

A last resort

Alternatives to restraint use improve safety and quality of life.



BY MELISSA
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Laura Wagner first used a restraint in the mid-90s, when she was a nursing student. She admits being unaware of the potential for injury – or even death – that could be linked to the device.

At the time, Wagner was working as a nursing assistant at a long-term care home in the U.S. She was caring for an elderly woman who was being restrained daily in a recliner with a tray strapped across her midsection (a Geri-Chair). The woman had Alzheimer's, and a tendency to become anxious and restless. Nobody really knew that she could walk, Wagner recalls.

Back then, Wagner says she felt impartial about restraints, and accepted them as a part of this woman's routine care. She looks back and realizes she was too inexperienced to know otherwise.

After a failed attempt to fit the woman's large Geri-Chair into a small wash-room, Wagner discovered the resident could walk, if given the opportunity. She began taking her on routine strolls to the dining hall and back, and up and down the hallway. Wagner noticed the woman became less agitated. "She didn't need to be restrained as much as a result of (regular walking)," she says. In fact, Wagner was able to help her become more mobile and free from restraints for longer periods of time. This experience made the young nurse realize just how detrimental restraints can be to a patient's safety and quality of life, and just how easy it can be for a nurse to make a difference.

Wagner's decision to walk with her patient was a small act with significant consequences. Without even realizing it, Wagner discovered a viable alternative to restraints. She says all nurses should look for alternatives to restraints whenever possible, and RNAO agrees. In fact, this is the central focus of one of the association's newest best practice guidelines (BPG), *Promoting Safety: Alternative Approaches to the Use of Restraints*.

Today, Wagner is a geriatric nurse practitioner who has dedicated part of her career to research on restraint use and improving safety in nursing homes. She co-led the panel of experts that created RNAO's BPG, and is an adjunct nursing scientist specializing in patient safety with Toronto's Baycrest health centre. Wagner lives in the U.S., working as an assistant professor at the San Francisco campus of the University of California's School of Nursing.



“We need to think creatively about how we can maintain that person’s safety without having to restrain them”

LAURA WAGNER

She explains some of the history behind the BPG, developed shortly after a coroner’s inquest into the death of Jeffrey James, a patient at the Centre for Addiction and Mental Health (CAMH) in Toronto. After five days of being physically restrained in July 2005, James collapsed, and later died in hospital after a blood clot formed in his leg. CAMH has since implemented a restraint prevention initiative that includes a revised policy that focuses on restraint prevention and use of restraints as a last resort in emergency situations. CAMH has also focused on staff training and the use of alternatives.

RNAO Past-President Wendy Fucile provided testimony and a nursing perspective at the inquest into James’ death. When it wrapped up, recommendations were set out by the province’s coroner, including one that RNAO develop a BPG to address restraints, accompanied by an educational program. That BPG – released in March 2012 – focuses on all patients – including those with mental illness – who are at risk of harming themselves or others.

Frances Lankin, a former NDP MPP and Minister of Health, was invited to review the guideline in light of her personal experience that ultimately led to a significant change in provincial legislation. Lankin’s mother, Frances Ollmann, was physically and chemically restrained in 2000 against her family’s request. The experience affected Lankin deeply. She championed a private member’s bill that aimed to regulate the use of restraints, and in 2001, the provincial government enacted the *Patient Restraints Minimization Act*.

A decade later, RNAO’s BPG is a reference guide for nurses, other health professionals, and health-care organizations. It recommends the use of restraints only when all other options have been exhausted. It’s meant to “challenge health-care providers to think about how we can provide care that’s safer,” says Wagner. “We’re not thinking enough about some of the alternatives that could be used.”

According to Wagner, health-care professionals use or rely on restraints for three reasons: (1) they are thought to prevent falls – though she notes there is ample research that states this is not the case; (2) to keep a person from acting out and kicking, hitting, or shoving staff or other patients – though the evidence is also clear that restraints can increase aggressive behaviours; and (3) to prevent interference with treatment such as feeding or breathing tubes. Methods of restraint use are not limited to physical means such as waist belts or mitt restraints. There are also chemical restraints, such as antipsychotic medications, and environmental restraints, like seclusion. All are commonly used in long-term care homes, acute

care, and mental health settings. According to a 2011 report from the Canadian Institute for Health Information, almost 25 per cent of people admitted to mental health beds in Ontario are restrained physically or with medication, predominantly to maintain safety of clients and staff.

Wagner says most nurses can likely recall an experience with restraints. These experiences are tough to forget, especially given restraints can contribute to physical and mental decline. They are physically demeaning, and can cause pressure ulcers, strangulation, and death, she says. In fact, studies cited in another RNAO BPG, *Prevention of Falls and Fall Injuries in the Older Adult*, suggest that restraints can actually increase the severity of falls.

Some nurses rely on restraints because they’re the easiest option during a busy work day, Wagner adds. And families can also factor into the decision. Relatives don’t want their loved one to fall, for example, and don’t

understand that people can be harmed from restraint use: “We need to think creatively about how we can maintain a person’s safety without having to restrain them.”

Wagner recalls the story of a man who used to perform in the circus. As he aged, he began falling often in his long-term care home, acquiring head injuries. His family wanted him to maintain an active lifestyle, so the interdisciplinary team began to discuss options, eventually allowing him to wear a helmet and use a walker. “He was able to walk around, and his family was grateful he had an active end of life,” she says. “That is the whole point of the guideline: to look at examples and alternatives.”

Athina Perivolaris, an advanced practice nurse at CAMH, co-led the organization’s three-year prevention of restraints and seclusion initiative. She also co-led the BPG panel with Wagner, and says that before alternatives can be considered, it is essential for nurses to develop therapeutic relationships with their patients. This will help them understand patient histories, and build trust. “...In a crisis situation, it’s hard to figure out what alternative might be effective...” if you don’t have that background knowledge, she says. Nurturing a rapport with the client will allow the patient and the nurse to discuss viable coping strategies and an individualized care plan.

“When you’re coming into a health-care environment, you’re looking to receive care that will offer you a feeling of safety, security and that will support you in your recovery,” she says. “Any time a restraint is used, it can negatively impact on the therapeutic relationship.”

RESTRAINT RISKS

Restraint use can lead to unfavourable – sometimes fatal – outcomes. Nurses should keep the following complications in mind when considering the use of restraints:

PHYSICAL

- bruising
- pain
- reduced muscle strength
- skin tears
- joint contractures
- severe bedsores
- aspiration
- constipation or urinary incontinence
- circulatory changes
- loss of movement
- dehydration and loss of appetite
- pulmonary emboli
- risk of self-injury
- asphyxia
- strangulation

COGNITIVE

- isolation
- increased stress or trauma
- confusion
- agitation
- frustration
- guilt
- loss of autonomy and dignity
- anger
- fear
- depression
- changes in self-image
- sleep disorders

Source: RNAO BPG *Promoting Safety: Alternative Approaches to the Use of Restraints*

Perivolaris notes that what works for one client, may not work for another. “We have a professional, moral, and ethical obligation to continue to explore options, to implement them and evaluate them,” she says. “You don’t develop an individualized plan...that will last for the entire span of care. It’s an ongoing, dynamic, collaborative process between the health-care team, the client and the family.”

Perivolaris acknowledges that it’s not always easy to find alternative options to restraint use. Practitioners may focus too much on the point at which troubling behaviour has already escalated. When care providers are “only looking at that end point, then you really have a limited opportunity to consider or even implement alternatives,” she says. The BPG focuses on the earlier stages of intervening, and collaboration with clients and families to come up with alternatives that are supportive.

Alternatives such as flesh-coloured “sleeves” camouflage tubing, which means the patient is less likely to tug or pull at it. Another example is an alarm that beeps when a patient or resident stands up or moves. Strategies that support regular expression of emotion – such as writing in a journal and listening to music – can also be effective. If nurses “start early in the process, there’s a greater possibility of potential alternatives that we might want to explore and evaluate,” Perivolaris says.

If a restraint is used, learning from each and every instance is also key, she adds. A debriefing with staff to address what could be put in place to prevent future use of a restraint, or a meeting with the client, will help health professionals to better understand the patient perspective.

Perivolaris says guidance from all levels of management, in addition to clear policies, is essential when health-care organizations begin steering the focus away from regular restraint use as an intervention for safety. “You can have a really good policy, but it’s just a policy unless you also have (strong leadership) to support the expectations in the policy,” she says.

Irmajean Bajnok, Director of RNAO’s BPG Program, agrees, and says leadership begins from the moment an organization decides to implement the guideline. “You need the organization’s

leaders to appreciate that this type of best practice may mean other supports, such as equipment and additional human resources, may need to be deployed.” Nurses, she says, welcome the BPG because it helps them think outside the box. “The guideline builds on skills the nurse can use as an alternative to restraints, because it’s often in the nurses’ hands as to whether restraints are used or not. We hope this guideline helps RNs to move away from using restraints as a part of their care.”

There isn’t any definitive statistical information on exactly how many patients in Ontario have died as a result of being restrained.

In addition to the story of Jeffrey James, there is the story of Toronto senior Florence Rose Coxon, who died in 2008 while struggling to free herself from a belt that was fixed around her waist in a wheelchair. It was reported she died of asphyxiation. These stories are powerful reminders of what can go wrong, and why restraints should be a last resort. In each case, the facilities where these individuals lived were responsible for revising their restraint policies. Some employers, however, have chosen to proactively revise their policies in advance of tragedy.

The Ottawa Hospital, for instance, is in the midst of adjusting its *Least Restraint, Last Resort* policy to ensure it reflects the most up-to-date research. It is implementing RNAO’s BPG, with a goal to improve patient safety, satisfaction and quality care, says Lisa Freeman, corporate co-ordinator of nursing best practices.

To ensure least restraint is always top-of-mind, Freeman says the hospital is focusing on the revision of its policy to create and promote additional alternatives to restraint use. Another priority will be to specifically address high risk patients – like the mental health population.

Patients, she says, are “the centre of our care, and we don’t want them to be in restraints.”

Wagner hopes the BPG will bring more attention to the issue, and encourage nurses to share their success stories and innovative alternatives. This, she says, will “help evolve the movement and (persuade practitioners) to consider how we can think differently about this topic.” **RN**

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