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Egyptian Regional Human Rights Authority
Report of Findings
10-110-9039
Chester Mental Health Center
August 24, 2010

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 250 male recipients. The specific allegation is as follows:

> A recipient at Chester Mental Health Center was inappropriately placed in restraints for an extended period of time.

Statutes

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

Section 5/2-102 (a) 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."

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 staff....(f) Restraint shall be employed in a humane and therapeutic manner and the person being restrained shall be observed by a qualified person as often as is clinically appropriate but in no event less than once every 15 minutes. The qualified person shall maintain a record of the observations. Specifically, unless there is an immediate danger that the recipient will physically harm himself or others, restraint shall be loosely applied to permit freedom of movement. Further, the recipient shall be permitted to have regular meals and toilet privileges free from the restraint, except when freedom of action may result in physical harm to the recipient of others."

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 therefor to (1) the recipient and, if the 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 in 'An Act in relation to the protection and advocacy of rights of persons with developmental disabilities and amending the Acts therein names', approved September 20, 1985, if either is so designated; and (5) the recipient's substitute decision maker, if any. The professional shall be responsible for promptly recording such restriction or use of restraints 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 for an extended period of time. To investigate the allegation, the HRA Investigation Team, consisting of two members and the HRA Coordinator, conducted two site visits at the facility. During both visits, an attempt was made to speak with the recipient whose rights were alleged to have been violated; however, the recipient refused to be interviewed on both occasions. A Representative from the facility's Human Rights Committee was interviewed. The Coordinator spoke via telephone with the recipient's legal guardian. The guardian provided written authorization for the HRA to review the recipient's clinical chart. The facility's policy pertinent to the allegation was reviewed.

I...Interviews:

A...Guardian:

The Guardian expressed concern regarding the recipient being placed in restraints in December 2009 for an extended period of time. According to the Guardian, the facility provided notification of the more than 27-hour restraint episode by sending him a Restriction of Rights Notice pertinent to the restraint. The Guardian provided written authorization for the HRA to review the recipient's clinical chart.

B...Representative:

During the initial site visit the Team spoke with the Representative regarding the allegation, presented the guardian's written authorization to review the recipient's clinical chart, and requested copies of information from the chart. The Team requested copies of the following: 1) Treatment Plan Reviews (TPRs) for December 2009, January 2010, and February 2010; 2) progress notes from the date of admission (11/04/09) to 03/01/10, and restraint records for 12/01/09 to 04/30/10. The Representative stated that the information would be sent via mail to the HRA as soon as the copies were made.

The Coordinator also spoke via telephone with the Representative after the site visit was conducted regarding the facility's policy of obtaining authorization from the facility director when a second restraint application is implemented within a 48 hour period. The Representative stated that once a restraint has been implemented within a 24-hour period, if the recipient exhibits behaviors that constitute a self threat or threat to others so severe that restraints are necessary within the 48-hour period, the facility director is contacted for approval and written authorization is provided via e-mail correspondence.

II: Clinical Chart Review

A....TPRs:

According to the recipient's 12/18/09 TPR, the recipient was transferred to Chester Mental Health Center from another state-operated mental health facility on 11/10/09 due to his aggressive behaviors. The record indicated that in September 2009 he physically attacked staff at the transferring facility. In October 2009 he was involved in two aggressive actions. On 10/16/09, he physically attacked staff, and on 10/22/09, he screamed, threw chairs and a garbage can, and slapped a nurse. Restraints were required for the safety of the recipient and others on all three occasions.

Documentation in the TPR indicated that the recipient's legal status was voluntary and he had an appointed guardian. His diagnoses were listed as follows: AXIS I: Schizophrenia, NOS (Not Otherwise Specified); Frotterusim; and AXIS II: Mental Retardation (Mild), AXIS III: BPH (Benign Prostatic Hyperplasia), Hypertension, Dyslipidemia, NIDDM (Non-Insulin Dependent Diabetes Mellitus), Lactose Intolerance, Constipation; History of Glaucoma; and AXIS IV: Chronic Mental Illness, Language Barrier. The record indicated that the recipient attended and participated in the 12/18/09 TPR, with the assistance of bilingual (Spanish-English) translation services provided by his therapist. According to documentation the recipient's medication had been reviewed by a medical doctor and a psychiatrist and titrated to insure control of his psychiatric symptoms and medical issues. However, the recipient required multiple restraint applications to prevent self injury or injury to others.

The recipient's medications were listed as follows: 1) Depakote ER 1000 mg twice daily for mood stabilization (increased on 11/15/09); Guetiapine 300 at bedtime for psychosis; Benedryl 50 mg at bedtime; Clonzaepam 2 mg at 4 PM and 1 mg at bedtime; Paxil 30 mg twice daily and Trazodone 100 mg at bedtime for insomnia.

Documentation indicated that the recipient was informed of the circumstances under which the law permits the use of emergency forced medication, and/or restraint. Should any of these circumstances arise, the recipient stated his preferred intervention was emergency medication, then restraint. The record indicated that seclusion was not an option due to the recipient's AXIS II diagnosis of Mild Mental Retardation.

The recipient's 12/18/09 TPR contained the following goals: 1) To be free of displaying aggressive behaviors toward others by November 2010; 2) To reduce psychotic symptoms, which consist of possible hallucinations, delusions and perceptual problems by November 2010; 3) To stabilize and manage blood sugar and prevent hyperglycemic/hypoglycemic episodes; 4) to lower and manage blood pressure to reduce the probability of permanent damage to the brain, heart, kidney; 5) To maintain optimal cardiac output; 6) To lower serum cholesterol and/or triglycerides; and 7) To be free from pain and discomfort and show signs of a healing ulcer.

Documentation in the Extent To Which Benefitting From Treatment Section of the TPR indicated that the recipient was being closely monitored by staff and his bilingual therapist to further assess his treatment needs and to prove adequate interventions aimed at stabilizing his psychiatric and behavioral profile. The record indicated that the recipient engages in aggression to avoid compliance when directed by STA staff, exhibits concrete thinking and understanding, and reports auditory and visual hallucinations. Documentation indicated that he required restraints on four occasions in November 2009 and five occasions in December 2009 when he lost emotional control and physically aggressed toward staff. According to the record, the recipient's clinical condition remained unstable at the time of the TPR.

Documentation in a 01/20/10 TPR indicated that until the week previous to the TPR meeting, the recipient had continued to have numerous outbursts after routine requests from staff during medication passing. The record indicated that the recipient's bilingual therapist met with the recipient and explained in English and Spanish the module routine and the need for safety and refraining from aggressive actions. The therapist reported that the recipient was reinforced with verbal praise after agreeing to follow instruction. However, the therapist indicated that the recipient had limited capacity to integrate the information which was presented. Documentation indicated that a facility physician had adjusted the recipient's medication in an effort to offer additional impulse control. Conversely, the recipient continued to experience mood instability, auditory hallucinations and disorganized thinking. The record indicated that he had also exhibited aggressive actions (verbal and physical) and had required numerous restraint applications.

A goal for the recipient to promote/improve ability to move all extremities and/or ambulate in a safe, effective manner was added to the 01/20/10 TPR with the objective of fall prevention. Documentation indicated that the recipient had experienced falls on 12/29/09, 01/03/10 and 01/04/10. An additional goal for the recipient to have a normal bowel elimination pattern was incorporated in the plan.

Documentation in the Extent to Which Benefitting From Treatment Section of the 01/20/10 TPR, indicated that the recipient had benefitted from the discontinuation of Trazodone and Benadryl, as they contributed to the increased sleepiness, a trigger for the recipient's violent behavior. The record indicated that during the week previous to the TPR, the recipient had appeared increasingly alert, oriented and compliant with the module routine. However, his overall clinical condition remained unstable.

Documentation in the recipient's 02/17/10 TPR indicated that a facility psychiatrist continued to adjust the recipient's psychotropic medication regimen to insure optimum control of his aggressive outbursts. The record indicated that early into the review period, the recipient required restraints twice; however, he had been free of aggressive outbursts the remainder of the TPR review, a period of almost two weeks.

The record listed his medications at the 02/17/10 review as follows: 1) Depakote 500 mg in AM, 1000 mg at bedtime for mood stabilization (decreased on 01/08/10), 2) Quetiapine 600 mg at bedtime for psychosis (increased on 02/17/10, 3) Clonazepam 1 mg at 4 PM, 1 mg at bedtime (decreased on 02/17/10/ and 4) Paxil 30 mg twice daily. Documentation indicated that the recipient was medication compliant.

Documentation in the Extent to Which Benefitting From Treatment Section of the 02/17/10 TPR indicated that during the previous two weeks, the recipient's clinical profile had improved as denoted by increased social activity and no aggressive outburst.

B...Restraint Records:

The Authority reviewed the recipient's restraint record for 12/01/09 to 04/30/10. The following restraint episodes are listed:

Date	Restraint (R)Orders Hold (H) Orders Timeframes	Restriction Notice yes (y) no (n)	Flowsheets	Reason for Restriction	Debriefing
Restraint I					
12/05/09	H (10:10 AM to 10:15 AM) 5 minutes hold	y	n/a	threw a shoe hit STA	n/a
12/05/09	R (10:15 AM to 1:15 PM) 4 hour restraint	y	y	failed to calm while in hold	y 1:15 PM
Restraint II					
12/06/09	H (4:25 PM to 4:30 PM) 5 minutes hold	y	n/a	threw blankets at staff and hit staff	n/a

12/06/09	R (4:30 PM to 7:30 PM) 4 hour restraint	y	y	continued phy. aggression while in hold	y 7:30 PM

Restraint III

12/13/09	H (12:25 PM to 12:30 PM) 5 minute hold	y	n/a	threw a chair at staff; tried to bite staff	n/a
12/13/09	R (12:30 PM to 3:30 PM) 3 hour restraint	y	y	continued with aggression while in hold	y 3:30 PM

Restraint IV

12/15/09	H (8:40 PM to 8:45 PM) 5 minute hold	y	n/a	threw a chair tried to bite staff	n/a
12/15/09	R (8:45 PM to 11:45 PM) 3 hour restraint	y	y	remained aggressive while in hold	y 11:45 PM

Restraint V

12/18/09	H (4:25 PM to 4:30 PM) 5 minute hold	y	n/a	threw milk in nurse's face, swung & fought violently	n/a
12/18/09	R (4:30 PM to 8:30 AM) (8:30 AM to 12:30 AM ..12/19) (12:30 AM to 4:30 AM) 12 hour restraint	y	y	would not cease fighting and hitting	y 4:30 AM 12/19/09

Restraint VI:

12/23/09	H (8:40 AM to 8:45 AM) 5 minute hold	y	n/a	tore shower curtain, kicked staff	n/a
12/23/09	R (8:45 AM to 12:45 PM) 4 hour restraint	y	y	would not become calm continued aggression	y 12:45 PM

Restraint VII:

12/24/09	H (4:10 PM to 4:15 PM) 5 minute hold	y	n/a	attacked a female staff member	n/a
12/24/09	R (4:15 PM to 8:15 PM) (8:15 PM to 10:15 PM) 6 hour restraint	y	y	failed to stop violent actions while in hold.	y 10:15 PM

Restraint VIII:

12/25/09	H (2:25 PM to 2:30 PM) 5 minute hold	y	n/a	attacked staff, kicked, hit, scratched	n/a
12/25/09	R (2:30 PM to 6:30 PM) (6:30 PM to 10:30 PM) (10:30 PM to 1:30 AM ..12/26/09) 11 hour restraint	y	y	continued aggression	y 1:30 AM 12/26/09

Restraint IX

12/26/09	H (1:40 AM to 1:45 AM) 5 minute hold	y	n/a	While staff helping him up from restraint VIII, recipient started kicking, hitting,& spitting at staff	n/a

12/26/09	R (1:45 AM to 5:45 AM) (5:45 AM to 9:45 AM) (9:45 AM to 1:45 PM) (1:45 PM to 5:45 PM) (5:45 PM to 9:45 PM) (9:45 PM to 1:45 AM..12/27/09) (1:45 AM to 5:30 AM...12/27/09) 27 ¾ hour restraint	y	y	continued aggression	y 5:30 AM 12/27/09

Restraint X

01/07/10	R (8:45 PM to 10:30 PM) 1 3/4 hour restraint	y	y	threatened harm, yelled at & cursed staff	y 10:30 PM

Restraint XI

01/08/10	H (12:40 PM to 12:45 PM) 5 minute hold	y	n/a	attacked staff with closed fist	n/a
	R (12:45 PM to 4:45 PM) (4:45 PM to 8:45 PM) 8 hour restraint	y	y	aggression did not cease while in hold	y 8:45 PM

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Restraint XII

01/08/10	R (9 PM to 1 AM 01/09/10) 4 hour restraint	y	y	when releasing from Restraint XI, spit at & kicked staff	y 2 AM 01/09/10

Restraint XIII

01/10/10	1) H (7:05 PM to 7:10 PM) 2) H (7:10 PM to 7:15 PM) (2 handcuffs to transfer to	y y	n/a n/a	spit, kicked & hit staff	n/a

	restraint room) two 5 minute holds				
01/10/10	R (7:15 PM to 11:15 PM) 4 hour restraint	y	y	continued aggression	y 11:15 PM

Restraint XIV

01/15/10	1) H (6:20 PM to 6:25 PM) 2) H (6:25 PM to 6:30 PM) (2 handcuffs to transfer to restraint room) two 5 minute holds	y y	n/a n/a	spit on & attacked staff	n/a n/a
01/15/10	R (6:30 PM to 10:30 PM) 4 hour restraint	y	y	continued aggression	y 10:30 PM

Restraint XV

01/30/10	1) H (7:20 AM to 7:22 AM) 2) H (7:22 AM to 7:30 AM) (2 handcuffs to transfer from dining area to restraint room) 1 2 minute hold, 1 8 minute hold	y y	n/a n/a	spit on & attempted to hit staff	n/a n/a
01/30/10	R (7:30 AM to 9:30 AM) 2 hour restraint	y	y	continued aggression while in hold	y 9:30 AM

Restraint XVI

01/31/10	H (1:55 PM to 2 PM) 5 minute hold	y	n/a	swung at staff	n/a
1/31/10	R (2 PM to 6 PM) R (6 PM to 9 PM) 7 hour restraint	y	y y	aggression continued while in hold	y 9 PM

Restraint XVII

02/03/10	H (4:10 PM to 4:15 PM) 5 minute hold	y	n/a	Hit a STA	n/a
02/03/10	R (4:15 PM to 8:15 PM) (8:15 PM to 10:15 PM) 6 hour restraint	y y	y y	continued aggression	y 10:15 PM

Restraint XVIII

04/04/10	H (4:05 PM to 4:10 PM) 5 minute hold	y	n/a	Hit staff	n/a
04/04/10	R (4:15 PM to 8:15 PM) 4 hour restraint	y	y	aggression continued	y 8:15 PM

Comments Regarding the above Restraint Episodes

During the HRA's review of the restraint records, it was noted that the following Restraint Orders did not have a specific time listed for the recipient to exhibit the behaviors specified in the criteria before the recipient would be released from the restraints: 1) Restraint I (12/05/09); 2) Restraint II (12/06/09), 3) Restraint V (12/18/09), 4) Restraint VII (12/24/09), 5) Restraint VIII (12/25/09), 6) Restraint IX (12/26/09....All Orders), 7) Restraint XI (01/08/10...all Orders) 8) Restraint XIV (01/15/10... all Orders).

The HRA did not observe documentation in the Flowsheets that indicated that the recipient was offered an evening meal while in restraints on 12/06/09 (Restraint II), 12/24/09 (Restraint VII), and 01/31/10 (Restraint XVI). The Authority also questioned the reason that a physical hold was discontinued at 4:10 PM and restraints were not applied until 4:15 PM on 04/04/10 (Restraint XVIII).

C: Progress Notes:

Restraint I

According to documentation in a 12/05/09 nursing progress note, the recipient had become combative, hit a staff member and threw a shoe at other staff member. The RN recorded that the recipient was placed in a physical hold and then restraints for the protection of self and

others. The RN documented that the recipient was examined and provided with Notices pertinent to the hold and restraints.

Restraint II:

Documentation in a 12/06/09 psychiatrist's progress note indicated that the recipient threw objects at staff and then started to fight the staff members. The psychiatrist recorded that the recipient was an imminent physical danger to others.

Restraint III:

An RN recorded in a 12/13/09 nursing progress note that the recipient was upset, hostile and angry. When staff attempted to redirect him from slamming doors, he picked up a chair and threw it at staff. According to the documentation, when attempts failed to calm him, he was placed in a physical hold and then restraints "with much difficulty".

Restraint IV:

According to an RN's 12/15/09 progress note, the recipient became highly agitated and aggressive to the point of attempting to throw a chair at staff. He was placed in a physical hold and transferred to restraints.

Restraint V:

Documentation in a 12/18/09 progress note indicated that the recipient threw his tray, which contained milk, in an attempt to hit staff. He was placed in a physical hold and then into restraints when his aggressive behaviors continued. According to the record, the recipient spit at staff while in the physical hold.

Restraint VI:

Documentation in a 12/23/09 progress note indicated that when the recipient was counseled about taking a shower, he started kicking and punching staff. According to the recordings, he was placed in a physical hold and when he failed to cease the aggressive actions he was transferred to restraints for the protection of all.

Restraint VII:

According to a 12/24/09 progress note, when the recipient was called to take his medication, he attacked a female staff member. He was placed in a physical hold. When he continued kicking and spitting, he was placed in restraints.

Restraint VIII:

According to an RN's 12/25/09 progress note, the recipient was found in the shower throwing clothing, towels and toileting items and refusing to take a shower. When staff counseled the recipient, he attacked them. As a result of his aggressive actions, he was placed in a physical hold and when he continued with the aggression he was placed in restraints.

Restraint IX:

Documentation in a RN's 12/26/09 progress note indicated that the recipient was released from restraints (Restraint VIII) and continued to lie on the bed. The RN recorded that after much encouragement, staff members were able to get him off the restraint bed and to walk out of the room. However, when he commenced to walk he fell onto his hand and knees. The RN documented that while staff members were attempting to help him, he got up and began spitting, hitting and kicking. He was placed in a physical hold, then into restraints.

An addition 12/26/09 nursing progress note indicated that the recipient stated, "I like being in restraints".

Restraint X:

Documentation in an RN's 01/07/10 progress note indicated that after the recipient experienced "disorganized behaviors", he voluntarily walked down the hallway into the restraint room and lay down on the restraint bed. Documentation indicated that when staff attempted to determine what was bothering him he spoke in Spanish despite requests for him to speak in English.

Restraint XI

According to an RN's 01/08/10 progress note when the recipient was asked to go to his room, he went into the room and then came out "swinging and attacked staff" The record indicated that the recipient was placed in a physical and then into restraints.

Restraint XII

According to an RN's progress note when the recipient was being released from restraints (Restraint XI) he starting hitting, spitting, and kicking staff. Due to these behaviors restraints were reapplied.

Restraint XIII

An RN documented that when the recipient began to experience increased agitation, a facility physician prescribed Lorazepam and Haldol. The RN recorded that the recipient refused

the medication and began kicking and hitting staff. Due to these behaviors, he was placed in a physical hold prior to restraint application.

Restraint XIV:

Documentation in a 01/15/10 progress note indicated that the recipient had attacked staff "quite strenuously" for no apparent reason. The RN recorded that the recipient's preferred emergency intervention, medication, was not utilized due to the severity of his aggression. He was placed in a physical hold prior to restraint application.

Restraint XV:

Documentation in a 01/30/10 progress note indicated that when the recipient was directed by staff to come to the nurses' cage to take his medication he came out of his room violently swinging at staff. The RN completing the note recorded that the recipient was placed in a physical hold to prevent harm to self or others, and when he continued to violently struggle physical restraints were initiated.

Restraint XVI

An RN documented in a 01/31/10 progress note that patients were lining up to go to church services when the recipient came down the hall and swung at a STA. The RN recorded that he recipient demanded to go to the church services; however, due to his previous restraint episode on 01/30/10 he was unable to attend any off the unit activities.

Restraint XVII

A STA recorded that the recipient was walking by other recipients' rooms hitting their doors in a loud manner. When staff requested that he cease the action, the recipient proceeded to physically attack a STA. Documentation indicated that he was placed in a physical hold and escorted to the restraint room.

The Authority did not request progress notes from the date of admission on 11/04/09 to 03/01/10; therefore, information pertinent to Restraint XVIII, which occurred in April 2010, was not reviewed.

III: Facility Policy and Program/Policy Directives

A...Use of Restraint and Seclusion (Containment) in Mental Health Facilities Policy (Policy)

The Policy Statement is listed 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 or others and follows the Department of Human Services Program Directive 02.02.06.030.

B: Illinois Department of Human Services Program Directive 02.02.06.030 (Directive)

The Policy Statement in the Directive is as follows, "It is the policy of the Department of Human Services, Mental Health (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. This directive is the primary directive for the use of restraint and seclusion in mental health facilities. It is consistent with the requirements of the Mental Health and Developmental Disabilities Code. It supersedes any previous DHS or mental health facility procedure. For clinical and administrative reasons the DHS may have chosen in this directive to exceed MHDD Code of Joint Commission on Accreditation of Health Care Organization (JCAHO) requirements; therefore, this directive takes precedence.

Neither restraint no seclusion may ever be used to punish or discipline an individual or as a convenience to staff. The least restrictive intervention that is safe and effective for a given individual will be used. It is the role of leadership to help create a physical, social, and cultural environment in which the approach to restraint and seclusion protects the individual's health and safety; preserves his or her dignity, rights, and well-being; and minimizes the risks to staff and others. Limiting restraint and seclusion use to clinically-appropriate and alternative strategies is the role of all staff. An approach to restraint and seclusion utilization that focuses on reduction while striving to assure the safety of the individual, other patients, and staff requires planning, thoughtful education, and continuous efforts at performance improvement.

The circumstances that result in the use of restraint or seclusion are complex. Consequently, the strategies for reducing and eliminating restraint and seclusion use may be 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 destruction 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 interventions for both patients and staff;
2. the implementation of staff training based upon a nationally-recognized training program in conflict de-escalation and prevention;
3. the inclusion of the consumer perspective on the restraint and seclusion experience and perceived opportunities for reducing utilization; and
4. effective assessment and treatment."

Summary

Documentation indicated that the recipient exhibited severe aggressive actions in the least restrictive setting necessitating his transfer to Chester Mental Health Center, the most restrictive mental health facility in the state. The recipient's record indicated that since his admission to the facility he was placed in restraints on numerous occasions during the HRA's target time of review. Documentation indicated that each application was due to the recipient's aggressive actions, which had the potential to cause harm to self or others, a criteria that is in accordance with the Code. However, the HRA's review indicated that there were occasions when the criteria for release appeared to be open ended rather than listing a specific time for the recipient to exhibit the targeted behaviors before release. Of special concern was the 12/25/09 (11 hour) and 12/26/09 (27 ¾ hour) restraint episodes. Additionally, the HRA did not observe any documentation in the Flowsheets for the 12/06/09, 12/24/09 and 01/31/10 restraints to indicate that the recipient was offered an evening meal.

Conclusion

Although, the reasons for the recipient's placement in restraints for all applications were in accordance with the Code, the facility failed to follow the Code's requirements during the restraint application. Therefore, the allegation that the recipient was inappropriately placed in restraints for an extended period of time is substantiated.

Recommendations:

The following recommendations are issued:

1. Consistent with the facility's standard practice and to ensure humane and least restrictive approaches in restraint application, orders for Restraint should specific the time that a recipient is required to exhibit the targeted behaviors prior to release. It the time is not specified the recipient should be released as soon as the behaviors occur.

2. When a recipient is in restraints during scheduled meal times, meals should be offered. Flowsheets should always record the offering of the meal, and if the recipient refuses the meal, the refusal.

Suggestions

Documentation throughout the recipient's chart indicated that the recipient has multiple medical problems, as well as communication issues. The following suggestions are issues:

1. Rule out medical factor related to the recipient's behaviors.
2. Rule out any communication issue (Spanish vs. English) that could have contributed to the recipient's behaviors.

Comments and Recommendation:

According to Section 5/2-108 (e) of the Code, "Restraint may be employed during all or part of one 24 hour period, the period commencing with the initial application of the restraint. However, once restraint has been employed during one 24 hour period, it shall not be used again on the same recipient during the next 48 hours without the prior written authorization of the facility director. During the investigation the HRA was informed that it is the facility's policy to contact the facility director via e-mail correspondence if a recipient is required to have second restraint application within a 48-hour period. However, the Authority did not observe any documented evidence in the recipient's records that the Director's prior authorization was obtained. The following recommendation is submitted.

1. Ensure facility director/administrator prior written authorization as required in Section 5/2-108 (e) in the Code. The written authorization should be made a part of the recipient's clinical record.

The HRA noted that there was a period of 5 minutes from the recipient's release from a physical hold until restraint application for the 04/04/10 restraint episode. However, there was no documentation to indicate what had occurred between releases from the hold until restraint application. The following suggestion is submitted.

1. Staff should ensure that adequate/accurate documentation occurs pertinent to the entire restraint process.

Additional Comments

The HRA acknowledges that the facility staff consistently monitored the recipient's treatment and made changes in an effort to assist the recipient with problem areas. Those efforts appeared to be successful with the documented evidence of reduction of restraint episodes from the time of admission to targeted end of the HRA's review.