Clinical Controversy Paper

 A Case Description and Term Paper

Presented to

Dr. Cheryl Juneau

GNRS 5668 FNP Older Adult Chronic Illness

by

Jacquana Hill, Elizabeth Lopez, Lauretta Onwukwe & Crystal Ugarte

on

October 21, 2013

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THE UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON
SCHOOL OF NURSING

***Introduction***

The use of physical restraints is a common practice in many inpatient healthcare settings throughout the world and in the United States. Physical restraints can be defined as any device attached to or adjacent to a person’s body that cannot be either easily removed or controlled by the person and it intentionally restricts a person’s freedom of movement (Kwok et.al, 2012). Healthcare providers explain many reasons for using this practice and although it is often accepted in the healthcare arena, questions are raised when it comes to certain populations. The role of restraint use becomes controversial when the dimension of vulnerable populations comes into question, such as children and the elderly. Restraining a patient that falls into the vulnerable population category can easily be perceived by a non-experienced outsider as abuse or neglect which is why they should only be used as a last resort. Even having the experience of working in a nursing home and having had restrained patients myself necessarily, I have to admit that I too would be skeptical if I arrived on a unit to see my loved one in restraints. Although recently the use of physical restraints amongst the elderly in US nursing homes has fallen from 40% in the 1980’s to 10% in present day it is still common practice and often considered by staff to help manage elderly patients (Castle & Engberg, 2009). A review by Agens states that in the United States, the use of restraints in long term care facilities the percentage is as high as 37% (2010). Other researchers claim that the prevalence of physical restraints in nursing home can vary substantially from states to state from 4% up to 85% (Gastmans & Milisen, 2006). Some international studies have reported the use of physical restraints amongst elderly ranging from 15% to 66% (Huizing et.al, 2008). Should restraints be used in the elderly population who are in long term care? Is the use of restraints proper management for this particular population? Does restraining an elderly prove to be more harmful than beneficial? Healthcare providers around the world and in the US are faced with this dilemma on a daily basis. The provocative topic of restraints in the elderly population will be explored, reasons for and against its use, and also a clinical case to invoke thought will be presented.

***Clinical Case***

 Imagine the floor of an 80 bed nursing home for the first time where you have taken a position as a nurse practitioner. Once you arrive you find out that for the 80 residents on the unit there is one head registered nurse (RN), two licensed vocational nurses (LVNs), and four certified nurse’s aides (CNAs). The resident population is made up of males and females, ranging from 70 to 103 years old that have different co-morbidities, weaknesses and needs. While at the nurses’ station reviewing charts to begin your day you notice an elderly woman approximately 86 years old with long silver hair walking unsteadily down the hall. Her legs are weak, her gait is unsteady but she refuses to stop walking around. She starts to wonder in and out of other residents rooms and is reaching out to grab a pot of hot water that was started for tea in the kitchen area. Running behind her is an exhausted CNA. The CNA quickly calls out, “Mrs. Hearn, please don’t grab that pot, it is hot! Let’s go have a sit somewhere comfortable before you fall” and grabs at her arm to redirect her. Mrs. Hearn responds by pulling away and screaming, “Don’t touch me, I don’t know you, you are trying to steal from me I don’t trust you foreigners”. Mrs. Hearn, although she appears to be frail, turns to swing at the CNA but he quickly pulls away. The CNA then calls for help and informs the LVN that Mrs. Hearn has been doing this all night long and is afraid she will hurt herself. The CNA then further explains that all PRN mediations have been given and that Mrs. Hearn’s behavior throughout the night that included pulling out her own IV when receiving antibiotics and going into another resident’s room and waking her up by shaking her, telling her that the end was coming. That other resident was so startled that she wet the bed and began to cry. This event caused a chain reaction in the residents because the resident that was woken up went on to spread the false message that the end was coming. The LVN goes on to state that maybe they might have to physically restrain the patient temporarily so that she doesn’t harm herself or others and gets the restraints to help situate the resident. Before the LVN applies take any restrictive action, the aide reports that Mrs. Hearn almost fell by stumbling down the hallway but was caught before she hit the floor. The nurse’s aide is afraid she will be “written up” for a fall that could have been prevented. The LVN shakes her head and states she remembers the resident’s daughter getting angry with the facility for not properly controlling her mother and watching out for her safety. The daughter threatened to sue and was angered that the facility didn’t do a better job at caring for her mother by ensuring her mother’s well-being. Just as their conversation continued Mrs. Hearn’s daughter appeared at the nurse’s station, agitated and asking “Why is my mother walking around in her night gown? She’s gonna fall! I knew I should not have trusted this facility to care for my mother”.

***The Argument For***

 Physical restraints, also known as mechanical restraints, are used as a common practice in many countries in the elderly as a way to benefit the care of the elderly. In nursing homes and hospitals the most used physical restraints are bed/chair belts, table chairs and also bedrails (Hammers & Huizing, 2005). The portrait of the elderly who is most often placed in restraints is one who has poor mobility, high dependency, and impaired cognitive status (agitated, dementia etc.) (Hammers & Huizing, 2005). According to Gastmans and Milisen (2006) older persons who suffer from functional disabilities, increased activities of daily living dependence, mobility problems, cognitive disturbances, behavioral problems, and a history of multiple falls run a much higher rate of being restrained. Proponents for the use of physical restraints among the elderly mainly base their argument around safety; safety for the patient and safety of the staff and others in close proximity to the elderly who is to have restraints placed. It is usually employed in order to keep patients safe from falling or injuring themselves, staff safe from violent patients who are undergoing treatment, and keeps medical interventions from being interrupted by deterring patients from pulling at IV lines or Foley catheters. According to the Hastings Report by Moss and La Puma (1991) the most common noted indication for the use of restraints is the perceived danger to self or others”. This was seen as residents who were violent, wandering, and those at risk for falls (Moss & La Puma, 1991). Healthcare providers use restraints when they are confronted by a moral obligation of a duty to protect those in their care from harm (Dodds, 1996). Restraints are also argued as a way to promote care by allowing treatments to be implemented such as medication administration and also to reduce interruptions of care as when a resident pulls out an IV line, PEG tube, or removal of oxygen (Moss & La Puma, 1991). Many proponents for the use of physical restraints justify their use by arguing that they are carrying out the principles of beneficence and non-maleficence because they are doing all they can to protect the welfare of the frail (Dodds, 1996). The application of the principles of beneficence and non-maleficence is an ethical, moral and professional duty of healthcare providers, especially to those who are vulnerable such as the elderly and frail. Providers attempt to fulfill their moral and professional obligation to their elderly residents by avoiding their physical injury while wondering such as stumbling and breaking a hip, falling out of bed, and reducing psychological harms such as agitation and anxiety about falling out of bed or confusion that leads to wandering, some of which can be fatal or serious (Dodds, 1996). These serious and even fatal risks can lead to increased costs and poor outcomes for elderly residents. In 2000, there were almost 10,300 fatal and 2.6 million medically treated non‐fatal fall related injuries. Direct medical costs totaled $0.2 billion dollars for fatal and $19 billion dollars for non‐fatal injuries. Of the non‐fatal injury costs, 63% ($12 billion) were for hospitalizations, 21% ($4 billion) were for emergency department visits, and 16% ($3 billion) were for treatment in outpatient settings (Stevens, Corso, Finkelstein & Miller, 2006).

***The Argument Against***

 The opposite side of the restraint conundrum is that of not using any physical restraints or having a restraint free environment when it comes to the care of the elderly. The opponents of physical restraints lay the claim that use of physical restraints during elderly care are in fact more detrimental than their supposed benefit. Some healthcare individuals believe that the use of physical restraints leads to more injuries compared to no restraint use. A study by Nuefeld etc. Al (1999) showed that serious injuries either declined or remained the same when restraint orders were discontinued. Case studies have also illustrated severe injuries due to restraints such as one of a 79 year old female with dementia and spinal stenosis who was restrained because she repeatedly attempted to remove her indwelling catheter which she had placed due to cauda equina syndrome and neurogenic bladder. Once restrained the resident attempted many times to get free from the restraints that she suffered bilateral shoulder dislocations and a hospital admission due to her injury (Agens, 2010). Another study by Tinetti et al (1992) also highlighted that there was a correlation amongst the use of restraints and the occurrence of serious fall related injuries amongst skilled nursing facilities. Dodds (1996) states that there is a body of evidence to suggest that restrained older patients suffer from ill effects caused by the restraints such as loss of bone mass, muscle tone, and the ability to walk independently, also skin abrasions, abnormal changes in body chemistry, basal metabolic rate and blood volume, lower extremity edema, contractures, cardiac stress and reduced functional capacity. Gastmans and Milisen (2006) points out that over the last few years physical restraints placed on the elderly have been associated with injuries such as bruises, decubitus ulcers, respiratory complications, urinary incontinence, constipation and even more distressing; mortality . Some research points out that there is an increased risk of fatalities caused by the restraints either by strangulation, asphyxia or as a consequence of serious injuries.

 Opponents of physical restraints amongst the elderly also state that not only do elderly suffer from physical harm but also emotional and ethical harm. Restrained elderly often also undergo psychological harm such as sensory deprivation, disorganized behavior, withdrawal, increased agitation, loss of self-image, dependency, depression, increased confusion, exhibit regressive behavior and withdrawal (Dodds, 1996). Opponents point to research that show many elderly feel more angered and feel demoralized; an example of which is that of a testimony by a resident who was restrained. He was a 72 year old man who said; “I felt like a dog and cried all night. It hurt me to have to be tied up. I felt like I was no body, like I was dirt. It makes me cry to talk about it….” (Dodds, 1996). The use of physical restraints limits the freedom of the elderly and threatens their personal dignity. Ethically the value of autonomy is challenged and voided with the use of restraints. Autonomy is vanished when the rights of elderly are taken from them. Autonomy is a basic human quality; it is what separates us from animals, the ability to make decisions for ourselves even if we may be in harm’s way. Healthcare providers have a legal and professional obligation to keep those under their care safe and also must preserve morally what make human life precious which is autonomy, dignity and freedom. Healthcare providers also have the obligation to do no harm and arguments of those opposing restraints point out that restraints contradict the values of beneficence and non-maleficence.

***Clinical Case Revisited***

 The nurse’s aide quickly rushes Mrs. Hearn back down the hallway to her room. Screaming and cursing can be heard from Mrs. Hearn as she is escorted down the lobby. The LVN goes to the pixis to grab the restraints and frantically runs to Mrs. Hearn’s room, almost running into the meal cart. Mrs. Hearn is taken to her room and asked to get on the bed. She refuses, struggling, becoming more and more agitated, while more and more afraid. Both nurses push Mrs. Hearn down on the bed. The nurse’s aide is holding Mrs. Hearn down as the LVN quickly ties her to the bedrails, but not without a fight. Mrs. Hearn’s limbs are flailing, kicking, punching, and screaming as she tries to escape the restraints. Mrs. Hearn’s screams and cursing turns into tears. She begins to call the nurses heathens, asking them “Why are you doing this to me?” The frail elderly lady is placed in restraints; one around each wrist and one around each ankle. Finally she is tied to the bed but she continues to struggle to get out of their hold. In the fiasco she urinates herself. The other residents are becoming startled by her screams and crying. The LVN tells the nurse’s aide that she hopes Mrs. Hearn tires out soon because she hates to see her this way and instructs her to get clean linen to clean up the urine that is pooling on the bed. The LVN whispers to Mrs. Hearn that she is sorry and attempts to block out the agony which the frail lady is experiencing. The nurse’s aide returns with fresh clean linen, with a sorrowful look on her face the LVN tells the aide that if she does not tire out soon she will have to use the chest restraint.

 Meanwhile at the nurses station is an agitated and irate daughter. She calls for the RN in charge. As the RN approaches her she begins to yell at her stating that the facility is not doing everything in its power to keep her mother safe. She begins to tell the RN how she found her mother aimlessly wondering down the halls about to burn herself with hot coffee. The RN is bombarded by the daughter but calmly tells Mrs. Hearn’s daughter that she understands she is angry and explains that she would like to make a positive solution that will appease her as well as keep her mother safe. The LVN and nurse’s aide meet the two ladies at the nurse’s station and inform the RN that Mrs. Hearn is in restraints. Immediately the RN states she wants Mrs. Hearn out of restraints because of the various articles which she had read with evidence of the risk outweighing the benefit of restraints. The daughter snaps and requests for them to stay on. The RN begins to explain to the daughter that in her facility she wishes to use physical restraints only as a last resort, once every other option has been exhausted and still the desired outcome of safety for Mrs. Hearn is not met and even then she only allows the least restrictive means of restraints necessary. She also educates the daughter on the growing amount of research that details that restraints can lead to physical, ethical and psychological harm to her mother.

 The RN tells the daughter that she will move her mother to a different room closer to the nurse’s station so that the nurses can closely monitor her. She also plans to request one of the volunteers to sit with the elderly lady to help keep her oriented and to monitor her safety. She also plans to have the elderly lady receive her medication first, so that she will have pain control and also to reduce her anxiety since this can lead to wandering and episodes of delirium. She also aims to keep her nutrition and hydration current, have routine toileting, and also cognitive stimulation by having a volunteer speak with her and play games with the elderly lady or even read to her. She also tells the daughter she will make a request for PT to give the resident balance and gait training as well as strengthening exercises should she happen to start to wander her risk of falling is reduced.

 The daughter begins to calm and voices that it is okay for her mother to be released from the restraints. She is okay with trying the alternative before resorting to the use of physical restraints. The RN instructs the LVN and aide to remove the restraints, to calmly and respectfully speak to Mrs. Hearn, reorient her, and explain to her why they had placed her in restraints and why they are taking her off of them. She also wants to the nurses to tell Mrs. Hearn the plans they have for her to keep her safe and comfortable in the facility.

***Alternative to Restraints***

 In 1987 the USA passed legislation, OBRA or the Omnibus Budget Reconciliation Act, which introduced standards which facilities which provide long term care must heed. OBRA 87 states that residents of long term care have the right to be free of the use of restraints when they are used for the purpose of discipline or convenience and when they are not required to treat the resident’s medical symptoms (Agens, 2010). OBRA 87 also mandated that the use of antipsychotic medications for residents who were uncooperative, restless, wandering, or unsociable was also unacceptable (Agens, 2010). The Joint Commission on Accreditation of Healthcare Organizations and CMS also have instituted similar regulations all of which have been born from the OBRA 87 legislation. JCAHO and CMS have policies that states that there must be procedures for safe techniques for restraint, face to face evaluation by a physician or other authorized licensed independent practitioner within one hour of institution of restraint, written modification of the patient’s care plan, no standing orders or prn use of restraints, use of restraints only when less restrictive interventions are ineffective, use of the least restrictive restraint that protects the safety of the patient, renewal of the order for a time period not to exceed four hours, restraint free periods of time, MD or licensed independent practitioner daily evaluation of the patient before reordering restraint, continuous monitoring, an documentation of strategies to identify environmental or patient specific triggers of the target behavior (Agens, 2010). Also, always alternatives to restraints must be weighed.

 Each elderly resident has the right to have individualized care. Alternatives to restraint use is imperative to take into consideration when dealing with the elderly. Beneficial alternatives include hip protectors, anti-slip floor mats, position alarms, motion devices, surveillance cameras, height adjustable beds, bed next to wall positioning, sitters, strategic placement of patients, reducing stimulation and sensory overload, ample lighting without glare, active listening, therapeutic touch, physical activities, PT, pain management , management of postural hypotension, redirection, defusing of agitated behavior, diversional activities, reality reorientation, cognitive stimulation, and the list continues (Gastmans & Milisen, 2006). Research is beginning to appear that a decrease in restraint use does not increase falls and therefore these alternative can be instated to help reduce or eliminate the use of restraints (Hammers & Huizing, 2005). Also education and management programs need to be introduced to nurses and other healthcare providers in order to educate on the use of restraints and its alternatives. A study by Neufeld (1999) where an educational intervention was introduced to help reduce the use of restraints in a selected group of nursing homes showed that there was a reduction in restrain use when nurses were educated on alternatives and also there was not an increase in serious injuries when there was a substantial decrease in restraint use.

***Conclusion***

 Although there has been changes in regulation and a reduction in elderly restraint use it is still a controversial topic and a measure that is often used. Much more research studies must be done in order to well document the ill effects of physical restraints on the elderly since this type of research is in it’s infancy. Healthcare providers must remember that the best interest of the elder must be priority. Although it may seem as if it is time to use restraints the provider must stop and review if every possible alternative has been tried and exhausted to no avail. If this is the case then the least restrictive restraints should be used and the regulations outlined by OBRA 87, JACHO, and CMS must be regarded. Age should not be a factor when it comes to ethics and the provider’s obligation to do no harm. Elders are humans who have the natural right of autonomy, dignity and freedom. If providers can keep this in the forefront of treatment then better clinical outcomes for the vulnerable elderly population can be achieved.

References

Agens, J E. (2010). “Chemical and physical restraint use in the older person.” British Journal of Medical Practitioners:3:34-39

Capezuti, E., et al. (1996) “Physical Restraint Use and Falls in Nursing Home Residents,” Journal of Gerontology 44 : 627-633

Castle, N. & Engberg, J. (2009). “The Health Consequences of Using Physical Restraints in Nursing Homes.” Medical Care; 47: 1164-1173

Dodds, S. (1996). “Exercising restraint: autonomy, welfare and elderly patients,” Journal of Medical Ethics 22 : 160-163

Evans, LK. & Strumpf, NE. (1989). “Tying down the elderly.” Journal of the American Geriatrics Society 37: 65-74

Gastmans, C. & Milisen, K. (2006). “ Use of physical restraint in nursing homes: clinical – ethical considerations.” Journal of Medical Ethics; 32 : 148-152

Hamers, J. & Huizing, A. (2005). “ Why do we use physical restraints in the elderly.” Gerontol Geriat; 38: 19-25

Huizing, A. et.al. (2009). “Preventing the use of physical restraints on residents newly admitted to psycho-geriatric nursing home wards: A cluster-randomized trial.” International Journal of Nursing Studies; 46: 459-469

Moss RJ & LaPuma J. (1991). “The Ethics of Mechanical Restraints,” Hastings Center Report 21 no.1 : 22-25

Nuefeld RR et. Al. (1999). “Restraint Reduction Reduces Serious Injuries Among Nursing Home Residents,” Journal of Gerontology 47: 1202-1207

Kwok, T. et.al. (1012). “Effect of Physical Restraint Reduction on Older Patient’s Hospital Length of Stay,” Journal of American Medical Directors Association; 13: 645-650

Tinetti, M. et.al. (1991). “Mechanical Restraint Use among residents of skilled nursing facilities.” Journal of the American Medical Association; 256 : 468-471

Stevens, J. A., Corso, P. S., Finkelstein, E. R., & Miller, T. R. (2006). The costs of fatal and non‐fatal falls among older adults. *Injury Prevention*, *12*(5), 290-295.