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Egyptian Regional Human Rights Authority
Report of Findings
10-110-9032
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 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 (Code) (405 ILCS 5/2-102 (a), 405 ILCS 5/2-108 and 405 ILCS 5/2-201).

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."

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 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 names', 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

Allegation: A recipient at Chester Mental Health Center was inappropriately placed in restraints: To investigate the allegation, the 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 to the recipient whose rights were alleged to have been violated and a Representative of the facility's Human Rights Committee. The recipient's clinical chart was reviewed with his written authorization.

I...Interviews:

A...Recipient:

The recipient informed the Team that shortly after his admission to the facility he was exiting the dining area when another recipient accidently hit his foot knocking off the back portion of his shoe. He stated that when he realized what had occurred, he reached down to place the shoe back of his foot and during the process noticed that his shoe laces were untied. When he commenced to tie the laces a Security Therapy Aide (STA) saw him bending down and requested that he get back into the line with other recipients. According to the recipient, he informed the STA that he was only tying his shoe. However, he complied with the request, got back into the line with other recipients and proceeded to his room. The recipient informed the Team that within minutes several staff members came into his room, accused him of waiting for someone while bending down in the dining room, and placed him in restraints. He stated that the restraint application was inappropriate because he was not involved in any type of aggressive action.

B...Representative:

According to the Representative, the issue had not been brought to the facility's human rights committee for review. With the recipient's written authorization, the Representative obtained the recipient's clinical chart for the Team's review and provided copies of requested information from the chart.

C...Clinical Chart Review:

1...Treatment Plan Reviews (TPRs):

Documentation in a 10/28/09 TPR indicated that the recipient was admitted to the facility on 10/27/09 as Unfit to Stand Trial (UST). The recipient's problem areas were listed as follows:

1) UST, 2) Aggression, and 3) Psychosis. Goals to address each of the problem areas were incorporated into the TPR.

His diagnoses were listed as follows: AXIS I: Psychotic Disorder NOS (Not Otherwise Specified), AXIS II: Deferred, AXIS III: Gunshot Wound x 5, Allergic to PCN (Penicillin) and Pork, and AXIS IV: Criminal History, H/O (History of) Incarceration; Poor Insight and Judgment, Non-compliance, UST.

Documentation indicated that the recipient refused to take any medication and to state his preference for any type to emergency intervention.

Documentation in an 11/17/09 TPR indicated that due to physical aggression the recipient had been placed in restraints and required emergency medication once since his admission.

According to a 12/15/09 TPR, the recipient had been involved in verbal and physical altercations with several peers with one of the incidents resulting in his being hit in the face with a chair which was thrown by a peer. There was no documentation to indicate that the recipient had required restraints during the reporting period. Additional documentation indicated the recipient denied having a mental illness and the need for medication. However, he had a very good understanding of court proceedings and had agreed to cooperate with his public defender. Therefore, the treatment team had recommended that the recipient be returned to court as fit to stand trial.

Documentation in a 01/12/10 TPR indicated that the recipient informed the treatment team that he was being "picked on" because of his religion. When he was counseled on his aggression towards a peer, he stated that he was called a derogatory racially offensive word and the peer invaded his personal space, so he defended himself. The Team informed the recipient that if he became involved in another altercation, his recommendation as fit to proceed would be reconsidered. The TPR did not contain any information that would indicate that the recipient had required restraints during the reporting period.

2...Restraint Records:

According to an Order for Physical Hold, the recipient was placed in a physical hold at 6:25 PM on 11/12/09 after he began to "swinging at staff". When efforts to calm the recipient failed, documentation indicated that the recipient was escorted to a restraint room, released from the hold at 6:30 PM and placed in four point restraints.

A Notice Regarding Restricted Rights (Notice) was given to the recipient for the 5 minute hold. The reason for the restriction was listed as the recipient was a threat to self and others. The record indicated that the recipient had not listed a preference for emergency intervention, and he was unable to calm down enough to be placed in a less secure setting. Documentation indicated that the Notice was delivered to the recipient in person, and he did not wish to have anyone notified of the physical hold.

A Restraint Order (Order) was issued at 6:30 PM with the specific behaviors for the restraint listed as, "patient attempted to hide in an offset of the hall when returning from dining room. When staff attempted to discuss this with him on the unit-patient attempted to strike staff with a closed fist." The record indicated that two attempts of empathic listening and conflict resolution failed and the recipient's behaviors escalated; therefore, he was placed in four point restraints. The Order was issued for up to four hours with hourly reviews to allow the recipient time to modify his behavior. The release criteria were listed as follows: 1) The recipient must be calm, cooperative with reviews for a 60 minute period; 2) He should show no sign of anger or agitation for a period of 60 minutes; and 3) He must be able to voice a plan for dealing with anger other than aggression. A Registered Nurse (RN) recorded at 6:30 PM the personal examination of the recipient and the assessment that the application did not pose any undue risk to the recipient. A facility physician also recorded at 7 PM that he had personally examined the recipient and had assessed that the restraints did not pose a threat.

Documentation in the Restraint/Seclusion Flowsheets (Flowsheets) indicated that the recipient's condition and behaviors were reviewed in 15-minute increments throughout the restraint episode. An RN checked his circulation, released his limbs, took his vital signs, and evaluated his physical and mental status hourly. He was offered fluids and toileting at the time of the evaluation.

Documentation on the Flowsheets indicated that after the restraints were applied a body search was completed. Staff examined the recipient to determine if the restraints were properly applied, his body was properly positioned, and he wearing proper clothing for the restraint. The staff member also determined that the room environment was appropriate. The recipient was informed of the reason for the restraint and the criteria for release.

When the recipient failed to meet the criteria for release when the initial Order had expired, a second Order was issued 10:30 PM on 11/12/09. Documentation indicated that the recipient denied any wrong doing and stated that staff members were "at fault". Documentation on the Order and the Flowsheets indicated that the restraint ended on 11/13/09 at 12:30 AM when the recipient met the criteria for release.

A Notice was provided to the recipient for the six hour restraint episode for the period of 11/12/09 at 6:30 PM to 11/13/09 AM. The reason for the restriction was listed as the recipient was unable to calm down for a less secure setting, and he was a threat to self and others. Documentation indicated that the recipient had not indicated a preference of emergency intervention and did not wish to have anyone notified of the restraint. The Notice was delivered to the recipient in person.

A Post-Episode Debriefing (Debriefing) was conducted at 12:30 AM by an RN. The recipient was able to identify the stressors occurring prior to restraint and to verbalize an understanding of the causes and consequences of his aggressive behaviors. He was able to identify methods to control the aggressive behaviors. He stated that he felt that staff could have helped him to remain in control, and he could have requested assistance from staff prior to the escalation of anxiety. The RN documented that the recipient was encouraged to discuss his

feelings related to the restraint. It was determined that the recipient did not receive any physical injuries during the restraint, and his physical well-being and privacy needs were addressed.

3...Progress Notes:

Documentation in a 11/12/09 Progress Note completed by a STA at 6:30 PM indicated that recipient was asked why he stopped in the hallway from the dining room and he became agitated and tried to "punch" staff. He was placed in a physical hold at 6:25PM, and when his aggressive actions failed to cease he was escorted to the restraint room and placed in restraints for the safety of all at 6:30 PM.

According to a facility physician's documentation at 7 PM on 11/12/09, he had assessed the recipient while in restraints. The restraint application was due to the recipient attacking a staff member when the staff member tried to question why he had appeared to be hiding in a recession in the hallway as if he were waiting for someone to pass by. The physician recorded that the recipient stated that he was placed in restraints because of his religion, denied any wrong doing, and continued to speak in loud speech making repetitive statements. The physician recorded agreement with the recipient's placement in restraints for the protection of the recipient and others.

An additional 11/12/09 Progress Note completed at 7 PM by an RN indicated that the recipient stopped in the hallway, became agitated, cursed and starting swinging at staff. He was placed in a physical hold and restraints for the protection of all. He was provided with a restriction notices and informed of the criteria for release; however, the recipient refused to speak with the RN. The RN recorded that a facility physician was contacted and came immediately to sign the Order and examine the recipient.

The RN recorded in a 10:30 PM Progress Note that the recipient continued to deny any wrong doing when asked how he could have handled his anger. The RN documented that the recipient was examined, limbs released, offered toileting, and his bed examined and found to be dry and clean. The RN recorded that the recipient had not met the criteria for release; and a facility physician had signed an Order to continue the restraint.

A facility physician recorded at 10:30 PM that the recipient had attacked staff and continued to be agitated. He had refused Ativan for anxiety. The physician recorded that continued restraint was appropriate. However, an RN recorded at 11:40 PM, the recipient had requested the Ativan for agitation and when the physician was contacted an order was issued for the recipient to receive the medication.

An RN recorded at 12:30 PM that the recipient had met the criteria for release, debriefing had been conducted, and he had been escorted to his room without incident. The RN documented that the recipient showed no adverse effects from being in the restraints.

Summary

According to the recipient, a peer accidently hit the back of his foot causing his shoe to come off. When he reached down to place the shoe on his foot, he noticed that his shoes laces were not tied. He stated that as he was attempting to tie the laces, a STA requested that he get back into the line with the other recipients. The recipient informed the Team that he conveyed to the STA that he was bending down to tie his shoe laces, complied by the STA's request to get into the line with other recipients and walked to his room. According to the recipient, shortly after he arrived in his room several STA's came into the room, accused him of lying in wait for someone and placed him in restraints. According to documentation in the recipient's clinical chart, when the recipient was approached he cursed at staff and attempted to hit them. Due to his aggressive actions, he was placed in restraints. Documentation indicated that an Order for a Physical, Restraint Orders, Flowsheets, Restriction Notices, and a Debriefing was conducted in accordance with Code requirements. The record indicated that the recipient did not have any other restraint episode during his stay at the facility.

Conclusion

The Authority recognizes that there may have been some misunderstanding regarding the reason that the recipient was out of line from other recipients and the motive for him bending down. The Authority also understands the recipient's concern when he attempted to explain. However, a display of aggressive actions would lead staff to believe that the recipient was a danger to self and others. Therefore, the allegation that the recipient was inappropriately placed in restraints is unsubstantiated. No recommendations are issued.

Suggestions

1. Staff members should make every effort to understand what a recipient is attempting to convey and act accordingly without placing themselves, the recipient, or others in physical danger.

2. Staff should make every effort to secure emergency treatment preferences from recipients.