



Caring for our patients & ourselves

By Doug Perry & Thom Dick

Count Your Fingers

More Stuff on Restraints

When I wrote the series on restraints that appeared in December and January, I showed you the best techniques I knew for taking down and restraining a truly violent patient. Since *JEMS* published that series, I have received some excellent input from a number of people who had better ideas.

Many didn't like that part about stabilizing the patient's head and neck with your elbow because it was too hard to avoid choking the patient. Actually, they're right. All of my experience with the technique was in a system where the paramedics and the first responders were all on the same schedule. I never thought



A patient who persistently tries to grab the clothing or anatomic features of the crew can be controlled using two-inch cloth tape as shown.



Using your forearms as struts, you can stabilize a patient's head as shown until the restraints are all in place.



Ordinarily, an oxygen mask makes a good spit shield. But if the patient shucks the mask, try a spit shield like this SpitSock.

about it at the time, but that's a critical variable. When everybody knows the system really well, you can routinely take somebody down in less than 10 seconds.

We suggested a number of modifications to the technique, and the team of people we were working with went a step further. We decided not to do take-downs, period, and developed a protocol to call in law enforcement to handle that part.

We had plenty of questions we couldn't find published answers to, and the one that bothered us most was how to keep from getting bitten while you're restraining someone. One text shows a two-handed hold for a patient's head, but it shows at least four of the caregiver's fingers in very close proximity to the patient's teeth. We thought that posed an unacceptable risk. Why?

Human bites almost always become infected. If you receive a bite in a fleshy area like your forearm, that could still happen; but even a forearm bite will probably heal without any loss of function, even if it requires debriding. That's not so likely if a patient's tooth penetrates a joint capsule of one of your fingers, in which case the capsule will likely seal itself, creating a closed infection site. Your hands are crucial to everything about your quality of life. But they also pose the greatest likelihood of penetration by a tooth because there's not

much soft tissue overlying their bony features.

If you leverage your forearms as struts against the head end of your cot, you could cup your hands around the patient's mandible and, thus, physically limit the patient's ability to flex or rotate their neck while they're being restrained. That gives you a good, stable grip. If you further shield yourself with leather gloves, you would almost surely protect your fingers and hands.

We're suggesting that once you get the patient on the cot, you can use this strategy to maintain the head in line instead of the one we suggested in January *JEMS*—at least until all of the patient's extremities are fastened to the cot.

We have some additional suggestions, as well.

One, as soon as you get the patient fastened to the cot, place him on mask oxygen—especially if he persists in struggling. That counters his oxygen debt and has a side-benefit of posing a barrier to continued spitting or biting.

Two, continuously monitor the patient via oximetry and capnometry, if you can. Document your readings from the time restraints are applied until your arrival at the receiving facility.

Three, pay attention to what the patient says, especially if it's about difficulty breathing. (Monitor changes in their overall degree of verbalization as well—a sensitive indicator of changes in mentation.)

One reader didn't like the idea of restraining the patient cross-chest. We still favor it, for a lot of reasons. But one of the most important, not mentioned in the first two articles, was that it's the only scheme we've seen or used that keeps the patient's palms facing down instead of up. Every palms-up technique

we've ever seen poses obvious risks to the male caregiver's genitalia.

When a patient won't tolerate an O₂ mask, another option is to use a spit shield. Restraint-maker Posey sells one for about \$10. But the Posey model has an opaque barrier that obscures your view of the lower face. That can impair your ability to monitor the airway and facial color.

The SpitSock is made of a plain, fine mesh (kind of like beekeepers use to protect them from stings) that may be a better option for the field. It's held in place by a mild elastic band around the base of the neck and can be quickly removed. The SpitSock is made by Stearns of Ramona, Calif., which caters primarily to law enforcement. The shield allows you to see the patient's face, and it runs less than \$3 (www.spitsock.com).

EMS old-timer Twink Dalton is a nurse/paramedic/author/teacher with lots of experience in behavioral emergencies (and not just because she's also a mom). She suggests that when you document any restraint scenario, you avoid adjectives like "violent," "belligerent" or "aggressive" in reference to the patient. You may be called upon years later to define what you meant when you chose those words. Instead, record in detail what the patient says (in quotes) and what the patient *does*.

And finally, we believe any patient considered violent enough to warrant these techniques in the field also warrants consideration of chemical restraint prior to transfer at the receiving facility.

We'd like to acknowledge our team members, who helped us research the available literature, survey the available equipment, write a protocol and develop an eight-hour training program for ourselves and our colleagues. The training program is designed to teach prehospital caregivers how to recognize the potential for violence and then to intervene—verbally, physically and chemically, in that order. We have also initiated a two-year focused audit of our agency's restraint calls and are considering partnering with other agencies to increase the sample size. We plan to publish what we learn. JEMS

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Our team members included Bruce Amdahl, Dennis Baker, Twink Dalton, Thom Dunn, Jamie Bosten, Kyle Buss, David Fending, Jeff Forster, Grant Gilliland, Art Kanowitz, Joanne Kean, Billy Kraft, Kevin Neu, Robert Putfark and Steve Whitehead. In addition, we received significant valuable input from Jim Page and from Officer Dave Snelling of the Arvada (Colo.) Police Department.

Acknowledgment: The authors would like to thank Tom Pedigo, PA-C and Laura Mamchur, RN, NREMT-P, for their assistance in the preparation of this article.

Publisher's note: For further review of the legal and medical issues surrounding restraints and their application, see "Exercise Restraint," March 2002 JEMS, at www.jems.com.