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Egyptian Regional Human Rights Authority
Report of Findings
11-110-9002
Chester Mental Health Center
January 25, 2011

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 240 recipients. The specific allegation is as follows:

> A recipient at Chester Mental Health Center was placed in restraints without a valid reason for the application.

Statutes

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

Section 5/2-108 states, "Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized. In no event shall restraint be utilized to punish or discipline a recipient, nor is restraint to be used as a convenience for staff."

Section 5/2-201 of the Code states, "Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefore to (1) the recipient and, if the recipient is a minor or under guardianship, his parent or guardian; (2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice; (3) the facility director; (4) the Guardianship and Advocacy Commission, or the agency designated under 'An Act in relation to the protection and advocacy of rights of persons with developmental disabilities and amending the Acts therein named 'approved September 20, 1985, if either is so designated; and (5) the recipient's substitute decision maker, if

any. The professional shall be responsible for promptly recording such restriction or use of restraints or seclusion and the reason therefore in the recipient's record."

## Complaint Information

According to the complaint registered via a letter to the Egyptian Regional Human Rights Authoirity, staff members at Chester Mental Health Center came into a recipient's room on 06/07/10, attacked him, and placed him in restraints. Additional information indicated that two Security Therapy Aides (STAs) consistently harassed the recipient, and another STA inappropriately touched him during a shakedown. When the complaint was received the allegations regarding harassment and sexual abuse were immediately reported to the Illinois Department of Human Services, Office of Inspector General (OIG).

## Investigation Information

To investigate the allegation, the HRA Investigation Team (Team), consisting of two members and the HRA Coordinator (Coordinator) conducted a site visit. During the site visit, the Team spoke with a Representative from the facility's Human Rights Committee. When a request was made to speak with the recipient whose rights were alleged to have been violated, the Team was informed that the recipient had been transferred to a less restrictive state-operated mental health center and his clinical chart had accompanied him to the facility.

After the site visit was conducted, the Coordinator contacted the recipient by mail regarding the allegation and to inform him that his written consent would be required before an investigation could be conducted. The recipient provided the required written authorization. The records were requested and received from the facility where the recipient presently resides.

The Authority reviewed copies of information from the recipient's clinical chart, Chester Mental Health Center's Facility Policy and Illinois Department of Human Services Program Directive pertinent to restraint, and an OIG report relevant to the complaint.

### I: Interviews:

### A: Representative:

During the site visit, the Representative stated that the facility abides by the Code's requirements when it is necessary to apply restraints to ensure the recipient's or others' safety. The Representative informed the Team that the recipient whose rights were alleged to have been violated had been transferred to a less restrictive state-operated mental health facility, and he provided the name of the receiving facility.

### B. Recipient:

During the site visit, the HRA Investigation Team was not able to interview the recipient; nor was the Coordinator able to speak with the recipient via telephone regarding the allegation. However, the recipient's written communication confirmed that he had allegedly been inappropriately placed in restraints on 06/07/10 after staff members entered his room and attacked him. The recipient denied any aggressive actions toward others or any actions or threats of self harm.

II: Clinical Chart Review:

A: Treatment Plan Review (TPR):

According to documentation in a 07/13/10 TPR, the 24 year old recipient was admitted to the facility on 02/19/10 from a less restrictive mental health center. The transfer to Chester Mental Health Center was implemented after the recipient became aggressive with staff and peers. The record indicated that the recipient was living in the community prior to his admission to the transferring facility on 02/07/10.

The recipient's diagnoses were listed as follows: AXIS I: Schizoaffective Disorder, Bipolar Type; History of Cannabis Abuse; AXIS II: No Diagnosis: AXIS II: History of Gastritis/Esophagitis; Exogenous obesity; AXIS IV: UST status; Confinement: Family Discord.

Documentation indicated that the recipient's current medications were listed as follows: 1) Carbamazepine 200 mg TID (three times daily) for mood stabilization; 2) Quetiapine 400 mg BID (twice daily) ; and 3) Divalproex NA ER 15000 mg every HS (at bedtime).

The recipient's problems were listed as: 1) psychotic symptoms, delusions; 2) obesity; 3) aggression; and 4) non-compliance with medication. The TPR contained goals and objectives to address all of the problem areas.

A goal for the recipient to reduce psychotic symptoms, which consist of auditory hallucinations, paranoia, prosecutory thinking, and unstable mood, was incorporated in the plan to assist the recipient in dealing with the issue. Taking medications as prescribed and no longer displaying speech or behaviors indicative of hallucinations, paranoia, prosecutory thinking, irritable mood, talking or laughing to self, and talking to unseen objects were listed as objectives to reach the goal. The target date was recorded as 12/30/10.

The TPR contained a goal for the recipient to slowly lose weight and stabilize his weight within the IBW (Ideal Body Weight), set by a nutritional screening. The recipient was placed on a regular diet with NCS (No Concentrated Sweets) in the commissary. Nursing staff would

ensure that the dietary recommendations were reviewed by the doctor and the orders for the diet followed. Additionally, nursing staff were assigned to educate the recipient on the complications of obesity. Activity therapy staff were to encourage the recipient to attend and participate in various activities in order to assist with weight control.

A goal for the recipient to be free of displaying aggressive behaviors toward others by 07/30/10 was incorporated in the plan to deal with the recipient's problem of aggression. Objectives were listed as follows: 1) The psychiatrist would prescribe the medications and report the effects on recipient; 2) Nursing staff would administer the medications, as well as encourage and monitor compliance. 3) In a one-to-one setting the recipient's therapist would discuss the issues related to his mental illness; and 4) Attendance in activity therapy to increase motivation, energy, interests, pleasure and quality of life. The record indicated that the recipient had many instances of documented maladaptive behaviors. He was placed in restraints on 06/07/10 and had experienced several verbal altercations during the reporting period. Documentation indicated that at the time of the TPR meeting, the recipient was on the Red Level, the lowest level of participation and allowable activities within the facility's level system.

A psychiatrist and the nursing staff were assigned to educate the recipient about his diagnosis, the risks and benefits of medications and side effects in order that his understanding and compliance might be increased.

In the Extent to Which Benefitting from Treatment Section of the TPR documentation indicated that the recipient had improved. He was less angry and threatening. However, his transfer to a less restrictive setting had been "placed on hold".

The recipient listed his preferred emergency intervention in order of preference: 1) Medication; 2) Seclusion; and 3) Restraints.

B: Restraint Records:

An Order for Physical Hold was implemented at 7:10 AM when the recipient exited his room swinging at STAs. Documentation indicated that the recipient was enraged and combative. The record indicated that the recipient was released from the hold at 7:15 AM. A Registered Nurse (RN) documented that she had personally examined the recipient at 7:10 AM, and it was her assessment that such application did not pose undue risk to the recipient.

A Notice Regarding Restricted Rights of Individual (Restriction Notice) was given to the recipient at 7:10 AM pertinent to the physical hold. Documentation indicated that the recipient was placed in the hold due to his attack on staff as soon as the door to his room was opened. The record indicated that the Restriction Notice was delivered to the recipient in person, and he did not wish to have anyone notified of the hold. The record indicated that he was placed in restraints after he was released from the hold.

An Order for Restraint was implemented at 7:15 AM on 06/07/10 after the recipient failed to calm down while in the physical hold. Documentation indicated that the recipient was yelling, screaming and banging on his door when staff entered his room. The recipient was

asked to step back from the door and have a seat on his bed while staff unlocked the door. When the door was unlocked, the record indicated that the recipient came out of the room and "viciously"attacked staff. He was placed in a physical hold; however, he failed to gain composure and was placed in restraints for the safety of all. According to the documentation, numerous attempts at redirection to a new task, empathic listening, distraction, verbal support and reassurance failed to assist the recipient in gaining control. Documentation indicated that an RN personally examined the recipient at 7:25 AM and determined that the restraint application did not pose undue risk to the recipient's health. A facility physician examined the recipient at 7:40 AM and documented that it was his assessment that the restraint did not pose a risk to the recipient's health.

The Release Criteria were listed as follows: 1) The recipient must be able to calmly discuss the incident that led to the restraint application; 2) He must no longer have tense, clenching fists; 3) He must not pull on the restraints; and 4) He must cease his angry actions. These criteria must be exhibited for a period of 60 minutes before release is implemented.

According to the record, the recipient failed to meet the release criteria when the initial Restraint Order expired at 11:15 AM; therefore a second Order was issued. The record indicated that an RN and a facility physician examined the recipient at 11:15 AM. Both professionals indicated that the continued restraint application did not pose any undue risk to the recipient's health.

The record indicated that a third Restraint Order was issued at 3:15 PM on 06/07/10. An RN and a physician examined the recipient at 3:15 PM when the second Restraint Order was issued. Both staff members indicated that the restraint application did not pose any undue risk to the recipient's health. The record indicated that the recipient met the criteria for release at 5:15 PM, 2 hours after the third Restraint Order was issued.

Documentation in the Restraint/Seclusion Flowsheets indicated that a body search was completed after the restraints were applied. An RN determined that the restraints were properly applied, the recipient was properly positioned, and he was wearing proper clothing for the restraint application. The RN also determined that the room environment was appropriate. Documentation indicated that the recipient was informed of the reason for the restraint application and the criteria for release. He was provided with a Restriction Notice pertinent the restraint. Additional recordings indicated that an RN checked the recipient's circulation, assessed his vital signs, and released his limbs on an hourly basis during the entire restraint process. He was offered toileting and fluids and his mental and physical status were evaluated when the examinations were conducted. He was provided with meals at 12:15 PM and 4:30 PM.

Documentation indicated that the recipient was given a Restriction Notice for the restraint that commenced at 7:15 AM and ended at 5:15 PM. According to the record, the recipient's preferred emergency intervention was not implemented due to the level of his aggressive actions toward staff members. The record indicated that the Restriction Notice was delivered to the recipient in person, and he did not wish to have anyone notified of the restraint.

An RN conducted a Post-Episode Debriefing at 5:15 PM on 06/07/10. During the debriefing the recipient was able to identify the stressors occurring prior to the restraint, and he was able to verbalize an understanding of the causes and consequences of his aggressive behaviors. He was also able to identify methods to control his behavior and was aware that he could request help from staff prior to the escalation of his anxiety. He was encouraged to discuss his feelings regarding the restraint. The following was determined: 1) He did not receive any physical injury during the restraint; 2) His physical well-being was addressed; and 3) His privacy needs were addressed.

C: Progress Notes:

An RN recorded in a Progress Note at 7:10 AM on 06/07/10 that the recipient was banging on his door, yelling and cursing. He was asked to back away from the door and have a seat on his bed; however, when the door was opened he came out of his room and attacked staff members. When he was placed in a physical hold, his aggressive actions continued; therefore, he was placed in restraints for the safety of all. The RN documented that a physician was notified and signed the Order for Restraint. Additional documentation indicated that the RN determined that the restraints were properly applied and the recipient's circulation was good in all four extremities.

In 11:15 AM Progress Notes, the physician, RN and a STA recorded that the recipient remained verbally aggressive, delusional and angry. He was issuing threats to retaliate against staff members who placed him the restraints. All recordings indicated that the physician had determined the continued need for the restraints.

Documentation in a 7:40 AM Psychiatry Progress Note recorded on 06/07/10 indicated that the recipient had been placed in restraints because he was yelling, cursing, banging on his door in a threatening manner, and when the STAs opened the door the recipient attacked them. The Psychiatrist documented that the recipient continued to be very angry; however, he denied his anger and stated, "I was singing, I am a DJ."

According to documentation in a 06/07/10 Progress Note completed at 5:15 PM, an RN recorded that the recipient was calm and cooperative. He was able to discuss the prior incident without displaying any aggressive actions. The RN documented that the recipient had met the release criteria and was freed from the restraints.

III: Facility Policy and Program/Policy Directives

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 others 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 of 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, or 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 may 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 destruction 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 interventions for both patients and staff;
2. the implementation of staff training based upon 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."

IV OIG Investigative Report (Report):

According to a 08/09/10 Report, the OIG received an allegation of abuse regarding an incident that occurred on 06/07/10. Documentation indicated that it was alleged that a recipient was inappropriately touched in a sexual manner by a STA during a shake down in the facility's gymnasium, and he had been constantly harassed by two additional STAs.

The record indicated that the recipient informed the OIG Investigator that during a shakedown search of his person, he was touched inappropriately. However, when the recipient

described the body pat down, it was a textbook description of an appropriate body pat down as described in the facility's procedure.

According to the report, the recipient stated that two STAs had harassed him; however, he could not provide any specific incident or manner in which the harassment had occurred, other than stating that he believed that the STAs did not treat him in a respectful manner.

Documentation indicated that the STA denied inappropriately touching the recipient during a body search, and the STAs accused of harassing the recipient also denied the charges.

The allegation of sexual abuse against the STA accused of sexual abuse was unfounded, and the allegation of mental abuse against the two additional STAs was also considered unfounded.

## Summary

According to the complaint, a recipient at Chester Mental Health Center was inappropriately placed in restraints. However, consistent documentation reviewed by the Authority indicated that the recipient was placed in restraints after he attacked staff members. Additional documentation indicated that facility staff adhered to the Code requirements, as well as, facility policy and program directives during the restraint episode. Therefore, the allegation that a recipient was placed in restraints without a valid reason for the application is unsubstantiated. No recommendations or suggestions are issued.