EMS Adult Protocols

Protocol Title: Agitation
Original Adoption Date: 8/2000
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Indications
1. Administration of meds to calm agitated/combative patient
   - To prevent harm to patient or others.
     - When all other interventions to reduce dangerous behavior fail.
   - To prevent disruption to life-saving treatment & transport.
   - To subdue excessive agitation & calm physically restrained patient who is struggling violently.
   - To rapidly sedate a patient presenting with signs/symptoms of Excited Delirium (EXD).

Materials
1. Medications of choice
   - MIDAZOLAM (Versed) IV/IM/MAD
     - Adult IV dose 1-2.5mg initially over 2 min; IM dose 5 mg.
     - Reduce dose in elderly or debilitated patients.
     - Repeat dosage with approval from On-Line Medical Control.
     - (IV) Onset 1-5 min, IM Onset 15 min; duration 30-60 min.
     - 5 mg Intranasal via mucosal atomizer device (MAD) (5 mg/ml) in cases where IV access is not readily available or in cases where presenting a needle will cause risk to emergency personnel via worsening agitation or needle stick injuries.
   - Ketamine IM
     - Indications
       - Patients with signs/symptoms of EXD
       - Further sedation of violent/aggressive patients who do not respond to Versed
     - Adult IM dose 4 mg/kg
       - May require multiple injection sites
     - Onset (IM) 3-5 minutes; duration 20-30 minutes
     - Emergence reactions, though rare, may occur.
Establish IV after initial sedation and be prepared to administer Versed for emergence reactions.

*When using Mucosal Atomization Devices (MAD) for intranasal administration, deliver half of the dose into each naris. For doses more than 1 milliliter use two separate syringes and MAD tips, this will insure accurate dosing to both nares. A single naris dose should not exceed 1 milliliter.

Excited Delirium (EXD)
1. Life threatening medical emergency that can result in sudden death
2. Requires early identification and rapid sedation to prevent deterioration or sudden cardiac arrest.
3. Excited Delirium Mnemonic (NOT A CRIME)
   - N: Patient is *naked* and sweating from hyperthermia
   - O: Patient exhibits violence against *objects*, especially glass
   - T: Patient is *tough* and unstoppable, with superhuman strength and insensitivity to pain
   - A: Onset is *acute* (e.g., witness say the patient “just snapped!”)
   - C: Patient is *resistant* and won’t follow commands to desist
   - I: Patient’s speech is *incoherent*, often with loud shouting and bizarre content
   - M: Patient exhibits *mental* health conditions or makes you feel uncomfortable
   - E: EMS should request *early* backup and rapid transport to the ED

Procedure
1. Remain cognizant of patients with special circumstances.
   - Medical conditions, known allergies, possibility of pregnancy.
   - Use EXTREME CAUTION in sedating intoxicated/ poisoned patients (when ingested substance & dose unknown).
2. After the decision to use chemical restraints, medicate immediately without further discussion or negotiation.
3. Medications will work quickly for agitation but psychotic symptoms will take longer to remit.
4. If the patient displays inadequate sedation, contact Medical Control for authorization to administer more medication.
5. Monitor patient for drug effects or signs and symptoms of distress.
   - ABCs
     - Loss of gag reflex
     - Respiratory depression
     - Hemodynamic stability
   - ECG monitoring for dysrhythmias.

Considerations
1. Underlying conditions
   - Must assess all agitated patients for hypoxia, hypoglycemia, drug/ alcohol intoxication, stroke, brain trauma.
2. Sedation side effects
- Benzodiazepines: hypotension, respiratory depression (hypoventilation, hypoxia).
3. Occasional paradoxical reaction results in an increase in agitation.
4. Increase risk of allergic reaction due to inadequate history.

Follow-up
1. Document carefully
   - Nature of dispatch information
   - Patient assessment
   - Description of behavioral symptoms & psychiatric history
   - Any behavior which suggests patient is dangerous to self or others
   - All information gathered from relatives & bystanders at scene
   - Efforts made to obtain patient's cooperation
   - Physical restraint procedure
   - Reason for chemical restraints
   - Patient's response to application
   - Location and position of patient during transport
   - All checks on patient condition while being transported
   - Care during transport
   - All law enforcement involvement
   - All communications with medical control
   - Condition of patient at handoff

Management of Violent or Resistive Patients: Use of Physical Restraints

Purpose:
To establish procedures for the use of physical restraints on violent or resistive patients who may cause harm to themselves, emergency responders, or other personnel.

Policy:
Contact the appropriate Law Enforcement Officials immediately upon determination that a patient is violent or resistive to medically necessary or medically advisable care, or if criminal activity may be involved, in order that law enforcement personnel may restrain such person(s) whenever possible. West Des Moines ECP’s are authorized to restrain patients as set forth in this Policy only when and if personnel at a scene have determined that the physical restraint of a patient is immediately necessary. This must be because there is an imminent reasonable risk of physical injury to the patient, themselves, or other personnel in close vicinity; or there is the likelihood that significant damage to property may occur if EMS personnel wait until law enforcement is at the scene.

This policy also applies in those circumstances when, in the reasonable best judgment of EMS person in charge, it is medically necessary or significantly better for the patient’s welfare for EMS to employ physical restraints rather than await the arrival of law enforcement. Only personnel with appropriate training in physical restraint procedures shall use such procedures.

Legal Considerations:
A patient generally has the right to be free from restraints unless physical restraint is necessary to treat medical symptoms or prevent them from harming self or others. Claims of battery, assault,
false imprisonment, and civil rights infringement may result from the use of physical restraints. Therefore, use this policy as a last resort, never for the “convenience of staff” or to “discipline a patient.”

**Methods:**
West Des Moines EMS shall employ, for the act of physical restraint, only soft restraints applied to each extremity with Velcro flaps and long webbing straps. Should it become necessary to remove the restraints quickly, they may be cut with trauma shears. Not approved for use are law enforcement handcuffs and plastic zip ties, unless the patient is in protective/legal custody by law enforcement and a law enforcement representative (with a key to the handcuffs) agrees to accompany EMS personnel to the receiving facility.

**Procedure:**
After all interventions to defuse violent patient behaviors have proven unsuccessful, employ physical restraint to:

1. Prevent elopement during evaluation for potential suicidal/homicidal behavior.
2. Allow assessment or treatment of a disoriented, intoxicated, or uncooperative patient.
3. Prevent disruption to life-saving treatment and transport (e.g., self-extubation).
4. Prevent physical harm to the patient and emergency responders.

When confronted with a violent or resistive patient, request law enforcement to the scene if they are not already present. If time permits, consult with medical control before taking action and always attempt verbally de-escalation of the situation before employing physical restraint!

Restraining a violent patient is generally the responsibility of law enforcement. Prepare the stretcher and other equipment in advance. Keep the restraints out of the patient’s view as long as possible. Assign a team leader to direct the effort, and have at least four people available (one for each limb). Encircle the patient and provide one final opportunity to cooperate. Verbalize to the patient the reason for physically restraints. Upon the team leaders command, each person secures an assigned limb and holds the patient down while applying restraints simultaneously. Avoid being bitten by maintaining adequate distance from the patient’s head. Avoid placement of numerous responders or excessive weight on the patient’s torso that could result in cardio-respiratory compromise.

Once controlled, situate the patient in a lateral recumbent (preferred) or supine position. To facilitate further control of the violent patient, cot straps or a long backboard and straps can be used.

- The patient shall not be restrained in a face down (prone) position.
- The patient shall not be sandwiched between long backboards or mattresses.
- Do not, in any manner, constrict a patient’s neck or compromise the airway.
- Hog ties or hobble restraints shall not be used.
  - Hog-tie restraint: Securing a person’s hands behind their back, binding their ankles together, securing their ankles and wrists together with a distance of less than 12 inches between their hands and feet.
Hobble restraint: Securing a person’s hands behind their back, binding their ankles together, securing their ankles and wrists together with a distance of more than 12 inches between their hands and feet.

Consider the use of a cervical collar to minimize movement and to prevent biting. If used, raise the head to prevent aspiration.

Do not remove restraints unless a medical emergency occurs and removal is necessary to provide treatment. Treat continued combativeness against physical restraint with chemical restraint (medications).

**Positional Asphyxia:**
Death of the patient may occur if placed in a position that prevents sufficient oxygenation and ventilation. The process of ventilation allows for correction of acidosis that may have occurred during a physical struggle. Positional asphyxia occurs more frequently when the patient is positioned face down and in hobble restraints, (wrists and ankles bound together and behind the patient’s back). This may lead to reduced vital capacity and circulatory return and may cause hypoxia, hypercapnia, and death.

Conditions of extreme physical and psychological excitement, known as excited delirium, may begin with a violent patient struggle and proceed to a paradoxical period of calming. This period of calming may be an ominous sign of impending cardiac arrest. Resuscitation is often unsuccessful.

It is imperative that all physically restrained patients receive assessments for underlying conditions that may contribute to violent behavior including:
- Hypoxia
- Hypoglycemia
- Drug/alcohol intoxication
- Stroke
- Brain trauma

**While ongoing assessment is important in the care of every patient, physically restrained patients shall be, carefully and continuously monitored to assure adequacy of ventilation and oxygenation, being particularly alert for signs of compromised airway, choking, vomiting, and/or decreasing mental status.**

**Documentation:**
It is mandatory to document the following in the patient care report:
- Nature of dispatch information
- Patient assessment findings
- Description of behavioral symptoms and psychiatric history
- Any behavior that suggests patient is dangerous to self or others
- All information gathered from relatives and bystanders at scene
- Effort made to obtain patient’s cooperation
- Restraint procedure, including equipment used
• Location and position of patient during transport
• Reassessment findings during transport
• Care provided during transport
• Name of law enforcement personnel and their involvement
• Communication with medical control
• Condition of patient at time of transfer to receiving staff

Chemical Sedation is often necessary if a patient continues to struggle against physical restraint.