

1.2.7 Use of Restraints

All individuals have a fundamental right to be free from unreasonable bodily restraint. At times, however, health conditions may result in behavior that puts patients at risk of harming themselves. In such situations, it may be ethically justifiable for physicians to order the use of chemical or physical restraint to protect the patient.

Except in emergencies, patients should be restrained only on a physician's explicit order. Patients should never be restrained punitively, for convenience, or as an alternate to reasonable staffing.

Physicians who order chemical or physical restraints should:

- (a) Use best professional judgment to determine whether restraint is clinically indicated for the individual patient.
- (b) Obtain the patient's informed consent to the use of restraint, or the consent of the patient's surrogate when the patient lacks decision-making capacity. Physicians should explain to the patient or surrogate:
 - (i) why restraint is recommended;
 - (ii) what type of restraint will be used;
 - (iii) length of time for which restraint is intended to be used.
- (c) Regularly review the need for restraint and document the review and resulting decision in the patient's medical record.

In certain limited situations, when a patient poses a significant danger to self or others, it may be appropriate to restrain the patient involuntarily. In such situations, the least restrictive restraint reasonable should be implemented and the restraint should be removed promptly when no longer needed.

AMA Principles of Medical Ethics: I,IV

Background reports(s):

CEJA Report 3-A-16 Modernized *Code of Medical Ethics*

CEJA Report 5-A-89 Guidelines for the use of restraints in long-term care facilities

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CEJA Report A – A-89
Guidelines for the Use of Restraints in Long Term Care Facilities

INTRODUCTION

At the 1988 Interim Meeting, the House of Delegates referred Resolution 2 to the Board of Trustees. The resolution asked that the American Medical Association investigate the medical and ethical impact of the use of physical restraints on patients in long term care facilities.

Since 1.6 million Americans currently reside in nursing homes, practices that govern the use of restraints in such facilities affect a sizable patient population. Moreover, the physical frailty and cognitive impairment of many of the residents of these facilities increase their vulnerability to bodily harm and create a conflict between the provision of a safe therapeutic environment and the right of the patient to basic liberty and self-determination.

CURRENT PERSPECTIVES ON THE USE OF RESTRAINTS

Studies to date do not provide a clear indication of the frequency with which physical restraints are used in long term care facilities. Nonetheless, it appears that they are widely employed. A recent survey of skilled nursing homes in upstate New York revealed, for example, that during a 30-day period, physical restraints were used on 47% of nursing home residents. In addition, studies conducted on the general medical wards of hospitals indicate that elderly patients are frequently subjected to physical restraint. According to these studies, the use of physical restraints increases significantly with advancing patient age. In fact, the findings from one such study suggested that at least one in five elderly patients is placed in mechanical restraints at some point in time during his or her hospital stay.

Similar data have emerged from studies of the use of psychoactive drugs as chemical restraints in elderly residents of long term care facilities. For example, one recent study of twelve intermediate-care facilities revealed that more than half of all residents were receiving psychoactive medication. Similar findings from several prior studies have been reported as well. For example, a study of the prescriptions issued to Medicaid recipients in Tennessee's 173 nursing homes revealed that 43% of such residents were receiving antipsychotic drugs. Similarly, a 1976 study published by the Office of Long-Term Care of the Department of Health, Education, and Welfare suggested that nearly 50% of nursing home residents received antipsychotic medications or other tranquilizers. The frequent use of these drugs has been criticized because their clinical indications are often not recorded in the medical record.

The reason most commonly cited to support the use of restraints is to assure that the nursing home resident does not harm himself or others. The prevention of unwitnessed falls or attempts by the resident to disrupt prescribed medical treatment (e.g., by disturbing catheters or intravenous lines) are examples of common justifications that are given for the application of physical restraints. Cognitive impairment, disorientation, restlessness, agitation, or wandering also frequently result in the use of physical or chemical restraints.

The extent to which nursing home residents need to be restrained in order to prevent or control potentially harmful occurrences has not been established. In addition, the available evidence indicates that less restrictive measures often may be equally effective. Alternative measures that have been used successfully as substitutes for restraint include environmental modifications or the use of innovative devices that permit maximum mobility, periodic reorientation of the resident to his or her environment, and enhanced communication between nursing home residents and staff.

Diversionary techniques and greater reliance upon available family or friends for direct supervision have also been used successfully. In short, the purpose of restraints frequently may be served by less restrictive measures. However, these measures may be labor intensive, require increased family participation, and result in significant cost for environmental modifications.

RISKS ASSOCIATED WITH THE USE OF RESTRAINTS

The use of restraints has been shown to expose nursing home residents to additional elements of bodily risk. For example, in addition to the emotional trauma that frequently accompanies the use of restraints, elderly residents who are physically restrained may suffer from a variety of integumentary complications, including chronic constipation, incontinence, pressure sores, loss of bone mass and muscle tone, and an increased inability to walk independently. Physical injuries sustained by residents during attempts to free themselves from restraints, instances of aspiration pneumonia, and death due to strangulation have also been reported in the elderly who were placed in physical restraints.

Comparable risks also are associated with the use of psychoactive drugs as chemical restraints. Toxic reactions to psychoactive drugs, particularly among the elderly, are well documented in the literature. These include dizziness, tremors, increased agitation, worsened confusion, dry mouth, constipation, oversedation, urinary incontinence, and involuntary facial movements. Moreover, studies have shown that the use of such drugs in the elderly is associated with an increased risk of falls and hip fractures.

Physicians must pay particular attention to the effect of psychoactive drugs on elderly individuals. The aging process has been shown to affect the absorption, distribution, metabolism, and excretion of pharmacologic agents. Drugs therefore must be carefully selected, and standard dosages appropriately modified, for elderly individuals. In addition, adverse drug interactions, which frequently involve psychoactive medications, are much more common in the elderly than in younger populations because the elderly experience a higher rate of multiple illnesses, requiring multiple medications. In fact, the incidence of adverse drug interactions and untoward side effects involving psychoactive medications is twice as great in the elderly as in younger age groups.

In addition, fears have been expressed that restraints are frequently used in long term care facilities as a convenience, an alternative to adequate staffing, or a device to discipline residents.

As described earlier, alternatives to restraint are available. When such alternatives are either unavailable or ineffective, and the use of physical or chemical restraints is necessary to the provision of a safe therapeutic environment, the misuse of restraints may be minimized by: specific documentation in the medical record of the clinical indications for restraint; periodic documentation of the continuing need for restraint; and careful attention to the manner in which PRN orders for restraint are implemented.

THE RIGHTS OF THE NURSING HOME RESIDENT

All individuals have a legal right to be free from unreasonable bodily restraint. Individuals may be entitled to decline even reasonable restraints by exercising their freedom of choice with respect to their medical care. Therefore, informed consent for the application of physical restraints or the administration of psychoactive drugs is appropriate.

The main exceptions to a requirement of informed consent occur when the patient or others would be at risk for harm if the patient were not restrained. Under such circumstances, the resident's right of self-determination creates a conflict with the obligation of the long term care facility to provide a therapeutic environment that is safe for all residents of the facility. A resident's refusal of reasonable restraint therefore must be carefully balanced against the safety concerns of the facility.

When consent is appropriate, nursing home residents may lack the decision-making capability to voluntarily consent to the use of physical or chemical restraints. In this situation, the use of restraints should be discussed with the resident's family or other surrogate decision-maker.

The right of nursing home residents to be free from unreasonable bodily restraint also requires that care be provided in the environment that offers the fewest possible restrictions on mobility and independent action. The type of restraint selected should therefore permit the maximum degree of mobility that is compatible with therapeutic goals.

RECOMMENDATIONS

The Council on Ethical and Judicial Affairs recommends that physical and chemical restraints be used only in accordance with the following guidelines:

1. The use of restraints is a therapeutic measure that, except in emergencies, may be implemented only upon the explicit order of a physician, in conformance with reasonable professional judgment.
2. Cautious judgment should be exercised in issuing PRN orders for the use of physical or chemical restraints, and the implementation of such orders should be carefully reviewed by the physician.
3. The use of restraints should not be punitive, nor should they be used for convenience or as an alternative to adequate staffing.
4. Psychoactive drugs and physical restraints should be used for elderly residents of long term care facilities only in accordance with appropriate clinical indications. These clinical indications should be documented, and a continuing need for restraints should be periodically documented as well. Alternatives to restraint should be used, if possible, to control potentially injurious behavior.
 - a. With respect to the use of psychoactive drugs, the medication selected, the dosage prescribed, and the frequency and duration of administration should be appropriate to the physiological condition and needs of the individual-resident. The use of psychoactive drugs should also take into account the modified effects of drugs in the elderly and the potential for side effects or adverse drug interactions.
 - b. With respect to physical restraints, the type of device selected, as well as the part of the body restrained, should permit the maximum degree of mobility that is consistent with therapeutic goals. The duration of physical restraint should be specified, and the needs and comfort of the resident during periods of restraint should be assured.
5. As with all therapeutic interventions, informed consent is a key element in the application of physical and chemical restraints, and should be incorporated into institutional policy.

6. In certain, limited situations, it may be appropriate to restrain a patient involuntarily. For example, restraints may be needed to prevent imminent harm to the resident or to others. When residents are restrained involuntarily, the restraints should be removed when they are no longer justified.

While this report specifically addresses the use of restraints in long term care facilities, its principles and recommendations may be applied in other settings, including acute care facilities.

The Council on Ethical and Judicial Affairs recommends that this report be adopted.

Report of the Council on Ethical and Judicial Affairs
of the American Medical Association
June 1989

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