RISK
CASE STUDY

Case: Restraints and Self-Harm

Abstract:

An agitated post-operative patient eloped and was found deceased in the hospital's parking garage. Inadequate patient monitoring and restraint use were identified by expert reviewers as contributing factors.

Key Words:

Acute Care

Mental Health

Restraints, Monitoring

Elopement

Documentation

Post-Operative Care

Agitation and Paranoia

Case summary:

A patient was admitted to hospital to undergo a pre-scheduled operative procedure to remove a malignant tumor. While the patient's initial post-operative recovery was uneventful, the patient became increasingly agitated and paranoid. Following an attempt to leave the unit, security was called and the patient was placed in restraints, as ordered by the attending physician.

After several hours in restraints, the nurse caring for the patient removed the restraints, documenting that the patient appeared calm and no longer voiced a desire to leave the premises. One hour after the removal of the restraints, the involved nurse noted that the patient was no longer in his room. The nurse immediately called security and reported the patient missing. (It is unclear to what extent search proceedings were carried out before the Code Yellow). Half an hour later, a Code Yellow was called. The patient was later found deceased, lying at the bottom of a stairwell in the hospital's parking garage.

Medical legal findings:

While the internal hospital review of the incident did not reveal any concerns with respect to the nursing care provided by the involved nurse, medical legal expert review of the case was critical of the care provided to the patient. While the frequency of monitoring appeared to follow the organization's Least Restraint Policy, the nurse's decision to remove the patient's restraints conflicted with the orders provided by the attending physician.

Expert review also questioned the nurse's decision to remove the restraints in spite of the patient's significant agitation in the hours prior. Review of the patient's chart revealed that ten minutes prior to the removal of the patient's restraints, the involved nurse had described the patient as "agitated". However, at the time of the removal of the restraints, the patient was noted to be "coherent and calm", with the nurse documenting that she had confirmed the removal of the restraints with the charge nurse on duty.

Reflections:

Reflecting on your practice as well as your facility's policies, procedures and processes:

1. Reflecting on your organization's policies, can nurses and other health care providers remove ordered restraints without a consult or new order from the patient's most responsible practitioner? If a healthcare provider disagrees with a nurse practitioner's or physician's order for restraint, describe what steps/action should be taken?
2. In this case the findings of the internal review and the medical legal experts conflicted as to whether the nurses' practice met the standard

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of care. What could lead to an incorrect or incomplete analysis during an internal review? What role does the health record play in internal and external reviews? Discuss the concept of reviewer bias (i.e. subjective interpretations influenced by prior knowledge)

3. Describe some of the differences between an internal 'system' review, performance/accountability review and medical legal review.
4. Reflecting on your local policy, what steps/actions are to be taken if an at-risk patient is noted to be 'missing'? Would your answer be different if the patient's status was voluntary?
5. Describe the resources in place at your facility to assist the care team/practitioners caring for patients with post-operative confusion/psychosis. Describe some of the risk factors and signs/symptoms associated with post-operative delirium.
6. The nurse appears to have followed the expected frequency for monitoring the patient while in restraints. Reflecting on your local policy, are healthcare providers expected to document each time they monitor/reassess the patient and/or remove the restraints? Or can healthcare providers rely on their normal practice and their program's Least Restraint Policy as evidence of meeting the standard of care?

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