Clinical Practice Guidelines: Behavioural disturbances/
The physically restrained patient

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<td>Purpose</td>
<td>To ensure consistent management of the physically restrained patient.</td>
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Physical patient restraint is an intervention used as a last resort to facilitate assessment, management and transportation, in situations where a patient is deemed to be a risk to themselves or others as a result of behavioural disturbance and are not otherwise able to be managed. **Police are the first point of contact for all physical restraint.**

It is essential that the safety of the patient and responders is monitored closely during physical restraint. If and when safe to do so, the least restrictive means must always be used to facilitate control. Paramedics **MUST NEVER** apply holds/pressure points or other strategies that cause pain.

In this CPG the following definitions will be used:

**Restraint**

Is a restrictive intervention that relies on external controls to limit the movement or response of a person. Restraint can be viewed in three modalities: physical (or bodily) restraint, mechanical restraint, or pharmacological restraint (*sedation*)

**Physical (or bodily) restraint**

Refers to the use of physical force to prevent a person from placing themselves in a dangerous situation or harming themselves or others.

**Mechanical restraint**

Is a form of physical restraint and refers to the application of a device, materials or equipment (including belt, harness, manacle, handcuffs, seat belt, sheet and strap) to prevent, restrict or subdue the voluntary movement of any part of the person’s body without consent.

**Pharmacological restraint**

Is where patients are administered sedative agents to achieve restraint.
Principles of management of physically restrained patients include:

- Simple reassurance, verbal de-escalation and pharmacological restraint are to be used preferentially to avoid the use of, or minimise the duration of, physical restraint.[1]
- CCP back-up should be considered for all behaviourally disturbed, physically restrained patients.
- If physical restraint is required, the least restrictive and minimal forceful options available that do not illicit pain are to be utilised.
- If mechanical restraints are placed by law enforcement officers (e.g. a police or corrective services officer), these officers are to be present with the patient at all times.
- Receiving hospitals should be notified of the impending arrival of all physically restrained or behaviourally disturbed patients to ensure rapid assessment, management and appropriate resource allocation in the facility.

Clinical features

Behavioural disturbances requiring patient restraint can stem from numerous aetiologies, although generally there are three broad categories:

- Organic disorders (e.g. dementia)
- Psychiatric disorders
- Situational crisis

The physical exertion and resultant acidosis and hyperthermia that may accompany resisting the application of physical restraints can compound the toxic effects of some poisonings (e.g. psychostimulants).[2] In addition there is concern that the use of physical restraints in the context of psychostimulant use and/or the existence of underlying heart or chronic disease is a risk factor for sudden death.[2]

NOTE: It is of paramount importance that organic causes of behavioural disturbance (e.g. hypoglycaemia, hypoxia, pain) are identified and addressed in conjunction with the use of any pharmacological or physical restraints.
Risk assessment

Paramedics are not expected to place themselves at risk of harm or injury and where possible should remove themselves from potential harm.
- Ensure safety precautions are taken.
- If a patient’s behaviour escalates to a point where physical restraint is required, urgent Queensland Police Service assistance should be requested.

**Use extra caution in the case of any of the following:**
- Cases of ‘excited delirium’ or prolonged struggle
- Intoxication or administration of acute sedation
- Suspected underlying medical or neurological conditions

**Harm from physical restraints may be minimised by ensuring:**
- Any physical restraint utilised is able to be rapidly removed should the patient’s condition deteriorate or a therapeutic intervention needs to be performed.
- Appropriate positioning, preferably with the patient on their side with their hands restrained in front of their body.
  - Ensure that a person is not restrained in the prone position for longer than 2 minutes
  - Prone positioning may impede breathing and may result in positional asphyxia.[4,5,6]
  - Supine positioning may contribute to the risk of aspiration
- Physical restraint(s) are removed as soon as safely possible.
- Direct pressure to the face, neck and chest is minimised or avoided.
- Any mechanical restraint device used does not cause neurovascular compromise to the limb.
- If possible, adequate padding is placed between the mechanical restraint and the patient.
- Continual visual observation including monitoring the patient’s face for signs of distress/difficulty. Vital sign monitoring, five minutely:[6]
  - Respiration rate and pulse oximetry
  - Heart rate and blood pressure
  - Glasgow coma score assessment
  - Perfusion assessment distal to the mechanical restraint
  - Initial BGL
  - Temperature (taken initially then every fifteen minutes)
- Beware of laboured respiratory efforts as sudden cardiovascular collapse may occur with little warning.[1]
- The stresses imposed during restraint, physical, pharmacological, psychological need to be considered as accumulative.[5]

**Additional information**
- At all times one officer must be responsible for the supervision of the patient’s airway.