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Egyptian Regional Human Rights Authority
Report of Findings
09-110-9009
Chester Mental Health Center
August 25, 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 allegation is as follows:

A recipient at Chester Mental Health Center was inappropriately placed in restraints.

Statutes

If substantiated, the allegation would be a violation of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/2-108 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 5/2-201 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

To investigate the allegation, the HRA Investigation Team (Team), consisting of two 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. With the recipient's written authorization, the Team requested copies of information from the recipient's clinical chart. When the information was received, it was reviewed by the Authority. The facility's policies pertinent to the allegation were also examined.

Interview:

During the site visit at the facility, the Team spoke with the recipient whose rights were alleged to have been violated. The recipient stated that he was sent to Chester Mental Health Center after being involved in a fight with a recipient at a less restrictive state-operated mental health facility. He informed the Team that he had been placed in restraints numerous times since his admission; however in November 2008 he was restraint free. He stated that during July or August 2008, he was not provided with an evening meal while in restraints. He informed the Team that he was on the red level, the lowest level of the facility's level system. (The facility's Level System Procedure was implemented to reinforce adaptive social behaviors through increased opportunities for facility activities and privileges.)

Chart Review:

Treatment Plan Reviews (TPRs):

According to the recipient's 06/30/08 TPR, the 21-year-old recipient was admitted to Chester Mental Health on 04/10/08 from a less restrictive mental health facility. The rationale for the transfer was listed as "ongoing antagonistic behavior toward peers resulting in multiple physical altercations." Additional reasons listed for the transfer were the recipient's hostility toward staff when limits were set and his inappropriate sexual talk to staff and visitors at the transferring facility. His legal status at the time of admission was listed as Voluntary.

When the recipient attended the 06/30/08 TPR he was accompanied by staff because he was on one-to-one observation; he had made repeated comments regarding plans to kill and rape others, commit arson and commit suicide by hanging.

The recipient's diagnoses were listed as follows: AXIS I: Schizoaffective Disorder, Bipolar Type, Obsessive Compulsive Disorder (OCD), Attention Deficit Disorder by History since age 5 years; AXIS II: Borderline Personality Disorder, Borderline Intelligence, AXIS III: GERD (Gastroesophageal Reflux Disease), and Right Bundle Branch Block, and AXIS IV: 5 DHS (Department of Human Services) hospitalizations and more than 10 other psychiatric hospitalizations.

Documentation indicated that on 05/13/08, a clinical case conference was held because the recipient had been receiving very high dosages of multiple medications. It was decided to gradually discontinue the least beneficial medication first. The Clomipramine 250 mg at bedtime for OCD and the Atomoxetine 80 mg daily were discontinued. The record indicated that the recipient was transferred to a community hospital on 05/30/08 after he developed severe tremors.

Neuroleptic Malignant Syndrome, a neurological disorder most often caused by an adverse reaction to antipsychotic drugs, was ruled out. However, it was determined that the recipient had an adverse reaction to Haldol. When he returned to the facility, he was placed in the facility infirmary for continued observation.

According to the record, while in attendance at the TPR, he verbalized self destructive thoughts, thoughts of harming a family member, and plans to bomb a government building. Documentation indicated that the Treatment Team had sought the advice of a statewide advisor of pharmacy services. The advisor recommended that most of the recipient's psychotropic medications be gradually discontinued before Clozapine, an antipsychotic that requires state approval prior to administration. The record indicated that this was the only medication that had previously improved the recipient's mental status; however, due to his previous low white blood count and EKG changes the medication was discontinued. However, after the pharmacy review, it was determined that the low white blood count and EKG changes were most likely due to the high dosage of multiple psychotropic medications and not Clozapine by itself.

According to documentation in the 06/30/08 TPR, the recipient had been in restraints during the reporting period due to his self-injurious behaviors and aggression toward others.

Documentation indicated that the recipient was in restraints when the TPR was conducted on 07/28/09. Three additional restraint episodes were listed for the reporting period. The record indicated that approval had been received to start the administration of Clozapine at 12.5 mg the following morning, and when the recipient was informed he asked why the medication could not be started on the day of the TPR. Documentation specified that the timing of starting Clozaril was due to more medical staff members being present at one time to monitor for adverse side effects.

The record indicated that the recipient was informed of the circumstances under which the law permits the use of emergency forced medication, restraint or seclusion. Documentation indicated that the recipient listed emergency medication as his preference followed by restraints. Seclusion was not listed as an option due to the recipient's history of self-inflicted abuse.

Treatment plan goals in the 07/28/09 TPR were listed as follows: 1) The recipient will be free of displaying aggressive behavior toward others by 11/2008 and 2) His psychotic symptoms, which consist of obsessive rumination, compulsive behavior, paranoid thoughts, poor impulse control, hallucinations, and psychotic agitation will be reduced by 11/2008.

Documentation in the recipient's 08/25/08 TPR indicated that the recipient was started on Clozapine on 08/02/08 to control psychosis and the medication had been increased 25 mg. every 5 days since the initial administration. The record indicated that the recipient's self injurious behavior and physical aggression had been controlled for 10 days. Additional documentation indicated that the recipient had required emergency medication twice; however, no restraints were required during the reporting period.

Restraint Records

The Authority reviewed the recipient's restraint records for restraint applications on 06/01/08, 07/05/08, 07/05/08, 07/16/08, 07/19/08, 07/27/08 and 08/01/08.

Restraint I:

Documentation indicated that the recipient was placed in a physical hold at 4:25 PM and remained in hold until 4:30 PM on 06/01/08 after he began screaming, cursing, hitting and scratching staff. When redirection failed, the recipient was placed in restraints at 4:30 PM. The record indicated that the recipient's emergency preference, medication, was not utilized due to the spontaneity of the attack.

An Order for Physical Hold on 06/01/08 was signed by an Registered Nurse (RN) at 4:25 PM. The RN documented that she examined the recipient at 4:30 PM and had determined that the hold did not pose undue risk to the recipient. A facility physician examined the recipient at 4:45 PM and documented that the hold did not pose an unwarranted threat to the recipient.

The recipient was given a Restriction of Rights Notice (Notice) for the physical hold. The record indicated that the Notice was delivered to the recipient in person. However, there was no documentation that indicated whether the recipient had been asked if he wanted the Notice sent to anyone.

The record indicated that after the recipient was released from the hold, he was placed in physical restraints. A facility physician ordered the restraints at 06/01/08 at 4:30 PM. The Order was issued for up to 4 hours with hourly reviews. The release criteria were listed as follows: 1) The recipient must be calm, cooperative, and able to discuss the incident without agitation. He must also be free of cursing, spitting and pulling on restraints for a period of 60 minutes. 2) He must be awake for review prior to release. The record indicated that a facility RN examined the recipient after the restraints were applied at 4:30 PM and determined that the restraint application did not pose any unwarranted risk to the recipient. Documentation indicated that a facility physician reached the same conclusion when he examined the recipient at 4:45 PM.

Documentation indicated that the Orders for Restraint were issued every four hours until the recipient met the criteria for release at 8:30 AM on 06/03/08. An RN assessed the recipient's condition within 15 minutes, and a facility physician examined the recipient within an hour after implementation of each Order for Restraint. Both medical professionals determined that the restraint application did not pose an excessive risk to the individual in light of his physical or mental condition.

Restraint/Seclusion Flowsheets (Flowsheets) pertinent to the restraint episode indicated that an RN took the recipient's vital signs, released his limbs, checked his circulation, offered him toileting and fluids and evaluated his mental and physical status hourly during the entire restraint. He was provided with a meal during regularly scheduled mealtimes. A body search was completed after the restraints were applied. The RN determined that the restraints were properly applied; he was correctly positioned; and he was wearing appropriate clothing for the

restraint. The room environment was determined to be appropriate. The recipient was informed of the reason for restraint and given the criteria necessary for release when the restraints were applied. Documentation in the Flowsheets indicated that the recipient was given a Notice relevant to the restraint episode.

Documentation in the Notice indicated that the recipient was placed in restraint from 4:30 PM on 06/01/09 and remained in restraints until 8:30 AM on 06/03/08. The record denoted that the restraints were applied to prevent self-injury, injury to staff and to allow the recipient time to "calm down and gain control of his behavior." The record indicated that the recipient's preferred emergency intervention was not used due to the spontaneity and violence associated with his attack. The Notice was delivered to the recipient in person. However, there was no documentation to indicate that the recipient was asked if he wanted anyone notified of the restraint.

A facility RN conducted a Post-Episode Debriefing with the recipient at 9:30 AM on 06/03/08. Documentation indicated that the recipient was able to identify the stressors that occurred prior to the restraint and to verbalize an understanding of causes and consequences of his aggressive behaviors. He stated that he felt that staff could have helped him to remain in control, and he was aware that he could have requested assistance prior to the escalation of his anxiety. He was able to identify one or more methods that he could have used to control his behaviors. Documentation indicated that staff members encouraged him to discuss his feelings related to the restraint. It was determined that he had not sustained any injuries, and his privacy needs were addressed during the restraint.

Restraint II:

Documentation indicated that a Order For Physical Hold was issued at 1:55 PM on 07/05/08 after the recipient became very disruptive, and threatened harm to himself, his family and staff members. The record indicated that he stated that he was going to make shanks to commit violent crimes. The recipient was released from the physical hold at 2 PM. An RN documented that she had examined the recipient at 2 PM and had determined that the hold did not pose an excessive risk. When a facility physician examined the recipient at 2:10 PM, he reached the same conclusion and certified with his signature.

When the physical hold failed to assist the recipient in gaining control of the aggressive behaviors, the recipient was placed in restraints. An Order for Restraint was completed at 2 PM. Documentation indicated that the restraints were applied when the recipient began talking about killing staff, kicking in mid air and fighting staff when they tried to calm him. Behavioral interventions used prior to restraint application were listed as follows; 1) empathic listening; 2) verbal support and 3) reassurance. Documentation in the Order for Restraint indicated that the recipient must be calm, cooperative, not pulling on the restraints, not spitting and talking appropriately for a period of 60 minutes. He must be awake to determine his ability to meet the release criteria. The Order was signed by an RN and a facility physician at 2:10 PM. Both medical professionals documented that they had examined the recipient and had determined that the restraint did not pose any undue risk to the recipient.

Documentation indicated Orders for Restraint were issued every 4 hours until the recipient met the criteria for release at 2 PM on 07/07/08, 48 hours after the initial Order was issued. An RN verified that she/he had examined the recipient within 15 minutes after each new Order was implemented. All orders indicated that a facility physician had personally examined the recipient within 1 hour of the initiation of restraints except the Order that was issued on 07/06/08 at 2 PM. The Order did not contain a physician's signature. Additionally, documentation indicated that the Order was not reviewed by an RN until 08/29/08 at 2 PM.

Documentation in the Flowsheets indicated the recipient's body was completely searched after the restraints were applied. An RN determined that the restraints were properly applied and the recipient was in an appropriate position. The RN also concluded that the recipient was wearing proper clothing for the restraint and the room environment was appropriate. The record indicated that the recipient was informed of the reason for the restraint and the criteria for release.

Additional documentation indicated that STAs recorded observations of the recipient at 15-minute intervals throughout the restraint. Facility RNs checked the recipient's circulation, released his limbs, took his vital signs and assessed his mental and physical status on an hourly basis. He was offered toileting and fluids at the time of the assessment, and provided with a meal at regularly scheduled meal times.

Documentation throughout the Flowsheets indicated that the recipient continued to remain restless, demanding, yelling, threatening to kill others, and expressing the thought that death was his only option. The record indicated that he did not meet the criteria for release until 48 hours after the restraints were applied.

The recipient was provided with Restriction of Rights Notices for the physical hold and the restraint episode. The reasons for the restrictions were listed as the recipient was threatening, kicking and fighting staff members. Documentation indicated that the recipient's preferred emergency intervention, emergency medication, was not utilized due his extreme vicious behaviors. The Restriction Notices were delivered to the recipient in person. However, there was no documentation in either Notice that indicated that the recipient had been asked if he wished to have anyone notified of the restriction.

Restraint III

According to documentation, on 07/16/08 at 8:10 PM the recipient "jumped up and hit another peer." An Order for a Physical Hold was completed at 8:10 PM and the recipient was released from the hold at 8:15 PM. An RN recorded that she examined the recipient and reviewed the order at 8:10 PM. A facility physician documented that he had personally examined the recipient at 9 PM.

The record indicated that the when the recipient was released from the physical hold, he was placed in restraints. The Order for Restraint was completed at 8:15 PM on 07/16/08. An RN signed the Order verifying that she had examined the recipient immediately after the restraints were applied at 8:15 PM. A facility Physician signed the Order at 9 PM. and verified that he had

personally examined the individual and assessed that the restraint application did not pose undue risk to the recipient's health. The criteria for release were listed as follows: 1) The recipient will be able to discuss the incident that led to the use of restraint in a normal and calm voice. 2) He will not pull on the restraints. 3) He must be awake to determine his ability to meet the criteria. The Order for Restraint was issued for 1 hour for 4 point restraints, and when his behaviors accelerated, at 9:15 PM an Order for 5 point restraints was issued. Documentation indicated that the recipient was attempting to bite the restraints prior to the application of the posey. The Criteria for release from the restraints remained the same as in the initial Order. Neither Order for Restraint contained an established time frame that the recipient must exhibit the criteria prior to release.

When the third Order for Restraint was completed, the release criteria were listed as follows: 1) The recipient must be calm and cooperative with hourly reviews. He must be free of thrashing on the bed or pulling on restraints. He must not yell or curse at staff. These conditions must extend for a period of 1 hour before the recipient is released. 2) He must be awake to determine his ability to meet the release criteria.

Additional Orders for Restraint were issued every 4 hours until the recipient met the criteria for release at 9:15 PM on 07/17/08. Facility RNs documented examination of the recipient within 15 minutes after each Order was implemented. Facility physicians recorded examinations of the recipient within an hour after each new Order was implemented and documented that the restraint did not pose an undue risk to the recipient's health.

When the Flowsheets pertinent to the restraint episode were reviewed, it was noted that from 9:30 PM on 07/16/08 until 11:45 PM on 7/16/08, there was no documented evidence that the recipient had been examined by a nurse or STAs had observed the recipient and recorded his behaviors. However, documentation throughout the remainder of the Flowsheets, verified that the recipient was examined by an RN on an hourly basis, his circulation checked, limbs released, vital signs taken, and his mental and physical status assessed. Documentation indicated that STAs observed the recipient and recorded his behaviors in fifteen minute increments. The record indicated that he was offered toileting and fluids hourly except during the above listed period. According to recordings in the Flowsheets, he was provided with meals at regularly scheduled meals during the entire restraint event.

The recipient was provided with Notices for the physical hold and the restraint episode. The recipient's spontaneous attack on another recipient was listed as the reason for the hold, as well as the restraint application. Documentation indicated the intervention preferred by the recipient was not used in either incident due to the spontaneity of the attack and to insure the safety of the recipient's peers and staff. Both Notices were delivered to the recipient in person. However, there was no documentation in either of the Notices to indicate that the recipient had been asked if he wanted anyone notified of the hold and restraint.

An RN conducted a debriefing at the conclusion of the restraint and documented that the recipient was able to identify the stressors occurring prior to the restraint. According to the RN, he was able to verbalize an understanding of the causes and consequences of his aggressive behavior and to identify methods to control those behaviors. The recipient stated that he was

aware that he could request help from a staff member prior to the escalation of his anxiety, but felt that staff could not have assisted him in remaining in control of this situation. The record indicated that the recipient was encouraged to discuss his feelings related to the restraint.

Restraint IV:

Documentation indicated that a physical hold was implemented on 07/19/08 at 2:55 PM after the recipient attacked staff members. The recipient was released from the hold after a 5 minute period and placed in restraints. The record indicated that the recipient failed to "calm down" while in the physical hold and his fighting continued. The recipient was placed in restraints at 3 PM and remained in the restraints until 12 PM on 07/19/08.

The Order for a Physical Hold, completed at 2:55 PM was in accordance with the Code's requirements. The initial Order for Restraint was completed at 3 PM and subsequent Orders for Restraint were completed every 4 hours until the recipient met the criteria for release at 12 PM on 07/19/09. The criteria for release were listed as follows: 1) The recipient must be calm, cooperative, and compliant with staff reviews. He must discuss his behaviors appropriately. He should not yell, curse, spit, thrash in the bed or pull on restraints for a period of 1 hour. 2) He must be awake to determine his ability to meet the criteria. The recipient was examined by an RN within 15 minutes and a facility physician within an hour of the issuance of each Order.

Recordings in the Flowsheets indicated that an RN conducted a body search after the restraints were applied. The RN determined the following: 1) The restraints were properly applied; 2) The recipient was suitably positioned; 3) He was wearing appropriate clothing for the restraint, and 4) The room environment was suitable. Documentation indicated that the recipient was informed of the reason for the restraint and criteria for his release.

Documentation in the Flowsheets indicated that STAs had continually monitored the recipient during the restraint and recorded his behaviors every 15 minutes. Additional documentation indicated that an RN had checked the recipient's circulation, released his limbs, monitored his vital signs, offered fluids and toileting, and assessed his physical and mental status during hourly reviews. The recipient was provided with a evening meal while he was in restraints.

The record indicated that the recipient was provided with Notices for the physical hold and the restraint. Documentation indicated that the recipient's preferred emergency intervention was not utilized due to the spontaneous nature of the attack on others. The record indicated that copies of the Notices were delivered to the recipient in person. However, there was no indication that the recipient was asked if he wanted either of the Notices sent to anyone of his choosing.

An RN conducted a debriefing with the recipient after he was released from restraints and recorded information obtained in a Post-Episode Debriefing Form.

Restraint V:

According to documentation, the recipient was placed in a physical hold on 07/27/08 at 7:40 PM due to his fighting with a peer. When he refused to cease the aggressive actions toward the peer and attacked staff members, he was placed in restraints at 7:45 PM. The record indicated that he remained in restraints until 07/29/08 at 12:30 PM.

A Physical Hold Order was completed pertinent to the 5 minute hold. The initial Order for Restraint was issued at 7:45 PM. The release criteria were listed as follows: 1) The recipient must be calm, cooperative, and non-threatening toward others. He must not pull on the restraints and curse and yell at others for a period of 60 minutes. 2) He must be awake to determine if he has the ability to meet the release criteria. Subsequent Orders for Restraint were issued every four hours during the entire restraint.

Documentation indicated that an RN examined the recipient within 15 minutes of the initiation of the restraints and determined that the restraint application did not pose a problem to the recipient's health. A facility physician documented by his signature that he had ordered the restraints when each Order for Restraint was completed. A facility physician signed that he had personally examined the recipient within 1 hour on the majority of the Orders for Restraint; however, the documentation was absent on the orders that commenced at 3:45 AM and 1 PM on 07/28/08. It was also noted that the 3:45 AM Order was not reviewed by an RN until 08/05/98 at 1:30 PM.

Documentation in the Flowsheets indicated an RN conducted a complete body search shortly after the restraints were applied. The RN determined that the restraints were appropriately applied, the recipient was properly positioned, and he was wearing clothing suitable for the restraint. The room environment was assessed to be suitable. According to the RN's recordings, the recipient was informed of the reason for the restraint and the criteria for release from the restraints.

At 15 minutes intervals, STAs documented on the Flowsheets their observations regarding the recipient's behavior. The record indicated that the recipient was examined and his vitals were taken on an hourly basis by an RN. At the time of the examination, the recipient's circulation was evaluated and his limbs released. His mental and physical statuses were assessed, and he was offered fluids and toileting. The record indicated that he was offered meals at regularly scheduled meal times.

The recipient was provided with Notices for the physical hold and the restraint application. Documentation indicated that the restrictive procedures were implemented due to the recipient fighting with another recipient and when staff attempted to intervene he began fighting with them. The record specified that the recipient's preferred emergency intervention, medication, was not used due to the level of his aggressive behaviors. The Notice was delivered to the recipient in person. There was no documented evidence that staff had asked the recipient whether he wanted someone notified of the restriction.

An RN conducted a post episode debriefing immediately after the recipient was released from the restraints. The record indicated that he was able to identify the stressors occurring prior to the restraint, and verbalized an understanding of the causes and consequences of his

aggressive behaviors. He was also able to identify methods to control his aggressive behaviors and stated that he was aware that he could request assistance from staff prior to the escalation of his anxiety. The record indicated that he was encouraged to discuss his feelings related to the restraint. The RN examined the recipient and determined that he had not received any type of injury during the restraint episode, and his privacy needs and physical well-being had been addressed.

Restraint VI

According to documentation, while the recipient was on one-to-one observation, he became agitated and threatened to kill himself. When an STA attempted to calm him, he turned away from the STA and hit his head on the wall. Due to the recipient's self-injurious behaviors, he was placed in a physical hold at 1:25 PM on 08/01/09 and remained in the hold until 1:30 PM. After being released from the hold, he was placed in restraints.

An Order for a Physical Hold was completed at 1:25 PM on 08/01/08. An RN signed the Order at 1:40 PM verifying that she had personally examined the recipient and assessed that the restraint application did not pose an unwarranted risk to the recipient's physical and mental condition. A facility physician signed the Order at 1:30 PM confirming that he had evaluated the recipient and found that the restraints did not pose an undue risk to his health.

The initial Order for Restraint was issued at 1:30 PM and every four hours until the recipient met the criteria for release at 12:30 PM on 08/02/08, 23 hours after the implementation. The criteria for release from the restraints were listed as follows: 1) The recipient must be calm, cooperative and compliant with the review team. He should be free of yelling, cursing, threatening, pulling and pulling on restraints for a period of 1 hour. 2) He must be awake to determine his ability to meet the release criteria prior to release. Documentation in all of the Orders indicated that the recipient was examined by an RN within 15 minutes and a facility physician within 1 hour of the application. Both professionals determined that the restraint application did not pose an unnecessary threat to the recipient's health.

According to documentation in the Flowsheets, STAs continually observed the recipient and recorded his behaviors in 15-minute increments throughout the restraint episode. An RN examined the recipient hourly, released his limbs, checked his circulation, offered him fluids and toileting, assessed his mental and physical status, and took his vitals signs. The record indicated that he was provided with meals at the regularly scheduled meal times.

Documentation indicated that the recipient was provided with Notices relevant to physical hold and the restraint event. Recordings in the Notices indicated that the recipient was placed in a physical hold in order to protect him from harming himself. According to the record the recipient threatened to kill himself and began banging his head against the wall. After being released from the hold, he was placed in restraints for self-protection. The recipient's preferred emergency intervention was not used due to the spontaneity of his aggressive actions. The Notices were delivered to the recipient in person. There was no documented evidence that the recipient was asked if he wished to have anyone to be notified of the physical hold or the restraint episode.

Policies

A…Use of Restraint and Seclusion (Containment) 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 the 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 for staff.

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."

Procedural factors that increase the risk to the recipient during the restraint process are 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 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, an 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 or 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.

An RN must conduct a debriefing with the individual who has been in restraints as soon as clinically appropriate, but by the end of the next shift. The purpose of the debriefing is to: 1) assess the physical and psychological effects of the restraint or seclusion on the individual; 2) address any trauma associated with the experience; 3) assist the individual in identifying stressors that occurred prior to the restraint or seclusion; 4) assist the individual and staff in

identifying early warning signs of possible future aggression; 5) assist the individual with identification of methods to control aggression and manage anxiety; 6) review with the individual why previously identified early interventions were not employed or were not successful; 7) assist the individual and staff to identify alternative interventions to prevent future episodes; 8) allow the recipient to discuss his or her feelings about the restraint or seclusion experience; 9) assess if the recipient's privacy was respected; and 10) assure the individual that he or she may request staff assistance prior to escalation of anxiety/aggressive behaviors. If the recipient's preferred interventions were not employed, the RN will inform the recipient of the reasons for the decision. If the individual desires, the family or significant other will be contacted by phone and offered the opportunity to participate in the debriefing, unless staff believe that family participation is clinically inadvisable. Documentation of the debriefing should be completed. The recipient's treatment team should review the restraint or seclusion event by the next working day and make modifications as needed in the individual treatment plan.

A section in the PPD addresses recipients' rights. The rights are listed as follows: 1) to be free from seclusion and restraints of any form that are imposed for coercion, discipline, convenience, or retaliation by staff; 2) to have privacy and dignity; 3) to be free of chemical restraint; 4) restraint and seclusion must be used only to protect individuals from harming themselves or others; 5) within one hour after restraint or seclusion, a RN or physician who ordered the restraint or seclusion must inform the individual of the restriction of his or her rights, and the right to have any person he or she chooses notified of this restriction; 6) the RN or physician must ensure that any person designated by the individual at the time or previously is notified of the restriction promptly after the initial application of restraint or seclusion. Written notification must be made via a Notice Regarding Restricted Rights Form; 7) when restraint is used for an individual whose primary mode of communication is sign language, he or she must be allowed to have his or her hands free from restraint for the purpose of communication at least five minutes every hour, except when such freedom may result in physical harm to self or others; 8) when restraint or seclusion is used with an individual whose primary language is other than English, every effort should be made to use a translator for communication during the restraint process.

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

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

The PPD mandates confidentiality of a recipient's records and provides measures to ensure performance improvement pertinent to the use of restraints and seclusion. Specifics

regarding nursing standards of care for individuals in restraints or seclusion are also incorporated in the PPD.

Additional Information:

When the HRA reviewed 2008 and 2009 cases involving restraints at the facility, it was noted that there were occasions when staff failed to ask a recipient if he wanted someone notified of a restriction; however, the majority of time documentation indicated that the recipient was informed of his right to have someone notified.

Summary

The Authority's review of the recipient's clinical chart indicated that the recipient had a history of aggressive actions toward others and engaged in self-abusive behaviors. Throughout the recipient's clinical chart, documentation indicated that the recipient's treatment team and medical staff at the facility had attempted to acquire the appropriate treatment to assist the recipient in alleviation of these problems. There was consistent documentation pertinent to each restraint application that specified that the recipient was either causing self harm or was attempting to harm other recipients or staff. According to the Code and DHS' PPDs relevant to restraint application, the use of restraint should be limited to emergencies in which there is imminent risk to an individual harming self, other recipients, or staff, and each application met that criteria. However, there was consistent lack of documentation in all of the Restriction of Rights Notice to verify that the recipient had been asked if he wanted anyone notified of the restraint application. Additionally, the 07/06/08 Order for Restraint issued at 2 PM lacked a physician's signature verifying that he/she had personally examined the recipient within one hour of the initiation of the Order, and documentation indicated that an RN did not review the Order until 08/29/08 at 2 PM. Flowsheets for 07/16/08 did not contain any documentation from 9:30 PM until 11:45 PM to certify that 15 minutes observations had been conducted, and the recipient had been examined by an RN. An Order for 4 point restraints issued at 8:15 AM on 07/16/08, as well as an Order for 5-point restraints at 9:15 AM did not contain an established time frame that the release criteria should be exhibited before the recipient's was released. The record indicated that the 5-point restraints were necessary due to the acceleration of the recipient's self abusive behaviors. The HRA also noted that in the 07/28/08 Orders for Restraint, which were implemented at 3:45 AM and 1 PM, documentation was absent pertinent to examination by a physician within 1 hour of the implementation. It was also noted that on the 3:45 AM Order , the RN did not review the order until 08/05/08.

Conclusion

The Authority recognizes that the recipient met the criteria for placement in restraints for each restraint episode. Therefore, the allegation that the recipient was inappropriately placed in restraints is unsubstantiated. However, due to the lack of documentation listed above, the Authority does substantiate rights violations per Code and PPD requirements regarding failure to ask the recipient if he wanted someone notified of the restraint, lack of documented observation for a period of time on 07/16/08, physician's examination on 07/06/08, lack of consistent documented examination by a facility physician and RN for the 07/28/08 restraint, and not listing

a established criteria for release from restraints associated with the 07/16/08 Orders for Restraint at 8:15 AM and 9:15 AM. The following recommendations are issued.

1. Whenever, a recipient's rights are restricted, the recipient must be informed of the restriction and the right to have any person he chooses notified of the restriction. Documentation should reflect that the recipient had been informed of his right to have a person of his choice notified and the notification of the requested individual.

2. A recipient should be personally examined by an RN within 15 minutes by a facility physician within an hour of the restraint application and the Order for Restraint signed by both medical professionals to certify their examinations.

3. There should be documented evidence in the Flowsheets to indicate that there has been consistent observation of the recipient while in restraints, and hourly examinations by an RN.

4. Orders for Restraint should have a time frame that the release criteria must be exhibited before the recipient is released from the restraints.