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The Use of Physical Restraints

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There are three main types of restraints: physical, chemical, and environmental. This article will explore physical restraints, looking at the definition, use, side effects, and possible benefits. Some suggestions and guidelines about the use of physical restraints will also be considered.

Restraints are used in many settings—hospitals, nursing homes, long term care facilities and psychiatric facilities. This means that their use affects the care of the elderly, including those with dementia and Alzheimer's disease, as well as many who suffer from mental illness.

Although the use of restraints has decreased over the years, the application of restraints raises various ethical questions: should restraints be used at all, and if so, under what circumstances? Should patient/client consent be required? What precautions should be taken to prevent injury or death? Do the perceived benefits outweigh the risks?

A physical restraint refers to "a manual method or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove and that restricts the patient's freedom or normal access to one's body."[1] A physical restraint can be "applied directly or indirectly to an individual with the aim of achieving immobilization or control."[2] According to the *Compendium of Standards of Practice for Nurses in Ontario*, a physical restraint is used to control the physical or behavioural activity of a person and is intended to limit a person's movement.[3] A four point restraint means tying down all four limbs, and a five point restraint adds tying at the waist.

There are several devices that can be used as a physical restraint. They include: lap belts, vests, straight jackets, bed or side rails, chairs that tip backwards, sheets that are intentionally tucked in too tightly, wheelchair belts that are buckled when the chair is not in transit, and limb and/or waist ties.

Being physically restrained can be a traumatic experience. So, why are restraints used? Physical restraints are used to prevent harm to the patient from potential falls, to prevent wandering, to check inappropriate behaviour in consideration for the safety, well-being, and property of others, to ensure the patient does not interfere with the insertion or removal of medical devices, to compensate for understaffing, lack of knowledge of alternatives, and to manage violent behaviour. Physical restraints provide support and safety to a person in a chair: the stabilizing support improves the person's functioning—to eat a meal, or read a book, for instance—without danger of falling or sliding from the chair.

A study published in the *International Journal of Nursing Studies*, looked at why physical restraints were used. The study classified reasons for use into four main categories: staff and organization-oriented, social-oriented, treatment-oriented, and patient-oriented.[4] Further, patient-oriented reasons were subcategorized into safety, agitation, behaviour control, wandering, and support.[5] When looking at the reasons for restraint in acute care settings under the staff and organization-oriented category, "54% of

studies found that responders cited reasons that were more for the benefit of the health care worker, or the health care organization, than for the patient being restrained. The most common of these reasons was to compensate for insufficient staff members."[6] In the residential care setting physical restraints were also used to enable staff to complete their shifts.[7] The study did not specify if a patient was restrained temporarily in order for a staff member to provide more urgent care to another patient. If that was the situation, it would be a reasonable use of a restraint.

Under the social-oriented category patients were physically restrained to maintain the safety of other patients, to protect staff, to prevent a patient from bothering others, including taking the possessions of others, and to maintain overall peace and harmony especially in residential care settings.[8]

Physical restraints were used more often in acute care settings than in residential care settings for treatment-oriented reasons. Restraints were used in these situations to prevent patients from removing IV lines, nasogastric tubes, catheters, oxygen and endotracheal tubes, sutures, and wound dressings.[9] A patient also might be restrained in order to insert a medical device (IV, tube) or allow the health care worker to treat a wound. This would be acceptable since the restraint is only being used for a specific time period, and the treatment given would be beneficial to the patient.

Patient-oriented reasons cover safety, agitation, behaviour, wandering, and support. Patient safety includes such things as preventing falls or injury, self-harm, avoiding hazardous materials (e.g. chemical cleaners) or places.[10] Prevention of falls is a major concern as many elderly patients (with and without dementia and Alzheimer's disease) have impaired mobility and balance. Patients with dementia or Alzheimer's disease can suffer from agitation. This study found that physical restraints were used on agitated patients to prevent them from hitting health care workers and others, as well as to manage violent behaviour.[11] Other behavioural concerns included: confusion, altered mental state, impulsive behaviour, and restlessness. These reasons were cited under the behaviour control subcategory.

The last two subcategories are wandering and support. Wandering can refer to walking but also to attempting to get out of a bed or a chair. In these situations a person may be restrained due to a lack of available supervision, or to prevent this activity in order to avoid injury. Restraints can be used to provide support to a person who needs it to maintain his/her position, balance, or for postural support. This is helpful when a person is eating or wishes to relax in a chair. If a physical restraint is used for support it should only be for a specified time period and the person should be monitored for safety. The patient should also be given the opportunity to use the washroom periodically if he/she is sitting in a chair for a period of time reading or relaxing.

The use of physical restraints may be necessary at certain times and may be beneficial to the patient, for example in the case of support. However, there can be serious side effects. They include: loss of muscle tone, pressure sores, decreased mobility, agitation, reduced bone mass, incontinence, constipation, fractures, strangulation, and death.[12] There are also psychological side effects such as anger, humiliation, helplessness, and demoralization.

Patients generally do not consider being restrained as a positive experience. Many see it as a loss of dignity, or as shameful, and they have feelings of anxiety, anger, and isolation associated with it.[13] Some patients worry about possible injury if they try to

escape and some develop depression and feelings of hopelessness.

The prevention of falls or some type of injury to the patient seems to be a primary reason for the use of physical restraints. Do physical restraints actually decrease the incidence of falls in the elderly? The answer is no. "An older person with reduced physical and/or mental capacity will be more prone than a healthy person to exhibit harmful effects resulting from physical restraint. It has also been observed that the methods used are not effective in preventing falls or serious injury."[14] The use of physical restraints can heighten anxiety in the person and result in a greater risk for injury or death.[15] In the article in the *International Journal of Nursing Studies*, the authors state that restraint devices do not prevent falls but can cause falls and other injuries including death due to asphyxia.[16] The real question is, why are restraints in these situations still being used? Is it a lack of staff to provide supervision, or a lack of viable alternatives?

The use of physical restraints raises the question of a person's right to autonomy. In North American society autonomy is highly valued. People want to decide what is best for them. They want to be able to choose or refuse a treatment option. For the most part autonomy is respected but it is not an absolute right. The decision to use physical restraints (assuming all other options have been exhausted) may be justified if there is imminent risk of serious harm to the patient or others. The person being restrained should be treated with respect and dignity. The least restrictive method should be used first in order to ensure that there is a proportionate balance between the physical restraint and the harm it intends to avoid.

Should restraints be used at all? Restraints should never be used to discipline or coerce a patient, nor should they be used for staff convenience, nor because of a lack of education about alternatives.[17] Restraints should only be used where there is an imminent risk of serious harm to the patient or others, and where all other options have been exhausted.[18] The use of restraints should be the exception, not the norm.

In Ontario it is up to each individual institution (nursing home, long term care facility, psychiatric hospital) to set policies and protocols for restraint use. Ontario's "Patient Restraints Minimization Act" (2001) states its purpose is to minimize the use of restraints and to encourage institutions to use alternative methods.[19] The Act includes general guidelines such as the necessity of keeping records, obtaining consent of the patient or substitute decision maker (the use of restraints would have been discussed with the patient and/or substitute decision maker as part of a treatment plan), the duty to monitor the patient, and that alternative methods should be utilized where possible.[20] Each institution needs to take responsibility to educate health care workers about the Act and the policies and protocols of that institution.

The 2008 inquest into the restraint-related death of Jeffrey James, a forensic psychiatric patient at the Centre for Addiction and Mental Health (CAMH) in Toronto, looked at the very question of restraint use and hospital policies. After being bound by physical restraints for five days, Mr. James died on July 13, 2005, shortly after being released from them. Ontario's chief pathologist Dr. Michael Pollanen testified that Mr. James died because of pulmonary embolisms which most likely came from a femoral vein in Mr. James' thighs and which developed because of the prolonged use of restraints.

The jury made several recommendations such as closer medical monitoring of a person in restraints, conducting a full psychiatric assessment within 24 hours of

admission to a facility, the availability of patient advocate offices twenty-four hours a day, seven days a week, and calling a mandatory inquest when a person dies in restraints. Since Mr. James' death in 2005, two other patients have died while in restraints at CAMH.*

Institutions need to have specific and detailed protocols on restraint use. Staff should be educated on policies and proper use of restraints as well as receive training on alternatives. There should be documentation on why a person was restrained, what discussions took place with the patient and/or substitute decision maker, and what alternatives were tried. Once a person has been restrained his/her medical condition should be monitored at specific intervals. The patient should be given the opportunity to use the washroom, receive food and fluids, and be periodically released from the restraint. Re-evaluation of the justification for restraint use should be carried out at specific intervals as well. A staff debriefing that looks at why the restraint was necessary and what was learned from the experience might also be helpful.

It would be beneficial for the Government of Ontario to set a standard policy for all hospitals and health care institutions (psychiatric facilities, nursing homes, long-term care facilities) on the use of restraints. Perhaps such a policy would prevent future deaths. Whether it is a governmental or institutional policy, it should address the ethical questions concerning restraint use. Unfortunately, there is no perfect policy or protocol for the use of restraints. Institutions should strive to decrease their use as much as possible and develop alternatives. ■

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[2] Róisín Gallinagh, Rosemary Nevin, David McIlroy *et al*., "The Use of Physical Restraints as a Safety Measure in the Care of Older People in Four Rehabilitation Wards: Findings from an Exploratory Study." *International Journal of Nursing Studies* 39 (2002): 147.
[3] College of Nurses of Ontario. *Compendium of Standards of Practice for Nurses in Ontario, Section III-Restraints. (2008)* www.cno.org/docs/prac/41043_Restraints.pdf Accessed on October 14, 2008.
[4] David Evans and Mary FitzGerald, "Reasons for Physically Restraining Patients and Residents: A Systematic Review and Content Analysis." *International Journal of Nursing Studies* 39 (2002): 737.
[5] *Ibid*., 737.
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[7] *Ibid*., 738.
[8] *Ibid*., 738.
[9] *Ibid*., 738.
[10] *Ibid*., 738.
[11] *Ibid*., 739.
[12] C. Gastmans and K. Milisen, "Use of Physical Restraint in Nursing Homes: Clinical-Ethical Considerations." *Journal of Medical Ethics* 32 (2006): 149.
[13] *Ibid*., 149.
[14] *Ibid*., 149.
[15] *Ibid*., 149.
[16] Róisín Gallinagh, Rosemary Nevin, David McIlroy *et al*., "The Use of Physical Restraints as a Safety Measure in the Care of Older People in Four Rehabilitation Wards: Findings from an Exploratory Study." *International Journal of Nursing Studies* 39 (2002): 148.
[17] Kevin Huckshorn, "Re-Designing State Mental Health Policy to Prevent the Use of Seclusion and Restraint." *Administration and Policy in Mental Health and Mental Health Services Research* 33, no. 4 (2005): 482.
[18] *Ibid*., 482.
[19] Government of Ontario, "Patient Restraints Minimization Act, 2001" www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_01p16_e.htm Accessed September 29, 2008.
[20] *Ibid*.

***** The jury verdict and recommendations will be available at: www.mcscs.jus.gov.on.ca/English/pub_safety/office_coroner/about_coroner.html