Appendix D

PATIENT RESTRAINT

PURPOSE

To establish a standard/guideline to be utilized only when necessary and in those situations where the patient is exhibiting behavior that the pre-hospital care provider believes presents a danger to the patient and/or others. This procedure applies to patients being treated under implied consent. Patients who are refusing treatment should not be subjected to this procedure unless police are on scene.

PROCEDURE

Verbal De-escalation Guidelines

1 Make every attempt not to aggravate or worsen pre-existing injuries or medical conditions
2 Attempt to control the patient with verbal counseling

Verbal De-escalation Procedure

1. Remain calm and friendly, be aware of your feelings
    - Be mindful of your body language
    - Breathe slowly and deeply
    - Maintain a safe distance and refrain from touching
    - Utilize contact and cover principles
2. Position yourself so that the patient cannot block your access to an exit
3. Keep your hands in front of your body in a non-threatening manner
4. Only one provider should communicate with the patient
5. Maintain a soothing tone of voice
6. Listen to patient's concerns
7. Empathize, use positive feedback
8. Be reassuring and point out choices
9. Be willing to slow down and disengage if appropriate
10. Calmly set boundaries of acceptable behavior

Patient Capacity Issues

1. Medical decision making capacity is defined as the ability to give informed consent to go through a particular medical test or intervention or the ability to refuse such intervention.
2. When tasked to determine the mental capacity of a patient to refuse treatment, ask yourself these questions about your patient:

    - Is the patient in danger of hurting himself or others?
    - Is there or could there be an underlying medical emergency that may lead to death or worsen considerably if not treated soon?
    - Is there an emergency medical intervention that must be made to avoid a worsening in your patient's condition?

- Does your patient understand the risks of refusing these treatments or interventions? Have you made those clear?

3. These questions apply only to the patient's immediate situation, not to long-term medical care.

☐Physical Restraint Guidelines

1. Use the minimum physical restraint required to accomplish necessary patient care and ensure safe transportation:
    - Soft restraints may be sufficient
    - If law enforcement or additional personnel are needed, call for it prior to attempting restraint procedures
    - Do not endanger yourself or your crew

2. Avoid placing restraints in such a way as to preclude evaluation of the patient's medical status (airway, breathing, and circulation). Consider whether placement of restraints will interfere with necessary patient care activities or will cause further harm.

Physical Restraint Procedures

1. Ensure sufficient personnel are present to control the patient while restraining him/her; **USE LAW ENFORCEMENT ASSISTANCE WHEN AVAILABLE**
2. Place the patient face up on long backboard
3. Secure **ALL** extremities to the long backboard
    - Try to restrain lower extremities first using Flex-cuffs (or equivalent) around both ankles
    - Next, restrain the patient's arms at the side using Flex-cuffs (or equivalent) around each wrist
4. If necessary, use cervical spine precautions (CID) to control violent head or body movements
5. Place padding under patient's head and wherever else needed to prevent the patient from further harming him/herself or restricting circulation
6. Secure the backboard onto the stretcher for transport using additional straps if necessary; remember to secure additional straps to the upper part of the stretcher to avoid restricting the wheeled carriage
7. Document circulatory status of restrained extremities every 15 minutes
    - Physical restraint MUST be used any time a potentially violent or unstable patient (i.e., head injury, altered mental status, or under the influence) is transported by **air ambulance**
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Chemical Restraint Guidelines

1. Sedative agents may be used to provide a safe, humane method of restraining the violently combative patient who presents a danger to themselves or others and to prevent the violently combative patient from further injury while secured by physical restraints
2. These patients may include but are not limited to the following:
    - Alcohol and or drug-intoxicated patients

- Restless, combative head-injury patients
- Mental illness patients
- Physical abuse patients (**more humane than physical restraint**)

Chemical Restraint Procedure

1. Assess the possibility of using physical restraint first; evaluate the personnel needed to safely attempt to restrain the patient
2. Have sedative medication prepared for injection; prepare for possible hypotensive side effects
3. Contact On-Line Medical Control prior to administration and clearly state the need for sedation if you think it is necessary for safety or patient care
4. Administer Haldol 5-10 mg 1M or IV *(Refer to the Combative Patient Protocol)*
    - Vital signs should be assessed within the first five minutes and thereafter as appropriate
    - If necessary, contact On-Line Medical Control for additional sedation.
5. Assess the need for sedation carefully.
    - The violently combative patient stands a lesser chance of injury when sedated
    - Patients who are physically restrained and aggressively fighting their restraints and head injury patients who are combative and compromising their airway and C-spine may be candidates for sedation
    - Chemical restraint precautions: Side effects of Haldol may include hypotension, tachycardia, and acute dystonic reactions. Treat symptoms of dystonic reaction with Benadryl 25-50 mg 1M or IV. Watch for increased sedation

Documentation (Minimum)

1. In what manner was your patient violent? Record patient's comments *verbatim*.
2. Did you feel threatened? Why?
3. Were you concerned about your patient's outcome without emergency medical interventions? Why?
4. Could you treat your patient appropriately without the use of restraints?
5. What Law Enforcement Officer was present?
6. What physician provided the order? Who was on-line medical control?
7. Document the frequency of respiratory and mental status change assessments. *
8. If your patient was physically restrained, was he prone or supine?
9. What kind of restraints did you use?
10. Where on your patient were these restraints placed?

* Constant evaluation of your patient's airway status and documentation of such is extremely important.