Patient Restraint in Emergency Medical Services

Approved by the NAEMSP® Board of Directors: 20 December 2016

The National Association of EMS Physicians (NAEMSP®) recognizes that emergency medical services (EMS) personnel often encounter agitated and combative patients, and these patients frequently require clinical treatment and transportation. When such encounters occur, both patients and EMS personnel may be at risk for injury. Reasonable steps must always be taken to help minimize the possibility of injury to patients and EMS personnel.

The NAEMSP® believes that:

- All EMS agencies should develop specific protocols for dealing with violent or combative patient(s).

- The safety of EMS personnel is the paramount factor during patient restraint, followed by the importance of protecting patients from injuring themselves or others.

- 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.

- The different clinical, operational, and safety-risk characteristics of the EMS environment compared to hospital-based environments, especially the mobile, confined space elements of EMS-based care, necessitate use of different restraint tactics and technologies as well as different thresholds for implementation of restraint protocols in the EMS environment.

- EMS agencies must assure that all EMS personnel are knowledgeable about the clinical conditions that are associated with agitated or combative behavior and that EMS personnel are trained to apply the principles of the system's restraint protocol during patient care.

- Restraint protocols should outline the clinical indications for patient restraint. The protocol should be consistent with accepted practices and regulation pertaining to patient's rights with respect to refusal of care and the EMS system's responsibility to care for patients with psychiatric or behavioral emergencies.

- Restraint protocols must direct appropriate patient assessment to identify and manage clinical conditions that may be contributing to a patient's combative or violent behavior. Such conditions include, but are not limited to, hypoxia, hypoglycemia, alcohol or drug intoxication, excited delirium, stroke, and brain trauma.

- Restraint protocols must address the restraint techniques that will be used (verbal de-escalation, physical, or chemical[1]), when each will be used, who can apply them, and when direct medical oversight must be involved.

- Restraint protocols should address the type of physical restraints that are permissible for EMS providers to utilize. Any physical restraint device used should allow for rapid removal if the patient vomits or develops respiratory distress. Hard restraints, such as handcuffs, are generally not acceptable for EMS application or use. If patients are restrained in devices that require a key, the key must accompany the patient during treatment and transportation.

- Restraint protocols should identify restraint techniques that should be expressly prohibited by EMS providers including: restraint or transport in a prone position with or without hands and feet behind the back (hobbling or "hog-tying"), "sandwiching" patients between backboards, techniques that constrict the neck or compromise the airway, or EMS provider use of weapons as adjuncts in the restraint of a patient.

- Continued patient struggling after restraint application, for example in excited delirium, can lead to hyperkalemia, rhabdomyolysis, and cardiac arrest. Chemical restraint may be necessary to prevent continued forceful struggling by the patient.

- Chemical restraint, usually with a butyrophenone, a benzodiazepine, ketamine or other dissociative agents, or a combination of these agents, is an effective and safe method of protecting the violent or combative patient from self injury. Paralytic agents are not acceptable chemical agents for restraint unless they are also clinically indicated to treat an underlying clinical condition.

- After patient restraint interventions occur, there must be regular and frequent evaluation of the patient's respiratory and hemodynamic condition and the neurovascular status of all restrained extremities.

- Patient care documentation of restrained patients should include: patient assessment, clinical indication for restraint, the type of restraint intervention(s) applied, frequency of reassessment and associated exam findings, and additional care provided during transport.

- Direct medical oversight of EMS provider interventions may be necessary for combative patients who refuse treatment, for orders to restrain a patient (before or immediately after restraint), or for orders for chemical restraint (before or after medication is administered).

- Use of restraint protocols should undergo quality improvement review with specific filters for: 1) the appropriateness of restraint for the patient, 2) the type of restraint(s) utilized, 3) the care provided to the patient during transport, and 4) documentation of the episode of care. EMS agencies should consider reviewing every case of patient restraint for compliance with the restraint protocol.

- 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.

- Local law enforcement restraint policies/practices may differ from EMS-based restraint protocols, but both agencies should recognize their roles and work cooperatively and proactively to ensure the safe care of EMS patients when application of restraint(s) is necessary.

- In some situations, it may be necessary for law enforcement to apply law enforcement-based restraint techniques or technologies that are not sanctioned by EMS protocols to people that are also in need of, or develop a need for, EMS assessment and intervention. When such events occur, a law enforcement officer must remain available to the EMS provider, and EMS personnel must assure that the patient is clinically assessed, treated, and reassessed based upon an EMS agency's relevant restraint and other clinical protocols.

- If a law-enforcement based restraint intervention must be continued during patient care and transport, but is otherwise not sanctioned for use by EMS providers, a law enforcement officer should either: 1) accompany the patient and EMS provider during transport to definitive care, or 2) the law-enforcement based restraint intervention should, when appropriate, be discontinued in favor of an appropriate and sanctioned EMS-based restraint intervention. Patients under police custody or who are under arrest, must always have an law enforcement officer present during EMS transport.

Footnote:

1. For the purposes of this document the terms: chemical restraint, pharmacologic restraint, chemical augmentation of behavior, pharmacologic augmentation of behavior, are considered interchangeable