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Egyptian Regional Human Rights Authority
Report of Findings
11-110-9010
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 inappropriately placed in restraints.

Statutes

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

## Investigation Information

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 Representative (Representative) from the facility's Human Rights Committee and the recipient whose rights were alleged to have been violated. The Coordinator spoke via telephone with an Illinois Department of Human Services, Office of Inspector General (OIG) Investigator (Investigator) regarding an allegation of abuse associated with the restraint episode.

With the recipient's written authorization, copies of records pertinent to the restraint were obtained and reviewed by the Authority. The Authority also reviewed copies of the facility's Restraint Policy and the Illinois Department of Human Services Program Directive pertinent to restraint.

### I... Interviews:

### A...Recipient:

The Recipient whose rights were alleged to have been violated informed the Team that he was transferred from a county jail in June 2010 to Chester Mental Health Center after being found Unfit to Stand Trial. According to the recipient, shortly after he arrived at the facility he was placed in restraints without a valid reason for the application. The recipient denied any type of self abuse or aggressive actions toward staff or peers. He stated that staff members involved in the restraint abused him during the application. The recipient informed the Team that the abuse was reported to the OIG and an OIG Representative came to speak with him regarding the allegation.

### B: Representative:

The Representative informed the Team that the facility adheres to the Code's requirements pertinent to restraint application. The Representative stated that restraints are only applied as a measure to protect a recipient from self-abuse or causing physical harm to others.

### C: OIG Investigator:

According to the Investigator, a report was made to the OIG regarding the recipient being physically abused during a 07/07/10 restraint episode. The Investigator stated that it was alleged that the recipient was hit and stabbed by staff members during the process. However, when the investigation was conducted, the recipient reported that the abuse had occurred while he was in jail rather than during the 07/07/10 restraint. The Investigator stated that the allegation that staff members physically abused the recipient was determined to be unfounded. No recommendations or suggestions were issued relevant to the incident.

II: Clinical Chart Review:

A...Treatment Plan Reviews (TPRs)

Documentation in a 06/25/10 initial TPR indicated that the recipient was found Unfit to Stand Trial (UST) on 06/22/10 and transferred to Chester Mental Health Center on 06/25/10. According to documentation, the recipient had deteriorated emotionally as well as physically while incarcerated. He had suffered from dehydration, severe delusions, visual and auditory hallucinations, and extreme mood swings while incarcerated.

The recipient's strengths were listed as follows: 1) articulate, 2) able to complete ADLs, and 3) good health. His legal status of being found UST was listed as a problem area.

The recipient's diagnoses were listed as follows: 1) AXIS I: Schizophrenia, H/O (History of) Alcohol Dependence; AXIS II: None, AXIS III: None; and AXIS IV: UST, Chronic Mental Health Problems.

The record indicated that when the recipient was admitted to the facility 10 mg Aripiprazole, an atypical antipsychotic medication, was administered every AM. Documentation indicated that the risks and benefits of the medication were discussed with the recipient, and he provided written authorization for the administration.

A goal for the recipient to be restored to a level of fitness to stand trial by 12/20/10 was incorporated in the recipient's initial TPR.

Documentation in the Extent to Which Benefitting From Treatment Section of the TPR indicated that the recipient was cooperative with the initial interview. He signed consent for medication and indicated his emergency preferences. The record indicated that the recipient stated that he hears voices, but did not elaborate on the content. When he was asked why he was sent to the facility, he reasoned, "I'm here to get help for my illness."

In accordance with the Code, the recipient was informed of the circumstances under which the law permits the use of emergency forced medications, restraints or seclusion. Should any of these circumstances arise, the recipient stated the following forms of emergency interventions in the order of preference: 1) emergency medication(s) 2) seclusion; 3) restraints.

Documentation indicated that it was explained to the recipient that his preference of seclusion may not be an option due to his history of self-injurious behaviors.

Documentation in a 07/13/10 indicated that the recipient's medication, Aripiprazole had been increased to 20 mg every AM to assist the recipient with the psychosis. The record indicated that the recipient had resisted redirection, been verbally abusive to peers and staff, destroyed property and threatened self abuse prior to the increase.

According to documentation in a 08/03/10 TPR, the recipient's problem area continued to be his UST status. The record indicated that the recipient's therapist would determine what was needed in order for the recipient to achieve fitness. The recipient would be enrolled in a fitness class and a social worker would give him a court procedure pre-test.

An activity therapist recorded that the recipient participates in on unit programming on a regular basis and always seemed interested in doing something. The record indicated that the recipient has also attended off the unit activities and his attendance had increased steadily throughout the reporting period. The Activity Therapist recorded that the recipient had made good progress towards his class goals.

Documentation in the 08/03/10 TPR listed the criteria for the recipient to be recommended to return to the county court for a fitness assessment as follows: 1) He must be able to communicate with counsel and assist in his own defense: 2) He must be able to appreciate his presence in relation to time, place and things; 3) He must be able to understand that he is in a court of justice charged with a criminal offense; 4) He must show an understanding of his charges and their consequences, as well as, court procedure and the roles of the judge, jury, prosecutor, and defense attorney; 5) He must have sufficient memory to relate the circumstances surrounding the alleged criminal offense, and 6) He must demonstrate that there has been a significant reduction in his aggressive behaviors.

According to documentation in a 09/08/10 TPR the recipient's overall behavior was favorable and without incident during the reporting period. However, at present, the treatment team believed that the recipient was currently unfit, but with treatment he would likely achieve fitness within one year from the original date of determination of his unfitness.

B... Restraint Records:

Documentation in an Order for Physical Hold issued at 5:25 PM on 07/07/10 indicated that the recipient called the control room saying he was being beat by staff. The record indicated that the control room staff contacted staff on the unit where the recipient resided. According to the documentation, when unit staff went to speak the recipient, he took of his shirt and starting swinging and fighting at the staff members. Documentation indicated that the recipient was placed in a five minute hold, then transferred into restraints when the recipient continued the aggressive behaviors.

Documentation indicated that a Registered Nurse (RN) examined the recipient at 5:25 PM on 07/07/10 when the hold was applied. The RN recorded that it was his assessment that the application did not pose an undue risk to the recipient's health. The record indicated that a facility physician examined the recipient at 6 PM and had determined that the application had not caused harm to the recipient.

The record indicated that the recipient was given a Restriction Notice (Notice) pertinent to the 5 minute hold. The reason for the restriction was listed as a hold was instituted to protect the recipient from himself and to protect others from the immediate risk of harm. Documentation indicated that the Notice was delivered in person, and the recipient did not wish to have anyone notified of the restriction.

According to a 07/07/10 Restraint Order issued at 5:30 PM, the recipient had called the Code Blue Line and when staff confronted him, he ripped his shirt off and attempted to strike staff with a closed fist. The record indicated that redirection to a new task, verbal supports, conflict resolution and emergency medication did not assist the recipient in regaining composure.

The release criteria were listed as follows: 1) The recipient must be calm and cooperative; 2) He must refrain from crying; 3) He must be absent of violent thrashing on his bed; and 4) He must be able to voice an appropriate plan for dealing with his anger without resorting to violence. These behaviors must be exhibited for a period of 60 minutes prior to release.

The record indicated that an RN examined the recipient at 5:30 PM and determined that the restraint application did not pose an undue risk to the recipient's health. A facility physician examined the recipient at 6 PM and also assessed that the restraint did not cause harm to the recipient's health.

Documentation in Restraint/Seclusion Flowsheets (Flowsheets) indicated that the recipient was continually observed during the restraint application. His behaviors were accessed and recorded in 15 minute increments. Recordings indicated that an RN examined the recipient on an hourly basis by checking his circulation, releasing his limbs, taking vital signs and assessing his physical status. During the assessment he was offered toileting and fluids.

Documentation indicated that the RN completed a body search after the restraints were applied. Post application the RN determined the following; 1) The restraints were properly applied; 2) The room environment was appropriate; 3) The recipient was wearing proper clothing; and 4) He was properly positioned. The RN documented that the recipient was informed of the reason for the restraint and the criteria for release, and he was given a Notice pertinent to the restraint.

According to the record, the recipient met the release criteria at 9:30 PM on 07/07/10, four hours after the restraints were applied.

Documentation indicated that an RN conducted a debriefing with the recipient when he was released from the restraints at 9:30 PM. The RN recorded that the recipient was able to identify the stressors occurring prior to the restraint and to verbalize an understanding of the

cause and consequences of his behaviors. The recipient stated that he was aware that he could request help from staff prior to escalation of anxiety; however, he did not feel that staff could have assisted him in remaining in control with this particular problem. The RN documented that the recipient was encouraged to discuss his feelings related to the restraint. Upon examination, the RN determined that no physical injury had occurred during the event, and the recipient's physical well-being and privacy needs had been addressed.

A Notice was given to the recipient relevant to the 4 hour restraint which began at 5:30 PM and ended at 9:30 PM on 07/07/10. An immediate risk of harm to self and others was listed as the reason for the restraint. Documentation indicated that the recipient's preferred intervention was utilized; however, the intervention failed. According to the record, the Notice was delivered to the recipient in person, and he expressed that he did not wish to have anyone notified of the restraint.

C... Progress Notes:

Documentation in an RN's Progress Note on 07/07/10 at 5:25 PM indicated that the recipient called the "Code Blue Line". When staff confronted him, he ripped off his shirt and attempted to strike them with a closed fist. A physical hold was initiated and when he continued to "violently struggle" restraint application was necessary. The RN recorded that the physical hold did not pose an undue health concern.

An STA recorded in a 5:30 PM Progress Note on 07/07/10 that the recipient called the control room requesting assistance. When staff went to his room to speak with him he removed his shirt and started swinging and fighting staff. The STA recorded that the recipient was placed in a physical hold at 5:25 PM and placed in restraint at 5:30 PM. Documentation indicated that there were no apparent injuries to the recipient or staff members involved in the incident.

In a 5:30 PM Progress Note, an RN documented that the restraints were properly placed, body alignment was correct, linen was on his bed, and a urinal was placed at the recipient's bedside. Additionally, the recipient was given Notices for the physical hold and the restraint. The RN recorded that the recipient denied having any injury associated with the restraint and none was noted. The RN recorded that the PRN given prior to the restraint was ineffective.

An RN recorded at 8:30 PM that the recipient was "a little calmer". In a 9:30 PM Progress Note, the RN documented that the recipient was calm, cooperative, and he was able to voice a plan for dealing with his anger without resorting to violence. Additionally, he voiced no intention of self-harm. According to the documentation, the recipient met the criteria for release.

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 or 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."

Summary

According to the complaint, a recipient at Chester Mental Health Center was inappropriately placed in restraints. When the Team spoke with the recipient, he stated that shortly after he was admitted to the facility, staff members placed him in restraints without his

displaying any self abusive or aggressive action. He informed the Team that the staff abused him during the restraint episode, and their actions had been reported to the OIG. When the Coordinator spoke with an OIG Investigator, the Investigator stated that the recipient had informed the OIG that the abuse had occurred while by he was in jail rather than at the facility. The Investigator indicated that the allegations were unfounded and no recommendations or suggestions were issued. According to the Representative, facility staff only apply restraints in accordance with the Code and facility Policy/Directives requirements. Consistent documentation reviewed by the HRA indicated that the restraints were applied after the recipient attacked staff and a physical hold failed to deescalate the recipient's aggressive behaviors. The record indicated that the restraints were applied to protect the recipient from self-harm, as well as harm to others.

## Conclusion

Based on information obtained during the course of the investigation, the Authority has determined that the facility followed the Code, facility Policy, and DHS Directives pertinent to the restraint application. Therefore, the allegation that the recipient was inappropriately placed in restraints is unsubstantiated. No Recommendations or suggestions are issued.