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HUMAN RIGHTS AUTHORITY - EGYPTIAN REGION
REPORT OF FINDINGS

Case # 13-110-9017
Chester Mental Health Center

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of a possible rights violation at Chester Mental Health Center. The complaints alleged the following:

1. A recipient was inappropriately restrained; the facility did not honor the recipient's right to refuse.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (MHDDC) (405 ILCS 5/2).

Chester Mental Health Center is a secure state-operated mental health facility located in Chester, IL which provides services for around 240 male recipients. The HRA investigated the above complaints by speaking with staff, reviewing relevant facility policies, and examining recipient records with consent from the individual. The complaint was also referred to the Illinois Department of Human Services, Office of the Inspector General.

To investigate the allegations, HRA team members reviewed documentation that is pertinent to the investigation. The allegations in this report were brought to the attention of the Chester Human Rights Committee chairperson.

COMPLAINT STATEMENT

The complaint states that a recipient was told by a Security Therapy Aide (STA) that he could not wear his shirt unbuttoned. The recipient argued with the STA which allegedly angered the staff member and the recipient was given a PRN (medication as needed). The patient allegedly accepted the medication and returned to his room. Later the STA entered the recipient's room and told him that they needed blood drawn. The recipient refused the blood being drawn and the STA returned with two other STAs and told the recipient he had a choice of either seclusion or restraints. The recipient said that he wanted to stay in his room and quiet down per protocol after receiving a PRN. The STAs reportedly grabbed the recipient and choked him until he passed out. The recipient was allegedly not acting physically aggressive but had been talking to himself in his room. When the recipient woke up, he was escorted to the restraint room where

he was restrained for 4 hours. After the recipient was in restraints, the facility drew the blood even though the recipient refused. The date of this alleged incident was 12/17/12.

FINDINGS (Including record review, mandates, and conclusion)
Record Review

The recipient's 30-Day treatment plan, dated 3/26/13, reads that on 12/17/12 "he [recipient] was put in FLR [full leather restraints] because he was agitated and argued in loud and threatening manner, not redirectable and approached STA in threatening manner." On a 2/25/13 treatment plan review, the recipient was told that he needed continued observation and treatment for agitation related to his excessive water intake. The same treatment plan reads that the recipient cooperated with the completion of a personal safety plan. In the plan "He [recipient] indicated that physical force can be upsetting enough to trigger a crisis for him and that if he is isolating himself this is an indication that he is upset." The treatment plan is broken into sections by the recipient's "Problem." This particular patient had an excessive thirst problem titled "Polydypsia" [sic] which was discontinued on the date of the treatment plan review. The goal is that the "Recipient will be able to have his water turned on in his room without consuming excessive amounts of fluid to the point of intoxication."

In reviewing the recipient's progress notes, at 0740 on 12/17/12 it reads that the recipient was loud and upset and weighs ten more pounds then the day before. A physician was notified and an ISTAT (handheld blood analyzer) was ordered. In reviewing the recipient's progress notes for 0800 on 12/17/12, it reads "Recip continued to escalate, yelling, cursing, making verbal threats towards staff, clenching fists, order obtained via telephone for ISTAT at 0745. Staff applied physical hold, recip continued to fight unable to redirect." The progress notes proceeded to state that the recipient was put into 5 point restraints. A psychiatry note within the progress notes on that date read "He [recipient] was put in FLR because of severe agitation and approached STA with closed fist." A note on 0845 reads that the results for the ISTAT were reported (name was illegible). Within the progress notes, there is another psychiatry note at 0855 on 12/17/12 which reads "He [recipient] was put on FLR because of severe agitation and approached STA with closed fist. Before that he was loud, oppositional. When counseled about [date illegible] weight gain. He woke up last night, went to wash room. Most probably he drank too much water. ISTAT recommended but he refused, couldn't be reasoned with." Later on in the progress notes, there is an undated note that indicated more of the ISTAT results.

The HRA reviewed another treatment plan from 1/2/13 which read "He [recipient] had a difficult few weeks this month. [Recipient] became upset at staff for asking him to dress properly. When staff attempted to redirect him, [Recipient] behavior escalated and he required the use of Full Leather Restraints. While in restraints, [Recipient] voided a large amount of urine. His labs indicated he had consumed excessive amounts of fluids which resulted in physical aggression." The statement regarding "labs" also indicates that blood was taken from the recipient. In the progress notes, there is mention that the recipient said that he was choked.

The notes state that the recipient did speak with the Illinois Office of the Inspector General (OIG) about the alleged abuse and requested x-rays on his throat.

The HRA reviewed the rights restrictions for the recipient. On 12/17/12, there was an order for physical hold from 0800 to 0805. The reasoning for the hold, as written on the order, was "Recip was threatening, PRN given with minimal success, continued threatening, closed fists as if to fight." On the rights restriction, the reasoning for the hold was "Threatening to harm staff." At 0805 on 12/17/12 there is an order for restraint of seclusion "for agitation. Wt (weight) up 10 lbs from last night. Cursing continued to escalate making verbal threats towards staff. Closing fists towards staff in an attempt to fight." The first restraint order on that day continued until 12am and then a second restraint was ordered. The behaviors cited for the second restraint read "Pt remains angry and hostile on review. Conts to void lg amts of urine. Remains a danger to others." According to the flow sheet, the recipient was released at 1400. The recipient's restraint/seclusion flowsheet also indicates that restraint protocol was followed (e.g. Checked every 15 mins, allowed to use the restroom) but there was no indication that the ISTAT was given during the times indicated above. The HRA also saw no other documentation in the record that the ISTAT was given. The HRA saw no evidence that the recipient had passed out.

The HRA reviewed an OIG report regarding the recipient being choked during the restraint incident and the report indicated that the agency investigated and found the complaint unsubstantiated.

The HRA reviewed the facility recipient rights statement which read "Each recipient admitted to Chester Mental Health Center shall be treated with respect and shall be ensured of all rights under Sections 2-100 to 2-111 of the Mental Health and Developmental Disabilities Code." The rights policy also reads "A recipient shall be provided with adequate and humane care and service in the least restrictive environment, pursuant to an individual treatment plan." The policy also states that recipients "… shall have a right to refuse medication" and not to be restrained except for as specified in the Code (2-108 and 2-109). The right's policy has an emergency restriction of rights section which reads "A restriction of a recipient's rights should be based on an assessment of the recipient and/or the situation affecting the safety of the recipient or others by clinical staff on duty who oversees the recipient's treatment plan."

The facility restraint policy reads "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 …"

The HRA reviewed the facility code of conduct which states that "At Chester Mental Health Center (CMHC) we strive to promote the welfare of those with whom we have contact and to prevent the visitation of harm. All recipients, employees and visitors shall be treated with dignity, respect and courtesy … Chester Mental Health Center has zero tolerance for workplace violence and intimidating and disruptive behaviors." The policy also states that intimidating and disruptive behavior includes harassment (which is defined as "verbal or physical conduct that denigrates or shows hostility or aversion toward an individual") and physical aggression.

Mandates

The Mental Health and Developmental Disabilities Code reads "Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others" (405 ILCS 5/2-108). The Code also reads "The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy" (405 ILCS 5/2-107). The Code also reads "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan" (405 ILCS 5/2-102).

Conclusion

The HRA found no evidence that the recipient was inappropriately restrained but did see an indication that the recipient had refused to have blood drawn but the blood was taken anyway. There was no documentation in the record that the recipient had retracted his decision about the treatment nor was there a right's restriction given for the blood being drawn. Because of this, the HRA finds the complaint **substantiated** and offers the following **recommendations:**

- Assure that the facility is following protocol regarding forced treatment per the Code (405 ILCS 5/2-108).
- The patient right's policy reads that recipients have the right to refuse "medication" but the Code reads "The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy" (405 ILCS 5/2-107). The HRA recommends changing the policy to adhere to the Code.

The HRA also offers the following **suggestion:**

- The recipient's treatment plan indicates that physical force could trigger a crisis for the recipient but, in this case, physical force was used. The HRA understands redirection may be difficult and the recipient was under water intoxication but it does appear that when staff were physical with the recipient a crisis may have occurred. The HRA suggests that when this is addressed in the treatment plan, assure that all other alternatives are explored before the recipient is subject to actions that may lead to a crisis.
- The HRA saw no indication of an order for the ISTAT. The HRA suggests that even if a verbal order is given, the facility create some documented hard copy of the order.
- As noted in the report, portions of the clinical chart were illegible. The HRA suggests that Chester ensure that case notes, doctor's orders and other chart documentation are printed legibly or returned for dictation rather than using handwritten notes.