6.5 Restraints

Procedure 6.5

EMT/ ADVANCED EMT STANDING ORDERS

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INDICATIONS

Any patient who exhibits an altered mental status and who may harm himself, herself, or others or interfere with their own care may be restrained to prevent injury to the patient or crew and facilitate necessary medical care. Restraining must be performed in a humane manner and used only as a last resort.

PROCEDURE

1. Request law enforcement assistance, as necessary.
2. When appropriate, attempt less restrictive means of managing the patient, including verbal de-escalation.
3. Ensure that there are sufficient personnel available to physically restrain the patient safely.
4. Restrain the patient in a lateral or supine position. No devices such as backboards, splints, or other devices may be placed on top of the patient. Never hog-tie a patient. In order to gain control, the patient may need to be in a prone position, but must be moved to supine or lateral position as soon as possible.
5. The patient must be under constant observation by the EMS crew at all times. This includes direct visualization of the patient as well as cardiac, pulse oximetry, and quantitative waveform capnography monitoring, if available.
6. The extremities that are restrained should have a circulation check at least every 15 minutes. The first of these checks should occur as soon possible after restraints are placed.
7. Documentation in the EMS Incident Report should include the reason for the use of restraints, the type of restraints used, the time restraints were placed, and circulation checks.
8. If a patient is restrained by law enforcement personnel with handcuffs or other devices that EMS personnel cannot remove, a law enforcement officer should accompany the patient to the hospital in the transporting ambulance. If this is not feasible, the officer MUST follow directly behind the transporting ambulance to the receiving hospital.

PARAMEDIC STANDING ORDERS

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- Paramedic Standing Orders continued next page.

Continued patient struggling against restraints may lead to hyperkalemia, rhabdomyolysis, and/or cardiac arrest, chemical restraint may be necessary to prevent continued forceful struggling by the patient.

PEARLS:

- There is an increase risk of apnea with >2 doses of benzodiazepines.
- Causes of combativeness may be due to comorbid medical conditions or due to hypoxia, hypoglycemia, drug and/or alcohol intoxication, drug overdose, brain trauma.
- Verbal de-escalation is the safest method and should be delivered in an honest, straightforward, friendly tone avoiding direct eye contact and encroachment of personal space.

Protocol Continues

Protocol Continued

PARAMEDIC STANDING ORDERS - ADULT

- *Midazolam 5 mg IM/IN, may repeat once in 10 minutes; or 2.5 mg IV, may repeat once in 5 minutes; **OR**
- Lorazepam 2 mg IM, may repeat once in 10 minutes; or 1 mg IV, may repeat once in 5 minutes; **OR**
- Diazepam 2 mg IV (preferred route), may repeat once in 5 minutes; or 5 mg IM, may repeat once in 20 minutes.

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For patients with suspected **Excited/Agitated** Delirium, extreme agitation or ineffective control with benzodiazepines above:

- **Ketamine (preferred):
  - 4 mg/kg IM rounded to nearest 50 mg, maximum dose 500 mg, repeat 100 mg IM in 5 – 10 minutes. **OR**
- *Midazolam 5 mg IM/IN, may repeat once in 10 minute; or 2.5 mg IV may repeat once in 5 minutes **AND**
- Haloperidol 10 mg IM; may repeat once in 10 minutes.

Contact **Medical Control** for additional doses.

- If cardiac arrest occurs with suspected excited delirium, consider early administration of: fluid bolus, sodium bicarbonate, calcium chloride/gluconate, see Cardiac Arrest Protocol 3.2A.

For acute dystonic reaction to haloperidol:

- Diphenhydramine 25 – 50 mg IV/IM.

*For IN administration of midazolam use a 5 mg/mL concentration.

**For administration of ketamine use a 100 mg/mL concentration

PARAMEDIC STANDING ORDERS - PEDIATRIC

Call **Medical Control** and consider:

- *Midazolam 5 mg/mL concentration (IM or IN preferred):
  - 0.2 mg/kg IM/IN (single maximum dose 8 mg) repeat every 5 minutes; or
  - 0.1 mg/kg IV (single maximum dose 4 mg) repeat every 5 minutes, **OR**
- Lorazepam 0.1 mg/kg IV(single maximum dose 4 mg) repeat every 5 minutes, **OR**
- Diazepam 0.1 mg/kg IV (single maximum dose 5 mg IV) repeat every 5 minutes.

The patient must be under constant observation by the EMS crew at all times. This includes direct visualization of the patient as well as cardiac, pulse oximetry, and quantitative waveform capnography monitoring, if available.

- Excited/Agitated Delirium is characterized by extreme restlessness, irritability, and/or high fever. Patients exhibiting these signs are at high risk for sudden death.
- Medications should be administered cautiously in frail or debilitated patients; lower doses should be considered.
- Administer haloperidol with caution to patients who are already on psychotropic medications which may precipitate serotonin syndrome or malignant hyperthermia.
- Placing a patient in prone position creates a severe risk of airway and ventilation compromise and death.