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Egyptian Regional Human Rights Authority
Report of Findings
09-110-9006
Chester Mental Health Center
June 2, 2009

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 was placed in seclusion without a valid reason for the placement.

Statutes

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/2-108, 405 ILCS 5/2-109 and 405 ILCS 5/2-201).

Section 5/2-108 of the Code states, "Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized. In no event shall restraint be utilized to punish or discipline a recipient, nor is restraint to be used as a convenience for the staff."

Section 5/2-109 states, "Seclusion may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. In no event shall seclusion be utilized to punish or discipline a recipient, nor is seclusion to be used as a convenience for the staff."

Section 5/2-201 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 therefore 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 the 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 restraints or seclusion and the reason therefore 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, 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 the Chairman of the facility's Human Rights Committee (Chairman). The Authority reviewed copies of information from the recipient's clinical chart, with his written authorization. The facility's policy and the Department of Human Services/Mental Health (DHS/MH) Program Directive (PPD) pertinent to Restraint and Seclusion were reviewed.

I...Interviews:

A…Recipient:

During the site visit, the Team spoke with the recipient about the allegation. He stated that he has a loud voice that seems to irritate the Security Therapy Aides (STAs). He informed the Team that he was placed in restraints several times in May 2008 because of his voice volume. He informed the Team that he came from a very large family and if you wanted to be heard you had to speak loudly. He stated that he continued to speak in a loud volume after he no longer lived with his siblings. He denied any aggressive actions toward himself or others.

B…Chairman:

According to the Chairman, the facility's policy is in accordance with the Code's requirements, which mandates that restraints only be used for the recipient's protection or the protection of others. When the Team spoke with the Chairman, the Team requested copies of the recipient's Treatment Plan Reviews (TPR) for May, June and July 2008, restraint and seclusion records for 2008 and Restriction of Rights Notices for 2008.

II…Record Review:

When the copies of the requested information were received, the Authority reviewed the information.

A…TPR Review:

According to the recipient's 05/13/08 TPR, he was admitted to Chester Mental Health Center on 04/18/02 from a psychiatric unit of a county jail. According to documentation, the recipient had 97 prior admissions to mental health facilities since the age of 13 years old.

His problem areas were listed as follows: 1) aggression and destruction of property; 2) psychotic symptoms; 3) non-compliance with medication; 4) substance abuse; 5) compromised immune system; 6) Hepatitis; and 7) Diabetes Mellitus. The recipient's TPR contained goals to address each of the problem areas.

His diagnoses were listed as follows: AXIS I: Schizoaffective Disorder (Bipolar Type 295.70) and Poly-Substance Dependence (in a controlled environment 302.80); AXIS II: Antisocial personality Disorder 301.7; AXIS III: Hypertension, Diabetes, Mellitus, Hepatitis C positive, HIV Positive; AXIS IV; Chronic mental illness, multiple medical problems, questionable primary support system and legal issues.

The recipient's medications were listed as follows: Haldol 30 mg twice daily, Clonazepam 1 mg three times daily, Oxcarbazepine 1200 mg twice daily, Benadryl 50 mg three times daily and Cogentin .5 mg twice daily.

In the Emergency Intervention/Rights Section of the TPR, documentation indicated that the recipient had been informed of the circumstances under which the law permits the use of emergency forced medication, restraints or seclusion. The record indicated that should any of these circumstances arise, the recipient preferred the following interventions as listed in order of preference: 1) emergency medication, 2) seclusion and 3) restraints.

Documentation in the TPR indicated that the recipient had become more manic in the previous week. He had exhibited more agitated threatening, loud, argumentative, demanding and uncooperative behaviors. These behaviors became so severe that he required seclusion on 05/12/08 in order to protect other recipients and staff from harm. His most recent prior restraint occurred on 03/26/08. However, during the reporting period there were seven episodes of physical aggression documented on Behavior Data Sheets.

Documentation in a 06/10/08 TPR indicated that the recipient had been in restraint on 05/22/08, 05/23/08, and 05/24/08-05/25/08. According to the record, when the recipient became very physically aggressive and kicked staff, he was placed in a physical hold followed by restraints. On 05/23/08, he became agitated, made verbal treats, yelled racial slurs at others and demanded to be placed in restraints. On 05/24/09, he became agitated once more, yelled and called staff members inappropriate names, verbally threatened them, and ultimately struck a staff member. Documentation indicated that the recipient had twenty eight behavior data sheets during the reporting period.

According to the recipient's 07/08/09 TPR, the recipient was placed in restraints on 06/13/08 due to physically aggressive behaviors toward others.

B… Physical Hold Orders, Restraint Order, and Restriction of Rights Notices:

Restraint 1...05/22/08

According to a 05/22/08 Physical Hold Order, the recipient kicked a staff member after attempts of redirection, assurance and empathic listening had failed. Documentation indicated

that due to the level of the behavior, no other interventions were attempted prior to the physical hold. The hold was implemented at 5:10 PM and the recipient was released from the hold at 5:15 PM and placed in restraints.

Documentation indicated that the recipient was provided with a Restriction of Rights Notice pertinent to the hold. The reason listed for the restriction was that the recipient had been upset when medications were being passed, had kicked a staff member in the thigh, and became combative with others. Documentation indicated that he was placed in a physical hold and escorted to the restraint room. According to the record, the recipient's preferred intervention was not used due to the level of intensity of his agitation and threats to harm self and others. The Notice was delivered to the recipient in person. The HRA did not observe any documentation to indicate whether staff had asked the recipient if he wanted anyone notified of the hold.

Orders for Restraint were issued at 5:15 PM and 9:15 PM on 05/22/08. The specific reason listed for the restraint was the recipient came out of his room, kicked a staff member, and continued to be combative during the physical hold. He was placed in restraints for his safety and the safety of others. The Orders were issued for up to 4 hours so that there would be an adequate amount of time to allow the recipient to gain control of his maladaptive behaviors. The criteria for release were as follows: 1) The recipient must be calm, cooperative and agree to follow module rules. 2) He should refrain from yelling, threatening others and pulling on restraints for 1 hour. The Orders were signed by a Registered Nurse (RN) at 7:15 PM and 9:15 PM. A facility physician signed the initial order at 5:30 PM and the second order at 9:15 PM.

Documentation indicated that the recipient was continually observed during the restraint episode and his behaviors were recorded on Restraint/Seclusion Flowsheets every 15 minutes. The recipient's arm and legs circulation, vital signs, mental status, and physical status were reviewed and documented on an hourly basis. His limbs were released hourly during the entire restraint. He was offered toileting and fluids when the reviews were conducted.

According to documentation in the Restraint/Seclusion Flowsheets, a body search was completed when the recipient was placed in restraints. Staff examined the recipient and determined that the restraints were properly applied and the recipient was properly positioned. Staff determined that the room environment was appropriate, and the recipient was wearing proper clothing for the restraint. The record indicated that the recipient was informed of the reason for the restraint and provided with a Restriction of Rights Notice.

Documentation indicated that the recipient met the criteria for release at 11:45 PM on 05/22/08. Upon his release from the restraints, an RN conducted a post-episode debriefing. The recipient was able to identify stressors occurring prior to the restraint, and he was able to verbalize an understanding of the causes and consequences of the aggressive behaviors. He stated that he felt staff could have helped him remain in control, and stated that he was aware that he could request a staff member's assistance prior to escalation of his anxiety. He was also able to identify one or more methods to control the aggressive behaviors. According to the record, he was encouraged to discuss his feelings related to the restraint.

Upon examination, it was determined that the recipient had not received any injury during the event and that his physica*l well-being and privacy needs had been addressed.

The HRA observed a Restriction of Rights Notice that was given to the recipient for the restraint episode that commenced at 5:15 PM on 05/22/08 and ended at 11:45 PM on 05/22/08. Documentation indicated that the recipient's preferred intervention was not used due to the level of severity of his actions and his potential to inflict harm to self and others. According to the record, the Restriction of Rights Notice was delivered to the recipient in person. The HRA did not observe any documentation that specified the recipient had been asked if he wanted to have anyone notified of the restraint.

Restraint 2…05/23/08

According to documentation in a 05/23/08 Order for Restraint, the recipient became upset with peers and began yelling threats of harm and racial slurs. The record indicated that he walked to the restraint room, demanded restraint use, and continued to verbally threaten peers. Documentation indicated that verbal support and reassurance did not assist the recipient in gaining control of these behaviors. A facility physician and an RN signed the Restraint Order, and he was placed in restraints at 7:45 PM on 05/23/08. The criteria for release were listed as follows: 1) The recipient must be calm, cease yelling slurs and verbal threats, refrain from spitting and cease pulling on the restraints. 2) He must be cooperative. 3) He must be awake to determine his ability to meet the release criteria.

According to documentation in the Restraint/Seclusion Flowsheets, the recipient met the criteria for release at 11:45 PM on 05/23/08. The record indicated that the recipient was continually observed during the four hour restraint episode, and his behaviors were documented at fifteen minute intervals. On an hourly basis, an RN released the recipient's limbs and reviewed his circulation. His vital signs were taken and his physical and mental statuses were assessed during the review. He was also offered fluids and toileting.

Documentation on the Restraint/Seclusion Flowsheets indicated that a body search was completed when the recipient was placed in restraints. An RN examined the recipient and determined that the restraints were properly applied and the recipient was wearing appropriate clothing for the restraint. The RN established that the recipient was properly positioned and the room environment was appropriate. He was informed of the reason for the restraint and the criteria for release. Documentation indicated the recipient was given a Restriction of Rights Notice.

According to a Restriction of Rights Notice for the 05/23/08 restraint, the recipient demanded to be placed in restraints. The record indicated that he was yelling, cursing and threatening to harm others. The restraint commenced at 7:45 PM and ceased at 11:45 PM on 05/23/09. The Restriction Notice was delivered in person, and the recipient designated an individual that he wanted notified of the restraint

Physical Hold and Restraint 3…05/24/08-05/25/08

According to documentation in an Order for Physical Hold, when the recipient became combative with staff, he was placed in a physical hold at 4:25 PM on 05/24/08 for a 5 minute period. When he continued to struggle with staff, he was escorted to the restraint room and placed in restraints at 4:30 PM. A RN signed the order at 4:25 PM and reported to a facility physician at time of signature. The physician signed the Order at 4:30 PM. A Restriction of Rights Notice was given to the recipient when the physical hold was implemented. Documentation indicated the recipient's preferred intervention was not utilized due to the severity of his agitation, verbal threats and physical aggression. A Restriction of Rights Notice was given to the recipient. He requested that a designee be notified of the restriction and the Notice was sent to the designee

Documentation indicated that an Order for Restraint was issued at 4:30 PM. The release criteria were listed as follows: 1) The recipient must be calm and cooperative and refrain from pulling on the restraints and spitting at others for one hour. 2) He must be awake to determine the ability to meet the release criteria.

Subsequent Orders for Restraint were issued at 8:30 PM on 05/24/08, 12:30 AM, 4:30 AM, 8:30 AM, 12:30 PM, 4:30 PM on 05/25/08. Documentation indicated that the recipient was released from restraints at 7 PM on 05/25/09 after an RN checked his vital signs and determined that his blood pressure was elevated.

According to Restraint/Seclusion Flowsheets for the restraint episode, the recipient's circulation, vital signs, and physical status were examined on an hourly basis. His limbs were released and he was offered toileting and fluids at the time of the hourly examinations. He was provided with meals at each scheduled meal time.

Documentation indicated that the recipient's body was completely searched when the restraints were applied. An RN examined the recipient and determined that the restraints were properly applied and that he was wearing proper clothing. The RN concluded that the room environment was appropriate, and the recipient was properly positioned during the restraint process. The record specified that the recipient was informed of the reason for the restraint and was provided with a Restriction of Rights Notice.

According to a Restriction Notice, the recipient was in restraints for 1 day and 2 ½ hours. The restraint commenced at 4:30 PM on 05/24/08 and ended at 7 PM on 05/25/08. The reason listed for the restriction was that the recipient had been kicking others. He had also yelled and verbally threatened to harm others. The Restriction Notice was delivered to the recipient in person, and he expressed that he wanted a designee notified of the restraint. The facility complied with the recipient's request regarding the notification.

Upon his release from restraints, an RN conducted a post-episode briefing. According to documentation, the recipient was able to identify the stressors occurring prior to the restraint, to

verbalize an understanding of the causes and consequences of his aggressive behaviors and to identify other methods to control those behaviors. The recipient informed the RN that he felt that staff could have helped him to remain in control, and he was aware that he could have requested assistance prior to escalation of his anxiety. According to the record, staff encouraged him to discuss his feelings related to the restraint. It was determined that he did not receive an injury during the event and his physical well-being and privacy needs were addressed. The record indicated that the recipient was released due to elevation of his blood pressure rather than his meeting the criteria for release from the restraints.

Restraint 4…06/13/08

According to a 06/13/08 Order for Restraint, the recipient was placed in restraints at 8:45 PM because he was threatening to harm others. Documentation indicated that staff had provided verbal support and reassurance prior to the application; however, those efforts failed to calm the recipient. The release criteria were listed as follows: 1) The recipient must be calm, cooperative, and no longer threatening to harm staff and peers. He must refrain from pulling on restraint cuffs. 2) He must be awake to determine if he meets the release criteria. The Order was signed by an RN at 8:45 PM and the facility physician at 9:35 PM on 06/13/08 after examining the recipient. Documentation indicated that the RN had contacted the physician via telephone at 8:45 PM, and the physician had approved the restraints at that time.

Additional Orders for Restraint were completed at 12:45 AM and 4:45 AM on 06/14/08. When the 4:45 AM Order for Restraint expired at 8:45 AM, the recipient was placed in seclusion, his preferred emergency intervention. After an Order for Seclusion was implemented, the recipient was placed in seclusion for a period of four hours. (The seclusion will be addressed in the investigation of allegation 2).

According to Restraint/Seclusion Flowsheets, the recipient's circulation, vital signs, and physical status were evaluated hourly. His limbs were released from restraints during the hourly examinations and he was offered toileting and fluids. He was provided with a meal at 7 AM on 06/14/08.

The recipient was provided with a Restriction of Rights Notice for the restraint that began at 12:45 PM on 06/13/08 and ended at 8:45 AM on 06/14/08. Documentation indicated that the recipient's preferred emergency intervention had not been effective, and restraints were the least restrictive means to maintain safety for the recipient and others. The Restriction of Rights Notice was delivered in person. Documentation indicated that the recipient specified that he didn't want anyone notified of the restraint.

Policies

A…Use of Restraint and Seclusion (Containment) Policy (Policy)

The Authority reviewed the facility's Policy pertinent to the allegation. Documentation indicated that the Policy was implemented 09/19/05 and reviewed 01/98, 12/14/01, 12/18/01, 09/27/04, 06/27/04, 06/20/05, 06/27/05, 08/03/05, 09/16/05, 09/19/05, and 04/04/07.

The Policy Statement is as follows, "Chester Mental Health Center uses restraint and seclusion only as a therapeutic measure to prevent an individual from causing physical harm to himself and others and follows the Department of Human Service Program Directive 02.02.06.030.

B…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

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.

Summary

The HRA's review of the recipient's clinical chart revealed that the recipient was in restraints on four occasions during the targeted review period. Documentation for the initial restraint episode indicated that the recipient was placed in a physical hold after he kicked a staff member. When the hold failed to cause the recipient's aggressive behaviors to cease, he was placed in restraints. When the HRA reviewed the second restraint, documentation indicated that the recipient requested to be placed in restraints because he could not regain self-control. When the HRA reviewed the third restraint episode, it was noted that the recipient was placed in a physical hold and when his aggressive behaviors failed to cease he was placed in restraints. Documentation indicated that when an RN conducted an hourly review, the recipient's blood pressure was elevated. When the RN contacted a facility physician, the physician ordered that the recipient be released from the restraints. The HRA's review of the fourth restraint revealed that when the recipient began to threaten harm to staff and his peers, his emergency preference, medication, was administered. Documentation indicated that after the medication was given, the recipient's aggressive behaviors did not cease. Due to his continued aggression, he was placed in restraints for self-protection and to prevent harm to others. The record indicated that the recipient was released from restraints prior to his meeting the established criteria and placed in seclusion, an emergency procedure that the recipient perceived to be less restrictive.

Conclusion

Based on the information obtained during the course of the investigation, the allegation that the recipient was inappropriately placed in restraints is unsubstantiated. No recommendations are issued.

Comments and Suggestion

The HRA observed that facility staff did not consistently ask the recipient if he wanted the Restriction of Rights Notice sent to a designee; therefore, the following suggestion is given:

1. The facility should follow the Code's requirements pertinent to issuance of a Restriction of Rights Notice. Whenever a recipient's rights are restricted, the staff member implementing the restriction should provide the recipient with the required Restriction of Rights Notice, ask the recipient if he desires that a designee be notified of the restriction and make certain that the designee receives a copy of the Restriction of Rights Notice.

Allegation 2… A recipient was placed in seclusion without a valid reason for the placement. To investigate the allegation, the Team spoke with the recipient and reviewed his clinical chart.

A…Interview with Recipient:

According to the recipient, he was placed in seclusion for a considerable amount of time without being involved in any type of aggressive action toward himself or toward others. He informed the Team that he could not remember the exact date of the seclusion.

B. Chart Review

Seclusion 1

According to a 05/12/08 Order for Seclusion, the recipient agreed to take medication for anxiety. However, when his agitation and threatening behaviors continued to escalate, he was placed in seclusion for his safety and the safety of others. Documentation indicated that the seclusion was implemented at 4:45 PM after redirection, empathic listening, distraction, verbal support and medication failed to calm him. The criteria for release were listed as follows: 1) He must be calm and cooperative. 2) He must be free of agitation, aggression, cursing and threatening staff. 2) He must be awake to determine his ability to meeting the criteria. Additional Orders for a 4-hour period were written at 8:45 PM on 05/12/08, 12:45 AM, and 4:45 AM on 05/13/08. None of the Orders listed an established time frame that the release criteria must be exhibited before the recipient could be released from the seclusion. Documentation indicated that the recipient was released at 8:45 AM on 05/13/08.

Documentation in the Restraint/Seclusion Flow Sheets indicated that the recipient was continually monitored during the seclusion process, and his behaviors documented in fifteen minute increments. The recipient had access to toileting and water in the restraint room. He was offered meals at 7:45 PM on 05/12/08, and 7:45 AM on 05/13/08, and he refused both meals. His mental and physical status were reviewed and documented on an hourly basis by a facility RN. Documentation indicated a body search was completed when the recipient was placed in seclusion. Facility staff determined that the room environment was appropriate and the recipient was wearing proper clothing. He was informed of the reason for the seclusion and the criteria for release. The recipient was provided with a Restriction of Rights Notice pertinent to the seclusion.

When the recipient was released from seclusion, a facility RN conducted a debriefing and documented on the Post-Episode Debriefing Form. Documentation indicated that the recipient was able to identify stressors that occurred prior to seclusion, as well as an understanding of the

causes and consequence of his aggressive behaviors. He stated that he felt that staff could have assisted him to regain control, and he was aware that he could request help from staff prior escalation of his anxiety. It was determined that his physical well-being and privacy needs were addressed during the seclusion episode. According to the documentation, he was unable to identify methods to control his aggressive behaviors. The record indicated that the recipient stated, "People bug me. I just want to be left alone. I don't want no more accuchecks or insulin."

According to a Restriction of Rights Notice, the recipient was placed in seclusion from 4:45 PM on 05/12/08 until 8:45 AM on 05/13/08, a period of 16 hours. The recipient's threatening behaviors and his agitation were listed as the reason for the recipient's seclusion. Documentation indicated that seclusion was implemented to provide safety for the recipient, as well as others. His first choice of an emergency intervention was utilized. The record indicated that the Restriction Notice was delivered in person. There was no documentation to indicate that the recipient had been asked if he wanted anyone notified regarding the seclusion.

Seclusion 2:

Per documentation in an Order for Restraint or Seclusion at 8:45 AM on 06/14/08, the recipient was placed in seclusion after he did not experience any notable improvement while in restraints, and he continued to be a physical threat to himself and to others. The record indicated that empathetic listening, distraction, verbal support, reassurance and medication were behavioral interventions utilized prior to his placement in seclusion. The criteria for release were listed as follows: 1) The recipient must be calm and cooperative, no longer verbally threatening harm to staff and peers. He must be free of yelling and thrashing about for a period of 1 hour. 2) He must be awake to determine his ability to meet the established criteria.

According to the Restraint/Seclusion Flowsheet, the recipient was continually observed and his behaviors were documented every fifteen minutes. Documentation indicated that he had access to a toilet and water. His physical status was monitored and documented by an RN on an hourly basis. He was provided with a meal at 11:45 AM, and the record indicated that he ate 100% of the food that was provided. The HRA did not observe any documentation in the comment section of the Flowsheet to indicate that the recipient was not calm, cooperative, and was yelling and verbally threatening to harm to others. However, the recipient was not released for 3 hours and 45 minutes; 2 hours and 45 minutes after the release criteria had been met.

Additional documentation in the Restraint/Seclusion Flowsheet indicated that a body search was completed when the recipient was placed in seclusion. The room environment was determined to be appropriate, and it was determined that he was wearing appropriate clothing. He was informed of the reason for the seclusion and the criteria for his release. Documentation indicated that he was provided with a Restriction of Rights Notice pertinent to the seclusion.

An RN recorded in a Post-episode Debriefing Form that the recipient stated; "You let me out of restraints. I wasn't calm enough to go back to my room. Let me go to my room." He was able to identify the stressors occurring prior to the seclusion and to verbalize an understanding of the causes and consequences of his aggressive behaviors. He stated that he felt that staff could have assisted him in remaining in control, and he was aware that he could request help from staff

prior to any escalation of anxiety. The record indicated that staff encouraged him to discuss his feelings related to the seclusion. It was determined that his physical well-being and his privacy needs had been addressed during the seclusion.

The recipient was provided with a Restriction of Rights Notice for the seclusion that commenced at 8:45 AM on 6/14/08 and ended 4 hours later. Documentation indicated that the notice was delivered in person and the recipient wished that no one be notified of the restriction.

Summary

Documentation indicated that the initial seclusion was implemented due to the recipient exhibiting threatening behaviors toward self and others. However, the Order for Seclusion did not list a time frame for the recipient to remain absent of the threatening behaviors in order to be released. Additionally, documentation in the Restriction of Rights Notice pertinent to the seclusion episode did not indicate if the recipient was asked if he wanted anyone to be notified of the restriction. When the second seclusion was implemented, documentation in the Order for Seclusion indicated that the recipient must be calm, cooperative, and free of yelling and verbal threats for a period of 1 hour. However, the HRA did not observed any documentation in the Restraint/Seclusion Flowsheets to indicate that the recipient had exhibited any of the targeted behaviors during the entire seclusion episode, a period of 3 hours and 45 minutes, 2 hours and 45 minutes longer that the established criteria for release.

Conclusion

The Authority recognizes that the criteria for placement in seclusion were in accordance with the Code's requirements. However, the facility did not adhere to the Code's requirement regarding the criteria for release from the restrictive procedure and assuring that the recipient be provided with the opportunity to notify a designee to be informed of the seclusion. Therefore, the allegation that the recipient was inappropriately placed in seclusion is substantiated.

Recommendations

1. The HRA recommends that the Order for Seclusion always contain an established time frame that the release criteria must be exhibited before a recipient is released from seclusion.

2. A recipient should be released from seclusion when the release criteria are met.

3. When a recipient's rights are restricted, the recipient must be provided with a Restriction of Rights Notice and be informed that he has a right to list a designee to receive the Notice.