the course of the investigation, the Authority does not substantiate that the recipient was inappropriately placed in restraints. No recommendations are issued.