Agitation and Combativeness

Note:

- **Ensuring the safety of EMS personnel is of paramount importance.** Whenever needed, summon law enforcement to secure the scene and patient before attempting to provide medical care to a combative patient.
- Physical restraints are only permitted when the patient is potentially dangerous to self or others.
- Never apply physical restraints for punitive reasons, or in a manner that restricts breathing and circulation, or apply in places that restrict access for monitoring the patient.
- Behavioral disturbances are often the result of underlying medical conditions that require immediate medical attention, including head trauma, alcohol or drug intoxication, metabolic disease, and psychiatric disorders. Agitation and combativeness may also be seen in patients with dementia, delirium, sepsis and seizures. Patients in need of medical attention must be transported in an ambulance, not a police vehicle.
- If law enforcement restrains the patient with handcuffs, an officer with a key must accompany the patient during transport.
- Patients most at-risk of dying in police custody are those who violently resist and struggle against restraints.
- Have law enforcement search the patient for weapons.

Priorities	***Assessment Findings***
Chief Complaint	"Violent behavior"
LOPQRST	Determine onset, duration and progression, triggering events or perception of severity by bystanders. Patient reports: feeling detached or unreal, feeling of losing control or going crazy, feeling faint or light headed.
AS/PN	Alcohol or drug intoxication, Head trauma
AMPL	Psychiatric medications? Noncompliance? History of schizophrenia or bipolar disorder? History of drug or alcohol abuse?
Initial Exam	Check ABCs and correct immediately life-threatening problems.
Detailed Focused Exam	**General Appearance**: Agitated/ Combative: Bizarre behavior, violent, aggressive, combative, loud, obnoxious, agitated; partial or complete undressing? Uncooperative: Does not respond to verbal commands to stop harmful behavior to self or others; Resisting against restraint? **Skin:** Diaphoresis? Cool, moist and pale? Warm, dry and flushed? **Respiratory Effort:** Labored breathing? Heavy breathing? **Lung Sounds:** Wheezes, rales, rhonchi or stridor? Decreased lung sounds? **Cardiovascular:** Hypertensive and tachycardic? **Extremities:** Trauma? **Neuro:** Excited, agitated, increased activity and increased intensity of activity? **Psych:** Bizarre thoughts and actions; Paranoia, delusional, confused, clouded consciousness?
Data	SpO2 on all patients (continuous or re-checks every 5 minutes); 12-lead EKG as soon as it becomes practical to obtain one; Blood glucose to rule out hypoglycemia as a cause of the behavioral disturbance.
Goals of Therapy	• Reduce the threat of further harm to the patient and others, especially emergency responders (law enforcement and EMS) • Achieve IV access

Monitoring	BP, HR, RR, cardiac monitoring, SpO_2, $ETCO_2$, Restraint check-list

EMERGENCY MEDICAL RESPONDER

- Scene size-up
- If law enforcement presence is needed, do not approach an agitated and combative patient before law enforcement has gained control of the situation.
- Provide an anxious patient with verbal reassurance and calming.
- It is reasonable to attempt verbal de-escalation, but do not persist if it appears to be futile or making the situation worse.
- First responders are not allowed to physically restrain a patient, but they are not prohibited from providing medical care to a patient who has been restrained by law enforcement.
- Initiate Routine Medical Care once it is safe and practical.
    - Check blood glucose level once it is safe and practical. If < 60 mg/dl refer to *Altered Level of Consciousness Guidelines*

Give a status report to the ambulance crew by radio ASAP.

EMERGENCY MEDICAL TECHNICIAN

- Consider physical restraints[1] as a last resort when verbal control is ineffective.
- Soft restraints or padded hard restraints are preferred for use by EMS personnel.
- No hog-tying or hobble restraints allowed. No “sandwiching” with long boards or scoop stretchers.
- Once restrained, the patient must be brought to a sitting position or the recovery (lateral recumbent) position.
- Do not keep the patient in a prone position once restrained.
- If EMS or law enforcement personnel must “pile on” to gain control, they must get off the patient as quickly as safely possible, once control has been achieved, so as not to cause harm to the patient.
- A spit net may be applied to the patient.

Give a status report to the ambulance crew by radio ASAP.

ADVANCED EMERGENCY MEDICAL TECHNICIAN/ INTERMEDIATE

- Do not attempt to initiate an IV until the patient becomes cooperative.
- IV normal saline @ KVO
- If signs of hyperthermia or hypovolemia are present, administer normal saline wide open.
- Consider a second IV

Contact Medical Control for the following:

- Additional fluid orders

PARAMEDIC

- For an agitated and combative patient that:

        - Is elderly or
        - Is a postictal seizure patient
    - Consider **Midazolam** 1 – 2 mg (PEDS under age 12, 0.05 mg/kg) IV/IO/IN[1]. May titrate to a maximum of 5 mg.
- For an agitated and combative patient that:
        - Law enforcement is attempting to or intends to restrain
        - May be or has been subject to police use of force (e.g. OC spray, Electronic Control Device, impact weapons)
        - Is struggling or a struggle is imminent. This may include struggling before, during or after restraint application.
    - Consider **ketamine** 5 mg/kg IM.
        - Provide enough restraint to deliver ketamine dose
        - Once ketamine effect is achieved, restraint may be discontinued (consider removal of hand-cuffs or hard restraints and placement of soft restraints).
    - Establish IV and administer normal saline 500 ml bolus
    - Consider **ziprasidone** (Geodon) 10 – 20 mg IM[2]
    - Carefully monitor for respiratory depression and EKG changes.
    - Continue sedation, if needed, with **midazolam** 1 – 2 mg IV/IO/IM/IN[3]
        - Titrate to effect with repeat doses of 1 – 2 mg **midazolam** every 2 min. to a max dose of 10 mg
    - Externally cool patient as needed
- Obtain a 12-lead EKG and transmit to receiving facility
- Reassess patient including vital signs every 5 minutes

Contact Medical Control for the following:

- Adding **diazepam** 2.5mg-5mg IV/IO/IM **-OR- lorazepam** (1 mg – 2 mg IM/IV) in addition to midazolam if patients do not respond to a max dose of midazolam
- Additional doses of midazolam, lorazepam, or ketamine
- Use of ziprasidone in elderly patients

FOOTNOTES:

[1] Mandatory Physical Restraint Documentation

- Why the restraints were applied (including a description of the threat to self or others)
- The time the restraints were applied, and the time(s) of restraint removal (if done before hospital arrival)
- Who (which agency) applied the restraints
- What kind of restraints
- Vital signs and observations about patient status every five minutes
- Evidence that distal neurovascular function was not impaired by the restraints
- The position of the patient after restraints were applied
- Medication(s) used and their effects, including adverse effects

[2] Consider dose ranges for the use of medications in patients with:

- Alcohol (or) drug intoxication
- Alcohol withdrawal
- Elderly (avoid if at all possible)
- Psychiatric disorders

[3] In the event of a midazolam medication shortage:

a. Lorazepam 1 – 2 mg ADULTS (0.1 mg/kg PEDS) IM/IN/IV/IO or
b. Diazepam 1 – 5 mg ADULTS (0.1 mg/kg PEDS) IM/IV/IO

[4] RSI/RSA requires 2 qualified paramedics at the patient's side

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