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Egyptian Regional Human Rights Authority
Report of Findings
08-110-9036
Chester Mental Health Center
August 26, 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. Facility staff failed to abide by the recipient's choice of emergency treatment.

Statutes

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

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 5/2-102 states, "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency 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 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:

Recipient:

According to the recipient whose rights were alleged to have been violated, he was placed in restraints after he had an altercation with another recipient. He informed the Team that staff did not require the other recipient to be placed in restraints or be subjected to any other adverse consequences. He stated that he believed that the restraint episode occurred in March 2008. He stated that his placement in restraints was unjustified, and facility staff did not deal with him and the other recipient in a consistent manner.

Chairman:

According to the Chairman, it is the facility's policy to only use restraint to prevent a recipient from causing harm to self or injury to others. He stated that staff members who apply the restraints are trained in the actual application of restraints and the requirements associated with the use of restraints when they are initially employed and yearly thereafter.

Chart Review:

Treatment Plan Reviews (TPRs)

According to the recipient's 01/15/08 TPR, the 31-year-old recipient was admitted to the facility on 06/12/07 on an emergency basis; however, the status was changed to Voluntary admission on 06/13/07. Prior to the recipient's transfer to Chester Mental Health Center, he was re-admitted to another state-operated mental health center on 05/30/07 after only 4 days of discharge.

The recipient's diagnoses were listed as follows: Axis I: Bipolar Mood Disorder with Psychotic Features; Axis II: Polysubstance Dependence History, Alcohol Dependence History; Axis III: History of Head Injury, Hypertension, Diabetes (Adult Onset), Hepatitis C and Hypothyroidism; Axis IV: Chronic Mental Illness.

According to documentation in the TPR, the recipient was informed of the circumstances under which the law permits the use of emergency forced medication, restraint or seclusion. Should any of the circumstances arise, the recipient listed the following forms of interventions in the order of his preference as follows: (1) emergency medication, (2) seclusion and (3) restraints.

The recipient's 01/05/08 TPR contained a goal to address the recipient's problem areas of emotional dysregulation, aggression, substance abuse, Hypertension, Diabetes Mellitus, and a thyroid disorder. A goal to increase the recipient's coping mechanisms through compliance with prescribed medication coupled with therapeutic guidance of alternate modes of coping were listed in the TPR to address the recipient's problem with aggressive behaviors. In the progress section pertinent to the goal, documentation indicated that the recipient had been in restraints twice during the reporting period.

Documentation in the recipient's 02/12/08 TPR indicated that the recipient was placed in restraints on 02/07/08 after he became verbally and physically aggressive to others. His 03/12/08 TPR indicated that he was placed in restraints on 02/23/08 when he became physically aggressive. According to the recipient's 04/08/08 TPR, he required restraints as a result of his physically aggressive behaviors on 03/14/08 and 03/24/08.

Conversely, when the 07/01/08 TPR was conducted, the record indicated that the recipient's response to treatment continued to be favorable. It was noted that he responded to redirection from staff with less arguing, and he had become more compliant with facility routines. Documentation indicated that the recipient had become active in structured

programming, which included on and off unit activity therapy. The record indicated that the recipient had not required restraint during the reporting period.

Restraint Records:

During the investigation process, the HRA reviewed the recipient's restraint records from 01/01/08 through 03/31/08.

Restraint I

Documentation indicated that the recipient was placed in a physical hold from 5:10 PM to 5:15 PM on 01/09/08 after he attacked another recipient. The hold was implemented after staff attempts at redirection, verbal support and reassurance failed, and the recipient was offered his choice of emergency treatment, medication, and he refused. When the recipient continued to fight during the hold process, four-point restraints were applied. The initial Order for restraint was issued at 5:15 PM on 01/09/08. Subsequent orders were issued at 9:15 PM on 01/09/08, 1:15 AM, 5:15 AM, 9:15 AM, 1:15 PM, 5:15 PM and 9:15 PM on 01/10/08 and 1:15 AM and 5:15 AM on 01/11/08.

The release criteria were listed as follows: 1) The recipient must be calm, cooperative and no longer pulling at cuffs, exhibit no aggressive gestures or hostile speech for 1 hour. 2) The recipient must be awake to determine his ability to meet the release criteria. The physician completing the Order documented that the recipient's agitation increased when staff was at his bedside and ordered that staff remain just outside the door of the restraint room.

A Notice Regarding Restricted Rights of Individual (Restriction Notice) was given to the recipient regarding the restraint episode for a period of 1 day and 15 ¾ hours. The reason for the restriction was listed, which stated that when the recipient was placed in a physical hold he continued to fight staff, and his aggressive behaviors escalated. Due to these behaviors, he was placed in restraints for the safety of "all". Documentation in the Restriction Notice indicated that the interventions preferred by the individual were not used because of the level of his aggressive action could cause self-harm or harm to others. The record indicated that the recipient did not wish to have anyone contacted about the restraint.

Documentation in the Restraint/Seclusion Flowsheet (Flowsheet) indicated that a Registered Nurse (RN), on an hourly basis, examined the recipient, checked his circulation, released his limbs, took his vital signs, offered toileting and evaluated his mental, physical and behavioral status. The recipient was offered meals at regularly scheduled meal times.

The Security Therapy Aide (STA) in charge of the recipient's observation documented the recipient's behaviors and any other observation in 15-minute increments during the entire restraint episode.

A RN conducted a post-episode debriefing with the recipient when he was released from restraints. The recipient was able to identify stressors occurring prior to the restraint and verbalize the causes and consequences of his aggressive behaviors. He was able to identify one or more methods to control his aggression, and stated that he was aware that he could request help from staff prior to escalation of his anxiety. However, he expressed that he did not feel that staff could have helped him remain in control of the situation that led to the restraint. It was determined that the recipient was not physically injured during the event, and his physical well-being and privacy needs had been addressed.

Restraint II

The record indicated that the recipient was placed in a physical hold at 7:10 PM on 02/07/08 after he engaged in a "fist fight" with a peer. Both recipients continued to fight after staff requested that their aggressive actions cease. Documentation indicated that the recipient continue to break free of the physical hold in an attempt to continue the fight with the other recipient. When the recipient continued to struggle and attempted further physical violence against the peer, as well as staff, the recipient was released from the physical hold at 7:15 PM and placed in restraints.

The Initial Order for restraints was completed at 7:15 PM on 02/07/08. Subsequent Orders were issued at 11:15 PM on 02/07/08, 3:15 AM, 7:15 AM, 11:15 AM, 3:15 PM, 7:15 PM, 11:15 PM on 02/08/08, and 1:15 AM, 11:15 AM and 3:15 PM on 02/09/08.

The recipient was provided with a Restriction Notice for the restraint episode that began at 7:15 PM on 02/07/08 and ceased on 02/09/08 at 7:15 PM. There was no documentation on the Restriction Notice to indicate the reason that the recipient's preferred emergency treatment was not used or that he was asked if he wished to have anyone notified of the restriction.

Release criteria on the Restraint Orders were listed as follows: 1) The recipient must be calm, cooperative, and exhibit no aggressive gesture and hostile speech. 2) He must be awake to determine the ability to meet the release criteria. The physician ordering the restraint indicated that the staff should remain just outside the door of the recipient's room, because staff presence would increases the recipient's agitation.

Documentation in the Flowsheets indicated that a RN, on an hourly basis, released the recipient's limbs from restraints, checked his circulation and vital signs, offered him fluids and toileting, and assessed his mental and physical status. The recipient was provided with meals at regularly scheduled meal times. The STAs assigned to monitor the recipient continuously observed the recipient and documented his behaviors on a Flowsheet every 15 minutes during the restraint process.

When a RN conducted a post-episode debriefing with the recipient, he was able to identify the stressors occurring prior to the restraint and to verbalize the causes and consequences of his aggressive behavior. He was also able to identify methods to control his aggressive behavior, and stated that he was aware that he could request assistance from staff prior to

escalation of anxiety. The RN reviewed the reason why previously identified early interventions were not successful. The RN also determined that the recipient was not injured during the restraint process, and his well-being and privacy needs had been addressed.

Documentation in the progress notes indicated that the recipient's treatment team met on 02/11/08 to review the restraint episode and to revise the recipient's treatment plan.

Restraint III

Documentation indicated that on 02/23/08 at 5:25 PM, the recipient was placed in a physical hold after the shoved and threatened to harm a staff member. When the recipient was released from the hold at 5:30 PM he was placed in restraints because he continued his combative behaviors. A RN signed the Physical Hold Order at 5:25 PM, and the physician signed at 5:30 PM.

The initial Order for Restraint was signed by the facility physician and the RN at 5:30 PM. Documentation indicated that the behavioral interventions of verbal support and reassurance had been used before the restraints were ordered. However, those interventions were not successful in calming the recipient. The release criteria on the Order were listed as follows: 1). He must be free from pulling on the restraint cuffs 2) He must be calm, cooperative and absent of verbal threats for a period of 1 hour. 3) He must be aware to determine his ability to meet the release criteria. The RN documented that she had personally examined the recipient within 15 minutes of the application of the restraint and had determined that the restraints did not pose an undue risk to the recipient's physical and mental health. A facility physician examined the recipient at 6:10 PM and documented that the restraints did not create any risk to the recipient's health in light of his physical and mental condition.

Subsequent Restraint Orders were issued at 5:30 PM and 9:30 PM on 02/23/08; and 1:30 AM, 5:30 AM, 9:30 AM, 1:30 PM, 5:30 PM and 1:30 PM on 02/24/08. According to the documentation, the recipient met the criteria for release at 1:30 PM on 02/25/08.

A Restriction Notice was given to the recipient pertinent to the physical hold on 02/23/08, and an additional Restriction Notice was given to him for the 1 day and 20-hour restraint episode. According to the documentation, the recipient stated that he did not wish to have anyone contacted about the restrictions. The record indicated that the recipient's preferences for emergency treatments were not used due to the severity of his aggressive attack on staff.

Documentation in the Flowsheets indicated that the recipient was provided with meals at regularly scheduled meal times, and he was offered water and toileting on an hourly basis. A RN examined the recipient each hour, took his vital signs, and released his limbs. A STA provided continuous observation from the door area of the room in accordance with the Restraint Order, and documented the recipient's behaviors every 15 minutes.

When a facility RN conducted a post-episode debriefing, the recipient was able to identify the stressors that had occurred prior to the restraint, and to verbalize the consequences of

his aggressive behaviors. He was able to identify methods to control aggression. He stated that he was aware that he could request help from staff prior to his escalation of anxiety; however, he did not feel that staff could have helped him to remain in control at the time of this particular incident. The RN determined that the recipient was not injured and his physical well-being and privacy had been addressed during the restraint.

Restraint IV

Documentation indicated that the recipient was placed in a physical hold at 8:10 PM on 03/14/08 after he physically assaulted staff. The Order for Physical Hold was signed by a RN at 8:10 PM and a facility physician at 8:15 PM. The RN and physician documented that they had examined the recipient and determined that the hold did not create excessive risk to the recipient's physical and mental wellbeing.

When the recipient continued to fight with staff, a facility physician ordered that the recipient be placed in restraints. The Restraint Order was commenced at 8:15 PM on 3/14/08. A subsequent Order was issued at 12:15 AM on 03/15/08. According to the Orders, the recipient must be calm, cooperative, no longer verbally threatening for a period of 1 hour, and must be awake in order to determine his ability to meet the release criteria.

Documentation in the Flowsheets indicated that a RN examined the recipient on an hourly basis, took his vital signs, released his limbs and offered him toileting. A STA continuously monitored the recipient from the door of the room, per physician's orders, and recorded the recipient's behaviors in 15-minute increments. The recipient met the release criteria at 1:15 AM on 03/15/08.

The recipient was provided with a Restriction Notice for the 5-minute physical hold and an additional Restriction Notice for the 5-hour restraint episode. The Notices were delivered in person to the recipient, and documentation indicated that the recipient did not wish anyone to be notified. Documentation indicated that the recipient's choice of emergency treatment, medication, was offered; however, he refused the medication. The record indicated that due to the level of the recipient's aggressive behaviors, restraints were applied rather than placing the recipient in seclusion, his second choice of emergency treatment.

Restraint V

According to documentation in the recipient's clinical chart, he argued with a peer over commissary food on 3/15/08, the same day of his release from Restraint IV. The record indicated that when the recipient attempted to start a fight, he was offered a medication to assist with his anxiety. However, he refused the medication and then attacked his peer. As a result of those aggressive actions, he was placed in a physical hold at 5:40 PM

When the recipient failed to cease his aggressive actions, an Order for Restraint was issued at 5:45 PM. Subsequent orders were issued at 9:45 PM on 03/15/08, and 1:45 AM, 5:45

AM, 9:45 AM, 1:45 PM, 5:45 PM, and 9:45 PM on 03/16/08. Documentation in the Orders indicated that the recipient must be calm and cooperative, express no threats toward staff members, and to refrain from pulling at the restraints for a period of 1 hour before he would be released. Additionally, the recipient must be awake to determine his ability to meet the release criteria.

Documentation in the Orders indicated that a RN examined the recipient within 15 minutes and a facility physician examined him within 1 hour of the issuance of each Order. Both medical staff determined that the restraints did not pose an undue risk to the recipient's physical and mental condition.

According to the Flowsheets, a RN examined the recipient hourly. The recipient's limbs were released, his vital signs were taken, and he was offered toileting and water. However, documentation did not indicate that the recipient was offered a meal at each regularly scheduled mealtime. During the 30-hour restraint episode, the record indicated that he only had 2 meals. According to the documentation, the recipient was asleep at breakfast time on 03/16/08 and no meal was offered when he awoke. There was no documentation that indicated that the recipient had been offered food at the time of the noon meal on 03/16/08. According to the record, the only meal that he was offered was at 4:15 PM on 03/16/08.

The record indicated that a RN conducted a post-episode debriefing when the recipient was released from restraints. He was able to identify stressors that occurred prior to the restraint and able to verbalize an understanding of the causes and consequences of his aggressive behaviors. He expressed that he could have asked staff to assist him in regaining control and was able to identify methods to control his aggressive behaviors. Documentation indicated that the recipient was encouraged to discuss his feelings related to the restraint, and the reasons why previously identified early intervention were not employed. The RN documented that the recipient was not injured during the restraint, and his well-being and privacy needs had been addressed during the restraint process.

A Restriction Notice was given to the recipient pertinent to the physical hold as well as the restraint episode. Documentation in both Restriction Notices indicated that the recipient's rights were restricted due to his physical aggression toward a peer. The record indicated that the recipient's choice of emergency treatment was not used because the recipient had refused medication and seclusion was not an option due to the severity of his aggressive acts. Documentation specified that the Restriction Notices were delivered to the recipient in person, and he stated that he did not wish to have anyone notified of the restrictions.

Restraint VI

According to documentation in the recipient's clinical chart, he was placed in a physical hold at 2:25 PM on 03/28/08. The record indicated the recipient became agitated due to his move to another room. The record indicated that when he entered the new room he hit the wall with his fist. When staff attempted to redirect him, he became verbally threatening and his behaviors accelerated to physical aggression toward staff members. An Order for Physical Hold

was implemented at 2:25 PM and continued until 2:30 PM on 03/28/08 in order to protect others from harm.

Due to the level of the recipient's continued physical aggression, an Order for Restraints was issued at 2:30 PM on 03/28/08. When the recipient was examined, it was determined that his right hand had been injured when he hit the wall with his fist. When it was established that the restraints were medically contraindicated, the recipient was released from the restraints at 2:45 PM and accompanied by staff to have an x-ray of his right hand.

Restriction Notices were given for the physical hold and the restraint episode. Documentation in the Flowsheet specified that when the recipient was initially examined after restraint application, a determination was made that the restraints were medically contraindicated As a result of the review, the recipient was released from the restraints and sent for an x-ray of the hand. There was indication that the recipient had been asked if he wanted someone to be notified of the hold or restraint episode. The record indicated that emergency medication was not given because there was not an order for the medication. Seclusion was not considered due to the recipient's self-abusive behaviors.

According to the x-ray findings report, the recipient did not receive any type of fracture to the hand when he hit the wall with his fist.

Restraint VII

The recipient's record indicated that when the recipient was brought back to his room after having an x-ray of his hand, his agitation increased, and he attempted to hit a staff member. As a result of his aggression toward the staff member, he was placed in a physical hold at 3:12 PM on 03/28/08, released from the hold at 3:15 PM and immediately placed in restraints. A Physical Hold Order was completed at 3:12 PM, and the initial Order for Restraint was completed at 3:15 PM. Documentation indicated that additional Orders for Restraint were completed at 7:15 PM and 11:15 PM on 03/28/08 and 3:15 AM and 7:15 AM on 03/29/08.

On each of the Orders for Restraint, the criteria for release were listed as follows: 1) The recipient must be calm and cooperative with reviews. 2) He must not exhibit aggressive gestures, hostile speech or self-injurious behaviors for a period of 1 hour. 3) He must be awake to determine the ability to meet the release criteria. According to the Orders, observation of the recipient should be just outside the door of the restraint room because a staff member's presence would increase his agitation.

Documentation in the Flowsheets indicated that a RN checked the recipient's circulation, released his limbs and checked his vital signs on an hourly basis. He was also offered toileting and fluids hourly and given meals at regularly scheduled meal times during the restraint episode. STAs in charge of observing the recipient documented the recipient's behaviors in 15-minute increments. Documentation on the Flowsheets indicated that the recipient was awake and quiet from 2 AM until 3:15 AM on 03/29/08, a period in excess of the 1 hour listed in the release criteria. However, the recipient was not released from the restraints and an additional Order was

implemented. Documentation indicated that the recipient was released from the restraints at 11:15 AM on 03/29/08, 20 hours after the initial implementation.

The recipient was provided with Restriction Notices pertinent to the physical hold and the restraint. Documentation in both Restriction Notices indicated that the recipient had verbally threatened staff and attempted to strike them. According to the record, the recipient's preferred interventions were not used. Documentation indicated that emergency medication was not given because there were no PRN medication prescriptions in the recipient's record. Seclusion was not considered an option because of the recipient's self-injurious behaviors earlier in the day. The record indicated that the Restriction Notices were delivered in person. Neither Restriction Notice indicated whether the recipient wanted anyone notified of the restrictions.

Progress Notes.

The HRA reviewed March 2008 Progress Notes in the recipient's clinical record. According to a 03/14/08 Progress Note completed by a STA, the recipient threw his food tray while in the dining area. When he was brought back to the unit, his agitation and cursing of staff continued. Documentation indicated that the recipient was offered medication for anxiety; however, he refused the medication. The record indicated that when the recipient struck staff at 8:10 PM, he was placed in a physical hold, followed by placement in restraints at 8:15 PM.

In a 1:45 AM Progress Note on 03/16/08, a facility physician documented that he had seen the recipient while in restraints and recorded that initially the recipient had denied any wrongdoing. However, after some discussion he was able to relate the details of his fight with another recipient and stated that the other recipient stopped fighting, therefore, he was not placed in restraints. Conversely, he was placed in restraints because he continued the fight. The physician recorded that staff had reported the recipient had been "threatening to break a staff member's jaw".

Facility nursing staff documented the recipient's behaviors in the Progress Notes on an hourly basis. Documentation indicated that the recipient met the criteria for release from the restraints at 11:45 PM on 03/16/08 and the debriefing was conducted at 12 PM on 03/16/08

Documentation in a nurse's 03/28/08 Progress Note indicated that the recipient was in the process of being moved into a new room when he hit the wall in the room with his fist. When redirection efforts failed, the recipient became physically aggressive with staff. The nurse documented the recipient was placed in a physical hold, then into restraints. When the initial examination was conducted, it was determined that the restraints were contraindicated due to the injured hand. According to the documentation, the recipient was released from the restraints and taken for x-rays of his left hand.

Additional documentation by a facility physician indicated that the recipient had returned from having the x-rays of the hand, and the preliminary radiology report indicated that there were no fractures to the hand. The physician documented that an ace wrap would be applied to the recipient's injured hand.

A RN documented that when the recipient was escorted to the unit at 3:12 PM on 03/28/08 after the x-rays were completed, he attempted to attack a STA. A physical hold was implemented and continued until 3:15 PM. At 3:15 PM, he was placed in restraints. The nurse documented that the recipient's preferences were not honored because he had "no PRN on order, seclusion is not an option as he was self-injurious earlier today."

A 3/28/08 Progress Note completed by a nurse at 4:05 PM documented that a facility physician had signed the Physical Hold and Restraint Orders, and he had also written a PRN order for Haloperidol.

A Progress Note completed by a nurse at 7:10 PM recorded that the physician had changed the recipient's PRN order to Lorazepam for agitation and had discontinued the Haloperidol as earlier prescribed due to a "listed allergy."

A STA documented in a 3:15 AM Progress Note that the recipient remained unstable and unpredictable and did not meet the criteria for release; however, the chest posey was removed.

A physician's Progress Note at 3:15 AM on 03/29/08 documented that the recipient remained unstable and unpredictable and restraints should be continued for the safety of all; however, the chest posey should be discontinued.

A RN documented in a 3:15 AM 03/29/08 Progress Note that the recipient's vital signs were taken and his circulation and skin evaluated. The RN recorded that no problems were noted with the recipient's circulation and there was no indication of skin breakdown. Additional documentation indicated that the recipient continued to yell and threaten staff. He also refused to use a urinal, and urinated on himself and the restraint bed. The RN documented that is was necessary for the recipient to have clean clothing and bed linens.

A STA recorded in a 7:15 AM Progress Note that the recipient continued to remain unstable and agitated.

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 have 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.

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

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: 1) 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 mental 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 associate 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 if employed was not successful; 7) assist the individual and staff to identify alternative intervention 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) to 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 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 of the recipient's right 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 use of restraints and seclusion. Specifics regarding nursing standards of care for individuals in restraints or seclusion are also incorporated in the PPD.

Summary for Allegation 1

When the HRA reviewed the recipient's restraint episodes from January 1, 2008 to March 30, 2008, documentation indicated that the recipient had been placed in physical holds and restraints on seven occasions. According to record, the recipient was placed in restraints on 01/09/08, 2/07/08 and 03/15/08 after he physically attacked other recipients. He was placed in

restraints on 02/23/08, 03/14/08, and 03/28/08 at 3:15 PM due to his attack on staff members. On 03/28/08 at 2:30 PM, he was placed in restraints after he hit the wall with his fist and then attacked staff. He was released within 15 minutes of the restraint application due to the injury to his hand.

According to the Mental Health and Developmental Disabilities Code, restraints may be used only as a therapeutic measure to prevent a recipient from causing harm to himself or physical abuse to others. Documentation in Progress Notes, Restraint Orders and Restriction Notices for all of the restraint episodes indicated that the restraint applications were implemented to prevent the recipient from causing harm to himself or to others.

However, when the recipient was provided with a Restriction Notice for the restraint episode that began on 02/07/08 at 7:15 PM and continued until 02/09/08 at 7:15 PM, the reason that the recipient's preferred emergency treatment was not used was not listed on the Restriction Notice. Additionally, there was no documentation that indicated whether the recipient wished to have someone notified of the restriction.

The Restriction Notice pertinent to the 02/23/08 restraint was in accordance with Code requirements. Documentation indicated that the recipient did not want anyone notified of the restraint, and indicated that the recipient's choice of emergency treatment was not used due to the severity of his physical aggression.

Documentation in the Restriction Notice pertinent to the 03/14/08 restraint indicated that the recipient had refused medication, his first choice of emergency treatment, and his level of aggression warranted restraint use. However, the Restriction Notice for the 03/28/08 restraint episode did not indicate whether the recipient had been asked if he wanted someone to be notified of the restraint. Additional documentation indicated that the recipient's first choice of emergency intervention could not be used due to the absence of an order for the emergency medication.

According to documentation in the Flowsheets associated with the 03/15/08 restraint event that continued for a 30-hour period, the recipient did not receive breakfast or a noon meal on 03/16/08. Nor did the HRA observe any recording in the progress notes that indicated that the recipient had received the meals.

According to documentation in the Flowsheets associated with the second restraint that began at 7:15 PM on 03/28/09, the recipient was awake and quiet from 2 AM until 3:15 AM on 03/29/08, a period in excess of the 1 hour listed in the release criteria on the Restraint Order. Documentation indicated that the recipient remained in restraints until 11:15 AM on 03/29/08. Conversely, recording in the progress notes associated with the restraint indicated that the recipient remained agitated and aggressive until an hour before his release.

Documentation in a Restriction Notices pertinent to the 03/29/08 restraint indicated that the recipient was not given medication, the recipient's first choice of emergency intervention, because there was no physician's order for the administration of the medication. The recipient's second choice of emergency intervention was not used, because of the self-injurious behaviors

that he had displayed earlier in the day. Documentation in a progress note completed by a facility nurse when the restraints were applied, indicated the recipient's preference for emergency treatment was not honored because he had "no PRN on order". A progress note completed by a nurse at 4:05 PM on 03/28/08 indicated that a physician had written a PRN for Haloperidol. In a 7:10 PM progress, the nurse documented that the physician had changed the recipient's PRN order to Lorazepam for agitation and had discontinued the Haloperidol as earlier prescribed due to a "listed allergy".

Documentation in Progress Notes indicated that the recipient's treatment team met on 02/11/08 to review the Restraint II episode. However, the HRA did not observe any documentation that indicated that the recipient's treatment team had met or made revisions in the recipient's TPR after the other restraint episodes.

Conclusion to Allegation 1

Although documentation indicated that each restraint application was implemented to prevent the recipient from causing self harm or physical abuse to others, the HRA concluded that the facility did not follow the Code's requirements and Program Directives for the following: 1) Documentation in the 02/07/08 Restriction Notice did not indicate the reason the recipient's preferred emergency treatment was not used, and, in the 02/07/08 and 03/28/08 incidents, whether the recipient wished to have someone notified of the restriction. 2) Documentation did not indicate that the recipient was provided with breakfast and a noon meal while he was in restraints on 03/16/08. 3) The recipient was not released from restraints when documentation in the flowsheet indicated that he had met the criteria listed in the Order issued on 03/28/08. 4) The recipient's preferred emergency treatment listed in his Treatment Plan was not utilized on 03/28/08 because documentation indicated that was no physician's order for emergency medication. 5) Documentation regarding the meeting of the recipient's treatment Team after each restraint episodes was not observed during the investigation. Therefore, the allegation that a resident was inappropriately placed in restraints is substantiated.

Recommendations for Allegation 1:

1) Facility staff should give consideration to the preference of the recipient regarding which form of emergency intervention is used per Code and policy requirements

2) Whenever the recipient's choice of emergency I intervention is not utilized, the recipient should be informed in a Restriction Notice of the reason his preferred intervention(s) could not be implemented per Code and Policy requirements.

3) A recipient must always be provided with a meal at regularly scheduled meal times while in restraints. The recipient's refusal or acceptance should be documented in the flowsheet pertinent to the restraint per Code and Policy requirements.

4) A recipient should immediately be released from restraints when he meets the

criteria listed in the Restraint Order per Code and Policy requirements.

5) Documentation in the Flowsheets and progress notes relevant to a recipient meeting the release criteria should correlate per Policy requirements.

6) The facility should ensure that a recipient's clinical chart is reviewed to determine if the recipient has any listed allergies prior to medication orders being issued per Code requirements pertinent to adequate care (405 ILCS 5/2-102).

7) A recipient's treatment team should review each restraint event by the next working day, make modification in the recipient's treatment plan if appropriate, and complete appropriate documentation per facility policies.

8) During a restraint episode, monitoring staff should encourage the recipient to achieve the release criteria and document the methods of encouragement per facility policies.

Allegation 2: Facility Staff failed to abide by the recipient's choice of emergency treatment. During a site visit at the facility, the Team spoke with the recipient about the allegation. Information obtained during the investigation process for allegation 1 was also reviewed.

Interview:

According to the recipient, when he was admitted to the facility he informed staff that in the event of an emergency situation he would prefer to have medication to assist him in regaining control. He stated that his second choice of emergency treatment was seclusion, and his least preferred intervention was listed as restraints. He informed the Team that his choice of emergency treatment(s) has been ignored, and his least favorite intervention has been consistently implemented.

Chart Review

According to the recipient's 01/05/08, 02/12/08 and 07/01/08 TPRs, the recipient was informed of the circumstances under which the law permits the use of emergency treatment may occur. Documentation in each of the TPRs indicated that the recipient listed emergency medication as the preferred intervention and seclusion as his second choice. Restraints were listed as his least favored form of intervention.

Restraint Records and Restriction Notices:

The HRA reviewed restraint records from January 1, 2008 through March 31, 2008. The record indicated that the recipient was placed in a physical hold, followed by physical restraints seven times during the period of review.

A Restriction Notice was given to the recipient for the 01/09/08 physical hold and another Restriction Notice was provided for the 1 day 15 ¾ hour restraint. Documentation in the Restriction Notice pertinent to the restraint indicated that the recipient's preferred interventions were not used due to the severity of the recipient's aggression toward others.

There was no documentation in the Restriction Notice for the restraint, which commenced at 7:15 PM on 02/08/08 and ended on 02/09/08 that indicated the reason that the recipient's preferred emergency treatment was not used.

According to the Restriction Notice given to the recipient for the 02/23/08 restraint of 1 day and 20 hours, the recipient's preferred emergency treatment was not utilized due to the severity of the recipient's physical attack on staff.

Restriction Notices were provided to the recipient for the physical hold as well as the restraint episode on 03/14/08. Documentation in the Restriction Notice for the restraints indicated that the recipient's choice for emergency interventions was not used due to the severity of the recipient's physical aggression toward staff.

Documentation indicated that the recipient argued with a peer over commissary food on 03/15/08 and when he attempted to start a fight with the peer he was offered medication. However, the recipient refused the medication and struck at the recipient. As a result of his aggressive actions, he was placed in a physical hold. When he continued fight and attempt to the hit the recipient, he was placed in restraints. Restriction Notices were provided to the recipient for the physical hold and the restraint application. According to the documentation, the recipient's choice of emergency treatment was not used because he refused medication, and seclusion was not an option due to the severity of his aggressive acts.

According to the record, the recipient became upset because he was being moved to a new room on 03/28/08. As a result of his frustration concerning the move to the new room he hit the wall with his fist. When staff attempted to redirect him, he became verbally threatening and his behavior accelerated to physical aggression toward the staff member. He was placed in a physical hold from 2:25 PM until 2:30 PM. When he continued to attempt to strike staff, he was released from the physical hold and placed in restraints. When the recipient was examined at 2:45 PM, it was determined that he had injured his right hand when he hit the wall with his fist, and the restraint application was medically contraindicated. He was released from the restraints at 2:45 PM and taken by a staff member for an x-ray of the hand. Restriction Notices were provided to the recipient for the physical hold as well as the restraints. According to the Restriction Notices, "no prn/emergency enforced medication order, seclusion not an option due to SIB" (self injurious behaviors).

After the recipient was brought back to his room after having an x-ray of the hand completed, documentation indicated that his agitation increased, and he attempted to hit a staff member. As a results his aggressive actions, he was placed in a physical hold at 3:12 PM, and to restraints at 3:15 PM. According to the Restriction Notices relevant to the physical hold and the restraints, the recipient's preferred choice of emergency intervention, medication, was not given

because there was no PRN medication orders and seclusion was not implemented because of the recipient's self-injurious behaviors displayed earlier in the day.

Summary of Allegation 2

According to the documentation, the recipient's choice of emergency treatment was not utilized for the 01/09/08, 02/23/08 and 03/14/08 restraints episodes. There was no documentation in the 02/08/08 Restriction Notice that indicated the reason that the recipient's preferred emergency treatment was not used. Documentation in the 03/15/08 Restriction Notice indicated that when the recipient was offered his preferred emergency treatment, medication, he refused the medication. Additional documentation indicated that seclusion was not an option due to the severity of his aggressive acts. According to the 03/28/08 Restriction Notices, the recipient did not receive medication because there was no order for emergency medication. Seclusion was not considered an option because the recipient had injured his hand earlier in the day when he hit the wall of his new room.

Conclusion

The Authority concludes that the facility abided by requirements in Section 5/2-200 of the Code in regard to the 01/09/08, 02/23/08, 03/14/08 and 03/15/08 restraint episodes. However, the Authority does substantiate a Code violation pertinent to the 02/2808 and 03/28/08 restraint applications. Since there was no documentation that indicated that the recipient had been informed of the reason that his preferred emergency treatment was not implemented when restraints were applied on 02/28/08, and since there was no physician's order for emergency medication although the recipient's choice of intervention was consistently expressed in his TPRs when restraints were applied on two occasions on 03/28/08, the allegation that facility staff failed to abide by the recipient's choice of emergency treatment is substantiated.

Recommendations

1. Recommendations 1 and 2 for allegation 1 are also relevant to allegation 2.

2. Facility staff should ensure that a recipient's treatment plan is thoroughly reviewed, his choice for emergency intervention noted and medication orders completed for emergency medication.