

MAINE EMS 2019 PROTOCOL LESSON PLAN

ORANGE SECTION		
SLIDE #	LESSON	NOTES
1	<p>1. Title slide</p> <p>a. Orange (NEW) – The Orange Section is a new section and was purposefully designated for behavioral emergencies, including two new protocols for the management of patients suffering from depression/suicidality and for circumstances in which patients may require restraints. In addition, the Orange section is the new location of the 2018 Agitation and Excited Delirium protocol.</p>	
2	<p>2. The Depression/Suicidal Ideation Protocol is new to the 2019 protocols and was intended to begin addressing the most common behavioral emergency encountered by EMS. It begins with elements most providers have historically performed (i.e. ensuring scene safety, engaging with law enforcement when the patient is an active harm to themselves), assessing for medical conditions that need to be stabilized, and establishing rapport with the patient.</p>	
3	<p>a. What may be new to some providers is the inclusion of 2 new screening tools the MDPB added to assist providers in communicating about a patient’s safety and standardize some of the evaluation of patients suffering from suicidal ideation. These are the SADPERSONS scale and the Columbia Suicide Screening Tool. MDPB members worked with leaders in Maine Behavioral Health services and these two screening tools were thought to be the most commonly used and helpful in evaluating patients with suicidal ideation. Please consider using these tools to assist in the assessment of patient safety. Each element of the SAD PERSONS scale is scored 1 and a score greater than 4 on the SAD PERSONS or any YES to the Columbia Suicide Screening tool suggests the potential need for hospitalization</p>	
4	<p>b. (Caution tape slide) PLEASE NOTE: These tools are <i>not</i> intended to determine which patients should be transported for evaluation but are instead intended to assist in the assessment of patients suffering depression or suicidal ideation.</p> <p>c. When using these tools, please pass on your findings to ED staff and please remember all patients presenting with a psychiatric emergency should be transported to the hospital for a comprehensive evaluation, regardless of their SAD PERSONS score or answers on the Columbia Suicide Screening tool.</p>	
5	<p>3. The other new protocol in the 2019 Maine EMS Protocols is the Restraint Protocol. This protocol is the result of provider input and concerns from the field regarding patient and provider safety. The MDPB worked with the Maine EMS Attorney General in crafting this protocol to balance the absolute need for provider safety with patient civil rights. The foundation of this protocol is the first statement, which does the following:</p> <p>a. Establishes the circumstances under which restraints are appropriate options, namely when a patient poses a significant danger to themselves or others.</p> <p>b. It also acknowledges that restraints should be a last option, and preferably invoked with the assistance of law enforcement, when available.</p>	

	<ul style="list-style-type: none"> c. The beginning statement also describes the approved restraint types, namely commercially available soft restraints d. Finally, the statement defines the duration of restraint, until arrival at the Emergency Department and transition of care. 	
6	<ul style="list-style-type: none"> e. Protocol Slide Review- Indications for restraint <ul style="list-style-type: none"> i. Indications <ol style="list-style-type: none"> 1. This protocol is for potentially violent patients at risk of harming themselves or others 	
7	<ul style="list-style-type: none"> ii. Indications <ol style="list-style-type: none"> 1. Pt poses a significant danger to self or others 2. This is done as a last resort 3. It is preferable to restrain the patient with law enforcement officer (LEO) on the scene 4. Only commercially available soft restraints are approved by MDPB 5. Contact OLMC after patient has been restrained and safety of the patient and providers has been secured. 	
8	<ul style="list-style-type: none"> f. The Next steps in the protocol describe the approach to patient restraint. <ul style="list-style-type: none"> i. It is always preferable to deescalate the patient when possible with verbal techniques including using a honest, non-confrontational language and tone. ii. Should these techniques fail, it is advised to include law enforcement assistance when available when considering restraint. It is also preferable to include ALS providers, as ALS providers bring the potential for medications in the form of benzodiazepines or ketamine. iii. The final preparation step is to have adequate staffing in place to restrain the patient. 	
9	<ul style="list-style-type: none"> g. The following steps describe HOW to safely restrain a patient – namely, in a lateral or supine position and NEVER in a prone position – and with restraints that can be easily removed if a medical emergency occurs. Objects should NOT be placed on top of the patient. A restrained patient requires 1 to 1 observation and monitoring if possible. Finally, when operationally feasible and safe for providers and the patient, please contact the receiving hospital’s physicians. These events are very highly regulated at the hospital and current hospital standards require notifying the treating physician as soon as possible. While there are no similar mandates in EMS, the MDPB felt that mirroring the practice of hospital’s was safest for EMS services and EMS providers. The bottom line: the DECISION to restrain a patient is yours, however, once the patient is restrained, it is important to let the receiving physician know. 	
10	<ul style="list-style-type: none"> h. It is important to document why restraints were used, when they were applied, what type of restraints were used and how they were used. Your documentation is a legacy of patient care and these features are essential for hospitals. Lastly, if restraints are applied by law enforcement, the law enforcement officer should attend the patient in route to the hospital in case the restraints require prompt removal. 	

11	<p>4. Agitation/Excited Delirium – The MDPB chose to place the agitation/excited delirium protocol in the new Orange Section. There is one modification and one point the MDPB wished to discuss.</p> <p>a. First – the MDPB opted to remove the suggestion to decrease the dose of ketamine in the context of suspected or known alcohol or sedative use. The MDPB felt that when used properly, in patients suffering from excited delirium, half dosing, even when alcohol or sedatives are present, should not be necessary.</p> <p>b. HOWEVER – it is important to remember, Ketamine is intended for patient suffering excited delirium, as defined by an AMSS score of +4. Patients who are agitated BUT NOT SUFFERING EXCITED DELIRIUM should receive benzodiazepines with ketamine limited to patients in excited delirium. Please document the patient’s AMSS score. The dosing of ketamine for these such patients is 4 mg/kg IM and this dose, in excited delirium patients is the safest, for both patient and providers. The protocol includes the exclusion criteria of age greater than 65, in part because it is less likely that a patient over the age of 65 is experiencing excited delirium. In addition, children do not commonly experience excited delirium and would therefore RARELY qualify for Ketamine in this context.</p>	
12	Questions???	<i>Instructors, please attempt to collect questions to be put into forthcoming FAQ</i>
END OF ORANGE SECTION		