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Egyptian Regional Human Rights Authority
Report of Findings
09-110-9016
Chester Mental Health Center
February 10, 2009

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed it 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). Section 5/2-201(a) of the Code is also pertinent to the allegation.

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(a) of the Code states, "Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to: (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian; (2) a person designated under subsection (b) of the Section 2-200 upon commencement of services or at any later time to receive such notice; (3) the facility director; (4) the Guardianship and Advocacy Commission, or the agency designated under 'An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named', approved September 20, 1985, if either is so designated; and (5) the recipient's substitute decision maker, if any. The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefor in the recipient's record."

Investigation Information

Allegation: A recipient at Chester Mental Health Center was inappropriately placed in restraints. 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 and the Chairman (Chairman) of the facility's Human Rights Committee. With the recipient's written consent, copies of information from the recipient's clinical chart were obtained for review by the Authority. The facility Policy entitled, "Use of Restraint and Seclusion (Containment) in Mental Health Facilities" and the Illinois Department of Human Services/Mental Health (DHS/MH) Policy Directive (Directive) were reviewed.

Interviews:

A…Recipient:

According to the recipient, when he returned to Chester Mental Health Center in November 2007, staff placed him on the facility's red level of access, the lowest level of programming at the facility. He stated that he has remained on that level the majority of time since his return. He informed the Team that staff members have also placed him in restraints without him being involved in any type of physical or verbal aggression. He stated that during his June 2008 Treatment Plan Review (TPR), three staff members became very angry with him, ordered him out of the meeting, and had him placed in restraints.

B…Chairman:

The Chairman informed the Team that restraints are applied for the protection of a recipient or to prevent the recipient from causing injury to others, never as a means to punish a recipient. The Chairman stated that the facility's written policy pertinent to restraint use is in accordance with the Code requirements. He related that the facility also follows the mandates of the DHS/MI Directive regarding restraint use.

Clinical Chart Review:

The HRA reviewed information from the recipient's clinical chart. The following records were examined: 1) the recipient's TPRs for June, July, and August 2008; 2) restraint records for June and July 2008; 3) restriction notices from June through September 2008, and 4) Progress Notes for June and July 2008.

A…TPRs:

According to the recipient's 06/19/08 TPR, he was admitted to the facility on 11/16/07 from a county jail. His legal status was listed as Involuntary Criminal (Unfit to Stand Trial). The recipient's theim date, anticipated date of release from DHS, was listed as January 2057.

The recipient's diagnoses were listed as follows: AXIS I: Schizoaffective Disorder Bipolar Type; AXIS II: Personality Disorder, (paranoid); AXIS III: Hypertension/Obesity; and Axis IV; impulsive aggression, behavioral/adjustment/coping problems, Legal-Criminal.

According to documentation in the 06/19/08 TPR, the recipient attended the TPR and as the meeting progressed, he began to demonstrate increasing psychomotor agitation, pressured speech, increased voice volume and threatening behaviors. As a result of these behaviors, staff requested that he leave the meeting.

Nursing staff recorded in the TPR that the recipient's behavior had deteriorated. He had refused medications and meals. Due to these actions, the facility petitioned the court for enforced medication(s) and the request was approved by the court.

Documentation in the recipient's 07/11/08 TPR indicated that the recipient had required restraints on 06/21/08 for a period of 5 hours and seclusion on 06/30/08 after he became aggressive. The record indicated that he was placed in seclusion "to ensure the safety of all concerned". Once again, the recipient's psychomotor agitation, pressured speech, and speech volume increased as the 07/11/08 meeting progressed.

Nursing staff and the recipient's therapist indicated at the 07/11/08 TPR that the recipient's behaviors were somewhat improved since the court-ordered medication had commenced.

The record indicated that the recipient had refused to attend the 08/12/08 TPR. According to documentation, the recipient had informed a Security Therapy Aide (STA), who went to the recipient's room to escort him to the TPR, that he would inform the Treatment Team if and when he ever desired to attend another TPR.

B: Restraint Records:

1)…Orders:

According to a 06/21/08 Restraint Order, when empathic listening, verbal support and reassurance failed to assist the recipient in gaining control of unstable behaviors, which included threats and attempts to harm staff members, the recipient was placed in restraints. Documentation indicated that a facility physician ordered the restraint at 4:30 PM for a period of up to 4 hours with 1 hour reviews. The physician recorded that he had examined the recipient at the time of restraint initiation, and it was his assessment that the application did not pose an undue risk to the recipient's physical or mental state. A Registered Nurse (RN) documented that she had examined the recipient when the restraint was commenced and had determined that the restraints did not present a risk to the recipient's health and physical condition. The criteria for release were listed as follows: 1) The recipient must be calm and cooperative with no aggressive or hostile speech for a period of 60 minutes and 2) He must be awake to determine the ability to meet the release criteria.

A second Restraint Order was completed at 8:30 PM on 06/21/08 after the recipient failed to meet the release criteria established in the initial order. A facility RN documented that she had examined the recipient and determined that the application did not pose an undue risk to the

recipient's health in light of his physical and mental condition. The record indicated that the recipient met the criteria for release at 9:30 PM. A facility physician did not examine the recipient during the second restraint due to his release within an hour of the implementation of the second order.

2)…Restraint/Seclusion Flowsheets (Flowsheets):

According to the Flowsheets associated with the restraint episode, the recipient was continuously observed by staff, and his behaviors documented every 15 minutes. He was offered toileting every 15 minutes. His vital signs were evaluated, circulation checked, and his limbs released each hour during the 5-hour restraint episode. He was also offered fluids on an hourly basis.

Documentation in the Flowsheets indicated the recipient's body was searched after the restraints were applied. Staff determined the following: 1) The restraints were properly applied; 2) The room environment was appropriate; 3) He was wearing proper clothing; and 4) He was properly positioned. The record indicated that the recipient had been informed of the reason for restraint, and he was given a Restriction of Rights Notice pertinent to the restraint application.

3)…Post Episode Debriefing-Nursing Debriefing (Debriefing):

According to documentation, a debriefing was conducted at 10 PM after the recipient was released from restraints. The recipient was able to identify the stressors that occurred prior to the restraint, to verbalize an understanding of the causes and consequences of his aggressive behaviors, and to identify other methods to control his aggressive behaviors. He stated that he felt that staff could have helped him to remain in control and expressed that he could have requested assistance from staff prior to the escalation of his anxiety. The RN conducting the debriefing reviewed the reasons why previously identified early interventions were not successful. It was determined that the recipient had not received any type of physical injury, and his physical well-being and privacy had been addressed during the restraint.

C…Seclusion Records:

1) Seclusion Orders:

Documentation indicated that an Order for Seclusion was issued at 1:30 PM on 06/30/08 after staff members' efforts of empathic listening, verbal support and reassurance failed to calm the recipient's verbal and physical aggressions. Documentation indicated that the recipient was offered medication to assist him in gaining control of the behaviors; however, he refused the medication. The initial Order and each subsequent order were issued every 4 hours with 1 hour reviews until the recipient met the release criteria at 2:30 PM on 07/01/08. The release criteria were listed as follows: 1) The recipient must be calm, cooperative, no longer yelling and threatening harm to others; 2) He must be able to able to discuss the situation rationally; and 3) He must be awake to determine his ability to meet the criteria for release.

Each Order was signed by an RN within 15 minutes and a facility physician within 1 hour of the initiation of the seclusion. Both professionals evaluated the recipient's physical and mental condition and recorded that the seclusion did not pose an undue risk to the recipient.

2)… Restraint /Seclusion Flowsheets:

Documentation indicated that the recipient's mental and physical status was evaluated hourly by a facility RN, and his behaviors were continually observed and documented every 15 minutes during the seclusion episode. Toileting facilities and water were available in the seclusion room. Staff members provided the recipient with three meals during the 24-hour seclusion.

Documentation indicated that a body search was completed after the recipient was placed in seclusion. Staff determined that the room environment was appropriate. The recipient was informed of the reason for the seclusion and given a Restriction Notice pertinent to the seclusion episode.

3)… Debriefing:

Documentation indicated that an RN conducted a debriefing with the recipient at 2:30 PM on 07/01/08. During the debriefing the recipient was able to identify the stressors that occurred prior to the seclusion and to verbalize an understanding of the causes and consequences of his aggressive behaviors. He was able to identify methods to control his aggressive behavior. Staff encouraged the recipient to discuss his feelings related to the restraint. He stated that he was aware that he could request assistance from staff prior to the escalation of his anxiety, but verbalized that he did not believe that staff could have assisted him in regaining control in this situation. It was determined that the recipient did not receive a physical injury during the seclusion episode and that his physical well being and privacy had been addressed.

D…Progress Notes:

Documentation in an STA Progress Note dated 06/21/08 indicated that when a staff member asked the recipient to keep his hands and arms off the serving line window in the cafeteria he started yelling, cursing and threatening to harm staff. An STA asked the recipient to return to the unit; however he continued to yell, curse and threaten staff. Two additional STAs recorded similar accounts of the incident in the Progress Notes. Documentation in all of the Progress Notes indicated that the recipient threatened physical harm to any staff member that was present at the time of the incident.

In a 06/21/08 Progress Note an RN recorded that the recipient stood in a threatening aggressive position and began to yell, curse and threaten harm to staff. Due to these actions, he was placed in restraints to protect others from physical harm.

E…Restriction Notices:

According to a 06/21/08 Restriction Notice, the recipient was placed in restraints from 4:30 PM on 06/21/08 until 9:30 PM on 06/21/08, a period of 5 hours. Aggressive posturing, cursing, and threatening staff were listed as the reasons for the restriction. Documentation indicated that the recipient's preferred intervention was not used due to the immediate risk of physical harm to others and the intensity of the recipient's confrontation. The recipient's physical stance, verbal threats, and attempts to cause harm to those around him were considered an imminent threat to others.

Documentation indicated that the Restriction Notice was delivered to the recipient in person, and he expressed that he did not wish anyone to be notified of the restriction.

A Restriction Notice was given to the recipient regarding the 06/30/08 seclusion. According to the documentation, the recipient was in seclusion from 1:30 PM on 06/30/08 to 1:30 PM 07/01/08, a period of 1 day. Verbal threats and physical aggression were listed as the reason for the seclusion. Documentation indicated that the recipient's preferred intervention was used.

The record indicated that the Restriction Notice was delivered in person, and the recipient expressed that he did not wish to have another individual notified of the restriction.

Policies and Directives:

A…Use of Restraint and Seclusion (Containment in Mental Health Facilities (Facility Policy/Procedure):

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

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

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

The nursing supervisor of the shift must notify the hospital administrator, the medical director, and the medical director's secretary by e-mail when the following circumstances occur: 1) When a recipient remains in restraint for more than 12 hours. 2) When an individual experiences 2 or more separate episodes of restraint of any duration within 12 hours. When either of these circumstances occurs, the medical director's secretary will arrange for appropriate psychiatric follow-up at the earliest possible time.

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

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

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

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

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, rights and well-being should be preserved; and the risk to staff and others minimized.

Documentation in the Policy Statement is as follows, "The circumstances that result in the use of restraint or seclusion are complex. Consequently, the strategies for reducing and eliminating restraint and seclusion use are multi-faceted and incorporate multiple points of view, including those of patients, consumers, and staff at all levels of the organization. It is the position of DHS/MH that the goal of reduced restraint and seclusion utilization be approached through a broad range of strategies for enhancing positive behaviors, preventing destructive behaviors, and limiting the circumstances that may necessitate the use of restraint or seclusion. These include, but are not limited to: 1) the use of nonphysical interventions as preferred intervention for both patients and staff; 2) the implementation of staff training based upon a nationally-recognized training program in conflict de-escalation and crisis prevention; 3) the inclusion of the consumer perspective on the restraint and seclusion experience and the perceived opportunities for reducing utilization; and 4) effective assessment and treatment."

In the Definitions Section of the PPD, a maximum secure setting is defined as Chester Mental Health Center. Restraint is defined as "restricting the movement of an individual's limbs,

head, or body by mechanical or other means or physical holding to prevent an individual from causing physical harm to himself/herself or others."

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

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

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

The PPD mandates the decision to use restraint or seclusion to be driven by an individual assessment, which concludes that for the individual at that particular time, the risk of using less restrictive measures outweigh the risk of using restraint and seclusion. Restraint or seclusion may never be used when the possible risk to the individual's medical condition outweighs the behavioral risk, as assessed by the physician or registered nurse. When the intervention used differs from the individual's stated preference, the rationale must be documented on the Notice Regarding Restriction Rights of Individual form.

According to the PPD, restraint and seclusion may be used only on a written order of a physician, and a PRN order for restraint or seclusion may never be written. Physicians and RNs writing initial and renewed orders for restraint must assess and document an individual's pre-

existing physical condition when ordering the body position and type of restraint. Within 15 minutes of the initial application of restraint or seclusion, 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 an 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) the right to privacy and dignity; 3) to be free of chemical restraint; 4) restraint and seclusion must be used only to protect individuals from harming themselves or others; 5) within one hour after restraint or seclusion, a RN or physician who ordered the restraint or seclusion must inform the individual of the restriction of his or her rights, and the right to have any person he or she chooses notified of this restriction; 6) the RN or physician must ensure that any person designated by the individual at the time or previously is notified of the restriction promptly after the initial application of restraint or seclusion. Written notification must be made via a Notice Regarding Restricted Rights Form; 7) when restraint is used for an individual whose primary mode of communication is sign language, he or she must be allowed to have his or her hands free from restraint for the purpose of communication at least five minutes every hour, except when such freedom may result in physical harm to self or others; 8) when restraint or seclusion is used with an individual whose primary language is other than English, every effort should be made to use a translator for communication during the restraint process.

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

According to the PPD, staff must be educated and demonstrate competency in the use of non-physical intervention for reducing and preventing violence and subsequent use of restraint or seclusion. When the use of restraint or seclusion is necessary, staff must insure the safe use of the procedures. Staff members involved in the use of restraint and seclusion are to receive ongoing training and demonstrate competence in the procedures. The viewpoints of the 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 measures to ensure performance improvement pertinent to the use of restraints and seclusion. Specifics regarding nursing standards of care for individuals in restraints or seclusion are also incorporated in the PPD.

Summary

According to documentation in the recipient's clinical chart, the recipient was placed in restraints on 06/21/08 after he maintained an aggressive posture and began to curse and threaten harm to staff. The record indicated that the recipient was placed in restraints to protect others from harm. Documentation indicated that the recipient's preferred emergency intervention was not used due to the immediate risk of physical harm to others and the intensity of the recipient's confrontation. The Code, facility restraint policy, and PPDs allow for use of restraint to protect a recipient or others from harm. Additional documentation indicated that facility staff continuously monitored the recipient while he was in restraints and provided him with a Restriction Notice, per Code and Policy requirements.

Conclusion

Based on review of information obtained during the course of the investigation, the allegation that a recipient at Chester Mental Health Center was inappropriately placed in restraints is unsubstantiated.

Comments

During the review of the 06/30/08 to 07/01/08 seclusion episode, it was noted in the release criteria of the Orders for Seclusion failed to list a time frame for the recipient to remain calm, absent of yelling, threatening behaviors and pacing in order to be released.

Suggestion

The HRA suggests that Orders for Restraint or Seclusion always contain an established time frame that release criteria must be exhibited before a recipient is released from restraints or seclusion.