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POSITION STATEMENTS

CLINICAL CARE AND RESTRAINT OF AGITATED OR COMBATIVE PATIENTS BY EMERGENCY MEDICAL SERVICES PRACTITIONERS

Douglas F. Kupas, MD, Gerald C. Wydro, MD, David K. Tan, MD, Richard Kamin, MD, Andrew J. Harrell IV, MD, Alvin Wang, DO

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POSITION

The National Association of EMS Physicians (NAEMSP) has had a position statement on patient restraint since 2002 (1), which was updated in 2017 (2). This document updates and replaces these previous statements and is now a joint position statement with the National Association of State EMS Officials (NASEMSO), National EMS Management Association (NEMSMA), National Association of Emergency Medical Technicians (NAEMT), and the American Paramedic Association (APA).

The NAEMSP, NASEMSO, NEMSMA, NAEMT, and APA recognize that emergency medical services (EMS) personnel frequently care for agitated,

combative, or violent patients who require clinical treatment and transportation. These situations are often complicated by alcohol use, substance use, or mental health illness. When clinical monitoring and treatment are indicated, these become health care issues.

When such encounters occur, patients, the public, and all emergency responders are at risk for injury. Furthermore, delirium with agitated behavior is associated with continued patient agitation or struggling, with or without physical restraint, and is associated with hyperthermia, hyperkalemia, rhabdomyolysis, and cardiac arrest. In these severely impaired patients, rapid pharmacologic management/sedation may prevent these adverse and life-threatening conditions and maximize patient safety.

Concerning the care of these patients, the NAEMSP, NASEMSO, NAEMSMA, NAEMT, and APA believe that:

- **Primary Goal:** It is of paramount importance to protect agitated, combative, or violent patients from injuring themselves, while simultaneously protecting the public and emergency responders from injury.
- **Agency Protocol:** Every EMS agency should have specific protocols for dealing with an agitated, violent, or combative individual. Such protocols may be developed in consultation with EMS system administrators, EMS practitioners, legal counsel, community stakeholders, and local law enforcement representatives, but ultimately this patient-centered clinical protocol must be overseen and approved by the agency's EMS medical director. Note: The term "protocol" is used throughout this document to define a written form of oversight provided by the medical director to direct patient assessment and treatment, realizing that in some systems terms such as guidelines, standing orders, policies, or procedures are used.
- **Assessment/Clinical Treatment:** EMS practitioners must quickly evaluate the situation and resources available, often with limited information available to

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Position statement approved by NAEMSP Board of Directors on September 24, 2020. This statement replaces the previous statement entitled Patient Restraint in Emergency Medical Services Systems.

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them. EMS practitioners must perform an appropriate patient assessment to identify and manage clinical conditions that may be contributing to a patient's agitated, combative, or violent behavior. EMS agencies should consider using an agitation score, like the Richmond Agitation Sedation Scale (RASS), as part of the assessment and reassessment of agitated patients. Agitated, combative, or violent behavior has varying presentations on a spectrum from agitated but cooperative to delirium with a dangerous inability to understand the situation or the dangers of their behavior. Assessment should be thorough to identify conditions causing this behavior including, hypoxia, hypoglycemia, alcohol or substance intoxication, stroke, seizure, traumatic brain injury, and delirium. Clinical treatment of some of these conditions may decrease agitation. EMS practitioners should consider early use of high-flow oxygen by mask as it serves to treat hypoxia in patients who are too agitated to assess pulse oximetry and preoxygenation is beneficial if the patient is sedated.

- Patient Dignity: Persons who lack decision-making capacity are assessed and treated with implied consent. EMS practitioners must maintain the patient's dignity to the extent possible, including use of the least restrictive method of restraint that protects the patient, the public, and emergency responders from harm. The use of appropriate de-escalation techniques should take precedence over physical restraint or pharmacologic management whenever possible.
- Unique EMS Environment: Compared with the controlled setting of a hospital, EMS practitioners face higher risks when caring for patients in the confined space of an ambulance or with limited resources in the field. These differences may require the use of restraint techniques and thresholds for the implementation of restraint techniques that are specifically intended for the out-of-hospital environment. These may differ from those used by health care providers within a hospital.
- Education/Credentialing: EMS agencies must ensure that their EMS practitioners have received education on how to identify and treat the clinical spectrum of conditions that are associated with agitated, combative, or violent behavior and that their EMS practitioners are trained to implement the principles and devices of the agency's restraint protocol during patient care. EMS practitioners should also be educated about patient reassessment. The EMS agency medical director should credential the agency's practitioners as competent in these skills.
- Indications for Restraint: Physical restraint and pharmacologic management/sedation when providing EMS care are only indicated to protect a patient, the public, and emergency responders from further injury, facilitate assessment, or allow for treatment of life-

threatening injury or illness. Restraint protocols should describe the clinical indications for restraining a patient. Although EMS practitioners work closely in the field with co-responders and frequently assist or are assisted by law enforcement officers, EMS practitioners must not administer sedating medications to an individual to facilitate arrest or to assist law enforcement to take the individual into custody. EMS practitioners should use the least restrictive restraint techniques to facilitate clinical patient assessment, medically indicated treatment, and safe transport to a hospital. In all circumstances, the decision about using pharmacologic management is a health care decision that must be made by the EMS practitioner with oversight by an EMS medical director.

- Strategies and Techniques: Restraint protocols must address the strategies, devices and techniques that will be used (verbal de-escalation, physical restraint, and/or pharmacologic management), when each will be used, who can apply them, and if direct medical oversight must be involved. EMS agencies should ensure that all practitioners are competent in the use of any devices, techniques or medications used for restraint. Agencies should ensure that practitioners also have training in techniques of verbal and environmental de-escalation and in communication with individuals who are agitated or have a behavioral illness. Preplanning in conjunction with law enforcement agencies can facilitate appropriate and safe management of these incidents.
- Physical Restraint: Restraint protocols should address the type of physical restraints and techniques that are permissible for use by EMS practitioners. Any physical restraint device used must allow for rapid removal if the patient's airway, breathing, or circulation becomes compromised. Rigid restraints, such as handcuffs, should not be used by EMS providers. If the patient is handcuffed by law enforcement officers, consideration should be made to transition to the least restrictive restraints that are safe for the patient and responders. Physical restraint devices that are easily removed by practitioners without a key are preferred. However, if a patient is restrained in devices that require a key, the key must accompany the patient during treatment and transportation.
- Prohibited Techniques: Restraint protocols should identify restraint techniques that are expressly prohibited for use by EMS practitioners. Patients must not be restrained in a position with hands and feet tied together behind their back or restrained with techniques that compromise the airway or constrict the neck or chest. During transport on a stretcher or other transport device, patients must not be restrained in a prone position nor under backboards or mattresses. EMS practitioners must not use weapons as adjuncts in the restraint of a patient.

- **Pharmacologic Management/Sedation:** Pharmacologic management, usually with a dissociative agent (ketamine), a benzodiazepine (for example, midazolam), butyrophenone (for example, droperidol), or a combination of these medications, is an effective method of protecting the violent or combative patient from self-injury. When pharmacologic management is required due to delirium with agitated behavior or risk of serious self-injury, a medication with rapid onset is preferred to reduce the risk as quickly as possible. Neuromuscular blocking agents that paralyze individuals are not acceptable for restraint, unless they are also clinically indicated to treat an underlying medical or traumatic condition by EMS practitioners in agencies that otherwise use these agents. Medications used for pharmacologic management may cause respiratory depression, and every individual who receives pharmacologic management must be continuously monitored and treated by EMS providers. These individuals must be transported to a hospital for additional clinical assessment and treatment.
- **Reassessment:** After patient physical restraint and/or pharmacologic management, physiologic monitoring and clinical assessment/reassessment of respiratory and hemodynamic status as well as neurovascular status of all restrained extremities must be done as soon as possible and at recurring intervals.
- **Documentation:** EMS patient care reports must be completed for all patients assessed or treated by EMS practitioners. Documentation should include details of patient behavior, patient assessment, clinical indication for restraint, type of restraint intervention(s) attempted or applied, frequency of reassessment and associated exam findings, and additional care provided during transport. If an agitation score is used by the agency, the initial and repeat scores should be documented.
- **Direct Medical Oversight:** In some systems, direct medical oversight of interventions performed by EMS practitioners may be required for combative patients who refuse treatment, as well as for orders to restrain a patient (before or immediately after restraint) or for orders for pharmacologic management (before or after medication is administered). If required, EMS medical directors should determine the point at which EMS practitioners are expected to contact a physician in these situations. Clinicians providing direct medical oversight through a base station should be educated to EMS protocols and their options.
- **Quality Assurance:** Every case of physical restraint or pharmacologic management by EMS practitioners should undergo quality assurance review, with specific filters for the appropriateness of restraint for the patient, the type of restraint(s) used, the quality and frequency of physiologic monitoring, protocol compliance, and documentation compliance. States are encouraged to develop a method of tracking the use of medications for the purpose of pharmacologic management of agitated patients and to consider a statewide quality improvement plan to ensure the appropriateness of their use.
- **Scene Safety Considerations:** Law enforcement officers, whenever available, should be involved in all cases in which a patient poses a threat to themselves, the public, or emergency responders. If the practitioners are in danger of harm they should retreat to a safe place and await the arrival of law enforcement. If there is no safe option for retreat, EMS practitioners who are being physically attacked may defend themselves as permitted by local law.
- **EMS and Law Enforcement Techniques Differ:** EMS restraint protocols and interventions will differ from those of law enforcement. All agencies should recognize their roles and work cooperatively and proactively to ensure the safe care of patients assessed or treated by EMS. EMS practitioners who are legally authorized to function in a law enforcement capacity or vice versa must be particularly cognizant of their role in the encounter and ensure that their actions are commensurate to their role.
- **Assessment of Patients Restrained by Law Enforcement:** In some situations, it may be necessary for law enforcement to apply restraint techniques or technologies to individuals which are not sanctioned by EMS protocols. These individuals may also need, or may develop a need for, EMS assessment or patient care. In these cases, a law enforcement officer must remain immediately available while the EMS practitioner assesses and manages the patient based upon the EMS agency's clinical protocols. At all times, the EMS practitioner must act as an advocate for the safety, medical monitoring, and clinical care of the patient.
- **Patients in Custody:** If a law enforcement-based restraint intervention (for example handcuffs, flex cuffs) which are not sanctioned for use by EMS practitioners must be continued during patient care and transport by EMS, a law enforcement officer should either accompany the patient during transport by ambulance or the law enforcement-based restraint intervention should, when appropriate, be discontinued in favor of a sanctioned EMS-based restraint intervention. Patients who are in law enforcement custody or who are under arrest, must always have a law enforcement officer present or immediately available during EMS transport.

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