Restraint in care homes for older people: a review of selected literature

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Report 26: Restraint in care homes for older people: a review of selected literature

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1 Introduction

A recent report[1] suggested that staff in care homes for older people are often confused as to what constitutes restraint, and unsure how to balance their responsibilities to look after residents with the rights of residents to make their own decisions. Authoritative voices from the voluntary sector[2] have commented on the lack of evidence about the extent of use of restraint in care homes for older people in the UK, and our limited understanding of how, when and why it is used. This report is based on reading literature that addresses these issues. The relevant literature has been searched, and brought together, by the Social Care Institute for Excellence (SCIE). The methodology for this is detailed in Appendix 1. Given the concerns of staff, and the broad range of issues of concern, the report gives prominence to conceptual discussions and descriptive articles as well as specific evidence from systematic reviews and evaluative studies. In reading the literature, priority was given to evidence and discussion that was rooted in the UK context, but some international evidence was also included (and identified as such) if it was thought that it might be of relevance to the UK, particularly if the studies contained primary evidence not available in the UK. A number of UK guidelines on restraint were also read for this study, and have been summarised in Appendix 2.

The report begins with the issue of definition, arguing that it may be helpful to recognise that the term 'restraint' has a range of related meanings, and that different kinds of definitions are needed for different purposes. The consideration of definitions is followed by a general comment on the quality and nature of the available evidence, indicating that there are certainly many gaps in our knowledge, but also that there are some kinds of evidence that it would be unreasonable to expect.

The report does not follow the practice, found in some of the literature, of structuring discussion around a list of methods of restraint. It is argued that the choice of restraint method relates as much to legal, professional and cultural contexts as to specific behaviours or problematic issues that may challenge staff, or their ways of working. In contrast, the reasons for using restraint seem to remain more consistent across different countries and a variety of settings, even if the prevalence of restraint use is very different. Therefore the choice has been made to begin with the reasons given for the use of restraint, and to consider alternatives to restraint that might address the problems and concerns which emerge from consideration of those reasons. This more general approach brings the focus closer to the reality of care practice, and seems preferable to introducing detailed discussion of methods of restraint that staff may never have seen.

Finally, the limited, but generally consistent, evidence on staff training and organisational issues is summarised. Main points are summarised at the end of each section throughout.

2 What is restraint?

This section discusses three different kinds of definition of restraint that occur in the literature. These definitions are all useful, but they have different purposes:

Broad everyday definitions, which aim to generate an understanding of the various possible meanings and interpretations of the concept of restraint, and are useful as an entry into discussion.

Scientific definitions that are designed to be the basis of data collection, and are used for identifying and counting instances of restraint that meet the specified definition.

Legal definitions, which aim to set out what is, and is not, permitted by law, and which vary from country to country, perhaps depending on the particular concerns that underpinned the introduction of the legislation at the time it was made.

Each kind of definition will now be discussed in turn.

2.1   Broad everyday definitions

Most guidance and discussion documents include, as a starting point, a plain English definition of restraint that serves as an orientation to fundamental aspects such as restricting freedom of movement, or actively trying to prevent people from behaving in a particular way:

Deprivation or restriction of liberty or freedom of action or movement.[3]

Either stopping people from doing what they want or doing things against their will.[1]

… anything which interferes with, or stops, a resident doing what they appear to want to do.[2]

These last two definitions may appear similar at first sight, but the addition of 'appear to' in the second is significant because it recognises that in a care context there may be some difficulty in being sure about what the person 'wants' to do. Broad definitions like these are useful for an initial orientation but they need to be expanded for a full understanding of the complexities surrounding the use of restraint with older people in care homes. Most guidelines, and some discussion papers, list a variety of restraint methods in order to illustrate the ways in which the global definition – stopping people from doing things they appear to want to do, or restricting their movement – may be translated into practice. Lists of methods of restraint usually include, among others: direct physical intervention by staff (or manual restraint); physical or mechanical restraint using devices or furniture; chemical restraint; environmental restraint; and social/psychological restraint. (Lists are not summarised here but may be found in the following references:[1, 2, 4, 5].)

Such lists indicate that there are many ways in which to prevent people from doing what they appear to want to do, or to restrict their movement, but consideration of the items in these lists also makes it clear, to quote the Royal College of Nursing (RCN) guidance:

> A piece of equipment, physical hold, or medication may equal restraint in some circumstances, but not others.[4]

The difference between whether a given method of intervention is, or is not, restraint, is to be found in the concepts of user control, consent and intended purpose. Much of the US literature for example, relies on a definition of physical restraint (from US regulations) that clearly excludes instances where the person is in control:

> Any device, material or equipment attached to or near a person's body *which cannot be controlled or easily removed by the person* and which deliberately prevents or is intended to prevent a person's free body movement to a position of choice and/or a person's normal access to their body.[6] (emphasis added)

There is very limited evidence reflecting the views of older people who have experienced restraint, but the responses given by older people in one UK study included[7] confirmed the importance of user control in affecting people's sense of whether they felt restrained or not. For example, a preference was expressed for user-controlled side rails for beds, and a person who was positive (and most people were not) about the use of a device that restricted their movement, stated that staff would remove the device whenever requested.

As an example of the importance of intended purpose, the difference between chemical restraint and treatment has been described as centred on the extent to which the patient has been assessed and medication prescribed as part of a treatment plan, or whether it has been given specifically and solely to control the patient's behaviour.[8]

Conceptually, Counsel and Care[9] make a useful distinction between:

> Direct physical restraint on a single person (for example arrangement of furniture, bedrails, drugs)

> Restraint that limits an individual's freedom (tagging, alarms, surveillance)

> Restraint that affects all residents (locks, rules, fences).

This distinction makes it clear that it is possible for all residents to be restrained by safeguards for the person most at risk.[10]

We are unlikely to be able to use everyday definitions to finally and definitively decide what actions should or should not be called restraint in every possible case. There are likely to be 'fuzzy edges' where a degree of uncertainty has to be accepted. This fuzziness may even be useful in generating debate about good practice. One

example of an issue in the 'fuzzy zone' would be the constraints on lifestyle imposed by communal living, such as having to eat at certain times or share a dining room,[1, 2] which, some have reportedly argued, might be seen as restraint, while others disagree.

2.2   Scientific definitions

In contrast to the broad-ranging definitions found in guidance or discussion papers, research investigations often use a more precise and limited definition, which has been framed so that, for example, instances of a particular form of restraint can be observed and counted:

> Any device applied to the body or immediate personal environment to limit freedom of voluntary movement.[11]

> Restraints were defined as mechanical devices/barriers that restrict the movement of a person in a chair, wheelchair, or bed.[12]

In a research context, fuzzy edges to definitions are not helpful. If researchers are seeking to make a comparison between the amount of use of restraint in different settings (or in one setting before and after an intervention such as staff training), then the decision about whether or not an instance of restraint use has been identified has to be consistently made every time, with as little scope for doubt as possible. As a consequence, these definitions are usually narrow and tightly drawn, so they often do not reflect the full range of types and methods of restraint that might fall under the broader everyday definitions. Making the distinction between restrained or not restrained, without any graduation of the amount or severity of the restriction involved, has been identified as a problem in research investigating restraint reduction. If the simple dichotomy 'restrained/not restrained' is used as an outcome measure, then this may mean that a move towards less restrictive alternatives, or towards using restraint for shorter periods, would not be counted as restraint reduction.[13]

Because a number of commentators have called for survey of the prevalence of the use of restraint,[2] or at least expressed concern at our lack of evidence on this subject,[1] it may be instructive to consider here the importance of definitions in collecting and using prevalence data. A systematic review of studies of physical restraint[6] (which was defined to mean the use of devices to restrict movement, rather than manual intervention), found that some studies had counted the use of bedrails as restraint, but other studies had not included these in their count. This simple difference meant that rates of prevalence could not easily be compared. Any survey of prevalence would have to give a great deal of attention to the issue of definition so as to be sure that its results would reflect the interests of potential information users.

2.3   Legal definition

The most relevant legal definition of restraint for care homes in England is that found in the Mental Capacity Act (2005) and its amendments:

Section 6(4) of the Act states that 'someone is using restraint if they:

- use force – or threaten to use force – to make someone do something that they are resisting, or

- restrict a person's freedom of movement, whether they are resisting or not.' ([14] Section 10.4)

The definition is deceptively short, but is supported by extensive guidelines to assist in its interpretation, and it is, or will be, ultimately interpreted through the decisions of the courts in specific cases. The brief outline that follows is not intended as a substitute for the code of practice but merely to indicate some of its salient features.

It is legal to use restraint only if certain conditions are satisfied:

> In an emergency: if a person who lacks capacity to consent has challenging behaviour, or is in the acute stages of illness causing them to act in way which may cause harm to others, staff may, under the common law, take appropriate and necessary action to restrain or remove the person, in order to prevent harm, both to the person concerned and to anyone else. (Section 6.43)

Any action intended to restrain a person can be legal if the person consents (as long as there has been no coercion), but restraint of a person who lacks capacity to consent has to meet two conditions:

- the person taking action must reasonably believe that restraint is *necessary* to prevent *harm* to the person who lacks capacity, and

- the amount or type of restraint used and the amount of time it lasts must be a *proportionate response* to the likelihood and seriousness of harm. (Section 6.41; the terms in italics are further elaborated in the code)

In addition, the person's lack of capacity cannot be assumed simply because they have some cognitive impairment or illness. The person who is considering undertaking restraint should take reasonable steps to establish whether the individual lacks capacity in relation to the matter in question, and should reasonably believe that it will be in the best interests of the person to use restraint, bearing in mind possible benefits, risks and consequences. There is a process (that is, a set of indicative questions) outlined in the code of practice to establish whether someone has capacity to make a particular decision (see the Quick summary in Chapter 4[14]).

2.4   Summary

- The literature contains everyday, scientific and legal definitions. These types of definitions are related, but are useful for different purposes.
- The definition 'stopping people from doing things they appear to want to do, or restricting their movement' gives a general idea of restraint.
- The same intervention might, or might not, be defined as restraint depending on whether:

> a person consents or has control; or
> there is a purpose for the intervention other than the control of behaviour, for example postural support or treatment of a medical condition.

- Scientific definitions tend to be relatively narrow and precise so that they can be used unambiguously to count things.
- The legal definition may be short but requires substantial guidelines for interpretation. Very briefly:
  > It is possible to restrain a person lawfully, legally and justifiably, either by the resident giving clear and informed consent or because the restraint is justified by law. ([2] page 15)
  > Restraint can be justified in law:
    - In an emergency, under common law, if it is used to prevent harm to the person or others, or to prevent a crime. ([14] Section 6.43)
    - If it is used in a planned way 'to prevent harm to a person lacking capacity, involves the minimum force necessary, and is used for the shortest duration possible'.[15]

3 Expectations of the evidence and the structure for the review

In moving on from conceptual issues to consider the available evidence, it may be useful to begin with a brief consideration of what can, and perhaps cannot, be expected from the evidence in this area. It will be argued that there are reasons why it may not be reasonable to expect the effectiveness of specific alternatives to restraint to have been scientifically evaluated, but, in contrast, restraint reduction programmes can be evaluated. Finally, in this section, the structure for the subsequent review of the evidence will emerge from consideration of some variations and consistencies in the international literature.

3.1   Can alternatives to restraint be evaluated?

It is probably unreasonable to expect specific alternatives to restraint to have been evaluated in the same way that one might evaluate a new drug. Assuming that alternatives are decided on in the light of examination of the function of the behaviour, or the risks, for that person, and development of personalised alternative interventions appropriate for that particular person, then there is not going to be a one-to-one match between a method of restraint (which can often take many forms) and a specifiable alternative which can sensibly be substituted in every case, and thereby evaluated. In the light of these issues about evidence, alternatives to restraint that have been described in the literature by informed professionals, or researchers, but not necessarily demonstrated by a randomised controlled trial (RCT) to be successful, are included in this report. When there is no RCT that proves their usefulness they are usually described as suggestions. Often there are logical reasons to suppose that these interventions may work in some cases, depending on the causes for the behaviour, or the risks that staff are attempting to ameliorate.

In considering an individual older person in their context, research and informed professional knowledge can supply a repertoire of possible alternatives to restraint that might work, but the development of a suitable alternative to restraint for a specific individual older person is also likely to require informed knowledge from, or about, the older person, as well as from their relatives, friends and care staff. Even then, trial and error may be needed.

3.2   Can restraint reduction programmes be evaluated?

It *is* possible to test whether the amount of restraint (precisely defined) that is used in a given setting can be reduced without deleterious consequences for the individuals previously restrained. Generally, as demonstrated in a systematic review of the literature, reductions can be achieved[6] but most of the experiments were done in the USA in the 1990s when initial levels of physical (mechanical) restraint use were high and there were funds available as a consequence of new legislation to reduce these levels. The interventions consisted of some combination of staff education events and consultancy, together with individual reassessment and implementation of new care plans, as well as organisational involvement and

managerial commitment. Substantial reductions were often achieved. Unfortunately, even where demonstrable reductions in restraint use occurred, it can be difficult to draw out precise implications for practice because reviewers[6, 16, 17] found it difficult to disentangle precisely which elements of multimethod interventions were actually the ones that brought about the changes observed (or, indeed whether combining methods was the necessary factor). In reading study reports there can be a problem that the definition of the intervention is not clear: the reader is left uncertain as to what was the content, length and nature of the educational intervention, the consultant's input or the extent of administrative or institutional support, and any other inputs. As a consequence 'it is difficult to identify ... which interventions would be appropriate for residents with specific characteristics or behaviours'.[16] Fortunately, in the case of physical restraint reductions, there is some good quality evidence from one study[18] showing that better results, in developing alternatives to restraint for individual older people, were achieved by coupling staff training with external consultancy to assist staff in the process, rather than by staff training alone.

Care is needed in assuming that these results are transferable to a different national context. A cautionary tale is provided by an account of an intervention, apparently based on the US model, designed to reduce the use of physical (mechanical) restraint in a care home for older people in Hong Kong. Staff education and the establishment of a restraint review committee failed to reduce restraint use below the existing low levels. The authors concluded that only 3 of 90 residents might have benefited from restraint removal, but they were unable to implement this in the face of resistance from relatives, staff, and, in some cases, the older people themselves.[13] The experience from this study suggests that it would be wise to have an accurate sense of the extent of a perceived problem before setting out to tackle it.

The main research evidence about attempts to reduce the use of chemical restraint can be found in a systematic review[17] of non-pharmacological interventions to control wandering, and a UK-based cluster randomised trial[19] to investigate whether the levels of prescribing of such drugs could be reduced in care homes (nursing homes). This trial was broadly successful in its attempt to reduce prescribing levels, and will be discussed later. The review of non-pharmacological interventions[17] was rather inconclusive, for precisely the kinds of reasons that have been outlined. There is no single definition of wandering, and since interventions should be tailored to individual causes, characteristics and histories, the chances of one particular method such as an exercise programme, or aromatherapy, producing an improvement in large numbers of differing cases are slim. The evidence of success in trials was very weak. Fortunately, this review also investigated the acceptability of specific alternative interventions from the perspective of carers, and discussed the associated ethical issues, so its usefulness as a resource is enhanced. It will be further discussed in the section on wandering (4.1.2).

3.3 Can we assess the prevalence of restraint use?

A few studies which offer international comparisons suggest a considerable degree of variation in rates of use of physical restraints, from use with less than five per cent of residents in care homes in Denmark[6] and Scotland,[11] to 40 per cent in care homes in Spain.[6] (The study in Scotland was reportedly based on nine Scottish facilities with

826 beds, and was conducted in the late 1980s.) More recent evidence quotes rates of 52 per cent, 40 per cent and 26 per cent of residents in Dutch, Swiss and German nursing homes respectively.[20] These comparative studies are often limited in their usefulness by the variations of definition that have been discussed. However, across the board, the evidence consistently indicates that physical restraints are more likely to be used with residents who are more physically frail, and have lower levels of cognitive functioning.[6] Prevailing professional opinion, certainly in the US literature,[11] seems to be that the use of physical restraints is relatively lower in the UK, but we do not have comprehensive data on the extent of use of physical restraints in UK care settings for older people. There is some evidence, from staff reports and studies in specific settings, that physical restraint is, at least sometimes, used in the UK in social care[21] and, possibly to a greater extent, in NHS wards for older people.[22, 23] However, in the UK context, professional and political concern[2, 24] seems to centre more on the over-prescription of antipsychotic drugs to control behaviour, rather than the over-use of physical restraint. As with physical restraint there is no comprehensive evidence about rates of prevalence of the prescription of neuroleptics, and some prescriptions are appropriate, of course, but rates of 50 per cent have been reported in nursing homes[19, 25] and 38 per cent in care homes,[25] and professional opinion is that these rates are too high.[24]

3.4   The structure for discussing the evidence

This overview of national variations suggests that the restraint method of choice, and the likelihood of restraint use, varies across international contexts. In contrast, as will be outlined in more detail later, the reasons that are given for the use of restraint are more consistent across the literature. If our aim is to reduce restraint use, then it is important that more is achieved than simply the substitution of one form of restraint for another. Therefore, this report will be structured in relation to the reasons why restraint is used, rather than in relation to specific methods of restraint. It is argued that this approach will mean that the knowledge from the literature will be more obviously relevant to staff, irrespective of the particular methods of restraint that might be employed in the care setting where they work. A second advantage is that a focus on reasons leads more directly into discussion of the search for alternative, less restrictive, ways to address those problems and concerns which initially give rise to the use of restraint. Finally, consideration of reasons takes us beyond factors related to individual older people to include consideration of the functions of restraint for the organisation and for staff.

4 Why restraint is used: problems, concerns and alternative solutions

4.1   Classification of reasons for the use of restraint

In 2002 a systematic review of the literature on the use of physical restraint identified 10 studies in care home settings (as opposed to hospital settings) that reported reasons for initiating the physical (mechanical) restraint of older people. None of these were conducted in the UK.[6]

The reasons identified for the use of physical (mechanical) restraint were:

Safety (9/10 studies) (for example fall prevention, injury prevention, safety and protection)

Managing agitation (9/10 studies) (for example to prevent disruptive behaviour or manage agitated behaviour, or prevent harmful consequences)

Prevention of wandering (6/10 studies)

Controlling behaviour (2/10 studies)

Physical support (3/10 studies) (for example postural support, assisting balance)

For the benefit of staff or the organisation (5/10 studies) (for example to reduce legal liability, compensate for understaffing, to enable work schedules to be completed)

Social group reasons (3/10 studies) (for example preventing interference with other residents, maintaining peace and harmony of the living and work environment)

Treatment related (2/10 studies) (for example preventing interference with medical devices – more common in a hospital setting)

Reasons were sometimes collected from records and sometimes ascertained from questionnaire surveys, so the results may not be strictly comparable, but the list does give an overview of the kind of reasons found for using physical restraint across a fairly sparse literature, and so provides a starting point for the discussion of reasons for restraint in general. No comparative UK studies have been found, although one study involving 102 older patients in rehabilitation wards in Northern Ireland[23] found that nurses were most likely to use physical (mechanical) restraint as a response to: wandering, confusion or a need for positional support (categories for them to choose were pre-supplied but do not seem to have included staff convenience). However, a linked study of 17 older people who had been restrained in these settings did identify staff convenience as one reason, citing, for example: 'easing their minds' and 'keeping things tidy, covering their backs'.[7] Continuing to focus on UK data, the Commission for Social Care Inspection (CSCI) report[1] was based on data from a range of informed

sources (group discussions with 76 older people and their carers and families; 253 responses to an online non-random survey, mostly staff and managers; a follow-up study of a sub-sample using vignettes; a survey of care home policies; and two stakeholder seminars). The report indicated that:

> The overriding reason people think that restraint is used is to protect older people, particularly those who are confused, agitated, threatening or persistently walking.

But also:

> There is widespread suspicion that actions explained as being for the safety and well-being of residents are actually designed to help staff manage workloads, especially where there are staffing and resource pressures. ([1] page 34)

It seems reasonable, then, to argue that the same kind of reasons apply to the use of physical restraint in the UK, as have been shown to apply internationally. Reasons given for using chemical restraint fall within similar categories. Organisations and professionals giving evidence to the All Party Parliamentary Group on Dementia indicated that chemical restraint was used for the control and management of behaviour that challenges services.[24] The themes of safety and protection for those who may fall or wander into danger, and the safe management of disturbed or challenging behaviour, are real areas of concern for staff in care homes (and relatives of residents), particularly given that two thirds of residents have some form of dementia,[24] which can be associated with behavioural symptoms that are challenging to staff.[26] At the same time, it is important to look beyond the immediate justifications for restraint use that might be given by staff, to consider organisational or cultural factors in the care home context that may also influence the use of restraint.

4.1.1   Safety: falling over and falling out of bed

4.1.1.1   Evidence on mechanical restraint and safety

It is easy to make assumptions about safety, and about what might cause harm, that are not based on good evidence. For example, it is sometimes assumed that without physical restraint, people will be at greater risk of falling. A systematic review of strategies to prevent falls and fractures included five studies on restraint removal and concluded:

> The available evidence indicates that the removal of physical restraint has no significant effect on falls or fractures in either direction.[27]

However, one should strike a note of caution that the included studies probably involved substituting physical restraint with some other (hopefully less restrictive) intervention, and were mostly conducted in the US where the initial levels of use of physical restraint will have been much higher than those in the UK (according to informed professional opinion in the UK[4] and the US[11]). Therefore it may be (but we have no research evidence) that the use of restraint to prevent falls in the UK is already more appropriately targeted.

The use of bedrails, ostensibly to prevent people falling out of bed, was once a taken for granted precaution. However, there is evidence that their use can be harmful. This issue has been subject to some discussion in the occupational therapy literature in the UK,[28] and a study in Australia found that reasons given by staff for restraint use were not usually based on actual incidents of compromised resident safety, but reflected only the 'anticipated preventative function' of bedrails.[29] Statistics on the Health and Safety Executive (HSE) website suggest about two fatalities a year involving bedrails, and the HSE site provides practical guidance and advice on appropriate use.[30] The National Patient Safety Agency undertook a systematic review[31] on the use of bedrails. Key points from its conclusion were:

- The risk of fatal bedrail entrapment is not random, and can be reduced further by following advice on using bedrails safely.
- Bedrail reduction programmes may result in increases in falls.
- Patients with bedrails appear less likely to fall, and less likely to be injured if they fall.
- Neither elimination of bedrails, nor routine bedrail use, is appropriate. Decision making on bedrails needs to be based on an assessment of risks and benefits as they apply to individual patients.

This literature suggests that an intervention which may be a genuine way to reduce the risk of harm in some individual cases can be unthinkingly extended to other cases where it may be of no use, or even positively dangerous. This must reinforce calls for careful individual assessment of risks, in order to decide on appropriate interventions aimed at reducing the risk of falling over or falling out of bed. There is no equivalent evidence on other mechanical devices used for restraint in the UK such as 'tipping chairs, wheelchairs with belts, chairs with belts, table tops, use of blanket, sheets and manipulation of furniture' (quoted in,[23] referring to rehabilitation wards in Northern Ireland), but it seems plausible that these interventions may also sometimes be over-used.

4.1.1.2 Alternatives

For the resident who is judged to be at risk of injury from falling, many strategies other than restraint have been suggested.[6, 11, 32] It is argued in NICE guidelines on fall prevention that as a first step the use of psychotropic medication should be reviewed and discontinued if possible.[32] If no medically treatable cause of falling can be found then there are many suggestions in the literature, for example adaptations to the individual environment (right down to suitable footwear, the arrangement of furniture to suit individuals and bed height adjustment, bed alarm systems or protective floor pads), as well as more general (physical or social) environmental changes such as grab bars, non-slip strips, monitoring alarms and lighting, or changes in the daily routine, for example toilet schedules, daily walks, times for sleep, observation and tracking.[11, 33] NICE clinical guidelines on fall prevention are shortly due for review and update.[32]

4.1.2   Safety: wandering and the promotion of safe walking

4.1.2.1   Definitions and evidence

The term 'wandering' encompasses a range of different behaviours, mostly shown by people with dementia (particularly, some evidence suggests, people with Alzheimer's disease rather than vascular dementia[34]). A recent systematic review[17] that evaluated the effectiveness and acceptability of non-pharmacological interventions to prevent, or reduce, wandering in people with dementia, listed the following terms that had been used in the literature: wandering, walking, pacing, ambulation, escape, elopement, orientation, agitation, restlessness and sundowning. Given the variety of behaviours subsumed under this heading, it is not surprising that the prevalence of wandering behaviour is difficult to measure. One paper reports estimates varying between 17 per cent and 63 per cent of people with dementia in the community and from 11 per cent up to 'all those capable of walking' in institutions.[34] Such behaviour is not necessarily associated with getting lost, and the exercise thus gained may even be beneficial, but it can undoubtedly pose difficulties for staff in care homes, especially if people appear to wish to leave the premises and are thought to be in danger if unaccompanied, or if the walking is accompanied by signs of agitation or distress. A survey in 1998 suggested that up to 40 per cent of individuals with dementia become lost at some point during their illness and five per cent get lost repeatedly over many months. Over 70 per cent of those who get repeatedly lost are admitted into institutional care.[35]

Reasons why wandering may occur are many, and some ideas can only be speculation, but suggestions include familiarising self with new environment; disorientation; looking for bedroom or lavatory; physical discomfort or pain; boredom; restlessness; seeking reassurance; communication difficulties; escaping stress; or following an activity pattern in previous employment.[11, 36]

4.1.2.2   Alternatives

As we have seen, wandering is given as a reason for physical restraint,[6, 37] but evidence from the systematic review of interventions to address wandering[17] suggested that carers, where their views were reported, found direct physical restraints an unacceptable response, except possibly in the short term in an emergency (there were no reports of the views of people with dementia, and the review is not entirely clear whether the carers, in those studies that included their views, were informal carers, professional carers or both). In contrast to the view of physical restraints, some alternative interventions were seen as acceptable and not posing ethical issues. These were: walking/exercise (interventions of this kind showed slight evidence of impact in the effectiveness study), music therapy, multi-sensory environments, massage/touch therapy (some evidence that it could reduce pacing) and aromatherapy (evidence of impact in one study). Some other interventions were seen as acceptable but raising ethical issues. These were: electronic devices, physical barriers and environmental modification. The reasons why the evidence for the general effectiveness of alternatives is likely to be weak have already been discussed. The systematic review concluded:

Acknowledgement that wandering encompasses a range of behaviours, which occur for a variety of reasons, should be mirrored in the management approach. A range of interventions, that can be tailored to individual need and the specific behaviour in question are required, together with the underlying reasons for these.

Why did electronic devices, physical barriers and environmental modification raise ethical questions? One reason is that it seems that they carry connotations of the tagging of criminals[5] and Big Brother surveillance.[38] There are also concerns that they should not be used as a substitute for direct personal care from staff.[2] The Scottish Mental Welfare Commission have coined the term 'wandering technologies' as a less emotive term than tagging,[5] just as the systematic review argued that 'the promotion of safe walking' has more positive connotations than 'reducing wandering'. Tagging, pressure pads, closed circuit television or door alarms can be used to alert staff that the person is trying to leave, or to monitor their movement. This, in itself, does not constitute restraint, but if it is going to trigger restraint, it should therefore, according to several available guidelines,[4, 35] only be used after: a careful assessment of the causes of the behaviour; assessment of risks; consideration of alternatives; consultation of the person, relatives and staff; legal and ethical implications; and as part of a regularly reviewed and agreed care plan. However, provided the potential for restraint is recognised, wandering technology to improve the quality of life of older people does seem to be increasingly accepted, as it has some advantages over baffle locks and other devices which restrict the movements not only of those who are at risk but also of others. Nevertheless, the Mental Capacity Act code of practice[14] recognises that in some circumstances a locked door may be a proportionate response to the risk of harm:

It may be appropriate to have a secure lock on a door that faces a busy road, but it would not be a proportionate response to lock someone in a bedroom all the time to prevent them from attempting to cross the road. (Section 6.47)

Alternative suggested ways of tackling the causes of wandering or promoting safe walking include the development of a safe garden area; providing broad-based or stationary rocking chairs; increased activity and stimulation during the day; creating a calm environment; and a variety of cueing devices, for example removing coats, hats and umbrellas from exit areas to avoid prompting residents to exit.[39] If some of these suggestions seem to conflict – increased stimulation and providing a calm environment, for example – that is precisely because the causes of wandering may differ, and a person who walks away to seek escape from over-stimulation will need a different response from a person who may be bored and restless. There have been a variety of attempts to limit, or direct, wandering through the use of subjective barriers such as floor patterns. There are interesting papers on the subject, for example,[40] which suggest this may be an area worthy of development and testing, but a systematic review (recently updated)[41] concluded that there was as yet no firm evidence for the effectiveness of such approaches.

Finally, a number of sources include professionally informed advice to train staff in techniques for appropriate management of residents who may wander, for example how to avoid hostile reactions by communicating reassurance and avoiding confrontation or argument; gently re-directing to an alternate activity, based on

knowledge of what might interest the person; accompanying the person on their walk; and welcoming people back rather than being punitive.[11, 36, 39] Suggestions for the organisation include: developing in advance a plan for what will be done if a person gets lost;[39] techniques of room management[36] and dementia-friendly design (avoiding corridors if possible, clear distinction of lavatories, bedrooms and other rooms to assist orientation).[35]

4.1.3   Disturbed and challenging behaviour

4.1.3.1   Definitions and evidence

There is evidence that restraint, of all kinds – manual, mechanical, chemical and social/environmental – is used in response to disturbed and challenging behaviour by older people in residential settings. There is limited evidence of the prevalence in the UK of challenging behaviour in care settings, although one study suggests that clinically significant behavioural symptoms are quite common among people in care homes, although of course not all such instances are perceived as challenging. A study in six homes in Newcastle found:

> … clinically significant symptoms arising in more than 70 per cent of residents. The most common individual symptoms were agitation, irritability and aberrant motor behaviour, whilst depression occurred in 25 per cent of residents and delusions were present in almost 20 per cent. The overall frequency … was similar in social and nursing care. The high level … indicates the considerable mental health care needs of residents in these establishments, and the range of skills required by staff.[25]

In relation to different kinds of restraint, there is evidence, already cited, about the use of antipsychotic drugs.[24, 25] Little was found in the literature about dealing with direct physical violence and aggression in care homes for older people, although there is more in relation to in-patient settings (not included in this review). It may be that direct aggression and violence is not a frequent problem, but this assumption is not based on evidence about prevalence, and some professional evidence suggests that staff need to be able to deal with this behaviour. [24, 26] Counsel and Care[2] observe that most care staff are younger and fitter than the older people in their care, and so advocate withdrawal from aggression, together with removal of any other resident at risk of harm. This may be sufficient, although in contrast, in the literature on learning disability, there is considerable discussion of techniques for breaking away from physical attack, and safely restraining people showing violent behaviour.[42, 43] Such training is certainly available, and in the context of services for people with learning disability and challenging behaviour, staff training in these techniques is advocated. However, there is also some evidence, in the learning disability literature, that training based on reported incidents, and staff beliefs about what might occur, is somewhat 'over the top' in comparison with what actually occurs in practice. That is, staff were being trained to use many more techniques than they actually used in practice,[44] because both written reports and staff perceptions tended to over-concentrate on rare but more extreme behaviours. This evidence should lead us to treat with caution any call for staff training in the

management of direct violence by older people in care homes, without any sense of the scale and nature of any such incidents.

There are, however, many forms of behaviour that provide a challenge to services in care homes for older people. A recent editorial in the *British Medical Journal* gave a list of examples of such behaviours: 'agitation, shouting, wandering, biting, throwing objects, repetitive talking, destroying personal possessions and other objects, agitation, general anger, physical attacks, waking others at night'.[45] One particular difficulty for care staff is resistance to personal care,[1] with staff responses defined, for example, in a study in Norway as 'holding of hands, legs or head for washing or dressing, showering or bathing when residents resist verbally or physically'.[46]

4.1.3.2   Causes and alternative responses

In a minority of instances, challenging behaviour is a continuation of a lifelong pattern, reflecting factors such as enduring mental illness or alcohol abuse,[2] but, given the nature of the population in care homes, behavioural and psychological symptoms associated with dementia are a more prominent influence. A guideline on supporting people with dementia[26] describes behavioural and psychiatric disturbances often seen in the later stages of dementia as linked to symptoms including 'depression, apathy, agitation, disinhibition, psychosis (delusions and hallucinations), wandering, aggression, incontinence and altered eating habits' (Section 4.1.2). However, the guideline makes it clear that there can be many other causes of such behaviour apart from the direct effects of the disease upon the brain. Among causes that should be investigated the guideline includes pain, distress, side-effects of medication, boredom and a wish to escape the setting.

> To simply see such behaviour as a symptom of dementia would be to miss the evident psychosocial factors, which interact with biological factors and influence greatly the presenting picture. Rather than clustering symptoms together, the key to individually tailored interventions will be to delineate the factors leading to a particular behaviour in a particular context – whether these be physical, social, environmental or psychological. (Section 8.1)

Other professionally informed literature from the US[11] is also clear about the importance of investigating causes:

> When a resident falls, pulls out a catheter, becomes restless and agitated, or begins to wander off, staff must ask the question, "What is the meaning of this behaviour?" Effects of a medication, dehydration, onset of acute illness, discomfort of full bladder, boredom, homesickness, frustration, or desire to feel secure or in control may each produce what may appear to be "unsafe", "noncompliant", or "troublesome" behaviours.

There is a stream of arguments in the literature, which, while acknowledging the role of neurological factors in some challenging behaviour, argues strongly for the importance of attempting to appreciate the world of the person with dementia,[47, 48] so as to see, for example how a person's past history, or their failure to understand the immediate motivations of others, may provide an explanation for apparently

difficult behaviour, as well as suggesting possible alternatives to restraint. Stokes argues compellingly:

> People with dementia are struggling to survive behind a barrier of cognitive destruction in a world they often do not know, attempting to communicate need that is rarely acknowledged....

and urges that:

> if meaningful contact is made with the person, their world appreciated, their rights acknowledged and their needs met, a significant proportion of challenging behaviours can be resolved.[47]

The advice feels ethically right, and on the face of it, plausible, but much of the evidence is based on case studies with very specific contextual factors, or on informed professional opinion.[49] Case studies can be useful in illustrating the ways in which a personalised approach can be implemented, and some of the possibilities of success, but on occasion they can also indicate the intensity of the effort that may be required if particular patterns of behaviour and the restraint response have become ingrained over a long time.[50, 51] The latter paper discusses forced bathing and contains many useful suggestions for making bath time more pleasant and acceptable for residents. A systematic review[52] of the effectiveness of psychological therapies in the management of neuropsychiatric symptoms of dementia illustrated the difficulties of reaching definitive conclusions from the large range of studies that have addressed this problem area. They found that:

> Only behavior management therapies, specific types of caregiver and residential care staff education, and possibly cognitive stimulation appear to have lasting effectiveness for the management of dementia-associated neuropsychiatric symptoms.

However, the authors immediately add: 'Lack of evidence regarding other therapies is not evidence of lack of efficacy'.

As with physical restraint, there is evidence (although in a smaller quantity)[19] that the overall inappropriate use of antipsychotic drugs can be reduced to levels that are more consonant with guidelines about good practice.[26] In the one UK-based study on reducing drug use the intervention followed the successful model from physical restraint reduction programmes in the US: that is, it included both staff training and external support (delivered to nursing home staff over 10 months), all of which focused on alternatives to drugs for the management of agitated behaviour in dementia. Of course, it was not thought desirable to reduce drug prescriptions to zero; some residents had conditions that precluded the withdrawal of neuroleptics, and others might appropriately be taking anti-depressants. It might be felt that the levels of drug prescription are the responsibility of medical staff only, but, in this study, psychiatrists reviewed prescriptions and made recommendations about best clinical practice in both intervention and control homes, but significantly fewer residents in the intervention homes remained on the drugs at the end of the trial.[19]

4.2　Summary

Evidence from a range of studies suggests that restraint is used for:

- safety and protection of those who may fall or wander into danger
- safe management of other disturbed and challenging behaviour
- convenience of staff and the organisation.

Safety: protection against falling

- Evidence suggests that some restraint methods have been over-used, particularly:
  > mechanical restraints in the US
  > bedrails.
- Many alternatives are available, but because their appropriate use depends on individual assessments, and individual circumstances, evidence of demonstrable success in RCTs may not be available.

Safety: wandering and promoting safe walking

- The term 'wandering' encompasses a range of different behaviours with different causes.
- There are many alternative less restrictive methods to address the issue. Evidence is again weak but walking/exercise, massage/touch therapy and aromatherapy show some evidence that they may be effective for some individuals.
- Other suggestions include: a safe garden area; increased stimulation; avoid cueing exits; increased ease of identification of facilities that the person might be seeking; training staff in how to avoid hostile reactions, and gently diverting people to other preferred activities.
- Some of the methods used, such as physical restraint and reality orientation, are felt to be unacceptable by carers.
- Electronic surveillance and other wandering technology can be of value but should not be a substitute for direct staff attention.
- If technology is likely to trigger restraint then restraint guidelines should be consulted before it is utilised.

Disturbed and challenging behaviour

- The limited evidence available indicates that people in care homes often show behavioural and psychological symptoms associated with dementia. These can be challenging to staff and services.
- In contrast to the literature on learning disability, there is little evidence on the prevalence of direct physical violence or the response, if any, it evokes in care homes.
- Behavioural and psychological symptoms associated with dementia are not always directly a result of disease processes. There are many possible causes that should be investigated including, for example, pain, dehydration, distress, other illness, boredom and homesickness.

- Suggested positive responses from staff include attempting to appreciate and understand the world of the person with dementia, their history and their current perceptions of the actions of others. There are useful illustrative case studies.
- There is some evidence for the effectiveness of behaviour management therapies, specific types of caregiver and residential staff education and possibly cognitive stimulation.
- There is concern, and some evidence, about chemical restraint, in particular the inappropriate prescription of antipsychotic drugs to control behaviour. There is some limited evidence that rates of prescribing in care and nursing homes can be reduced, but intensive multidisciplinary intervention would be required.
- RCTs have not yet been able to demonstrate positive impacts on older people's well-being from the removal of chemical restraint.

5 Staff training and organisational issues

This section focuses first on knowledge from staff and organisations working in the UK. The evidence is not very extensive, but it indicates that at least some staff recognise that restraint is used, and identifies a perceived need for clear local policy frameworks, appropriate training and guidance (or access to existing guidance). Following this, the focus is broadened to consider the evidence on factors important in making a difference to levels of restraint use. To support this discussion the sources of evidence are widened, to include international literature, as well as UK literature, relevant to organisational change and restraint use.

5.1 UK-based studies that report staff and organisational views

Among the literature reviewed, there was no comprehensive or demonstrably representative survey of staff views on restraint, or the prevalence and practice of restraint, in care homes in the UK. The sources of evidence in this section are professional (derived from individuals, organisations and surveys where the respondents were self-selected).

A survey of 170 qualified nurses working in elderly care in various settings was conducted at a *Nursing Times* live event in September 1998.[22] This evidence is now more than 10 years old, but the results suggested that the respondents had received inadequate training in the use of restraint, and that some of the restraint methods that nurses were using were in the author's opinion, questionable – morally, legally and professionally. Methods cited included: manual restraint, cot sides and removal of walking aids. At the same time it was made clear that these members of staff did experience aggression and even assault from some of the older people in their care. Professional knowledge suggests that these issues persist:[24] recent NICE-SCIE guidelines recommend that:

> Health and social care staff should be trained to anticipate behaviour that challenges and how to manage violence, aggression and extreme agitation, including de-escalation techniques and methods of physical restraint. ([26] paragraph 1.7.3.2)

In relation to care homes, Bright reported examples given by care home staff who had attended training courses in the 1990s.[2, 21] These reports illustrate a variety of interventions that staff perceived to be restraint, and constitute further evidence, from professional sources, that these methods have been used with at least some older people in care homes, at some point. Methods listed included the use of furniture; locking people up; cot sides; restricting freedom of movement; buzzers; alarms; locks; pressure pads; and removing walking aids. Also mentioned were medication and restricting how people spend their money.

Subsequently, responses to an online survey by CSCI, in which respondents were self-selected, included the views of around 200 professionals from a variety of social

care and health organisations.[1] Like previous evidence, the CSCI survey again provides examples, this time in the form of quotes, that illustrate that restraint does occur, with the addition that there is evidence from carers and a small number of older people as well as staff. It seems that 74 per cent of respondents knew of at least one instance of restraint, although not necessarily one that involved them personally. Of course this is not a credible estimate of prevalence, nor was it reported as such. CSCI argued that inspectors' reports revealed that levels of restraint were much higher than those recorded by staff in care homes, but did not give figures for the recorded episodes. Examination of inspectors' reports for the year 2006-07 found mention of restraint in 610 reports (the total number of reports was not given, although there are around 10,000 care homes for older people). In addition, 0.6 per cent of complaints and allegations received between April 2004 and February 2007 were identified as relating to restraint. This latter figure does not immediately suggest that this was an issue of relatively great prominence among possible areas of dissatisfaction with residential services.

The above survey, and wider consultations published in 2007, led CSCI to conclude that staff are confused as to what constitutes restraint, and often unsure how to balance the rights of residents with their own duty to care. Restraint was a topic that gave rise to differences of opinion between staff, and between staff and residents, and thus there was a need for advice on policies that might be helpful in the day-to-day situations that occur in care homes. Respondents thought that policies should cover: definition of restraint; knowing when it is appropriate to use restraint; circumstances when restraint is never allowed; legal implications; management of certain behaviours; training and safety for staff; residents' rights; decision making and whom to involve; differences between types of restraint; ethos/philosophy, for example 'restraint only as a last resort'; and good and safe practice. Appendix 2 on guidance indicates that these issues are broadly covered in existing guidance.

In 2002 Counsel and Care argued:

> We do not know how widespread is the use of restraint in care homes for older people. We do not know who uses it, why they use it and how. ([2] page 23)

This review of literature suggests that the above remains broadly true, although from the CSCI survey there is now some sense of the areas of confusion for staff, and the desired coverage of policies for local use.

5.2 Making a difference to levels of restraint use: the wider literature

As we have seen, the evidence does indicate that staff training, and some kind of external expert support with the assessment of individuals and the analysis of their behaviour, are both required (together) to make a difference to the overall levels of use of chemical and/or physical restraint. At the same time, in their day-to-day work, staff need to have an understanding of the legal position on restraint, which is set out in a number of available guidelines, so that they see the value of careful recording and the importance of searching for less restrictive alternatives.[1]

Detailed accounts of, and commentary on, the process of implementation of restraint reduction programmes in the US[33, 53] make it clear that support and commitment from administration and managers was essential for success and longer-term maintenance of change. Equally, much of the evidence about the impact of staff training comes from the US, from studies conducted in the late 1980s and through the 1990s. A little history is important to understand the context in which these studies took place. In the 1980s the position in nursing homes in the US was definitely in need of reform. Prevalence of the use of physical restraints in nursing homes at this time was reported to vary, from 19 per cent of residents to 85 per cent. From this era came evidence that physical restraints were used with older people who had lower levels of cognitive and physical functioning, and the impact of prolonged use was such as to actually cause incontinence, increase agitation and decrease socialisation.[6, 12, 33] A reform movement to 'untie the elderly' developed. The impetus for change brought about, and was reinforced by, the Nursing Home Reform Act passed in 1987 (part of the Omnibus Budget Reconciliation Act and usually referred to as OBRA-87), which included new regulations stating that nursing home residents had the right to be free of restraints, and that physical restraints could be used only if required for treatment and not for the purpose of discipline or the convenience of staff. The implementation of OBRA regulations (which came into force in 1990) triggered a number of studies aiming to evaluate programmes designed to achieve reductions in the amount of physical restraint used in nursing home settings. A systematic review of these studies[6] did demonstrate that various combinations of staff training, expert consultancy and individual reassessment could substantially reduce the amount of physical restraint used, without the negative consequences that some feared such as increased numbers of falls or injury from falls. The scientific quality was variable: there was only one RCT, but all the evidence pointed in the same direction. The one RCT[18] indicated that although education alone had an effect on the amount of physical restraint used, this effect was far greater when education was combined with consultation to assist staff in providing individualised, high-quality care for clinically challenging residents. In addition, restraint removal was safer (fewer injuries) in the intervention group with consultation than the intervention group with training only. Common issues covered in staff training were: residents' rights and autonomy; the negative impacts of physical restraints; myths and misconceptions about the benefits of restraint use; legal aspects of restraint use; specific behavioural problems (reasons and management); and alternatives to restraint.[6]

Given our different context in the UK, and relatively lower levels of physical restraint use, is the evidence from these studies of use to us? These studies are a mine of information on alternatives to physical restraint, on possible causes of behaviour which is troubling to staff, on environmental and other alternatives and on the views and attitudes of staff in relation to restraint use.[6, 11, 12, 33] Much of this knowledge is reflected in guidelines, although not always in such detail. In addition, there are some general messages about change: first, that change in practices which have persisted because they are convenient for staff, and embedded in the culture of the organisation, will require support at every level and, second, that policy can be a driver of change in practice.

One must be cautious about whether these changes in practice always lasted, once the intervention was over. There is some evidence of the way in which at least some organisations abandoned improved technology and stuck with mere paper compliance to new care standards (that is, they recorded that things had been done, such as release from restraints at regular intervals, which had not been done) because this meant less work for staff, and provided the appearance of quality care for state inspectors.[54] A recent commentary[53] on the barriers which have hindered the implementation of restraint elimination processes in the US listed the following: traditional thinking that it is more important to keep people physically safe than emotionally secure; ineffective organisational leadership and the inappropriate deployment of resources in the face of competing demands and an alleged lack of staff time; lack of management and human resource skills among supervisory staff whose qualifications were clinically based; high levels of staff turnover, inadequate training and rotating assignments for frontline staff that militated against getting to know residents; physicians who have not changed their practice; family members who insist that restraint is best; anticipation of higher insurance rates if risks are taken; (mistaken) beliefs that state inspectors will prefer restraints to be in use; and fear of lawsuits. This paper[53] emphasised the effort and resources needed to bring about culture change when people (managers, staff, physicians, informal carers) (a) believe themselves to have always been acting in their residents' interests, and (b) are attached to long-established practice and wary about untried (in their experience) new approaches. Many of these barriers sound familiar, and some will assuredly operate also in the UK (although there is little evidence on such issues). Even so, the existence of these barriers does not obviate the finding that levels of restraint use could be, and were, reduced through staff training and individual reassessment, in the US context at least.

Reduction of the use of physical restraints in the US did not seem to be associated with an increase in the use of chemical restraint. Indeed, it seemed that a reduction in chemical restraint went along with the reduction in physical restraints.[55] Certainly, the OBRA-87 regulations were framed in such a way as to guard against such a substitution. This is of interest because there is concern in the UK that in some cases antipsychotic drugs are being used instead of physical restraint, and so to reduce one might increase the other. The US experience suggests that attempts to reduce restraint use need not lead to the substitution of one form of restraint for another.

The more limited UK evidence already cited demonstrates that change can be achieved in levels of antipsychotic drug prescription to people with dementia without worsening behavioural symptoms (and thereby, presumably, without creating any need for other forms of restraint). However, there remains a difficulty in demonstrating measurable impacts on the well-being of the older residents.[19] There were no impacts on resident well-being evident in this trial, apart from a slight decrease in the amount of time spent in a state classified as 'withdrawn'. After surveying available evidence the NICE-SCIE guideline[26] concluded:

> Changes in staff behaviour (for example, avoiding use of restraints and reducing medication use) may be easier to achieve than changes in residents' patterns of behaviour and function but are, arguably, an important part of enhancing quality of care and well-being. Input to care homes from multidisciplinary teams providing

training, support and advice on management of residents is associated with favourable outcomes, but it appears that the input may have to be more intensive than has typically been the case in the past and should address the needs of all residents with dementia, not simply those who currently present "problems". (page 279)

To illustrate the intensity of intervention, and the multidisciplinary involvement that may be needed in relation to chemical restraint, it may be worth quoting here the full description of the intervention by Fossey and colleagues, in the trial to reduce antipsychotic drug use:

The package involved a systemic consultation approach. This tackled "whole home" issues, such as environmental, care practice, and attitudinal factors. The clinicians started and supported the use of activities through didactic training, skills modelling, and supervision of groups and individual staff. Key elements in the programme involved initial skills training, behavioural management techniques, and ongoing training and support. Initial skills training for care staff involved the philosophy and application of person centred care, positive care planning, awareness of environmental design issues, the use of antecedent behaviour consequence models, development of individualised interventions, active listening and communication skills, reminiscence techniques, and involvement of family carers. Behavioural management techniques included training in the Cohen-Mansfield approach. Ongoing training and support included group supervision and further development of skills involving individual case supervision and supervision of issues requiring organisational change within the home.[19]

Cohen-Mansfield and colleagues, mentioned above, have developed an approach that they call Treatment Routes for Exploring Agitation (TREA), designed to develop non-pharmacological interventions within a larger framework of human factors: addressing the needs of residents and staff members, and using environmental factors as well as human factors analysis. The approach is illustrated in a recent paper using a case study of a resident who strongly resisted bathing. The paper is worthy of mention for its emphasis not only on staff training but also on the resource support and emotional support that is needed for staff.[50] Resource support for staff does not just mean 'more resources' but a willingness to provide items that enhance the care experience where there may be problems, for example: soft towels, pleasant lighting and quality soaps to make bathing a more pleasant experience for all. Although it does not seem to have been investigated in the UK, there is some evidence from a study in Norway that a successful programme of restraint reduction can improve staff job satisfaction and reduce rates of turnover.[56]

5.3   Summary

- Most evidence is from the US but seems to be consonant with the more limited UK literature.
- Training should aim to generate the skills and understanding required to respond in the least restrictive way to behaviour that challenges.
- Staff training alone is not enough: ongoing expert advice and consultancy are also needed to change practice.
- Staff may also need
  > resource support
  > emotional support.
- Commitment and effort throughout the organisation is essential to sustain and maintain improvements in practice.
- Change may be needed not just in the practice of individual staff, but also in areas such as environmental design and organisational policies.
- Research might valuably investigate impacts on staff as well as residents of attempts at restraint reduction.

5.3   Summary

6 Conclusion

The basic concept of restraint is not difficult to grasp, but there will be occasions when its implementation in practice can be subject to a range of interpretations. In practice these differences will usually be resolved through negotiation and discussion. The legal framework and associated guidance related to the Mental Capacity Act (2005) is, in general, helpful in clarifying the importance of the rights of individual service users (even if their capacity to make some decisions is limited), as well as the circumstances in which staff are legally protected if they take action to restrain someone. There are guidelines available (see Appendix 2 for details), which provide important ingredients for local policies. These ingredients include: the legal framework; aims and values (including respect for autonomy and positive risk taking); understanding 'best interests' of residents; and how the organisation ensures its policy is implemented. There is no research on the impact of these guidelines, nor on the extent to which staff in care homes for older people have access to them, but there is some evidence that staff and managers perceive a need for such documents.

The evidence about what happens in practice in the UK is very limited. Staff and carers report that physical restraint is sometimes used, but there is no evidence that reveals the extent of such restraint use with older people in care homes in England, nor is there representative UK-based research evidence that would enable us to understand how it is used, nor how older people, or staff, perceive its use. Knowledge from professional sources, and a small amount of research, suggests that antipsychotic drugs are currently over-prescribed to older people in care homes in the UK. Evaluative research indicates that, if high, these levels of prescribing can be reduced with staff training, organisational commitment and expert support from psychological and psychogeriatric services.

Considering the literature as a whole, all demonstrably successful models for reducing overall levels of restraint use in care settings involve both staff training and ongoing expert support, with the development of alternative strategies for individuals. Organisational commitment is also regarded as important, and as an obstacle to success if lacking. Restraint reduction is valued for ethical reasons, but the direct impact on older people of using alternatives to restraint has not been easy to demonstrate. This may be an area for research to develop suitable measures.

Case studies and descriptive research provide information about a range of different interventions and approaches which may be successful in reducing the amount of restraint used in individual cases, depending on the history and characteristics of the person, the reasons underlying their behaviour and the capacity of the organisation and its staff to make the responses that are needed to provide a less restrictive alternative. The skills required should not be underestimated.

Finally, a historical perspective indicates that the history of restraint use often features the over-generalisation of solutions to genuine problems that can arise in the care of older people. The right solution for some people becomes unthinkingly adopted as the answer for everyone, with deleterious effects on the care of many.

Research on how organisational cultures arise and persist might valuably be applied in the area of restraint in order to understand better how to address the issue of over-use of restraint, if it occurs. The impacts of restraint reduction programmes on staff satisfaction and job turnover is similarly an area worthy of further research.

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Appendix 1: Methodology

To support this review, literature and relevant resources were searched and gathered during three background and research scopes. The scoping methods draw on the Social Care Institute for Excellence's (SCIE's) approach to systematic mapping and reviews, including pre-determined criteria for searching and for including material in the scope. However, the search was selective, rather than exhaustive, and full systematic review methods of quality rating and double data extraction were not employed. The work is therefore a selective scoping review.

The scopes were carried out in February, May and October 2008. Each scope built on previous work and was developed as themes emerged for further investigation, and as experts provided input by suggesting further topics and resources. Topics investigated included:

- types of restraint (for example physical, chemical and other barriers such as language)
- wandering in dementia
- the ethics of restraint (for example risk management)
- guidance and legal issues such as the Mental Capacity Act 2005, Protection of Vulnerable Adults and Deprivation of Liberty Safeguards
- managing aggression.

On scanning output from broad exploratory searches on restraint, material emerged on issues such as the views of staff and service users, and on assessment and review. The literature also revealed overlapping topics that were considered outside the remit of this review – these included studies on abuse of adults, literature covering the full range of people with learning disabilities (but not focusing on older people) and research based in hospital settings. While assessing the relevance of search output, we looked for systematic reviews specific to restraint.

Resources drawn on for the scopes included:

- Recent SCIE work on dignity in care, and recent work by the Institute for Evidence-based Social Work Practice, Sweden, on the impact of carer training on the quality of older people's services
- Bibliographic databases of published research:
  - > AgeInfo
  - > Applied Social Science Information Abstracts (ASSIA)
  - > Cumulative Index to Nursing and Allied Health Literature (CINAHL)
  - > EMBASE
  - > Health Management Information Consortium (HMIC)
  - > Medline
  - > Social Care Online
  - > Social Work Abstracts
  - > Zetoc

- Portals and resource collections, including:
  - > *Community Care* website (www.communitycare.co.uk)
  - > The British Library Welfare Reform on the Web (www.bl.uk/welfarereform/)
  - > Intute (www.intute.ac.uk/)
  - > BioethicsWeb (www.intute.ac.uk/healthandlifesciences/bioethicsweb/)
- Websites of organisations such as government agencies, academic centres, research networks, professional bodies, third sector organisations
- Research journal contents
  - > *The Journal of Dementia Care*
- Expert opinion

Bibliographic databases were searched using a mixture of index (or keyword) and free text search terms. Portals and websites were browsed for relevant resources. Publication date for relevant material was limited to 1990–2008. All the material gathered in this way was checked for relevance to the review topic by SCIE researchers, either by reading the abstract or by reading the full text of the record.

Appendix 2: Overview of guidelines

Guidance specific to the use of restraint in care homes for older people

Counsel and Care (2001) *Residents taking risks: Minimising the use of restraint: A guide for care homes*, London: Counsel and Care.

These guidelines are intended to assist managers and staff to think about their practice, the process of dealing with risks to residents and their own responses to risk. It takes the position that responsible risk taking is part of normal life and emphasises the importance of striking a balance between safety and quality of life. A suggested format for making and recording a risk assessment is provided. The guidelines, which have been widely distributed, are backed up by a further booklet which is intended to discuss the issues in more depth and provides an extended discussion of the definition of restraint and more references: Clarke, A. and Bright, L. (2002) *Showing restraint: Challenging the use of restraint in care homes*, London: Counsel and Care.

Although these publications were written before recent changes in the law – in particular the 2005 Mental Capacity Act– reference is made to Law Commission reports that influenced that legislation and the advice is generally consonant with the principles now enshrined in law.

Guidance specific to the use of restraint but covering other user groups in addition to older people, and other settings as well as care homes

RCN (Royal College of Nursing) (2008) *"Let's talk about restraint" – Rights, risks and responsibility*, London: RCN (www.rcn.org.uk/__data/assets/pdf_file/0007/157723/003208.pdf)

These guidelines apply to all nursing settings and all user groups but the examples and case studies are particularly geared towards the care of older people. Although it is primarily aimed at nurses and healthcare assistants, the summaries of the legal position (incorporating more recent legal changes since the Counsel and Care guidance in 2002), definitional issues and employer and individual responsibilities are all relevant to social care and to care homes. Useful case studies are provided to illustrate the issues.

CSCI (Commission for Social Care Inspection) (2007) *Guidance for inspectors: How to move towards restraint free care*

This is guidance for inspectors aiming to help them understand why it is important to limit the use of restraint, how it should be managed and what they should look for. Definitional and legal issues are covered but the guidance would benefit from some corrections to improve clarification (particularly of definitions on pages 3 and 7 and of the law, in particular the statement of Mental Capacity Act principles on page 5, in which some of the principles seem unnecessarily truncated in a way which probably

is not helpful), and there are a few typographical errors. Also the tone, or framework, of discussion about restraint is perhaps too negative: the idea of a framework for using restrictive physical interventions positively (see section below on learning disability) does not come across.

CSCI (Commission for Social Care Inspection) (2007) *Rights, risks and restraints: An exploration into the use of restraint in the care of older people* (www.cambridgeshire. gov.uk/NR/rdonlyres/46979CAB-51B2-4305-B64B-E5201D56D7/0/Restraint.pdf)

A further CSCI publication, which does not present itself as guidelines but as an exploration of the issue, provides more detailed but broad-ranging discussion with a large number of quotes from CSCI datasets and inspectors, group discussions with older people and carers and a non-random survey of staff. In terms of guidance, Appendix 1 provides a summary of the relevant regulations from the 2001 Care Homes regulations (as amended) and the 2002 Domiciliary Care regulations (as amended). These regulations refer to physical restraint and physical interventions only. Appendix 3 sets out constituents of good restraint policies under the headings: principles, procedures, policy documents.

DH (Department of Health) (2007) *Independence, choice and risk: A guide to best practice in supportive decision making*, London: DH

This aims to promote a culture of choice that entails responsible, supported decision making, but the only explicit mention of restraint is in relation to a case study involving forced medication. It is not the most useful guidance for the particular context of restraint in care homes for older people.

Guidelines with a focus on people with dementia

NCCMH (National Collaborating Centre for Mental Health) (2007) *Dementia: The NICE-SCIE guideline on supporting people with dementia and their carers in health and social care*, London: NCCMH

This is a guideline developed specifically to advise on supporting people with dementia and their carers in health and social care. It includes evidence-based recommendations for the treatment and management of the care of people with dementia. The section most relevant to restraint is 8.6 on responses to non-cognitive symptoms and challenging behaviour in people with dementia. This includes advice on the use of antipsychotic drugs to address behavioural symptoms (chemical restraint), assessment and alternative interventions and discussion of the need for staff training in how to anticipate behaviour that challenges and how to manage violence, aggression and extreme agitation, including de-escalation techniques and methods of physical restraint (Section 8.6.3.2).

http://nccmh.claromentis.com/intranet/documents/2031/15950/CG042fullguideline. pdf

Mental Welfare Commission for Scotland (2002) *Rights, risks and limits to freedom: Principles and guidance on good practice in caring for residents with dementia and related disorders and residents with learning disabilities where consideration is being given to the use of physical restraint and other limits to freedom*, Edinburgh: Mental Welfare Commission for Scotland (http://www.mwcscot.org.uk/web/FILES/Publications/Rights_Risks_web.pdf)

These are guidelines based on the belief that restraint should be seen as a 'last resort' intervention, used only where there is absolutely no alternative that would reduce an identified, specific risk to the person concerned to an acceptable level. The guidelines aim to help staff strike the right balance between freedom and risk of harm so as to decide when they should intervene. The legal position is outlined with reference to Scottish law. Methods of restraint and alternatives to restraint are outlined.

Legal position in England

DCA (Department for Constitutional Affairs) (2007) *Mental Capacity Act 2005: Code of practice* (www.justice.gov.uk/guidance/mca-code-of-practice.htm)

Sections 6.40-6.48 set out the definition of restraint and the conditions that have to be satisfied in order for it to be legally justified, particularly if the person being restrained does not have the capacity to consent. Elsewhere in the code it explains the principles that have to be followed in establishing whether or not a person has capacity in relation to a particular decision. The code is clear and helpful.

Ministry of Justice (2008) *Mental Capacity Act 2005 – Deprivation of Liberty Safeguards code of practice* (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476)

Reflecting an amendment to the Mental Capacity Act, this code of practice provides safeguards for people who lack capacity specifically to consent to treatment or care in either a hospital or a care home that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty (as opposed to a restriction of liberty), and where detention under the 1983 Mental Health Act is not appropriate for the person at that time. They were introduced to prevent breaches of the European Convention on Human Rights (ECHR) such as the one identified by the judgment of the European Court of Human Rights (ECtHR) in the case of *HL v the United Kingdom* (commonly referred to as the 'Bournewood' judgment), when a person was admitted to hospital on an informal basis under common law in his best interests, but this decision was challenged by his carers. The European court found that the deprivation of liberty had not been in accordance with 'a procedure prescribed by law' and that he had no means of applying quickly to a court to see if the deprivation of liberty was lawful. These safeguards provide the legal structure to protect people, who lack the capacity to consent, from being deprived of their liberty without recourse to law, and come into force in 2009.

Guidelines that relate to people with a learning disability but contain material that may be relevant to older people

Harris, J. et al (2008) *Physical interventions: A policy framework* (revised edn), Kidderminster: British Institute of Learning Disabilities

This publication applies to people with a learning disability, but provides useful information on the nature of policies to deal with physical interventions, the law (in more detail than the RCN guidance), common values, prevention, how to analyse behaviour, promoting the best interests of service users, risk assessment, minimising risk, management responsibilities, employers' responsibilities to staff and staff training. The emphasis is on planned rather than emergency interventions. In contrast to much work on restraint and older people, it is taken for granted that there will be times when restrictive physical interventions are necessary, indeed helpful. Therefore a distinction is made between emergency or unplanned interventions and planned interventions. The latter involve implementing agreed procedures in response to anticipated incidents and clearly defined behaviours. The emphasis of the book is on preparation and planning to ensure that as far as possible restrictive physical interventions are always used in the best interests of the service user. There are useful sections on behaviour analysis. Their specific advice on contraindications for restrictive physical interventions includes the statement that the organisation should take medical advice on the use of restrictive physical interventions if the service user is an older person. An evaluation of an earlier policy framework from the same organisation indicated that staff and managers valued a policy framework produced by a professional body, if they knew about it, but staff in non-specialist facilities were less likely to know of it. This result may not be generalisable to work with older people, but it suggests that the production of guidelines should be coupled with ways of ensuring they get to people at the front line, in all settings where they might be needed. (Murphy, G. et al [2003] 'Physical interventions with people with intellectual disabilities: staff training and policy frameworks', *Journal of Applied Research in Intellectual Disabilities*, June, vol 16, no 2, pp 115–25.)

Paley, S. and Brooke, J. (2006) *Good practice in physical interventions: A guide for staff and managers*, Kidderminster: British Institute of Learning Disabilities

This guide was written to support practitioners using physical interventions in their workplace. The focus is on adults and children who have a learning disability. It includes a professional, ethical and legal perspective for use of physical restraint, consideration of risk and a code of practice for trainers. Most importantly from the point of view of the present literature review, and given the significant lack of evidence about the perspectives of people who are restrained, there is a chapter written by a service user, who is a person with autism with experience of physical intervention. Without suggesting that the subjective world of a person with autism is similar to the subjective world of an older person with cognitive disability, it does seem possible that there are commonalities in terms of fear, confusion, lack of understanding of the intentions of others and not being given the time and space to work out what is happening in a situation where there are too many external stimuli.

Both of these publications are stronger on how to analyse behaviour that challenges than much of the guidance on working with older people. Some of the frameworks for looking at triggers to challenging behaviour might be helpful.

Overview of commonalities

Ethical foundation

Most guidance is explicitly based on a philosophy/value position that older people living in care homes or nursing homes retain the same rights to make choices and decisions about their lives as people living in their own homes; and, at the same time, workers caring for older people have a duty to protect them from harm and to act in their best interests, rather than for the convenience of staff or the service.

It is usually acknowledged these two principles can sometimes generate difficult decisions for staff if they perceive that a resident is acting, or seems to wish to act (Mitchell and Glendinning, 2007), in a way that puts him or herself, or others, at risk, particularly if it is possible that the resident's capacity to make decisions may be compromised by cognitive impairment or illness. The aim of most guidance is to assist staff in negotiating their way through the process of decision making about restraint in an ethical and legal way.

There is evidence pertinent to the principles, although, of course, as statements of values, they cannot be 'proved'. For example, it is clear that older people living with illness or impairment at home do choose to engage in behaviour which carries risks in order to live in the way that they wish as well as evidence that restraint has at times (and in various settings and countries) been used in ways that have not been in residents' best interests, indeed have been demonstrably harmful (see the literature review for details).

Principles for using restraint found in guidance

Restraint is usually described as 'a last resort', to be used only if there is no alternative way to prevent the risk of harm, when it should be used for the shortest viable length of time in the least restrictive way. It should not occur for staff convenience, or for the smooth running of the setting.

The management of behaviour that challenges services should begin with a full assessment to try and establish a cause, and incorporate attempts to understand the world of the person concerned.

As well as making every effort to ascertain the wishes of the resident, consultation with relatives is often urged, but only the Counsel and Care document (2002) suggests that 'carers and relatives have the right to see their loved one responsibly cared for'. However, the same document makes it clear that the views of 'relatives, friends and carers of the resident must never override the best interests, choice, views and needs of the resident' (Counsel and Care, 2002, p 13).

The importance of responsible but not over-defensive risk-taking policies and practices is recognised, as is the need to support staff in implementing them, if alternatives to restraint that may involve some risk are to be implemented. Counsel and Care (2001) offers a template for a risk assessment format.

The importance of careful recording of reasons, consultations, agreements, risk assessments, time limits and review periods is often emphasised. CSCI, at the end of its exploratory study, offers some indications as to what might be covered in a written policy.

Guidelines variously summarise the legal position in relation to the use of restraint with older people in care homes or nursing homes. The most up-to-date and concise in this respect at the time of writing are the RCN guidelines, but a broader and more detailed approach is to be found in the Harris et al policy framework above; however, the code of practice to the Mental Capacity Act is, while lengthy and comprehensive, in general clear and helpful. English guidance written after the Mental Capacity Act 2005 usually incorporates the Act's definition of restraint (see the section on legal definitions for exposition of this). Guidance written before the Act is usually consistent with this definition, and may indeed have influenced the drafting of the Act. Employers, too, have legal responsibilities around safety of the workplace.

The RCN guidance provides some useful case studies in relation to restraint and medical treatment, which illustrate the importance (legal and ethical) of making an attempt to involve the person in decision making, for example by providing information and explanations, before taking any action to restrain.

In addition to national law, Care Homes in England are also subject to regulations, some of which repeat, or prefigure, the current law, but that, in addition, require certain records to be kept if a person is subject to physical restraint (these are outlined in the CSCI 2007 publication, *Rights risks and restraints*, as described above).

Other legal requirements, including the obligation to observe the human rights of service users, are, or will be, embodied in Regulations and Minimum Standards for Care Homes. A paper by Smith (2008) discusses the relevance of articles in the Human Rights Act which relate to: the right to life (article 2), the prohibition of any inhuman or degrading treatment or punishment (article 3), the right to respect for private and family life, home and correspondence (article 8), and freedom from discrimination (article 14). In particular, he points to the fact that Article 3 of this Act includes anything which arouses 'fear, anguish or humiliation' under the heading of degrading treatment, and suggests that instances where care workers threaten to withdraw privilege from residents they find uncooperative might be an example of this. He also suggests that serious physical restraint, or chemical restraint, should be condemned under this article. However, apart from the Bournewood case, already mentioned, there is little case experience to go on as yet, and it may be that providers who reportedly feel that existing arrangements for regulation already provide plenty of protection for service users will be shown to be correct, and recourse to this law will rarely be necessary.

Evidence of impact

No studies were found that investigated the impact of any of the above restraint-related guidelines on staff attitudes or practice.

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Restraint in care homes for older people:
a review of selected literature

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