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Egyptian Regional Human Rights Authority
Report of Findings
11-110-9025
Chester Mental Health Center
March 29, 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 allegation is as follows:

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

Statutes

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

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, or 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."

Investigation Information

To investigate the allegation, the HRA Investigation Team (Team), consisting of two HRA members and the HRA Coordinator (Coordinator) conducted a site visit at the facility. During the visit, the Team spoke with the recipient whose rights were alleged to have been violated and a Representative (Representative) of the facility's Human Rights Committee. With the recipient's written authorization, the Authority reviewed copies of information from his clinical chart The Authority also reviewed the facility's policy and an Illinois Department of Human Services Program Directive relevant to restraint usage.

I: Interviews:

A: Recipient:

When the Team spoke to the recipient about the allegation, he stated that he did not understand the reason for his placement in restraints. He denied being aggressive toward other recipients or staff members, as well as exhibiting any self abusive actions. The recipient stated that he had been placed in restraints several times during his hospitalization.

The recipient expressed additional concerns regarding his food being poisoned and served by individuals with serious illnesses.

B: Representative:

The Representative informed the Team that the facility has a written policy and directives that is in accordance with the Code mandates. He stated that a recipient is only placed in restraints when it is necessary to protect other recipients and/or staff members from physical harm and to protect recipients from causing self-injury.

According to the Representative, documentation relevant to any restraint application is incorporated into the recipient's clinical chart, including the explanation for the restraint application.

II: Clinical Chart Review

A: Treatment Plan Reviews (TPRs)

Documentation in a 11/04/10 TPR indicated the 30-year-old was transferred to the Chester Mental Health Center from another state-operated mental health facility on 11/16/06. The record indicated that the recipient was transferred due to his aggression, agitation, paranoia, delusions, and inappropriate sexual behavior. The recipient's legal status was listed as Involuntary.

The recipient's diagnoses were listed as follows: AXIS I: Schizoaffective Disorder, Bipolar Type, History of Poly-substance Dependence; AXIS II: Borderline Intellectual Functioning; AXIS III: Hypertension-controlled with treatment; Diabetes Mellitus-controlled

with treatment; Hypothyroidism- controlled with treatment, PUD (Peptic Ulcer Disease)-controlled with treatment, Water Intoxication Risk, AXIS IV: 1994-2006 DHS hospitalization x 15.

The recipient's medications were listed as follows: 1) Haloperidol D 150 mg IM (intra muscular) every 3 weeks for psychosis; PO (by mouth) Quentiapine 400 mg BID (twice daily), Diazepm 5 mg PO 1 PM , Valproic Acid Syrup 1000 mg AM and 1500 mg @ 5 PM for control of agitation and to stabilize mood (increased 04/29/09); Haloperidol 5 mg PO BID for psychosis (started 07/15/10), Metformin 500 mg BID for diabetes; Levothyroxine 0.1 mg 6 AM daily for hypothyroidism; Amiodipine Tab 10 mg @ 9 AM daily for hypertension: Senna/Docusate 1 tablet daily for constipation; and Ranitidine 150 Mg 9AM daily for PUD.

Documentation in the 11/04/10 TPR listed the recipient's problem areas as follows: 1) psychotic symptoms; 2) Diabetes Mellitus; 3) Thyroid Disorder; 4) Abnormal blood pressure (Elevated); 5) Aggression; and 6) Substance Abuse. His strengths were listed as: 1) able to complete Activities of Daily Living (ADLs); 2) cooperative with staff; 3) compliant with medication; and 4) currently stable.

Documentation 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 the circumstances arise, he stated the form of intervention in order of his preference: 1) seclusion: 2) medication and 3) restraints.

The recipient's TPR contained goals to deal with each of his problem areas. A goal for the recipient to reduce psychotic symptoms include the following objectives; 1) to take the medications as prescribed (on court order enforced medication); 2) to report decreased side effects of medication; and 3) to no longer display speech or behaviors indicative of hallucinations (such as talking or laughing to self, staring off in space, nodding head, talking about unseen objects and pacing for no reason). Treatment interventions included: 1) psychiatrist to prescribe medications and report the effect on the recipient and any side effects associated with the medications; 2) Nursing staff to administer the medication, encourage and monitor compliance, as well as, the recipient's statements and actions related to the psychosis; 3) the rehabilitation case manager to schedule academic and rehabilitation orientation sessions; and 4) Activity therapy staff members to increase the recipient's motivation, energy, interests, pleasures and to improve his quality of life.

To address the recipient's problem with aggression, the following treatment interventions were listed: 1) STA (security therapy aide) staff members will inform the recipient of the limits of his behaviors; 2) A therapist will work one-to-one with the recipient to determine triggers for his anger and to provide skills to avoid his aggressive impulses; and 3) The recipient will receive an explanation and the purpose and the behavioral expectations of the facility's Level System. His behaviors will be monitored on a daily basis.

The TPR contained a goal for the recipient to show no signs or symptoms of hypoglycemia or hyperglycemia associated with Diabetes Mellitus. Treatment interventions included 1) nursing staff to administer and monitor medication compliance; and 2) nursing staff

to provide instruction about Diabetes, including necessary hygiene, diet, foot care, medication and exercise benefits.

Treatment interventions to address the goal of stabilizing and maintaining thyroid hormone levels within normal range included: 1) a physician to order medication and monitor the medication for necessary changes; 2) Nursing staff to administer the medication, encourage compliance; and 3) Nurses to monitor thyroid levels, document results and notify a physician of any abnormal levels.

A goal was incorporated in the TPR for the recipient to lower and manage his blood pressure in order to minimize the probability of permanent damage to the heart, brain, or kidneys. Treatment interventions included: 1) a physician to prescribe medication; 2) nursing staff to administer the medication, encourage compliance and report any side effects; and 3) nursing staff to document any complaints of headache, dizziness, blurred vision, nose bleeds, weakness, fatigue and report the finding to the physician.

A treatment intervention of the recipient's having one-to-one sessions with a therapist in order for him to engage in the recovery process associated with his potential for substance abuse.

In the Extent to Which Benefitting from Treatment Section of the 11/04/10 TPR documentation indicated that the recipient continues to be psychotic, both delusional and responding to internal stimulation. He continued to be argumentative and a have a high risk for aggression.

Documentation in the 11/01/10 TPR indicated that the recipient had Seventeen Behavior Data Reports (BDRs) and two restraint episodes (10/22/10 and 10/31/10) during the previous month. Eight BDRs and one restraint application (12/25/10) were recorded in the 12/30/10 TPR. According to a 01/27/11 TPR, the recipient had seven BDRs and no restraint applications since 12/25/10.

According to documentation in the 01/27/11 TPR, despite being in a maximum security setting, the recipient continues to present a risk of harm to self as well as others. Additionally, he is unable to provide for his basic physical needs. He continues to hallucinate and have a vast array of delusions.

B: Restraint Records

1)... Restraint 1

Documentation indicated that an Order for Physical Hold was implemented from 12:20 PM to 12:25 PM on 10/22/10. The reason for the hold was listed as the recipient screamed, threatened to attack and then attacked staff members. According to the record, an RN and a physician personally examined the recipient at 12:20 PM and determined that the restraint application did not pose a threat to the recipient's physical condition. Both professionals signed the Order to verify their assessments.

The Authority reviewed a copy of a Restriction of Rights Notice which was given pertinent to the Hold. Documentation indicated that the recipient was asked by staff to go to his door for medication pass; however, he refused to follow the staff's direction, began to threaten staff, and attempted to hit two STAs. According to the documentation, the recipient was assessed as an imminent risk to the safety of others, as well as to self. The Notice was delivered to the recipient in person, and the record indicated that he did not wish to have anyone notified of the hold.

Documentation in an Order for Metal Cuffs indicated that the recipient had been threatening to kill staff all morning. When a staff member asked him to go to his room for medication pass, he attempted to hit two STA staff members with his fists. When the recipient was placed in a physical hold, he began to hit, kick, spit, and attempted to bite staff. Metal cuffs were applied to facilitate safe transport to a "security room" for placement in restraints. The record indicated that the recipient was in the metal cuffs from 12:25 PM to 12:30 PM. An RN and facility physician documented examination and assessment and determined that the use of the metal cuffs did not pose an undue risk to the recipient's health.

A Restriction of Rights Notice was given to the recipient for use of the metal cuffs for a 5 minute period on 10/22/10. According to the record, the Notice was delivered to the recipient in person, and he did not wish anyone to be notified of the event.

An Order for Restraint was issued at 12:30 PM on 10/22/10 after the recipient continued to kick, scream, spit, threaten, and attempt to bite staff while in the hold and metal cuffs. The Order was written for up to four hours with hourly reviews. Documentation indicated that attempts at redirection to a new task, empathic listening, verbal support and reassurance failed prior to the restraint application. The release criteria were listed as follows: 1) The recipient is to be calm, not verbalizing any intent to kick, spit, or bite others. 2) He must not scream, make threats or try to get out of the restraints. No time frame was listed for the recipient to exhibit the behaviors before release. A RN documented examination and assessment of the recipient at 12:30 PM, and a facility physician recorded examination at 12:40 PM. Both professionals indicted that it was their assessment that the restraint application did not pose an undue risk to the recipient's health.

A second Order for Restraint was issued at 4:30 PM when the recipient failed to meet the release criteria listed in the initial Order. The release criteria remained the same as listed in the initial order. There was no established time for the recipient to exhibit the release criteria behaviors before release was implemented. According to documentation in the Order, an RN and a facility physician examined the recipient at 4:30 PM. Both professionals assessed that the restraints did not pose an unwarranted risk to the recipient's health.

Documentation indicated that the recipient had not met the release criteria when the second Order expired. Therefore, a third Order for Restraint was issued at 8:30 PM on 10/22/10. The release criteria were listed as follows: 1) must be calm, 2) not verbalizing any intent to harm others, 3) not screaming threats of harm, 3) not biting, kicking or spitting, 4) not attempting to get out of the restraints. No time frame was listed for the recipient to exhibit the targeted behaviors before release would occur. The record indicated that the recipient was examined by

an RN and a facility physician at 8:30 PM. Both medical professionals assessed that the application did not pose an undue risk to the recipient's health.

Documentation in Flowsheets indicated that the recipient was continually observed and his behaviors recorded in fifteen minute increments. On an hourly basis, an RN released his limbs, checked his circulation, took his vital signs, assessed his physical status, and offered toileting and fluids during the entire restraint episode. The recipient was provided with a meal at 4:30 PM.

Additional documentation in the Flowsheets indicated that post application, the recipient's body was searched. An RN determined the following: 1) the restraints were properly applied; 2) the room environment was appropriate; 3) the recipient was wearing proper clothing for the restraint; and 4) he was properly positioned. He was informed of the reason for the restraint, the criteria for release and given a Restriction Notice relevant to the restraint.

The Authority reviewed the Restriction of Rights Notice for the 12 hour restraint episode which commenced at 12:30 PM on 10/22/10 and ended at 12:30 AM on 10/23/10. Documentation indicated that the recipient's preferred emergency intervention was not used due to level of his aggression. The record indicated that the Notice was delivered to the recipient in person, and he stated that he did not wish anyone to be notified.

An RN conducted a debriefing session with the recipient as soon as he was released from the restraints. Documentation in the Post-Episode Debriefing-Nursing Debriefing Form indicated that the recipient was able to verbalize an understanding of the causes and consequences of his aggressive behaviors, to identify methods to control the behaviors, and to state that he was aware that he could request assistance from staff prior to the escalation of his anxiety. However, he was not able to identify the stressors occurring prior to the restraint, and expressed that staff could not have helped him to remain in control. According to the documentation, the recipient did not receive an injury during the restraint process, and his physical well-being and privacy needs were addressed. The RN recorded that the recipient was encouraged to discuss his feeling related to the restraint.

2)...Restraint 2:

Documentation in an Order for Physical Hold indicated that the recipient was placed in a physical hold at 2:50 PM on 10/31/10 due to his attack on staff. The record indicated that the recipient began screaming, yelling and slamming the door to his room. When staff members attempted to verbally redirect, he violently attacked them causing physical injury to several of the staff. The record indicated that the recipient was placed in a physical hold for five minutes. According to the record, an RN and facility physician examined the recipient as soon as he was placed in the hold and assessed that it did not pose any undue risk to his health. A Restriction of Rights Notice was given to the recipient for the 5 minute hold. Documentation indicated that the recipient did not wish to have anyone notified of the hold.

An Order for Metal Cuffs was signed by an RN and physician at 2:55 PM. According to the documentation, the Order was issued for up to 10 minutes to allow the recipient's safe transport to the restraint room after he fought violently. Documentation indicated that the RN and a facility physician examined the recipient and determined that the cuffs did not pose an undue risk to the recipient's health. The recipient was provided with a Restriction of Rights Notice relevant to the cuff application. The record indicated that the recipient did not wish to have anyone notified that the metal cuffs had been applied.

An Order for Restraint was signed by an RN at 3 PM after the recipient was released from the metal cuffs. Documentation indicated that the recipient was given emergency medication when the incident began. However, his aggressive behaviors continued to accelerate and his violent fighting resulted in several staff members being injured. The release criteria were listed as follows: 1) must be calm and cooperative; 2) must not yell, curse or threaten others; 3) must not exhibit attempts to bite, kick, or spit; 4) must not attempt to get out of restraints; 5) will voice an intent to follow unit rules and staff directions; and 5) must not make any delusional statements. The record indicated that the recipient must exhibit the release criteria for one hour before he would be eligible for release. Documentation indicated that an RN and a facility physician examined the recipient at 3 PM and recorded that the restraint did not pose a threat to the recipient's health and well-being.

After empathic listening, verbal support, reassurance and medication failed, a second Order for Restraint was issued at 7 PM for a four hour period. Documentation indicated that the recipient met the criteria for release at 10 PM. The record indicated that the recipient was examined by an RN and a facility physician at 7 PM.

Documentation in the Restraint Flowsheets indicated that staff continually observed the recipient while he was in restraints and recorded his behaviors in fifteen minute increments. Additional recordings indicated that an RN checked his circulation, released his limbs, took his vital signs, and assessed his physical status hourly. The RN also offered the recipient fluid and toileting when the assessments were conducted. The recipient was provided with a meal at 4:30 PM. The record indicated that post application a body search was completed. An RN determined the following: 1) the restraints were properly applied; 2) the room environment was appropriate; 3) the recipient was wearing proper clothing for the restraints; and 4) he was properly position. According to documentation, the recipient was informed of the reason for his restriction, the criteria for his release from the restraints, and provided with a Restriction of Rights Notice.

An RN completed a debriefing session with the recipient after he was released from restraints. Documentation indicated that the recipient verbalized an understanding of the causes and consequences of his behaviors, and stated that he felt staff could have assisted him to remain in control. He was able to identify one or more methods to control his behaviors and stated that he was aware that he could request assistance from staff prior to escalation of his anxiety. Documentation indicated that the recipient was unable to identify stressors occurring prior to the restraint and blamed staff for the issue. According to the documentation it was determined that the recipient did not receive a physical injury and his well-being and privacy needs were addressed while he was in restraints.

The Authority observed a Restriction of Rights Notice pertinent to the 10/31/10 restraint episode. Documentation indicated that the recipient received emergency medication at 2 PM, however, he continued to escalate. He screamed, slammed doors and became very delusional. When staff attempted to verbally redirect him he attacked them. A physical hold was implemented; however the recipient violently fought the staff resulting in three staff members being injured. The record indicated that the recipient expressed that he did not want anyone notified of the restraint.

3)...Restraint 3:

Documentation in an Order for Physical Hold indicated that the recipient was placed in a physical hold at 4:20 PM on 12/25/10 and remained in the hold until 4:30 PM. The record indicated that when the recipient began yelling and cursing staff asked him to "calm down" and redirected him several times. However, the recipient refused to comply and pushed a staff member. According to the documentation, he was placed in a physical hold with great difficulty. Recordings indicated that an RN and a physician examined the recipient at 4:30 PM. Both professionals determined that the physical hold did not pose an undue risk to the individual's health.

A Restriction of Rights Notice was given to the recipient for the physical hold. The reason listed for the restriction was the recipient began yelling and cursing, and then proceeded to push a staff member. The record indicated that the recipient's emergency preference was not utilized due to the level of his violent behaviors. According to documentation, the recipient was in the physical hold from 4:20 PM to 4:30 PM on 12/25/10, and he expressed that he did not wish to have anyone notified of the hold.

An Order for Restraint was issued at 4:30 PM on 12/25/10 after the recipient failed to cease the aggressive behaviors. Documentation indicated that emphatic listening, verbal support, reassurance and medication failed to calm him. The release criteria were listed as follows: 1) must be calm and cooperative with reviews; 2) exhibit no aggressive gestures and hostile speech; and 3) must be awake to determine the ability to meet the release criteria. The recipient must exhibit the behaviors for 60 minutes before release would occur. The Order was signed by an RN and a physician at 4:30 PM, and both staff determined that the restraint application did not pose a risk to the recipient's health.

Additional documentation indicated that Orders for Restraint were issued at 8:30 PM on 12/25/10, 12:30 AM and 4:30 AM on 12/26/10. The Orders were issued after the recipient failed to meet the release criteria when the previous Order expired. The record indicated that the recipient met the release criteria at 8:30 AM on 12/26/10.

Documentation in Restraint Flowsheets indicated that the recipient was continually observed and his behaviors documented in fifteen minute increments. An RN examined the recipient hourly during the entire restraint episode. During the examination, the recipient's limbs were released, circulation check, vital signs taken and his physical condition assessed. He was offered toileting and fluids. He was provided with a meal at 7:15 AM on 12/26/10. Additional

documentation in the Flowsheets indicated that post application of the restraints, an RN searched the recipient's body. The RN determined the following: 1) The restraints were properly applied; 2) The recipient was wearing proper clothing for the restraint; 3) The room environment was appropriate; and 4) The recipient was properly positioned. Documentation indicated that the RN informed the recipient of the reason for the restraint, the criteria for release and provided him with a Restriction of Rights Notice.

An RN conducted a Post-Episode Debriefing when the recipient was released from the restraints. Documentation indicated that the recipient was able to identify methods to control his aggressive behaviors and stated that he was aware that he could request staff's assistance prior to escalation of his anxiety. However, he was not able to identify the stressors occurring prior to the restraint application and the causes and consequences of his aggressive behaviors. He stated that he did not feel that staff could have helped him to remain in control. It was determined that his physical well-being and privacy needs were addressed while he was in the restraints.

A Restriction of Rights Notice was given to the recipient for the restraint episode which commenced at 4:30 PM on 12/25/10 and ended at 8:30 AM on 12/12/10. Documentation indicated that the recipient did not wish to have anyone notified of the restraint.

Documentation indicated that the Treatment Team met the following day after each restraint episode to evaluate the effectiveness of the recipient's treatment intervention and to determine if any modifications should be made in the recipient's treatment.

C: Progress Notes:

Documentation in a RN's 10/21/10 Progress Note at 9:45 PM indicated that the recipient was yelling, screaming, and threatening to kill a peer. The record indicated that after five to ten minutes of verbal redirection and reassurance the recipient agreed to the administration of emergency medication to assist with his aggressive behaviors.

An RN recorded in a 10/22/10 Progress Note that when staff requested that the recipient go to his room for medication pass, he became combative and attempted to strike staff. He was placed in a physical hold from 12:20 PM to 12:24 PM. When he continued to struggle; metal hand cuffs were applied from 12:25 PM to 12:30 PM in order that he might be transferred to a restraint room. A facility physician provided the same account in a 12:45 PM progress note.

Additional 10/22/10 Progress Notes at 8:30 PM, 9:45 PM and 11 PM indicated that the recipient had not met the criteria for release from restraints. An RN recorded in a 12:30 AM Progress Note on 10/23/10 that the recipient had met the release criteria, and in a 1:30 AM entry indicated that he appeared to be sleeping and had not suffered an adverse effects from the restraint application.

Documentation in an RN's 10/31/10 Progress Note indicated that the recipient was sitting in the day room and when he was asked to go to his room, he began arguing, yelling, and slammed the door to his room. According to the record, the recipient shouted, "I have worms in

my belly" and he accused staff of placing the worms in his stomach, then attacked a staff member. The record indicated that a physical hold was applied and the recipient continued to fight injuring several staff members. The record indicated that the recipient was placed in metal handcuffs for transport to the restraint room.

According to documentation in an RN's 10/31/10 Progress Note at 10 PM, the recipient was calm and had agreed to follow module rules. He denied any suicide ideation or intent to engage in any self-injurious behaviors. Therefore, he had met the criteria for release from the restraints.

An STA recorded in a Progress Note at 4:30 PM on 12/25/10 that the recipient was very loud, disruptive, cursing and threatening harm to staff. He was asked several times to "quiet down"' however, he refused and started pushing staff. Documentation indicated that the recipient was placed in a physical hold with great difficulty, then escorted to the restraint room and placed in restraints. Additional Progress Notes completed by an RN, a facility physician, and another STA provided the same account of the conditions which led to the restraint application.

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 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 of 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 both 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

When the Team spoke with the recipient, he stated that he had been placed in restraints on several occasions during his hospitalization at the facility. He informed the Team that he had not engaged in any behaviors that warrant restraint usage. However, documentation in the recipient's clinical chart indicated that restraints were applied on 10/22/10, 10/31/10 and 12/25/10 after the recipient attacked staff members. The record indicated that the recipient's level of aggressive were so severe that he required metal handcuffs during transport to the restraint room. According to documentation, several staff members were injured during the 10/31/10 restraint application. Facility Policy and an Illinois Department of Human Services Program Directive reviewed during the investigation were in accordance with the Code's requirements which mandate that restraints only be used as a therapeutic measure to prevent an individual from causing physical harm to self or others.

Conclusion

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

Comments and Suggestion

It was noted that the Orders for Restraint for the 10/22/10 Restraint episode did not have a time frame listed for the recipient to exhibit the release criteria behaviors before release would occur. Therefore, the following suggestion is offered.

1. All Orders for Restraint should list the time frame that a recipient must exhibit the targeted behaviors before release occurs. If a time frame is not listed the recipient should be released as soon as the behaviors are exhibited.