



A. Introduction

Patient restraint is a means of modifying a patient's physical activities to protect the patient or others from injury. Restraints should only be used when less restrictive means of controlling a patient's behavior have been exhausted.

B. Indications

When facing a violent person, scene safety is our first priority. Verbal measures to control the patient's behavior should be attempted, if possible. This should include the use of family members, friends, or a law enforcement officer. The goal is to stop the person from detrimental behavior. At no time should the patient be verbally abused or humiliated. Law enforcement should be requested on a "3" signal with a reference as soon as possible. Physical restraint may be necessary under the following conditions:

1. A patient exhibiting violent behavior towards themselves or others.
2. Incapacitated patients who require emergency medical intervention as defined under FS 401.445 (**Protocol 2**).
3. A person who is in immediate danger, such as walking into the path of oncoming traffic, trying to move downed electrical wire, or moving towards the tail rotor of Air Rescue.

C. Types of Restraints

Acceptable Restraints

1. Verbal restraint - as defined in the indication section.
2. Soft-type restraint:
 - a) Must be >1" wide and non-binding.
 - b) Towels, sheets, and blankets.
 - c) Commercially available extremity restraints.
3. Manual restraint.
4. Chemical restraint such as Versed (Midazolam).

Unacceptable Restraints

1. Any restraint <1" wide.

NOTE: Handcuffs / "flexcuffs" may be left in place as long as the patient is in the custody of, and accompanied by, a law enforcement officer who can remove the restraint in case of an emergency. This action must be closely coordinated with law enforcement officers both on the scene and during transport.



D. Procedure

BLS

1. Patient Positioning:
 - a) Immobilize patients who meet spinal immobilization criteria (**Protocol 40**).
 - b) If the patient is to be restrained in the sitting position, secure restraints by tying or taping around the sidebars of the main stretcher frame. DO NOT secure to the fold-down side rails.
 - c) For patients who need to be placed supine, first place them on a backboard and secure the restraints to the board. If the patient vomits, the patient can be turned as a unit.
 - d) Extremely violent patients may be placed prone on the stretcher and the restraints secured as defined in (b) or (c) above.
2. Applying Soft Restraints:
 - a) Place the restraint around the wrist or ankle and form a bight holding the running pieces together and close to the patient.
 - b) Secure the running pieces together with tape. DO NOT tie a knot unless the device is specifically made as an extremity restraint.
 - c) If needed, additional restraints such as a rolled sheet or blanket may be used around the chest and under the armpits, over the hips, or over the legs.
 - d) After restraints are applied, assess distal circulation via capillary refill and document its presence a minimum of once after the restraints are applied and upon release at the hospital.
 - e) Continually monitor the patient's circulatory and respiratory status. Always keep scissors on hand to release restraints in the event the patient experiences any respiratory or circulatory compromise.
3. Manual Restraint
 - a) Physically restraining a patient or persons who are violent or in harm's way may be necessary at times.
 - b) The use of as many fire rescue or law enforcement personnel as possible is preferred in order to reduce the chance of injury to personnel or the person being restrained.



- c) Care should be taken not to injure the person being restrained. Continually reassess the patient's circulatory and respiratory status. Be prepared to modify or release physical restraint in the event the patient experiences any respiratory or circulatory compromise.

ALS

4. In situations where the patient is extremely combative and in danger of harming themselves or others during transportation, chemical restraint by means of IV or IM Versed (midazolam) may be indicated. In these situations, careful assessment and documentation should support the need.
 - a) Obtain and document a pre-sedation Glasgow Coma Score (GCS) as well as pupillary reaction. Note any significant neurological findings such as movement of extremities, posturing, or changes while under care.
 - b) Establish IV access (**Procedure 13**). If already obtained, ensure and document patency by dropping the bag and examining for blood return.
 - c) Monitor and record ECG. Monitoring should continue throughout the procedure. If the patient's heart rate decreases at any time more than 20 bpm, STOP any attempt and oxygenate with 100% O₂ via BVM for a minimum of 2 minutes.
 - d) Monitor SpO₂ throughout procedure.
 - e) Administer **Versed (midazolam), 5mg SLOW IV or IM.**

NOTE: Patients who are elderly or who have received Valium (diazepam) prior to sedation, should only receive as an initial Versed (midazolam) bolus, 1 mg SLOW IV then titrate subsequent doses.

5. Document clearly on the ePCR the reason for restraint and the method used.