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Egyptian Regional Human Rights Authority
Report of Findings
08-110-9032
Chester Mental Health Center
July 15, 2008

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

1. A recipient at Chester Mental Health Center was inappropriately placed in restraints.
2. A recipient has not been provided adequate treatment for a medical condition.

Statutes

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/2-102, 405 ILCS 5/2-108 and 405 ILCS 5/2-201). Sections 5/2-112, 5/1.101.1, 5/1-117.1 and, 5/1-101.2 of the Code are also pertinent to the allegations.

Section 5/2-102 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 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 under guardianship, his parent or guardian; (2) a person designated under subsection (b) of the 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."

Section 5/1-112 states, "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect."

Section 5/1.101.1 states, "'Abuse' means any physical injury, sexual abuse, or mental injury inflicted on a recipient of services other than by accidental means."

Section 5/1.117.1 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."

Section 5/1-101.2 of the Code 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 reasonably 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."

Investigation Information

Allegation 1.A recipient at Chester Mental Health Center was inappropriately placed in restraints. To investigate the complaint, the HRA Investigation Team (Team), consisting of three 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 reviewed his clinical chart with his written authorization. The Team also spoke with the Chairman of the facility's Human Rights Committee (Chairman) regarding the allegations. The facility's Restraint Policy/Procedure was reviewed.

I. Interviews:

Recipient:

During a site visit at the facility, the Team spoke with the recipient whose rights were alleged to have been violated. He informed the Team that he had been placed in restraints several times since admission to the facility in October 2007. He stated that each restraint application was implemented as a means of punishment rather than for his protection or the protection of others. The recipient denied any aggressive actions toward staff or other recipients that would have warranted restraint application.

Chairman

When the Team spoke with the Chairman about the allegation, he stated that the issue had not been brought to the facility's Human Rights Committee for review. He informed the Team that Security Therapy Aides (STAs) receive training regarding the Code's requirements for the application of restraints when they are initially employed and yearly thereafter. He related that it is the facility's policy to only use restraints when necessary for the self-protection of the recipient who is being restrained or for the protection of others.

II. Record Review:

According to the recipient's 01/08/08 Treatment Plan Review (TPR), the recipient was admitted to the facility on 10/20/07 as a voluntary transfer from another state operated mental health facility. Documentation indicated that the transfer was implemented due to the recipient's threatening behaviors at the transferring facility. The record indicated the recipient's behavior had deteriorated since the previous reporting period. Documentation indicated that he had gone into another recipient's room, pulled the mattress from the recipient's bed onto the floor and put the bed linens in the toilet. Other behavioral reports included the following: stealing, making inappropriate sexual remarks to other recipients, verbal threats to staff, possession of contraband, and physical aggression toward others.

The recipient's Diagnoses were listed as follows: AXIS I: Bipolar Disorder I (hypomania) and History of Polysubstance Dependence; AXIS II: Borderline Personality Diorder; Axis II: Temporomandibulor Jaw (TMJ) and a healed scar on the forearm: and AXIS IV: Mild Stressors and Legal Problems.

The recipient's 01/08/08 TPR listed aggression toward others as a problem area, and a goal for him to be free of displaying aggressive behavior toward others was incorporated in the TPR. The recipient's therapist reported that the recipient's behavior had deteriorated over the reporting period. According to the therapist, he had numerous behavioral data reports written for inappropriate behaviors, and he was placed in restraints on 01/07/08. The recipient's psychiatrist and the nursing staff reported that the recipient had been compliant with taking medications for his mood disorder. The hypothesis for the recipient taking medication prescribed for the mood disorder was that he would be able to interact with others in a less aggressive manner.

Documentation in the TPR indicated that the recipient was informed of the circumstances under which the law permits the use of emergency forced medication, restraint or seclusion. When asked if any of these circumstances arose, what his preferred intervention would be, he listed emergency medication.

According to documentation in the recipient 02/05/08 TPR, the recipient continued to receive behavioral data reports written about his maladaptive behaviors. On 01/29/08 while another recipient held a peer, the recipient repeatedly punched and caused injury to the peer. After the incident, documentation indicated that the recipient requested that charges be brought against him for the assault. The recipient informed staff that he believed that by going to prison he could be released to the community in a timelier manner than if he remained at the facility.

Documentation in the recipient's 02/26/08 TPR indicated that the recipient continued to receive behavioral data reports written about his maladaptive behavior. On 02/15/08 he was placed in restraints after performing martial arts while on the unit. During the reporting period there were incidents recorded regarding the recipient hitting and kicking the walls, attempting to enlist other recipients into his "organization" and recruiting another recipient to assist him in an attempt to kill a lower functioning recipient.

Restraint Records:

The recipient's clinical chart contained documentation regarding three restraint episodes. According to a 01/07/08 Order for Physical Hold, the recipient began hitting and kicking his door, and when he was asked to calm down he became aggressive toward staff. Due to these aggressive actions, he was placed in a physical hold. Documentation indicated that during the physical hold he continued to threaten staff and attempted to pull out of the hold. The record indicated that the physical hold was implemented at 1:55 PM, and the recipient was released from the hold at 2 PM and subsequently placed in restraints. A Restriction of Rights Notice was given to the recipient for the physical hold. Documentation indicated that the recipient did not request that anyone be contacted regarding the restriction.

An Order for Restraint was issued at 2 PM after the recipient was released from the physical hold and attempts to assist him in alleviating the maladaptive behaviors were unsuccessful. Documentation indicated that when the recipient was informed by staff that he needed to go into his room for patient count, he went into his room and began hitting and kicking the door and threatening to harm staff. When the recipient was placed in a physical hold his aggressive actions continued. Due to theses action he was placed into 5-point restraints. Documentation indicated a Registered Nurse (RN) and a facility physician examined the recipient as soon as the restraints were applied and documented that the restraint application did not pose an undue risk to the recipient's physical and mental health.

According to documentation on the Restraint/Seclusion Flowsheet, a body search was completed after the restraints were applied. When the RN checked the restraints, it was determined that they were properly applied, and the recipient was appropriately positioned. The room environment was determined to be suitable, and it was concluded that the recipient was wearing appropriate clothing. The recipient was informed of the reason for the restraint and the criteria for his release. It was determined that there were no medical contraindications to the restraint.

Documentation indicated that an STA observed the recipient while he was in restraints and recorded his behaviors/condition every 15 minutes. An RN examined the recipient at hourly intervals and recorded that his circulation was adequate, his vital signs within normal limits, and his physical and mental status was not compromised. The RN released the recipient's limbs when the evaluations were conducted, and he was offered toileting and fluids. The record indicated that he was offered and accepted a meal at 4:15 PM.

When the initial Order for Restraint expired at 6 PM, a new Order was issued because the release criteria, which included the recipient being calm, cooperative, and no longer yelling or

cursing staff for a period of one hour, had not been met. A facility physician and a RN examined the recipient when the 6 PM Order was issued, and documented that the continued restraint did not pose a risk to him.

The record indicated that the recipient did not meet the criteria for release until 10 PM. At that time, he was able to discuss the incident in a calm and responsible manner. In a post-episode debriefing session, documentation indicated that the recipient was able to identify the stressors occurring prior to the restraint, verbalize understanding of the causes and consequences of his aggressive behaviors, express that staff could have helped him to remain in control, and to identify other more effective methods to control his aggressive behavior. The recipient was encouraged to discuss his feelings related to the restraint, and he expressed that he could have requested help from staff prior to the escalation of his anxiety. Following the debriefing, a nurse examined the recipient and determined that no physical injury had occurred during the restraint episode. It was also concluded that the recipient's physical well being and his privacy needs had been addressed during the event.

A Restriction of Rights Notice was given for the Restraint Episode that commenced at 2 PM on 01/7/08 and ended at 10 PM on the same day. Documentation indicated the recipient's preferred emergency treatment was not used due to the recipient's level of aggressive behaviors. Documentation indicated that the recipient did not request that anyone be notified regarding the restraint.

According to the recipient's record, an Order For Physical Hold was issued on 02/15/08 at 7:55 PM after the recipient began to perform "Karate Kicks" while on the module threatening to harm others. A facility physician and an RN signed the Order at 7:55 PM. The recipient was released from the physical hold at 8 PM.

An Order for Restraint was issued at 8 PM when the recipient continued to threaten harm to other recipients and staff. Documentation indicated that the recipient posed an immediate threat to himself, as well as others, and seclusion was not indicated because of the recipient's history of self-harm when he becomes distressed. According to the Order, a facility physician and an RN examined the recipient after the restraints were applied and assessed that the application did not pose undue risk to the recipient's health or mental condition, and signed the order to verify their assessments. The release criteria were listed as follows: The recipient should be calm, cooperative, and exhibit no aggressive gestures or hostile speech for a period of 60 minutes. He must be awake to determine his ability to meet the release criteria.

Documentation on the Restraint/Seclusion Flowsheet pertinent to the 8 PM Order indicated that STAs observed the recipient during the restraint episode and recorded his behaviors every fifteen minutes. At 10:15 PM, an STA documented that the recipient was sleeping and continued to sleep until the Order expired at 12 PM. Additional documentation in the Flowsheet indicated that an RN examined the recipient on an hourly basis. His circulation was evaluated, and his limbs were released. The RN reviewed his vital signs, mental status, and physical well-being and documented the findings. During the RN's evaluation process, the recipient was also offered toileting and fluids.

An additional Order for Restraint was issued at 12 PM after the recipient failed to meet the criteria for release. After the restraints were applied, a facility physician and an RN examined the recipient and determined that the restraints did not pose any undue risk to the recipient's mental and physical health. Both medical personnel signed the Order after an assessment was made.

Documentation in the Restraint/Seclusion Flowsheet associated with the 12 PM Order indicated that an RN examined the recipient hourly. His vital signs were taken, circulation assessed, and his limbs released. His mental and physical status was also evaluated. At the time of each assessment, the recipient was offered toileting and fluids. STAs monitored the recipient and recorded his behaviors every fifteen minutes. Documentation indicated that the recipient was awake at 12:15 AM. At that time he became restless, agitated and began pulling on the restraints. The behavior continued until he fell asleep at 2:30 AM and remained asleep at the expiration of the Order at 4 AM.

Since the criteria for release listed that the recipient needed to be awake to determine eligibility to meet the release criteria, another Order for Restraint was issued at 4 AM. Documentation in the Restraint/Seclusion Flowsheet pertinent to the 4 PM Order indicated that the recipient met the release criteria at 8 AM. The record indicated that the recipient was offered and accepted a meal at 7 AM.

Documentation indicated that a post-episode debriefing was conducted. The recipient was able to identify stressors that occurred prior to his placement in restraint. He was also able to verbalize an understanding of the causes and consequences of his aggressive behaviors, and to identify methods to control those behaviors in the future. The RN who spoke with the recipient during the debriefing indicated that the recipient was aware that he could ask assistance from staff prior to escalation of his anxiety and felt that staff could assist him in gaining control. Documentation indicated that the RN examined the recipient and determined that no physical injury had occurred during the event. The RN also reviewed with the recipient the reasons why previously identified early interventions were not successful prior to his placement in restraints.

A Restriction of Rights Notice was given to the recipient for the 12-hour restraint episode that began at 8 PM on 02/15/08 and ended at 8 AM on 02/16/08. Documentation indicated that the recipient's preference for emergency treatment was not used because an immediate application of restraints was needed to protect the recipient from harming himself or causing harm to others. Seclusion was not indicated because of the recipient's history of abusing himself whenever he becomes distressed. The Restriction Notice was delivered to the recipient in person. Documentation indicated that the recipient did not request that anyone be notified of the restraint.

According to documentation in an Order for Physical Hold, while in the dining room on 03/02/08 the recipient got into a fight with a peer. When staff attempted to intervene, the recipient refused to cease his fighting. The record indicated that the hold was instituted at 5:55 PM, and the recipient was released at 6 PM. A facility physician and an RN documented that the recipient had been examined, and a determination was made that the hold did not pose an undue risk to the recipient's physical and mental condition. A Restriction of Rights Notice was given

to the recipient regarding the restrictive hold. The recipient did not request that anyone be notified regarding the restraint.

Documentation indicated that when the recipient did not regain control during the physical hold, a Restraint Order was completed. The record indicated members attempted empathic listening, verbal support and reassurance prior to the restraint application. However, those efforts were unsuccessful, and the recipient was placed in 4-point restraints at 6 PM. The release criteria were listed as follows: The recipient will be calm, cooperative, non-threatening, absent of cursing and spitting on others for a period of 1 hour prior to release. He must be awake to determine the ability to meet the criteria. Documentation indicated that an RN and a facility physician examined the recipient as soon as the restraints were applied. Both medical personnel indicated that the restraint did not pose any undue risk to the recipient's physical or mental health.

An RN took the recipient's vital signs, checked his circulation, and released his limbs on an hourly basis. Additionally, the RN assessed the recipient's medical and mental status and offered him toileting and fluids. The information was recorded on a Restraint/Seclusion Flowsheet. Observations of the recipient's behaviors were recorded by STAs at 15-minute intervals.

Additional Orders for Restraint were issued at 10 PM on 03/02/08, 2 AM on 03/03/08 and 6 AM on 03/03/08. According to the 6 AM Order on 03/03/08, the recipient met the criteria for release at 9 AM on that day.

Documentation in the Restraint/Seclusion Flowsheets indicated that the recipient slept from 12:15 AM until 6:15 AM on 03/03/08. However, when he awoke he continued to be restless and uncooperative. The record indicated that a RN examined the recipient on an hourly basis in addition to the 15 minute checks and recorded his vital signs, circulation, physical and mental status, fluid offering and intake, and toileting. He was offered and accepted a meal at 7:15 AM, took his medication at 7:45 AM and was released from restraints at 9 AM on 03/03/08.

The recipient was provided with a Restriction of Rights Notice pertinent to the restraint episode. Documentation indicated that his choice of intervention was not utilized because of the level of his aggression. The Notice was delivered to the recipient in person. The record indicated that he did not wish that any one else be notified of the restraint episode.

III: Facility Policy Review:

The HRA reviewed the facility's Policy/Procedure entitled "Use of Restraint and Seclusion (Containment) in Mental Health Facilities". According to the Policy Statement, "Chester Mental Health Center uses restraint and seclusion only as a therapeutic measure to prevent an individual from causing physical harm to himself or other and follow the Department of Human Services Program Directive 02.02.06.030."

The Procedure outlined the following: (1) appropriate application, (2) use of appropriate equipment, (3) required observations and documentation during restraint/seclusion, (4) required assessments by medical personnel, (5) review by the recipient's treatment team the day after the restraint, (6) staff training pertinent to restraint/seclusion (7) care and cleaning of restraint devices, and (8) review of all restraint and seclusion orders by a supervising nurse to assure compliance with program directive and standards of care.

Summary for Allegation 1

According to the complaint, a recipient at the facility was inappropriately placed in restraints. When the Team spoke with the recipient whose rights were alleged to have been violated, he stated that he had been placed in restraints several times. He denied doing anything that would warrant use of restraints and informed the Team that the restraints were applied to "punish". When the HRA reviewed the recipient's clinical chart, three restraint episodes were noted. Documentation indicted that each time the restraints were applied the recipient had been involved in an aggressive action. When less restrictive measures and a physical hold failed to calm the recipient, he was placed in restraints. Documentation for each episode, as well as the facility's restraint policy, was in accordance with the Code requirements.

Conclusion for Allegation 1

The Authority acknowledges that the recipient may have perceived that the restraints were applied as a form of punishment. However, the Code allows for restraint use as a therapeutic measure to prevent a recipient from harming himself or causing harm to others. Therefore, the allegation that the recipient was inappropriately placed in restraints is unsubstantiated. No recommendations are issued.

Allegation 2: A recipient has not received adequate treatment for a medical condition. To investigate the allegation, the Team spoke with the recipient and reviewed his clinical record. The Team also spoke with the Chairman about the allegation. A facility policy pertinent to the complaint and information from the MayoClinic.com website were reviewed.

I: Interviews:

Recipient

When the Team spoke with the recipient about the allegation, he stated that he had been diagnosed with "Cerebral Malignant Carcinoma." He informed the Team that when the brain tumor was discovered in 2005, it was benign. However, 2007 testing indicated that the tumor had become malignant. He stated that he had refused chemotherapy, but wanted medication to relieve the pain. He informed the Team that facility medical staff had failed to provide adequate medication to control his pain.

Chairman:

The Chairman related that a similar complaint had not been registered with the facility's Human Rights Committee, and he could not provide any pertinent information.

II Record Review:

The HRA reviewed the recipient's 01/08/08, 02/05/08 and 02/26/08 TPRs. Documentation in each of the TPRs indicated that the recipient had a history of mood swings with all the classic manic and depressive symptoms being exhibited since the age of 11 years old. According to the documentation, the 21-year-old recipient believes that he developed a nation and a gang in 2004, and he is a gangster. The recipient's AXIS I Diagnoses were listed as Bipolar Disorder I (hypomanic) and a history of Polysubstance Dependence. The only physical problem noted and documented in the AXIS III Diagnosis was TMJ. There were no treatment goals in any of the TPRs to address any serious medical problem.

The recipient's initial physical examination and medical history, which was completed when he was admitted to the facility, did not indicate that the recipient had a malignant brain tumor or any other type of malignancy. There was no evidence in monthly nursing assessments, progress notes, physician's notes, physician's orders and referrals, laboratory testing, and Medication Administration Records that the recipient had been diagnosed with a malignant brain tumor or was receiving any type of pain medications. The HRA did not observe any infirmary reports or community hospital admission/discharge summaries that indicated that the recipient had a malignancy.

III. Facility Policy

The Facility's Policy entitled, "Conducting Initial and Annual Physical Examination and Medication Histories Policy" was reviewed. According to the Policy, each recipient is examined by a qualified physician within twenty-four hours of admission and annually thereafter. The physical examination and physical assessments include a medical history, bowel elimination assessment, functional assessment screening, and appropriate laboratory work-up.

The medical history includes the following information: the recipient's main complaint; details of present illness (when appropriate); an assessment of a recipient's emotional, behavioral and social status; relevant past and family medical histories; an inventory of the body systems and an alcohol and drug history.

According to the Policy, the physician will also complete nutritional, occupational therapy, physical therapy, speech therapy and audiological assessments. The physician will order a referral for follow-up services if any significant findings are noted.

The physician, in conjunction with the admitting nurse, will complete an initial bowel elimination assessment when a recipient is admitted, and significant findings will be documented in order that appropriate interventions can be initiated.

After examining the recipient, the physician will document in the recipient's chart, if there are any pre-existing medical conditions or physical limitation that would place the recipient at greater risk during a restraint or seclusion episode.

Any special problems, precautions, or consideration, including significant physical disorder or condition for inclusion on AXIS 11, should be documented and presented for review at the recipient's 3-day TPR.

The Policy mandates that a summary of the findings obtained during the recipient's physical examination and medical history be conveyed to the recipient, or if under guardianship, his guardian.

Additional physical exams, laboratory testing, and diagnostic procedures are to be conducted as needed during the recipient's hospitalization at the facility.

IV. Information from the MayoClinic.com website.

According to the information, TMJ disorder includes a variety of conditions that cause tenderness and pain in the temporomandibular joint. The TMJ is a ball-and-socket joint on each side of your head where your lower jawbone (mandible) joins the temporal bone of your skull. The lower jaw has rounded ends that glide in and out of the joint socket where you talk, chew or yawn. The surfaces of that area are covered with cartilage and separated by a small disk, which absorbs shock and keeps the movement smooth. The muscles that enable you to open and close your mouth stabilize this joint.

According to information from the website, pain or tenderness in the jaw, aching pain in and around the ear, difficulty chewing, aching facial pain, a clicking sound or grating session when you open your mouth or chew, locking of the jaw, headaches, and uncomfortable or uneven bite are symptoms of the disorder.

Treatments and interventions listed are as follows: (1) Breaking bad tension-related habits, such as grinding your teeth or chewing on your lip; (2) avoiding overuse of the jaw muscles; (3) stretching and massaging the area; (4) applying warm, moist heat or ice to the side of the face; (5) using anti-inflammatory medications, such as aspirin or ibuprofen; (6) use a biteplate and/or night guard appliance, and (7) the use of cognitive-behavioral therapy.

In the event, that the conservative, non-surgical treatments do not alleviate the pain, corrective dental treatment, injection of corticosteroid drugs, artrocentesis (insertion of a needle into the joint to irrigate the area and remove inflammatory byproducts), or surgery may be recommended.

Summary for Allegation 2

According to the complaint, a recipient at the facility was not receiving adequate treatment for a medical condition. When the HRA Team spoke with the recipient whose rights were alleged to have been violated, he stated that he had been diagnosed with a malignant brain tumor and had refused chemotherapy for the condition. He also stated that facility medical staff had failed to provide an adequate amount of medication to relieve the pain associated with the malignancy. According to numerous documentations in the recipient's clinical chart, the only medical diagnoses that the recipient had was listed as TMJ, a condition that may cause tenderness or pain in the jaw area. However, the recipient has mental health diagnosis of Bipolar Disorder, and documentation indicated that he frequently had delusions. The facility has a policy that outlines medical care of recipients, and documentation in the recipient's clinical chart indicated that the policy was followed.

Conclusion for Allegation 2

The review of the recipient's clinical chart did not indicate that the recipient had been diagnosed as having a malignant brain tumor. Nor was there any documentation that indicated that the recipient had informed facility staff that he was having severe pain. Therefore, the Authority does not substantiate that the facility did not provide adequate care by failing to provide sufficient medication to alleviate the recipient's pain caused by the malignancy. No recommendations are issued.

Suggestion

Facility medical staff should speak with the recipient to find out if he is experiencing headaches and other symptoms of TMJ in order to determine if treatment is needed for the condition.