"Tied Down or Safely Secured..?"

Pitfalls and Myths of Patient Restraint

Pulse Check

October 2, 2010

Objectives

- Identify patients requiring physical restraint
- Discuss legal rights of patients and responsibilities of EMS providers
- Review regional protocols for “Physical Restraint”
- Outline “best practice” criteria and documentation needs for restraining patients
- Describe techniques used for proper physical restraint with and with out devices

Background

- NAEMT indicates that over 5% of all patients are violent
- Majority of patients requiring involuntary treatment and restraint are managed solely by EMS
- EMS historically directed to “call for police” in event of combative patient
- Protocol on Physical / Chemical restraint are relatively new
- Very few agencies provide training

What is Patient Restraint?

"The use of a physical, chemical, or mechanical device to involuntarily restrain the movement of the whole or a portion of a patient's body for the reason of controlling physical activities to protect the patient or others from injury."

Patients Requiring Restraint (4)

1. Patients where medical access is necessary and resistance or violence can be *reasonably* anticipated .
2. Anticipation of improved patient condition producing combativeness.
3. Evaluation or treatment of a combative person when illness or injury is suspected to be the cause of the combativeness
4. Involuntary treatment of person incompetent to refuse treatment.

Medicolegal Aspects

- EMS responsibility to protect self, patient, and third parties
- Competence is the ability to: [3]
  - Communicate a choice.
  - Understand relevant information.
  - Appreciate the situation and its consequences.
  - Weigh the risks and benefits of options, and rationally process this information
- The need to restrain should be entirely based on the *patient's needs*

Lawsuit: Woman Claims Ambulance Company Caused Mother to Suffocate

- "When Menter Ambulance workers arrived, they strapped Caniff face down on the gurney"
- "On the way to the hospital, she suffered cardiac arrest in the ambulance"

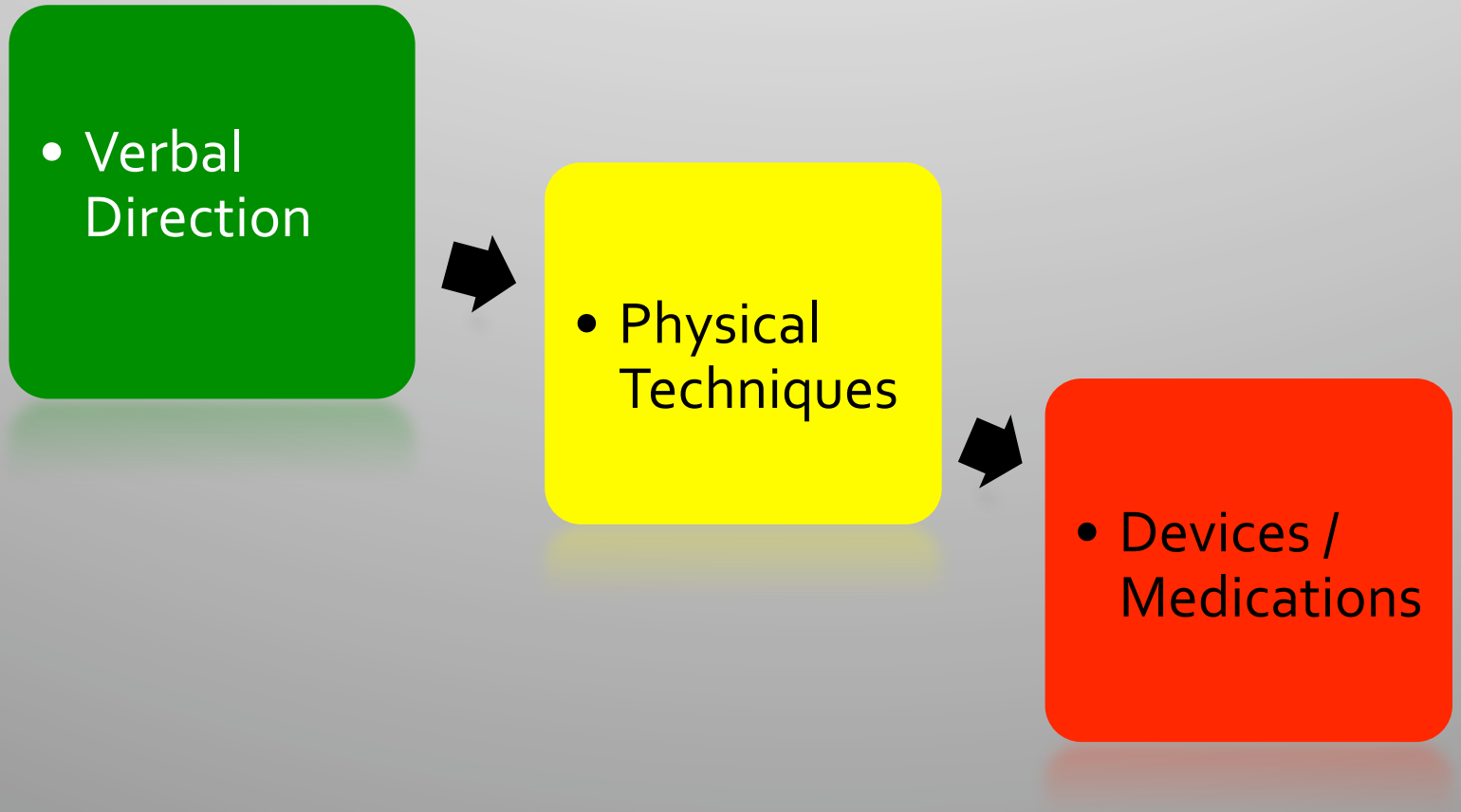
- "Paramedics placed Caniff on the gurney in violation of state protocols for EMTs."
- "Over the past four years, 19 people in Onondaga County have died from positional asphyxia"

Patient May Not Refuse If:

- Confused
- Intoxicated
- A Minor
- Hostile or Threatening
- Suicidal
- Developmentally or Psychologically disabled

With signs and/or symptoms of injury or illness

Means of Restraint



Verbal De-escalation

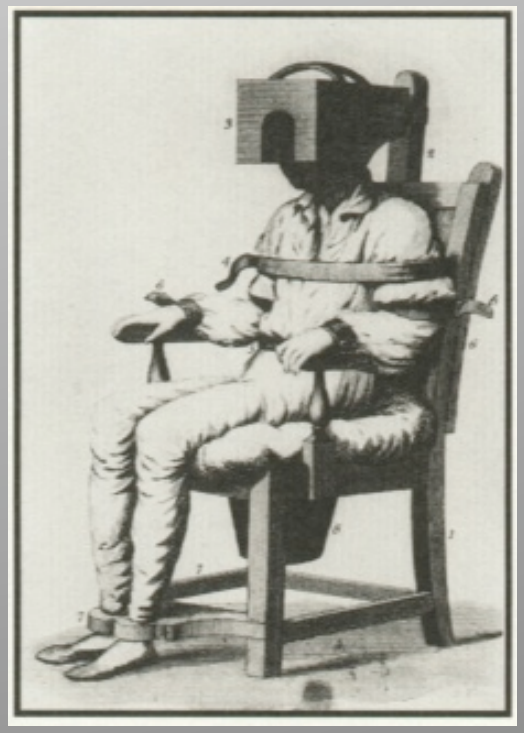
- Verbal commands considered the “least restrictive “ means of control
- Validate the person’s feelings and help them understand their behavior is being viewed as threatening
- Be empathetic and attempt to help find a solution
- Openly communicate what is going to happen – no threats
- Be aware that most verbal commands are unsuccessful on those under the influence of mind alerting substances

Gaining Trust and Compliance

- Appearance / Presence
- Greet people
- Identify yourself and agency
- Ask to come in / turn off TV
- Tell people why are there
- Explain options and reasons

Other Concerns

- A violent patient is still a patient
- View from the family and/or public
- Liability
- Injuries
  - Physical
  - Psychological
- Documentation

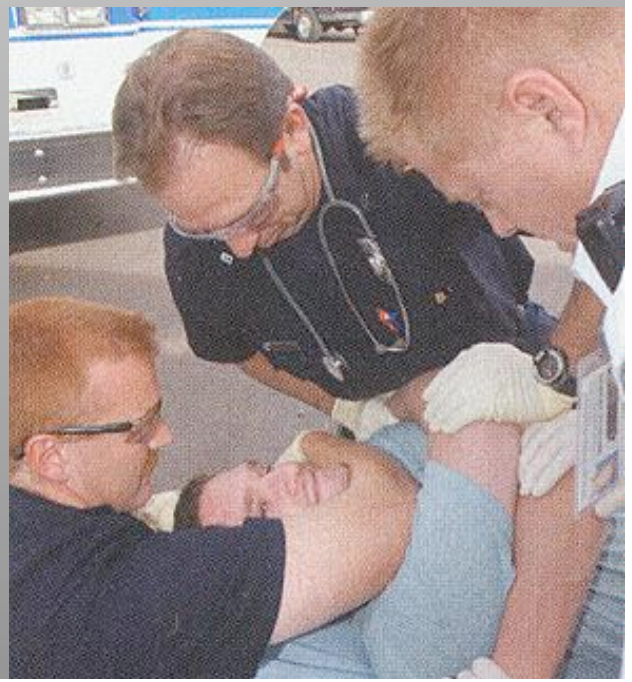


Self Defense

- Legal term where the law allows a person to use physical force against another person
  - Physical harm
  - Prevent a crime
  - When assisting the police
- Must have *"reasonable fear"* that physical safety is threatened
  - Or a 3rd party
- Force *only necessary* to protect self and ESCAPE
- Does not allow for retaliation

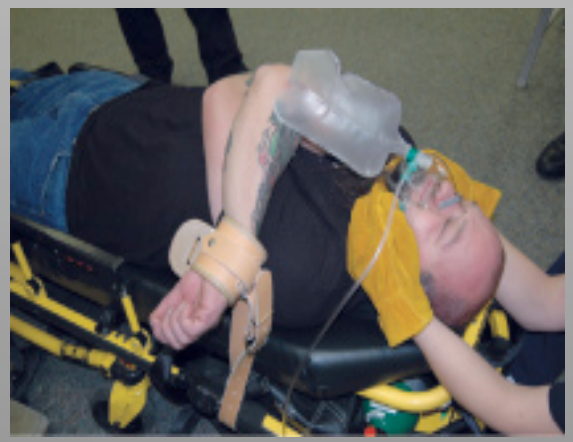
Means of Physical Restraint

- Simple
- Joint Locks
- Muscle Control and Confusion
- Pressure Point Control
- Devices



Joint Locks

- Head
  - Simple as hand on forehead
  - “Opening Airway”
- Arm / Elbow
  - Supinate
  - Abduction



- Hips
  - Reduces lower extremity movement and use of abdominal muscles
- Knees
  - Pressure ABOVE knee
  - Reduce chance of getting kicked

Muscle Confusion

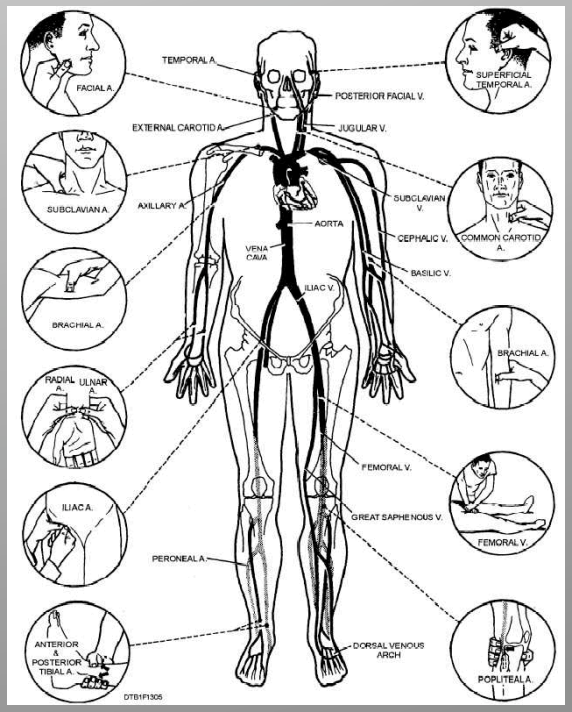
- Large muscle groups working together is your biggest enemy
- Separation of these muscles through strategic positioning reduces their strength greatly
  - Arms high and low
  - Supinate Arm
  - Legs slightly apart

Pressure Point Control

- Designed to create pain
- Nerve pressure point steps:
  - Stabilize target
  - Pressure / counter pressure
  - Apply pressure using digital tip
  - Loud repetitive commands
  - Release pressure once compliant

Pressure Point Control

- Mandibular Angle
  - Base of ear between mandible and mastoid
  - Most reliable and effective pressure point
- Jugular Notch
  - Hollow area just above sternum
  - Pain / distraction
- Hypoglossal
  - About 1 inch forward of jaw angle



Restraint Devices

- Seat belts – not required to document as a "restraint"
- Handcuffs
  - Impeded examination / treatment
  - Do not allow for "quick release"
- Leather
  - Bulky and slow to apply
  - Become brittle over time

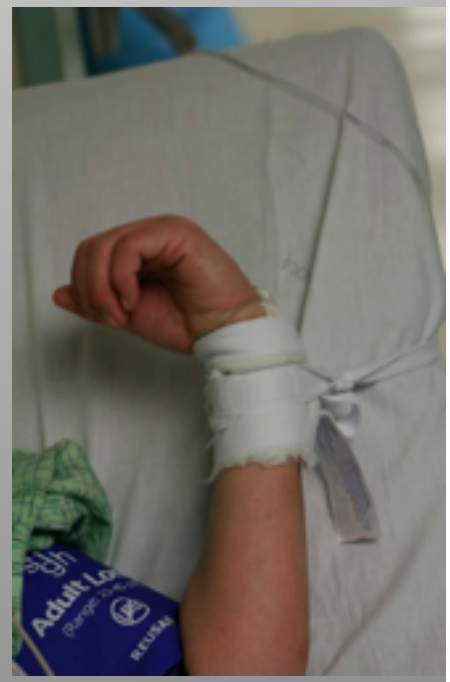
- Soft
  - Allow for most comfortable / humane restraint
  - Easy to use / Disposable

Restraint Devices

- Cravats
  - Loosen as knots are being tied
  - Short ends
- Gauze
  - Stretches
  - Needs to be twisted to tighten
- Soft
  - Most “comfortable”
  - Humane
  - Easy to use / Disposable

Procedures

- Patient must already be on ground.
- Ensure personnel are clear on specific tasks
- Explain procedure to family / bystanders
- Secure in order:
  - Head
  - Arms
  - Legs
  - Hips
- Backboard / Apply restraint device



General: Patient Restraint

EMT

- Call for Law Enforcement
- ABC and vital signs
- Airway management and appropriate oxygen therapy, if tolerated
- Check blood glucose level, if equipped. If level is abnormal refer to Diabetic Protocol

EMT STOP

INTERMEDIATE

- Vascular access, with bloods drawn if possible and safe for provider

INTERMEDIATE STOP

CCT

PARAMEDIC

- No standing orders

CCT and PARAMEDIC STOP

PHYSICIAN OPTIONS

- Patient less than 70: Haloperidol (Haldol) 5mg and Midazolam (Versed) 2mg IM or IV
- Patient greater than 70: Haloperidol (Haldol) 5mg IV or IM
- Midazolam (Versed) 2 – 5 mg IV, IM or atomized intranasal
- Additional Haloperidol (Haldol)

Key Points/Considerations

- For patients at risk of causing physical harm to emergency responders, the public and/or themselves
- Patient must NOT be transported in a face-down position
- If the patient is in police custody and/or has handcuffs on, a police officer must accompany the patient in the ambulance to the hospital
- EMS personnel may only apply "soft restraints" such as towels, cravats or commercially available soft medical restraints

Chemicals

- **Haldol**
  - Antipsychotic
  - Tranquilizer
- Pharmacokinetics
  - Onset
    - 20 – 30 min
  - Peak effects
    - 60 - 90 min
  - Half-life
    - 13-40 hours

- **Versed**
  - Short acting Benzo
- Pharmacokinetics
  - Onset
    - 5 - 15 min
  - Peak effects
    - 20 – 30 min
  - Half-life
    - 2-3 hours

Chemicals

- **Haldol**
- Precautions
  - May impair mental & physical abilities
  - Orthostatic hypotension if other sedatives are used in conjunction
  - Dystonic reactions may occur following administration
    - 3-10% of patients

- **Versed**
- Precautions
  - Emergency resuscitation equipment must be present
  - Vitals must be constantly monitored
  - Respiratory depression/ arrest is possible

Chemicals

- **Haldol**
- Side effects
  - Hyperthermia
  - Restlessness
  - Drowsiness
  - Seizures
  - Respiratory depression
  - Hypotension
  - Tachycardia

- **Versed**
- Side effects
  - Laryngospasm
  - Bronchospasm
  - Dyspnea
  - Respiratory arrest
  - Premature ventricular contractions

Special Situations

- Seizures
  - If a patient begins to seize, cut restraints immediately
  - Contractions may be powerful enough to cause fractures
  - Case law present holding “restrainer” responsible for the injuries
- Pregnancy
  - Be aware of *supine hypotensive syndrome* caused by compression of inferior vena cava.
- Children
  - No protocol for “pediatric restraint”

Special Situations

- C-Spine and the combative patient
  - No research published to date
  - No known protocols
  - Attempt verbal cues:
    - If you keep moving your head you may become paralyzed or even die."
- Patients posing significant threat
  - Severe developmentally disabled patients
  - Patients on PCP
  - Methamphetamine use

Documentation

- That an EMERGENCY existed & the need for treatment/transport was evident
- Lack of the patient's competence (or ability) to refuse treatment
- Less restrictive methods of restraint attempted *including* verbal requests
- Assistance from law enforcement officials requested
- Restraint was for the patient’s BENEFIT and SAFETY.

Documentation

- Reasons for restraint were explained to the patient / family.
- The type(s) of restraint used
- Any injuries that occurred during or after restraint.
- Circulation checks every 15 (or fewer) minutes.

Closing

- Would failure to restrain and/or treat the patient result in imminent harm to the patient or other persons?
- Once restrained – Always restrained
- Never hesitate to back out and wait for adequate personnel to arrive
- Avoid terms like “tie you down” or “restraint”. Try using “safely secure” instead
- Document and request CQI review of physical / chemical restrained patient

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Questions

Shawn@escapeprogram.net