I. **DEFINITIONS**

A. **Behavioral emergencies** are those in which the patient's problem is that of mood, thought, or behavior that is dangerous or disturbing to himself/herself or to others.

B. **Behavioral health services** is the contemporary term for mental health, chemical dependency, and mental retardation/developmental disabilities services for which care is provided in settings such acute, long term, and ambulatory care (JCAHO).

C. **Decisional capacity**: Decisional capacity is determined by evaluating the patient's **a**ffect, **b**ehavior, and **c**ognitive (intellectual) ability. Psychiatric signs and symptoms are grouped into the systems that they affect: consciousness; motor activity; speech; thought; affect; memory; orientation; and perception. The components may be remembered by the mnemonic **CAST-A-MOP**. The **determination of decisional capacity** generally depends on the person's ability to

1. communicate a choice;
2. understand relevant information;
3. appreciate the situation and its consequences; and
4. weigh the risk and benefits of options and rationally process this information before making a decision (Miller, 2001).

D. **Delirium:** Impairment in cognitive function that comes on rapidly.

E. **Dementia**: Chronic process resulting in deficits in memory, abstract thinking, and judgment.

F. **Mental illnesses** include, but may not be limited to, the following: Schizophrenia (often accompanied by hallucinations, delusions, altered thought processes, inappropriate affect and disorganization in thought and dress), catatonic schizophrenia (may maintain rigid or bizarre posture for hours), paranoid schizophrenia (persecutory delusions, grandiose delusions, delusional jealousy, or hallucinations with persecutory or grandiose content), undifferentiated schizophrenia, major affective disorders such as bi-polar disease (mania to major depression or alternating between them over time), unipolar depressive disease, and anxiety disorders or "panic attacks".

G. **Life-threatening psychiatric conditions**

1. **Suicide:** Any willful act designed to end one's own life.
2. **Homicidal risk**: Any willful act designed to end another's life.
3. **Grave mental disability**: A state of impaired judgment such that the patient is unable to provide for his basic needs of food, clothing, and shelter.

H. **Petition:** A petition is a legal psychiatric form from the Illinois Department of Mental Health that, when completed, represents the first step in the process to *admit* a person against his or her will. When used by EMS personnel, it provides first hand information to the physician for his/her consideration of a certificate. It does not, by itself, admit the patient.

II. **Broad categories of behavioral emergencies**

A. **Situational**: When normal individuals develop abnormal reactions to stressful events. Almost anyone can lose control if subjected to enough stress but some are more vulnerable than others. When a person's basic needs are threatened, the severity of the crisis will depend on their ability to deal with their feelings. They may cope by finding ways to alter the situation or their perception of it so that it is no longer stressful. Alternatively, they may attempt to decrease the discomfort by escaping from the stress in the form of alcohol, drugs, suicide, or psychiatric symptoms.

B. **Organic:** Consider when a person is suffering from a physical illness or is under the influence of a substance that interferes with normal cerebral function. Diabetes, seizures, severe infections, hypoxia, acidosis, metabolic disorders (thyroid), head injury, stroke, alcohol intoxication, and drugs may all cause disturbed behavior. Consider organic diseases in ALL patients with behavioral emergencies.

C. **Psychiatric (mental illness)**: Caused by problems that arise in the mind of the patient. Psychiatric syndromes can be divided up into the following categories: psychotic disorders characterized by an impaired view of reality; affective disorders of mood; anxiety disorders involving overwhelming fear; disorientation and disorganization; hostile and violent patients.

III. **POLICY**

The NWC EMSS believes that non-decisional patients need their rights protected, including the right to acute medical evaluation and care. When a patient is not competent to accept or refuse care, his/her judgment must be replaced by someone else's. If a person is believed to be mentally ill and/ or is experiencing a behavioral emergency and they are non-decisional, they must be transported to the nearest hospital, against their will, if necessary, for their ultimate safety and benefit.

IV. **GENERAL APPROACH**

A. **Evaluate scene safety**. Risk factors for violence:

1. Locations with alcohol consumption
2. Crowds
3. Incidents where violence has already occurred (GSW, stabbing, domestic)
4. Individuals under the influence of, or withdrawal from, drugs or alcohol
5. Psychosis; especially manic and paranoid types
6. Delirium from any cause
7. Potential exists for (concealed) weapons

B. **Warning signs of a potentially violent situation**

1. Posture: People who sit tensely at the edge of a chair or grip an arm rest
2. Speech: Loud, critical, threatening, profanity, or voice rising in pitch or volume
3. Motor activity: Inability to sit still, pacing, easily startled, increased muscular tension, jabbing the air with a pointed finger or fist
4. Body language: Clenched fists, turning away, avoidance of eye contact
5. Subjective feelings: If one believes that they are in danger
6. Presence of any weapons

C. Identify yourself and attempt to gain the patient's confidence in a non-threatening manner

D. Consider and attempt to evaluate for possible physiological causes of behavioral problems and initiate treatment as required. Examples hypoxia, hypotension, hypoglycemia, head injury, alcohol/drug intoxication or reaction, stroke, postictal states, electrolyte imbalance, thyroid disorders, infections and dementia.

E. Assess decisional capacity and potential danger to self or others by observation, direct exam and reports from family, bystanders, or police.

F. Attempt to orient the patient to reality, gain cooperation and persuade him or her to be transported to the hospital so he or she can be examined by a physician.

G. If the patient is judged to be mentally ill and/or is experiencing a behavioral emergency, and poses an immediate danger to self or others, EMS personnel should initiate treatment and transport in the interest of the patient's welfare, employing the following guidelines:

1. **Assure your personal safety** at all times. This may mean a delay in the initiation of treatment until the personal safety of EMS responders is assured.
2. Try to obtain cooperation through conventional means.
3. If the patient resists or poses a threat to the safety of themselves, the EMS responders and/or bystanders, police shall be notified for assistance and reasonable force may be used to restrain the patient from doing (further) harm to self or others. (See procedure on use of restraints.)
4. Contact the nearest System hospital via the telemetry radio/phone and explain your situation. Discuss possible options for an action plan.

H. **Petition forms.** It the patient is judged to have a psychiatric cause for their illness that meets one of the eligibility requirements on the petition form, EMS personnel should initiate The **Petition for Involuntary/Judicial Admission Interim Form** (IL 462-2005 R-01-10).

1. A Petition for Involuntary Judicial Admission form is the first step in a legal process that protects the patient's rights and is necessary before a physician can determine if an involuntary admission is necessary.
2. A petition form is to be completed when EMS personnel or family members have first hand knowledge and reasonably suspect that a patient **is mentally ill** and because of their illness **would intentionally or unintentionally inflict serious physical harm upon themselves or others in the near future, is mentally retarded and is reasonably expected to inflict serious physical harm upon himself/herself or others in the near future, or is unable to provide for his or her own basic physical needs so as to guard himself or herself from serious harm** and needs transport to a hospital for examination by a physician (Ill Mental Health Code).
3. A petition form should be completed for all patients that meet the above criteria. They may be transported with or without their consent for medical evaluation. Careful documentation of first-hand observations is critical.
4. **Instructions for completing the petition form**

   a. **Statutory reason for initiation of petition**: Leave first page blank except for the patient's name. ~~Check only one box; generally the first, "Emergency admission by certificate".~~

   b. **Assertions (p. 2):** The EMS responder must insert the patient's name and check the assertion that applies; they believe the patient is:

      (1) A person with mental illness and because of his/her illness is reasonably expected to inflict serious physical harm upon himself/herself or another in the near future (prior standard); or

      (2) A person who is mentally ill and who because of his/her illness is unable to provide for his/her basic physical needs so as to guard himself/herself from serious harm without the assistance of family or outside help; or

      (3) A person who is mentally retarded and is reasonably expected to inflict serious physical harm upon himself/herself or others in the near future; and/or

      (4) In need of immediate hospitalization for the prevention of such harm.

c. Insert a **detailed description of any acts or significant threats supporting the assertion** and the time and place of their occurrence. Quote any statements made by the patient that substantiate the determination of risk.

d. Complete the witness section to the best of your ability. List a spouse, parents, close relative, or guardians, or if none, any known friend of the patient who witnessed the behavior supporting the assertion of risk. List their addresses and phone numbers in the designated area. If unable to locate any, indicate that you were unable to do so. Do not leave this section blank.

e. Page 3:

(1) Leave first statement area blank. Hospital will fill in.

(2) Insert information regarding police officer involvement if applicable.

(3) Notification statements: If another adult or the EMS responder is signing the petition form, they have the option of requesting or declining notifications as listed.

(4) The person who signs the petition (petitioner) must be 18 years or older and be an eyewitness to the patient's behavior. It is not appropriate for a petition to set forth facts which are true "according to family members". A family member/ advocate/guardian should sign the petition if they are the only witnesses. If the family is not available or refuses to sign the form, the next most appropriate person would be a police officer who witnessed or was informed about the behavior. **The one who observes the behavior should sign the form.** If police are not present or refuse to sign, EMS personnel who witnessed the behavior must sign the form. EMS personnel should indicate if involuntary transport has been ordered per on-line medical control.

(5) List the petitioner's relationship to the patient and a statement as to whether the petitioner has legal or financial interest in the matter or is involved in litigation with the patient as known to you at the time of the call.

(6) The petition must indicate the date it is filled out.

f. Page 4: Leave blank.

5. The IL 462-2005 (IL 462-2005 R-01-10). form should be attached to the EMS Patient Care Report left at the hospital and shall become a part of the patient's permanent medical record in the ED. If this form is completed appropriately by EMS personnel and a physician determines that an involuntary hospital admission is indicated, the Petition Form may be added to the physician's certificate and admission orders as part of the statutorily required documents.

V. **Good faith - Exemption from liability**

A. "All persons acting in good faith and without negligence in connection with the preparation of applications, petitions, certificates or other documents, for the apprehension, transportation, examination, treatment, habitation, detention, or discharge of an individual under the provisions of the Act incur no liability, civil or criminal, by reason of such acts."

B. "Any duty which any person may owe to anyone other than a resident of a mental health and developmental disabilities facility shall be discharged by that person making a reasonable effort to communicate the threat to the victim and to a law enforcement agency, or by a reasonable effort to obtain the hospitalization of the patient" (5/6-103).

VI. In an uncooperative patient, the requirement to initiate full care in the field may be waived in favor of assuring that the patient is transported to an appropriate facility. Contact medical control and communicate the circumstances favoring abbreviation of routine care.

VII. If a patient refuses medication after a petition is signed, the medication shall not be given unless it is necessary to prevent the patient from causing serious harm to himself or others (section 5/3-608). EMS personnel must thoroughly document what treatment is given and which is refused.

John M. Ortinau M.D., FACEP
EMS Medical Director

Connie J. Mattera, M.S., R.N.
EMS Administrative Director

Attachments: Petition form; Procedure on Use of Restraints

NWC EMSS Policy Manual
Use of Restraints
Revised 3/1/03

Definitions

"**Restraint** is the direct application of physical force to an individual, without the individual's permission, to restrict his or her freedom of movement. The physical force may be human, material, mechanical devices, or a combination thereof attached to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to ones body. " (JCAHO, TX.47, NCH, 2001).

"Momentary periods of physical restriction by direct person-to-person contact, without the aid of material or mechanical devices, accomplished with limited force, and that are designed to prevent a recipient from completing an act that would result in potential physical harm to himself or another shall not constitute restraint, but shall be documented in the recipient's clinical record" (Ill Mental Health Code, 5/1-125).

Medications used to control behavior or to restrict the patient's freedom of movement that is not a standard treatment for the patient's medical or psychiatric condition is a restraint.

Restraint for behavior management is the emergent use of restraint to prevent imminent danger to self or others in the event of unanticipated, severely aggressive or destructive behavior.

Immobilizing devices are those associated with medical or trauma procedures and are based on standard practice for the procedure, i.e., IV arm boards, splints.

Least restrictive measures are the use of restraining techniques or methods that pose the least possible restriction to the patient while ensuring adequate safety.

Emergency for the purposes of restraint: Instance in which there is an imminent risk of an individual harming himself or herself or others, including staff; when non-physical interventions are not viable; and safety issues require an immediate physical response (JCAHO, 2000).

False imprisonment: Restraining a person from freedom of movement against his will. Restraint without legal justification. False imprisonment is considered under civil law and does not require violent abduction. Its equivalent in criminal law would be "kidnapping". The threat of confinement of a decisional patient, combined with an apparent ability to accomplish the threat, and some limitation of movement is sufficient to uphold a charge of false imprisonment (Miller, 2001).

Policies/assumptions

Prehospital providers are to take all reasonable precautions for the safety of both themselves and their patients in the process of providing patient care at all times. The use of restraint and seclusion poses an inherent risk to the physical safety and psychological well-being of the individual and staff.

Therefore, restraint and seclusion shall be used only in *emergency* situations with adequate, appropriate clinical justification based on the assessed needs of the patient in the immediate care environment (JCAHO, 2000). Restraints may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself/herself or physical abuse to others. In no event shall restraint be used for purposes of coercion, discipline, convenience, or retaliation by EMS personnel (JCAHO, 2000).

Every effort shall be made to avoid the use of physical restraint by using alternative interventions unless safety issues demand an immediate physical response. If alternative methods fail, physical restraint may be necessary to maintain safety and will be implemented in a manner that preserves the rights and dignity of the patient.

The System affirms that EMS procedures are to be safely and appropriately implemented by qualified EMS personnel. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be used.

The type of restraint should be individualized to use the least restrictive method that protects the patient and EMS personnel from harm.

Indications for restraint

"Restraints may be used in response to emergent, dangerous behavior; addictive disorders; as an adjunct to planned care; as a component of an approved protocol, or in some cases, as part of standard practice" (JCAHO, TX.47).

Examples in EMS may include patients who are, or may become combative, agitated, uncooperative, and pose an imminent risk of injury to themselves or others due to a medical or behavioral health disability.

- Those who have been intubated using DAI and are attempting to remove the ET tube.
- Safe and controlled access for medical procedures when involuntary patient-interference or resistance is **reasonably anticipated**. Examples: patients who are not combative, but are confused, and may withdraw or strike out when being stuck with a needle.
- Anticipation of improved patient condition producing combativeness/ resistance:
    - Unconscious hypoglycemic patient who may arouse combative when dextrose is given;
    - Cardiac arrest patient with spontaneous return of circulation may attempt to extubate themselves without deflating the cuff;
    - Narcotic overdose patients may become combative when reversed with naloxone.

- Evaluation and treatment of combative persons when illness or trauma is suspected to be the cause of combativeness.
- For the purpose of facilitating assessment, stabilization, and/or treatment of nondecisional patient who are refusing treatment and/or transportation.

No patient shall be restrained to prevent him or her from leaving the ambulance unless the patient is a potential threat to self or others.

Clinical criteria that must be met

The patient must be exhibiting behavior that is judged as

- posing a risk of injury to self, others, or property. This may include being directed by appropriate authorities to transport a person based on a mental health hold or one in police custody; or
- seriously compromising the effectiveness of a procedure/intervention through self-removal of therapeutic devices.

Associated factors that may be present

- Impaired memory
- Increased motor activity (restlessness, plucking, picking)
- Disorientation to person, place or time
- Impaired attention and concentration
- Inability to follow directions

These guidelines DO NOT apply to the following:

- Standard practices that include limitation of mobility or temporary immobilization related to medical, diagnostic, or invasive procedures and the related post-procedure care, i.e. spine immobilization, use of IV arm boards, protection of treatment sites, or routine securing of patients to ambulance stretchers or patient conveyance devices for safety during transport. The use of restraining devices may or may not be described in the practice descriptions for these skills.
- Therapeutic holding or comforting of children.
- Forensic and correction restrictions used for security purposes.
- Protective equipment such as helmets.

Medicolegal issues

EMS personnel must be aware of the laws related to an individual's rights, the processes for involuntarily restraining or holding patients with mental health disorders, an individual's right to refuse treatment, and other related laws. In the United States, a person has the right to come to what others would consider an "unreasonable" decision as long as that person can make the decision in a "reasoned" manner...meaning they are capable of reasoning, or are "competent" to make a decision.

Foreseeable risks

"Application of restraints has the potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of an individual's rights, and even death" (JCAHO, TX - 47). Other complications include skin chaffing, pressure ulcers, bone fractures, psychological distress, increased agitation, depression, humiliation, fear and anger.

Overstepping the boundaries of restraint may be perceived as **battery, assault, or false imprisonment**. It could even lead to serious allegations of civil rights violations (NAEMSP, 2002).

False imprisonment requires that the person be aware of the restraint and requires intent on the part of the actor (EMS personnel) to *unjustifiably* remove a person's liberty.

"**Doctrine of Necessity**" There are three elements to this defense: EMS personnel must act under a reasonable belief that:

- there is a danger of imminent harm to the patient or others,
- the confinement last no longer than necessary to get the patient the necessary treatment and,
- the least restrictive measures of preventing harm are used. (Eilers v. Coy, 582 F. Supp. 1093 D. Minn. 1984).

If these elements are all satisfied, there should be no liability for false imprisonment.

Whenever possible, personnel of the same gender should accompany a restrained person during treatment and transportation. This is of particular importance if pharmacologic agents are used for chemical restraint (NAEMSP, 2002).

Sometimes, the failure to restrain can constitute negligence (Morrison v. Commonwealth, 1992 WL 111797 (Pa. Cmwlth.) Slip. Op. #2232 C.D. 1991)(cert, granted for evidentiary matters).

Given the urgent medical necessity of applying restraints to protect a combative patient, informed consent from a combative and/or non-decisional patient may be waived.

PROCEDURE

Scene size up; ensure scene safety: Protect yourself! There is no legal duty to risk injury in order to provide patient care.

- If an individual is known to be violent, assure that law enforcement has secured the scene before you enter.
- Survey the environment for items that could be used as projectiles or weapons. If the patient appears aggressive, hostile, violent and/or homicidal, move out of range and call for police assistance and appropriate EMS backup.
- Remain at a safe distance (at least one leg length) from the patient while conducting the scene size-up.

- If the patient has the potential for violent behavior, attempt to keep furniture between you and them. Position yourself between the patient and the door. **Always maintain a means of escape**. Whenever possible, avoid confronting hostile patients in a kitchen as they are filled with potential weapons.
- If there are two EMS personnel, stand apart from each other at equal distances from the patient. Do not allow a single EMT to remain with the patient.
- Anticipate the potential for exposure to blood or body fluids. Wear appropriate BSI.

Patient assessment

Perform an assessment to determine any clinically evident immediate life -threats. Treat to the extent patient permits prior to applying restraints.

Assess affect, **b**ehavior, and **c**ognition (thought processes) and the risk of harm. The display of any of the following behaviors with the intent or possible result of harming self, others, or property may require medical immobilization/restraint:

- Confusion or altered mental status such that the patient is unable/ unwilling to follow commands related to their safety and/or well being. Are they thrashing about with a possible spine injury? Experiencing hallucinations or hearing voices suggesting self-destructive behavior?
- **Dangerous or potentially violent behaviors:** Is the patient pacing or agitated, demonstrating threatening mannerisms (clenched fists/tense muscles), brandishing a weapon, shouting or being verbally abusive? Is the patient combative, striking out, overturning furniture, punching or kicking inanimate objects, biting or spitting? Is he or she protecting physical boundaries?
- Are they in need of resuscitative treatment but are non-decisional and refusing care?

Assess for a medical cause of the patient's behavior: Hypoxia, substance abuse/overdose/reaction; alcohol/ chemical intoxication, cardiovascular disorders, neurologic disease (stroke, seizure, brain trauma, intracerebral bleed, tumor); metabolic disorders (hypoglycemia, hyperglycemia, acidosis, electrolyte imbalance, liver or kidney disease), hyperthermia, and infectious or degenerative diseases.

Oxygen, dextrose and naloxone should be used to treat underlying conditions when appropriate.

Restraint should not be the only intervention for acute confusion which may be a significant symptom of underlying pathology.

Note: A detailed physical exam may be difficult to impossible to conduct in a patient with a behavioral emergency. You may not be able to proceed beyond the initial assessment.

An assessment to determine clinical justification for restraint must occur prior to the initiation of restraint. This assessment includes a determination:

- as to whether the patient is at risk of harm to him/ herself or others;
- of whether alternative interventions could be used to maintain safety of patient and others;
- that less restrictive measures (other than restraint) were ineffective in preventing harm or potential harm to the patient or others.

Types of restraint

Verbal de-escalation
Verbal intervention sometimes diffuses the situation, can prevent further escalation, and may avoid the need for further restraint tactics (NAEMSP, 2002).

- Attempt neutral language to verbally deescalate inappropriate/potentially harmful behavior
- Use active listening with support for the patient's feelings. Verbalize the behaviors the patient is exhibiting. Attempt to help the patient recognize that these behaviors are threatening.
- Avoid direct eye contact and encroachment upon the patient's personal space as this may provoke stress and anxiety (NAEMSP, 2002)
- Provide gentle reassurance
- Attempt to gain the patient's cooperation
- Reorient them; send clear, simple messages
- Set limits to out-of-control behavior
- Allow choices wherever possible
- The conversation must be honest and straightforward with a friendly tone. Avoid phrases or words that could be perceived as demeaning or trigger aggressive behavior. Avoid using phases that imply a threat, "Lay still or we will be forced to tie you down" etc. Instead, use the terms, "safe", "secure" and "comfortable" as often as possible. "For your safety, I'm going to secure your arms and legs".
- Use a non-confrontational approach. Do not argue with a violent patient. Verbal communication should cease if they become more threatening.
- Decrease environmental stimuli as much as possible, i.e., noise, number of people present etc.
- Provide appropriate pain control
- Conceal therapeutic devices as much as possible (i.e., cover IVs/tubing in children or those with hallucinations)
- Provide diversion through conversation during transport

Physical restraint

If it becomes necessary to physically prevent a patient from aggravating their existing injuries or causing imminent harm to themselves or others, they must be restrained using the least-restrictive, safe and effective means.

Only **reasonable force** may be used when applying physical control. Use only the force equal to, or minimally greater than, the amount of force being exerted by the resisting patient. Excessive force may be a cause for liability even if the patient needs restraining. If not in imminent danger, explain the options of physical restraint before applying force. Offer the patient one final opportunity to cooperate and tell him/her that he/she will be assisted in maintaining self-control by restraint.

Chemical restraint

Defined as the addition of specific pharmacological agents to decrease agitation and increase the cooperation of patients who require medical care and transportation. The goal of chemical restraint is to subdue excessive agitation and struggling against physical restraints (NAEMSP, 2002).

Continued patient struggling before or after restraint application can lead to hypoxia, positional asphyxia, aspiration, severe acidosis, hyperkalemia, rhabdomyolysis, hyperthermia, fatal dysrhythmia and sudden cardiac arrest. The agent administered should change the patient's behavior without reaching the point of amnesia or altering their level of consciousness. Administer **VERSED** IM or IVP per SOP to sedate the patient.

Procedure for selecting and applying physical restraint

Physician authorization: Restraint use must be ordered by either an on-line medical control physician or via standing medical orders approved by the EMS MD through this policy or SOP. If a patient poses an immediate risk of injury to themselves or others, emergency restraint application is approved by EMS protocol. Apply restraints first and obtain the on-line physician's confirmation as soon as possible thereafter. When an emergency physician is not immediately available to authorize the use of restraint, an ECRN may make the determination and notify the physician immediately thereafter.

Selection of device

The choice of restraint is determined by the patient's assessed needs. Restraints must be reasonable in type and amount. The goal is to restrict movement, not to injure. The least restrictive device that will protect the patient and rescuers should be used, applying only the force necessary for the safety of EMS personnel and the patient.

Types of restraints
(listed from least to greatest restriction)

- Spine board and stretcher straps
- **Soft restraints:** Roller gauze (Kerlix or Kling made into wristlets, sheets, blankets or chest Posey): Usually applied to keep a confused patient from removing a device such as an IV or ET tube or moving on the stretcher in a harmful manner.
- **Hard restraints:** May include velcro limb restraints, plastic ties, and leathers.

  Leather restraints may be used if they are non-locking and cleanable to OSHA standards of disinfection for blood and body secretions.
- **Forensic restraints**, such as handcuffs, are generally not acceptable for EMS use (NAEMSP, 2002). Restraints such as handcuffs or flex-cuffs should only be applied by law enforcement officers. The arresting officer is responsible for the safekeeping of all prisoners in handcuffs.

  The officer may accompany the prisoner in the ambulance or may follow immediately behind the ambulance in a police vehicle. Officers must give handcuff keys to EMS personnel if they do not accompany the patient.

  A patient who is handcuffed behind their back must be transported in a seated position or on their side. They may not be transported supine or prone. EMS personnel should not transport a patient who has both hands handcuffed in front of their torso. This position allows the patient to use their hands as a weapon.

Any restraint used must allow for rapid removal if the patient vomits, has a seizure, develops respiratory distress or cardiac arrest.

It is not appropriate for EMS personnel to use weapons as adjuncts in the restraint of a patient (NAEMSP, 2002).

In rare situations, it may be necessary for law enforcement to apply restraint techniques to patients that are not sanctioned by EMS policies (pepper spray, mace, defensive spray, stun guns, air tasers, stun batons, and telescoping steel batons).

The use of these agents should be avoided since they may exacerbate the patient's agitation and increase the risk of injury or death. In these cases, a law enforcement officer must accompany the patient during transportation, and EMS personnel must assure that the patient is medically assessed, treated, and reassessed based upon the restraint protocol (NAEMSP, 2002).

General guidelines regarding applications of restraints

- Use the proper size product for a given patient
- Use the correct product to prevent patient injury to himself or others
- Secure the straps of a restrictive device to a spine board or stretcher parts that move with the patient when the stretcher is adjusted
- Secure the straps of restrictive devices out of reach of the patient
- Use a quick releasing tie to secure non-velcro straps. A quick releasing tie will not tighten when the patient pulls against the strap.
- Infection control guidelines will be followed for appropriate cleaning of reusable devices, or appropriate disposal for single-use items, when no longer needed by a given patient.
- Any form of restraint must be "informed" restraint. As early as feasible in the restraint process, the patient must be made aware of the rationale for restraint and the behavior criteria that is expected of them at the hospital for its discontinuation.

Application of soft restraints

Patient preparation prior to application of restraints for medical necessity in a non-violent patient. EMS personnel shall

- remove all jewelry from the area(s) to be restrained.
- expose the area (remove clothing if possible) to assess SMV of extremities.
- provide as much privacy as possible.
- tie a slip knot in the center of a piece of Kerlix or Kling and place over the patient's hand.
- pull snugly to the wrist and tie to the stretcher.
- repeat for the other hand as necessary.

Application of four point restraints

- If the patient is uncooperative at the scene, all issues of cooperation and restraint should be resolved prior to beginning transport.
- A minimum of five people should ideally be present to safely apply physical restraint to a violent patient. This allows control of the head and each limb (NAEMSP, 2002). A team leader should direct the process. Plan your approach and act quickly. Include a back-up plan should the initial action fail.
- Gather the restraints, making sure that there are 2 wrist and 2 leg restraints.
- At least two rescuers should rapidly move towards the patient from different directions and position themselves close to and slightly behind the patient. The patient cannot focus on both at once. Another person should continue talking with the patient.
- The two persons near the patient should position their inside legs in front of the patient's legs and force the patient forward into a prone position. Gaining initial control of the patient in the prone position limits the patient's visual awareness of the environment and decreases the range of motion of the extremities.
- Assign one person to control each limb by grasping at clothing and large joints, such as the knees, ankles, or elbows.
- As soon as the team has control of the patient's movements, move the patient into supine or side-lying position, preferably on a backboard. This position allows for continuous assessment of the airway and ventilations. A side-lying position is especially desired if there is a potential for vomiting and aspiration.
- Adjust the stretcher to its lowest position to improve stability. Move the patient to the stretcher. Patients should never be restrained in a prone position with hands and feet behind the back (hobbled or "hog-tied"). Patients should never be transported while "sandwiched" between backboards or mattresses (NAEMSP, 2002).
- Restrain one arm at the patient's side and the other above the patient's head.
- Restrain one ankle at a time to the back board or the metal T-braces of the stretcher under the mattress and tie the ankle restraints together.
- Place stretcher straps across the bony prominences, over the shoulders and criss-crossed over the chest, pelvis, and legs but don't cinch too tightly. Tethering the thighs, just above the knees, often prevents kicking. Restraint techniques should never constrict the neck, chest, abdomen, or compromise the airway (NAEMSP, 2002).
- Remove shoes and socks once restrained. Assess skin for soft tissue injury, limb color, temperature, and distal pulses after placing restraints.
- If a change in position is necessary, reposition one limb at a time.
- Once restrained, the patient should never be left unattended.

Time limits/terminating restraint: It is understood that once restraints are applied, they will remain in place until the patient is safely transported to a medical facility and responsibility for care is transferred to hospital personnel unless the patient is reassessed to be fully decisional and cooperative and EMS personnel receive an order from on-line medical control to discontinue restraint.

Protection/preservation of patient rights, dignity, and well-being during restraint:

Nothing should be placed over the face, head or neck of a patient. A surgical or oxygen mask may be placed over the patient's face to discourage biting and spitting. An appropriately fitted cervical collar may limit the mobility of the patient's neck and decrease their range of motion in attempting to bite. **Do not** place anything in the pt's mouth.

Modesty, visibility to others, and comfortable body temperature must be maintained during restraint use.

Monitoring during restraint use

The method of restraint must allow for continuous patient assessment and for medical interventions during transport. If a patient vomits, becomes unstable or develops cardiopulmonary arrest, prompt treatment is needed (NAEMSP, 2002). Patients shall be monitored by continuous in-person observation, direct interaction, and examination throughout the prehospital phase of care.

Monitoring is done to assure

- the physical and emotional well-being of the patient;
- that the patient's rights, dignity and safety are maintained;
- whether less restrictive methods of restraint are possible; and
- whether the restraint has been appropriately applied, removed, or reapplied.

Attempt to meet the patient's on-going physical/emotional needs.

Take and record vital signs (P and RR), airway patency, and neurovascular status of all restrained extremities no less often than once every **15 minutes** while the patient is restrained. Periodically reassess the patient's ability to cooperate, but DO NOT release the restraints.

Risks associated with special needs populations

Pediatric patients shall have a responsible adult with them at all times while restrained.

- Attempt to prevent a child from seeing things that will increase their distress
- Keep explanations brief and simple using terms and phrases that are appropriate for the child's developmental level
- Remain calm and speak softly and slowly
- Allow the child to cry and express their emotions/fears

Elderly patients may present with physical problems that manifest as behavioral emergencies, i.e., organic brain syndrome, chronic illness, diminished eye sight and hearing, and depression which of often mistaken for dementia.

- Assess their ability to communicate
- Provide continued reassurance
- Compensate for their loss of sight or hearing with reassuring physical contact
- Treat them with respect using their name, not a patronizing term
- Take time to describe what you are going to do

Foreign language speaking patients

Whenever an explanation is required to be given a patient who does not understand English, such explanation shall be provided to him/her in a language which he/she understands through an interpreter on the scene or as soon as possible after arrival at the hospital. It is understood that prehospital resources for interpreters are very limited and patients may need to be restrained for their own protection prior to an explanation that they understand.

Whenever restraint is imposed upon any patient whose primary mode of communication is **sign language**, the patient shall be permitted to have his hands free from restraint for brief periods, except when freedom may result in physical harm to the patient or others.

Reportable conditions

Should death occur while a patient is in restraint, the event will be reported to the EMS Medical Director within two hours so he can investigate and report to the appropriate regulatory bodies.

Documentation

Whenever restraints are applied, the run sheet must reflect the following:

- Clinical justification for use. Describe the scene and patient behaviors in exact terms leading to the conclusion that the patient would have harmed themselves or others without interjecting opinions or unprofessional comments.
- Failure of non-physical methods of restraint (if conscious), failure of verbal attempts to convince the nondecisional patient to cooperate and/or consent to treatment.
- That the reasons for restraint were explained to the patient.
- Whether the restraints were ordered by a physician or applied per SOP; the physician's name who authorized the restraints.
- Rationale for the type of intervention selected.
- The type of restraint used, the limbs restrained, time of application, responders who assisted in the restraint process (including law enforcement personnel and bystanders), and the measures taken to protect the rights, dignity and well-being of the patient including monitoring, reassessment, and attention to patient needs.
- The q. 15 minute reassessments of VS, limb SMV, and the patient's behavior and/or mental status after restraint.
- Care during transport.
- Any injuries sustained by the individual or staff and the treatment provided to the patient for these injuries (NAEMSP, 2002).

- If a patient with a primary behavioral health emergency (psychiatric focus) is restrained for transport against their will, **complete a petition form** and provide it to the ED staff for additional documentation. Examples include neuroses (a restricted ability to achieve optimal functioning in social life) or psychoses (maladaptive behavior that involves major distortions of realty.) Clinical responses include depression, withdrawal, catatonic state, violence, suicidal thoughts/acts, paranoia, phobias, anxiety disorders including panic attacks, conversion hysterias, disorientation or disorganization with psychotic behavior, delusions, or hallucinations as seen in schizophrenia.

Competency of EMS personnel

Restraint use competency must be demonstrated at least bi-annually by all direct EMS patient care providers through an EMS agency-conducted in-service program. Skill proficiency must be documented using forms created by the System's education committee and submitted to the Resource Hospital.

EMS personnel must receive ongoing training in and demonstrate an understanding of the following:

- Principles of assessment for clinical justification for use of restraint
- The underlying causes of threatening behaviors

- How their own behaviors can affect the behaviors of the individuals they serve
- Definitions and exclusions relative to restraint use
- Alternatives interventions to use of restraints
- Self-protection techniques
- Types of restraints; differences between least to most restrictive type of devices
- Regulatory requirements
- Assessment and care of the patient in restraints
- Protection of patient's rights while in restraint
- Documentation requirements; and
- Recognizing signs of physical distress in individuals who are being held, restrained, or secluded (JCAHO, 2000)

Personnel who are authorized to physically apply restraint must receive ongoing training in and demonstrate competence in the safe use of restraint, including

- physical holding techniques,
- take down procedures, and
- the application and removal of mechanical restraints.

Evidence of competency may be randomly audited by the EMS System.

Quality improvement monitoring

The measurement and assessment process (CQI) related to restraint seeks to understand why it is used and incorporates this understanding into the System's plans and priorities to evaluate and reduce the risks associated with restraint use through an initial baseline assessment and targeted monitoring.

The patient care reports will be evaluated for all patients who were placed in physical restraints or who received chemical restraints for appropriate and complete documentation.

Data from all episodes are analyzed to identify opportunities for improvement.

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