Protocol
M-14

SECTION: M-14

PROTOCOL TITLE: Behavioral Emergencies & Combative Patients

REVISED: November 1, 2021

ADULT BEHAVORIAL EMERGENCIES

GENERAL COMMENTS: Medical responses involving behavioral emergencies and combative patients are some of the most perilous emergencies EMS personnel will encounter. Many of these patients have multiple underlying pathologies, which are often exacerbated by or derived from illicit substance abuse. As such, these emergencies pose many challenges to the provider. Patient care shall be driven by appropriate clinical care, never at the convenience of Law enforcement, and should be focused on preventing/mitigating hyperthermia, agitated delirium, positional asphyxia, hypoxia, and physical self-harm.

BLS SPECIFIC CARE: *See Adult General Medical Care Protocol M-01*

- Assess for medical causes of altered LOC/violent behavior.
- Minimize noxious stimuli and create a low stimulus environment as feasible. Verbally deescalate as possible.
- Obtain a BG
- For actively agitated patients: provide oxygen as soon as possible consider blow-by for non-compliant patients.
- Involve law enforcement as early as possible for combative/violent patients requiring restraint or sedation.
- Restraints may be used for patient and/or rescuer safety when clinically appropriate.
    - Do not restrain any patient in the prone position.
    - Observe and prevent positional asphyxia, and monitor the airway and respirations closely
    - Any patient restrained with a device provided by Law Enforcement must have a LEO ride with the patient that can remove the device if needed.
    - If restrained, do not release restraints until at the hospital (unless required for essential patient care)
- Do not leave the patient unattended
- Allow for adequate heat dissipation
- *Any patient restrained should be closely monitored for decompensation with an mRass documented before and after restraint, sedation or anxiolysis.*

AEMT/O.M. SPECIFIC CARE: *See Adult General Medical Care Protocol M-01*

- IV access (to a max of 3 attempts) if needed due to severity of underlying injury or illness; otherwise, defer until arrival of ALS providers
- Assess BGL to rule out a hypoglycemic episode

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ALS SPECIFIC CARE: ***See Adult General Medical Care Protocol M-01***

Patients who are being sedated, or who have an mRASS >+3 or < -3 should have enhanced monitoring, (EKG, ETC02, SP02, BGL, and Blood Pressure) to catch any early signs of decline. (Blood pressure every 5 minutes if possible). Exception to these standards should be clearly documented.

Sedation/Anxiolysis: *If removal of noxious stimulus and/or de-escalation fails to resolve episode (or is not practical), pharmacologic therapy may be indicated.*

- Diazepam (Valium)
  - **IV:** 2-5 mg, repeat every 5-10 minutes PRN, max total dose 20 mg
  - **IM:** 5-10 mg, repeat once in 20 minutes PRN, max total dose 20 mg
- Midazolam (Versed)
  - **IV/IM:** 0.5-2.5 mg, repeat every 5-10 min PRN, max total dose 5 mg
  - **IN:** 2.5 mg, may repeat once at 10 minutes, max total dose 5 mg
- Lorazepam (Ativan)
  - **IV/IO:** 0.5-2 mg, may repeat at 10 minutes, max total dose 2 mg
  - **IM:** 1-2 mg (If no vascular access), max total dose 2 mg
- Haloperidol (Haldol)
  - **IV/IM:** 2.0-5.0 mg, repeat PRN, max total dose 10 mg
  - Strongly consider co-administration of Benadryl
  - Caution with hyperthermia, seizure risks, and hyperdynamic drug use

Adjunctive Medications: These medications are given for their potentiation of other drugs effects or for the prevention/treatment of certain side effects (nausea, EPS, etc.) of drugs used in sedation.

- Benadryl (Diphenhydramine)
  - **IV/IM:** 25-50 mg

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Agitation/Sedation Scoring

The *Modified* Richmond Agitation Sedation Score (mRASS) should be used to estimate the need for continued sedation/ anxiolysis and/or restraint. Use of sedation/ anxiolysis is context specific and subject to clinical judgement. The goal during a behavioral emergency may be a mRASS of -2 to +2; whereas the goal for prehospital sedation in the mechanically ventilated patient may be a -4 or -5. *Providers should document an estimated mRASS before and after the application of restraint, sedation anxiolysis.*

Procedure for mRASS Assessment:

1. **Observe patient:**
   - **a.** Patient is alert, restless, or agitated. **(score 0 to +4)**
2. **Verbally stimulate the patient: If not alert, state patient's name and *say* to open eyes and look at speaker. Ask "Describe how you are feeling?"**
   - **a.** Patient awakens with sustained eye opening and eye contact. **(score –1)**
   - **b.** Patient awakens with eye opening and eye contact, but not sustained. **(score –2)**
   - **c.** Patient has any movement in response to voice but no eye contact. **(score –3)**
3. **Physically stimulate the patient: When no response to verbal stimulation, physically stimulate patient by shaking shoulder and/or rubbing sternum or similar appropriate and non-punitive action.**
   - **a.** Patient has any movement to physical stimulation. **(score –4)**
   - **b.** Patient has no response to any stimulation. **(score –5)**

Score	Term	mRASS Description
+4	Combative	No attention; overtly combative, physically violent, immediate danger to staff or self.
+3	Very agitated	Very distractible; repeated calling or touch required to get or keep eye contact or attention.; cannot focus; pulls or removes tube(s) or catheter(s); aggressive; fights environment not people
+2	Slightly agitated	Easily distractible; rapidly loses attention; resists care or uncooperative; frequent non-purposeful movement, attempting to get out of bed/cot/chair.
+1	Restless	Slightly distractible; pays attention most of the time; anxious, but cooperative; movements not aggressive nor vigorous.
0	Calm	Pays attention; makes eye contact; aware of surroundings; responds immediately and appropriately to calling name and touch
-1	Wakes Easily	Slightly drowsy; eye contact<10 sec; not fully alert, but has sustained awakening; eye-opening/eye contact to voice <10 seconds
-2	Wakes Slowly	Very drowsy; pays attention some of the time; briefly awakens with eye contact to voice >10 seconds
-3	Difficult to wake	Repeated calling or touch required to get or keep eye contact or attention; needs repeated stimuli (touch or voice) for attention, movement, or eye opening to voice (but no eye contact)
-4	Want stay Awake	Arousable but no attention; no response to voice, but movement or eye opening to physical stimulation
-5	Unarousable	No response to voice or physical stimulation

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PHYSICIAN PEARLS:

General Principles:

- Providers should strive for the least restrictive methods of restraint for the situation while considering safety and clinical concerns.
- The management of behavioral emergencies is often time consuming.
- At minimum, the patient should be assessed for pain, delirium, and anxiety. Providers should use objective, validated scoring to assist in the clinical decision making and documentation of sedation and restraint.
- Other underlying causes of agitation should be investigated and treated as appropriate.

Pharmacological Considerations:

- The use of medications to restrain a patient can absolutely improve patient and provider safety but require constant vigilance and significant clinical judgement.
- Medications for "*Anxiolysis"* may be used for severe and refractory anxiety and emotional distress with or without the need for physical restraints.
- Medications for "*Sedation*" may also be used to facilitate and increase the safety of physical restraints in combative and violent patients, or other interventions such as mechanical ventilation
- Cautions with using medications for sedation/anxiolysis:
    - Patient may experience respiratory depression or loss of gag reflex
    - Occasionally, a paradoxical reaction results in increased agitation
    - Medication may potentiate the sedative effect of other CNS depressants
    - Mental status assessment and neurologic examination will be limited during sedation
- *ALS Providers may decrease the dosage or prolong the administration intervals of any medication with sedative properties when doing so would decrease adverse effects and still likely obtain the clinical goal.*

Assessment Considerations:

Among the most difficult tasks in providing care during an adult behavioral emergency is determining the etiologies of combative patients and treating accordingly, be it medical, toxicological, or traumatic in nature. Approximately two-thirds of behavioral emergency patients have a non-psychiatric (organic) etiology:

- Psychiatric (functional)
- Non-psychiatric (organic)
    - Medical (CVA, hypoglycemia, increased ICP, meningitis, etc.)
- Toxicological