New Theories about Patient Restraint

By Kim Oriole

July 2003, MERGINET - EMS patient restraint is a hot topic, with several EMS workers across the country being charged, sued, or losing their licenses either temporarily or permanently when restrained patients die.

EMS transporters often deal with agitated, violent, and combative patients. Yet with the proper guidelines and adherence to protocols, the risk to these patients can be minimized, according to Bryan E. Bledsoe, DO, FACEP, EMT-P.

"It's kind of become the thing to sue paramedics about," said Bledsoe, a prominent EMS author and emergency medicine professor. "I've been called to testify in trials on deaths. A lot of EMTs and paramedics are being sued. It's really going on everywhere."

Most deaths occur in patients with psychiatric or behavioral problems, or those intoxicated on drugs (particularly stimulants) or alcohol, he said.

Outdated textbooks
Many EMS personnel don't know the right way to deal with these patients, Bledsoe said. Partly to blame are the US Department of Transportation EMT and Paramedic curricula, which, he said, are simply wrong.

"We have a lot of paramedics following guidelines and getting sued because the guidelines are wrong," he said. "It's in the textbooks. It takes years to get that corrected."

Yet people are trying. Bledsoe and David Phillips, BS, EMT-P, wrote an article called "Issues in Patient Restraint" that will appear in ***EMS Magazine*** this fall, and the **National Association of EMS Physicians** (NAEMSP) put out a position paper last year that addresses changes and improvements in patient restraint.

Risk factors
Most deaths occur when patients are prone, or face down, Bledsoe said, so new guidelines warn against that. He said the main risk factors for sudden death are:

- Excited delirium
- Restraining patients face down
- Using hobble or hog-tie restraints
- Patients continuing to fight against restraints
- Obesity

He said the right way to restrain patients includes:

- Having plenty of help to use restraints—five is a good number
- Restrain in three phases—(1) verbal de-escalation and verbal restraint, (2) restrain with patient on back, using soft restraints, then (3) chemical restraint with proper medical assessment

Bledsoe said even with proper restraint, there will be tragedies. “It's the needs of society versus the rights of the individual—some of these people are going to be lost,” he said. “You have to intervene.”

NAEMSP recommendations
A 2002 position paper from the NAEMSP outlines how it believes patients must be restrained to prevent deaths and legal problems for EMS services and providers.

Each EMS service should write its own protocol for prehospital patient restraint, then train its responders.

The NAEMSP paper lists 15 important factors that should be included in each department's protocol, including these ten items:

- Patient dignity should be maintained, and EMS should use the least restrictive form of restraint
- Patients must be assessed to manage medical conditions that contribute to their violent behavior, such as hypoxia, hypoglycemia, alcohol or drug intoxication, stroke and brain trauma
- Direction on the types of restraints to be used (verbal de-escalation, physical or chemical restraints), when each will be used, who will apply them, and when direct medical oversight must be required
- What types of physical restraints are permissible. Any restraint should allow for rapid removal
- Patients should never be transported while hobbled, hog-tied, or restrained in a prone position with hands and feet behind the back, and never be transported while sandwiched between backboards or mattresses
- Restraint must never constrict the neck or compromise the airway
- Hard restraints, such as handcuffs, should be avoided. If a key is needed to release restraints, that key must be with EMS personnel
- Continued patient struggling after physical restraint may lead to cardiac arrest, so chemical restraint, usually with butyrophenone or benzodiazepine, or both, may be needed to prevent continued struggling
- After patient restraint, there must be regular and frequent patient evaluations
- All patients require documentation of assessment, reason for restraint, restraint procedure, frequency of reassessment, and care during transport