Agitated or Violent Patient / Behavioral Emergencies

History

- Situational crisis
- Psychiatric illness / medications
- Injury to self or threats to others
- Medical alert tag
- Substance abuse / overdose
- Diabetes

Signs and Symptoms

- Anxiety, agitation, confusion
- Affect change, hallucinations
- Delusional thoughts, bizarre behavior
- Combative / Violent
- Expression of suicidal / homicidal thoughts

Differential

- *See Altered Mental Status differentials*
- Alcohol intoxication
- Toxin / Substance abuse
- Medication effect / overdose
- Withdrawal syndromes
- Depression / Anxiety disorder
- Bipolar (manic-depressive)
- Schizophrenia
- Seizure / Postictal

EMR, EMT-Basic & EMT-Intermediate

1. **UNIVERSAL PATIENT CARE**.
   a. Maintain and support airway.
   b. Note respiratory status—monitor pulse oximetry. Capnography should also be used if available.
   c. Check blood glucose level.
2. Note medications / substances on scene that may contribute to the agitation or may be relevant to the treatment of a contributing medical condition.
3. If a medical or traumatic condition is suspected as the cause of the behavior, refer to the appropriate protocol.
4. Establish patient rapport
   a. Attempt verbal reassurance and calm patient prior to use of pharmacologic and/or physical management devices.
   b. Engage family members / loved ones to encourage patient cooperation if their presence does not exacerbate the patient's agitation.
   c. Continued verbal reassurance and calming of patient following use of chemical / physical management devices.
5. Physical Management Devices (*See PHYSICAL RESTRAINTS Procedure)*
   a. Patient must be out of control and a threat to themselves and/or others.
   b. If physical restraint is required, make sure adequate personnel are present. This generally means four people, one for each of the patient's extremities.
   c. Stretcher straps should be applied as the standard procedure for all patients during transport.
   d. Secure all four extremities to the stationary frame of the stretcher if needed.
   e. Physical management devices, including stretcher straps, should never restrict the patient's chest wall motion.
6. Relay information to incoming ambulance or call for intercept per INTERCEPT CRITERIA.

Protocol Continues

Reviewed
11/2019

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Paramedic

1. Continue **EMR / BLS / ILS TREATMENT**.
2. Sedate patient as necessary based on patient's presentation and potential for self-harm. Contact medical control prior to sedation if questions / concerns exist regarding care.
3. Administer **MIDAZOLAM** or **KETAMINE** as per the Richmond Agitation-Sedation Scale below.
    - **MIDAZOLAM**
        - **IV/IM/IN: 5 mg**; May repeat after max onset up to a maximum total dose of 10 mg.
            Onset: IV: 3-5 min; IM: 10-15 min; IN: 3-5 min
    - **KETAMINE****
        - **IM: 4 mg/kg** *Onset: 3-5 minutes*
        - **IV: 2 mg/kg** *Onset: 1 minute*
4. If sedation is used, continuous cardiac, pulse oximetry and $EtCO_2$ monitoring and vital signs every 5 minutes are required.

** If Ketamine is used, the ECIEMS office shall be notified within 24 hours for QA.

Richmond Agitation-Sedation Scale

Score	Term	Description	ECIEMS Treatment
+4	Combative	Overtly combative, violent, immediate danger to staff	**MIDAZOLAM or KETAMINE****
+3	Very agitated	Pulls or removes tubes and catheters, aggressive	**MIDAZOLAM**
+2	Agitated	Frequent, nonpurposeful movements, fights interventions	**MIDAZOLAM**
+1	Restless	Anxious but movements are not aggressive or vigorous	Verbal reassurance and calm patient
0	**Alert and Calm**		
-1	Drowsy	Not fully alert but has sustained awakening and eye contact to voice (> 10 seconds)	
-2	Light Sedation	Briefly awakens with eye contact to voice (< 10 seconds)	
-3	Moderate Sedation	Movement or eye opening to voice (no eye contact)	
-4	Deep Sedation	No response to voice but movement or eye opening to physical stimulation	
-5	Unarousable	No response to voice or physical stimulation	

Adult Medical

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Patient Safety Considerations

The management of violent patients requires a constant reevaluation of the risk / benefit balance for the patient and bystanders in order to provide the safest care for all involved. These are complex and high-risk encounters. There is no one size fits all solution for addressing these patients.

1. Don PPE.
2. Do not attempt to enter or control a scene where physical violence or weapons are present.
3. Dispatch law enforcement immediately to secure and maintain scene safety.
4. Urgent de-escalation of patient agitation is imperative in the interest of patient safety as well as for EMS personnel and others on scene.
5. Uncontrolled or poorly controlled patient agitation and physical violence can place the patient at risk for sudden cardiopulmonary arrest due to the following etiologies:
    a. Excited delirium / exhaustive mania: A postmortem diagnosis of exclusion for sudden death thought to result from metabolic acidosis (most likely from lactate) stemming from physical agitation or physical control measures and potentially exacerbated by stimulant drugs (e.g. cocaine) or alcohol withdrawal.
    b. Positional asphyxia: Sudden death from restriction of chest wall movement and/or obstruction of the airway secondary to restricted head or neck positioning resulting in hypercarbia and/or hypoxia.
6. Apply a cardiac monitor as soon as possible, particularly when pharmacologic management medications have been administered.
7. All patients who have received pharmacologic management medications must be monitored closely for the development of hypoventilation and oversedation.
    a. Must utilize capnography
8. Placement of stretcher in sitting position prevents aspiration and reduces the patient's physical strength by placing the abdominal muscles in the flexed position.
9. Patients who are more physically uncooperative should be physically secured with one arm above the head and the other arm below the waist, and both lower extremities individually secured.
10. The following techniques should be expressly prohibited by EMS providers:
    a. Secure or transport in a prone position with or without hands and feet behind the back (hobbling or "hog-tying").
    b. "Sandwiching" patients between backboards.
    c. Techniques that constrict the neck or compromise the airway.
    d. EMS provider use of weapons as adjuncts in managing a patient.

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PEARLS

- Direct medical oversight should be contacted at any time for advice, especially when patient's level of agitation is such that transport may place all parties at risk.
- Stretchers with adequate foam padding, particularly around the head, facilitates patient's ability to self-position the head and neck to maintain airway patency.
- For patients with key-locking devices, applied by another agency, consider the following options:
    a. Remove device and replace it with a device that does not require a key.
    b. Administer pharmacologic management medication then remove and replace device with another non-key-locking device after patient has become more cooperative.
    c. Transport patient, accompanied in patient compartment by person who has device key.

Use SAFER model:

Stabilize the situation by containing and lowering the stimuli (remove unnecessary personnel, remove patient from stress, reassure, calm and establish rapport.) Keep hands in front of your body (non-threatening posture.) Only one provider should communicate with patient. Outline the patient's choices and calmly set some boundaries of acceptable behavior.

Assess and acknowledge crisis by validating patient's feelings and not minimizing them.

Facilitate resources (Friends, family, police, chaplain).

Encourage patient to use resources available and take actions in their best interest.

Recovery or referral: Leave patient in care of responsible person, professional or transport to medical facility.

KEY DOCUMENTATION ELEMENTS

- Etiology of agitated or violent behavior if known
- Patient's medications, other medications or substances found on scene
- Patients medical history
- Physical evidence or history of trauma
- Adequate oxygenation by pulse oximetry
- Blood glucose measurement
- Measures taken to establish patient rapport
- Dose, route, number of doses and response of medications administered
- Number and physical sites of placement of restraints
- Duration of placement of restraints
- Repeated assessment of ABC's

PERTINENT ASSESSMENT FINDINGS

- Continuous monitoring of:
    a. Airway patency
    b. Respiratory status with pulse oximetery and capnography
    c. Circulatory status with frequent blood pressure measurements
    d. Mental status and trends in level of patient cooperation
    e. Cardiac status, especially if the patient has received pharmacologic management medication
    f. Extremity perfusion with capillary refill in patients in physical management device

QUALITY METRICS

- Incident of injuries to patient, EMS personnel or others on scene or during transport
- Medical or physical complications (including sudden death) in patients
- Use of Ketamine triggers Medical Director review