Healthcare Inspection

Use of Restraints
Salem VA Medical Center
Salem, Virginia
To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/contacts/hotline.asp)
Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding the use of restraints at the Salem VA Medical Center (the facility), Salem, Virginia. A complainant alleged that a nurse made comments that provoked a patient into striking two staff members which resulted in the patient being kept in restraints as punishment for more than 24 hours, and that facility leadership did not respond to past reported allegations of other patient mistreatment.

We did not substantiate the allegations. We found no evidence that a nurse provoked the patient to act out, or that the patient was kept in restraints as a form of punishment. The initiation and continued use of restraints was appropriate and adequately documented to ensure the patient’s and staff members’ safety.

We found that facility leaders investigated the patient’s mistreatment allegations and determined that no further action was required.

We identified an opportunity to improve the observation and 15-minute check sheets used for patients in restraints. We discussed this with facility leaders while on-site. Therefore, we made no recommendations.
TO: Director, Mid-Atlantic Health Care System (10N6)

SUBJECT: Healthcare Inspection – Use of Restraints, Salem VA Medical Center, Salem, Virginia

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) reviewed allegations of inappropriate restraint usage and improper management actions on the mental health unit at the Salem VA Medical Center (the facility) in Salem, VA. The purpose of the review was to determine whether the allegations had merit.

Background

The facility provides a broad range of inpatient and outpatient medical and mental health care services and serves as a commitment facility for long-term mental health patients with complex diagnoses. The facility is part of Veterans Integrated Service Network 6 and serves a veteran population of approximately 112,500 throughout southwest Virginia.

A commitment facility is specifically designed and staffed to evaluate, manage, and treat patients who are committed both voluntarily and involuntarily. Involuntary commitment is the process whereby individuals who are a danger to themselves or others, may, under state law, be temporarily detained and placed in a hospital setting for psychiatric evaluation and treatment.

A physical restraint is any physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a person to move his or her arms, legs, body, or head freely. The most common types of physical restraints are belts and soft wrist restraints which are used to restrict freedom of movement and are designed to prevent injury to the patient or others. Restraints should only be used after other options have been tried without success.

1 The American Psychiatric Nurses Association, May 2000; Revised May 2007
When restraints are necessary to control potentially harmful or dangerous behavior, The Joint Commission (TJC) and local policy require that:

- The patient is informed of the behavioral criteria he or she needs to meet in order for the restraints to be discontinued.
- The physician assesses the need for and re-orders restraints every 4 hours.
- Nursing personnel (registered nurses) assess the patient and document their observations every 2 hours.
- Nursing personnel (nursing assistants and/or licensed practical nurses) observe and document the patient’s behaviors every 15 minutes, and document services provided to meet the patient’s physical needs (e.g. toileting and feeding).

On October 10, 2011, OIG received a complaint alleging that:

- A nurse made comments that provoked a patient into striking two facility staff members.
- This same patient was then kept in restraints as punishment for more than 24 hours.
- Facility leadership did not respond to reported allegations of other patient mistreatment in the past.

The complainant also reported that because staff were intimidated, they entered false documentation into the patient’s record. However, we were unable to evaluate this allegation further as the complainant was unable to provide specific information or examples supporting this claim.

**Scope and Methodology**

We conducted a site visit November 14–15, 2011. Prior to our visit, we reviewed relevant facility and Veterans Health Administration (VHA) policies, directives, and handbooks; select patient medical records; quality assurance documents; VA police and patient advocate reports; staff training records; and TJC standards related to restraint use on mental health care units. While onsite, we interviewed the Mental Health Service Chief, the subject nurse, an attending physician, a case manager, and other clinical and administrative staff knowledgeable about the issues. In addition, we toured the inpatient mental health unit.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.
**Case Summary**

The patient is a male in his early 30s with a past mental health history significant for schizoaffective disorder–bipolar type. He was most recently hospitalized at a non-VA psychiatric center since early September 2011, under an involuntary commitment temporary detainment order for aggressive behavior and psychosis.

In early October 2011, the Chief of Mental Health accepted the patient for transfer from the non-VA psychiatric center to the facility’s locked inpatient mental health unit. The involuntary commitment temporary detainment order remained in effect.

The following day, the Sheriff’s department in the originating city transported the patient to the facility’s emergency department (an approximately 5 hour drive) where he was directly admitted to the locked inpatient mental health unit. VA police officers escorted him to the locked inpatient mental health unit; he arrived between 1:00 a.m.–2:00 a.m. According to the progress notes, the patient was exhibiting psychotic symptoms and was irritable and uncooperative. The mental health provider continued all of the patient’s current medications, and wrote orders for olanzapine (an antipsychotic medication) PRN (as needed) and for staff to observe the patient every 15 minutes.

To avoid disturbing the other patients, the charge nurse assigned the patient to a private sleeping room near the nurses’ station for the night (the room did not have a bathroom). Nursing staff documented that the patient slept/rested for more than 4 hours that night, but that he refused breakfast. The record reflected, “Progression toward treatment goals: no insight, needs re-direction; compliant with medications.” The following morning, the day shift charge nurse and the subject nurse approached the patient to facilitate moving him to a different room. The subject nurse told us the patient was “eerily spooky acting” when she was attempting to talk with him.

At about the same time (around 9:00 a.m.), a nurse administered most of the patient’s medications; however, he refused to take an anti-seizure medication prescribed for mood stabilization and depression. Because staff were familiar with the patient and knew of his aggressive, challenging, and non-compliant behavior, they took precautions to have two VA police officers stand-by on the unit. Further, the police officers’ presence would ideally be enough to persuade the patient to remain calm and take his medication.

Because the subject nurse knew the patient from a previous admission, she believed that he responded better to coaxing rather than being told what to do. The attending physician also approached the patient and reminded him that he needed to refrain from aggressive behavior and comply with the medication orders. When one of the officers started walking towards the patient in an attempt to speak with him, the patient turned without provocation and struck a male nurse, then struck the officer. Staff were able to subdue the patient, and the attending physician ordered 4-point restraints (plastic devices attached with Velcro to the wrists and ankles and secured to the sides of the

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2 A mental health condition that causes both a loss of contact with reality [psychosis] and abnormal mood states.
bed) to prevent further harm to staff or the patient. An order for restraints automatically requires nursing reassessment every 2 hours, one on one observation (within arm’s reach of the patient at all times), and 15-minute checks.

The following day, staff determined the restraints could be removed as the patient contracted for safety (he agreed that he would come to staff if he started hearing voices telling him to harm himself or others). The provider wrote orders to discontinue the restraints, and the patient remained restraint free for the remainder of his 30 day hospitalization. He nevertheless continued to demonstrate aggressive behavior and pushed limits which resulted in the restriction of his privileges. The patient was ultimately discharged to the care of his mother with plans for mental health follow-up. However, he was readmitted 3 days later to the facility’s locked inpatient mental health unit.

**Inspection Results**

**Issue 1: Nurse’s Actions**

We did not substantiate that the subject nurse provoked the patient or intimidated staff. The subject nurse and attending physician told us that they were familiar with the patient from a previous admission and he responded better to coaxing. Therefore, they attempted to explain the plan to move him to a more suitable room, and the need for him to refrain from aggressive behavior and comply with medication orders. This was a reasonable approach that had been effective with this patient in the past. We interviewed all of the staff members who were present during the encounter. None of them described the subject nurse’s actions as provocative or expressed concern about how the event was handled.

A large majority of the unit’s staff members and the Nurse Executive for Mental Health told us the subject nurse was doing a good job and they supported her efforts. We found no evidence that staff felt intimidated, and as a result, could not adequately perform their jobs.

**Issue 2: Use of Restraints**

We did not substantiate that the patient was kept in restraints as punishment. The patient met criteria for initial restraint use as he was a danger to himself and others when he became combative and struck staff members without provocation. When the patient refused medication, the subject nurse and attending physician attempted to de-escalate the situation by coaxing the patient to comply with expectations, an approach that had been successful with this patient in the past. Once the patient struck the employees, however, less restrictive techniques were no longer appropriate.

We found that the patient met criteria for continued use of restraints as he would not contract for safety and continued making verbal threats toward staff. The attending physician assessed the patient every 4 hours and re-ordered the restraints accordingly. Nurses assessed the patient every 2 hours and documented as required. Nursing
assistants documented the patient’s vital signs and activities of daily living every 15 minutes while providing one-on-one observation, as required by policy.

We found that the initiation and continued use of restraints was appropriate to ensure the patient’s and staff members’ safety.

**Issue 3: Facility Leaders’ Responsiveness**

We did not substantiate that facility leaders did not respond to allegations of patient’s mistreatment on the inpatient mental health unit. There were two other reported cases of patient mistreatment for the inpatient mental health unit in the past 5 years. The subject nurse was accused of using excessive force while placing the patients in restraints. The acting Nurse Executive for Mental Health Service and the Risk Manager investigated the allegations and spoke with the patients, interviewed staff, and reviewed the medical records. They determined that the allegations had no merit and no further action was required.

**Issue 4: Nursing Assessment Template**

The use of restraints can impact the physical safety of patients. The patient was restrained for 29 hours. TJC and local policy both state that “an assessment of the circulation and skin must occur when appropriate to ensure that the restraints are properly applied.” Staff told us the 15-minute checks included assessments of range of motion of the extremities and circulation checks; however, we found minimal documentation that range of motion was assessed or that his skin and circulation were checked. Further, the patient observation and 15-minute check sheets were unclear, difficult to read, and were not scanned into the medical record until after the patient was discharged.

This patient did not suffer any adverse skin or circulation problems while in restraints. Nevertheless, nursing staff should consistently document patient care and safety measures (such as the appropriate release of a patient’s limbs) that improve patient outcomes and uphold patients’ rights.

**Conclusions**

We did not substantiate the allegations. We found no evidence that the subject nurse provoked the patient to act-out, or that the patient was kept in restraints as a form of punishment. The initiation and continued use of restraints was adequately documented and appropriate to ensure the patient’s and staff members’ safety.

We found that facility leaders investigated the patient mistreatment allegations and determined that no further action was required.
We identified an opportunity to improve the observation and 15-minute check sheets used for patients in restraints. We discussed this with facility leaders while on-site. Therefore, we made no recommendations.

**Comments**

The VISN and the Facility Directors agreed with the report.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for Healthcare Inspections
Department of Veterans Affairs

Memorandum

Date: February 13, 2012
From: Network Director, VA Mid-Atlantic Health Care Network, VISN 6 (10N6)
Subject: Healthcare Inspection–Use of Restraints, Salem VA Medical Center, Salem, Virginia
To: Director, Atlanta Office of Healthcare Inspections (54AT)
Thru: Director, VHA Management Review Service (10A4A4)

1. Your draft report outlining the use of restraints at the Salem VA Medical Center has been reviewed and accepted.

2. An opportunity to improve the documentation associated with restraint/seclusion care was clearly identified and our Salem facility promptly took action to correct the matter. The findings otherwise validated the exceptional care provided to veterans at Salem VA.

3. A sincere thank you is extended for the time and resources your agency offered to complete a thorough and objective review at Salem. The trust you have in the care and services given to veterans has great meaning for all concerned.

(original signed by:)
DANIEL F. HOFFMANN, FACHE
Facility Director Comments

Department of Veterans Affairs Memorandum

Date: February 13, 2012

From: Director, Salem VA Medical Center (658/00)

Subject: Healthcare Inspection–Use of Restraints, Salem VA Medical Center Salem, Virginia

To: Director, Mid-Atlantic Healthcare System (10N6)

1. Thank you for recently visiting the Salem VA Medical Center. We were proud to showcase our facility and staff to your representatives.

2. Salem VA Medical Center gladly seeks opportunities to improve our care and services; therefore the observations of your team were found to be very constructive and useful. Soon after the November 2011 site visit, the Nurse Manager on our acute psychiatric ward initiated a service-level workgroup to review the restraint/seclusion assessment sheet. The group has redesigned the assessment form, incorporating the suggestions offered by your team. The revised form should be ready for implementation within the next 30 days.

3. Please contact the Mental Health Associate Chief Nurse, Linda Riffel, at 540-982-2463, extension 1808 with any questions you may have concerning our efforts to improve restraint/seclusion documentation.

(original signed by):
Miguel H. LaPuz, MD, MBA
Director, Salem VA Medical Center (658/00)
OIG Contact and Staff Acknowledgments

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<tr>
<th>OIG Contact</th>
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