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Egyptian Regional Human Rights Authority
Report of Findings
08-110-9035
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 is the most restrictive mental health center in the state, provides services for approximately 300 male residents. The specific allegations are as follows:

1. A recipient was inappropriately secluded in his room.
2. The recipient was not given a meal while he was required to remain in his room.
3. The items that the recipient had purchased in the facility commissary were taken from the recipient.

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 5/1-101.2 and 5/1-126 of the Code are also pertinent to the allegation.

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, "Seclusion may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. In no event shall seclusion be utilized to punish or discipline a recipient, nor is seclusion 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 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."

Section 5/1-101.2 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 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."

Section 5/1-126 states, "'Seclusion' means the sequestration by placement of a recipient alone in a room which he has no means of leaving. The restriction of a recipient to a given area or room as part of a behavior modification program which has been authorized pursuant to his individual services plan shall not constitute seclusion, provided that such restriction does not exceed any continuous period in excess of two hours nor any periods which total more than four hours in any twenty-four hour period and that the duration, nature and purposes of each such restriction are promptly documented in the recipient's record."

Investigation Information for Allegation 1

Allegation 1. A recipient was inappropriately secluded in his room. To investigate the allegation, 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 written authorization. The Team also spoke with the Chairman of the facility's Human Rights Committee (Chairman) about the allegation. Facility Policy pertinent to the allegation was reviewed.

Interviews:

I Recipient:

According to the recipient, a staff member became angry with him because he refused to "take a cold shower", and sent him to his room where he was isolated for a "considerable amount of time." The recipient did not provide information about the specific date or time that he was secluded in his room. However, he informed the Team that he was not allowed to have meals during the meal time period, and items that he had purchased in the commissary were taken from him. The recipient did not provide the names of any individuals who might have been aware of the seclusion.

II. Chairman

When the Team spoke with the Chairman about the allegation, he stated that the facility's policy is that seclusion should only be used to prevent an individual from causing harm to self or others. He informed the Team that when seclusion is implemented, the recipient is placed in a seclusion room rather than in his own room.

The Chairman stated that it is a standard practice when there is a disturbance on the module that poses a safety issue, staff will request, not require, each recipient go to his room for a short period of time until the situation can be resolved. He informed the Team that most disturbances are resolved in less than 15 minutes.

Clinical Chart Review:

I. Treatment Plan Reviews (TPR)

According to the recipient's 01/15/08 TPR, the 31-year-old recipient was admitted to the facility on 06/12/07 on an emergency basis; however, the status was changed to a Voluntary admission on 06/13/07. Prior to the recipient's transfer to Chester Mental Health Center, he was re-admitted to another state-operated mental health center on 05/30/07 after only 4 days of discharge.

The recipient's diagnoses were listed as follows: Axis I; Bipolar Mood Disorder with Psychotic Features; Axis II; Polysubstance Dependence History, Alcohol Dependence History; Axis III; History of Head Injury, Hypertension, Diabetes (Adult Onset), Hepatitis C and Hypothyroidism; Axis IV; Chronic Mental Illness.

According to documentation in the TPR, the recipient was informed of the circumstances under which the law permits the use of emergency forced medication, restraint or seclusion. Should any of the circumstances arise, the recipient stated that the following forms of intervention are to be used in order of his preference: (1) emergency medication; (2) seclusion and (3) restraints.

The 01/15/08 TPR contained a goal to address the recipient's problem areas of emotional dysregulation, aggression, substance abuse, hypertension, Diabetes Mellitus, and a thyroid disorder. To address the recipient's problem with aggression, a goal to increase his coping mechanisms through compliance with the prescribed medication regime coupled with therapeutic guidance of alternate modes of coping were listed in the TPR. In the progress section related to the goal, documentation indicated that the recipient was in restraints twice during the reporting period. However, there was no indication that the recipient had been placed in seclusion during the same time frame.

Documentation in the recipient's 02/12/08 TPR indicated that the recipient was placed in restraints on 02/07/08 after he became verbally and physically aggressive to others. The HRA did not observe any documentation in the TPR that specified that the recipient had been placed in seclusion.

According to the recipient's 03/12/08 TPR, he was placed in restraints on 02/23/08 due to physically aggressive behaviors; however, there was no documentation to indicate that the recipient had required seclusion.

II. Restraint, Physical Hold, and Seclusion Review (01/01/08 to 03/31/08)

According to documentation in the recipient's clinical chart the following physical holds and restraints were listed for the period of 01/10/08 through 03/31/08: (1) The recipient was placed in a physical hold at 5:10 PM on 01/09/08 after he physically attacked another recipient. After being released from the physical hold at 5:15 PM, he was placed in restraints. He remained in restraints until 9 AM on 01/11/08. (2) The record indicated that the recipient was placed in a physical hold on 02/07/08 at 7:10 PM due to his fighting with another recipient. He was released from the physical hold at 7:15 PM on 02/07/08 and placed in restraints. He remained in restraints until 7:15 PM on 02/09/08. (3) On 02/23/08, he was placed in a physical hold at 5:25 PM after he shoved a staff member. He was released from the physical hold and placed in restraints at 5:30 PM on 02/23/08. He remained in restraints until 02/25/08 at 1:30 PM. (4) The recipient was placed in a physical hold on 03/14/08 at 8:10 PM after he attacked staff members. He was released from the hold at 8:15 and placed in restraints. He remained in restraints until 03/15/08 at 1:15 AM. (5) He was placed in a physical hold at 5:40 PM on 03/15/08 after he attacked a peer following an argument over commissary food. When the recipient was released from the physical hold at 5:45 PM, he was placed in restraints until he met the criteria for release at 11:45 PM on 03/16/08. (6) Documentation indicated that when the recipient hit the wall of his room on 03/28/08, an attempt to redirect him failed. As a result he became physically aggressive toward staff and exhibited behaviors that would cause physical harm to self. He was placed in a physical hold at 2:25 PM and released from the hold at 2:30 PM. He was immediately placed in restraints; however, he only remained in the restraints for a 15-minute period. He was released from the restraints to have an x-ray of his hand that was injured when he hit the wall in his room prior to his placement in the physical hold and restraints. (7) When the recipient was brought back from having the x-ray, he attempted to strike a staff member. As a result, he was placed in a physical hold at 3:12 PM on 03/28/08. He was released from the physical hold at 3:15 PM and placed in restraints. He met the criteria for release at 11:15 AM on 03/29/08. HRA Case 08-110-9036 Report of Findings provides information regarding a detailed review of the above restraint episodes listed for the recipient.

III. Additional Information

The Team did not observe any documentation in the recipient's clinical chart that indicated that the recipient was placed in seclusion during his hospitalization at the facility.

Facility Policy/Procedure (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 others and follow the Department of Human Services Program Directive 02/02/06/030."

The Procedure includes the following: (1) When a seclusion room is being used for seclusion, the door to the room will be key locked. (2) A STA II will assign a qualified staff member to the monitoring room within 50 feet from the seclusion to provide constant observation by video/audio monitoring (3) The door to the monitoring room is to remain closed at all times, except when notifying other staff of necessity to intervene with a recipient. A staff member is not to leave the monitoring room unless relieved by another qualified staff member. (4) The STA II is responsible for the qualified staff that is assigned to the monitoring room to be reasonably relieved. Monitoring room assignments should not exceed two consecutive hours without a relief period. (5) No eating or any other activity is allowed in the monitoring room. (6) A two-way radio and a telephone are provided in the monitoring room in order that necessary communication may be available. (7) Recipients being monitored by staff assigned to the monitoring room will be monitored on a one to one basis. (8) The staff member monitoring the seclusion should report any unusual recipient behaviors or sounds immediately to the STA II via the two-way radio or telephone. These behaviors/sounds should also be communicated to other module staff and those staff members should respond to the seclusion room. The STA II should ensure that necessary communication is implemented. (9) The monitoring staff member is responsible for completing the appropriate documentation pertinent to the seclusion, as well as to participate in providing required reviews for the recipient being monitored. (10) The STA's completing Unit Security Rounds checks, in accordance with facility procedure, are to be available to consult with the monitoring staff member to determine if secluded recipient required additional monitoring. The security rounds are conducted at least each fifteen minutes.

According to the procedure, the recipient's available treatment team members will meet with recipient to encourage the recipient to achieve the release criteria. An assessment will be conducted by a clinician familiar with the recipient and will include the potential for suicide and self-injurious behaviors.

The procedure mandates the nursing supervisor of the shift to notify the hospital administrator, the medical director and the medical director's secretary by e-mail when any of the following circumstances occur. (1) When the recipient remains in restraint or seclusion for more than 12 hours. (2) When a recipient experiences 2 or more separate episodes or restraint and/or seclusion of any duration within 12 hours. When the medical director's secretary is notified, the secretary will arrange for appropriate psychiatric follow-up at the earliest possible time.

The recipient's treatment team will meet by the next working day following the restraint/seclusion to review and modify the treatment plan.

Summary of Allegation 1

According to the recipient whose rights were alleged to have been violated, he was inappropriately secluded in his room. When HRA reviewed the recipient's clinical chart, several restraint episodes were documented; however, there was no indication that the recipient had been placed in seclusion in his room. According to the Chairman, seclusion is implemented in a seclusion room rather than in the recipient's own room. However, recipients may be requested to remain in their room for a short period of time in the event there is a disturbance on the module that might pose a safety issue. The facility has a policy that is in accordance with the Code's requirements regarding seclusion.

Conclusion of Allegation 1

Based on the information obtained, the Authority does not substantiate that the recipient was inappropriately secluded in his room. No recommendations are issued.

Allegation 2. The recipient was not given a meal while he was required to remain in his room. To investigate the allegation, the Team conducted a site visit at the facility. During the visit, the Team spoke with the recipient and reviewed his clinical chart. The Team also spoke with the Chairman about the allegation. The facility's procedure pertinent to the allegation was reviewed.

Interviews:

According to the recipient, staff failed to provide him with meal during the time that he was secluded in his room.

Chairman:

The Chairman informed the Team that it is the facility's policy to provide meals at regular meal times when a recipient is placed in seclusion or restraints, and facility staff members are required to document that the meal was offered.

Clinical Chart Review:

When HRA reviewed the recipient's clinical chart, there was no documentation that indicated that the recipient had been placed in seclusion. However, the record indicated that the recipient had been placed in restraints numerous times since he was admitted to the facility in June 2007. According to documentation in the Restraint Flowsheet for the restraint episode that began on 03/15/08 at 5:45 PM and ended at 11:45 PM on 03/16/08, the recipient was not offered meals at the scheduled mealtimes. Each of the recipient's restraint episodes, including documentation of the offering of meals, is thoroughly reviewed in HRA Case Number 08-110-9036.

Facility Policy

According to the facility's policy, staff members must offer meals to the individual in restraints or seclusion at regular meals time, or more frequently if specified by the physician or Registered Nurse (RN) with supervisory responsibilities.

If the individual accepts the offer, staff must provide the meal and monitor the eating of that meal on a one-to-one basis unless the physician or RN with supervisory responsibilities, after observing and evaluating the individual, determines that release could result in serious harm to self or others. Meals should not be given to individuals lying in a supine position.

The staff member who has observed the individual must document on the Flowsheet that the recipient has accepted the meal or the reason that the meal was not offered.

Summary of Allegation 2

According to the recipient, when he was secluded in his room he was not offered meals. The HRA did not observe any documentation that indicated that the recipient had been placed in seclusion; however, numerous restraint episodes were recorded. According to documentation regarding a restraint episode from 3/15/08 through 3/16/08, the recipient was not offered food at regularly scheduled mealtimes. A Report of Findings pertinent to the restraint episodes for the same recipient is addressed in HRA Case 08-110-9036.

Conclusion of Allegation 2

Due to the lack of documented evidence, the HRA does not substantiate that facility staff failed to provide the recipient with meals when he was alleged to have been secluded in his room. No recommendations are issued.

Allegation 3: The items that the recipient had purchased in the facility commissary were taken from the recipient. To investigate the allegation, the Team spoke with the recipient and reviewed his clinical chart.

Interview:

According to the recipient whose rights were alleged to have been violated, items that he had purchased in the commissary were taken from him when he was secluded in his room, and the items were not returned when he was released from seclusion. The recipient did not provide the name(s) of staff that took the items or any witnesses to the confiscation.

Clinical Chart Review:

The HRA did not observe any documentation in progress notes that indicated that the recipient's commissary items were taken. His clinical chart did not contain any restriction notice(s) pertinent to restriction of any food items.

According to a 03/12/08 TPR, the recipient had a goal to stabilize and manage blood sugar levels and to prevent hyperglycemic/hypoglycemic episodes associated with Diabetes Mellitus. Objectives were listed as follows: 1) The recipient will take medication for Diabetes as prescribed. 2). He will be compliant with labs. 3) He will be able to determine possible symptoms associated with hypoglycemia or hyperglycemia and 4) He will demonstrate an understanding of the importance of proper nutrition, exercise and maintaining weight within his Ideal Body Weight range. Documentation indicated that the recipient weighs 252 lbs.

Nursing staff documented in the 03/12/08 TPR that the recipient had no problems with blood sugar levels and all of his labs were with the normal range. A facility physician indicated that the recipient had not exhibited any symptoms associated with Diabetes, and no problems were reported by STAs. Documentation indicated that on 03/15/08, the recipient got into an argument with another recipient over commissary food and the argument escalated to physical violence. As a result of the recipient's physical aggression toward the peer, he was placed in restraints. There was no documentation that indicated that commissary items were confiscated when he was placed in restraints or were restricted due his diabetic diagnoses.

Summary

According to the recipient, the items that he had purchased were confiscated when he was placed in seclusion. The record indicated the recipient argued with a peer over commissary food items and that the argument spiraled into physical violence. As a result of the altercation, the recipient was placed in restraints. However, when the recipient's records were reviewed, the HRA did not discover any evidence that indicated that the recipient had been secluded and his commissary items confiscated.

Conclusion

Based on review of the recipient's clinical chart and lack of supporting evidence, the Authority does not substantiate that the items that the recipient purchased in the facility commissary were confiscated when the recipient was placed in seclusion. No recommendations are issued.