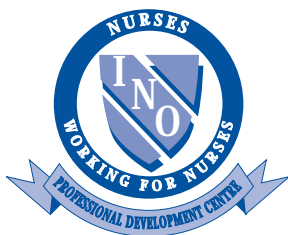




Guidelines on The Use of Restraint in the Care of the Older Person

**Irish Nurses Organisation
Focus Group from the
Care of the Older Person Section**

May 2003



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Members of the Focus Group

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Introduction

The issue of restraint is a difficult and emotive one that nurses frequently face in caring for Older Adults. The Care of the Older Person Section of the Irish Nurses Organisation has prepared this document to achieve the following aims.

- To raise awareness of restraint use and alternatives among members
- To increase knowledge to ensure that restraint is used only when all alternatives have been explored
- To explore nursing interventions that have a more therapeutic orientation
- To clarify the legal position in the use of restraints
- To advise of the need for clear policies in restraint use

The use of restraint can have untoward physical and psychological side effects. The goal of a restraint free environment is considered the most desirable but when restraint is required it is important that the rights, risks and responsibilities of the practice are considered carefully. Walter (1994) challenges nurses to develop interventions that have a more therapeutic orientation.

Definition of restraint

Restraint may be defined as *"any device that limits an individual's freedom for voluntary movement."* (Sullivan-Marx, 1995). It can be described as an intervention that prevents a person from causing harm to themselves, others or property (Duff et al, 1996).

Restraint is often applied because staff members believe that there is no alternative.

Lee et al, (1999) highlight that nurses perceive the following reasons for using restraint:

- To prevent falls
- To protect from injury
- To maintain treatment regimens
- To control people exhibiting confusion or agitation

Types of restraint

Broadly, restraints can be classified under two categories: physical and chemical. Examples of these are as follows:

- Cot sides
- Harness
- Locks (Mechanical and Electronic)
- Arranged furniture to impede movement
- Specially designed chairs to immobilize
- Inappropriate use of night wear during the day
- Putting a person into bed during the day who doesn't need rest
- Vests, body harnesses or wrist restraint garments
- Controlling language, body language and non-verbal behaviour
- Isolation from others
- Sedative medication

Effects of Restraint

In Ireland, apart from the Mental Treatment Act 1945 there is no law authorising the restraint of an adult and thus depriving them of a fundamental human right. In addition to this, there is increasing evidence advocating restraint free care. Watson (2001) suggests that when using restraint, nurses may believe that they are acting in the best interests of the older person. However restraint has adverse physical and psychological consequences. In physical terms these include:

- muscle atrophy
- loss of bone density
- pressure sores
- nosocomial infection
- strangulation
- functional decline
- cardiac stress
- incontinence.

Psychological effects include:

- depression
- cognitive decline
- emotional isolation
- confusion and agitation.

(Watson, 2001).

Therefore, it is imperative for nurses to consider the necessity and reasoning behind the use of restraint.

Avoiding/Reducing restraint

Avoiding restraint involves an element of risk. Raising awareness of restraint as an issue is an essential first step in reducing its use. Strumpf and Evans (1991) believe that restraint free care should be established as the standard of care for older adults in all settings. The key points in an examination of the ethical problems that he identifies include:

- The rising prevalence of physical restraint warrants careful examination of the moral, ethical and legal dimensions of the practice. For the frail elderly, quality of life, decision making and informed consent are significant issues.
- The ethical dilemmas created by the use of physical restraints and the need to consider restraint as an issue fundamental to the nursing home milieu and beliefs about quality of life, require understanding of and commitment to care that is individualised and person-centred.
- The elements identified in care settings where restraints are rarely, if ever, used evolve from an awareness of the needs of the individual resident, continuous monitoring of health status, and appropriate adjustments in the care plan.

In an attempt to reduce restraint Quinn (1994) suggests that all care staff and nurses should consider the use of the '**Four A's**' of restraint reduction;

- **Attitude** - this is the development of the attitude of "last resort, not first choice."
- **Assessment** - this involves the careful systematic assessment of patient mobility, mental status and behavioural cues.
- **Anticipation** - consider the application of knowledge of treatment interventions, therapeutic goals and the needs of older people.
- **Avoidance** - the implementation of alternative nursing measures to accomplish treatment goals without physical restraint.

It is essential to have appropriate staffing levels, linked to client dependency needs, in order to uphold a restraint free ideology.

Professional nurses, caring for older persons, can combine specialist knowledge and experience when addressing the multifaceted problems that might lead to the consideration of restraint as a treatment option.

As suggested by Quinn (1994) a thorough, ongoing assessment of patient/client situations should be undertaken. The purpose of this is to ensure that preventive measures can be utilised to prevent the need for restraint. This is particularly important in the areas of mobility, mental status and disruptive behaviours.

Practice Review/Education

Rieth et al (1998) states that to initiate a change in restraint policy nurse managers should review current practice to include research in legal and moral issues. There is a need to implement a staff education programme culminating in an evaluation process. This requires much consultation/agreement with the multi disciplinary team.

Setting up of such an educational programme should increase staff awareness of the hazards of restraint. In addition to policy change and education, nurses need to know what to do when caring for an older person with behaviour that they find difficult to manage. Skill based training in assessing and managing the behaviour of older persons should be provided. Ongoing support for staff is imperative in order to effectively implement new practice.

Nurses need to know how to assess and interpret the challenging behaviour of individuals in order to implement care that will effectively manage behavioural challenges. The essence of this approach is individualised skillful care that should have the effect of reducing the perceived need for restraint.

The legal side of restraints

In principle, a patient should receive treatment only after consenting to it. Consent is rooted in the Irish Constitution's guarantee of bodily integrity.

To be legally valid, consent should be made by a competent patient without coercion and upon relevant information about the treatment's side-effects and alternatives.

The use of a restraint, therefore, runs contrary to the principle of consent. However, the Irish law also recognises that in many cases restraints are necessary to ensure a right even higher than the right of consent - the right to life.

In such a way, anyone who uses chemical, physical, or psychological restraints must ensure that the restraints are necessary to prevent patients from harming themselves or others.

Restraints, however, should not be used as a means to compel competent patients to receive treatment. The law recognises that competent patients possess the right to refuse medical treatment even where that treatment will bring about their deaths.

Although obtaining a patient's consent to restraints may seem paradoxical, nurses should endeavour to obtain consent from competent patients. Those patients may consent in circumstances where the nurse can persuade such patients that restraint is for their own good. Of course, in most circumstances, the patient is not competent to consent or refuses to consent. In such circumstances, a nurse can still use a restraint to prevent harm - despite the objection of a competent patient.

Although many institutions often ask family members to "consent" to the restraint of an incompetent or unwilling adult patient, such "consent" has little legal effect. In law, only the adult individual can give a valid consent.

Deciding what type of restraint to use is based not on law but on good clinical practice. What the law requires is that any restraint be the minimum type of restraint necessary to achieve the result of preventing harm.

As with any other form of care, nurses should document any use of restraint, including the reason for the restraint.

Any nurse who works in an institution where a patient is unnecessarily or improperly restrained has an ethical duty to complain to the relevant authority about the restraint. Any nurse who witnesses unnecessary or improper restraint in the community should educate those caring for the patient about the appropriate use of restraints.

Creating a restraint free environment

Individualised care requires that a baseline history of the patient/client prior to their admission is obtained. This will help to gain understanding of the person. In particular ask about:

- sleeping patterns
- areas of mobility
- mental status
- behaviours of disruptive nature

This assessment will advise the relevant multi disciplinary team of the appropriate care needs of the patient/client.

Restraint is often used when the patient/client demonstrates confused agitated behaviour.

Confusion is often the first sign of an underlying condition. Examples of underlying problems could include:

- Hypoxia
- Electrolyte imbalance
- Depression
- Pain
- Infection
- Unintended effects of medication due to Polupharmacy or drug interactions
- Constipation

DeProspero and Bocchino (1999) and Quinn (1994) make suggestions on therapeutic interventions that may help. Consideration should be given to the following:

- Moving the patient nearer to the nurse's station. Human contact may calm him/her. Watching activities may distract him/her.
- Chairs should be made more comfortable and assessed as suitable for the person's requirements.
- Wheelchairs should be used for transport purposes only unless their use is necessary for the individual needs of the person.
- Patients who have to sit for extended periods should be positioned in a chair that provides adequate support for their back, arms and legs.
- Reassess the need for intravenous infusions, feeding tubes and urinary catheters as part of the restraint assessment.
- Comfort measures can reduce need for restraint in some situations. An example of this is the use of humidification and comfortable tape when delivering nasal oxygen.
- The patient/client's environment should also be considered. The bed should be placed in a low position. The pathway to the bathroom should be clear of obstacles and the floor should be checked regularly for spills or obstructions. Suitable lighting may be necessary to allay anxiety and increase safety.

In a research study bedrails were identified as a particular risk for patients (Hangar, 1999). This study suggests that bedrails can be reduced without increased risk to older people. Lee et al (1999) suggest that bedrails have potential for the occurrence of more serious accidents because the patient may fall from a greater height. Watson (2001) concurs with this and states that the patient/client can receive injuries if they put their limbs between the bars. Patients/clients may choose to have bedrails as a measure of security. It is advised that if a decision is made to use them the reasons should be documented in the patient/client's care plan.

Nurses must also be attentive to situations that might over stimulate the older person e.g. sitting in front of the TV. Wandering behaviour can help to use energy associated with agitation and over stimulation. DeProspero Rogers and Poccino (1999) suggest that therefore restricting mobility often increases the person's agitated state.

Approaches that may reduce the need for Restraint

There is an expanding range of therapeutic activities that can be utilised to enrich the environment of care. Many behavioural challenges can arise because of impoverished, under stimulated environments.

Selection of activities available -

Sonas aPc is a way of activating potential for communication in older people with communication difficulties using sensory stimulation i.e. music, touch, fragrance, taste and vision. (Sonas is Irish for wellbeing and aPc stands for activating potential for communication.) Research has shown that Sonas aPc has a beneficial effect on patient behaviour, improving cognition, mood, communication, self-care and reducing behavioural disturbance (Connors, 2000). There is evidence of a reduction in the occurrence of inappropriate behaviour using Sonas aPc (Linehan & Birkbeck 1996)

Music therapy and **creative intervention** can provide companionship for the older persons. Encouraging family and friends to visit are often welcomed activities. These will require supervision and support from the multi-disciplinary team. Facilitating families to learn communication skills may be necessary.

Reality orientation is a method of communication using cues from the surrounding environment. There are arguments for and against reality orientation. However the use of aspects of reality orientation may be useful in reducing confusion. Some units benefit from simple aspects of the intervention such as using orientation boards, clocks and calendars etc (Woodrow, 1998).

Multi-sensory rooms may also be used in the care of people with dementia. Research has shown that multi-sensory rooms can have a calming effect on patients. They can use to promote relaxation and communication (Hope, 1997).

Taking the resident to his or her own room can be helpful. Giving them 'quiet time' can be beneficial.

Reminiscence Therapy is designed to share memories of the past. It is thought to increase self esteem, increase socialisation and increase awareness of the uniqueness of the individual. It can help older people resolve past conflicts and maintain their identity (Matteson and McConnell 1997). However adequate training is needed to

ensure that nursing staff have the appropriate skills to facilitate cathartic responses that may occur with the revival of old memories.

The RCN(1999) identify other approaches. These include:

- Validation approach
- Relaxation
- Massage
- Aromatherapy

Guidelines for good practice if restraints are deemed necessary

Stumpf & Evans (1991) suggest that the use of restraints and beliefs about quality of life require a clear understanding of and commitment to care. This care should be individualised and person centred.

Restraint policies should reflect the following ethical principles:

Beneficence: the intention to do good.

Non-maleficence: the intention to do no harm.

Justice: to treat all clients fairly and equally.

Autonomy: to aid and respect the patient/client's right of self-determination.

If, despite all alternative approaches having failed, restraint is assessed as an appropriate intervention an individualised care plan should be made detailing the outcome of the initial assessment. The decision to use a restraint should be made in consultation with the multi-disciplinary team that includes doctors, nurses, occupational therapists and physiotherapists, patient (if possible) and family. This decision should be documented in the patient/client's notes. This record forms the basis for ongoing evaluation of the need for restraining devices and ensures that abuse of restraint doesn't happen.

Restraint should only be used when all other nursing interventions have failed.

An agreed number of the multidisciplinary team should meet with the client and relatives and communicate the professional decision outlining the purpose of the restraint and the anticipated duration.

The restraint must be a time limited intervention and promote the following best practice benchmarks.

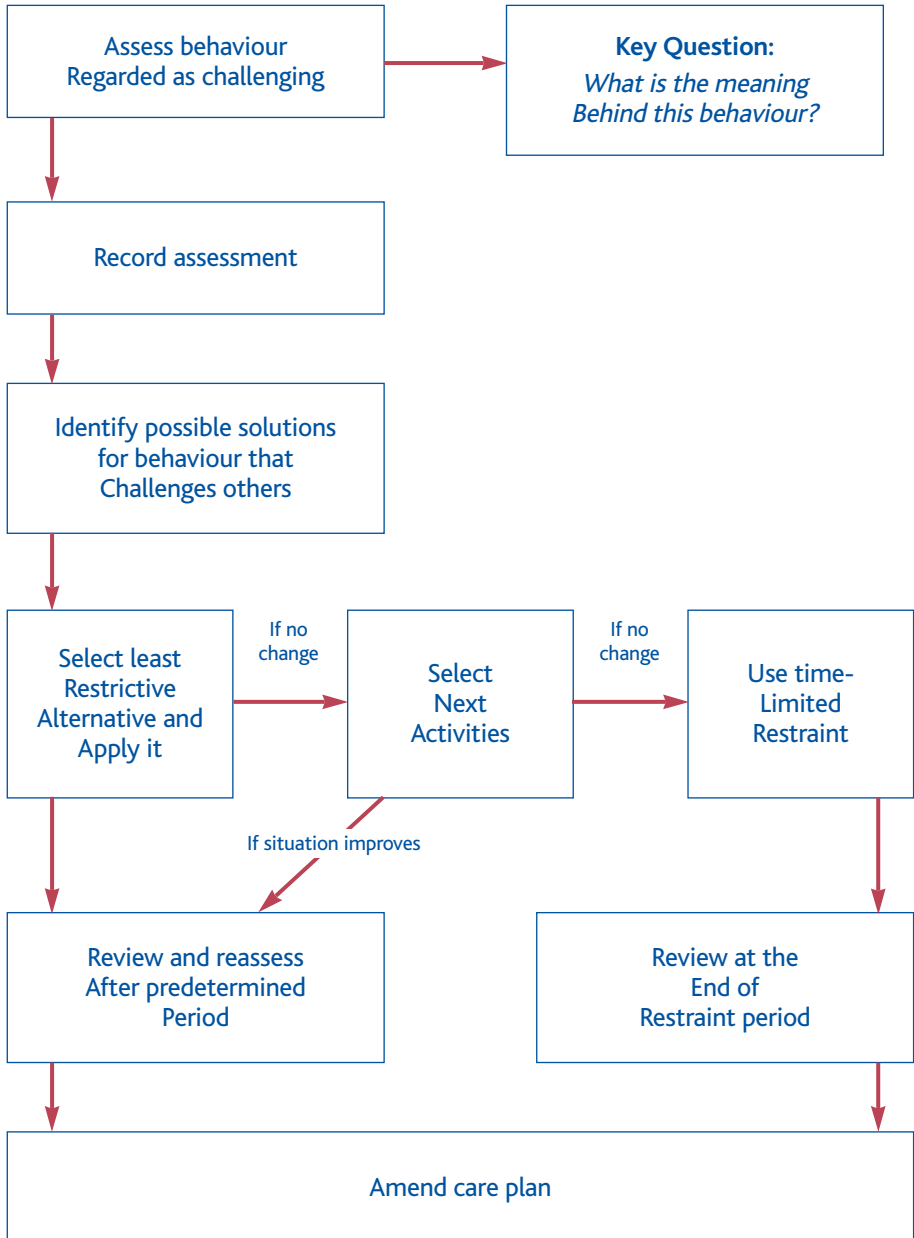
- It should be for the shortest time possible.
- The resident must be provided with a means of calling for assistance.
- Review times must be specified in advance and it should be documented that review took place.
- Where a patient has been restrained for over a period of two hours the restraint must be removed to change the patient/client's position and/or exercise limbs.
- If the patient is restrained for over four hours, the multi-disciplinary team must undertake a full review.

Family involvement in the patient/client's care should be encouraged. The restraints should be removed during family visits. Nursing staff must ensure that the family are fully consulted about the need for ensuring safety on their departure. It may be appropriate to encourage them to spend as much time as possible with their relative. This may significantly reduce the need for restraint.

All planned nursing care must continue during the period of restraint e.g. pressure area care, toileting etc.

The following scheme of care planning, designed by the RCN (1999), will assist nurse members when the need for restraint is considered.

A Scheme for the implementation of restraint (RCN, 1999):



Recommendations

- Nursing practice should embrace a holistic approach to care that ideally will reduce the need for restraint.
- Continuous education in the alternatives to restraint should be provided which will hopefully create a positive attitude to the reduction/ elimination of restraint, in all care of the older person facilities.
- Integrating diversional activities as part of the care plan for the older person may help in managing the avoidance of restraint.
- A policy on the use of restraints should be introduced in all older person care facilities. This policy introduction should have a consultative approach.
- The use of restraint should only be initiated following appropriate assessment and evaluation. All aspects of the action must be documented in the nursing documentation.
- Discuss the proposed restraint with the patient regardless of their mental ability and try to reassure them.
- Discuss the plan of action with the family and explain the reason why restraint is necessary and the proposed method.
- Restraint must be temporary and the patient's position should be changed at least two hourly and reviewed regularly.
- Continuous monitoring and review of staffing levels to ensure appropriate levels of nursing care, restricted use of restraint and increased quality of life for the older person.

Summary

- Restraint is an emotive issue with physical, psychological, legal and ethical dimensions. (Watson, 2001).
- Nurses have a duty of care towards their clients. They should treat their clients according to the ethical, legal and professional principles of a registered nurse.
- Underlying causes of behaviour should be assessed. Solutions to these problems may be quite simple and treatable thus reducing the need for restraint.
- Restraint should be a last resort and should only be considered when alternative measures have failed.

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Acts:

Mental Health Act 1945

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