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Egyptian Regional Human Rights Authority
Report of Findings
09-110-9062
Chester Mental Health Center
June 8, 2010

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 250 male residents. The specific allegation is as follows:

> A recipient at Chester Mental Health Center was inappropriately placed in restraints and required to remain in the restraints for a considerable amount of time.

Statutes

If substantiated, the allegation would be a violation of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-108, 405 ILCS 102 (a), 405 ILCS 5/200 and 405 ILCS 5/2-201).

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 staff."

"(a) Except as provided in this Section, a restraint shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities. No restraint shall be ordered unless the physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of restraint is justified to prevent the recipient from causing physical harm to himself or others. In no event may restraint continue for longer than 2 hours unless within that time period a nurse with supervisory responsibilities or a physician confirms, in writing, following a personal examination of the recipient, that the restraint does not pose an undue risk to the recipient's health in light of the recipient's physical or medical condition. The order shall state the events leading up to the need for restraint and the purposes for which restraint is employed. The order shall also state the length of time restraint is to be employed. The order shall also state the length of time restraint is

to be employed and the clinical justification for that length of time. No order for restraint shall be valid for more than 16 hours. If further restraint is required, a new order must be issued pursuant to the requirements provided in this Section.

(b) In the event there is an emergency requiring the immediate use of restraint, it may be ordered temporarily by a qualified person only where a physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities is not immediately available. In that event, an order by a nurse, clinical psychologist, clinical social worker, or physician shall be obtained pursuant to the requirements of this Section as quickly as possible, and the recipient shall be examined by a physician or supervisory nurse within 2 hours after the initial employment of the emergency restraint. Whoever orders restraint in emergency situations shall document its necessity and place that documentation in the recipient's record. (c) The person who orders restraint shall inform the facility director or his designee in writing of the use of restraint within 24 hours. (d) The facility director shall review all restraint orders daily and shall inquire into the reasons for orders for restraint by any person who routinely orders them. (e) Restraint may be employed during all or part of one 24 hour period, the period commencing with the initial application of the restraint. However, once restraint has been employed during one 24 hour period, it shall not be used again on the same recipient during the next 48 hours without the prior written authorization of the facility director.

(f) Restraint shall be employed in a humane and therapeutic manner and the person being restrained shall be observed by a qualified person as often as is clinically appropriate but in no event less than once every 15 minutes. The qualified person shall maintain a record of the observations. Specifically, unless there is an immediate danger that the recipient will physically harm himself or others, restraint shall be loosely applied to permit freedom of movement. Further, the recipient shall be permitted to have regular meals and toilet privileges free from the restraint, except when freedom of action may result in physical harm to the recipient or others.

(g) Every facility that employs restraint shall provide training in the safe and humane application of each type of restraint employed. The facility shall not authorize the use of any type of restraint by an employee who has not received training in the safe and humane application of that type of restraint. Each facility in which restraint is used shall maintain records detailing which employees have been trained and are authorized to apply restraint, the date of the training and the type of restraint that the employee was trained to use.

(h) Whenever restraint is imposed upon any recipient whose primary mode of communication is sign language, the recipient shall be permitted to have his hands free from restraint for brief periods each hour, except when freedom may result in physical harm to the recipient or others.

(i) A recipient who is restrained may only be secluded at the same time pursuant to the explicit written authorization as provided in Section 2-109 of this Code. Whenever a recipient is restrained, a member of the facility staff shall remain with the recipient at all times unless the recipient has been secluded. A recipient who is restrained and secluded shall be observed by a qualified person as often as is clinically appropriate but in no event less than every 15 minutes.

(j) Whenever restraint is used, the recipient shall be advised of his right, pursuant to Sections 2-200 and 2-101 of this Code, to have any person of his choosing, including the Guardianship and Advocacy Commission or the agency designated pursuant to the Protection and Advocacy for Developmentally Disabled Persons Act notified of the restraint. A recipient who is under guardianship may request that any person of his choosing be notified of the restraint whether or not the guardian approves of the notice. Whenever the Guardianship and Advocacy Commission is notified that a recipient has been restrained, it shall contact the recipient to determine the circumstances of the restraint and whether further action is warranted."

Section 5/2-102 (a) 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. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in the writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided, the recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan."

Section 5/2-200 (d) states, "Upon commencement of services, or as soon thereafter as the condition of the recipient permits, the facility shall advise the recipient as to the circumstances under which the law permits the use of emergency forced medication or electroconvulsive therapy under subsection (a) of Section 2-107, restraint under Section 2-108, or seclusion under Section 2-109. At the same time, the facility shall inquire of the recipient which form of intervention the recipient would prefer if any of these circumstances should arise. The recipient's preference shall be noted in the recipient's record and communicated by the facility to the recipient's guardian or substitute decision maker, if any, any -other individual designated by the recipient. If any such circumstances subsequently do arise, the facility shall give due consideration to the preferences of the recipient regarding which form of intervention to use as communicated to the facility by the recipient or as stated in the recipient's advance directive."

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 the 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 designed under 'An Act in relation to the protection and advocacy of rights of persons with developmental disabilities and amending the 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 be responsible for promptly recording such restriction or use of restraints or seclusion and the reason therefor in the recipient's record."

Investigation Information

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 a Representative (Representative) from the facility's human rights committee and the recipient whose rights were alleged to have been violated. The recipient's clinical chart was reviewed with the written authorization of the recipient's legal guardian.

I...Interviews:

A...Representative:

When the Team spoke with the Representative regarding the allegation, the Representative stated that the issue had not been presented to the facility's human rights committee for review. After documentation authorizing the release of information was supplied, the Representative made the recipient's clinical chart available for review and provided copies of requested information from the chart.

B...Recipient:

According to the recipient whose rights were alleged to have been violated, he was placed in restraints for two days after he got into a fight with another recipient. He informed the Team that he was punched during the fight; however, he did not have any injuries. He stated that prior to the restraint application, staff members had been angry with him because he had gone into the wrong shower on the unit where he resides and had reprimanded him for doing so.

II: Clinical Chart Review:

A...Treatment Plan Reviews (TPR):

According to a 05/06/09 TPR, the recipient was admitted to the facility 10/31/08 from a less restrictive state-operated mental health facility due to his unmanageable and aggressive behaviors. His legal status was listed as Voluntary on 09/08/08 with the most recent affirmation on 04/07/09.

The recipient's diagnoses were listed as follows: AXIS I: Impulse Control Disorder, History of Cannabis Dependence, Mood Disorder (Not Otherwise Specified); AXIS II: Antisocial Personality Disorder, Moderate Mental Retardation by History; AXIS III: Obesity; AXIS IV: Chronic Mental Illness 2002 to 2008 Five Hospitalizations in Department of Human Services Facilities.

The recipient's medications were listed as follows: 500 mg Valproic Acid in AM and 1000 mg at bedtime to stabilize mood; and Risperidone 3 mg twice daily to control aggression

and improve impulse control. Documentation indicated that the recipient's legal guardian signed the informed consent form for the medications.

The recipient's problem areas were listed as aggressive behaviors toward others, inadequate social skills, overweight/obesity, non compliance with medication and the potential for substance abuse.

To address the recipient's problem with aggression, the TPR listed a goal for the recipient to refrain from exhibiting aggressive behaviors toward others by 8/2009. The objectives to reach the goal were listed as follows 1) to take medication as prescribed; 2) to demonstrate an increased understanding of medication dosage, potential side effects, and expected effects, 3) to follow unit rules, and 4) to have no instances of verbal or physical aggression.

The recipient's TPR contained a goal for the recipient to increase his understanding of socially acceptable boundaries. Objectives included the following: 1) to verbalize a basic understanding of staff/recipient relationships; 2) to verbalize and demonstrate how to respect his peers' personal space; 3) to use skills learned in Life Skills Group sessions to cope with his feelings of anger and to better relate to others in a more positive manner. The target date for completing the objectives was listed as 08/2009.

A goal for the recipient to lose weight slowly and to stabilize within the Ideal Body Weight (IBW) range set per nutritional screening was incorporated in the recipient's TPR. Objectives listed were for the recipient to lose weight slowly; to demonstrate a basic understanding of the five basic food groups; and to learn the importance of eating a balanced diet with exercise.

A goal for the recipient to be compliant with medication regimen by 08/2009 was incorporated in the TPR. The hypothesis was if the recipient understands the role medication plays in treating his mental illness, he will be compliant with taking the medication. The following objectives were listed to assist the recipient in reaching the goal: 1) to state the symptoms of his diagnosed mental illness; 2) to demonstrate an increased understanding of medication dosage, potential side effects, and expected effects; 3) to take the medication as prescribed; and 4) to express an intent to continue taking medication after leaving the facility.

A goal for the recipient to engage in the recovery process for substance abuse was included in the TPR. An objective was listed for the recipient to be able to give a correlation between his substance use and the negative events that have happened in his life.

Documentation in the TPR indicated that the recipient was making improvement in that he had not required contingency medication or restraints during the reporting period. The record indicated that the recipient required a physical hold and five point restraints on 11/13/08 after he attempted to hit a staff member who had requested that he turn down the volume on his radio. On 11/18/08, he required a physical hold and four point restraints due to physical aggression toward a peer. He was also placed in a physical hold and four point restraints on 02/11/09 after his attack on staff.

According to the TPR, it was the opinion of the treatment team that when the recipient's aggression was controlled and his mental illness stabilized, he could best be served in a facility

for persons with cognitive impairments. This placement would optimize opportunities for him to acquire independent living skills and training in acceptable social behaviors.

Documentation indicated that the recipient was informed of the circumstances under which the law permits the use of emergency forced medication, restraint or seclusion; however, he did not express a preference. The record indicated that seclusion was not an option due to the recipient having a diagnosis of Mental Retardation. The HRA did not observe any documentation which indicated the recipient's guardian was contacted to inform the guardian that the recipient had not chosen a preferred emergency treatment.

B...Progress Notes:

According to a 3 PM Progress Note on 05/06/09, Security Therapy Aid (STA) staff redirected the recipient to his room multiple times; however, the recipient ignored the staff, became angry regarding their requests and escalated to the point of striking a STA. Documentation indicated that the recipient was placed in a physical hold, transported to the restraint room and placed in restraints.

At 7 PM on 05/06/09, a facility psychiatrist recorded that the recipient was asked if he would listen to staff after his release from restraints, and he replied "No" and became very angry to the point of posing an imminent physical danger to others. According to documentation in the Progress Notes, the recipient did not meet the criteria for release from the restraints until 1 PM on 05/07/09.

Documentation indicated that on 05/07/09 at 8:25 PM the recipient refused his PM medications, threatened to hit staff and approached staff in a threatening matter. Due to the behaviors, the recipient was placed in a physical hold. The record indicated that he continued to attempt to hit staff with his fists while in the hold; therefore, he was placed in restraints. He was also given an injection of Haloperidol 5 mg and Lorazepam 2 mg.

Documentation in a RN's 12:30 AM Progress Note on 05/08/09 indicated that the recipient was released from restraints and a debriefing was conducted. The record indicated that after he was released from the restraints he used the toilet then went to his room and lay on his bed.

C ...Restraint Records:

1...Restraint 1:

Documentation indicated that an Order for Physical Hold was completed at 2:55 PM on 05/06/09 after the recipient "punched" a STA. According to the record, the recipient began to scream and kick at staff when the hold was implemented. The recipient was released from the hold and placed in restraints at 3 PM.

A Restriction of Rights Notice (Notice) was given to the recipient for the 5 minute physical hold. Documentation on the Notice indicated that the physical hold was implemented

after multiple attempts to redirect the recipient to his room failed, and he angrily hit a STA. The record indicated that the recipient's preferred intervention was not used due to immediacy of the problem. Documentation indicated that the Notice was delivered to the recipient in person and a copy of the Notice was mailed to the recipient's guardian. However, documentation in the recipient's TRP indicated that the recipient had not expressed a choice of emergency treatment.

An Order for Restraint (Order) was completed at 3 PM by a facility physician. According to the documentation, restraints were implemented due to the recipient's physical attack on a STA. Behavioral interventions of verbal support and reassurance failed to calm the recipient. The Order was implemented at 3 PM on 5/6/09 and ended at 7 PM on 05/06/10. The criteria for release were listed as follows: 1) The recipient must be calm, cooperative, and not threatening others. 2) He must be able to discuss the incident without yelling, cursing and threatening others. A RN documented that she had personally examined the recipient within 15 minutes of the initiation of restraints and determined that the application did not pose any undue risk to the recipient's health in light of his physical and medical condition. A Medical Doctor (MD) verified that he had examined the individual within 1 hour of the initiation of the restraint, and it was his assessment that the application did not pose a risk to the recipient's physical and mental status.

Additional Orders were issued at 7 PM and 11PM on 05/06/09 and 3 AM, 7 AM and 11 AM on 05/07/09. Documentation indicated that the recipient met the criteria for release at 1 PM on 05/07/09.

Documentation in Restraint/Seclusion Flowsheets indicated that the recipient was continually monitored during the restraint episode, and his behaviors recorded in fifteen minute increments. His circulation, vital signs, physical and mental status were evaluated during hourly reviews by a RN. His limbs were released, and he was offered toileting and fluids when the hourly evaluations were conducted. The record indicated that he was provided with breakfast at 7:15 AM on 05/07/09 and lunch at 11:30 AM on 05/07/09. According to documentation, the recipient ate 100% of his breakfast and 70% of his lunch.

According to the record the following procedures were implemented post application of the restraint: 1) A body search was completed; 2) An evaluation determined that the restraints were properly applied; 3) The room environment was determined to be appropriate; 4) The recipient was informed of the reason for the restraint and the criteria for release; 5) It was determined that the recipient was wearing proper clothing for the restraint; 6) It was determined that the recipient was properly positioned; 7) The recipient was given a Restriction of Rights Notice; and 8) It was established that there were no medical issues to prohibit restraint use.

A Notice was given to the recipient for the 22 hour restraint that commenced at 3 PM on 05/06/09 and ended at 1 PM on 05/07/09. Documentation indicated that the Notice was delivered to the recipient in person, and the recipient's guardian was mailed a copy of the Notice.

When a Post-Episode Debriefing was conducted an hour after the recipient's release from restraints, the record indicated that the recipient was in his room lying quietly, and had suffered no ill effects from the restraint episode. An Action to be taken in order to de-escalate and calm the patient in the future was listed as offering PRN medication. Documentation indicated the

recipient was unable to identify the stressors occurring prior to the restraint or express an understanding of the causes and consequences of his aggressive behaviors. According to the recording, the recipient expressed that he did not feel that staff could ~~not~~ have helped him to remain in control. Conversely, he blamed staff for the behaviors. Documentation indicated that the recipient was encouraged to discuss his feelings related to the restraint and stated that he was aware that he could request assistance from staff prior to the escalation of anxiety. It was determined that the recipient did not receive any physical injury during the event, and his physical well-being and privacy needs had been addressed.

2...Restraint 2:

Documentation indicated that at 8:25 PM on 05/07/09, the recipient began yelling, cursing and threatening to slap staff members. When the recipient stood up in a threatening manner, he was placed in a physical hold and remained in the hold for a 5 minute period. An RN documented that that she had personally examined the recipient at 8:25 PM during the application of the physical hold, and it was her assessment that the application did not pose an undue risk to the recipient's health.

A Notice was given to the recipient for the 5 minute hold. The reason for the restriction was listed that the recipient had attempted to hit staff with his fists. Documentation indicated that the Notice was delivered to the recipient in person, and his guardian was provided with a copy of the notice via mail.

An Order for Restraint was issued at 8:30 PM on 05/07/09 when the recipient continued to exhibit aggressive behaviors. Documentation indicated that restraints were implemented after numerous attempts at reassurance and redirection failed to calm the recipient, and he attempted to attack staff. The record indicated that an RN examined the recipient as soon as the restraints were applied and determined that the application did not pose an undue risk to the recipient's health. Documentation indicated that a facility physician had personally examined the recipient at 9:15 PM and had determined that the application did not pose an unwarranted danger to the recipient's physical condition. The criteria for release were listed as follows: 1) the recipient must be calm and cooperative with staff. 2) He must be able to verbalize willingness to comply with module rules and listen to staff without expressing hostility.

Documentation in the Restraint/Seclusion Flowsheets indicated that as soon as the recipient was placed in restraints, a body search was conducted. An RN examined the recipient to determine if the restraints were properly applied and he was properly positioned. A determination was made that the recipient was wearing proper clothing for the restraint, and the room environment was appropriate. The RN determined that there were no medical issues that would cause any problems during the restraint. The record indicated that the recipient was continually observed during the entire restraint episode, and his behaviors documented in fifteen minute increments. An RN took the recipient's vital signs, checked his circulation, released his limbs and assessed his mental and physical status on an hourly basis. At the time of the evaluations, he was offered fluids and toileting. Documentation indicated that the recipient met the criteria for release from the restraints at 12:30 AM on 05/08/09.

As soon as the recipient was released from the restraints, the RN conducted a Post-Episode Debriefing. Documentation indicated that the recipient was able to identify stressors occurring prior to the restraint and stated, "I don't want to take any pills." The record indicated that he verbalized an understanding of the causes and consequences of his aggressive behaviors; however, he was not able to identify any methods to control the behaviors. According to the documentation, the recipient was encouraged to discuss his feelings related to the restraint. Additionally, the RN recorded that the recipient did not receive any injuries during the restraint episode, and it was determined that his physical well-being and privacy needs had been addressed during the restraint.

The recipient was provided with a Notice for the 4 hour restraint episode. The reason for the restriction was listed as the recipient continued to fight staff after the physical hold was implemented. Documentation indicated that the recipient had indicated no preference for emergency intervention. According to the record, the Notice was delivered to the recipient in person and copy of the Notice was mailed to the recipient's guardian.

3...Additional Information;

The HRA did not observe any documentation that indicated the prior written authorization had been obtained from the facility director for the 05-07-09, 8:30 p.m. restraint that exceeded 24-hours since the initial restraint application.

Summary

According to documentation, the recipient was placed in a physical hold at 2:55 PM on 05/06/09 after he hit a staff member. During the hold the recipient continued his aggression toward staff; therefore, he was placed in restraints at 3 PM. The criteria listed for release was for the recipient to be calm, cooperative, non-threatening and to be able to discuss the incident without yelling. Documentation indicated that the recipient met the criteria for release at 1 PM on 05/07/09, 22 hours after the implementation. The record indicated that the recipient was placed in a 5-minute physical hold at 8:25 PM on 05/07/09, 7 hours and 25 minutes after his release from the initial restraint. When he continued the aggression, he was placed in restraints at 8:30 PM and remained in restraints for a 4 hour period. The record indicated that at 12:30 AM on 05/08/09 he met the criteria of being calm and cooperative with staff, being able to verbalize a willingness to comply with module rules, and listen to staff without expressing hostility. Documentation indicated that Physician's Orders, behavior observations during the restraint; evaluations by medical staff, post-episode debriefings, and issuance of Notices were in accordance with the Code's mandates. However, there was no documented evidence that staff had received written authorization from the facility director prior to the application of the 05-07-09 restraint ordered at 8:30 p.m., which occurred after a twenty-four hour period lapsed since the initial restraint application. Additionally, the criteria for release listed on the Orders for Restraint for each restraint episode did not list a specific time frame that the recipient was required to remain calm and cooperative before the restraints were removed.

Conclusion

According to the Code's mandates, restraints may be applied to prevent a recipient from causing harm to self or physical abuse to others, a behavior that the recipient was exhibiting prior to the application. However, in the Orders for Restraint, there was no specified time frame that the recipient had to exhibit the targeted behaviors prior to release. Additionally, the HRA did not observe any documentation that indicated that the facility Administrator had approved the 05-07-09, 8:30 p.m. restraint application after a 24-hour period had lapsed. Therefore, the allegation that a recipient at Chester Mental Health Center was inappropriately placed in restraints and required to remain in the restraints for a considerable amount of time is substantiated.

Recommendations

1. The release criteria listed on an Order for Restraint should be specific regarding the time the recipient is required to exhibit the targeted behaviors prior to release.

2. If restraint is employed during all or part of a 24 hour period since the commencement of the initial restraint application, secure written authorization from the facility director for restraint applications occurring in the next 48 hours as per the Code.

Comments and Suggestions

During review of the recipient's clinical chart, the HRA observed numerous documentations regarding the recipient refusing medication and emergency medications being administered. Documentation in a 05/12/09 Nursing Note indicated that the RN had discovered that it was the last day for emergency enforced medication; however a petition for court enforced medication had not been completed. The Authority would like to remind the facility of the Code's requirements (405 ILCS 5/2-107), which state, "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..."

According to the recipient's 05/06/09, the recipient had not expressed a preference for emergency treatment. However, a Notice for a 05/06/09 physical hold indicated that the recipient's preferred form of emergency intervention was not implemented due to the immediacy of the problem. The HRA suggests that facility staff become aware of and document each recipient's preferred emergency intervention(s) and give due consideration to those preferences.