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Egyptian Regional Human Rights Authority
Report of Findings
10-110-9016
Choate Mental Health Center
Developmental Disabilities Division
February 23, 2010

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Choate Mental Health Center located in Anna. The facility is comprised of two divisions, a division for persons with mental health issues and a division for persons with developmental disabilities. The report is regarding services within the developmental disabilities division of the facility. The specific allegation is as follows:

> A recipient at Choate Mental Health Center (Developmental Disability Division) was placed in restraints without proper authorization for the restraints.

Statutes

If substantiated, the allegation would be a violation of the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-125, 405 ILCS 5/2-108, 405 ILCS 5/2-102 and 405 ILCS 5/2-201).

According to Section 5/1-125 restraint is defined as "…direct restriction through mechanical means or personal physical force of the limbs, head or body of a recipient. The partial or total immobilization of a recipient for the purpose of performing a medical, surgical or dental procedure or as part of a medically prescribed procedure for the treatment of an existing physical disorder or the amelioration of a physical handicap shall not constitute restraint, provided that the duration, nature and purposes of the procedures or immobilization are properly documented in the recipient's record and, that if the procedures or immobilization are applied continuously or regularly for a period in excess of 24 hours, and every 24 hour period thereafter during which the immobilization may continue, they are authorized in writing by a physician or dentist; and provided further, that any such immobilization which extents more than 30 days be reviewed by a physician or dentist other than the one who originally authorized he immobilization."

"Momentary periods of physical restriction by direct person-to-person contact, without the aid of material or mechanical devices, accomplished with limited force, and that are designed to prevent a recipient from completing an act that would result in potential physical harm to

himself or another shall not constitute restraint, but shall be documented in the recipient's clinical record."

Section 5/2-108 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. (a) Except as provided in this Section, restraint shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker or registered nurse with supervisory responsibilities. No restraint shall be ordered unless the physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of restraint is justified to prevent the recipient from causing physical harm to himself or others...."

According to Section 5/2-201, "Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to : (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian; (2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice; (3) the facility director; (4) the Guardianship and Advocacy Commission, or the agency designated under 'An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named', approved September 20, 1985, if either is so designated; and (5) the recipient's substitute decision maker, if any. The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefor in the recipient's record."

Section 52-102 states, "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan."

## Investigation Information:

To investigate the allegation, the HRA Team (Team), consisting of one member and the HRA Coordinator (Coordinator), spoke with the Guardian of the recipient whose rights were alleged to have been violated. On another occasion the Team, consisting of one member and the Coordinator, spoke with four staff members at the HRA office. The Team, consisting of two members and the Coordinator, interviewed the Administrator, two staff members, the recipient whose rights were alleged to have been violated, and the recipient's Qualified Mental Retardation Professional (QMRP)/Case Manager during a site visit to the facility. A written statement was obtained from an additional staff member. The Authority reviewed the Illinois Department of Human Services (IDHS), Office of Inspector General's (OIG) Reports of Findings pertinent to the allegation, and the resident's guardian's appeal to the initial findings. The recipient's records were reviewed with the written authorization of her Guardian. The Authority reviewed the IDHS Policy/Procedure entitled, "Restraint Use in State Operated Developmental Centers and Programs".

I...Interviews:

A...Guardian:

The Guardian informed the Team that the recipient was admitted to Choate Mental Health Developmental Disabilities Division on 07/22/09 from a county jail after being found unfit to stand trial (UST). The Guardian stated that the recipient had experienced some maladaptive behaviors from the time of her admission; however, she had not been placed in restraints until 08/13/09. The Guardian informed the Team that a Behavior Plan was not in place at the time of the incident, and a Special Program Review was not conducted after the restraint application. The Guardian stated that a Behavior Plan had been formulated; however, approval had not been obtained for the implementation. The Guardian stated that she was informed that the recipient was exhibiting the self-abusive scratching and agitation on 08/19/09; however, when the supervising Registered Nurse (RN) assessed the situation the RN determined that the recipient did not meet the criteria for placement in restraints. According to the Guardian, when the RN left the area, a Residential Service Supervisor (RSS) placed the recipient in restraints. As soon as the RN learned that the recipient had been placed in restraints she went into the recipient's room, evaluated the situation and requested that the recipient be immediately released. The Guardian stated that she was informed by the recipient's Case Manager that the recipient had been placed in restraints; however, the Case Manager was not aware of and did not report the conditions surrounding the application. The Guardian informed the Team that the recipient's clinical chart did not contain Physician's Orders for the physical hold or the restraints, nor did she receive a Restriction of Rights Notification pertinent to the restraint.

The Guardian informed the HRA that the recipient did not have a Behavior Intervention Plan in place at the time of the incident. Conversely, the formulation process had commenced prior to the incident.

The Guardian stated that the recipient has a history of having been physically and psychologically abused which resulted in her having a Post Traumatic Stress Disorder (PTSD). The Guardian informed the Team that she had concerns that the PTSD might be intensified by any type of physical altercation that was considered unnecessary. The Guardian stated that since recipient has been remanded to IDHS after being found unfit to stand trial, the use of restraints for behaviors could be perceived by a Judge as non-compliance.

B...RN:

The RN stated that the recipient whose rights were alleged to have been violated came to the facility from a county jail. She stated that the recipient has a diagnosis of Mild Mental Retardation. Additionally, she has some maladaptive behaviors; however, those behaviors have improved since her hospitalization. The RN informed the Team that on 08/13/09, she was working on the 3 PM to 11 PM shift when the recipient began to experience some agitation and self abusive behaviors, which consisted of scratching herself. She stated when she entered the Group I Room, she observed RSS I and a Mental Health Technician (Technician I) holding the recipient. The RN stated after assessing the situation she determined that the recipient did not

meet the criteria for placement in the physical hold and requested that the staff members release the recipient and to continue to observe her behaviors. She informed the Team at that point, she departed from the area to deal with an issue concerning another recipient who had returned to the clinic. While attending to the other recipient's needs, she heard a staff member state that restraints were needed in the recipient's room. The RN stated as soon as she completed addressing the other individual's issues, she went into the recipient's room. She stated upon entry to the room she observed the recipient in restraints, assessed the situation, and requested that the recipient be immediately released. The RN stated the restraint was not ordered by a physician or authorized by her as the supervising nurse; nor did she receive a call at any time during the evening to request the restraints prior to the application. The RN informed the Team that the restraint episode continued for approximately 15 minutes.

The RN stated that staff members receive training regarding the Code's mandates pertinent to restraint application. The RN informed the Team that RSS I has received training, as well as acted as an instructor to train other staff members regarding the criteria for restraint application.

C...RSS (I):

During the site visit at the facility, the Team spoke with RSS I who was alleged to have been involved in the 08/13/08 restraint episode. According to the RSS I, he was working overtime on the evening shift when the recipient and the supervising RN had a disagreement. RSS I stated that the recipient attempted to run from the living area into the bathroom; however, he blocked her pathway. He informed the Team that due to her previous history, he did not want her to be alone in the bathroom. He stated that he cleared the living room to ensure that the recipient and others might not be injured. He stated that a Technician (Technician I) was able to calm the recipient. However, later she once more became agitated regarding a medication issue and attempted to leave the room. RSS 1 stated that he blocked her from leaving the living area and closed the door so that the recipient could have some privacy. RSS I informed the Team that he and Technician I attempted to calm the recipient. However, the recipient used her finger nails to scratch her arm, and she attempted to bite her shoulders. He stated that the recipient was also screaming that she intended to kill herself. RSS I informed the Team that he and Technician I had the recipient in a hold for approximately 15 minutes to prevent her from injuring herself. He related that the lead worker came into the area several times to assess the situation. However, when the supervising RN came into the room she requested that the recipient be released from the hold and stated that if the recipient exhibited any other maladaptive behaviors to place her in restraints. He stated when the recipient became calm she exited the living area and walked to her bedroom. He informed the Team when the incident ceased he also departed from the area.

RSS I stated that shortly after he was called back to the unit because the recipient's behaviors had commenced once more. He stated that when he arrived on the unit, he and the technician placed ~~in~~ the recipient in four point restraints to protect her from causing self-harm. He stated that when the supervising RN came into the area she requested that the recipient be released from the restraints. He informed the Team that the restraints episode lasted for

approximately 5 minutes. RSS I stated that there were no physician's orders for the physical hold or the restraint.

RSS I informed the Team that he had received training pertinent to the Code's requirements for restraint application and had provided in-service training to other staff members regarding the mandates for restraint application.

D...Technician I:

Technician I informed the Team that she was the group leader on the evening shift on 08/13/09 when the recipient became verbally aggressive and ran into the bathroom. Technician I stated that she requested that the evening RSS (RSS II) assist her in getting the recipient out of the bathroom and into the group room. She stated with the assistance of RSS I and RSS II, she was able to lead the recipient out of the bathroom. Technician I stated that after the recipient entered the group room she began to scratch her arms and bite herself. After an attempt to have the recipient cease the self-abuse behaviors failed, she and RSS I placed the recipient in a physical shoulder/wrist hold. Technician I informed the Team that after approximately 15 minutes, the supervising RN came into the room and informed them to release the recipient from the physical hold, and instructed them to place her in restraints if she became aggressive again.

Technician I stated that when the RN left the area, the recipient began to scratch herself once more and yelled that she wanted to return to jail. She stated that to protect the recipient from harming herself she was placed in a hold down in her bedroom and she and RSS I applied 4-point restraints. When the recipient continued to bite herself, the shoulder strap ($5^{th}$ point) was added. She stated that shortly after the restraints were applied the RN came into the room and requested that the recipient be released from the restraints. Per the RN's request, the recipient was released from the restraints.

E...RSS II

RSS II informed the Team that she is the RSS for the evening shift on Cypress Upper Unit. She stated that on the evening of 08/13/09 she heard the RN tell RSS I and Technician I to release the recipient from a physical hold. RSS II stated that later in the afternoon she was informed by the RN that the recipient had been placed in an unauthorized restraint. RSS II informed the Team that the recipient's clinical chart does not contain any physician's order for the restraint.

F...Technician II.

Technician II stated that she observed the lead worker obtain restraints and take them to the recipient's room. When the lead worker got to the recipient's room, RSS I took the restraints and would not allow the lead worker to enter the room. Technician II listed someone other than Technician I as the lead worker. Technician II, who was present during the entire 3 PM to 11 PM shift, stated that a facility physician did not examine the recipient during that period of time.

Technician II informed the Team that the restraint was not authorized by the supervising RN, and upon observing the recipient in restraints the RN ordered an immediate release.

G...Technician III:

Technician III stated that he was not working on 08/13/09. He stated that when he came to work the following day, he was informed that RSS I had placed the recipient in restraints without obtaining a Physician's Order, and the supervising RN had requested that the recipient be immediately released. At the time of the interview Technician III stated that the recipient had not been placed in restraint prior to or since to the 08/13/09 episode.

H...Administrator:

On October 28, 2009, the Team spoke with the Administrator who was in charge of the DD Services at the time of the visit. The Administrator stated that the recipient came to DD services from a county jail with a legal status of UST. She stated the recipient had a history of self abusive and aggressive behaviors. She informed the Team that the recipient was placed in a physical hold and restraints for a short period of time on 08/13/09 after she exhibited self-abusive behaviors. The Administrator stated that physician's orders were not completed pertinent to the restraint.

The Administrator stated that the staff member who ordered the restraints was sent to serve as a supervisor on the Cypress Upper Unit (Unit) to ensure that recipients on the unit were involved in community outings. She informed the Team the staff member had served as a training coordinator prior to being transferred to the Unit. The Administrator stated that his duties as training coordinator included instructing other staff members regarding the Code's mandates for restraint use as well as other facility policies and procedures.

The Administrator informed the Team that the responsible staff member was disciplined and retrained due to the unauthorized restraint application.

I...Recipient:

The recipient stated that she was transferred to the facility after spending three years in a county jail. She informed the Team that in August 2009, she "got mad" at the supervising nurse and refused to take the medication that was prescribed for an ear infection. She stated that she went from the clinic area to the bathroom to "calm down". The recipient informed the Team that Technician I came into the bathroom to persuade her to relax, leave the bathroom area and to come into the living area of the unit. She stated that she went into the living area; however, she became frustrated, began to scratch at her arm, and attempted to leave the area several times. She stated that when she began to scratch her arm, Technician I and RSS I placed her in a physical hold and then into restraints. She stated that restraints were placed on her legs and arms, and then a strap was positioned across her chest.

A QMRP was present during the interview with the recipient.

J. QMRP:

The QMRP informed the Team that the recipient was required to have one-to-one staff observation due to a suicide threat; therefore, it would not be possible for the HRA to speak with her without a staff member present. The QMPR stated that the recipient had ceased the suicidal ideation; however, the observation order remained in effect at the time of the site visit.

K...Additional Information Pertinent to Interviews:

The HRA made numerous attempts to speak with an additional technician, who was listed as being present at the time of the restraint episode. One of the technicians interviewed listed the technician as the lead worker at the time of the restraint episode. The HRA was informed that the worker was on medical leave from the facility, and all of the HRA's endeavors to reach the individual by telephone failed. Numerous messages were left on the technician's voice mail asking her to contact the HRA for an interview; however, the technician did not respond to the requests.

II... Written Statement by Technician IV:

According to a written statement, Technician IV documented that she worked on the Cypress Upper evening shift until approximately 4:10 PM. At that time she was relieved by another staff member. Technician IV stated that the recipient appeared calm until shortly before she was departed from the unit. She documented that it appeared that the recipient was having a problem with her medication, and the nurse had informed staff that in the future the recipient was to be escorted by staff into the clinic. Technician IV stated that she was not aware of the reason that the recipient was placed into restraints, who ordered the restraints, or who placed the restraints on the recipient.

III...OIG Report of Findings and Guardian's Request for Reconsideration:

The Authority reviewed the OIG Investigation Report of Findings pertinent to the allegation. According to a 09/23/09 letter to the recipient's Guardian, the OIG had completed its investigation into mental and psychological abuse of the recipient and determined that the findings were unfounded.

When the Guardian received the letter, she sent a letter to the OIG on the same day requesting reconsideration of the unfounded findings based on the following evidence: 1) The recipient did not meet the facility's criteria for any type of physical restraint and no doctor's orders were verbalized or written to place the recipient in either the two person hold or mechanical restraints. 2) The recipient has a history of receiving physical and psychological abuse which has resulted in a diagnosis of PTSD, and the Guardian expressed concern that the condition might be exacerbated by any unwarranted altercation. 3) The recipient is currently serving a mandatory term and use of restraint for behavior could be perceived as non-compliance with parole when reviewed by the judge.

On 11/10/09, the Guardian received a letter from the OIG stating the Guardian's request for re-consideration had been granted, and she would be advised of the results of the reconsideration upon completion of the OIG's review.

In a 01/04/10 letter to the Guardian, the OIG stated that the reconsideration had been completed, and it was determined that there was insufficient information to warrant a change in the findings. The findings were listed as unsubstantiated.

IV: Clinical Chart Review:

A: Personal Service Plan (PSP):

Documentation in a 08/04/09 PSP indicated that the recipient was released from a three year term in jail with time served on 07/22/09, and she was currently serving a one-year probation. The record indicated that the recipient is required to call her probation office twice monthly.

The recipient's diagnoses were listed as follows: AXIS I: Bipolar Disorder, depressed and agitated type; AXIS II: Mild Mental Retardation and AXIS III: Asthma, GERD (Gastroesophageal reflux disease), chronic constipation, chronic Allergic Rhinitis, Dysmenorrhea.

The recipient's medications were listed as follows: Flonase Nasal Spray (Nasal corticosteroid/prevention of asthma), Eucerin Cream (skin moisturizer), Albuterol Inhaler (antiasthmatic), Mirtazapine (antidepressant), Prilosec (antisecretory/proton pump inhibitor), Seroquel (antipsychotic), Depakote (antiepileptic/treatment of bipolar mania, prophylaxis of migraines),QVAR Inhaler (maintenance treatment of asthma), Colace (emollient laxative), Milk of Magnesia (laxative) and Motrin (anti-inflammatory).

According to documentation, the barrier to discharge planning was the recipient's history of physical aggression. The record indicated that a Behavior Intervention Plan would be completed if warranted upon initiation of discharge planning and the pre-admission screening agency would be contacted to help identify homes within the community to ensure a successful placement.

Learning Objectives were listed as follows: 1) The recipient will be able to answer questions regarding her parole; 2) She will be able to state the name of her medications. 3) She will be able to "get along with others"; 4) and she will go to [a cafe] with staff to make purchases of preferred items

Documentation indicated that the recipient was considered a risk for physical aggression towards others due to her history. However, at the time of the PSP a Behavior plan was not warranted. She was to be monitored for other signs of possible risk.

B: Behavior Progress Note:(Note)

According to a 08/13/09 Note, Technician I asked the recipient to take her medication at approximately 4:15 PM. The recipient began to yell and scream at another peer stating, "You better not hit me. I will knock you out." Technician I recorded that the recipient went into the clinic yelling and refused to take her medication. Documentation indicated that when the recipient departed the clinic she returned to the group room. Technician I recorded that upon her return to the group room, she was able to convince the recipient to take her medication and walked with her to the clinic. The record indicated that the recipient took the medication; however, she continued to scream and curse and requested to go into the bathroom to gain composure. Technician I recorded that she walked with her to the restroom and stood in the doorway. When the recipient continued with the behaviors for approximately ten minutes, Technician I recorded that she asked the recipient to come back to the group room. After refusing to return to the group room, documentation indicated that the recipient began to push and kick at staff, ran out of the bathroom and attempted to leave the unit. However, staff blocked her by standing in front of the door. Technician I recorded that the recipient began yelling, "I'd rather be in jail", threatened to stop taking her medications, and continued to attempt to leave the unit. Technician I recorded that she called for assistance and informed the recipient that her rights were being restricted. Documentation indicated that the recipient was walked back to the group room with a two man forward walk; however, she continued to attempt to the leave the designated area. When she was blocked from exiting the area, the recipient attempted to hit staff, commenced scratching her arm and attempted to bite herself. Documentation indicated that a holding restraint was used, and the nurse was called; however, when the nurse arrived the recipient appeared to calm herself. Technician I recorded that when the nurse departed from the area, the recipient once again became combative and started scratching and biting herself. A hold was applied, and she continued to scratch and bite herself. Technician I documented that the recipient was placed in restraints per RSS I's orders.

C: Restraint Records:

According to the Restraint Monitoring Record, the recipient was placed into holding restraints due to biting and scratching herself at 5 PM on 08/13/09. She was released from the holding restraint at 5:15 PM and upon release she started to scratch herself. She was placed in 4-point restraints at 5:17 PM and the 5th restraint added at 5:18 PM due to her continued attempts to cause self injury by biting. She was released from restraints at 5:22 PM.

The Team reviewed a Restriction of Rights Notice (Notice) that listed a physical holding restraint, restraint device and two man forward walk were implemented when the recipient scratched and bit herself. The Notice was signed by Technician I on 08/13/09, and the record indicated that a copy of the notice was given to the individual. However, there was no documentation to indicate that the Notice had been sent to the recipient's guardian.

The Restraint Usage Log indicated that the recipient was placed in restraints on 08/13/09 due to an emergency involving the recipient's self-injurious behaviors. The recipient was placed in a holding restraint at 5:15 PM, released from the holding restraints and placed in 4-point restraints at 5:17 PM, and placed in 5-point restraints at 5:18 PM. The time of release was listed as 5:22 PM.

The HRA did not observe any Physician's Orders pertinent to the restraint in the recipient's clinical records.

V: Restraint Use in State Operated Developmental Centers and Program's Policy/Procedure (Policy):

The Policy Statement is listed as follows, "It is the policy of the Illinois Department of Human Services to teach appropriate alternative skills/behaviors to replace maladaptive behaviors, and use of behavior intervention procedures that do not involve restriction of rights of individuals receiving DHS services. These are the preferred methods of reducing and/or eliminating aggressive and/or self injurious behavior in State Operated Developmental Centers (SODC) and programs. If less restrictive interventions fail or are not effective in preventing an individual from causing harm to self or others and the use of restraint is determined warranted, then the use of restraint is to be employed in accord with the provisions set forth in this Directive".

Procedures were listed as, "1. Positive and reinforcing interactions between staff and individuals served, teaching appropriate alternative skills/behaviors to replace maladaptive behaviors, and the use of behavior intervention procedure that do not involve restriction of rights are preferred methods of reducing and/or eliminating aggressive and/or self injurious behavior in State Operated Developmental Center (SODC) and programs. Department of Human Services (DHS) Policy and Procedure Directive 02.06.09.09, 'Behavior Intervention Review Procedures for Individuals with Developmental Disabilities' provides interdisciplinary teams the framework for analyzing a maladaptive behavior, determining the intervention procedure, developing an individualized behavior intervention program and specifying the requirements for behavior intervention programs involving rights restrictions. Restraint and psychotropic medication used in response to maladaptive behavior are among the most restrictive interventions and are used only when positive or less restrictive interventions have been tried and documentation as ineffective. Restraint (physical holding devices, chemical, etc.) are only to be used to prevent an individual from causing harm to self or others when less restrictive interventions have failed or are not effective. 2. Restraint is only used when there is an emergency necessitating its use. Some emergencies can be 'planned' for based on knowledge and experience with the individual's behavior and the function of the behavior enabling restraints to be incorporated into an individualized behavior intervention program resulting in the programmatic us of restraint. Use of restraint in an emergency and outside of a program is 'Unplanned Restraint'. Whenever feasible, planned (or programmatic) restraint, rather than unplanned restraint, should be used to ensure the individual has the opportunity to be appraised of the risks and benefits associated with the use of restraint, the opportunity to consent to or protest the use of restraint and the opportunity to have the planned use of restraint reviewed by the Behavior Intervention Committee and the Human Rights Committee prior to restraint being employed. In addition, programmatic use of restraint results in greater staff consistency and competency in the management of an individual's behavior which would be harmful to self and/or others...."

In the definition section of the Policy, an authorized person is defined as follows,"...an employee who may order the use of restraint: a physician, a licensed clinical psychologist, a licensed clinical social worker, or an RN with supervisory responsibility."

## Summary

Although during the interview process there was conflicting information presented to the HRA regarding the restraint episode, there was consistent evidence that the recipient was placed in physical holds and restraints (4-point, and subsequently 5-point) without a physician's orders for any of the restrictive procedures. Interviews and documentation indicated that the restraint procedures were ordered by RSS I, whose job title does not meet the Code or DHS Policy's definition of an "Authorized Person." Additional information obtained indicated the Supervising RN, who meets the definition of an "Authorized Person" expressed that she did not believe that restraints were warranted.

## Conclusion

Based on the information obtained, the allegation that a recipient who resides in the developmental disabilities division of Choate Mental Health Center was placed in restraints without the proper authorization for the restraints is substantiated.

## Recommendations

1. A decision to place an individual in restraints should be only be made by a physician, a licensed clinical psychologist, a licensed clinical social worker, or an RN with supervisory responsibilities per Code and IDHS Policy.

2. Physician's Orders should be completed in accordance with the Code's mandates.

3. The recipient's guardian should be informed of any restrictive process and provided with a Restriction of Rights Notice pertinent to the restriction.

4. A Restriction of Rights Notice should be issued for each restrictive Procedure.

## Comments and Suggestions

During the investigation process, the HRA learned that the recipient was admitted to the facility on 07/22/09 from a county jail as UST with a history of aggressive behaviors. According to the recipient's guardian, a Behavior Intervention Plan had been formulated; however, the facility's process to approve and implement the Plan had not been completed prior to the 08/13/09 restraint episode. Documentation in the recipient's clinical chart indicated that a Behavior Intervention Plan would be completed upon initiation of discharge. Therefore, the following is suggested:

1. Development and implementation of a Behavior Intervention Plan should be completed in a timely fashion to ensure consistency in management of a recipient's maladaptive behaviors in the least restrictive manner.

The Authority also expresses concerns that a staff member, who has knowledge of the Code and DHS Policies pertinent to restraint application and whose previous responsibility was to train other staff members regarding those mandates, ordered the restraint. For that reason, HRA suggests the following:

1. The facility should ensure that staff members are provided with accurate/adequate training regarding the Code and DMH Policy requirements by qualified and knowledgeable instructors.