The Village Residence. Policy on Restraint Revised August 2023

Policy on Restraint	
Developed by: Director of Nursing Office and Clinical Nurse Managers.	**Date Developed: Revised February 2011** **Revised March 2014, May 2020, November 2021, August 2023**
Developed By: Nursing Department.	**Date Approved: February 2011, March 2014, May 2017, May 2020 November 2021 August 2023**
Implementation Date: April 2009	**Review Date: May 2023 or sooner if required. 31/08/2023**
Policy Reference Number: HIQA Schedule 5 Restraint	**No. of Pages: 16**
Status of the Policy: Final	

Please read in conjunction with Policy on Enhanced Care and Policy on Restrictive Practices.

31.08.2023

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1.0 POLICY STATEMENT

The Village Residence is committed to a policy of restraint free environments. However, it is acknowledged, that in a small number of very exceptional cases and as a last resort, time limited restraint may be considered as part of the residents care plan. This policy applies to physical restraint and does not apply to environmental restraint.

2.1 PURPOSE

The purpose of this policy is to outline those exceptional, limited circumstances in which restraint may be permitted as part of the residents care plan. It also outlines the circumstances and methods of restraint that are not permitted. The policy is accompanied by evidence based procedures to be taken, prior to, during, and after the period of restraint and guidelines to support staff to seek alternatives to restraint.

2.2 SCOPE

- This applies to all residents admitted for respite or extended care.
- This policy applies to all staff working in The Village Residence. It is guided by the National Quality Standards for Residential Care developed by Health Information and Quality Authority (HIQA)
- This policy is set within the context of the HSE's Quality and Risk Management Standard 2007 and Policy on the use of Physical restraints in residential care settings (HSE 2010).
- For the purpose of this policy, the term interdisciplinary team members refers to staff working within the unit i.e. nursing staff, care staff and those who may provide services to residents on a sessional basis i.e. general practitioners, therapists.

2.3 DEFINITION OF RESTRAINT

"Any physical, chemical or environmental intervention used specifically to restrict the freedom of movement – or behaviour perceived by others to be antisocial – of a resident designated as receiving care in an aged care facility.

It does not refer to equipment requested by the individual for their safety, mobility or comfort. Neither does it refer to drugs used – with informed consent – to treat specific, appropriately diagnosed conditions where drug use is clinically indicated to be the most

appropriate treatment. (Nay and Koch 2006).adapted

In this policy the term enabler is used. An Enabler is viewed as a device applied to a resident for the purpose of positioning or enhancing resident function. Devices are not considered a restraint if they have been requested by the patient / resident and enable the resident to function at a higher level within their environment (Payne et al, 2006, Shannex Health Care Management Incorporated, 2005).

***On occasion a device may restrict movement but enable function e.g. Lap tray for self feeding. However, it is the intent behind using the device that determines whether it is a restraint or an enabler**.*

- If a device does not restrict freedom of movement and assists the resident to function at a higher level, it is an enabler not a restraint.
- If a device restricts freedom of movement but allows a resident to function at a higher level it is an enabler and a restraint, **therefore it must be used only for the periods of its intended purpose for example, a lap tray must be removed after mealtimes.**
- If a device restricts freedom of movement and does not assist the resident to function at a higher level it is a restraint and should only be used in accordance with this policy.

2.4 AIMS OF THE POLICY

The aims of the policy are:

- To ensure that restraint will only be used as a last resort in exceptional circumstances following a comprehensive interdisciplinary assessment.

2.5 THE LAW AND RESTRAINT

Any person using restraint has to be able to justify it in a court of law. It is for the person using it to justify both the use of restraint and the way in which he or she used it.

2.6 CIRCUMSTANCES IN WHICH RESTRAINT IS PERMITTED IN A Very TIME LIMITED WAY IN A RESIDENTIAL CARE SETTING

- For behaviour when there is an immediate and significant risk to the resident's safety or the safety of others and the behaviour may result in a significant injury to that resident or others (for example where a resident who repeatedly harms themselves,

unprovoked or uncontrollable physically violent/injurious behaviour toward self or others).

- For the brief provision of essential personal care when there is an immediate and significant risk to the resident's well being.
- For risk of falls when the risk of falling is immediate as in severe imbalance (E.g. stroke with severe neglect, gross cerebellar ataxia) or where a person may have suffered a hip fracture or another type of lower extremity fracture in which weight-bearing is restricted.
- There is clear evidence that an extensive range of measures have been tried, for a reasonable period of time and they have proved unsuccessful in maintaining the safety of the person from causing significant harm to themselves or others

2.7 THE USE OF RESTRAINT IS NOT PERMITTED (HIQA SS21.17)

- For wandering behaviour
- For risk of falls unless the risk of falling is immediate as in severe imbalance
- For the removal of a medical device unless the residents require emergency care and physical restraint is used for a brief period to permit medical treatment to proceed.
- Routine or 'as needed orders for restraints are not permitted
- Restraint should never be used to cover any deficiency of service, lack of professional skill, or defects in the environment.

Except in rare, time-limited emergencies, or for brief provision of essential care, no physical restraint is used that causes the resident distress, discomfort, anger, agitation, pleas for release, calls for help or constant attempts to untie or release him/ herself. . (HIQA 21.21)

2.8 THE FOLLOWING METHODS OF RESTRAINTS CAN ONLY BE USED WHEN A DECISION TO RESTRAIN A PERSON HAS BEEN MADE AND ONLY EVER FOR A SPECIFIC MEDICAL SYMPTOM

- Lap Belts
- Hand mitts
- Bed rails (see policy on use of bed rails)
- Chairs. Any chair that has the effect of restraining a person must be individually fitted by an appropriately trained health care professional for his or her requirements. It should allow the resident to engage in eating and drinking and, in other activities such

as reading, or manipulating objects with their hands for diversion. Similarly, a chair should not inhibit a resident from being in contact with other people.

All restraints must be applied in a manner, according to manufacturer's recommendations, to decrease the chance of pressure damage and abrasion to the skin ands underlying tissues. The proper size and type of equipment must be used.

2.9 THE USE OF ALL OTHER TYPES OF DEVICES OR INTERVENTIONS IS NOT PERMITTED AND THEIR USE IS CONTRARY TO PROMOTING RESIDENT'S DIGNITY. THESE INCLUDE:

- Pelvic, groin, vest and ankle restraints and four-point (restraint of all 4 limbs).
- Use of bed tables or other furniture to restrict movement
- Use of controlling language or inappropriate holding of the resident
- Removal of spectacles or other aids
- Use of clothing to restrict movement
- Use of bean bags or similar items to restrict movement.

Electronic Technologies

When used correctly, electronic can greatly reduce the incidence and severity of potentially dangerous elopements. However these are a severe restriction on any resident. These devices have battery-powered identification "triggers" with built-in transmitters that cause an alarm to sound only when an individual sitting on a trigger attempts to stand up or get out of bed. They have an impact on other residents.

THEY SHOULD NOT BE USED WITHOUT THE INVOLVBEMENT OF ALL TIMES OF THE RESIDENT.

There are cameras in all areas of Butterfly Cottage, Red Robin Cottage and Forget me not. There are no cameras in Sunnyside or Meadowview. Cameras are only focused on exit points and will only be used for a review should there be a serious incident of a person leaving the premises or where there was a security breach.

2.10 RESIDENT AND FAMILY INVOLVEMENT

Residents or their appointed decision makers/advocate should always be involved in any

discussion of restraint, no matter how incapacitated they are. Almost all residents will have some ability to express, verbally or otherwise (e.g. by gesture or by signing) their views about how they wish to be treated, or may have expressed them in the past. To the extent to which it is possible and reasonable, the resident's informed, free and full consent to any restraining action should be obtained. Any relatives, advocates, or guardians should be involved in the discussions. In all cases an explanation should be given in a manner the person can understand.

2.13 CONSENT

No resident may ever be restrained without their informed consent.

If a resident does not consent to receiving care of any form, then move away from the resident and attempt to go back at another time.

Where a resident is soiled and in need of assistance, the only person who can give permission for any form of restriction is the Person in Charge. No other person is authorised in this service to undertake any procedure that would restrict a person's freedom to express their views.

2.14 RESIDENTS WHO LACK CAPACITY TO CONSENT

With regard to residents who lack capacity to consent to restraints and who do not express a clear and consistent preference:

- Family members and others cannot insist on or give permission to use restraints
- The resident's physician cannot insist on or give permission to use restraints for the sake of discipline or staff convenience or when a restraint is not necessary to treat the resident's medical symptom.
- Decisions for those lacking capacity are made with the person's best interests in mind. **Best interests include quality of life and are not simply a matter of 'safety' or of 'duration of life' or medical concerns**

While family members cannot give consent for the use of restraint they should be involved in the decision making process.

The decision to use any devise that disables a person's freedom of movement lies with the Nurse.

3.0 PROCEDURES

1. The resident assessment
2. The care Plan
3. The care of resident during the period of restraint

4. Restraint procedure in an emergency situation
5. Review procedures

A plan will be drawn up with the person in charge and the person in charge will take full responsibility for any intervention

The person in Charge may delegate this function to senior nurses.

This plan will outline the procedure to be followed.

Only one person will communicate with the resident

Where all efforts have been tried with the resident, any intervention will be very time limited.

A resident will be encouraged, praised throughout the procedure.

The resident must be left in a safe and unstressed manner after the procedure.

After the event the staff involved must de-brief each other on:

What went well

What didn't go well

What did we learn/

3.1 RESIDENT ASSESSMENT

When there is a change in the resident's condition and restraint is being considered a systematic and collaborative assessment should be initiated that includes the resident, their family/representative and members of the multi-disciplinary team.

3.2 CO-ORDINATING THE ASSESSMENT

It is important that the assessment is coordinated by the nurse. See **Appendix 2.**

3.3 THE ASSESSMENT SHOULD CONSIDER THE RISKS ASSOCIATED WITH:

- The person's own wishes and preferences
- The person's physical health
- The person's mental, social and psychological health
- The environment in which the person resides
- Any contributing factors which include how staff manage challenging behaviours
- The severity and potential consequences of the resident's behaviour for both the resident and others

3.4 DEVELOPMENT OF THE CARE PLAN TO REFLECT NEEDS/RISKS IDENTIFIED IN THE ASSESSMENT. THIS SHOULD INCLUDE:

- The specific symptom to be treated or behaviour to be contained or prevented
- The steps taken to identify the underlying physical, psychological and/or environmental causes of the symptom.

- The alternative measures that have been taken, for how long; how recently, and the outcomes.
- The risks involved in using the physical restraint, see **Appendix 4**.
- The type of restraint, the reason for use, period of restraint, and location of physical restraint.
- The names of the inter-disciplinary team members involved in the decision.
- The conditions or circumstances under which the restraint is to be used
- The time frame under which it will be used and the associated date for review

3.5 CARE OF RESIDENT DURING THE PERIOD OF RESTRAINT

- In an emergency situation or during periods of extreme behaviour the resident is continuously observed.
- In all other situations where restraint is used, the resident is checked regularly at intervals defined in his/her care plan.
- A record of these checks must be documented, see **Appendix 5.**
- Opportunity for motion and exercise must be provided for a period of not less than 10 minutes during each two hour period in which restraint is employed and the resident is awake, and a record of such activity must be kept.
- During any period where a resident's movements are subject to restraint one or more staff members must be in direct, continuing visual and verbal contact with the resident.
- Family involvement in the residents care should be encouraged, if it is safe to do so restraints should be removed during family visits. Staff should ensure that the family recognises the need to inform staff on their departure to ensure the safety of the resident.
- The resident must be provided with a means for calling for assistance and shown how to use the system
- Ensure residents physical needs are met as promptly as possible such as toileting nutrition warmth, comfort and hydration.
- Special consideration should be given when restraining residents who are known, by the staff involved in restraining the resident to have experienced some form of physical or sexual abuse.

3.8 RESTRAINT REVIEW

The registered nurse arranges a multidisciplinary review of the residents condition linked to the use of restraint as soon as possible (no later than 24 hours) A full review of the

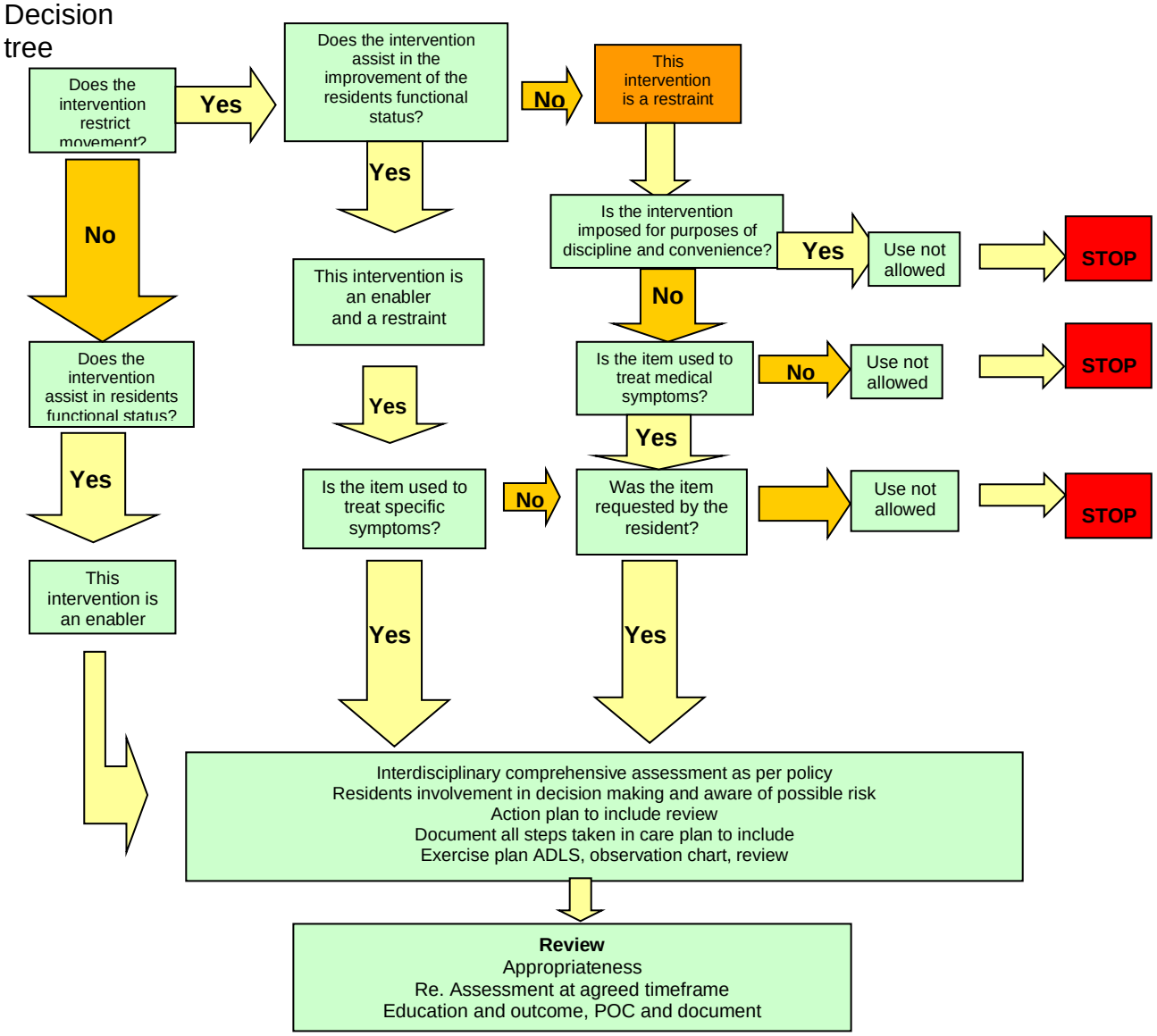
decision to restrain is undertaken with the multi-professional team as soon as is practically possible (within 72hrs).

GUIDELINES TO SUPPORT STAFF DECISION MAKING.

4.0 DECISION MAKING TOOL

This decision making tool aims to assist management and staff to make informed decisions in relation to the use or non use of restraint in responding to behaviours of concern**. The decision to apply restraint must be made using the following flow chart.**

Restraint Decision tree



4.2 POLICY FOR THE USE OF BED RAILS

For the purpose of this policy, the term bed rail will be used.

Bed rails should be used with care and only after a full, documented risk assessment has been carried out within 24 hours of admission for each resident. All existing residents should be re-assessed. This will determine if their use is the most appropriate method of bed management in each case.

4.9.1 WHENEVER BEDRAILS ARE USED THE FOLLOWING CHECKS SHOULD BE CARRIED OUT: FOR ALL TYPES OF BEDRAIL

- Are there any signs of damage, faults or cracks on the bedrails? If so, do not use and label clearly as faulty and have removed for repair;
- If using detachable/non detachable bedrails: the gap between the top end of the bedrail and the head of the bed should be less than 6cm or more than 25cm; the gap between the bottom end of the bedrail and the foot of the bed should be more than 25cm;
- the fittings should all be in place and the attached rail should feel secure when raised;
- Side rail bumpers, padding or padded enveloping covers, in some instances, can also be used to reduce the potential for entrapment. Their primary use is to prevent the resident from impact injuries, and that the risk of entrapment may still exist.

5.0.2 ADJUSTABLE OR PROFILING BEDS

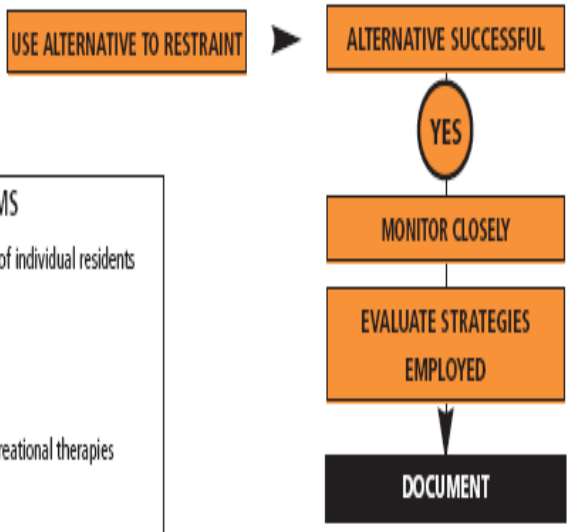
Low low beds must never be used to prevent a person from moving or standing up

- Most profiling beds feature bed rails that are incorporated into the bed design or are offered as an optional extra by the manufacturer. These types of bed rail are involved in fewer incidents than third party bed rails. The following points should be considered when using this type of bed:
- Many beds have a single piece bed rail along each side of the bed. When the bed is profiled there is an increase risk of the resident toppling over the bed rail.

- To overcome this problem some profiling beds are fitted with split bed rails, one at the head end and one at the foot end. With this type of bed rail there is a further risk of entrapment between the two halves of the bed rail, which needs to be considered.

5.0.3 BED RAIL PROTECTORS

- Padded bumpers are primarily designed to reduce the injury from impact against the bed rail. They can reduce the risk of entrapment, however if they move or are compressed this can introduce an entrapment risk.
- There is a risk of suffocation that needs to be considered if covers are not air-permeable.
- Mesh covers are also used to prevent the risk of entrapment.



Alternatives to the use of restraint

ENVIRONMENTAL

- improved lighting
- lights that are easy to use
- non-slip flooring
- carpeting in high use areas
- ensure a clear pathway
- easy access to safe outdoor areas
- activity areas at the end of each corridor
- lowered bed height to suit individual needs
- remove wheels from beds
- appropriate mobility aids close at hand (railings on the wall, trapeze to enhance mobility in bed)
- appropriate signage and visual reminders to aid orientation (eg use pictures)
- seating to meet the needs of individual residents
- appropriate alarm systems to highlight to staff of risky situations such as a resident who has wandered into a dangerous area
- a quiet area
- reduce environmental noise
- safe areas for residents to wander such as circular corridors with activity stations
- protected out door areas
- transfer rails
- provide familiar objects from the resident's home e.g. photo albums, furniture etc
- 'Snoozelen' room

ACTIVITIES AND PROGRAMS

Develop programs to meet needs of individual residents such as:

- rehabilitation and/or exercise
- regular ambulation
- continence program
- physical, occupational and recreational therapies
- exercise program
- night-time activities
- individual and group social activities
- appropriate outlets for industrious people (e.g. gardening, folding linen)
- facilitate safe wandering behaviour
- offer a change of seating arrangements at regular intervals with their consent, for residents who are not independently mobile
- falls prevention program
- activities box containing, for example laundry to fold, stuffed animals, purses and wallets

ALTERATIONS TO NURSING CARE

- increased supervision and observation
- regular evaluation and monitoring of conditions that may alter behaviour e.g. noise level
- increased staffing level
- individualised routines e.g. toileting, naps
- structured routine
- know the residents as individuals
- check 'at risk' residents regularly
- appropriate footwear
- body padding (hip protectors)
- better communication strategies

PHYSIOLOGICAL STRATEGIES

- comprehensive physical check-up
- comprehensive medication review
- treat infections
- pain management
- physical alternatives to sedation e.g. warm milk, soothing music

PSYCHOSOCIAL PROGRAMS AND THERAPIES

- companionship
- active listening
- visitors
- staff/resident interaction
- familiar staff
- therapeutic touch
- massage
- relaxation programs
- reality orientation
- sensory aids
- sensory stimulation
- decreased sensory stimulation

Adapted from Joanna Briggs Institute (2002) Physical Restraint—Pt 2: Minimisation In Acute and Residential Care Facilities. *Best Practice, Vol 6 Issue 4*, Blackwell Publishing Asia, Australia

Appendix

RESTRAINT RELEASE & REVIEW CHART

The Village Residence. Policy on Restraint Revised August 2023

Patient / Resident Name: _____ MRN _____

Date Restraint First Initiated_____

In consultation with Doctor _____

Type of Restraint: _____

NB: Restraint to be removed **every two hours for 10 minutes when awake & while visitors are present, unless documented to the contrary**.***

Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	24 hr review 2 signatures & code
Monitor needs during restraint use:				***Potential negative outcomes of restraint use:***								
Activities / Behaviour / Mood Comfort / Socialization Circulation / Safety Hydration / Nutrition Range of Motion / Function Toileting				Declines in the resident's physical functioning and/or muscle condition Contractures / Injury Increased incidence of infections Compromised circulation Skin Breakdown / Bruising / Abrasions				Withdrawal from social activities Agitation / Delirium Depression / Sensory deprivation Decreased appetite Sleeping pattern disturbance Incontinence / Constipation				

✓ = Assessment completed and still is applicable,

⃠ = Change noted, the MDT consulted and the care plan changed

✕ = refer to documentation entry in care plan

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Date	08.00-10.00		10.00-12.00		12.00-14.00		14.00-16.00		16.00-18.00		18.00-20.00		
	20.00-22.00		22.00-24.00		24.00-00.00		00.00-02.00		02.00-0400		04.00-06.00		
Date	08.00-10.00		10.00-12.00		12.00-14.00		14.00-16.00		16.00-18.00		18.00-20.00		
	20.00-22.00		22.00-24.00		24.00-00.00		00.00-02.00		02.00-0400		04.00-06.00		
Date	08.00-10.00		10.00-12.00		12.00-14.00		14.00-16.00		16.00-18.00		18.00-20.00		
	20.00-22.00		22.00-24.00		24.00-00.00		00.00-02.00		02.00-0400		04.00-06.00		
Date	08.00-10.00		10.00-12.00		12.00-14.00		14.00-16.00		16.00-18.00		18.00-20.00		
	20.00-22.00		22.00-24.00		24.00-00.00		00.00-02.00		02.00-0400		04.00-06.00		
Date	08.00-10.00		10.00-12.00		12.00-14.00		14.00-16.00		16.00-18.00		18.00-20.00		
	20.00-22.00		22.00-24.00		24.00-00.00		00.00-02.00		02.00-0400		04.00-06.00		
Date	08.00-10.00		10.00-12.00		12.00-14.00		14.00-16.00		16.00-18.00		18.00-20.00		
	20.00-22.00		22.00-24.00		24.00-00.00		00.00-02.00		02.00-0400		04.00-06.00		
Date	08.00-10.00		10.00-12.00		12.00-14.00		14.00-16.00		16.00-18.00		18.00-20.00		
	20.00-22.00		22.00-24.00		24.00-00.00		00.00-02.00		02.00-0400		04.00-06.00		

2. Detailed risk balance tool

See comment under Alternative A about the advantages and disadvantages of this type of tool

THE RISK OF NOT USING BEDRAILS	THE RISK OF USING BEDRAILS
How likely is it that the patient will fall out of bed? Patients may be more likely to slip, roll, slide or fall out of bed if they: • have fallen from bed before; • have been assessed as having a high risk of falling; • are very overweight; • are semi-conscious; • have a visual impairment; • have a partial paralysis; • have seizures or spasms; • are sedated, drowsy from strong painkillers or are recovering from an anaesthetic; • are delirious or confused; • affected by alcohol or street drugs; • are on a pressure-relieving mattresses which 'gives' at the sides; • use bedrails at home; • have self-operated profiling beds. **How likely is it that the patient could be injured in a fall from bed?** Injury from falls from bed may be more likely, and more serious for some patients than others, for example, if they: • have osteoporosis; • are on anti-coagulants; • are older; • have fragile skin; • have a vascular disease; • are critically ill; • have long term health problems; • are malnourished. **Will not using bedrails cause the patient anxiety?** Some patients may be afraid of falling out of bed even though their actual risk is low.	**Would bedrails stop the patient from being independent?** Bedrails can be a barrier to independence for patients who otherwise could leave their bed safely without help **Is the patient likely to climb over their bedrails?** An injury's severity can be increased if the patient climbs over a bedrail and falls from a greater height. It is patients who are significantly confused and have enough strength and mobility to clamber over bedrails that are most vulnerable. **Could the patient injure themselves on their bedrails?** Bedrails can cause injury if the patient knocks themselves on them or traps their legs or arms between them. The most vulnerable patients are those: • with uncontrolled limb movements; • who are restless and significantly confused; • with fragile skin. Bedrails, even when correctly fitted, carry a very rare risk of postural asphyxiation. Patients who are very confused, frail and restless are most likely to be at risk. **Will using bedrails cause the patient distress?** Bedrails may distress some patients who feel trapped by them.
BEDRAIL USE IS RECOMMENDED IF THE RISKS ABOVE ARE GREATER THAN THE RISKS ON THE RIGHT	**BEDRAIL USE IS NOT RECOMMENDED IF THE RISKS ABOVE ARE GREATER THAN THE RISKS ON THE LEFT**

Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations

Zone	Dimensional Limit Recommendations
1 Within the rail	<120 mm (< 4 3/4 “)
2 Under the rail, between rail supports or next to a single rail support	< 120 mm (< 4 3/4 “)
3 Between rail and mattress	<120 mm (< 4 3/4 “)
4 Under the rail, at the ends of the rail	<60 mm (< 2 3/8 “) AND >60° angle

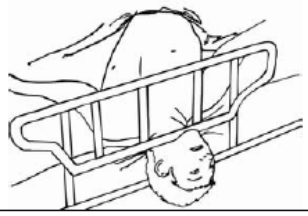
APPENDIX 10 Must be demonstrated to all relatives who insist on Bedrails

APPENDIX E

Drawings of Potential Entrapment in Hospital Beds

Zone 1 – Entrapment within the rail

Zone 2 – Entrapment under the rail, between the rail supports or next to a single rail support



Zone 3 – Entrapment between the rail and the mattress

Zone 4 – Entrapment under the rail, at end of rail

Zone 5 – Entrapment between split bed rails

Zone 6 – Entrapment between the end of the rail and the side edge of the head or foot board

Zone 7 – Entrapment between head or foot board and the mattress end

Appendix 11

Residential Restraint Register

Name of Organisation _____

Week Beginning ---------- 2023

To be completed every morning by the Clinical Nurse Manager or designated person in charge and to be held in Nursing Administration and must be available for inspection on request