NORTHWEST COMMUNITY EMERGENCY MEDICAL SERVICES SYSTEM

EST 1972

NWC EMS System Continuing Education March 2020

Suicide Screen: Instruction on screening tool; documentation using new ImageTrend documentation tool for screen

Decisional capacity: steps of assessment

Policies: E1: Emotional Illness/Behavioral Emergencies/Restraint
L1: Patients in Law Enforcement Custody
O1: Procedure for Handling Overrides

SOPs: Psyc/Behavioral SOP

Objectives:

Upon completion of the assigned readings, class, and/or credit questions, each participant will independently do the following with at least an 80% degree of accuracy and no critical errors for their scope of practice:

1. Thoroughly assess a patient with a behavioral emergency for decisional capacity.
2. Describe the legal considerations for managing pts experiencing acute behavioral emergencies.
3. Identify situations in which EMS personnel may legally and ethically transport a patient against their will.
4. Discuss safe methods of agitation management and restraint within EMS scopes of practice.
5. Identify risk factors for suicide and behaviors that may indicate that the patient is at risk.
6. Discuss elements of situational awareness and potential dangers to EMS personnel when responding to a pt. with a possible behavioral emergency.
7. Select appropriate situations in which to ask suicide screening questions as part of the patient history.
8. Using Image Trend, accurately document the Suicide screen on pts at high risk.
9. Explain essential elements to document when a patient is transported against their will.
10. Demonstrate understanding of the Behavioral SOP and the E1 Policy by effectively applying their content to hypothetical patient scenarios involving suicide risk, determination of decisional capacity, whether to restraint or not, and whether to transport against a patient's wishes.
11. Discuss how EMS' demeanor and communication impacts patient response and the actions and attitude of successive caregivers
12. Demonstrate supportive communication with persons demonstrating possible behavioral illness symptoms.

Psychomotor objective: Competently assess and manage a patient who presents with behavior or other indications potentially suggestive of a behavioral emergency, while maintaining the safety of the patient and EMS responders.

Affective objective: Value and defend the need for careful assessment of decisional capacity and risk for suicide, and for judicious use of EMS interventions that impact a patient's rights.

Behavioral Health Resources

National Suicide Prevention Lifeline

Call 1-800-273-TALK (8255). Free, confidential crisis hotline available to everyone 24/7. The Lifeline connects callers to the nearest crisis center in the Lifeline national network. These centers provide crisis counseling and mental health referrals. People who are deaf, hard of hearing, or have hearing loss: TTY at 1-800-799-4889.

Crisis Text Line

Text "HELLO" to 741741. Available 24/7 throughout the U.S. Serves anyone, in any type of crisis, connecting them with a crisis counselor who can provide support and information.

Veterans Crisis Line

Call 1-800-273-TALK (8255) and press 1 or text to 838255. Free, confidential resource that connects veterans 24/7 with a trained responder. Free to all veterans, even if they are not registered with the VA or enrolled in VA healthcare. Deaf, hard of hearing, or have hearing loss: call 1-800-799-4889.

Substance Abuse and Mental Health Services Administration (SAMHSA): General information on mental health and locating treatment services in your area. 1-800-662-HELP (4357). SAMHSA also has a Behavioral Health Treatment Locator on its website that can be searched by location.

Mental Health and Addiction Insurance Help: Website from U.S. Dept of Health and Human Services provides resources to help answer questions about insurance coverage for mental health care.

Natl Institute of Mental Health: Offers health information and free easy-to-read publications on various mental disorders on its website in the Mental Health Information section. For all mental health-related questions, contact a health information specialist at the NIMH Information Resource Center. 1-866-615-6464 (toll-free). 1-301-443-8431 (TTY). 1-866-415-8051 (TTY toll-free). Mon-Fri 8:30 am- 5:00 pm ET. **Live Online Chat, Live Help.**

National Agencies and Advocacy and Professional Organizations: Good source of information when looking for a mental health provider. They often have information on finding a mental health professional on their website, and some have practitioner locators on their websites.

- Anxiety and Depression Association of America
- Depression and Bipolar Support Alliance
- Mental Health America
- National Alliance on Mental Illness

Resources: "Mental Health and Developmental Disabilities Code". (Source: P.A. 80-1414.)

I. **DEFINITIONS**

A. **Behavioral emergencies** are those in which the patient's problem is that of mood, thought, or behavior that is dangerous or disturbing to himself/herself or to others.

B. **Behavioral health services** is the contemporary term for mental health, chemical dependency, and mental retardation/developmental disabilities services for which care is provided in settings such acute, long term, and ambulatory care (JCAHO).

C. **Decisional capacity**: Decisional capacity is determined by evaluating the patient's **a**ffect, **b**ehavior, and **c**ognitive (intellectual) ability. Psychiatric signs and symptoms are grouped into the systems that they affect: consciousness; motor activity; speech; thought; affect; memory; orientation; and perception. The components may be remembered by the mnemonic **CAST-A-MOP**. The **determination of decisional capacity** generally depends on the person's ability to

1. communicate a choice;
2. understand relevant information;
3. appreciate the situation and its consequences; and
4. weigh the risk and benefits of options and rationally process this information before making a decision (Miller, 2001).

D. **Delirium:** Impairment in cognitive function that comes on rapidly.

E. **Dementia**: Chronic process resulting in deficits in memory, abstract thinking, and judgment.

F. "**Guardian"** means the court appointed guardian or conservator of the person. (405 ILCS 5/1-110) (from Ch. 91 1/2, par. 1-110) Sec. 1-110

G. **Mental illnesses (405 ILCS 5/1-129)** Mental illness" means a mental, or emotional disorder that substantially impairs a person's thought, perception of reality, emotional process, judgment, behavior, or ability to cope with the ordinary demands of life, but does not include a developmental disability, dementia or Alzheimer's disease absent psychosis, a substance use disorder, or an abnormality manifested only by repeated criminal or otherwise antisocial conduct Source: P.A. 100-759, eff. 1-1-19). This includes, but may not be limited to, the following: Schizophrenia (often accompanied by hallucinations, delusions, altered thought processes, inappropriate affect and disorganization in thought and dress), catatonic schizophrenia (may maintain rigid or bizarre posture for hours), paranoid schizophrenia (persecutory delusions, grandiose delusions, delusional jealousy, or hallucinations with persecutory or grandiose content), undifferentiated schizophrenia, major affective disorders such as bi-polar disease (mania to major depression or alternating between them over time), unipolar depressive disease, and anxiety disorders or "panic attacks".

H. **Life-threatening psychiatric conditions**

1. **Suicide:** Any willful act designed to end one's own life.
2. **Homicidal risk**: Any willful act designed to end another's life.
3. **Grave mental disability**: A state of impaired judgment such that the patient is unable to provide for his basic needs of food, clothing, and shelter.

I. **"Mental health facility"** (405 ILCS 5/1-114) (from Ch. 91 1/2, par. 1-114) Sec. 1-114. means any licensed private hospital, institution, or facility or section thereof, and any facility, or section thereof, operated by the State or a political subdivision thereof for the treatment of persons with mental illness and includes all hospitals, institutions, clinics, evaluation facilities, and mental health centers which provide treatment for such persons. (Source: P.A. 88-380.)

J. **Petition:** A petition is a legal psychiatric form from the Illinois Department of Mental Health that, when completed, represents the first step in the process to *admit* a person against his or her will. When used by EMS personnel, it provides first hand information to the physician for his/her consideration of a certificate. It does not, by itself, admit the patient.

K. **"Restraint"** (405 ILCS 5/1-125) (from Ch. 91 1/2, par. 1-125) means direct restriction through mechanical means or personal physical force of the limbs, head or body of a recipient. The partial or total immobilization of a recipient for the purpose of performing a medical, surgical or dental procedure or as part of a medically prescribed procedure for the treatment of an existing physical disorder or the amelioration of a physical disability shall not constitute restraint, provided that the duration, nature and purposes of the procedures or immobilization are properly documented in the recipient's record and, that if the procedures or immobilization are applied continuously or regularly for a period in excess of 24 hours, and for every 24 hour period thereafter during which the immobilization may continue, they are authorized in writing by a physician or dentist; and provided further, that any such immobilization which extends for more than 30 days be reviewed by a physician or dentist other than the one who originally authorized the immobilization.

Momentary periods of physical restriction by direct person-to-person contact, without the aid of material or mechanical devices, accomplished with limited force, and that are designed to prevent a recipient from completing an act that would result in potential physical harm to himself or another shall not constitute restraint, but shall be documented in the recipient's clinical record. (Source: P.A. 99-143, eff. 7-27-15.)

L. (405 ILCS 5/1-126) (from Ch. 91 1/2, par. 1-126**) "Seclusion"** means the sequestration by placement of a recipient alone in a room which he has no means of leaving. The restriction of a recipient to a given area or room as part of a behavior modification program which has been authorized pursuant to his individual services plan shall not constitute seclusion, provided that such restriction does not exceed any continuous period in excess of two hours nor any periods which total more than four hours in any twenty-four hour period and that the duration, nature and purposes of each such restriction are promptly documented in the recipient's record.

M. **"Substitute decision maker"** means a person who possesses the authority to make decisions under the Powers of Attorney for Health Care Law or under the Mental Health Treatment Preference Declaration Act. (405 ILCS 5/1-110.5) Sec. 1-110.5. (Source: P.A. 91-726, eff. 6-2-00.)

II. **Broad categories of behavioral emergencies**

A. **Situational**: When normal individuals develop abnormal reactions to stressful events. Almost anyone can lose control if subjected to enough stress but some are more vulnerable than others. When a person's basic needs are threatened, the severity of the crisis will depend on their ability to deal with their feelings. They may cope by finding ways to alter the situation or their perception of it so that it is no longer stressful. Alternatively, they may attempt to decrease the discomfort by escaping from the stress in the form of alcohol, drugs, suicide, or psychiatric symptoms.

B. **Organic:** Consider when a person is suffering from a physical illness or is under the influence of a substance that interferes with normal cerebral function. Diabetes, seizures, severe infections, hypoxia, acidosis, metabolic disorders (thyroid), head injury, stroke, alcohol intoxication, and drugs may all cause disturbed behavior. Consider organic diseases in ALL patients with behavioral emergencies.

C. **Psychiatric (mental illness)**: Caused by problems that arise in the mind of the patient. Psychiatric syndromes can be divided up into the following categories: psychotic disorders characterized by an impaired view of reality; affective disorders of mood; anxiety disorders involving overwhelming fear; disorientation and disorganization; hostile and violent patients.

III. **POLICY**

The NWC EMSS believes that all patients, particularly those who are non-decisional ~~patients~~ need their rights protected, including the right to acute medical evaluation and care. When a patient is not decisional or has been declared to be incompetent to accept or refuse care, his/her judgment must be replaced by someone else's. If a person is believed to be mentally ill and/ or is experiencing a behavioral emergency and they are non-decisional, they must be transported to the nearest hospital, against their will, if necessary, for their ultimate safety and benefit.

IV. **GENERAL APPROACH – See SOPs**

A. **Evaluate scene safety**. Risk factors for violence:

1. Locations with alcohol consumption
2. Crowds
3. Incidents where violence has already occurred (GSW, stabbing, domestic)
4. Individuals under the influence of, or withdrawal from, drugs or alcohol
5. Psychosis; especially manic and paranoid types
6. Delirium from any cause
7. Potential exists for (concealed) weapons

B. **Warning signs of a potentially violent situation**

1. Posture: People who sit tensely at the edge of a chair or grip an arm rest
2. Speech: Loud, critical, threatening, profanity, or voice rising in pitch or volume
3. Motor activity: Inability to sit still, pacing, easily startled, increased muscular tension, jabbing the air with a pointed finger or fist
4. Body language: Clenched fists, turning away, avoidance of eye contact
5. Subjective feelings: If one believes that they are in danger
6. Presence of any weapons

C. Maintain a safe distance from the patient until consent to touch is given unless immediate intervention/restraint indicated.

D. Do not touch the patient without telling them your intent in advance.

E. Limit stimuli and number of people around and treating pt as safely possible, isolate if needed.

F. Identify yourself and attempt to gain the patient's confidence in a non-threatening manner

G. **Consider and attempt to evaluate for possible physiological causes** of behavioral problems and initiate treatment as required. Examples hypoxia, hypoperfusion, hypotension, hypoglycemia, head injury, substance use disorder (alcohol intoxication; drugs), stroke, seizure, postictal states, cerebral bleed, delirium, dementia, developmental impairment, autism, electrolyte imbalance, acidosis, thyroid/renal disorders, infections, dementia and trauma.

H. Assess decisional capacity and potential danger to self or others by observation, direct exam and reports from family, bystanders, or police. See SOPs for determination of decisional capacity assessments.

I. Attempt to orient the patient to reality, gain cooperation and persuade him or her to be transported to the hospital so he or she can be examined by a physician.

J. If the patient is judged to be mentally ill and/or is experiencing a behavioral emergency, that poses an immediate danger to self or others, EMS personnel should initiate treatment and transport in the interest of the patient's welfare, employing the following guidelines:

1. **Assure your personal safety** at all times. This may mean a delay in the initiation of treatment until the personal safety of EMS responders is assured.

2. Try to obtain cooperation through verbal de-escalation techniques.

3. **Aggression managemen**t:

a. **Physical restraint:** If the patient ~~resists or~~ poses an immediate threat to the safety of themselves, EMS responders and/or bystanders, police shall be notified for assistance and reasonable force may be used to restrain the patient from doing (further) harm to self or others.

(1) All forms of restraint are to be used for therapeutic purposes and only to the extent necessary to preserve the safety of the patient and others and. shall allow a patient to breathe and speak normally.

(2) Physical restraint is never to be used as a form of punishment for maladaptive behavior.

(3) Physical restraint shall not rely upon pain as an intentional method of control.

Physical restraint may only be employed when:

(4) the patient poses a physical risk to self or others, and

(5) the EMS responders applying the restraint have been competencied in de-escalation, restorative practices, and behavior management practices including safe restraint application as indicated by written evidence of participation and competency (See Section VI of this policy and the EMS procedure on use of restraints.).

b. Medications may be used to address aggressive and/or agitation that interferes with appropriate medical care per the SOPs.

4. Contact the nearest System hospital via the telemetry radio/phone and explain your situation. Discuss possible options for an action plan.

V. **Documentation**

A. In a form and manner prescribed by the EMS System, each episode of aggression management and application of restraint shall be documented in the patient's PCR, including at a minimum, the following:

1. Description of any relevant events leading up to the incident;
2. A description of any interventions used prior to the implementation of aggression management and/or physical restraint;
3. A description of the patient's behavior that resulted in a need for aggression management and/or restraint;
4. A description of the patient's behavior during aggression management and/or use of restraints;
5. A description of the aggression management and/or restraint technique used and other interactions between the patient and/or guardian/petitioner and EMS responders and law enforcement officers;
6. A description of any injuries or property damage; and
7. Notation of all persons who participated in the implementation, monitoring, and supervision of the patient during aggression management and/or restraint.

B. **Petition forms.** It the patient is judged to have a psychiatric cause for their illness that meets one of the eligibility requirements on the petition form, EMS shall initiate The **Petition for Involuntary/Judicial Admission Form**.

1. A Petition for Involuntary Judicial Admission form is the first step in a legal process that protects the patient's rights and is necessary before a physician can determine if an involuntary admission is necessary.

2. A petition form is to be completed when EMS personnel or family members have first hand knowledge and reasonably suspect that a patient **is mentally ill** and because of their illness **would intentionally or unintentionally inflict serious physical harm upon themselves or others in the near future, is mentally retarded and is reasonably expected to inflict serious physical harm upon himself/herself or others in the near future, or is unable to provide for his or her own basic physical needs so as to guard himself or herself from serious harm** and needs transport to a hospital for examination by a physician (Ill Mental Health Code).

3. A petition form should be completed for all patients that meet the above criteria. They may be transported with or without their consent for medical evaluation. Careful documentation of first-hand observations is critical.

4. **Instructions for completing the petition form**

   a. **Statutory reason for initiation of petition**: Leave first page blank except for the patient's name.

   b. **Assertions (p. 2):** The EMS responder must insert the patient's name and check the assertion that applies; they believe the patient is:

      (1) A person with mental illness and because of his/her illness is reasonably expected to inflict serious physical harm upon himself/herself or another in the near future (prior standard); or

      (2) A person who is mentally ill and who because of his/her illness is unable to provide for his/her basic physical needs so as to guard himself/herself from serious harm without the assistance of family or outside help; or

      (3) A person who is mentally retarded and is reasonably expected to inflict serious physical harm upon himself/herself or others in the near future; and/or

      (4) In need of immediate hospitalization for the prevention of such harm.

   c. Insert a **detailed description of any acts or significant threats supporting the assertion** and the time and place of their occurrence. Quote any statements made by the patient that substantiate the determination of risk.

   d. Complete the witness section to the best of your ability. List a spouse, parents, close relative, or guardians, or if none, any known friend of the patient who witnessed the behavior supporting the assertion of risk. List their addresses and phone numbers in the designated area. If unable to locate any, indicate that you were unable to do so. Do not leave this section blank.

   e. Page 3:

      (1) Leave first statement area blank. Hospital will fill in.

      (2) Insert information regarding police officer involvement if applicable.

(3) Notification statements: If another adult or the EMS responder is signing the petition form, they have the option of requesting or declining notifications as listed.

(4) The person who signs the petition (petitioner) must be 18 years or older and be an eyewitness to the patient's behavior. It is not appropriate for a petition to set forth facts which are true "according to family members". A family member/ advocate/guardian should sign the petition if they are the only witnesses. If the family is not available or refuses to sign the form, the next most appropriate person would be a police officer who witnessed or was informed about the behavior. **The one who observes the behavior should sign the form.** If police are not present or refuse to sign, EMS personnel who witnessed the behavior must sign the form. EMS personnel should indicate if involuntary transport has been ordered per on-line medical control.

(5) List the petitioner's relationship to the patient and a statement as to whether the petitioner has legal or financial interest in the matter or is involved in litigation with the patient as known to you at the time of the call.

(6) The petition must indicate the date it is filled out.

f. Page 4: Leave blank.

5. The IL IL462-2005 (R-4-14) Petition for Involuntary/Judicial Admission form should be attached to the EMS Patient Care Report left at the hospital and shall become a part of the patient's permanent medical record in the ED. If this form is completed appropriately by EMS personnel and a physician determines that an involuntary hospital admission is indicated, the Petition Form may be added to the physician's certificate and admission orders as part of the statutorily required documents.

VI. **Restraint competency: Required annually**

Training and competency measurement with respect to physical restraint applied by EMS responders may be provided by a qualitied EMS employer educator (Peer I-IV) or hospital EMS educator and shall include, but not be limited to, the following:

A. Appropriate procedures for preventing the need for physical restraint, including the de-escalation of problematic behavior, relationship building, and the use of alternative to restraint;

B. A description and identification of dangerous behaviors that may indicate a need for physical restraint and methods for evaluating the risk of harm in individual situations in order to determine whether the use of restraint is warranted;

C. The simulated experiences of administering a variety of physical restraint techniques ranging from minimal physical interventions to very controlling interventions;

D. Instruction regarding the effects of physical restraint on the patient, including instruction on monitoring physical signs of distress and providing medical assistance;

E. Instruction regarding documentation and reporting requirements; and

F. Demonstrating proficiency in safely applying physical restraint without critical error.

VII. **Good faith - Exemption from liability**

A. "All persons acting in good faith and without negligence in connection with the preparation of applications, petitions, certificates or other documents, for the apprehension, transportation, examination, treatment, habitation, detention, or discharge of an individual under the provisions of the Act incur no liability, civil or criminal, by reason of such acts."

B. "Any duty which any person may owe to anyone other than a resident of a mental health and developmental disabilities facility shall be discharged by that person making a reasonable effort to communicate the threat to the victim and to a law enforcement agency, or by a reasonable effort to obtain the hospitalization of the patient" (5/6-103).

VIII. In an uncooperative patient, the requirement to initiate full care in the field may be waived in favor of assuring that the patient is transported to an appropriate facility. Contact medical control and communicate the circumstances favoring abbreviation of routine care.

IX. If a patient refuses medication after a petition is signed, the medication shall not be given unless it is necessary to prevent the patient from causing serious harm to himself or others (section 5/3-608). EMS personnel must thoroughly document what treatment is given and which is refused.

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Attachments: Petition form; Procedure on Use of Restraints

NWC EMSS Policy Manual
Use of Restraints – DRAFT #1
Revised 12/7/19

Definitions

"**Restraint** is 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, material, mechanical devices, or a combination thereof attached to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to ones body." (JC).

"Momentary periods of physical restriction by direct person-to-person contact, without the aid of material or mechanical devices, accomplished with limited force, and that are designed to prevent a recipient from completing an act that would result in potential physical harm to himself or another shall not constitute restraint, but shall be documented in the recipient's clinical record" (Ill Mental Health Code, 5/1-125).

Medications used to control behavior or to restrict the patient's freedom of movement that is not a standard treatment for the patient's medical or psychiatric condition is a restraint.

Restraint for behavior management is the emergent use of restraint to prevent imminent danger to self or others in the event of unanticipated, severely aggressive or destructive behavior.

Immobilizing devices are those associated with medical or trauma procedures and are based on standard practice for the procedure, i.e., IV arm boards, splints.

Least restrictive measures are the use of restraining techniques or methods that pose the least possible restriction to the patient while ensuring adequate safety.

Emergency for the purposes of restraint: Instance in which there is an imminent risk of an individual harming himself or herself or others, including staff; when non-physical interventions are not viable; and safety issues require an immediate physical response.

False imprisonment: Restraining a person from freedom of movement against his will. Restraint without legal justification. False imprisonment is considered under civil law and does not require violent abduction. Its equivalent in criminal law would be "kidnapping". The threat of confinement of a decisional patient, combined with an apparent ability to accomplish the threat, and some limitation of movement is sufficient to uphold a charge of false imprisonment (Miller, 2001).

Policies/assumptions

EMS providers are to take all reasonable precautions for the safety of both themselves and their patients in the process of providing patient care at all times. The use of restraint and seclusion poses an inherent risk to the physical safety and psychological well-being of the individual and staff.

Therefore, restraint and seclusion shall be used only in *emergency* situations with adequate, appropriate clinical justification based on the assessed needs of the patient in the immediate care environment. Restraints may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself/herself or physical abuse to others. In no event shall restraint be used for purposes of coercion, discipline, convenience, or retaliation by EMS personnel.

Every effort shall be made to avoid the use of physical restraint by using alternative interventions unless safety issues demand an immediate physical response. If alternative methods fail, physical restraint may be necessary to maintain safety and will be implemented in a manner that preserves the rights and dignity of the patient.

The System affirms that EMS procedures are to be safely and appropriately implemented by qualified EMS personnel. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be used.

The type of restraint should be individualized to use the least restrictive method that protects the patient and EMS personnel from harm.

Indications for restraint

"Restraints may be used in response to emergent, dangerous behavior; addictive disorders; as an adjunct to planned care; as a component of an approved protocol, or in some cases, as part of standard practice" (JC).

Examples in EMS may include patients who are, or may become combative, agitated, uncooperative, and pose an imminent risk of injury to themselves or others due to a medical or behavioral health disability.

- Those who have been intubated using DAI and are attempting to remove the ET tube.
- Safe and controlled access for medical procedures when involuntary patient-interference or resistance is **reasonably anticipated**. Examples: patients who are not combative, but are confused, and may withdraw or strike out when being stuck with a needle.
- Anticipation of improved patient condition producing combativeness/ resistance:
  - Unconscious hypoglycemic patient who may arouse combative when dextrose is given;
  - Cardiac arrest patient with spontaneous return of circulation may attempt to extubate themselves without deflating the cuff;
  - Narcotic overdose patients may become combative when reversed with naloxone.
- Evaluation and treatment of combative persons when illness or trauma is suspected to be the cause of combativeness.

- For the purpose of facilitating assessment, stabilization, and/or treatment of nondecisional patient who are refusing treatment and/or transportation.

No patient shall be restrained to prevent him or her from leaving the ambulance unless the patient is a potential threat to self or others.

Clinical criteria that must be met

The patient must be exhibiting behavior that is judged as

- posing a risk of injury to self, others, or property. This may include being directed by appropriate authorities to transport a person based on a mental health hold or one in police custody; or
- seriously compromising the effectiveness of a procedure/intervention through self-removal of therapeutic devices.

Associated factors that may be present

- Impaired memory
- Increased motor activity (restlessness, plucking, picking)
- Disorientation to person, place or time
- Impaired attention and concentration
- Inability to follow directions

These guidelines DO NOT apply to the following:

- Standard practices that include limitation of mobility or temporary immobilization related to medical, diagnostic, or invasive procedures and the related post-procedure care, i.e. spine immobilization, use of IV arm boards, protection of treatment sites, or routine securing of patients to ambulance stretchers or patient conveyance devices for safety during transport. The use of restraining devices may or may not be described in the practice descriptions for these skills.
- Therapeutic holding or comforting of children.
- Forensic and correction restrictions used for security purposes.
- Protective equipment such as helmets.

Medicolegal issues

EMS personnel must be aware of the laws related to an individual's rights, the processes for involuntarily restraining or holding patients with mental health disorders, an individual's right to refuse treatment, and other related laws. In the United States, a person has the right to come to what others would consider an "unreasonable" decision as long as that person can make the decision in a "reasoned" manner...meaning they are capable of reasoning, or are "competent" to make a decision.

Foreseeable risks

"Application of restraints has the potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of an individual's rights, and even death" (TJC TX - 47). Other complications include skin chaffing, pressure ulcers, bone fractures, psychological distress, increased agitation, depression, humiliation, fear and anger.

Overstepping the boundaries of restraint may be perceived as **battery, assault, or false imprisonment**. It could even lead to serious allegations of civil rights violations (NAEMSP, 2002).

False imprisonment requires that the person be aware of the restraint and requires intent on the part of the actor (EMS personnel) to *unjustifiably* remove a person's liberty.

"**Doctrine of Necessity**" There are three elements to this defense: EMS personnel must act under a reasonable belief that:

- there is a danger of imminent harm to the patient or others,
- the confinement last no longer than necessary to get the patient the necessary treatment and,
- the least restrictive measures of preventing harm are used. (Eilers v. Coy, 582 F. Supp. 1093 D. Minn. 1984).

If these elements are all satisfied, there should be no liability for false imprisonment.

Whenever possible, personnel of the same gender should accompany a restrained person during treatment and transportation. This is of particular importance if pharmacologic agents are used for chemical restraint (NAEMSP, 2002).

Sometimes, the failure to restrain can constitute negligence (Morrison v. Commonwealth, 1992 WL 111797 (Pa. Cmwlth.) Slip. Op. #2232 C.D. 1991)(cert, granted for evidentiary matters).

Given the urgent medical necessity of applying restraints to protect a combative patient, informed consent from a combative and/or non-decisional patient may be waived.

PROCEDURE

Scene size up; ensure scene safety: Protect yourself! There is no legal duty to risk injury in order to provide patient care.

- If an individual is known to be violent, assure that law enforcement has secured the scene before you enter.
- Survey the environment for items that could be used as projectiles or weapons. If the patient appears aggressive, hostile, violent and/or homicidal, move out of range and call for police assistance and appropriate EMS backup.
- Remain at a safe distance (at least one leg length) from the patient while conducting the scene size-up.
- If the patient has the potential for violent behavior, attempt to keep furniture between you and them. Position yourself between the patient and the door. **Always maintain a means of escape**.

Whenever possible, avoid confronting hostile patients in a kitchen as they are filled with potential weapons.

- If there are two EMS personnel, stand apart from each other at equal distances from the patient. Do not allow a single EMT to remain with the patient.
- Anticipate the potential for exposure to blood or body fluids. Wear appropriate BSI.

Patient assessment

Perform an assessment to determine any clinically evident immediate life -threats. Treat to the extent patient permits prior to applying restraints.

Assess affect, **behavior**, and **cognition** (thought processes) and the risk of harm. The display of any of the following behaviors with the intent or possible result of harming self, others, or property may require medical immobilization/restraint:

- Confusion or altered mental status such that the patient is unable/ unwilling to follow commands related to their safety and/or well being. Are they thrashing about with a possible spine injury? Experiencing hallucinations or hearing voices suggesting self-destructive behavior?
- **Dangerous or potentially violent behaviors:** Is the patient pacing or agitated, demonstrating threatening mannerisms (clenched fists/tense muscles), brandishing a weapon, shouting or being verbally abusive? Is the patient combative, striking out, overturning furniture, punching or kicking inanimate objects, biting or spitting? Is he or she protecting physical boundaries?
- Are they in need of resuscitative treatment but are non-decisional and refusing care?

Assess for a medical cause of the patient's behavior: Hypoxia, substance abuse/overdose/reaction; alcohol/ chemical intoxication, cardiovascular disorders, neurologic disease (stroke, seizure, brain trauma, intracerebral bleed, tumor); metabolic disorders (hypoglycemia, hyperglycemia, acidosis, electrolyte imbalance, liver or kidney disease), hyperthermia, and infectious or degenerative diseases.

Oxygen, dextrose and naloxone should be used to treat underlying conditions when appropriate.

Restraint should not be the only intervention for acute confusion which may be a significant symptom of underlying pathology.

Note: A detailed physical exam may be difficult to impossible to conduct in a patient with a behavioral emergency. You may not be able to proceed beyond the initial assessment.

An assessment to determine clinical justification for restraint must occur prior to the initiation of restraint. This assessment includes a determination:

- as to whether the patient is at risk of harm to him/ herself or others;
- of whether alternative interventions could be used to maintain safety of patient and others;
- that less restrictive measures (other than restraint) were ineffective in preventing harm or potential harm to the patient or others.

Types of restraint

Verbal de-escalation

Verbal intervention sometimes diffuses the situation, can prevent further escalation, and may avoid the need for further restraint tactics (NAEMSP, 2002).

- Attempt neutral language to verbally deescalate inappropriate/potentially harmful behavior
- Use active listening with support for the patient's feelings. Verbalize the behaviors the patient is exhibiting. Attempt to help the patient recognize that these behaviors are threatening.
- Avoid direct eye contact and encroachment upon the patient's personal space as this may provoke stress and anxiety (NAEMSP, 2002)
- Provide gentle reassurance
- Attempt to gain the patient's cooperation
- Reorient them; send clear, simple messages
- Set limits to out-of-control behavior
- Allow choices wherever possible
- The conversation must be honest and straightforward with a friendly tone. Avoid phrases or words that could be perceived as demeaning or trigger aggressive behavior. Avoid using phases that imply a threat, "Lay still or we will be forced to tie you down" etc. Instead, use the terms, "safe", "secure" and "comfortable" as often as possible. "For your safety, I'm going to secure your arms and legs".
- Use a non-confrontational approach. Do not argue with a violent patient. Verbal communication should cease if they become more threatening.
- Decrease environmental stimuli as much as possible, i.e., noise, number of people present etc.
- Provide appropriate pain control
- Conceal therapeutic devices as much as possible (i.e., cover IVs/tubing in children or those with hallucinations)
- Provide diversion through conversation during transport

Physical restraint

If it becomes necessary to physically prevent a patient from aggravating their existing injuries or causing imminent harm to themselves or others, they must be restrained using the least-restrictive, safe and effective means.

Only **reasonable force** may be used when applying physical control. Use only the force equal to, or minimally

greater than, the amount of force being exerted by the resisting patient. Excessive force may be a cause for liability even if the patient needs restraining. If not in imminent danger, explain the options of physical restraint before applying force. Offer the patient one final opportunity to cooperate and tell him/her that he/she will be assisted in maintaining self-control by restraint.

Aggression management

Defined as the addition of specific pharmacological agents to decrease agitation and increase the cooperation of patients who require medical care and transportation. The goal of chemical restraint is to subdue excessive agitation and struggling against physical restraints (NAEMSP, 2002).

Continued patient struggling before or after restraint application can lead to hypoxia, positional asphyxia, aspiration, severe acidosis, hyperkalemia, rhabdomyolysis, hyperthermia, fatal dysrhythmia and sudden cardiac arrest. The agent administered should change the patient's behavior without reaching the point of amnesia or altering their level of consciousness. Administer midazolam IM or IVP per SOP to sedate the patient.

Procedure for selecting and applying physical restraint

Physician authorization: Restraint use must be ordered by either an on-line medical control physician or via standing medical orders approved by the EMS MD through this policy or SOP. If a patient poses an immediate risk of injury to themselves or others, emergency restraint application is approved by EMS protocol. Apply restraints first and obtain the on-line physician's confirmation as soon as possible thereafter. When an emergency physician is not immediately available to authorize the use of restraint, an ECRN may make the determination and notify the physician immediately thereafter.

Selection of device

The choice of restraint is determined by the patient's assessed needs. Restraints must be reasonable in type and amount. The goal is to restrict movement, not to injure. The least restrictive device that will protect the patient and rescuers should be used, applying only the force necessary for the safety of EMS personnel and the patient.

Types of restraints
(listed from least to greatest restriction)

- Spine board and stretcher straps
- **Soft restraints:** Roller gauze (Kerlix or Kling made into wristlets, sheets, blankets or chest Posey): Usually applied to keep a confused patient from removing a device such as an IV or ET tube or moving on the stretcher in a harmful manner.
- **Hard restraints:** May include velcro limb restraints, plastic ties, and leathers.

  Leather restraints may be used if they are non-locking and cleanable to OSHA standards of disinfection for blood and body secretions.
- **Forensic restraints**, such as handcuffs, are generally not acceptable for EMS use (NAEMSP, 2002). Restraints such as handcuffs or flex-cuffs should only be applied by law enforcement officers. The arresting officer is responsible for the safekeeping of all prisoners in handcuffs.

  The officer may accompany the prisoner in the ambulance or may follow immediately behind the ambulance in a police vehicle. Officers must give handcuff keys to EMS personnel if they do not accompany the patient.

  A patient who is handcuffed behind their back must be transported in a seated position or on their side. They may not be transported supine or prone. EMS personnel should not transport a patient who has both hands handcuffed in front of their torso. This position allows the patient to use their hands as a weapon.

Any restraint used must allow for rapid removal if the patient vomits, has a seizure, develops respiratory distress or cardiac arrest.

It is not appropriate for EMS personnel to use weapons as adjuncts in the restraint of a patient (NAEMSP, 2002).

In rare situations, it may be necessary for law enforcement to apply restraint techniques to patients that are not sanctioned by EMS policies (pepper spray, mace, defensive spray, stun guns, air tasers, stun batons, and telescoping steel batons).

The use of these agents should be avoided since they may exacerbate the patient's agitation and increase the risk of injury or death. In these cases, a law enforcement officer must accompany the patient during transportation, and EMS personnel must assure that the patient is medically assessed, treated, and reassessed based upon the restraint protocol (NAEMSP, 2002).

General guidelines regarding applications of restraints

- Use the proper size product for a given patient
- Use the correct product to prevent patient injury to himself or others
- Secure the straps of a restrictive device to a spine board or stretcher parts that move with the patient when the stretcher is adjusted
- Secure the straps of restrictive devices out of reach of the patient
- Use a quick releasing tie to secure non-velcro straps. A quick releasing tie will not tighten when the patient pulls against the strap.
- Infection control guidelines will be followed for appropriate cleaning of reusable devices, or

appropriate disposal for single-use items, when no longer needed by a given patient.

- Any form of restraint must be "informed" restraint. As early as feasible in the restraint process, the patient must be made aware of the rationale for restraint and the behavior criteria that is expected of them at the hospital for its discontinuation.

Application of soft restraints

Patient preparation prior to application of restraints in a non-violent patient. EMS personnel shall

- remove all jewelry from the area(s) to be restrained.
- expose the area (remove clothing if possible) to assess SMV of extremities.
- provide as much privacy as possible.
- tie a slip knot in the center of a piece of Kerlix or Kling and place over the patient's hand.
- pull snugly to the wrist and tie to the stretcher.
- repeat for the other hand as necessary.

Application of four point restraints

- If the patient is uncooperative at the scene, all issues of cooperation and restraint should be resolved prior to beginning transport.
- A minimum of five people should ideally be present to safely apply physical restraint to a violent patient. This allows control of the head and each limb (NAEMSP, 2002). A team leader should direct the process. Plan your approach and act quickly. Include a back-up plan should the initial action fail.
- Gather the restraints, making sure that there are 2 wrist and 2 leg restraints.
- At least two rescuers should rapidly move towards the patient from different directions and position themselves close to and slightly behind the patient. The patient cannot focus on both at once. Another person should continue talking with the patient.
- The two persons near the patient should position their inside legs in front of the patient's legs and force the patient forward into a prone position. Gaining initial control of the patient in the prone position limits the patient's visual awareness of the environment and decreases the range of motion of the extremities.
- Assign one person to control each limb by grasping at clothing and large joints, such as the knees, ankles, or elbows.
- As soon as the team has control of the patient's movements, move the patient into supine or side-lying position, preferably on a backboard. This position allows for continuous assessment of the airway and ventilations. A side-lying position is especially desired if there is a potential for vomiting and aspiration.
- Adjust the stretcher to its lowest position to improve stability. Move the patient to the stretcher. Patients should never be restrained in a prone position with hands and feet behind the back (hobbled or "hog-tied"). Patients should never be transported while "sandwiched" between backboards or mattresses (NAEMSP, 2002).
- Restrain one arm at the patient's side and the other above the patient's head.
- Restrain one ankle at a time to the back board or the metal T-braces of the stretcher under the mattress and tie the ankle restraints together.
- Place stretcher straps across the bony prominences, over the shoulders and criss-crossed over the chest, pelvis, and legs but don't cinch too tightly. Tethering the thighs, just above the knees, often prevents kicking. Restraint techniques should never constrict the neck, chest, abdomen, or compromise the airway (NAEMSP, 2002).
- Remove shoes and socks once restrained. Assess skin for soft tissue injury, limb color, temperature, and distal pulses after placing restraints.
- If a change in position is necessary, reposition one limb at a time.
- Once restrained, the patient should never be left unattended.

Time limits/terminating restraint: It is understood that once restraints are applied, they will remain in place until the patient is safely transported to a medical facility and responsibility for care is transferred to hospital personnel unless the patient is reassessed to be fully decisional and cooperative and EMS personnel receive an order from on-line medical control to discontinue restraint.

Protection/preservation of patient rights, dignity, and well-being during restraint:

Nothing should be placed over the face, head or neck of a patient. A surgical or oxygen mask may be placed over the patient's face to discourage biting and spitting. An appropriately fitted cervical collar may limit the mobility of the patient's neck and decrease their range of motion in attempting to bite. **Do not** place anything in the pt's mouth.

Modesty, visibility to others, and comfortable body temperature must be maintained during restraint use.

Monitoring during restraint use

The method of restraint must allow for continuous patient assessment and for medical interventions during transport. If a patient vomits, becomes unstable or develops cardiopulmonary arrest, prompt treatment is needed (NAEMSP, 2002). Patients shall be monitored by continuous in-person observation, direct interaction, and examination throughout the prehospital phase of care.

Monitoring is done to assure

- the physical and emotional well-being of the pt;
- that the patient's rights, dignity and safety are maintained;
- whether less restrictive methods of restraint are possible; and
- whether the restraint has been appropriately applied, removed, or reapplied.

Attempt to meet the patient's on-going physical/emotional needs.

Take and record vital signs (P and RR), airway patency, and neurovascular status of all restrained extremities no less often than once every **15 minutes** while the patient is restrained. Periodically reassess the patient's ability to cooperate, but DO NOT release the restraints.

Risks associated with special needs populations

Pediatric patients shall have a responsible adult with them at all times while restrained.

- Attempt to prevent a child from seeing things that will increase their distress
- Keep explanations brief and simple using terms and phrases that are appropriate for the child's developmental level
- Remain calm and speak softly and slowly
- Allow the child to cry and express their emotions/fears

Elderly patients may present with physical problems that manifest as behavioral emergencies, i.e., organic brain syndrome, chronic illness, diminished eye sight and hearing, and depression which of often mistaken for dementia.

- Assess their ability to communicate
- Provide continued reassurance
- Compensate for their loss of sight or hearing with reassuring physical contact
- Treat them with respect using their name, not a patronizing term
- Take time to describe what you are going to do

Foreign language speaking patients

Whenever an explanation is required to be given a patient who does not understand English, such explanation shall be provided to him/her in a language which he/she understands through an interpreter on the scene or as soon as possible after arrival at the hospital. It is understood that prehospital resources for interpreters are very limited and patients may need to be restrained for their own protection prior to an explanation that they understand.

Whenever restraint is imposed upon any patient whose primary mode of communication is **sign language**, the patient shall be permitted to have his hands free from restraint for brief periods, except when freedom may result in physical harm to the patient or others.

Reportable conditions

Should death occur while a patient is in restraint, the event will be reported to the EMS Medical Director within two hours so he can investigate and report to the appropriate regulatory bodies.

Documentation

Whenever restraints are applied, the PCR must reflect the following:

- Clinical justification for use. Describe the scene and patient behaviors in exact terms leading to the conclusion that the patient would have harmed themselves or others without interjecting opinions or unprofessional comments.
- Failure of non-physical methods of restraint (if conscious), failure of verbal attempts to convince the nondecisional patient to cooperate and/or consent to treatment.
- That the reasons for restraint were explained to the patient.
- Whether the restraints were ordered by a physician or applied per SOP; the physician's name who authorized the restraints.
- Rationale for the type of intervention selected.
- The type of restraint used, the limbs restrained, time of application, responders who assisted in the restraint process (including law enforcement personnel and bystanders), and the measures taken to protect the rights, dignity and well-being of the patient including monitoring, reassessment, and attention to patient needs.
- The q. 15 minute reassessments of VS, limb SMV, and the patient's behavior and/or mental status after restraint.
- Care during transport.
- Any injuries sustained by the individual or staff and the treatment provided to the patient for these injuries (NAEMSP, 2002).

- If a patient with a primary behavioral health emergency is an imminent danger to themselves or others or is unable to care for themselves, **complete a petition form** and provide it to the ED staff for additional documentation. Examples include neuroses (a restricted ability to achieve optimal functioning in social life) or psychoses (maladaptive behavior that involves major distortions of realty.) Clinical responses include depression, withdrawal, catatonic state, violence, suicidal thoughts/acts, paranoia, phobias, anxiety disorders including panic attacks, conversion hysterias, disorientation or disorganization with psychotic behavior, delusions, or hallucinations as seen in schizophrenia.

Competency of EMS personnel

Restraint use competency must be demonstrated at least bi-annually by all direct EMS patient care providers through an EMS agency-conducted in-service program. Skill proficiency must be documented using forms created by the System's education committee and submitted to the Resource Hospital.

EMS personnel must receive ongoing education in and demonstrate an understanding of the following:

- Principles of assessment for clinical justification for use of restraint
- The underlying causes of threatening behaviors
- How their own behaviors can affect the behaviors of the individuals they serve
- Definitions and exclusions relative to restraint use
- Alternatives interventions to use of restraints
- Self-protection techniques
- Types of restraints; differences between least to most restrictive type of devices
- Regulatory requirements
- Assessment and care of the patient in restraints
- Protection of patient's rights while in restraint
- Documentation requirements; and
- Recognizing signs of physical distress in individuals who are being held, restrained, or secluded (TJC, 2000)

Personnel who are authorized to physically apply restraint must receive ongoing training in and demonstrate competence in the safe use of restraint, including

- physical holding techniques,
- take down procedures, and
- the application and removal of mechanical restraints.

Evidence of competency may be randomly audited by the EMS System.

Quality improvement monitoring

The measurement and assessment process (CQI) related to restraint seeks to understand why it is used and incorporates this understanding into the System's plans and priorities to evaluate and reduce the risks associated with restraint use through an initial baseline assessment and targeted monitoring.

The patient care reports will be evaluated for all patients who were placed in physical restraints or who received chemical restraints for appropriate and complete documentation.

Data from all episodes are analyzed to identify opportunities for improvement.

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PURPOSE:

To establish guidelines whereby local, county, state and federal law enforcement jurisdictions and correctional institutions collaborate with EMS in the provision of medical care to prisoners/inmates and patients in law enforcement custody.

POLICY

I. **Workplace violence definition**: Act of aggression directed towards persons at work or on duty and ranges from offensive or threatening language to homicide. Workplace violence is commonly understood as any physical assault, emotional or verbal abuse or threatening, harassing or coercive behavior in the work setting that causes physical or emotional harm (ENA, 2010).

Workplace violence response policy: Ideally, the workplace should be free of violent threats or actions and staff should feel safe while at work. Violence against any healthcare worker is not permitted and will not be tolerated. Assaults are not considered part of the job or acceptable behavior. Report all violent incidents to employer and to EMS MD as soon as possible.

"**Universal Precautions for Violence**": Violence should be expected but can be avoided or mitigated through preparation. All EMS personal shall understand the importance of maintaining a culture of respect, dignity, and active mutual engagement in preventing workplace violence.

EMS agencies shall take reasonable precautions to prevent workplace violence against their personnel. If responding to a person in custody, they shall take steps to provide adequate EMS staffing and PD security, good lighting; eliminate sight and communication barriers, and when possible respond to areas with surveillance and alarm systems (OSHA).

Procedures should ensure ongoing identification of workplace hazards and risk evaluation; tracking of progress in implementing controls; formal post-incident evaluation and after action reviews (OSHA roadmap). EMS personnel should undergo education on hazard recognition and control and steps to take during emergency situations involving persons in law enforcement custody that may involve hostage situations or violence. Training should include preventive measures such as how to recognize cues that a patient or situation may become violent, neutralize potentially violent situations, prevent or manage violence and avoid physical harm.

II. **EMS will promptly assess and treat within EMS scope of practice all patients in law enforcement custody for whom an emergency response is requested.**

A. Patients in law enforcement custody are entitled to and will receive the same standard of care provided to other EMS patients.

B. Patients in law enforcement custody will be afforded normal courtesies and in turn will display the same to EMS and public safety personnel. Use professional tone of voice; call the patient Mr. or Ms. if you do not know his/her first name.

C. When called by law enforcement to assess/transport a person in custody, law enforcement shall communicate to EMS the following behavioral history of the patient relative to past violence, drug abuse, criminal activity, or assaultive behaviors if known:

1. Type of substance abuse or violence including nature, severity, and pattern.
2. Any event triggers if known and de-escalation responses.

Information gained should be used to formulate individualized plans for early identification and prevention of future violence.

D. It is not within a PM's scope of practice to give prisoners **prescription medications** or to assist or observe them taking their own medications as EMS has no way of verifying that the medication in the containers present with the prisoner is the drug or dose purported to be on the label. Law enforcement agencies are responsible for creating policies for prisoner medication administration that usually involve nursing personnel.

E. Should the behavior of any patient in law enforcement custody become maladaptive (i.e., harassing any emergency responder, making threats, asserting him/herself in such a manner that is offensive), this is to be immediately reported to the law enforcement/ correctional officer [OFFICER]. EMS should take immediate precautions to protect their safety and the safety of the prisoner/patient per policy and SOP. Appropriate actions must also be taken by the OFFICER/correctional facility personnel.

III. **PATIENT CARE**: Patients in law enforcement custody are classified by the law enforcement jurisdiction/correctional facility according to their level of security risk; therefore their **right to privacy will not be the same as a non-prisoner patient.**

A. All patients in custody will be accompanied by OFFICER(s), the number and proximity to the patient to be determined by the jurisdiction. The OFFICER(s) must be present at all times unless asked to temporarily leave the area by a physician. Stay within sight of the OFFICER at all times. This may mean that an OFFICER is traveling immediately behind the ambulance if the patient is considered low risk for violence or flight.

B. OFFICERS are authorized to carry weapons while accompanying patients in custody in EMS vehicles.

C. Treat and interview aggressive or agitated patients in relatively open areas that still maintain privacy and confidentiality

D. Focus assessment only on information necessary to determine the patient's needs and provide care.

E. Perform activities simultaneously at the point of patient care to minimize traffic in and out of the point of patient contact.

F. Make sure that oral medications have been swallowed and all sharps have been secured

G. For all situations that require a patient in law enforcement custody to be sedated by EMS, the OFFICER must remain with the patient.

H. For security reasons, do not give any information regarding return transports or scheduled procedures to patients in law enforcement custody. Limit your information to pertinent medical issues.

I. Do not accept inquiries or calls about the patient. Prisoners are not allowed to communicate or come into physical contact with attorneys, family members or any non-law enforcement persons while being transported. Notify the OFFICER immediately of any inquiries or calls received. The patient in law enforcement custody may not receive any calls while in the care of EMS.

J. EMS staff shall adhere to the stated security measures and will not intervene or interfere with security measures instituted by accompanying OFFICER(s). If they sincerely believe them to be illegal and/or unethical and pose an imminent unnecessary risk of harm to the patient, EMS has a duty to report their concerns to their immediate supervisor and OLMC.

K. **DO NOT:**

1. Wear a stethoscope, lanyard, or jewelry around the neck; hoop or drop earrings
2. Wear your ID badge while in the prisoner's presence
3. Carry pens, scissors, or sharp instruments in your pocket
4. Provide care without an OFFICER present, unless classified as a low security or violence risk
5. Reveal the destination or anticipated activities once at the destination facility
6. Make or respond to small talk or exchange pleasantries with prisoner patients
7. Give personal information to the patient in law enforcement custody
8. Take unnecessary equipment to the point of patient contact or leave healthcare supplies in that location upon departure

L. **DO**

1. Announce your presence before touching a sleeping or nonresponsive patient in law enforcement custody.
2. Wear long hair up, even if in a ponytail. Grabbing hair is an easy way to get physical control over you.

IV. **Patient Rights to Consent and Refusal of Assessment/Care**

A. If the PD has determined via breathalyzer that a person has a blood alcohol level above the legal limit and the **EMS assessment reveals** no altered mental status/impairment, no hypoglycemia, no hypoxia or hypercarbia, no slurred speech, the person answers questions appropriately, can perform rapid alternative movements and has a steady gait, **they may be considered decisional** if they understand any medical concerns or reasons why the PD wants them transported and the potential consequence of no transport. Legal intoxication numbers alone do not correlate with decisional capacity. If in doubt, contact OLMC for a recommendation.

B. **If decisional, they do not lose the right to make decisions regarding their medical treatment.** Law enforcement agents cannot compel healthcare personnel to act in disregard of the rights of any person, regardless of whether or not such person is in police custody. If a police officer denies treatment of a prisoner that appears medically indicated, provide the officer with full disclosure of risk and attempt to gain their cooperation. Contact OLMC and have the officer speak directly with a physician.

C. Patients in law enforcement custody have the same **rights to informed consent** as any patient treated by EMS. They are to receive sufficient information in order to make informed decisions about their care, including consent for or refusal of treatment. The patient will receive verbal instructions regarding his/her care including disclosure of risks.

D. If a prisoner is non-decisional, they shall be treated under implied consent.

E. **Ensure patient confidentiality is maintained**. Confidentiality of patient information will be accomplished through the System's electronic patient care report and Confidentiality policy per usual and customary procedure. Do not discuss the patient with anyone outside of health care or law enforcement personnel with a need to know. Law enforcement does not communicate medical information with an adult prisoner's family. If a juvenile is in custody that needs treatment, officers will coordinate notification with the hospital and the subject's family.

V. **Restraints**

A. The use of administrative restraints (handcuffs, shackles) shall be determined by the OFFICER unless such use is contraindicated by certain medical considerations specified by the patient's condition and approved by OLMC (pt in labor). The escorting OFFICER(s) are responsible for notifying the appropriate individual(s) at the local law enforcement agency/correctional institution should the administrative restraints be removed for medical reasons per their internal policies. EMS personnel must be notified in all cases when administrative restraints are removed so appropriate medical restraint precautions can be applied concurrently.

B. If physical and/or chemical restraint is needed, EMS policy/procedures shall apply.

C. Any conflicts in the degree and/or type of restraint-use will be resolved in consultation with OLMC and the OFFICER.

VI. **Infection Control**

EMS infection control policies/procedure will be followed per usual and customary procedures

VII. **Movement/Transport of a Patient in Custody**

A. Exercise extra vigilance and care in elevators, stairwells, and in safely securing patient in the ambulance.

B. EMS personnel will have the final decision about persons (other than OFFICERS) wishing to be transported with a patient in custody in the ambulance. Safety is paramount to minimize distractions for EMS responders in executing their professional duties.

C. PD has a right to transport any prisoner for medical evaluation based on their own guidelines. A decisional patient can ride in a squad car if PD believes there is a reason for hospital evaluation when the patient is refusing EMS transport.

D. Patients in law enforcement custody will enter the hospital through the emergency department. After entering, he/she will be escorted to the assigned bed and/or special area. The registration process should be expedited to minimize disruption to regular operations.

E. **Transfer from one Medical Facility to Another**

Coordination and arrangements for transfer from one medical facility to another will be made in concert with the local law enforcement jurisdiction/correctional facility and Healthcare facility administration. Consideration is given to the best mode of transportation, security, and directions provided by the physician at the receiving facility.

VIII. **Escape Risk**

A. In the event of escape of a patient in law enforcement custody, EMS personnel are to stand clear and not attempt to detain the patient. Take all appropriate precautions for personal safety if escape is attempted. Law enforcement officers will likely wish to interview witnesses to determine course of action.

B. It is the responsibility of the OFFICER to contact law enforcement/correctional facility for further contacts with and assistance from the appropriate legal system.

C. If, in the opinion of the ranking institutional official, the local or state police should be notified, the Shift Commander or Security Lieutenant shall assume the responsibility for notifying the appropriate law enforcement agency(ies). During treatment, OFFICER on scene will make necessary notifications. If a prisoner is being transported and/or admitted to a hospital and not being guarded, EMS personnel/hospital security should call 911 and report the escape immediately. The local PD will respond and contact the home agency.

IX. **Death of a Prisoner Patient**

Upon the death of a patient in law enforcement custody, the appropriate local, county, state, or federal law enforcement jurisdiction/correctional institution will be notified. Instructions for disposition will be received from the jurisdiction/institution.

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https://www.emsworld.com/article/12073030/evaluating-patients-decision-making-capacity

Evaluating Patients' Decision-Making Capacity

05/11/2015 **Issue:** June 2015. Thom Dunn, NRP, PhD

EMS is called to a local drinking establishment for a report of a bar fight with injuries. After arriving on scene and checking in with the police, the crew is directed to a 22-year-old male standing outside, holding a bloody bar towel to the upper left quadrant of his abdomen. "I've been stabbed in the gut!" he shouts. The attending paramedic finds a strong radial pulse of 124 and directs the man to start walking toward the ambulance. "I'm not going to the hospital, and you can't kidnap me!" he shouts even louder. The paramedic calls medical direction, which asks, "Is he sober and competent?"

EMS providers are regularly challenged with ethical issues during the course of their work. Ethical dilemmas are situations that present with no clear right answer and where more than one course of action can be defended. In the case above, there is a patient with penetrating trauma to the abdomen. In any EMS system, this is a priority patient. But wait: He is objecting to treatment and transport. The ethical dilemma is created due to our value of patient autonomy and shared decision-making between provider and patient. However, many would argue this patient is at high risk for a bad outcome if he doesn't seek medical care.

I started thinking about these issues long after I started working in EMS in the 1980s. I'm an active paramedic field instructor for an urban EMS system, but I'm also a clinical psychologist in an academic medical center. As a psychologist, I am regularly called upon to assess the decision-making capacity of patients who refuse lifesaving care.

After several years of this, I was invited to sit on the hospital's ethics committee, where many issues are similar to the case above: Someone refuses care or cannot voice their wishes, and others make decisions for them. What struck me most was how many EMS providers face the same ethical dilemmas as physicians, but without the support often found in hospitals (such as on-call specialists like psychologists, an ethics committee, risk managers, legal department, etc.). This article is intended to help guide EMS providers through an ethical dilemma they encounter often: the patient who needs treatment but declines help.

The Shared Decision-Making Model

EMS providers and physicians share many parallels. Both meet their patients and ascertain a chief complaint, then form a clinical impression after taking a history and performing a physical exam and using other diagnostics. Options are discussed, and a treatment plan is decided upon. This model, "shared decision-making" (SDM), came about in the early 1990s and honors the patient's right to autonomy over their own body.[1] This is the bedrock of informed consent. The patient is given options, risks and benefits are explained, and the patient makes an informed choice. Conflict arises when the provider and patient are unable to reach a decision together about the best course of action, typically when the patient decides differently than what the clinician believes to be the best.

EMS providers regularly meet patients who decline ambulance transport. For example, there are individuals who are injured in motor vehicle collisions, but not sufficiently that they believe they need prehospital care and transport. Similarly, diabetics who have become hypoglycemic and recovered after the administration of glucose often decline transport. In most EMS systems, the patient and provider complete paperwork documenting the patient's decision not to be transported by ambulance. Often this paperwork documents the risks to declining care and that the patient has been informed of such risks in deciding against transport.

Less common but far more risky are the patients who *would* likely benefit from transport and treatment who decide against it. In some instances these patient may be making decisions that will lead to death or disability. It's a fine line for the paramedic or EMT to walk: Respect the patient's right to autonomy to refuse care, while knowing such a decision may lead to that patient's death. In these instances, most EMS systems require the EMT or paramedic to assess the patient's capacity to decline transport and make contact with medical control. The case at the beginning is an extreme one, but exploring it can help frame how to approach such situations.

Evaluating Capacity

While the word *competent* is often used when discussing decision-making ability, such a term is typically reserved for use only by judges making legal decisions.[2] Our discussion concerns medical decision-making ability (as opposed to the capacity to make other decisions, such as financial ones). The physician's question, "Is he sober and competent?" speaks directly to this. It means, "Are there features about this patient that impair his ability to make decisions?" including intoxication. It's important that EMS providers are able to evaluate medical decision-making capacity.

There are several different approaches to assessing decision-making capacity. I am partial to this one and use a modified version of it when working as a paramedic and or assessing patients as a psychologist.[3]

1. Is the patient an adult without a guardian? In the prehospital arena, children may not refuse transport. Some adults also have guardians who make their decisions. In these instances the EMS providers deal with the patient's parent or guardian.

2. Can the patient communicate a choice about his or her care? For obvious reasons, if the patient cannot communicate their wishes, decisions have to be made by someone else. I also believe patients who refuse to cooperate with an evaluation regarding their decision-making capacity fall into this category. By refusing to communicate with me, these patients are deemed as lacking decision-making capacity. Steps 3 and 4 are incumbent on the patient being able to process information. Inherent in these steps is whether the patient is free from an altered mental status and not under the influence of an intoxicating substance. I also worry about patients with possible head injuries or other disease processes known to impair cognition (such as hypoglycemia, seizure/postictal phase, dementia, CVA, etc.). Be very careful about leaving patients behind who have central nervous system impairment and who you believe would otherwise benefit from ambulance transport. EMS providers need to be able to perform a thorough mental status exam (beyond "alert and oriented") and be aware of different signs of intoxication.

3. Does the patient have a factual understanding of their medical condition? It need only be a layperson's level of understanding, as evidenced by statements like, "You're worried a blood vessel in my heart is blocked," or "This pain in my stomach might mean I have internal bleeding after my car accident," or "Since I'm taking a blood thinner, there might be bleeding in my brain after I fell." Can the patient understand the risks and benefits of ambulance transport? Can they describe the risks of *not* being transported? Have the patient articulate them. Common risks are a condition that worsens and there's no provider to intervene or that without intervention they are likely to die. There are no risks to ambulance transport. (Getting into a crash is not a risk; medical risks are things like bleeding during an operation, not that the hospital might catch fire.)

4. Can the patient reason and come to a decision with a certain degree of logic? Perhaps the patient can talk about a medical condition and its possible consequences, but is still making an illogical decision—e.g., "I know you're worried I'm going to bleed to death, but bad things don't happen to me, so I don't need to go." This is an illogical conclusion. Finally, does the patient's decision present as rational and stable across time? This may be the hardest for a field provider to assess, but when it comes to whether the decision is rational, I ask, "What makes

you decide this way?" When the rationale for the decision is odd—like "I'm not going to the doctor because the mind control beams tell me not to!"—question whether it's a rational decision.

In a hospital setting, the more serious the decision being made, the more scrutiny is placed on the process that leads to that decision. For example, a patient making a decision that might lead to their death has to demonstrate an extraordinary capacity for making such decisions. In the field, there may not be time to perform a thorough decision-making capacity evaluation that rises to this level. Further, many EMS providers may not feel comfortable documenting that they let a person die instead of transporting because they documented the patient had sufficient capacity to make such a decision.

EMS systems do not typically have ethics committees or attorneys on speed dial because in an emergency, there is considerable leeway given to simply doing what seems to be in the patient's best interest. If the EMS provider believes the patient has impaired decision-making capacity *and* a bad outcome will happen if that patient is not transported, most EMS systems will permit an intervention over the patient's objections. That is, the patient's autonomy takes second place to intervening in a life- or limb-threatening emergency.

A patient with impaired decision-making capacity and a serious medical condition needs a capable person to start making decisions on their behalf. That may be the EMS provider or a family member in conjunction with the EMT or paramedic. This should never be seen as "kidnapping." While some patients are transported over their objections, this is a medical intervention to go the hospital. Ransom demands aren't made, and there is no ill intent. In the case of the person stabbed in the abdomen, it is unlikely he has enough decision-making capacity to let him decline care.

Conclusion

In summary, I believe patients have a right to make informed decisions I don't necessarily agree with. As EMS providers, we have to be careful about thoroughly assessing decision-making capacity and mental status, following protocols for patients who refuse transport, and documenting every encounter. Many systems also mandate discussing such cases with online medical control. Savvy EMTs and paramedics develop methods for resolving patients' concerns about being transported. Sometimes it's as easy as making sure a pet will be cared for or a loved one is contacted.

References

1. Brock DW. The idea of shared decision making between physicians and patients. *Kennedy Inst Ethics J,* 1991; 1(1): 28–47.

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3. Jones RC, Holden T. A guide to assessing decision-making capacity. *Cleve Clin J Med,* 2004; 71(12): 971–5.

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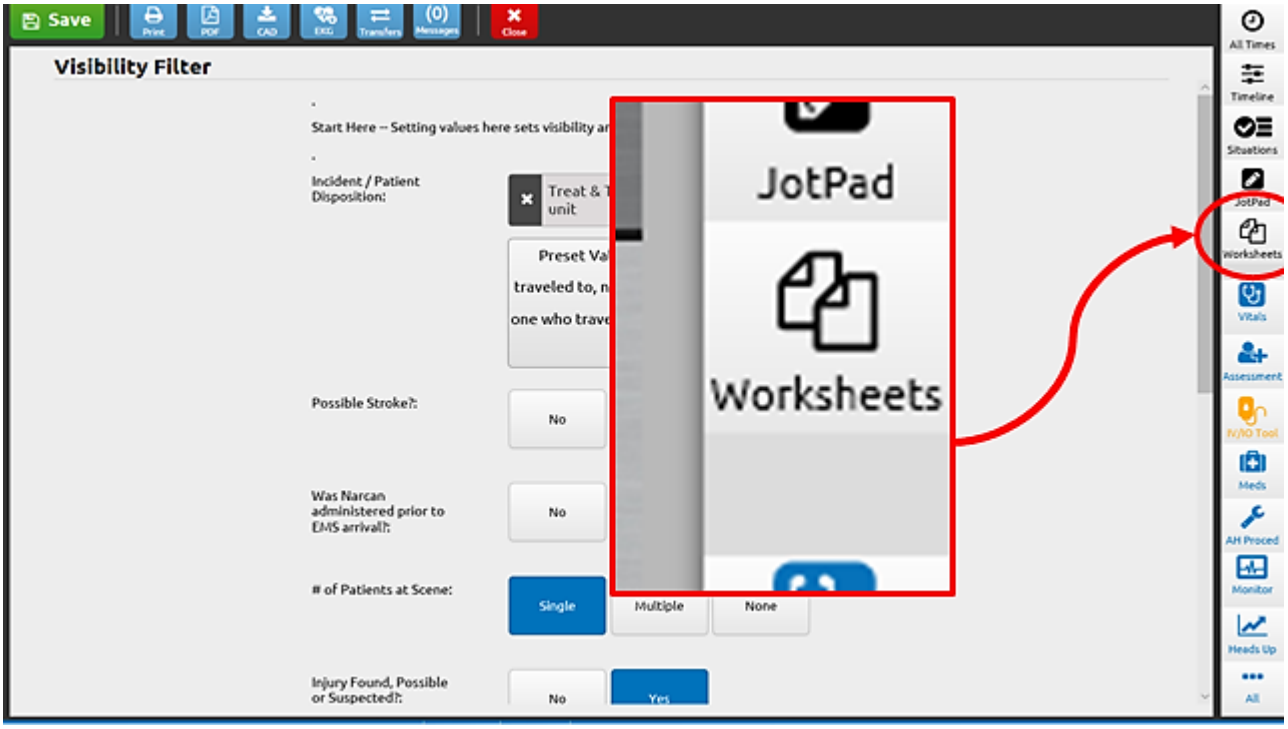
Slide 1



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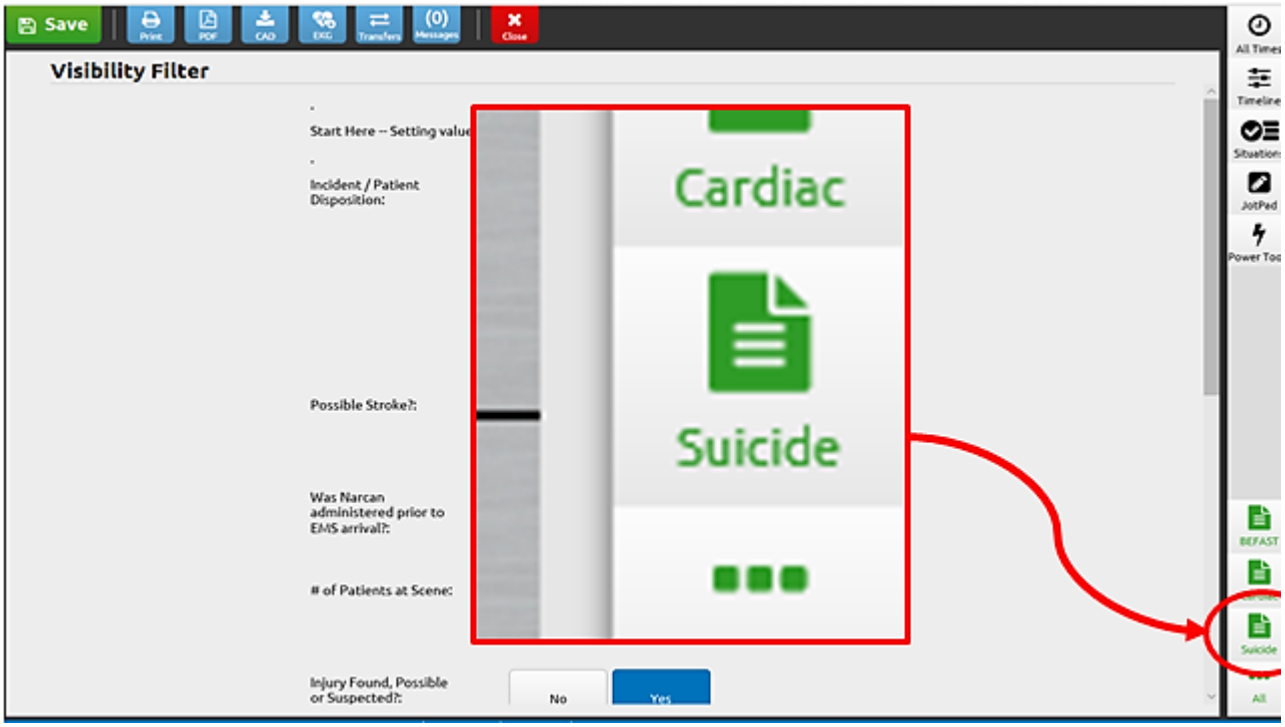

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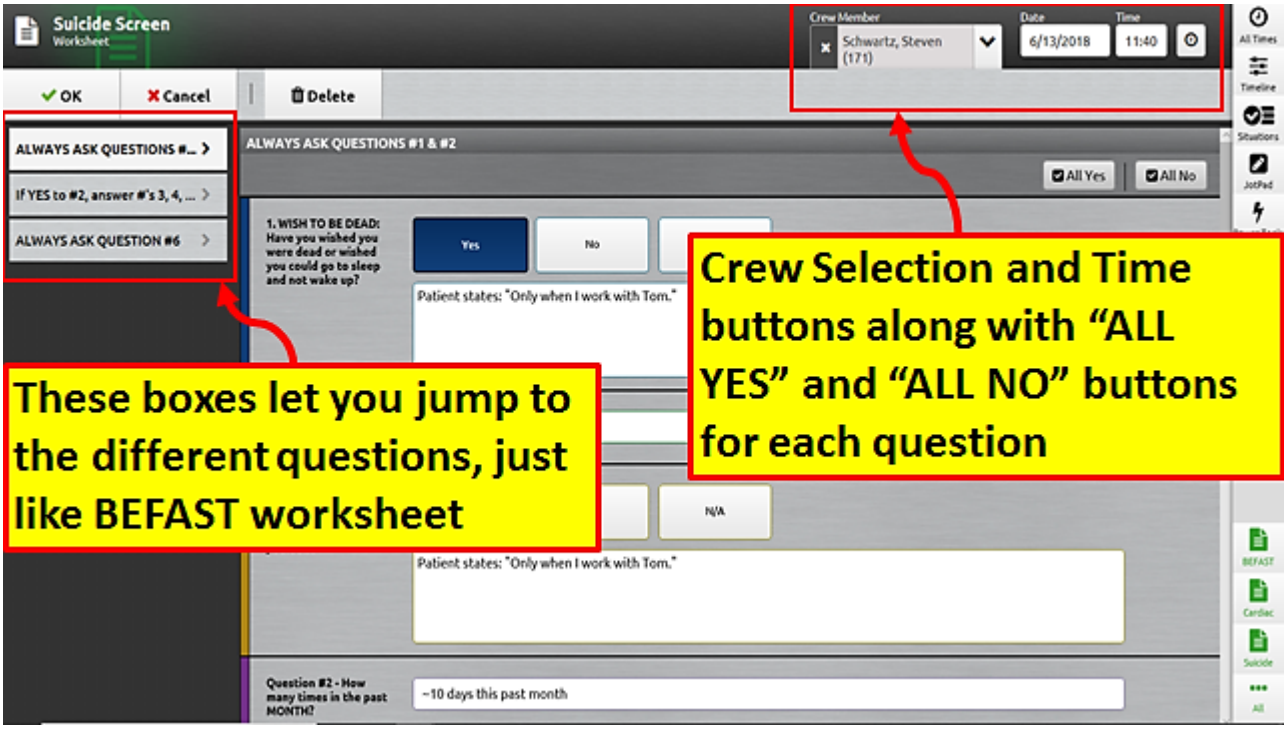

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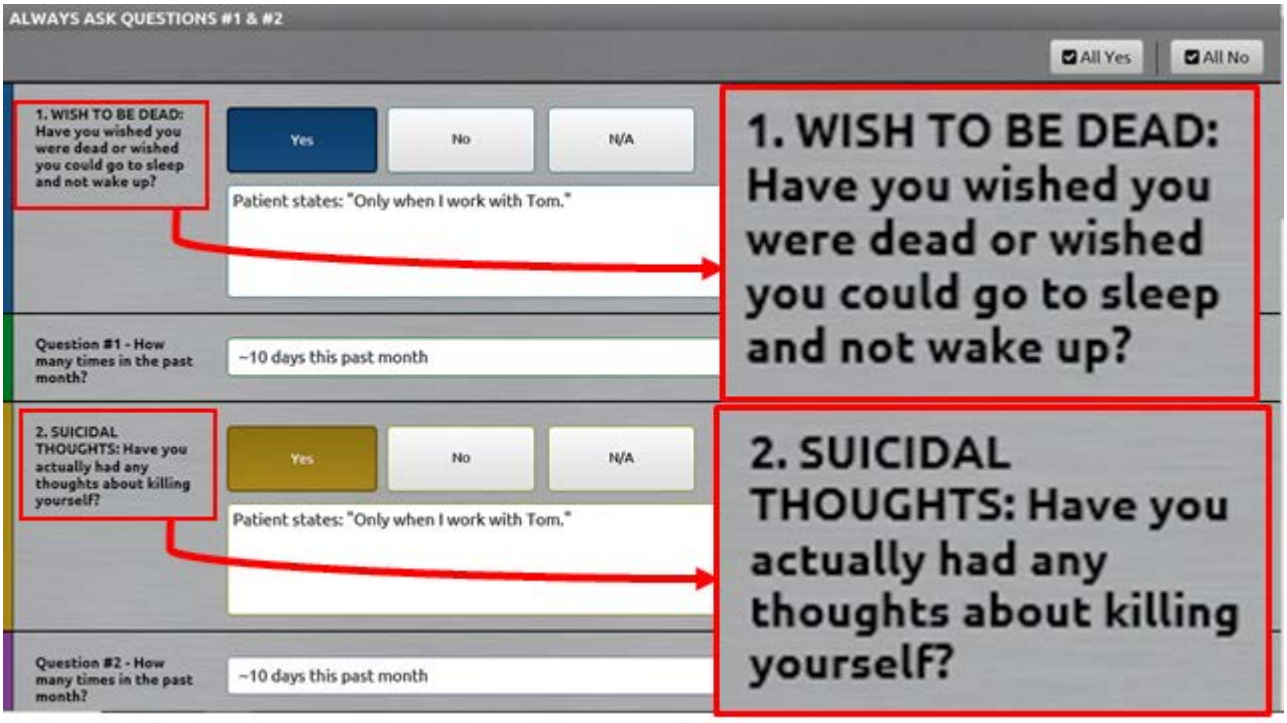

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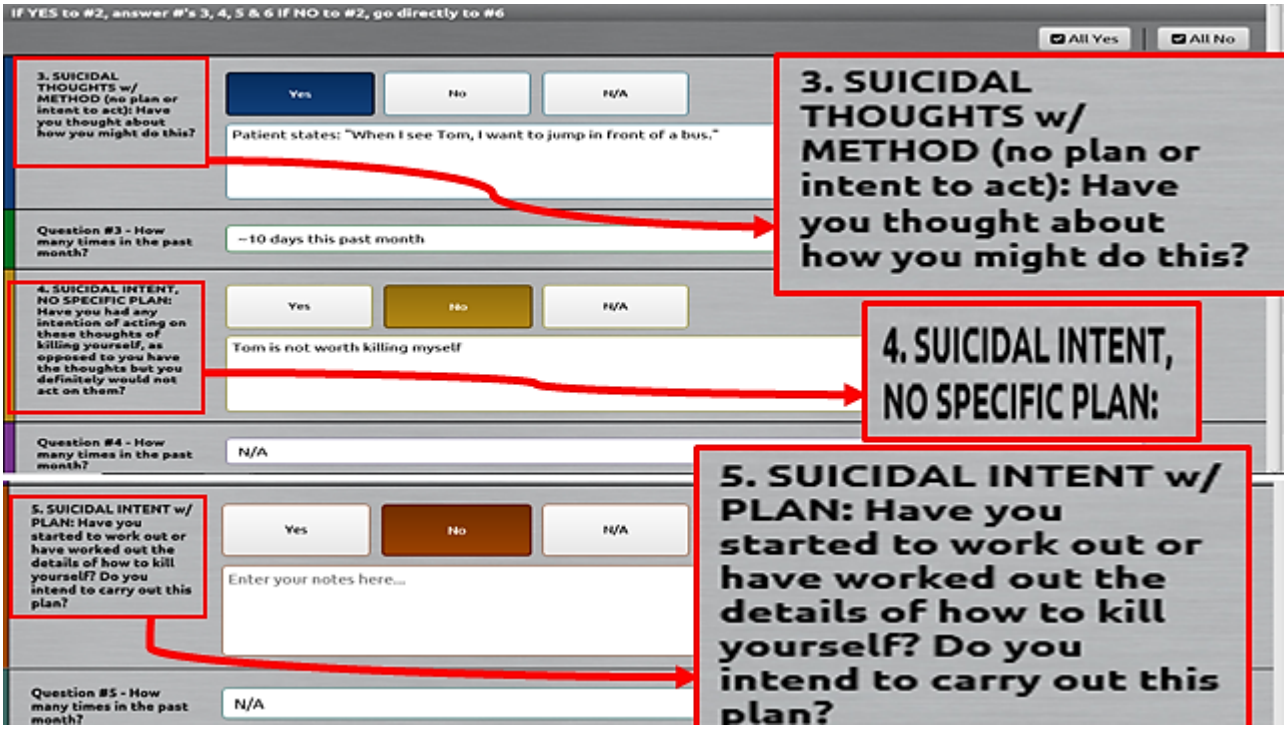

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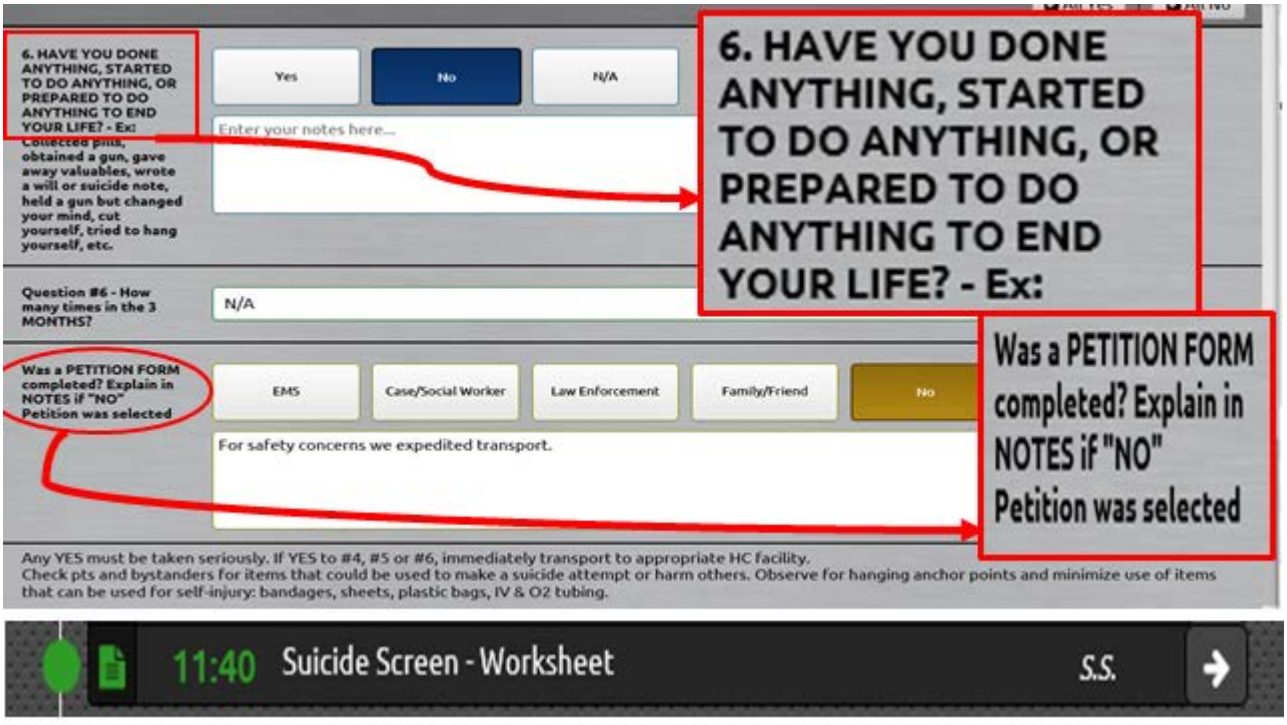
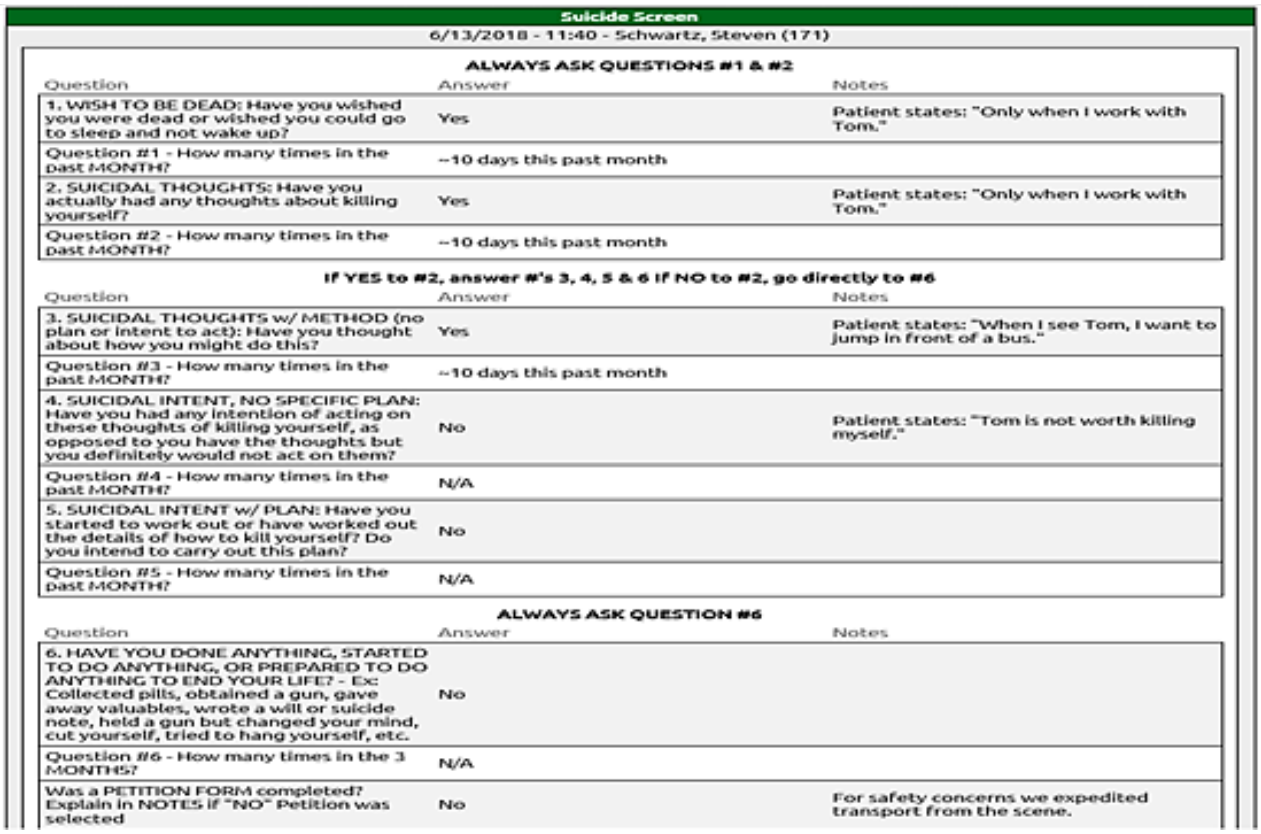


Question #6 shown in BOLD type as to highlight what to say to the individual. If you needed to expedite transport you could justify it in the petition note field. The black pic shows how it is in the "TIMELINE"

Slide 7



Suicide Screen

6/13/2018 - 11:40 - Schwartz, Steven (171)

ALWAYS ASK QUESTIONS #1 & #2

Question	Answer	Notes
1. WISH TO BE DEAD: Have you wished you were dead or wished you could go to sleep and not wake up?	Yes	Patient states: "Only when I work with Tom."
Question #1 - How many times in the past MONTH?	~10 days this past month	
2. SUICIDAL THOUGHTS: Have you actually had any thoughts about killing yourself?	Yes	Patient states: "Only when I work with Tom."
Question #2 - How many times in the past MONTH?	~10 days this past month	

If YES to #2, answer #'s 3, 4, 5 & 6 IF NO to #2, go directly to #6

Question	Answer	Notes
3. SUICIDAL THOUGHTS w/ METHOD (no plan or intent to act): Have you thought about how you might do this?	Yes	Patient states: "When I see Tom, I want to jump in front of a bus."
Question #3 - How many times in the past MONTH?	~10 days this past month	
4. SUICIDAL INTENT, NO SPECIFIC PLAN: Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?	No	Patient states: "Tom is not worth killing myself."
Question #4 - How many times in the past MONTH?	N/A	
5. SUICIDAL INTENT w/ PLAN: Have you started to work out or have worked out the details of how to kill yourself? Do you intend to carry out this plan?	No	
Question #5 - How many times in the past MONTH?	N/A	

ALWAYS ASK QUESTION #6

Question	Answer	Notes
6. HAVE YOU DONE ANYTHING, STARTED TO DO ANYTHING, OR PREPARED TO DO ANYTHING TO END YOUR LIFE? - Ex: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.	No	
Question #6 - How many times in the 3 MONTHS?	N/A	
Was a PETITION FORM completed? Explain in NOTES if "NO" Petition was selected	No	For safety concerns we expedited transport from the scene.

This is what the summative report (in the printed PCR left with ED) will look like.