INVESTIGATIONS INTO SERIOUS INCIDENTS –PART 2

NARPA

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ANALYSIS OF AN ACTUAL INVESTIGATION

- This portion of the presentation involves a review of an actual incident and the investigation that followed.

- While the information is provided in the ppt, your handout provides the same information (The handout is offered to make it easier to follow the case).

INVESTIGATORY CASE SUMMARY

- ZZ is a private psychiatric hospital with 4 adult units each consisting of 25 beds.
- Mr. J is a 42 year old man who had been civilly committed to ZZ for a period of 4 months. He had been admitted to Unit 1 of the hospital upon his commitment.
- Due to administrative reasons the hospital informed Mr. J. that he was going to be transferred to Unit 2. As Mr. J. had been on Unit 1 for over a month, he informed the hospital that he did not want to be transferred to an unfamiliar unit. The hospital transferred him despite his objections.

INVESTIGATORY CASE SUMMARY

- Unit 1 sent the transfer paperwork to Unit 2. While the paperwork contained information that Mr. J. has medical issues with both of his wrists, that information was not orally conveyed to anyone upon the transfer.
- Staff felt Mr. J. had a history of making unfounded medical complaints.
- The day after transferred to Unit 2, Mr. J. informed the staff, if given the opportunity, he was going to kill himself.
- At 8:00 a.m. a unit psychiatrist placed Mr. J. on a 1:1 observation status.

INVESTIGATORY CASE SUMMARY

- After being placed on 1:1 Mr. J. was in his room with the door open. The staff was sitting in a chair outside the room.
- Mr. J began to yell at the staff, and expressed his anger over having been involuntarily moved to this new unit. He threw a plastic water bottle out of his room which landed in the hallway outside of his room.
- Mr. J. walked out of his room, picked up the water bottle, and walked across the hall into an empty activity room and sat down in a chair located in the corner of the room.

INVESTIGATORY CASE SUMMARY

- His 1:1 staff went into the activity room and informed Mr. J. that he needed to leave the activity room and go back into his room. Mr. J. said he was not going to leave the activity room and was fine right where he was.

- The staff walked out of the activity room and instituted a silent STAT call summoning staff from other units to engage in a "show of force" hoping to make Mr. J. comply with the request to go back to his own room. 8 additional staff appeared at the activity room.

- The 1:1 staff then asked Mr. J. if he was now ready to leave the activity room and go back to his room. Mr. J. quickly stood up, pushed the chair he was sitting on to the ground and yelled "NO FUCKING WAY!"

INVESTIGATORY CASE SUMMARY

- The 8 staff descended upon Mr. J. and instituted what was known to staff as a "Unit 2 carry restraint", in which the staff immobilize the patient and carry him/her to the restraint room to be placed on a bed in mechanical restraints.
- The staff then picked up Mr. J. who almost immediately cried out in pain stating he thought they had broken his wrist. A doctor was summoned who examined the wrist but did not think it was broken.
- Mr. J. was placed in four point mechanical restraints for 1 and ½ hours.

INVESTIGATORY CASE SUMMARY

- Mr. J.'s wrist became swollen and a mobile X-ray was ordered which showed that his wrist had been broken.

- He was subsequently transferred by ambulance to the city hospital emergency room where he was treated for the fracture.

INVESTIGATION METHODOLOGY

1. Review of Mr. J's records from ZZ psychiatric hospital.
2. Review of Mr. J.'s medical records from the City Emergency Room related to treatment of his wrists.
3. Review of ZZ's staff training program, (ABC), specifically use of seclusion and restraint including transport techniques. **The review indicated the training did not include a "carry restraint".**
4. Review of ZZ's policies and procedures on restraint and psychiatric emergencies.
5. Review of restraint and emergency treatment regulations under both state and federal laws and regulations.
6. Review of ZZ's internal investigation report of this incident.
7. Independently interviewing 20 witnesses including staff, patients and the CEO of ZZ.
8. Consultation with John Doe, Executive Director of ZZ, via email
9. Telephone consultation with Jane Doe, ZZ Training's executive director of Instruction and Standards.
10. Telephone/written consultation with Dr. Joe Smith, MD M.P.H., Professor of Psychiatry at State University.
11. Telephone/written Consultation with Dr. Jane Smith, MD, City Hospital Emergency Room physician who initially treated Mr. J at the emergency room.
12. Written consultation with Dr. Joe Jones, MD, a doctor with The City Orthopedic Center.
13. View and photograph all areas associated with the event.

REVIEW OF INCIDENT

1. What are the allegations?
   - *Restraint absent a risk of harm, excessive force of manual restraint, inappropriate use of mechanical restraint, medical neglect.*

2. Was there inappropriate use of seclusion?
   - *Forcing Mr. J from the activity room back to his room would have constituted use of seclusion in the absence of a risk of an emergency.*

REVIEW OF INCIDENT

3. Was there incitement or provocation on the part of the staff?
   - *Possibly, the show of force to coerce J from the activity room to his room.*

4. Was there anything that could have been done differently to prevent the situation from escalating to a physical altercation?
   - *Perhaps allowing Mr. J. to vent his frustration and fear related to the move.*

REVIEW OF INCIDENT

5. Did any policies/procedures contribute to the incident?
   - *Transfer from Unit 1 to Unit 2 for administrative reasons? Lack of knowledge pertaining to the pre-existing concern about the wrists?*

6. How would you determine if the 1.5 hours of mechanical restraint was in violation to the rules?
   - *Know the regulations governing use of mechanical restraints, know the release behaviors and examine the record and witnesses to see if those were met. The justification for continuing should be an ongoing risk of harm, otherwise it is punishment!*

REVIEW OF INCIDENT

7. How would you identify the potential witnesses?
   - *Diagram of room with initials indicating who was present and where. Review unit logs to see which staff and who else were in the area. Gathering additional information from the interviews that occur.*
8. How should the interviews be conducted with the witnesses?
   - *Discuss order, written statements vs interviews, credibility issues*

REVIEW OF INCIDENT

9. Was the transport to the restraint room in keeping with the training provided by ABC?
   - *Review of the training program indicated no such technique.*

10. Was there neglect of medical treatment?
    - *Was the doctor who examined the wrist in the restraint room influenced by J's previous history and lack of knowledge about medical issues with both wrists?*

RECOMMENDATIONS

- Amend treatment plan forms to include, in a separate sheet, any special considerations that should be considered regarding the use of restraint/Seclusion/emergency meds for any patient and that all staff that will be working with the patient sign off that they have read this part of the treatment plan BEFORE working with the patient. Particularly important for individuals who are trauma survivors.

- Perform a hospital wide review of all current patients plans to ensure the above occurs.

- That an independent medical review of this incident be conducted in order to ascertain if the general medical care received after the restraint episode fell below the medical standards of care guaranteed under whatever laws would be applicable.

- That the actual day-to-day restraint practices of staff be studied in order to determine what type of restraint techniques they are actually using on patients.

RECOMMENDATIONS

- Evaluate those practices to ensure they comply with the policy and the law and their training, an institute some type of period review to ensure that going forward they don't deviate from those techniques.

- The P&A be notified when any person suffers an injury when it is reasonable to conclude that the injury is a result of having been placed in restraint or if a patient is transported to an outside hospital within 24 hours after having been in restraint.

- Once every year they hire an outside consultant to review the above and issue a report that is given to the P&A