Carroll County Department of Fire & EMS
Standard Operating Procedure

DOCUMENT DETAILS

Standard Operating Procedure: 3.18	**Effective Date: February 20, 2024**
Subject: Patient Restraints	**Section: Emergency Medical Services**
Authorized: Eric Zaney, Assistant Chief	**Revision Date: May 16, 2025**

Applicability: **[X] Volunteer** **[X] Career**

I. PURPOSE

This policy outlines the procedure for Department of Fire and EMS personnel to safely restrain and transport combative or violent patients whose behavior poses a threat of physical harm to themselves or others. Clinicians should consider less restrictive alternative options before administering physical or chemical restraint procedures, as restraint infringes on a patient's autonomy and dignity.

II. DEFINITIONS

Combative Patient – One who displays behavior that is aggressive or violent towards healthcare providers while engaging in physical actions that threaten harm to self or others.

Violent Patient – One who intentionally uses physical force or power towards healthcare providers potentially leading to injury or harm to self or others.

Chemical Restraint – Emergency sedation used in the management of acute behavioral emergencies.

III. PROCEDURES

A. General:

1. Some situations may require Departmental personnel to restrain a combative or violent patient in order to safely facilitate emergency medical care and transport, or to prevent the patient from injuring themselves or others.
2. A competent patient that demonstrates anger or hostility but does not present a threat may not be restrained.
3. Clinicians are reminded that verbal communication with the patient can help de-escalate the situation.

B. Indications for Patient Restraint:

1. A patient exhibiting combative or violent behavior as a direct result of a medical or Traumatic emergency, or
2. A patient exhibiting combative or violent behavior presenting as a psychiatric emergency. These situations may include those where a patient requires treatment for a medical emergency or is under an emergency petition for psychiatric evaluation.

C. Coordination with Law Enforcement:

1. A law enforcement officer shall be requested to the scene of incidents involving combative or violent patients when Departmental personnel are restraining a patient to protect them from injuring themselves or others.
2. A law enforcement officer shall accompany the patient onboard the transport unit in the patient compartment to the hospital if:
    a. The patient is deemed to be a potential threat to Departmental personnel, regardless of the law enforcement custody status of the patient.
    b. The patient is in law enforcement custody, and it is determined that there is a potential threat that the patient may escape custody,
3. When law enforcement accompanies a patient to the hospital, their role is to assure the safety of Departmental personnel. Law enforcement officers may participate in provisions of medical care only if such participation is determined to be necessary by Departmental personnel and, if so, under the direction of Departmental personnel.

D. Containing the Combative or Violent Patient:

1. In a law enforcement custodial situation, law enforcement personnel will be responsible for the initial restraint of the patient. Departmental personnel may assist as requested by law enforcement personnel provided it is safe to do so.
2. Law enforcement shall be requested to assist in the initial restraint of any combative or violent patient when not already in custody.
3. Once the patient has been restrained, Departmental personnel will direct the positioning of the patient as appropriate to allow for medical care and treatment.
4. Clinicians shall maintain constant, direct supervision of the restrained patient at all times.
5. Clinicians shall provide emergency medical care and treatment in accordance with the Maryland Medical Protocols

E. Securing Combative or Violent Patients During Transport:

1. The preferred position of transport for patients will be semi-fowlers on the stretcher, with safety belts appropriately used. This position reduces the risk of aspiration and decreases the patient's physical strength by placing the abdominal muscles in a flexed position.

2. Patients who are combative, violent and actively resistant should be physically restrained to prevent injury to self or others. Patients who require physical restraint should be secured to the stretcher or transport device with the right upper extremity above their head, the left upper extremity below their waist, and both lower extremities individually secured.

3. If the severity of the patient's agitation necessitates the use of a backboard for safe transport, the patient shall be placed in the supine position ONLY. Patients who require physical restraint should be secured to the backboard with the right upper extremity above their head, the left upper extremity below their waist, and both lower extremities individually secured,

4. Clinicians shall ensure that the restrained patient cannot reach to release cot safety belt buckles during transfer / transport.

5. All physical restraints employed shall not be placed in a manner that interferes with the patient's respiratory status, circulation or inhibits the clinician's ability to continually monitor vital signs. Every effort should be made to prevent the placement of restraints in a manner which may aggravate existing injuries.

6. Law enforcement handcuffs are not considered a medical restraint. If handcuffs are in place by law enforcement, Departmental personnel shall request that the handcuffs be moved to the front of the patient during transport.

7. All Physical restraint devices must allow for their rapid removal if the patient's airway, breathing, or circulation becomes compromised.

F. Prohibited Restraint Practices:

1. The following restraint techniques are expressly prohibited and shall not be employed by EMS clinicians:

   a. Securing or transporting a patient in the prone (face down) position with or without hands and feet behind the back, in a position known as "hobbling" or "hog tying";

   b. Placing, securing or transporting a patient between two backboards "Sandwiching";

   c. Hands and feet shall not be tied together.

2. EMS clinicians are prohibited from using any restraint method or technique that has the potential to constrict the patients' neck and compromise their airway or constrict their breathing.

G. Monitoring and Transport:

1. The EMS clinician will continuously monitor the patient's condition to include pulse, oxygenation, ventilation, respiratory status and level of consciousness. The clinician will completely document all assessment and reassessment information within the PCR.

2. Appropriate changes or adjustments may be made to the restraints by the clinician at any time to address any change in the patient's condition.

3. Upon arrival at the hospital, Department personnel will work in concert with hospital staff to ensure the safe and efficient transfer of the patient to the hospital stretcher.

H. Use of Sedating Medications for Chemical Restraint:

1. In accordance with the Maryland Medical Protocols for EMS Personnel, medications may be administered, as indicated, for moderate and severely agitated patients.

2. All patients receiving sedating medications for the treatment of moderate to severe agitation shall be placed on continuous SpO2, ETCO2 and cardiac monitoring as soon as possible. Clinicians shall also obtain the patient's temperature and blood glucose level.

3. Vital signs shall be assessed every 5 minutes for the duration of the transport.

4. Clinicians shall obtain IV access.

5. Advanced airway management equipment shall be immediately available for use in all patients receiving sedating medications.

6. A second EMS clinician (Minimum EMT-B) must be present in the patient compartment throughout transport for any patient that has received or is anticipated to receive Midazolam as a sedating medication for the purposes of chemical restraint.

a. If chemical restraint sedation using Ketamine is initiated or anticipated a second ALS clinician who is trained and cleared in the use of sedation dose ketamine must accompany the patient in the patient compartment throughout transport.

b. The use of Droperidol as a sedating medication in the treatment of psychosis / agitation does not require a second EMS clinician to be present during transport. Although not required, clinicians should exercise

clinical judgement in determining a need for a second clinician to accompany during transport.

c. When using a sedating medication EMS clinicians should strongly consider having a second clinician onboard whenever possible during transport to assist in care and monitoring.

7. A police officer or the ambulance operator does not count as a second EMS clinician.

8. The selection and use of all medications for sedation / chemical restraint shall be reviewed within 24 hours by QA/QI personnel and if applicable the Shift Commander, Assistant Chief of EMS and/or Medical Director.

9. If the use or administration of a sedating medication by a clinician results in an unanticipated or adverse patient outcome the clinician shall make immediate verbal notification to the on-duty Shift Commander. The administering clinician must also provide a complete and factual written account of all circumstances surrounding the incident. Documentation shall be completed as soon as possible not to exceed 24 hours from incident conclusion. All written documentation will be completed on official Departmental / Corporation letterhead, will be signed by the clinician and will be forwarded through the proper chain of command. All unanticipated or adverse patient outcomes shall be reviewed by the Assistant Chief of EMS and / or Medical Director as soon as possible.

I. Documentation:

1. Restraint documentation in the patient care reports shall include the following:

a. The reason for the restraint use.

b. The type(s) of restraint used.

c. Alternatives employed to avoid restraint use (i.e. verbal de- escalation, physical hold, etc.)

d. The agencies and the number of personnel involved in the restraint

e. Patient response to restraint

f. Any rationale for any deviation from preferred restraint techniques

g. Any impact(s) on treatment resulting from the patient's combativeness or violence.

2. Documentation of sedating medication administration for agitation / psychosis / chemical restraint shall additionally include the following:

a. Available history of present illness, medical and psychiatric history, medications, allergies

b. Initial patient assessment, to include, at a minimum: overt evidence of trauma, skin exam, mental status, respiratory status and pulse

c. Vital signs prior to the administration of sedating medications (to the extent possible). Repeat vital signs completed every 5 minutes

d. Rational for medication administered

e. Patient's actual or approximate weight

f. Selected medication name, dose, and route of administration

g. All reassessments of patient to include at a minimum skin exam, mental status, respiratory status and pulse

h. Patient's Blood Glucose Level and EKG

IV. RECISION

This Standard Operating Procedure rescinds all directives regarding Patient Restraint or similar content previously issued for personnel of the Carroll County Department of Fire & EMS.

V. RELATED STANDARD OPERATING PROCEDURES / DOCUMENTS

VI. ATTACHMENTS