1 Remote context

Cultural safety

Primary health care in remote and rural Australia often involves working with culturally diverse and socio-economically disadvantaged groups. To provide effective health care, practitioners must be committed to providing culturally appropriate health care.

Good practice requires practitioners to recognise and manage the power they have. Without this, consultations can be a demeaning and disempowering experience for patients — contributing to further ill health.

Culturally appropriate health care

Involves consideration of cultural awareness, cultural safety/security and cultural competence.

- **Cultural awareness** — developing knowledge about a particular people or cultural group. Includes its history, traditions, belief system/s, language/s, geographical features
- **Cultural safety/security** — an environment that is safe for people, where there is no insult or harassment, imposition, or denial of a person's identity. It is about living and working together with dignity and respect for differences
  - Indigenous people working in the clinic and broader community (eg ATSIHPs, ALOs, clinic board members) can influence how the health service operates and to help ensure it is a safe environment for patients
- **Cultural competence** — a commitment to engage respectfully with people from other cultures. It requires the ability to identify and challenge one's own cultural assumptions, prejudices, and one's values and beliefs

Tips

- **Remember**
  - Always show respect and consideration. Ask local experts about appropriate forms of respect for your community
  - Medical procedures can be invasive, frightening, painful
  - Always maintain dignity, privacy, confidentiality for patients
  - Public rather than private settings may be more suitable for some people, on some occasions. Make sure the person is able to make an informed choice
  - It is not always the patient who gives the history or makes decisions — this may be the role of others, usually relatives
  - Be aware of local time (eg school bell, shop hours) and local activities (eg sports carnival, ceremonies)
    - These can also influence whether the person can attend appointments
- **Cultural beliefs**
  - Traditional beliefs about health and illness remain intact, embedded and valid in many Indigenous communities

- In many cases Indigenous people will use traditional healers and traditional medicines before presenting to the clinic. It is very important to acknowledge and respect this. Traditional medicines/therapies can work in conjunction with Western medicine
- Be aware of non-verbal body language and gestures — pointing, hand signals, eye contact. May have very different meanings for patient and practitioner
- Culture can influence the way people react to stressful or traumatic situations, including wailing, silence, inflicting harm on others or self-harming after traumatic events including death

- **Loss and grief** (*p136*)
  - Indigenous communities may follow some or all of these practices after a death
    - Deceased person's name should not be spoken
    - Deceased person's house is smoked, painted or vacated
    - Special rituals undertaken
    - Certain relatives of deceased may choose not to speak
    - Relatives of the deceased may live outside the community to mourn. May need special clinic visits
    - In some communities 'sorry business' (grieving) involves self-inflicted injury (sorry cuts) and family fighting
    - Payback may be part of grieving/healing process
- **Effective communication**
  - English can be a second or third language for Indigenous Australians
    - Ask if person would like an interpreter to assist
    - Using family members to interpret can be sensitive. Be cautious, let person guide you. Using local Indigenous staff may be an option, if appropriate
  - Don't assume that conversations conducted in English have the same meaning for practitioner and patient
  - Don't try to speak a language learnt in another community. Similar sounding words can have different meanings and may be offensive
  - Hearing problems, common in all age groups, can make communication more difficult
  - Don't shout. Always speak clearly and warmly
- **Consider how you question patients**
  - Direct questions can be considered rude. Consider getting permission if you need to ask a lot of questions
    - Only ask one question at a time and allow person time to consider it
    - Be aware that they may be thinking about it in their own language before responding
  - Avoid double negatives (eg 'You don't do nothing like that, do you')

  - Be wary of ready agreement. It can be a sign of misunderstanding, or simple courtesy
  - Silence is often OK, give people plenty of time to answer. But remember that silence can also mean misunderstanding, or that practitioner is on culturally unsafe ground
  - Make detailed notes of what person says about themselves, so you have accurate records for the future, don't need to ask same questions again
- **At end of consult, check that**
  - What you're doing is respectful of the person's needs and wishes
  - You have understood what the person has told you, and cleared up any uncertain points
  - Person has understood what you have said to them and can repeat any instructions you have given them

Remember:

- People generally want to do what is best for themselves and their families
- Conflicting priorities and past experiences can impact on their decisions
- Important to respect and support person's decisions, even when they challenge your clinical advice
- In the long term, relationships and trust between practitioners, patients and families enable quality health care

Travelling in remote areas

This procedure is a guide only. All staff should do an accredited 4-wheel drive and/or boat skills course.

Attention

- Travelling in remote areas can be dangerous
  - Weather, road/sea and vehicle/boat conditions, driver tiredness and inexperience make remote travel more dangerous than urban travel
- Treat it seriously and follow procedures, even on short trips
  - If you don't, you will endanger yourself, your patients, people who go to look for you

Two essential safety precautions for travelling in remote areas.

1. **Carry enough drinking water** for you and your passengers, as well as fuel, spare tyre and tools
2. **Give an estimated time of arrival** (ETA)

- Don't change your travel plans once you have given an ETA
- Don't change your route without telling person expecting you

Not turning up when expected may be the only sign that you are in trouble and need rescuing, and they will need to know where to look.

What you need to know

About the vehicle

- Where spare set of vehicle keys kept
- Health service policies regarding use of the vehicle
- If it had been regularly serviced
- How to
  - Do a basic vehicle or boat check (*p11*)
  - Fill both tanks with fuel, change over tanks, prime fuel pump
  - Check spare tyre, change a tyre, use jack/tools
  - Change tyre pressure for hard/soft surfaces
  - Use 4-wheel-drive gears, engage hubs
  - Set up UHF/HF radio antenna, use radio or satellite phone
  - Troubleshoot marine engines

Basic safe driving principles apply

- **Do not** eat/drink, use radio/phone, change music when driving
- Keep both hands on wheel at 10 and 2 o'clock positions
  - Don't wrap thumbs around steering wheel. If you hit a big rock and wheel spins suddenly, it can break your thumbs
- Keep your eyes on the road when talking
- Wear seat belts, use baby/child restraints
- Don't drive when tired, upset or hungry. Wait until next day if necessary

Dirt roads are always dangerous

- Recommended maximum speed for 4-wheel-drive ambulances on dirt or gravel is 80km/hr
- Adjust speed to allow for slippery conditions in the wet or for poor road surfaces (eg bull dust, corrugations)
- Never drive outside your personal level of skill (comfort zone). Drive at 60km/hr all the way if you want to. Don't let passengers pressure you
  - Colleagues also have the right to tell you if they don't feel safe with your driving skills
- Try not to drive at night or into setting sun. If it can't be avoided — take someone with you to help watch out for livestock and native animals

Motoring deaths in the bush are most commonly single vehicle roll-overs caused by driving too fast or driver fatigue, often while not wearing a seat belt.

What you need

Properly equipped vehicle

- Seat belts, child/infant restraints
- 2 engine batteries
- Bull bar, cargo barrier
- Oxygen cylinder carry racks — for emergency vehicles
- 2 spare tyres (at least), that can be reached whatever your height
- Tyre-changing tools, hydraulic jack, shovel, adjustable spanner
- Spotlights, as well as main headlights
- Communications devices — UHF/HF radio, satellite phone, location beacon
- 20L of water (minimum) per person stored in 5L containers. Carry in plastic crate/s held by straps
- Basic first aid kit
- Snow chains, snow and ice tools for windows etc, if needed
- 4 x hazard-warning road signs or flashing lights that can sit on top of vehicles, to warn other vehicles in case of an accident
- Large torch
- **Desirable**
  - Roof rack
  - Music or radio to help keep you awake

Properly equipped boat

- Working engine/motor
- Bungs in right places
- Radio/communications
- Compass, other navigational aids
- Safety equipment
  - Lifejackets, V-sheet, first aid kit
  - Flares, water dye, Emergency Positioning Infra Red Beacon (EPIRB)

- Tarpaulin — to use as a makeshift sail or temporary cover
- Oars, anchor, ropes
- Torch, mirror

What you do before travelling

Vehicle check

- Fuel. If 2 tanks, fill both. Use alpine grade diesel in cold climates
- Fan belt tight
- Radiator and battery water, hydraulic fluid levels
- Clean windscreen and lights
- Tyres and spares — inflated, minimum 3mm tread, wheel nuts tight but able to be undone
- Wheel-changing gear, tools, safety equipment for your area
- First aid kit, torch
- Make sure following are working — UHF/HF radio or phone, lights, brakes, wipers, dash instruments, trip meter, horn

Boat check

- Bungs in place
- Fuel — full tanks plus half as much again as spare
- Correct load — **do not** overload
- Radio/satellite phone, compass and/or navigational aids all working
- Safety equipment on board

Personal check

- Enough water and food for driver and passengers**.** When travelling in remote, dry, hot areas take extra drinking water. Will be needed if you have to wait for help or change a tyre
- Sun protection — cream, hat, sunglasses etc
- Personal breakdown kit — small torch, matches, sunscreen, snack food, fishing tackle, multi-purpose penknife, insect repellent, book etc

Weather and conditions check

- Check weather and road/sea conditions with local people, police and/or road/maritime services
- Allow for road/sea/weather conditions when making your ETA

Make a travel plan

The trip

- Work out which route to take, who will come with you
- Tell person/service at your destination
  - Time you expect to depart (ETD)
  - Time you expect to arrive (ETA)

    Remember: Allow an extra 1½–2 hours for tyre changes or problems

- Plan a halfway stop to take a break and call person/service with UHF/HF radio or satellite phone to let them know where you are, everything is OK

As you are leaving

- Set trip meter, so that if there are any incidents on the road, you can tell emergency services your exact distance from base
- Make sure **you, your passengers, patients on stretchers** are all wearing seat belts, restraining belts etc

At end of trip

- Tell person/service at destination you have arrived. Searches have been conducted for people who were safe at home but forgot to report in

Accidents and breakdowns

- Use UHF/HF radio or satellite phone to arrange emergency recovery vehicle
- If UHF/HF radio or phone damaged in accident — need to wait until ETA passed and people come looking for you
- If passing vehicle — use their radio/phone or send message with them but stay with your vehicle

ALWAYS follow these basic rules

- **Stay with vehicle**. **Do not** try to walk for help
- Find nearby shade, conserve water
- If you think aircraft might be searching for you — clear some ground and mark SOS in big letters. Use clothes, rocks, colourful equipment etc
- If aircraft flies overhead — run/walk quickly across ground waving your arms to attract attention
- If you have **absolutely no choice** but to leave vehicle — leave note telling rescuers direction you headed, day and time you left, how you will mark trail (eg 'Will leave red-coloured cloth in branches of mulga')

Consult by telephone, satellite phone, or radio

Attention

- Make sure you know how clinic/vehicle radio or satellite phone works in case there are problems with normal phones. Keep instruction manuals handy for new staff
- **In every consultation, including emergencies**
  - Speak clearly and slowly
    - Allow for time delay after each sentence if needed
  - Use simple terms, and numbered anatomy pictures F 1.1 – F 1.5 (*p14*) to describe issue, eg
    - Position of lump
    - Position of pain
    - Place (site) of injury
  - Always **recheck** management plan with consulting doctor, especially at night when everyone is tired

What you do

- **Before ringing doctor on call**
  - Do as much assessment as possible and practical. See *Clinical assessment of adults* (*p94*), *Clinical assessment of children* (*p98*)
  - Have file notes with you
- Work through consultation logically. Use ISBAR (Identify, Situation, Background, Assessment and Recommendation) to help with clear communication
  - **I** dentity
    - Who you are talking to (name and role for file notes)
    - Who you are (name, role), where you are, contact details
    - Person you are talking about — name (and carer's name if child), date of birth, patient record number, community
  - **S** ituation — why you are calling
    - Is it urgent
    - Any abnormal observations, POC test results
  - **B** ackground
    - Patient's story — name, age, current complaint, relevant history
    - Procedures or treatments already tried, any outcomes
  - **A** ssessment
    - What you think the problem is — be clear, state the obvious, indicate how concerned you are
    - What you think should happen
  - **R** equest
    - What do you want them to do — advice, review, refer, evacuate
- Ask doctor to repeat all management and medicine orders, read them back

- **If not happy with advice**
  - Tell doctor straight away and explain why. Always try to maintain a professional relationship
  - If still concerned — get second opinion from more senior doctor or specialist (follow local policy/practices)
- **Record in file notes** full name of consulting doctor, their advice, what you have agreed to do

If person being evacuated

- Permission needed from person and/or family for evacuation
- Consider options available
  - Local conditions that may affect evacuation
    - Weather, condition of road/airstrip, night lighting on airstrip
  - Which most suitable — doctor, clinic staff, patient and family may be involved in deciding
    - Emergency — RFDS, Aerial Medical Service, ambulance
    - Non-emergency — mail plane, bus, private car, other transport
- Is medical and/or family escort needed
- Any risks for person, escort or transport provider — alcohol, sniffing volatile substances, risk of violence (*p23*), risk of condition deteriorating
- **Medical consult** about
  - Will this problem, or underlying condition make person unwell if they fly
  - Antiemetic (*CARPA STM p105*) to stop vomiting, especially if hot weather, windy conditions, rough or windy road, choppy seas. Best given at least 20 minutes before travelling
  - Pain relief if needed (*CARPA STM p377*)
- Check you understand evacuation plan before you finish phone/radio call
- See *Evacuations* (*p16*) for how to prepare

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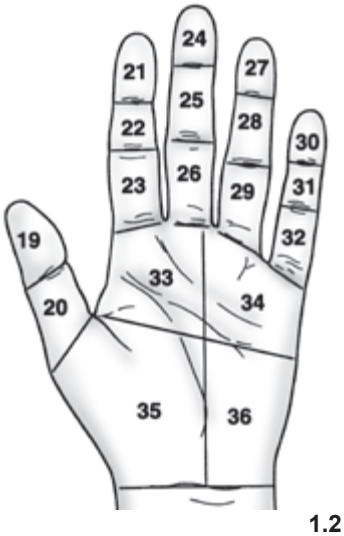

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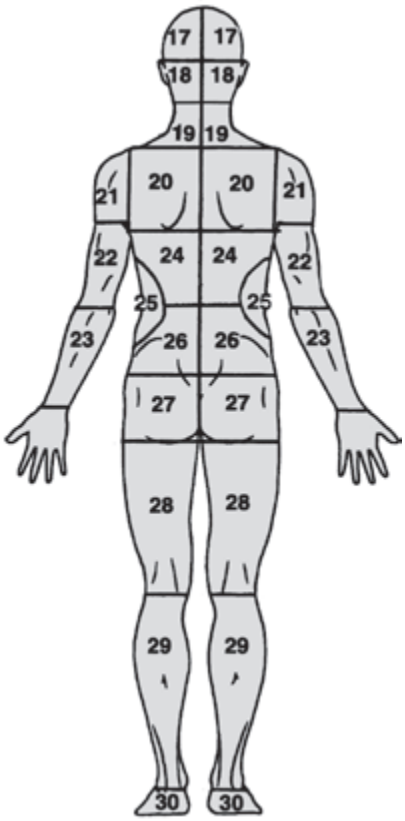
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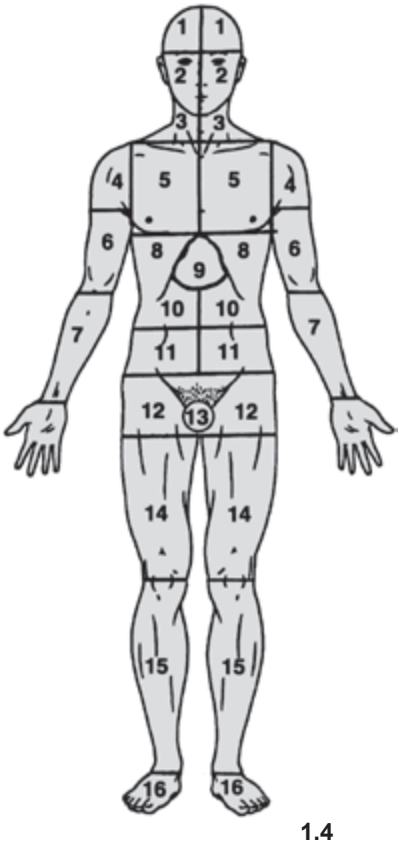
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Evacuating by air

Attention

- Decision to do medical evacuation is not made lightly, make sure you know and follow correct procedures
- Usually 3 categories for evacuation
  - Priority 1 — Life-threatening emergency. Flight departs in shortest possible time subject to weather and essential safety requirements
  - Priority 2 — Urgent medical transfer. Flight departs promptly
  - Priority 3 — Elective transfer. Flight arranged to make best use of resources and crew hours
- If person uncooperative and/or a risk to crew or aircraft (eg person with psychosis, dementia, affected by drugs or alcohol) — **medical consult**
- Make sure
  - Person and/or family/guardian have agreed to evacuation
    - Ask person and/or escort to get ready (clothes, money etc), where they will be (eg home address and directions)
    - Remind them about luggage limits (usually less than 7kg) and dangerous goods as per CASA/CAA regulations
  - Contact details recorded for next of kin/person responsible
  - Doctor or flight organiser aware of
    - Airstrip where person is being collected
    - Weather conditions in area
    - Weight of everyone travelling
    - Phone/satellite phone number you will be available on until evacuation completed — and 2 other ways to contact you in case this doesn't work (eg radio channel)
- Someone must stay near clinic radio/phone during wait for evacuation so messages from flight/ambulance base or doctor can get through

Rules for aircraft arrival and departure

- Person opening gate to airfield for an evacuation (or in charge of evacuation) is responsible for who enters airfield at that time
- People and vehicles must stay behind fence with gate shut until aircraft door is opened, propellers have stopped turning
  - You can't see a spinning propeller — F 1.6
- If no fences — people and vehicles must stay at least **30m** from aircraft
- No smoking
- Vehicles
  - Have headlights on park — don't blind pilot
  - **Do not** reverse vehicle toward aircraft unless directed to by crew member

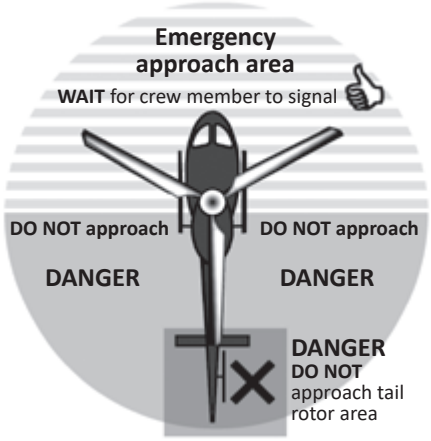
Spinning propellers cannot be seen

1.6

  - Park vehicle loading/unloading person at least **5m** (or length of wing) from aircraft, engine turned off
  - **Do not** drive across line from aircraft nose to wingtip, or tail to wingtip — F 1.6, keep parallel to aircraft
- Pilot will not start aircraft engines until all people and vehicles are back behind fence line or at least **30m away**
- **Do not** approach aircraft when door is closed or rotating beacon on aircraft belly is on
  - **Do not** walk under the aircraft wings
- Always stay by airstrip until aircraft has taken off safely. If there are problems with person or aircraft — they may return

Helicopters

- **Do not** approach helicopter until rotors have stopped turning
- If an emergency and you must approach helicopter while it is running —
  - Approach within the 9 to 3 o'clock position only — F 1.7
  - Stop and wait well clear of rotor arcs until pilot has seen you
  - Make sure pilot or crew member aware of your intention by giving a **thumbs up** signal, wait for **thumbs up** reply before going further
- **Never** go toward rear of helicopter, even if it is shut down, unless directed to do so by a crew member — F 1.7



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- On sloping ground, approach and depart on downhill side — F 1.8
- Under rotor arcs — duck (crouch down) — F 1.8, don't wear hats, make sure you carry loose items securely
- Be careful of long objects such as IV poles. **Do not** carry pointing upward
- **If blinded by dust from rotor downwash** — stop and sit on ground until dust clears or help arrives

1.8

Practitioners

- Your first responsibility is clinical care for your patient
  - Other members of community should help during evacuation
- **When you arrive in new community** — find out as soon as possible
  - How air medical evacuation takes place
  - Where airfield is, person responsible for maintaining and checking it, their 24 hour contact information
  - What sort of lighting the airstrip uses — see *Lighting airstrip* (*p19*)

- Who helps with transfers, checking and lighting airstrip. How are they contacted
- If there is no help — you need to know how to do this for yourself

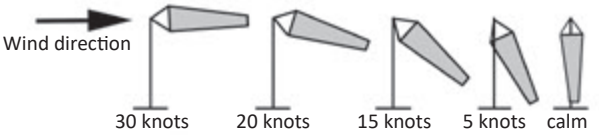
- **Helping the air medical retrieval crew**
  - Follow their directions
  - Give doctor on call or flight organiser all relevant information about person, including weight. Helps make sure they bring correct equipment (eg longer straps for obese patient)
  - Keep them up to date on developments, especially clinical deterioration
  - Plan ahead to make sure aircraft is not kept waiting on airstrip
    - If you will need to stay in clinic with patient — have someone else collect crew
    - Have lifting team ready to load person onto stretcher and/or aircraft. Consider weight of person and how many needed to lift them safely
  - Choose appropriate transport vehicle. Retrieval team may refuse to travel in vehicle they consider unsafe — check their requirements

What you do

Prepare for landing

Make sure you or person collecting retrieval team are at airfield 15 minutes before expected arrival time. **Do not** speed — drive carefully.

- **Weather — check and tell flight organiser**
  - Visibility — how far you can see, fog, rain, cloud covering hilltops
  - Cloud cover — estimate in 8s. 8/8 = total cover, 4/8 = half sky covered
    - If a dark night — how many stars can you see (indicates clear sky)
  - Position of windsock — which direction wind is coming from and how strong it is — F 1.9
- **Safety check for airstrip**
  - **Airstrip runway** — check condition well before aircraft lands, day or night. Is it safe — hard smooth surface, free of people, animals, vehicles, etc



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  - **Test firmness** — drive stiffly sprung vehicle up and down at a speed of 75km/hr. Ride should be comfortable, no potholes
  - **Test for wetness** — drive heavy vehicle (eg 4-wheel drive) in zigzag pattern at less than15km/hr along whole length of airstrip runway
    - If you slide, slip or tyre tracks more than 2cm deep (10 cent coin) — surface not good enough for a landing
  - **No objects within 30m** of centre of airstrip so there is room for aircraft to manoeuvre in an emergency
  - If you have any concerns — contact flight organiser

- **Check again**
  - Satellite phone and vehicle UHF/HF radio switched on and tuned in. Pilot must be able to talk to someone on ground as they approach airfield
  - About 5 minutes before arrival — airfield free of wildlife/cattle

Night time procedures

Airstrip must be lit

- 30 minutes before landing and until aircraft has parked
- 10 minutes before take-off and until 30 minutes after departure — in case they have to come back and land in an emergency

- Contact person whose job it is to set out and light flares or work electric lights. Know who alternate person is and how to contact them
- **Lighting airstrip**
  - Number of lighting systems available — solar lights that activate automatically at dusk, pilot or manual activated, mains or battery powered. Some airstrips have backup lighting system
  - Know how your airstrip lights work before you need them
- **Setting out flares or portable lights**
  - Begin at end aircraft will land. Aircraft always land into the wind — F 1.10
  - Put flares about 100m apart. Measure with vehicle trip meter
  - Move down one side of airstrip, going toward middle
    - When you get to middle, cross to other side of airstrip and work back up
    - Then start at other end, work toward middle, cross to other side of airstrip then work back to end again
    - This means any uneven gaps will be in middle of airstrip
  - **2 lights** should be placed at all 4 corners of the airstrip, 4m apart — F 1.10
  - If light set has lights with red and green lenses — put these across each end of the airstrip with red facing onto strip and green facing away
- **Indicating wind direction**
  - Park **beside** windsock with vehicle lights on high beam facing **into wind** — 'wind on the windscreen' — F 1.10. This tells pilot wind direction and that airstrip has been checked
  - **Do not** try to light windsock with hand-held spotlights

To stop a landing

- If you arrive at airfield and it is **no longer safe for aircraft to land** — contact pilot/doctor/flight organiser immediately
- **If you can't get through in time**
  - Put white cross on middle of airstrip, or use cones to make one. White cross is universal symbol for 'strip closed'
  - *OR* park your vehicle in middle of airstrip, facing direction the aircraft will land, with lights blazing. Leave the vehicle. Have a good explanation ready…

    Note: Under normal circumstances, never park on or near airstrip when aircraft is due to land.

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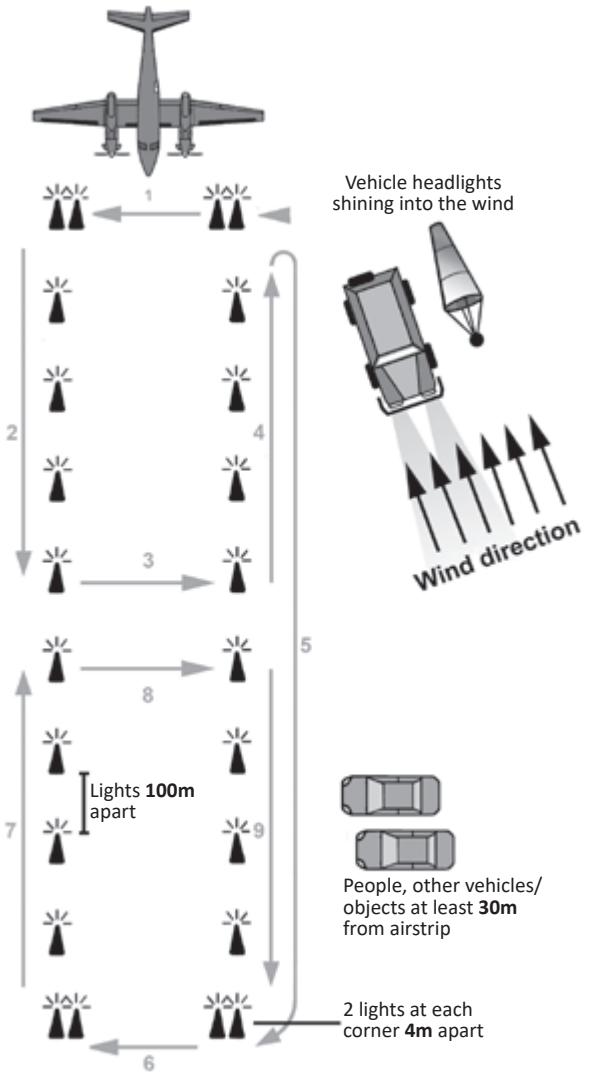
Prepare and hand over patient

- **Weigh person and their escort** (if there is one) **before** you talk with doctor/ flight organiser
- **Talk with doctor/flight organiser** about
  - How sick the person is, how soon they need evacuating
  - Whether person
    - Should wait in clinic for retrieval team, or be taken to airstrip
    - Needs additional pain relief, sedation, other interventions (eg indwelling catheter)
    - Needs an escort, who it will be, if there is room on aircraft
  - Whether person and family agree to evacuation



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- **Check weather and prepare airstrip** — see *Prepare for landing* (*p18*)
- **Get person ready**
  - Make sure they are in best condition they can be — pain relief, antiemetic, sedation, other pre-flight medicine needed, fluids replaced, urinary catheter in, oxygen on, etc
  - Have at least 2 functioning, secure IV cannula and access points
  - POC tests or others as directed by doctor/flight organiser
- Get paperwork ready, photocopy or print 2 copies of file notes (1 for flight crew, 1 for person), include any faxed confirmation of orders given over the phone
- Services may use ISBAR (Identify, Situation, Background, Assessment and Recommendation) for handover (*p13*)
- Stay near radio/phone for aircraft's expected time of arrival (ETA)
- Do regular observations according to person's clinical condition
  - Do final set of observations **just before** aircraft is due to arrive, so you are confident of person's condition before you hand over
  - **If person's condition has changed — medical consult**
- **Collect together and put ready in vehicle**
  - Person's travel bag (small, less than 7kg), check no dangerous goods packed
  - All paperwork
  - **Pathology** — packed according to aviation requirements (*p368*)
    - Wrap in absorbent material, put in sealed bag/container, then put in another sealed container before being put in protective outer package
    - If you need more information — contact RFDS/local provider
  - Any medical items person might need for flight — another bag of IV fluid, infusions, bottle of ORS made-up for child/adult with diarrhoea
  - If person needs oxygen while waiting — they will need it during transfer
    - Take oxygen cylinder with you in vehicle running at the rate you need
    - Have portable oxygen cylinder for transfer between vehicle and aircraft
  - Keep IV fluids running. Hard to monitor in a bumpy vehicle, but do your best
- **Go to airstrip 15 minutes before aircraft due to arrive**. **Keep to ETA**
  - Allow for time needed to load person from clinic into vehicle
  - Make sure they have been to the toilet
- Follow rules for aircraft arrival (*p16*)
- Check person's hands for matches or lighters, make sure crew aware if any being carried
- Hand over person and paperwork to air medical staff *OR* if instructed collect air crew from airstrip
- Wait until aircraft has taken off and is on its way before leaving airstrip
- Remember to turn off lights/flares 30 minutes after departure

Evacuating by road or water

Attention

- **Principles are the same as for evacuating by air** (*p16*)
  - **Medical consult**
  - Organise evacuation with service to be used — ambulance, boat, etc
  - Check weather — road/tide/water conditions
  - Prepare person
  - Hand over to ambulance/boat crew/hospital

What else you do — principles and tips

- Check your vehicle/boat, and that you have enough fuel
- Collect all paperwork, pathology, emergency equipment etc
  - If possible — organise to take along a family member and another staff member to help with person and/or the driving
- Do a set of observations before you leave clinic
- Follow all medical instructions given during medical consult
- Make sure you are able to get in touch with doctor if person's condition gets worse. You may need to stop vehicle regularly to check person's condition, IV infusions etc

If doing a 'halfway meet' with ambulance/boat —

- Make sure you know exactly when they are leaving their base. You don't want to be travelling with a very sick person any longer than needed
- When you see ambulance coming toward you, stop your vehicle in a safe place on side of road. **Do not** park on crests of hills or on corners
- Wait for ambulance crew to position their vehicle
- Do a set of observations before you hand over
- **At night** — ambulance and clinic staff can pass one another on road
  - Slow down whenever another vehicle approaches, look for blue and red lights
  - If ambulance — flash your headlights or turn on your own roof beacon, pull over safely on side of road
- **After handover** — you need to turn round and drive back to your community
  - You will be tired so drive slowly, keep watch for bad road conditions and wild animals or stock, especially at night
  - Radio/phone control base, give them an ETA (*p9*) for your return journey. **Let them know** when you do get back

If driving through to hospital —

- Hand over person to emergency department staff, **medical consult** about event, person's condition, changes, treatments, concerns
- Give them your contact details in case they need further information

Transport — person who may become violent

If transporting person who is or may become violent — **always** do **medical consult** about assessment and management plan.

Person can be transported against their wishes if they meet criteria for involuntary assessment or treatment under state/territory *Mental Health Act*.

If physical problems (eg head injury, delirium) — can be transported under common law. If under adult guardianship — can be transported with consent of guardian.

- **Call police for help when transporting violent person if any of**
  - Crime has been committed, weapons involved
  - Threat of violence is **not** because of mental or medical illness
  - You believe physical safety of attendants is under threat
  - You need help to physically restrain person to give sedation
  - Person needs supervision while awaiting transfer

Person may become violent during transfer if

- History of violence or volatile substance misuse, drunk, under influence of drugs
- Making violent threats, very suspicious of others (paranoid)
- Delirium (*CARPA STM p199*), head injury (*CARPA STM p72*)

If person is or may become violent

- Need to be sedated (medicine to make them calm) and usually restrained
  - **Do not** use mechanical restraints (eg straps, blankets, handcuffs) unless necessary for safety of person or others. Follow local protocol, legal requirements and restrictions
- Explain sedation and restraint clearly to person and family
  - "You seem to be getting a bit agitated/cranky/wild, we want to give you some medicine to help you be calm, so you won't hurt anyone"
- Decide how you are going to transport person — talk with retrieval team

Sedation

See *Mental health emergency* (*CARPA STM p192*).

Remember: If wrist restraints needed during transport — IV cannula needs to be in cubital fossa/upper forearm. Splint elbow straight.

For transport by air

Air retrieval services must follow aviation regulations.

- Pilot and medical team will determine if travel safe
- Will usually involve restraint
- Pilot has ultimate responsibility

For transport by road

- If medium/high risk of violence *OR* IV/IM sedation — must travel by ambulance
  - Must be able to restrain and provide IV medicine
  - Police transport to be considered as last resort only
- If low risk of violence — may travel by car
  - Patient sits back seat on passenger side
  - Need 2 people apart from driver and patient
  - Helps if at least 1 escort known to patient, can help keep them calm
  - Can use child lock on patient's door — but never on escort's door

Assessing or treating someone in custody

If asked to assess or treat someone in custody — **always** do **medical consult** about assessment and treatment plan.

Assessing person in custody needs to be done carefully. May be mixture of injury, sickness, alcohol, drugs, mental illness problems. Person often scared, angry or sad about being in custody.

Make sure person knows where you are from, why you are there. Often happy to see health staff because they are there to help, and not part of police or court system.

- **Do not** be judgemental — leave that to legal system
- **Do** treat person with respect — doesn't matter what they are in jail for
- **Always** do assessment in clinic, not in a police cell, unless life-threatening emergency
- Know your health service policy regarding your authority to sign police forms
- If assessing someone who doesn't usually speak English — use interpreter or you may miss important cultural, family, personal matters. If no interpreter available — record this clearly in file notes
- Police must provide staff to make you and person safe during the assessment
  - If possible, have police stand outside door or at a distance so they can't hear you talking. Police presence may stop person talking and make assessment difficult
- If person violent or aggressive — **do not** put yourself in danger
  - Stop assessment if you have to, talk calmly and quietly, give them time to settle down, get advice

Check file notes

- Medicines used
- Medical or mental health problems
- Drug or alcohol problems and risk of withdrawal
- Loss and grief, risk of suicide

Ask

- Do they have any concerns about their health
- Do they have pain needing treatment (*CARPA STM p377*)

Do

- **Medical consult**
- Take full history, do head-to-toe examination (*p94*), do mental status exam (*p113*), check for injuries
  - See relevant section/s of manual for area/s of concern
- Make sure person has been eating and drinking (hydrated)
- Advise them how to get police officer/nurse attention

- Arrange further assessment if needed. May need to transfer person while still in custody
- Record all findings and management plan in file notes
- If monitoring or treatment needed — give police clear written instructions
- If you think they are at risk due to physical or mental condition
  - Make this clear to police
  - **Medical consult** to consider evacuation