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Egyptian Regional Human Rights Authority
Report of Findings
Case #13-110-9015
Chester Mental Health Center

The Egyptian Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning Chester Mental Health Center:

1. **A recipient was not told the type of emergency medication he was given in spite of inquiries.**

2. **Restraints were used even though the recipient did not meet the restraint criteria.**

3. **Inappropriate care is provided in that a recipient does not have sufficient clothing.**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code. Chester Mental Health Center is a state-operated mental health facility serving approximately 240 recipients; it is considered to be the most secure and restrictive state-operated mental health facility in the state.

To investigate the allegations, an HRA team interviewed a service recipient and Center staff, examined a recipient's record, with recipient consent, and reviewed pertinent facility policies.

According to the complaint a recipient was given forced medication on 10-20-12; however, the recipient was reportedly not told what type of medication was administered in spite of inquiries to nursing staff. The complaint also stated that the recipient was restrained without cause on 12-15-12. Finally, the complaint stated that the recipient does not have enough clothing in that he only has 2 sets.

FINDINGS

Interviews

The HRA team reported the concerns to the facility's human rights chair upon receiving the complaints. Subsequently, the facility conducted a file review which was documented on a form. The file review only indicated the HRA's report, the recipient's status, and a "long term special observation due to alleged phone conversation requesting a gun be smuggled into CMH. Threatened to shoot staff."

The HRA corresponded with facility administration regarding the issues pertinent to the case. The HRA was informed that nursing staff inform patients of the emergency medication being given and the reason for its administration. Restriction of rights notices are issued when administering emergency medication as per staff. For restraint use, the HRA was informed that restraints are applied when there is an imminent risk of the recipient harming himself or others. Staff reported that prescribed medication can be given to recipients while in restraints, and, there are situations in which emergency medication is administered while an individual is in restraints if there is an imminent risk of physical harm. With regard to clothing issues, staff reported that recipients are typically allowed to have six sets of clothing or more. If a recipient does not have six sets of clothing or none at all, state clothing will be supplemented so that the patient has six sets of clothing. Recipients can have no more than two pairs of shoes. The HRA inquired about the clothing situation of the recipient in this case and was informed that he had been discharged from the hospital.

Record Review

With recipient consent, the HRA examined the record of the recipient in this case. The recipient was admitted to Chester on 09-27-12 after having been found unfit to stand trial. He was previously at Chester from 12-22-11 to 03-02-12. A 21-day treatment plan was held on 10-16-12. His diagnoses include: Intermittent Explosive Disorder, Personality Disorder Not Otherwise Specified (Antisocial and Paranoid); and, history of a Head Injury. Treatment goals include restoring fitness to stand trial and eliminating aggressive behaviors. It was noted that he refused to consent to medication. In the discussion portion of the treatment plan it noted that he was placed in restraints on 10-10-12 after threatening his therapist and refusing to calm down. The notes stated that he has threatened other recipients resulting in transfers to other units and he was verbally aggressive toward a nurse during medication pass. He voiced his intention of not taking medication. The recipient participated in his treatment plan meeting.

Another treatment planning meeting was held on 11-13-12. A goal was added to address a diagnosis of Hypertension. The recipient refused medication for this condition indicating that it upset his stomach. He refused to consider any other medication.

A treatment plan dated 12-11-12 documented another incident of restraint use on 10-20-12 for "threatening behaviors toward staff." There were no new goals listed and he continued to refuse any medications.

The recipient's 01-07-13 treatment plan documented another incident of restraint application on 12-26-12. On 12-28-12, a report alleged the recipient was "overheard on the telephone to tell someone to come down with a gun and shoot staff in parking lot," which the recipient denied. This incident resulted in a unit restriction, telephone restriction and frequent observation. The treatment team discontinued the telephone restriction and frequent observation. He refused to attend the treatment plan meeting. Goals were continued and he refused medication.

The treatment plans included statements to the effect that the recipient was trying to beat charges for a crime and stated that the recipient admits to this and has indicated that he does not have a mental illness. The HRA found no treatment plan documentation about clothing concerns or questions about the administration of an emergency medication. All but one of the treatment

plans include a patient section and of those that had a patient section all were signed by the patient except for one with statements that the recipient was not agreeing to anything but his presence at the treatment planning meeting was noted. Each treatment plan included a section on the recipient's emergency treatment preferences which all state that the recipient has declined to identify any emergency treatment preferences.

Interim treatment plans were held on 10-11-12, 10-22-12 and 12-17-12. The interim plan dated 10-11-12 stated that the recipient "…required restraints on 10-10-2012 from 1015 - 1415 after making threats to harm his therapist, continued to escalate, refused to calm down." There were no changes to his treatment plan. The interim treatment plan dated 10-22-2012 stated that the recipient "…required restraints on 10-22-2012 [incorrect date?] after being placed in seclusion and began yelling and beating the wall - he was placed in restraints to prevent injury to himself - he was upset due to being told he was to sit by himself due to taking other patients food - he was placed in restraints at 1845 - give prn at 1850 and released at 2145." There were no changes in his treatment plan. The 12-17-12 interim treatment plan stated that the recipient "…required full leather restraints on 12-15-12 at 1015 after becoming focused on staff - became verbally threatening and angry with the charge aid refusing to calm down and continued to escalate - he requested to be placed in restraints. He was released at 2:15 am." There were no changes to the treatment plan after the 12-15-12 restraint episode.

The HRA examined physician's orders related to the October 20, 2012 incident as reported by the recipient. An order for a physical hold, dated 10-20-12, stated that "Pt in quiet room to calm down [after] dinner (caught giving his food away) when he started pounding wall. Pt placed in physical hold [and] placed in FLR's [full leather restraints] for his safety." The order is signed by the physician and a nurse with both indicating that they had examined the recipient. The hold began at 1840 and was released at 1845. A restriction of rights notice was issued at 1840. The restriction notice stated that the "Pt was sitting in quiet room to allow him time out of milieu to calm down [and] regain control of his behavior. While in there he began pounding the wall. Pt. counseled [and] [as needed medication] offered [without] success. He persisted. [Physical Hold] utilized for his own safety. " A separate order form for what appears to be the actual restraint indicated that it began at 18:45 although there is no end time listed. The restraint form documented that the facility attempted other interventions prior to the restraint, including redirection, empathic listening, distraction, verbal support and reassurance; however, the recipient's behavior escalated and it was noted that staff at the recipient's bedside only increased his agitation. A debriefing form indicated no psychological or physical impact from the restraints, the precipitating aggressive behaviors was "trading food in dining room, counseling about rules," the early warning signs of "talking loudly, pacing," and action to be attempted in the future PRN (as needed) medication, counseling, time out and redirection. A separate review form was also completed with the results of the review stating "Pt calm and cooperative, able to discuss reasons for FLR [and] verbalized appropriate plan of action upon release as well as intent to follow module rules [and] staff directions." The restraint flowsheet began at 1900 and appeared to have ended at 2145, with 15 minute checks being done and periodic opportunities for toileting. At the time of release, the documentation indicated that the recipient was calmer and talking rationally. A restriction of rights form was issued for the restraint that began at 1845.

Also examined were orders related to the 12-15-12 incident as reported by the recipient. A restraint order dated 12-15-12 stated that "Pt ranting raving threatening charge aid quite [sic] room offered He the [sic] escalates when get there said Fuck you put me in restraints." The order form stated that empathic listening, distraction verbal support, voluntary time out and reassurance were offered prior to restraint application but these approaches failed. A physician and nurse signed the form indicating a personal examination. The restraint began at 2230 and ended at 0230. A restraint review form stated that the recipient was argumentative and an immediate threat of harm to others. A nurse debriefing form stated that the recipient was resting quietly with no signs or symptoms of distress. Identified stressors leading to the aggression stated that the recipient was impulsive and aggressive toward authority; the rest of the debriefing form was difficult to read. The restraint flow sheet documented 15 minute checks, offers of toileting and fluids, and release upon calmer behavior. A restriction of rights form was issued at 2215 and the reason for the restraint was listed as "patients behavior places self and others at risk of harm."

With regard to emergency medication administration, the HRA found an order for 10-20-12 at 1900 for the emergency medication of Lorazepam 2mg intramuscularly with Diphenhydrmine 50 mg IM for severe agitation. The HRA did not find an accompanying restriction of rights notice. It was unclear in the medication administration records reviewed by the HRA if the emergency medication was actually administered.

Progress notes were reviewed as well. Documentation on 10-20-12 stated that "Pt requested to sit in quiet room [after] being counseled about giving his food away in dining room, once in quiet room he escalated, loud threatening, cursing [and] then started pounding on walls. Pt offered prn, refused, pt placed in physical hold [and placed in FLR's for his protection. Dr…notified, …RN notified…restraints [and] chest posey applied appropriately. Chest posey on as he started thrashing bed linen…RoR given. 1850 pt. extremely agitated thrashing even [with] chest posey. Dr…give [telephone order] for Benadryl 50 mg with Lorazepam 2mg IM…."

Also in the progress notes were comments by the psychiatrist who documented the following: "1. In restraints on 10-20-12 for threatening and started banging on the wall. 2. He has been uncooperative, refusing to participate in fitness education. 3. Denies MI. Denies court order for Admission….Instead he claims judge sent him for 'his aggression control.' Also believe the judge is not going to take him back until he is stable. 4. Refused Meds - Also complained he was given enforced med on 10-20-12 when he went into restraints and also says it is illegal. 5. When came for interview - he insisted his mother should be present on the phone for any meetings. 6. He is not psychotic depressed or showing any other psych problem. 7. He is deliberately not cooperating with an intention Not to return to court for fitness and a trial. 8. Did take the fitness test material, but did not finish. Agreed to take fitness class starting 10-23-12 with a therapist. 9. He clearly said (spontaneous) 'when I go back to court. I get my charges quashed. They did illegally without a warrant they arrested me.' 10. He has been creating behavioral problems about the incident of quiet room to restraints he fabricated the information. He said ' I told them to put me in seclusion/quiet room because I had problems/ I needed to work it out.' However, the STAS reported that he was banging the door in quiet room, would not stop, would not take meds to stay calm. However, he was given enforced emergency IM meds." Another progress notes, dated 10-25-12, stated that "Received call from STA IV that this pt. called OIG to report

alleged abuse for a 'shot' he received while in restraints. Apparently it happened on 10-20-12 as this was his last restraint episode when he received an injection. He refused any exam; he stated 'I got a shot the other day and it left a bump.' Unable to determine extent of injury and apparently it is in the R upper quadrant as per nursing note 10-20-12 at 1840. Will have Dr…examine." The physician noted an injury report on the same day. A psychiatrist's note also on 10-25-12 indicated the psychiatrist's attempt to bring the recipient into a treatment planning meeting and eventually went to the recipient and discussed issues of concern, including the recipient's concern that he was given a shot at the time he was placed in restraints which the patient indicated was illegal. There was no questions/concern documented about the type of medication given.

Progress notes on 11-23-12 indicated that the recipient began yelling when staff asked him about taking a shower which he indicated he already had; when he remained upset, staff offered a PRN medication and he refused it. The recipient was escorted from the dining room to the unit after cursing and threatening staff when he was asked to refrain from flashing "gang signs."

A note on 12-13-12 stated that the treatment team was advised that the recipient is using the phone for more than 10 minutes at a time and then bullying other recipients about their phone use.

On 12-15-12, the progress notes stated that the patient was places in 4 point restraints for "acting out and refusing to quiet down. Pt asking for drugs 'PRN' and when refused he told staff he would hurt them (he has refused regular meds.) Pt. Instructed/offered seclusion or quiet room but refused this. He told staff he wanted to be restrained and is now saying that since he is restrained he needs 'PRN Med' to calm down and that he will sing and shout till then. Pt. walked to restraints voluntarily. He is now singing loud and verbally being disruptive. Considered PRN but pt is behaving in extremely manipulative way to gain meds. None will be given now. Following restraint protocol." A progress note by a different staff person stated that the recipient "…was loud, cussing and threatening staff calling staff 'bitches.' Pt. was escorted to A-3 and asked if he wanted to go to quiet room and pt. said put me in restraints. Pt layed on the bed and placed in restraints. No further action taken."

The HRA did find documentation in the progress notes regarding blood pressure medication being started and education on the blood pressure medication being given. It was also noted that the recipient would refuse the blood pressure medication.

Policy Review

The HRA examined policies pertinent to the complaints. The "Use of Psychotropic Medication" Policy states that when emergency medication is used "The physician or RN initiating the use of emergency medication must document in the progress note that due consideration was given to the patient's treatment preference regarding emergency medication and must include justification for deviation from the patient's preference."

The policy entitled, "Refusal of Psychotropic Medication," requires the documentation of psychotropic medication refusals. A physician is required to conduct a review before pursuing

emergency medication to ensure that the criteria for emergency medication administration has been met.

The "Medication Compliance" policy states that "Patients have the right to refuse medication under the Mental Health Code unless they are imminently physically dangerous to self or others….When possible, the time of medication administration should be utilized by the RN/LPN to provide individual education of patients about their medication including name, dosage and expected effect. The nurse will encourage medication compliance and ask about and assess for side effects and adverse reactions which hamper compliance."

The "Use of Restraint and Seclusion (Containment)" policy requires a nurse to be present to authorize the restraint in the absence of a physician. Treatment team members are to encourage the recipient to achieve release criteria and a review form is to be completed that lists recipient behaviors and why release criteria have not been met. Recipients are assessed by a clinician before a restraint is released. An interim treatment plan meeting is held after the restraint incident to determine the need for any revisions to the recipient's treatment plan. The "Procedure for Operational Guidelines for Use of Restraints" requires the completion of an information report that documents the events that precipitated the use of restraints, a physician's order, a monitoring form, a restriction of rights notice form, a restraint review form and a progress note. Monitoring of the recipient in restraints is to be conducted and documented every 15 minutes. Reviews are also to be conducted every two hours to determine the continued need for restraint.

The "Patient Rights" policy states that the facility is to respect patient rights and any restrictions should have "clinical rationale and serve to facilitate a therapeutic treatment setting." Recipients are to "…be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual treatment plan." Recipients are to have access to their personal property unless his clinical condition warrants a restriction. A restriction notice is to be issued when rights are restricted.

The Illinois Department of Human Services policy entitled, "Administration of Psychotropic Medication," states that a physician can prescribe emergency medication when it is determined that the medication is needed to prevent a recipient "…from causing serious and imminent physical harm to self or others." Furthermore, the policy requires that the physician or a nurse in consultation with a physician determines, based on personal examination that an emergency exists and a physician's order is completed. Alternative treatment options prior to medication administration is to be documented and a restriction of rights notice is to be issued. No long-acting psychotropic medications are to be given for emergencies. Upon admission to the state-operated facility, facility staff are to inform the recipient of conditions that permit the use of emergency admission, inquire about the existence of a declaration for mental health treatment, and document emergency treatment preferences. The HRA notes, as it did in the prior HRA Case #13-110-9014, that the DHS policy on psychotropic medication defines "emergency" to include action needed "…to prevent deterioration of the individual's condition…" which is inconsistent with the Code's mandated criteria of serious and imminent physical harm to self and others. (405 ILCS 5/2-107).

MANDATES

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) guarantees the right to:

> *adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan.…In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions….shall be noted in the recipient's treatment plan.*
>
> *(a-5) If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated.*

Section 5/2-104 of the Code guarantees the right of recipients "… to receive, possess and use personal property and shall be provided with a reasonable amount of storage space…." Property can be restricted "…when necessary to protect the recipient or others from harm."

With regard to emergency medication, the Code guarantees the right to refuse medication and, if refused, they are not to be given except under the following circumstances:

> *unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available. The facility director shall inform a recipient, guardian, or substitute decision maker, if any, who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services.*
>
> *(b) Psychotropic medication or electroconvulsive therapy may be administered under this Section for up to 24 hours only if the circumstances leading up to the need for emergency treatment are set forth in writing in the recipient's record….*
>
> *(e) The Department shall issue rules designed to insure that in State-operated mental health facilities psychotropic medication and electroconvulsive therapy are administered in accordance with this Section and only when appropriately authorized and monitored by a physician or a nurse under the supervision of a physician in accordance with accepted medical practice….*
>
> *(g) Under no circumstances may long-acting psychotropic medications be administered under this Section….*
>
> *(i) The Department shall conduct annual trainings for all physicians and registered nurses working in State-operated mental health facilities on the appropriate use of emergency administration of psychotropic medication and electroconvulsive therapy, standards for their use, and the methods of authorization under this Section.*

The Code addresses restraint use in Section 5/2-108 as follows:

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 the staff.

(a) Except as provided in this Section, restraint shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities. No restraint shall be ordered unless the physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of restraint is justified to prevent the recipient from causing physical harm to himself or others. In no event may restraint continue for longer than 2 hours unless within that time period a nurse with supervisory responsibilities or a physician confirms, in writing, following a personal examination of the recipient, that the restraint does not pose an undue risk to the recipient's health in light of the recipient's physical or medical condition. The order shall state the events leading up to the need for restraint and the purposes for which restraint is employed. The order shall also state the length of time restraint is to be employed and the clinical justification for that length of time. No order for restraint shall be valid for more than 16 hours. If further restraint is required, a new order must be issued pursuant to the requirements provided in this Section.

(b) In the event there is an emergency requiring the immediate use of restraint, it may be ordered temporarily by a qualified person only where a physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities is not immediately available. In that event, an order by a nurse, clinical psychologist, clinical social worker, or physician shall be obtained pursuant to the requirements of this Section as quickly as possible, and the recipient shall be examined by a physician or supervisory nurse within 2 hours after the initial employment of the emergency restraint. Whoever orders restraint in emergency situations shall document its necessity and place that documentation in the recipient's record….

(f) Restraint shall be employed in a humane and therapeutic manner and the person being restrained shall be observed by a qualified person as often as is clinically appropriate but in no event less than once every 15 minutes. The qualified person shall maintain a record of the observations. Specifically, unless there is an immediate danger that the recipient will physically harm himself or others, restraint shall be loosely applied to permit freedom of movement. Further, the recipient shall be permitted to have regular meals and toilet privileges free from the restraint, except when freedom of action may result in physical harm to the recipient or others.

(g) Every facility that employs restraint shall provide training in the safe and humane application of each type of restraint employed….

(j) Whenever restraint is used, the recipient shall be advised of his right, pursuant to Sections 2-200 and 2-201 of this Code, to have any person of his choosing, including the Guardianship and Advocacy Commission or the agency designated pursuant to the

Protection and Advocacy for Developmentally Disabled Persons Act [FN1] notified of the restraint…..

Section 5/2-201 of the Code mandates that for any rights restriction, a notice of that restriction is to be issued to the recipient, guardian or other individual as designated by the recipient.

CONCLUSIONS

Complaint #1: A recipient was not told the type of emergency medication he was given in spite of inquiries.

Based on the record documentation, the recipient was given emergency medication while also being placed in restraints after an incident in which his behavior escalated and he was striking the walls. Staff documented that the emergency medication administration was needed to prevent harm to self.

The HRA found documentation of the recipient's concern about having received the "shot" but it was not clear whether or not he had voiced concerns or questioned the type of medication administered. Instead, he seemed to be concerned about the actual administration of the medication and its use in conjunction with restraints. At the same time, there is no reference to medication education information on the emergency medication having been provided to the recipient. In addition, the HRA found no restriction of rights notice related to the emergency medication administration.

The HRA found that the facility has policy in place regarding the administration of psychotropic medication. The DHS policy incorrectly defines an emergency, in part, as a deterioration in a recipient's mental health status.

The Mental Health Code allows for the administration of psychotropic medication in an emergency to prevent serious and imminent physical harm to self or others and requires the issuance of a restriction of rights notice. The Code also requires mental health facilities to provide medication education when administering psychotropic medications. The HRA found no mandate that prohibits the administration of emergency medication in conjunction with a restraint.

Based on the lack of documentation that the recipient received medication education information related to the emergency medication and the lack of a restriction of rights notice, the HRA substantiates rights violations related to the administration of emergency medication and recommends the following:

1. **Consistent with the Mental Health Code, ensure that medication education information is provided to recipients when administering psychotropic medication, including when emergency medication is administered.**
2. **Issue restriction of rights notices when emergency medications are administered as per the Mental Health Code.**
3. **Notify the DHS Administration regarding the psychotropic medication policy definition for "emergency" being inconsistent with the Mental Health Code.**

The HRA found that some of the documentation was vague with regard to describing the recipient's behavior (e.g. threatening) and strongly suggests that specific behaviors be documented to ensure that the Code's criteria for emergency medication have been met.

Complaint #2: Restraints were used even though the recipient did not meet the restraint criteria.

According to the record review, the recipient had two incidents of restraint application. In one instance, the recipient was hitting the walls of the quiet room and was at risk of injuring himself. In the other instance, the recipient was described as acting out and refusing to quiet down, refusing the quiet room, requesting but was denied PRN medication, singing and shouting and then he voluntarily laid down for the restraint application.

The HRA contends that the second incident did not meet the Code's criteria of preventing physical harm to the recipient or physical abuse to others.

In both incidents, the facility secured the appropriate orders, provided 15 minute checks, offered toileting and hydration and issued restriction notices. The facility also followed its policies with regard to documented reviews; however, the HRA questions whether the review includes a review of whether or not restraint criteria had been met.

Due to the incident that resulted in restraint application when the recipient was vaguely described as acting out and then willingly laid down for restraint application, the HRA substantiates the complaint with regard to the December 2012 incident but not the October 2012 incident. The HRA recommends the following:

1. **Follow the Mental Health Code and ensure that the criteria of preventing physical harm to self or others is met before employing the use of restraints.**

2. **Ensure that restraint reviews include a review of whether or not the Code criteria for restraint application is met.**

The HRA includes some additional comments. The HRA noted that an interim treatment plan documented the wrong date for restraint application, one restriction document did not list the time that a restraint application ended and one treatment plan did not include the patient section. The HRA suggests that the facility continue efforts to complete documents thoroughly and accurately and include such details in any reviews. The HRA also noted that the recipient had not identified emergency treatment preferences and suggests that the facility continue efforts to obtain this from recipients and document its attempts. Finally, the HRA was concerned about a statement in the rights policy that restrictions are allowed if there is clinical rationale; the HRA reminds the facility that the Code defines parameters with regard to rights restrictions and suggests that these parameters be included in the rights policy when describing restrictions.

Complaint #3: Inappropriate care is provided in that a recipient does not have sufficient clothing.

The HRA found no evidence that the recipient had insufficient clothing or had voiced complaints of having insufficient clothing. In a prior HRA case, an HRA team observed a large stock of

different sized and types of clothing available to recipients who come to the facility without many clothes. In interviews with the recipient, the HRA found the recipient to be appropriately dressed with clean clothing. Staff reported that recipients are to have six sets of clothing and if they do not have six sets, they can obtain state clothing.

The Code guarantees the right to adequate and humane care and treatment. In addition, the Code guarantees access to personal belongings unless considered a harm to self or others.

Based on the available evidence, the HRA does not substantiate the complaint. The HRA noted that the Patient Rights policy mentions that access to personal belongings can be restricted due to a clinical condition versus the Code's criteria that property can be restricted to protect the recipient or others from harm. The HRA suggests that the facility review its rights policy regarding property restriction to ensure that it is consistent with the Code.