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Egyptian Regional Human Rights Authority
Report of Findings
08-110-9026
Chester Mental Health Center
September 30, 2008

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Chester Mental Health Center, a state-operated mental health facility located in Chester. The facility, which is the most restrictive mental health center in the state, provides services for approximately 300 male residents. The specific allegations are as follows:

1. A recipient at Chester Mental Health Center was inappropriately placed in restraints.
2. The recipient is not receiving services in the least restrictive environment.

Statutes

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/2-108, 405 ILCS 5/2-108 (j), 405 ILCS 5/2-102, 405 ILCS 5/2-200 (d) and 405 ILCS 5/2-201 (a).

Section 5/2-108 states, “Restraint may be used only as a therapeutic measure to prevent a recipient from causing 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."

Section 5/2-108 (j) states, "Whenever restraint is used, the recipient shall be advised of his right, pursuant to Sections 2-200 and 20201 of this Code, to have any person of his choosing, including the Guardianship and Advocacy Commission or any 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."

Section 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 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 intervention under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan."

Section 5/2-200 (d) states, "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 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."

Section 5/2-201 (a) states, "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, 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 therefor in the recipient's record."

Investigation Information for Allegation 1

Allegation 1: A recipient at Chester Mental Health Center was inappropriately placed in restraints. To investigate the allegation, the HRA Investigation Team (Team), consisting of three members and the HRA Coordinator (Coordinator) conducted a site visit at the facility. During the visit the Team spoke with the recipient whose rights were alleged to have been violated and reviewed his clinical chart with his written authorization. The Team also spoke with the Chairman of the facility's Human Rights Committee (Chairman) about the allegation. The facility Policy entitled, "Use of Restraint and Seclusion (Containment) in Mental Health Facilities" and the Illinois Department of Human Services/Mental Health (DHS/MH) Policy Directive pertinent to the allegations were reviewed.

Interviews:

I. Recipient

When the Team spoke with the recipient whose rights were alleged to have been violated, he stated that when another recipient attacked him he tried to defend himself. He informed the Team that as a result of the altercation, he was placed in restraints. He related that he believed that he should be able to defend himself without being punished for his actions. The recipient did not provide a specific date for the restraint episode.

II. Chairman

According to the Chairman, restraints are applied for the protection of the recipient or to prevent injury to others, never as a means to punish a recipient. The Chairman stated that the facility has a policy pertinent to use of restraints and also follows DHS Program Directives regarding restraint use.

Clinical Chart Review

The HRA reviewed information from the recipient's clinical chart. Restraint records from December 2007 through March 2008 and a Treatment Plan Review (TPR) for April 2008 were examined.

Restraint Records

Restraint I

Documentation indicated that the recipient was placed in a physical hold on 11/17/07 after he hit another recipient and then attacked staff members. An Order for Physical Hold was completed at 2:25 PM on 11/17/07 and continued until 2:30 PM on11/17/07. The recipient was provided with a Notice Regarding Restricted Rights of Individual (Notice) for the physical hold. The reason for the restriction was listed as physical aggression. Documentation indicated that the recipient's preferred emergency intervention was not used due to the level of his violent aggression. The Notice was delivered in person to the recipient, and the record indicated that he did not wish to have anyone notified of the restriction.

According to the documentation, when the recipient's aggressive behaviors continued, and he failed to respond to staff's redirection to a new task, he was released from the physical hold and placed in restraints. The initial Order for Restraint was completed at 2:30 PM. According to the record, the recipient's first choice of emergency intervention, medication, was unrealistic due to the level of the recipient's violence. The criteria for release from the restraints were listed as follows: 1) The recipient must be calm, cooperative, and able to discuss the incident; 2) He must
show no signs or symptoms of agitation or anger; 3) He must be free from pulling on the restraints and thrashing on the bed for a period of 60 minutes; 4) He must be awake to determine his ability to meet the release criteria prior to release. The record indicated that when the recipient had not met the release criteria when the Order expired at 6:30 PM, a second Order was issued. Documentation indicated the recipient met the criteria for release at 10:30 PM.

Documentation in the Restraint/Seclusion Flowsheet (Flowsheet) indicated that when the restraints were applied a body search was completed. Staff examined the recipient to make certain that the restraints were properly applied and he was appropriately positioned. The room environment was surveyed and found to be appropriate. It was determined that the recipient was wearing proper clothing for the restraint. Documentation indicated that the recipient was informed of the reason for the restraint and provided with the criteria for release. Staff determined that the recipient had no medical contraindications to the restraint.

Documentation in the Flowsheet indicated that Security Therapy Aides (STAs) continually monitored the recipient during the entire restraint episode and documented his behaviors every 15 minutes. A facility nurse checked the recipient's circulation, released his limbs, checked his vital signs, and assessed his mental and physical status each hour and recorded the findings on the Flowsheet. The recipient was offered toileting and fluids every hour, and he was provided with an evening meal.

Documentation indicated that the recipient was provided with a Notice pertinent to the 8 hour restriction on 11/17/07. According to the record, the recipient's preferred intervention was not used due to the level of his violent, aggressive behaviors. The record indicated that the Notice was delivered in person to the recipient, and the recipient did not wish to have anyone notified of the restriction.

After the recipient was released from restraints, a post-episode debriefing was conducted by a facility nurse. Documentation indicated the recipient was able to identify the stressors that occurred prior to the restraint application. He was able to verbalize an understanding of the cause and consequences of his aggressive behavior. He stated that he felt that staff could have helped him to remain in control, and was aware that he could request their assistance prior to escalation of his anxiety. He was also able to identify methods to control his aggressive behavior. The record indicated that the recipient was to discuss his feelings concerning the restraint. According to the documentation the nurse reviewed the reasons why previously identified early interventions were not employed. Documentation indicated that the recipient's physical well-being was addressed, and he did not receive an injury during the restraint episode.

Restraint II

According to the record, the recipient was brought back from the facility gym on 11/30/07 after he exhibited some maladaptive behaviors. Documentation indicated that when the recipient's aggressive behaviors continued to escalate, he was placed in a physical hold at 10:55 AM. According to a Physical Hold Order, the recipient was released from the hold at 11 AM and placed in restraints.

The recipient was provided with a Notice pertinent to the 5 minute hold. The Notice was delivered in person to the recipient. There was no one listed to receive the Notice.

Documentation in the Order for Restraint indicated that empathic listening and verbal support were behavioral interventions used prior to the application of the restraints; however,

those interventions were unsuccessful. The criteria listed for release were as follows: 1) The recipient must be calm, cooperative and agree to follow module rules. 2) He must not curse, argue, or threaten to harm others. 3) He must be free from pulling on the restraints. 4) He must not spit on others. 5) He must be awake or awakened to determine his ability to meet the criteria for release.

According to the Flowsheet, a STA continually observed the recipient while he was in restraints and documented his observations in 15-minute increments. A facility nurse examined the recipient's circulation, released his limbs, checked his vital signs and accessed his mental and physical status hourly and documented the findings. The recipient was also offered fluids and toileting each hour. He was also offered a noon meal and documentation indicated that he ate 95% of the food that was given to him. A body search was completed post application of the restraint. When a facility nurse examined the recipient, it was determined that the restraints were properly applied, and he was suitably positioned. It was concluded that the recipient was wearing proper clothing for the restraint, and the room environment was appropriate. Documentation in the Flowsheet indicated that the recipient was informed of the reason for the restriction and the criteria for release from the restraints.

The record indicated that a Notice was given to the recipient relevant to the 4 hour restraint on 11/30/07. Documentation indicated that the recipient's choice of emergency intervention was used prior to the restraint. He was given medication at 10:30 AM; however, the medication did not prevent the recipient from engaging in aggressive behaviors toward others. The record indicated that the Notice was delivered in person. There was no indication that staff had asked the recipient if he wished to have anyone notified of the restraint.

In a post-episode debriefing, the recipient was able to inform the nurse conducting the debriefing of the stressors that occurred prior to the restraint and to verbalize an understanding and consequences of his aggressive behaviors. He stated that he felt that staff could have helped him to remain in control, and he was aware that he could request assistance from staff prior to the escalation of his behaviors. The nurse documented that the recipient was encouraged to discuss his feelings related to the restraint. Additionally, the nurse recorded that the reasons why previous early interventions were not successful was discussed with the recipient. When the nurse examined the recipient, no injuries were noted. It was determined that the recipient's physical well-being and his privacy needs were addressed during the restraint.

Restraint III

According to a Physical Hold Order, the recipient was placed in a physical hold on 01/11/08 after he attacked another recipient. The hold began at 7:20 PM, and he was released from the hold and placed in restraints at 7:30 PM. A Notice was delivered to the recipient in person. Documentation indicated that the recipient did not wish to have anyone notified of the restriction.

An Order for Restraint was issued at 7:30 PM when the recipient failed to cease his aggressive behaviors while in the physical hold. The recipient was examined by a Registered Nurse (RN) within 15 minutes and a physician within one hour of the initiation of restraints and

after each additional Order for Restraints was issued. Both professionals documented that it was their assessment that such application did not pose undue risk to the individual. Additional Orders for Restraint were issued at 11:30 PM on 01/11/08, 3:30 AM on 01/12/08, and 7:30 AM.

The criteria for release from restraints were listed as follows: 1) The recipient must be calm. 2) He should be free from yelling, spitting, and pulling on restraints. 3) He must be able to calmly discuss the event/behavior. 4) He should be free of the behaviors listed in 1-3 for a period of 1 hour before release. 5) He must be awake to determine if he is able to meet the release criteria. Documentation indicated that the recipient met the criteria for release at 9:30 AM on 1/12/08.

According to the Flowsheets associated with the restraint episode, the recipient was continually observed by STAs, and their observations were documented every fifteen minutes. Documentation indicated that a facility nurse assessed the recipient's circulation, released his limbs, took vital signs, and evaluated his physical and mental status on an hourly basis. The recipient was offered toileting and fluids when the assessments were conducted. The record indicated that the recipient was offered meals at regularly scheduled meal times.

Upon the recipient's release from restraints, a nurse conducted a post-episode debriefing. The recipient was able to identify the stressors that occurred prior to the restraint and to verbalize the causes and consequences of his aggressive actions. He was able to identify methods to control his aggressive behaviors. He stated that he was aware that he could request assistance from staff prior to the escalation of anxiety; however he expressed that he did not feel that staff could have helped him to remain in control. The reasons that previously identified early interventions were not successful were reviewed with the recipient. It was determined that he did not acquire any type of physical injury during the restraint process and that his privacy needs and well-being were addressed.

The recipient was provided with a Notice pertinent to the 14 hour restraint episode that commenced at 7:30 PM on 01/11/08 and ended at 9:30 AM on 01/12/08. Documentation in the Notice indicated that the recipient's choice of emergency intervention was not used due to spontaneity of the attack on a peer and the risk of safety to the peer as well as the recipient. The record indicated that the Notice was delivered in person to the recipient, and the recipient did not wish to have anyone notified of the restriction.

Restraint IV

An Order for Physical Hold was issued on 01/18/08 at 8:25 PM. Documentation indicated that the recipient was physically attacked by another recipient while he was in his room. When the recipient was hit by the peer, he began to fight and continued to do so until staff could separate them. The hold continued until 8:30 PM.

The recipient was provided with a Notice relevant to the hold. Documentation indicated that the recipient's preference for emergency intervention was not used due to the level of his

aggressive action. The record indicated that the Notice was delivered in person, and the recipient did not wish to have anyone notified of the restraint.

When the recipient failed to terminate his aggressive actions, he was placed in restraints. An Order for Restraint was completed at 8:30 PM on 01/18/08. The criteria for release were listed as follows: 1) The recipient must be calm, cooperative, and agree to follow module rules. 2) He must not curse or threaten others. 3) He should refrain from resisting restraints. 4) He must not spit on others. 5) He must be aware to determine his ability to meet the criteria for release. Documentation indicated that the recipient was examined by a RN within 15 minutes and a physician within 1 hour of the application. Both professionals certified that the restraints did not pose an undue risk to the recipient's physical and mental health. Documentation indicated that the recipient was released from the restraints at 12:30 AM on 01/19/08.

According to the Flowsheet, a RN evaluated the recipient's vital signs, circulation, mental status, and physical status on an hourly basis. He was offered toileting and fluids, and his limbs were released when the evaluations were being conducted. A STA continually monitored the recipient during the 4 hour restraint and documented his observations in 15-minute increments.

The recipient was provided with a Notice for the restraint episode that commenced on 01/18/08 at 8:30 PM and ended on 01/19/08 at 12:30 AM. Documentation indicated that the recipient's choice of emergency intervention was not used due to the violent manner in which he was fighting with a peer. The record indicated that the Notice was delivered in person to the recipient, and he informed staff members that he did not wish to have anyone notified regarding the restriction.

When a RN conducted a debriefing after the recipient was released from restraints, he was able to identify the stressors as a conflict with a peer, which led to the restraint. He was able to verbalize an understanding of the causes and consequences of his aggressive behaviors and to identify methods to control those behaviors. Documentation indicated that he was encouraged to discuss his feelings related to the restraint. The RN and the recipient discussed the reasons why previously identified early interventions were unsuccessful. The RN documented the following: 1) The recipient did not receive any type of injury during the restraint. 2) His physical well-being had been addressed. 3) His privacy needs were considered.

Restraint V

According to an Order for a Physical Hold, when the recipient made an unprovoked attack on staff at 7:40 AM on 03/21/08, he was placed in a physical hold. He was released from the hold at 7:45 AM and placed in restraints.

The recipient was given a Notice pertinent to the hold. The Notice was delivered to the recipient in person. There was no documentation that indicated whether staff had asked the recipient if he wanted anyone notified of the restriction.

An Order for Restraint was issued at 7:45 AM when the recipient refused to cease his aggressive actions toward staff. The criteria for release were listed as follows: 1) He must be

calm, cooperative, not cursing and physically threatening others for a period of 60 minutes. 2) He must be awake to determine if he has met the criteria for release. Documentation indicated that the recipient had been examined by a RN within 15 minutes of the application, and the RN had assessed that the restraints did not pose an undue risk to the recipient's health or mental condition. A facility physician recorded that he had examined the recipient within 1 hour of the initiation of the restraints and had concluded that the restraints did not pose a risk to the recipient's physical or mental well-being. A subsequent Order for Restraint was issued at 11:45 AM after the recipient did not meet the established criteria for release. Documentation indicated that the recipient met the criteria for release at 3:45 PM on 03/21/08.

Documentation in the Flowsheets associated with the restraint episode indicated that the recipient was continually observed by STAs and their observations were recorded in 15-minute increments. A RN released the recipient's limbs, reviewed his vital signs and circulation, and assessed his mental and physical status on an hourly basis. The recipient was offered toileting and fluids each hour and was provided with a noon meal. Documentation indicated that as soon as the restraints were applied a body search was completed. A RN examined the recipient and determined that the restraints were properly applied, and he was appropriately positioned. It was also determined that the clothing that he was wearing was suitable. The room environment was reviewed and determined to be appropriate. The RN recorded that the recipient was informed of the reason for the restraint and the criteria for release. Documentation in the Flowsheets indicated that he was provided with a Notice pertinent to the restraint.

The recipient was provided with a Notice for the 8 hour restraint that began at 7:45 AM on 03/21/08 and ended at 3:45 PM on 03/21/08. Documentation indicated that the recipient's choice of emergency intervention was not implemented because he refused to take the medication. The Notice was delivered in person to the recipient. There was no documentation to indicate that the recipient was asked if he wished to have someone notified of the restriction.

When a RN conducted a post-episode debriefing with the recipient he was unable to identify the stressors occurring prior to the restraint, unable to verbalize the causes and consequences of his aggressive behavior, and to identify methods to control his aggressive behavior. He was encouraged to discuss his feelings about the restraint. He stated that he was aware that he could request assistance from staff prior to the escalation of his anxiety. After examination, the RN determined that the recipient had not received any type of physical injury during the restraint. It was also determined that his privacy needs and physical well-being were addressed while he was in restraints.

Additional Information :

Documentation indicated that the day following each restraint episode, the recipient's treatment team met to evaluate the recipient's treatment plan and make necessary revisions.

Treatment Plan Review (TPR)

According to a 04/02/08 TPR, the recipient was admitted to Chester Mental Health Center on 12/21/06 from a less restrictive state-operated mental health facility. The transfer was

implemented due to the recipient's extreme hostility, aggressive actions, and repeated restraint episodes at the transferring facility. The recipient's legal status was listed as Voluntary.

The recipient's diagnoses were listed as follows: AXIS I: Schizoaffective Disorder, Bipolar Type, Intermittent Explosive Disorder; AXIS II: Mild Mental Retardation; AXIS III: Seizure Disorder, Right Thigh Hematoma (due to injury); AXIS IV: Mild Stressors=Chronic Illness.

Documentation indicated that the recipient was informed of the circumstances under which the law permits the used of emergency forced medication, restraint or seclusion. The recipient stated that he preferred the following forms of intervention in the order of preference: (1) medication and (2) seclusion. The recipient did not list restraints as a third option.

Facility Policy Review:

The HRA reviewed the facility's Policy/Procedure entitled, "Use of Restraint and Seclusion (Containment) in Mental Health Facilities". According to the Policy Statement, "Chester Mental Health Center uses restraint and seclusion only as a therapeutic measure to prevent an individual from causing physical harm to himself or others and follows the Department of Human Services Program Directive 02.02.06.030."

According to the Procedure, the use of restraint and seclusion will be implemented in accordance with the Department of Human Services Program Directive Restraint/Seclusion Procedure, which requires that when restraints are indicated, a RN must be present to temporarily authorize the restraint in the absence of a physician. The Hospital Administrator must approve the use of ambulatory restraints prior to the physician's initial order and the application of ambulatory restraints. When restraints are indicated, four point restraints are to be applied. If the patient's condition warrants further restriction of movement, a fifth restraint in the form of a chest strap may be applied. However, a physician or the RN must approve the fifth restraint prior to application and be present when the restraint is applied.

At the time of the RN assessment of the recipient, the treatment team (as many as are available) will meet with the patient to encourage the patient to achieve the release criteria. The therapist or RN, if the therapist is not available will document the results of the review on the Seclusion/Restraint Review Form including specific recipient behaviors that indicate release criteria has not been met. Prior to the recipient's release from restraints, the recipient will be assessed for self-harm. The assessment will be conducted by a clinician familiar with the recipient and will include suicide potential and self-injurious behavior.

The nursing supervisor of the shift must notify the hospital administrator, the medical director, and the medical director's secretary by e-mail when the following circumstances occur: 1) When a recipient remains in restraint for more than 12 hours. 2) When an individual experiences 2 or more separate episodes of restraint of any duration within 12 hours. When

either of these circumstances occurs, the medical director's secretary will arrange for appropriate psychiatric follow-up at the earliest possible time.

The recipient's treatment team will meet the next working day following the restraint to review and modify the treatment plan. Any extended restraint use and the results of the recipient's debriefing should be considered in modifying the treatment plan. Results of the meeting will be documented and filed in the recipient's clinical record and reviewed at the next TPR.

The Procedure addresses the location of the restraints, types of approved restraints and cleaning of the restraints.

According to the Procedure, when the census at the facility is such that patients are required to use the restraint or seclusion room for living the rooms will be prepared such that they do not reflect immediate use of restraint or seclusion. As soon as another room on the unit is available, the patient will be relocated to that room.

Performance improvement is addressed in the Procedure. The unit-supervising nurse is required to review each order for restraint and seclusion to assure compliance with the program directive and standards of care. The supervising nurse completes a data collection form and forwards the information to medical records for data entry and to allow Quality Management staff to analyze the data and to provide recommendations. The Procedure provides mandates for recording and storing data pertinent to restraint and seclusion use.

DHS/MH Program Policy Directive (PPD) "Use of Restraint and Seclusion in Mental Health Facilities".

According to the PPD, it is the policy of DHS/MH that the use of restraint or seclusion be limited to emergencies in which there is an imminent risk to an individual harming himself or herself, other patients, or staff. Neither restraint nor seclusion may ever be used to punish or discipline an individual or as a convenience to the staff. The least restrictive intervention that is safe and effective for the given individual is to be used. When restraint or seclusion is necessary, the individual's health and safety should be protected; his or her dignity, right and well-being should be preserved; and the risk to staff and others minimized.

Documentation in the Policy Statement is as follows, "The circumstances that result in the use of restraint or seclusion are complex. Consequently, the strategies for reducing and eliminating restraint and seclusion use are multi-faceted and incorporate multiple points of view, including those of patients, consumers, and staff at all levels of the organization. It is the position of DHS/MH that the goal of reduced restraint and seclusion utilization be approached through a broad range of strategies for enhancing positive behaviors, preventing destructive behaviors, and limiting the circumstances that may necessitate the use of restraint or seclusion. These include, but are not limited to: 1) the use of nonphysical interventions as preferred intervention for both patients and staff; 2) the implementation of staff training based upon a nationally-recognized training program in conflict de-escalation and crisis prevention; 3) the

inclusion of the consumer perspective on the restraint and seclusion experience and the perceived opportunities for reducing utilization; and 4) effective assessment and treatment."

In the Definitions Section of the PPD, a maximum secure setting is defined as Chester Mental Health Center. Restraint is defined as "restricting the movement of an individual's limbs, head, or body by mechanical or other means or physical holding to prevent an individual from causing physical harm to himself/herself or others."

According to the PPD, restraint is an intervention that can involve physical and psychological risks. The factors that predispose an individual to risk of death during a restraint were listed as follows: Cocaine or PCP induced delirium, alcohol or drug intoxication, extreme violent activity and struggle during the restraint process, sudden unresponsiveness or limpness, and pre-existing risk factors such as obesity, alcohol and drug use, heart disease, tobacco use, chest wall or limb deformities, acute or chronic respiratory conditions, and ambient heat.

Procedural factors that increase the risk to the recipient during the restraint process are also listed in the PPD. Pre-existing factors are exacerbated when the recipient is placed in a face down position (prone). In this position, the recipient's lungs are compressed and breathing may become labored. Conversely, when a recipient is restrained in a face up (supine) position, this position may predispose the recipient to aspiration. Inadequate numbers of staff to safely manage the mechanical restraint application may increase the likelihood that staff will place their body weight across the patient's back and use other unsafe practices which enhance the danger of patient injury. Too many staff may also present a problem. When excessive staff members are involved in the restraint process, there may be an increase of excessive pressure to the person's torso regardless of the position (prone or supine). Failure to search the recipient for contraband can result in harm. Placing a pillow, blanket or other item under or over the patient's face as a part of the restraint or holding process may result in suffocation. Incorrect application of a mechanical restraint device increases the risk of asphyxiation. Leaving a patient in mechanical restraints without continuous staff observation precludes timely corrective action in response to physical distress and behaviors.

According to the PPD, a recipient should have an initial assessment at the time of admission in order to identify early interventions that may help minimize or prevent the need for restraint and/or seclusion. The assessment will be used to help formulate an appropriate treatment plan and will identify early indicators of escalating behaviors as well as techniques, methods, and tools that might help the recipient manage his or her thoughts and feelings. Preference for emergency treatment as well as identification of any pre-existing medical condition, physical disabilities, trauma victimization and psychological factors that might have placed the recipient at greater risk during the restraint should also be identified in the initial assessment.

The PPD mandates the decision to use restraint or seclusion to be driven by an individual assessment, which concludes that for the individual at that particular time, the risk of using less restrictive measures outweigh the risk of using restraint and seclusion. Restraint or seclusion may never be used when the possible risk to the individual's medical condition outweighs the behavioral risk, as assessed by the physician or registered nurse. When the intervention used

differs from the individual's stated preference, the rationale must be documented on the Notice Regarding Restriction Rights of Individual form.

According to the PPD, restraint and seclusion may be used only on a written order of a physician, and a PRN order for restraint or seclusion may never be written. Physicians and RNs writing initial and renewed orders for restraint must assess and document an individual's pre-existing physical condition when ordering the body position and type of restraint. Within 15 minutes of the initial application of restraint or seclusion, a RN must personally assess the individual to confirm that the restraint or seclusion does not pose an undue risk to the individual in light of his physical or medical condition

The Initial Order for Restraint or Seclusion for recipients in a maximum secure setting is for no more than four hours for adults aged eighteen years and older. A physician must personally examine the recipient and complete a written order within one hour of the initial implementation of the restraint or seclusion. If restraint or seclusion is discontinued prior to the expiration of the original order, a new order must be obtained prior to re-initiating restraint or seclusion use. The use of the restraint or seclusion may be authorized temporarily by a RN only when a physician is not immediately available. Renewed orders in the maximum secure setting must be completed for no more than four hours for adults aged eighteen and older.

The PPD mandates that only qualified staff members apply restraints or implement seclusion with no fewer than three staff persons present to apply the restraints. At no time is pressure to be placed upon the recipient's back while he is in a prone position. Staff body weight is not to be applied to the recipient's torso and above the upper thighs. Unless specifically ordered by the treating psychiatrist, the recipient will be restrained in the supine position, and the nurse will ensure that the recipient's head is free to rotate. If the individual is placed in a prone position for any reason, he or she should be rolled or turned to the supine position as soon as possible. A recipient should be placed on his or her side if the recipient is vomiting or at risk for vomiting. Nothing should be placed over the individual's face or mouth at any time during the application of the restraints or while the recipient is in restraints, and staff should ensure that the individual's breathing is not obstructed in any way. Staff should promptly search for contraband and other objects that might present a risk to the recipient or to others. Staff should ensure that recipients are restrained as comfortably as possible.

According to the PPD, an individual who is restrained or secluded must be continuously observed by one-to-one supervision from a qualified staff member. The qualified staff member who is observing the individual should be no further away than the door to the restraint room. If a physician determines that the presence of a staff member in the room or at the door to the room is non-therapeutic, the staff member shall be stationed outside the door and provide continuous one-to-one monitoring through the window that provides visual access to the room. The door to the restraint room should not be locked or left unattended at any time during the recipient's restraint.

When a recipient is restrained or secluded, the individual must be placed in a safe location that is approved for the purpose. The individual's privacy and dignity must be respected to the maximum extent possible. The recipient must be informed of the specific release criteria

that is listed in the Restraint or Seclusion Order and that he or she will be released as soon as the release criteria is met. During the restraint or seclusion episode, the RN, physician and monitoring staff will encourage the recipient to achieve the release criteria. Nursing care will be provided to the recipient. If the recipient remains in restraint or seclusion for more than 12 hours, the facility director of his or her designee must be immediately notified. The designee is not to be the physician who ordered the restraint or seclusion. If the individual experiences two or more separate episodes of restraint and/or seclusion of any duration within 12 hours, the facility director or his or her designee must be notified. The designee must not be the same physician who ordered the restraint or seclusion.

According to the PPD, the individual must be released when the written behavioral criteria specified in the restraint or seclusion order are met. The behavioral criteria for release from restraint or seclusion must state if the individual is to be released if he or she falls asleep and whether the individual should be awakened to make this determination. If the restraint or seclusion order expires prior to the behavioral criteria being met, the individual must be released or a new order written.

A RN must conduct a debriefing with the individual who has been in restraints as soon as clinically appropriate, but by the end of the next shift. The purpose of the debriefing is to: 1) assess the physical and psychological effects of the restraint or seclusion on the individual; 2) address any trauma associated with the experience; 3) assist the individual in identifying stressors that occurred prior to the restraint or seclusion; 4) assist the individual and staff in identifying early warning signs of possible future aggression; 5) assist the individual with identification of methods to control aggression and manage anxiety; 6) review with the individual why previously identified early interventions were not employed or were not successful; 7) assist the individual and staff to identify alternative interventions to prevent future episodes; 8) allow the recipient to discuss his or her feelings about the restraint or seclusion experience; 9) assess if the recipient's privacy was respected; and 10) assure the individual that he or she may request staff assistance prior to escalation of anxiety/aggressive behaviors. If the recipient's preferred interventions were not employed, the RN will inform the recipient of the reasons for the decision. If the individual desires, the family or significant other will be contacted by phone and offered the opportunity to participate in the debriefing, unless staff believe that family participation is clinically inadvisable. Documentation of the debriefing should be completed. The recipient's treatment team should review the restraint or seclusion event by the next working day and make modifications as needed in the individual treatment plan.

A section in the PPD addresses recipients' rights. The rights are listed as follows: 1) to be free from seclusion and restraints of any form that are imposed for coercion, discipline, convenience, or retaliation by staff; 2) the right to privacy and dignity; 3) to be free of chemical restraint; 4) restraint and seclusion must be used only to protect individuals from harming themselves or others; 5) within one hour after restraint or seclusion, a RN or physician who ordered the restraint or seclusion must inform the individual of the restriction of his or her rights, and the right to have any person he or she chooses notified of this restriction; 6) the RN or physician must ensure that any person designated by the individual at the time or previously is notified of the restriction promptly after the initial application of restraint or seclusion. Written notification must be made via a Notice Regarding Restricted Rights Form; 7) when restraint is

used for an individual whose primary mode of communication is sign language, he or she must be allowed to have his or her hands free from restraint for the purpose of communication at least five minutes every hour, except when such freedom may result in physical harm to self or others; 8) when restraint or seclusion is used with an individual whose primary language is other than English, every effort should be made to use a translator for communication during the restraint process.

The PPD mandates that only approved restraint devices are used and that those devices be properly inspected and cleaned. Mandates for restraint and seclusion rooms are also listed in the PPD.

According to the PPD, staff must be educated and demonstrate competency in the use of non-physical intervention for reducing and preventing violence and subsequent use of restraint or seclusion. When the use of restraint or seclusion is necessary, staff must insure the safe use of the procedures. Staff members involved in the use of restraint and seclusion are to receive ongoing training and demonstrate competence in the procedures. The viewpoints of the recipient who have experienced restraint and seclusion are to be incorporated into the staff training.

The PPD mandates confidentiality of a recipient's records, and measures to ensure performance improvement pertinent to the use of restraints and seclusion. Specifics regarding nursing standards of care for individuals in restraints or seclusion are also incorporated in the PPD.

Summary

According to the recipient's April 2008 TPR, the recipient was transferred from another less secure state-operated mental health facility due to his extreme physical aggression and his repeated restraint episodes. When he was informed of the circumstances under which the law permits the use of emergency interventions, he listed medication as his choice of intervention and seclusion as his second choice. When the HRA reviewed the recipient's restraint records from 12/01/07 through 03/31/08, the record indicated that the recipient had been in restraints on five different occasions. Documentation indicated that the recipient was physically aggressive toward staff or other recipients in each of the incidents. In four of the incidents, the recipient initiated the physical aggression, and in the other incident he responded to the aggressive acts of another recipient. In the latter incident, the recipient refused to cease fighting when staff requested that he do so. Based on the documentation, the Authority believes that the application of the restraints were in compliance with the Code requirements, facility policy and program directives. However, the Notices associated with Restraint II (11/30/07) and Restraint V (03/21/08) did not contain documentation that indicated whether the recipient had been asked if he wanted the notice of the restriction sent to anyone. The Authority recognizes that prior to each restraint application the recipient was involved in physically aggressive behaviors that had the potential for harm to the recipient or to others, and restraint applications for those behaviors were in accordance with Code requirements. Therefore, the allegation that the recipient was inappropriately placed in restraints is unsubstantiated.

Suggestions:

Because the HRA investigation revealed that the facility did not consistently follow the Code requirements pertinent to informing the recipient of his right to notify any person of his choosing about the restriction of his rights and documenting the notification in the Notice, the following is suggested.

1. Facility staff should ensure a recipient is advised of the right to have any person of his choosing informed of the restraint.

2. Documentation in the Notice should reflect that the advisement and indicate the recipient's choice of persons to be notified or that he did not wish that anyone be notified of the restraint.

When Restraint II (11/30/07) and Restraint IV (1/18/08) Orders for Restraint were implemented, a time frame for the recipient to be free of the behaviors specified in the release criteria were not listed. The Authority suggests the following:

Orders for Restraint should consistently list a time frame for a recipient to be free of the behaviors listed in the criteria for release. e.g.: Recipient should be free from spitting, yelling, and pulling on restraints for a period of 30 minutes.

Allegation 2: The recipient is not receiving services in the least restrictive environment: To investigate the allegation, the Team conducted a site visit at the facility. During the visit the Team spoke with the recipient whose rights were alleged to have been violated and reviewed his clinical chart.

Interview:

The recipient informed the Team that he does not believe that he should be hospitalized in a facility as restrictive as Chester Mental Health Center. He stated that he was transferred to the facility from a less restrictive setting, and he believes that he could function appropriately at that locale.

The recipient related that he had been in restraints several times since his admission. He informed the Team that at the time of the site visit he was on the red level of the facility's level system procedure. According to the recipient, red is the lowest level of the classification, which allows the least amount of opportunity for a recipient to participate in facility activities. He stated that the system is arranged so that a recipient can progress to the yellow level, the intermediate level with increased opportunities for participation and then to the green level with the highest level of opportunities for leisure and educational activities.

Record Review:

TPRs

According to the recipient's 01/09/08 TPR, he was admitted to the facility on 12/21/06 from another state-operated mental health facility. His legal status was listed as Voluntary. Documentation indicated that the recipient was hostile, aggressive and had repeated restraint episodes at the transferring facility. According to the record, verbal redirection, multiple emergency medications, and numerous modifications in the recipient's medications at the transferring facility had been unsuccessful. Recommendations by the staff at the less restrictive facility were to eliminate the recipient's physically aggressive behaviors, reduce his impulsivity, and to maintain those behaviors for a minimum of three months before returning him.

The recipient's medications were listed as follows: 1) Seroquel 200 mg 4 times daily for psychosis; 2) Valporic Acid Syrup 1000 mg by mouth in the morning and at bed time for mood swings; 3) Benadryl 50 mg twice daily for extra pyramidal symptoms; 4) Haldol 10 mg by mouth at 8 AM and 12 PM for aggression: 5) Ativan 1 mg twice daily for Akathisia/agitation and Oxcarbazepine 900 mg Twice daily for mood stability.

A facility Psychiatrist documented in the 01/09/08 TPR that the recipient had been compliant with taking prescribed medications and had suffered no side effects from the administration. The Psychiatrist recorded that the recipient continued to have ongoing verbal aggression and had experienced two restraint episodes during the reporting period.

Documentation indicated that in order for the recipient to be recommended for transfer to an "open" hospital, he must exhibit an ability to inhibit any significant impulses of violence towards himself or others. Additionally, he must express a genuine desire for transfer and his behavior must be brought under sufficient control in order to function appropriately in a less restrictive hospital.

Documentation in the recipient's 04/02/08 TPR indicated that on 03/05/08, the recipient's treatment team recommended that he be transferred to a less secure facility. On 03/21/08, he hit a peer and ended up in restraints. Documentation indicated that during the debriefing after the restraint, the recipient stated that he did not want to leave the facility.

The recipient's psychologist recorded that the recipient engaged in aggression requiring restraints on 3/21/08. However, until that event his mood and behavior had been stable. The psychologist recorded that the recipient stated that he was fearful of going home and getting into fights with his family. The psychologist documented that the recipient's "transfer will be placed on hold until his behavior is consistently free from aggression."

Additional documentation in the 04/02/08 TPR indicated that the recipient has an "entrenched behavioral pattern of aggression which results from his response to fear of the unknown." When the recipient was aggressive towards a peer on 03/21/08, he was aware that his transfer recommendation would be stopped.

Documentation in a 04/20/08 TPR indicated that the recipient had shared his feelings of fear and apprehension during an individual therapy session. When family members refused to

speak with him, frustration triggered an aggressive incident on 04/22/08. Until this occurred, the recipient had displayed emotional control and overall socially appropriate behaviors.

In a 05/28/08 TPR, the recipient's psychologist documented that the recipient had engaged in aggression requiring restraints on two occasions since the last TPR, and he had one incident of self-injurious behaviors. The psychologist recorded that the recipient's transfer recommendation was deferred until his behavior is consistently free from aggression.

Documentation in the recipient's 06/25/08 TPR indicated that the recipient had engaged in one incident of aggressive actions toward his peers and staff. A facility psychologist recorded that the recipient continues to have great difficulties with family communication. Antecedents to the aggressive behaviors are to gain staff's attention and to deal with the emotional pain he has suffered as a result of his family members refusing his telephone calls. The psychologist recorded that the recipient would remain at the facility until his behavior is consistently free from aggression.

Additional documentation in the 06/25/08 TPR indicated that there had been some periods of improvement; however the recipient continues to use aggression as a response to socially challenging situations. The record indicated that a facility psychiatrist continues to adjust his medication regiment to control his impulsive actions. The psychologist recorded facilitation of weekly phone calls by the recipient to his family to insure family support and transfer planning at the time of his departure from the facility.

Criteria for transfer to a less restrictive setting were listed in the 06/25/08 TPR as follows: 1) The recipient must exhibit the ability to inhibit any significant impulses of violence toward himself or others; 2) He must express a genuine desire for transfer; 3) His behavior must be brought under sufficient control in order for him to function appropriately in an "open hospital".

Summary

According to documentation in the recipient's TPRs, he had been recommended for transfer to a less restrictive hospital. After the recommendation was issued, he was placed in restraints after becoming aggressive toward another recipient. During the debriefing process, the recipient stated that he was apprehensive about leaving the facility. Documentation throughout the TPRs indicated that there were some communication problems between the recipient and his family, and this issue was creating distress for the recipient. The record indicated that facility staff members were working with the recipient and his family to ensure that the recipient was able to speak with family members on a weekly basis. Documentation indicated that the recipient's behaviors, progress in programming, and medications were reviewed monthly and adjustments made in an attempt to stabilize the recipient's condition in order that he might meet the criteria for transfer to a less restrictive setting.

Conclusion

Based on the information obtained during the course of the investigation, the Authority does not substantiate that the recipient is not receiving services in the least restrictive environment. No recommendations are issued.