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## *Use of Patient Restraints*

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The American College of Emergency Physicians (ACEP) supports the careful and appropriate use of patient restraints or seclusion.

The administration of restraints can be dangerous not only to patients but to the staff. Safety should always be of paramount concern and should be considered for the application of restraints for agitated patients. Staff should be appropriately trained for the safety of all patients.<sup>1</sup>

CMS defines restraints as “Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or a drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.”<sup>1</sup>

Restraints can be both physical and chemical. CMS explains that a medication constitutes a restraint if it is not considered “standard treatment” and if “the overall effect of a medication is to reduce the patient’s ability to effectively or appropriately interact with the world around the patient.”

Treatment for acute psychiatric conditions often includes medication that can also be used for medical restraints therefore the use of a specific medication does not by itself constitute a restraint.<sup>1</sup> Consider oral medications, if appropriate, prior to IM, IV routes of administration.

ACEP recognizes that patient restraint involves issues of civil rights and liberties, including the right to refuse care, freedom from imprisonment, and freedom of association. However, there are circumstances when the use of restraints is in the best interest of the patient, staff, or the public.

Patient restraint should be considered when a careful assessment establishes that the patient is a danger to self or others by virtue of a medical or psychiatric condition and when verbal de-escalation is not successful.

ACEP endorses the following principles regarding patient restraints:

- When appropriate and safe, verbal de-escalation and standard treatment of underlying medical or psychiatric conditions should be attempted before restraints.

- Restraint of patients should be individualized and employed in a manner that makes all reasonable attempts to maintain the patients' privacy and dignity.
- The method of restraint should be the least restrictive necessary for the protection of the patient and others.
- Staff should be properly trained in de-escalation, trauma informed care, the appropriate use and application of restraints and in the monitoring of patients in restraint and seclusion.
- Protocols to ensure patient safety should be developed to address observation and treatment during the period of restraint and periodic assessment as to the need and means of continuing or discontinuing restraint.
- The use of restraints should be carefully documented, including the reasons for and means of restraint, alternatives to restraint, and the periodic assessment of the restrained patient.
- ACEP opposes any requirement by hospital representatives or medical staff that emergency physicians provide inpatient restraint or seclusion orders. Patient restraint or seclusion requires comprehensive patient assessment, and the emergency physician's principal legal and ethical responsibility is to patients who present to be seen and treated in the emergency department.
- The use of restraints should conform to applicable laws, rules, regulations, and accreditation standards.

<sup>1</sup> Department of Health and Human Services, Centers for Medicare and Medicaid; Hospital Conditions of Participation: Patients' Rights; 42 CFR Part 482