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Egyptian Regional Human Rights Authority
Report of Findings
11-110-9034
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 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, 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 the HRA Coordinator (Coordinator) and one member 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 with the recipient's written authorization reviewed information from his clinical chart. Additionally, the Team spoke with the Chairman (Chairman) of the facility's Human Rights Committee. The Authority reviewed facility policy and program directives relevant to restraint.

II: Interviews:

A... Recipient:

According to the recipient, he was inappropriately placed in restraints in March and April 2011. He stated that during that period he had learned of the death of a family member and was very "upset" over the loss. However, he did not exhibit any aggressive actions toward self or others.

He related that during a restraint episode on 04/08/11, when he lost control of his bowels a staff member did not clean him in a timely manner. However, after he was cleaned he was required to wear a diaper, a requirement which he considered very degrading.

B.. Chairman

The Chairman stated that the facility policy and program directives are in accordance with the Code's requirements pertinent to restraint, and facility staff members abide by those policies. Restraints are only applied to protect a recipient from injuring himself or causing harm to others.

The Chairman informed the Team that a recipient may be required to wear a diaper/Depends during a restraint episode if the recipient is incontinent; a physician's order is necessary prior to the application.

II...Clinical Chart Review:

A...Treatment Plan Reviews (TPRs)

Documentation in the recipient's 02/22/11 TPR indicated that the recipient was admitted to the facility on 02/18/11 after being adjudicated as Unfit to Stand Trial on 02/14/11. His diagnoses were listed as follows: AXIS I: Bipolar Disorder, Hypermanic; AXIS II: Personality Disorder NOS (Not Otherwise Specified), Cyclothymiac; AXIS III: No Diagnosis: AXIS IV: Chronic history of mental illness, hospitalizations and treatment, Current legal problems.

The recipient's medications were listed as follows: Haloperidol 10 mg AM and HS (at bedtime) for control of psychosis and mania; Valproic Acid Syrup 500 mg AM and 1000 mg HS

for mood swings; Lorazepam 2 mg HS PO (by mouth) for anxiety, 2 mg IM (Intramuscular injection) BID (twice daily) PRN (as needed).

In accordance with the Mental Health Code, 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 stated the following forms of intervention in order of his preference: 1) medication; 2) seclusion; and 3) restraints.

The 02/22/11 TPR listed the recipient's problem areas as Unfit to Stand Trial and psychosis. To address the problem areas a goal for the recipient to achieve fitness to stand trial and a goal to reduce his psychotic symptoms were incorporated in the plan. Objectives to reach the goals included the following: 1) taking medication as prescribed; 2) cooperating with a fitness evaluation; 3) participating in fitness education; 4) monitoring for speech or behaviors indicative of hallucinations, delusions and/or disorganized thought processes; and 5) reinforcing appropriate social behaviors by offering a behavioral support program with a consistent reward system and clear expectations of the recipient's behaviors.

In the Extent to Which Benefitting from Treatment Section of the TPR documentation indicated that the recipient had signed consent for medication and was taking the medication without incident.

The criteria for separation and recommendation to return for a fitness assessment included the following criteria: 1) To be able to communicate with counsel and assist in his own defense; 2) To be able to appreciate his presence in relation to time, place and things: 3) To be able to understand that he is in a court of justice charged with a criminal defense; 4) To have an understanding of his charges and their consequences, as well as, court procedure and roles of the judge, jury, prosecutor and defense attorney; 5) To have sufficient memory to relate the circumstances surrounding the alleged criminal offense; and 6) To demonstrate that there is a significant reduction in his aggressive behaviors.

Documentation in the recipient's 03/11/11 TPR indicated that the recipient continued to remain manic, but his symptoms had been lessening in intensity. He had experienced a favorable response to medication changes and had not encountered any negative side effects. He had been medication compliant and behavioral incidents had been decreasing as the mania decreased. The record indicated that the Haloperidol had been increased from 10 mg to 20 mg HS since the previous TPR was conducted.

Additional documentation indicated that the recipient had been overly excitable, and when this occurs he becomes very loud and disruptive. The record indicated that he had three or four restraint applications during the reporting period; however, overall he was showing progress.

B... Restraint Records:

Documentation indicated that the recipient was in restraints on the following days: 02/23/11, 03/01/11, 03/09/11, 03/15/11, 04/07/11, and 04/09/11.

Restraint 1:

According to documentation, the recipient was placed in a physical hold after he started punching the wall, screaming and yelling at others. The record indicated that blood was seen coming from his hand as a result of his actions. An Order for Physical Hold was completed at 8:55 AM on 02/23/11. An RN examined the recipient at 8:55 AM and a facility physician examined him at 9 AM. Both professionals indicated that it was their assessments that the initiation of the physical hold did not pose an undue risk to the recipient's health.

When the recipient continued to struggle, scream, and yell after the hold was initiated, he was released from the hold and placed in physical restraints. An Order for Restraint was issued at 9 AM on 02/22/11 for up to 4 hours. Documentation indicated that the recipient was in his room yelling, screaming, and hitting the wall with his fist. He was placed in hold however, he remained hostile. Therefore, he was placed in restraints for his own protection, as well as the protection of others.

Documentation indicated that the recipient was given verbal support and PRN medication, his preference of emergency intervention, prior to the implementation of the restraints; however, the behavioral intervention failed to calm the recipient.

The criteria for release were listed as follows: 1) The recipient must be calm, cooperative, non-threatening, and non-argumentative; 2) He must be able to relate the circumstances leading to the restraints; 3) He must refrain from making threats toward others; 4) He must be able to verbalize appropriate actions/behaviors upon release. No time frame was listed for the recipient to exhibit the behaviors prior to release.

The record indicated that an RN and a physician had examined the recipient at 9 AM and had assessed that the application did not pose a risk to the recipient's health.

When the recipient continued to yell and was unable to calm himself, a second Order was issued at 12:30 PM, 30 minutes before the initial order expired. The criteria for release remained the same as the initial order. There was no documented time frame listed for the recipient to exhibit the criteria before release would be implemented. The record indicated that an RN examined the recipient at 12:30 PM and a physician examined him at 1 PM. Both professionals assessed that the restraint application did not pose a risk to the recipient's health.

Documentation in the Restraint Flowsheets indicated that the recipient was continually monitored, and his behaviors recorded in 15 minute increments. The record indicated that an RN checked the recipient's circulation, released his limbs, checked his vital signs and assessed his physical status. He was offered fluids and toileting at the time of the evaluations.

Documentation indicated that an RN conducted a complete body search after the restraints were applied and determined the following: 1) The restraints were properly applied, 2) The recipient was properly positioned, and 3) He was wearing proper clothing for the restraint. The RN also determined that the room environment was appropriate. The record indicated that

the recipient was informed of the reason for the restraint, the criteria for release, and given a Restriction of Rights Notice for the restraint episode, as well as the physical hold.

The record indicated that the recipient met the criteria for release at 3 PM, and upon release the RN conducted a Post-Episode Debriefing. Documentation indicted that the recipient was able to identify the stressors occurring prior to the restraint, and to express an understanding of the causes, consequences, and methods to control the aggressive behaviors. He stated that he did not feel that staff could have helped him to remain in control in this incident. He informed the RN that he was aware that he could request help from staff prior to the escalation of his anxiety. The record indicated that his choice of emergency intervention was not used because his self-injurious behaviors required an immediate action. The RN determined that during the restraint episode the recipient's physical well-being and privacy needs had been addressed, and he had not received any type of physical injury during the event. Documentation indicated that the recipient was encouraged to discuss his feelings related to the restraint.

Restraint 2:

Documentation indicated that the recipient was hit by a peer while eating breakfast. He sat down to eat but began yelling and threatening harm to others. He was placed in a physical hold at 8:05 AM and escorted back to his unit. The record indicated that he was released from the hold at 8:15 AM. The Order for Physical Hold indicated that the recipient was personally examined by an RN at 8:10 AM and a physician at 8:15 AM. Both professionals determined that the hold did not pose undue risk to the individual's health.

An RN conducted a Post-Episode Debriefing after the recipient was released from the hold. Documentation indicated the recipient was able to identify the stressors occurring prior to the hold, the consequences of the aggressive behaviors and methods to control those behaviors. He informed the staff that he felt that they could have helped him to remain in control, and he stated that he was aware that he could request help from staff prior to escalation of his anxiety. The record indicated that he was given medication at 8:20 AM in an attempt to alleviate his anxiety. The RN determined that he did not receive an injury during the hold and his physical well-being and privacy needs had been addressed.

The recipient was provided with a Restriction of Rights Notice. The record indicated that the recipient did not want anyone notified of the hold.

Documentation indicated that the recipient began yelling and striking at items in his room and asked to be put in restraints before he hurt someone. Documentation indicated that when empathic listening, conflict resolution and medication were unsuccessful, he was placed in restraints. An Order for Restraint was issued at 8:30 AM.

The release criteria were listed as follows: 1) He must be calm, cooperative, non-threatening, and non-argumentative; 2) He must refrain from issuing threats toward others; and 3) he must not yell. These behaviors should be exhibited for 60 minutes prior to release.

Documentation indicated that at 9:30 AM the recipient was calm and able to communicate effectively, and he no longer felt that he was going to hurt someone. He also denied any suicidal, self-destructive, or self-injurious ideation. The record indicated that he was released from the restraints after his vital signs were taken, circulation checked and his physical status evaluated. He was also offered fluid and toileting at that time. The record indicated that he was continually monitored during the one hour restraint, and his behaviors were documented in fifteen minute increments on a Restraint Flowsheet.

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

The RN conducted a Post-Episode Debriefing after the restraint and recorded that the recipient stated, "I'm calm now".

Restraint 3:

An Order for Physical Hold was implemented on 03/09/11 at 8:40 AM due to the recipient being highly agitated, yelling, cursing and threatening staff members. The record indicated that the recipient was given medication for the agitation, but continued to escalate. According to documentation, while an STA and the Unit Director attempted to talk with the recipient, he attacked the staff members. He was placed in a physical hold for five minutes.

Documentation in the Physical Hold Order indicated that an RN and a physician examined the recipient at 8:40 AM and determined that the hold did not pose a risk to the recipient's health.

The recipient was provided with a Restriction of Rights Notice at 8:45 PM. Documentation indicated that the recipient expressed that he did not want anyone notified of the hold.

The record indicated that an Order for Restraint was issued at 8:45 AM after the recipient was released from the hold. The specific behaviors requiring restraints were listed as follows: The recipient began yelling, demanding and trying to provoke staff when he came up to the cage for medication. He was given medication, and STAs and the Unit Director spoke with him in an attempt to calm him. The record indicated that the behavioral interventions failed, the recipient's behaviors escalated, and he attacked the staff members. Documentation indicated that the recipient fought violently while in the hold; therefore, he was placed in restraints for his personal safety, as well as the safety of others.

Documentation indicated that an RN examined the recipient at 8:45 AM and a physician examined him at 8:50AM. Both medical staff members determined that the restraint application did not pose an undue risk to the recipient's health.

The release criteria were listed as follows: 1) He must be calm, cooperative, non-threatening, non-argumentative and able to relate the circumstances lead to the restraints. 2) He must refrain from issuing threats toward others. 3) He must be able to verbalize appropriate actions and behaviors upon release. All of the behaviors must be exhibited for 60 minutes prior to release.

Documentation in the Restraint Flowsheets indicated that the recipient was continually observed, and his behaviors documented in 15 minute increments. An RN checked his circulation, released his limbs, took his vital signs and assessed his physical status on an hourly basis. When the hourly assessments were conducted, he was offered fluids and toileting. The record indicated that he was given a meal at 11:45 AM, and he ate 100% of the food that he received.

The record indicated that the recipient met the criteria for release at 12:45 PM. According to documentation the recipient was calm, cooperative and able to answer questions appropriately without becoming hostile.

When the RN completed the Post-Episode Debriefing at 12:45 PM, the recipient was able to identify the stressors occurring prior to the restraint. He was able to verbalize and understanding of the cause, consequence, and methods to control his aggressive behavior. Documentation indicated that he stated that he was aware that he could request assistance from staff prior to escalation of his anxiety, but stated that he did not feel that staff could have helped him to remain in control for this incident. The RN recorded that the recipient was encouraged to discuss his feeling related to the restraint. Following the debriefing the nurse determined that the recipient had not received any physical injuries and his physical well-being and privacy needs had been addressed during the restraint episode.

The recipient was provided with a Restriction of Rights Notice for the four hour restraint that began at 8:45 AM and ceased at 12:45 PM. Documentation indicated that the recipient stated that he did not wish for anyone notified of the restraint application.

Restraint 4:

The recipient's record indicated that he was placed in a physical hold at 8:40 PM on 03/15/11 after medication and counseling failed to calm him. Documentation indicated that the recipient continued yelling, screaming and proceeded to assault a staff member. Due to these aggressive behaviors and as a protection to others, the recipient was placed in a hold. The hold was implemented for 5 minutes.

Documentation indicated that an RN and a physician examined the recipient at 8:40 PM and determined that the hold did not pose a risk to the recipient's health. The recipient was provided with a Restriction of Rights Notice for the hold. The record indicated that he did not wish to have anyone notified of the hold.

When redirection, verbal support, conflict resolution, reassurance, medication and the hold failed, and the recipient's behaviors of yelling, cursing, threatening and attempts to strike staff accelerated, he was placed in restraints. An Order for Restraint was issued at 8:45 PM.

Documentation indicated that for a period of 60 minutes, the recipient must be calm, cooperative, non-threatening and able to relate the circumstances leading to the restraint before release would be implemented. He must also verbalize the appropriate actions and behaviors upon release.

Documentation indicated that an RN examined the recipient at 8:45 PM and a physician examined him at 9:30 PM. Both medical professionals determined that the restraint did not pose a risk to his health.

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

Documentation in the Flowsheets indicated that the recipient was continually monitored, and his behaviors recorded in 15-minute increments. The record indicated that an RN checked the recipient's circulation, released his limbs, took vital signs and assessed his physical status on an hourly basis. When the assessments were conducted the recipient was offered fluids and toileting.

The record indicated that the recipient met the release criteria at 12:45 AM on 03/16/11. Upon release an RN conducted a Post-Episode Debriefing. The RN documented that the recipient was able to verbalize an understanding of the causes, consequences and methods to control his aggressive behaviors. However, he was unable to identify the stressors occurring prior to the restraint, and stated that he did not feel that staff could have helped him to remain in control. The RN recorded that the recipient stated that he was aware that he could request assistance from staff prior to escalation of his anxiety. After the debriefing, the recipient determined that the recipient did not receive any physical injury, and his physical well-being and privacy needs had been addressed during the restraint episode.

The recipient was given a Restriction of Rights Notice relevant to the four hour restraint episode, which was implemented from 8:45 PM on 03/15/11 to 12:45 AM on 03/16/11. Documentation indicated that the recipient did not wish to have anyone notified of the restraint.

Restraint 5:

Documentation indicated that the recipient attacked a staff member while being escorted from one module to another. He was placed in a physical hold at 9:55 AM on 04/07/11 and remained in the hold until 10 AM. An Order for Physical Hold indicated that the recipient was

examined by an RN at 9:55 AM and a physician at 10:10 AM. Both professionals determined that the hold did not pose a risk to the recipient's health.

According to documentation in the Restriction Notice issued pertinent to the hold, the recipient was asked to get in line to clear the module, and when he was crossing the stem area he attacked a staff member. When a copy of the Restriction Notice was given to the recipient he stated that he did not wish to have anyone notified of the hold.

When the recipient's aggressive behaviors continued, an Order for Restraint was issued at 10 AM on 04/07/11. Documentation indicated that when behavioral interventions of redirection to a new task, empathic listening, verbal support, reassurance, a walk with staff and the hold failed to calm the recipient, he was placed in restraints. The criteria for release were listed as follows: 1) The recipient must be calm, cooperative, non-threatening, non-argumentative; 2) He must be able to relate the circumstances leading to the restraints; 3) He must refrain from threatening staff and other recipients; and 4) He must verbalize the appropriate actions/behaviors upon release. All of the listed criteria must be exhibited for sixty minutes prior to release. When he failed to meet the release criteria at the time of expiration of the Order, a second Order was issued at 1:30 PM

Documentation in the Restraint Flowsheets indicated the recipient was continually observed and his behaviors documented every 15 minutes. An RN checked the recipient's circulation, released his limbs, took his vital signs, and assessed his medical condition on an hourly basis during the entire restraint episode. The recipient was offered fluids and toileting when the assessments were conducted. The record indicated that he was provided with lunch at 11:30 AM on 03/15/11 and dinner at 4:45 PM. Documentation indicated that the recipient met the criteria for release at 5:30 PM on 04/17/11.

An RN conducted a Post-Episode Debriefing at 5:30 PM after the recipient was released from restraints. The RN recorded that the recipient was able to identify the stressors occurring prior to the restraint, the consequences of his aggressive behaviors and the some methods to control those behaviors. He stated that he was aware that he could request help from staff prior to escalation of anxiety; however, he did not believe staff members could have helped him in this incident. The RN documented that the recipient was encouraged to discuss his feelings related to the restraint. Following the debriefing, the RN determined that the recipient had not received any physical injury during the event and his physical well-being and privacy needs had been addressed.

The recipient was provided with a Restriction of Rights Notice for the restraint event. Documentation indicated that the recipient expressed that he did not want anyone notified of the restraint.

Restraint 6:

According to documentation, an Order for Physical Hold was implemented on 04/08/11 at 6:25 PM after the recipient cursed, yelled and threatened a peer, kicked at a door and spit at a nurse. The record indicated that the recipient was released from the hold at 6:30 PM. A RN

recorded personal examination of the recipient at 6:25 PM, and a facility physician documented that he had assessed the recipient's condition at 6:30 PM. Both medical authorities assessed that the hold did not pose an undue risk to the recipient's physical condition.

The recipient was provided with a Restriction of Rights Notice relevant to the hold. The reason listed for the restriction was the recipient's behaviors placed him and others with immediate risk of harm. Documentation indicated that recipient did not wish to have anyone notified of the hold.

An Order for Restraint was issued at 6:30 PM after the physical hold was unsuccessful, and the recipient continued to spit at a nurse and attempted to strike others. Additional documentation indicated that additional behavioral interventions such as redirection, empathic listening, distraction, verbal support, conflict resolution, and reassurance were unsuccessful. The criteria for release were listed as follows: 1) The recipient must be calm, cooperative, and able to discuss the episode leading to the restraint. 2) He must not display signs of agitation, such as cursing, yelling, clenching his fists or spitting at others. No time frame was listed for the recipient to exhibit the release criteria prior to being released.

When the recipient did not meet the established release criteria, a second order was issued at 10 PM. The release criteria remained the same as listed in the initial Order. No time frame was established for the recipient to exhibit the criteria prior to release. Documentation indicated that the recipient was released at 1 AM on 04/09/11.

The recipient was provided with a Restriction Notice for the restraint, and documentation indicated that he did not wish to have anyone notified of the restraint.

An RN conducted a Post-Episode Debriefing at 2 AM on 04/09/11. During the debriefing the recipient was able to identify the stressors occurring prior to the restraint and an understanding of the causes, consequences and methods to control his aggressive behaviors. The RN recorded that the recipient was encouraged to discuss his feelings regarding the restraint. The RN also documented that the recipient was aware that he could request assistance from staff prior to escalation of his anxiety; however, he did not believe that staff could have helped him to remain calm in this incident.

Following the debriefing, the RN determined that the recipient did not receive any injuries and his physical well-being and privacy needs were addressed during the restraint episode.

Restraint 7:

According to documentation in an Order for Physical Hold, the recipient was "upset" and when staff asked him to relax in the quiet room, he starting beating on the security cameras and hitting on doors. A physical hold was implemented at 12:40 PM. The recipient was released from the hold at 12:45 PM and placed in restraints. The record indicated that an RN examined the recipient at 12:40 PM and a physician assessed his condition at 12:50 PM. Both

professionals determined that the hold had not posed any unwarranted risk to the recipient's health.

Documentation in the Restriction Notice relevant to the hold indicated that when the recipient was asked to get out of bed for a meal he became irate. When staff asked him to sit in the quiet room to regain composure, he became escalated and commenced to hit doors and attempted to hit the security cameras on the unit.

The record indicated that after redirection, empathic listening, distraction, verbal support, reassurance and the hold failed to calm the recipient, he was placed in restraints for the safety of all. The Order for Restraint was issued at 12:45 PM on 04/09/11. The criteria for release were listed as follows; 1) For 60 minutes, he must be calm, cooperative with no yelling, screaming, threatening harm to others and struggling with the restraints. 2) He must be able to state alternative behaviors to prevent placement in restraints. Subsequent Restraint Orders were issued at 4:45 PM and 8:45 PM on 04/09/11 and 12:45 AM on 04/10/11. Documentation indicated that the recipient met the release criteria at 2:30 AM on 04/10/11.

Documentation in the Restraint Flowsheets indicated that the recipient was continually observed and his behaviors recorded in 15 minute increments. An RN checked the recipient's circulation, released his limbs, took his vital signs and assessed his overall physical status hourly during the entire restraint episode. The recipient was offered toileting and fluids when the assessments were conducted. Documentation indicated that when the RN asked if he needed to toilet during the hourly reviews, he refused. However, he used a urinal at 3:30 PM and a bedpan at 4 PM on 04/09/11. The record indicated that he requested a urinal at 7:30 PM on 04/09/11, and when the urinal was brought to him he refused to use it. Additional documentation indicated that the recipient attempted to use a urinal at 12:30 AM on 04/10/11. According to recordings in the Flowsheets, at 7 PM on 04/09/11, the recipient was incontinent. In the 7:15 PM entry, the record indicated that the recipient had been cleaned and a diaper applied. An additional fecal incontinence was recorded at 11:30 PM on 04/09/11. Documentation indicated that the recipient was cleaned, dried, diapered and his clothing changed before 11:45 PM on 04/09/11. The record indicated that the recipient met the criteria for release at 2:30 AM on 04/10/11. There was no documentation in the Flowsheets to indicate that the recipient was provided with an evening meal.

An RN conducted a Post-Episode Debriefing with the recipient at 2:30 AM on 04/10/11, immediately after he was released from the restraints. The record indicated that the recipient was able to identify the stressors occurring prior to the restraint and an understanding of the causes, consequences, and methods to control these aggressive behaviors. The recipient expressed that he was aware that he could have requested assistance from staff prior to escalation of his anxiety. However, he expressed that he did not feel that staff could have helped him to remain in control for this incident.

When the RN examined the recipient, it was noted that he had an abrasion on his right knuckle. Therefore, an injury report was completed and medical treatment implemented. The RN noted that the recipient's physical well-being and privacy needs had been addressed during the restraint.

The recipient was provided with a Restriction of Rights Notice pertinent to the restraint which began at 12:45 PM on 04/09/11 and ended at 2:30 AM on 04/10/11. Documentation indicated that the recipient stated that he did not want anyone notified of the restraint.

Additional Information:

Documentation indicated that after each restraint episode, the treatment team met to evaluate the recipient's current TPR and to determine if modifications should be made to the TPR.

III: Progress Notes:

An RN documented in a 8:55 AM Progress Note on 02/23/11 that during the AM medication pass, the recipient began making noises that sounded as if he had hit something. Upon investigation, staff witnessed the recipient striking the wall with his left fist. The RN recorded that upon initiation of a physical hold the recipient began to violently fight with staff and was transferred from the hold to restraints. The RN documented that the recipient's circulation and the restraint application were assessed and determined to be adequate. A facility physician was present to sign the Restraint Order.

A Social Worker recorded in a 3 PM Progress Note on 02/23/11 that the recipient was calm, cooperative, voiced no intention of self harm and was able to express an appropriate plan for his behavior. The Social Worker documented that the recipient had met the release criteria.

Documentation in a 03/01/11 Progress Note by an RN recorded that the recipient was brought back from the dining room due to a confrontation with a peer. He was offered and accepted Lorazapam for anxiety and then voluntarily went to his room stating he wanted to "calm down". Documentation indicated that as he entered the room he started yelling and banging on the wall and requested that staff place him in restraints before he hurt someone. The RN recorded that the recipient walked to the restraint room and was placed in restraints at 8:30 AM.

A Social Worker recorded in a 9:30 AM Progress Note on 03/01/11 that the recipient was calm and able to communicate effectively. He voiced that he was no longer suicidal; nor did he want to hurt others, or exhibit any type of destructive behaviors. The Social Worker recorded that the recipient had met the criteria for release from the restraints.

An RN documented in an 8:40 AM Progress Note on 03/09/11 that the recipient approached the nurses' cage for medication administration and immediately began yelling and demanding to see a physician. The RN recorded that the recipient was informed that the physician would be contacted as soon as he returned from court, and informed the recipient that he need to "calm down and talk quieter". According to the documentation, the recipient turned toward a STA stating, "I dare you, I'll kill you." The RN recorded that when the STA asked the recipient to go to his room to regain composure, the recipient complied but yelled and threatened staff as he moved toward the room. The record indicated that the recipient was offered Lorazepam IM to deal with his anxiety, and he accepted the medication. However, his aggressive behaviors did not cease, and he "jumped and lunged at staff." He was placed in a physical hold and subsequently transferred to restraints for the safety of all.

In a 12:45 PM Progress Note on 03/09/11, documentation indicated that the recipient was calm, cooperative and able to answer questions without becoming hostile. He was released from restraints and returned to the unit.

Documentation indicated that the recipient received Lorazepam by mouth at 8:35 PM on 03/15/11. However, after receiving the medication he jumped up from sitting on his bed and attempted to strike staff. An RN recorded that a hold was initiated at 8:40 PM and when his behaviors continued he was placed in restraints at 8:45 PM

In a 12:45 AM Progress Note on 03/16/11, an RN recorded that the recipient was released from restraints after meeting the established criteria and escorted to his regular room. The RN recorded that the recipient did not express any complaints or concerns, and he was calm and cooperative at the time of release.

An STA recorded in a 04/07/11 Progress Note that when the recipient was being escorted from Unit A1 to Unit A3 he turned and started to hit staff members. He was placed in a physical hold at 9:55 AM, and when he continued to fight, for the safety of all, he was transferred to restraints at 10 AM.

Documentation in an RN's Progress Note at 5:30 PM on 04/07/11 indicated that the recipient was released from restraints. He was calm, cooperative and able to discuss the restraint episode.

Documentation in a 04/08/11 Progress Note indicated that the recipient was beating on a door, cursing and threatening to hurt others. He was placed in a physical hold at 6:25 PM after attempts to calm the recipient failed. The record indicated that while in the physical hold the recipient continued to attempt to hit staff and began then to spit at them. Due to the continuation of the maladaptive, aggressive behaviors he was placed in restraints.

An RN recorded in a 4:45 Pm Progress Note on 04/09/11 that the recipient continued to threaten harm to the doctors, nurses and STAs at the facility. He had failed to meet the criteria for release from the restraints. Documentation indicated that during the review, the recipient was offered a bedpan and fluids and his circulation was checked. The RN recorded that the recipient was provided with an evening meal, and he ate 100% of the food that was given to him.

An RN recorded that the recipient was reviewed for possible release from the restraints at 1 AM on 04/09/11. The RN documented that the recipient was calm and cooperative with the review. He denied having any suicidal, homicidal, or self injurious ideations. He was released from the restraints and escorted from the restraint room to his room on the unit.

A STA recorded in a 12:45 PM Progress Note on 04/09/11 that the recipient was "upset" and when staff asked him to relax in a quiet room; he started hitting a door and beating on a security camera. He was placed in a physical hold from 12: 40 PM to 12:45 PM. According to the record, when the behaviors continued the recipient was placed in restraints for the safety of self and others on the module.

An RN recorded in a 6:50 PM Progress Note on 04/09/11 that the recipient was intentionally soiling his pants. Documentation indicated that a physician's order to use depends was obtained, the recipient was diapered, and he was given a bed bath.

Documentation in a 2:30 AM Progress Note on 04/10/11, an RN indicated that the recipient was resting quietly, and he was calm and cooperative. He was released from the restraints, and upon release he did not voice any complaints regarding the restraint episode.

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 restrain 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 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

Documentation indicated the recipient was placed in restraints on seven different occasions during the targeted period of the HRA's review. According to the record, on all of the occasions the recipient was involved in self-injurious, threatening, and/or aggressive behaviors toward others. Two of those incidents also involved attempts at property destruction. Documentation indicated that staff members determined that restraints were appropriate to protect the recipient from harm to self or others in six of the events. However, Restraint 2 was implemented at the recipient's request because he felt that he might cause harm to others. According to the Code, facility policy, and program directives restraints may only be used to prevent a recipient from causing physical harm to himself or physical abuse to others, decisive factors that were present prior to each restraint episode.

Conclusion

Based on the information that was received during the course of the investigation, the allegation that the recipient was inappropriately placed in restraints is unsubstantiated. No recommendations are issued.

Comments and Suggestions

It was noted that the Orders for Restraint for Restraint 1 did not have a time frame listed for the recipient to exhibit the release criteria behaviors before release would be implemented. Therefore, the following suggestion is issued:

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.

Additionally, there was no documentation observed in the Flowsheets for Restraint 7 to indicate that an evening meal was served to the recipient. However, when the HRA reviewed Progress Notes associated with the restraint, the record indicated that the recipient had received an evening meal. The HRA suggestions the following:

2. Flowsheets associated with a restraint episode should adequately reflect assessments conducted, meals provided, and any significant events which occur while the recipient is in restraints.

It was noted that during Restraint 7, the record indicated that staff frequently offered the recipient toileting. However, while in the restraints he experienced incontinence of bowel and bladder. The record indicated that the recipient was cleaned in a timely manner, and a facility physician was contacted regarding the issue. According to the documentation, the physician ordered Depends, and upon receiving the order staff applied the Depends. According to the recipient's account, he was embarrassed by having to wear the Depends, a situation that the HRA understands. However, the Authority has determined that the application of the Depends in this instance is not a violation of the recipient's rights.