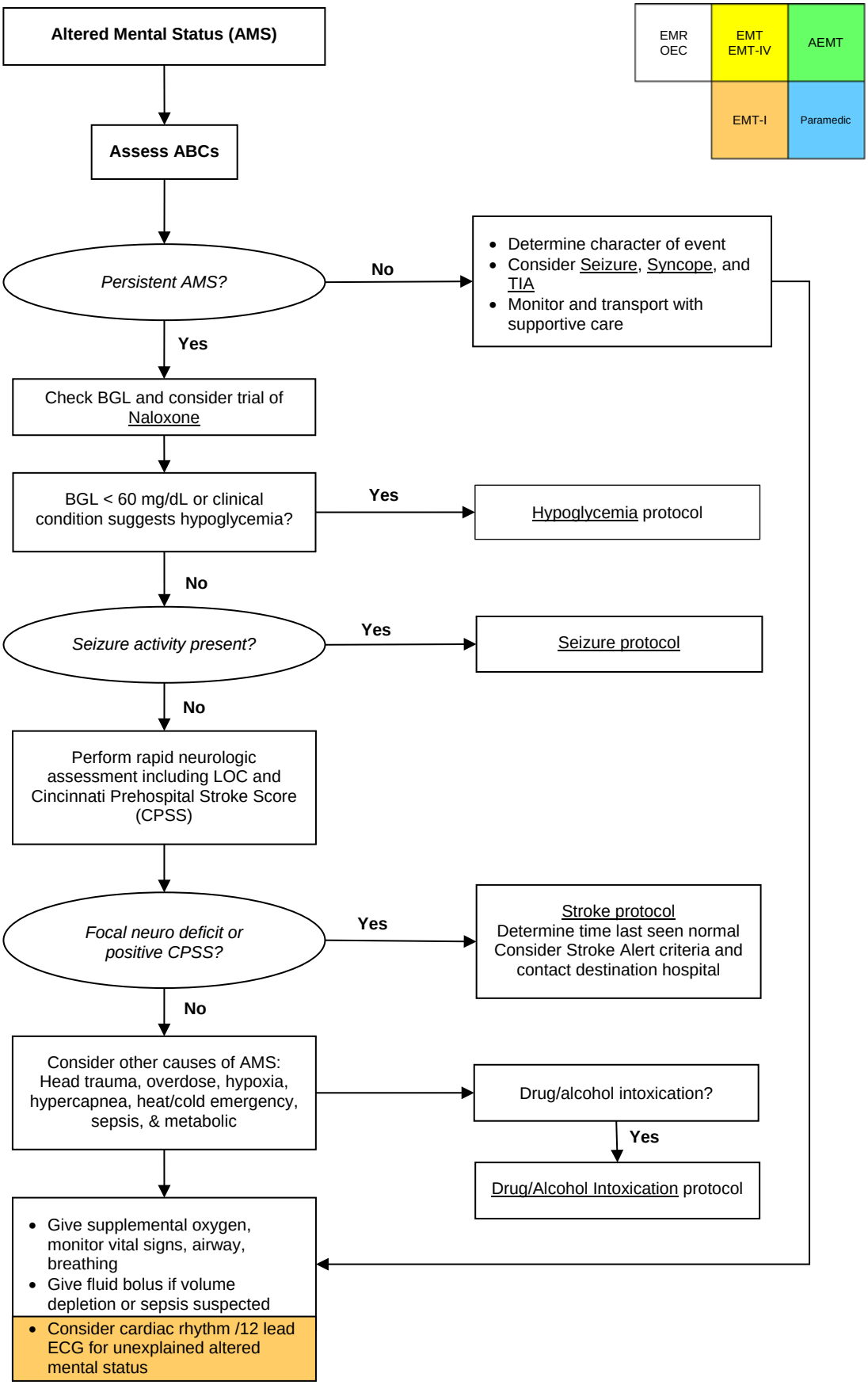
4010 UNIVERSAL ALTERED MENTAL STATUS



6000 PSYCHIATRIC/BEHAVIORAL PATIENT PROTOCOL

EMT	AEMT
EMT-I	Paramedic

Scene Safety

A. Scene safety and provider safety should be assured prior to initiating care. Consider police contact if scene safety is a concern.
B. Refer to restraint protocol as needed, especially as it relates to A.

Specific Information Needed

A. Obtain history of current event; inquire about recent crisis, toxic exposure, drugs, alcohol, emotional trauma, and suicidal or homicidal ideation.
B. Obtain past medical history; inquire about previous psychiatric and medical problems, medications.

Specific Objective Findings

A. Evaluate general appearance
    1. E.g.: Well groomed, disheveled, debilitated, bizarrely dressed
B. Evaluate vital signs.
    1. Is a particular toxidrome suggested, e.g.: sympathomimetic?
C. Note medic alert tags, breath odors suggesting intoxication.
D. Determine ability to relate to reality.
    1. Does the patient know who s/he is, where s/he is, who you are and why you are there?
    2. Does the patient appear to be hallucinating or responding to internal stimuli?
E. Note behavior. Consider known predictors of violence:
    1. Is the patient male, intoxicated, paranoid or displaying aggressive or threatening behavior or language?
F. Consider potential for sudden unexpected death in the presence of severe agitation.
    1. Assess for presence of severe agitation
        i. Pre-existing psychiatric disorders with breakthrough psychosis
        ii. Non-compliance with psychiatric medications
        iii. History of current use of amphetamines, cocaine, PCP, LSD or ecstasy
    2. Stages of severe agitation with potential for unexpected sudden death include:
        i. Stage 1 Euphoria – Episode of exertion, feeling euphoric from early rush of epinephrine release
        ii. Stage 2 Paranoia – As body temperature rises, brain triggers paranoia and fear responses, delusions and generalized fear occur. Due to hyperthermia, patient may disrobe or engage in inappropriate behaviors, like rolling in snow.
        iii. Stage 3 Rhabdomyolysis – Insensitivity to pain and exhaustion results in pushing muscles past normal limits. Patient may have unusual strength. The muscles begin to breakdown due to need for energy. The resulting cellular breakdown results in a phenomenon known as Rhabdomyolysis.
        iv. Stage 4 Acidosis and death – Prolonged anaerobic metabolism produces metabolic acidosis. Body core temperature may reach 105° F. The patient may lapse into a state of calm listlessness as toxins begin to clog the renal system. At this point the patient is at risk for lethal cardiac rhythms, unconsciousness, and death.
    3. Patients who undergo a prolonged phase of agitation should be considered in danger of sudden death, even after the combativeness has resolved.

Treatment

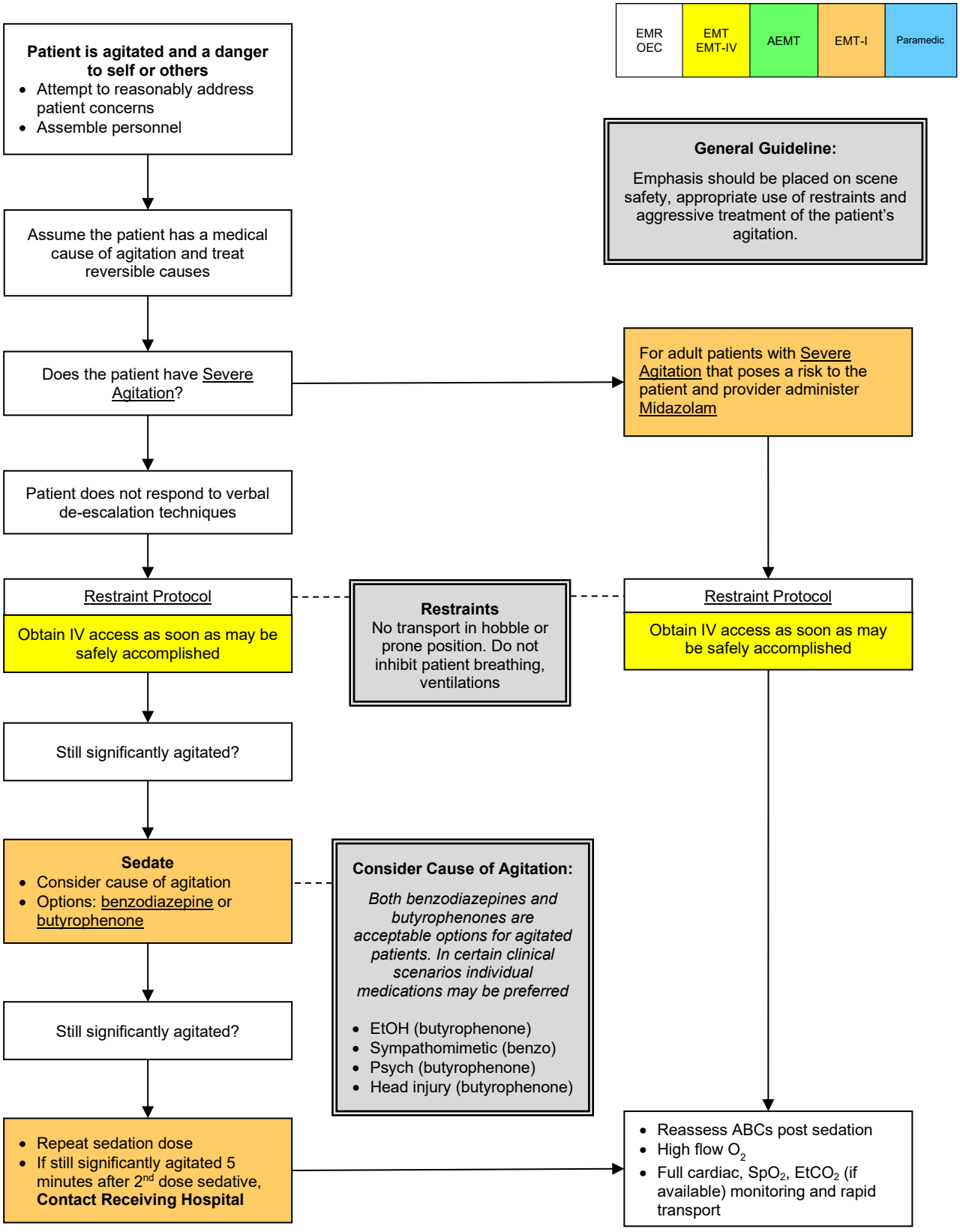
A. If patient agitated or combative, see Agitated/Combative Patient Protocol
B. Attempt to establish rapport
C. Assess ABCs
D. Refer to Mental Health Clearance Form for determining appropriate patient destination
E. Be alert for possible elopement
F. Consider organic causes of abnormal behavior (trauma, overdose, intoxication, hypoglycemia)
G. If patient restraint considered necessary for patient or EMS safety, refer to Restraint Protocol.
H. Check blood sugar
I. If altered mental status or unstable vital signs:
    1. Administer oxygen.
    2. Establish venous access.
    3. Refer to Universal Altered Mental Status Protocol.

6000 PSYCHIATRIC/BEHAVIORAL PATIENT PROTOCOL

Transporting Patients Who Have a Psychiatric Complaint

A. If a patient has an isolated mental health complaint (e.g. suicidality), and does not have a medical complaint or need specific medical intervention, then that patient may be appropriately transported by law enforcement according to their protocols.
B. If a patient has a psychiatric complaint with associated illness or injury (e.g. overdose, altered mental status, chest pain, etc), then the patient should be transported by EMS
C. Reasonable concern for suicidal or homicidal ideation, or grave disability from psychiatric decompensation, is sufficient to assume that the patient may lack medical decision-making capacity to refuse ambulance transport. Effort should be made to obtain consent for transport from the patient, and to preserve the patient's dignity throughout the process. However, the patient may be transported over his or her objections and treated under implied consent if patient does not comply.
D. Accusations of kidnapping or assault of the patient are only theoretical and rarely occur. The Boulder County Medical Directors feel strongly that the risk of abandonment of a potentially suicidal or otherwise gravely impaired patient is far greater. Be sure to document your reason for taking the patient over their objections, that you believe that you are acting in the patient's best interests and be sure to consult a **Receiving Hospital Physician** if there are concerns.

6010 AGITATED/COMBATIVE PATIENT PROTOCOL



6020 TRANSPORT OF THE PATIENT IN LAW ENFORCEMENT CUSTODY

Purpose:

1. Guideline for the safety of care providers and the patient in custody

Guideline:

1. Handcuffs are only to be placed by law enforcement. EMS personnel are not permitted to use handcuffs.
2. Request that law enforcement remain with the patient in the ambulance, if possible. If not possible, request a handcuff key and that police ride behind ambulance so as to be readily available.
3. The care provider can always refuse transport if the situation is unsafe.
4. EMS personnel are not responsible for the law enforcement hold on these patients.
5. Handcuffed patients will not be placed in the prone position.
6. Handcuffs may be used with spinal stabilization. Medical priorities should take priority in the positioning of the handcuffs.