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HANDLE With CARE



>> BY THOMAS M. DUNN, PHD, NREMT-P

In July 2007, a suburban Denver ambulance began a routine “psych transfer” of a 36-year-old woman from a hospital to a psychiatric facility. During transport, the woman leapt from the moving ambulance onto a busy interstate. She later died of her injuries.¹

Similar incidents are by no means uncommon. In September 2007, another psych transfer ended in tragedy after a suicidal patient jumped from a moving ambulance in Lansing, Mich., and was hit and killed by a car. Three other deaths from patients jumping from ambulances (one in 2002 and two more in 2005) in Michigan were reviewed recently in a medical journal as a warning to providers about the possibility of suicidal patients killing themselves during transport.² Deaths resulting from intoxicated persons jumping from moving police cars have also been documented.³

Managing the suicidal patient during transport can be extremely challenging, particularly during transports from one facility to another. Further, 9-1-1 calls involving psychiatric patients are vastly different from interfacility transfers of the same patient population. Psychiatric emergencies in a 9-1-1 system typically involve the police and other providers and may be handled with primarily safety in mind. Conversely, acute interfacility psych transfers are almost always relegated to BLS units that may not routinely run 9-1-1 calls. Therefore, it's common for lesser experienced

EMS providers to manage complicated psychiatric transfers.

This article considers two different suicidal patient ambulance transport scenarios. The first concerns managing a suicidal patient from the field to the hospital. The second examines interfacility transport of psychiatric patients.

FROM THE FIELD TO THE HOSPITAL

Dealing with suicidal patients is inherently challenging because they may be difficult. Prehospital treatment options are limited for this population, which

is generally medically uncompromised, leaving few disposition alternatives other than transport. These scenarios are generally more dangerous than most 9-1-1 calls because they commonly involve transporting patients against their will who may become combative. Finally, it can be very difficult for EMS providers to determine the seriousness of a suicidal gesture or comment. Even highly trained mental-health practitioners can never be certain who will or won't commit suicide.⁴

The threshold for transporting a potentially suicidal patient should be very low. If the patient is *not* transported,

the disposition should be well-documented and may be appropriate only when the patient is turned over to the police or released at the direction of medical control.

Pointed statements by a patient about self-harm or suicide can't be retracted or explained away with statements such as, "I didn't mean it." It may be helpful to explain to a patient that such comments are always taken seriously.

In most jurisdictions, patients who have tried to hurt or kill themselves, or who have expressed a desire to do so, may be involuntarily placed on a mental health hold (MHH) so they can't refuse evaluation or treatment. State laws vary as to who has the authority to initiate an MHH. There are clear advantages for placing suicidal patients on an MHH as early as possible, even if they're willing to be transported and are cooperative on scene.

Placing a patient on an MHH has several advantages, including: 1) It alerts the receiving facility of the seriousness of the patient presentation, and 2) it often opens doors to otherwise inaccessible mental-health resources, and 3) it prevents the patient from becoming uncooperative with the assessment by changing their mind about being voluntarily evaluated.

It may be impossible for the hospital staff to start an MHH based solely on an EMS report or handoff. An opportunity to intervene on behalf of the suicidal patient may be lost if they meet criteria in the field but the EMS provider fails to initiate an MHH. Some EMS systems allow paramedics to initiate an MHH; others require coordination with law enforcement.

An early MHH is essential because accurately predicting who won't commit suicide is extraordinarily difficult. If someone is determined to commit suicide, they may do so without showing a single risk factor or communicating their intent in a way detectable to even the best trained clinician.⁵



If your patient hasn't been aggressive and has no recent history of attempted suicide, you can consider allowing them to walk to the ambulance. But if there's any potential for injury to providers or the patient, it's best to use restraints.

PHOTO GRANT THERRIEN

The prehospital provider should be especially wary of older men who abuse substances, live alone and have chronic illnesses, because these patients are the leading demographic in completed suicides.

Individuals who can articulate a plan to commit suicide are also at high risk. Again, it should be stressed that predicting who will actually attempt suicide is almost impossible and only the *slightest* indication that someone may try to hurt themselves should convince the EMS provider to either transport or consult medical direction.

INTERFACILITY TRANSFERS

Transporting suicidal patients who are already hospitalized is vastly different than encountering the same patient in the field. Often, such psych transfers are assigned to BLS crews. Although these calls can be a source of irritation for crews having to run them, EMS providers should keep in mind that if ambulance transport has been requested, it's usually because the patient is considered dangerous and/or may be a flight risk.

Further complicating the psych transfer is the wide range of patient presentations.

Some may be floridly psychotic and already in restraints when contacted at the hospital. Other patients may have been difficult to manage in the hospital, but having since been medicated, demonstrate manageability prior to transport.

In other circumstances, the hospital may elect to *not* restrain a dangerous patient whose behavior can be managed with one-on-one staffing. More common, however, is the patient who hasn't needed restraints during their hospital stay and who's cooperative and non-threatening.

Writing protocols that anticipate every situation when transporting a psych patient is impossible and ill advised. No single policy can cover every possible presentation. Worse, some protocols requiring mechanical restraint of *all* psych patients, regardless of their presentation, can adversely affect some patients.⁶ Take, for example, an adolescent female who presents to the ED exhibiting severe psychiatric symptoms and requires transport to a psychiatric facility. Her past medical history includes violent rape involving restraints. Restraining this otherwise cooperative

HANDLE WITH CARE

>> CONTINUED FROM PAGE 88

GO WHERE STRETCHERS CANNOT

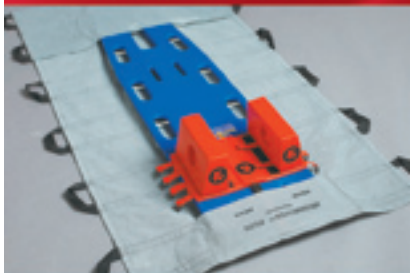
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sexual assault victim based on protocol alone could cause considerable psychological trauma to the patient.

In such cases, no one protocol can replace critical thinking and assessment by an experienced provider who can determine the least amount of restraint necessary for safety, which should always be the goal when transporting suicidal patients.

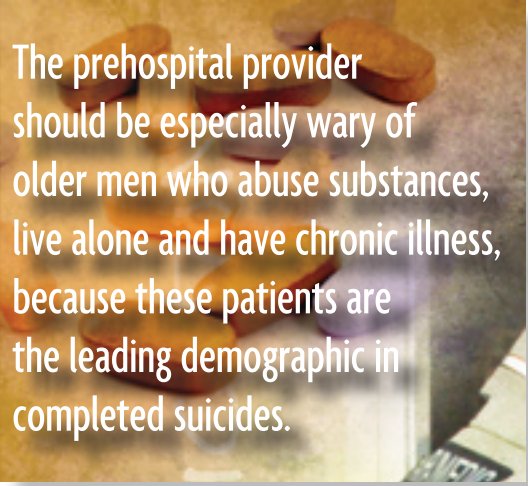
Assessing the degree of restraint required during transport begins at handoff from the hospital to EMS.

A history of violence, suicide attempts or elopement (trying to run from the hospital) by the patient should strongly indicate the need for restraint during transport. If the patient has been difficult to manage during their hospital stay (requiring physical restraint or sedation), or has been aggressive to staff members, it should be assumed that this behavior will continue during transport and appropriate restraint is required. Many EMS crews have witnessed firsthand that the more relieved the hospital staff seems about discharging the patient, the more likely the patient will be difficult to manage during transport.

Fear has been identified as a major cause of psych patients becoming combative or violent.⁷ Allaying a patient's fear may be an important part of avoiding trouble during transport. The first meeting with the patient is a crucial time for building rapport. If the patient's behavior has been appropriate, ask the nurse involved in the case to introduce you and assure the patient that EMS providers are "nice people" who will take care of them during transport.

If the patient has been behaving badly, introduce yourself and say something along the lines of, "How have they been treating you here?" This tends to set you apart from the staff, by whom the patient may feel antagonized, and gives the patient a brief opportunity to get something off their chest. Don't let them go on and on, but let them know you sympathize.

It's also important to give the patient a little warning (e.g., five to 10 minutes) that they're going to be transported. Hospital staff may resist this, believing the warning



The prehospital provider should be especially wary of older men who abuse substances, live alone and have chronic illness, because these patients are the leading demographic in completed suicides.

will only make the patient act out about leaving. However, if the patient is going to resist transport, it's better to know that before leaving the hospital and not after locking yourself in the back of a moving ambulance with a combative patient.

When meeting the suicidal patient for the first time, also be observant of aggressive behavior. Pacing, throwing things, destroying items, shouting, etc., are obvious signs of agitation. Also look for more subtle signs, such as making fists, talking through a clenched jaw, grinding teeth (the muscles in the temple moving during this action), staring directly at an individual or standing in an aggressive posture. These are clear indicators that the patient needs to be managed carefully and early restraint is sensible.

Be equally wary of the silent patient who refuses to make eye contact or answer questions. Such behavior is often indicative of profound mental illness or hostile intent. These patients should be managed carefully. If the patient is talkative and cooperative, and the staff indicates no history of trouble, consider asking the patient directly, "Are you going to try and do anything silly during our trip together? You won't try to run from me or try to hurt me, will you?" Anything other than an emphatic denial should be considered a "yes." In either case, you must be continuously on guard for an inappropriate reaction during transport.

PREPARING FOR TRANSPORT

Carefully consider whether the patient needs to be physically restrained before moving them to the ambulance. If any doubt exists about applying restraints, restrain the patient.

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A patient who's already in restraints should be kept that way. If restraint is required, have this procedure completed before leaving the hospital room, in a contained environment with plenty of help.

Once the patient has been restrained, the only reason the restraints should be removed during transport is to manage a complication of the ABCs. Be wary of a patient who tries to negotiate the removal of the restraints.

Often, patients who begin to act out will be the ones who feel they have no sense of control. If your patient hasn't been aggressive with the staff, has no recent history of suicide attempts, has been otherwise cooperative and communicative, and won't require restraint during transport, you can consider allowing them to walk to the ambulance instead of being transferred there on your cot. Allowing the patient to make a choice (ultimately both choices lead to the same outcome of transport) allows them to retain some dignity and sense of control.

If the patient chooses to walk, allow them to walk as far as the doors that exit to the ambulance bay and then direct them onto the cot. Making the transfer to the cot inside the doors of the hospital allows the EMS provider to call for help if needed. Once the patient is on the cot, use all the cot belts, including shoulder belts. Explain that the seatbelts are non-negotiable and at no time are they allowed to unbuckle, readjust, or otherwise have anything to do with the seatbelts. Explain that this is due to safety reasons, that touching the belts at any time is forbidden and that doing so will cause you to restrain them. Most patients will understand that seatbelts are necessary in a moving vehicle and will rarely resist them.

If a blanket is used, the seatbelts—and the patient's hands—should remain on top of the blanket. Make a habit of turning the buckles upside-down; this makes it harder for the patient to unbuckle themselves. Pre-position soft restraints so they're in easy reach if the patient becomes combative.

Prior to transport, the attendant and driver should decide on a few words or short phrases they can use to quickly communicate in the event the patient becomes uncooperative or otherwise unmanageable. One phrase signals to the driver that help is needed in the back, but the situation isn't yet out of control (e.g., "I need some help."). This allows the driver to

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pull over and get in back to help. Another phrase should be used only in the event of imminent danger to the patient or provider, such as when the patient is attempting to attack the provider or jump from the moving ambulance. This phrase signals the driver to make a sudden stop (in traffic if necessary) and activate the emergency lights and radio for help before getting into the back.

This second phrase should not signal to the patient what's about to happen. Keeping the element of surprise may help distract the violent patient away from the back doors or the attendant. For example, you could say, "Dog in the road!"

DURING TRANSPORT

The driver should always be attentive to what's happening in the back. Turning the patient compartment lights to their brightest setting may help the driver see what's happening in the back during transport.

At no time should a suicidal patient be transported on the bench seat or in the attendant chair. The cot, in its collapsed position, puts the patient's center of gravity low to the ground. As a result, getting off of a cot is much more difficult than rising from the bench or third rider's chair. This can be used to the advantage of the provider reacting to a patient who's trying to attack the attendant or exit the ambulance while it's in motion.

It's extremely important for the attendant riding with the patient to closely monitor the suicidal patient during transport. If you have serious concerns for your safety, consider requesting a police officer or hospital security to accompany you in the patient compartment. Keep the head of the cot upright and sit on the bench seat slightly behind the patient, lining up your left knee with their left ear. This way, they're never sure if you're actively watching them, and the act of their turning around to look at



PHOTO COURTESY GARDE SYSTEMS LLC

There are products, such as the Garde Systems BuckleGarde, to help deter patients from removing their seatbelts.

you signals that they may be formulating a plan of attack or escape.

Also, from this position, should the patient try to unbuckle the seatbelts or work out of the restraints, you can lower the head of the stretcher, put your knee between the patient's shoulder and neck, and call for help from your partner. This also lets you keep your hands free until your partner can get to the back.

Obviously, a threat to provider safety sometimes takes precedence over an attempt to keep a violent patient restrained and in the ambulance. However, the method described above at least allows the driver to bring the ambulance to a quick stop and slow down a patient intent on jumping from the vehicle so that any escape will be done after the vehicle is stopped.

CONCLUSION

When you're transporting the suicidal patient, being vigilant and communicating well with your partner, the

hospital and ancillary agencies can help ensure the safety of all patients during transport. To further maximize safety, hospitals should encourage their clinical staff to specifically address the safety of ambulance transport when assessing the suicidal patient.

Specific concerns should be made known to the EMS crew in order to allow additional resources to be sought for transport as necessary. The call-taking protocol for interfacility transfer of psych patients should specifically address flight and assault risks of the pa-

tient. While not always practical, dispatch can make some judgment about which crew would be most appropriate to handle the transfer. It makes sense that an experienced ambulance crew is a better choice for such a transfer, even if it isn't the closest unit. The EMS agency should also specifically train its members for running these kinds of transfers. Finally, keep in mind that the techniques described here are also useful for a variety of patients (particularly the intoxicated) and regular

practice and communication ensures everyone's safety. **JEMS**

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REFERENCES

1. "Nurse jumps to her death from moving ambulance." www.thedenverchannel.com/news/13649298/detail.html
2. Greenwood MJ: "Self-inflicted death during interfacility transfer." *Annals of Emergency Medicine*. 47(2):212, 2006.
3. Jacobs W: "Fatalities due to intoxicated arrestees jumping out of moving police vehicles." *American Journal of Forensic Medicine & Pathology*. 27(4):332-334, 2006.
4. Paris J: "Predicting and preventing suicide: Do we know enough to do either?" *Harvard Review of Psychiatry*. 14(5):233-240, 2006.
5. Simon RI: "Imminent suicide: The illusion of short-term prediction." *Suicide and Life-Threatening Behavior*. 36(3):296-301, 2006.
6. Frueh BC, Knapp RG, Cusa ck KJ, et al: "Special section on seclusion and restraint: Patients' reports of traumatic or harmful experiences within the psychiatric setting." *Psychiatric Services*. 56(9):1123-1133, 2005.
7. Robins CS, Sauvageot JA, Cusack KJ, et al: "Special section on seclusion and restraint: Consumer's perceptions of negative experiences and 'sanctuary harm' in psychiatric settings." *Psychiatric Services*. 56(9):1134-1138, 2005.

A history of violence or suicide attempts should strongly indicate the need for restraint during transport.

For more on patient restraint, read "Holding Back: Issues in patient restraint" at jems.com