

Physical restraint

Standardised care process



Objective

To promote evidence-based practice in seeking the alternatives to physical restraint for older people who live in residential care settings.

Why the alternatives to physical restraint are important

A restraint-free care environment is the recommended standard of care (Bellman 2016).

Physical restraint is most often used to address responsive behaviours and prevent falls. However, the evidence indicates restraint does not prevent falls or fall-related injuries (Qureshi 2009) and is likely to exacerbate behaviours.

The use of physical restraint has ethical, legal and clinical consequences. It violates a resident's right to freedom and dignity. There is evidence that its use is associated with adverse physical, psychological and social outcomes and increases the risk of death (Department of Health 2015).

Assessing the resident and the situation followed by implementing appropriate alternative strategies can negate 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' (DoHA 2012, p. 24).

Examples of physical restraint devices include: lap belts, bed rails, Posey restraints or similar, 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. Devices that are categorised as extreme restraint and should never be used in residential aged care are: criss-cross vests, leg or ankle restraints, manacles/shackles and soft wrist/hand restraints (DoHA 2012, p. 25).

Responsive behaviours: a term originating from, and preferred by, people with dementia that represents how their actions, words and gestures are a response, often intentional, to something important to them. Residents may use words, gestures, or actions to express something important about their personal, social or physical environment (Murray Alzheimer Research and Education 2018).

Team

Manager, registered nurses (RNs), enrolled nurses (ENs), personal care attendants (PCAs), leisure and lifestyle staff, general practitioner (GP), allied health professionals (such as a physiotherapist, occupational therapist and exercise physiologist), residents and/or family/carers.

Acknowledgement

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Brief standardised care process

Recognition and assessment

On admission and when behaviour change occurs, identify residents at risk of restraint and conduct an assessment including:

- a cognitive assessment using the Psychogeriatric Assessment Scale – Cognitive Impairment Scale (PAS)
- a medical history
- a history of their responsive behaviours
- an assessment of the resident's usual routines, likes, dislikes and preferences
- a pain assessment
- an assessment of the resident's communication ability
- a screen for delirium
- a medication review
- a mental state assessment
- a falls risk assessment
- a psychosocial needs assessment
- an assessment of the resident's physical environment.

If indicated by this 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 responsive behaviours, ensure the safety of the resident and others and:
 - conduct an assessment as above
 - assess the resident's behaviour to identify the reason for the behaviour and to develop response strategies using the *Addressing responsive behaviours* flow chart.
- 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 or activities worker
- Occupational therapist
- Physiotherapist
- Dementia Support Australia for responsive behaviours

Evaluation and reassessment

- Ongoing evaluation of behaviour interventions
 - If at any time a behaviour exacerbates or a new behaviour presents, repeat the behaviour assessment using the 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 about the risks surrounding physical restraint

Staff knowledge and education

- Ethical, legal and professional issues relating to physical restraint
- Alternatives to restraint
- Falls prevention
- Dementia and responsive behaviours



Full standardised care process

Recognition

On admission or when behaviour change occurs identify residents who present with factors that increase the risk of restraint use.

Identify practice based risk factors for restraint use (staff shortages philosophy of care, absence of a policy/procedure for managing behaviours).

Assessment

Conduct an assessment including:

- a cognitive assessment using the Psychogeriatric Assessment Scales – Cognitive Impairment Scale (PAS)
- a medical history: *Is there a diagnosis of dementia? Is there a history of delirium?*
- a history of responsive behaviours
- an assessment of the resident's usual routines, likes, dislikes and preferences
- a physical assessment (including constipation, sensory impairment)
- a pain assessment
- an assessment of the resident's communication ability
- a screen for delirium (see SCP: delirium)
- a screen for medicines that increase agitation
- a mental state (mood disorders, psychosis) assessment
- a falls risk assessment
- an assessment of the resident's psychological coping strategies, cultural needs, meaningful activity, boredom, level of stimulation
- an assessment of the resident's physical environment (noise, lighting, visual cueing).

If cognitive impairment is indicated and/or there is a history of responsive behaviours:

- develop (with the resident's family) a more detailed personal history specific to what triggers behaviours, how they present and what reduces them
- identify the frequency, severity and level of distress of the behaviour
- identify the level of risk the behaviour presents to the resident or to others
- develop and implement with the resident's family an individualised care plan to minimise the responsive behaviour presenting

- ensure the resident's 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 a resident might be restrained (usually to prevent falls and/or the resident is exhibiting responsive behaviours) and to identify appropriate alternatives to using physical restraint. A combination of interventions may prove more successful than a single intervention.

- If at any time the resident exhibits responsive 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 *Addressing responsive behaviours* flow chart.
- 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 communication and de-escalation strategies and alternatives to restraint based on the findings from the behaviour and falls risk assessments (see page 5 for strategies for alternatives to restraint).

Referral

- GP for medical assessment of falls risk factors and reversible causes of behaviours
- Lifestyle coordinator or activities worker
- Occupational therapist to assess the need for assistive devices
- Physiotherapist to assess special seating considerations for comfort
- Dementia Support Australia for behaviours that have not responded to interventions

Evaluation and reassessment

- Responsive behaviours:
 - Ongoing evaluation of behaviour interventions
 - If at any time a behaviour exacerbates or a new behaviour presents, repeat the behaviour assessment using the 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 about the risks surrounding physical restraint

Staff knowledge and education

- Ethical, legal and professional issues relating to physical restraint
- Alternatives to restraint
- Falls prevention
- Dementia and responsive behaviours

General communication and de-escalation interventions

- Individualise the resident's routine: make their daily routine as close as possible to their routine at home (for example, showering, sleeping patterns).
- Be aware of and respect the resident's communication needs.
- On approaching the resident, be calm, call the resident by their preferred name, identify yourself, give verbal reassurance ('You are in a safe place and we are here to help').
- Use non-threatening behaviour: make eye contact, adopt non-threatening gestures and stance, come to the resident's level without standing over them.
- Minimise invasion of the resident's personal space.
- Tell the resident what you are going to do before you do it.
- Communication: keep it slow, clear and simple, and use concise language or instructions.
- Use distraction, reminiscence or orientation techniques if appropriate.
- Leave the resident if it is safe to do so and return later.
- Ensure a flexible routine: enable care to be provided in line with resident's normal routines and to discontinue care when necessary and return at a later time.
- Individualise the intervention to the behaviour in line with the individual's preferences, interests and ability.
- Allow the resident to do as much as they can and give choices within their abilities (promote self-care and self-determination within the limits of their ability).
- Where possible, let the resident suggest alternatives and choices.
- Ask the resident to tell you what the problem is, allow time for their response and actively listen to them.
- If they are upset at something that has happened, apologise if this is reasonable.
- Validate the resident's concerns: listen and acknowledge their concerns and acknowledge their feelings ('I can see you're upset').
- Ensure a calm environment: minimise noise and invite the resident to talk to you in a quieter area with less stimulation (away from other residents) while ensuring your own safety.

- Involve family members: seek information from family; identify the level of involvement they wish to have; and allow family to stay with the resident if wanted.

Strategies for alternatives to restraint

Physical environmental strategies

Personal areas

- The bed height is adjusted to meet the individual's needs. The brakes are applied.
- Mobility aids are close at hand.
- Seating meets the needs of the individual resident.
- Provide familiar objects from the person's home.
- Initiate an appropriate 'alarm' system to alert staff to risky behaviours (falls, wandering in an unsafe area).

Indoor areas

- Indoor areas are clutter-free and glare in corridor areas is reduced.
- Install non-slip or carpet flooring in frequented areas.
- Display appropriate signage and other visual reminders to aid orientation.
- Provide safe areas for residents to wander.
- Provide quiet areas and, where possible, reduce overstimulation due to environmental noise and bright lighting.

Outdoor areas

- Increase the ease of access to a safe and protected outdoor area.

Social and emotional environmental strategies

- Encourage visitors (staggered if indicated) and promote appropriate staff-resident interaction.
- Promote continuity of staff.
- Offer relaxation activities such as therapeutic touch and massage.
- Assist with reality orientation.
- Provide sensory aides and appropriate stimulation.
- Decrease sensory overload.

Psychosocial strategies

Develop and implement individualised psychosocial strategies such as:

- rehabilitation and/or exercise
- a continence program
- physical, occupational and recreational therapies
- night-time activities
- individual and small group activities
- activities for promoting success through the use of overlearned skills
- facilitating safe wandering behaviour
- regularly changing the seating arrangement (for residents who are not independently mobile)
- a falls prevention program.

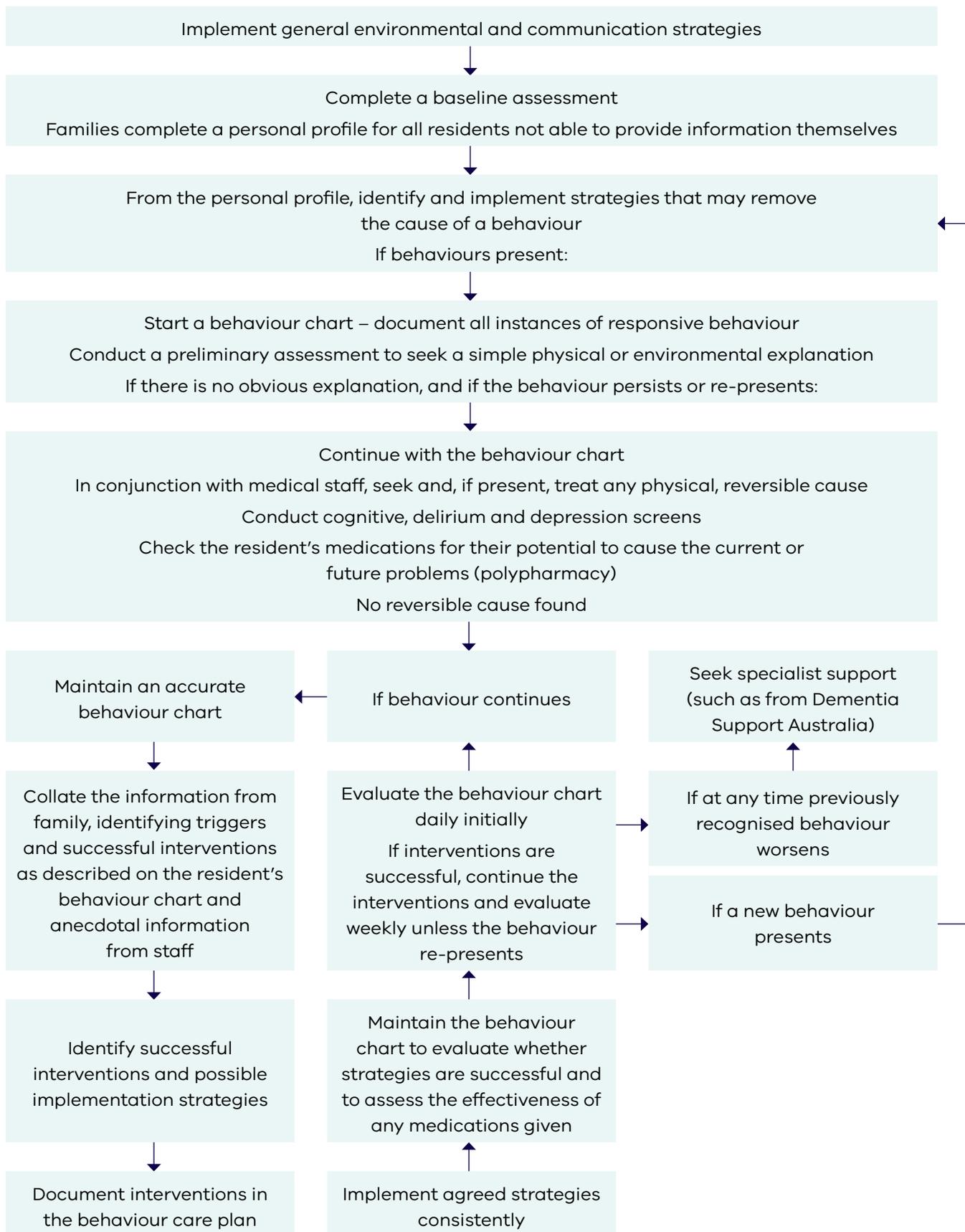
Care approach

- Ensure increased supervision and observation by all staff.
- Conduct regular evaluations of and monitor conditions that may alter behaviour.
- Ensure person-centred care (knowing the residents as individuals).
- Instil individualised routines such as for toileting and naps.
- Check 'at risk' residents regularly.
- Improve communication strategies.

Physiological strategies

- Conduct a comprehensive medical examination.
- Conduct a comprehensive medication review.
- Treat infections.
- Manage the resident's pain.
- Offer non-pharmacological alternatives to sedation.

Flow chart: Addressing responsive behaviours





Evidence base for this standardised care process

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Important note: This SCP is a general resource only and should not be relied upon as an exhaustive or determinative clinical decision-making tool. It is just one element of good clinical care decision making, which also takes into account resident/patient preferences and values. All decisions in relation to resident/patient care should be made by appropriately qualified personnel in each case. To the extent allowed by law, the Department of Health and Human Services and the State of Victoria disclaim all liability for any loss or damage that arises from any use of this SCP.

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