Standardised care process (SCP): physical restraint

health

Topic

Alternatives to physical restraint

Objective

To promote evidence-based practice in seeking alternatives to physical restraint

Rationale

Physical restraint is associated with poor outcomes for residents including incontinence, reduced functional ability, immobility, pressure ulcers, agitation, withdrawal and social isolation, serious injury and death.

Physical restraint therefore should never be used without demonstrated consideration being giving to the reasons for restraint, the potential harm of restraint, what alternatives to restraint could be used and strategies to ensure the safety and wellbeing of the resident whether restrained or not.

Assessment of the resident and the situation prior to restraining the resident and implementation of appropriate alternative strategies can reduce the need for restraint.

Definitions

Physical restraint: 'the intentional restriction of a resident's voluntary movement or behaviour by the use of a device, or removal of mobility aids, or physical force.' (Department of Health and Ageing (DoHA), 2004 p. 6).

Physical restraint is most often used to manage need driven behaviours and prevent falls. However, the evidence indicates restraint does not prevent falls or fall related injuries (DoHA, 2007) and is likely to exacerbate behaviours.

Examples of physical restraint devices include: lap belts, bed rails, posey vests, chairs with tables attached, and chairs or mattresses that are difficult to get out of such as tip back chairs, water chairs, bean bags and curved edge mattresses.

Need driven behaviours (NDBs): people with dementia may not be able to communicate emotions such as fear and anxiety, or needs such as pain, hunger or thirst. These needs may be expressed through behaviours such as anger, aggression, restlessness, wandering or withdrawal and are often referred to as challenging, behaviours of concern, unmet need behaviours or Behavioural and Psychological Symptoms of Dementia (BPSDs).

Team

Manager, RNs, ENs, PCAs, resident and/or family, Lifestyle co-ordinator/activities worker, GP, physiotherapist, occupational therapist

Evidence base for this SCP

Australian Centre for Evidence Based Aged Care (ACEBAC) 2006, Responding to needs driven behaviours. Unpublished guideline.

Cotter VT & Evans LK 2007, *Avoiding restraints in older adults with dementia*, retrieved 5 March 2012, <http://consultgerirn.org/uploads/File/trythis/try_this_d1.pdf>.

Department of Health and Ageing 2004, *Decision–making tool: responding to issues of restraint in aged care*, Commonwealth of Australia, Canberra.

Radziewicz, RM, Amato S, Bradas C, Mion LC 2009, *Use of physical restraints with elderly patients.* Hartford Institute for Geriatric Nursing, retrieved 5 March 2012, <http://consultgerirn.org/topics/physical_restraints/want_to_know_more>.

Registered Nurses' Association of Ontario 2012, Promoting safety: alternative approaches to the use of restraints, Registered Nurses' Association of Ontario, Toronto, ON.

Brief SCP: physical restraint

Recognition and assessment	On admission, conduct an assessment including: • a cognitive assessment using the Psychogeriatric Assessment Scales – Cognitive Impairment Scale (PAS) • medical history: Is there a diagnosis of dementia? Is there a history of delirium? • is there a history of need driven behaviours? • resident's usual routines, likes, dislikes and preferences • pain assessment • falls risk assessment. If indicated by assessment develop an individualised care plan and/or falls prevention plan.
Interventions	• Identify and address the reason why a resident might be restrained • If at any time the resident exhibits need driven behaviours ensure the safety of the resident and others and: – conduct assessment as above – assess the resident's behaviour to identify the reason for the behaviour and to develop response strategies using the ACEBAC flow chart: *Responding to unmet need behaviours* • If at any time the resident falls or there is a change in his/her condition affecting the risk of falling repeat the falls risk assessment and review the falls prevention plan • Implement appropriate alternatives to restraint based on the findings from the behaviour and falls risk assessments
Referral	• GP for medical assessment of falls risk factors and reversible causes of behaviours • Lifestyle coordinator/activities worker • Occupational therapist • Physiotherapist
Evaluation and reassessment	• Ongoing evaluation of need driven behaviour interventions • If at any time a behaviour exacerbates or a new behaviour presents repeat the behaviour assessment using the ACEBAC flow chart • Ongoing evaluation of falls prevention strategies • If at any time the resident falls or their condition changes, repeat the falls risk assessment and review falls prevention strategies
Resident involvement	• Resident and/or family involvement in developing and implementing alternative strategies • Resident and/or family involvement in discussions as to the risks surrounding physical restraint
Staff knowledge and education	• Legal and professional issues relating to physical restraint • Alternatives to restraint • Falls prevention • Dementia and need driven behaviours

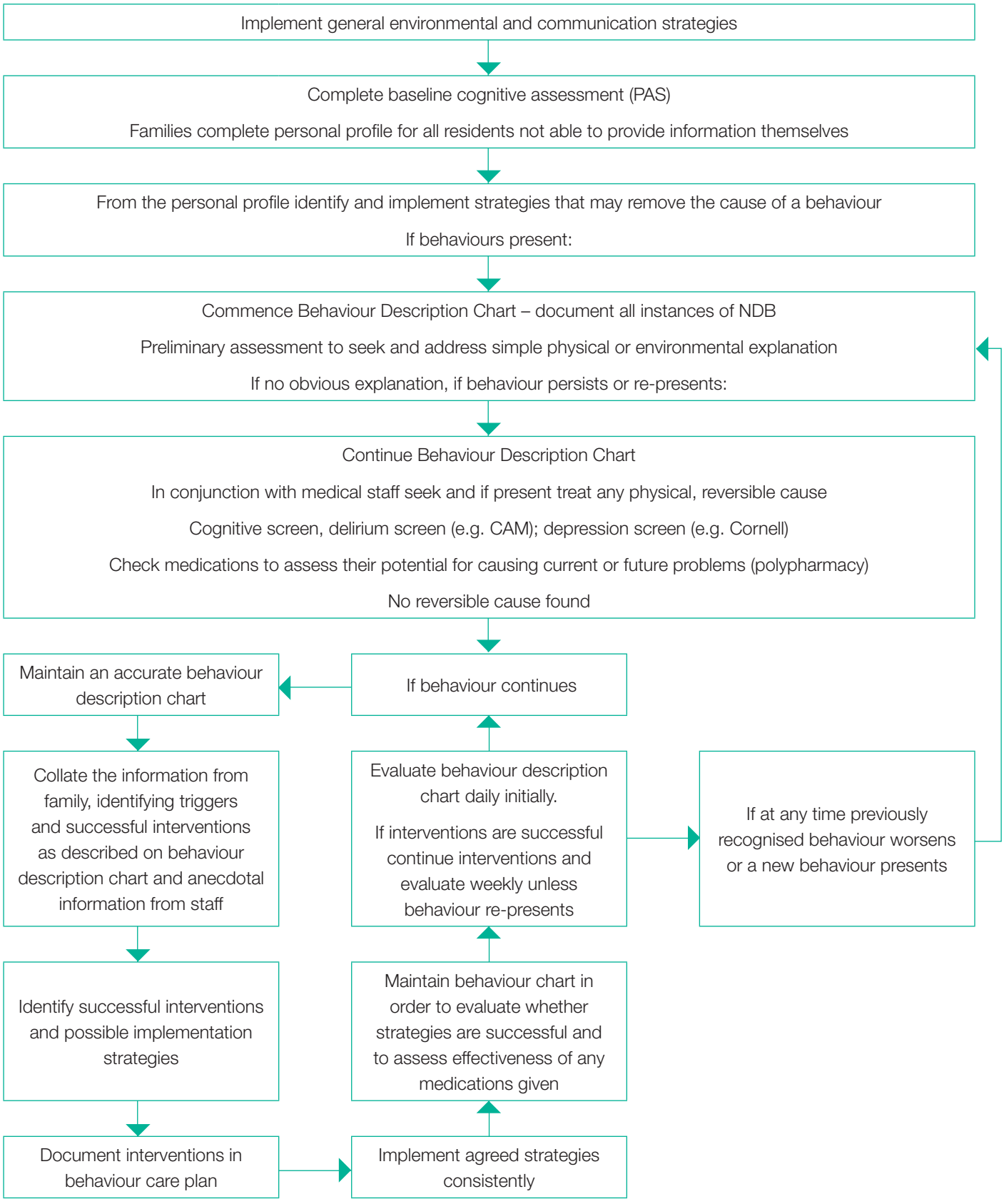
Full SCP: physical restraint

Recognition and assessment	On admission: • conduct an assessment including: – a cognitive assessment using the Psychogeriatric Assessment Scales – Cognitive Impairment Scale (PAS) – medical history: Is there a diagnosis of dementia? Is there a history of delirium? – is there a history of need driven behaviours? – resident's usual routines, likes, dislikes and preferences – physical assessment – pain assessment – falls risk assessment • If cognitive impairment is indicated and/or there is a history of need driven behaviours develop and implement an individualised care plan to minimise the need driven behaviours presenting: – develop with family a more detailed personal history specific to what triggers behaviours, how they present and what reduces them – develop and implement with family an individualised care plan to minimise the need driven behaviours presenting – ensure family is aware of the risks of restraining and not restraining and that your policy is to use restraint only as a last resort • If a risk of falling is identified develop and implement an individualised falls prevention plan
Interventions	The focus of intervention is to address the reason why a resident might be restrained, that is, falls prevention and/or the exhibition of need driven behaviours, and to identify appropriate alternatives to the use of physical restraint. • If at any time the resident exhibits need driven behaviours: – ensure the safety of the resident and others – repeat the above assessment (except the falls risk component) – assess the resident and the behaviour to try to identify the reason for the behaviour and to develop response strategies using the ACEBAC flow chart: *Responding to needs driven behaviours* • If at any time the resident falls or there is a change in his/her condition affecting the risk of falling repeat the falls risk assessment and review the falls prevention plan • Implement appropriate environmental and communication strategies and alternatives to restraint based on the findings from the behaviour and falls risk assessments (See page 6 for strategies and alternatives)

Referral	• GP for medical assessment of falls risk factors and reversible causes of behaviours • Lifestyle co-ordinator/activities worker • Occupational therapist to assess need for assistive devices • Physiotherapist for evaluation of special seating considerations for comfort
Evaluation and reassessment	• Need driven behaviours: – ongoing evaluation of need driven behaviours interventions – if at any time a behaviour exacerbates or a new behaviour presents, repeat the behaviour assessment using the ACEBAC flow chart • Falls prevention: – ongoing evaluation of falls prevention strategies – if at any time the resident falls or their condition changes, repeat the falls risk assessment and review falls prevention strategies
Resident involvement	• Resident and/or family involvement in developing and implementing alternative strategies • Resident and/or family involvement in discussions as to the risks surrounding physical restraint
Staff knowledge and education	• Legal and professional issues relating to physical restraint • Alternatives to restraint • Falls prevention • Dementia and need driven behaviours

General environmental and communication interventions	
Allow the person to do as much as they can and give choices within abilities (promotion of self-care and self-determination within limits of ability)	Flexible routine: to enable care to be provided in line with resident's normal routines and to discontinue care when necessary/return at a later time
Individualise intervention to the behaviour and the individual's preferences, interests and ability	Identify and treat medical causes
Individualise routine: daily routine as close as possible to routine at home (for example, showering, sleeping patterns)	Check medications to assess their potential for causing current or future problems – minimise sedatives
Communication: calm approach; clear, simple instructions; maximise resident's abilities	Involve family member: seek information from family; identify the level of involvement they wish to have; allow family to stay with resident if wanted
Validate concerns: listen and acknowledge resident's concerns	Use of multiple interventions: combination of interventions may prove more successful than a single intervention
Use non-threatening behaviour: make eye contact; come to resident's level, do not stand over resident	Wherever possible allow access to safe external areas
Calm environment: minimise noise; use calm approach; calm voice tone	Minimise reflective surfaces (for example, floors)
Minimise invasion of resident's personal space	Low, shadow free lighting
Secure environment to allow safe wandering	Make exits less evident
Clear signage – using a combination of written and photographic signs	

Flow chart: Responding to need driven behaviours



Alternatives to restraint (Joanna Briggs, 2002)			
Individualised person centred care	Relaxation techniques	Individual and group recreational and social activities	Call bell within reach and visual cues to encourage the resident to use call bell
Individual needs of person known to staff	Sensory stimulation	Encouraging resident not to transfer unaided	Reduced environmental noise
Companionship using family, friends or volunteers	Sensory aids	Continence assessment	Adjustable height beds that lower to just above floor height
Encourage staff and resident interaction	Quiet room	Individualised toileting schedule	Individualised bed height relevant to resident's ability and needs
Increase social interaction	Decreased sensory stimulation	Cleaning promptly after soiling	Use of body length pillows to aid positioning
Therapeutic touch/massage	Individualised structured daily routines	Bedside commode	Soft floor mat or a mattress by the bed to minimise injury from any falls
Additional supervision and observation	Exercise incorporated into the daily plan of care	Safe space to wander	Sleeping on a mattress on the floor
Individualised structured daily routines	Individualised rehabilitation and exercise programs	Bed, chair or wrist alarms could be considered for those with impaired cognition	Non-slip mats or strips on floor by bed
Appropriate outlets for industrious or anxious behaviour	Walking program	Exit door alarm	Trapeze to enhance mobility in bed
Familiar staff	Night time activities for those who wander at night	Electronic sensor system	

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Authorised and published by the Victorian Government, 50 Lonsdale St, Melbourne.