CARE AND RESTRAINT OF AGITATED OR COMBATIVE PATIENTS

PURPOSE

Agitated, combative, or violent behavior has varying presentations on a spectrum from agitated but cooperative to excited delirium with a dangerous inability to understand the situation or the dangers of their behavior. This guideline is intended to define standards and techniques that may be used by the EMS practitioner for the management of agitated or combative patients.

NOTE:

- If the patient is suspected to have a mental illness or appears to be emotionally distressed, also refer to "Care of the Mentally Ill or Emotionally Distressed Person"

RESPONSE GUIDELINES

The following are response guidelines to any call which may present the practitioner with an agitated, combative, or potentially violent patient:

- Based on dispatch information, a crew may always exercise the option to stage near the scene or in quarters. If the decision is made to stage, notify the respective dispatcher of your staging location.
- The general response to all staging areas is non-emergent. Response may be upgraded if you receive information that you are cleared into the scene and the reported patient's condition warrants an emergent response.
- The responding unit should consider requesting a paramedic, if not already available, to reports of extreme agitation or combativeness for consideration of advanced monitoring capabilities and, as clinically appropriate, the use of sedation per the appropriate protocol. If the patient does not need sedation and has no other indications for advanced interventions or monitoring, that patient may be released to BLS for transport, following all applicable protocols.

SCENE SAFETY CONSIDERATIONS

- Often law enforcement will enter the scene first to assess the scene safety prior to the ambulance crew arriving. However, there may be situations whereby staging may not be prudent. This may include a situation where a psychiatric patient is reported to be unresponsive and to the judgment of the responding EMS practitioner based upon the circumstances at the time the risk of harm is low.
- Patient contact may be delayed if the practitioners believe the scene may be unsafe, based on either dispatch information or a scene size-up. EMS units should stage out of sight from any potentially hostile incident and notify their respective dispatch center of their staging location.

- If patient contact is delayed due to a potentially dangerous environment, it should be reported to their respective dispatch center and documented with both the reason and the time.
- If EMS practitioners are already on scene and the situation becomes hostile, the providers should exit the situation to a safe area, until law enforcement can establish a safe scene.
- Practitioners should apply the following techniques on every call to promote their safety and the safety of those around them:
    - Have two means of communication with the respective dispatch center at all times
    - Ensure that location changes are reported to the respective dispatch center
    - Be aware of an exit route from the scene
    - Have a plan for an alternate source of cover or concealment
    - Request that dogs and other potentially hostile animals be secured
    - Scan the scene for improvised weapons
    - Be alert to the body language of all persons on the scene

DE-ESCALATION

Practitioners are reminded that verbal statements made to the patient can help de-escalate the situation. The following are some standard approaches that should be used in all situations with distressed individuals:

- Use the phrase, “slow down” to encourage the individual to calm down. Using the phrase “calm down” can often have a paradoxical effect. For example, “could you please slow down a bit? I want to understand what you are saying and it’s hard to understand you when you are talking so fast.”
- Use empathy as much as possible. Empathetic statements let the patient know you understand what is upsetting them. Once a patient feels “heard”, there will be better rapport and more cooperation. To be empathetic:
    - Listen carefully to what the patient is saying
    - Pay particular attention to the emotion(s) he/she is experiencing
    - Communicate with the patient. For example: “I can understand how angry that makes you,” “That really is painful, isn’t it?” or “That’s a lot to deal with.”
    - Rather than confronting the delusions (e.g., “you can’t possibly be living without a heart”) or feeding into them (e.g.; “yes, we’ve seen other individuals who have had their heart stolen”), an empathetic approach will be much more effective. For example: "It sounds like your chest feels empty to you” and/or “that must really be scary.”

USE OF PHYSICAL RESTRAINT

EMS restraint protocols and interventions will differ from those of law enforcement. The goal of any restraint use by EMS is to prevent harm to self or others while being able to provide medical interventions and maintain the patient's dignity.

- It may be necessary for law enforcement to apply restraint techniques or devices to an individual which are not sanctioned for use by EMS practitioners. The individual being restrained may also need, or may develop a need for EMS assessment or care. In these cases, a law enforcement officer must remain immediately available while the EMS practitioner assesses and manages the patient based on established protocol and policy. At all times, the EMS practitioner must act as an advocate for the safety, medical monitoring, and clinical care of the patient.

- If a law enforcement-based restraint intervention (eg handcuffs, flex-cuffs, hobble restraint, etc) which are not sanctioned for use by EMS practitioners must be continued during patient care and transport by EMS, a law enforcement officer must accompany the patient during transport by ambulance; or the law enforcement-based restraint intervention should, when appropriate, be discontinued in favor of a sanctioned EMS-based restraint intervention. Patients who are in law enforcement custody or who are under arrest must always have a law enforcement officer present or immediately available during EMS transport.

- If the patient exhibits agitated, combative, or violent behavior, following de-escalation EMS practitioners should use the least restrictive restraint techniques to facilitate clinical patient assessment, medically indicated treatment, and safe transport to a hospital.

- In all circumstances, the decision to use pharmacologic management is a health care decision that must be made by the EMS practitioner. Refer to the Agitated Patient Protocol for patients where environmental modification and verbal de-escalation is not successful or not possible and/or the Excited Delirium Protocol for additional details about identifying and managing individuals displaying extreme behavior.

If physical restraint is required to protect the patient and/or practitioners from injury, the following represents the approach and techniques sanctioned for use by EMS practitioners:

- If safe and feasible, the EMS practitioner should explain to the patient and as appropriate bystanders such as family, the reasons for restraint use.
- ***Maintain constant, direct supervision of the restrained patient at all times.***
- Patients should be restrained on a backboard or gurney in a supine position. ***The patient may never be restrained in a prone (face-down) position.***

- When placing a patient into restraints:
  1. The patient's limbs should be restrained preferably using a commercial soft restraint, however in its absence a cravat or spiral gauze may be used.
  2. Place a webbed belt or strap around the patients' lower thighs, just above the knee; and upper chest, immediately underneath the armpits. Both belts should be secured tightly but the chest belt must not restrict chest expansion. Any additional belts may be used to secure the patient provided they do not restrict chest expansion.
  3. One hand is to be secured to the backboard slot above the patient's head or the head of gurney.
  4. The other hand is to be secured to the backboard slot or gurney rail at the patient's side (on the same side as the limb being restrained).

- When transitioning a handcuffed patient to a backboard:
  1. Move the patient to a backboard or gurney.
  2. Apply thigh strap above the knees.
  3. Apply soft restraints to both wrists.
  4. Remove one hand from handcuffs.
  5. Ideally, secure the right arm to the backboard/gurney above the patient's head, then secure the left arm to the backboard/gurney.
  6. Apply chest strap as high up on the chest as possible.
  7. Re-tighten all straps, check all limb restraints.
  8. Assure breathing is not compromised with strap placement.

- If necessary, the patient's ankles can be secured with commercial soft restraints, cravats, or gauze to the lower slots of the backboard or gurney frame.

MONITORING THE PATIENT DURING RESTRAINT USE

Once restraints are applied, the EMS Practitioner must:

- Regularly reassess vital signs, to include respiratory rate and quality.
- Assess restrained extremities for circulatory, motor, and sensory status distal to the restraint.
- Monitor restrained extremities for constriction, ischemia, or other signs of injury.
- Continually monitor the patient's overall medical status.
- If sedation has been used, when safe and feasible, the paramedic is expected to continuously monitor capnography and oxygen saturation at a minimum.
- **The patient may never be left alone.**

USE OF HANDCUFFS

- Neither handcuffs, flex-cuffs, nor hobble restraints are sanctioned restraint devices for EMS practitioners.
- Handcuffs or flexi-cuffs should be replaced with commercial soft restraints, gauze, or cravats if feasible.
- Handcuffing to a backboard is favored over handcuffing to a gurney to allow for patient movement should their condition deteriorate.
- If handcuffs are requested by law enforcement, a means for removal must be readily available at all times to allow rapid access to the patient for medical management.

LAW ENFORCEMENT ACCOMPANYING EMS

- If the patient is restrained using the accepted restraint guideline (above) and the EMS practitioner feels comfortable with transporting the patient, the responsible law enforcement officer may follow the ambulance to the hospital.
- If the EMS practitioner is not comfortable transporting the patient alone, the responsible law enforcement officer should be requested to ride along in the patient compartment.
- The responsible law enforcement officer may at their discretion decide to ride in the ambulance even if the EMS provider does not request it.
- If there is disagreement between the EMS practitioner and responsible law enforcement officer with regard to the proper method of safe transport in the ambulance, or the request of the officer to ride along, the EMS practitioner should contact their supervisor, as well as the appropriate law enforcement supervisor.

USE OF SPIT CONTROL DEVICES

- If the patient is spitting, it is appropriate to apply either: a nonrebreather mask with oxygen flowing if oxygen administration is necessary, a surgical mask, or a “Spit Sock” to reduce the practitioners’ biohazard exposure risk.
- The EMS practitioner must constantly monitor the patient’s airway, respiratory status, and level of consciousness while the spit control device is in place.
- The use of a spit control device should be discontinued as soon as practical.

QUALITY IMPROVEMENT

- Agencies are expected to have in place a program that allows for reviewing all uses of restraint for consistency with this guideline and best practice.
- Agencies must review all uses of sedation when given for agitation or excited delirium.
- Best practices for documentation include:
  - Steps taken to control patient prior to use of physical restraints, including the reasons restraints were needed and why less restrictive measures were unable to be utilized.
  - Baseline skin color and integrity prior to application of restraints.
  - The time restraints were applied.
  - Pertinent observations, including vital signs, and any changes in behavior.
  - Name of law enforcement agency, and if possible, name of law enforcement officer if the individual is being transported involuntarily.
  - A patient evaluation should be documented at least every 5 minutes for restrained patients.