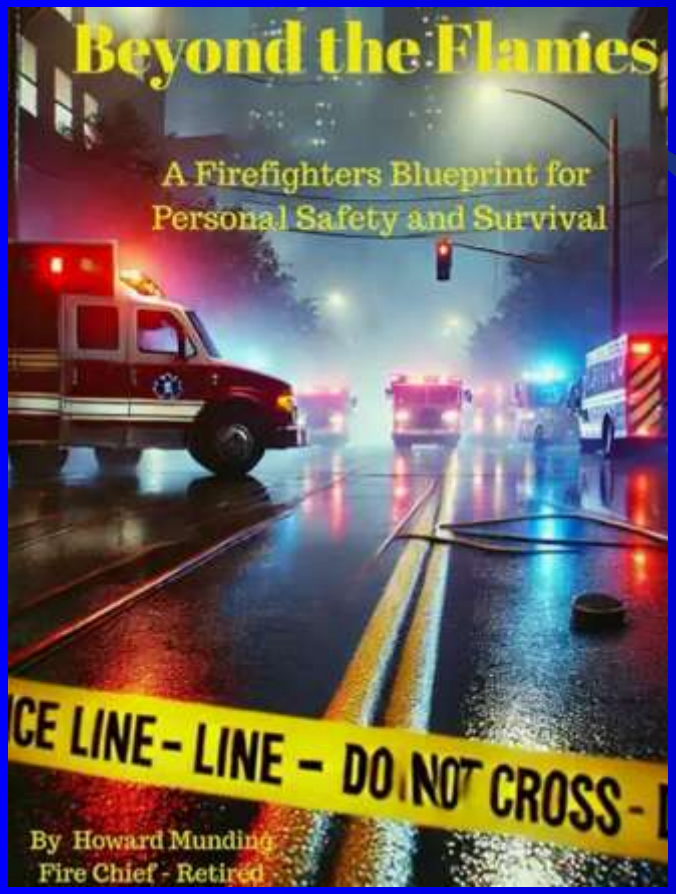
Beyond the Flames: Violence Against Firefighters and Responder Wellness—



Physical, Psychological, and Legal Self-Defense

Agenda

- Introduction
- Background of violence against fire & EMS providers
- Risk Factors
- Employer Responsibilities
- Employee Responsibilities
- Potential solutions/recommendations

Introduction

- Fire/EMS Experience
  - Entered fire service in 1978
  - EFO Graduate 2008
  - Peoria Fire Department 1988-2008
  - El Mirage Fire Chief 2008 – 2014
- Martial Arts
  - 7th Degree Black Belt in Chun Kuk Do
    - Founded by Chuck Norris
  - Certified Defensive Tactics Instructor
    - CDT® Non Deadly Force Training
    - Force Options
  - Reality-Based Self Defense
    - USA Head Instructor Krav Maga Force
    - Chief Instructor UFAF Krav Maga (Chuck Norris System)
    - ICCS Krav Maga Instructor
    - Commando Krav Maga Instructors

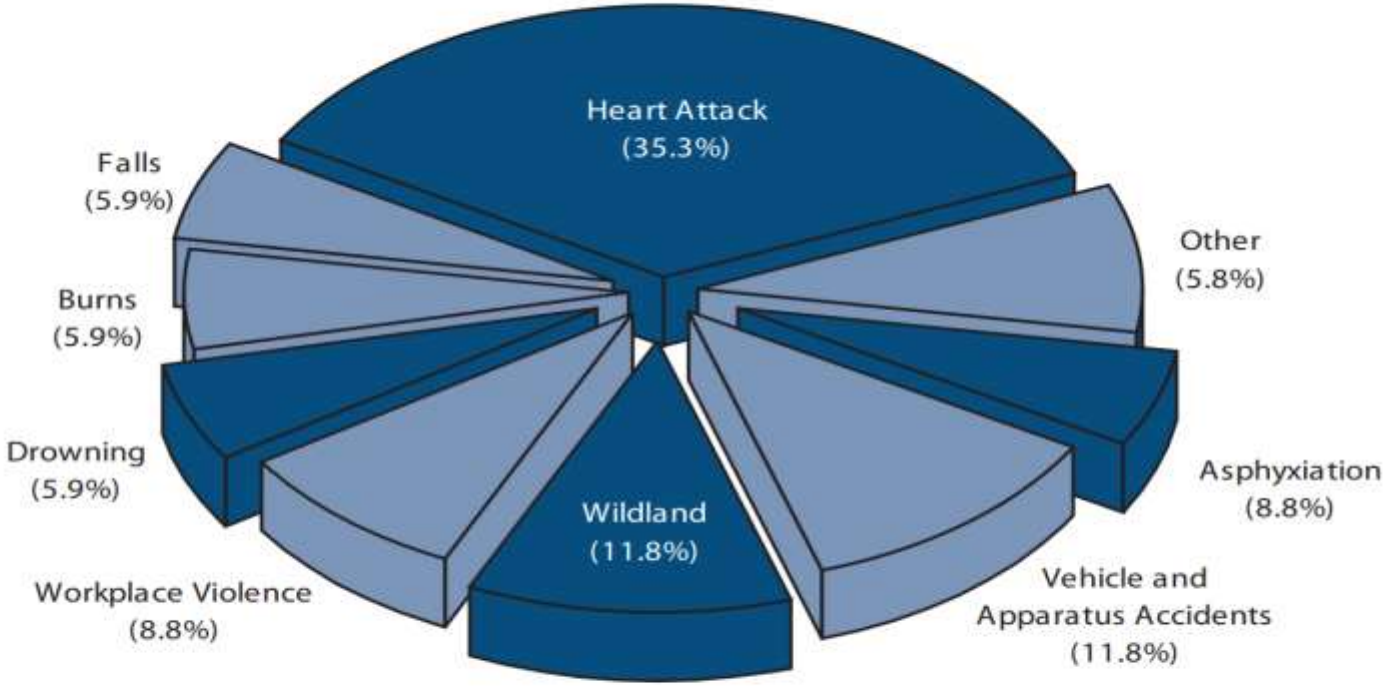
Is this really a problem?

Is this really a problem

- In 2024 thre were 248 media stories of assaults to first responders
- 76% of fire and EMS reported an act of verbal violence
- 46% of fire and EMS reported an act of physical violence
- Paramedics have 14 times higher odds of violent injury than firefighters
- 8% of Nationally registered EMTs suffered fatalities due to assaults

Source Firefighter Close Calls

Breakdown of Line of Duty Deaths by Cause



Source: Public Safety Officers' Benefit Program, U.S. Fire Administration, and National Fire Protection Association, International Association of Fire Fighters.

Source: 2000 IAFF Death and Injury Survey

Is violence really an issue?

- Violence against Health Care workers is a worldwide problem - WHO lists violence against health care workers at 24% of all workplace violence
- International Association of Fire Fighters (IAFF) show that up to 40% of firefighters have experienced an assault while on duty in the past five years.
- 3/4/25 Shooting at HonorHealth Scottsdale Shea Medical Center.
- In USA 700,000 assaults on Paramedics & EMT's each year
- Low Frequency/High Risk Activity
  - 5% (1 out of 20) calls for service are "known violent incidents" (Phoenix Regional CAD)
  - Other estimates are as high as 8.5%

16 Firefighter Life Safety Initiatives

1. Define and advocate the need for a cultural change within the fire service relating to safety; incorporating leadership, management, supervision, accountability and personal responsibility.

2. Enhance the personal and organizational accountability for health and safety throughout the fire service.

3. Focus greater attention on the integration of risk management with incident management at all levels, including strategic, tactical, and planning responsibilities.

4. All firefighters must be empowered to stop unsafe practices.

5. Develop and implement national standards for training, qualifications, and certification (including regular recertification) that are equally applicable to all firefighters based on the duties they are expected to perform.

6. Develop and implement national medical and physical fitness standards that are equally applicable to all firefighters, based on the duties they are expected to perform.

7. Create a national research agenda and data collection system that relates to the initiatives.

8. Utilize available technology wherever it can produce higher levels of health and safety.

16 Firefighter Life Safety Initiatives

9. Thoroughly investigate all firefighter fatalities, injuries, and near misses.

10. Grant programs should support the implementation of safe practices and/or mandate safe practices as an eligibility requirement.

11. National standards for emergency response policies and procedures should be developed and championed.

12. National protocols for response to violent incidents should be developed and championed.

13. Firefighters and their families must have access to counseling and psychological support.

14. Public education must receive more resources and be championed as a critical fire and life safety program.

15. Advocacy must be strengthened for the enforcement of codes and the installation of home fire sprinklers.

16. Safety must be a primary consideration in the design of apparatus and equipment.

Vocabulary

- Assault –

  unlawful threat or unsuccessful attempt to cause physical harm

- Battery-

  Any illegal beating or touching of another person

- Workplace Violence –

  violence inflicted by patients, clients, family members, or by- standers against staff

OSHA Definition

"Violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty."

CDC/NIOSH. Violence. Occupational Hazards in Hospitals. 2002

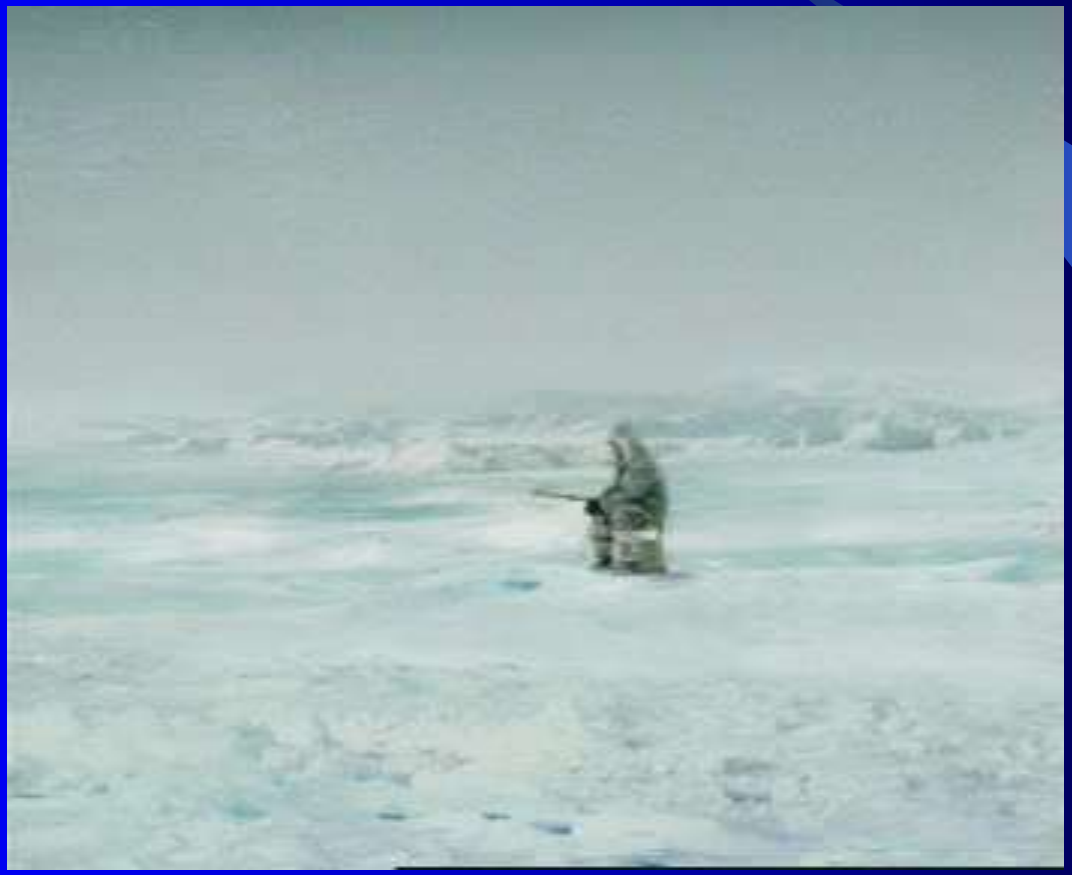
Vocabulary

- Combative patient
  - Patient who demonstrates resistance to patient care, no intent to harm caregiver
- Violent patient
  - Intentional aggressive behavior

Workplace Violence Categories

- Type 1 - Criminal Intent
- **Type 2 – Customer/Client**
- Type 3 – Worker on Worker
- Type 4 – Personal relationship (Domestic violence)

Proactive or Paranoid



You make the call

- Fall injury at nursing home
  - 44 year old man squares off on paramedics called to assist patient that had fallen
- Chest pain
  - 25 year old man became agitated, retrieved a rifle from the bedroom and shot twice at firefighters killing one
- Truck fire
  - Booter shot and killed as he steps off the truck on the scene of a truck fire in a driveway

You make the call

- Man down
  - 32 yr old man shoves paramedic attempting to help the man's intoxicated father
- 962
  - Off duty Fire captain stops at 962 to render aid and is shot & killed by the driver
- Diabetic
  - Elderly diabetic patient reaches into recliner and pulls out a handgun

Examples

- Shots fired at firefighters – Atlanta, GA July 21, 2009
- Crews need stab vest as standard – UK, July 18, 2009
- Paramedic punched in face by patient – UK, July 4, 2009
- Shots fired into North Carolina Firehouse – Sanford, NC, June 15, 2009
- PCP User Hijacks Ambulance – Washington DC, June 10, 2009
- Paramedic Assaulted – Allentown, PA, May 17, 2009
- Woman shove paramedic responding to unconscious person – Dayton, OH , May 12, 2009
- Suspect indicted in death of EMT – Cape Vincent, NY, May 1, 2009
- Shots fired at wellness check – Firefighter Near Miss Report FEMA Region IX, April 29, 2009
- Drunken bar patron charged with punching paramedic – Edgewater, IL, April 7, 2009
- Burglary suspect bites ambulance worker – Fayetteville, NC, April 4, 2009
- Man tried to stab EMT responding to call to help him – Jersey City, NJ April 4, 2009
- Paramedic Assaulted – Chicago, IL, January 11, 2009
- Another Crew attacked on EMS Call – July 22, 2008

More Examples…

- Man pulls gun on Rome Paramedics – Rome , GA April 7, 2008
- Woman arrested after trying to stab paramedic – Stockton, CA, March 28, 2008
- NY EMT hospitalized after alleged assault - Staten Island, NY, February 28, 2008
- Big Rig driver assaults medic after morning crash – Prune dale, CA February 23, 2008
- Man accused of assaulting paramedics in Ohio –Warren, Ohio, February 20, 2008
- EMT Students killed in Louisiana Shooting - BATON ROUGE, LA, February 10, 2008
- PATIENT GOES AFTER LOADED HANDGUN – January 20, 2008
- Drunk Attacks firefighter/paramedic – Winnipeg, Canada, October 7, 2007
- Parents attack paramedics at scene- Monroe County, Tennessee, September 28, 2007
- BSI NEEDED FOR COMBATIVE PATIENT – Long Island, NY, September 14, 2007
- Firefighters attacked by son of deceased patient. August 5, 2007
- COPS NOT DOING THEIR JOB LEADS TO CLOSE CALL FOR FIRE/EMS RESPONDERS, July 25, 2007

…and more…

- Patient charged with assault after attacks on Texas paramedics, Houston Chronicle 7/17/2007
- Terrifying growth in assaults on paramedics - UK July 10, 2007
- Man jailed over paramedic attack - UK July 6, 2007
- DUI Suspect charged with assault on EMT – Macon, Tennessee, February 2007
- Man Dies in Ambulance Following Assault on Firefighter, Los Angeles, June 28, 2006
- In an email from the Gila River Fire Department, Arizona their EMS chief was asking what other departments in the Phoenix area were doing besides staging to protect their crews. In recent months their fire trucks and crews have received gunfire while responding to and on the scene of EMS calls (A. Parrish, personal communication, December 5, 2005).
- October 20, 2005, Toledo, Ohio during civil unrest, two firefighters in their life squad were attacked by people throwing bricks and other objects (Hall, 2005).
- September 2005, one firefighter was assaulted by a participant attending “The Edge Fest”, an alternative rock concert held each year in the City of Peoria (City of Peoria, n.d.).
- August 25, 2005, Anderson Township, Ohio, four teenagers shoot paramedics with pellet guns (Relyea, 2005).

…and more…

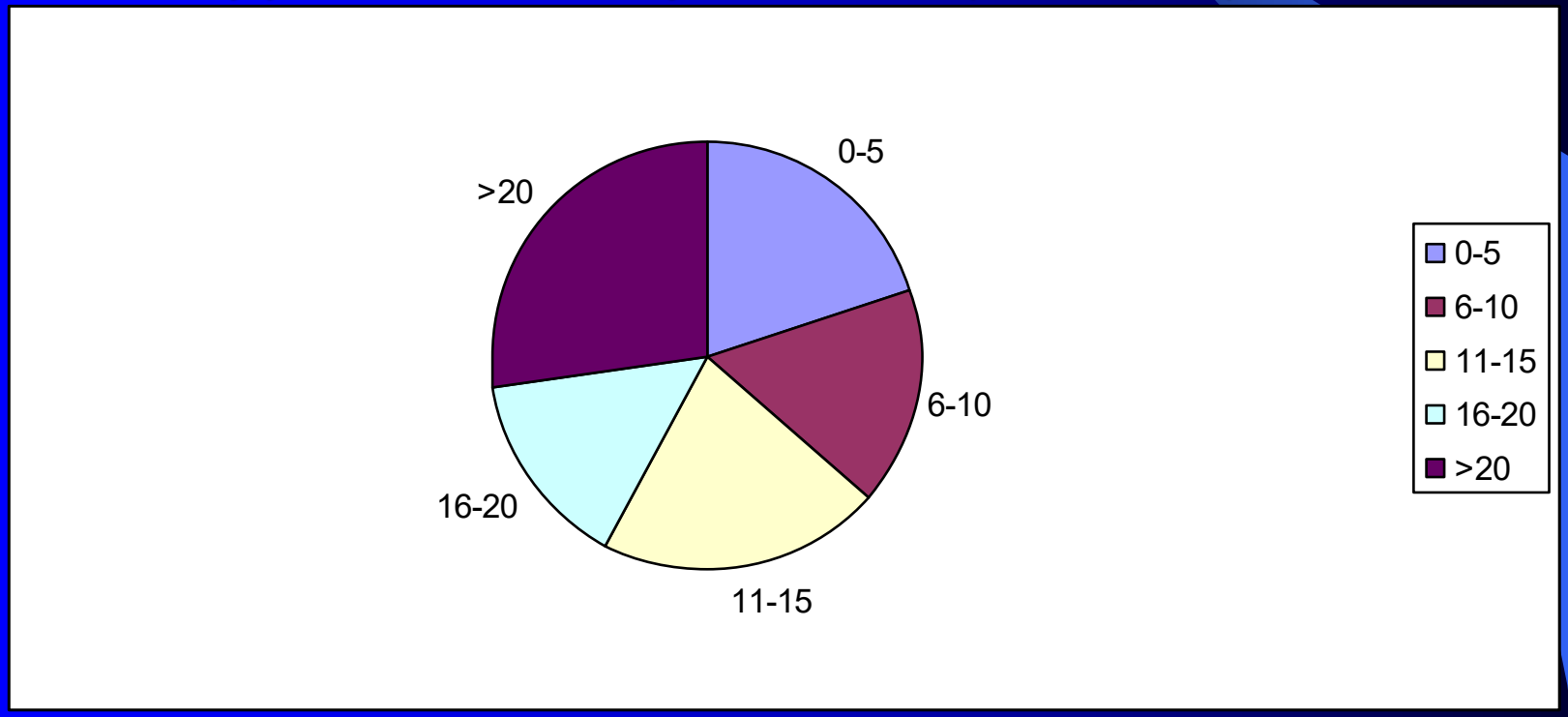
- On June 30, 2005, a veteran Chicago Fire Department Paramedic was struck in the face by a group of teenagers while treating a patient on Chicago's west side (Firefighter Close Calls.com [FCC], June 30, 2005).
- Recent violence against fire fighters requires fire chiefs to take action, IAFC, April 2004.
- March 2, 2004, while providing aid to the victim of a rollover, Las Vegas Firefighters had to wrestle a .45 caliber handgun away from the vehicle's driver after being shot at (Krebs, 2004).
- February 13, 2004, Lexington, Kentucky a fire lieutenant was killed and her partner was wounded as they approached a home where they were dispatched to for a domestic violence call (Blackstone, 2005).
- January 30, 2002, San Diego, California a patient broke loose from the stretcher kicking the attending medic in the face and placing the driver in a choke hold causing the ambulance to veer off the road (Krebs, 2003, 189).
- March 16, 2002, Roswell, New Mexico, the fire chief and an EMT were gunned down at the scene of a house explosion by a burn victim (Fallen Brothers Foundation [FBF], 2002).
- April 29, 2002, Los Angeles, California a firefighter was shot by a passing motorist while driving the ladder truck (Louderback, 1998, 14).
- November 6, 2002, Merseyside, UK a crew of firefighters were attacked by a crowd (McDougal, 2002).
- 2001, Washington D.C., while transporting a shooting victim the fire department ambulance was forced off the road and a gunman opened the rear doors and fatally shot the patient to death (Louderback, 1998, 14).

AFCA Survey
(64 AZ Departments) n=518

What type organization do you work for?	
Full Time Paid Fire Department	**465**
Volunteer Department	4
Combination Department	47
Private Ambulance Service	2
Other (please specify)	9

AFCA Survey
(64 AZ Departments) n=518

How many years of service do you have as a pre-hospital provider?



AFCA Survey
(64 AZ Departments) n=518

"…of greater concern is the likely under reporting of violence and a persistent perception within the health care industry that assaults are part of the job." OSHA

Violence is accepted as part of the job.	
True	**217 (42.8%)**
False	290 (57.2%)

AFCA Survey
(64 AZ Departments) n=518

Have you even been verbally threatened while in the performance of your duties?	
Yes	**442 (85.3%)**
No	76 (14.6%)

AFCA Survey
(64 AZ Departments) n=518

Have you ever been physically assaulted while in the performance of your duties?	
Yes	**283 (54.6%)**
No	232 (44.8%)

AFCA Survey
(64 AZ Departments) n=518

Have you ever restrained a patient?	
Yes	**489 (94.4%)**
No	24 (4.6%)

AFCA Survey
(64 AZ Departments) n=518

Have you been provided "formal" training on how to safely and effectively restrain a patient?	
Yes	**385 (74.3%)**
No	133 (25.7%)

AFCA Survey
(64 AZ Departments) n=518

Do you now or have you ever carried a weapon on the job for self defense?	
Yes	**51 (9.8%)**
No	467 (90.2%)

Indirect Effects of WPV

- Slower response times
  - Waiting on PD
- Prejudices
- Decrease in customer service
- PTSD stress on responders
- Less FD & PD units available
  - Sending multiple units

Organizational Risk Factors

www.cdc.gov/niosh/violrisk.html & World Health Organization

- Contact with the public
- Delivery of passengers, goods, or services
- Having a mobile workplace
- Working with unstable or volatile persons in health care, social service, or criminal justice settings
- Working alone or in small numbers
- Working late at night or early morning hours
- Working in high crime areas
- Guarding valuable property or possessions
- Working in community-based settings

Contributing Factors

- Prevalence of handguns
- Increasing use of hospitals by the justice system for criminal holds and care of acutely disturbed or violent individuals
- Increasing number of mentally ill patients being released without follow-up care.
- Availability of drugs
- Gangs, chemical abusers, distraught family members
- Isolated work with customers in unsecure areas
- Lack of training in managing hostile and aggressive behavior

Society is becoming more violent

The Sheepdog (warrior) is the 1% who protects the 98% (the Sheep) from the remaining 1% (the Wolves) who would do harm to them.

Contributing Factors

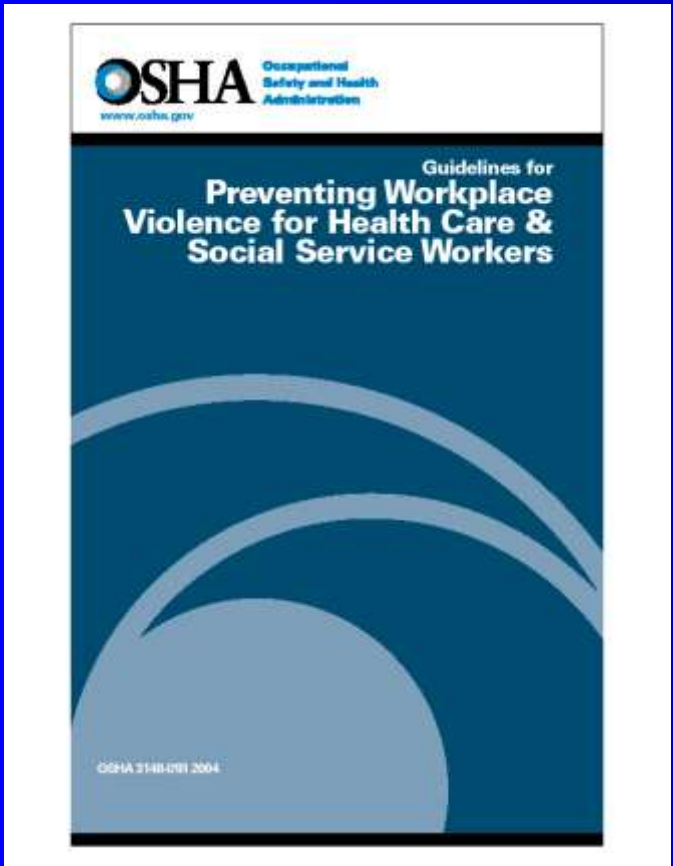
- Culture
  - 42.8% of AZ firefighters surveyed feel that "violence is an accepted part of the job."
  - Feeling of Invulnerability
    - "…we already …overwhelm the patient with sheer mass or numbers and or wait for PD backup. "
    - "We can kick the $#!+ out of anybody"
  - Important but Not Urgent
    - Fire Chiefs have stated
      - "I don't want my guys to know this stuff, they might use it."
      - "We already have too many training requirements."

Employer Responsibilities

The Arizona Occupational Safety and Health Act of 1972 mandates that, in addition to compliance with hazard-specific standards, all employers have a general duty to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harm.

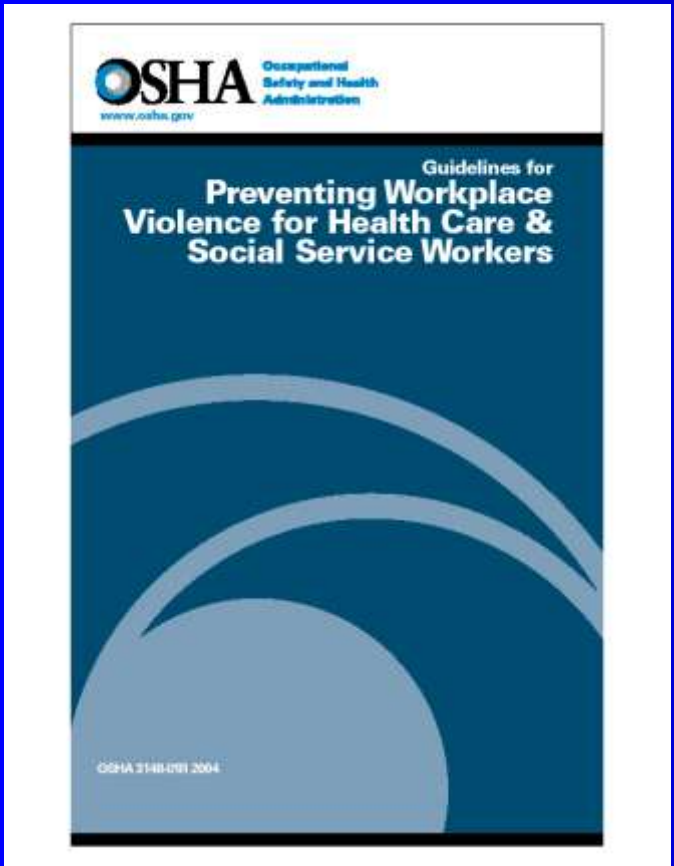
ADOSH will rely on Section 23-403.A of the Act, the General Duty clause, for enforcement authority. Employers can be cited for violating the General Duty clause if there is a recognized hazard of workplace violence in their establishment and they do nothing to prevent or correct it.

Elements of Workplace Violence Program



- Management Commitment
- Employee Involvement
- Worksite Analysis
- Safety & Health Training
- Recordkeeping
- Program Evaluation

Violence Prevention Program



Minimum Requirements:

- Zero Tolerance policy for workplace violence
- No reprisals against employees the report or experience WPV
- Encourage employees to promptly report incidents
- Comprehensive workplace security plan
- Assign responsibility and authority for the program
- Affirm management commitment to employee health and safety

Management Commitment

- Demonstrating organization concern for employee emotional and physical health
- Exhibit equal commitment to the safety of workers, patients, and clients
- Assign responsibility for various aspects of workplace violence prevention program
- Allocating appropriate authority and resources
- Maintain a system of accountability
- CISD program
- Support for recommendations from safety and health committees

Employee Involvement

- Understand and comply with workplace violence prevention program and other safety & security measures
- Participate in complaint or suggestion program covering safety & security concerns
- Report violent incidents promptly and accurately
- Participate in safety & health committees
- Participate in continuing education program in area of violence prevention

Worksite Analysis

- Threat Assessment Team
  - Review unit logs, industry reports, employee reports of incidents or near-incidents to identify and analyze trends
  - Review Procedures
  - Employee survey to get the employee's view of workplace violence history and potential.
  - Work place security analysis
  - Engineering controls
  - Administrative controls

Engineering Controls

- Station security
- Apparatus Security
- Scene Security
- Emergency Traffic Button
- Radio code

Administrative & Work Practice Controls

- SOP/SOG
- Report all incidents of violence
- Establish procedure for requesting police assistance
- Ensure adequate and properly trained staff are available to restrain patients if necessary
- Supervise movement of patients and bystanders

Administrative & Work Practice Controls

- Treat patients in open areas (HIPPA)
- Discourage wearing of items around neck
- Name badges with only first name
- Discourage carrying of items that can be used as weapons
- Use extra caution in enclosed areas
- Post incident support

Possible Abatement Controls

PRE-EVENT

Phase	Human	Process	Physical Environment	Socio-Economic Environment
Pre-event	• Attitude • Culture • Naïveté	• Lack of written policy • Lack of training • Communication training • De-escalation training • Personal Protection training • First names only on uniforms, Ds	• Fire Station/Vehicle • Relatively Safe environment • Low level of threat awareness • Secure items in ambulance that could be used as weapons • Syringes, scalpels, needles, and drugs in locking cabinets • Pad or replace sharp edged objects • Smooth or cover sharp surfaces	• Perception of invulnerability • Funding for training

EVENT

Phase	Human	Process	Physical Environment	Socio-Economic Environment
Event	• Awareness • Tunnel Vision • Complacency	• Rushing into the scene • Lack of info from dispatch	• Patient's home • Street • Night clubs • Low level lighting • Limited egress • Confined spaces • Scene security • Workers given discretion as to whether or not they begin or continue service if they feel threatened or unsafe. Procedure to follow to get assistance from PD	• Financially stressed customers • Language barrier • Culture/Religious beliefs • Area for patients/family members to de-escalate • Training on how to properly/safely enter a client's home • Ensure assistance if children will be separated from parent being transported

POST- EVENT

Phase	Human	Process	Physical Environment	Socio-Economic Environment
Post event	• Physical Injury • Emotional Trauma • Prejudices • Legal Liabilities • Disciplinary Action • Infectious disease	• Lack of written policy • Lack of training • Blood and/or airborne diseases • Report all violent incidents to employer • Update dispatch history for address about previous violence	• Counseling • Medical treatment • Overtime impacts • Hospitalization • Contraction of communicable disease	• Increase in health insurance premiums • Increase in Workers comp premiums • Budget impact due to lost work time

"Should firefighters be disciplined if we don't like the way they handle violent patients?

It's like telling firefighters to enter a burning building, but failing to provide them with the necessary equipment or training – then punishing teem when we don't like the way they perform"

– James O. Page
Fire Rescue, December 2000

Safety & Health Training

OSHA & WHO recommendations

- Universal Precautions for Violence
  - Violence should be expected but can be avoided or mitigated through preparation.
- Formal instruction in:
  - Workplace Violence Policy
  - Risk Factors
  - Specific hazards
  - Early Recognition of Potential Violence
  - BLS/ALS Treatment Protocols
  - Ways to limit physical interventions
  - Interpersonal & Communication skills
    - Empathetic listening and interaction skills
  - Management of assaultive behavior
    - Application of restraints
  - Personal Safety/Self Defense training
    - According to risk assessment
- Annual Training at a minimum

Employee Responsibilities

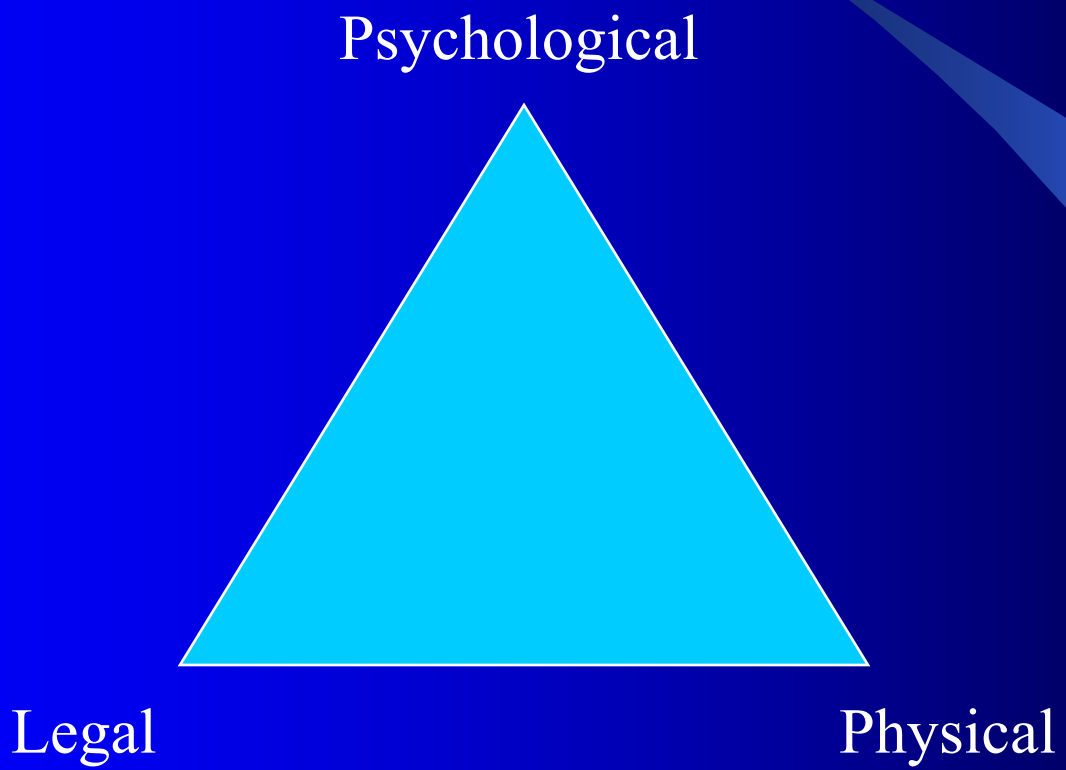
Recordkeeping

- OSHA 300 Log
- Record of incidents of abuse, verbal attacks or aggressive behavior (Violent Incident report)
- Information on customers with a history of violence, drug abuse, or criminal activity in CAD
- Safety meeting minutes
- Training records

Evaluation

- Health & Safety committee review of:
  - Policies
  - Incidents
  - Trends
  - Periodic survey of employees
  - Periodic law enforcement or outside consultant review of program

Survival Triangle



Psychological

- CISD
- Chaplain
- Counseling

Physical

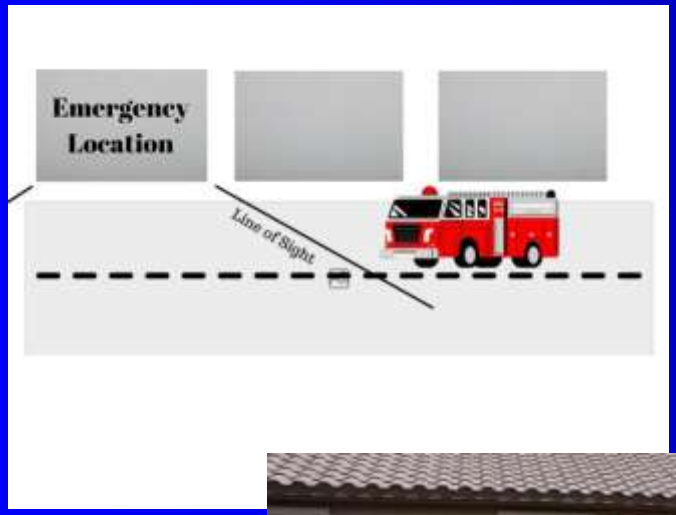
- Scene Safety – AAA Method
- Communication Skills
  - LEAPS – Active Listening
  - De-Esclation
- Recognizing the Warning Signs
- DONE
- Physical Skills
  - Principle based
  - Non-Lethal Force
  - Designed to Extricate the crew

Size-up - Use the A.A.A. Method

- Area
- Atmosphere
- Assessment

Scene Awareness

Approaching homes or vehicles



LEAPS


The LEAPS Communication Model
Better Communication. Stronger Relationships. Better Results.
L
LISTEN
Give full attention
Listen to understand
Don't interrupt
Show you care
People don't care how much you know until they know how much you care.
E
EMPATHIZE
Put yourself in their shoes
Acknowledge their feelings
Validate their perspective
Build connection
Empathy builds understanding.
A
ASK
Ask open-ended questions
Seek clarity
Encourage dialogue
Show curiosity
Good questions lead to better conversations.
P
PARAPHRASE
Restate in your own words
Confirm understanding
Show you're listening
Reduce miscommunication
Paraphrasing shows understanding and builds trust.
S
SUMMARIZE
Recap key points
Ensure alignment
Clarify next steps
Close the loop
Summarizing creates clarity and agreement.
When we LEAPS in our communication, we build stronger connections, solve problems better, and achieve more—together.

DONE MODEL

SIGNS IT'S TIME TO SHIFT FROM COMMUNICATION TO ACTION.

D DANGER

Immediate risk to personal or public safety that cannot be resolved through communication alone.

O OVERRIDING CONCERN

When a critical safety or operational priority must take precedence, necessitating a different approach.

N NO PROGRESS

If communication is no longer productive, it may be time to act.

E ESCAPE

If there is an opportunity to safely exit a potentially violent situation, taking it is often the best course.

RECOGNIZE. ▸ ASSESS. ▸ ACT. STAY SAFE.

YOUR SAFETY. OTHERS' SAFETY. THE MISSION.

Warning Signs of Violence

- Glaring stares
- Verbal abuse
- Shoving
- Argumentative
  - Tone of voice
  - Use of profanity
- Clenching/unclenching fists
- Sputtering anger
- Usually preceded by excessive amounts of alcohol
- Hair on the back of your neck

Legal

- Documentation
- Creating good witnesses
- Get PD on scene

Legal Self Defense

EMS >>>

By GARY LUDWIG

Smile – You May Be On Camera!

Do Something Wrong on a Call and the World Can Watch You on YouTube

Last year, my two teenagers were with me in the car on the night of the Fourth of July. In most communities, nighttime on the Fourth of July is busy with fires and EMS calls. As we were heading home, an emergency call came in for a house fire only a couple of blocks away. As one who does not shy away when an emergency is within close driving distance, I proceeded to the scene. From a block away, I could see there was a "working fire," as evidenced by the large glow in the night sky.

As I rounded the corner, I saw a two-story frame house fully involved in flames. Being the first emergency responder on the scene, I properly positioned my car so it would not block access for the engines and trucks that would be coming in. I also told my children to stay in the car. However, they could see the action from their vantage point.

After the fire was knocked down, I went back to my car to leave the scene. To my amazement, in the 15 minutes in which I had been out of the car, my children had clicked off many pictures on their camera phones and e-mailed them to numerous friends. It took just minutes for images from an emergency scene to be transmitted anywhere in the world.

How many times are you on an emergency scene in a public place and when you look around, somebody is snapping a picture with a camera phone? How many public buildings do you think you walk into on calls and security cameras are recording your movements? How many intersections do you think you drive through and some traffic-light camera captures your driving expertise? Many of us have seen the collision of two St. Louis, MO, fire apparatus at an intersection while both were running "urgent" to a house fire. It is clear from the video that one engine had a green light and the other had a red light. The video was rampant on the web among fire professionals soon after it was released. If you have not seen it, it can be found on YouTube.com.

Police officers have been using dashboard cameras to record traffic stops and other incidents, and firefighters are starting to do the same. Most, however, are not using dashboard cameras. Rather, they are placing video cameras on the dashboard of apparatus and upon arrival at a scene, they point the apparatus at the buildings on fire. The end result is the cameras capture all fireground activity. Again, go to YouTube.com and you can find many of them.

The use of camera and video phones and their ability to transmit images from emergency scenes can be good – and bad.

What about helmet cameras? For about $300, you can capture all the video and audio of a scene with a camera mounted on your fire helmet. They are usually waterproof and shock resistant, and they hold up well to heat. Videos from firefighter helmet cameras can be found on many websites. Just visit Google.com and search for "fire helmet cam" – they'll all pop up. Lots of fire station pranks have also been captured on video for posterity. You can also find these all over YouTube.com.

This brings us to the use of cameras and video equipment when treating patients. This adds a new dimension to the use of cameras and video recorders. The use of these devices and their ability to transmit images from emergency scenes can be good and bad for firefighters. It can be good if the pictures or videos validate that you did the right thing after someone complains or something goes wrong. But the opposite is also true. Do something wrong and as the saying goes, "a picture is worth a thousand words."

Patient confidentiality is the main reason why cameras and video recorders should not be used by firefighters when treating or transporting patients. In 2007, a paramedic found himself in trouble after posting pictures of accident victims on his MySpace page. His actions caught up with him when a man whose 16-year-old son was killed in a traffic accident was charged with assault after he beat up the paramedic for taking pictures of his deceased son. The paramedic denied taking any pictures of the deceased boy, but witnesses at the scene contended that he did. According to the father, the paramedic "crossed the line" when he took pictures of his dead son.

This incident, amid the tremendous proliferation of mobile and video phones that take pictures and growing concerns about patients' privacy rights, should raise alarm bells for fire departments. However, this is balanced by some fire departments that let employees take pictures and video of the scene so that they can show the emergency room staff the mechanism of injury.

Cameras and video recorders capable of capturing pictures and videos are becoming commonplace. There are advantages to this technology, but there are also opportunities for abuse. Because of potential abuses, firefighters should be fully aware of their departments' policies and their moral responsibilities when it comes to protecting patients and others from those who would exploit the technology for self-satisfaction or personal gain.

GARY LUDWIG, MS, EMT-P, a Firehouse® contributing editor, is a deputy fire chief with the Memphis, TN, Fire Department. He has 30 years of fire-rescue service experience. Ludwig is chairman of the EMS Section for the International Association of Fire Chiefs (IAFC), has a master's degree in business and management, and is a licensed paramedic. He is a frequent speaker at EMS and fire conferences nationally and internationally, and can be reached through his website at www.garyludwig.com.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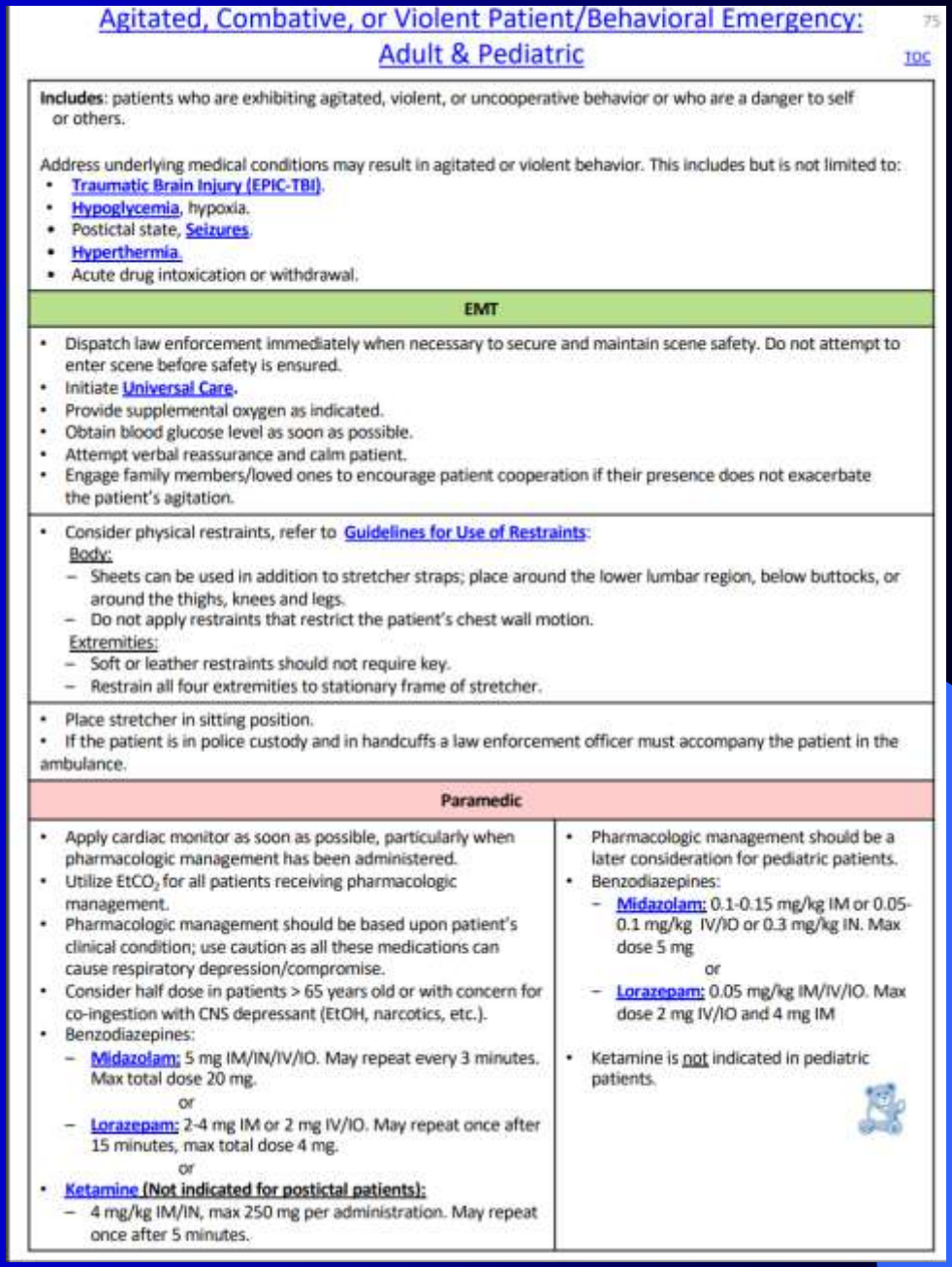
Valley Off-Line Protocols

January 2025

If patient is violent and an immediate threat to the patient, EMS crew, or bystander safety exists, physical restraint may be used to prevent patient from harming him or herself or others.



Agitated, Combative, or Violent Patient/Behavioral Emergency: Adult & Pediatric

75

TOC

Includes: patients who are exhibiting agitated, violent, or uncooperative behavior or who are a danger to self or others.

Address underlying medical conditions may result in agitated or violent behavior. This includes but is not limited to:

- Traumatic Brain Injury (EPIC-TBI).
- Hypoglycemia, hypoxia.
- Postictal state, Seizures.
- Hyperthermia.
- Acute drug intoxication or withdrawal.

EMT

- Dispatch law enforcement immediately when necessary to secure and maintain scene safety. Do not attempt to enter scene before safety is ensured.
- Initiate Universal Care.
- Provide supplemental oxygen as indicated.
- Obtain blood glucose level as soon as possible.
- Attempt verbal reassurance and calm patient.
- Engage family members/loved ones to encourage patient cooperation if their presence does not exacerbate the patient's agitation.

- Consider physical restraints, refer to Guidelines for Use of Restraints:
  Body:
  - Sheets can be used in addition to stretcher straps; place around the lower lumbar region, below buttocks, or around the thighs, knees and legs.
  - Do not apply restraints that restrict the patient's chest wall motion.

  Extremities:
  - Soft or leather restraints should not require key.
  - Restrain all four extremities to stationary frame of stretcher.

- Place stretcher in sitting position.
- If the patient is in police custody and in handcuffs a law enforcement officer must accompany the patient in the ambulance.

Paramedic

- Apply cardiac monitor as soon as possible, particularly when pharmacologic management has been administered.
- Utilize $EtCO_2$ for all patients receiving pharmacologic management.
- Pharmacologic management should be based upon patient's clinical condition; use caution as all these medications can cause respiratory depression/compromise.
- Consider half dose in patients > 65 years old or with concern for co-ingestion with CNS depressant (EtOH, narcotics, etc.).
- Benzodiazepines:
  - Midazolam: 5 mg IM/IN/IV/IO. May repeat every 3 minutes. Max total dose 20 mg.
    or
  - Lorazepam: 2-4 mg IM or 2 mg IV/IO. May repeat once after 15 minutes, max total dose 4 mg.
    or
- Ketamine (Not indicated for postictal patients):
  - 4 mg/kg IM/IN, max 250 mg per administration. May repeat once after 5 minutes.

- Pharmacologic management should be a later consideration for pediatric patients.
- Benzodiazepines:
  - Midazolam: 0.1-0.15 mg/kg IM or 0.05-0.1 mg/kg IV/IO or 0.3 mg/kg IN. Max dose 5 mg
    or
  - Lorazepam: 0.05 mg/kg IM/IV/IO. Max dose 2 mg IV/IO and 4 mg IM

- Ketamine is not indicated in pediatric patients.

AEMS Off-Line Protocols

January 2025

Guidelines for Use of Restraints

TOC

Restraints may be used to ensure patient safety when the prehospital provider determines that the patient requires medical evaluation and/or treatment, and/or the patient's behavior and/or actions may potentially cause harm to himself or to others.

The prehospital provider that is confronted with a combative patient shall at all times consider the safety of himself, bystanders, and the patient. He/she shall avoid unreasonable force with the objective being the quickest and safest restraints called for by the situation. Use of additional manpower should be utilized as needed. Consider use of pharmacologic management for agitation as indicated. Assistance from law enforcement should be requested.

Once restrained, it is the prehospital provider's duty to protect the patient from harm and to treat all apparent emergency medical problems. The patient should be restrained in such a manner that allows adequate assessment of the patient's status and immediate access to the patient for necessary care without compromising a safe environment for the patient, prehospital providers, and bystanders.

Patient Assessment

1. An ALS provider must assess a patient that is restrained.
2. The patient must be under direct supervision at all times during treatment and transport.
3. The patient's airway, breathing, and vital signs – including pulse oximetry – must be monitored.
4. Circulation to the extremities shall be evaluated and documented at least every 10 minutes when restraints are applied.
5. Any patient in restraints shall have a cardiac monitor applied, and a monitor strip documented, as soon as is reasonable after restraints are applied.
6. A patient in restraints requires ALS transport to the hospital with at least one ALS provider in the back of the ambulance during transport.
7. Notify the receiving facility of the incoming restrained patient.
8. Obtain VS every 5 minutes if possible

Type of Restraint

1. Handcuffs may only be used as restraint devices when a law enforcement officer accompanies the patient to the hospital.
2. Only leather or other agency-approved "soft" restraints may be used. If locking restraints are used, the key must be transported with the patient in the ambulance. The use of linens as a restraint device is acceptable, providing they can be secured in a manner that allows rapid patient access if needed in an emergency.

Guidelines for Use of Restraints

TOC

Patient Positioning

1. Patients shall be positioned in a manner that does not compromise airway or breathing.
2. Access to the airway must be maintained for possible advanced airway management.
3. Access to the chest must be maintained for possible CPR or defibrillation.
4. Access to the extremities must be maintained for possible IV/IO placement.
5. No patient will be restrained in a prone position or "hog-tied."
6. No patient will be placed between backboards or stretchers.
7. Patient is preferably restrained to a backboard allowing transfer of the patient without removing the restraints, and also to allow patient to be turned to the side in case vomiting occurs.
8. Restraints shall be placed in such a manner as to not preclude evaluation of the patient's medical status or to cause injury.

Documentation

If restraints are necessary, documentation must include:

1. Reason restraint was required (patient's behavior prior to application of restraints, including statements made by the patient, family members, or bystanders)
2. Type of restraint used
3. Position of the patient during treatment and transport
4. Patient response to application of restraints
5. Data indicating constant supervision of ABCs and vital signs, including pulse oximetry
6. Status of circulation distal to restraints
7. Total time the patient was restrained while in the care of EMS
8. Any assessment or treatment that cannot be implemented due to the patient's combative or uncooperative state
9. Patient status at the time of transfer of care

ARS 13-403: A person acting under a reasonable belief that another person is about to commit suicide or to inflict serious physical injury upon himself may use physical force upon that person to the extent reasonably necessary to thwart the result.

ARS 13-404

"…a person is justified in threatening or using physical force against another when and to the extent a reasonable person would believe that physical force is immediately necessary to protect himself against the other's use or attempted use of unlawful physical force."

I'm afraid that the crews will miss use their skills

"There are risks and costs to a program of action, but they are far less than the long range costs of comfortable inactions."

-President Kennedy

Low Frequency – High Risk

- Crices
  - <1% of codes
  - Medic refresher skills lab
- Buddy Breathing
  - Fires account for < 20% of calls
  - Annual training
- Violence Risk
  - 5%-8% of all calls are known “violent incidents”
  - Training????

A little bit of knowledge can be dangerous

A little bit of knowledge can be dangerous

93% of respondents report that they have restrained patients while only 72% reported that they have received formal training on how to restrain patients.

2009 AFCA Survey

"If the EMS provider is properly trained they will respond in a reasonable manner rather than leaving the type and level of response to the judgment of the individual."

James R. Cross, Adjunct Instructor George Washington University School of Medicine

" If you train your people to a certain level, the liability is lessened rather than allowing them to set their own guidelines."

Daniel Smiley, Deputy Chief Director California EMS Authority

"…with the continued trend of violence directed toward EMS personnel, it is incumbent upon the employer to provide some kind of orientation or training that addresses the issue of personal safety."

Paul Maniscalco, Deputy Chief New York City EMS

Solutions/Recommendations

- Address culture
  - Violence is NOT the cost of doing business
- Establish a formal Workplace Violence Prevention Program
- Develop a comprehensive training program
  - Scene awareness
  - Approaching homes & vehicles
  - Management of violent individuals
  - De-escalation techniques
  - Weapons management
  - Effective communication
  - Reporting requirements
  - Legal issues surrounding self defense & use of force
  - Practical/effective Personal Protection principles and techniques
- CISD program

Restraint Documentation

- Standard of Care
  - ALS must be present at all times
  - Patient must be under direct supervision
  - Continuously monitor patient's airway, breathing, and vitals, including pulse oximetry
  - Monitor circulation of extremities every 10 minutes
  - Establish IV @ 30mL/hr. and check blood sugar
  - If needed administer Versed for chemical restraint
  - Apply cardiac monitor, run strip, and document
- Reason for the restraint
- Type restraint
- Position of patient during treatment and transport
- Patient response to application of restraints
- Vitals
- Circulation status
- Total time patient was restrained while in care of Agency ALS members
- TX that could not be performed because of patient's combative state
- Patient status and transfer of care

Three Sectional Angle

Secure/Control Head

Arm Bar

IV access

Helmet

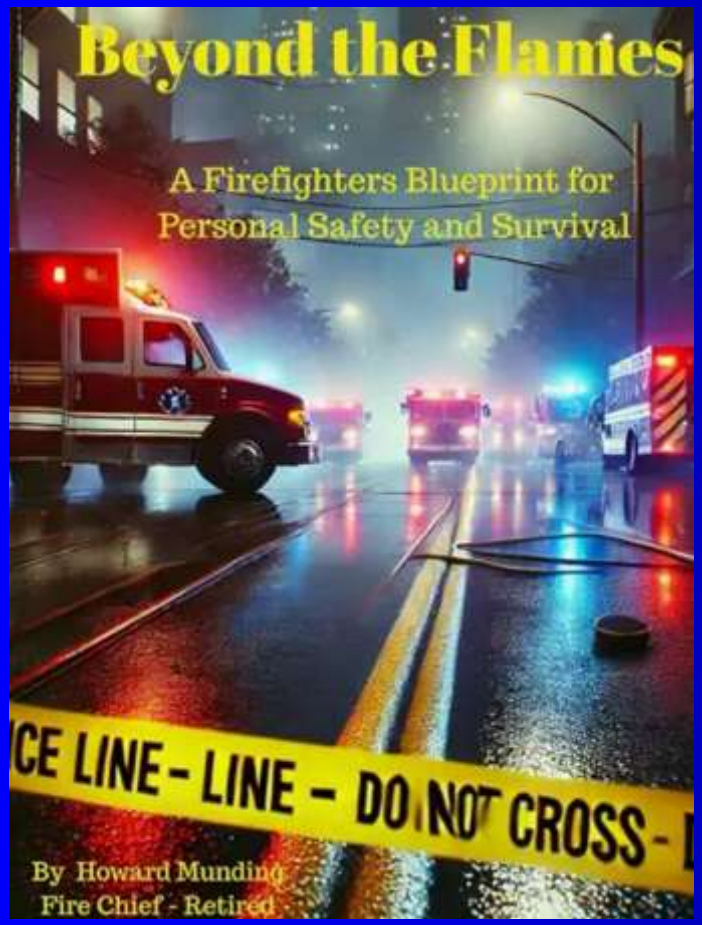
Defense Against Any Strike

Secure the Legs

Speed Shield

Tackle Defense

Beyond the Flames



PowerPoint Slides

Sample SOP

Sample Use of Force Report

Where to Get More Information

- OSHA 3148 Guidelines for Preventing Workplace Violence in Health Care and Social Service Settings
- OSHA CPL 02-01-058 : Enforcement Procedures and Scheduling for Occupational Exposure to Workplace Violence
- Beyond the Flames – Munding
- IAFF
- AEMS Redbook
- ALS Algorithms
- AZ Revised Statutes
- Banner Estrella, Thunderbird, and West Valley Paramedic Standing Orders
- EMS Magazine January 2007
- EMS Safety: Techniques and Applications - US Fire Administration
- www.emsnetwork.org
- www.firefighterclosecalls.com
- www.emsclosecalls.com
- www.who.int
- IFSTA Essentials of Fire Fighting and Fire Department Operations, 5th Ed.
- NFPA 1500
- Peoria MP 206.24P
- PHX MP 205.12
- PHX MP 206.1
- The Law and Martial Arts – Brown
- Violence Against Firefighters (EFOP)- Munding
- 16 Firefighter Life Safety Initiatives – National Fallen Fire Fighter Foundation
- When Violence Erupts – Krebs

Thank you

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