NWC EMSS Skill Performance Record

Care of agitated, combative, violent patients
Use of RESTRAINTS

Date:	EMS Agency		
Name:		☐ Pass	☐ Re-education
Name:		☐ Pass	☐ Re-education
Name:		☐ Pass	☐ Re-education
Name:		☐ Pass	☐ Re-education
Name:		☐ Pass	☐ Re-education

Instructions: Use this checklist in conjunction with the NWC EMSS SOPs. System agencies and hospitals shall ensure that all EMS practitioners are competent in the use of devices, techniques, and medications used for EMS assessment, de-escalation, sedation, monitoring, and restraint of patients with a BHE. Agencies shall ensure that practitioners have training in communicating and engaging with individuals who are agitated, uncooperative, and/or violent (NAEMSP). Each EMS practitioner must have their competency assessed using this checklist annually. Randomly ask questions requiring a verbal response of all team members.

Performance standard	Yes	No
SCENE/Personal SAFETY: If in jeopardy, request law enforcement protection; withdraw until scene is safe for EMS ☐ Quickly evaluate the situation and resources (often with limited information available) ☐ Apply appropriate PPE /source control ☐ Call for help/additional resources if indicated		
Assess pt for imminent risk of harm to self or others: verbal; non-verbal, or written threats/threatening behavior ***List at least three examples of behaviors suggesting an imminent risk of harm:*** ☐ Combative ☐ Shouting ☐ Pacing ☐ Punching or kicking ☐ Anger ☐ Shaking fists ☐ Intentionally slamming doors ☐ Destroying property/vandalism ☐ Sabotage ☐ Throwing objects ☐ Self-injurious behaviors ☐ Disordered eating ☐ Physical attacks (hitting, shoving, biting, pushing or kicking) ☐ Extremes: rape; arson, use of lethal force		
Inspect environment for clues suggesting substance use (bottles, drugs, toxins); letters, notes, plans to harm others		
General pt appearance; hygiene, grooming, odors | Inspect for Medic alert jewelry; impairment; trauma		
☐ **Obtain collateral information from informants**: Hx (if known); recent mood, behavior, or thought changes ☐ Confer with law enforcement if applicable; determine the pt's condition prior to EMS arrival What happened to create the situation? What changed? What is the goal?		
Describe the spectrum of agitated behaviors: Anxiety to high anxiety, to agitated and cooperative to aggression. Patient may exhibit delirium with agitated behavior & a dangerous inability to understand the situation or dangers of their behavior. Associated motor activity is usually repetitive and non-goal directed: Foot tapping, hand wringing, hair pulling, and fiddling with clothes or other objects; may exhibit repetitive thoughts and statements; irritability, and hyper-responsiveness to stimuli		
Use the Richmond Agitation Sedation Scale (RASS), as part of the assessment and reassessment of agitated patients (See bottom of skill sheet)		
****Role play at least 8 assessments that must be performed to determine decisional capacity*** Ability to understand and appreciate the nature and consequences of a decision re: medical Rx or foregoing life-sustaining treatment and the ability to reach and communicate an informed decision (755 ILCS 40/10 [1996], as amended by P.A. 90-246). **Capacity can be influenced by** medications, pain, time of day, mood, medical or mental illness. If any S&S below are abnormal/ impaired the pt may lack capacity Attempt to assess if changes are new (acute) or features of chronic dx and how grossly abnormal EMS interprets the exam findings to be.		
Has pt been declared an emancipated minor? ☐ Yes ☐ No | Has pt been declared legally incompetent? ☐ Yes ☐ No		
Alertness (Abn. GCS 13 or less): E (3 or 4 OK): V (5): M (6) Total:		
Orientation X 4: Answers accurately person, place, time, and situation (Abn. X 3 or less / 4)		
Speech: Speaks with normal rate, volume, articulation, content | (Disorganized, repetitive utterances?)		
Affect: Mood/emotional response (sad, depressed, flat, anxious, irritable, angry, elated, inappropriate, and incongruent with speech content)		

Performance standard	Yes	No
Behavior: Posture, gestures, abnormal movements, repetitive behaviors; is pt. quiet, restless, inattentive, hyperactive, agitated, violent? Is pt cooperative and able to remain in control?		
Cognition: Intellectual ability/thought processes - Note if linear, confused, disorganized, obsessive thoughts, not making sense; evidence of delusions, delirium, dementia, hallucinations, phobias, suicidal or homicidal ideations.		
Memory: Immediate, recent, remote (amnesia/dementia?)		
Insight: Can pt articulate lucid and logical implications of the situation and consequences to their choices? Do they understand relevant information? Can they draw reasonable conclusions based on facts and communicate a safe and rational alternative choice to recommended care?		
Assess for and Rx causes of AMS per symptom-specific SOP (Consider baseline/normal ranges for pt)		
BALANCE/Coordination – Ataxia (upper or lower extremities); tremors | EYES: Nystagmus		
☐ **A**: **Alcohol/drugs/toxins (substance use);** ACS/HF, arrhythmias, anticoagulation, anemia ☐ **E**: Endocrine/exocrine (thyroid/liver/renal/adrenal dx); electrolyte/fluid imbalances; **ECG**: dysrhythmias / prolonged QT ☐ **I**: Insulin disorders: ✓**glucose for hypo or hyperglycemia** (DKA/HHNS) ☐ **O**: O_2 deficit (**hypoxia – ✓ SpO_2**), **opioids/OD,** occult blood loss (GI/GU) ☐ **U**: Uremia; other renal causes including hypertensive problems ☐ **T**: (recent) Trauma, temperature changes (hypo-hyperthermia) ☐ **I**: Infections, neurologic and systemic (**sepsis**) ☐ **P**: Psychological*; poisoning; perfusion deficits; massive pulmonary embolism ☐ **S**: Space occupying lesions (epi or subdural, SAH, tumors); stroke, shock **(hypotension),** seizures ☐ **Neuro:** Delirium, dementia (Alzheimer's dx), developmental impairment, autism, Parkinson's dx; migraine/other HA ☐ **Metabolic**: Acidosis **(✓ $EtCO_2$)**, vitamin/dietary deficiencies; disordered eating / malignancies ☐ ***Psych/behavioral:** Anxiety or mood disorders; PTS, mental health crisis; personality and bipolar disorders; delusions, psychosis; hallucinations (auditory, visual, tactile)		
Determine decisional capacity + mental health safety risk ☐ **Low risk:** Flat affect; low suicide risk; thoughts disordered (confused) with insight, cooperative ☐ **Medium risk**: Intoxicated, disinhibited, no insight, unpredictable, cooperative ☐ **High risk:** Violent; agitated; aggressive, uncooperative; no insight | high risk to self/others		
Sequence the general approach to agitated/combative/violent patients: ☐ **IMC** special considerations | **MEDICAL care = MEDICAL decision** | Work collaboratively w/ mental health / LEO ☐ **Priority: Pt & Personal SAFETY |** Recognize warning signs | Wait to approach/maintain safe distance until adequate resources are available unless urgent interventions are indicated ☐ **Containment: Use least risk/force possible** to protect all from injury; facilitate assessment ☐ Take all reasonable steps to assess and properly care for an individual who is plainly in distress; do not require a pt with AMS to walk; lift and move using standards-based techniques; bring appropriate conveyance devices to pt; Rx life-threats ☐ Maintain dignity and protect modesty to the extent possible ☐ Express concern for their well-being; declare your intent to touch them for an assessment or safety hold ☐ Consider need for early O_2 ***General approach:*** ☐ **Verbal de-escalation & crisis communication** ☐ Defensive tactics ☐ Physical safety hold / physical device ☐ Sedation & monitoring		
Provide low stimulus & calm environment; limit responders to minimum safe levels, isolate from bystanders		
If S&S of anxiety | verbal aggression/confrontation | Cooperative | Low-medium safety risk: **Empathetic communication:** Verbally redirect and de-escalate when possible with coaching & reassurance **Respect personal space** while maintaining a safe position: maintain at least 2 arm's length distance and out of striking or kicking distance **Do not be provocative/antagonistic and avoid coercive interventions that escalate agitation**; Stay calm; body language must reflect desire to prevent a confrontation; avoid staring, clenching or concealing your hands, and closed body language that implies judgment **Establish verbal contact/rapport** (one responder) provide emotional reassurance**.** Speak in a calm, professional voice. Explain who you are; attempt to reorient them as able; do not yell or speak to them disrespectfully. Build a bond. Assure pt that the goal is to help resolve the issue and keep everyone safe. Do not reinforce delusions or hallucinations. **Be concise** Use clear, short sentences and simple words; give pt time to process and respond Repeat key information as needed		
Help pt manage their emotions or distress and maintain or regain control if possible **Identify wants and feelings:** Respond with empathy and compassion even if expectations are unrealistic **Actively listen** to complaints or concerns		

Performance standard	Yes	No
Try to find common ground; **agree or agree to disagree** but acknowledge patient's feelings		
A severely agitated person may be unable to engage in any conversation and requires very different interventions than one who is able to engage.		
Set boundaries and clear limits that are essential (mutual respect); calmly inform pt re unacceptable behaviors (violence) and potential consequences; communicate in a factual, nonthreatening manner. **Attempt verbal de-escalation**		
Offer realistic and alternative choices to violence and optimism if possible:		
If pt lacks decisional capacity	poses medium-high risk to self or others: **DO NOT LEAVE ALONE** ☐ Provide **continuous visual observation** and ability to intervene immediately ☐ Rx per implied consent ☐ Try to ensure safety of the physical space in which the patient is encountered and transported. ☐ Search for, secure, and remove items that could be thrown or used as a ligature point or weapon. ☐ Avoid extremes of sensory stimuli/sound (no lights or sirens)		
If patient is an immediate threat: try to isolate the aggressor in as limited an area as possible and evacuate others as quickly as possible by all means of egress available.		
Define physical restraint (May paraphrase): Direct application of force to an individual without the person's permission to restrict freedom of movement.		
Give 2 examples of patients on whom a form of restraint might be indicated *EMS practitioners face higher risks when caring for pts in the confined space of an ambulance or with limited resources in the field. These differences may require the use of restraint techniques and thresholds for the implementation of restraint techniques that are specifically intended for the out-of-hospital environment. These may differ from those used by health care providers within a hospital.* ☐ Physical restraint and pharmacologic management / sedation are only indicated to protect a patient, the public, and emergency responders from further injury, facilitate assessment, or allow for treatment of life-threatening injury or illness ☐ EMS practitioners should use the least restrictive restraint techniques to facilitate clinical patient assessment, medically indicated treatment, and safe transport to a hospital		
State at least 1 example of a soft restraint ☐ Roller gauze ☐ Sheets/blankets ☐ Chest Posey		
State at least one example of a hard restraint ☐ Velcro limb restraints ☐ Plastic ties ☐ Leather restraints		
State one example of a forensic restraint (Handcuffs)		
State who is responsible for a prisoner in handcuffs (Arresting law enforcement officer)		
State what an officer must give to EMS personnel if a prisoner is in handcuffs and they follow the ambulance in the police vehicle (Handcuff key)		
****Verbalize 2 approved positions for a prisoner being transported in handcuffs behind their back*** ☐ Seated ☐ On their side		
Verbalize two civil torts (wrongs) that EMS practitioners can be accused of if restraints are incorrectly or inappropriately applied ☐ False imprisonment ☐ Assault/battery		
Have criminal charges been alleged against EMS relative to sedation and restraint use? *Yes; manslaughter, negligent homicide, and murder*		
State a Federal allegation that may be brought due to improper restraint use ☐ Violation of civil rights to liberty ☐ Use of excessive force under the Constitution		
Application of 4 point limb restraints		
****Process steps (See SOPs)*** ☐ Avoid threatening or ALS interventions or restraint unless necessary for patient, crew/bystander safety. ☐ Explain to patient that their cooperation is needed in remaining still and in control. If they cannot do that right now that you will secure their arms and legs for their safety and protection. ☐ If patient remains an imminent risk of harm to self or others: Provide physical restraint. ☐ Ensure patient safety using continuous visual observation (CMS) ☐ Provide as much privacy as possible		
State the minimum number of rescuers needed to apply restraints to a violent pt. (5)		
Who must provide authorization for restraints either before or after their application? On-line medical control physician. In an emergency, apply restraints; then confirm necessity with OLMC		
Prepare equipment for full limb (4 point) restraint: 2 wrist; 2 leg restraints: Use proper size for patient and correct product to prevent patient injury.		
Plan the approach to the patient based on location, patient situation, & resources available		

Performance standard	Yes	No
Demonstrate application of 4 point restraints with team members ***Take patient safely down to a prone or supine position** ☐ *One person controls each limb by grasping clothing and large joints; ideally one controls the head ☐ Use only enough force to protect patient and/or EMS personnel (do not slam pt to ground or cot). ☐ Restraint should not be unnecessarily harsh or punitive. ☐ Never apply force to the neck or back Aguirre v City of San Antonio, 995 F.3d 395 (5th Cir. 2021) "it is clearly established … that exerting significant, continued force on a person's back while that person is in a face-down prone position after being subdued and/or incapacitated constitutes excessive force."		
*Adjust pt to a supine or side-lying position as soon as EMS has control of pt's movements		
☐ Expose area to assess limb SMV. Remove all jewelry from areas to be restrained. ☐ Apply limb restraint in compliance with manufacturer's directions for a particular product ☐ Ensure peripheral perfusion distal to restraint | Allow for rapid removal if ABCs compromised ☐ *Restrain 1 arm at side and other above head; both legs to cot or scoop stretcher ☐ Avoid injury | Never use prone, hogtie (hobble) positioning nor place under a backboard or mattress		
☐ *Place stretcher straps over bony prominences, crisscrossed over chest, pelvis, and legs in a manner that restrains movement, but ensures adequate oxygenation, ventilation and perfusion ☐ Secure straps to scoop stretcher or cot part that moves with the patient ☐ Secure straps out of patient's reach ☐ Cardiac arrest can happen quickly | Watch for sudden giving up, quiet compliance, collapse ☐ Use quick release ties for non-Velcro restraints for rapid removal if a medical emergency occurs that requires resuscitation		
State at least 3 signs of physical distress in individuals who are being held or restrained ☐ Shortness of breath ☐ Reduced/absent pulse distal to restraint (adjust application) ☐ Inability to speak ☐ Cool/pale limb distal to restraint ☐ Hypoxia ☐ Hyperthermia ☐ Pain due to restraint ☐ Cardiac dysrhythmia; unstable VS ☐ Soft tissue injury ☐ Patient continues to move/thrash about		
Under what circumstances are EMS personnel authorized to remove restraints once applied? EMS receives orders from OLMC to D/C restraint.		
What steps may EMS personnel take if a patient is biting or spitting at them? Place a surgical or oxygen mask over the patient's face		
Special populations		
Who must accompany a child in restraints? Responsible adult		
How can one compensate for an elderly adult's loss of sight or hearing? Reassuring physical contact		
What special accommodations must be made for hearing impaired persons whose primary mode of communication is sign language? Hands must be freed for brief periods unless freedom may result in physical harm		
Besides normal EMS-related reporting, to whom must EMS personnel report a death of a pt while in restraints or following sedation? EMS MD *Within what time frame? ASAP;* 2 hours		
Sedation and monitoring indications/contraindications (Paramedics/PHRNs) ☐ Not used to prevent an agitated state**.** In severely impaired pts, rapid pharmacologic mgt/ sedation may be indicated to prevent adverse/life-threatening conditions and maximize pt safety. ☐ EMS practitioners must not give sedating medications based on LEO's request to an individual to facilitate arrest or to assist LEO to take the individual into custody.		
State at least 5 complications of delirium and severe agitation if the pt is struggling before or after physical restraint application ☐ Aspiration ☐ Positional asphyxia ☐ Severe acidosis ☐ Trauma ☐ Hypoxia ☐ Hyperthermia ☐ Hyperkalemia ☐ Hypoglycemia ☐ Dysrhythmia ☐ STEMI ☐ Cardiac arrest ☐ Rhabdomyolysis ☐ Stroke		
Pharmacologic sedation and monitoring ☐ **Which agent is used to achieve sedation for **anxious** patients?* Midazolam ☐ **State the IN dose for adult patients* 0.2 mg/kg IN up to 10 mg ☐ **State the IV dose for adult patients* 2 mg increments slow IVP q. 2 min up to10 mg ☐ **State the IM dose for adult patients*: 5-10 mg (0.1-0.2 mg/kg) max 10 mg ☐ State the max dose for all routes: 20 mg if SBP ≥ 90 (MAP ≥ 65) unless contraindicated If hypovolemic, elderly, debilitated, PMH chronic dx (HF/COPD); prone to ventilatory depression (SCI); and/or suspect use of opioids or CNS depressants: reduce total dose to 0.1 mg/kg.		

Performance standard	Yes	No
☐ **Which agent is indicated to achieve sedation in violent, combative patients?* Ketamine Use care/caution with dose selection. ***How can body weight be accurately estimated?*** ☐ Mid-upper arm circumference (MUAC) formula: Wt in kg = 4 X MUAC (in cm) – 50 ☐ **State the IN/IM dose for adults* 4 mg/kg (max 300 mg) (OLMC required for addl. dose) ☐ **State the IV dose for adults* 2 mg/kg slow IVP (max 300 mg) **Optional dosing approach if urgent need for SEDATION and NO IV/IO & based on pt. wt.:** ☐ Up to 50 mg (1 mL) IN (NASAL) each nostril (unless contraindicated); may repeat within 90 seconds +/or ☐ Up to 150 mg (3 mL) IM (may use both thighs through clothing prn). Max cumulative dose: 300 mg per SOP.		
How must a pt be monitored after restraint and/or sedation administration? ☐ GCS ☐ RASS ☐ Airway ☐ VS ☐ SpO_2 ☐ $EtCO_2$ ☐ WOB ☐ ECG q. 5 min ☐ Document untoward events after sedation or restraint ☐ Watch for complications of delirium w/ severe agitation		
Follow infection control guidelines for cleaning restraints after removed from patient.		
***Documentation:** *List at least 6 things that must be documented if a patient was placed into restraints:* ☐ Clinical justification for use | EMS assessment of pt safety | Rationale for type of intervention selected ☐ Failure of non-physical methods of de-escalation and/or restraint ☐ Reasons for restraint were explained to patient (informed restraint) ☐ Restraint order confirmed by OLMC - physician's name who authorized restraint ☐ If applicable: Describe how restraint was applied by others and reassessed by EMS ☐ Type(s) of restraint used ☐ Time of application; reassessments every 5 minutes ☐ Care during transport ☐ Any injuries or adverse outcomes sustained by patient or rescuers **Documentation in addition to usual history and exam (ImageTrend worksheet)** ▪ Who called EMS? What happened? ▪ Where/when did event happen? ▪ Preceding factors (prior events) ▪ Decisional capacity/risk assessment findings ▪ Suicide screen (if applicable) ▪ Interventions (type and nature)/responses ▪ Any challenges encountered during the call ▪ Pt's access to lethal means of harm ▪ Types of threat alleged or observed: verbal or physical (nature) ▪ Witnesses; others involved; account of situation/statements by pt ▪ Verify injuries sustained: emotional/physical ▪ Evidence to support risk assessment (notes/social media posts) ▪ Scene factors/observations to support risk concerns ▪ Pt's stated preferences regarding Rx if different from EMS ▪ LEO/mental healthcare worker presence/engagement ▪ Patient disposition		
Critical errors ☐ Use of excessive force or pressure to neck or back ☐ Failure to assess and ensure patient safety throughout encounter ☐ Failure to position and support patient appropriately ☐ Performs in a way that could cause harm to a pt or is inconsistent with competent care ☐ Exhibits unacceptable affect with patient or other personnel		

Scoring: All steps must be independently performed in correct sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the person to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Rating: (Select 1)

☐ **Proficient**: The paramedic can sequence, perform and complete the performance standards independently, with expertise and to high quality without critical error, assistance or instruction.

☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 1/23

Preceptor (PRINT NAME – signature)

Modified Richmond Agitation Sedation Scale (RASS)

Used for Behavioral Health Emergency patients prior to / during / after sedation

Score	Responsiveness	Speech
+4	Combative, violent, out of control	Continual loud outbursts or growling
+3	Very anxious and agitated	Loud outbursts
+2	Agitated, overstimulated but self-controlled	Fast speech; flight of ideas
+1	Anxious or restless	Normal, talkative
0	Awake, alert, calm, cooperative	Normal
-1	Drowsy, asleep, rouses to voice	Slurring or slowing
-2	Light sedation; rouses to physical stimulation	Marked slowing; few recognizable words
-3	Moderate sedation; responds to pressure stimulus	Words or no speech
-4	Deep sedation; no response to stimulus – hold further med	No speech

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