CLINICAL ETHICS

Use of physical restraint in nursing homes: clinical-ethical considerations

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This article gives a brief overview of the state of the art concerning physical restraint use among older persons in nursing homes. Within this context we identify some essential values and norms that must be observed in an ethical evaluation of physical restraint. These values and norms provide the ethical foundation for a number of concrete recommendations that could give clinical and ethical support to caregivers when they make decisions about physical restraint. Respect for the autonomy and overall wellbeing of older persons, a proportional assessment of the advantages and disadvantages, a priority focus on the alternatives to physical restraint, individualised care, interdisciplinary decision making, and an institutional policy are the central points that make it possible to deal responsibly with the use of physical restraint for older persons in nursing homes.

In caring for older people it is sometimes necessary to carry out actions that limit their freedom of movement. Usually, this is done for reasons of good care; sometimes practical considerations or necessity play a part. Empirical research has given us a better idea of the prevalence of, the reasons behind, and the physical consequences of restraint use among older persons. What is less well known are the psychological and social consequences of physical restraint use. Until now, the ethical values that may come into conflict when applying physical restraint have received scant serious attention.

This article will give a concise overview of the clinical state of the art with regard to physical restraint use in nursing homes. Against this background, certain values and norms will be identified, which must be borne in mind in the ethical evaluation of physical restraint. These values and norms are the basis for a number of recommendations that can support caregivers in their clinical and ethical decision making in such situations. Whereas these recommendations are chiefly applicable to older persons in long-term care, they can also serve as an inspiration for dealing with physical restraint with other groups, such as geriatric patients admitted to hospital or psychiatric patients.

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STATE OF THE ART

Clinical ethics aims to resolve the ethical problems that arise in clinical practice; clinical practice constitutes both the departure point (in the form of ''a problem'') and the end point (in the form of ''a solution'') of reflection in clinical ethics. In what follows we outline the clinical state of the art concerning physical restraint use among older people.

Definition and prevalence

Physical restraint can be defined as

> any device, material or equipment attached to or near a person's body and which cannot be controlled or easily removed by the person and which deliberately prevents or is deliberately intended to prevent a person's free body movement to a position of choice and/or a person's normal access to their body.[1]

Examples of physical restraint include vests, straps/belts, limb ties, wheelchair bars and brakes, chairs that tip backwards, tucking in sheets too tightly, and bedside rails.[1 2] The reported use of physical restraint in nursing homes varies from 4% to 85%.[1 3–9] The great variation in these statistics is determined by differences in the study populations—for example, whether or not to include older persons with physical and/or cognitive problems; the country in which a study was carried out—for example, differences in legislation, education, and culture; the method used—for example, survey questionnaires, review of nursing and medical files, direct observation; and the definition employed—for example, whether or not to include bedside rails.[6 10]

In addition to physical restraint—the most frequently used method—a small number of studies also refer to chemical restraint—for example, sedatives, antipsychotics, and anxiolytics, and to other methods such as being locked in a room, electronic surveillance, force or pressure in medical examination or treatment, and force or pressure in activities of daily living.[6 9 11] The ethical considerations arising from the use of these other methods are not considered in this article.

Personal aspects and non-personal influences

Older persons who are submitted to physical restraint differ in many aspects from those whose freedom is not restricted. Older people with functional disabilities, increased activities of daily living dependence, mobility problems, cognitive disturbances, behavioural problems, or a history of multiple falls run a much higher risk of being physically restrained.[12–16]

Moreover, a shortage of manpower and a request by the family could influence the decision to use methods of physical restraint.[4 17 18] Safety considerations regarding older people (such as harming themselves, falling) or others (perhaps by injuring others) also have a significant part to play. Physical restraint may also be motivated by routine behaviour, a negative and/or paternalistic attitude towards older people, a fear of litigation, ignorance of the negative consequences of physical restraint or of alternatives to it, or a limited ability to deal with problem behaviour.[1 14 18 19]

Physical risks

Over the last few years, a consensus has been building up about the physical risks associated with the application of physical restraint to older people, the physical consequences of which are:

- bruises
- decubitus ulcers
- respiratory complications
- urinary incontinence and constipation
- undernutrition
- increased dependence in activities of daily living
- impaired muscle strength and balance
- decreased cardiovascular endurance
- increased agitation
- increased risk for mortality caused by strangulation or as a consequence of serious injuries—for example, fracture, head trauma.[4 13 20–23]

These risks are not always directly attributed to the physical restraint itself but more usually to the older person's physical and mental condition. 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 as a consequence of aggressive behaviour. In many cases, the discomfort and anxiety of a restrained older person is only increased, resulting in a heightened risk of injury and even death as a result.[22 24]

Psychosocial experience

The use of physical restraint for older persons in nursing homes is experienced in a particular manner by both older people themselves and their relatives and caregivers.

The older person

Older people report mixed feelings about their experience with physical restraint.[25] For some, these methods—for example, bedside rails or wheelchair bars, have a positive significance. They can lend a feeling of security and stability: ''I feel safer with bed rails.'' Dependence is not always experienced as something negative by older people. Many of them greatly appreciate the assistance being offered. One could say that in these cases there is a positive reception of care: ''I don't feel that it really restricts me. I don't actually think about it much. If I want to stand up, they help me. But I need it for my pillows; otherwise my arm slides away. I think it's a good idea.''

In general, however, physical restraint is not experienced as something positive.[25] For many older people the use of these methods has more of a traumatic than a therapeutic character. This is accompanied by feelings of shame, loss of dignity and self-respect, loss of identity, anxiety and aggression, social isolation, and disillusionment. Many older people express feelings of imprisonment: ''I feel like a bird in a cage'', and restriction of their freedom of movement: ''I can't even bring my two hands together.'' They worry about the possibility of injury in their attempts to escape from physical restraint. Others express feelings of depression and apathy concerning the use of these methods.[4 26 27]

Relatives

From the limited research into relatives' experience of physical restraint it can be seen that it is primarily associated with the idea of finality—a sense of the beginning of the end of life as these persons had known it: ''When I saw the restraint, I lost all hope'', and ''Seeing the restraint makes it so real to me. It is so real, that we can never do the things we planned.'' Restraint symbolises the inevitably finite and limited nature of human life.[28] Other meanings ascribed to restraint include control of the situation: ''I don't want him to fall'', denial: ''If I don't see the restrictions on movement, then everything is all right'', anger: ''I don't think they are doing it to help him'', disillusionment: ''Because of the restrictions, it seems as if he no longer has all his mental faculties.'' Most of the relatives expressed the need for emotional support for older persons and their relatives.

Caregiver

The application of physical restraint brings about a certain structure. The failure to apply these methods of restraint would put this structure at risk, increasing the chance of chaos.[29] This has led to a situation where the application of restraint has, in certain circumstances, become a kind of ritual that rather meets caregivers' need for a fixed structure than older persons' therapeutic needs.

In addition, caregivers often have the impression that applying methods of restraint affords them a measure of control over older people; they experience it as a way of maintaining order.[30] It is noteworthy in this respect that some caregivers use child-like language to structure the experience of older persons. This sort of approach is often regarded by older people themselves as a humiliating experience (infantilisation) and is frequently intended to sustain existing power relationships.[31]

For some caregivers, the application of physical restraint gives the feeling that they can escape legal proceedings.[32] Nevertheless, various inner conflicts can also be observed among caregivers, such as frustration, ambivalence, and guilt feelings about the use of physical restraint.[33–35]

ETHICAL ASSESSMENT OF VALUES AND NORMS

Clinical ethicists cannot restrict themselves to a description of the clinical state of affairs; they must interpret clinical reality in the light of human dignity.[36 37] In more concrete terms, clinical ethics is about weighing up ethical values and norms that serve as guidelines for clinical actions. Values express what caregivers must aim at in order to attain greater human dignity; norms express concrete rules of behaviour that are generally accepted as responsible and adequate for imparting human dignity to caring. In what follows, we explain some of the values and norms that are important for an ethical evaluation of physical restraint in nursing homes.

Respect for the dignity of older people

As a first value, we could state that every senior citizen should be treated as a person. Being a person embodies human dignity. This dignity is grounded in the fact that everyone is a unique individual who becomes more and more human by contact with others, thus taking part in society as a whole.[36 37] Human dignity cannot be relinquished, not even through illness, handicap, or approaching death.

This value gives rise to the ethical norm that caregivers must give priority to respect for the dignity of older persons.

Respect for autonomy

As a second value, one should always consider older persons as responsible people. Human beings are not objects like the

material things that surround us; they are persons who normally act according to their conscience, in freedom, and in a responsible manner.[36]

The ability of human beings to make choices must always be respected in the context of physical restraint.[38] From this derives the ethical norm that caregivers, when physical restraint is being considered, should inform competent older persons and their relatives as fully as possible about the various options. They should provide information—as objectively as possible and in a way that is understandable to older persons and their relatives—about the various treatment possibilities, their nature and aim, their pros and cons, and effects and risks. Caregivers, older people, and their relatives should attempt to arrive at a well-considered choice on the basis of this information.[39] The application of physical restraint to mentally competent older persons without their consent is unacceptable.[40 41] Even mentally incompetent older persons should be involved as much as possible in the decision-making procedure, since the loss of cognitive functioning—usually a gradual process as in dementia—does not necessarily mean that people can no longer make their own choices and decisions.[38] Caregivers should ask relatives to make an attempt to determine what the mentally incompetent older person would have wanted.

Promoting overall wellbeing

In the practice of care, the physical aspects of wellbeing are often a main focus because they can be translated most easily into objectifiable complaints, and physical restraint is often used in order to prevent physical harm.[4] However, when considering older people as full persons, we must accept that care because their wellbeing involves more than just preventing physical harm. Respect for overall wellbeing is the third value that must be protected. In certain cases, this value can come into conflict with the value of physical integrity.[40] Although the protection of physical integrity can be considered as a fundamental value, one cannot claim that this value always takes priority over all others. In certain cases, the choice of another value can be justified, even though it may entail risks to physical wellbeing. During their lives, people pursue many kinds of activities with the aim of attaining values that they find important, even though it may cause harm to their physical integrity. There is no reason to suppose that the lives of older persons must be dominated by the protection of their safety and physical integrity.

From the choice of overall wellbeing as a priority value, we can derive the norm that, when making decisions about physical restraint, not only older persons' physical wellbeing should be taken into account, but also the social (possibility for contact), psychological (experience of themselves and their relatives), and moral (respect for autonomy, informed consent) dimensions of their wellbeing.

Promoting self-reliance

The fourth ethical value gives priority to optimal support for older persons' ability to do things independently (self-reliance). Creating a home-like atmosphere for those who may be disorientated or ill at ease—for example, a quiet room, lighting during the night, contacts with volunteers and relatives; providing support for people with mental degeneration by setting a clear daily routine—for example, fixed appointments, an activity calendar; organising group activities—for example, movement exercises, etc. are all care interventions with great psychological and social significance, for both older persons and their caregivers. Concern for ''ordinary'' daily activities deserves the highest priority, not only for its human value but also because it can, in a great many cases, postpone or even preclude the need to apply physical restraint.[42] Examples of interventions that could be applied in order to reduce the use of physical restraint are:

- specific measures: lower bed, mattress placed on the floor, bed/chair alarms, family/sitters/volunteers/hospice workers, shock-absorbing floor covering, hip protectors, non-slip floor and footwear, walking aids, strategic placement of patients (compatibility, location)
- measures to optimise the environment: balancing environmental stimulation to prevent/minimise sensory overload/understimulation, familiar surroundings and orientation, ample lighting without glare, correct/adjust glasses, allow wandering
- individualised care: continuity of care; clear, meaningful, communication that reflects courtesy and respect; active listening; documentation and analysis of behaviour; encourage visits from family and relatives; description and explanation before therapeutic interventions; therapeutic touch; encourage participation in physical activities; regular rest periods to compensate for fatigue and loss of reserve energy
- preventing/minimising predisposing and precipitating factors for falls and delirium: nutrition and hydration management, pain management, routine toileting, elimination/minimising unnecessary medication, cognitive stimulation, use of sensory protocols, management of postural hypotension, balance and gait training, and strengthening exercises.[2 24 42–45]

With a view to supporting older persons' self-reliance in an optimal way, we would put forward the norm that the application of physical restraint methods should be considered only in exceptional circumstances, whenever it would pose a serious risk to older people or to others, and only if the above-mentioned means of avoiding physical restraint are unsuccessful.

CLINICAL-ETHICAL DECISION MAKING

On the basis of the normative interpretation just given, we can now sketch some concrete guidelines for good clinical and ethical decision making with respect to physical restraint use.

The benefits should outweigh the shortcomings

For caregivers, it is often not clear if physical restraint should be applied or if it would be pointless. It is justified only if the benefits outweigh the shortcomings. The benefits can be physical, psychological, or social in nature, so physical restraint methods should be considered only if older persons' health, integrity, or living and caring environment would be seriously damaged by not using them.[39] As far as form, duration, and frequency are concerned, the caregiving team must assess carefully which procedure is most appropriate for attaining their goals and which is best adapted to a particular older person's needs and wishes. The least restrictive methods should always be tried first. Older people's freedom should not be restricted any longer, or to any higher degree, than is strictly necessary. In other words, there should be a reasonable or proportionate relationship between the physical restraint and the harm it intends to avoid.[39 41]

Starting from a concern to avoid unnecessary physical restraint, we propose that restraint can be considered only when:

- specific benefits are envisioned
- there is a reasonable expectation that these benefits can be attained through physical restraint (effectiveness)
- there are no practical alternatives to physical restraint (as listed above)

- the application of physical restraint hinders the older person as little as possible.

Every method should be individualised

The choice to use or not to use physical restraint should be based on an individualised comprehensive assessment—for example, cognitive, physical, mobility, and sensory state; drug therapy; past history; and environmental issues.[2 43] If physical restraint is applied, then certain additional measures need to be used in order to respect the older person's human dignity as much as possible and to avoid complications. Measures recommended for use with physical restraint are:

- continuous monitoring of physical health status—for example, skin color, extremity movement, and sensation, and personal needs—for example, toileting, food, and fluids
- maximum protection of privacy and optimisation of psychosocial comfort
- interruption of physical restraints at regular intervals
- re-evaluation of the justification for physical restraint at regular intervals.[16 43]

Organisation of open discussion with all involved

Dealing with physical restraint involves a difficult decision-making process in which all parties must participate on the basis of their own expertise.

Management

Dealing with physical restraint requires an organisational policy supported by the daily management of the nursing home. The key points of such a policy are vision, guidelines, operational policy, training, and communication.[38 43]

Management personnel must develop an ethical view with respect to physical restraint. A policy based on ethical values can serve to motivate caregivers.

The application of methods of physical restraint should, ideally, take place in accordance with previously established evidence-based guidelines that are recognised by management and caregivers, and applied consistently.

The reduction of physical restraint requires an operational policy. Elements of such a policy would include: adaptation to environmental factors—for example, architecture, choice of materials; appointment of resource persons; an interdisciplinary approach (including the older persons and their relatives); registration of the use of physical restraint; communication about the policy pursued, and so on.

The development of an ethical view, guidelines, and a policy goes hand in hand with the continuous training of caregivers in the application of methods of physical restraint, their ethical and legal aspects, their risks and indications, alternatives, etc.

Finally, good communication must ensure that all parties involved are aware of the institutional policy with respect to physical restraint.

Caregiving team

Caregivers should pose critical questions of one another about the responsible use of physical restraint. The search for new ways of promoting an older person's wellbeing is part of the task of an ethically motivated expert caregiver. That search is, however, not merely a question of individual expertise; it is much more a collective undertaking by people who are open to one another's input. The various responsibilities could be summed up as follows:[8]

- every nurse and doctor can resort to the application of physical restraint methods on the basis of observation
- the request is discussed within the interdisciplinary care team—the team supervises compliance with institutional policy
- whenever there is a necessity to apply physical restraint "unexpectedly and quickly", then prolongation of, or alternatives to, the method should be considered as soon as possible
- the care team informs all parties involved about their decision.

The older person

The care team must involve the older person as much as possible (even in cases of cognitive decline) in the decision-making process.[38] The caregiver should provide accessible information to the older person about treatment possibilities so that he or she can make real choices. In this, it is not so much the quantity of information that is important but what the older person can do with the information. It is essential to the decision-making process that the older person's wishes are taken into account as much as possible.[38 46]

Relatives

The care team assists the relatives by informing them at an early stage—for example, on admission, about the institution's policy concerning physical restraint.[46] Although the aim is to involve relatives in the decision-making process about their family member, it must be stressed that the ultimate decision is taken by the care team, and they retain full responsibility for their decision. Often, the family is under great stress owing to being confronted with the older person's decline, and they should not be made to feel responsible for the entire process of care as well, since this could give rise to guilt feelings.

Feelings of guilt can be combated by, as far as possible, involving the relatives directly (according to their ability and capacity to deal with it) in a caring process that aims at the avoidance of physical restraint. Through more intense contact with their familiar environment and with people they know, older persons will be given cognitive, physical, psychological, and social stimulation, whereby disorientation, aggressive behaviour, and feelings of boredom can in many cases be reduced. Moreover, the mere presence (supervisory function) of older people's relatives can already serve to prevent physical restraint.[2] This inclusion in the care process can heighten the feeling, for both older persons and their relatives, that the situation is a meaningful one. Of course, it goes without saying that relatives must be able to choose freely whether or not they want to participate in the caring process.

CONCLUSION

This article has dealt with two problems related to the physical restraint of older persons. First, there is sufficient empirical evidence to support the idea that, in many cases, physical restraint causes more harm than benefit. In addition, the application of physical restraint often goes together with a disproportionate infringement of the principle of respect for the autonomy of older people. This does not preclude the use of physical restraint in exceptional cases; however, the emphasis should be on finding adequate alternatives. In this way, attempts are made to protect older people from harm and to respect their personal freedom as much as possible.

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