

Psychiatric Patient Handling

Combative and non-combative presenting patients in medical transport

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Introduction

There remains a great deal of uncertainty regarding the legal principles applicable to EMS response to combative patients and psychiatric non-combative presenting patients in both emergency and non-emergency transport. This article will address some of those legal principles, concepts and court findings concerning legal and appropriate restraint measures used to control and protect patients and others. It will also provide some guidance on generally agreed upon best practices to protect patients in medical transport.

Discussion

The role of providing emergency medical care in the relatively uncontrolled pre-hospital environment frequently places Emergency Medical System (EMS) personnel in harm's way. Agitation or confusion related to medical problems and violence from psychiatric disorders are frequently encountered by EMS personnel. A convenience sample of registrants at a National Association of EMS Physicians (NAEMSP) meeting found that about half of the EMS systems sampled did not have protocols for the management of violent patients.¹

The right to legally touch a patient being transported in emergency and non-emergency situations is determined by the concept of consent to medical care. This is a pre-requisite to the delivery of pre-hospital care for every single patient, regardless of their state of mind. Without consent, there is no right to treat and transport and, therefore, no legal authority to physically restrain a patient, unless done in self-defense such as with combative patients. To do so without meeting the legal interpretation of consent the EMS provider could be considered to have committed acts defined as assault and battery or false imprisonment. Additionally however, this authority requires the restraint applied must be "objectively reasonable" under the circumstances presented. Fortunately in some cases courts have found that EMT's are protected from negligent liability. For example, " the U. S. District Court for the Eastern District of Michigan, Southern Division found that in the course of providing EMS services the Defendants actions were "objectively reasonable" under the circumstances, entitling Defendants to governmental immunity for their actions. Protection is limited based on the nature and degree of the restraint." ⁴ The state of Michigan established a law, The Emergency Medical Systems Act (EMSA), that provides statutory authority to the EMS provider to restrain a patient pursuant to medical protocols and only to the degree necessary to administer medical care and treatment of the patient and not for the sole purpose of physically restraining or injuring the patient. ⁴

There remains a great deal of uncertainty regarding the legal principles applicable to EMS response to combative patients and psychiatric non-combative presenting patients in both emergency and non-emergency transport. This article will address some of those legal principles, concepts and court findings concerning legal and appropriate restraint measures used to control and protect patients and others. It will also provide some guidance on generally agreed upon best practices to protect patients in medical transport.

Guidance

Combative presenting patients in medical transport

Patients presenting combative behavior before or during initial attempts to restrain them are a danger to themselves or others, in particular when being transported for emergency and non-emergency treatment. According to a leading legal authority "EMS service providers face combative, agitated and at times even violent patients on a consistent basis."⁴

A 1998 survey addressing experiences with pre-hospital violence was administered to 774 EMS providers in Southern California. Once law enforcement was excluded from the sample of EMS providers responding to the questionnaire, 490 EMS providers (63%) responded to the survey. Of the EMS providers responding, 61% reported having been assaulted on the job, with 25% of those reporting injury. Of those injured, 37% required medical attention. Interestingly, however, only 35% of the EMS providers surveyed reported working at the time for a provider that had specific protocols for management of combative and/or violent patients and only 28% reported having received any formal training, despite the fact that nearly all 490 EMS providers responding (95%) reported having restrained patients."¹

In 2002 the National Association of EMS Physicians (NAEMSP) presented a summary of the most comprehensive data available regarding the magnitude of violence against EMS providers. The data summarized by the NESP indicate that despite an increasing number of EMS encounters with combative patients, less than half of EMS agencies surveyed across the country had established protocols and guidelines for dealing with such patients. ¹

Providing reliable information concerning how to deal with these types of situations routinely experienced by EMT providers requires an understanding of existing state and federal laws and regulations, many not always defined or interpreted in a uniform and precise manner. For example, the Michigan law, the Emergency Medical Services Act (EMSA) identifies basic legal requirements for the management of patients in general and combative patients in particular. This law treats the administration of restraints as a medical procedure and as such EMT's are legally authorized to administer restraints so long as they are employed as part of an EMT's duties in rendering medical treatment and transport to a patient. ⁴ However, there are conditions and limitations applicable to a "health facility or agency" under the Michigan Patient Bill of Rights. The statutory definition of "health facility or agency" includes ambulance operations and personnel. ⁴

The Michigan law codifies the right of a patient to refuse EMS care and transport. Under the provision entitled "Objection to Treatment or Transportation" which expressly provides that the rules promulgated thereunder "do not authorize medical treatment for or transportation to a hospital of an individual who objects to the treatment or transportation."⁴ There are two generally recognized forms of consent codified in the law. "Express consent (the patient voluntarily stating his or her consent to treatment and transport."⁴ Implied consent, the EMS provider implying the consent based on the patient's condition and circumstances, i.e., unconscious patients."⁴

One common misconception among EMS providers when dealing with combative patients relates to the use of physical force in restraining a combative patient. Implied consent provides legal authority to administer treatment and transport for the patient, not to use physical force for this intended purpose. Physical and chemical restraint of a patient is considered a medical procedure when done properly and not an enforcement procedure, as might be applied by police.

In the Michigan law it states, "If emergency medical services personnel, exercising professional judgment, determine that the individual's condition makes the individual incapable of competently objecting to treatment or transportation, emergency medical services may provide treatment or transport despite the individual's objection unless the objection is expressly based on the individual's religious beliefs". Furthermore, the State Protocol, approved by the Michigan Department of Community Health, includes a definition of a "Competent Individual" which clearly recognizes the legal authority of EMS to imply consent to provide care and transport for a combative patient. It defines a competent individual as:

- One who is awake, oriented and is capable of understanding the circumstances of the current situation.
- Does not appear to be under the influence of alcohol, drugs or other mind altering substances or circumstances that may interfere with mental functioning.

- Is not a clear danger to self or others.
- Is 18 years of age or older, or an emancipated minor.

So, there is no question that in the case of a combative patient, an EMS provider has the legal authority to provide treatment and transportation over the objection of the patient, so long as the provider has first determined that the patient is not competent to refuse care based on any of the protocol criteria, including the criteria exhibited by every combative patient; “clear danger to themselves”. In Michigan’s law it recognizes that restraining a combative patient is a medical procedure, when it is administered pursuant to the orders of a physician or in an emergency to prevent the patient from causing harm to himself/herself or others. 4

Legally exercising physical force and police powers over a patient

“EMT providers do not have the legal authority to exercise police powers over a patient. The authority to exercise physical force (i.e., arrest and detain) is limited by statute to those entities and individuals with legal authority to exercise police powers.” 4

The right of EMT’s to self-defense in the case of a combative patient

“If a combative patient physically attacks an EMS provider, that provider has the right to exercise such reasonable force as may be necessary to protect him or herself from bodily harm in repelling the assault.” 4

Non-combative presenting patients in medical transport

Psychiatric patients are often transported in non-medical situations as inter-facility transfers for a variety of reasons ranging from appointments at doctor’s offices, off site therapy and medical procedures such as kidney dialysis. These patients frequently do not present combative or serious medical conditions requiring continuous care, observation and control by medical doctors or nurses. Often these patients need assistance walking using crutches or walkers to move about. Patients needing inter-facility transfers may require qualified EMT’s or paramedics to monitor their vital signs and are transported by ambulance. Usually the ambulance litters are equipped with standard three or four strap passenger restraints that are usually sufficient to prevent the patient from freely moving off the litter. But patients initially seeming to be in a stable state of mind may have underlying mental conditions causing them to become fearful. They may cause the EMT’s to assume they do not need close observation and they can sit facing the head of the patient to complete transport paper work. The patient may see this as an opportunity to escape a fear inducing situation and release themselves from their restraints without the ambulance personnel notice. The worst possible scenario is when patients have become so fearful or agitated they attempt to flee the situation by escaping through the rear doors of the ambulance while the vehicle is still moving. Patients falling from a moving ambulance are likely to suffer serious injury and can result in a fatality.

In 1993 the National Association of State EMS Directors (NASEMSD) and the National Association of EMS Physicians (NAEMSP) issued a joint position statement on Emergency Medical Services and Emergency Medical Services Systems in response to a white paper by the National Academy of Science’s National Research Council describing inadequacies in the emergency health care available in the United States. The statement provided a list of the resources needed of a comprehensive EMS system. These resources included identification of professional, occupational and lay disciplines; facilities, agencies, and organizations; equipment; funding; 1 and described in detail the functions of EMS systems all of which created the foundation of the current emergency management systems in place today. There have been expected changes and modifications since then, many reflected in best practices and standards developed by these and other associations over the years. Listed below are many of those standards and best practices. 3

Best Practices for the restraint of emergency/non-emergency transport of patients

- EMS providers should carefully and thoroughly document all the facts contributing to the decision that the patient was not competent when deciding to imply consent. The documentation should determine if there was any evidence of factors affecting the patient’s level of consciousness (i.e. alcohol, drugs, head injury, altered level of consciousness, etc.).

- Transferring and accepting physicians know the problems and needs of patients requiring transportation, but are not always cognizant of the capabilities of transport services and personnel.
- Emergency medical services systems and their medical directors must be knowledgeable regarding system capabilities and role regarding transportation 2

Medical direction during an inter-facility transport

Options for medical direction during transport include:

- Transferring physician assumes medical direction, or the medical director of the transport service assumes medical direction, or the accepting physician assumes medical direction or a shared pre-defined responsibility with a transfer of control en route.
- Appropriate transfer is defined by these variables:
- Provision of medical treatment within the transferring physician/hospital's capacity that minimizes the risks to the patient or unborn child's health
- Accepting facility has available space and qualified personnel for treatment of the patient and agrees to accept the patient in transfer.
- Medical records from the transferring hospital be sent to the accepting hospital
- Transport by qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measure during the transport.
- The transport personnel must be qualified to handle potential complications or deterioration in the patient's condition that might occur during transport "3

It is important to note the success of this last factor is dependent on the personnel selected who must have the level of training required, dependent usually on the severity of illness or injury of the patient. Case law has established that "qualified personnel and equipment" may be a higher level of care than is generally available on most routine EMS transport vehicles. The transferring physician is usually responsible for the order to transfer and for the treatment orders to be followed during the transport. This varies by state statute and can be conflicting with medical instructions. In some states, only an authorized medical direction physician may give orders to EMS personnel. Under those circumstances, the transporting service's medical director or an approved online medical direction physician becomes responsible for the orders.

Pre-hospital patient restraint (PPR) protocols in EMS systems

Pre-hospital patient restraint provides verbal, physical, and/or chemical restraint to allow for the safe transportation and treatment of the violent, combative, or agitated patient by EMS personnel. Properly applied PPR may reduce the possibility of patient injury, reduce the potential for injury to EMS providers, and allow for timely and appropriate treatment and transportation of a patient to a medical or psychiatric facility. There are hazards to improperly applied restraint. Severe and potentially life-threatening complications have been reported in individuals who were restrained by law enforcement, health care, and EMS personnel. The American College of Emergency Physicians endorses restraint principles, and provides recommendations that are consistent with these principles. The Joint Commission on Accreditation of Healthcare organizations (JCAHO) requires restraint policies and procedures within hospitals in an effort to minimize adverse events. EMS services that are owned or operated by hospitals should consult with their hospital administration during the development of the PPR protocol to assure that the protocol is consistent with applicable JCAHO requirements.

Guidance to EMS providers and medical directors in developing PPR policies and protocols:

An overview of assessment of the methods that are currently in use throughout the United States.

1. The safety of EMS personnel is the paramount factor during PPR, followed by the importance of protecting patients from injuring themselves or others.
2. Every EMS service should have a PPR protocol that is applicable to all violent or combative patients.
3. The protocol should outline the indications for patient restraint. The policy should be consistent with state laws and local EMS protocols regarding patient refusal of care and the EMS system's responsibility to care for patients with psychiatric or behavioral emergencies.
4. Patient dignity should be maintained during restraint, and the method of restraint should be individualized to use the least restrictive method of restraint that protects the patient and EMS personnel from harm.
5. The protocol must include a patient assessment to identify and manage medical conditions that contribute to a patient's violent behavior. Such conditions include, but are not limited to, hypoxia, hypoglycemia, alcohol or drug intoxication, stroke, and brain trauma.
6. The protocol must address the types of restraint devices that will be used (verbal, physical, or chemical), when each will be used, who can apply them, and when direct medical oversight must be involved.
7. Direct medical oversight may be required for combative patients who refuse treatment, for orders to restrain a patient (before or immediately after restraint), or for orders for chemical restraint (before or after medication is administered).
8. The PPR protocols should address the type of physical restraints that are permissible. Any restraint used should allow for rapid removal if the patient vomits or develops respiratory distress. Patients should never be transported while hobbled, "hog-tied," or restrained in a prone position with hands and feet behind the back. Patients should never be transported while "sandwiched" between backboards or mattresses. Restraint techniques should never constrict the neck or compromise the airway.
9. Hard restraints, such as handcuffs, are generally not acceptable for EMS use. If patients are restrained in devices that require a key, the key must accompany the patient during treatment and transportation.
10. Continued patient struggling after restraint application can lead to hyperkalemia, rhabdomyolysis, and cardiac arrest. Chemical restraint may be necessary to prevent continued forceful struggling by the patient.
11. Chemical restraint, usually with a butyrophenone, a benzodiazepine, or both, is an effective method of protecting the violent or combative patient. Paralytic agents are not an acceptable alternative for PPR unless they are also clinically indicated to treat an underlying medical or traumatic condition.
12. After patient restraint, there must be regular and frequent evaluation of the neurovascular status of all restrained extremities and the respiratory and hemodynamic condition of the patient.
13. Documentation of patient assessment, reason for restraint, restraint procedure, frequency of reassessment, and care during transportation should occur for all patients who require restraint. These components should be evaluated during system continuous quality improvement processes. Systems should consider reviewing every case of patient restraint for compliance with the PPR protocol.
14. Local law enforcement policies may differ from the EMS restraint policies, but both agencies should recognize their roles and work cooperatively and proactively to assure the safe restraint of EMS patients when necessary.
15. Law enforcement officers should be involved in all cases when a patient poses a threat to EMS personnel or others. If law enforcement is not immediately available, EMS personnel should retreat to a safe place and await the arrival of law enforcement. If there is no option for retreat, EMS personnel may use reasonable force to defend themselves against an attack.
16. It is not appropriate for EMS personnel to use weapons as adjuncts in the restraint of a patient.

17. In rare situations, it may be necessary for law enforcement to apply restraint techniques to EMS patients that are not sanctioned by EMS policies. 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 PPR protocol. 1

If proper PPR protocols have been created then EMT providers need to follow a few simple steps to insure that the protocols are understood and followed by EMT's and paramedics. Here are the most basic steps for ensuring protocols are effective.

- Formally educate personnel on proper restraint techniques and equipment.
- Develop and disseminate appropriate protocols and guidelines. Every EMS service should have a written policy or guideline to outline the indications for patient restraints which should be consistent with State law and EMS System Protocols
- Coordinate with hospital and other agencies to identify combative patients, communicate treatment prior to transport and generally communicate when/how patients will need restraints.
- Once in transit have procedures to monitor restrained patients in both emergency and non-emergency transport.
- Thorough documentation by management of all training, performance evaluations and documentation by transport personnel of any and all events, procedures and services occurring or provided during each transfer.

References

1. Position Paper, National Association of EMS Physicians, "Patient Restraint in Emergency Medical Services Systems, Kupas, Douglas F., MD; Wydro, Gerald C. MD, February 28, 2002
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3. Joint Position Statement on Emergency on Emergency Medical Services and Emergency Medical Services Systems, National Association of State EMS Directors, October, 1992 and National Association of EMS Physicians, January 1993
4. MAAS SIWCF, Lansing, MI, May 2012; Volume 91, Safety Update, " MANAGING THE COMBATIVE PATIENT: WHEN A LITTLE RESTRAINT IS NOT ENOUGH", Blanco, Orlando, JD, Blanco Wilszynski, PLLC, Troy Michigan