Restraint
Development of a National Policy

Ann Coyle
Planning Specialist for Older People
John Linehan
Coordinator of Services for Older People

- Draft Quality Standards for Residential care
  - Challenging Behaviour
  - Use of psychotropic medication
  - Use of Physical Restraints

National Working Group

- Partnership between the Public and Private Sector
- Health Professionals
- Patients advocates

Features of the policy

Forward Looking

Outward looking

Evidence Based

Inclusive

Joined up

Review

Evaluation

Forward looking

- Long term view. What is the likely effect for the next 5-10 years.
- Clear Vision
- Defined outcomes

Outward looking and Evidence based

- Take account of the experiences elsewhere.
- Evidence based
- Lots of research in this area.

Inclusive

- Working groups are multidisciplinary
- Patient advocates
- Consultation process in four regions

Joined up

- Work elsewhere on
  - Falls
  - Management of Violence and Aggression
  - Consent
  - Elder Abuse

Review

- Need to put in place actions to review policy
- Evaluate its effectiveness
- Learn form experience of what works
- Supportive process

Work to date

- Two working groups
  - The use of Physical restraints
  - The use of Psychotropic medicines
  - Consultation workshops in each region

Challenges

- How to enable (drive) best practice in the spirit of support.

Why are restraints used?

- Major justification related to patient orientated factors
  - To prevent falls and subsequent injury
  - To protect from injury to self or others
  - To maintain treatment regimes
  - To control challenging behaviours

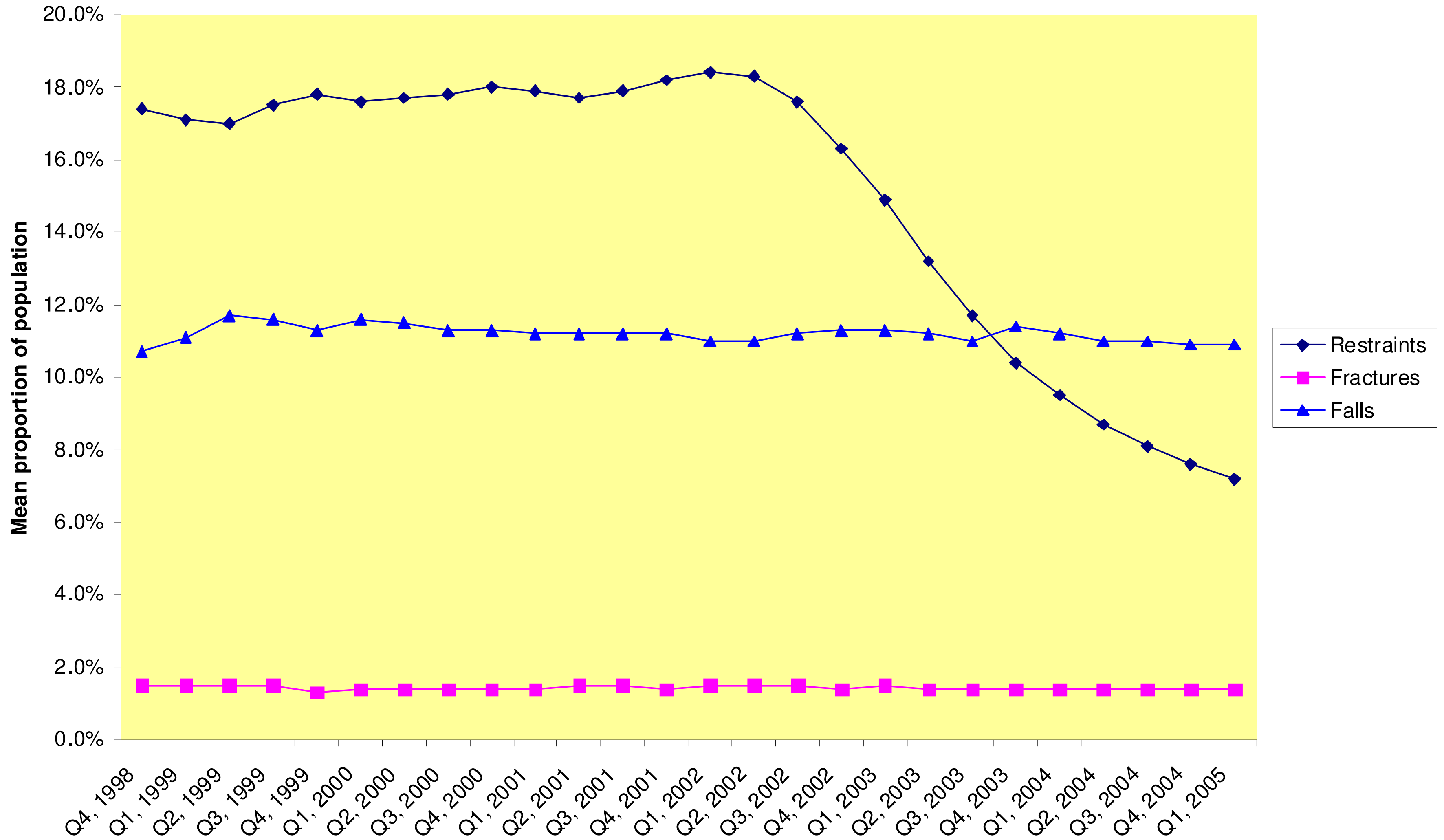
- Achieve organisational goals
  - Placate other residents/relatives
  - Facilitate ward routine and save time

The evidence!!

- Research evidence has now established
  - Restraint is not an effective method of preventing falls & injuries (Hill et Al 2004)
  - Reducing restraint does not result in an increase in falls & injuries
  - Restrained residents – sustain more serious injuries when they do fall & have equal risk of falling as unrestrained do (Evans et al, 2002; Hamers, 2004)
  - They do not save time

TMF
Health Quality Institute

Texas trends for restraints, fractures, and falls
Quality Indicator Data, Oct. 1998 - March 2005



Underlying philosophy

- Person centred
- Person’s rights to independence,
- Positive ageing
- Resident safety and positive outcomes
- Process consent
- Interdisciplinary approach
- Supportive of staff in a cultural change
- Clinical governance (user involvement, clinical effectiveness, risk management)
- Ethical issues

Definition

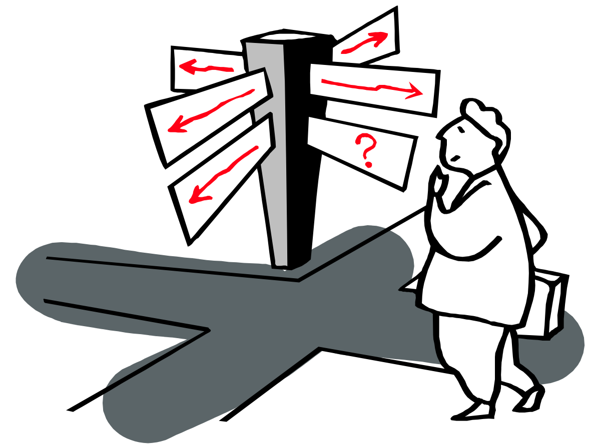
- No universally accepted one but common themes
- Types
- Enabling/safety versus restraint
  - If a chair is used to prevent challenging behaviour during a designated meal time, it may be considered a restraint; however if a chair is used to promote optimal positioning for swallowing during a designated meal time, it may be considered a safety device.
- No restraint versus minimal restraint
- Where consent is given….
- Change from chemical restraint to use of psychotropic medication

Definition

- ***"Any physical, chemical or environmental intervention used specifically to restrict the freedom of movement – or behaviour perceived by others to be antisocial – of a resident designated as receiving care in a residential care setting. It does not refer to equipment requested by the individual for their safety, mobility or comfort. Neither does it refer to drugs used – with informed consent – to treat specific, appropriately diagnosed conditions where drug use is clinically indicated to be the most appropriate treatment. Thus restraint by definition may be seen to be a human rights rather than a medical issue" (Nay and Koch 2005).***
- ***** *On occasion a device may restrict movement but enable function e.g.. Lap tray for self feeding. However, it is the intent behind using the device that determines whether it is a restraint or an enabler.*

Assessment

- **Comprehensive**
  - Related to the person's physical well being
  - Psychosocial well being
  - Environment
  - Facility
- **Interdisciplinary**
  - "everyone's responsibility"
- **Objective**
  - Reliable and valid assessment tools
  - Clinical knowledge and skills
  - Clear identification of the behaviour/risk



Assessment

- **Gather information**
  - Pre admission/on admission
  - When a change occurs
  - Continuous review
- **Relate to the behaviour**
  - Challenging – behavioural assessment tools
- Facilitates clarity, insight, understanding, creativity & more appropriate interventions

(Park & Tang, 2007)

Assessment

- **The assessment process should involve:**
  - examining the behaviour of the resident in context
  - assessing the contributing sources
  - assessing the severity and potential consequences of the resident’s behaviour for both the resident and others.
  - Who is it a problem for??

The decision should be….

- Interdisciplinary (person/family)
- Co-ordinated
- Show that all other alternatives have been tried and proved unsuccessful
- If applied:
  - Last resort
  - Follow clear protocols
  - Least restrictive (to include dose etc)
  - Shortest duration possible
  - Risk assessment
  - Closely observed and monitored
  - Reviewed

Decision making

- Out of hours/emergency:
  - Immediate and significant danger
  - Individual clinical judgement
  - Decision review by the team as soon as possible
  - Short term
  - Continuous observation
- The intervention will improve the situation and promote a positive outcome for the resident

Process

- **The process is documented**
  - Record of assessment
  - Interventions used in avoiding restraint
  - Clear indication of why it didn't work
  - Record of restraint use to include type (restraint register)
  - Decision makers
  - Review times
    - Observation schedules
    - Residents response and adverse reactions
    - Preventative care plan
- Clinical audit and resident tracking

Barriers

- Fear of resident injury & litigation
- Staffing & resource issues
- Poor clinical skills/practice not evidence based/subjective norms
- Poor review practices
- Communication barriers- staff/relatives
- Environmental constraints
- Policy & management issues

(Black & Haralambous, B. 2005)
(O'Sullivan, Marx 2001)

A thought to finish with……

- *If we spent as much time on trying to understand behaviour as we spend trying to manage or control it, we might discover that what lies behind it is a genuine attempt to communicate.’*

Goldsmith, M (1996) Slow down and listen to their voices.
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