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Egyptian Regional Human Rights Authority
Report of Findings
10-110-9027
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 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

Statutes

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

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 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 designated 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 two 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 records were reviewed after receiving his written authorization for the review.

I...Interviews:

A... Recipient:

During a site visit at the facility, the Team spoke with the recipient regarding the allegation. He informed the Team that he was sent to the facility in June or July 2009 from another state-operated mental health facility. He stated that he had been in restraints on numerous occasions since admission. However, his concerns were regarding an 11/16/09 restraint application. He stated that he was placed in restraints without an apparent reason for their application and required to remain in the restraints for an extended period of time. He informed the Team that he was not offered food during the entire restraint episode.

B... Representative:

During the site visit, the Team also spoke with the Representative regarding the allegation. The Representative stated that the issue had not been brought to the attention of the facility's human rights committee for review of a rights restriction. The Team provided the Representative with a Release signed by the recipient authorizing the HRA to review his clinical records. When the Team requested specific information from the recipient's chart, the Representative stated that she would make copies of the information and send the records via mail to the HRA. The Representative provided copies of the requested information shortly after the request was made.

II Clinical Chart Review:

A...Treatment Plan Reviews (TPRs):

According to a 09/08/09 TPR, the recipient was admitted to the facility on July 22, 2009 from a less restrictive mental health center. Documentation indicated that at the transferring facility the recipient was physically and verbally assaultive toward his peers and staff, and would ignore all staff attempts of redirection. Documentation indicated that at the prior placement the recipient had required the use of restraints seven times in a three day period due to his aggressive behaviors. The admission records indicated when he does not get what he wants he will threaten to hurt himself.

The recipient's legal status was listed as Involuntary Admission. The record indicated that he had criminal charges in Illinois, fled to another state to avoid prosecution and while in that state was arrested for trespassing and subsequently returned to Illinois. Upon returning to Illinois his previous charges were dropped.

The recipient's Diagnoses were listed as follow: AXIS I: Bipolar Disorder, most recent episode manic, History of Poly-substance Dependence; AXIS II: Anti-Social Personality Disorder by History; AXIS III: Reported History of Petit Mal Seizure; AXIS IV: Lack of primary support system, Problem with medication, Non-Compliance, Confinement.

The recipient's medications were listed as follows: 1) Valporic Acid 500 mg BID (twice daily) for mood stabilization; 2) Alprazolam 0.5 mg TID (three times daily); 3) Haloperidol 5 mg IM (intramuscular) every 4 hours PRN (as needed) for severe agitation and 4) Lorazepam 2 mg IM for severe agitation.

Documentation in the Emergency Intervention/Rights Section of 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. Should any of these circumstances arise, he listed the following forms of interventions in order of his preference: 1) medication; 2) seclusion; and 3) restraints.

The recipient's problems areas were listed as follows: 1) aggression to self and others and 2) risk of self injurious behaviors. A goal for the recipient to be free of displaying aggressive behaviors toward self and others by 12/20/09 was listed in the TPR. An objective was listed for the recipient to take medications as prescribed and to take part in medication education to learn the names, dosage and purposes of his medications. Documentation indicated that if the recipient takes medication as prescribed to reduce mania and stabilize his mood disorder, he will be able to interact with others in a less aggressive manner. Additional objectives included following unit rules and routines by 09/09 and having no instances of verbal or physical aggression, including 0 threats of self injurious behaviors. A goal for the recipient to refrain from self injurious behavior for a period of not less than six months was also listed in the TPR. An objective for the recipient to engage in therapy related to the reason for his self injurious behaviors and/or suicidal ideation by 12/20/09 was also listed in the TPR.

Documentation in a 12/29/09 TPR indicated that the recipient had remained medication compliant since medication for his psychosis was changed from Haloperidol to Olanzapine per his request. The record indicated that the recipient had not required seclusion or restraints since the medication change and had exhibited overall improvement. According to documentation in the TPR, the recipient had required the use of restraints eight times since his admission on 07/22/09; however, he had not required restraints since 11/16/09. Nor had he received any behavioral data reports since the change in his medication.

According to a 01/28/10 TPR, the recipient had shown significant improvement. There were no documented incidents of verbal/physical aggression or threats of self injurious behaviors. The record indicated that the recipient had been medication compliant. He had continued to learn more about his illness and ways to recognize the signs of anxiety prior to his becoming angry. Documentation indicated that the recipient's last restraint episode was 11/16/09.

<u>B...Restraint Records:</u>

According to the records, during a medication pass the recipient became angry, began to threaten peers and staff, picked up a chair and threw it at staff. Due to these actions, staff placed the recipient in a physical hold. An Order for Physical Hold was completed at 8:40 PM and continued until 8:45 PM on 11/16/09.

The recipient was provided a Notice for the physical hold. Documentation indicated that the Notice was delivered in person, and the recipient did not wish to have any one notified of the restriction.

An Order for Restraint was issued at 8:45 PM after the hold failed to calm the recipient. Documentation indicated that the behavioral interventions of empathic listening, verbal support and medication administration had been unsuccessful. The release criteria were listed as follows: 1) The recipient must be calm and cooperative, and 2) He must no longer exhibit cursing or threatening behaviors. The release criteria must be exhibited for a period of 1 hour. An RN documented examination of the recipient at 8:45 PM, and recorded that the application did not pose undue risk to the individual's health in light of his physical or medical condition. A facility physician recorded an examination of the recipient at 8:55 PM and reached the same conclusion as the RN.

According to documentation in Restraint Flowsheets, as soon as the restraints were applied, the recipient's body was searched. It was determined that the restraints were properly applied, the recipient was properly positioned, and he was wearing proper clothing for the restraint. It was also determined that the room environment was appropriate. He was informed of the reason for the restraint and the criteria for his release, and he was provided with a Notice. Documentation indicated that the recipient was continually monitored, and his behaviors recorded in 15-minute intervals. An RN checked his circulation, released his limbs, checked his vital signs and evaluated his mental/physical status on an hourly basis. At the time of the hourly evaluations, the recipient was offered toileting and fluids. The record indicated that the recipient met the criteria for release at 12:45 AM on 11/17/09, four hours after the implementation. Since the restraint episode was completed before a scheduled meal time, no food was offered.

Documentation indicated that an RN conducted a Post-Episode Debriefing at 12:45 AM on 11/17/09. The recipient was able to identify the stressors which had occurred prior to the restraint and to verbalize an understanding of the causes and consequences his aggressive behavior. The recipient stated that he felt that staff could have assisted him to regain control, and he was able to identify other methods to control his aggressive actions. Staff encouraged the recipient to discuss his feelings related to the restraint and was informed that he could request assistance from staff prior to escalation of his anxiety. The RN determined that no physical injury had occurred during the restraint and that his physical well being and privacy needs had been addressed during the episode.

The recipient was provided with a Notice pertinent to the restraint that commenced at 8:45 PM on 11/16/09 and ended at 12:45 AM on 11/17/09. The reason listed for the restriction was that the recipient had picked up a chair and threw it at staff. Documentation indicated that the recipient's preferred intervention was used. A copy of the Notice was delivered to the

recipient in person, and the record indicated that the recipient did not wish to have anyone notified of the restraint.

The Authority reviewed additional restraint episodes on 08/13/09, 09/22/09, 10/13/09 10/26/09. According to 08/13/09 documentation, the recipient was placed in physical hold, prior to placement in restraints and after he hit another patient. The aggressive behaviors occurred while the recipient was waiting in line to have breakfast. On 09/22/09, he was placed in a physical hold and restraints after he attempted to strike staff members during a shakedown. Documentation indicated that on 10/14/09, the recipient was involved in a physical altercation with another recipient, and when staff intervened he continued to fight. Due to his aggression to peers, he was placed in a physical hold for a 5 minute period and transferred to restraints when the physical hold failed to calm him. On 10/26/09, the record indicated that the recipient became extremely hostile, threatening and slammed doors, he was offered and accepted medication. However, when the interventions failed to calm the recipient, he was placed in a physical hold for 5 minutes. When the behaviors continued, staff attempted to take the recipient to seclusion, which was listed as a preference over restraints. During this attempt, the recipient hit a staff member twice in his head. Due to his continued aggressive behaviors, the recipient was placed in restraints.

Documentation indicated that the recipient met the criteria for release from restraints 4 hours after the restraints were applied on 08/13/09, 7 ¾ hours after the 09/22/09 and 10/26/09 applications, and 8 hours after the 10/13/09 implementation. The record indicated that the recipient's preferred emergency interventions were not used prior to the restraint application on 08/13/09, 09/22/09 and 10/13/09 due to the spontaneity and intensity of his aggressive actions. However, on 10/26/09, the recipient was given medication and an attempt was made to place him in seclusion prior to the restraint application.

During the review of the additional restraint episodes, the HRA determined that Orders, Flowsheets, Notices, etc. were in accordance with the Code's requirements.

C...Progress Notes:

An RN documented that the recipient had been given Haloperidol 5 mg and Lorazepam 2 mg at 8 PM to assist him with agitation. The RN documented that the recipient had been yelling and was argumentative with staff and peers.

At 8:40 PM on 11/16/09, the RN documented that the recipient continued to yell and picked up a chair and threw it at staff. The RN recorded that due to these actions, he was placed in a physical hold; however, he continued to struggle with staff. Documentation indicated that the recipient was placed in restraints at 8:45 PM for the safety of all. The RN documented that a facility physician had been contacted regarding the recipient's aggressive actions.

At 8:55 PM, a facility physician recorded that the recipient had made an unprovoked attack on staff members after they tried to redirect him. For the safety of all the recipient was placed in a physical hold for 5 minutes followed by restraints.

Summary

When the Team spoke with the recipient, he stated that he was placed in restraints on 11/16/09 for an extended period of time without a valid reason for the application, and he was not provided with food during the restraint. However, documentation in progress notes and restraint records indicated that the reason for the recipient being placed in a physical hold and restraints was because he had thrown a chair at staff. Documentation indicated that the when the physical hold failed to calm the recipient, the restraints were applied. The restraints were implemented at 8:45 PM on 11/16/09 and removed 4 hours later, a time frame that does not include a mealtime. The HRA's review of the 11/16/09 restraint, as well as additional restraint episodes, indicated that in all incidents restraints were applied due to the recipient's aggressive actions toward peers or staff. The review of Physical Hold Orders, Restraint Orders, Restriction Notices, observations recorded on Flowsheets, and Post-Episode Debriefings indicated that the procedures were implemented in accordance with Code requirements.

Conclusion

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

Comments

According to the 11/16/09 Notice, the recipient' preferred intervention (restraints) was used. However, documentation in the Emergency Intervention/Rights Section of the recipient's TPR indicated that restraints were the recipient's least desired form of emergency intervention. The HRA suggests that facility staff become aware of and accurately document each recipient's preferred emergency intervention and give due consideration to those preferences.