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Egyptian Regional Human Rights Authority
Report of Findings
08-110-9041
Chester Mental Health Center
February 10, 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 at Chester Mental Health Center was inappropriately placed in restraints.
2. A recipient was not allowed to refuse a medically prescribed diet.

Statutes

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/2-107, 405 ILCS 5/2-108 and 405 ILCS 5/2-201).

Section 5/2-107 of the Code states, "An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disabilities services, including but not limited to medication or electroconvulsive therapy. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available. The facility director shall inform a recipient, guardian, or substitute decision maker, if any, who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services.

Section 5/2-108 of the Code 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 of the Code 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 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."

Investigation Information

Allegation1: A recipient at Chester Mental Health Center was inappropriately placed in restraints. To investigation the allegation, the HRA Investigation Team, consisting of two members and the HRA Coordinator (Coordinator), conducted a site visit to the facility. During the visit, the Team spoke with the recipient whose rights were alleged to have been violated and the Chairman (Chairman) of the facility's Human Rights Committee. With the recipient's written authorization, the Team requested and received copies of pertinent information from his clinical chart.

Interviews:

A…Recipient:

According to the recipient whose rights were alleged to have been violated, another recipient hit him in the head and then threw a garbage can at him. The recipient stated that in order to protect himself, he jumped on top of the offending recipient causing him to fall and "bust his head". The recipient informed the Team that staff intervened and placed both he and the aggressor in restraints. Additionally, their facility access levels were lowered to red level, the lowest level of participation in the facility system. The recipient stated that he did not believe that he should have been placed in restraints because he was only trying to protect himself.

B…Chairman:

According to the Chairman, the facility's policy is to only place a recipient in restraints for self-protection or to prevent the recipient from causing harm to another person. He informed the Team that when a recipient is placed in restraints, he is provided with a Restriction Notice which lists the reason the restraint was implemented. He stated that the facility follows the Code requirements when restraints are necessary.

The Chairman informed the Team that the facility's level system was implemented to reinforce recipients' adaptive social behaviors. When a recipient exhibits improved social functioning, he is able to gain access to more areas of the facility and to be a part of an increasing number of programs as his access level increases. The levels include the following: 1)

Red Level, with the least amount of activities; 2) Yellow Level, the mid-level of activities; and 3) Green Level, the highest level in the system.

Chart Review:

A…Progress Notes:

According to a Registered Nurse's (RN) Progress Note completed at 9:45 AM on 03/22/08, the recipient was placed in a physical hold following a fight with a peer. The RN recorded that the fight was started by the peer; however, when staff directed the recipient to cease fighting he continued the physical altercation. As a result, he was released from the physical hold and placed in restraints. Documentation indicated that during the fight the recipient received an abrasion on the knuckles of his left hand.

Documentation in a 10:10 AM Progress Note indicated that the recipient informed the staff member that he hit another recipient because that recipient had "picked a fight with him over a cup of coffee". Additional documentation indicated that the recipient would not stop fighting despite staff's direction to do so. As a result of his failure to cease the aggressive action, he was placed in a physical hold, then into physical restraints for the protection of others.

B…Order For Physical Hold:

Documentation in an Order for a Physical Hold dated 03/22/08 indicated that the recipient was fighting with another recipient with both individuals "throwing punches with intent to harm." The record indicated that the physical hold began at 9:40 AM and the recipient was released at 9:45 AM. After being released from the hold he was immediately placed in physical restraints.

According to the documentation, an RN had examined the recipient after the application of the physical hold and had assessed that the application did not pose an undue risk to his physical or mental condition. A facility physician recorded that he had examined the recipient within one hour of the initiation of the physical hold and had determined that the application did not pose a risk to the recipient's mental or physical health.

C…Order Restraint or Seclusion (Restraint Order):

The record indicated that a Restraint Order was implemented at 9:45 AM immediately after the recipient was released from the physical hold. The recipient's failure to cease fighting with a peer after staff had requested that he cease the aggressive behavior was listed as the reason for the restraint application. According to the record, the recipient's choice of emergency treatment was not implemented due to the level of his aggressive actions.

The Restraint Order was issued for up to 4 hours with 1 hour reviewed to allow adequate time for the recipient to gain control of his behavior. The release criteria were listed as follows: 1) He must be calm for a 60 minute period with no verbal threats of harm to self or others. 2) He

must relate that he can control his aggression and report problems with peers to staff. 3) He must be awake to determine his ability to meet the release criteria.

Documentation indicated that the nurse examined the recipient at 9:50 AM, 5 minutes after the restraint was implemented and recorded that the application did not create an excessive risk to the recipient's mental and physical health. Documentation indicated that a facility physician examined the recipient at 10:10 AM and reached the same conclusion as the RN.

C… Restraint/Seclusion Flowsheet (Flowsheet):

According to the Flowsheet, a body search was completed after the restraints were applied. The following assessments were conducted: 1) A determination that the restraints were properly applied; 2) An assessment that the room environment was appropriate; 3) A determination that the recipient was wearing proper clothing; and 4) A determination that he was properly positioned. Documentation indicated that he was informed of the reason for the restraint and the release criteria. He was also provided with a Restriction of Rights Notice. It was determined that he did not have any medical condition that would indicate that the restraints would cause harm.

Documentation in the Flowsheet indicated that as soon as the recipient was placed in restraints, his aggressive behaviors ceased. The recipient was continually observed and his condition was recorded in fifteen minute intervals. According to the record, he was released at 10:45 AM, an hour after the restraint implementation.

D. ..Restraint Review Form:

Documentation in a 10:45 AM Restraint Review Form indicated that the recipient was calm, voiced no animosity toward the other recipient, and he was able to relate more appropriate behaviors to deal with a similar situation. According to the record, the recipient was released at the 10:45 AM review.

E…Post-Episode Debriefing:

Documentation indicated that an RN conducted a debriefing with the recipient at 11:45 AM. During the debriefing, he was able to identify the stressors that occurred prior to the restraint. He was also able to verbalize an understanding of the causes and consequences of his aggressive behaviors and able to identify other methods to control those behaviors. He was encouraged to discuss his feelings related to the restraint and to verbalize that he can request assistance from staff prior to an escalation of anxiety. Documentation indicated that the recipient stated that he did not feel that staff could have helped him to remain in control of the situation that resulted in the restraint.

Additional documentation indicated that the RN reviewed the reasons why previously attempted interventions were either not employed or were not successful. He was assessed for any physical injury and it was determined that his privacy needs were addressed.

F…Notice Regarding Restricted Rights of Individual (Restriction Notices):

The recipient's clinical chart contained two Restriction Notices pertinent to the 03/22/08 incident. A Restriction Notice was provided to the recipient for the physical hold, as well as the restraint. Both Restriction Notices were delivered to the recipient in person and indicated that his preferred interventions were not used due to the level and the spontaneity of his aggressive actions. According to the documentation, the recipient did not wish anyone to be notified of the restrictions.

Summary

According to the recipient whose rights were alleged to have been violated, he was attacked by another recipient and when he attempted to defend himself, staff placed him in physical restraints. Documentation in the recipient's clinical chart verified that the recipient did not commence the aggressive actions. However, when staff requested that he cease exchanging blows with the other recipient he failed to do so. The record indicated the recipient was placed in a physical hold for a 5 minute period prior to being placed in 4 point restraints for a period of one hour. Documentation indicated that the procedures were implemented due to the level of the aggression, potential for self harm, and physical harm to others. The recipient was provided with Restriction Notices for the physical hold and the restraint episode. All documentation relevant to the restraint episode was in accordance with the Code's requirements.

Conclusion

Based on information obtained during the course of the investigation, the allegation that the recipient was inappropriately placed in restraints is unsubstantiated. No recommendations are issued.

Allegation 2: A recipient was not allowed to refuse a medically prescribed diet. To investigate the allegation, the HRA Team spoke with the recipient about the allegation and reviewed information from his clinical chart with his written authorization.

Interview:

Recipient:

According to the recipient he receives a diabetic diet that is not sufficient for his needs and when he requests changes in the diet, staff will not comply with his requests.

Chart Review:

A…Treatment Plan Reviews (TPR):

According to the recipient's 04/16/08 TPR, the recipient was admitted to the facility on 02/29/08 from the Illinois Department of Corrections as an Involuntary Admission. On 03/04/08, his status was changed to Voluntary.

The recipient's Diagnoses were listed as follows: AXIS I: Schizoaffective Disorder, Bipolar Type, History of Non-compliance with medications; AXIS II: Antisocial Personality Disorder; AXIS III: Hypertension, Non-Insulin Dependent Diabetes Mellitus, Dyslipidemia, Overweight; and AXIS IV: Longstanding Mental Illness, Numerous Psychiatric Hospitalizations, and History of Incarcerations.

Goals listed in the TPR were as follows: 1) To reduce psychotic symptoms which consist of delusions; 2) To lower and manage his blood pressure in order to minimize the probability of permanent damage to his brain, heart and/or kidneys; 3) To lose weight and stabilize within his Ideal Body Weight (IBW).

To address the goal to lose weight, documentation indicated that nursing staff will ensure the following: 1) The dietary recommendations are reviewed by the doctor and orders for the diet are followed; 2) The recipient will be weighed monthly; 3) He will be sent for dietary referrals if needed; 4) He will be provided with educational information on the complications of obesity; and 5) He will attend gym and exercise sessions five times weekly.

An RN recorded in the 04/16/08 TPR that a facility dietician, physician and nursing staff are in frequent contact regarding the patient's diet and dietary reviews are completed on a regular basis. The RN documented that the recipient refused to attend educational classes pertinent to nutrition issues. However, a facility Activity Therapist recorded that the recipient surpassed his objectives by attending 33 off-unit sessions and actively participating in most of the scheduled activities.

In the recipient's 05/14/08 TPR, an RN documented that a nutritional review was completed on 04/15/08 with no dietary changes recommended at that time. The recipient was listed as being on a 2200 American Diabetic Association (ADA) diet. The RN recorded that reviews are done regularly when the patient has issues with his diet. The RN documented that the recipient weighed 251 lbs, 63 lbs above his IBW. Additional documentation indicated that the dietician, physician and nursing staff were in frequent contact with the recipient concerning his requests for dietary changes. The record indicated that the recipient continued to refuse educational classes regarding the complications of obesity, but continued to be actively involved in attending exercise and gym activities.

Documentation in the 06/11/08 TPR indicated that the recipient's diet had been changed to a No Concentrated Sweets (NCS) diet with reviews regularly upon request by the recipient. Additional documentation indicated that the recipient weighed 249 lbs, 61 lbs above his IBW. An RN documented that she had attempted to educate the recipient about proper nutritional issues, such as fats and sodium, reading labels, but he had "angrily" refused to take part in the educational program.

<u>B… Dietary Referral and Report Consultations (Consultations):</u>

Documentation indicated that the recipient was referred for a dietary consultation on 02/29/08 and received the consultation on 03/04/08. The consultation indicated that the recipient had diabetes, elevated cholesterol levels, obesity and had a family history of heart disease. The recipient's medications and laboratory reports were reviewed, and he was placed on a 2200 calorie diet. When an additional consultation was conducted on 4/1/08, the recipient's diet was changed to NCS with fruit at bedtime. All labs were reviewed at the time of the consultation.

Summary

According to the recipient, he is required to have a diabetic diet and staff members have refused to make adjustments to accommodate his preferences. According to the recipient's TPRs, he has a diagnosis of Non-Insulin Dependent Diabetes Mellitus. The recipient's TPRs contained a goal to address the medical condition, as well as his obesity. Documentation indicated that the dietician had met with the recipient and had made changes in his diet to accommodate his preference, taking into consideration his medical condition. When he was initially evaluated, he was on an ADA diet. However, later documentation indicated that his diet had been changed to a NCS diet, a diet that did not contain any concentrated sweets. There was consistent documentation throughout the recipient's clinical chart that indicated dietary issues had been addressed in the recipient's TPRs. Additionally, nursing staff had attempted to provide information about proper nutrition and the impact that diet had on his medical condition to address TPR goals; however, the recipient refused to take part in the educational classes.

Conclusion

Documentation in the recipient's clinical chart supports the facility's effort to accommodate the recipient's preference, while taking into consideration his medical condition as a part of the treatment planning process.

Therefore, the Authority has determined that a rights violation has not occurred. Therefore, the allegation that the recipient has not been allowed to refuse a medically prescribed diet is unsubstantiated. No recommendations are issued.