

**AN INVESTIGATION INTO THE EXCESSIVE USE  
OF RESTRAINT AT THE EMERGENCY DEPARTMENT  
OF FLETCHER ALLEN HEALTH CARE**

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## I. INTRODUCTION

This report documents Vermont Protection & Advocacy Inc.'s (VP&A's) investigation into the Fletcher Allen Health Care (FAHC) Emergency Department's (E.D.'s) treatment of RD on August 6, 2006. At the time of admission, 11:37 a.m., RD was demonstrating "agitated" and "paranoid behavior". As a result, he was placed in the mental health section<sup>1</sup> of the E.D. Security Officers (SOs) were posted in the hallway outside of RD's room. RD remained in the E.D., awaiting treatment, for nine hours. During this period he was physically restrained<sup>2</sup> on six occasions. At 9:37 p.m. RD was discharged from the E.D. and escorted in handcuffs to FAHC's inpatient psychiatric unit.

The numerous incidents of physical restraint significantly impacted RD's mental health and ultimately had an adverse effect on his recovery. According to RD's Resident Psychiatrist, RD perseverated over the occurrences of August 6, 2006 for over a month. FAHC Progress Notes detail the traumatic impact of RD's experience in the E.D. in the days immediately following the incidents:

*(Progress Notes 8/07/06) Patient is angry and irritable very upset about situation in the ED last night and about being in the hospital.*

*(Progress Notes 8/09/06) Patient is very upset still about the "abuse" he received in the ED.*

*(Progress Notes 8/10/06) He continues to be angry about incidence (sic) at admission...*

This report will provide the findings of VP&A's independent investigation into the August 6, 2006 incidents. We would like to thank FAHC for their cooperation and seemingly genuine interest in the outcome of our investigation.

At the conclusion of our investigation VP&A found that FAHC diverged from several standards regarding the proper care of patients with acute mental illness. These divergences caused RD to suffer from unnecessary distress, physical injury, and

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<sup>1</sup> In VP&A's interview with E.D. Nurse, she described the E.D. as being broken down into sections. The E.D. Nurse referred to the section in which RD was placed as the mental health section.

<sup>2</sup> The term "restraint" includes either a physical restraint or a drug that is being used as a restraint. A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body. 42 CFR 482.13(f).

Iatrogenic Trauma<sup>3</sup>. In this report, VP&A provides recommendations aimed at remedying the concerns identified and improving FAHC's E.D. care and treatment for patients with acute mental illness.

## **II. BACKGROUND**

RD is twenty four years old. He was raised in Baltimore, Maryland. He has two siblings ages seventeen and twenty two. His parents and seventeen year old sister continue to reside in Baltimore. RD relocated to Burlington, Vermont in 2001 after being accepted to the University of Vermont (UVM). While attending UVM RD studied Forestry and maintained a GPA of over 3.01. He is currently not attending UVM, however he intends to return in the near future in order to complete a degree in Forestry. Ultimately RD would like to work as a professor in the environmental field.

### **A. Inpatient Hospitalizations**

RD has a documented history of mental illness. His first episode occurred in August of 2002 while attending his second year at UVM. Subsequent to this episode, RD has been hospitalized as an inpatient on four occasions. Two of these hospitalizations were at FAHC. Records from these inpatient hospitalizations describe RD as experiencing "auditory hallucinations" and reacting to "internal stimuli." RD was ultimately given a diagnosis of Bipolar Affective Disorder.

### **B. July 23<sup>rd</sup> and August 4<sup>th</sup> 2006 FAHC Emergency Department Visits**

In addition to RD's four inpatient hospitalizations, on two occasions he has visited the FAHC E.D. in regard to his psychiatric condition. The first of these visits occurred on July 23, 2006 at 1:59 p.m. FAHC E.D. records of this visit are scant and offer limited insight into RD's mental health status. They do note however that RD was exhibiting "bizarre behavior." RD left the E.D. after waiting for an hour and a half to be seen by a Howard Center for Human Services (HCHS) Crisis Evaluator.

RD's second E.D. visit occurred on August 4, 2006 at 1:27 a.m. According to the FAHC E.D.'s Physician Summary, RD was brought into the E.D. by friends. Again documentation of this visit is scant. However, it is noted in the Physician's Summary that RD was exhibiting "bizarre" and "paranoid behavior." RD left the E.D. at approximately 2:45 a.m.

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<sup>3</sup> Trauma survivors may be especially vulnerable to additional traumatic and/or iatrogenic (physician-caused) experiences that occur within the psychiatric setting. For example, routine use of seclusion, restraints, or handcuffs may serve to recapitulate previous traumatic experiences, and thereby exacerbate symptoms of PTSD. Cohen, L. J. (1994). Psychiatric hospitalization as an experience of trauma. *Archives of Psychiatric Nursing*, 8, 78-81; Frueh, B. C., Dalton, M. E., Johnson, M. R., Hiers, T. G., Gold, P. B., Magruder K. M., Santos, A. B. (November 2000). Trauma within the psychiatric setting: conceptual framework, research directions, and policy implications. *Administration and Policy in Mental Health*, Vol.28, No. 2.

On the same evening, at 4:45 a.m., the E.D. staff found RD lying outside of the hospital. RD was again admitted to the E.D. Shortly thereafter he was evaluated by HCHS Crisis Evaluator #1. According to Crisis Evaluator #1's notes, "Clt's mood and behavior fluctuated rapidly between being anxious and depressed due to apparent grief over his condition verses being fearful based on paranoid delusional thought content." RD did not meet the criteria for involuntary admission and as a result, RD was discharged to ASSIST<sup>4</sup> by Physicians Assistant (PA) #1. RD had an ongoing relationship with HCHS, which operates the ASSIST Program.

### **C. Howard Center for Human Services**

RD initially requested Community Rehabilitation and Treatment (CRT) services through HCHS on July 28, 2005. His request for services followed a 2005 hospitalization at Central Vermont Hospital (CVH). RD was evaluated by a HCHS's Dr. The Dr. noted that RD "voices paranoid delusions that he believes there may be CIA agents watching him and grandiose delusions that he can hear the inner voices of others." (*HCHS Diagnosis and Evaluation, 7/28/2005*).

On February 28, 2006 RD was discharged as a client of HCHS due to his relocation to Baltimore. On July 13, 2006 RD returned to Vermont and reapplied for CRT services. RD was evaluated by a second HCHS's Dr. The Dr. recommended that RD be accepted for CRT services noting that during previous episodes he had "experienced decreased sleep, racing thoughts, disorganized behavior, and prominent grandiose and paranoid delusions." (*HCHS Diagnosis and Evaluation, 7/13/2006*).

Upon re-acceptance for CRT services, RD attended an appointment with a HCHS Dr. on July 27, 2006. In his assessment the Dr. stated that RD "feels that he is being potentially followed and/or watched..." (*HCHS Physicians Progress Note, 7/27/06*). RD was scheduled for a follow up appointment on August 3, 2006. RD failed to appear for this appointment.

On the following day, August 4, 2006, after being discharged from the FAHC E.D., RD was admitted to the HCHS ASSIST Program. HCHS records document that on August 4, 2006 RD was "manic, psychotic, delusional" and had "ripped an I.D. badge from a doctor's coat during a FAHC interview..." (*HCHS Discharge Summary/ Transition Plan, 8/05/2006*).

RD spent the day and evening of August 4<sup>th</sup> and the day of August 5<sup>th</sup> at ASSIST. According to HCHS records, "his stay was marked by increasing paranoia..." (*HCHS Discharge Summary/Transition Plan, 8/05/2006*). He was noted as asking the staff if

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<sup>4</sup> The ASSIST Program is a short-term psychiatric crisis residential program that offers hospital diversion, stabilization, and step-down services to people experiencing an acute emotional crisis. The program primarily serves persons with psychiatric disabilities and is designed as an alternative to inpatient hospitalization. The program is provided by the Howard Center for Human Services. See [http://www.howardcenter.org/ABHS/abhs%20 programs/abhscrisisrcc.htm](http://www.howardcenter.org/ABHS/abhs%20programs/abhscrisisrcc.htm)

they knew of a good place to hide because the CIA was after him. (*HCHS Discharge Summary/Transition Plan, 8/05/2006*).

### **III. AUGUST 6, 2006 FAHC EMERGENCY DEPARTMENT ADMISSION**

#### **A. Events Leading Up to E.D. Admission**

As evidenced by HCHS and FAHC E.D. records, in the weeks leading up to August 6, 2006 RD's mental health began to deteriorate. On the morning of August 5, 2006 RD left HCHS's ASSIST to have breakfast with his parents. During this period RD was acting extremely agitated. Due to RD's agitation his parents contacted the Burlington Police Department (BPD) in order to have RD escorted back to ASSIST.

RD remained at ASSIST for the duration of the morning, however he left that afternoon. RD may have spent the evening of August 5, 2006 at a friend's apartment. On the morning of August 6, 2006, RD called his father and requested that they meet. RD insisted that his father bring neither his mother nor the police. Fearing that RD was suicidal, RD's parents notified the BPD in order to have RD transported to the E.D. Upon arrival officers from the BPD were able to convince RD to accompany them to the FAHC E.D.

#### **B. Documented Interactions with Mental Health Care Professionals in the E.D.**

RD arrived at the FAHC E.D. sometime after 11:00 a.m. His official registration time is noted as 11:37 a.m. The hospital staff was unable to triage<sup>5</sup> RD in the customary fashion due to his mental state. As a result the E.D. Nurse triaged RD in an examination room. The examination room was located in the Mental Health section of the E.D. According to the E.D. Nurse several exceptions to the normal routine were made for RD due to his level of agitation and other symptoms. These exceptions included not requiring RD to change into hospital-approved clothing and not requiring RD to be searched by SOs. Aside from triaging RD, the E.D. Nurse had numerous other contacts with him throughout the day. The E.D. Nurse considered herself to be the nurse responsible for RD's care throughout his stay in the E.D.

At 12:24 p.m. RD was evaluated by P.A. #2. P.A. #2 was the senior medical provider in charge of RD's care. According to the security video this evaluation lasted approximately three minutes. Despite requests, no documentation of this meeting has been provided to VP&A. During VP&A's interview with P.A. #2 he indicated that his first visit with a patient is ordinarily an initial evaluation. Other than the fact that RD was delusional, P.A. #2 did not remember specifics of this initial evaluation. However, P.A. #2 did remember that after the evaluation he contacted a Crisis Evaluator due to the fact

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<sup>5</sup> Triage is an initial assessment of patients whereby they are sorted on the basis of need to ensure that medical staff are most effectively utilized. At FAHC patients are normally triaged in the triage room which is located in the front of the E.D. near the waiting room.

that RD was exhibiting “paranoid behavior.” P.A. #2 had various other contacts with RD throughout the day.

At 1:08 p.m. Crisis Evaluator #2 from HCHS met with RD. According to the security surveillance, their meeting lasted for approximately twenty-two minutes. According to Crisis Evaluator #2’s report, RD appeared to be “suspicious”, “frightened” and “paranoid.” Crisis Evaluator #2 went on to note that RD stated, “the CIA is around and after me.” Crisis Evaluator #2 stated in his interview with VP&A that he had several other contacts with RD throughout the day.

At 2:18 p.m. FAHC surveillance video shows the Psychiatric Resident having contact with RD. This contact lasted for under two minutes. According to our interview with the Psychiatric Resident the short interaction was due to RD’s unwillingness to cooperate. VP&A has not been provided any records documenting this interaction.

At 5:35 p.m. FAHC surveillance video shows a second interaction between the Psychiatric Resident and RD. This interaction lasts until 6:02 p.m. In an interview with VP&A, the Psychiatric Resident stated that during this time period RD was “extremely paranoid delusional ... afraid of anyone who entered the room.” As a result of his mental state, the Psychiatric Resident made the decision to admit RD involuntarily to the FAHC psychiatric unit. The Psychiatric Resident went on to state that over the next several hours he briefly checked in on RD while attempting to find a psychiatric bed for him. There is no documentation of any of these contacts other than a physician’s summary with a time of examination of 2:45 p.m. According to the surveillance video there is no contact with RD at that time.

### **C. Restraints**

Throughout RD’s August 6, 2006, nine hour stay in the FAHC E.D. he was physically restrained by SOs six times. The remainder of this section will detail each restraint. The details have been derived from hospital records, video surveillance, and interviews.

#### **1<sup>st</sup> Restraint**

At approximately 2:55 p.m. RD was standing in the hallway outside of his examination room, room 37. While in the hallway, he was talking to the SOs. According to responses in interviews conducted by VP&A, the SOs stated that RD was “verbally abusive”, “cursing”, and stating he could leave the hospital if he wanted. The SOs went on to state that RD behavior was bothering other patients in the E.D. In response to RD’s verbalizations the SOs used verbal encouragement to move him back in front of the door to his room. Once in the doorway SOs #1 and #2 took RD by his arms and physically escorted him onto the bed. The SOs then left the room and shut the door. RD denies that he used any vulgar or abusive language.

During VP&A’s interviews, all of the SOs, except SO #1, stated that RD made no threatening or suicidal statements. SO #1 felt that RD’s statement that he could leave the

hospital constituted threatening language. The SO in charge, Lieutenant (Lt.), attributed the restraint not to threatening behavior, but rather to nursing staff's direction to keep RD in his room. SO #2 stated his opinion that nursing staff's request to keep patients in their room is enough in itself to use force to carry out that order.

## **2<sup>nd</sup> Restraint**

At approximately 3:06 p.m., RD was once again standing in the doorway of room 37. Again while in the doorway he was speaking to the SOs stationed outside. According to interviews, RD was again loud and abusive and in general disruptive. In response to RD's behavior, and after checking with the nursing staff, the Lt. pushed RD into his room while SO #2 secured the door. In VP&A's interviews, all SOs, except SO #1, believed that RD did not pose a threat of harm. SO #1 felt that RD's threat to leave the hospital did pose a threat of harm to the SOs. Again, RD denies that he used abusive language.

## **3<sup>rd</sup> Restraint**

At approximately 3:17 p.m. RD was again restrained by the SOs. Prior to this incident RD was in the restroom across the hall from his examination room and adjacent to the nursing station. While in the restroom RD pushed the call bell. Nurse #2 responded to the bell by entering the bathroom. She informed RD that she was not his nurse. Following a brief discourse, Nurse #2 left the bathroom and began to walk away. RD followed Nurse #2 out of the bathroom and down the hall. As RD approached the SOs, they grabbed RD and took him down to the floor.

The SOs involved in the incident believed that RD posed a threat to Nurse #2. They stated that it appeared Nurse #2 did not want RD to pursue her and was moving away quickly. The SOs stated that at first they attempted to place themselves between the Nurse #2 and RD. When their presence did not prevent RD from proceeding they attempted to use a MOAB<sup>6</sup> complaint restraint. However, due to a blanket wrapped around RD, which made it difficult to control RD's arms, that restraint was not possible. The SOs improvised in order to take RD to the ground.

After the SOs gained control on the ground, RD was placed in an escort hold and led back into room 37. According to SO #1, RD attempted to grab a pen from his own pocket. As a result, the SOs forcefully placed RD on the bed in order to recover the pen. RD was driven head first into the bed. After a brief struggle the SOs removed the pen from RD's hand. According to RD, he had brought in the pen upon admission. There was nothing in the record to demonstrate that any measures were taken to ensure that RD was not given another pen.

## **4<sup>th</sup> Restraint**

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<sup>6</sup> MOAB is an in-depth training program that teaches individuals how to recognize, reduce, and manage violent and aggressive behavior. MOAB Instructor Manual, Roland W. Ouellette, 1993.

At approximately 4:19 p.m. RD was again restrained by the SOs. Prior to this incident, RD's mother entered room 37. SO #1 stated that he noticed that RD's mother was carrying a bag that appeared to contain prescription medication bottles. RD's mother denies having carried in any medications and suggests that RD was in possession of these medications from the time of admission. As a result of SO #1's perception, Mr. #1 informed Lt. Lt that prescription medications may have been brought into RD's room. Lt. Lt relayed this information to the E.D. Nurse. The E.D. Nurse requested that the Lt. confiscate the medications.

In an effort to confiscate the medications, the SOs approached RD's room. SO #3 entered the room first while the other three SOs waited just outside of the doorway. SO #3 stated that he explained to RD that he needed to take the medications. RD refused to relinquish the medications. SO #2 stated in his interview with VP&A that at one point during SO #3's conversation, RD agreed to relinquish possession of his medications to his mother. However according to SO #1, RD stated that, "he would give them to his mom only, but they would stay in the room." RD's mother acknowledged that she would give the SOs the medications and RD refused to pursue this course.

For under a minute SO #3 continued to ask RD for the medications while the other SOs waited behind SO #3 in the hallway. RD continued to refuse to comply with SO #3's request. SO #3 moved toward RD and reached for the medications. RD got off the bed, where he had been sitting, and moved toward the corner of the room. RD held the medications over his head. SO #2 and SO #3 followed RD as he moved to the corner. The SOs attempted to gain control over the medications by grabbing for them and RD's arms. While SO #3 was pulling on his arm, RD threw the bag of medications toward his mother. In the process the bag of medications knocked off SO #1's eyeglasses.

Eventually the SOs gained control of RD and forced him down on the bed. According to SO #1, "due to my vision I was unable to see well, so I held his head down on the bed till someone could relieve me to retrieve my glasses." According to Mrs. Dyer, SO #1 was holding RD by the neck. Due to the angle of the surveillance tape SO #1's hand positioning was unclear.

While being restrained on the bed by the SOs, RD was searched. The search lasted for approximately three minutes. As a result of the search additional medications, paper, a lighter and matches were recovered.

During interviews conducted by VP&A the SOs gave varying answers as to the threat that RD posed while he remained in possession of the medications.

The Lt. stated that RD had not threatened to eat the medications, was not talking about suicide and was not wielding the bag in a threatening manner. However, the Lt. felt that RD's positioning in the corner of the room was threatening.

SO #3 stated that he did not remember RD making any threats with the bag of medications. Furthermore, SO #3 did not feel that RD's move to the corner was a threat to staff; however he felt that the act of throwing the medications was threatening.

SO #1 was clear in stating that RD did not make any verbal threats to use the medications in any way. Furthermore, SO #1 did not feel that RD's move to the corner was threatening.

SO #2 had no opinion as to whether the bag of medications posed a threat.

### **5<sup>th</sup> Restraint**

The fifth restraint occurred at approximately 6:35 p.m. At this point the SOs were no longer present. An Emergency Medical Technician (EMT) was posted as a sitter<sup>7</sup> for RD. With the EMT's permission RD was sitting on a chair in the hallway outside of his room. The EMT was sitting next to RD. RD can be seen via security surveillance abruptly standing up and heading out of the hallway. Prior to reaching the exit RD was met by SOs #3 and #2. The SOs led RD back to his room under a resistive escort. The details of this encounter were not captured on video surveillance.

### **6<sup>th</sup> Restraint**

The sixth restraint occurred at approximately 8:37 p.m. Prior to the restraint RD was sitting at the nursing station at the end of the hallway. At some point a clerk from the registration department approached and presented RD with admission forms and a pen to use in filling them out. According to the EMT, upon presentation of the paperwork, RD became agitated and began speaking and cursing in a loud voice.

The EMT approached RD in an attempt to diffuse the situation. Soon thereafter RD's parents arrived in the hallway. The EMT noted that the presence of his parents further agitated RD. At 8:35 p.m. the SOs approached RD. With the presence of the SOs there were now six individuals surrounding RD (three SOs, RD's parents, and the EMT). The SOs requested that RD lower his voice. According to reports and interviews with the SOs, RD continued to yell and swear in a loud manner. RD alleges that he was confused by the paperwork and that prior to the confrontation with the SOs he was neither yelling nor cursing. RD goes on to state that one of the SOs stated, "you're going to be in the hospital for a long time."

After brief attempts at calming RD, the Lt. informed RD that his room on Shepardson Six was now available. RD continued to yell and refused to accompany the SOs to Shepardson Six. According to the Lt. at this point the SOs identified that RD was holding a pen. Lt. requested that RD hand over the pen. Lt. then noted that RD began holding the pen in a "threatening manner". Lt. Lt did not note what was threatening

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<sup>7</sup> According to VP&A's interview with the EMT, all EMT's are trained in MOAB for the purpose of sitting with potentially dangerous patients to ensure that the patients do not pose a threat of harm to self or others.

about the manner in which RD was holding the pen. Review of the video does not clarify how the pen was being held.

As a result of the SOs' perception, SOs #1 and #2 initiated a resistive escort while Lt. attempted to remove the pen. RD continued to struggle while being restrained by the two SOs and the Lt. The Lt. ordered handcuffs be applied to RD. As handcuffs were being applied RD broke free. In an attempt to subdue RD the three SOs took him to the ground. According to the Lt.'s statement, "[I]n my attempt to stop the subject from fleeing by grabbing him around the shoulder to slow him down my arm went around his neck and we went to the ground." Upon hitting the ground RD nearly hit his head on a laundry basket in the hallway. After a brief struggle on the ground RD was handcuffed, placed in a wheel chair and escorted to Shepardson Six.

#### **IV. LAW, STANDARDS & POLICY**

FAHC's treatment of patients is governed by several standards of care. These standards include Center for Medicare and Medicaid Services (CMS) Conditions of Participation (COP), the Joint Commission on Accreditation of Health Care Organizations (JCAHO), FAHC's internal policies, and Management of Aggressive Behavior (MOAB) techniques. The remainder of this section will cite the standards that are relevant to VP&A's investigation.

#### **CMS Condition of Participation<sup>8</sup>: Patient's Rights, 42 CFR 482.13(f)**

(1) The patient has the right to be free from seclusion and restraints, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. The term "restraint" includes either a physical restraint or a drug that is being used as a restraint. A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body. A drug used as a restraint is a medication used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition. Seclusion is the involuntary confinement of a person in a room or an area where the person is physically prevented from leaving.

(2) Seclusion or a restraint can only be used in emergency situations if needed to ensure the patient's physical safety and less restrictive interventions have been determined to be

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<sup>8</sup> CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These minimum health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called "deeming") meet or exceed the Medicare standards set forth in the CoPs / CfCs. <http://www.cms.hhs.gov/CfCsAndCoPs/>

ineffective.

- (3) The use of a restraint or seclusion must be—
- (i) Selected only when less restrictive measures have been found to be ineffective to protect the patient or others from harm;
  - (ii) Implemented in the least restrictive manner possible;
  - (iii) Ended at the earliest possible time.
- (B) The treating physician must be consulted as soon as possible, if the restraint or seclusion is not ordered by the patient's treating physician.

(6) All staff who have direct patient contact must have ongoing education and training in the proper and safe use of seclusion and restraint application and techniques and alternative methods for handling behavior, symptoms, and situations that traditionally have been treated through the use of restraints or seclusion.

### **CMS Interpretive Guidelines §482.13(f)**

Handcuffs; manacles; shackles; and other chain type devices are considered law enforcement restraint devices and would not be considered safe appropriate health care restraint interventions for use by hospital staff to restrain patients in hospitals.

### **JHACO<sup>9</sup>**

#### **Standard PC. 12.50**

1. Nonphysical techniques are always the preferred intervention

**Standard PC.1260:** Restraint or seclusion is limited to emergencies in which there is an imminent risk of a patient physically harming himself or herself, staff or other, and nonphysical interventions would not be effective.

#### **Elements of Performance:**

1. Restraint or seclusion is used only when nonphysical interventions are ineffective or not viable and when there is an imminent risk of a patient physically harming him or herself, staff or others
2. The type of physical intervention selected considers information learned from the patient's initial assessment
3. The hospital does not permit restraint or seclusion for any other purpose, such as coercion, discipline, convenience, or retaliation by staff.

**Standard PC. 1270:** A licensed independent practitioner orders the use of restraint or seclusion.

#### **Elements of Performance:**

1. All restraint and seclusion are applied and continued pursuant to an order by the licensed independent practitioner who is primarily

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<sup>9</sup> JCAHO is the national accrediting body for hospitals and other health care delivery organizations.  
<http://www.mlanet.org/resources/jcaho.html#Q1>

responsible for the patient's ongoing care, or his or her licensed independent practitioner designee, or other licensed independent practitioner.<sup>10</sup>

2. As soon as possible, but no longer than one hour after the initiation of restraint or seclusion, qualified staff does the following:

- notifies and obtains an order from the licensed independent practitioner

- consults with the licensed practitioner about the patient's physical and psychological condition

3. The licensed independent practitioner does the following:

- reviews with staff the physical and psychological status of the patient

- supplies an order

**Standard PC. 12.120:** Clinical leaders are told of instances in which patients experience extended or multiple episodes of restraint or seclusion

**Elements of Performance:**

1. The clinical leaders are immediately notified of any instances in which a patient...experiences two or more separate episodes of restraint and/or seclusion or any duration within 12 hours.

**Standard PC.12.160:** The patient and staff participate in a debriefing about the restraint or seclusion.

**Elements of Performance:**

1. The patient and, if appropriate, the patient's family participate with staff members who were involved in the episode and who are available in a debriefing about each episode of restraint or seclusion.

2. The debriefing occurs as soon as possible and appropriate, but no longer than 24 hours after the episode.

3. The debriefing is used to do the following:

- Identify what led to the incident and what could have been handled differently

- Ascertain that the patient's physical well-being, psychological comfort, and right to privacy were addressed

- Counsel the patient for any trauma that may have resulted from the incident

- When indicated, modify the patient's plan of care, treatment and services

## **Fletcher Allen Health Care Internal Policy**

### **Restraint and Seclusion: Behavioral Health/Psychiatric Emergency**

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<sup>10</sup> Because restraint and seclusion use is limited to emergencies (in which an independent licensed practitioner may not be immediately available), the organization may authorize qualified trained staff members who are not licensed independent practitioners to initiate restraint or seclusion before an order is obtained from the licensed independent practitioner.

## *Definitions*

Restraint: The direct application of physical force to an individual, without the individual's permission, to restrict his or her freedom of movement. The physical force may be human mechanical devices or a combination thereof.<sup>11</sup>

Seclusion: Involuntary confinement of a person in a locked room or an area where a patient is physically prevented from leaving.

## *Policy Statement*

Because the use of seclusion and restraint have the potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of an individual's rights, and even death, we will continually explore ways to prevent, reduce and strive to eliminate the use of seclusion and restraint through effective performance improvement initiatives.

The use of seclusion and restraint poses inherent risk to the physical safety and psychological well being of the individual and staff. Therefore, seclusion and restraint will only be used in an emergency, when an individual is at imminent risk of physically harming herself/himself or others, and when non-physical interventions have not been effective, or are not expected to be effective, in maintaining physical safety of the patient and others.

The choice of seclusion or restraint will always be the least restrictive method possible and based on the patient's need.

## *Limiting the Use of Seclusion or Restraint to Emergencies*

Non-Physical techniques are the preferred intervention in the management of behavior. Such interventions may include redirecting the individual's focus, employing verbal de-escalation, and the appropriate use of medication.

The organization does not permit use of seclusion or restraint for any other purpose such as coercion discipline, convenience or retaliation by the staff.

## *Procedure*

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<sup>11</sup> FAHC's policy contains two definitions of restraint. The definition in the body of report is taken by FAHC directly from JCAHO. The following definition also used by FAHC is taken from CMS: Any manual method or physical or mechanical devices that restricts the freedom of movement or normal access to one's body, material or equipment attached or adjacent to the patient's body that he/she cannot easily remove. Holding a patient in a manner that restricts his/her movement constitutes restraint for that patient.

Registered Nurse responsibilities immediately after initiating seclusion or restraint:  
Inform the Resident/Physician of the need for a face to face assessment of the patient and an order for seclusion or restraint.

Physician/Licensed Independent Practitioner responsibilities when a patient is in seclusion or restraint:

- Assess the patient face to face immediately following the initiation of seclusion or restraint
- Review with nursing staff the physical and psychological status of the individual
- Supply staff with guidance in identifying ways to help the individual regain control in order for seclusion or restraint to be discontinued
- Within one hour of the initiation of seclusion or restraint, document the reason for the use of seclusion or restraint, and write an order for the use of seclusion or restraint
- Inform the attending physician of record or the physician covering for the attending of record.

Within 24 hours after the episode of seclusion or restraint, those members of the staff who were involved in the episode and who are present at the time, the patient, the patient's family (if appropriate), will participate in a debriefing about the episode of seclusion or restraint

## **Evaluation and Care of Psychiatric Patients in the Emergency Room**

### *Procedure*

Patients will be asked to disrobe and will be offered a choice of hospital gown or disposable clothing. If appropriate security staff will be called to assist as needed. (this will eliminate the possibility of the patient retrieving a weapon, dangerous implement or drugs from their clothing). NOTE: if disrobing is not an option due to potential traumatic triggers or obvious escalating patient behavior, Security will be contacted to perform a weapons pat down on the patient and remain with the patient.

Bathroom Options – the patient should never be left alone. Below are the options for use of bathroom

- a. Accompany the patient to the bathroom (this may require two staff members – one inside the bathroom and one outside the bathroom to assist.)
- b. Utilize a portable commode in patient's room.

### **Modification of Aggressive Behavior (MOAB)**

MOAB presents principles, techniques, and skills for recognizing, reducing, and managing violent and aggressive behavior. In analyzing the MOAB techniques and other efforts employed by SOs on August 6, 2006, VP&A consulted with MOAB trainer Glen Doulette. Mr. Doulette has over ten years of experience working with psychiatric patients in various hospital settings. He has trained in numerous behavioral intervention

programs and currently holds instructor level certificates in both MOAB and MANDT (an alternative behavioral management system utilized in psychiatric facilities around the country).

## **V. VERMONT PROTECTION & ADVOCACY'S FINDINGS**

VP&A concludes that the FAHC E.D.'s care of RD on August 6, 2006 was deficient in several material respects. These deficiencies resulted in unnecessary delay, distress, trauma, and physical injury to RD. The following sections detail specific findings supporting RD's and VP&A's concerns over his treatment.

### **A. Posting of Uniformed Guards**

VP&A concludes that FAHC's policy of posting uniformed guards outside the room of patients experiencing acute paranoia and other delusional thinking is not best practice. According to FAHC's Psychiatric Resident, using uniformed guards as caretakers is not ideal when dealing with a patient with delusional paranoia. This untrusting relationship can lead to an increase in agitation level, which in turn can result in conflict.

FAHC and HCHS records clearly demonstrate that RD had long record of paranoid ideations. In addition the record demonstrates that FAHC was or should have been aware that RD suffered from delusions and paranoia. RD was a patient with a long-standing and documented history of these symptoms. His most common and documented delusion involved being followed by C.I.A. According to RD's medical records he was currently suffering from this paranoid delusion. RD's August 4, 2006 FAHC E.D. records state clearly that he "continues to have paranoid behavior." (*E.D. Physicians Summary, 8/4/06*) FAHC records from August 6<sup>th</sup> further demonstrate that RD "has had anxiety and been paranoid and had hallucinations and delusions." (*E.D. Nursing Summary, 8/6/06*). In an interview the Psychiatric Resident referred to RD as, "extremely paranoid delusional...afraid of anyone who entered the room."

Despite FAHC's knowledge of RD's paranoid state of mind and the impact that uniformed SOs may have on a patient exhibiting paranoid behavior,<sup>12</sup> FAHC relied on uniformed SOs to manage RD's behaviors. VP&A finds that FAHC disregarded known risks of exacerbation that such a posting entailed. This disregard was a contributing factor in elevating RD's agitation level and ultimately resulted in the ensuing six incidents of restraint.

### **B. Lack of Interaction with Mental Health Providers**

VP&A concludes that mental health providers' interactions with RD and the E.D. staff were insufficient. According to the Psychiatric Resident, treatment of a patient should

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<sup>12</sup> Susan Stefan, "Emergency Department Treatment of the Psychiatric Patient (Oxford University Press 2006) p. 36 & 137 (describing the negative effects that uniformed security officers may have on psychiatric patients).

not wait until the patient reaches a particular unit, rather treatment should begin when the patient enters the hospital. Providers specializing in mental health are better suited to treat an individual suffering acute mental illness than E.D. staff.

Mental healthcare providers' interactions with RD and the FAHC E.D. staff during his nine hours stay in the E.D. were inadequate. After admission RD was not seen by a mental healthcare provider for one hour and thirty minutes. At this point RD was evaluated by Crisis Evaluator #2. RD's next contact with a mental healthcare provider was with Psychiatric Resident. This interaction lasted for less than two minutes. A formal evaluation did not take place until 5:35 p.m. This interaction was nearly six hours and five restraints after admission to the E.D.

Although there were limited contacts between the E.D. and mental healthcare providers, these contacts did not include guidance on dealing with a delusional patient. The contacts were limited to medication requests on two occasions. Despite these requests, there is no documentation suggesting that RD was offered medications. When asked, E.D. staff indicated that treatment of patients with acute mental illness would benefit from better communication between themselves and mental healthcare providers.

VP&A finds that because mental healthcare providers had inadequate contacts with both RD and the E.D. staff, the E.D. operated on model based on detention rather than treatment. This detention model at times disregarded RD's psychological/ psychiatric needs and was a contributing factor to the ensuing restraints.

### **C. Deviations From Requirements of CMS, JCAHO, FAHC's Restraint Policy, and MOAB**

VP&A concludes that several of the physical restraints initiated upon RD were contrary to standards set forth in the Center for Medicare and Medicaid's Conditions of Participation, the Joint Commission on Accreditation on Health Care Organizations, FAHC Policy, and/or Management of Aggressive Behavior guidelines. The following section will analyze the six restraints in accordance with the standards mentioned above.

VP&A considers each of the six incidents described as a restraint under CMS, JCAHO, and FAHC's internal policy because in each incident the SOs physically restricted RD's freedom of movement.

#### **1<sup>st</sup> Restraint**

During the first incident of restraint the SOs reacted to verbalizations made by RD. The SOs describe RD's behavior as "verbally abusive", "cursing", and in general bothersome. The SOs' attempts to negotiate with RD last for only one minute and ten seconds. After being convinced verbally to return to his examination room, RD stopped at the doorway. At this point he was immediately grabbed by two SOs and pushed into the room. After being pushed into his room the SOs closed the door.

### *Threat of Harm and Least Restrictive Measures*

During this incident VP&A finds that RD's behavior did not rise to a level that would justify the use of seclusion or restraint. According to CMS, JCAHO and FAHC's internal policy, restraint and seclusion are only justified if an individual is an imminent threat of harm to themselves or others. Three of the four SOs present during this incident stated that RD did not pose a threat of harm. One of the SOs explained that RD posed a threat in that he stated he could leave the hospital if he wanted. VP&A finds that vague and constant verbalizations, even of a desire to leave the hospital, do not constitute behaviors that threaten imminent harm to self or others.

In addition to RD not being an imminent threat of harm to self or others, VP&A finds that RD was restrained for improper purposes. According to CMS, JCAHO, and FAHC policy, restraints cannot be imposed as a means of coercion, discipline, or convenience. The SOs indicated that their reason in using force in order to keep RD in his room was to comply with nursing staff's direction. This justification for restraint and seclusion is prohibited by CMS, JCAHO, and FAHC's own policy.

In addition to the conclusion that force was not warranted by RD's actions, least restrictive measures were not attempted. According to CMS, JCAHO and FAHC policy, restraint and seclusion may be implemented only when less restrictive measures have been deemed ineffective. In this instance the SOs' attempt at negotiation lasts for only one minute and ten seconds. Despite the fact that negotiations appear to be successful, as evidenced by the fact that RD is talked back to the doorway, once in the doorway the SOs immediately apply force in placing RD on his bed. There is no evidence that the SOs or other FAHC staff attempted to negotiate in order to avoid using force against RD once in the doorway. This immediate use of force by the SOs, absent any indication that RD was an imminent threat, demonstrates the SOs' failure to attempt alternative methods prior to implementing restraint and seclusion.

### **2<sup>nd</sup> Restraint**

During the second incident of restraint RD was standing in the doorway speaking to SO #2, while the other three guards were at the other end of the hallway. The SOs describe RD as loud, abusive, and generally disruptive. RD denies the use of any vulgar or abusive language. According to the SOs, the E.D. staff requested that RD be placed in his room. The SOs attempted to talk with RD for one minute and twenty-two seconds prior to applying force. At this point RD was shoved into his room. The SOs closed and forcibly held the door shut.

### *Threat of Harm and Least Restrictive Measures*

VP&A concludes that in this incident RD's behavior did not rise to the level which would justify the use of seclusion and/or restraints. Other than RD's constant and vague statements that he intended to leave the hospital, all four of the SOs interviewed did not

believe that he posed an imminent threat of harm to himself or others. As such restraint and seclusion were applied contrary to CMS, JCAHO and FAHC policy.

In addition to RD not being a threat of harm to self or others, VP&A finds that RD was restrained for improper purposes. The SOs stated that their use of force in this incident was specifically to enforce the E.D. staff's request that that RD be placed in his room. This explanation leads to the conclusion that the restraint and seclusion were enacted as means of coercion, discipline, and/or convenience, rather than to prevent imminent harm.

In addition to the conclusion that this restraint was not in response to an imminent threat of harm, VP&A concludes that least restrictive measures were not attempted. In this instance the SOs' attempts at negotiation are brief. Negotiations last for only one minute and twenty seconds. According to interviews with the SOs, the negotiations consisted of little more than demanding that RD return to his room. VP&A finds that this short period of negotiation with no evidence that alternatives were offered indicates a lack of alternative solutions to physical restraint and thus a violation of the requirement that least restrictive measures be attempted and deemed ineffective.

### **3<sup>rd</sup> Restraint**

Just prior to the 3rd incident of restraint, RD was in the hallway bathroom. While in the bathroom he pressed the call button and Nurse #2 responded. Upon arriving in the bathroom Nurse #2 described RD's behavior as "agitated". RD stated to Nurse #2 that he did not ring the call bell. In response Nurse #2 walked away from RD and out into the hallway. According to the surveillance video and interviews with FAHC staff, RD appeared to follow Nurse #2 down the hall.

In response the SOs initiated a restraint which resulted in RD being taken to the ground. According to security an improvised technique was required due to the fact that RD had a blanket wrapped around his shoulders. After the SOs gained control over RD, he was lifted to his feet and escorted to his room. Prior to reaching RD's room SO #1 stated that RD was reaching for a pen. As a result RD was placed headfirst on the bed. He was held down on the bed until the pen was removed.

#### *FAHC Hospital Bathroom Policy for Psychiatric Patients in the E.D.*

VP&A concludes that this restraint was implemented in part due to FAHC staff's failure to conform to hospital policy. According to FAHC hospital policy, a psychiatric patient should never be left alone. Furthermore, policy dictates that when a patient uses the bathroom, he/she should be accompanied by one or more FAHC staff or be provided a portable commode. In this instance RD attended the bathroom without staff supervision. This violation of policy clearly set the stage for the situation leading up to the ensuing restraint.

#### *Improper MOAB Technique*

Towards the end of the restraint the guards placed RD's legs in a scissor hold to compensate for lower body movement. According to Mr. Doulette this hold is not taught by MOAB and should not be applied or be necessary if MOAB technique is applied correctly. MOAB teaches extending an individual's arms beyond a 45-degree angle. This technique ensures that the individuals applying a restraint are safely away from the legs. Applying the scissor hold can lead to several negative consequences, including compromising the knee joints as well as pressure on the abdomen which could place the individual at a higher risk for asphyxia.

#### **4<sup>th</sup> Restraint**

The fourth restraint occurred approximately four and a half hours after RD's admission into FAHC. At nursing staff's direction the SOs were asked to remove a bag of medications that RD's mother had brought into the examination room. After a brief discussion with RD concerning handing over the medications, SO #3 escalated the situation by approaching and attempting to grab the bag out of RD's hand. At this point RD stood up and moved to the corner of the room. The SOs followed RD to the corner of the room and a physical restraint ensued. At some point during this restraint RD threw his bag of medications. Even after RD had disposed of the medications the restraint continued. RD was eventually taken down chest first onto his bed. At this point the SOs searched RD for approximately three minutes.

#### *Threat of Harm and Least Restrictive Measures*

VP&A concludes that in this incident neither the presence of RD's medications nor his behavior justified the use of restraints. According to the witnesses to this incident RD did not threaten to eat the medications. When asked what threat RD posed the SOs stated that they did not believe that the medications posed a threat of harm. Furthermore, at the time of the incident the fact that the SOs were posted outside of RD's room and the fact that RD's mother was in his room made it extremely unlikely that RD would have been able to harm himself by taking the medications. Due to the fact that no staff member perceived an imminent threat and the unlikelihood that RD would have been able to harm himself with the medications, even if he wanted to, VP&A concludes that RD's possession of the medications did not pose an imminent threat of harm to himself or others.

VP&A finds that at no point following the SOs' attempts to secure the medications did RD pose a threat of harm to self or others. Two of the SOs felt that RD posed a threat of harm during different points of this incident. The Lt. felt that RD's position in the corner by itself posed a threat of harm because it constituted a strategic advantage. SO #3 felt that RD's act of throwing the bag with his medications in it during the struggle rose to the level of behavior that threatened imminent harm to the SOs. VP&A disagrees with the SOs' interpretations of RD's threat levels in both instances.

VP&A concludes that once RD relieved himself of the medications the original purpose behind the restraint had ended and so too should have any further restraints. According

to CMS, JCAHO and FAHC policy, once the threat of harm subsides so too should the use of restraints. Contrary to this rule, FAHC staff continued to restrain RD. RD was forced onto his bed and searched for a period of just under three minutes.

In addition to the conclusion that this restraint was not in response to a threat of harm, VP&A also concludes that least restrictive measures were not attempted. In this instance the SOs' attempts at negotiation last for forty-two seconds prior to their attempting to reach for the bag of medications. Forty-two seconds, without a threat of imminent harm, is an insufficient amount of time to constitute an attempt at using least restrictive measures. This limited amount of time is even more egregious considering that alternatives, such as handing the medications to his mother, were suggested and not properly explored. As a result of the extremely brief de-escalation period in conjunction with the SOs' failure to explore alternatives, VP&A finds that the SOs did not attempt less restrictive alternatives in violation of CMS, JCAHO, and FAHC's internal policy.

VP&A respects and acknowledges the logic in a policy aimed at preventing delusional or suicidal patients from possessing their medications while being involuntarily detained in the E.D. However in this case neither RD's possession of medications nor his actions posed a threat of imminent harm to self or other. At one point the basis for the restraint had ended. Despite RD's relinquishment of control of his medications the use of force escalated. In the end RD was restrained for a period of just under three minutes. This restraint was traumatizing for RD and was contrary to CMS, JCAHO standards and FAHC policy.

#### *Improper MOAB Technique*

VP&A concludes that SOs deviated from MOAB in its restraint of RD. During this incident SOs attempted to initiate a MOAB restraint and RD resisted. At various times throughout the incident the four SOs positioned themselves on top of RD. While holding RD in this position the SOs applied pressure to RD's shoulder area. While pressure was being applied, the SOs were holding RD's arms behind his back. This position is unnecessarily dangerous to a patient as it can put an individual at risk for positional asphyxia. MOAB teaches an alternative prone position which involves the individual's arms being extended away from their body.

#### *FAHC Disrobing and Search Policy for Psychiatric Patients in the E.D.*

VP&A concludes that the search which resulted from the restraint was contrary to FAHC policy. According to FAHC policy a psychiatric patient is required to disrobe upon admission in the E.D. FAHC policy goes on to state that, "[i]f disrobing is not an option due to potential traumatic triggers or obvious escalating patient behavior, Security will be contacted to perform a weapons pat down on the patient and remain with the patient." RD was not required to disrobe upon admission. According to the E.D. Nurse this decision was made due to RD's agitated behavior. Although the SOs were called to guard RD, they did not conduct the required search. Such a search may have alleviated any need to conduct the search which occurred during this incident. VP&A believes that

this search was conducted at an inopportune time and resulted in unnecessary trauma to RD.

### **5<sup>th</sup> Restraint**

The fifth incident of restraint occurred approximately seven hours after RD's admission into FAHC. Prior to this restraint the SOs had been relieved of their duty to remain with RD. The EMT gave RD permission to sit in a chair in the hallway. Several minutes after taking his seat, RD stood up from his chair and headed towards the E.D. exit. The SOs met RD at the exit and escorted him back to his room via resistive escort. This restraint was not captured on surveillance video.

#### *Inconsistent Application of Policy*

VP&A concludes that this restraint was partially the result of FAHC's inconsistent application of its internal policies. During VP&A's interviews with FAHC employees, all interviewees questioned stated that the general policy is to restrict all patients to their respective rooms. Despite this policy, at different times and at the will of different individuals RD was given permission to leave his room. These inconsistencies may have led to RD being confused about his ability to leave his room. At one point RD was allowed to leave his room and interact with E.D. staff. At other points he was being forcefully placed in his room by the same staff. VP&A does not advocate for a policy which restricts patients to their room (especially if they are being held in the E.D. for lengthy periods); however VP&A does believe that all FAHC policies should be consistent so that patients know what to expect. VP&A concludes that inconsistent policy enforcement that RD was exposed may have led to confusion which ultimately resulted in this and other episodes of restraint.

### **6<sup>th</sup> Restraint**

The sixth incident of restraint occurred just prior to RD's transfer to Shepardson Six. RD was seated at the nursing station at the end of the hallway. Approximately seventeen minutes prior to the restraint, a clerk from admission presented RD with a pen and admission paper work. Upon presentation of the admission paperwork RD became agitated and according to reports began speaking loudly. Between the time RD was presented with the registration paperwork until just before the restraint there were up to six people surrounding RD. These people included the EMT, RD's parents, and eventually three SOs.

Upon approaching the SOs requested that RD lower his voice. At some point the SOs identified that RD was holding a pen in a threatening manner. Due to this perception the Lt. attempted to gain control RD's left arm. At the same time SOs #1 and #2 initiated a resistive escort. Shortly thereafter Lt. ordered that handcuffs be applied to RD. As the SOs attempted to apply the handcuffs, RD broke free of the escort hold. In an attempt to subdue RD, the SOs took him to the ground. During the takedown Lt. held RD around the neck. Upon hitting the ground RD nearly hit his head on a laundry basket in the

middle of the floor. After a brief struggle on the floor, RD was handcuffed and escorted by the SOs to Shepardson Six.

#### *Interaction with Admission Clerk*

VP&A concludes that the admission clerk's contact with RD resulted in increasing his agitation level which contributed to this incident of restraint. According to 42 CFR 482.13(f)(6), "all staff who have direct patient contact must have ongoing education and training in the proper and safe use of seclusion and restraint application and techniques and alternative methods for handling behavior, symptoms, and situations that traditionally have been treated through the use of restraints or seclusion." According to information received from FAHC Risk Management, the admission clerk did not have proper training in the use of restraint and seclusion or techniques and alternative methods for handling behavior, symptoms, and situations that traditionally have been treated through the use of restraints or seclusion. Such training would likely have had a significant impact on how this clerk approached and interacted with RD. As a result of his contact with the admission clerk RD's agitation level rose and the situation ended in restraint.

#### *Staff Supplying RD with a Pen*

VP&A concludes that FAHC's negligence in providing RD with a pen was a direct cause of this restraint. RD's possession of a pen had directly led to a prolonged restraint earlier in the day. Despite this FAHC staff provided RD with a pen. According to the Lt. this restraint was initiated due the threatening manner in which he perceived RD to be holding the pen. VP&A suggests that providing RD with a pen given his specific situation was unacceptable and in this instance directly led to the ensuing struggle and subsequent restraint.

#### *Failure of Security to Use adequate De-escalation Techniques*

VP&A concludes that prior to this incident of restraint least restrictive measures were not attempted. In this instance the SOs' attempts at negotiation last for only two minutes and five seconds prior to initiating restraints. In addition to this short period of time the SOs' de-escalation techniques were ineffective. According to interviews and reports the SOs' presence was in response to complaints, by other patients, of foul and loud language. The SOs' attempts at de-escalation appear to be limited to attempts at quieting RD down and encouraging him to go to the psychiatric unit. While both the records and interviews identified RD's confusion over the requirements of the paperwork as being obvious at the time, neither source indicates any effort was made to engage RD about those concerns as part of the de-escalation process. In addition to ineffective de-escalation techniques RD alleges that one of the SOs engaged in improper behavior. According to RD an SOs stated, "your going to be in the hospital for a long time."

#### *Improper MOAB Technique*

VP&A concludes that several of the techniques used during this restraint were not MOAB compliant. First, prior to initiating contact with RD, staff should have removed potentially dangerous objects from the area (i.e. laundry container). By not clearing the area RD was subject to unnecessary risk of injury. Next, the SOs' positioning gave the appearance of cornering RD. According to Mr. Doulette, cornering a psychiatric patient can lead to an increase in a patient's agitation level. Third, while in the process of taking RD to the ground the SOs should have let go of at least one of his arms so that he could protect his head. This safety measure is explicitly taught by MOAB. Failing to release patient's arms again exposes a patient to unnecessary risk of injury. Fourth, one of the guards applied a headlock hold. This hold is not taught nor recommended by MOAB due to the unnecessary risk of injury that could be inflicted on a patient. Finally, RD's legs were again placed in a scissor hold. This technique is not taught by MOAB and can lead to unnecessary damage to the knee joints and places pressure on the abdomen which could place the individual at a higher risk for asphyxia.

#### *Use of Handcuffs*

VP&A concludes that the use of handcuffs on any patient in any hospital setting by a hospital staff member is contrary to standards regulating hospitals participating in Medicaid and Medicare programs. According to CMS's interpretive guidelines, "handcuffs; manacles; shackles; and other chain type devices are considered law enforcement restraint devices and would not be considered safe appropriate health care restraint interventions for use by hospital staff to restrain patients in hospitals." RD was handcuffed and escorted through the hospital by FAHC employed SOs. This clearly demoralizing treatment is directly addressed and prohibited by the interpretive guidelines.

#### **D. Failure to Comply with Procedural Requirements**

FAHC policy uses both CMS and JCAHO's definition of restraint. In both of those definitions application of manual force is considered a restraint if it restricts an individual's access to one's body. FAHC's policy is more precise in that it states that "holding a patient in a manner that restricts his/her movement constitutes restraint for that patient."

When a restraint is applied, several procedural requirements are triggered under CMS, JCAHO and FAHC policy. VP&A finds that FAHC disregarded several of these requirements in each incident of restraint.

#### *Restraint Order*

VP&A concludes that during each incident of restraint FAHC E.D. staff failed to obtain an order of restraint from the treating physician. According to JCAHO, standard PC. 1270, a licensed practitioner must order the use of restraint or seclusion. The authors of JCAHO recognized the impractical nature of obtaining an order prior to seclusion or restraints in emergency situations. As such according to a footnote to PC. 1270, "the organization may authorize qualified trained staff members who are not licensed

independent practitioners to initiate restraint or seclusion before an order is obtained from the licensed independent practitioner.” Despite the fact that a restraint may be initiated without an order, JCAHO requires that as soon as possible, but no longer than an hour after the initiation of a restraint a qualified staff member must obtain an order from the licensed independent practitioner.

On August 6, 2006, RD was subjected to several manual interventions, which would qualify as restraints under CMS, JCAHO and FAHC policy. The restraints were carried out by the SOs either at their own will or at the will of the nursing staff. There is no indication that either the SOs or the nursing staffs are practitioner designees. Even assuming the SOs and nursing staff were considered practitioner designees, VP&A finds that there is no indication in FAHC records of the required order from a licensed independent practitioner.

#### *Consultation with Licensed Practitioner/Treating Physician*

VP&A concludes that contrary to law and policy FAHC E.D. staff failed to consult a licensed practitioner/treating physician after the initiation of restraint. CMS, JCAHO and FAHC policy require that a treating physician/licensed practitioner be consulted as soon as possible after a restraint is initiated. JCAHO requires that this consultation occur within one hour of the restraint and that the licensed practitioner review with the staff the physical and psychological status of the patient. Despite these requirements VP&A found no indication in the records that either a treating physician or a licensed practitioner was consulted. VP&A’s interview with FAHC E.D. staff confirmed this finding. Staff members interviewed indicated that there were no meaningful contacts between themselves and qualified mental health staff regarding each incident of restraint. Furthermore, many of the interviewee’s felt that they could benefit from increased contacts and guidance from mental healthcare providers. Consultations between staff and a licensed practitioner could have proved meaningful in helping staff to deal with RD’s mental state and related disruptive behaviors.

#### *Face to Face Evaluation*

VP&A concludes that FAHC violated internal policy by not having a physician conduct an immediate face to face evaluation with RD after each incident of restraint. According to FAHC policy after initiating a restraint a registered nurse must inform a resident or physician of the need for a face to face evaluation of the patient. There is no indication in the records that after the restraints a nurse informed a resident or physician of the need for a face to face evaluation. FAHC Resident The Psychiatric Resident and P.A. #2 each indicated that they were not even aware that several of the incidents of restraint had occurred.

#### *Multiple Restraint Requirements*

Contrary to JCAHO standards, FAHC E.D. staff failed to notify clinical leaders regarding the reoccurring restraints. According to standard PC. 12.120 clinical leaders must be

immediately notified when a patient experiences two or more episodes of restraint within a twelve-hour period. RD experienced six episodes of restraint within a nine-hour period. Despite this there was no indication in the records that clinical leaders were notified

### *Debriefing*

There is no record in FAHC's files indicating that any debriefing took place. According to both JCAHO and FAHC policy a debriefing must occur within 24 hours of an episode of seclusion or restraint. That debriefing must include the members of the staff who were involved in the episode, the patient, and the patients' family (if appropriate). Finally the debriefing's purpose is to identify what led to the incident and what could have been handled differently, counsel the patient for trauma, and to ascertain the patient's well being and psychological comfort.

RD was subjected to six episodes of restraint, each of which met CMS, JCAHO, and FAHC's definition of restraint. After RD was escorted to Shepardson Six there was a meeting between the Hospital Supervisor, RD's parents and the Lt. For two reasons this meeting did not comply with the requirement for a debriefing as intended by JCAHO. First, several of the attendants required by FAHC policy were not present. Missing from the meeting was RD and a majority of the staff members involved in the restraint. Second, the purpose of the meeting was to address RD's parents concerns and not to analyze the restraint.

### **E. Documentation**

VP&A finds FAHC staff's documentation to be inadequate in several instances. First, FAHC staff failed to document injuries inflicted on RD during his stay. On August 8, 2006, a VP&A advocate visited with RD on the inpatient psychiatric unit. During this visit it was noted that RD had sustained several bruises on his wrists and upper arms. Despite the presence of bruising our advocate found no documentation of these injuries in either the E.D. or inpatient psychiatric records.

Second, the E.D. staff's documentation surrounding medication orders is unclear. In its review of this incident Vermont Protection & Advocacy could not decipher when medications were ordered, if and when they were administered, and if not, why. Furthermore, FAHC E.D. staff members, in their interviews with VP&A, were unable to clarify these issues. While VP&A does not advocate for the application of involuntary medications, we do advocate for clear and complete documentation when they are considered and ordered.

Finally, E.D. staff failed to appropriately document instances of restraint. There is no mention in the medical records, other than the incident reports, of four of the six restraints. Furthermore, there is not mention in any of the records of the first two restraints. In each of the first two incidents RD was shoved into his room while in his doorway. Without the security surveillance there would be no record of these incidents.

## **F. Peer Review Process**

REDACTED. Pursuant to federal law and a consistent agreement with FAHC, VP&A cannot comment on any peer review process that FAHC may have engaged in regarding the incidents relevant to this report. In the event such review occurred, VP&A would use this section to communicate our findings regarding that process to FAHC as permitted under both the federal law and our agreement with FAHC.

## **VI. CONCLUSION**

After a thorough investigation of RD's August, 6 2006 E.D. stay, VP&A concludes that FAHC violated: Internal Policy, JCAHO Accreditation Standards, CMS Conditions of Participation, and MOAB Protocol. The above violations resulted in both physical injury and trauma to RD. The remainder of this report will provide recommendations aimed at preventing injury to future patients with mental illness who visit the FAHC E.D. We strongly suggest that FAHC administration review and establish time periods within which to implement these recommendations.

## **VII. RECOMMENDATIONS**

- 1) Develop capacity to use staff other than uniformed security officers to monitor and interact with patients suffering from acute mental illness in the E.D. Develop and implement policies describing utilization of such resources.
- 2) Change the E.D. model for psychiatric patients from a detention based model to treatment based model. This change would require more interactions between mental health staff and patients and increased contacts between the E.D. staff and psychiatry and/or mental health care practitioners.
- 3) Additional and intensified training for security officers on legal standards regarding restraint and seclusion. This training should provide staff with: 1) an understanding of the legal definition of a restraint and seclusion, 2) an understanding of when restraint and/or seclusion may be implemented, 3) the requirement of using least restrictive measures, and 4) an understanding of the importance of de-escalation techniques in this process.
- 4) Additional and intensified training for all relevant staff on the procedural legal requirements triggered after restraint and or seclusion is implemented (Physician's order, consultation, face to face evaluation, and debriefing).
- 5) Additional and intensified training for all relevant FAHC (i.e. security officers, nurses, physicians, and "sitters") staff on ED Policies (bathroom policy, search policy).

- 6) Create a new training curriculum and adequately train on a policy that restricts agitated psychiatric patients access to pens or other items that could be perceived as a weapon and justify initiating restraint.
- 7) Stress with staff the importance of consistency of policy application (room restriction policy).
- 8) Re-training of all relevant staff in behavioral management techniques. Preferably in a system that furthers the goal of a seclusion and restraint free environment.
- 9) Immediately cease the use of handcuffs/shackles/leg irons on patients.
- 10) Make sure that all FAHC employees who have contact with a patient suffering from an acute mental illness have training in the proper and safe use of seclusion and restraint application and techniques and alternative methods for handling behavior, symptoms, and situations that traditionally have been treated through the use of restraints or seclusion
- 11) REDACTED.
- 12) Overall improvements in documentation. VP&A recommends that the importance of accurate and detailed documentation be discussed and improvements be assured by review, perhaps by an outside entity engaged specifically for that purpose.
- 13) Review, and revise as necessary, all ED policies and procedures to deliver services that are sensitive and responsive to the needs of trauma survivors. An effort should be made to reduce or eliminate any potentially re-traumatizing practices such as restraint/seclusion and involuntary medication. One way this can be accomplished is by creating an individualized de-escalation plan to identify triggers, warning signs, and behavioral strategies.
- 14) Written apology to RD and his parents for the mistakes and missed opportunities apparent in FAHC's treatment of him on August 6, 2006 and the subsequent distress and difficulties those incidents have caused and may continue to cause him in the future.