"Clinical Observations and Notes"
July 1, 2003

Searching for Contraband

We have observed the increasing use of Maryland Emergency Departments (ED) by patients suffering from psychiatric disorders. In the situation described below, what seemed like routine evaluation and treatment of a patient known to suffer from a psychiatric disorder turned into a patient nearly dying because of the failure of a very basic responsibility on the part of Emergency Department staff to properly, quickly, and effectively search a patient with behavioral health concerns.

Patient A was brought by police to a Maryland ED on an Emergency Petition because she was delusional and agitated. She was known to the staff from previous visits, and had never before shown any suicidal or homicidal ideation. She was evaluated in the main ED, treated with Geodon (an anti-psychotic medication used for acute agitation), medically cleared and sent to an area adjacent to the ED where psychiatric patients are taken for stabilization and evaluation before being admitted to an inpatient psych unit. Her toxicology screen was positive for PCP, cocaine, and THC.

She was quickly evaluated by nursing staff and a psychiatrist and then medicated with Haldol and Cogentin (an anti-psychotic and a medication to reduce the side effects of the anti-psychotics).

She had arrived in 4-point restraints. After being medicated, the RN removed the ankle restraints, leaving the wrist restraints on. The patient was placed in a private room directly across from the entrance to the nurse's station, with the door open and a camera operating, although no one was actively watching the monitor. After a very brief amount of time, a nurse tech smelled smoke and found patient A on fire. The patient had apparently been able to put her hand in her pocket, and light her cigarette lighter. The patient suffered 2nd and 3rd degree burns of the left flank, leg, chest, arm, and hand. She was sedated and intubated, and sent to the burn center of another hospital.

A subsequent investigation by the hospital revealed that the patient was restrained in her street clothes and had not been searched, either in the main ED or in the adjacent psychiatric evaluation area. The hospital's policy regarding searching psychiatric patients did not specify when the search should take place, or who should do the searching—nursing staff or Security. The lack of a coherent and specific policy regarding searching and retention of clothes by psychiatric patients contributed to this very unfortunate outcome

Could this happen in your hospital ED? Is there a policy in effect, with properly trained staff, to ensure that this kind of error could not occur?

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