Guideline: Disposition Decision of Adults with Severe Behavioural Disturbance Escorted by Police

Purpose

This guideline has been written to assist in the assessment and rapid determination of disposition of severely agitated or violent patients escorted by police to the emergency department.

This is in line with a zero violence policy and maintaining EC staff, patient and visitor safety.

This guide is supplementary to the Guideline for the **Management of Adults with Severe Behavioural Disturbance** (See EC guidelines)

Scope of Use

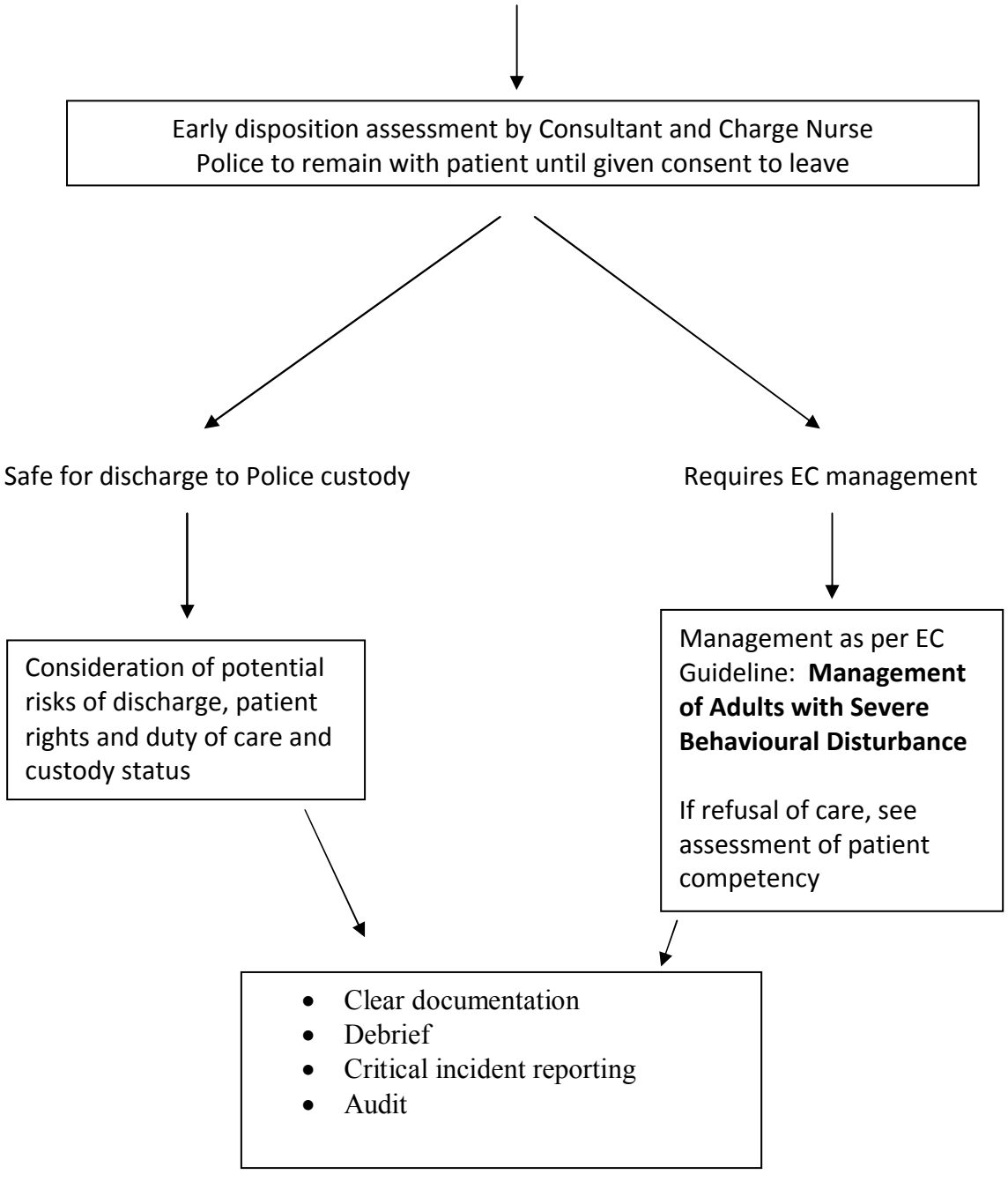
All EC medical and nursing staff

Guideline Content

- Decision flowchart
- Guideline key points
- Competence assessment in those that refuse treatment
- Key principles
- ACEM policy
- Legal obligations

Flowchart for Assessment and Disposition of Adults with Severe Behavioural Disturbance Escorted by Police to the EC

BEHAVIOURALLY DISTURBED
Safety to Staff and Others = Paramount
Treat all in quiet/low stimulus environment
Gain as much history, examination and reasonable investigations as possible



Guideline Key Points

1. Protect yourself, staff and patients
    - Call Charge Nurse *3704
    - Call CART (Calming and Restraint Team) consists of: Security, Registrar, Orderlies, Nurses
    - **Notify Consultant *3703**
    - **Avoid unsafe interaction If possibility of weapon**

2. Police to remain with the patient until determination of situation safety, disposition plan, and de-escalation methods (verbal +/- chemical) are complete if felt appropriate
    - Determination of patients custody status with the police
    - Police must remain with the patient at all times until verbal consent is provided for them to leave from the Consultant or Charge Nurse
    - Expected time limit for required police presence to determine disposition would be up to one hour. Certain circumstance may require longer police presence if ongoing safety concerns for patients health and persistent violent behaviours.

3. Early rapid assessment of patient by Consultant and Charge Nurse (or most senior available team). Consider potential causes of aggression/behaviour:
    - Organic/medical/traumatic
    - Psychiatric
    - Drugs and alcohol
    - Behavioural

4. Most patients can be safely verbally de-escalated for full assessment

5. If **no** concerns for any medical, acute psychiatric, or serious toxicological problem, patient can be discharged to police care
    - Consider delayed complications
    - Ensure patient safety and rights are maintained at all times
    - At risk groups should have a low threshold for EC management. These include, but are not limited to:
        - Elderly or those with cognitive impairment
        - New onset/acute behavioural change
        - Patients with mental health conditions
        - Medically comorbid
        - Those under the influence of drugs and alcohol
        - Those with a history of serious intentional drug overdose
        - Those with any history or sign of head injury

6. Those who are considered unsafe for discharge to police custody should be managed in the usual way as per EC guideline **Management of Adults with Severe Behavioural Disturbance.**
    - If refusal of ED treatment; assess patient competence in relation to autonomous decision making

7. Clear documentation must be maintained at all times documenting assessment and process.

8. Critical incident reporting and debrief as required

Assessing Competence in Non-consenting Patients

Please see separate printable decision making guideline for assessing competence

Background notes for the assessment to treat and/or detain potentially incompetent patients. **Consult CMDHB guides/policy**.

Three foundation points:

1. Patients have a right to refuse treatment, no matter how important that treatment might seem to the clinicians. However, under certain circumstances explicit or apparent refusal of care might be over-ruled and treatment provided. These circumstances often involve impaired patient 'autonomy' – often called 'incompetence' or 'lack of decision making capacity.'

2. Autonomy includes (among other things) these three key competencies:

    - knowing enough (being sufficiently informed),
    - thinking enough (cognitive ability), and
    - being free enough (not being forced into a decision)

3. Providing treatment without consent is ethically justified – and should have legal authority if **ALL** of the following three elements are present:

- There is good clinical reason to provide treatment.

AND

- There is good reason to believe the patient is not able to express his true autonomous wishes because the patient doesn't know enough, can't think enough or isn't free enough.

AND

- There is good reason to believe that, if the patient was able to adequately exercise his true autonomous wishes, the patient would consent to the treatment suggested.

Three final key points:

1. Such decision making isn't black and white. Discuss with (senior) colleagues.

2. The provision of treatment should be by the least freedom restricting method that works, with the following being an indicative 'ladder' of options. It is expected that each step will be entertained, albeit briefly in some circumstances, before going to the next:
    a) Reassurance (*"It's okay, we're doctors and nurses, we'll look after you…"*)
    b) Bargaining (*"Sit down and we'll have a look at that wound and then…"*)
    c) Threats (*"We'll have no choice but to call security if you…"*)
    d) Medical symptom management (analgesics, anxiolytics, sedatives)
    e) Physical restraint
    f) Medical sedation / anaesthesia

3. Documentation is very important and the 'ABC' format might be used:
    A. Autonomy – what is the proof of deficient competence?

    For example: *"Unable to understand or repeat anything I told him. Clearly confused, disorientated in place and only speaking in grunts / groans / prophanities."*

    B. Beneficence – what is the clinical need for treatment?

    For example: *"Nature of injury and subsequent increasing agitation could represent extradural haematoma. Urgent CT scan indicated."*

    C. Concordance – does the outcome match 'A' and 'B'? For example: *"Autonomy impaired, worried re EDH. I believe he would consent to CT scan if autonomous, therefore restrained, sedated and escorted to CT."*

From: Competence assessment to treat and/or detain potentially incompetent patients. CDHB. Ardagh, M. (2015) Ethics in Emergency Medicine: An Ethics Toolkit for the Emergency Department

Key Principles

1. Health staff to have the right to work in a safe workplace. Patients and visitors have the right to visit, or receive health care, in a therapeutic environment free from risks to their personal safety and from exposure to acts of violence

2. Ensure legal requirements and professional obligations are adhered to (see following section)

3. Attempts should be made to de-escalate the patient in a safe environment as an active partner in the process of assessment, treatment and recovery with the express purpose of alleviating current distress and de-escalating any level of acute severe behavioural disturbance in order to reduce risk

4. Where patients continue to present a risk to safety without discernible concerning medical or psychiatric cause, and does not put the patient at foreseeable health risk, consideration for discharge to police custody should be undertaken

ACEM Policy

1. Statement on Responsibility for Care in Emergency Departments

- Primary responsibility for the management of patients physically in ED and undergoing the care process rests with the medical practitioner designated in charge of the ED at the time. Responsibility extends until the conclusion of the emergency care process
- There may be some statutory exceptions to the principle that patients in the emergency department are the responsibility of the emergency department. This might include patients in custody, as well as certain mental health and public health emergencies

2. Policy on Patients' Rights to Access Emergency Department Care

- Any individual with symptoms that may lead them to believe that they have an injury or illness that could place their health at jeopardy, or lead to impairment of their quality of life has the right to attend the emergency department

3. Policy on Access to Care for Patients with Mental Health Conditions

- Mental health conditions are a significant cause of distress within the community. Emergency departments play a key role in the initial assessment and management of patients' presenting with acute mental health problems or behavioural disturbance
- Triage assessment of patients with behavioural disturbance will involve consideration of risk of suicide or self-harm, risk dangers to others, management of possible aggressive behaviour, and keeping the patient and others safe
- A focused mental health assessment in the emergency department will include consideration of organic delirium
- Patients with a mental health problem or behavioural disturbance that causes them to be an immediate threat to themselves or others should be dealt to urgently

4. Policy on Violence in the Emergency Department

- Acts of violence are defined as physical assault, threats, verbal abuse, and aggressive behaviours
- There should be a consistent "zero violence" approach to acts of violence
- All emergency departments must have rapid access to trained security and law enforcement personnel at all times

Legal and Professional Obligations

Legal and professional obligations

- Human Rights Act 1993
- Health & Disability Act 1993
- Crimes Act 1961
- Intellectual Disability Act 2001
- Restraint Minimisation and Safe Practice Standards 2001

Mental Health Act

Compulsory Assessment and Treatment Act 1992

Emergency Treatment

Where treatment is a matter or urgency to save the patients life or prevent serious damage to patient's health & it is not possible to obtain consent, emergency treatment can be given

Duty of Care

References

1. ACEM Policy on Violence in Emergency Departments
2. ACEM Policy on Access to Care for Patients with Mental Health Issues
3. ACEM Policy on Patients' Rights to Access to Emergency Department Care
4. ACEM Statement on Responsibility for Care in Emergency Departments
5. Management of Patients with Acute Severe Behavioural Disturbance in Emergency Departments. NSW Government Health Guideline 2015
6. Preventing and Managing Violence in the NSW Health Workplace – A Zero Tolerance Approach. NSW Government Health Policy Directive 2015
7. Competence assessment to treat and/or detain potentially incompetent patients. CDHB. Ardagh, M. (2015) Ethics in Emergency Medicine: An Ethics Toolkit for the Emergency Department

Associated Documents

Other documents relevant to this guideline are listed below:

NZ Legislation	Human Rights Act 1993 Health & Disability Act 1993 Crimes Act 1961 Intellectual Disability Act 2001 Compulsory Assessment and Treatment Act 1992
CMDHB Clinical Board Policies	Guideline: Informed consent. Policy: Informed consent. Policy: Refusal of treatment. Providing services without informed consent to an adult patient with diminished competency. Policy: Restraint minimisation and safe practice.
NZ Standards	Restraint Minimisation and Safe Practice Standards 2001
Organisational Procedures or Policies	
Other related documents	