AMERICAN MEDICAL DIRECTORS ASSOCIATION
HOUSE OF DELEGATES
RESOLUTION D91

SUBJECT: **Guidelines for Restraint Use Developed by the Clinical Practice Committee of the American Geriatrics Society**

INTRODUCED BY: **AMDA Board of Directors**

INTRODUCED ON: **December, 1991**

Introduction

The very essence of geriatric health care embodies achievement of the highest level of independent functioning, emphasizing an individualized approach to effect the highest quality of life possible. Restraints, physical or chemical agents that are designed to inhibit voluntary movement, are commonly used in acute and long term care settings purportedly to prevent injury and protect patients. While their intended use is to "prevent harm," numerous studies have shown that the use of restraints neither decreases the number of falls, nor do they ensure freedom from injury, which is often severe among the restrained.

Background

The Omnibus Budget Reconciliation Act of 1987 (OBRA) set forth regulations regarding the use of restraints in nursing homes. Specifically, these regulations forbid restraint use for the purpose of discipline or convenience. They call for a comprehensive nursing assessment of problematic behaviors and physician concurrence prior to the institution of restraint use as last resort after all alternatives have failed. In addition, once the restraining device has been explained to the patient, family member, or legal representative, it should be used only for a specific reason and for only a specified period of time, followed by reassessment. If a life-threatening symptom or illness occurs, the restraint may be temporarily emergently used. Finally, monitoring of the indication for restraint use must be ongoing.

Restraint-free environments will necessitate consideration of various alternative measures for preventing and managing problematic behaviors. Measures such as wedge cushions and pads, enhanced physical therapy and recreational activities, and environmental manipulations are a few successful ways to lessen wandering and prevent injury to patents who heretofore would have been restrained.

Guidelines

Despite alternatives to restraint use, the OBRA regulations, and the good intentions of caregivers of older impaired patients, instances may arise when restraints may need to be considered. The Clinical Practice Committee of the American Geriatrics Society believes that guidelines for

restraint use in these situations should fulfill the following criteria:

1) In non-emergency situations, restraints may be applied only after careful and comprehensive review, assessment and documentation provides substantial evidence that no safer alternative or setting can be found to prevent their use. This should be a collaborative decision between the patient/family, nursing staff, attending physician and other relevant care providers (e.g., social worker, physical therapist). The least restrictive device should be used. The restraint order in this case should be reviewed on a periodic basis, no less than every 30 days. (Chemical agents may be used when there is a specific medical/psychiatric indication. Attempts should be made to withdraw these agents or temporarily discontinue their use [e.g., drug holidays]).

2. Behavior which precipitates the decision to restrain should first trigger investigation and treatment aimed at understanding and eliminating the cause of the behavior.

3. All mechanical restraints should be padded to decrease the change of pressure damage and abrasion to skin and underlying tissues; proper size and type must be used.

4. On rare occasions, short-term use of restraints may be indicated to enable life sustaining treatment which may often result in a less confused patient. In this situation and in an emergency life-threatening situation, when the patient is at significant risk of self injury or injury to others or at the patient's request, restraints may be used. Such use requires an emergency physician order which is renewed every 24 hours.

5. Both the patient and restraining device must be checked frequently and released every 1-2 hours. The restrained limbs should be periodically exercised and, if possible, the patient should be ambulated at reasonable intervals. Attention to need for hydration, elimination, comfort, and social interaction must be assured.

6. Reassessment at regular intervals to determine if safe alternatives are available or if there has been a change in underlying behavior is mandatory.

7. Restraints should be removed or discontinued at reasonable intervals to reaffirm the need for or effectiveness of their use.

8. Periodic staff education as to the hazards of restraint use and alternative behavior management strategies to their use must be ongoing.

9. Research into innovative alternatives to restraint use in acute and long term care settings must be encouraged.

RESOLUTION RESULTS: Approved as "Guidelines" December, 1991.