Irish Institute of Mental Health Nursing

An Institiúid de Altrai Meabhair-Slainte na hEireann

Position Paper No. 1:
A Restraint Free Environment in Nursing Homes

This position statement was prepared by Dr Kate Irving and endorsed by the IIMHN Executive on the 28 April 2010.

IIMHN Position Statement

We view the restraint of elderly people as a threat to the human rights and dignity of older adults. Person-centred care is the espoused principle of all policy regarding health and well-being of the older person. As a therapeutic tool, restraint use is completely at odds with the prevailing theory of person-centred care to the extent that it would be very hard to envisage how care can be person-centred while restraints are in place. In order to get restrained, as it is generally regarded as socially unacceptable, people have to demonstrate that they are not able to govern their own conduct. Thus it is only the most vulnerable of the elderly population who get restrained (Irving, 2002, 2009). Ethically this is something we must reflect on.

Restraints are an abuse of power, where restraint use is justified by one of a number of myths about the increased safety it affords the person or those around them. These myths are well documented (Strumpf *et al* 1998) and the assertion of myth status for many justifications staff give for the use of restraints have stood the test of time and repeated research studies and systematic reviews (JIB 2002a; Evans *et al.* 2002; Evans & Fitzgerald 2002). All the research points to the fact that there is no beneficence to be claimed with restraint use and that it is a non-validated therapy (in this era of evidence based care). A CINAHL and PubMed search for any studies claiming benefits of restraint, use highlighted not a single paper. Conversely substantial negative physical, social and psychological ramifications are clearly evident in the literature (Castle & Engberg 2009; Evans & Wood 2002; Evans & Fitzgerald 2002).

There are two legal remedies for restraint, one being consent - if the person has asked for a restraint to be put in place and the other being 'real and immediate danger'. Real and immediate danger probably would not include – 'this person might fall if I'm not in the room when they choose to get up'. However, real and immediate danger in this case has not been legally tested, so it is not clear what is constituted by it. Consent is muddied by the fact that most people who are restrained do not have capacity to consent in any legal sense so it is also unhelpful.

Any policy addressing restraint use needs to be clear about what it understands as restraint. The definition should help to highlight those instances of restraint that are ethically problematic and not just instances where one of a list of pre-defined appliances are used. There is a danger that policy that bans certain devices may cause other more dangerous methods of restraint to be used. A sheet can be a restraint if used in such a way that a frail person cannot get out of bed because of how it is applied. Clearly sheets cannot be banned.

One can broadly define restraint as any intervention for which the primary intent is limitation of movement. You can argue that a plaster cast, skin traction or IV pump can 'constrain' movement but that the 'constraint' is an unwanted side effect of a medical intervention. So this mode of restraint is ethically unproblematic. Drugs given to treat psychiatric symptoms are not considered restraint under this definition if the symptom is distressing to the person (such as an acute anxiety state) and the intent is to ease the symptom. Giving the drug should be the least restrictive alternative after a well meaning search for such alternatives. Difficulties arise here as high level assessment of the person's response to a new drug is required. While paradoxical reactions to psychotropic medications are common in this population and should indicate a need to stop the treatment it often leads to more of the same drug being given. Particular caution where drugs are prescribed PRN is required and should be addressed in this policy.

Some interventions that might at first seem restrictive become reasonable if there is a clear formulation of the problem and justification that this intervention is the 'least restrictive' and the most therapeutic alternative. For example - some chairs that recline are the only way to keep a person with a severe stroke in a therapeutic position. If the individual is unable to weight bear then reclining the chair slightly enables better positioning and

place to maximise quality of life. Of course this decision making on risk must take into consideration the research based risks of using restraint which are considerable. Research based alternatives to restraint are not typically high tech. Facilities who have demonstrated restraint free environments have done so via a culture change rather than introducing new technology (JIB 2002b).

While we welcome the introduction of the discourse of 'restraint free care' as it firmly makes visible the idea that restraint use is not acceptable, we would argue that policy would need to reflect a search for ***least restrictive alternatives*** rather than dogmatic adherence to the absence of certain devices. We would encourage a positively framed policy with guidelines which promote the search for least restrictive alternatives and explore example cases which are not straightforward. These example cases should highlight the decision making processes involved in searching for least restrictive alternatives.

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