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Rick Rader, MD
VP, Policy & Advocacy

Stephen B. Sulkes, MD
President

Allen Wong, DDS
President-Elect

Medical Immobilization and Procedural Stabilization Policy Statement
Committee on Public Policy and Advocacy // AUG 2017

SUBJECT: AADMD Guidelines for Medical Immobilization and Procedural Stabilization

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Medical Immobilization and Procedural Stabilization (MIPS) is the application of protocols used to provide the clinician with the best scenario for a successful outcome of a clinical procedure that could not be completed with a patient that is unable or incapable of adhering to the recommendations provided by the clinician. Examples of these procedures include suturing, removal of foreign bodies, dental procedures, injections, venipuncture, examination of injuries etc. MIPS are employed during procedures when there is potential for medical or dental benefit to the patient and the patient's physical movements may produce harm to the patient during the procedure. Explanations of benefits, necessity, rationale, alternative considerations, ramifications and rights and choices will always be provided to the individual and legal conservators. MIPS constitutes a body of available approaches to protection of a patient requiring such procedures; it is recommended that the clinician be both familiar with the continuum of approaches and consider the most humanistic, safe and efficacious choice for the individual patient for that time and setting. The AADMD is committed to periodically reviewing these guidelines, amending them as called for and providing clinicians, patients and families with updates on its applications.

GUIDELINES ON MEDICAL AND DENTAL PROCEDURE STABILIZATION

Purpose:

These guidelines are intended to describe, promote and support the employment of techniques used to stabilize, immobilize and brace patients with intellectual and developmental disabilities (IDD) for whom the use of these techniques is clinically indicated and appropriate. Stabilization techniques are promoted to facilitate the clinician's ability to successfully perform diagnostic and treatment procedures for the most optimal patient outcomes. They are designed to safely support the patient and the clinical staff and to prevent, to the extent possible, unsatisfactory outcomes, undue pain and associated injuries that could result from an unstable work field. Examples of these diagnostic and treatment procedures include, but are not limited to, suturing, foreign object removal, injections, venipunctures, insertion of nasal gastric tubes, pelvic examinations, digital rectal examination, drainage of furuncles and carbuncles, examination of ears, nose and throats, introduction of eye medication, all dental procedures, and aberrant behaviors related to psychiatric episodes.

Acknowledgements:

The American Academy of Developmental Medicine and Dentistry recognizes that the use of procedural stabilization (or medical immobilization) involves issues of civil rights, human rights and liberties, and self-determination (the right to refuse care, freedom of association). There are however situations, circumstances and scenarios when the use of procedural stabilization is in the best interest of the patient.

Decisions regarding the use of stabilization techniques must ultimately be made by the lead physician or dentist, and should be used only as a last resort after full consideration of benefits and risks and then only to facilitate excellent clinical outcomes.

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Rationale:

The AADMD believes that all individuals with IDD deserve the highest quality of medical and dental care. To achieve that goal it is imperative that the clinician understands the cognitive, behavioral, sensory, reasoning and experiential histories of the patient. There will be circumstances where it is reasonable to expect that a patient may not present a cooperative, compliant and optimal patient. (See WHO Manual on Mental Health Law and Human Rights and Quality Rights tool [1]) Should there be a risk of the patient becoming agitated, unsteady, thrashing, contorted, flailing and spasmodic, which has the potential for an unsuccessful outcome of the procedure with unhealthy consequences, and/or the procedure has to be repeated or the results compromised, the AADMD believes measured interventions that increase the opportunity for a successful procedure with a successful outcome is preferred to going to the surgical suite for general anesthesia with all the inherent risks that provides. Sir William Osler, the doyen of American medicine observed, "Do the kindest thing and do it first." Often the kindest (and safest) thing is to stabilize and immobilize the patient to ensure a clinically successful procedure.

Background:

Procedural stabilization or immobilization is defined 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."

Consistent with the UN principles for the Protection of Persons with Mental Illness and Care [2] and principles Least Intrusiveness and Least Restrictiveness, and as may be indicated with any patient, techniques that serve to desensitize a patient should always be employed prior to consideration of the use of stabilization, immobilization or bracing of people. Furthermore, a full range of person-centered positive behavioral supports must be considered and utilized with people prior to, during and after any application of stabilization, immobilization or bracing.

Historically and now, there is substantial debate over the philosophy and clinical wisdom of using general anesthesia (GA) or intravenous (IV) sedation for general dentistry for patients with IDD. Notwithstanding, GA or IV sedation must be considered as part of the continuum of medical immobilization, and then only when clinically indicated.

Indications:

Procedural stabilization is indicated when:

- A patient requires diagnosis and/or treatment and cannot be safely examined and/or treated without stabilization.
- Medical or dental treatment is needed and uncontrolled movements risk the safety of the patient, staff, dentist, physician, nurse, aide, or parent without the use of protective stabilization.
- A previously cooperative patient quickly becomes agitated during the appointment, in order to protect their safety and help to expedite completion of treatment.
- A sedated patient may become unexpectedly active during treatment.
- A patient with special health care needs may experience uncontrolled movements that would be harmful or significantly interfere with the quality of care.

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Benefits:

When used correctly and in accordance with these guidelines, procedural stabilization provides the following benefits:

- Provides the clinician with (as near as possible) an examination and operatory field with a reduction in untoward movements.
- Provides protection for the patient and the healthcare team.
- Provides the patient with a familiarity of expectations which can diminish future anxiety promoting healthcare visits.

Contraindications:

Procedural stabilization is contraindicated for:

- Compliant and cooperative non-sedated patients.
- Patients with medical, dental, psychological, sensory, behavioral, psychiatric or physical conditions that prevent them from being safely immobilized.
- Patients with a history of significant physical or psychological trauma due to previous restraints (unless no other alternatives are available).

Principles and Core Values:

- The full array of positive behavioral supports should be considered prior to, during and following the application of stabilization techniques.
- Procedural stabilization should, to the extent possible, be person centered and conducted in a fashion that maintains the patients' privacy and dignity.
- Procedural stabilization should be provided in the least restrictive manner possible.
- Staff should be trained in the safe, efficacious employment of any devices, techniques or protocols. Their training requires documentation and evidence of competency based training with refresher training based on frequency of use of stabilization techniques, confidence level and self-assessment, but no less frequently than every two years.
- Patients should be monitored (health status) during and after the use of any procedural stabilization.
- The use of procedural stabilization requires documentation and should include the reason for the stabilization, any alternatives that were tried (where possible), members of the healthcare provider team, outcomes and any recommendations for future use of the stabilization protocols with this patient.
- Obtain informed consent/ascent. Communicate the intention to use procedural stabilization to the patients, parents, family members, legal guardians/conservators, direct care staff and others responsible for their custody and care at the first available opportunity. Provide them with the rationale, risks, consequences and expectations. Document the dialogue. (If the person is receiving long term services and supports, it is likely appropriate to review any recommended use of stabilization with the person's interdisciplinary team. In addition, laws and applicable regulation should be consulted for involvement of human rights committees or their equivalent.)

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Equipment:

Numerous devices are available to achieve procedural stabilization (medical immobilization). The staff should be knowledgeable regarding the ideal characteristics of the devices they will be using; these devices should be:

- Easily used
- Appropriately sized for the patient
- Soft and contoured to minimize potential injury to and provide comfort to the patient
- Specifically designed for patient stabilization (no improvised equipment)
- Able to be sanitized and disinfected after each use.
- Mouth props may be used for oral and dental procedures as an immobilization device. The use of a mouth prop in a compliant patient is not considered procedural stabilization.
- Hand guarding (the use of the clinician's hands and arms or that of the assistant) to provide adjunct stabilization can be employed providing that at no time the hand guarding should restrict blood flow or respiration.

References

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Our Lives, Our Health Care: Self Advocates Speaking Out About Our Experiences with the Medical System, Autistic Self Advocates Network, 2014

Joint Policy Statement – Guidelines for Care of Children in the Emergency Department, American Academy of Pediatrics, Committee on Pediatric Emergency Medicine, American College of Emergency Physicians, Pediatric Committee, Emergency Nurses Association Pediatric Committee, 2009

[1]**WHO Manual on Mental Health Law andHuman Rights**
http://ec.europa.eu/health//sites/health/files/mental_health/docs/who_resource_book_en.pdf

[1]**WHO Quality Rights Tool**
http://apps.who.int/iris/bitstream/10665/70927/3/9789241548410_eng.pdf?ua=1

[2]**UN Principles for the Protection of Persons with Mental Illness**
http://www.un.org/documents/ga/res/46/a46r119.htm