# LESSON NEVER LEARNED:

## Lethal Restraint at Western State Hospital

A report from the disAbility Law Center of Virginia

October 2015

Erin Haw, lead investigator

## INTRODUCTION

EB died at the age of thirty-seven in September 2013, while involuntarily committed to Western State Hospital (WSH) in Staunton, Virginia. In January 2014, the Office of the Chief Medical Examiner finalized a Report of Autopsy for Ms. EB. The Medical Examiner determined Ms. EB's cause of death was pulmonary thromboembolism due to deep venous thrombosis (DVT). In this type of medical event, an individual develops a blood clot, often in the leg, which detaches from the vein where it was formed, travels to the lung's main artery and blocks the flow of blood to the lung, leading to pain, shortness of breath, and in some cases, death. The Medical Examiner further determined restraints contributed to the formation of Ms. EB's fatal DVT and pulmonary embolism. Additional pathological diagnoses discovered at autopsy included: blunt force injury to the head, occipital subgaleal hemorrhage (bleeding between the skull and scalp), and contusions involving the brain. Upon receipt and review of this report, the disAbility Law Center of Virginia (dLCV) launched an investigation into the circumstances surrounding Ms. EB's death as authorized by federal law.

The disAbility Law Center of Virginia is the federally mandated Protection and Advocacy System for Virginians with disabilities. dLCV's protection and advocacy services are legally based and authorized by a number of federal statutes, including the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act. Advocates and attorneys knowledgeable about disability rights provide individual representation to, and systemic advocacy on behalf of, qualifying individuals with disabilities throughout the Commonwealth. dLCV maintains a regular presence in Virginia's publicly operated mental health hospitals, including Western State Hospital. dLCV monitors facility conditions at these hospitals, investigates abuse and neglect, and represents individuals whose rights have been violated.

dLCV found that Western State allowed Ms. EB to deteriorate medically and psychiatrically over the twenty-six day period preceding her death – the entirety of which she spent mechanically restrained[A]. The facility's top administrators and clinicians were wholly knowledgeable of, and complicit in, development and approval of the restrictive treatment plan that authorized staff to restrain Ms. EB in non-emergency situations for unconscionably long periods of time. Moreover, following Ms. EB's premature death, WSH failed to undertake a meaningful investigation and to implement comprehensive corrective action to prevent similar tragedies. Therefore, other individuals committed to Western State's care remain at risk.

## WESTERN STATE HOSPITAL'S HISTORY OF SECLUSION AND RESTRAINT

Western State has a long history of abusive and unlawful seclusion and restraint practices predating EB's death. The US Department of Justice investigated the facility in 1998 pursuant to the Civil Rights of Institutionalized Persons Act. At that time, the Department of Justice cited WSH for substantially departing from accepted professional standards:

[A] dLCV's findings are based on extensive review of Ms. EB's treatment records, seclusion and restraint data, and other documents furnished by WSH and the Office of the Chief Medical Examiner. The Center also utilized expert consultation for this investigation.

*Restraint and seclusion practices depart substantially from accepted professional standards. Western State utilizes an excessive amount of seclusion and restraint for inappropriate reasons and for inappropriately long periods of time, contrary to accepted professional practice…Staff lack an understanding of less restrictive measures that could be utilized where appropriate. Patients, therefore, often remain in restraints long past the point, when according to accepted professional practice, release should occur.*

Similarly, in 2001, the Department for Rights of Virginians with Disabilities (DRVD) released an investigation report focused on the use of seclusion and restraint at Western State Hospital. During that investigation, DRVD found:

*…WSH's tendency to use seclusion and restraint methods before attempting other, less intrusive, interventions is particularly troubling…Another troubling trend was WSH's use of seclusion and restraint in non-emergency instances.*

In 2008, the Legal Aid Justice Center (LAJC) appealed to the State Human Rights Committee. LAJC contended that Western State Hospital violated state regulations and violated the rights of Cesar Chumil by forcing him to live in seclusion for years on end. The State Human Rights Committee upheld a Local Human Rights Committee's earlier findings that Western State had violated Ms. Chumil's rights.

In response to a patient death involving restraint in August 2011, Western State was investigated by medical facilities investigators on behalf of the Centers for Medicare and Medicaid Services. Findings from that investigation included:

*…the facility staff failed to ensure the safe implementation of restraints. The facility restraint education and training program was inadequate…The training did not include information to recognize and respond to the signs of physical distress, to include asphyxia, respiratory distress or compromised circulation or other signs of physical distress.*

Tragically, just two years later, on September 2, 2013, EB died proximate to restraint as well. WSH failed to complete a root cause analysis after EB's death as required by the Joint Commission and, as noted above, failed to implement comprehensive corrective action.

As of June 5, 2015, the Director of Clinical Quality and Risk Management for the Department of Behavioral Health and Developmental Services publicly announced that Western State Hospital remains an outlier within the state mental health system. This outlier status is based on the facility's high restraint rates—reportedly the highest in Virginia.

**RESTRAINT OF EB**

EB experienced significant trauma throughout her life. Early trauma began for her around age eight in the form of sexual abuse. As an adult, EB struggled with polysubstance dependence, incarceration, poverty, loss of significant familial connections, persistent thoughts of suicide, and a significant history of self-injury.

In total, EB was admitted to state operated institutions thirteen times during her short life, including multiple admissions to DeJarnette Center (now known as Commonwealth Center for Children and Adolescents) during her youth. Over the years, EB was admitted to countless non-state operated treatment settings as well. She was admitted to Western State Hospital for the fourth and final time on October 22, 2009; this involuntary civil commitment, just shy of four years, lasted until her death proximate to restraint on September 2, 2013. EB's diagnoses at admission included: bipolar affective disorder (depressed with psychotic features), posttraumatic stress disorder, and borderline personality disorder.

EB was initially assigned to Ward A1, where she remained until her transfer to the Opie Ward on January 19, 2010. EB was again transferred on July 11, 2011 to Ward C7/8 and finally on November 13, 2012 to Ward A5, "a 24 bed, coed, program to enhance self-management and social/interpersonal skills required for community living and treatment."[B] EB was assigned to A5, at the time of her death. Dr. Stephen "Steve" Nichols served as EB's attending psychiatrist and the head of her treatment team throughout her time on A5[C].

Unfortunately, after only two months on this ward, and despite her well-documented history of trauma and ongoing struggles with emotional distress, EB's psychologist, Dr. Jason Stout, remarked, "I do not feel that [EB] is appropriate for in-depth therapy…" Again, in May 2013, Dr. Stout stated, "Because of her affective distress, I did not meet with EB this month for individual therapy sessions…" Similarly, in June 2013, "Because of her affective distress, I did not meet with EB this month for individual therapy sessions…"

Records provided by WSH show that, in addition to routinely being denied in-depth therapy, EB was subjected to 151 separate behavioral restraints during her time on A5, totaling 2,133.04 restraint hours in less than one year's time. EB spent thousands of additional hours in behavioral restraints on other wards as well.

Ultimately, EB passed away after twenty-six continuous days in mechanical restraint (totaling 566.88 hours of continuous restraint). EB was shackled in four-point ambulatory restraints when she was emergently transferred from Western State Hospital to Augusta Health for treatment of suspected dehydration just a few short hours before her death. Other forms of restraint during this twenty-six day stretch included the emergency restraint chair (commonly known as "The Chair" or ERC), four-point ambulatory restraint, four-point bed restraint, two-point ambulatory restraint, two-point ambulatory flexicuff restraint (during bathroom and shower privileges only), and one-point dominant hand ambulatory restraint.

Western State Hospital's policy dictates that "universal criteria" for release from restraint shall be used in *most* instances. The hospital's universal criteria for release are "non-threatening to self or others, calm and redirectable."[D] dLCV's comprehensive review of treatment records indicates that universal release criteria did not apply to EB. Rather, EB's doctors required her to complete a restrictive restraint-based "step down" treatment plan. This "step down" plan dictated that, rather than releasing EB from restraints once she was no longer a threat to herself or others, the hospital required her to prove her ongoing safety by traversing a range of increasingly "less restrictive" restraint methods. These "less restrictive" methods include the aforesaid four-point ambulatory restraints and two-point ambulatory restraints. The "step down"

[B] Western State Hospital Program Location/Description dated 9/19/2012

[C] Approximately a month and a half after EB's death, WSH relocated to a newly constructed replacement facility. What used to be known as Ward A5 (in terms of staffing and treatment team composition) is now known as 1-Pine.

[D] Hospital Instruction Number 4015: Emergency Use of Seclusion and Restraint

treatment plan was in effect for EB at the time of her death, and included patient-specific guidelines for initiating and terminating restraint. Between August 8, 2013 and September 2, 2013, EB is noted, sometimes for hours at a time, to be sleeping, at other times to be calm and cooperative. Yet restraints continued indefinitely.

Due to the sheer number of physician orders and nurse assessments required for 566.88 hours of continuous restraint, many of Western State's licensed clinicians directly witnessed EB's decline throughout August and early September. In the weeks preceding her death, EB reported numerous physical complaints. EB had chronic pain that appears to have been worsened by prolonged restraint use. Nursing staff seems to have responded appropriately when they assessed and documented EB's reports of back, leg, thigh, and head pain, and again when they referred her to Western State's physical therapy department for further assessment and treatment. However, August 2013 physical therapy records indicate that therapeutic services were often deferred or limited due to the physical limitations associated with EB's mechanical restraint.

Subjecting EB to restraint during this period did little to curtail her self-injury, and in fact appears to have exacerbated self-directed aggression. For example, EB attempted suicide on August 24, 2013, approximately two weeks into the continuous restraint that preceded her death. While EB survived this suicide attempt, throughout the last two weeks of her life she sustained head injuries from falls (some reportedly intentional) and head banging. EB was observed to have impaired gait, coordination, and speech during multiple assessments around this same time. Staff also documented that EB often refused food and water during this time.

Stasis (lack of movement) is one of the biggest risk factors for deep vein thrombosis. EB, whose movement was severely limited for almost a month due to continuous restraint, presented with several additional warning signs and risk factors in the weeks preceding her death. For example, WSH documented that EB's oxygen level dropped below 92 at least twice with no intervention – in violation of hospital policy. EB was also known by the hospital to have a number of ongoing risk factors for developing dangerous blood clots: she was obese, taking hormonal birth control, a known smoker, and on very high doses of antipsychotics. Moreover, clinical staff repeatedly documented that EB was refusing fluids (dehydration is known to make individuals develop blood clots more easily).

EB's restraint plan was vetted and approved on a quarterly basis by an internal Behavior Management Committee (BMC)[E] and Western State Hospital's Local Human Rights Committee (LHRC). EB's last BMC review was held on June 26, 2013. Her last LHRC review was held on July 22, 2013. The BMC's analysis of EB focused only on the benefits of restraint and did not include an analysis or discussion of the risks. In fact, whenever risks are addressed in EB's records, they are always discussed in relation to risks to others if restraints are not used, rather than risks to EB if restraints *are used*.

EB's final treatment planning conference was held on August 27, 2013. EB was restrained in the emergency restraint chair at that time and it is unclear whether she was afforded an opportunity to participate in her planning meeting.

[E] During Ms. EB's final WSH admission, BMC membership included Jack Barber, WSH Facility Director, and Mary Clare Smith, WSH Facility Medical Director.

As noted above, the Medical Examiner determined EB's cause of death was pulmonary thromboembolism due to DVT. Restraints contributed to the formation of EB's fatal DVT.

**SYSTEM FAILURE**

Unfortunately, the circumstances surrounding the death of EB are not isolated. For years, WSH has repeatedly failed to promote a culture of trauma informed care consistent with best practices, relying instead on abusive seclusion and restraint. Data furnished by the facility for state fiscal year 2015 indicates that nine individuals were subjected to restrictive restraint-based "step down" treatment plans during the year—the same kind of treatment plan in effect for EB at the time of her death—that circumvent the facility's universal restraint release criteria. Collectively, these nine individuals were subjected to 11,721.60 restraint hours during the year.

**CONCLUSION**

EB was not just a woman who died due to prolonged restraint. EB was a woman involuntarily committed to the state's care for symptoms born out of significant sexual and other life traumas. A woman who sadly foreshadowed her own end, at one point telling a WSH psychologist that she would die in the hospital, she just did not know when. A woman who was denied an environment committed to trauma informed care and recovery. When the State of Virginia committed EB against her will to a publicly funded and operated facility, she was entitled to adequate and appropriate treatment for her mental illness. She did not receive that treatment.

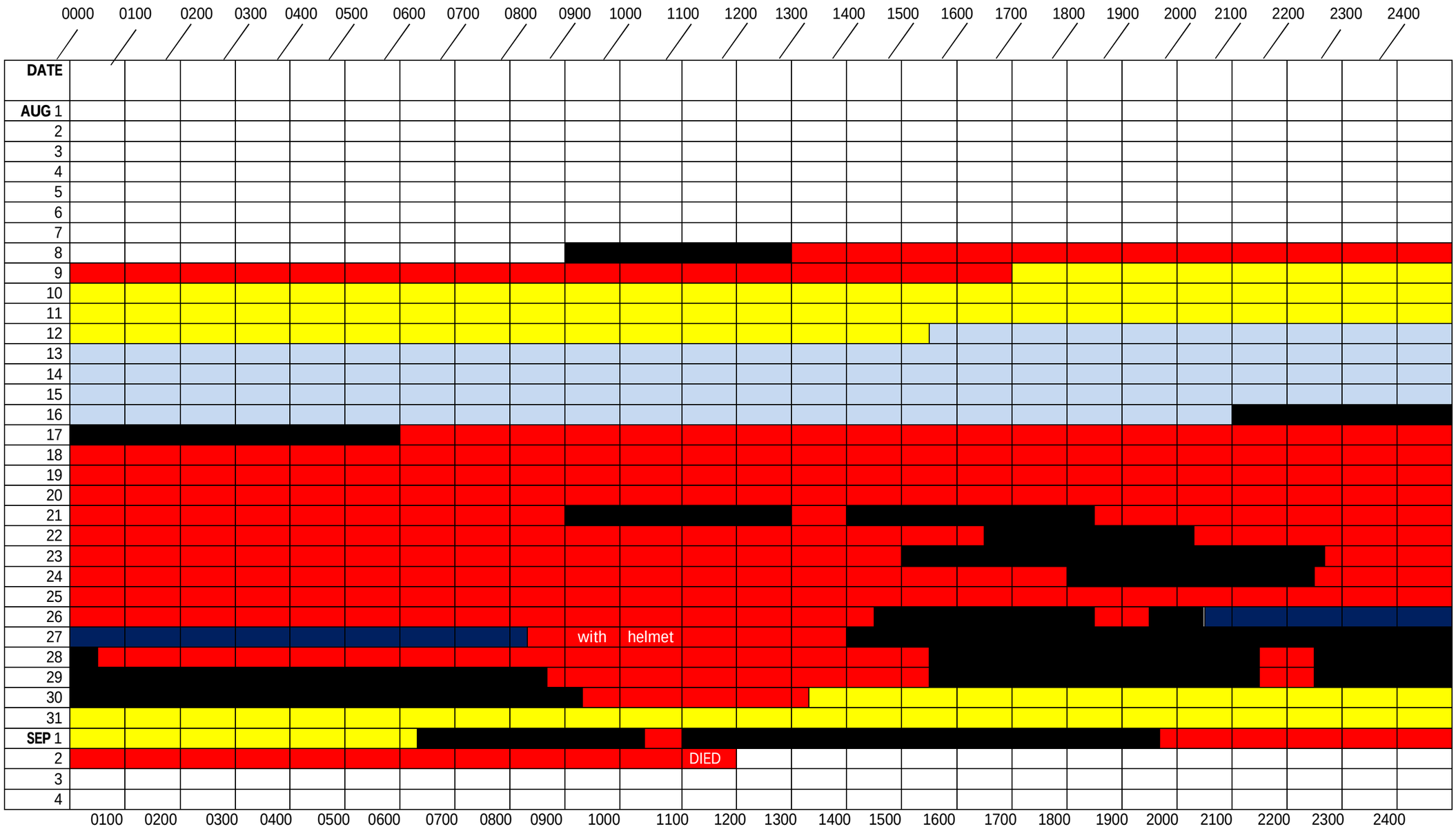
The prolonged use of restraint as a substitute for active treatment in this case did not conform to best practices and represented a deprivation of EB's right to receive services provided consistent with sound therapeutic practice. EB's death, unfortunately and tragically, is not the first proximate to restraint at Western State Hospital. Western State has a clear pattern and practice with respect to seclusion and restraint that does not conform to best clinical practice. We urge DBHDS to promptly take all necessary steps to ensure all individuals served at WSH are safe, free from unlawful and abusive seclusion and restraint, and receive trauma-informed services at all levels of patient care.

Appendix 1 – EB Restraint Matrix, August 2013 and September 2013
Appendix 2 – EB Annotated Restraint Timeline, August 8, 2013 – September 2, 2013

**APPENDIX 1:**

**EB Restraint Matrix – August 2013 and September 2013**

1 Point Ambulatory | 2 Point Ambulatory | 4 Point Ambulatory | 4 Point Bed | Emergency Restraint Chair (ERC)



**APPENDIX 2:**

**Annotated Restraint Timeline**
**August 8, 2013 – September 2, 2013**

This timeline represents the 26 days of continuous Restraint that immediately preceded EB's death. Documentation comes from hourly RN assessment records, except where otherwise noted in endnotes.

**August 8, 2013 (Emergency Restraint Chair, 4-Point Ambulatory Restraints)[1]:**

- 09:04—Restraint initiated[2]
- 15:55—"[complains of] #3 back and leg pain"
- 19:00—"asking staff to tell night shift that she needs assistance to get up [and] down off the mat due to ongoing back [and] and leg pain."
- 21:00—"needs assistance to get up and down off the mat."
- 23:00—"[complains of] #3 back pain"

**August 9, 2013 (4-Point Ambulatory Restraints, 2-Point Ambulatory Restraints)[3]:**

- 11:00—"having trouble swallowing"
- 12:00—"going from staff to staff [complaining of] not being able to swallow"
- 14:00—"getting ready to leave for [physical therapy] appt."
- 16:00—"[complains of] 3 back [and] leg pain"
- 23:45— "[complains of] general pain 3/5 but says she cannot sit up to take prn Tylenol"
    - "Speaking [with] slurred words at times."
    - "Complained of pain but stated she was too uncomfortable to sit up to take the Tylenol."

**August 10, 2013 (2-Point Ambulatory Restraints)[4]:**

- 01:10— "[complains of] #3 back pain"
- 03:45—"shaky and moves slowly and methodically. Speaks at times in a mumble."
- 06:45—"walking/talking slowly."
- 09:45—"Acetaminophen given for chronic back pain."
- 10:45—"'I need a prn. I want my mattress from my room in here; my back hurts.'"
    - "…back pain #3"
- 16:45—"[complains of] 'sprained' R ankle."
- 18:45— "requested PRN for back pain"
- 19:45— "[complains of] back pain"

**August 11, 2013 (2-Point Ambulatory Restraints)[5]:**

- 10:45—"'I can't get up, lift me up.' [Patient] offered bathroom but refused to get up stating above. She spent several minutes requesting to be lifted up. Her dominant hand released to aid in getting up."
- 17:45—"'I'm not playing any games. I can't get up.'"
- 18:45—"'I can't get up. I can't roll over.'"
- 21:45—"'I broke my hip. Call Kevin. It's not right'"
- 22:45—"denies that she can get up."
- 23:45—"'I can't move.'"
    - "lying on the floor in seclusion room and refused to lie on mattress. Assisted to the mattress with her assistance."

**August 12, 2013 (<u>2-Point Ambulatory Restraints, 1-Point Dominant Hand Ambulatory Restraints</u>)[6]:**

- EB attended physical therapy on this date. Physical therapy notes, "Progress somewhat limited by restraints and [increase] in client sedentary actions. Pt reinforced for need to move to [decrease] pain."[7]
- 07:45—"[complains of] #4 pain to [left] arm [and] thigh."
- 08:45—"still [complains of] #4 pain to [left] arm and [left] thigh"
- 09:40—"Rerated pain at #5 Called ward RN"
- 15:30—"no [complaint of] pain voiced or [request] for analgesics but acts like she can't move about"[8]
- 20:30—"'I can't get up. I need help. I am so fucking weak. I can't do it.'"
    - "laying on the floor [after] attempting to get up off the floor. Security called to assist her up."
- *She refused lunch and supper on this date*

**August 13, 2013 (<u>1-Point Dominant Hand Ambulatory Restraints</u>)[9]:**

- 09:30—"Mumbling, asking for fluids asking I call [Physical Therapist], 'Wendy'"
- 10:30—"Slurring words"
    - "Used restroom in slow motion."
- 13:30—"requested Tylenol 650 mg [orally] for back pain"
- 15:30—"mumbling and very hard to understand."
- 16:30—"Dr. Nichols made aware that [patient] is refusing her meals but [increase] [oral] fluids."
- 21:05—"Tylenol 650 mg […] for #4 leg pain"
- 21:30—"ongoing leg pain"
    - "'I'm so fucking weak.'"
    - "[complains of] leg pain and having difficulty moving."
- *She refused breakfast and supper on this date*

**August 14, 2013 (<u>1-Point Dominant Hand Ambulatory Restraints</u>)[10]:**

- 15:30—"[complains of] #5 pain to both legs."
    - "'I'm in pain. I don't want to die.'"
    - "Patient is laying in [Seclusion Room] on mat crying, stuttering [complaining of] #5 pain to both thighs."
- 16:30—"[complains of] #4 pain"
    - "commented at one point that she wants to die."
- 20:30—"[complains of] #4 pain to both legs"
- 21:30—"[complains of] #4-5 leg pain (both legs)"
    - "stuttering."
    - "reported at 2100 that pain had [decreased] to #3 but reported on this assessment that it is #4-5. Dr. Guidry informed."
- 22:02—"Ibuprofen 600 mg one time now only for lower extremity pain"
    - "encourage ambulation"[11]
- *She refused breakfast and supper on this date*

**August 15, 2013 (<u>1-Point Dominant Hand Ambulatory Restraints</u>)[12]:**

- 08:30—"had #3 [right] hip pain"
- 09:30—"continues to [complain of] thigh pain." She tells staff "'The PRN didn't help. My thigh still hurts."
- 10:30—"pain reduced to #2 of thigh pain"

- 11:30—"continues to [complain of] thigh pain still #2"
- 17:30—"[complains of] leg pain bilateral [both sides]"
    - "acetaminophen 650 mg [orally] for 4/5 bilateral leg pain"
- 23:30—"'I can't move'"

**August 16, 2013 (<u>Emergency Restraint Chair, 1-Point Dominant Hand Ambulatory Restraints</u>)[13]:**

- 03:30—"[complains of] bilateral leg pain"
- 07:30—"stuttering at times"
- 08:30—"ongoing leg pain, refused tylenol"
- 09:30—"'I feel like hurting myself.'"
    - "'I'm hearing voices telling me to hurt myself.'"
- 11:30—"[right] thigh is sore/stiff."
    - "crying and pacing talking about hurting herself and going to jail."
- 17:30—"[complains of] leg pain"
- 22:00—"[complains of] bilateral leg pain, PRN [medication] to begin shortly"
- *She refused breakfast and dinner on this date*

**August 17, 2013 (<u>Emergency Restraint Chair, 4-Point Ambulatory Restraints</u>)[14]:**

- 01:00— "[complains of] #4 leg pain"
- 09:00— "[complains of] #4 pain – both legs"
- 12:00— "[complains of] #4 pain to [left] leg"
    - "'I'm not eating.'"
    - "refused [range of motion], [oral] fluids [and] lunch."
- 17:00—"refused offer of supper tray [and] fluids off her tray."
- 19:00— "[complains of] pain in her legs"
    - "'I want to do my feet [and] legs. They hurt me.'"
- *She refused lunch and supper on this date*

**August 18, 2013 (<u>4-Point Ambulatory Restraints</u>)[15]:**

- 07:00— "repetitive of phrases"
    - "Refused to get up off of floor."
- 08:00— "[complains of] #3 pain to legs"
    - "'I can't get up.'"
    - "Stuttering and repeats the same phrases over and over again."
- 09:00— "[complains of] #3 pain to legs."
    - "Speech unclear at times, stutters. [Complains of] pain to legs but refused PRN tylenol."
- 10:00— "[complains of] #5 pain to legs at 0950"
    - "'My leg hurts'"
- 13:00— "[complains of] #3 leg pain"
    - "Speech is unclear, stutters at times and repeats sentences."
- 16:00— "states that she isn't going to eat supper tonight either."
- 19:00— "[complains of] #4 leg pain [and] received Tylenol 650 mg [orally] at 1850."
- 20:00—"'I'm weak because I'm not eating my meals. I can't get up by myself.'"
    - "had to be assisted to get up off the mat."
- *She refused breakfast and supper on this date*

**August 19, 2013 (<u>4-Point Ambulatory Restraints</u>) [16]:**

- 00:00—"mumbling to self leaning on side trying to sit up."
    - "'I can't get up. My legs won't let me move. They're fxxkin' [*sic*] stuck.'"

- 02:00—"mumbling at times."
- 03:00—"mumbling again to self, flailing some"
- 06:00—"moving very gingerly about to bathroom."
    - "bumped head while sitting, trying to sit back on mat. [On-duty physician] notified."
- 07:00—"In the [illegible] she bumped her head getting down on the mat. No [complaint of] pain or other [symptoms]. No sign of injury on exam."[17]
- 15:00—"'My legs are getting tired'"
- 16:00—"Acetaminophen 650 mg [orally] for 3/5 back pain."
    - "'I can't walk. I'm gonna piss myself!' [She complains of] not being able to walk. [Patient] educated about her ability to walk and [she] went to the restroom."
- 20:00—"sat down on mat and leaned head back and tapped it on the wall. No [complaint of] pain. No injury noted."
- *Refused dinner on this date*

**August 20, 2013 (<u>4-Point Ambulatory Restraints</u>)** [18]**:**

- EB attended physical therapy this date. Physical therapist notes, "in 4 point restraints with connector. Unable to perform [illegible] progression of P.T. exercises in the restraints. Will reschedule for 08/23/13."[19]
- 17:00—"'I want the leg restraint off.'"
- 19:00 – "sat down and tapped head on wall due to her position during sitting."
    - "seen hitting self in leg [with] arms (self-injurious)."
- 21:30—"given PRN Acetaminophen 650 mg [orally] for 3/5 [headache]"

**August 21, 2013 (<u>Emergency Restraint Chair, 4-Point Ambulatory Restraints</u>)**[20]**:**

- 01:00—"Wailing aloud in high pitched sing-song voice."
- 07:00—"Wailing off [and] on."
- 08:00—"previously lying on floor, mumbling to self, saying 'I can't get up.'"
- 09:02—"'My feet hurt.'"[21]
- 11:00—"repeats words over [and] over (unintelligible)."
- 14:05-- "sat in chair – stood up walked several steps, then threw self back onto floor, hitting buttocks, then head."
    - "seen by Dr. Hunt, no bleeding, no swelling, no discoloration at site"[22]
- 14:30—" threw herself down (witnessed by staff) potentially leading to injury/self harm."[23]
- 17:30—"given PRN Acetaminophen 650 mg [orally] for 3/5 leg/buttocks pain."

**August 22, 2013 (<u>Emergency Restraint Chair, 4-Point Ambulatory Restraints</u>)**[24]**:**

- 00:00— "Standing by door, wailing in high pitched voice, urinated on herself while waiting for security to arrive on ward."
- 01:00—"Yelling, Wailing, Talking to self, Standing in Doorway"
- 02:00—"Wailing lying on mat."
- 02:30—"'My head hurts'"
    - "Sent to ER because [it is] unknown why she fell [and] whether or not she hurt her head"[25]
- 03:00—"straight fell backwards [and] hit the back of her head hard on the floor."[26]
- 03:00—"[complains of] head pain"
    - "to be evaluated @ Augusta Health post fall."
- 04:00— "'It hurts.' [She is] lying in bed @ Augusta Health being evaluated for injuries post fall. [Patient complains of] pain on head and neck."

- 05:00— "[complains of] head pain"
- 06:30— Returns to WSH from Augusta Medical Center after "head CT. Currently asleep."[27]
- 15:00—"lying in middle of [seclusion] room mumbling"
- 19:45—"appears to be drowsy. Mumbling to self."
- *She refused lunch on this date*

**August 23, 2013 (Emergency Restraint Chair, 4-Point Ambulatory Restraints)[28]:**

- EB attended physical therapy on this date. Physical therapist notes, "remains in [4-Point Restraints with] connector. Unable to [illegible] exercise program. Will reschedule."
- 01:00—"Intermittently wailing in a high pitched tone of voice"
- 02:00—"Intermittently wailing"
- 09:00—"has a blank stare, mumbling to self."
- 11:00—"repeats one word several times, example – 'water, water, water) (shoe, shoe, shoe)'."
- 17:45— "[complains of] pain #3 legs"

**August 24, 2013 (Emergency Restraint Chair, 4-Point Ambulatory Restraints)[29]:**

- 00:00—"moaning loudly at times. Slurring her speech and difficult to understand. Asking for water then refusing to suck on the straw or sit up."
- 01:00—"talking to herself incoherently and moaning loudly at times."
- 02:00—"continues to moan and talk incoherently to herself. Speech unintelligible."
- 03:00— "mumbling incoherently to herself incessantly."
- 04:00—"continues [with] moaning, crying, and talking incoherently to herself."
- 05:00—"continues to moan and talk to herself incoherently. Speech slurred but able to speak clearly when she wants. Crawling on the floor and acting like she can't' stand. Stumbled when going from kneeling to standing."
- 11:00—"moaning talking to self, stuttering"
- 14:00—"repetitive movements and utterances"
- 17:45—"attempted to choke self by swallowing bottle cap @ 1738. [Patient] put her finger in her mouth and pushed it back and swallowed it. Heimlich maneuver performed x 20. Clean sweep performed. Heimlich and clean sweep took 30 secs. Bottle cap removed."[30]
    - "attempted suicide by choking"[31]
- *She refused breakfast on this date*

**August 25, 2013 (4-Point Ambulatory Restraints)[32]:**

- 0845—"continues to refuse food"
- 0945—"alert, continues to moan/groan, chant [and] hum."
    - "Her speech is occasionally incomprehensible."
- 1645—"'I can't get up'"
- *She refused dinner on this date*

**August 26, 2013 (Emergency Restraint Chair, 4-Point Bed Restraints, 4-Point Ambulatory Restraints)[33]:**

- 0745—"yelling out constantly while lying on the mat in [seclusion] room on her side."
- 1345— "[complains of] leg discomfort from leg restrains"
    - "My leg hurts."
    - "she refuses leg exercise."
- 1430— "exhibiting self-injurious behavior, banging head on floor."[34]
    - "EB began head-banging (against floor) on return to ward from Barber PSR"[35]
    - "No medical distress."[36]
- 1530—"blank stare, mumbling to self, but speaking clearly @ times"

- 1630— "Reddened area on head from banging head on floor"
- 1845—"moving very gingerly after being transitioned from ERC. Mumbling. Not speaking clearly at all." [37]
    - "lying stiff on mat in [seclusion] room"[38]
- 1935—"banging head on floor in [seclusion] room."[39]
- 2215—"No injuries noted except for reddened area on forehead."
- *She refused breakfast on this date*

**August 27, 2013 (<u>Emergency Restraint Chair, 4-Point Bed Restraints, 4-Point Ambulatory Restraints with Helmet</u>)**[40]**:**

- 0815—"wiping feces on hand, moving in 'slow motion'"
    - "placed in [4-point ambulatory] restraints w/connecting belt and helmet"[41]
    - "Patient banging head"[42]
- 1340—"attempting to suffocate self, banging head, trying to remove helmet"[43]
    - "No medical distress."[44]
- 1430—"banging head repeatedly on the floor of [Seclusion] room."[45]
- 1830—"[complains of] restraints being tight on feet"
- 2030—"hit her head on the (cushioned) back of ERC"

**August 28, 2013 (<u>Emergency Restraint Chair, 4-Point Ambulatory Restraints</u>)**[46]**:**

- 0730—"came out of [the seclusion room] several time; uncooperative; banged head"[47]
- 0810— "Lying on floor, tapping head against floor, repeating 'I'm sad, I'm sad, I'm sad' and shrieking"[48]
- 0930—"Disorganized, biting herself, acting like she is going to fall."
- 1230—"continues loud screams, stuttering and tapping forehead on floor."
- 1530— "superficial abrasions to left arm" [49]
    - "she began scratching her left arm w/finger nails"[50]
- 1530—"EB was engaging in SIB while in [4-point] restraints." [51]
    - "No medical distress."[52]
- 1730—"banging head at times"
- 2245—"moaning, yelling. [She] began biting her fingers." [53]
    - "[Patient] placed in [Emergency Restraint Chair] at 2245 for self injurious behavior"[54]
- 2245—"Moaning [and] yelling, speech not understood at this time."[55]
- 2345—"Small scratches, same reddened noted to LT arm."

**August 29, 2013 (<u>Emergency Restraint Chair, 4-Point Ambulatory Restraints</u>)**[56]**:**

- 0245—"Scratch [and] reddened area to [left] arm persist."
- 0840—"approaching ten hours in [the Emergency Restraint Chair]"[57]
- 0840—"No medical distress."[58]
- 1430—"Continues to mumble to self."
- 1530—"Speech [is] unintelligible."
- 1930—"Continues to refuse [orally-administered] fluids"
- 2230—"Tense, yelling, speech unclear, biting on fingers, tapping head on the floor."[59]
- *She refused supper on this date*

**August 30, 2013 (<u>Emergency Restraint Chair, 4-Point Ambulatory Restraints, 2-Point Ambulatory Restraints</u>)**[60]**:**

- 0230—"continued to attempt to bite/scratch at self in bathroom"[61]
- 0530—"Refused [orally administered] fluids. Talking to self."

- 0730—"'When is my ten hours up in the chair'"
- 0915— "maximum ten hour for ERC close"[62]
    - "'I want out of the chair'"[63]
    - "no medical distress"[64]
- 1215—"Refused food [and] fluid"
- *She refused breakfast, lunch, and 85% of dinner on this date*

**August 31, 2013 (2-Point Ambulatory Restraints)[65]:**

- 0815—"mumbling to self, not speaking clearly to staff, moaning."
- 1215—"[complained of] restraint being too tight"
- 2115—"laying on mattress speech unclear, crying, refusing to get up off mattress"
- 2215—"Patient laying on mattress in SR, screaming at intervals, nibbles on [right] forefinger at intervals."
- 2315—"Pulled on staff in order to help herself off the mattress."
- *She refused breakfast and lunch on this date*

**September 1, 2013 (Emergency Restraint Chair, 4-Point Ambulatory Restraints, 2-Point Ambulatory Restraints)[66]:**

- 0015—"muttering to herself, trying to bang her head on the floor."
    - "Reddened areas observed to LT hand."
- 0910—"mumbling to self. Staring @ the wall, did not make good eye contact"
    - "bit self, scratching forearm"
- 1010—"moving very slowly, gingerly."[67]
- 1145—"banging head on floor, transitioned to ERC."[68]
    - She is observed to have a "blank stare, face reddened"[69]
- 1445—"moving slowly, guarded, slow to respond"
- 1545—"that restraints were tight"
- 2245—"Eyes [are] closed, cries out in her sleep at intervals."
- *She refused lunch and 90% of dinner on this date*

**September 2, 2013 (4-Point Ambulatory Restraints)[70]:**

- 0045—"Reddened areas noted to hands (? from bites, self inflicted)."
- 0745—"'I'm dizzy, I'm dizzy' [She] attempted to get up to go to bathroom and was unable to stand…she appears weak and pale…wheezing and labored breathing."
- 0845—"moaning at times"
    - Physician order her transport via Staunton Augusta Rescue Squad to Augusta Medical Center in 4-point ambulatory restraints
- 0945— "[complains of] stomach ache to SARS personnel"
    - "I'm weak I don't feel good."
- "Patient has not been eating nor drinking for several days. Her vitals have deteriorated. She [complains of] feeling weak and dizzy, she is unable to stand."[71]

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[1] Emergency Behavioral Seclusion/Restraint Physician Order/Note – 8/8/13 – 0904
[2] RN Hourly Assessment – 8/8/13
[3] RN Hourly Assessment – 8/9/13
[4] RN Hourly Assessment – 8/10/13
[5] RN Hourly Assessment – 8/11/13
[6] RN Hourly Assessment – 8/12/13
[7] Physical Therapy Treatment Record (8/5/13 – 8/12/13)
[8] WSH RN Initial S/R Assessment Note – 8/12/13
[9] RN Hourly Assessment – 8/13/13
[10] RN Hourly Assessment – 8/14/13

[11] Physician's Orders – 8/14/13 – 2202
[12] RN Hourly Assessment – 8/15/13
[13] RN Hourly Assessment – 8/16/13
[14] RN Hourly Assessment – 8/17/13
[15] RN Hourly Assessment – 8/18/13
[16] RN Hourly Assessment – 8/19/13
[17] Emergency Behavioral Seclusion/Restraint Physician Order/Note – 8/19/13 – 0700
[18] RN Hourly Assessment – 8/20/13
[19] Physical Therapy Treatment Record (8/5/13 – 8/12/13)
[20] RN Hourly Assessment – 8/21/13
[21] RN S/R Release Note – 8/21/13 – 0902
[22] Post Falls Assessment – RN Documentation – 8/21/13 – 1405
[23] Emergency Behavioral Seclusion/Restraint Physician Order/Note – 8/21/13 –1430
[24] RN Hourly Assessment – 8/22/13
[25] Post Falls Assessment – RN Documentation – 8/22/13 – 0230
[26] Patient Emergency Transfer Form – 8/22/13 – 0300
[27] Emergency Behavioral Seclusion/Restraint Physician Order/Note – 8/22/13 – 0630
[28] RN Hourly Assessment – 8/23/13
[29] RN Hourly Assessment – 8/24/13
[30] RN S/R Release Note – 8/24/13 – 1745
[31] WSH RN Initial S/R Assessment Note – 8/24/13 – 1745
[32] RN Hourly Assessment – 8/25/13
[33] RN Hourly Assessment – 8/26/13
[34] RN S/R Release Note – 8/26/13 – 1430
[35] Emergency Behavioral Seclusion/Restraint Physician Order/Note – 8/26/13 – 1430
[36] Emergency Behavioral Seclusion/Restraint Physician Order/Note – 8/26/13 – 1430
[37] WSH RN Initial S/R Assessment Note – 8/26/13 – 1845
[38] WSH RN Initial S/R Assessment Note – 8/26/13 – 1845
[39] RN S/R Release Note – 8/26/13 – 1935
[40] RN Hourly Assessment – 8/27/13
[41] WSH RN Initial S/R Assessment Note – 8/27/13 – 0815
[42] Emergency Behavioral Seclusion/Restraint Physician Order/Note – 8/27/13 – 0815
[43] RN S/R Release Note – 8/27/13 – 1340
[44] Emergency Behavioral Seclusion/Restraint Physician Order/Note – 8/27/13 – 1340
[45] WSH RN Initial S/R Assessment Note – 8/27/13 – 1430
[46] RN Hourly Assessment – 8/28/13
[47] RN Hourly Assessment – 8/28/13 – 0730
[48] Emergency Behavioral Seclusion/Restraint Physician Order/Note – 8/28/13 – 0810
[49] RN S/R Release Note – 8/28/13 – 1530
[50] RN S/R Release Note – 8/28/13 – 1530
[51] Emergency Behavioral Seclusion/Restraint Physician Order/Note – 8/28/13 – 1530
[52] Emergency Behavioral Seclusion/Restraint Physician Order/Note – 8/28/13 – 1530
[53] RN S/R Release Note – 8/28/13 – 2245
[54] RN S/R Release Note – 8/28/13 – 2245
[55] WSH RN Initial S/R Assessment Note – 8/28/13 – 2245
[56] RN Hourly Assessment – 8/29/13
[57] WSH RN Initial S/R Assessment Note – 8/29/13 – 0840
[58] Emergency Behavioral Seclusion/Restraint Physician Order/Note – 8/29/13 – 0840
[59] RN S/R Release Note – 8/29/13 – 2230
[60] RN Hourly Assessment – 8/30/13
[61] Emergency Behavioral Seclusion/Restraint Physician Order/Note – 8/30/13 – 0230
[62] RN S/R Release Note – 8/30/13 – 0915
[63] WSH RN Initial S/R Assessment Note – 8/30/13 – 0915
[64] Emergency Behavioral Seclusion/Restraint Physician Order/Note – 8/30/13 – 0915
[65] RN Hourly Assessment – 8/31/13
[66] RN Hourly Assessment – 9/1/13
[67] WSH RN Initial S/R Assessment Note – 9/1/13 – 1010
[68] RN S/R Release Note – 9/1/13 – 1145
[69] WSH RN Initial S/R Assessment Note – 9/1/13 – 1145
[70] RN Hourly Assessment – 9/2/13
[71] Patient Emergency Transfer Form – 9/2/13 – no time