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Egyptian Regional Human Rights Authority
Report of Findings
11-110-9020
Chester Mental Health Center
May 26, 2011

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 240 recipients. The specific allegations are as follows:

1. Recipients on specialized diets do not have an adequate amount of food.
2. A recipient at Chester Mental Health Center was inappropriately placed in restraints.
3. Recipients are required to remain in their rooms for an excessive amount of time.

Statutes

If substantiated, the allegations would be a violations of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/2-108, 405 ILCS 5/2-200 and 405 ILCS 5/2-102).

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."

Section 5/2-201 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 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, the agency designated under 'An Act in relation to the protection and advocacy of rights of persons with developmental disabilities and amending the Acts therein named 'approved September 20, 1985, if either is so designated; and (5) the recipient's substitute decision maker, if

any. The professional shall be responsible for promptly recording such restriction or use of restraints or seclusion and the reason therefor in the recipient's record."

Section 5/2-102 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. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan."

Investigation Information

Allegation 1: Recipients on specialized diets at Chester Mental Health Center do not receive an adequate amount of food. To investigate the allegation, the HRA Investigation Team (Team) conducted two site visits to the facility. During the initial visit, the Team, consisting of two members and the HRA Coordinator (Coordinator), spoke with the recipient whose rights were alleged to have been violated and observed a noon meal being served to recipients from Unit B. During the second visit to the facility, the Team, consisting of one member and the Coordinator spoke with the Chairman of the facility's Human Rights Committee (Chairman) and examined a vegetarian diet lunch tray. With a recipient's written authorization, information from his clinical chart was reviewed. The Authority reviewed facility policies pertinent to the allegation.

I...Interviews:

A... Recipients:

During the initial visit to the facility in January 2011, the Team spoke with four recipients regarding the amount of food served at meal times. Recipient 1 reported that he has requested a vegetarian diet. However, a facility physician added chicken and fish, but excluded red meat for the order. Recipient 1 stated that he receives an ample amount of food and Ensure has been added as a supplement. Recipient 2 stated that he requested to be served a vegetarian diet, and a facility physician wrote the order for the diet. However, the specialized diet did not provide an adequate amount of food to satisfy his hunger. Recipient 3 stated that he is on a regular diet, which includes an ample amount of food. Recipient 4 informed the Team that he doesn't find any problem with the amount of food that is served, but believes that staff members are poisoning some of the items served to the recipients.

B...Chairman

The Chairman informed the Team members that specialized diets are ordered by a facility physician and served in accordance with the Physician's Orders. He stated that recipients with specialized diets are served prior to those with regular diets. The trays for the recipients are set up by staff as recipients enter the dining room, and recipients return their dietary tray, bowls and cups to the dish room to be prepared for washing upon completion of the meal.

During the initial visit, the Chairman accompanied the Team into the dining area to observe recipients from one of the units being served lunch. During the second visit, the Chairman brought a vegetarian tray from the facility kitchen for the Team members to examine.

II...Observations:

During the initial visit, the Team observed a noon meal being served to recipients who reside on Unit B. When the Team entered the dining room, approximately 2/3 of the recipients were sitting at the table eating their meals. The remainder of the recipients individually obtained a tray from the serving area and went to a dining room table. Some recipients sat alone at the table, while others sat with another individual. Although the serving of trays to persons with specialized diets had been completed prior to the Team's entry, it was noted that all of the trays observed had ample servings of each menu item.

During the final site visit, the Team observed a sample of a tray prepared for a recipient who has an order for a vegetarian tray. The tray contained a generous serving of the following: 1) green beans, 2) scalloped potatoes, and 3) beans with rice. The recipient was also provided with a 4 oz carton of orange sherbet, a slice of bread, a pat of butter and tea.

III:...Clinical Chart Review:

According to Recipient 2's 11/01, 12/02 and 01/11 TPRs, he does not have a diagnosed medical condition which would require a specialized diet. However, documentation in a 12/15/10 progress note indicated that the recipient's diet had been changed per recommendations of the facility dietician. According to the record the dietician had recommended and the physician ordered a meat free diet with a half of peanut butter and jelly sandwich and fruit at bedtime. On 02/03/11, the dietician recorded that the recipient remained on a meat free diet with one half of a peanut butter and jelly sandwich and fruit at bedtime. According to the dietician's documentation, the recipient remained within his ideal body range. In a 02/08/11 medical progress note, a facility physician recorded that the dietician's report had been reviewed, accepted and an order written. On 02/16/11 and 02/17/11, an RN recorded that the recipient had refused to eat breakfast and stated that he was not hungry. Documentation indicated that staff encouraged the recipient to eat, but he continued to refuse.

A Physician's Order for a pork free diet was issued on 11/09/10 and 12/01/10. However, the diet was changed to meat free with a half of peanut butter and jelly sandwich and fruit at bedtime in the 12/29/10 and 01/25/11 Physician Orders. In a 02/08/11 Physician Order a continued meat free diet was ordered. However, the physician ordered that the bedtime snack be discontinued and a house snack provided.

IV: Facility Policies:

A...Monthly Weight Policy

According to the Policy Statement, "It is the policy of Chester Mental Health Center to keep an accurate record of weight on all patients in order to readily identify those patients with significant weight losses or gains."

The procedures are listed as follows: 1) Unit nursing staff will assess the weights of all recipients on a monthly basis. 2) All weights are to be record within three working days of the time that the weight was previously taken. 3) A referral for a nutritional assessment will be made if the recipient has lost five percent or more of weight in the previous month, seven and a half percent or more in the previous three month period, or ten percent or more in the previous six-month period. A recipient is also referred for an assessment if he has a weight gain of ten percent or more in the previous one month period.

B...Ordering and Serving Modified Diets:

The Policy Statements states, "At Chester Mental Health Center, the Dietary Manager II (Registered Dietitian) shall monitor the planning and serving of all modified diet menus to assure that diets are planned for and served to all patients according to their medical and psychological needs.

The procedures are divided into the following: 1) Nursing and Physician Responsibilities, 2) Dietary Department Responsibilities; and 3) Menu Rationale.

In the Nursing and Physician Responsibilities Section, documentation indicated that all modified/special diets must be ordered by a physician. The unit nurse will contact the dietary supervisor by phone to inform her/him of the modified/special diet order and will deliver the Diet Prescription Form to the dietary department by the end of the shift. Any diet changes or discontinuations are phoned into the dietary department by the unit nurse and the Diet Prescription submitted with the appropriate change(s). The unit nurse will also contact the commissary and inform them of the modified/special diet orders, diet changes, or discontinuation of a diet. All modified/special diet must be reviewed by a facility physician at least every thirty days. Any modified/special dietary need that is a result of the recipient's personal preference request that is not medically warranted must be referred to the recipient treatment team for consideration and approval prior to a physician ordering the special dietary request. If the physician feels a special dietary request is needed and documents the justification for the special dietary need, he may implement the diet change or request prior to receiving the treatment teams' approval.

Procedures outlined in the Dietary Department Section of the Policy were listed as follows: 1) regular and modified/specialized diets are prepared in the kitchen by the cooks and served by assigned support service workers. Modified diets are identified by color-coded cards upon which the recipient's name, unit and specific diet listed. e.g. (a green card indicates a limited concentrated sweets diet). Copies of the regular menu with diet spreadsheet are given to the support service workers to follow when serving diet trays to the recipients. A card for each

modified diet is set up on the recipient's stray for the recipients who come to the dining room. Trays going to the units for patients on modified diets will have a paper tray card indicating the recipient's name and the specific diet to assure that the tray is delivered correctly.

Documentation in the Menu Rationale Section of the procedure indicated that a regular diet is designed for persons who do not require any modifications. The diet provides approximately 2200 to 2400 calories. A limited concentrated sweets diet is less restrictive than a calorie controlled diet and may be appropriate for diabetics with controlled blood sugars and those with a weight maintenance regiment. The diet provides approximately 1800 to 1900 calories. Meat-free and pork-free diets will follow the regular diet pattern, and the meat item will be replaced with fish, eggs, peanut butter, or dairy products. A bland diet is designed to minimize gastric secretions and gastric irritation for those recipients with chronic ulcer disease. A mechanical soft diet is used for recipients who have difficulty chewing. The diet follows the regular diet with foods being fork tender or cut/chopped as needed. A pureed diet is designed for those individuals who have difficulty swallowing or who cannot chew foods of the mechanical soft consistency. The regular diet is followed with foods pureed or soaked as needed. A clear liquid diet is designed to prevent dehydration and to promote oral intake with minimal stimulation of the gastrointestinal tract. The low fat/heart health diet restricts total fat and food that are high in cholesterol. The diet averages 1800 calories and is limited to approximately 50-60 grams of total fat daily. Fried foods, high fat meat, and organ meats are omitted and skim meal is served. The increased calorie diet is used when additional essential nutrients and calories are needed. The diet is based on the regular diet with 1 ½ times the normal protein vegetable and starch portions, and two times the normal milk proteinposrtion. Calories in the diet average between 2900-3300 daily.

Summary of Allegation 1

Two of the four recipients interviewed indicated that they had requested meat free diets. Recipient 1 stated that a physician had ordered a diet free of red meat; however, chicken and fish were included in the physician's orders. Recipient 2 stated that the vegetarian tray that he is served did not have enough food to satisfy his hunger. Recipient 3 informed the Team that he was served a regular diet which included ample amounts of food. Recipient 4 stated that he felt that staff members were poisoning some of the food items. During an initial visit to the facility, the Team observed recipients from a unit being served a noon meal. All trays observed included ample amounts of food. During the second visit, the Team examined a tray specified as vegetarian and found no problem with the amount of food served. Documentation in a recipient's chart indicated that a dietician conducted an assessment, provided recommendations, and a facility physician had written an order for the dietician's recommended diet. The record indicated that the recipient's diet was assessed monthly and new orders written after each assessment. The facility has a policy which mandates monthly weight checks and referral for nutritional assessments when there is a significant weight change. An additional policy outlines the requirements for specific diets, as well as staff responsibilities to ensure that the diets are appropriately ordered, monitored and made available to the recipients.

Conclusion of Allegation 1

Based on observation, interviews and records obtained during the course of the investigation, the allegation that recipients on specialized diets do not receive an adequate amount of food is unsubstantiated. No recommendations are issued.

Comments

The HRA did not observed documentation to indicate the reason that Recipient 1's request for a total vegetarian diet was not honored, and an order was written for a vegetarian diet with chicken and fish. The HRA suggests a review of this recipient's diet order and preference request.

Allegation 2: A recipient was inappropriately placed in restraints. To investigate the allegation, the Team spoke with the recipient whose rights were alleged to have been violated and the Chairman of the facility's Human Rights Committee. With the recipient's written authorization, copies of information pertinent to the allegation were obtained and reviewed by the Authority. Facility Policies and Directives relevant to restraint usage were also examined.

I...Interview:

A: Recipient:

When the Team spoke with the recipient he stated that in November 2010 Security Therapy Aides grabbed and placed him in restraints without having a valid reason to do so. The recipient stated that he was not involved in any type of aggressive action toward others nor was he threatening to cause self harm.

B: Chairman:

The Chairman informed the Team that it is the facility's policy and practice to only place a recipient in a physical hold or restraints when that recipient is causing or threatening harm to self or others. The Chairman stated that the facility follows the Code's requirements relevant to restraint application, and has a written policy and program directives that are in accordance with the Code.

II: Clinical Chart Review:

A: Treatment Plan Reviews (TPRs)

Documentation in the recipient's 11/08/10 TPR indicated that the recipient was admitted to the facility on 11/05/10 from a county jail after being adjudicated as Unfit to Stand Trial (UST) on 08/27/10.

The recipient's diagnoses were listed as follows: AXIS I: Mood Disorder by history, Bipolar Disorder, hypo-manic with psychotic features by history, R/O (Rule Out) Psychotic Disorder NOS (Not Otherwise Specified), R/O Depressive Disorder NOS, Poly-substance Abuse by History; AXIS II: Antisocial Personality by History; AXIS III: Deferred; and AXIS IV: UST Status, Confinement; H/O (History Of) Medication Noncompliance; H/O Substance Abuse. The record indicated that the recipient was referred with a diagnosis of Mood Disorder NOS. However, at a prior admission to the facility, his diagnosis was listed as Bi-Polar Disorder, Hypomanic with psychotic features. The record indicated that further observations and assessments would be helpful in determining the nature of his psychology and if his symptoms and behaviors are self controlled.

In an 11/23/10 TPR, the recipient's strengths were listed as follows: 1) Able to articulate needs; 2) Good physical health; and 3) Average intellectual functioning. His problem areas were listed as: 1) Unfit to Stand Trial and 2) Aggression. According to documentation, while in jail, the recipient's aggression was so severe that he had to be "Maced, Tazed, and placed in a restraint chair". The record indicated that the recipient was housed in segregation during his incarceration at the county jail.

Treatment goals in the 11/23/10 TPR included a goal to restore the recipient to a level of fitness in order that he might stand trial by 11/01/11. Objectives included cooperation with an evaluation of fitness and participating in fitness education by 02/05/11. An additional goal for the recipient to reduce verbal and aggressive actions toward others by 11/01/11 was included in the plan. Objectives to reach the goal were listed as follows: 1) Cooperation with a mental status evaluation; 2) To express intent to take medication; and 3) To monitor speech or behaviors indicative of hallucinations and delusions.

The record indicated that the recipient was informed of the circumstances under which the law permits the use of emergency forced medication, restraint or seclusion. Should any of these circumstances arise, the recipient was asked to state the form of intervention in order of preference; however the recipient declined to state any preference of emergency treatment.

The recipient's medication plan was listed as follows: 1) Risperidone 2 mg HS (at bedtime) for mood stabilization and psychosis; 2) Benztropine 1 mg HS for EPS (Extrapyramidal Syndrome); 3) Lorazepam 2 mg PO (by mouth) every 6 hours PRN (as needed) for anxiety; and 4) Haloperidol 5 mg every 4 hours PRN for agitation.

Documentation in an 11/23/10 TPR indicated that the recipient had required restraints once during the reporting period. One restraint episode was recorded in the recipient's 12/21/10 TPR.

Documentation in a 01/21/11 TPR indicated that the recipient had received numerous reports of argumentative, disrespectful, non-compliant, and manipulative behaviors. According

to the record, the recipient had scored a 100% on his Fitness Test and would be recommended as fit to proceed with trial for two counts of murder. Criteria to be recommended to proceed as fit include: 1) To be able to communicate with counsel and assist in his own defense; 2) Be able to appreciate his presence in relation to time, place and things; 3) To show an understanding of his charges and their consequences, as well as, court procedures and the roles of the judge, jury, prosecutor, and defense attorney; 4) To have sufficient memory to relate the circumstances surrounding the alleged criminal offense, and 5) To demonstrate that there has been a significant reduction in his aggressive behaviors.

B...Restraint Records:

Documentation indicated that an Order for a Physical Hold was issued at 4:35 PM on 11/05/10 after the recipient attacked a peer. The recipient was released from the 10 minute hold at 4:45 PM and placed in restraints. An RN recorded an examination of the recipient at 4:35 PM and a physician examined the recipient at 4:45 PM. Both medical professionals assessed that the hold did not pose an undue risk to the recipient's health and signed the Order verifying their examinations.

The recipient was provided with a Restriction of Rights Notice pertinent to the hold. The reason listed for the restriction was the recipient was in a fight with a peer. Documentation indicated that the recipient had not listed a preference for an emergency intervention. The record indicated that the Notice was delivered to the recipient in person, and he expressed that he did not want anyone notified of the hold.

An Order for Restraint was completed at 4:45 PM. The Order was issued for up to four hours with hourly reviews to allow the recipient time to modify his behavior. The release criteria were listed as follows: 1) The recipient must be calm and cooperative; 2) He must show no signs of anger or agitation; and 3) He must voice appropriate behaviors upon release. The behaviors should be exhibited for a period of sixty minutes prior to release.

Documentation in the Restraint Flowsheets indicated that a complete body search was conducted after the recipient was placed in restraints. Post application an RN determined the following: 1) The restraints were properly applied; 2) The room environment was appropriate: 3) The recipient was properly positioned; and 4) The recipient was wearing proper clothing for the restraint. The RN informed the recipient of the reason for the restraint and the criteria for release. Additionally, the RN provided the recipient with a Restriction of Rights Notice for the restraint episode.

The record indicated that the recipient was continually monitored during the restraint and his behaviors recorded in 15-minute increments. According to documentation, an RN examined the recipient on an hourly basis. During the examination, the recipient's circulation was checked, his limbs released, vital signs taken and his physical status evaluated. He was offered fluids and toileting. Documentation indicated that the recipient met the release criteria at 8:45 PM.

The record indicated that an RN conducted a Post-Episode Debriefing with the recipient upon his release from the restraint. He was able to identify the stressors occurring prior to the restraint. He stated, "We got to mouthing each other while we were eating." He was able to verbalize an understanding of the cause, consequence and methods to control his aggressive behaviors. He stated that he was aware that he could request staff assistance prior to escalation of his anxiety. He informed the RN that he did not feel that staff could have helped him to remain in control in this particular incident because it occurred "pretty fast". The RN recorded that the recipient was encouraged to discuss his feelings related to the restraint. The RN determined that during the restraint the recipient's well-being and privacy needs had been addressed, and he did not receive any type of injury. He was provided with a Restriction of Rights Notice for the restraint.

According to documentation, when the recipient threatened a staff member he was offered PRN medication; however, he refused the medication and proceeded to attack staff. A Physical Hold Order was issued on 11/06/10 at 10:10 PM for the 5 minute hold. Documentation indicated that an RN examined the recipient at 10:10 PM and a physician conducted an examination at 10:15 PM. Both individuals determined that the hold did not pose an undue risk to the recipient's health.

The recipient was provided with a Restriction of Rights Notice for the five minute hold on 11/06/10. Documentation indicated that the Notice was delivered to the recipient in person, and he stated that he did not wish to have anyone notified of the hold.

When the recipient's aggressive behaviors did not cease while in the hold, an Order for Restraint was issued at 10:15 PM. The Order was issued for up to four hours with hourly reviews to be conducted. Documentation indicated that the recipient was pacing on Module B3 and threatening staff. When verbal redirection was not effective, the recipient was offered PRN medication, but refused. The record indicated that the recipient's behaviors quickly escalated to aggression, and he swung at staff. He was placed in a physical hold for the safety of all; however, he continued to struggle and fight with staff members while in the hold. The record indicated that an RN and a physician personally examined the recipient at 10:15 PM and assessed that the restraints did not pose an undue risk to his health.

Documentation in the Restraint Flowsheets indicated that an RN conducted a body search after the restraints were applied. The RN determined the following: 1) The restraints were properly applied; 2) The room environment was appropriate; 3) The individual was wearing proper clothing; and 4) The recipient was properly positioned. Additionally, the recipient was informed of the reason for the restraint and the criteria for release. The record indicated that the recipient was continually observed during the entire restraint process, and his behaviors were recorded on the Flowsheets every fifteen minutes. An RN checked his circulation, released his limbs, took vital signs, assessed his physical status and recorded the assessments on an hourly basis. He was offered fluids and toileting when the assessments were conducted. According to the documentation, the recipient met the criteria for release at 2:15 AM on 11/07/10, four hours after the restraints were applied.

The record indicated that an RN provided the recipient with a Restriction of Rights Notice. The Notice was delivered to the recipient in person, and he stated that he did not wish anyone notified of the restraint episode.

The RN conducted a Post-Episode Debriefing at 2:15 AM on 11/07/10. Documentation indicated that the recipient was not able to identify the stressors occurring prior to the restraint. However, he verbalized an understanding of the cause and consequences of the aggressive behavior, and stated that he felt that staff members could have helped him to remain in control. He was able to identify methods to control the aggressive behaviors, and stated that he was aware that he could request assistance from staff prior to escalation of his anxiety. The RN documented that the recipient was encouraged to discuss his feelings related to the restraint. It was determined that his well-being and privacy needs had been addressed during the restraint.

Documentation in a 12/15/10 Order for Physical Hold indicated that the recipient was agitated, yelling and threatening others. When staff asked him if he would like PRN medication, he agreed. However, the behaviors escalated, and he attacked staff members. As a result of these aggressive actions, he was placed in a physical hold for containment, then escorted to the restraint room when the behaviors did not cease. The hold was implemented at 8:40 PM and continued for a 5 minute period. The record indicated that an RN examined the recipient as soon as the hold was implemented and assessed that the application did not pose undue risk to the recipient's health. A facility physician examined the recipient at 8:45 PM and reached the same conclusion.

When the recipient continued to exhibit aggressive behaviors, an Order for Restraint was issued at 8:45 PM on 12/15/10 after the recipient was released from the physical hold. Documentation indicated that the incident started as a result of the recipient's concern about some personal property issues. According to the record, the recipient started throwing items at staff, verbally threatening harm to other recipients and attempted to hit staff members with his fist.

Release criteria were listed as follows: 1) The recipient must be calm, cooperative, non-threatening, non-argumentative and be able to relate the circumstances leading to the restraints; 2) He must refrain from making threats toward staff or other recipients; and 3) He must verbalize appropriate actions and behaviors upon release. All of the behaviors should be exhibited for a period of sixty minutes prior to release.

An RN and a physician verified by their signatures that they had examined the recipient at 8:45 PM. Both professionals documented that it was their assessment that the restraint application did not pose an undue risk to the recipient's health.

Documentation in the Restraint Flowsheets indicated that the recipient was continually observed, and his behaviors recorded in fifteen minute increments. According to the record, an RN released the recipient's limbs, checked his circulation, took his vital signs, and evaluated his physical status hourly during the entire restraint episode. At the time of the evaluations, he was offered fluids and toileting. Documentation indicated that he met the criteria for release at 11:45 PM on 12/15/10.

An RN conducted a Post-Episode debriefing at 11:45 PM after the recipient was released from the restraints. According to the documentation, the recipient was not able to identify stressors occurring prior to the restraint, and he denied any wrong doing. The RN recorded that the recipient was able to verbalize an understanding of the causes and consequences of the aggressive behaviors and was able to identify methods to control those behaviors. However, he stated that he did not feel that staff could have helped him to remain in control. The RN documented that the recipient was encouraged to discuss his feelings regarding the restraint application. Additionally, the RN determined that during the restraint application the recipient's privacy needs and well-being had been addressed.

The recipient was provided with Restriction Notices for the physical hold and restraint application. According to the record, the Notices were delivered to the recipient in person, and he did not want anyone notified.

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 or Joint Commission on Accreditation of Health Care Organization (JCAHO) requirements; therefore this directive takes precedence.

Neither restraint nor 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 create a physical, social, or 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 reduction and eliminating restraint and seclusion may be multifaceted and incorporate multiple points of view, including those 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 or strategies of 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 interventions for patients and staff;
2. the implementation of staff training based upon nationally-recognized training;
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 of Allegation 2

When the Team spoke with the recipient whose rights were alleged to have been violated, he denied being involved in any type of aggressive actions that would warrant the use of restraints. However, according to documentation, the recipient was placed in restraints on 11/05/10, 11/06/10 and 12/05/10 after he became physically aggressive toward others. The HRA's review of records associated with the restraint episodes revealed that the facility had adhered to the facility's restraint policy, program directive mandates, and the Code's requirements.

Conclusion

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

Allegation 3: Recipients are required to remain in their rooms for excessive amounts of time. To investigation the allegation, the HRA Team spoke with the Chairman and five recipients. The facility's policy, "Conducting Unit Count" and the Patient Handbook were reviewed.

I...Interviews:

A....Chairman

According to the Chairman, recipients are required to stay in their rooms at the following times: 1) fifteen to twenty minutes during shift changes; 2) 10:30 PM to 7 AM for sleeping: and 3) when an altercation or any type of emergency situation occurs which would have the potential to cause harm to the recipients if they remained outside their rooms.

B... Recipients:

Recipient 1 stated that he did not have a problem with the time recipients are required to remain in their rooms. He informed the Team that recipients stay in the room during the nighttime hours, at shift change, and when there is a problem on the unit.

Recipient 2 informed the Team that recipients are required to stay in their rooms during shift change, at night and if there is any problem on the unit that could create a safety issue, such as an altercation between recipients.

According to Recipient 3, recipients are required to stay in their rooms for approximately fifteen minutes at each shift change, at night for sleeping and if there is a problem on the unit. He stated that he did not perceive the time required to remain in his room as a problem

Recipient 4 informed the Team that there he did not believe that there was a problem regarding the time recipients are required to remain in their rooms. However, he did not elaborate on the specific times recipients are mandated to remain in their rooms.

Recipient 5 informed the Team that recipients remain in their rooms for a few minutes at shift changes, several hours at night for sleeping, and when there is a problem on the unit. He stated that he did not believe that there was an issue with the amount of time that recipients are required to remain in their rooms.

II..."Conducting Unit Count" Policy:

The Policy statement is as follows, "To maintain safety and security, CMHC shall account for patients at the beginning and at the end of each shift."

According to the procedure prior to shift change one STA from the oncoming shift and one STA from the shift being relieved on each module will conduct a module count prior to the shift being relieved. Ten minutes prior to shift change, recipients are asked to stand by their room doors for accountability. On the 11 PM to 7 AM shift, at 10:40 PM recipients will be asked to stand by their doors for count. The doors will be locked after staff members confirm that all recipients are in their rooms prior to locking the door. Recipients' rooms are unlocked at 7 AM, and recipients are allowed to exit their rooms after the module count is completed.

III...Patient Handbook:

When the Authority reviewed the Patient Handbook, which is given to a recipient upon admission to the facility, no information was provided regarding the facility's policy pertinent to the allegation.

Summary

According to the complaint, recipients are required to spend excessive amounts of time in their rooms. However, when the Team spoke with the Chairman and five recipients, there was consistent information about the times that recipients were required to remain in their rooms. None of the recipients interviewed indicated that time was excessive and restrictive. The facility's policy relevant entitled, "Conducting Unit Count" specifies that recipients are to remain by their doors at shift change until a count is made to ensure that all recipients are present; However, it does not specify that the doors are locked at that time. The Authority did not observe any documentation in the Patient Handbook to indicate that recipients are informed that they would be required to remain in their rooms at shift changes and as a measure of protection when safety issues occur.

Conclusion

Based on the consistency of the information obtained, the allegation that recipients are required to remain in their rooms for an excessive amount of time is unsubstantiated. No recommendations are offered.

Suggestions

1. Information regarding the facility's policy of requiring recipients to remain in their rooms at shift change until a module count is conducted should be included in the Patient Handbook.

2. If the doors are locked during the shift change count, the "Conducting Unit Count Policy" should specify that the doors are locked.

3. The Patient Handbook should inform recipients that when an incident occurs on the unit that has the potential for harm to the recipients, they will be required to remain in their rooms until the issue has been resolved.