

# Patient Restraint

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## 1. INTRODUCTION

- 1.1. Patients have the right to refuse treatment and/or transport if they are of legal age and are competent. Competence is defined as the capacity or ability to understand the nature and effects of one's acts or decisions. A patient under the age of 18 should be transported unless a competent parent or guardian refuses treatment for the patient. A person is considered to be competent until proven otherwise. There are situations, however, in which the interests of the general public outweigh an individual's right to liberty.
- 1.2. Certain medical, traumatic, and psychological conditions can cause incompetence and behavior that interferes with the ability of EMS personnel to care for the patient, or that threatens the physical well-being and safety of the patient or others. These conditions include, but are not limited to: drugs, metabolic disturbances, central nervous system injury or insult, infections, hypo/hypertension, hypo/hyperthermia, hypoxia, psychological disorders, poisons and toxins.
- 1.3. MGL Chapter 54 of the Acts of 2000 states that "subject to regulations and guidelines promulgated by the department, an emergency medical technician may restrain a patient who presents an immediate or serious threat of bodily harm to himself or others. Any such restraint shall be noted in the written report of said emergency medical technician." If an EMS provider feels uncomfortable with any patient, even when they have not been actively combative, the provider has the right to provide the patient and others with the security of patient restraint. Verbal threats are a legitimate reason for restraint. The following is a guideline for the use of restraints in the prehospital care setting. It is not intended to dictate police action that may be necessary to subdue someone.

## 2. GENERAL GUIDELINES

- 2.1. The safety of EMS personnel is the paramount factor during prehospital patient restraint, followed by the importance of protecting patients from injuring themselves or others.
- 2.2. Law enforcement officers should be involved in all cases when a patient poses a threat to EMS personnel or others. If law enforcement is not immediately available, EMS personnel should retreat to a safe place and await the arrival of law enforcement. If there is no option for retreat, EMS personnel may use reasonable force to defend themselves against an attack.
- 2.3. All personnel must recognize that there is no duty to act when faced with violent behavior, whether that behavior is being directed at a caregiver, a patient or their family, or another member of the community at large.

- 2.4. Law Enforcement personnel have statutory authority and training to deal with violent persons and should be part of any prepared incident management plan.
- 2.5. Patient dignity should be maintained during restraint, and the method of restraint should be individualized to use the least restrictive method of restraint that protects the patient and EMS personnel from harm.
- 2.6. The goal of managing a patient exhibiting violent behavior is to prevent further harm to the patient and others by exercising only that force which is necessary to neutralize the aberrant behavior, without causing harm to the patient, EMS personnel, or bystanders.
- 2.7. EMS personnel should anticipate the potential for exposure to blood and body fluids. Based on the situation, appropriate barrier protection should be worn during patient restraint activities.
- 2.8. Any restraint used should allow for rapid removal if the patient vomits or develops respiratory distress. Whenever a restraint is utilized, a key (in the case of handcuffs) or scissors must be immediately available should the restraint need to be removed.
3. **USE OF CONTROL CONTINUUM.** The methods of restraint include verbal de-escalation and increasing levels of physical restraint. The chosen method of restraint should be the least restrictive method that assures the safety of the patient and EMS personnel. These methods of restraint may be used in a sequential fashion in many cases, but in extremely violent individuals, immediate physical restraint may be indicated to assure the safety of the patient and personnel. The patient's presentation or actions dictate what level of control is exercised. EMS personnel must document what actions on the part of the patient forced the care-provider to choose or escalate to each progressive intervention level.
  - 3.1. Command Presence – Often times, a professional and competent presentation will be enough to defuse a situation. Personnel should identify themselves and Department affiliation and desire to render assistance (e.g. "I'm an EMT from Boston EMS and we were called here to see how we could help you"). Providers should try to avoid encroachment upon the patient's personal space, as this may provoke stress and anxiety. A show of force may initially be sufficient to gain cooperation of the patient.
  - 3.2. Verbal Commands – The application of verbal techniques to calm the patient is the next method that EMS personnel should employ. This method is safest because it does not require any physical contact with the patient. Verbal intervention sometimes diffuses the situation, and can prevent further escalation, and may avoid the need for further restraint tactics. Request that the patient follow commands relative to treatment and transportation.
  - 3.3. Focused Direction - Using hand signals, body position, or natural barriers to channel a patient toward the transport device.
  - 3.4. Physical Restraint - Application of Department approved restraints using least invasive applications necessary. When physically restraining a patient, EMS personnel should make every effort to avoid injuring the patient.

4. APPROVED RESTRAINT DEVICES. The department approves the use of the following restraint devices.
  - 4.1. Soft roller bandage or “Kling”
  - 4.2. Webbed straps to augment limb restraint devices and to stabilize patients on backboards, wheeled cots, stair-chairs, and scoop stretchers.
  - 4.3. Hard restraints, such as handcuffs or “flex-cuffs”. These devices may be used for initial restraint when other approved devices are not practical or readily available. If carried, handcuffs must be kept in a covered case.
5. RESTRAINT PROCEDURE
  - 5.1. Dispatch Operations should be notified immediately that a potential prehospital patient restraint situation exists. Following the notification to Dispatch Operations, a supervisor along with other appropriate resources should be dispatched to the incident. If available, a supervisor should be present during the restraint process. If a supervisor is unable to respond to the incident, a supervisor should meet up with the crew as soon as practical to check on the crew, the patient and review the response.
  - 5.2. Ensure sufficient personnel are present to control the patient. As resources allow, four (4) to five (5) public safety personnel will develop and implement an action plan to temporarily immobilize each of the patient’s limbs as required.
  - 5.3. A wheeled cot, backboard, or stairchair should be brought to the patient’s side or to a staging area in the immediate active incident area. When the situation allows, an explanation of the restraint process will be made to the patient and bystanders and the patient will be given a last opportunity to choose transportation without restraint providing that that mode of transportation does not compromise the safety of the EMS personnel, bystanders, or patient.
  - 5.4. Personnel will restrain patients using the least amount of force necessary to meet the patient’s resistance. The least number of points of control will be used to meet the objective of effectively controlling the patient.
  - 5.5. Restrained patients shall be placed in a supine position, a lateral recumbent position, or semi-fowler’s position. Restrained patients shall not be transported in a prone or “hog tied” position, nor shall they be “sandwiched” between backboards or scoop stretcher. No restraint should be applied over the patient’s face, or so tightly across the chest that it interferes with respirations.
  - 5.6. A continuing dialog will be maintained with the patient and bystanders to communicate that everything possible is being done to ensure the patient’s safety.
  - 5.7. The patient will be closely monitored for signs of potentially negative affects of restraint, including respiratory compromise or circulatory impairment. The patient’s restraints will be checked for such compromises at a minimum of five (5) minute intervals.

- 5.8. Patients that are actively seizing should not be restrained. An active incident area will be cleared and the patient will be supported and padding placed around the patient to minimize potential for injury until the tonic-clonic activity subsides or the patient receives medical intervention.
- 5.9. Changing the type of restraint from a hard-mechanical restraint to a softer form of restraint is recommended whenever possible. It may also be appropriate to reduce the number of restraint points if a patient's condition improves due to medical intervention.
- 5.10. If a person is restrained by police pursuant to a Section 12 or is under arrest and requires transport by ambulance, a police officer should accompany the patient inside the ambulance when practical to provide protection to the patient and EMTs, as well as to alter the restraints as necessary for medical treatment. If riding in the ambulance is not practical, the police officer will escort the ambulance to the hospital.
- 5.11. A patient in restraint must never be left unattended. Personnel must have immediate access to a pair of scissors or, when handcuffs have been applied, a key to be able to remove the restraint should the patient seize or need to be repositioned.

## 6. SPITTING PATIENT

- 6.1. Consider placing a non-rebreather mask (use only 15 lpm) or a face mask (NOT N95/P100) on the spitting patient's face. If either of these options are not feasible given patient agitation and provider safety, consider utilizing a Department approved "spit sock" device.
- 6.2. The spit sock is a lightweight, see through protective mesh material. It is designed to allow the patient to breathe without obstruction but does not allow saliva to be projected to the outside. The "spit sock" is a single patient use disposable piece of equipment.
- 6.3. The "spit sock" is not appropriate if a patient requires oxygen. Patients with a spit sock applied shall be frequently evaluated for change in mental status or cyanosis. If any signs of medical distress are observed, the spit sock should be removed to initiate appropriate medical care. Consider monitoring oxygen saturation whenever practical.

## 7. TRANSPORT ISSUES

- 7.1. The decision to restrain a patient should usually be made prior to transport.
- 7.2. If an unrestrained patient becomes assaultive during transport, the vehicle operator will bring the vehicle to a safe stop and assist his/her partner in the patient care compartment. The standard "ambulance in trouble" response will be initiated as necessary.
- 7.3. If the crew believes their personal safety is at risk, they should not inhibit a patient's ability to leave the ambulance. Every effort should be made to release the patient into a safe environment.

7.4. Restrained patients must be carried on a wheeled cot, backboard, scoop stretcher, or stair-chair.

8. **CHEMICAL RESTRAINTS:** In circumstances when a violent patient is unable to be restrained by physical means and the safety of the patient or EMTs is compromised, chemical restraint should be considered. The statewide treatment protocols allow for specific medications to be used for acute behavioral emergencies, ALS providers should keep up to date on the current medications, dosage and precautions.

9. **PEDIATRIC CONSIDERATIONS**

Always attempt to involve parents when restraining children.

10. **PREGNANCY CONSIDERATIONS**

Pregnant women requiring restraint should be transported in a semi-reclining or left lateral recumbent position.

11. **DOCUMENTATION REQUIREMENTS**

All uses of restraints and spit sock must be documented thoroughly on the patient care report, and at a minimum must include:

- a. reason for restraint use;
- b. time of application;
- c. types of restraints used in addition to cot straps;
- d. patient position;
- e. neurovascular evaluation of extremities;
- f. issues encountered during transport;
- g. other treatment rendered;
- h. police and/or other agency assistance; and
- i. whether any injuries occurred during the restraint procedure.

All responses involving the application of restraints will be reviewed as part of the continuous quality improvement (CQI) process to ensure conformity with department policy.

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MGL Chapter 54, section 18: <https://malegislature.gov/Laws/SessionLaws/Acts/2000/Chapter54>

OEMS A/R “Requirement for EMT Use of Patient Restraints” See part

II.B.b.iii <http://www.mass.gov/eohhs/docs/dph/emergency-services/ar/5-500.pdf>