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Egyptian Regional Human Rights Authority
Report of Findings
Chester Mental Health Center
09-110-9017
August 25, 2009

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 allegation is as follows:

> Chester Mental Health Center has failed to provide adequate care and services for a recipient at the facility.

Statutes

If substantiated, the allegation would be a violation of the Mental Health and Developmental Disabilities Code (Code) 405 ILCS 5/2-102. Section 5/1-101.2 of the Code is also pertinent to the allegation.

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 5/1-101.2 states, "'Adequate and humane services' means services reasonably calculated to result in a significant improvement of the condition of the 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

To investigate the allegation, the HRA Investigation 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 reviewed his clinical chart. The facility's policy pertinent to monitoring recipients was reviewed.

Interview:

The recipient informed the HRA that staff members at Chester Mental Health Center have failed to protect him from being injured by other recipients. He stated that he has received two injuries to his nose and his thumb has been dislocated. He related that each injury was caused by a different recipient. He stated that when he received the dislocated thumb, the injury was initially treated in the facility infirmary; however, he was transferred to a community hospital emergency room for additional treatment. The recipient denied initiating any of the altercations.

Chart Review:

I…Treatment Plan Review (TPR)

Documentation in the recipient's 06/18/09 TPR indicated that the 41-year-old recipient was admitted to the facility on 06/28/07 with a legal status of Not Guilty by Reason of Insanity (NGRI) with a Theim date of 08/21/07. His present legal status is listed as Involuntary. The record indicated that the recipient was transferred from Chester Mental Health Center on 06/14/07 to a less restrictive state-operated mental health hospital. However, after 14 days he was returned to the facility due to his aggressive behaviors toward staff and other recipients at the receiving hospital.

According to documentation, the recipient had adjusted well and had not been a behavioral management problem since his return. At the time of the TPR, the record indicated that he was on green level, the highest level in the facility's level system. (The facility's Level System Procedure was implemented to reinforce adaptive social behaviors through increased opportunities for facility privileges.)

The recipient's diagnoses were listed as follows: AXIS I: Schizoaffective Disorder, Bipolar Type, History of Poly-Substance Dependence; AXIS II: Personality Disorder NOS, (Not Otherwise Specified); AXIS III: No Diagnosis, and AXIS IV: Medication non-compliance, resistance to treatment, Psychotic relapses, NGRI.

His medication plan included the following : 1) Olanzapine 10 mg AM and 20 mg at bedtime for psychosis: 2) Oxcarbazepine 1200 mg AM and bedtime for mood swings; and 3) Lorazepam 2 mg twice daily (as needed) for agitation.

The recipient's strengths were listed as follows: 1) average intelligence; 2) able to perform ADLs (Activities of Daily Living), 3) strong family support; 4) high school education and 5) above average communication skills for the patient population.

Individualized Treatment Goals addressed his psychotic symptoms, which can lead to aggressive behaviors, and his obesity. Documentation indicated the recipient had been in an altercation with another recipient two months prior to the TPR and had received an injury to his face. However, during the TPR reporting period he had not been involved in any aggressive actions, even though he remained actively psychotic. The record indicated that he had gained 4 lbs. with his current weight listed as 247 lbs., 69 lbs. above his ideal body weight. A Registered

Nurse (RN) documented that the recipient had refused the recommended diet and remained on a regular diet.

According to documentation in the recipient's 07/16/08 TPR, the recipient had been medication compliant and restraint free during the reporting period. The record indicated that the recipient has a history of excessive water intake and had been sent to the infirmary for weight calculation and water protocol.

According to the recipient's 08/13/08 TPR, he had engaged in horse play with a peer on 07/18/08, and he was observed arguing with another peer on 07/22/08. Both incidents were dealt with redirection, and the intervention was successful in stopping the behaviors. The record indicated that water intoxication remained a concern due to the recipient becoming \increasingly delusional and his mood unstable whenever the consumption is excessive. Nevertheless, documentation specified that Security Therapy Aide (STA) staff members continue to report overall progress with only minor infractions which resulted in two behavioral data reports for the period. The record indicated that the recipient had not required restraints, seclusion or emergency medication.

II…Injury Reports:

According to 07/25/07 Injury Report completed by a facility RN, the recipient received a 7 inch scratch and abrasion to his right forearm. The record indicated that the injury was received when another patient attacked the recipient. The RN documented that minor first aid was administered by cleaning the area and applying Betadine. Documentation indicated that the recipient refused to have a facility physician examine the injured area.

Documentation in a 10/28/07 Injury Report indicated that the recipient was hit in the nose by a peer causing a deep 2 inch laceration, swelling and bruising to the bridge of the nose. The record indicated that there was a moderate amount of bleeding associated with the injury. Documentation specified that the area was cleansed with soap and water, and Betadine was applied. After a facility physician examined the recipient, he applied an ice pack and ordered that he be sent to a community hospital emergency room for examination of a possible fracture to the nose.

On 01/01/08 the recipient was involved in a confrontation with another recipient and he sustained a reopening of a previous wound on his nose. An RN recorded in an Injury Report that the small area was cleansed, and a facility physician was notified. According to documentation, when the physician examined the recipient the wound was closed with a band-aid, and the bleeding spontaneously ceased.

According to a 08/22/08 Injury Report, the recipient received a very small scratch on his head when he was struck by another recipient. Documentation indicated that no bleeding, swelling, or bruising occurred. Minor first aid was applied by a facility nurse. The record indicated that it was not necessary for the recipient to receive treatment from a facility physician.

III…Infirmary Admission and Discharge Summary

Documentation indicated that the recipient was admitted to the facility infirmary on 06/04/08 for water intoxication. He remained in the infirmary until 06/13/08. His condition on discharge was stable. The final physical diagnosis was listed as Hyponatremia (low concentration of sodium due to excessive water consumption). A facility physician ordered that the water intoxication protocol be continued after his discharge from the facility infirmary. He directed facility staff to weigh the recipient twice daily, three times weekly.

IV…Progress Notes:

The Authority reviewed Progress Notes pertinent to the 10/28/07 and 08/22/08 injuries. Documentation indicated the recipient was struck in the nose by a peer causing a laceration to the bridge of his nose. The incident occurred on 10/28/07 at 7:30 AM. An RN recorded that the affected area was cleansed with soap and water, Betadine was applied, and a facility physician was notified.

When an RN completed a Progress Note at 7:40 AM on 10/28/07, she indicated that the physician had examined the recipient and wrote orders for him to be sent to an area hospital emergency room for evaluation.

A 10:50 AM Progress Note indicated the recipient had returned to the facility from the emergency room. The assessment at the community hospital revealed that the recipient's nose was not fractured; however, he required seven stitches to close the wound.

According to an 11 AM Progress Note on 10/28/07, the recipient was admitted to the facility infirmary after returning from the community hospital emergency room. Documentation indicated that medical staff examined the recipient at frequent intervals during his stay in the infirmary. Documentation in a 8:40 AM Progress Note on 10/29/07 indicated that a facility physician had examined the recipient, removed the dressing on his nose and ordered that he return to his unit. Nursing staff were to continue cleaning the area and applying Bacitracin, an antibiotic ointment.

A Social Worker documented in a 12:50 PM Progress Note on 10/29/07 that the recipient was placed on red level, the lowest level of the facility's level system, due to his altercation with a peer on 10/27/07. The Social Worker recorded that the recipient stated that the disagreement was due to the other recipient approaching him in a sexually inappropriate manner. The Social Worker documented that as a result of the 10/27/09 incident; the recipient approached the peer and hit him. The peer responded by returning a blow to the recipient causing an injury that required the recipient to have seven stitches on his nose to close the wound.

According to a 08/22/08 Progress Note, the recipient was struck on his right left forehead by another recipient. The RN documented that the recipient a very small scratch to his head with no bleeding or bruising. A client injury report was completed; however, the injury was not significant enough to notify a facility physician.

Facility Policy

The HRA reviewed the facility's Policy entitled, "Routine Observation-Patient Visual Observation Checks." The Policy Statement is listed as follows: "In order to ensure the continued safety and security of patient, STA staff assigned to each module are required to visually observe and account for each patient assigned to that module at least every 15 minutes. Any unusual behavior and/or situation noted requiring intervention shall be promptly responded to in accordance with facility procedures and documented as required."

The Procedure requires for all recipients to be observed and accounted for every 15 minutes. Visual observation should be made by looking at each individual recipient and recording on a Routine Visual Observation Check Sheet. Recipients who are in their rooms or sleeping should be observed through the window with the least disruption possible to assure that the correct recipient is in bed and that there is exposed skin as evidence that the patient is in the bed and not in distress. The STA conducting the observation is required to initial the bottom of the column for that time period. Any recipient noted to be in distress or unaccounted for should be immediately referred to the unit nurse and/or a STA II for immediate corrective action. The STA II responsible for assigning STA staff for the visual observation is required to periodically review the observations during the shift. The Unit Director or Unit Manager is required to complete random checks, as well as the administrative staff assigned to complete facility inspections.

Documentation indicated that the facility was conducting 15 minute observations in accordance with the facility policy.

Summary

According to the recipient whose rights were alleged to have been violated, he has received numerous injuries since his June 2007 admission to the facility. He informed the HRA that his nose was injured on two occasions, and his thumb was dislocated. Documentation indicated that the recipient was transferred from Chester Mental Health Center to a less restrictive hospital on 06/14/07 and returned on 06/28/07 due to his aggressive behaviors toward other recipients and staff. The record indicated that the recipient's behaviors improved after his second admission. However, he had been involved in several altercations with other recipients since his return. The HRA reviewed four Injury Reports pertinent to the recipient's most recent admission at the facility. The record indicated other recipients initiated the attacks on the recipient, which resulted in his 07/25/07 and 01/01/08 injuries. However, documentation specified that the recipient initiated the altercations that caused the 10/28/07 and 08/22/08 injuries. According to Injury Reports, TPRs and Progress Notes, the injury that occurred on 10/28/07 required emergency room treatment at a community hospital, seven stitches to close the wound, and observation in the facility infirmary for a short period of time. However, other injuries required minor first aid at the facility. The HRA did not observe any documentation that indicated that the recipient's thumb had been dislocated. According to facility policy and documentation pertinent to the policy, staff members observe each recipient every 15 minutes and record their observations.

Conclusion

Based on the information obtained, the allegation that Chester Mental Health Center failed to provide adequate care and services for the recipient is unsubstantiated. No recommendations are issued.