



CIS

Adverse Events relating to restraint notified to the State Claims Agency under the terms of the Clinical Indemnity Scheme

## NATIONAL FEEDBACK REPORT

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## Contents

1.0 Background .....	2
2.0 Overview .....	3
3.0 Data Quality .....	4
4.0 Key findings from <i>Restraint related events reported</i> nationally relating to HSE Residential Care Units .....	5
5.0 Discussion and Conclusions.....	10
6.0 References .....	13

## 1.0 Background

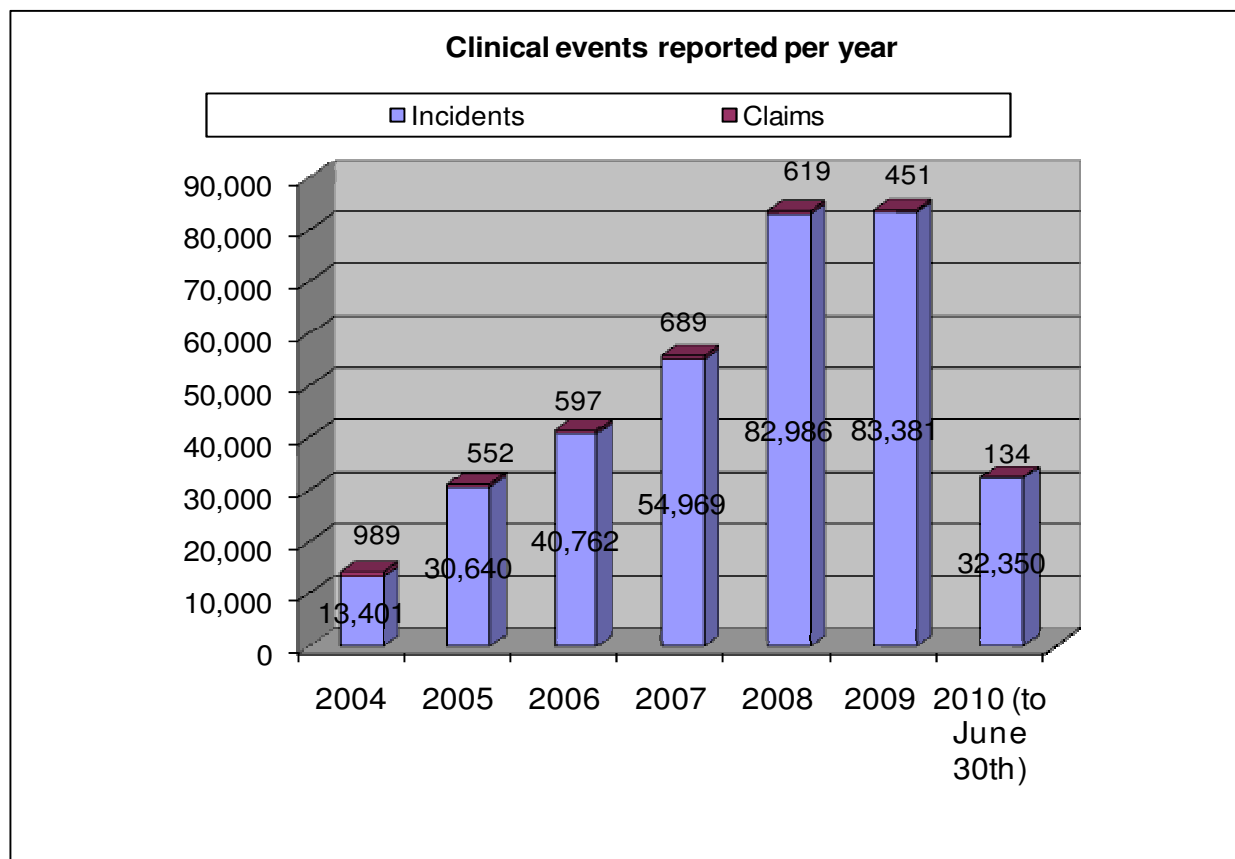
This feedback report was developed in response to a written email request (dated 13<sup>th</sup> July, 2010) from Ms Ann Coyle, HSE National Planning Specialist for Older People, on behalf of the Department of Health & Children.

The information requested was:

*I have been requested by the Department of Health to provide details of any adverse incidents of restraint in residential care units for older people where harm was caused to residents. Would you be able to extract that information from the STARS system?*

## 2.0 Overview

Total events reported to STARSWeb from Jan 1<sup>st</sup>, 2004 up to and including June 30<sup>th</sup>, 2010 is 343,520 of which 4,031 are claims (Figure 1). Events include incidents, near misses, pre-claims and claims, regardless of status.



**Figure 1. Clinical events reported on STARSWeb from January 1st, 2004 -June 30th, 2010 inclusive.**

Of these 343,520 events, some 1,215 (0.35%) relate to “restraint”. 84% (n= 1,022) of restraint-related events occurred in Primary, Community and Continuing Care (PCCC) with the remainder happening in the Acute sector as defined by the HSE.

It is worth noting that larger hospitals within Dublin Mid-Leinster (DML) were capable of reporting to STARSWeb from May 2005. The majority of acute hospitals (80%) across the country were capable of reporting into the STARSWeb system from March 2006. Some large hospitals within HSE South only had the necessary infrastructure to report from August 2005 and this was finalised for the region as a whole in July 2007. However, HSE Dublin North East (DNE) and HSE West were among the original pilot sites for STARSWeb, beginning reporting from January 2004 and March 2004 respectively and finalising their reporting capabilities for the region as a whole in August 2004 and March 2006 respectively.

### 3.0 Data Quality

Pertinent data was extracted from STARSWeb in keeping within internal quality control procedures. The events were screened for duplicates which were removed. The final report includes data from the specific category of events *Restraint*. To broaden the search the *Further details* data field was also trawled using such terms as *restraint*, *CPI*, *crisis prevention intervention*, *breakaway technique(s)*, *physical intervention technique(s)*, *seclusion*, *escalation/de-escalation skills*, *control and restraint technique(s)*, *containment technique(s)*. It is worth noting that 99.5% of events (n=1,209) have the *further details* field completed.

## 4.0 Key findings from *Restraint related events reported nationally* relating to HSE Residential Care Units

Of the restraint related events reported to STARSWeb from January 1<sup>st</sup>, 2004 to June 30<sup>th</sup>, 2010 inclusive some 2.6% (n=31) pertain to residential care units listed in an excel document, titled 09 30<sup>th</sup> 09 National Register of Public Residential Care Beds HSE Units, submitted on 30<sup>th</sup> Jul, 2010. Given the mismatch between the location structures on STARSWeb since its inception (December 2003) and the revised location structures currently operating in the HSE since 2005 these events were manually counted using location fields levels C and D.

To determine whether these events have caused harm the following fields were examined:

**Outcome, Severity of Injury and Risk rating.**

**Outcome** was completed in 58% (n=18) of cases. Of these 83% (n= 15) resulted in *No apparent injury/reaction*. The remaining reported outcomes of *bruising* (n=2) and *laceration* (n=1).

55% (n=17) of events completed the **Severity of Injury** field. Of these one (n=1) was denoted as Moderate and the remainder were considered Minor (n=12) or Low/none (n=4).

When cross-tabulated with the Outcome field one notes that the case denoted as Moderate (with a risk rating of Moderate also) has an outcome of *No apparent injury/reaction* and is categorised as a *patient self harm* event.

Nurse came across PT appeared agitated and trying to get past beds, knocking bed with wheelchair, Nurse assumed PT was going to be sick but PT pushed the fire exit door and tried to get through door toward fire stairs, patient was restrained.

**Risk rating** was completed on over 50% (n=16) of reports, of which three (n=3) were considered Moderate and the remainder either Low (n=4) or Very Low (n=9). Risk rating is used by enterprises to determine the actual or potential impact on service users (unintended or unexpected) and the likelihood of reoccurrence (Figure 2).

	Impact Score					
		Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Likelihood score	Almost Certain (5)	5	10	15	20	25
	Likely (4)	4	8	12	16	20
	Possible (3)	3	6	9	12	15
	Unlikely (2)	2	4	6	8	10
	Rare/Remote (1)	1	2	3	4	5

Low Risk 1 – 5 ■ Moderate Risk 6 - 12 ■ High Risk 15 - 25 ■

**Figure 2. HSE Risk Rating Matrix**

When risk rating is cross-tabulated with outcome to try and discern the impact of the fall or rather how it was perceived by the organisation one notes that all events have *No apparent injury/reaction* and relate to the specific nature of event categorisation *Patient absconsion–No harm* and *Patient fall moving w/o supervision* respectively.

Samples of information available in the **Further Details** field of those events rated Moderate help to build understanding as to what actually happened.

Patient absconded 4 times, last time accompanied by xxxxx, 2 HCAs and security. Had to be restrained as was walking on road. Brought back to ward and put back into bed. Seen by Dr.

Pt was restrained in a chair with a table attached to minimise his risk of falling. Pt removed the table and fell to the floor.

Given the non-completion of the outcomes, severity of injury and the risk rating fields in over 40% of events reported, this finding prompts the need for managers of the STARSWeb dataset at local enterprise level to ensure that the quality of the data submitted is accurate, appropriate and timely. In addition, any data entered needs to be upgraded to reflect enterprises' risk management interventions to minimise risks and learn lessons to prevent reoccurrences.

It is not surprising that the **sub-speciality** of Geriatric Medicine reports the majority of restraint related events (n=21 or 68%) pertaining to residential care units (Figure 3).

	Frequency	Percent	Valid Percent
Valid Elderly Services	8	25.8	25.8
Geriatric Medicine	21	67.7	67.7
Rehabilitation Medicine	2	6.5	6.5
Total	31	100.0	100.0

**Figure 3. Sub-speciality area where restraint related event occurred**

Patient falls from chairs (n=10 or 32%) and falling while moving without supervision (n=9 or 29%) account for the majority of restraint related events reported as happening in the residential care setting (Figure 4).

	Frequency	Percent	Valid Percent
Valid Aggressive behaviour	1	3.2	3.2
Assault - Physical	2	6.5	6.5
Attempted self harm	1	3.2	3.2
Patient absconsion - No harm	2	6.5	6.5
Patient fall from bed/cot	2	6.5	6.5
Patient fall from chair	10	32.3	32.3
Patient fall moving under supervision	1	3.2	3.2
Patient fall moving w/o supervision	9	29.0	29.0
Restraint	3	9.7	9.7
Total	31	100.0	100.0

**Figure 4. Specific nature of event category selected for restraint related events**



The **Further Details** field of the reporting form allows enterprises to capture additional sentinel information in free text format with respect to restraint related events. Samples of information available in the *Further Details* field relating to **patient fall from chair** are as follows:

Pt attempts to get up out chair stopped by table on chair N/inj Placed in chair without restraint phone call to wrd on admis pt vdrowsy med reviewed & sedatives reduc Pt more alert & agitated Hip protect now in place & pt sits in low chair when out of bed

Patient fell from chair. When restraint was off chair - patient fell to the floor. No injury. Family have given permission for use of lap belt

Pt found on floor beside wheelchair, pt had opened his restraint belt. No injury noted.S/b dr. no follow up treatment required.

Pt broke safety belt on her chair and slipped off sam onto floor. Pt lifted up and put into another chair and restraining safety belt.

EM found slumped forward on ebba chair her head touching floor. restraint in situ neurological obs recorded. responsive. Returned to bed.Bruising noted across both hips from restraint.1/2/08 s/b Dr. MCC.900hrs o/e NAD

Patient sitting in armchair restrained by strap but fell over the side of the chair

Staff found pt sitting on floor in sitting room. Pt appeared to have undone the tie restraint which was securly positioned previous to incident.

Attendant found resident lying on floor having fallen out of chair.Did not have restraint on.Assessed on floor prior to putting her back to bed.Did not complain of pain.Obs recorded.Review by Surgical SHO.GP informed to come to review pt also.

Samples of information available in the *Further Details* field relating to **patient falling while moving w/o supervision** are as follows:

Patient found on floor no injury reviewed by GP. Phonecall to ward - family give admission for pt to use Kirton chair and a strap restrained with patient. Care plan to be put in place for use of restraint

Pt witnessed walking out of dayroom unaided, dragging long table behind him, steady whilst walking, assisted back to chair. Pt as risk of falling as unsteady, family refused to sign restraint form.

Pt was standing upright on tilt table with knee/pelvis restraints. Pt called for help after suffering reported faint episode & had slumped fully flexed of isp was able to return upright with mod A X 1.

Pt found lying on floor in ladies day hall. Ass back to ebba chair aid 2 staff. Checked for injury - no evidence of same. Pt restrained in ebba chair due to inc falls risk # or pt safety. Constant supervision required. For r/v by Dr X mane.

Patient was found by staff in a lying position outside room 412. No witnesses as to what happened.

At unit 4 does not restrain patients, patient was advised not to try to walk unaided, but feel this may be what happened.

Pt was restrained in a chair with a table attached to minimise his risk of falling. Pt removed the table and fell to the floor.

Pt. was found sitting on floor in female 4-bedded in east wing. Pt. managed to get out of restraining belt in her chair. Her chair was sitting in an upright position with pt. sitting across from her chair

## 5.0 Discussion and Conclusions

According to established international definitions, restraint is defined as *“the intentional restriction of a person’s voluntary movement or behaviour”*.

In this context “behaviour” means planned or purposeful actions, rather than unconscious, accidental or reflex actions or simply put “stopping a person doing something they appear to want to do” (1).

Restraint where persons are at risk can be justifiable in the following circumstances where persons are:

- displaying behaviour that is putting themselves and/or others at risk of harm,
- requiring treatment by legal order as, for example, under the Mental Health Act 2001,
- requiring urgent life-saving interventions and
- needing to be maintained in secure settings (2), p 4.

There are ethical, legal, practical and professional issues that must be grappled with if health and social care practitioners are to understand the difference between unacceptable or abusive restraint and the circumstances in which restraint may be justified to strike the correct balance between independence and safety. In order to avoid the need for physical restraint where possible the Royal College of Psychiatrists’ Guidelines (3) emphasise the importance of pre-emptive actions, as does the British Institute of Learning Disability (4) and the UK Department of Health (5).

With respect to older persons restraint can be avoided by a proactive risk assessment and changes to the provision of care. The use of restraint as a first line response is not conducive to a positive social environment such that where possible policies or guidance should be discussed in multidisciplinary teams to include the older person and their carers as partners in care. Where service users are unable to give informed consent as part of a planned programme of care then every effort must be made to explain and document the rationale for what is happening, seeking where possible as much agreement and understanding as practically possible (6).

Organisations/enterprises and their agents have a duty of care to ensure that restraint is used appropriately and that practitioners are supported in their decision-making and not put in positions where restraint is used because of inadequate staffing levels or skill mix to provide safe care (2) p10-11. Governance structures should include a policy, a multidisciplinary approach, regular planned reviews of care, systems for reporting and raising concerns, access to independent service user advocates, proactive risk assessments to reduce restraint usage, best practice and competency based training around restraint and dementia and regular audits, including benchmarking where appropriate. In turn, health and social care practitioners are responsible for ensuring that they co-operate with any such employer initiatives.

Examples of interventions that could be applied to reduce the use of restraint include identifying individualized risk factors, using these as an indicator to prompt initial assessment and reassessments, putting in care plans to address modifiable risk factors, learning from incident reporting as part of governance, educating and training staff in effective falls prevention methods and optimizing the physical environment so that it is safer for all (7) p150.

With respect to service users who are disturbed and are acting violently, rapid tranquillisation and physical restraint should only be considered when other strategies have failed (8). The guidance recommends that all mental health service providers should have a full risk management strategy for assessing risk and preventing violence, to include calming measures and safety interventions when violence actually occurs. Failure to act in accordance with best practice may have legal consequences in some circumstances.

When restraint is required then the method should be appropriate to the age, size, physical condition and sex of the service user, with the minimum amount of force being deployed for the shortest possible duration (9) p9. Following the use of restraint interventions, it is vital to report and record the incident in detail but also to reflect on the incident to help identify precipitating factors and learn lessons to minimise the occurrence of such situations in the future. While incident reporting is a useful risk identification tool it depends on good quality data being collated and inputted at local level to ensure quality outputs and analysis for shared learnings locally, regionally and nationally. In addition, any data entered needs to be upgraded to reflect enterprises' risk management strategies to minimise risks and learn lessons to prevent reoccurrences.

A Minimum Data Set for restraint-related events must include outcomes, risk rating, further details and the completion of the risk management fields as outlined in STARSWeb. Attaching systems analysis review reports so as to build understanding of the contributory factors for restraint-related events could complement this by relating to enterprises' governance structures, safety cultures, systems and processes. Fields such as *Outcome* and *Action taken/Planned* will need to be updated to capture any X-ray reports or other investigations and/or risk management interventions undertaken over time to ensure lessons are being learned and implemented to prevent reoccurrences.

Encourage those completing the *Further details* field to include such key information as

- Type of restraint being used i.e. physical, mechanical, technological surveillance, chemical, psychological.
- Level of restraint to help gauge the amount of force required i.e. stage 1, 2 or dose if chemical restraint etc.
- Duration of the restraint.
- Numbers of personnel involved and staff categories i.e. CA X, Std. Nurse Y, CNM Z, Porter W, Dr P etc.

- Reference made to Standard Operating Procedures and/or legal requirements regarding documentation.
- Interventions tried and the results i.e. 2:1 special, medical review, high observations, PRN medications, use of bedrails/cot sides or lap belt, pressure pads, door alarms, de-escalation techniques worked well, etc.
- Other key factors that may have contributed to the use of restraint i.e. patient factors such as h/o alcohol or drug abuse, self injurious behaviour, confused/anxious/aggressive/etc and task factors such as unprovoked attack, refused to co-operate, etc.
- Reference to Public Liability, Employer Liability and/or Property Damage Incident Report forms, as necessary.

It is expected that the implementation and monitoring of such standards as the National Quality Standards for Residential Care Settings for Older People in Ireland (10), those concerning Residential Services for People with Disabilities (11) who are also ageing and the National Standards for Safer Better Healthcare when available, coupled with the potential strategic approach of the HSE in implementing its integrated service delivery model for Ireland (12) to include such strategies as the National Strategy to Prevent Falls & Fractures in Ireland's Ageing Population (13) will serve to positively impact any initiatives needed to address issues contributing to *restraint related events* concerning older persons.

## 6.0 References

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