

Restraints, Bedrails and Falls. Evidence and Ethics

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What I will talk about..

- **I: Restraints:**
 - Definitions and types. (inc. Bedrails)
- **II: The controversy**
- **III: Why it matters?**
 - Prevalence of use, falls and reasons for use
- **IV: The evidence-base and problems with it**
 - Clinical Trials, Quasi-Experimental, Observational studies.
 - Bedrails as separate topic
- **V: Ethical (and legal?) controversies**
 - Autonomy, Paternalism, Freedom, Rights, Duty of Care (to individuals and all patients)
 - Well intended versus abusive use
 - Attitudes/perceptions in different groups
- **VI: Suggested ways forward**
 - “Permissions”/Specifications for use
 - Alternatives

Why it matters

- Falls and Falls injuries are common in institutions (and harmful to patients/residents)
- So are frailty, postural instability, delirium, dementia and behavioural disturbance
- As the population ages this will continue to be the case
- There is much pressure for “something to be done” to manage these risks
- This sometimes/often involves restraints and bedrails
- There are many strong opinions in the literature advocating against restraint use in all circumstances
- So we need a better understanding of the evidence base for harm versus benefit and of the ethical issues

Definitions

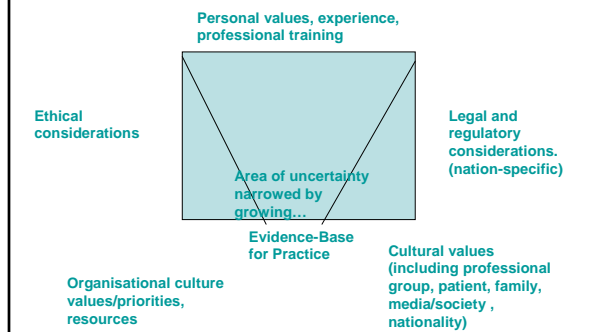
- “the intentional restriction of a person’s voluntary movement or behaviour – where behaviour means planned or purposeful actions rather than unconscious, accidental or reflex actions” *Evans D et al J Adv Nurs 2005*
 - “stopping them from doing something they appear to want to do” *Counsel and Care 1993 “What if they hurt themselves”*
 - “Any manual method or physical or mechanical device, material or equipment attached to or adjacent to a patient or resident’s body that cannot be removed easily, which restricts freedom of movement or access to his/her body” *Mahoney J Clin Ger Med 1998*
 - “The use or threat of force where an incapacitated person resists and any restriction of liberty of movement whether or not the person resists” *Mental Incapacity Act (England and Wales 2005)*
- “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 hospitals and care homes 2005*

Types of restraint *Draft RCN Guidance 2008*

- **Physical:** Being held by one or more persons
- **Chemical:** (e.g. sedation)
- **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?



Framework for decision-making



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)

3 key elements in the case against restraint (Healey and Oliver 2008) – the talk will explore all three

- 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

I: “Dangerous and Harmful”

- There are observational series of deaths and injuries from bedrails and restraints
- Many harms due to unsafe use or faulty equipment
- Potential psychological and emotional harms
- Potential for deconditioning, muscle weakness, pressure damage, worsening of delirium etc
- But need to balance against falls and injuries which would occur without restraints/bedrails in place
- *Just because sometimes dangerous and harmful doesn't mean they should never be employed*

II “Ineffective”

- The evidence base is full of quasi-experimental and confounded studies
- Systematic reviews of bedrails, restraints and falls interventions in general provide little conclusive evidence in either direction
- Observational data on falls from bed suggest that most happen with no bedrail or restraint in place
- Again, the blanket statement that they are “ineffective” (in all cases) doesn't bear scrutiny

III: “Morally Impermissible” (i.e. “unethical”)

- By reference to Beauchamp and Childress “four principles” of beneficence, non-maleficence, respect for autonomy and justice
- And the “balancing rules” when one of these norms must be infringed to achieve the others
- There are circumstances where the use of restraints may be morally permissible and we can specify these

n.b. “Respect for autonomy”

- It is crucial to realise that whilst personhood and human dignity and the right to autonomy (“self-determination”) should be respected...
- A person without sufficient mental capacity to appreciate their risk of falls and injury is not a truly autonomous agent
- Which may justify acting in their “best interests” – paternalistically
- So the use of restraints does not always “breach autonomy”

Combining ethics and evidence to arrive at “specifications” for acceptable restraint use

- If restraints are used with the beneficent intention of preventing someone from serious harm or injury
- If the person does not have sufficient capacity to make an informed refusal of the devices (or has freely agreed to use them)
- If the devices are safe and used safely
- If the indication for use is reviewed regularly
- If all alternatives have been explored first (including better management e.g. of delirium, falls risk, agitation; better supervision and assistance etc)
- Then as a final rather than first resort, it seems reasonable to employ restraints on a limited basis

But...

- They should never be used casually and routinely
- Never as a substitute for adequate assessment, care or supervision
- Never as an abusive or punitive measure
- Never against the express wishes of an autonomous person