Restraints 6.3

EMT/ ADVANCED EMT STANDING ORDERS

E/A

INDICATIONS

Any patient who may harm himself, herself, or others may be restrained to prevent injury to the patient or crew. Restraining must be performed in a humane manner and used only as a last resort.

PROCEDURE

2. Request law enforcement assistance, as necessary.
3. When appropriate, attempt less restrictive means of managing the patient, including verbal de-escalation.
4. Ensure that there are sufficient personnel available to physically restrain the patient safely.
5. 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.
6. 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.
7. 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.
8. 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.
9. 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.

PEARLS:

- Causes of combativeness may be due to comorbid medical conditions or due to hypoxia, hypoglycemia, drug and/or alcohol intoxication, drug overdose, brain trauma.
- Struggling against restraints may lead to hyperkalemia, rhabdomyolysis, and/or cardiac arrest.
- 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

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Once physically restrained:

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

For patient with suspected Excited/Agitated Delirium or extreme agitation:

- Midazolam 5mg IV/IM/IN; may repeat once in 10 minutes.
  - If agitation continues after the second dose of midazolam, then consider:
    - Haloperidol 10mg IM; may repeat once in 10 minutes.

NOTE: Contact **Medical Control** for additional doses.

- If cardiac arrest occurs, consider fluid bolus and sodium bicarbonate early, see Cardiac Arrest 3.2A.

For acute dystonic reaction to haloperidol:

- Diphenhydramine 25 – 50mg IV/IM.

- 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.