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Egyptian Regional Human Rights Authority
Report of Findings
10-110-9047
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:

1. A recipient at Chester Mental Health Center was placed in restraints without a valid reason for placement in the 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), 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 to 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 of 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 placed in restraints without a valid reason for placement in the restraints. To investigate the allegation, the Investigation Team (Team), consisting of three members and the HRA Coordinator (Coordinator), conducted a site visit at the facility. During the visit, the Team spoke with a Representative (Representative) from the facility's Human Rights Committee. Prior to the site visit, the Coordinator spoke via telephone with the recipient whose rights were alleged to have been violated, and the Team attempted to speak with him during the site visit. The recipient's clinical chart was reviewed with the recipient's written authorization. The facility's policy pertinent to the allegation was also reviewed.

I...Interviews:

A...Recipient:

When the Coordinator spoke via telephone with the recipient whose rights were alleged to have been violated, he stated that shortly after he was admitted to the facility, he was placed in restraints on two occasions without a valid reason. He stated that he was admitted in January 2010, and the restraint applications occurred in February and March 2010. The recipient denied exhibiting any behaviors that would be considered a danger to self or others.

B: Representative:

During the site visit, the Representative informed the Team that the recipient had been found fit to stand trial and was returned to a county jail to await trial. When the Team presented the recipient's signed authorization for review of his records, the Representative stated that the records remained at the facility. The Team requested copies of the recipient's Treatment Plan Reviews (TPRs) from 02/01/10 to 5/30/10, Restraint Records for February and March 2010, and progress notes pertinent to any restraint. The Representative stated that copies of the information would be obtained and sent via mail to the Authority. The Authority received and reviewed the information that is listed in this report.

II: Clinical Chart Review:

A...TPRs:

Documentation in a 02/09/10 TPR indicated that the recipient was admitted to the facility from a less restrictive state-operated mental health facility. According to the TPR, the recipient was found UST on 11/02/09 for Criminal Trespass to Land. On 12/09/09, he was sent from a county jail to a state-operated mental health facility. Due to his aggressive behaviors at the

facility, he was transferred on 01/22/10 to the more restrictive setting of Chester Mental Health Center.

The recipient's diagnoses were listed as follows: AXIS I: Schizophrenia, Paranoid Type, Cannabis Abuse, Alcohol Abuse; AXIS II: Deferred; AXIS III: No Diagnosis, and AXIS IV: Legal Problems, Chronic Mental Illness.

The recipient's problem areas were listed as: 1) Unfit to Stand Trial; 2) Psychosis, and Elopement. His strengths were listed as: 1) Family support; 2) Able to complete Activities of Daily Living; 3) High school graduate; 4) Compliant with treatment; 5) Articulate; 6) Average intelligence; and 7) Good health.

When the recipient was informed of the circumstances under which the law permits the used of emergency forced medication, restraints or seclusion, emergency medication was the only preference that he listed.

The recipient's 02/09/10 TPR contained the following goals: 1) To restore to a level of fitness to stand trial by 11/20/10; 2) to reduce psychotic symptoms by 11/20/10; and 3) To refrain from attempted escape while hospitalized at Chester Mental Health Center with a target date of 04/10.

Documentation in the recipient's 03/03/10 TPR indicated that the recipient's preferred emergency intervention was medication; however he became physically violent on 02/27/10 and required restraints.

According to documentation in the Extent To Which Benefitting From Treatment Section of the 03/03/10 TPR, the recipient had made no attempts to escape. The record indicated that he continued to have auditory and visual hallucinations, and maintained poor insight into his mental illness. On 02/15/10 Zyprexa was discontinued due to a poor response and Geodon was started. However, since the change in medication the record indicated that the recipient had shown even more psychiatric decomposition, including more agitated and threatening behaviors. During the 03/03/10 TPR meeting, a decision was made to discontinue the Geodon and Celexa and restart the Zyprexa at the maximum dosage.

Documentation in the recipient's 04/06/10 TPR indicated that when the recipient came to the meeting he was cooperative and participated in the treatment plan process. The record indicated that the recipient denied any auditory or visual hallucination; however he expressed that some anxiety remained. During the meeting he requested to be referred to ceramic and art therapy classes at the facility.

According to the 04/06/10 TPR, a facility psychiatrist stated that the recipient was medication compliant and his delusions and hallucinations have receded. Documentation indicated that the recipient was making good progress toward becoming fit for trial.

Documentation in the recipient's 05/04/10 TPR indicated that the recipient participated and was cooperative during the treatment team meeting. The record indicated that the treatment

team was in agreement that the recipient had met the criteria to return to the court as fit due to his great improvement during the previous month.

B... Restraint Records:

1)....Restraint 1

Documentation in a 02/27/10 Order for Physical Hold indicated that the recipient had been calling the town police saying that he was being held hostage. When staff requested that he cease the calls, he became agitated, threw a chair at staff, and came out of his room kicking at the staff members. The record indicated that he was placed in a physical hold at 4:40 PM and released from the hold and placed in restraints at 4:45 PM.

The recipient was given a Restriction of Rights Notice (Notice) relevant to the 5 minute hold. Documentation indicated that the recipient's preferred emergency intervention was not used because of the recipient's high degree of agitation and aggressive behaviors. The record indicated that the Notice was delivered to the recipient in person, and he expressed that he did not wish to have anyone notified of the hold.

An Order for Restraint was issued at 4:45 PM after the physical hold that was utilized was not effective, and the recipient continued his aggressive behaviors. Documentation indicated that attempts at redirection to a new task had failed to defuse the recipient's aggressive behaviors.

The release criteria were listed as follows: 1) The recipient must be calm, cooperative, non-threatening, and non-argumentative; and 2) He must be able to relate the circumstances leading to the restraints; 3) He must refrain from making threats toward staff and others; and 4) he must be able to verbalize appropriate actions and behaviors upon release. The recipient must exhibit the listed behaviors for a period of 60 minutes prior to release.

An RN signed the Order at 4:45 PM and documented that she had personally examined the recipient and had determined that the restraint did not pose undue risk to the individual's health. A facility physician recorded that he had examined the recipient at 5 PM and that he concurred with the RN's assessment. When the recipient's aggressive behaviors continued a second Order was issued at 8:45 PM. Documentation indicated that an RN and a facility physician examined the recipient when the second Order was implemented and determined that the restraints did not pose a threat to the recipient's condition.

Documentation in the Restraint/Seclusion Flow Sheets indicated that the recipient's body was completely searched after the restraints were applied. Staff determined that the restraints were properly applied; the room environment was appropriate; the recipient was properly positioned, and he was wearing appropriate clothing for the restraint. The record indicated that the recipient was informed of the reason for the restraint application and was given a Notice relevant to the restraint.

Recordings in the Flowsheets indicated that the recipient was continually observed and his behaviors recorded in fifteen minute increments. An RN checked the recipient's circulation, released his limbs, took his vital signs and assessed his mental and physical status on an hourly basis. He was offered toileting and fluids at the time of the examination. Documentation indicated that the recipient met the criteria for release on 02/27/10 at 11:45 PM; 7 hours after the restraints were applied.

A Notice was provided to the recipient pertinent to the restraint episode that began at 4:45 PM on 02/27/10 and ended at 11:45 PM on 02/27/10. Documentation indicated that the recipient's preferred emergency intervention was not used due to the level of the recipient's physically aggressive behaviors. The record indicated that the Notice was delivered to the recipient in person, and he did not wish to have anyone notified of the restraint.

The record indicated that an RN conducted a debriefing with the recipient at 11:45 PM on 02/27/10. According to the documentation, the recipient was able to identify the stressors occurring prior to the restraint and to verbalize an understating of the cause and consequences of his aggressive behaviors. He was able identify one or more methods to control his aggressive behavior, and he stated that he was aware that he could request assistance from staff prior to escalation of his anxiety. However, he stated that he did not feel that staff could have helped him to remain in control for this incident. The RN documented that the recipient was encouraged to discuss his feelings.

2)...Restraint 2:

An Order for Physical Hold was completed at 7:55 AM on 03/02/10 after the recipient walked past a STA, punched him on the cheek with a closed fist and attempted to kick him with his foot. Documentation indicated that the recipient's first choice of emergency intervention was not used due to the recipient's loss of control and the lack of time to honor his choice of medication prior to his attack on staff. The record indicated that the recipient was released from the hold at 8 AM and placed in restraints. Documentation indicated that an RN and a facility physician signed that Order at 7:55 AM. The RN documented examination of the recipient at 8 AM and recorded that the hold did not pose undue risk to the recipient's health. A facility physician recorded that he had examined the recipient at 8:30 AM and had determined that the hold had not caused any risk to the recipient's health.

The recipient was provided with a Notice for the 5 minute hold on 03/02/10. Documentation indicated that the recipient's preferred emergency intervention was not utilized because he attacked staff without any warning. According to the recordings, the Notice was delivered to the recipient in person, and he expressed that he did not want anyone notified of the hold.

When the recipient failed to cease his aggressive actions while in the hold, he was transferred to restraints. An Order for Restraint was issued at 8 AM. The criteria for release from the restraints were listed as follows: 1) The recipient must be calm, cooperative, non-threatening; 2) He must be able to verbalize the circumstance leading to the restraints; and 3) he

must verbalize appropriate actions and behaviors. These behaviors must be exhibited for a period of 60 minutes prior to release.

Documentation in the Restraint Flowsheets indicated that the recipient's body was completely searched by an RN after the restraints were applied. The RN documented the following: 1) The restraints were properly applied; 2) The room environment was appropriate; 3) The individual was wearing proper clothing; and 4) The recipient was properly positioned. The record indicated that the recipient was given a Notice and was informed of the reason for the restraint and the criteria for release.

According to documentation on the Flowsheets, the recipient was continually monitored and his behaviors recorded in fifteen minute increments. The record indicated hourly examination by an RN. The RN checked the recipient's circulation, released his limbs from the restraints and took his vital signs. The recipient's physical status was assessed and he was offered toileting and fluids when the assessment was conducted. Documentation indicated that the recipient was offered and accepted a meal at 11:45 AM. According to the record, the recipient ate 100% of the meal. He met the criteria for release at noon on 03/02/10.

The recipient was provided with a Notice for the 4 hour restraint from 8 AM to noon on 03/02/10. The Notice was delivered to the recipient in person, and he expressed that he did not wish for anyone to be notified of the restraint.

Documentation indicated that an RN conducted a post episode debriefing with the recipient at 1 PM on 03/02/10. The RN recorded that the recipient was able to verbalize an understanding of the causes and consequence of his aggressive behaviors and to identify one or more methods to control those behaviors. The recipient expressed that he could have requested assistance from staff prior to escalation of his anxiety. However, he was not able to identify the stressors occurring prior to the restraint and he did not feel that staff should have helped him to remain in control. The RN recorded that the recipient was encouraged to discuss his feelings related to the restraint.

The RN documented that the recipient did not receive any type of injury and his physical well-being and privacy needs had been addressed during the restraint episode.

C...Progress Notes:

Documentation in a 02/27/10 RN's progress note indicated that the recipient became very angry when he was directed by staff to refrain from calling the town police department telling them that he was being held hostage, and he was God. His aggressive behaviors escalated, and he threw a chair at staff. For self protection and the protection of others, he was placed in a physical hold then transferred to restraints when he continued to fight and hit at staff. The RN documented that the recipient bit his lower lip during the restraint process. The area was cleansed and the physician notified for assessment of the injury.

A STA recorded on 02/27/10 that the recipient had been calling the town police saying that he was being held hostage. When he was asked to cease calling the police, be became

agitated and attacked staff. As a result he was placed in a physical hold and then into four-point restraints.

A STA recorded in a 03/02/10 progress note that the recipient hit a STA in the face with his closed fist. A physical hold was implemented and he was escorted to the restraint room.

An RN recorded that the recipient was placed in a physical hold after striking a STA in the face with a closed fist. When he did not calm himself while in the physical hold he was placed in restraints for the safety of all.

Summary

According to the recipient, he was placed in restraints on two different occasions without a valid reason. However, documentation in the recipient's clinical chart indicated that the recipient was placed in restraints on 02/27/10 and 03/02/10 after he became physically aggressive toward staff. The record indicated that the restraints were applied for self protection and the protection of others.

Conclusion

The HRA's review indicated that the restraints were applied in accordance with the Code's mandates. Therefore, the allegation that the recipient was placed in restraints without a valid reason is unsubstantiated. No recommendations are issued.