Restraints

SCOPE:
Poudre Valley Hospital EMS and represented Northern Colorado services [See page 1]

PURPOSE:
To define the assessment and treatment using restraints

PROCEDURES AND GUIDELINES:
A. EMT/Paramedics may restrain a person who presents a danger to self or others, but physician or law enforcement support should be engaged as soon as possible in any decision to restrain/transport a patient against their will, as well as an authorizing party for a mental health hold (MHH).
B. A person who appears to lack decision making capacity (DMC) and may be an imminent danger to self or others can be restrained.
C. Anticipation that an incapacitated person may attempt to remove or prevent needed treatments such as IVs, intubation, splinting, etc. or an incapacitated person who has threatened to attempt suicide or assault. Restraint in anticipation is legitimate because of the danger to the provider in the confined ambulance space and/or danger to the patient trying to elope.
D. Patients should be restrained in a supine position using two or four point approved restraints. Approved restraints are:
   a. Soft Velcro limb restraints
   b. Standard “hard” restraints
   c. Cot mounted Velcro wrist restraints
E. Kerlix, tape, zip ties, handcuffs and other improvised devices are not approved.
F. A “spit sock hood” or oxygen mask may be used on patients who are spitting. If an oxygen mask is used it must have appropriate oxygen flowing.
G. Pillowcases, tape or other improvised devices are not approved.
H. Patients are never to be restrained in prone position due to the potential for positional asphyxia.
I. Request police assistance to remove handcuffs, hobbles and place patient in medical restraints. If police mandate handcuff use they must accompany the patient.
J. Always ensure that the patient has been searched for weapons.
K. All restrained persons require continuous monitoring of ABCs and distal circulation. Never leave a restrained patient alone.
L. Record CMS of limbs before applying restraints; recheck every 15 minutes and upon arrival at hospital.
M. Consider chemical restraint.
N. Patient on a mental health hold transferred by ambulance require a minimum two point physical restraints and/or chemical restraint.
Protocol: Physical Restraint

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<th>Protocol</th>
<th>EMT- B</th>
<th>EMT - IV</th>
<th>EMT-I</th>
<th>EMT-P</th>
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<tr>
<td>Initial restraint</td>
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<td>Mental health hold (MHH) or alcohol hold to be immediately obtained from medical control if not already authorized by law enforcement</td>
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<td>Inter-facility transfer of patient on MHH</td>
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ADDITIONAL CONSIDERATIONS:

A. In the field, law enforcement involvement in critical, particularly when involuntary consent and subsequent restraint is related to suicidal or homicidal ideation. In patients who are actively a threat to self or others, it is preferable that law enforcement place the patient on a hold. If the involuntary hold is based on alcohol intoxication, law enforcement should be able to place the patient on a hold. In cases where involuntary consent is based on medical criteria (dementia, head injury, major illness impairing thought process), contact the base physician.

B. Documentation should include the logical progression of events that led to the patient being restrained to include:
   1. The reason for call and patient actions to include objective descriptions of the patient’s mental status/attitude and the actions that necessitated restraints i.e. active or anticipated safety issues (threat to self or others). Any statements by the patient that may be pertinent should be included.
   2. The process you followed to gain cooperation.
   3. Discussions with police, licensed social workers, or physician authorizing the use of medical restraints.
   4. Information given to the patient regarding need for care and transport
   5. The method of restraint

REFERENCES: