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Egyptian Regional Human Rights Authority
Report of Findings
10-110-9040
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 with the recipient whose rights were alleged to have been violated and with his written authorization reviewed his clinical chart. The Team also spoke with a Representative from the facility's Human Rights Committee. The facility's Policy and Program/Policy Directive pertinent to restraints was reviewed.

I: Interviews:

A...Recipient:

During the site visit, the recipient informed the Team that he was transferred from another state-operated mental health facility in December 2009 with an Involuntary Status. He stated that he is presently on the yellow level (mid-level) of the facility's level participation system. The recipient informed the Team that staff at the facility had placed him in restraints several times since his admission without having a valid reason for each application. The recipient denied exhibiting any type of aggressive behaviors.

B: Representative:

When the Team spoke with the Representative regarding the issue, the Representative stated that the issue had not been addressed by the facility's Human Rights Committee. When the recipient's written authorization was provided, the Representative made available the recipient's clinical chart for the Team's review and provided copies of pertinent information from the chart.

II: Clinical Chart Review:

A...Treatment Plan Reviews (TPRs)

According to a Three-day TPR dated 12/07/09, the 23-year-old recipient was admitted to the facility on 12/04/09 from a less restrictive mental health facility where he had been since 12/01/09. The record indicated that the transferring facility referred the recipient to Chester Mental Health Center due his physically aggressive behaviors toward peers and staff, especially female staff. The record indicated that in addition to the recipient's uncooperative and aggressive behaviors, he had exhibited positive symptoms of psychosis, including bizarre, delusional content of speech.

Problem areas in the initial TPR were listed as follows: 1) psychosis including mood instability, and 2) verbal and physical aggression. His diagnoses were listed as: Axis I: Bipolar Disorder with Psychotic Features; AXIS II: Deferred; AXIS III: Deferred; and Axis IV: Chronic Mental Illness/Aggression.

The record indicated the recipient was taking Chlorformezine 200 mg by mouth twice daily and Lorazepam 1 mg by mouth four times daily.

In accordance with the Mental Health and Developmental Disabilities Code, 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, the recipient stated that he preferred the following forms of intervention in order of preference: 1) emergency medicine; 2) seclusion; and 3) restraint.

To address the problem with the recipient's psychotic symptoms, including delusions and mood instability, a goal to reduce the psychotic symptoms was incorporated in the TPR. Objectives were for the recipient to take medication as prescribed and to no longer display speech or behaviors indicative of delusions, such as referring to self as a leader of the 'Italian Mafia'. An additional goal for the recipient to be free of displaying aggressive behaviors toward others by 11/20/10 was also incorporated in the TPR. STA staff members were instructed to monitor compliance, report non-compliance, to inform the recipient of the limits on his behaviors and that the violent behaviors would not be tolerated. The record indicated that the recipient's therapist would work with him on developing strategies to improve his social functioning while decreasing/eliminating his aggressive behaviors.

The 12/07/09 TPR also contained a goal for the recipient to decrease and/or alleviate his back and neck pain. Treatment interventions included the following: 1) Nursing staff will administer medication as prescribed. 2) Nursing staff were assigned to assess the recipient's pain by question him, looking for nonverbal signs, and using the appropriate pain rating scale before and after giving pain medication document result in the recipient's chart. 3) Nursing staff were also assigned to inform a facility physician if the pain was not relieved in order that further evaluations could be conducted.

Documentation in a 12/31/09 TPR indicated that initially the recipient had been very uncooperative and aggressive, and he had been placed in restraints on 02/04/09 due to the aggressive behaviors. However, he had shown gradual but significant improvement. The record indicated that the recipient stated that since he had become more stable he understood the importance of cooperating and following treatment recommendations.

Documentation in a 01/25/10 TPR indicated that the treatment team met with the recipient to review his response to treatment, which had been unfavorable during the reporting period. Documentation indicated that he had required restraints as a result of his aggressive behaviors. According to the record, the recipient did not do as well while residing on Module B-1 as he had done when he resided on module B-3. Therefore, he was transferred back to Module B-3.

According to the documentation, the recipient acknowledged that he had a mental illness that required medication and requested that changes be made in his medication regimen. Documentation indicated that a psychiatrist went over the medication regimen and recommended some changes, including the addition of Lamictal and Benztropine, decreasing Thorazine, and switching from Ativan to Xanax. The record indicated that the recipient was agreeable with the medication changes.

Professional and direct care staff recorded that the recipient had been verbally aggressive and on 01/23/10 had become physically aggressive necessitating the use of restraints.

Documentation in the recipient's 02/24/10 TPR indicated that the recipient had experienced significant difficulty in social functioning. He had been quite verbally aggressive. However, he had not been involved in any physically aggressive actions.

The recipient's strengths were listed as having maintained a private residence, having at least an average intelligence, and having 12 years of formal education.

Documentation in a 03/23/10 TPR indicated that the recipient's legal status had been changed to Voluntary on 02/16/10. It was noted that the recipient had required restraints on 03/22/10 after he became upset during a "shakedown". Documentation indicated that the recipient was unable to remain calm and became physically assaultive. The record indicated that the recipient's therapist stated that an intervention should be added to his treatment plan in order for his social functioning to improve. According to documentation, the recipient would be given a one page calendar at the beginning of each month. He was instructed to, each day, rate his behavior on a scale from 1-3 (1 would equal frequent behavior problems/especially with physical aggression; 2 would equal verbal aggression, but no physical aggression and 3 would equal no verbal of physical aggression). The record indicated that on the occasion when the recipient performed well, he would be given extra individualized attention from his Therapist. However, when he had not performed well, the therapist would provide information on how he could improve his social functioning.

B...Restraint Records:

According to documentation, an Order for Physical Hold was issued on 12/04/09 at 6:55 PM due to the recipient refusing to follow staff requests and directions with the recipient's behaviors escalating to an attack on staff. The hold was discontinued at 7 PM, and the recipient was placed in restraints when his aggressive behaviors did not cease. An RN signed the Order for Physical Hold at 6:55 PM, and a facility physician signed the Order at 7 PM. The RN and facility Physician recorded a personal examination of the recipient and the assessment that the restraint application did not pose any undue risk to the recipient.

A Notice was given to the recipient for the 5 minute physical hold. The reason for the restriction was listed as aggression with attack on staff. The record indicated that the Notice was delivered to the recipient in person, and he did not wish that anyone be notified of the hold.

An Order for Restraint was issued at 7 PM on 12/04/09 when the recipient failed to cease his attack on staff members. Documentation indicated that distraction, verbal support and reassurance were implemented. Whenever those interventions failed, four point restraints were applied. The Order was issued for up to four hours. In order for the recipient to be released from the restraints documentation indicated that he must be calm, cooperative, refrain from exhibiting verbal threats or not spitting on others for a period of one hour. He must also be able to respond to female staff without exhibiting sarcasm or scorn. An RN and facility physician recorded that they had personally examined the recipient at 7 PM and found that the restraint application did not pose an undue risk to the individual's health. A second order was issued when the recipient had not met the criteria for release prior to the end of the initial Order at 11 PM. Documentation indicated that the recipient was still yelling, and being "foul mouthed" and hostile toward females. A physician and RN recorded an examination of the recipient at 11 PM and determinations that the restraints were not posing any risk to the individual. Documentation on the Order indicated that the restraint ended at 1 AM on 12/05/09, when the recipient met the criteria for release.

The record indicated that in fifteen minute increments staff members documented the recipient's behaviors on the Flowsheets. An RN released his limbs, checked his circulation, took vital signs, and assessed his physical status on an hourly basis. He was offered fluids and toileting when the assessments were conducted. As soon as the restraints were applied, a body search was completed. Staff examined the recipient and determined that the restraints were properly applied, and he was properly positioned. Additionally, a determination was made that the recipient was wearing appropriate clothing for the restraints and the room environment was appropriate. 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.

A Notice was provided to the recipient for the 6 hour restraint episode which commenced at 7 PM, on 12/04/09 and ended at 1 AM on 12/05/10. Documentation indicated that the recipient was placed in restraints because he had attacked staff. Recordings in the Notice indicated that the recipient had not designated his preference for emergency interventions prior to the restraint application. The Notice was delivered to the recipient in person. There was no documentation to indicate if the recipient had been asked if he wanted the Notice sent to anyone.

The record indicated that an Order for Physical Hold was completed on 01/23/10 at 4:40 PM when the recipient attempted to kick a staff member. The recipient was released from the hold at 4:45 PM and placed in restraints after he continued to fight the staff.

A Notice was given to the recipient for the 5 minute hold from 4:40 PM to 4:45 PM. Documentation indicated that the hold was implemented after the recipient attacked staff. According to the record, the recipient had refused to take oral medication to assist him with his anxiety. The Notice was delivered to the recipient in person, and he indicated that he did not want anyone notified of the physical hold.

An Order for Restraint was completed at 4:45 PM on 01/23/10 after the recipient failed to regain composure and cease his aggressive actions. Documentation indicated that the behavioral interventions of distraction, verbal support and reassurance failed to assist the recipient in

gaining control of his behaviors. According to the documentation, the recipient "must be calm, cooperative, able to verbalize ability to control acting out impulses no glaring at staff or arguing about tx (treatment) or meds (medication)." No time frame was listed for the recipient to exhibit the targeted behaviors before release would be implemented. When the recipient did not meet the criteria for release the second Order was completed at 8:45 PM for 01/23/10. The record indicated that the RN examined the recipient at 8:45 PM, and the physician examined the recipient at 9:30 PM. Both professionals determined that the restraint did not pose an undue threat to the recipient. The record indicated that the recipient met the criteria for release at 10:30 PM on 01/23/10.

Documentation in Flowheets indicated the recipient's behaviors were monitored and recorded in 15 minute increments. An RN checked his circulation, released his limbs, checked his vital signs and assessed his mental and physical status on an hourly basis. He was offered toileting and fluids when the assessments were being completed.

The recipient was provided with a Notice pertinent to the 01/23/10 restraint that was implemented after he attacked staff members. The record indicated that the recipient's preferred emergency interventions were not used because he had refused all oral medications just prior to his spontaneous attack on staff. The record indicated that the Notice was delivered to the recipient in person and he stated that he did not want anyone notified of the restraint.

An RN conducted a debriefing with the recipient as soon as he was released from restraints. The RN documented that the recipient was able to identify the stressors occurring prior to the restraint and an understanding of the cause and consequences of his aggressive behaviors. He stated that he felt that staff could have helped him to remain in control and that he was aware that he could request assistance from staff prior to escalation of his anxiety. Documentation indicated that the recipient was able to identify one or more methods to control his aggressive behaviors. The RN determined that the recipient's physical well-being and his privacy needs were addressed during the restraint episode.

Documentation indicated that staff members were doing a shakedown on 03/22/10 at 6:55 PM and when the recipient was asked to step out of his room so his room could be searched he became angry and attempted to attack staff. He was placed in a physical hold and when he continued to fight he was placed in restraints. The record indicated that an Order for Physical Hold was completed for the 5 minute hold, and the recipient was provided with a Notice pertinent to the hold.

An Order for Restraint was completed at 7 PM when the recipient continued his attack on staff during the hold. Documentation indicated that two attempts at verbal support and reassurance failed to calm the recipient. Release criteria were listed as follows: The recipient must be calm and cooperative with staff and exhibit no agitation or hostility for a period of 60 minutes. He must voice compliance with facility rules. The Order was issued for up to four hours with hourly reviews. Documentation indicated that the recipient met the criteria for release at 10 PM; three hours after the restraints were applied.

Documentation in the Flowsheets indicated that the recipient's behaviors were monitored and recorded every 15 minutes. An RN checked his circulation and vital signs, released his limbs and evaluated his mental and physical status on an hourly basis. He was offered liquids and toileting when the assessments were conducted. Documentation indicated that as soon as the recipient was placed in the restraints, his body was searched. Staff members determined that the restraints were properly applied, and he was adequately positioned. Staff also determined that the recipient was wearing appropriate clothing for the restraint. He was informed of the reason for restraint, the criteria for release and provided with a Notice pertinent to the restraint.

At 11 PM, an RN documented on a Post-Episode Debriefing Form that the recipient was resting quietly in his bed. He informed the RN that he became upset over the shakedown. He was able to verbalize an understanding of the cause and consequences of his aggressive behavior. He stated that he felt that staff could have assisted him to remain in control and stated that he was aware he could request help from staff prior to any escalation of anxiety. He was able to identify one or more methods to control his aggressive behaviors. The RN determined that the recipient did not receive any type of physical injury during the restraint episode. Additionally, the RN concluded that during the restraint episode the recipient's physical well-being and privacy needs had been addressed.

<u>C: Progress Notes;</u>

Documentation in a 12/04/10 Progress Note indicated that the recipient was admitted to the Unit at 5:50 PM. At 6:55 PM he attempted to attacked staff for no apparent reason. The record indicated that he was placed in a physical hold and when his aggressive behaviors continued he was placed in restraints. The record indicated that at the time of the restraint, the recipient had not stated his preference for emergency intervention. An RN completing the progress note indicated that the recipient was offered an evening meal three times; however, he consistently refused the meal.

An RN documented in a 01/23/10 that when the recipient was called for his medications he became angry, threatening and proceeded to attack staff. Due to his aggressive behaviors he was placed in a physical hold at 4:40 PM, and when the behaviors continued he was placed in four point restraints.

A STA documented in a 01/23/10 progress note that when the recipient was asked to come to the nurses' cage to take his medication, he became very angry. According to the STA, the recipient threatened staff with" bodily harm" and then physically attacked a staff member. The recipient was placed in a physical hold at 4: 45 PM and escorted to the security room where he was placed in 4 point restraints.

Additional progress notes completed by a facility physician and an RN documented examination of the recipient during the 01/23/10 restraint episode. A facility physician recorded at 9 PM, if the recipient's behavior improved he could go to his room by 10:30 PM. Additional documentation indicated that the recipient met the criteria for release at 10:30 PM.

In a 01/25/10 psychologist's progress note recorded at 9:55 AM, the psychologist documented that the treatment team had met with the recipient regarding the weekend restraint and to discuss the recipient's recent regression. Documentation indicated that the recipient agreed that his behavior had worsened over the past few days since his move to Unit B-1. A facility physician attending the meeting recommended that the recipient's thyroid function be tested and the medication, Lamictal, started. The psychologist documented that the recipient agreed to the medication changes and additional testing. An additional progress note completed by the facility physician documented the change in medication, the recipient's agreement to the change, and a discussion with the recipient regarding the possible side effects of the medication.

According to a 03/15/10 psychologist's progress note, the recipient had shown a decrease in his aggression; however, he continued to have problematic social behaviors. The psychologist documented that he had asked the recipient to "keep track" of his intrusive, demanding behaviors by recording on a calendar when he was asked to control these behaviors. The psychologist documented that the recipient stated that he would work on being less intrusive and would report his progress to the psychologist within a few days. Documentation in a 03/22/10 progress note indicated that the recipient was asked by staff to walk out of his room for the "shakedown process". The recipient initially refused and then charged at and attacked the STA. The RN completing the progress note recorded that the recipient was placed in a physical hold and then restraints.

An STA recorded in a 03/22/10 progress note completed at 7 PM that he had responded to a "scuffle" on Unit B-2 and found the recipient in a physical hold. The STA documented that the recipient refused to calm himself and continued to struggle. He was taken to Unit B-3 and placed in restraints. The STA recorded that restraints were the recipient's third choice of emergency interventions. However, medication was not offered due to the spontaneity of the recipient's actions, and he was too combative to be placed in seclusion.

An RN documented at 10 PM on 03/22/10 that the recipient had remained calm and cooperative with no displays of aggression, agitation or hostile behaviors for a period of 60 minutes; therefore he had met the criteria for release from the restraints.

<u>II ...Facility Policies:</u>

<u>A: Use of Restraint and Seclusion (Containment in Mental Health Facilities Policy (Policy)</u>

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 others and follows the <u>Department of Human Services Program Directive 02.02.06.030"</u>

<u>B: Illinois Department of Human Services Program Directive 02.02.06.030 (Directive)</u>

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 too

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 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 may necessitate the use of restraint or seclusion. These include, but are not limited to:

1. the use of nonphysical interventions as preferred intervention 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

The recipient whose rights were alleged to have been violated informed the Team that he had been placed in restraints several times since his admission and felt that the restraint applications were unwarranted. Documentation in the recipient's clinical chart indicated that the recipient had been placed in restraints on 12/04/09 (the day of his admission), 01/23/10, and 03/22/10, and each application was due to the recipient attacking staff. The record indicated that Restraint Orders, Flowsheets, Post-Episode Debriefings, and Restriction Notices were completed for each restraint episode. Documentation indicated that the treatment team reviewed the restraint application and made changes in the recipient's TPR, and the recipient's medications were reviewed and changes made.

Conclusion

Based on information obtained, the allegation that a recipient at Chester Mental Health Center was inappropriately placed in restraints is unsubstantiated. No recommendations are issued.

Suggestions

During the HRA review, it was noted that in the 01/23/10 Order for Restraint a specific time frame was not listed for the recipient to exhibit the targeted behaviors before being released. The Authority suggests the following:

1. Chester Mental Health Center should ensure that all orders include a specified time frame that a recipient must exhibit the criteria for release behaviors before restraint release.

It was also observed that the 12/04/09 Restriction Notice relevant to the restraint application did not contain any documentation that would indicate that the recipient had been asked if he wanted anyone sent a copy of the Notice. The Authority suggests;

2. Facility staff should make certain that recipients are consistently informed of their right to have a person of their choice notified of a restriction and the designated individual provided with a copy of a Notice.