BEHAVIORAL PATIENT MANAGEMENT

ELDERLY AGGRESSIVE PATIENTS

Graying of America

Describes increasing number of older Americans

Increase in both the number of older Americans and the need for physicians

Need for cost-effective and efficient service

Most prehospital geriatric patients do not reside in nursing homes.

Nursing home admissions are increasing as the number of older patients increases.−

A countertrend is that older persons are maintaining independent lives.

Psychosocial factors influencing aging

Feeling useless or unproductive in society, leading to self-esteem issues

Mourning/feeling frustrated over loss of ability

Feeling freedom or sense of accomplishment in retirement

Changes in the Musculoskeletal System

Decrease in bone mass in men and women

Causes brittle, easily breakable bones

Joint problems

Tendons and ligaments lose elasticity

Synovial fluids thicken

Cartilage decreases

Geriatric Patient Assessment

Illness inevitable with aging

Widespread incorrect belief that older adults are hypochondriacs

Older patients tend to not complain, even with real symptoms.

Signs and symptoms altered from aging

Myocardial infarctions may not present with chest pain.

Pneumonia may not include fever.

Uncontrolled diabetes may be present.

Some afflictions present as delirium.

Multiple pathologic conditions:

Symptoms of one disease may hide or alter symptoms of another.

Disturbance in one body system may cause a domino effect.

It may be difficult to determine which condition is causing which symptoms.

Primary Assessment

Use GEMS diamond to form a general impression.

G—Geriatric patient

What is normal for this patient mentally?

Have they had physical outbursts in the past?
What has worked in the past to calm the patient?

E—Environmental assessment

Alcohol, drugs (prescribed or illicit)

Living conditions
Home care assistance

M—Medical assessment

Underlying medical Conditions

Acute
Chronic

S—Social assessment

The GEMS Diamond

- ***G***eriatric patients: Normal aging, atypical presentation

- ***E***nvironmental assessment: Safety, neglect

- ***M***edical assessment: Past history, medications

- ***S***ocial assessment: Basic needs, social network

Neurologic Conditions

Normal age-related cognitive changes:

Relatively isolated – each individual is different

Not sudden or extreme

Delirium

A symptom, not a disease

Temporary

Reflects underlying disturbance

a. Also known as acute brain syndrome or acute confusional state
b. Temporary state (a reflection of underlying disturbance) and usually reversible

Characterized by:

Disorganized thoughts
Inattention
Memory loss
Disorientation
Personality changes
Hallucinations
Delusions

Symptoms may mimic:

Intoxication

Drug abuse

Severe psychologic disorders

Assess for recent changes in:

Level of consciousness or orientation

Vital signs

Temperature

Glucose level

Medications

Often replaces or confounds typical presentations caused by:

Medical problems

Adverse medication effects

Drug or alcohol withdrawal

Causes of delirium include:

a. Medications
b. Poisons
c. Electrolyte imbalances
d. Nutritional deficiencies
e. Respiratory, cardiovascular, or nervous system disorders
f. Hyperglycemia or hypoglycemia
g. Environmental emergencies
h. Trauma
i. Infections
j. Neurologic and endocrine causes (most important to consider)
   i. Alzheimer disease
   ii. Parkinson disease
   iii. Diabetes

Onset is abrupt (hours to days).

Delirium usually resolves with treatment of the underlying problem.

Treatment may be complicated by uncooperative behavior.

DEMENTIA

- Produces irreversible brain failure.
- Symptoms include:
- Short-term memory loss, short attention span
- Jargon aphasia
- Confusion and disorientation
- Difficulty retaining new information
- Personality changes

May be caused by conditions that impair vascular and neurologic brain structures:
Infection
Stroke
Head injury
Poor nutrition
Medications

Two most common degenerative dementias:

Alzheimer disease

Multi-infarct or vascular dementia

May also be caused by:

Brain tumors

Emotional disorders

Parkinson disease

Huntington chorea

Diagnosed when two or more cognitive or psychomotor brain functions are impaired:

- Language
- Memory
- Visual perception
- Emotional behavior/personality
- Cognitive skills

ALZHEIMER DISEASE

- Most common form of dementia
- Progressive function loss with subtle symptoms
- Losing things, difficulty recalling names
- Losing ability to think and reason clearly
- Forgetting identities and own experiences

STAGES

- Mild cognitive impairment
- Forgetfulness
- Difficulty in performing more than one task
- Diminished problem-solving skills

Early-stage disease

Language problems

Misplacing items

Getting lost

Personality changes

Progressed disease

Forgetting current events

Changing sleep patterns

Difficulty reading and writing

At severe or end stage, cannot:

Understand language

Recognize close family members

Perform self-care

Interact verbally

Daily medication may include:

Antidepressants

Cholinesterase inhibitors to prevent further decline

No single cause has been identified

It is not believed to be part of the normal aging process.

BEHAVIORAL EMERGENCIES

NOTES:

1. **Primary consideration should be given to EMS provider safety.**
2. **Notify law enforcement; approach patient only when safe to do so.**
3. **Talk in an even, reassuring tone; only one provider should speak.**
4. **Never allow a patient to get between you and a potential exit.**
5. **Avoid threatening gestures and body language.**

CRITERIA: Any may be present:

1. Emotional distress
2. Psychological emergencies
3. Potential or attempted suicide
4. Aggressive or hostile behavior

FR/BLS/ILS TREATMENT:

1. **INITIAL MEDICAL CARE**.
2. Restrain patient as needed if patient has a life-threatening emergency or suicidal/homicidal behavior **(see Region 6 Restraint Care Guideline).**
3. Assessment and history:
   a. Look for medical or traumatic causes of patient's behavior
   b. Note (and later document) behavior and mental status in detail.
   c. Obtain medical history, alcohol and psychiatric history if able.
4. If a medical or traumatic condition is suspected as the cause of the behavior, refer to the appropriate protocol.

SEDATION FOR THE EXTREMELY AGITATED PATIENT (ALS ONLY)

NOTE: Patient must be 14 years of age or older.

CRITERIA: Any may be present:

1. Extreme psychological and physiological excitement/agitation
2. Aggressive or hostile combative behavior marked by incoherence
3. Superhuman strength with near complete tolerance to pain
4. Impaired thinking and perception, paranoia
5. Relative inability to "talk down"

ALS TREATMENT:

1. Continue **FR/BLS/ILS TREATMENT.**
2. Sedate patient as necessary (as per #4 below) based on patient's presentation and potential for self-harm. Contact medical control prior to sedation if questions/concerns exist regarding care.
3. IV of NS or saline lock if able.
4. Administer VERSED:
   IM: 0.1 mg/kg IM; may repeat up to a maximum dose of 10 mg
   IN: 0.2 mg/kg IN; maximum dose 10 mg (if weight less than 50kg, max dose 5 mg)
5. Transport. If restrained, have law enforcement accompany patient.

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SEDATION FOR THE EXTREMELY AGITATED PATIENT

SPECIAL SITUATIONS

NOTE:

1. **Primary consideration should be given to EMS provider safety.**
2. **Notify police. Approach patient only when safe to do so.**
3. **Talk in an even, reassuring tone; only one provider should speak.**
4. **Restrain as needed if patient has a life-threatening emergency or suicidal/homicidal behavior. (see Region 6 Restraint Care Guideline)**
5. **Patient must be 14 years of age or older.**

CRITERIA: Any may be present

1. Extreme psychological and physiological excitement/agitation
2. Aggressive or hostile combative behavior marked by incoherence
3. Superhuman strength with near complete tolerance to pain
4. Impaired thinking and perception, paranoia
5. Relative inability to "talk down"

TREATMENT: ALS ONLY

1. Initial Medical Care. Sedate patient as necessary (as per #5 or #6 below) based on patient's presentation and potential for self-harm. Contact medical control prior to sedation if questions/concerns exist regarding care.
2. Airway and OXYGEN 15 L NRB.
3. Assessment and history:
    a. Look for medical or traumatic causes of the patient's behavior.
    b. Note (and later document) behavior and mental status in detail.
    c. Obtain medical history, alcohol and psychiatric history if able.
4. IV of NS or saline lock if able.
5. Administer KETAMINE 5 mg/kg IM or 1.5 mg/kg IV.
6. Alternative chemical sedative: VERSED 0.1mg/kg IM May repeat up to a maximum dose of 10mg..
7. Determine blood glucose.
8. If glucose <60 mg/dl, administer DEXTROSE 50% 25g IV. If no IV access, administer GLUCAGON 1 mg IM.
9. Transport. If restrained, have police accompany patient.

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USE OF RESTRAINTS CARE GUIDELINES

PURPOSE:

To establish guidelines for the use of safe reasonable force necessary to keep a patient from injuring himself/herself or others. Reasonableness is determined by all circumstances, remembering that scene safety is paramount.

EQUIPMENT:

1. Soft or leather restraints
2. Posey or sheet.

PROCEDURE:

1. Form a plan.
2. Be sure adequate help is available.
3. One person is assigned to calm and reassure the patient.
4. Approach with at least 4 persons (one for each limb).
5. Acting in unison, take hold and secure all four limbs to cot with restraints. Secure patient's midsection (waist) with a Posey or sheet to prevent patient from "bucking." Position patient supine.

DOCUMENTATION:

1. Who performed the procedure.
2. BSI and equipment used.
3. Time of application.
4. Documentation on Utstein style report.

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THE WHY

- Why is the patient having this specific demeanor
- Why is the situation developing
- Why are our treatments required and to what level.

HOW

How is the best way to mitigate this situation? Utilize family, care givers, or ancillary help in making the decision that works best for this situation.

How much help do we have available?

How can family and or staff of a facility help to resolve or mitigate the situation?

How can we keep the safety of everyone as our priority?