

Template Handover Protocol for Patients Brought to ER by Police

Preamble;

This protocol applies to patients apprehended under the Mental Health Act and not being charged with a criminal offense. Patients being charged and brought for assessment, medical or psychiatric, but who will remain in police custody do not undergo a handover.

- Patient should be registered/documented as a referral from law enforcement (NACRS field 31).
- Police should complete an EDP form. Triage OR secondary RN should confirm form is legible, identifies the officers and their Division, and clearly documents the concerning behaviour leading to apprehension.
- ER staff (triage or primary nurse or delegate) should confirm with police the identity of the patient, any information regarding past medical or criminal history (outstanding warrants or charges) known to them, and whether the patient has been searched for weapons.
- Hospital security should be summoned to take over observation of the patient pending medical assessment and disposition.
- In most cases once documentation including EDP form has been completed and full report received, and security has arrived, police can be released. In some cases police may be required until patient is restrained; chemically or physically, or may be asked to assist with patient identification or contacting of next of kin.

At St. Michael's Hospital, the following process should be followed:

This process is enabled by the principle that, under the Health Care Consent Act (HCCA) **any care provider within the hospital may restrain or detain a patient** (or provide an order for this) for their own safety or the safety of others, when the patient's capacity or competence is in question.

The **triage RN** will receive the patient and conduct a typical triage assessment and note in the triage assessment that the patient is accompanied by police. The patient will then be assigned to the appropriate area within the department. **In all cases where it is expected that security personnel will be required to provide ongoing monitoring and/or detain the patient, the patient will be triaged to the intermediate area of the department.** If the patient requires immediate placement of physical restraints, the RN can solicit an MD order and triage the patient to the most appropriate area of the department. Security can be paged to the area to apply the restraints as per protocol.

The secondary nursing assessment will be done within the designated area (usually intermediate). The **secondary RN** will determine with the police officers if there are any reasons why the patient cannot safely be transferred to hospital custody (under arrest, significant history of violence, etc). If, for whatever reason, the secondary nursing assessment is delayed, this determination can also be done by the triage RN.

The secondary RN will confer with security to determine if there are adequate security resources and an appropriate physical space to accept responsibility for the patient.

Only if there is agreement between nursing, security and police that the patient can be safely transferred to hospital custody, the **RN will notify security** of this decision and **both will note the decision on their respective documents**.

The transfer will only be completed upon receipt of a **completed EDP form** from the police clearly documenting the following:

1. The nature of the behavior before and during police custody,
2. A summary of past history of the patient if known (e.g. history of violence, elopement, etc),
3. Details regarding the scene (evidence of suicide attempt, evidence of lack of self-care, etc), and
4. Names, badge numbers and contact information for the officers.

If the EDP form is not completed to the satisfaction of the RN, the police will be expected to remain with the patient until an MD is available to assess the patient.