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Egyptian Regional Human Rights Authority
Report of Findings
11-110-9026
Chester Mental Health Center
May 26, 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 5/2-200).

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 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, 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 therefor 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 recipient whose rights were alleged to have been violated and the Chairman (Chairman) of the facility's Human Rights Committee. With the recipient's written authorization, copies of pertinent information in the recipient's clinical chart were provided to the HRA for review. The Authority also reviewed the facility's restraint policy (Policy), and an Illinois Department of Human Services (DHS) Program Directive (Directive).

I: Interviews:

A... Recipient:

When the Team spoke with the recipient whose rights were alleged to have been violated, he informed the Team that he had been restraint free for eleven months, and he had not required seclusion for over nine months. However, staff placed him in restraints on 01/04/11 after he expressed concern about some commissary items. The recipient informed the Team that the restraint application was unjustified since he was not involved in any type of self abuse or attempts to cause harm to other recipients or staff members.

B...Chairman:

The Chairman stated that the facility adheres to the Code requirements regarding restraint usage. He stated that recipients are only placed in restraints for self protection or the protection of others and are not utilized for staff members' convenience. The Chairman informed the Team that the facility's Policy and DHS Directive pertinent to restraint use are in accordance with the Code requirements.

II: Clinical Chart Review:

A...Treatment Plan Reviews (TPRs):

Documentation in a 12/02/10 TPR indicated that the recipient was admitted to the facility on 07/22/09 as a transfer from another state-operated mental health facility. The transfer to the more restrictive setting was implemented due to the recipient's aggressive behaviors. The record indicated that the recipient had numerous psychiatric hospitalizations with two prior admissions to Chester Mental Health Center.

According to documentation during the TPR reporting period, the recipient had one episode of aggressive behaviors on 11/11/10 when he participated in a verbal altercation with a peer in the dining room. The record indicated that the recipient responded to redirection, returned to the unit, and did not require restraint application or placement in seclusion. According to documentation, the recipient received two additional Behavioral Data Reports (BDRs) for the reporting period. On 11/09/10 he became agitated over commissary issues and cursed at staff, and on 11/10/10 he was disruptive during medication administration.

The recipient's diagnoses were listed as follows: AXIS I: Bipolar Disorder, most recent episode manic, History of Poly-Substance Dependence; AXIS II: Anti-Social Personality Disorder by History; AXIS III: Reported History of Petit Mal Seizures, GERD (Gastroesophageal Reflux Disease); AXIS IV: Lack of primary support system, Problem with medication compliance, Confinement. Additional documentation indicated that the recipient has a history of head injuries related to a fall from a second story window when he was three years old and a car accident as an adult.

The recipient's medications were listed as follows: Valproic Acid 500 mg AM and 1500 mg HS (at bedtime) for mood stabilization; Olanzapine 20 mg HS for mood stabilization; Alprazolam 1 mg TID (three times daily) for anxiety. PRN (as needed) Haloperidol 5 mg IM (Intermuscular) every 4 hours for severe agitation; and Lorazepam 2 mg IM every 4 hours for severe agitation.

The recipient's strengths were listed as follows: 1) He is familiar with rules/procedures at the facility; 2) He is in relatively good health; 3) He is capable of completing ADLs (Activities of Daily Living) independently. His problem areas were listed as follows: 1) Non-Compliance with medication; 2) Mood Disorder; 3) Aggression and 4) GERD.

The recipient's 12/02/10 TPR contained individualized treatment goals to address each of his problem areas. Documentation indicated that the recipient had shown progress toward the goal of taking medication as prescribed for psychiatric and medical issues. A facility psychiatrist documented that he had not observed the recipient having any signs of depression and mania; however his mood swings and low frustration tolerance continued. The record indicated that the recipient had not required restraints; however, he had displayed verbally aggressive behavior on 11/11/10. According to documentation the recipient had participated in two sessions of medication education pertinent to the GERD diagnosis.

The record indicated that the recipient was informed of the circumstances under which the law permits the use of emergency forced medication, restraint or seclusion. Should any of the circumstances arise, the recipient listed the following forms of interventions in the order of his preference: 1) medication; 2) seclusion; and 3) restraints.

Documentation in a 12/30/10 TPR indicated that the recipient had exhibited the following maladaptive behaviors during the reporting period: 1) loud/disruptive behaviors at medication time on 12/15/10; 2) congratulated a peer for hitting a staff member on 12/15/10; 3) loud/non-cooperative behaviors in the dining room on 12/24/10; and 4) verbal aggressive outburst related to commissary issues on 12/28/10. There was no documentation to indicate that the recipient required restraints for any of the listed behaviors.

Documentation in a 01/27/11 TPR indicated that the recipient had exhibited physically aggressive behaviors and property destruction during the reporting period. On 01/04/11, he became agitated regarding commissary issues and attempted to choke a staff member. The level of aggression was so severe that the recipient was placed in restraints. On 01/24/11, the recipient attacked a peer who teased him about a commissary item. However, restraint application was not necessary to defuse the situation. On 01/25/11, the recipient became upset about commissary

issues and threw water on the module's television set. The recipient's actions resulted in the facility having to replace the television. The record indicated that on 01/26/11, the recipient once again became agitated about commissary issues and verbally threatened to kill staff members. He was placed in seclusion for the safety of all. Documentation indicated that during the reporting period the recipient had received thirteen BDRs.

The record indicated that commissary issues were recognized as a behavioral trigger and a constant source of agitation for the recipient. The recipient believes that he has money in his trust fund when, in reality, he does not. According to the documentation, the recipient accuses staff of stealing his commissary items and using the commissary to humiliate him. For example, the recipient stated "The staff all laugh at me when my commissary isn't there". Documentation indicated that reasoning with the recipient and showing him his trust fund balance are not effective due to the effects of the traumatic brain injuries.

The STA report in the 01/27/11 TPR indicated that the recipient argues every day about something. The Nursing report indicated that the recipient had periodically refused medication as retaliation over the commissary issues. The Unit Director recorded that he had attempted to review with the recipient the fact that the treatment team had wanted to transfer him to a less restrictive setting but could not due to his aggressive behaviors. The Unit Director stated that the recipient laughed and stated, "I don't want to hear it. You all lie. You are all liars."

B...Progress Notes

Documentation in a 01/04/11 Progress Note indicated that the recipient lunged at a STA and grabbed him around the neck over a commissary issue. He was placed in restraints for the safety of other recipients and staff members.

An additional 01/04/11 Progress Note recorded by a Registered Nurse (RN) at 9:45 AM indicated that the recipient had increased agitation over commissary items. He began yelling loudly and proceeded to attack a staff member. Due to the attack on staff he was placed in a physical hold and then into restraints for the safety of all.

C...Restraint Records:

Documentation indicated that an Order for Physical Hold was implemented at 9:40 AM on 01/04/11 after the recipient became agitated over commissary items. According to the documentation, the recipient requested medication to assist him to calm himself; however, as he started toward the nurses station to receive the medication he attacked a staff member. The record indicated that the recipient was placed in a physical hold to stop his attack, but while in the hold he refused to "calm down" According to documentation, the recipient continued to threaten and curse at staff.

The record indicated that an RN and physician examined the recipient at 9:40 AM. Both professionals documented that it was their assessment that the hold did not pose an undue risk to the recipient's health. The record indicated that the recipient was released from the hold at 9:45 AM and placed in restraints.

Documentation in a 9:45 AM Restraint Order on 01/04/11 indicated that the recipient became irate over commissary issues. When a STA attempted to redirect the recipient, the recipient lunged at the STA and grabbed him around the throat. Documentation in the Order indicated that the recipient had not responded to reassurance and redirection. He became increasingly loud, threatening, lunged at the STA, grabbed the STA around the throat, and attempted to choke him. The record indicated that the Order was issued for up to 4 hours with hourly reviews to allow the recipient time to gain control of his behavior.

The release criteria were listed as follows: 1) Recipient will verbalize an understanding of the reason for his being placed in restraints; 2) He will calmly verbalize an understanding of the commissary procedures; 3) He will not exhibit yelling, cursing, or threaten to harm others. The criteria must be met for a period of one hour before release is implemented.

The record indicated that an RN and a physician had personally examined the recipient at 9:45 AM. Both professionals assessed that the restraint application did not pose an undue risk to the recipient's health and signed the Order verifying their examination.

The record indicated that after the restraints were applied, the recipient's body was completely searched. An RN examined the recipient and determined the following: 1) The restraints were properly applied; 2) He was properly positioned; and 3) He was wearing proper clothing. The RN documented that the room environment was appropriate for the restraint. The recipient was informed of the reason for the restraint, the criteria for release, and provided with a Restriction of Rights Notice.

Documentation in the Restraint Flowsheets indicated that the recipient was continually observed during the entire restraint process, and his behaviors recorded in 15-minute increments. The record indicated that during the restraint episode an RN checked the recipient's circulation in all four extremities, released his limbs, checked his vital signs, assessed his physical status, and offered toileting and fluids on an hourly basis. He was provided with a meal at 11:30 AM.

Documentation indicated that the recipient met the release criteria at 1:45 PM on 01/04/11. Upon release from the restraints, the RN conducted a Post-Episode Debriefing with the recipient. The RN recorded that no psychological difficulties, physical problems or ill effects were noted after the recipient's release from the restraints. The stressors precipitating the aggressive behaviors were listed as the recipient was concerned over commissary items, moved close to the stem door and did not follow requests to move away. Documentation indicated that in the future staff members should watch for early warning signs, which include the recipient exhibiting pressure, rapid speech and ignoring STAs requests. Approaching the recipient in a calm manner and speaking in slow, specific terms and redirections were identified as actions to de-escalate and calm the recipient.

Restrictions of Rights Notices were issued for the Hold from 9:40 AM to 9:45 AM on 01/04/11 and the Restraint application which from 9:45 AM to 1:45 PM. Documentation indicated that the recipient was placed in a physical hold after he lunged at a STA and grabbed him around the throat. When the hold failed to calm the recipient he was placed in restraints to

prevent injury to self and to others. Recordings indicated that the recipient did not wish to have anyone notified of the hold or the restraint application.

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 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 reduction and eliminating restraint and seclusion may be multifaceted 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 or strategies of 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 interventions for patients and staff;
2. the implementation of staff training based upon nationally-recognized training;
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

During a site visit to the facility, the recipient whose rights were alleged to have been violated informed the Team that he was placed in restraints for no apparent reason. However, documentation in the recipient's clinical chart indicated that on 01/04/11, the recipient became agitated concerning a commissary issue, lunged at a STA, grabbed him by the neck and attempted to choke him. Due to the recipient's attack on staff, he was placed in a physical hold, and when his aggressive behaviors continued he was transferred from the hold to restraints. The HRA's review of records associated with the 01/04/11 restraint episodes revealed that the facility had adhered to the facility restraint policy, DHS Directive mandates, and the Code's requirements.

Conclusion

Based on information obtained during the course of the investigation, the allegation that the recipient was inappropriately placed in restraints is unsubstantiated. No recommendations are issued.

Comments and Suggestion:

The HRA acknowledges that recipient's belief that during commissary periods staff members are making comments that cause him stress may be a result of his disability. However, since commissary issues appear to be a consistent trigger for the recipient's agitation and maladaptive behaviors, the Authority suggests that the staff members who are in charge of the recipient's commissary period be reminded of the necessity to be extremely sensitive in word and action to the recipient's perceptions. Also, the HRA suggests that if related behavioral programming continues to be ineffective in reducing restraint episodes that the programming be reviewed for possible revisions with the recipient included in the review process.