(EMT/ PARAMEDIC/MICN)

SUBJECT: **APPLICATION OF PATIENT RESTRAINTS** REFERENCE NO. 838

PURPOSE: To provide guidelines for emergency procedures and use of restraints in the field or during transport of patients who are violent or potentially violent, or who may harm self or others.

AUTHORITY: California Code of Regulations, Title 22, Sections 100063, 100145, 100169(a)(1,2) and (c)(1)
Welfare and Institutions Code, 5150
California Code of Regulations, Title 13, Section 1103.2
Health and Safety Code, Section 1798(a)

PRINCIPLES:

1. The safety of the patient, community, and responding personnel is of paramount concern when considering the use of restraints.

2. Staff should be properly trained in the appropriate use and application of restraints and in the monitoring of patients in restraints.

3. The application of restraints is a high-risk procedure due to the possibility of injury to both the patient and the provider; therefore, the least restrictive method that protects the patient and emergency medical services (EMS) personnel from harm should be utilized.

4. Restraints should be used in situations where the patient is potentially violent or is exhibiting behavior that is dangerous to self or others, only as necessary, when all lesser restrictive measures (e.g., verbal de-escalation) have failed.

5. EMS personnel must consider that aggressive or violent behavior may be a symptom of medical conditions such as head trauma, alcohol, substance abuse, metabolic disorders, emotional stress and, behavioral and psychiatric disorders. Base contact criteria shall be strictly adhered to for those conditions that require it.

6. Authority for scene management (e.g., controlling the activities that occur in the environment or space around the patient; ensuring bystanders are kept away; and EMS personnel are provided with a safe environment to treat the patient) shall be coordinated by law enforcement (LE), where applicable.

7. The responsibility for patient health care management rests with the highest medical authority on scene. Therefore, medical intervention and patient destination shall be determined by EMS personnel according to applicable policies.

    a. The preferred restraint modality should be coordinated with LE, when applicable.

    b. The method of restraint used should allow for adequate monitoring of vital signs and should not restrict the patient's ability to breathe freely. Restraints should neither prevent ability to protect the airway nor compromise neurological or vascular status.

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8. This policy is not intended to negate the need for LE personnel to use appropriate restraint equipment approved by their respective agency to establish scene management control.

POLICY

I. Forms of Restraining Devices

A. Restraint devices applied by EMS personnel (including for the purpose of interfacility transport of psychiatric patients) must be either padded hard restraints or soft restraints (i.e., vest with ties, Velcro or seatbelt type). Both methods must be keyless and allow for quick release. Restraints shall be applied as four point padded wrist and ankle restraints, or a two-point padded wrist and belt restraint.

B. The following methods of restraint shall NOT be utilized by EMS personnel:

1. Applying hard plastic ties or any restraint device requiring a key to remove.

2. Restraining a patient's hands and feet behind their back.

3. Restraining patients in prone position.

4. Placing a patient on a gurney and then placing a device (e.g., backboard, scoop stretcher or flats) on top of the patient, referred to as "Sandwich" method.

5. Applying materials in a manner that could cause vascular, neurological or respiratory compromise (e.g., restriction of limbs, the neck or chest using gauze bandage or tape).

C. In some situations, it may be necessary for LE to apply restraints (e.g., handcuffs, flex-cuffs, herein referred to as LE-restraint), which are not approved by EMS protocols. When appropriate, patients requiring ongoing patient care or EMS transported patients should have LE-restraints discontinued in favor of an EMS approved restraint intervention.

II. Application and Monitoring of Restraints

A. A restrained patient shall never be left unattended.

B. Any restraint device used must allow for rapid removal if the patient's airway, breathing, or circulation becomes compromised.

C. Restrained extremities should be evaluated for pulse quality, capillary refill, color, temperature, nerve and motor function immediately following application and at a minimum of every 15 minutes thereafter (or more often if clinically indicated). Any abnormal findings require adjustment, removal and reapplication of restraints if necessary.

D. Restraint methods must allow the patient to straighten the abdomen and chest such that they can take full breaths.

E. Under no circumstances are patients to be transported in the prone position regardless of who applies the restraint.

F. EMS personnel must ensure that the patient's position allows for adequate monitoring of vital signs, does not compromise respiratory, circulatory, or neurological status, and does not preclude any necessary medical intervention to protect or manage the airway should vomiting occur.

G. EMS restraints shall not be attached to movable side rails of a gurney.

H. Restraint devices applied by LE require the officer's continued presence to ensure patient and scene management safety.

1. The LE officer should accompany the patient in the ambulance.

2. In the unusual event that this is not possible, the LE officer should follow by driving in tandem with the ambulance on a pre-determined route.

3. A method to alert the LE officer of any problems that may develop during transport should be discussed prior to leaving the scene.

4. If the patient is handcuffed by LE officers, consideration should be made to transition to the least restrictive restraints that are safe for the patient and responders, including consideration of transfer to EMS restraints.

III. Pharmacologic Management of the Patient in Restraints

A. A patient who has undergone physical restraint should not be allowed to continue to struggle against the restraints as this may lead to injury (i.e., rhabdomyolysis, strains, sprains, severe acidosis, cardiac ischemia).

B. Patients who are agitated while in physical restraint may receive midazolam by EMS personnel to reduce agitation with continued monitoring for respiratory depression, in accordance with (*TP 1209, Psychiatric/Behavioral Emergencies*).

1. If the patient remains agitated in BLS care and there is an ongoing concern for patient safety, ALS upgrade shall be initiated.

2. Resuscitation and monitoring equipment, including oxygen and bag valve mask, should be near the patient and accessible prior to proceeding with sedation.

3. Initiate monitoring of pulse oximetry, cardiac rhythm, and capnography (when available) as soon as possible peri-/post-sedation and prior to transport. Contact Base for guidance if persistent agitation prevents monitoring prior to transport.

IV. Required Documentation on the Patient Care/EMS Report Form

A. Reason restraints were applied

B. Type of restraints applied

C. Identity of agency/medical facility applying restraints

D. Assessment of the overall cardiac and respiratory status of the patient; and the circulatory, motor and neurological status of the restrained extremities at a minimum of every 15 minutes

E. Reason for removing or reapplying the restraints or any abnormal findings

V. Quality Assurance:

A. Develop a process for review of selected cases where physical restraint and/or medication are used by EMS personnel to manage agitation, with attention to the type of restraint(s) used, the quality and frequency of physiologic monitoring, protocol compliance, and documentation compliance.

B. Agencies shall track the use of medications for the purpose of management of agitated patients.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 502, **Patient Destination**
Ref. No. 703, **ALS Unit Inventory**
Ref. No. 1200.2, **Base Contact Requirements**