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Egyptian Regional Human Rights Authority
Report of Findings
Case #18-110-9017
Choate Mental Health and Developmental Center
July 12, 2019

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

Inappropriate seclusion of patients in their rooms

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2 et al.)

Choate Mental Health and Developmental Center provides services to both persons with mental illness and persons with developmental disabilities. The allegations of this complaint involve a recipient housed on the mental health unit. To investigate the allegations, an HRA team met with the recipient and examined the recipient's record with written consent, and reviewed pertinent policies and mandates related to admission.

FINDINGS

Interviews:

Recipient: The recipient has been at the facility off and on for 5 years and had been at the facility approximately 2 consecutive years at the time interviewed. She stated that in mid-April she was administered shots and placed in restraints after informing staff they could not send her to her room. The patient explained that she was not loud or belligerent, just wanted to pace the unit because she could not sleep. It was her understanding that she could be awake, walking or looking at magazines but could not have flashlights or disrupt sleeping roommates. However, staff told her she had to go to her room. She had a 1:1 staff at that time who observed her in her room and in the restrooms etc. She speculated that her 1:1 staff may have not wanted to walk the hallways. The nurses told her she had to be in her room during lights out time. She complained to a Supervisor who stated that she does not have to be secluded in her room and that she can pace the unit or look at magazines when she cannot sleep. After that, she did not have any more trouble and could pace the unit at night when she could not sleep.

Chart Review:

Notes in the chart from late March/early April documented that the recipient complained she could not sleep well at night because of her peers on the unit and back pain that was making her restless. She had agitation/anxiety and requested and received PRN (as needed) medication of Ativan and Chlorpromazine. She was placed on 1:1 supervision in early April for suicidal ideation. She began refusing medication on April 13th. A behavior note on 4/15/18 at 12:15 a.m. documented that just prior to midnight, the recipient stated *"I want to pace, It's against the rules to seclude me. I will call OIG in the morning. I'm tired of these [expletive] rules. That stupid [expletive] thinks its funny to spit on people. I'll kick her ass. Midnight shift better get used to me breaking the rules. I'm not taking my meds this is the new [name]."* The mental health technician (MHT) documented that the recipient made these statements and began to pace. The MHT tried to redirect the recipient "due to unit guidelines" but the recipient became upset and loud and made threatening comments towards a peer as she walked by her dorm room. The recipient yelled "you can't control me, I'm not a dog. Well, I am a dog but not a very good dog." The MHT documented that the recipient was *"noncompliant with unit guidelines, loud, disruptive, agitated, non-redirectable, threatening physical aggression."* The MHT notified the nurse, a physical hold was administered at 11:50 p.m. followed by emergency medication at 11:55 pm. A Nursing note at 5:00 a.m. stated that the recipient had been resting in bed with eyes closed and there were no reports of threats or attempt to self-harm. At 9:30 a.m. on 4/16/18 a debriefing was attempted but the recipient refused and called the psychiatrist names. A behavior note on 4/16/18 at 9:05 p.m. documented that the recipient was restricted to one end of the unit at 7:48 p.m. because she made threats to kill a peer. At the time of this note it was documented that the recipient continued to yell, make threats, posture and verbal redirection was unsuccessful. An order for emergency medication was received and Chlorpromazine, Ativan and Diphenhydramine was administered. A nursing note at 10 p.m. documented continuous threats being made to peers and staff. At 10:30 p.m. it was documented that the recipient continued to threaten to kill a female peer, attempted to break into another peer's room and attempted to hit staff with a chair. She also threatened to kill a female peer or herself if not placed in restraints. The recipient told the nurse *"put me in restraints or I'm going to kill that [expletive] and you can't stop me or kill myself. You people are idiots and unreasonable."* Assistance was called she was placed in a physical hold and then placed in restraints at 10:30 p.m. The physician was notified and ordered emergency medication which was administered. A restriction of rights form was given at 10:40 p.m. A nursing note on 4/17/18 at 5:00 a.m. documented that the restraint episode lasted until 12:30 a.m. when the recipient met release criteria.

The HRA reviewed Emergency Medication Progress Notes, Order for Restraint and Restriction of Rights forms for both instances on 4/15/18 and 4/16/18. The forms corroborated what the case notes had stated. 15-minute checks from the 1:1 staff documented the recipient was "pacing hall yelling at staff" at 11:30 p.m. on 4/15/18. The note at 12:00 a.m. on 4/16/18 stated the recipient was "pacing refusing to sit" but it did not say if pacing was in the room or on in the hall. This continued until 2:00 a.m. when the recipient was "in bed awake quiet." Around 2:30 a.m. the recipient appeared to be sleeping until 7:15 a.m. when she refused medication and breakfast. A note at 8:30 a.m. stated she was "laying on bed going over the issue of not being able to pace last night" [with her 1:1 staff]. It was documented that the recipient refused debriefing of the episode the next morning with the social worker, psychiatrist and staff stating,

"I have nothing to say to you." The HRA also reviewed a "7-day Restriction of Rights Flow Sheet" which stated the recipient was restricted to the East end of the unit for 7 days. Meals and medications to be given on the unit. The reasons listed for the restriction were verbal aggression, threatening psychiatrist, interfering with psychiatrist completing job duties, being disruptive and refusing medication. Daily reviews of the restriction documented that the recipient continued to have behaviors and made threats 5 days but the restriction to the East end of the unit was removed on day 4. On day 7 it was noted that the recipient was a "continued elevated risk but taking medications now."

Policy Review:

The Unit Guideline/Patient Handbook outlines unit information including rights, expectations and the grievance process. The unit expectations section states *"Please be respectful and courteous. Everyone is in varying stages of recovery. If someone is bothering you, please talk to the staff about what you can do…It is expected that you will be up and dressed by 7:00 a.m. Programming is made available seven (7) days per week; routine participation in programming is expected, and participation in programming is viewed as a vital component of your recovery. It is expected that everyone will be out of bed between 7:00 a.m. and 5:00 p.m. daily, unless one's clinical condition warrants otherwise (e.g., a medical condition that would require bed rest per doctor's order) …You are asked to retire to your room at 10:30 p.m. Sunday through Thursday and by 12:00 Midnight on Fridays, Saturdays and evenings preceding holidays…Televisions may be viewed only during these non-programming hours Monday through Friday: 6:00 a.m.-7:30 a.m., 2:15 p.m.-3:00 p.m., and 5:00 p.m. - lights out 10:30 p.m. Sunday –Thursday and 12:00 a.m. Friday, Saturday and evenings preceding holidays."*

STATUTES

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. 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 Code (405 ILCS 5/2-109) states *"a) Seclusion may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. In no event shall seclusion be utilized to punish or discipline a recipient, nor is seclusion to be used as a convenience for the staff. Seclusion shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, clinical professional counselor, or registered nurse with supervisory responsibilities…"*

CONCLUSION

The complaint alleged inappropriate seclusion of patients in dorm rooms. Prior to the date of the alleged incident, the recipient had been complaining about peers and back pain making her restless and unable to sleep. A behavior note from the recipient's 1:1 staff on 4/15/18 documented that the recipient was complaining and yelling because she wanted to pace

the unit just before midnight. Staff tried to redirect the recipient "due to unit guidelines" but was unsuccessful and a nurse was notified which resulted in a physical hold followed by restraints and medication. On 4/16/18 the recipient was again pacing and making threats which resulted in a physical hold, restraints and medication. Upon review of the Unit Guidelines policy, nothing was found that required patients to be in their rooms until a certain morning hour. There was a "lights out" expectation for patients to be in their room by 10:30 p.m. Sunday through Thursday and by 12:00 Midnight on Fridays, Saturdays and evenings preceding holidays. The policy did state that patients are expected to be up and dressed by 7:00 a.m. The policy did list television viewing hours which began at 6:00 a.m. which could explain why staff might assume patients are to stay in their rooms from 10:30 p.m. (or midnight) until 6:00 a.m. Although it seems staff were mistaken about unit guidelines for "in room time," it was well documented that the recipient was being disruptive on the unit and was making threats to peers and staff. The HRA contends that redirection of the recipient to her room was attempted to de-escalate the situation and protect others from harm and was not meant as seclusion. On one occasion, when redirection failed, the recipient received emergency medication and restraints. The HRA also did not find an Order for seclusion as required by the Mental Health Code (405 ILCS 5/2-109) which further supports that seclusion was not the intention. Therefore, this allegation is **unsubstantiated**. The HRA offers the following suggestions:

1. The Unit Guidelines should be reviewed, and the expectations of patients between "lights out" and waking hours should be clarified. Although the unit guidelines state that patients are asked to retire to their room at either 10:30 or midnight, depending on the day of the week, special consideration should be given in situations where patients are experiencing insomnia providing they are not disruptive to other patients on the unit. Ensure that staff fully understand what those expectations are.

2. The recipient had complained prior to this incident, that she was having trouble with peers and her back causing her insomnia. The HRA suggests that in the future a special treatment meeting should be held to address issues such as this in an attempt to prevent the issues from escalating into maladaptive behaviors. The recipient's insomnia should also be addressed in her treatment plan.