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Egyptian Regional Human Rights Authority

Report of Findings

10-110-9031

Chester Mental Health Center

August 24, 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 recipients. The specific allegations are as follows:

1. A recipient at Chester Mental Health Center was inappropriately placed in restraints.
2. A recipient has been forced to take medication.
3. A recipient's property has been confiscated.
4. A recipient is not allowed to make telephone calls.
5. The recipient has not been provided with adequate care and services.

Statutes

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/2-102 (a), 405 ILCS 5/2-103, 405 ILCS 5/2-104, 405 ILCS 5/2-107, 405 ILCS 5/2-107.1, 405 ILCS 5/2-108, and 405 ILCS 5/2-201).

Section 5/2-102 (a) 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 5/2-103 states, "Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation. (a) The

facility director shall ensure that correspondence can be conveniently received and mailed, that telephones are reasonably accessible, and that space for visits is available. Writing materials, postage and telephone usage funds shall be provided in reasonable amounts to recipients who reside in Department facilities and who are unable to procure such items. (b) Reasonable times and places for the use of telephones and for visits may be established in writing by the facility director. (c) Unimpeded, private and uncensored communication by mail, telephone, and visitation may be reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission. When communications are restricted, the facility shall advise the recipient that he has the right to require the facility to notify the affected parties of the restriction and to notify such affected parties when the restrictions are no longer in effect. However, all letters addressed by a recipient to the Governor, members of the General Assembly, Attorney General, judges, state's attorneys, Guardianship and Advocacy Commission, or the Agency designated pursuant to '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, officers of the Department or licensed attorneys at law must be forwarded at once to the persons to whom they are addressed without examination by the facility authorities. Letters in reply from the officials and attorneys mentioned above must be delivered to the recipient without examination by the facility authorities. (d) No facility shall prevent any attorney who represents a recipient or who has requested to do so by any relative or family member of the recipient, from visiting a recipient during normal business hours unless that recipient refuses to meet with the attorney."

Section 5/2-104 states, "Every recipient who resides in a mental health or developmental disabilities facility shall be permitted to receive, possess and use personal property and shall be provided with a reasonable amount of storage space therefor except in the circumstances and under the conditions provided in this Section. (a) Possession and use of certain classes of property may be restricted by the facility director when necessary to protect the recipient or others from harm, provided that notice of such restriction shall be given to all recipients upon admission. (b) The professional responsible for overseeing the implementation of a recipient's services plan may, with the approval of the facility director, restrict the right to property when necessary to protect such recipient or others from harm. (c) When a recipient is discharged from the mental health or developmental disabilities facility, all of his lawful personal property which is in the custody of the facility shall be returned to him."

Section 5/2-107 states, (a) "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 alternative services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services."

Section 5/2-107.1 (a) states, "Notwithstanding the provisions of Section 2-107 of this Code, psychotropic medication and electroconvulsive therapy may be administered to an adult recipient of services without the informed consent of the recipient under the following standards: (1) Any person 18 years of age or older, including any guardian, may petition the circuit court for an order authorizing the administration of psychotropic medication and electroconvulsive therapy to a recipient of services. The petition shall state that the petitioner has made a good faith attempt to determine whether the recipient has executed a power of attorney for health care under the Powers of Attorney for Health Care law or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act and to obtain copies of these instruments if they exist. If either of the above-named instruments is available to the petitioner, the instrument or a copy of the instrument shall be attached to the petition as an exhibit. The petitioner shall deliver a copy of the petition, and notice of the time and place of the hearing, to the respondent, his or her attorney, any known agent or attorney-in-fact, if any, and the guardian, if any, no later than 3 days prior to the date of the hearing. Service of the petition and notice of the time and place of the hearing may be made by transmitting them via facsimile machine to the respondent or other party. Upon receipt of the petition and notice, the party served, or the person delivering the petition and notice to the party served, shall acknowledge service. If the party sending the petition and notice does not receive acknowledgement of service within 24 hours, service must be made by personal service. The petition may include a request that the court authorize such testing and procedures as essential for the safe and effective administration of the psychotropic medication or electroconvulsive therapy sought to be administered, but only where the petition sets forth the specific testing and procedures sought to be administered. If a hearing is requested to be held immediately following the hearing on a petition for involuntary admission, then the notice requirement shall be the same as that for the hearing on the petition for involuntary admission, and the petition filed pursuant to this Section shall be filed with the petition for involuntary admission."

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 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 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 in '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 for Allegation 1

Allegation 1: A recipient at Chester Mental Health Center was inappropriately placed in restraints. 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 a Representative from the facility's Human Rights Committee (Representative). The recipient's clinical chart was reviewed with his written authorization. The facility's Policy and Program/Policy Directive pertinent to restraints were reviewed.

I...Interviews:

A...Recipient:

The recipient informed the Team that he was transferred from a county jail to Chester Mental Health Center as Unfit to Stand Trial (UST). He stated that shortly after his admission, facility staff placed him restraints without having a valid reason for the restraints. The recipient denied exhibiting any type of physically aggressive or self-abusive behaviors prior to the application. He stated, "Staff were placing drugs and salt peter in my food, and when I spoke to them about the matter, they placed me in restraints."

B...Representative:

According to the Representative, restraints are applied in accordance with the Code's requirements, which necessitate a recipient to be a danger to self or others. The Representative stated that the facility has a written restraint policy and also follows program directives which mirror the Code's requirement of self-abuse or a danger to others before the application of restraints.

II...Record Review:

A...Treatment Plan Reviews (TPRs)

According to an 11/11/09 TPR, the recipient was admitted to the facility on 10/26/09 from a county jail with a Legal Status of UST. The record indicated that the recipient was found unfit on 10/01/09. Documentation indicated that he was initially housed with his peers in the county jail; however, when he became disruptive and fought with others he was housed in a private cell. The Forensic Psychiatric Evaluation conducted while the recipient was in the county jail indicated that the recipient exhibited delusions of grandeur, paranoia, and persecution. The Psychiatrist recorded that the recipient's understanding of his legal charges was distorted due to his delusional beliefs. Based on these findings, he was determined UST.

The recipient's diagnoses were listed as follows: AXIS I: Schizoaffective Disorder, manic; AXIS II: Personality Disorder NOS (Not Otherwise Specified) (antisocial traits); AXIS III: H/O (History Of) Craniotomy Scar (occipital region), H/O Seizure Disorder, Type II Diabetes, Hypertension, Atheromatous Heart Disease, Penicillin Allergy, and AXIS IV: Psychiatric Hospitalization in DHS (Department of Human Services) x 29 from 1975 to 2009, Legal Charges, UST for Failure to Register as Sex Offender.

Documentation in the 11/11/09 TPR listed the recipient's problem areas as psychosis, a seizure disorder, peptic ulcer disease, and a metabolic disease. The following goals were listed in the TPR: 1) to restore the recipient to a level of fitness to stand trial by October 2010; 2) to reduce psychotic symptoms, which consist of grandiose delusions and delusions of persecution by October 2010; 3) to manage and minimize seizure episodes and to prevent injury in the event of a seizure; 4) to be free of gastric discomfort; and 5) to maintain/improve his general health as exhibited by stable blood pressure, blood sugar and lipid levels.

Recordings in the Extent to Which Benefitting From Treatment Section of the 11/11/09 TPR indicated that upon admission, the recipient had refused offers of psychotropic medications. Since admission, he had been seen by a facility physician for treatment of his various medication issues. He had been placed in restraints for aggression toward staff on 10/28/09, and on 11/04/09, the court approved enforced medication. Upon approval of the court-ordered medication(s), a facility physician prescribed Abilify, an atypical antipsychotic and antidepressant, and the medication was administered. The record indicated that the recipient had shown some improvement in his clinical condition.

Documentation in a 12/09/09 TPR indicated that the recipient was informed of the circumstances under which the law permits the use of emergency forced medication, restraint or seclusion, and his only preference was listed as seclusion. However, in the prior TPR, he did not list any preference.

Documentation in the Extent to Which Benefitting From Treatment Section of the 12/09/09 TPR indicated that the recipient had been in restraints on 11/18/09 due to his

aggression toward staff members when he felt that they were poisoning his food. The record indicated that a facility psychiatrist increased the Abilify on 11/24/09.

According to a 01/05/10 TPR, the recipient had a urinary tract infection which at the time of the meeting could have altered his mental status. The record indicated that he had been somewhat more manic during the reporting period; however, the psychiatrist did not want to adjust the psychotropic medication until the treatment for the infection was completed. The record indicated that the recipient had exhibited some episodes of anger; however it was not to the extent that restraint application was necessary. The record indicated that he had not required any restraint application since the 11/18/09 incident.

B...Restraint Records:

1) Restraint 1...(10/28/09)

Documentation in a 10/28/09 Order for Physical Hold indicated that when the recipient was asked to take a shower, he started yelling and making racial slurs toward staff. According to the record, when staff members attempted to calm the recipient, he proceeded to attack them. As a result of these aggressive actions, the recipient was placed in a physical hold from 7:25 AM to 7:30 AM. A facility physician and a Registered Nurse (RN) recorded that they had examined the recipient at 7:30 AM and had assessed that the hold did not pose an undue risk to the recipient's physical or medical conditions.

A Restriction of Rights Notice (Notice) was given to the recipient for the five minute hold. The reason for the restriction was listed as "aggressive, violent behaviors toward staff". Documentation indicated that at the time of the hold, the recipient had not expressed a preference for emergency intervention. The record indicated that the Notice was delivered to the recipient in person, and he stated that he did not wish to have any one notified of the physical hold.

The record indicated that when the recipient's aggressive behaviors continued during the hold, he was placed in four point restraints. An Order for Restraint was issued after three attempts at redirection to a new task and empathic listening failed. The record indicated that the recipient became upset during AM showers, began yelling and shouting at staff stating, "I demand respect. Do you hear me? I am President". His verbal aggression was followed by a physically aggressive attack on staff members.

The record indicated that the Order for Restraint was issued at 7:30 AM on 10/28/09 for up to four hours with one hour reviews. The release criteria were listed as follows: 1) The recipient must be calm, cooperative, non-threatening, and non-argumentative; 2) He must be able to give alternatives to cope with his violent aggressive thoughts; 3) He must refrain from making

racial remarks or political statements regarding being President; and 4) He will be able to verbalize appropriate behaviors and actions. No time frame was listed for the recipient to exhibit these behaviors before release would occur. The Order was signed by a facility physician and an RN at 7:55 AM. Documentation indicated that both medical professionals had examined the recipient and determined that the restraints did not pose an undue risk to the recipient's health in light of his physical and/or medical conditions.

Documentation in the Restraint Flowsheets (Flowsheets) indicated that the recipient was constantly monitored with his behaviors recorded in fifteen minute increments. He was provided breakfast while in restraints. An RN checked his circulation, released his limbs, took his vital signs and evaluated his mental and physical status on an hourly basis. He was offered fluid and toileting during the reviews. The record indicated that the recipient met the criteria for release at 9:30 AM on 10/28/10, two hours after the restraints were applied. Additional documentation indicated that the recipient's body was searched after the restraints were applied. Staff members determined that the restraints were properly applied, and the recipient was in an appropriate position. Staff also concluded that the room environment was appropriate, and the recipient was wearing proper clothing for the restraint. Documentation indicated that the recipient was informed of the reason for the restraint and the criteria for release.

The record indicated that the recipient was given a Notice pertinent to the restraint. Documentation in the Notice indicted that the recipient was placed in the restraints because he continued to struggle violently while in the physical hold. His verbally hostile, threats of harm to others, and his lack of control were reasons listed for the restraint application. The record indicated that the recipient had not stated his preference for the emergency intervention prior to the restraint application. According to documentation, the Notice was delivered to the recipient in person, and the recipient expressed that he did not wish for anyone to be notified of the restraint.

An RN conducted a Post-Episode Debriefing at 9:30 AM after the recipient was released from the restraints. The RN recorded that the recipient was unable to identify stressors occurring prior to the restraints, and he could not identify one or more methods to control his aggressive behaviors. He stated that he did not feel that staff could have helped him to remain in control. However, he was able to verbalize an understanding of the cause and consequences of his aggressive behaviors, and he stated that he understood that he could request assistance from staff prior to the escalation of his anxiety. The RN recorded that the recipient was encouraged to discuss his feelings regarding the restraint. Documentation indicated that the RN had determined that the recipient did not receive any type of injury, and his physical well-being and privacy needs were addressed during the restraint.

2)...Restraint 2....(11/18/09)

Documentation indicated that an Order for Physical Hold was completed at 8:20 AM on 11/18/09 after the recipient became agitated, yelled at staff stating that they were poisoning his food and proceeded to fight the staff members. The record indicated that the recipient remained in the hold for ten minutes and was placed in restraints when his aggressive behaviors continued. The record indicated that an RN authorized the physical hold at 8:20 AM and examined the recipient at 8:30 AM. A facility physician was notified of the hold and examined the recipient at 8:30 AM. Both professionals determined that the hold did not pose an undue risk to the recipient's physical and medical health.

A Notice was given to the recipient for the ten minute hold from 8:20 AM to 8:30 AM on 11/18/09. Documentation indicated that the Notice was delivered to the recipient in person and he did not wish to have anyone notified of the hold.

An Order for Restraint was implemented at 8:30 AM when the recipient could not be redirected or calmed while in the physical hold. Documentation indicated that the recipient was screaming loudly regarding drugs being placed in his foods and continued to struggle, scream at and hit staff while he was in the physical hold. The record indicated that restraints were applied for the safety of all. The Order was written for up to four hours with hourly reviews. According to the documentation, in order for the recipient to be released he must be calm, cooperative and non-threatening for a period of sixty minutes. He must be free of verbally and physically aggressive behaviors for sixty minutes. He must also be able to discuss events leading up to the restraint application. The Order was signed by a physician at 8:30 AM and an RN at 8:45 AM on 11/18/09. The record indicted that when the RN examined the recipient at 8:35 AM, she assessed that the restraint application did not pose an undue risks to the recipient. The record indicated that a facility physician examined the recipient at 8:50 AM and also concluded that the restraints did not pose a risk.

According to documentation in the Flowsheets, the recipient's body was searched after the restraints were applied. Staff determined that the restraints were properly applied, he was suitably positioned, and he was wearing proper clothing for the restraint application. The RN assessed the room environment and determined that it was appropriate. The recipient was informed of the reason for the restraint and the criteria for release from the restraints. A Notice was given to the recipient pertinent to the restraint. The record indicated that the recipient met the criteria for release at 11:30 AM, three hours after the restraints were applied.

The record indicated that an RN conducted Post-Episode Debriefing at 11:30 AM. During the Debriefing, the recipient was able to identify the stressors occurring prior to the restraint. He was able to verbalize an understanding of the causes and consequences of the aggressive behaviors. He was also able to identify one or more methods to control his behavior. The recipient stated that he was aware that he could have asked staff members to assist him in order that he might remain in control and prior to the escalation of his anxiety. The RN documented that the recipient was encouraged to discuss his feelings regarding the restraint application. As soon as the restraints were removed, the RN examined the recipient for injuries,

and determined that his physical well-being and privacy needs had been addressed during the restraint episode.

Progress Notes:

According to a STA's documentation in a 10/28/09 progress note, when the recipient was asked to shower he began yelling, made racial slurs and attacked staff. The STA documented that the recipient was placed in restraints for the protection of all persons.

An RN recorded in a 10/28/09 Progress Note that the recipient became upset and began yelling and screaming. He shouted that he should be respected because the he was the President. When staff members attempted to calm him he tried to strike them with his fists. He was placed in a physical hold for five minutes without de-escalation of the aggressive behaviors, and then placed in restraints for self protection and the protection of others

A psychiatrist recorded in a 10/28/09 7:55 AM Progress Note that he examined the recipient after he was placed in restraints. He recorded that the recipient informed him that he had been hurting all night the previous night due to having gallstones. He stated that he was given a couple of Tylenol; however, his request for Morphine was not honored. The psychiatrist documented that the recipient made several attempts to have him prescribe Morphine; however, after numerous endeavors the recipient was able to be redirected. The psychiatrist recorded that when he asked the recipient to state why he was placed in the restraints, he stated that was due to an argument; however, he denied any type of physical attack on staff members.

An RN recorded in a 10/28/09 9:30 AM Progress Note that the recipient was released from restraints per the review team. He was calm and cooperative. He ate all of his breakfast. His circulations in all extremities were assessed as good. The RN recorded that there was no skin tissue break down noted after the restraint application.

An STA recorded in an 11/18/09 Progress Note that the recipient became highly agitated and yelled at staff accusing them of poisoning his food. The record indicated that the behaviors began while the recipient was in the dining room. When staff escorted the recipient out of the dining room, the recipient turned and began to hit the staff members. The STA recorded that the recipient was placed in a physical hold for ten minutes and then in restraints due to his behaviors and for the safety of all. An additional Progress Note completed by a STA at 8:20 AM on 11/18/09 recorded the same account of the incident.

An RN documented in an 11:30 AM 11/18/09 Progress Note that the recipient had met the criteria for release from the restraints and was calm and cooperative at the time the note was written.

III...Facility Policy and Program/Policy Directive

A... Use of Restraint and Seclusion (Containment) in Mental Health Facilities Policy (Policy)

The Policy Statement is listed as follows, "Chester Mental Health Center uses restraint and seclusion only as a therapeutic measure to prevent an individual from causing physical harm to himself or other and follows the Department of Human Services Program Directive 02.02.06.030"

B: Illinois Department of Human Services Program Directive 02.02.06.030 (Directive).

The Policy Statement in the Directive is as follows, "It is the policy of the Department of Human Services, Mental Health (DHS/MH) that the use of restraint or seclusion be limited to emergencies in which there is an imminent risk to an individual harming himself or herself, other patients, or staff. This directive is the primary directive for the use of restraint and seclusion in mental health facilities. It is consistent with the requirements of the Mental Health and Developmental Disabilities Code. It supersedes any previous DHS or mental health facility procedure. For clinical and administrative reasons the DHS may have chosen in this directive to exceed MHDD Code or Joint Commission on Accreditation of Health Care Organization (JCAHO) requirements; therefore, this directive takes precedence.

Neither restraint nor seclusion may ever be used to punish or discipline an individual or as a convenience to staff. The least restrictive intervention that is safe and effective for a given individual will be used. It is the role of leadership to help create a physical, social, and cultural environment in which the approach to restraint and seclusion protects the individual's health and safety; preserves his or her dignity, rights, and well-being; and minimizes the risks to staff and others. Limiting restraint and seclusion use to clinically-appropriate and alternative strategies is the role of all staff. An approach to restraint and seclusion utilization that focuses on reduction while striving to assure the safety of the individual, other patients, and staff requires planning, thoughtful education, and continuous efforts at performance improvement.

The circumstances that result in the use of restraint or seclusion are complex. Consequently, the strategies for reducing and eliminating restraint and seclusion use must be multi-faceted and incorporate multiple points of view, including those of patients, consumers, and staff at all levels of the organization. It is the position of DHS/MH that the goal of reduced restraint and seclusion utilization be approached through a broad range of strategies for enhancing positive behaviors, preventing destructive behaviors, and limiting the circumstances that my necessitate the use of restraint or seclusion. These include, but are not limited to:

1. the use of nonphysical interventions as preferred interventions for both patients and staff;
2. the implementation of staff training based upon a nationally-recognized training program in conflict de-escalation and prevention;
3. the inclusion of the consumer perspective on the restraint and seclusion experience and perceived opportunities for reducing utilization; and
4. effective assessment and treatment."

Summary for Allegation 1

When the Team spoke with the recipient whose rights were alleged to have been violated, he denied exhibiting any type of aggressive action(s) which would warrant the use of restraints. However, according to documentation in the recipient's chart indicated that the recipient was placed in restraints on 10/28/09 and 11/18/09 after he physically attacked staff members. Documentation in Orders for Physical Holds, Orders for Restraints, Flowsheets, Restriction of Rights Notices, and Post-Episode Debriefings were in accordance with the Code requirements. The facility's Policy and the DHS Program Directives mandate that the use of restraint be limited to emergency situations, in which there is an imminent risk to the recipient and to other individuals.

Conclusion for Allegation 1

Based on consistent documentation pertinent to the restraint episodes, the allegation that a recipient at Chester Mental Health Center was inappropriately placed in restraints is unsubstantiated. No recommendations are issued.

Comment and Suggestion for Allegtion 1

It was noted in the 10/28/09 Order that no time frame was listed for the recipient to exhibit the established criteria before release from the restraints was implemented. Therefore, the following suggestions are issued.

1. The release criteria on each Order or Restraint should include a time that the recipient must exhibit the determined measures before release is executed.

2. Cessation of the behaviors that led to the restraint application should be listed in the criteria for release, be relevant, and in accordance with the Code. (i.e. listing of refraining from making political statement regarding being President, criteria listed in restraint 1, does not appear to be relevant to restraint application.)

Investigation of Allegation 2

Allegation 2: A recipient has been forced to take medication. To investigate the allegation, the Team spoke with the recipient whose rights were alleged to have been violated and reviewed his clinical chart. Information obtained for the investigation of allegation 1 was also reviewed.

I...Interview:

According to the recipient, he had informed staff that he did not want to take medications for a mental illness because he doesn't need the medication and doesn't like the way it makes him feel. He stated that he had no plans to harm himself or others; therefore, he did not believe that the medications were warranted. He informed the Team that he refused to sign a consent authorizing the administration of the medications; however, he had been required to take the medications against his will.

II...Clinical Chart Review:

A...TPRs

Documentation in the Extent To Which Benefitting From Treatment Section of the recipient's 11/11/09 TPR indicated that the recipient had refused offers of psychotropic medication upon admission to the facility. However, on 11/104/09, court enforced medication was granted in the county courts. Documentation indicated that the recipient was started on Abilify and had been showing some improvements since the administration.

Documentation in a 12/09/09 TPR indicated that the recipient had been medication compliant after being placed on court enforced medication. His mood had improved, and he was no longer combative. In a 01/05/09 TPR, a facility psychiatrist documented that the recipient was medication compliant. His mania was receding, and he had exhibited no aggression or suicidal ideation. The psychiatrist recorded that the recipient had been recommended for fitness training; however, he remained UST. An RN and STA recorded that the recipient had been compliant with the court enforced medication.

B...Progress Notes

A facility psychiatrist recorded in a 10/26/09 progress note that the recipient had refused to give consent for taking psychotropic medication. An RN documented that the recipient had also refused medications for medical conditions and stated that he did not need the medications. The RN recorded that several attempts were made to encourage compliance since his blood pressure had been elevated, but the recipient adamantly refused. The RN documented that a facility physician was contacted.

An RN documented in an 11/01/09 progress note that the recipient had refused all of his medication in the AM. The RN recorded that she had explained the need for the medications, which included an antibiotic for an infection. However, the recipient replied that he had been "kidnapped', his diet was inadequate, and he would not take medication.

Documentation in an 11/02/09 progress note indicated that the recipient's therapist had spoken to him regarding his refusal to having a surgical evaluation due to having gall stones. The therapist recorded that the recipient was very focused on his hearing scheduled at the county court to review a petition for enforced medication. The therapist documented that the recipient remained delusional, stating that he "was being treated unfairly as a world leader and the entire world was watching the way he was being treated".

A psychiatrist recorded in an 11/04/09 progress note that in an AM court hearing on 11/04/09, the order for involuntary medication administration had been approved based on the recipient's severe mental illness, schizophrenia. The psychiatrist order that Aripiprazole (Abilify) 10 mg by mouth be administered in the AM, and if the recipient refused give Haldol 5 mg IM (intramuscular) as court ordered medication. The psychiatrist ordered that the recipient be monitored closely after the administration.

An RN documented that he had provided medication information sheets and discussed medication. An additional RN's progress note indicated that the recipient had been provided with a Restriction of Rights Notice for the court enforced medication.

Documentation in an 11/24/09 psychiatrist's note indicated that the recipient was tolerating the medication, Abilify, without any difficulties. The psychiatrist recorded that the recipient was refusing medication from time to time for medical problems; however, he continued on enforced medication for mental health issues. The psychiatrist documented that the recipient remained grossly grandiose and ended up in restraints for combative behaviors. Based on these behaviors, the psychiatrist increased the Abilify to 20 mg in the AM for the psychosis.

The recipient's clinical chart contained the 11/04/09 court document authorizing the involuntary court ordered medication.

Summary of Allegation 2

According to the recipient, he has refused to take medication for a mental illness; however, he has been forced to take the medications. Documentation in the recipient's clinical chart indicated that the recipient had exhibited psychotic symptoms due to a mental illness diagnosed as schizophrenia. According to the record, a petition for involuntary court ordered medication was approved on 11/04/09. Additional documentation indicated prior to the approval of the court ordered medications the recipient was allowed to refuse psychotropic medications. Documentation in a psychiatrist's 11/24/09 progress note indicated that on occasion the recipient refused to take medication for medical problems.

Conclusion of Allegation 2

The Authority acknowledges that the recipient was being forced to take psychotropic medication against his will after the involuntary administration was approved the court. However, the medications were administered in accordance with a court order, and the Code's mandates pertinent to the administration of involuntary medication. Therefore, no rights violations have occurred, and the allegation is unsubstantiated. No recommendations are issued.

Investigation of Allegation 3

Allegation 3: A recipient's property has been confiscated. To investigate the allegation, the Team spoke with a recipient and reviewed his clinical chart. A Representative (Representative I) was interviewed during the site visit, and the Coordinator spoke with another Representative (Representative II) of the facility's Human Rights Committee via telephone. The Authority reviewed the Patient Handbook.

I...Interviews:

A...Recipient:

The recipient informed the Team that when he arrived at the facility his property was taken from him. He stated that some of the items had been returned; however others have not been given to him. He related that staff gave him a list of the items that he had brought to the facility and was informed that the items that were not given to him had been placed in storage. He stated that he needed additional underwear and socks from his clothing. When asked by the Team if he had contacted any staff members to request the desired items he stated that he had not

made a request. The recipient stated that he would like the HRA's assistance in obtaining the clothing items.

The recipient stated that he had a radio taken from him during the time that he was placed in restraints; however, the radio was returned to him after the restraint episode.

B...Representative I:

The Representative stated that when a recipient is admitted to the facility all of his clothing is inventoried and sent to the facility laundry for washing. The items are marked with the recipient's name in order that they may be appropriately returned after washing/cleaning. According to the Representative, each recipient has a least six sets of clothing. If the recipient does not have an adequate number of personal clothing items, those items will be provided by the facility. The Representative stated that all personal items are also inventoried and sent to personal property storage. A recipient may contact a staff member to request an item from the property storage, and that item will be provided if the item is not considered contraband.

C...Representative II:

Representative II informed the Coordinator that when a recipient is released from restraints, he is allowed to return to his room. Items in his room are not removed unless the recipient has used the items for aggressive actions toward self or others. Representative II stated that recipients are allowed facility-approved radios, and the radio would remain in the room while a recipient was in restraints and be allowed when the recipient returned to his room, unless the radio had been used to cause harm.

II...Clinical Chart Review:

The HRA's review of the progress note from the date of admission (10/26/09) to 12/31/09 did not reveal any documentation to indicate that the recipient's property had been restricted. The HRA did not observe any documented evidence that the recipient had informed staff that he needed additional clothing items. Neither was there any documentation in the 11/11/09, 12/09/09 and 01/05/10 TPRs regarding any problems associated with the recipient's property, including clothing. During the review the HRA did not observe any Restriction of Rights Notices pertinent to property restrictions

III...Patient Handbook (Handbook):

The Authority reviewed the facility's Handbook, which is provided to recipients upon admission to the facility. The Handbook provided information regarding the following: 1) general guidelines for visitors; 2) information about bringing or sending items to recipients; 3) a description of the hospital; 4) patients served; 5) the treatment program; 6) security; 7) frequently asked questions; 8) national patient safety goals; and 9) quality/safety notice.

In the section designated for frequently asked questions, information is provided about a recipient's clothing. Recipients are informed that upon arrival at the hospital, a member of the clothing room staff will measure each recipient to assure issuance of proper fitting clothing, including shoes. Documentation indicated that recipients are encouraged to wear their personal clothing whenever possible. If no suitable personal clothing is available, State issued clothing will be provided; however, when the recipient is discharged the clothing must be returned. Recipients are informed that clothing is laundered in bulk; therefore, wash and wear and permanent press items are recommended. If an item requires dry cleaning, the cost of cleaning is the responsibility of the recipient.

According to the Handbook, before clothing is given to recipients, all personal clothing is inventoried and sent to the clothing room to be labeled with the recipient's name and documented on the patient's personal property list. Documentation indicated that the process takes several days, but once completed, the recipient may request items from his personal property by contacting his Unit Manager. If the item is not considered contraband and there is sufficient space in the recipient's room, the item is given to the recipient.

Questions regarding a recipient's personal property are also answered in the Handbook. Documentation indicated that since storage space within the hospital is limited, the amount of items a recipient may keep with him are limited. To ensure the safety and security of recipients and staff, many items are not permitted. Items with a recipient at the time of admission which are considered contraband will either be sent home at the recipient's expense or, if space is available, will be stored in the Personal Property Office. A record of all such items is maintained. A recipient is informed in the Handbook that if he wants items from personal property storage a request should be made to his therapist or the unit manager. If the recipient's clinical condition justifies, the item will be sent to him. According to the documentation, from time to time, a recipient's clinical condition may require temporary removal and storage of an item and when appropriate, the items will be returned to the recipient.

IV....Additional Information

When staff members were made aware that the recipient had requested additional underwear and socks, the items were provided to the recipient.

Summary of Allegation 3

According to the recipient whose rights were alleged to have been violated, when he was admitted to the facility, staff took all of his property, including clothing. A list of the items taken was given to the recipient. According to the recipient some of the items were returned; however, he needed additional underwear and socks. The recipient informed the Team that he had not made a request to the staff for the items. The recipient informed the Team that when he was in restraints, his radio was taken. However, when he returned to his room, he was allowed to use the radio. Representative I informed the Team of the facility's process pertinent to recipient's clothing, and Representative II informed the Coordinator that a recipient is allowed to have a facility approved radio in his room after he returns to his room after a restraint episode unless the recipient has used the item to cause harm to self or others. A review of the recipient's clinical chart did not reveal any restrictions pertinent to property. Additionally, after staff members were made aware that the recipient needed additional clothing items, those items were provided.

Conclusion of Allegation 3

Based on information obtained, the allegation that a recipient's property has been confiscated is unsubstantiated. No recommendations are issued.

Suggestion for Allegation 3

Facility staff should assure that a recipient is provided with the information in the Patient Handbook in an understandable manner when the recipient's clinical condition is at optimal status.

Investigation Information for Allegation 4

Allegation 4: A recipient is not allowed to make telephone calls. To investigate the allegation, the Team spoke with the recipient and reviewed his clinical chart. After speaking with the recipient, the Team spoke with a Representative. The Handbook and the facility's policy relevant to the allegation were reviewed.

I: Interviews:

A...Recipient:

According to the recipient, he is able to make telephone calls; however, he does not have an adequate amount of time allotted for the calls. He informed the team that "the phone will cut off after I dial so I have to redial taking time off my phone card. The phones need to be fixed." The recipient denied having any type of communication restriction.

B: Representative:

After speaking with the recipient, the Team spoke with the Representative to report a possible problem with the phones on Unit A at the facility. The Representative informed the Team that the issue would be investigated and addressed if a problem was found.

II...Clinical Chart Review:

A review of the recipient's clinical chart did not reveal any information that indicated that the recipient had any type of communication restriction. Documentation in the recipient's 11/11/09, 12/09/09, and 01/05/10 TPRs indicated that the recipient had reported that he had regular contact with his family and a female friend.

III...Handbook

Recipients are informed in the Handbook that each module has a phone available for recipients' use for long-distance collect phone calls. A patient's therapist will make arrangements for circumstantial calls necessary for the patient. Recipients are informed that they may not receive personal calls. When someone calls a recipient, the information will be given to the recipient so that the recipient may return the call.

Recipients are also informed that mandates of the Mental Health and Developmental Disabilities Confidentiality Act, which became a law in 1979, makes it illegal to release any information about a recipient, except under specific circumstances, without the prior written consents of the patients. Information about the recipient's status as a patient or his individual progress can not be communicated in any manner unless the written consent has been obtained.

IV...Policy

The Authority reviewed the facility's policy entitled, "Patient Telephone Calls". The Policy Statement is as follows, "It shall be the policy of Chester Mental Health Center to foster communication between patients and others outside the facility via telephone calls."

Recipients are informed that it is the facility's policy to permit newly admitted recipients to place two telephone calls at the facility's expense as soon as possible after admission. Recipients are encouraged to maintain contact with family or others outside the facility on an on-going basis. According to the Policy pertinent to outgoing calls, recipients are to be informed of the following: 1) the location of the module recipient phones; 2) the phone schedule; 3) the procedure for placing collect, toll-free and calling card calls; 4) the duration of calls; 5) supervision of calls; 6) non-routine calls; 7) and restrictions (to protect the recipient or others from harm, harassment or intimidation). The Policy states that to ensure that the patient's rights are protected, all telephone calls for recipients received at the facility are to be dealt with as follows: 1) Any telephone calls received by the switchboard for patients are to be routed to the shift supervisor. 2) The shift supervisor, while not acknowledging that the recipient resides at the facility will inquire as to whether or not an emergency situation exists. 3) The shift supervisor will note the name of the person making the call and the phone number while informing the party that the recipient, if at the facility, will be given the opportunity to return the call. 4) The recipient will be notified as soon as possible of the call and given the opportunity to return the call.

The Policy also addresses the procedure for handling calls inquiring about patients. Steps outlined in the Policy ensure that a recipient's confidentiality is maintained and no information is released without the written authorization of the recipient.

A patient phone schedule is included in the policy. Phone times are listed in one hour increments. Recipients who reside on Module A-1 are allowed to use the module phones daily from 11 AM to 12 AM, 4PM to 5 PM, 5 PM to 6 PM and 8 PM to 9 PM. Recipients who reside on Module A-2 have access to module phone from 2 PM to 3 PM, 5 PM to 6 PM, 7 PM to 8 PM and 9 PM to 10 PM. Recipients living on Module A-3 are able to use the module phone from 9 AM to 10 AM, 10 AM to 11 AM, 5 PM to 6 PM and 7 PM to 8 PM.

According to the Policy, a recipient's call should be limited to a 10 minute period if another recipient is waiting to make a call. Otherwise, there is no time limit on recipient calls during the designated calling periods. If an emergency situation arises during the course of a call, the recipient may be asked to curtail his call and re-initiate another call once the emergency situation is over.

Summary of Allegation 4

The recipient whose rights were alleged to have been violated informed the Team that he had not been restricted from using the telephone; however, he had experienced some difficulties when placing telephone calls. He stated that he believed that the phones needed to be repaired.

The Team informed a Representative of a possible problem with the telephones on the unit where the recipient resides. The Representative related that the issue would be addressed and an investigation would conducted to determine if any phone problems exsisted When the recipient's clinical chart was reviewed, there was no indication that the recipient had any type of communication restriction. When a recipient is admitted to the facility information concerning the facility's telephone policy is provided to the recipient in the Handbook. According to the facility's telephone policy, recipients are encouraged to maintain communication with others and are provided with one hour blocks of time four times daily to make the calls.

Conclusion of Allegation 4

Based on the interview with the recipient and review of his clinical chart, the allegation that the recipient is not allowed to make telephone calls is unsubstantiated. No recommendations.

Comments for Allegation 4:

1. Refer to suggestion for Allegation 3.

Investigation for Allegation 5

Allegation 5: A recipient has not been provided with adequate care and services: According to the allegation, the facility failed to provide the adequate care when a recipient did not receive needed surgery due to gallstones. To investigate the allegation, the Team spoke with a recipient and reviewed his clinical chart. The Team also spoke with a Representative concerning the allegation.

I...Interviews:

A...Recipient:

When the Team spoke with the recipient during a site visit at the facility, the recipient stated that he had surgery in February 2010 to remove his gallbladder. He stated that he had suffered with the pain associated with gallstones and needed the surgery for some time before staff made the arrangements for him to have the procedure. He stated that he had some x-rays of his abdomen and was told that he might have "a hole in his stomach".

B...Representative:

The Representative stated that since admission, the recipient had voiced complaints regarding having pain in his abdomen. Due to his voiced concerns, testing was conducted and revealed that the recipient had gallstones. The Representative stated that an appointment was scheduled with a community surgeon to determine if the recipient needed to have surgery to remove his gallbladder. However, the recipient refused to have the evaluation. The Representative stated that when the recipient's pain continued, another appointment was scheduled, and the recipient agreed to keep that appointment. The surgeon recommended that the recipient have a cholecytectomy (removal of the gallbladder) and the surgical procedure was completed on 02/05/10. When the recipient returned to the facility he was placed in the facility infirmary for several days after the procedure.

II. Clinical Chart Review:

A...TPRs

Documentation in the recipient's 11/11/09 TPR indicated that since admission on 10/26/09 the recipient had registered complaints regarding pains in his abdomen. A goal for the recipient to be free of gastric discomfort was listed in the plan. Documentation indicated that a dietary consult was pending and a stool for occult been had been ordered. The recipient's current diet was listed as a NCS (No Concentrated Sweets)/low fat. The record indicated that the recipient had been treated for his medical issues.

Documentation in a 12/09/09 TPR indicated that the recipient was receiving Omeprazole (Prilosec) 20 mg twice daily; the dietary consult was pending and the occult blood results were pending.

According to the recording in the 01/05/10 TPR, the recipient had been seen by a medical doctor and was being treated for various medical issues. Documentation indicated that results for the occult blood were negative, and facility nursing staff were directed to continue to acknowledge his complaints of gastric pain, rate the degree of discomfort and inform a medical doctor of the results.

B...Progress Notes:

An RN documented at 9:30 PM on 10/27/09 in a Progress Note that the recipient was given Acetaminophen 650 mg for gallbladder pain. The recipient assessed his pain at level 7 on

a scale of 10. The RN documented at 10:20 PM that the recipient complained that the pain had worsened. He was walking in the hallway, bent over holding his abdomen, and relating that he could not lie down. The recipient stated that his pain was at a level 10. The RN recorded that she had called a facility physician to examine the recipient.

Documentation indicated that the physician examined the recipient at 10:30 PM. The physician recorded that there was no real tenderness noted in the upper right quadrant. The physician diagnosed the recipient's condition as possible gallbladder pain from stones, prescribed 800 mg of Ibuprofen to be given every 4 hours as needed for the pain, and follow up examination by the unit physician.

When the unit physician examined the recipient on 10/28/09 at 10 AM, the physician recorded that the recipient had reported that he had mild nausea and had vomited; however the pain had improved. The physician recorded that the recipient's abdomen was soft, with mild tenderness to the touch, and his bowel sounds were hyperactive. The physician ordered that the recipient be transferred to the facility infirmary for observation and an abdominal ultrasound conducted.

Documentation indicated that the recipient was admitted to the infirmary at 12:45 PM on 10/28/09. The record indicated that an abdominal ultrasound had been scheduled at the community hospital. An RN recorded in a 1:40 PM progress note that the recipient had been escorted by an STA staff member to the community hospital for the ultrasound. An RN documented in a 3:50 PM Progress Note on 10/28/09 that the recipient had returned from the community hospital; however "no papers were returned from the hospital". Documentation indicated that when the recipient was examined at 5 PM he assessed his pain at level 6; however when an examination was conducted at 7 PM he stated that the pain had decreased to a level 3 or 4 and he was resting.

A facility physician recorded in an 8:30 PM note on 10/28/09 that the results from the ultrasound indicated that the recipient had multiple gallstones. An additional recording indicated that the recipient was observed throughout the night.

An RN recorded at 8:30 AM on 10/29/09 that the recipient denied having any abdominal pain at that time. A physician documented that he had examined the recipient at 8:30 AM and found that he was not experiencing any pain, nausea or vomiting. In a 3:30 PM note, the physician recorded that he had spoken to a physician at an area hospital regarding the possibility of the recipient having an evaluation for a cholecylectomy due to the cholecystites. The physician recorded that an appointment was scheduled for 11/02/09 at 8:20 AM.

Documentation indicated that the recipient refused all medications on 11/01/09 and refused to have the surgical evaluation on 11/02/09. Documentation in an 11/02/09 progress

note indicated that the recipient's therapist had spoken to him regarding his refusal to see the surgeon. The therapist recorded that the recipient was focused on the court hearing scheduled for 11/04/09 for enforced medication, and he expressed that he only wanted to deal with getting discharged.

C...Additional Documentation:

A community hospital's Abdominal Ultrasound findings Report dated 10/28/09 recorded that multiple gallstones were identified and it could not be entirely excluded that the recipient's gallbladder was inflamed. However, there was no evidence of pericholecystic fluid or dilation of the common hepatic duct.

Documentation in a Referral and Report (Consultation) dated 11/03/09 indicated that the recipient had refused a consultation with a community physician for possible cholecystectomy.

Documentation indicated that the recipient agreed to re-schedule the consultation, the appointment was made and the consultation completed on 01/14/10. According to the consultation report, the surgeon examined the recipient and reviewed the information provided. The surgeon's suggested plan was for the recipient to have a laparoscopic cholecstectomy. The surgeon recorded that he had explained the procedure, the risks and benefits of the procedure to the recipient. The expected recovery time was also discussed. The surgeon documented hat the recipient had verbalized an understanding of the procedure and the procedure had been scheduled. The record indicated that another community physician had reviewed the report and had agreed with the diagnosis and the suggested treatment plan.

Documentation in a community hospital's Same Day Surgery Report dated 02/05/10 indicated that the laparoscopic cholecystectomy had been performed. Special instructions were given for the care of the recipient, and he was provided with a follow-up appointment date on 02/17/10.

An Infirmary and Discharge Summary indicated that the recipient was admitted to the infirmary at 4:15 PM on 02/05/10 for post cholecsytectomy monitoring. Additional documentation indicated that the recipient was discharged from the infirmary on 02/17/10 after the post operative surgical appointment with the community surgeon had been conducted.

Documentation indicated that the surgeon had examined the recipient on 02/17/10 for a post operative follow-up. The physician recorded that the recipient was doing well and no additional follow-ups were needed.

Documentation in the facility's Wound Assessment Forms indicated that post operative evaluation of the recipient's surgical site was assessed and treatment conducted on 02/06/10, 02/12/10, and 02/16/10. Documentation on the 02/16/10 indicated that the surgical incision had healed, and no additional steri-strips were required.

Summary of Allegation 5

According to the recipient, he experienced pain associated with gallstones for a considerable amount of time before surgery was performed. Documentation in the recipient's clinical chart indicated that when staff members were made aware of the recipient's complaints, a facility physician examined the recipient, conducted diagnostic testing, placed the recipient in the facility infirmary for observation and made a referral to a community surgeon. According to the record, the recipient refused to have the initially scheduled surgical evaluation on 11/02/09. However, when his pain continued, the recipient agreed to the have the surgical evaluation, which was conducted on 01/14/10. After the evaluation was conducted the surgeon recommended that the recipient have laparoscopic surgery to remove his gallbladder. The surgeon's treatment plan was reviewed and approved by an additional community physician, and the surgery was performed on 02/05/10. After the recipient was released from the same-day surgery clinic, he returned to the facility where he was placed in the infirmary. He remained in the infirmary until 02/17/10. The release from the infirmary was implemented after the recipient's post operative surgical appointment with the community physician was conducted, and the surgeon determined that the recipient was doing well and did not need additional examinations. According to documentation, the recipient's condition was continually monitored while he was in the infirmary. Pain was assessed, wound care was conducted, and vital signs were taken.

Conclusion for Allegation 5

Based on the information obtained, the Authority has determined that the recipient received the standard of care for the medical condition. Therefore, the allegation that the recipient did not receive adequate care and services is unsubstantiated. No recommendations are issued.