Restraint in the care of older patients: Ethical and legal aspects

Dr David Oliver
BGS Spring Meeting
Bournemouth April 2009
I: Why this matters so much right now
II: Definitions and types of restraint (versus protective measures or deprivation of liberty)
III: Main moral tensions...
IV: Moral arguments and permission/specification (using “four principles” approach)
....and how these are reflected in law
V: Alternatives to restraint

I won’t critique the empirical evidence. That’s for the debate.
Restraints and bedrails *can* be dangerous/harmful and *have* caused serious injury and death. But do we conclude that they should *never* be used?
Empirical evidence - issues

- Paucity/quality of interventional studies
- RCTs hard to perform (removal, application of restraint)
- Especially in this vulnerable/acute/confused population
- Limitations of observational/quasi-experimental studies
- Harms from use of devices
- But denominator?
- Or control group?
- Basis for “strong assertions” not too clear
- That’s all I am saying on this..
I: Why this matters
Why this matters

- Patients over 65 – c 70% bed days
- **Falls**: common cause of admission.
- **Falls**: 30-40% safety incidents *(NPSA report)*
- **Dementia** and neuro-psychiatric symptoms common even in non-psychiatric hospitals *(e.g. Who cares wins.* *Dementia Strategy)*
- **Delirium** 11-40% hospital admissions *(RCP Delirium Guidelines. Young and Inouye BMJ 2007)*
- **Care homes**, 40% residents fall twice or more p.a.
- **Dementia/behavioural disturbance** affect 50-70% even in “non EMI” homes *(Bowman et al national census 2004. Selbaek G et al 2005)*
Why this matters

- **Falls**... (leading to injury, complaint, litigation, fear of falling, worsened rehab, prolonged stay etc etc)
- Median age (hospital) 81
- Common risk factors, dementia, delirium, agitation, postural instability, visual impairment
Why this matters: Location of falls (NPSA Report 2007) (90% unwitnessed in this and other reports)

- Fall whilst mobilising: 2%
- Fall from bed: 10%
- Fall circumstances unclear: 9%
- Fall from chair: 18%
- Fall from toilet or commode: 32%
- Fall in bathroom or shower: 28%
- Fall other: 2%
Why this matters – policy/law/guidance

- NPSA Report on falls 2007 *(and bedrail guidance)*
- Health Care Commission Standards *(now to CQC)*
- Dementia Strategy
- Growing public concern around dignity, safety
- More complaining/litigious culture
- Safeguarding vulnerable adults
- Mental Capacity Act 2005 *(including guidance on restraint use)*. Scottish Adults with Mental Incapacity Act.
- Bournewood Ruling and deprivation of liberty safeguards 2009
II. Definitions and types of restraint
Important distinction *(or continuous spectrum?)*

- Protective Measures
- Restraint
- Deprivation of Liberty
Types of restraint

- **Physical:** Being held by one or more persons
- **Chemical:** (e.g. sedation) (n.b. National Dementia Enquiry)
- **Psychological:**
  - e.g. being told repeatedly to sit down/avoid a particular activity
  - Having everyday objects taken away (aids, clothes etc)
- **Mechanical:** *(Overt and Covert)*
  - Specifically designed/prescribed devices e.g. lap belts, mittens, chair-top trays.
  - Use of everyday equipment e.g. wedging furniture, bedclothes, soft or low chairs
  - Alarms/tagging/monitoring/surveillance?
  - Bedrails?
Increased the awareness of restraints

The Provision states “Residents have the right to be free from ... any physical or chemical restraint imposed for the purposes of discipline or convenience and not required to treat the resident’s medical symptoms”
US 1987 OBRA guidelines restraints include:

- Physical or mechanical
- Vest Restraints
- Mitts, Wrist Restraints
- Geriatric chairs – lap top trays & cushions
- Chair to close to a wall
- Bed rails
- Sheets tucked too tight
- Drugs
“Gerichair”
“Posey Hugger”
“Posey Belt”
“Posey wrist restraint”
Posey “deluxe”
“Posey Vest”
“Sleep restraint”
¾ length bedrails
“If an item is used as a mechanism to control behaviour, the item may be considered a restraint. If on the other hand a patient/resident is incapable of moving him or herself the device should not be viewed as a restraint”.

Australian guidelines for the prevention of falls in hospital and in care homes 2005
Protective Measures

- Obligation to carry out risk assessments and minimise accidents
- “Routine” use of protective measures more controversial
- Some measures *should* be routine (e.g. HSE report on scalding injuries from too-hot water and need for mixer valve with temperature restrictor)
- Electronic tagging for wandering?
- Bed and chair alarms to prevent/detect falls?
- So “*protective measures*” *sounds* benign but could be more restrictive than restraint in some cases
Deprivation of Liberty Safeguards
(Amendment to Mental Capacity Act)

“Deprivation of liberty is a combination of factors – type, duration, effect and degree – that constitutes a deprivation of liberty.”

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III: Main moral tensions
Framework for decision-making

Ethical considerations

Personal values, experience, professional training

Professional decision-making constrained by...

Evidence-Base for Practice

Organisational culture values/priorities, resources

Legal and regulatory considerations. (nation-specific)

Cultural values (including professional group, patient, family, media/society, nationality)
HL Mencken

- “For every complex problem, there is a solution which is simple, obvious and wrong”
Strong opinions… (e.g. bedrails)

- ‘The more backward the ward, the more bedrails’ (Hazell 1990)
- ‘Indignity and inherent dangers’ (Miller 1989)
- ‘Institutionalisation of the worst kind’ (RCN 1992)
- ‘Dangerous and unethical’ (Jehan 1999)
- ‘Degrading’ (Gray and Gaskell 1990)
Assertions are not arguments!

- e.g. for bedrails, a relative evidence vacuum filled with strong opinions
- Staff sometimes uncritically take opinions in published papers as “gospel”
- Critique of empirical evidence for effectiveness may help
- But for ethics, so might a proper examination of the moral arguments....
Woman was ‘tied to chair’

An MP today demanded action after an elderly woman was seen tied to her chair with a dog lead at a private care home.

The Lincolnshire care home 80-year-old lived is in the constituency of Labour’s Shona McIsaac.

She told BBC Radio 4’s Today programme: “It’s an incredible story. The use of a dog lead is utterly wrong, it is clearly inappropriate. Restriction should be used in only rare and exceptional circumstances and it also must be done by people who are trained in restraint technique.”

The home is now under investigation and is being monitored. The National Care Standards Commission has made sure Mrs Scott was placed elsewhere, because the home admitted they could not cope with her.

Man died after falls at hospital

A SUTTON man prone to epileptic fits died following a series of falls.

- Use of restraints (overt or covert) is an infringement of autonomy and dignity of patient and therefore is maleficent
- Vs
- Acting (paternalistically) in the patient’s presumed best interest is part of duty of care
- (Mutually exclusive position?)…
3 key elements in the case against restraint (Healey and Oliver 2008 Age Ageing)

1. “Dangerous and Harmful”
   - So we need to examine the evidence and risk/benefit analysis

2. “In any case, ineffective”
   - So we need to examine the empirical evidence and its limitations

3. “Morally impermissible”
   - So we need to examine the moral arguments
3 Key arguments for use? Not easy to find supporter but would go...

1: “Paternalistic duty of care to protect the patient from harm”

2: “Use of restraint proportionate to the potential degree of harm”
   - Moreso if the person is confused and doesn’t appreciate risk

3: “Wider duty to avoid complaints/upset from family members or legal action for failure to protect from harm”
Other scenarios?

- Protecting other patients/residents from harm?
- Protecting from self-harm (rather than risk)?
- Or inadvertent sabotage of own treatment?
- Patients with mental capacity?
IV: Developing an ethical framework

And how this is reflected in law
Prima facie ethical principles

not going to critique “principlism” here – it works for examining our arguments

- Respect for patient
  - Autonomy (self-determination)
  - Beneficence
    - Duty of care to maximise benefit to patient
  - Non-maleficence
    - Duty to minimise the risk of harm
  - Justice
    - Equity in resource allocation
    - Equal rights to treatment/care
To turn these principles into practical rules for actions in specific circumstances, i.e., “specifications” and “permissions.”

- Consider **scope** of decision-making (for individuals, institutions, policy-makers etc).
- If any of these prima facie norms are to be **infringed**, then need to consider “**balancing rules**”… for balancing one norm against another.
Balancing Rules

1. “Better reasons can be offered to act on the overriding than infringed norm”
2. “The moral objective justifying the infringement must have a realistic prospect of achievement”
3. “The infringement is necessary in that no morally preferable alternative actions can be substituted”
4. “The infringement selected must be the least possible infringement needed to achieve the primary goal”
5. “The agent (i.e. doctor/nurse) must seek to minimise any negative effects of infringement”
6. “Must act impartially in regard to all affected parties and not influenced by morally irrelevant information”

Let us apply this to the real-life use of restraints...
Why might physical restraints/bedrails be used in "real life"?

1. Patient has asked for device
2. Beneficent aim of preventing falls/injuries in people who might roll or slide out of bed or chair
3. Beneficent aim of preventing falls/injuries in people who are agitated & unsteady and who keep trying to leave bed or chair.
4. Prevent disturbed, wandering patients from endangering /harming themselves or sabotaging own treatment (e.g. fluids)
5. Or harming/worrying other patients/residents
6. They consume so much staff attention that care of others compromised (i.e. “opportunity costs”)
7. Routine custom and habit (e.g. with bedrails) rather than any conscious management decision –i.e. casual/unthinking application
8. Staff and skills are inadequate to manage problems restraint-free
9. Patients’ relatives are insisting
10. Deliberately abusive or punitive measure
11. In someone who does have mental capacity to refuse
So...back to argument 3... – i.e. “Restraint use is always morally impermissible”

- There are permissions and circumstances...
- Where the person has requested the device or...
- Or lack autonomous capacity to appreciate risk
- And where they are at serious risk of injury
- And where degree of restraint proportionate to degree of possible harm
- And restraint is a “last resort” after other alternatives fully explored
- And is reviewed regularly and applied safely

- Protection of staff/other residents is morally more grey...
- Moral responsibility to advocate for better staffing levels?
- Though scope of personal/insitutional moral responsibility cannot extend to factors which you/the institution cannot control/influence
Mental Incapacity Act UK 2005. Five Key principles

- A presumption of capacity unless proved otherwise;
- The right for support in decision-making. All appropriate help should be given before any conclusion that someone cannot make their own decisions;
- Individuals retain the right to make what might be seen as eccentric or unwise decisions;
- Best interests – must be the aim of anything done on behalf of people without capacity. There is a checklist of factors for use in deciding what is in a person’s best interests. A person can also put his wishes into a written statement. Carers and family members gain a right to be consulted;
- The intervention least restrictive to basic rights and freedoms should be applied.
Mental Capacity Act and Restraint

- “The use or threat of force where an incapacitated person resists and any restriction of liberty of movement whether or not the person resists”
- “Restraint is only permitted if the person using it believes it is necessary to prevent harm (to the incapacitated person)”
- “And if the degree of restraint is proportionate to the degree of harm”
Proportionality...
A misunderstanding of “Respect for autonomy” is the main source of the “strong opinions”

- i.e. “self-determination” as opposed to personhood/human dignity
- Many of the assertions in the literature about “infringement of autonomy” ignore this
- Need to distinguish “normative” autonomy (i.e. the overall principle of right to self-determination and respect for personhood)...
- from “empirical autonomy” i.e. whether one actually has the capacity to do this
Empirical (actual) autonomy

- May be impaired due to:
  - Cognitive impairment (can the person appreciate how unsteady they are, how high the risk of falls, the fact that they have fallen before, the chance of serious harm from falls?)
  - Also....
  - Nausea
  - Pain
  - Anxiety
  - Unfamiliar environment
  - Irrational fears
  - Depression
  - Family pressure
  - Lack of information/communication
  - Hopelessness
  - Fatigue
  - Carer Stress
  - Obligations to Others
  - Sense of meaninglessness/existential crisis
(Legitimate) paternalism

“heteronomy” – defined as “any controlling influence over the will other than motivation by moral principles

JS Mill On Liberty

“Paternalism may be defined as the interference with a person’s liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests or values of the person being coerced”

R Dworkin 1972

“Soft” Vs “Hard” Paternalism

J Feinberg
Conditions for legitimate paternalism (Beauchamp and Childress)

1. “A patient is at risk of a significant preventable harm”
2. “The paternalistic action will probably prevent the harm”
3. “The projected benefits outweigh the risks”
4. “The least-autonomy restrictive alternative that will secure the benefits and minimise the risks is adopted”
Questions about “autonomy” ...

- Are health professionals too respectful of respect for autonomy or confidentiality at the expense of a duty of care to ensure patient safety (i.e. libertarian)?

- Or are patients’ relatives too inclined to compromise freedom and autonomy and to infantilise older people in favour of physical “safety” without thinking about other harms? (i.e. paternalistic)

- Do the professionals understand what autonomy actually means?

- Do lay people actually respect autonomy in older people or have they subconsciously decided that “different rules apply” if you are old – just as if you are a child?
Inquest told victim broke hip while left unattended in hospital

THE DISTRAUGHT family of an elderly Earley man heard at his inquest that he had fractured his hip when hospital nurses left him unattended.

Mr., was admitted to the Royal Berkshire Hospital after suffering a stroke on May 21 – his second in 10 years – and was later transferred to Battle Hospital’s specialist stroke unit.

The court heard the 72-year-old from was diabetic, had heart problems and was blind in one eye but was “reasonably independent”.

Later that evening, daughter-in-law , of Whiteknights Road, received a call from the hospital telling her was being moved back to the Royal Berkshire Hospital because they had discovered he had a broken hip and needed an operation.

said: “We were really shocked because none of the x-rays or tests had indicated he had broken any-thing, but we were not given any explanation to how it happened.”

It was only after hearing the nurses statements at the inquest that the family learnt senior nurse and health care assistant had taken to the toilet. But they left him unattended and went for a break, claiming in the interests of “privacy and dignity” they would not stay inside a toilet with a patient.

The remaining nurse, ran to the toilet after hearing a crash to find on the floor and had to summon a patient to call for help.

Coroner said: “I was concerned about fall and there should have been better dialogue with the family.

“I’m concerned to learn that one member of staff was left responsible for 13 patients when I’m told there should be a minimum of two members of staff and I'd like to think lessons may be learnt.

“If you are dealing with an elderly patient who has suffered two stroke who is agitated, has an issue with sight it seems to me his privacy and dignity comes at a very low second to his immediate safety.

“There must have been a better way of supervising and preventing the injury that suffered on a special ward, which in my view is extremely regrettable.”

Post mortem results revealed died on May 25 from a diseased heart and contributing factors including pneumonia.

Recording a verdict of natural causes, said the injury and shock of the fall “can’t have helped” but was unable to determine whether the fall hastened death but he could not rule out it as a contributing fact-or.
Restraint is an infringement of personal freedom? (Vassallo et al)

P<0.0001

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<th>Agreement (%)</th>
<th>Health Care Professionals</th>
<th>Patients and Relatives</th>
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<td></td>
<td>66</td>
<td>35</td>
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Restraining methods are acceptable at the discretion of health care professionals? (Vassallo et al)

P < 0.0001
Differences in Acceptability: Bed or chair alarms (Vassallo)

Alarms that alert staff that a patient is getting out of bed or chair (having a ringing alarm)

Acceptability %

- Health care professionals: 74%
- Patients and relatives: 86%

p = 0.052
Differences in Acceptability: Nursing patients on the floor (Vassallo)

Nurse patient on a mattress placed on the floor

Acceptability
%

64

p=<0.0001

19

health care professionals

patients and relatives
Mentally Competent Individuals?

- Right to freedom of movement enshrined in Human Rights Act 1998, which protects individuals from arbitrary restrictions on their liberty.

- Any form of restraint which restricts competent individuals’ freedom, without their consent or other overriding justification, could be in breach of the Act.

- An overriding justification could arise in exceptional cases where a competent person has to be restrained because their activities would cause harm to others.

- Competent patients of any age have rights to risk their own health but are justifiably restrained if they represent a significant harm to other people.
Professionals have a common law right to use restraint to prevent harm to a person in their care or to another person. They should also intervene if the individual seriously compromises the therapeutic environment. Restraint should always be the minimum necessary to prevent harm. Responses to any threat of violence must be reasonable and proportionate to the risk. Where there is a foreseeable need to manage violent patients, this needs to be planned for and staff should be trained in appropriate skills.
V: Other points of law
Negligence Tests

- Duty of Care *(see Bolam and Bolitho)*
- Breach
- Reasonably foreseeable and preventable
- Identifiable harm

*(See Oliver et al QSHC 2008 for review of NHSLA cases)*
Human Rights

- **Article 3. Right to Prohibition of torture**
  
  “No one shall be subjected to torture or to inhuman or degrading treatment”

- **Article 5. Right to liberty and security**
  
  “Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in specific exceptions.”
Bournewood ruling  
*European court of human rights re autistic man who consented to inpatient treatment but clearly lacked capacity*

### Identifying deprivations of liberty

The court gave some directions on what would contribute to deprivation of an individual’s liberty: these were:

- Use of *restraint or sedation* to admit a person who is resisting
- Professionals exercising *complete control over care* and movement for a significant period
- Professionals controlling assessments, treatment
- Being *prevented from leaving* residence
- Request by other carers for the person to be *discharged* being refused
- Individual *unable to maintain social contacts* since restrictions placed on access to other people
- Individual loses autonomy due to *continuous supervision or control*
Deprivation of Liberty Safeguards
(Amendment to Mental Capacity Act)

A combination of factors – type, duration, effect and degree – are what constitutes a deprivation of liberty

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VI: Alternatives to restraint?
Alternatives

Alzheimer Europe
Position Paper

Guidelines on the use of various measures designed to restrict liberty of movement

Rights, risks and limits to freedom

Principles and good practice guidelines for practitioners considering restraint in residential care settings
### Alternatives e.g.

#### RESTRAINT ALTERNATIVES

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<th>Behavior/Medical Condition</th>
<th>Therapeutic Intervention</th>
<th>Environmental &amp; Equipment Intervention</th>
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| Unsafe Mobility Unsteady Gait | ✓ Evaluate medications that may produce gait disturbances.  
✓ Evaluate for orthostatic hypertension and change positions slowly.  
✓ Evaluate visual system and proper correction of eye glasses.  
✓ Evaluate vestibular system - making sure ears are clear & balance system is intact.  
✓ Reevaluate physical needs such as toileting program, comfort, pain.  
✓ Exercise peddles while sitting.  
✓ Generalized activity programs.  
✓ Ambulation and/or exercise programs.  
✓ Group ambulation and/or accompanied walks in or out of doors.  
✓ 1:1 visitations.  
✓ Encourage repositioning frequently.  
✓ Identify customary routines (late sleepers and early risers) and allow for preferences.  
✓ Evaluate for a restorative program.  
✓ PT/OT referral for screening. | ✓ Evaluate for proper fitting and appropriate condition of footwear.  
✓ Non-skid socks.  
✓ Evaluate ambulation devices for good working condition.  
✓ Adequate lighting, especially at night.  
✓ Remove wheeled furniture used for support.  
✓ Bed lowered so resident can touch toes to the floor.  
✓ Place glasses on daily to enhance visual acuity.  
✓ Call bell in reach at all times.  
✓ Evaluate need for bedside commode at night.  
✓ Avoid use of throw rugs.  
✓ Floor alarm.  
✓ Motion detectors.  
✓ Bed &/or chair alarms.  
✓ Hip protectors.  
✓ Merry Walker - fade use as strength increases. |
Alternatives


Some evidence around injury prevention (flooring/hip protectors etc)

Some evidence around single interventions such as medication review and adjustment (Zermansky 2006. Vitamin D and Calcium e.g. Boonen S 2007, Bischoff-Ferrari 2006)

Better management of agitation/restlessness (e.g. RCP Delirium Guidelines)
In Conclusion…