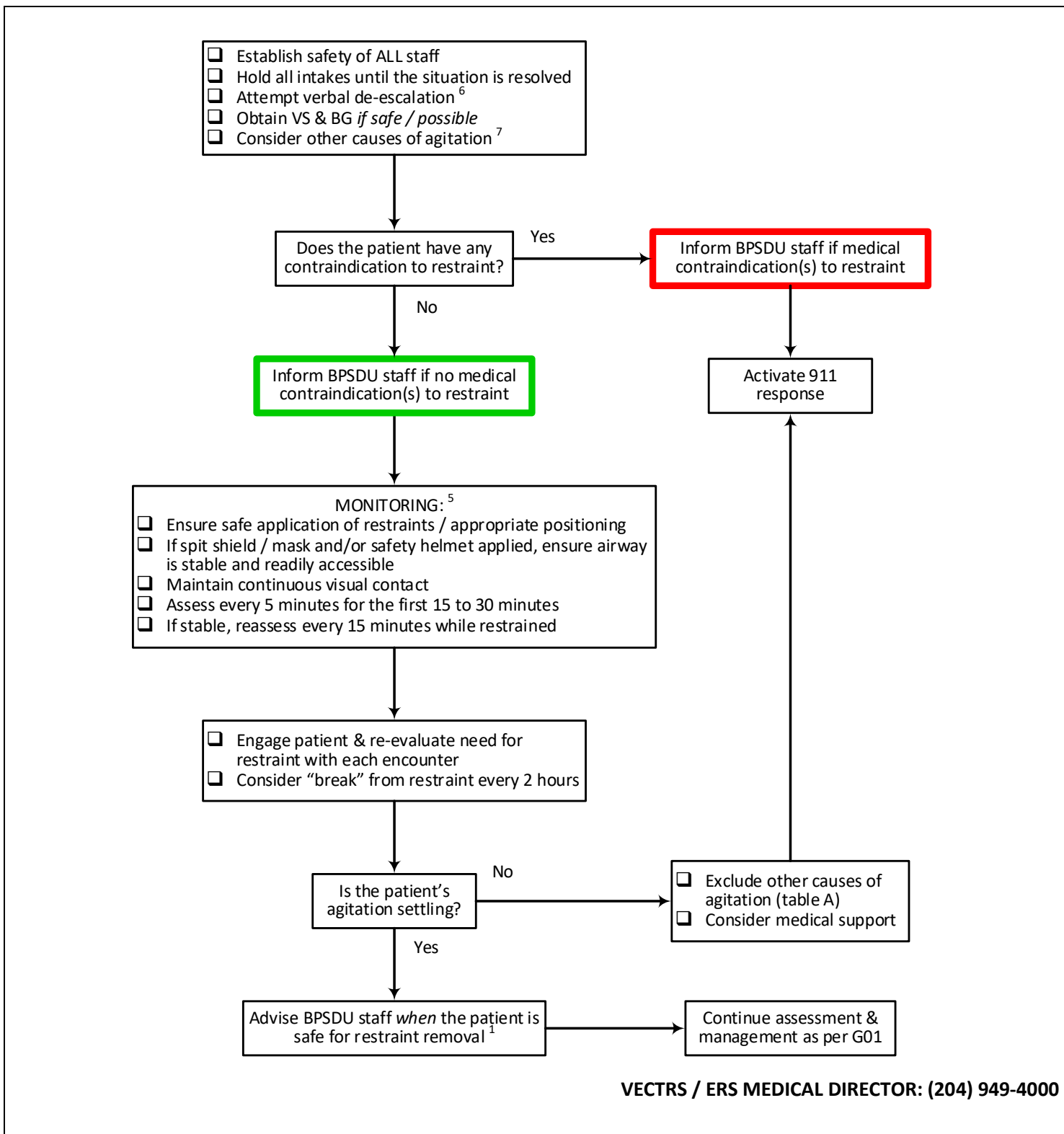
	G04 - BRANDON POLICE SERVICE EMERGENCY RESTRAINT CHAIR	
	Version date: 2025-06-24	Effective Date: 2025-07-02 (07:00)
CPP - DETENTION UNIT PARAMEDICS	ADULT	



INDICATIONS

- The emergency restraint chair may be implemented for the following reasons:
 - To control behavior that is self-destructive, can cause harm to others, or can result in damage to BPS property
 - To maintain control when moving a high-risk detainee within the detention unit

WARNINGS:

CAUTIONS:

- An agitated patient can sustain injuries during emergency restraint. The duration of restraint should be limited to the minimum necessary to defuse the situation or arrange a safe disposition.

CONTRAINDICATIONS:

- Glasgow coma scale less than 15
- Vital signs at the upper and lower ends of normal as they relate to the presenting complaint (especially if they differ from the patient's normal values)
- Known or suspected drug-induced agitation
- Known or suspected active medical condition or acute traumatic injury
- Active mental health concern³
- History of seizures / epilepsy
- Chronic lung disease (*if using chest restraint*)⁶
- Known or suspected pregnancy
- Missing limb

NOTES

NOTE: Verbal de-escalation is the gold standard for managing an agitated patient. However, sometimes physical restraint is unavoidable. Chemical restraint is not available in the BPSDU.

The emergency restraint chair is intended for the protection of the patient from harm and the staff from injury. It is not applied punitively, and should not itself cause injury to the patient. It should not avoid or delay transporting a patient who needs urgent hospital care.

The role of the detention unit (DU) paramedic is to assess the patient and advise law enforcement as to the medical safety of implementing emergency restraint. The authority and decision for using the emergency restraint chair is at the sole discretion of BPS officers. BPS staff will be responsible for applying and removing emergency restraint.

When the emergency restraint chair is in use, the DU paramedic is responsible to provide appropriate monitoring and medical care to the patient, and advise law enforcement when it may be appropriate to remove the patient from the restraint chair.

The detention unit (DU) paramedic will comply with all directions from a BPS officer, excluding issues related to medical care, and must act in accordance with the BPS Emergency Restraint Chair Policy with respect to authorization, application, monitoring, reporting and documentation.

1. While in the BPSDU the individual is considered a patient under the care of Shared Health ERS. Under usual circumstances *informed consent* from the patient (or their health care proxy) is required for any medical intervention (A05). However, severe agitation should be considered a medical emergency and *implied consent* for medical assessment and care can be assumed.

2. A paramedic may contact the Virtual Emergency Care & Transport Resource Service (VECTRS) and consult with the ERS medical director at any time, especially you are uncertain about a patient's condition and whether or not they are medically safe for emergency restraint.
3. A number of medical and mental health conditions may cause a patient to be agitated (table A). These must always be considered and ruled out before applying restraint.

Active suicidal ideation (SI) is of itself not a contraindication to the use of the emergency restraint chair. However, once settled the SI must be evaluated by a qualified mental health practitioner.
4. An individual in restraint requires close observation and frequent reassessment. As the use of the restraint chair will require the near-continuous attention of the DU paramedic, all further intakes should be suspended until the situation is resolved.
 - In the initial 15 minutes of restraint, the patient undergo repeat measurement of vital signs (VS) and calculation of the Glasgow coma scale (GCS) score every 5 minutes.
 - If the patient is stable after the initial 15 minutes, the DU paramedic should continue to reassess the VS and GCS every 15 to 30 minutes. Limb neurovascular and respiratory status should be evaluated with every reassessment.
5. The DU paramedic should check to ensure that the shoulder and limb restraints are not causing any awkward positioning which could result in musculoskeletal injury.
6. If a chest restraint is used, the DU paramedic must ensure that it is not restricting full respiratory movement. If improperly applied, this can compromise respiratory function and cause deterioration in an individual with preexisting obstructive or restrictive lung disease.
7. Every encounter with the patient should be used to re-evaluate their mental state and determine if continued restraint is necessary. Oral fluids and toileting should be offered at each encounter.
8. The duration of restraint should generally be limited to 2 hours. Complications of prolonged restraint include dehydration, urinary retention, deep venous thrombosis or pulmonary thromboembolism, compressive neuropathy, and pressure sores.

More importantly, if the patient's agitation is not improving within a couple of hours (or worsening), they require transfer to hospital for further assessment and management.
9. If a patient is restrained longer than 2 hours, consult with BPSDU staff about potentially releasing them from the chair for a brief recess. Alternatively, each limb can be released one at a time and the patient encouraged to move them through a full range of motion.
10. Any injury from restraint or the takedown should be noted, assessed and documented in the electronic patient record (EPR).

TABLE A: DIFFERENTIAL DIAGNOSIS OF THE AGITATED PATIENT

DRUGS & TOXINS:

- Intoxication
- Withdrawal
- Overdose / poisoning
- Side effects of prescribed or non-prescribed medications

INFECTIONS:

- Systemic infections (e.g. sepsis)
- CNS infections (e.g. encephalitis, meningitis)

METABOLIC DERANGEMENTS

- Hypoglycemia
- Hypoxemia
- Hyperthyroidism

CENTRAL NERVOUS SYSTEM DISORDERS

- Dementia
- Seizures (e.g. non-convulsive status epilepticus)
- Acute head injury
- Hypertensive encephalopathy
- Hyperthermia

PSYCHIATRIC DISORDERS:

- Acute psychosis
- Mania / bipolar illness
- Anxiety / panic attack

FIGURE 1



LINKS

- G01 - Brandon Police Service Detention Unit

APPROVED BY

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VERSION CHANGES (refer to X07 for change tracking)

- New