FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 08-030-9016
JACKSON PARK HOSPITAL

Summary: The Human Rights Authority substantiates the complaint that Jackson Park Hospital did not follow Mental Health Code procedures when it detained, restrained and administered psychotropic medication to a recipient.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission has completed an investigation into possible rights violations within the Emergency Department and the Behavior Medicine Unit at Jackson Park Hospital. Jackson Park Hospital is 326-bed acute, short-term comprehensive care facility that offers a wide range of inpatient and outpatient diagnostic, therapeutic and ancillary services. The Behavioral Medicine Unit contains 25 beds. The following has been alleged:

> The facility did not follow Code procedures when it detained, restrained, and administered psychotropic medication to a recipient.

If substantiated, this allegation would be a violation of the Mental Health and Developmental

Disabilities Code (405 ILCS 5/100 et seq.).

METHODOLOGY

To review this complaint, the HRA conducted a site visit and interviewed the Senior Vice-President of Patient Care, the Vice-President of Patient Care, the Director of Public Safety, the Executive Director of Quality and Compliance, the Clinical Director of the Behavioral Health Unit, and an emergency department intern.

The recipient in this case is an adult who maintains her legal rights. Relevant program policies were reviewed as were the recipient's records upon written consent from the recipient.

FINDINGS

According to the record, the recipient was taken to Jackson Park Hospital Emergency Department on 3/11/08 by the Chicago Police Department. The Triage Form states that the recipient arrived at 7:55 p.m. and the hospital face sheet indicates that she was admitted at 8:14 p.m. The Emergency Physician Record, completed at 9:00 p.m., states that the recipient was "agitated, hostile" and that she "hit bystander in the street and also staff in ER." An 8:20 p.m. entry in the Emergency Department Nursing Flow Sheet states, "…. pt. 46 yr. old into Obs Psych #1 with c/o - brought in by Chicago Police for fighting on the street- pt. is combative and hostile here in ER. Pt. was medicated with Haldol 5mg Ativan 2 on the left thigh. Pt. is asleep at 2100…." The medication route is indicated as IM and the medication time is given as 8:20 p.m.

The recipient was contacted for her account of the alleged incident. She stated that she had been at a bar in the afternoon of the event and became involved in an altercation with a female employee there whom she had known from previous encounters and with whom she argued over a boyfriend. The recipient struck the employee and police arrived on the scene. No charges were brought and the police left the scene. The recipient stated that she was then walking down the street on the way to a convenience store when she was stopped by police. She stated that she argued with them regarding the fact that she was being stopped for no reason and they told her they were taking her in because "I was not taking my medication." She told them that she was not on medication and did not want medication. She was taken to a police station where she was questioned and the decision was made to have her involuntarily committed. The petition, completed at 7:08 p.m. states, "The above subject did strike the victim…in the face for no reason. The victim does not know the offender subject."

A certificate for involuntary admission was completed at 8:30 p.m. on 3/11/08. The statement of clinical observation and factual information states, "Pt. brought to ER by CPD after she had reportedly struck an unknown female at a fast food store. The attack was unprovoked and pt. attempted to leave the area. Guarded and evasive- denies past psych history though computer record shows pt. treated at JPH April, 2007. Struck staff in ER while pt. was being triaged. Judgment appears impaired. Diagnosis- Psychotic Disorder NOS." The certificate is signed by the physician. A Psychiatry Consult Form is included in the record. The report of the consultation states, "Pt. is a 46 AAF was brought to JPH by the cops after striking a 67 yof in the face for no reason. The victim doesn't know the offender. Pt. refuses to give hx and refuses to cooperate with anyone. Pt. is violent, aggressive, hostile, pt is not a reliable source. Denied drug and ETOH usage. Pt. is alert and oriented. Her speech is coherent. Pt. is aggressive, hostile, and abusive [verbally]."

The Rights of Individuals Receiving Mental Health Services Form was not signed by the recipient and there was no indication that she refused to sign. The section of the Petition for Involuntary Treatment that indicates that the recipient had her rights explained to her and was provided with a copy of the petition is not signed. The Right to Decide paperwork, along with Consent for Medical Treatment form and Privacy Practices form all state, "Due to condition patient unable to sign."

A Community Mental Health Crisis Intervention Summary was completed on the recipient at 8:30 p.m. on 03/11/08. In the Description of Behaviors section the entry reads, "Pt. uncooperative during assessment. Exhibiting increasing agitation and hostility toward CPD and JPH staff requiring meds and restraints. 'I need you to give me my wig and take the restraints off….'." The staff that were interviewed by the HRA stated that the recipient had not been placed in restraints. There is no supporting documentation of a physician's order, observation flow sheet notes, or statement of no undue danger to the recipient caused by restraint

At 1:30 a.m. the recipient was admitted into the locked psychiatric unit from the ED. Nursing Notes entered into the record at 1:30 a.m. state, "Admitted this 46 yrs old brought in by CPD for disruptive behaviors exhibiting increased agitation, physical altercation on the street, non compliant with medications. On assessment pt. was very uncooperative refused to sign any papers, states 'Nothing wrong with me. I am physically OK'. Pt. remains an involuntary patient."

At 1:30 p.m. on 3/12/08 the Nursing Notes indicate that the recipient was administered 5 mg Haldol and 2 mg Ativan IM for "Agitated, mood angry, hostile, intrusive, indecent exposure of genitals, difficult." There is no accompanying Restriction of Rights Notice. Again, at 11:30 p.m. the same evening, the recipient was given 5 mg Haldol and 2 mg Ativan and the Nursing Notes state, "Pt. agitated, hostile behavior, with mood swings." There is no Restriction of Rights Notice for this event. Staff were interviewed regarding the lack of Notice for these events and they stated that probably the recipient did not refuse these medications. They stated that sometimes, based on the assessment of the nurse at the time, the medications are given intramuscularly so that the effect is reached more quickly and the patient realizes that they will feel better faster, so they do not object.

The record does not contain thorough evidence of informed consent for psychotropic medications. There is a psychiatric evaluation that states, "She will be started on Seroquel 100 mg b.i.d. Haldol p.r.n. I explained to her about the benefits and side effect. The patient agreed to take", but there is no indication of whether the drugs' information was shared in writing and no physician's statement determining the recipient's decisional capacity. There is no consent or information given for Ativan, although it was included in the Medication Administration Record (MAR) with a standing order for both the tablet and injection. The MAR also lists a standing order for Haldol 5 mg for injection as well as 5 mg tablet. Staff reported that patients are given verbal information about medications and their consent is verified by the signature of the physician. Physicians do not complete separate capacity statements.

On 3/12/08 at 9:30 p.m. the recipient signed an application for voluntary admission.

At 10:00 p.m. on 3/14/08 Haldol and Ativan were injected into the recipient's buttocks per the Nursing Notes however the record is not legible enough to decipher the rationale for the medication (staff were unable to read). There is no corresponding Restriction of Rights Notice for this event. On the same day at 6:50 p.m. the recipient was administered 5mg Haldol and 2mg Ativan IM. The Nursing Notes state, "Altered thought process. Pt. offered prn Ativan 2mg. Received prn Ativan 2mg IM Haldol 5mg IM with security assist." There is no Restriction of Rights Notice for this event, however staff acknowledged that this incident must have been a

forced medication event. Additionally, the file does not contain emergency intervention preferences, if she was advised of her right to designate them.

There is a request for discharge signed by the recipient on 3/12/08 at 4:00 a.m. Staff were interviewed regarding the discrepancy between the application for voluntary admission that the recipient signed at 9:30 p.m. on 3/12/08 and this document signed at 4:00 a.m. They did not offer an explanation. The recipient was released to her residence on 3/18/08.

STATUTORY BASIS

The Mental Health Code describes a "mental health facility" as "...any licensed private hospital, institution, or facility or section thereof, and any facility, or section thereof, operated by the State or a political subdivision thereof for the treatment of persons with mental illness and includes all hospitals, institutions, clinics, evaluation facilities, and mental health centers which provide treatment for such persons" (405 ILCS 5/1-114).

The Mental Health Code states that when a person is asserted to be in need of immediate hospitalization, any person 18 years of age or older may complete a petition (5/3-601). The petition is to be accompanied by the certificate of a qualified examiner stating that the recipient is in need of immediate hospitalization. It must also contain the examiner's clinical observations and other factual information that was relied upon in reaching a diagnosis, along with a statement that the recipient was advised of his right to not speak to an examiner (3-602). Upon completion of one certificate, the facility may begin treatment, however at this time the recipient must be informed of his right to refuse medication (3-608). Also, within 12 hours after his admission, the recipient must be given a copy of the petition and within 24 hours he must be asked if he wants this document sent to any other persons. At least two of his designated persons shall receive this documentation (3-609).

The Mental Health Code guarantees all recipients adequate and humane care in the least restrictive environment. As a means to this end, it outlines the how recipients are to be informed of their treatment and provides for their participation in this process to the extent possible:

"(a) 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.

(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. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment. The physician or the physician's designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only (i) pursuant to the provisions of Section 2- 107…." (405 ILCS 5/2-102).

Should the recipient wish to exercise the right to refuse treatment, the Mental Health Code guarantees this right unless the recipient is a serious and imminent physical threat of harm to himself or others:

"An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. 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. If such services are refused, they shall not be given 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" (405 ILCS 5/2-107).

Additionally, the Code states that whenever any rights of the recipient of services are restricted, notice must be given to the recipient, a designee, the facility director or a designated agency, and it must be recorded in the recipient's record (ILCS 405 5/2-201).

Restraint is a therapeutic tool that the Mental Health Code carefully regulates. Although its use is to prevent harm, the Code outlines specific measures to ensure that it is safe and professionally applied:

"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….

(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....

(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 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" (405 ILCS 5/2-108).

HOSPITAL POLICY

Jackson Park Hospital policy states that adult patients involuntarily admitted into the mental health unit will be admitted following the process set forth in the Mental Health and Developmental Disabilities Code (RI 121). It includes policy for the completion of the petition, including informing the patient of their rights, providing a copy of the petition to the patient, and completion of certificates within the mandated time frame.

The Jackson Park Hospital policy (RI 105) mandates that the "Rights of Recipients" is posted conspicuously on all units of the hospital. Also, patients are read and explained the Rights and questioned concerning the patient's understanding of them. Copies of the Rights are given to patients and filed in the record. Charts are then reviewed to determine if the Rights paperwork has been signed by the patient and patients will be assisted in signing unsigned documents if necessary.

Jackson Park Hospital policy (R-3) defines restraint as "any method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his arms, legs, body, or head freely; or a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition." Forced psychotropic medication is considered a form of restraint.

The hospital policy outlines the use of restraint and maintains that restraint or seclusion will only be used "when necessary to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of a patient, staff or others." It separates the procedure for managing violent and non-violent self-destructive patients. Included in the policy and procedure for the management of violent patients are the elements mandated by the Mental Health Code to include physician orders for all restraints, 15 minute assessments, and documentation in the clinical record.

Additionally, the policy states:

"The patient's plan of care must be modified immediately upon initiation of restraints or seclusion with the goal of expediting the release of restraints or ending the seclusion, as applicable. An entry must be made in the patient's record describing the patient's behavior that led to the use of restraints or seclusion; the alternatives to restraints or seclusion that were considered; the time that the restraints were applied or seclusion initiated; type of restraint applied; and notification of patient/family, if possible….Any patient placed in restraints or seclusion has the right to notify the Guardianship and Advocacy Commission and any person of their choice. The patient shall be informed in writing of his/her restriction of rights and a copy of the document placed in the patient's chart."

CONCLUSION

The complaint in this case alleged that Jackson Park Hospital did not follow Mental Health Code procedures when it detained, restrained, and administered psychotropic medication to a recipient. Although the recipient was properly petitioned when taken to Jackson Park Hospital emergency department, it is unclear if she was admonished of her rights, as mandated by the Code (405 ILCS 5/2-200 and 5/3-609) and hospital policy (RI 105 and 121). The rights paperwork was not signed and did not indicate that the recipient refused to sign, the section within the petition that indicates admonishment of rights was not signed, and there is no indication that she was given her petition and rights information once she was admitted or stabilized on the psychiatric unit. Even if the recipient had refused to sign at the time of her admission, hospital policy states that records are reviewed for signatures and recipients are assisted in signing them if documents are unsigned (RI 105).

The hospital staff reported that the recipient had not been restrained either in the emergency department or on the psychiatric unit. A statement by the Crisis worker who completed the Crisis Intervention Summary stated in the assessment that the recipient had to be placed in restraints and she included a quotation of the recipient that indicated she had been placed in restraints. The Mental Health Code and Jackson Park Hospital have diligently outlined the procedures for restraint and seclusion (405 ILCS 5/2-108 and R-3) and if this intervention was utilized, then numerous procedures were circumvented in the treatment of this patient, such as a Restriction of Rights Notice, physician orders for restraint, statement of no undue risk, and 15-minute check-up notes. Even if restraints were not used on the recipient, an explanation of the statements within the record that assert that this treatment was given should be investigated and clarified.

The Mental Health Code states that if a recipient refuses medication, then it shall not be given unless such medication is necessary to prevent the recipient from causing serious and imminent physical harm and no other less restrictive alternative is available (405 ILCS 5/2-107). The recipient in this case was administered injected emergency psychotropic medication 5 times throughout her hospitalization. In the emergency department the record indicates repeatedly that the recipient struck staff and this seems reasonable justification for emergency medication.

However, the record offers very little justification for the injections that were given once the recipient was taken to the psychiatric unit. On 3/12/08 the Nursing Notes describe her behavior as "agitated, mood angry, hostile, intrusive, indecent exposure of genitals, difficult" and later, as "agitated, hostile behavior with mood swings." Two days later the recipient was again injected, and for the first occurrence there is an illegible entry into the Nursing Notes, and for the second injection the reason is, "Altered thought process. Pt. offered prn Ativan 2 mg. Received prn Ativan 2 mg IM Haldol 5mg IM with security assist." None of these justifications appear to rise to the level of potential dangerousness that the HRA believes should be present in order to override a recipient's legal right to refuse treatment. If the staff is correct that these injections were not refused, then the record must contain consents for these medications, which it does not. Additionally, the record does not contain emergency intervention preferences, if the recipient was given the opportunity to identify them.

The Mental Health Code also mandates that whenever a right of a recipient of services is restricted, notice must be given to the recipient and their designee and it must be recorded in the recipient's record (405 ILCS 5/2-201). There were no notices completed for the incidents of forced medication in this recipient's file whether in the emergency department or the behavioral unit. Although staff reported that the recipient had probably not objected to the injections, it is not reasonable to believe that a recipient who had refused all other services and interventions, including medication, would willingly accept an injection. Additionally, for the final incident of medication there is a "security assist."

The Mental Health Code states that if a recipient's services include psychotropic medication, the physician must advise the recipient of the side effects, risks and benefits of treatment as well as alternatives. Also, the physician is to determine and state in writing whether the recipient has the capacity to make informed decisions regarding their treatment (405 ILCS 5/2-102). In this case there is one statement within the psychiatric evaluation that states that the patient has been given information regarding two medications, Seroquel and Haldol. The medication Ativan that was given as emergency medication was included as a standing order but the record does not indicate that any information was offered regarding its risk, benefits or side effects. The record did not contain a written decisional capacity statement.

The Human Rights Authority substantiates the complaint that Jackson Park Hospital did not follow Mental Health Code procedure when it detained, restrained, and administered psychotropic medication to a recipient.

RECOMMENDATIONS

1. Ensure that staff are trained to follow Mental Health Code procedure and Jackson Park Hospital policy in ensuring that recipients are informed of their rights as recipients and that this is signified on the petition and the certificate and noted in the recipient's clinical record (405 ILCS 5/2-200, 5/3-609 and RI 105 and 121).

2. Develop policy and train staff in the Mental Health Code procedure regarding the administration of forced psychotropic medication (405 ILCS 5/2-102) to include the consent for

medication, the physician's statement of decisional capacity and Notice of Restriction of Rights (405 ILCS 5/2-201).

3. Ensure that recipients are given the opportunity to select preferences for emergency treatment and that the facility gives due consideration to these preferences should the need arise (405 ILCS/5/2-200 d).

4. Develop policy to address the recipient's right to refuse medication and train staff that if medication is refused it must not be given unless it is necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available (405 ILCS 5/2-107).

5. Jackson Park Hospital has developed a thorough policy and procedure for the use of restraints (R-3). In this case the record indicated that physical restraints were applied however none of the very detailed hospital procedures were recorded, so we are asked to assume that restraint was not used. If restraints were not used, then the accuracy of the record is in jeopardy since there is one documented reference suggesting that they were. However if restraints were applied, then the Code as well as hospital policy was circumvented. The HRA feels that this issue is serious enough to warrant a review of the file and an explanation from Jackson Park Hospital regarding this issue.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

ATTACHMENT
A

Plan for Improvement

JACKSON PARK HOSPITAL AND MEDICAL CENTER

JACKSON PARK HOSPITAL AND MEDICAL CENTER

PLAN FOR IMPROVEMENT

Based on our review, we concur with your recommendations and will initiate the following corrective steps immediately.

1. Jackson Park Hospital will review and in-service all Behavioral Medicine and Emergency Department personnel on the JPH policies for:
   - Restraint and seclusion
   - The Mental Health Code procedure for petition and certificate
     At the conclusion of this in-service staff will understand that any patient who presents to JPH will not be treated, without the execution of a certificate, unless the patient demonstrates that he/ she is a potential harm to themselves or others. If the certificate is not completed, the patient will be verbally informed of our intent to restrict their rights. JPH will complete a Restriction of Rights form, providing the patient with a copy, and the Hospitals intent to restrict their rights will be documented in the medical record .
   - Patients' rights as recipients
     405 ILCS 5/2-200-5/3-605) (Attachment A)

2. Jackson Park Hospital will amend its medication administration policy, Policy PF102: Patient and Family Education on the use of Medication, to include and outline steps to be initiated with the administration of forced psychotropic medications (Attachment B).

3. Jackson Park Hospital Emergency Department and Behavioral Medicine personnel will be in-serviced and educated that the admission process must include documentation of the patient preference relative to the forms of intervention, should circumstances arise which require forced medication, restraint or seclusion (405ILCS 5/2-200 Sections 2-107, 2-108 and 2-109) (Attachments C & D).

4. Jackson Park Hospital will amend its Medication Administration policy, Policy PF 102: Patient and Family Education to include steps to be initiated when the patient refuses medication. Personnel will be in-serviced that if medication is refused it **must not** be given unless it is necessary to prevent the patients from causing serious and imminent physical harm to themselves or others and no less restrictive alternative is available (405ILCS 5/2-107) (Attachment E).

JACKSON PARK HOSPITAL AND MEDICAL CENTER

5. Jackson Park Hospital will review and in-service all Behavioral Medicine and Emergency Department personnel on the JPH policies for:
    - Restraint and seclusion

    In reviewing the patient's record again, it was determined that restraints were applied to the patient in the ED. Reinforcement of the importance to following the policy and procedure of JPH and the Mental Health Code will be conducted. More importantly, emphasis will be placed on the rights of the patient in regards to physical or chemical restraints. (Attachment A)

Please see additional supporting documentation Attachments F through I for:

- Certificate
- Petition
- Medication attestation and
- Restriction of rights

The processes and forms will be reviewed with all staff.

ATTACHMENT
A & C

Jackson Park Hospital & Medical Center
Department of Nursing Service

DRAFT

POLICY: Restraint/Seclusion Policy	Effective Date Issued	Policy Number
	October, 2008	R-3
	Revision Date	Page Number
	October, 2008	1 of 13
	Departmental ☐ Administrative ☑	Approved by:

I. PURPOSE:

To provide guidelines for the safe and effective use of restraints and /or seclusion in situations where appropriate to prevent or minimize harm to self or others.

II. PHILOSOPHY:

It is the philosophy of Jackson Park Hospital to eliminate or significantly reduce the use of restraints. Restraints are to be used only in emergent situations where there is an imminent risk of a patient harming him/her self, or others. Because restraint has the potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of patient rights, and even death, the Hospital leaders explore ways to prevent, reduce and strive to eliminate restraints.

III. DEFINITIONS:

Restraint: Any manual method, physical, or mechanical device , material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely.

Chemical Restraint: A drug or medication that is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's medical or psychiatric condition.

- **Patients have a right to refuse medication. Refusal of medication must be documented in the medical record. If medication is refused, it must not be given until it is necessary to prevent the patient from causing serious and imminent physical harm to his/her self or others and no less restrictive alternative is available.**

Seclusion: The involuntary confinement of a patient alone in a room or area from which

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the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.
Emergency: An instance in which there is imminent risk of a patient harming himself/herself or others, when non-physical interventions would not be effective, or not viable, or when safety issues require an immediate physical response.

IV. POLICY:

Acute Medical/Surgical (Non-Behavioral) Care
This applies to restraint use within the Hospital for patients of all ages where the intervention is necessary to improve the patient's well-being by preventing removal of intravenous lines, endotracheal tubes, feeding tubes, or to prevent injury of temporarily, mentally incapacitated patients after surgery or a procedure.

Please note: The decision to use a restraint is driven by comprehensive individual assessment that concludes that for the patient at this time, the use of less intrusive measures poses a greater risk than the risk of using a restraint.

Behavioral Management
This applies to restraint use in any setting within the Hospital where the intervention is necessary to prevent physical harm to patient and staff because of an outburst of unanticipated aggressive or destructive behavior.

Please note: Restraints used for managing behavior can only be applied in emergency situations (see Appendix C) as a last resort in order to ensure the patient's, another patient's or staff's safety. Restraints are never ordered as "PRN", used as a means of coercion, discipline, convenience, or retaliation.

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The use of restraint is not based on a patient's restraint history, or past history of dangerous behavior.

Clinical indications for the use of restraints/seclusion shall outweigh known contraindications. Restraints/seclusion are only used in emergency situations when a patient is a danger to him/herself or to others including staff. Non- physical interventions are the first choice, unless safety issues demand an immediate physical response. Management of patients in restraint and/or seclusion will be done in accordance with the following:

1. Restraints/seclusion will be used to manage violent or self destructive behavior that jeopardizes the immediate physical safety of the patient, staff members, or others.
2. Restraints/seclusion will be used only after less restrictive measures have failed or have been evaluated to be ineffective.
3. Restraints may only be applied by a person(s) trained in the specific type of restraint that is utilized. The safety of the patient in restraints in maintained by providing face-to-face continuous observation. Simultaneous use of restraint and seclusion is permitted only if (1) the patient is continually monitored face-to-face by an assigned, trained staff member or (2) by trained staff using both video and audio equipment in close proximity to the patient.
4. Use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by Hospital policy (e.g. covering physician).
5. In an emergency, a nurse with supervisory responsibility, or an RN trained according to the established standards, may initiate the use

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POLICY: Restraint/Seclusion Policy	Effective Date Issued	Policy Number
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of restraint prior to obtaining an MD order or licensed independent practitioner order. The order must be obtained either during the emergency application of the restraints or immediately (without interval after the restraint has been applied.

6. The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion. When the attending is not available and has delegated patient responsibility to another physician, the covering physician is considered the attending physician.
7. Within one (1) hour of restraint/seclusion application **for the management of violent or self-destructive behavior**, the trained practitioner MD, PA, RN, or APN) must conduct a face-to-face evaluation to determine the following:

- The patient's immediate situation.
- The patient's reaction to the intervention
- The patient's medical and behavioral condition.
- The need to continue or terminate the restraint or seclusion.

8. The restraint order must specify:
   - Date and time ordered
   - Type of restraints
   - The length of time that restraints are authorized.
   - Purpose or reasoning for restraints (imminent risk for injury to self or others).
   - Continuous observation to protect the patient from adverse outcome secondary to the restraint process.

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Department of Nursing Service

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POLICY: Restraint/Seclusion Policy	Effective Date Issued	Policy Number
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9. Violent or self-destructive patient
The order must be time limited, not to exceed:

- Four (4) hours for adults (ages 18 & over;
- Two (2) hours for children & adolescents (age 9-17);
- One (1) hour for children (under the age of 9);

A physician's order for restraint or seclusion **is valid for 4 hours only** for individuals 18 or older, **2 hours only** for those between ages 9 and 17, and **1 hour only** for children under age 9. A physician/LIP must see and evaluate the need for restraint or seclusion within one hour after the initiation or restraints or seclusion by phone order. Patients must be continually assessed, monitored, and re-evaluated. Restraints and seclusion must be reported at change of shift; whenever there is a patient who has remained in restraints or seclusion for 12 hours, or has had two or more episodes of restraints during 12 hours, this must be reported to Nursing Administration and the Behavioral Health Medical Director.

A new order is required when the original order expires. After 24 hours, before writing a new order for the use of restraint or seclusion **for the management of violent or self-destructive behavior,** a physician or other licensed independent practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion **must see and assess the patient.**

10. Non-violent or non –self-destructive patient
The order must be time limited not to exceed twenty-four (24) hours. A new order is required when the original order expires. The attending physician or designee, licensed independent practitioner must be contacted and given a status report and re-evaluate the need for continuing restraint or seclusion prior to the expiration of the restraint or seclusion order.

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11. Orders for restraint or seclusion must never be written as a standing order or on an as needed basis (e.g. PRN order).
12. Time-limited orders do not mean that restraint must be applied for the entire length of time for which the order was written. Restraint must be discontinued as soon as the individual meets the behavioral criteria for discontinuation.
13. Clinical Director/Nursing Supervisor will be notified if restraint is in place for more than 12 hours or if there are two (2) or more separate episodes within a twelve (12) hour period. Thereafter, Clinical Director/Nursing Supervisor will be notified every 24 hours if either of those conditions continues.

For the Behavioral Health Unit Only (14 thru 16)

14. Once a restraint has been initiated during all or part of one 24 hour period, it shall not be used again on the same individual during the next 48 hours without the prior written authorization of the Chairmen of the Department of Behavioral Medicine or his/her designee. (Illinois Mental Health and Developmental Disabilities Code 2006-Section 5/2-108).
15. Once seclusion has been initiated during one 16 hour period, it shall not be used again or the same individual during the next 48 hours without the prior written authorization of the Chairmen of the Department of Behavioral Medicine or his/her designee.(Illinois Mental Health and Developmental Disabilities Code 2006-Section 5/2-108).

    Note: Designee for the Chairmen of the Behavioral Medicine Unit is defined as any Psychiatrist or Physician with Medical Staff privileges.

16. The Chairmen of the Behavioral Medicine Unit or his/her designee reviews and

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monitors restraint orders for the appropriate use. (Illinois Mental Health and Developmental Disabilities Code 2006-Section 5/2-108).

17. The Clinical Director/Nursing Supervisor must be notified of all restraint or seclusion use.

Documentation:
Nursing documentation will include the following:

- RN Summary- assessment of patient's behavior prior to restraints and/or seclusion application.
- Events leading up to the need for the restraints and/or seclusion
- Alternative interventions used and inadequacy of less restrictive intervention techniques.
- Patient teaching and criteria for release of restraints/seclusion.
- Length of time restraint and/or seclusion used.
- Clinical justification for the length of time.
- Patient and/or family/other designee informed of hospital policy or use of restraint.
- Any pre-existing medical conditions, history, or physical/sexual abuse that may potentially place the patient at greater risk during restraints/seclusion.
- Written or telephone orders for the use of restraints/seclusion.
- Periodic assessments of patient in restraints/seclusion upon initiation and thereafter according to policy (see attached Restraint/Seclusion Flow Sheet).
- Each in-person evaluation and re-evaluation.
- Assistance provided to help the patient meet behavior criteria for discontinuation of restraints/seclusion.
- Patient debriefing with staff.
- Any injuries sustained and treatment received.

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- Death occurrences.
- Patient response to restraints/seclusion and patient response during relief periods (including patients physical well being and psychological comfort).
- Medication requested and administered prior to the use of restraints/seclusion. Rationale for medication not being administered.

PROCEDURE:

MD,LIP, PA, RN

1. The physician or Advanced Practice Nurse must assess the patient's behavior and cognitive state that places the patient or others at risk, ensuring that the patient meets criteria for Restraint or Seclusion set forth in this policy. The initial assessment of the patient should identify all of the following:
   - Techniques, methods, or tools that would help the patient control his or her behavior. As appropriate, the patient and/or surrogate decision maker and family should be consulted to help in identifying such techniques.
2. Assesses the clinical necessity of restraints or seclusion including type of restraint to be used.
3. Assesses the effectiveness of alternative interventions to control behaviors.
4. Provides written order (MD) or obtains telephone order (RN) for restraints or seclusion by completing the Restraint Physician Order Form.
5. Initiates restraints or seclusion.
6. Personally observes and examines the restrained or secluded patient to determine that the use of restraints or seclusion is clinically justified and that the restraint or seclusion poses no undue health risk to the patient. After the assessment, documents the findings on the restraint order. The assessment must be completed within one hour of the restraint application by the MD, Supervisors, RN, or, LIP, when the patient is placed in restraint and /or seclusion for violent or self-destructive behavior.

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7. Gives verbal support, assuring the patient that staff is protecting him/her from harming himself/herself or others.
8. When a Code Grey is called, the Code Gray Response Team assists the staff in placing the patient in restraints or seclusion. If a medical bed is used, restraints must be applied to the bed frame and side rails must be secured in the up position.

RN, NT, PT, MHW

9. Checks the patient for contraband.
10. Communicates the criteria for release from restraints to the patient.
11. Informs patient, guardian (if applicable and any other designated person of the patient's restriction of rights.
12. Completes a "Restriction of Rights" Form.
13. The monitoring of the patient is essential to evaluate the needs and the well being of the patient and will be performed by the above health care provider as specified in the policy.

Note: Whenever a restraint /seclusion is imposed on any patient whose primary mode of communication is sign language, the patient shall be permitted to have his hands free for brief periods of time, each hour, except when such freedom may result in harm to the patient or others. For non-English speaking patients, an interpreter will be enlisted to assist (Refer to Administrative Interpreter Services Policy).

Evaluation and Reassessment for Continued Need for Restraint/Seclusion

1. Performed by an RN.
2. Performed every 2 hours.
3. Review of clinical reasons that precipitated the use of restraints..

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4. Review of present clinical condition.
5. Review of continued use of restraints/seclusion.
6. Determination if less restrictive measures of intervention is appropriate.

Additional Restraints/Seclusion requirements:

1. Patient's placed in restraints and /or seclusion must be searched for potentially harmful objects, such as shoes, belts etc. Patients will be placed in a hospital gown.
2. Only clinical staff may enter the patient's room.
3. Restraints will be removed from the room when not in use.
4. Restraints should not be left attached to the bed frame.

Discontinuation of Restraints and Seclusion

Criteria for Release of Restraints/Seclusion

1. A patient may be released from restraints or seclusion before the expiration of the physician's order if, in the professional judgment of the nurse, the patient is no longer exhibiting violent or self-destructive behavior.
2. When safety or health of the patient, staff, or others is no longer compromised.
3. Fire/emergency or a disaster that can endanger the patient's life if the patient is not released from restraint or seclusion. The criteria must be documented in the patient's record.

Discontinuation of restraints/Seclusion

A. The nurse (RN) may discontinue restraints/seclusion prior to the expiration of order when the patient's behavior no longer poses harm to himself/herself and/or

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others.

B. If a restraint order is discontinued prior to expiration, a new order must be obtained to re-initiate the use of restraint or seclusion.

Post-Restraint and seclusion Practices

1. The patient, patient's family/guardian or other designee (as requested by patient), and appropriate staff member(s) will participate in a debriefing about each episode of restraint/seclusion.
2. When possible, the debriefing will occur at the earliest time possible, but no longer than 24 hours post-restraint or seclusion episode.
3. The debriefing will be conducted to seek an understanding of the event that led to the incident and understanding of how the situation could have been handled differently. Efforts will be made to ensure the patient's well being, psychological comfort, and right to privacy. Staff will provide support for the patient regarding trauma that may have resulted from the incident and modify the patient's treatment plan accordingly.

Reporting Restraint Related Deaths

The following information must be reported (by the Hospital Risk Manager) to the Centers for Medicare and Medicaid Services (CMS):

1. Each death that occurs while a patient is in restraint or seclusion.
2. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
3. Each death known to the Hospital that occurs within one (1) week after restraint or seclusion where it is reasonable to assume that the use of restraint or placement in seclusion contributed directly or indirectly to the patient's death ("Reasonable to assume") in this context includes, but is not limited to deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression,

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restriction of breathing or asphyxiation).

4. Each death must be reported by telephone no later than the close of business the next business day following knowledge of the patient's death.
5. Staff must document in the patient's medical record the date and time the death was reported to CMS.
6. The risk manager will report (via telephone) each restraint/seclusion related death using the following information:

CMS Region 5
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601
312-886-6432

Performance Improvement and Training Requirements

Performance Improvement

The Department of Nursing will collect, and maintain, and analyze restraint and seclusion data to ensure data-driven approaches to patient safety and quality of care are implemented. Restraint monitoring will be incorporated into hospital-wide performance improvement, patient safety, and risk management programs. Data will be collected, and held confidential in accordance with Section 210 of the Medical Studies Act, 735 ILCS 5/8-2101.

Collection of restraints/seclusion data includes the following:

1. Shift
2. Staff who initiated process
3. Time length of application
4. Date and time initiated
5. Day of week initiated
6. Type of restraint used
7. Sustained injuries
8. Age and gender of patient

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9. Other indicators specified on the Restraint Monitoring Log

Staff Training Requirements:

1. Staff will be trained to demonstrate competency on the application of restraint and seclusion prior to participating in any restraint/seclusion episode, during hospital or departmental orientation, and on an annual basis.
2. Education and training will address the following:
   - Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require restraint or seclusion.
   - Use of non-physical intervention
   - Choice of the least restrictive intervention based on individualized assessments of patient's medical or behavioral status or condition
   - Safe application and use of all types of restraint or seclusion used in the hospital, including training on how to recognize and respond to signs of physical and psychological distress (positional asphyxia)
   - Clinical identification of specific behavioral changes that indicate the need to discontinue restraint or seclusion
   - Monitoring the physical and psychological well being of the patient who is restrained or secluded, including but not limited to respiratory and circulatory status, skin integrity, vital signs, 1-hour face-to face evaluation, and cardio-pulmonary resuscitation techniques.
3. Documentation of the training on restraints and seclusion shall be kept in the staff personnel records.
4. Physicians, other licensed independent practitioners, and particular dependent practitioners (PA, APN) authorized to order restraint or seclusion must have a working knowledge of Hospital policy regarding the use of restraint or seclusion.

ATTACHMENT
B & E

Patient Family Education – Use of Medications Policy

Jackson Park Hospital & Medical Center
Department of Behavioral Medicine

POLICY:	Effective Date Issued	Policy Number
Patient/Family Education-Use of Medications	January 1, 2006	PF 102
	Revision Date	Page Number
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	Departmental X Administrative	Approved by:

I. PURPOSE:

To assure that patient/family is provided with education regarding the provision of medications and the administration of forced psychotropic medications.

II. POLICY:

1. The Attending Psychiatrist/Physician is responsible for informing the patient/guardian/continuing care provider of the benefits, purpose, side effects and interactions of medications being taken.

2. In addition to giving informed consent, patients taking psychotropic medication will be provided written information which includes at a minimum: name of medication, dosage, expected duration, purpose, desired effects, possible side effects, potential food-drug interactions, and the right to refuse.

3. Patients/guardians/continuing care providers receive instruction at the time of discharge regarding self-administration, intended use, potential side effects, refill information and actions to be taken in the event problems arise.

4. Instruction on the use of medications is presented in ways understandable to the patient/guardian/continuing care provider.

5. Patients have a right to refuse medication. Refusal of medication must be documented in the medical record. If medication is refused, it must not be given until it is necessary to prevent the patient from causing serious and imminent physical harm to his/her self or

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Patient/Family Education-Use of Medications	January 1, 2006	PF 102
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others and no less restrictive alternative is available.

III. PROCEDURES:

1. The Attending Psychiatrist/Physician must assess the patient/family's previous knowledge and uses of medication upon admission. The Physician will document a statement of the patient's decisional capacity and notice restriction of rights.

2. The Attending Psychiatrist must advise patient/significant other of the intended use, risks, and benefits of medication to be prescribed.

3. If the patient refuses medication, the hospital may medicate patients only if the circumstances leading up to the emergency treatment is documented in the medical record.

4. The Attending Psychiatrist must secure and document informed consent for psychotropic medication including:

    a. Review of purpose.

    b. Desired effects of prescribed medications.

    c. Possible side effects of prescribed medications.

    d. Potential interactions: food-drug/drug-drug.

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e. Right to refuse psycho-tropic medications.

5. Transcribe the physician orders to the Medication Administration Record.

6. Reinforce the patient's understanding of all medications being given before the first dose is administered.

7. Provide the patient with written instruction on the use of psychotropic medication to include special monitoring procedures required when indicated for drug level monitoring, etc.

8. Document instruction given by notation on the Medication Administration Record.

9. Provide medication teaching continuously throughout the patient stay as new medication is ordered or questions arise.

10. Provide medication teaching groups and individual patient instruction.

11. Notify the psychiatrist of questions requiring medical clarification or if the patient refuses prescribed medication.

12. Notify clinical staff of potential medication related side effects to be observed. Provide verbal and written instruction to patient/guardian/continuing care providers regarding medication prescribed for use after discharge.

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13. Advise patient/guardian/continuing care provider to inform the physician/nurse/other care provider if any medication side effects are experienced. Validates the patient/significant other's understanding by requesting verbalization of a summary of:

    a. Knowledge usage;

    b. Prescribed medication(s) – expected effects;

    c. Prescribed medication(s) – possible side effects; and

    d. When to report side effects to the physician.

14. The patient/guardian shall provide physician with complete/accurate information about medical conditions and medications used upon admission.

15. The patient/guardian shall review medication instruction with RN/LPN and accepts responsibility for compliance.

16. The pharmacist shall disclose to medical staff contents of all drugs: chemical and biological.

17. The pharmacist shall communicate new product information to medical and nursing staffs, and other appropriate hospital personnel.

18. The pharmacist shall participate in education of medical and nursing staff regarding

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medications and their use in the hospital.

19. The pharmacist shall provide medical and nursing staff with information on:

    a. Monitoring "start" and "stop" dates;

    b. Optimum drug effects;

    c. Initial signs of toxicity; and

    d. New drugs.

ATTACHMENT
D

JACKSON PARK HOSPITAL AND MEDICAL CENTER

DEPARTMENT OF BEHAVIORAL MEDICINE

PATIENT PREFERENCE FOR EMERGENCY TREATMENT / INTERVENTION

☐ Medication

☐ Seclusion

☐ Time Out

☐ Restraint

_____

Patient Signature (and or surrogate decision maker or family)

_____

Date

_____

Staff Witness

Addressograph

ATTACHMENT
F

Psychotropic Medication Attestation

JACKSON PARK HOSPITAL AND MEDICAL CENTER
DEPARTMENT OF BEHAVIORAL HEALTH

PSYCHOTROPIC MEDICATION ATTESTATION

I have discussed the following with_____
(Patient)

Benefits/Risk
Side Effects
Alternative treatment options
The right to refuse this/these medication[s] except under those circumstances in which refusal may be harmful to self or others

MEDICATIONS	DATE	PHYSICIAN SIGNATURE
ATIVAN		
DALMANE		

Patient is also given written information about his/her medication[s].

ATTACHMENT G

Certicate

Ref.: 405 ILCS 5/3-403, 5/3-602, 5/3-607, 5/3-610, 5/3-702, 5/3-813, 5/4-306, 5/4-402, 5/4-403, 5/4-405, 5/4-501, 5/4-611, 5/4-705

Certificate

Re: _____
(name)

I personally informed the above-named individual of the purpose of this examination and that he or she did not have to speak to me, and that any statements made might be related in court as to the individual's clinical condition or need for services. Additionally, if this examination was for the purpose of determining that the above-named individual is mentally retarded and dangerous, I informed the individual of his or her right to speak with a relative, friend or attorney before the examination, and of his or her right to have an attorney appointed for him or her if he or she so desired.

_____
Signature of Examiner

On _____, _____, at _____ ○ a.m. ○ p.m., I personally examined the
(date) (year) (time)

above-named individual. The examination was conducted at _____
(name of location)

Based on the foregoing examination it is my opinion that he or she is:

☐ A person with mental illness who, because of his or her illness is reasonably expected to engage in *dangerous conduct which may include threatening behavior or conduct that places that person or another individual in reasonable expectation of harm;

☐ A person with mental illness who, because of his or her illness is unable to provide for his or her basic physical needs so as to guard himself or herself from serious harm, without the assistance of family or outside help;

☐ A person with mental illness who, because of the nature of his or her illness, is unable to understand his or her need for treatment and who, if not treated, is reasonably expected to suffer or continue to suffer mental deterioration or emotional deterioration, or both, to the point that the person is reasonably expected to engage in *dangerous conduct;

☐ A person who is mentally retarded and is reasonably expected to inflict serious physical harm upon himself or herself or others in the near future;

☐ Is in need of immediate hospitalization for the prevention of such harm.

I base my opinion on the following (including clinical observations, factual information):

I believe that the individual is subject to (check one): ○ involuntary admission and is in need of immediate hospitalization
○ judicial admission and is in need of immediate hospitalization

Date: _____ Signature: _____

Title: _____ Printed Name: _____

*Dangerous conduct means threatening behavior or conduct that places another individual [illegible]

ATTACHMENT H

Petition

PETITION FOR INVOLUNTARY/JUDICIAL ADMISSION

IN THE CIRCUIT COURT OF _____ COUNTY, ILLINOIS

IN THE MATTER OF)
)
_____)
(Respondent)

Who is asserted to be a person subject to _____ admission to a facility and for whom
(judicial/involuntary)
this petition is initiated by reason of (check ONLY one) :

[ ] Emergency admission by certificate (405 ILCS 5/3-600).

[ ] Admission by court order (405 ILCS 5/3-700).

[ ] Voluntary patient submitted written notice of desire to be discharged (405 ILCS 5/3-403).

[ ] Voluntary patient failed to reaffirm a desire to continue treatment (405 ILCS 5/3-404).

[ ] Patient continues to be subject to involuntarily admission (405 ILCS 5/3-813).

[ ] Emergency admission of the mentally retarded (405 ILCS 5/4-400).

[ ] Judicial admission of the mentally retarded (405 ILCS 5/4-500).

[ ] Developmentally disabled client or an interested person on behalf of the client submitted written objection to admission (405 ILCS 5/4-305).

[ ] Administrative client (or person who executed application) failed to authorize continued residence (405 ILCS 5/4-310).

[ ] Client continues to meet standard for judicial admission (405 ILCS 5/4-611).

I assert that _____ is in need of immediate hospitalization in that he/she is
(Respondent)
(check ALL that apply) :

[ ] A person with mental illness and who because of his/her illness is reasonably expected to engage in dangerous conduct which may include threatening behavior or conduct that places that person or another individual in reasonable expectation of being harmed;

[ ] A person with mental illness and who because of his/her illness is unable to provide for his/her basic physical needs so as to guard himself/herself from serious harm without the assistance of family or outside help; or

[ ] A person with mental illness who, because of the nature of his/her illness, is unable to understand his/her need for treatment and who, if not treated, is reasonably expected to suffer or continue to suffer mental deterioration or emotional deterioration, or both, to the point that the person is reasonably expected to engage in dangerous conduct;

[ ] A person who is mentally retarded and is reasonably expected to inflict serious physical harm upon himself/herself or others in the near future;

I base the foregoing assertion on the following (provide a detailed statement including a description of the signs and symptoms of a mental illness and of any acts, threats, or other behavior or pattern of behavior supporting the assertion. Include the date and place of their occurrence(s)). Additional pages(s) may be attached as necessary.

_____

_____

_____

_____

_____

ATTACHMENT
I

Restriction of Rights Form

Reference: 405 ILCS 5/2-102, 2-103, 2-104, 2-107, 2-108, 2-109, 2-200 and 2-201

NOTICE REGARDING RESTRICTED RIGHTS OF INDIVIDUAL

Name: _____ Identification Number: _____ Facility: _____

Part I

A. On _____ at _____ ○ A.M. ○ P.M. he or she:

☐ was placed in restraints ☐ was placed in seclusion ☐ received emergency forced medication

B. Had restriction placed on certain rights (which are check and explained below) for the duration of:

_____ Hours _____ Days From: _____ To: _____
Date and Time Date and Time

☐ To refuse medical services - x-ray ☐ To refuse medical services - laboratory specimens ☐ To refuse medication

☐ To refuse other medical services ☐ Refuse search of person or living area ☐ To retain personal property

☐ To be allowed communication via: ☐ To manage his or her own personal hygiene ☐ To refuse dental services

☐ telephone ☐ mail ☐ visitation ☐ Other (specify): _____

The reason(s) for the restrictions are:

Date: _____ Signature: _____ Title: _____

Part II

In accordance with the Mental Health and Developmental Disabilities Code, the individual designated his or her preference for emergency intervention if circumstances arise.

On _____, the individual required emergency intervention, as described in Part I above.

○ The individual indicated "No Preference" for emergency intervention(s) and

☐ restraint ☐ seclusion ☐ administration of emergency medication was used.

○ The intervention(s) preferred by the individual ○ was used (see IL 462-0120M) ○ was not used due to the following:

Reason preferred interventions not used:

Part III

I certify that on _____ Name: _____ Title: _____

☐ delivered in person ☐ mailed a copy of this notice in ☐ English ☐ Spanish ☐ Other (specify) _____

☐ individual wished no one be notified. Exception: Guardian of Person must be notified.

Guardian of Person: _____ Address: _____

Designee of Individual: _____ Address: _____

Guardianship and Advocacy Commission/ Equip for Equality _____ Address: _____

Part IV

I certify that a copy of this Notice has been placed in the individual's record. _____