FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
17-110-9010
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 allegation concerning Chester Mental Health Center:

A recipient's emergency preferences were not honored.

If found substantiated, the allegation represents a violation of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2 et al.) and Chester policies.

Chester Mental Health Center is a state-operated mental health facility serving approximately 240 recipients; it is considered the most secure and restrictive state-operated mental health facility in the state.

To investigate the allegations, the HRA interviewed the recipient and staff, reviewed the recipient's record with consent, and examined pertinent policies and mandates.

I. Interviews:

Recipient: The recipient said that on November 18th or 19th he was in the cafeteria and asked to go to the module. The Charge Aide kept throwing his hands into the recipient's until the recipient pushed his hands back. He apologized but the staff took him to the restraint room anyway. He stated that he was not screaming or acting aggressively and was calm so he told the staff he could go to seclusion, but staff put him in restraints anyway. His emergency preferences are seclusion, medication and then restraints. Staff also gave him an Ativan in pill form and the recipient said that he took it even though he did not feel he needed it, but he knew if he did not take it in pill form they would give him an injection. He was in restraints for approximately 4 hours.

Since nursing staff typically make the determination on whether or not to use restraints in emergency situations, the HRA decided to question two that were involved in making that decision for this incident to see why restraints were chosen over seclusion, which was the recipient's first preference.

RN 1: This nurse stated that in emergency situations, they have to take the whole situation into account when deciding which emergency intervention to use. An example given was if the recipient is swinging and combative then it is usually better to try seclusion or restraints first because giving an injection in that situation would not be safe for anyone involved. They can use medications when a recipient is first escalating or just making verbal threats with no physical hold or aggression; if those things are present then it is better to try seclusion or restraints for the safety of all. If a recipient has a PRN (as needed) medication ordered they can give it in oral form if the recipient agrees, if not then they have to call a physician to get an order before medication can be given. If the recipient has an intellectual disability, they do not have PRN medications and a physician has to be called every time before medication can be given to calm the recipient down. The nurse did not fully remember who this recipient was, but stated that if it is who she was thinking of, he was stubborn and uncooperative at first but then after he was stabilized on medications he was cooperative and was transferred. She could not recall this specific incident.

RN 2: This nurse was questioned regarding this particular incident and why restraints were used over seclusion. She did not recall this incident so she described how the situations are handled in general. She said that in order to utilize seclusion, they have to be able to take off the recipients shoes and belt so if they are combative, that is not always possible. If the recipient is physically aggressive and violent, they cannot use emergency medications because it would be too dangerous for everyone involved as you risk a needle breaking etc… In that situation, they would have to get the recipient in restraints first before medications could be given. Their goal is to get the recipient out of restraints as soon as possible due to the restriction level of restraints. The nurse said that this recipient was not one that was too much trouble, once he was stabilized on medication he was fairly cooperative and was able to be transferred.

II. Clinical Chart Review

A. Progress Notes: On 11/23/16 a nursing note at 12:40-12:45 documented that the recipient *"was in the dining room for lunch and became agitated lunging at staff and attempting to strike him. He was placed in physical hold at 12:40 and returned to unit. He continued to make verbal threats toward staff. He was placed into 4 points at 12:45. [Physician] notified of restraint …seclusion and meds are preference but not used due to [increased] level of aggression."* On 11/23/16 at 12:50 another nursing note documented that the recipient alleged abuse for 11/16/16 stating staff *"bear hugged me on the stem and hurt my lower ribs and back."* It was documented that his pain level was rated at zero and the OIG (Office of Inspector General) liaison was notified. At 1:30 p.m. a nursing note documented that the physician ordered *"aripiprazole 10 mg PO daily x 2 and then 20 mg daily lorazepam 1mg po bid and prn consent signed give 1st dose now."* On 11/23/16 at 4:45 p.m. a nursing note documented that the recipient met release criteria for 4 point restraints. It was noted that he was *"cooperative and able to communicate with staff effectively on ways to avoid and de-escalate aggression in future. Understands and verbalizes cause of this episode. 1st dose of lorazepam and aripiprazole effective. No s/s of adverse reaction. Pt in module lying down in room at this time."* It was documented that on 11/26/16 the recipient complained that his medication made him feel sick and tired when he takes it and that he was having thoughts of wanting to harm himself. The nurse spoke with the physician who placed him on 1:1 observation for suicidal ideation. On 11/27/16 and 11/28/16 he

refused the Abilify but took his Lorazepam. The physician was notified and later discontinued the Abilify and Added Olanzapine and also Zoloft for depression. The 1:1 was discontinued on 11/30/16. There was no previous 1:1 that would have prevented the recipient from utilizing the seclusion room.

B. Restriction of Rights (ROR): There was no ROR form with the date of November 18th or 19th but there was one dated November 23rd at 12:40 p.m. which would be the appropriate time of day as described by the recipient. The ROR was for restraints due to the recipient being verbally and physically aggressive towards staff. It was noted that the individual's preference was not utilized due to "level of aggression." The Order for restraints documented that the recipient "lunged at staff and swung fist. Verbally aggressive P.H. [physical hold] x 5 min restraints for safety of all." The restraint episode began at 12:45 p.m. and ended at 4:45 p.m. The restriction of rights form indicated that the recipient did not want anyone to be notified of his restriction.

C. Treatment Plan Reviews (TPRs): The 11/9/16 TPR documented that the recipient was admitted 8/24/16 as unfit to stand trial (UST). His emergency preferences were listed as seclusion, medication and then restraints. It was noted that he had made significant progress since admission, was cooperative with his treatment team and worked well with his therapist on fitness education. He had gained insight into his mental illness and triggers that cause him to become agitated. He was being recommended as Fit to Stand Trial at that time. In the extent to which benefitting from treatment section, it was documented that he had been provided with communication skills to assist him with expressing concerns in a socially acceptable manner and had been provided with relaxation techniques which have helped him with anxiety. The recipient signed the treatment plan indicating he was in agreement with it. An Interim Treatment Plan/Change in Condition review was conducted on 11/23/16 at 12:40 p.m. It was noted that the recipient *"lunged and swung at staff, verbally aggressive, P.H. x 5 min struggling and placed in 4 point restraints for safety of all."* On 11/28/16 Another Interim Treatment Plan/Change in Condition was completed. The discussion section stated that *"On 11/23/16 [recipient] became highly agitated that staff were near him. He then became verbally aggressive, lunged and took a swing at staff. Pt. was placed into a physical hold then FLR's after he continued to struggle."* The 12/6/16 TPR documented that the recipient had aggression toward staff on 11/23/16 which resulted in 4 point restraints. It was also noted that he had suicidal ideations and was on 1:1 observation for 5 days. It was also documented that he had refused medication but at that time was agreeing to begin it again and was compliant. However, he was placed on crush and observe status *"due to concerns with compliance and for safety to pt. since he was placed on 1:1 obs status this reporting period for thoughts of self-harm."* Due to this decline in mental status, restraints and thoughts of self-harm, the treatment team changed his status to not fit to stand trial at that time. The recipient signed his treatment plan and indicated he was in agreement with it. The 1/3/17 TPR documented that the recipient had no more restraint episodes and that he had been compliant with medication and had shown significant improvement with the ability to cooperate and paranoia. The treatment team recommended him as fit to stand trial at that time.

D. Restraint Information: The restraint/seclusion evaluation is mostly illegible and the signature on the form cannot be deciphered. It was completed at 1:05 approximately 20 minutes after the restraint was initiated. It stated that the recipient lunged at staff and swung his fist and

was verbally aggressive and that a 5 point restraint was utilized. The patient's reaction to the intervention was listed as "I am okay" The patient's medical and behavioral condition was listed as "medically stable, behaviorally angry…no evidence of [illegible]." 15 minute checks were completed and the comments included the following: At 1:00 p.m. "treatment team came in to speak with and refused to speak with them…pulling at restraints uncooperative…talking to the STA IV [at 1:30 p.m.]…took meds for agitation…remains angry [at 1:45 p.m.]…shaking pulling at restraints…talking to self, restless…laughing says he needs out became argumentative and started to yell at staff, restless [at 2:45 p.m.]…refuses to talk, mocks who is speaking, restless, pulling at restraints…complaints about discomfort [at 3:30 p.m.]…patient remains argumentative, pulling at restraints does not follow commands…attempting to talk to staff while eating tray [at 4:00 p.m.]…continues to remain restless pulling on restraints…complaining and talking to himself…meets criteria for release no SIB or suicidal ideation observed or reported [at 4:45 p.m.]" A restraint review form that was completed by a nurse at 1:45 p.m. stated that the recipient "*took medication @1335 Remains angry tugging on restraints. Unstable and unpredictable.*" Another review by that same nurse at 2:45 p.m. stated he was "*argumentative and uncooperative. Remains unstable and unpredictable.*" At 3:45 p.m. another nurse completed a review that stated "*uncooperative refuses to follow direction of STAII argumentative and pulls @ restraints release criteria reviewed with pt.*" At 4:45 the review from that same nurse stated that the recipient was "*calm and cooperative with staff release criteria discussed and pt meets parameters. No SIB [self-injurious behavior] or suicidal ideations observed or reported.*" The post episode debriefing was also completed by the same nurse at 4:45 p.m. documented the recipient's understanding of the reason for restraint and why previous calming strategies were "not used and not successful" no injuries were noted. The recipient was calm and lying down in his room in the "stressors precipitating aggressive behaviors" section N/A was written as the response. The "warning signs to watch for and immediately intervene with" are listed as clenched fists, pacing, and restlessness. "Actions to de-escalate patient in the future" are listed as PRN, empathetic listening, and conflict resolution. Finally it noted that the recipient was informed of the reason his preferred emergency intervention was not used.

III...Facility Policies:

RI .01.01.02.01 Patient Rights: The Patient Rights policy states "*It is the policy of Chester Mental Health Center (CMHC) to respect the rights of patients and not to abridge said rights without cause and without due process. Restrictions, as such, should have a clinical rationale and serve to facilitate a therapeutic treatment setting. Each patient 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. Restrictions of rights and corresponding rationale shall be properly documented in the patient's clinical records.*" This policy states that a patient has the right to *"be provided with adequate and humane care and services in the least restrictive environment pursuant to an individual treatment plan…*

Emergency Restriction of Rights

1. A restriction of a patient's rights should be based on an assessment of the patient and/or the situation affecting the safety of the patient or others by clinical staff on duty who oversees the

patient's treatment plan. A Notice Regarding Restricted Rights of Individuals (IL462-2004M) will be issued to temporarily restrict the patient's rights. A progress note will be documented in the patient's record showing justification for the restriction of rights and explanation of actions taken.

2. A restriction imposed during off hours as an emergency intervention shall be reviewed by the treatment team on the next working day to determine whether continuation is indicated. If continuation is indicated the form IL462-2004M must be signed by the Facility Director or designee..."

TX .06.00.00.03 Use of Restraint and Seclusion policy states that *"The goal of Chester Mental Health Center is to limit the use of Restraint or Seclusion to emergencies in which there is a clear and present danger of an individual harming himself, other patients, or staff. Neither Restraint nor Seclusion may ever be used as a means of coercion, discipline, punishment, convenience or staff retaliation. The least restrictive intervention that is safe and effective for a given individual will be used… When restraints are indicated, a RN must be present to temporarily authorize the restraint in the absence of a physician…*

Personal Safety Plan

a. A Personal Safety Plan will be developed with all individuals within 24-72 hours of admission. The purpose of the Personal Safety Plan is to identify calming strategies (early interventions) as well as signals of distress (early warning signs) in advance of a crisis. If the individual is unable to participate in the completion of the Personal Safety Plan, staff will identify knowledge, skills, or abilities that the individual lacks that would help them manage their thoughts, feelings or behavior.

b. The Personal Safety Plan will be used to help formulate the treatment plan. When appropriate and consistent with confidentiality requirements, the family or significant others will assist in this process.

c. The Personal Safety Plan will ask the individual to designate which Emergency intervention (Restraint, Seclusion or medication) should be attempted first to ensure their safety in the event that the calming strategies identified fail or are not viable and Emergency intervention is needed. The individual's Emergency intervention designation will also be identified on the individual's treatment plan.

d. Individuals will be informed about the DHS/MH policy regarding Seclusion and Restraint and education about the circumstances under which Restraint or Seclusion may be necessary.

e. If an individual is unable to participate in the completion of a Personal Safety Plan prior to the 72-hour Treatment Planning meeting, efforts to obtain this information should be ongoing as needed."

DHS Directive on Restraint and Seclusion: This directive states that *"the use of restraint or seclusion is limited by DHS/MH to emergencies in which there is a clear and present danger of an individual harming himself or herself, other patients or staff…the least restrictive intervention that is safe and effective for a given individual will be used…The determination of which emergency intervention to use should be based on assessment and monitoring of the individual, staff experience with the individual, patient and staff safety, and the emergency intervention as identified by the individual and documented on the treatment plan or the individual's personal*

safety plan…if the emergency intervention used differs from the emergency intervention identified by the individual and documented on the treatment plan or personal safety plan, the rationale must be documented on the Notice regarding restricted rights of individual form…Discontinuation of Mechanical Restraint or Seclusion 1. The individual must be released from mechanical Restraint or Seclusion as soon as is safely possible. 2. The individual must be released as soon as the written behavioral criteria specified in the Restraint or Seclusion order are met.
3. If the mechanical Restraint or Seclusion order expires prior to the behavior criteria being met, the individual must be released or a new order written."

Statutes

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) states *"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. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment 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 under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan.*

The Code (405 ILCS 5/2-108) provides the following guidelines regarding restraint use. *"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...*
(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, clinical professional counselor, or registered nurse with supervisory responsibilities is not immediately available. In that event, an order by a nurse, clinical psychologist, clinical social worker, clinical professional counselor, 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…
(i) A recipient who is restrained may only be secluded at the same time pursuant to an explicit written authorization as provided in Section 2-109 of this Code. Whenever a recipient is restrained, a member of the facility staff shall remain with the recipient at all times unless the recipient has been secluded. A recipient who is restrained and secluded shall be observed by a qualified person as often as is clinically appropriate but in no event less than every 15 minutes.
(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 Persons with Developmental Disabilities Act1 notified of the restraint. A recipient who is under guardianship may request that any person of his choosing be notified of the restraint whether or not the guardian approves of the notice. Whenever the Guardianship and Advocacy Commission is notified that a recipient has been restrained, it shall contact that recipient to determine the circumstances of the restraint and whether further action is warranted."

The Code (405 ILCS 5/2-200d) provides that *"Upon commencement of services, or as soon thereafter as the condition of the recipient permits, the facility shall advise the recipient as to the circumstances under which the law permits the use of emergency forced medication or electroconvulsive therapy under subsection (a) of Section 2-107, restraint under Section 2-108, or seclusion under Section 2-109. At the same time, the facility shall inquire of the recipient which form of intervention the recipient would prefer if any of these circumstances should arise. The recipient's preference shall be noted in the recipient's record and communicated by the facility to the recipient's guardian or substitute decision maker, if any, and any other individual designated by the recipient. If any such circumstances subsequently do arise, the facility shall give due consideration to the preferences of the recipient regarding which form of intervention to use as communicated to the facility by the recipient or as stated in the recipient's advance directive."*

The Code (405 ILCS 5/2-201) requires that *"(a) 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 such 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 the rights of persons with developmental disabilities, and amending Acts therein named", approved September 20, 1985,1 if either is so designated; and
(5) The recipient's substitute decision maker, if any.
The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefore in the recipient's record."

Conclusion

The complaint alleged that a recipient's emergency preferences were not honored. The recipient stated that his preferences are seclusion first, then medication and then restraints. On 11/23/16 the recipient lunged at and swung at staff in the cafeteria. He was placed in a physical hold and escorted back to the unit where he was placed in restraints for 4 hours. The recipient stated that he was calm when arriving at the unit and requested to be placed in seclusion, which was his first preference, rather than being placed in restraints. Despite this request, the recipient was placed in restraints. The STA involved was not identified so no interview could be completed. The two nurses involved in ordering the restraint were interviewed but neither of

them remembered the details of this restraint episode and explained in general terms how the determination of whether to use restraints, seclusion or medication as an emergency intervention is typically made. One nurse stated that seclusion cannot be used if the recipient's shoes and belt cannot be removed first or if there are concerns for self-injury and medications cannot be used if the recipient is combative. However, the HRA did not find the requirement to remove shoes and belt in the facility's restraint and seclusion policy. The reason the nurse had documented in case notes as to why emergency preferences were not utilized was due to the "increased level of aggression." Other documentation found was the interim treatment plan which stated that the recipient was verbally aggressive, lunged at and took a swing at staff and that he "continued to struggle" after being placed in restraints. Therefore, according to the typical procedure described by the nurses, since he was struggling and swinging, medication would not have been a viable option. The HRA then searched for documentation that would justify why seclusion would not have been used. Documentation was found in case notes that at 12:45 the recipient was placed in restraints and documentation confirmed that he was able to voice that he was "okay" at that time which corroborates what he stated to the HRA; at 12:50 the recipient filed a complaint of a previous abuse allegation with a nurse; at 1:30 the recipient was speaking with a STA IV and a nursing note at that same time documented that the physician ordered medication for agitation, the first dose was given at that time and the recipient signed a consent form for the medication. The HRA found documentation that the staff considered the recipient's preferences, thus, the complaint is not substantiated. However, the HRA has several suggestions for consideration:

1. One nurse stated that shoes and belts should be removed in order for seclusion to be utilized. The HRA did not find this requirement in the facility policy and recommends staff training on policy to ensure that staff involved in restraints are aware that this is not a criteria for seclusion.

2. The HRA was concerned that this recipient was in restraints for 4 hours when early restraint documentation just stated "remains angry…pulling at restraints" etc… In reviewing documentation, it appeared that the longer he was in restraints the more escalated he became. Administration should ensure that restraint use is lifted as soon as possible as required by DHS directives.
3. If/when it is not feasible to use a recipient's preferred emergency interventions, staff should have specific and detailed documentation as to why preferences were not followed rather than general statements such as "increased aggression or agitation."

4. The HRA understands that the decision for restraint or seclusion is an individualized one based on the current situation, patient history and other factors, however, Administration should consider developing guidelines or conducting training for staff responsible for ordering restraints to allow a more unified approach in determining whether restraint or seclusion is the least restrictive intervention.