

Physical Restraints: Court Says Nurses' Temporary Use Of Posey Vest Not Patient Abuse.

An nursing home resident had become agitated, and was burning himself by putting lit cigarettes in his pants pockets. He tried to eat objects such as plastic pudding containers, began scratching himself to the point of causing open sores on his arms, and smeared his feces on himself and the walls of his room.

For a nurse to place a patient temporarily in a posey vest to prevent self-harm is not patient abuse. The vest was discontinued when the nursing home's medical director declined to order physical restraints on an on-going basis.

However, the medical director ratified the nurse's decision after the fact as appropriate action in an emergency situation.

SUPREME COURT OF WASHINGTON, 1996.

According to the Supreme Court of Washington, the nursing home had a sound policy of allowing nurses to use their professional judgment in applying physical restraints to patients in emergencies to prevent patients from harming themselves, provided the nurses' decision was promptly reviewed by the nursing home's medical director, and provided further that restraints would be discontinued if the medical director refused to order physical restraints continued. The court said a staff member who claimed she was fired for reporting this incident as abusive had no basis for a wrongful-discharge lawsuit. White vs. State of Washington, 929 P. 2d 396 (Wash., 1996).

Elopement Risk: Psych Facility's Staff Faulted For Patient's Escape, Suicide.

When a psychiatric patient has been assessed as potentially suicidal, suicide and elopement precautions must be undertaken at once.

If the patient is on an "open" psych unit, this may mean initiating a transfer to a more secure setting. In the mean time, the doors to the facility should be locked.

A suicidal patient should be monitored continuously or physically secluded pending transfer to the security of a locked setting.

A patient's suicidal condition and elopement risk must be communicated at once to all staff members.

All staff who have keys to the unit, physicians, nurses, counselors and non-professionals, whether or not they are assigned to care for that patient, are responsible for preventing the patient's escape.

All staff must be taught that any time they unlock a door, especially in a setting where the doors normally are not locked, the potential exists for a patient to elope whose safety from self-harm may be compromised by elopement.

COURT OF APPEALS OF TEXAS, 1995.

There were two doors between the psych unit and the outside. An alert patient bent on elopement could dash through one door with relative ease as it was unlocked from the inside or the outside by a staff member, but it would be almost impossible to get past both doors, if both were locked and staff were properly vigilant. It was an "open" unit, and normally neither door was locked.

However, in a recently-published court opinion from the Court of Appeals of Texas, despite the fact that a patient had been assessed by the psychiatric medical staff as a potential elopement and suicide risk, only the outer door was locked. Between the two doors were the phones the patients used. The patient in question, who had not been secluded and was not being closely watched while arrangements were being made to transfer him to a locked facility, walked out and pretended to use the phone. When the unit secretary unlocked the outer door from the outside, to get her purse so she could go to lunch, the patient made his escape.

Staff from the facility and the police went after him, but only got close enough to watch him run out on an Interstate highway to be struck by a truck and killed. The court ruled the family had the right to bring a lawsuit against the facility and its staff.

According to the court, doors must be securely locked and all staff must be notified when a patient is an elopement and suicide risk. The responsibility for informing all the staff starts with the physician or other professional who makes the assessment, and extends to all professional and non-professional staff who are warned, whether or not the patient has been assigned as theirs to care for. Physical seclusion and close or continuous monitoring are also advisable in addition to locking the doors securely and alerting all the staff, the court ruled. Bossley vs. Dallas County Mental Health and Mental Retardation, 934 S.W. 2d 689 (Tex. App., 1995).