TITLE: **RESTRAINT OF PATIENTS** EMS Policy No. **5107**

PURPOSE:

The purpose of this policy is to provide for the use of patient restraints in the prehospital environment for patients who are violent, potentially violent, or who may harm themselves or others.

AUTHORITY:

Health and Safety Code § 1797.200 & 1798 et seq.

DEFINITIONS: See SJCEMSA Policy Definitions.

POLICY:

It is the policy of SJCEMSA to allow under specific conditions prehospital personnel to properly apply restraints to specific patients while ensuring the safety of the patient, community, and responding personnel. When restraining a patient is necessary such activity shall be undertaken in a manner that protects the patient's health and safely preserves his or her dignity, rights, and well-being. Restraining a patient is a last resort after alternative interventions including verbal de-escalation and less restrictive intervention have been considered or attempted and EMS personnel shall use the least restrictive intervention reasonably necessary. Prehospital personnel must consider that aggressive or violent behavior may be a symptom of medical conditions and that behavioral restraints are to be used only in circumstances where an immediate or credible threat of physical harm is present.

I. INDICATION FOR PHYSICAL RESTAINTS:

A. The patient lacks decision-making capacity and is actively interfering with assessment, treatment, or transport necessary to address a suspected emergency medical condition.

B. The patient lacks decision-making capacity and restraint is reasonably necessary to prevent significant unintended self-harm, including removal of medically necessary devices or unsafe movement.

C. Restraint is otherwise necessary to safely accomplish emergency medical care and less restrictive measures have failed, are clearly inappropriate, or cannot safely be attempted.

D. The indication for restraint must continue to exist for restraint to remain in use.

Approved:

Medical Director EMS Administrator

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II. INDICATION FOR CHEMICAL RESTRAINT:

A. In coordination with SJCEMSA Policy No. 5700 ALS Treatment Protocols, AGEN-05, patients exhibiting signs of "Severe Agitation" creating an immediate or credible risk of physical harm to the patient, responders, or others.
B. Physical restraint is not required before medication when attempting restraint alone would create unnecessary risk.

III. APPLICATION OF PHYSICAL RESTRAINT:

A. Use commercially manufactured padded or soft, quick-release restraints.
B. Ensure access to the airway and adequate ventilation, circulation, neurologic function, monitoring, and treatment.
C. Restraint equipment, applied by prehospital personnel, must be either padded leather restraints or soft restraints. Both methods must allow for quick release.

IV. PROHIBITED METHODS FOR RESTRAINT:

A. Hard plastic ties or any restraint device requiring a key to remove.
B. Sandwiching patients between backboards, scoop-stretchers, or flat, as a restraint.
C. Restraining a patient's hand and feet behind the patient, i.e. hog-tying.
D. Methods or other materials applied in a manner that could cause respiratory, vascular, or neurological compromise, including prone restraints.
E. Use of chokeholds, neck restraints, pain-compliance techniques, and body weight or pressure on the chest, back, abdomen, or neck.

V. LAW ENFORCEMENT ROLE AND RESTRAINTS:

A. Replace law enforcement restraints with soft restraints before transport when safely feasible and continued law enforcement restraint is unnecessary.
B. EMS retains authority and responsibility for medical assessment, treatment, positioning, monitoring, and EMS restraint devices.
C. Restraint equipment applied by law enforcement shall be secured to the fixed frame of the stretcher and shall not be attached to movable side rails or other components whose position may change during transport or patient care and must provide sufficient slack in the restraint device to

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allow the patient to straighten the abdomen and chest and to take full tidal volume breaths.

D. Restraint devices applied by law enforcement require the officer's continued presence to ensure patient and prehospital personnel safety. The officer should, if possible, accompany the patient in the ambulance, or follow by driving in tandem with the ambulance on a predetermined route. A method to alert the officer of any problems that may develop during transport should be discussed prior to leaving the scene.

VI. MONITORING OF PATIENT IN RESTRAINTS:

A. Document vital signs and clinical status at least every five (5) minutes while the patient is actively struggling, significantly agitated, or following medication administered for severe agitation, through transfer of care.

B. Obtain neurovascular checks before application when feasible, immediately afterward, after adjustment or repositioning, and at least every 15 minutes through transfer of care.

VII. POSITIONING AND TRANSPORT:

A. Patients shall not be transported in a prone position unless required by a concomitant medical condition e.g. impaled object preventing supine transport.

B. Place restrained patients supine, lateral, semi-fowlers, or fowlers as clinically appropriate.

C. Maintain direct observation and continuous visual assessment of airway and respiratory effort.

D. Reduce or remove restraints as soon as they are no longer necessary.

E. Restrained patients should be transported to an appropriate receiving facility based on the patient's condition per SJCEMSA Policy No. 5201 Medical Patient Destination and or 5215 Trauma Patient Destination.

VIII. DOCUMENTATION:

A. Documentation on the patient care report shall include:

i. Specific observed behavior or medical indication supporting restraint.
ii. Decision-making capacity when relevant.
iii. De-escalation attempted or why it was unsafe.
iv. Type, time, personnel/agency, and patient position.
v. Vital signs, respiratory and neurovascular monitoring.
vi. Continued need for restraint and time adjusted or removed.
vii. Injuries, complications, medications, and response to treatment

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