3J BEHAVIORAL EMERGENCIES

PATIENT CARE GOALS

- Identify and manage potential life threats associated with a behavioral emergency.
- Safely manage patients with behaviors potentially dangerous to themselves or others.
- Use physical and chemical restraints only to the level necessary to ensure effective control and safe transport of patients.
- Provide frequent reassessment of physically and chemically restrained patients.

EMT

1. If safe to do so, assess the patient and provide initial care, including oxygen and vascular access, if needed, as per **1B General Assessment and Care**.
2. During initial assessment and care, identify and address primary or secondary behavioral problems that may be due to emotional, psychosocial, mental, or physiological causes.
3. Recognize that behavioral problems may present secondary to a number of medical or traumatic conditions that are potentially life threatening, including hypoxia, head trauma, stroke, drug or alcohol use, hypoglycemia, or situational stress. Identify causes and provide specific treatments as needed.
4. **Verbal de-escalation** is the first method to employ in managing the patient and defusing the situation. Attempt communication, calming/soothing techniques, reorientation and active listening first, rather than force, to gain permission to assess, provide care, and transport patients experiencing behavioral emergencies.
5. **Physical restraints, holds and devices** can be employed for patients who meet the restraint criteria per **Clinical Policy 9.16 Physical and Chemical Restraint**.
    - Physical restraint devices include: buckle guards, padded leather or soft restraints, spinal immobilization equipment, hand cuffs, or any other devices and supplies primarily applied to control behavior or to prevent escape. ***Stretcher safety straps or seat-belts are not considered restraint devices for the purposes of this guideline.***
    - The type and number of restraint devices employed should be appropriate to the patient's condition and adequate to impede the patient from easily getting off the stretcher per **Clinical Policy 9.16 Physical and Chemical Restraint.**
    - When using physical restraints, holds and devices, subdue and secure combative patients using physical holds in as humane a manner as possible, avoiding the use of submission holds or other extreme tactics as a means to maintain control.[1]
    - Treat patients with respect during all phases of management.
6. **Transport Position.** Physically restrained patients should be transported on the stretcher in a supine or semi-sitting position. Use left lateral recumbent position, if possible, for patients who must be transported on their side. No prone restraint positions should be used during transport.
    - Additional physical restraints should be deployed as needed to provide a margin of safety for the crew and patient.
    - Keep stretcher straps and other restraint devices clearly visible at all times, and inspect them periodically to ensure their integrity.

PARAMEDIC

7. For patients with suspected **excited delirium (ED)**: [2]
    - Carefully monitor ECG and vital signs, including SpO2 and EtCO2 when possible, for possible progression to cardiovascular collapse. This monitoring is especially important for the patient who suddenly becomes quiet and stops resistance.
    - Obtain a baseline temperature, if possible, and, if the patient is or appears to be hyperthermic, begin cooling procedures during transport.
    - Establish vascular access and administer IV fluids for rehydration.
    - All patients with excited delirium require transport and hospital intervention. ED may contribute to unexpected sudden deaths of restrained individuals.
8. Treat hypoglycemia per **3G Hypoglycemia**.
9. **Chemical Restraint**. The goal of chemical restraint is to control excessive agitation and struggling, reduce the patient's level of exertion and oxygen demand, ensure safety for patients and providers, prevent injury, and avoid aggravation of other medical conditions. Frequently monitor vital signs of all patients receiving chemical restraint. Use the minimum level of sedation needed to control behavior and minimize alteration of the patient's level of consciousness by administering the following:

ADULT	PEDIATRIC (less than 60 kg)
For routine agitation[3] 1. Administer **lorazepam (Ativan) 1 to 2 mg IV/IO** slowly, diluted with an equal volume of IV fluid and titrated to effect. May repeat dose once in 15 minutes, if needed. **Maximum total dose is 4 mg.** **OR** Administer **lorazepam (Ativan) 1 to 2 mg IM**, undiluted. May repeat dose once in 15 minutes, if needed. **Maximum total dose is 4 mg.** 2. Be prepared to support ventilations. **For severe agitation**[4] 1. Administer **haloperidol (Haldol)**[5] or **droperidol (Inapsine) 5 mg IM**. May repeat once in 15 minutes if needed. 2. For suspected dystonic reactions[6] to **haloperidol (Haldol)** or other antipsychotic medications, administer **diphenhydramine (Benadryl) 50 mg IM or IV slowly**.	**For routine agitation**[3] 1. Administer **lorazepam (Ativan) 0.1 mg/kg IV/IO** slowly, diluted with an equal volume of IV fluid and titrated to effect. May repeat dose once in 15 minutes, if needed. **Maximum total dose is 4 mg.** **OR** Administer **lorazepam (Ativan) 1 mg IM**, undiluted. May repeat dose once in 15 minutes, if needed. **Maximum total dose is 4 mg.** 2. Be prepared to support ventilations. **For severe agitation**[4] 1. For patients weighing 30 to 60 kg (6 to 13 years of age) administer **haloperidol (Haldol)**[5] or **droperidol (Inapsine) 0.05 mg/kg IM**. May repeat once in 15 minutes if needed. 2. For suspected dystonic reactions[6] to **haloperidol (Haldol)** or other antipsychotic medications, administer **diphenhydramine (Benadryl) 1 mg/kg IM or IV slowly**.

ADULT	PEDIATRIC (less than 60 kg)
For excited delirium[2] 1. Administer **haloperidol (Haldol)** or **droperidol (Inapsine)** **10 mg IM**. If inadequate response after 15 minutes, administer an additional **haloperidol (Haldol)** or **droperidol (Inapsine)** **5 mg IM**. 2. May use **lorazepam (Ativan)** **1-2 mg IM/IV** as secondary sedative. Repeat in 15 minutes if inadequate response. 3. Establish 2 large bore IV/IO with normal saline. 4. Check blood glucose level. 5. Mix **sodium bicarbonate** **100 mEq in 1-liter normal saline** and infuse wide open to treat acidosis. 6. Administer second liter of normal saline wide open, minimum of 2 liters to treat acidosis. 7. Treat hyperthermia with cold packs to axilla and spray patient with water and fan to promote heat loss. 8. Obtain 12-lead ECG to assess for hyperkalemia. 9. If cardiac arrest develops administer **sodium bicarbonate** **100 mEq IVP** and proceed to **2B Cardiac Arrest Management**, the appropriate cardiac arrest algorithm (**2C VF/VT** or **2D PEA/Asystole**) and perform **7G High Performance CPR**.	**For excited delirium**[2] 1. Contact Medical Control for orders.

DOCUMENTATION KEY POINTS

- Detailed description of the patient's behavior used as a basis for employing restraints.
- Methods used to gain control of the uncooperative patient.
- Method(s) and effectiveness of physical and chemical restraints employed.
- Frequently record assessments of distal circulation and motor-sensory (CMS) status of restrained extremities.
- For chemically restrained patients, initial and repeated assessments of vital signs, including level of consciousness.

- Involvement of law enforcement, Medical Control, medical practitioners, or court orders in deciding to use restraints or in exercising involuntary transport of patients.
- Position of the patient during transport.

NOTES

[1] Whenever possible, allow law enforcement officers to take the lead in gaining control of uncooperative and combative patients. For safety, always use a sufficient number of personnel.

[2] **Excited delirium (ED)** is a syndrome characterized by extreme agitation and hyperactivity, hyperthermia, sweating, immune to pain, and exceptional strength and endurance without apparent fatigue. It may include confusion, hostility, aggression, paranoid delusions, hallucinations, and incoherent speech and shouting. Be suspicious of ED syndrome in hyper-excited patients who appear hyperthermic, or who required multiple Taser strikes or Taser strikes combined with considerable physical restraint to subdue. ED is often associated with the use of cocaine, methamphetamine, PCP, LSD, and lithium, but it may be purely psychogenic in origin.

[3] Patients experiencing **routine agitation** present with agitation and combativeness but are not in a state of excited delirium or severe agitation. These patients generally do not require the use of physical restraints.

[4] Patients experiencing **severe agitation** present similarly to those with routine agitation, but require the use of physical restraints.

[5] **Haloperidol (Haldol)** is not indicated for use in patient's less than 6 years of age. It is not to be administered IV for any patient due to risk of over sedation and extrapyramidal reactions.

[6] **Extrapyramidal reactions** include dystonic reactions or akathisia. These may actually be adverse effects of **haloperidol (Haldol)** and may be mistaken for worsening of the patient's behavioral status.

- *Dystonic reactions* are involuntary muscle contractions that may affect the neck, jaw, tongue, eyes, or torso areas. The muscle contractions are often accompanied by pain, anxiety, diaphoresis, and tachycardia. Laryngospasm may occur, endangering the airway. Dystonic reactions are treated with diphenhydramine (Benadryl).
- *Akathisia* is motor restlessness and anxiety, which often presents as squirming, pacing, complaints of jitteriness, or feeling like "jumping out of one's skin".
- *Neuroleptic malignant syndrome* is a rare syndrome that may include life-threatening hyperthermia, muscle rigidity, altered mental status, and unstable vital signs (may be confused with excited delirium).