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7B – PHYSICAL RESTRAINT ADULT & PEDIATRIC

EMERGENCY MEDICAL RESPONDER

EMT

EMT-INTERMEDIATE 85

ADVANCED EMT

PARAMEDIC

Indications:

1. Reducing likelihood of patient doing harm to self.
2. Reducing likelihood of patient doing harm to others (including EMS professionals).
3. Reducing likelihood of patient disrupting medically necessary interventions.
4. Patient requires/required chemical restraint per Protocol 7C.

Alternatives to physical restraint as outlined below are to be utilized so as to minimize the use of physical restraints. However, if alternatives to physical restraints are unsuccessful, then physical restraints will be applied in an effective and compassionate manner. Throughout the use of alternatives to physical restraint and physical restraint, the patient and the patient's concerned parties (family, friends, co-workers, etc.) shall be treated with respect and informed of the need for these procedures. This protocol is not intended to place EMS professionals at higher risk for injury. If personal safety is compromised or threatened during the course of patient care, appropriate law enforcement personnel should be summoned for assistance. If at any time questions arise as to appropriateness of using alternatives to physical restraint or physical restraint, OLMC should be consulted for direction.

Contraindications:

1. Patient (or patient's legal guardian or medical power of attorney) possesses medical decision making capacity and is refusing evaluation, treatment, and/or transport (in the absence of threatened or actual harm to self or others).
2. Patient is compliant with medically necessary interventions.
3. Reducing likelihood of patient doing harm to self and/or others and reducing likelihood of patient disrupting medically necessary interventions can be successfully accomplished with alternatives to physical restraint in the best judgment of the EMS professional(s) treating the patient.

PROTOCOL 7B: Physical Restraint – Adult & Pediatric, cont.

Technique:

The following steps shall be taken and documented in determining the need for physical restraints:

1. **Assessment of mental status** - Observe for uncontrolled agitation, combativeness, threats of violence to self or others, disorientation, altered mental status impeding medically necessary interventions, or pulling at necessary medical interventions (eg. oxygen, IV lines, endotracheal tubes).

2. **Alternatives to physical restraint**- Reassurance, support of concerned parties (family, friends, co-workers, etc.), reorientation, diversionary activity, explanation of illness, injury, and medically necessary interventions.

3. **Justification for physical restraint**- Failure of alternatives to physical restraint, reduce likelihood of patient harm to self, reduce likelihood of patient harm to others, enable medically necessary interventions per EMS protocols.

4. **Inform patient and concerned parties of physical restraint use.**

5. **Apply physical restraints.**

Restraints are to be soft and are not to impede airway patency, respiratory mechanics, or circulation. Patients will not be restrained prone unless an impaled object or airway patency necessitates such positioning. Restraints will be applied in an effective, yet compassionate manner. Every effort should be made to avoid injury to the patient during application of physical restraints.

Humane restraints that reduce potential for patient injury from the restraints are those made from roll gauze, soft leather, and those designed as single-patient use, disposable foam with cloth ties. Restraints are to be non-locking unless applied by law enforcement officers in appropriate circumstances and able to be released rapidly if patient condition mandates.

During treatment and transport of a patient in law enforcement-instituted restraints (including handcuffs), EMS professionals should monitor for and advocate for change in restraints that compromise airway patency, respiratory mechanics, or circulation. Patients will not be transported with wrists cuffed to ankles either directly or indirectly (also referred to as “hog-tying”). These positions have been shown to impair respiratory mechanics and pose significant obstacles to definitive airway management if required enroute. During transport of patients in law enforcement-instituted locking restraints, a law enforcement officer should either accompany the patient in the ambulance or provide the treating EMS professionals means to unlock the restraints. This policy allows rapid restraint release should the patient deteriorate to a condition requiring restraint release to properly treat.

Patients restrained using this protocol should generally be restrained to a backboard. This facilitates patient transfer in the emergency department and in the case of airway secretions or vomiting, enables rapid positioning of the patient to reduce aspiration. Patients will not be transported “sandwiched” between two backboards; this positioning impedes patient care and increases risk of aspiration.

PROTOCOL 7B: Physical Restraint – Adult & Pediatric, cont.

Once physical restraints are applied, they will be left in place until the patient is transferred to emergency department personnel. This policy prevents recurrent harm to self, harm to others, and disruption of intact medical devices and treatment. Despite assurance from the patient that they will comply with treatment, restraints are to be left in place unless a direct order from OLMC is given to release the physical restraints. Such an order must be clearly documented on the patient care form.