



Avoiding Restraints in Hospitalized Older Adults with Dementia

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WHY: Use of physical restraints in older adults is associated with poor outcomes: functional decline, decreased peripheral circulation, cardiovascular stress, incontinence, muscle atrophy, pressure injuries, infections, agitation, social isolation, psychiatric morbidity, serious injuries, longer length of hospital stay, and death. Of all patients, older adults with dementia have the highest risk for being restrained when hospitalized. Impaired memory, judgment, and comprehension contribute to the difficulty these patients have in adapting to the hospital. Patients may try to 'escape' or 'resist' care because they feel 'lost' and afraid, yet language deficits associated with dementia limit their ability to clearly express these concerns. Brain damage associated with dementia also places patients at greater risk for delirium or acute confusional state, further increasing agitation, disorientation and confusion.

TARGET POPULATION: Older adults admitted directly or via the emergency department from home, nursing home or other non-hospital setting. At particular risk for restraint use are patients whose behavior (agitation, confusion, pulling at medical devices, exiting the bed unassisted) is judged to be 'unsafe,' e.g., potentially contributing to falls or interfering with treatment.

BEST PRACTICE: Best practice supports individualized care that permits **nursing the person safely** and without physical or chemical restraint. There is no single instrument to assess the meaning of behavioral communication in hospitalized older adults with dementia. Knowledge gained from careful interview of family members or other caregivers about the patient's usual behavior and function is critical to individualizing care. Standardized screening of cognition should be done at admission and periodically to detect delirium (See *Try this:*® Mini Cog; Confusion Assessment Method). Finally, communication strategies for patients who are nonverbal due to intubation are warranted.

ASSESS COMMUNICATION AND BASELINE BEHAVIORS; ASSESS RESTRAINT RISK

- **Assess the message in the patient's behavior:**
 - Ask the patient what she or he needs: Many patients with dementia can still communicate needs, both verbally and nonverbally.
- **Consult knowledgeable others:** Ascertain from family members or previous caregivers the patient's personal and medical history and typical communication style, behavior, daily routines, and abilities. With greater emphasis on their role in care, expect that family members may increasingly question the use of restraints.
- **Assess for unmet needs and behavioral changes:**
 - View any increase in confusion and agitation as a prompt to assess for changes in the patient's health status.
 - Assess for hunger, fatigue, sleep deprivation, pain, need to urinate or defecate, infection, bowel obstruction, fear, or hallucinations. Observe facial expressions, body language and listen "beyond the words" for the emotions being expressed to better understand what the patient is trying to communicate.
- **Use standardized screening instruments on admission and periodically; Note any change from baseline to prompt further assessment:** Screen for cognitive function (e.g., See *Try this:*® Mini Cog; MoCA), delirium (e.g., See *Try this:*® Confusion Assessment Method-CAM), and mobility and transfer performance (ADLs). (See *Try this:*® Mini Cog; MoCA; CAM; Katz ADL).
- **Assess behaviors that place a patient at risk for restraint use:**
 - Fall risk, e.g., unassisted bed exits (**NOTE: restraints do not prevent falls or fall-related injuries**).
 - Interference with treatment devices (feeding tubes, intravenous lines, sensors and monitors, urinary catheters, dressings, oxygen catheters or masks, ventilators).
 - Agitation, restlessness, combativeness, verbal or physical aggression.

USEFUL INTERVENTIONS TO PREVENT AND RESPOND TO PATIENT BEHAVIORS

Match specific interventions to the individual patient and his/her expressed needs

- **Communicate clearly, slowly, calmly:** Face the patient; always call the patient by the preferred name; use gestures; relax and smile.
- **Remove bedside rails or use only half rails; remove/avoid restraints**

- **Understand the patient's reason for attempting bed exit:** Most often, it is a need to toilet. Anticipate and meet needs by individualized elimination routine based on the patient's history; consider bedside commode.
- **Attend to bed, chair and wheelchair safety:** Lower height; use bed alarms for high-risk patients only, bed-boundary markers, trapeze or transfer enabler. Use portable chair alarms as appropriate; avoid wheelchair for primary seating.
 - Remember, an alarm system is merely an alert for a potential emergency; staff must be prepared to respond to prevent injury.
 - Identify all patients with bed or chair alarms as each shift begins.
- **Protect against falls and injuries:**
 - Provide night light in bathroom
 - Preserve function with daily weight-bearing, comfortable seating, ambulation devices at the bedside
 - Provide non-skid slippers
 - Place fall risk “alert” on the bed or door frame
 - Be especially alert at change of shift times
- **Modify the immediate environment:**
 - Reduce excessive noise and activity (TV off unless patient requests)
 - Provide for interaction with and visualization of and by others
 - Provide appropriate light levels
 - Remove confusing art or other objects from room
- **Provide frequent/constant surveillance:** Move patient closer to nursing station or to a room with a window to the hallway; use monitors.
- **Reassess frequently need for invasive treatment devices:**
 - **Use the least invasive method to deliver care for shortest time possible**
 - **Repeatedly use verbal explanation and a mirror for guided exploration:** Help the patient understand what is in place and why; repeat often
 - **Provide comfort care to the site:** Oral/nasal care, anchoring of tubing
 - **Use camouflage:** Clothing or elastic sleeves, temporary air splint
 - **Provide diversionary activities:** Something to hold and squeeze; favorite music in a headset
 - **Discontinue invasive treatments as early as possible**
- **Communicate early and frequently with interprofessional team to identify and intervene in health changes**
- **Provide for ‘familiarity’:** Encourage use of family photographs, favorite personal mementos, audiotapes of family members. Assign the same staff to the extent possible.
- **Encourage family and familiar others to participate in care:** Frequent visiting, ADL assistance, and remaining at the bedside around the clock for 1-2 days post admission and/or during the evening; encourage family reporting of behavioral changes.
- **Strive for consistency in personnel, normal function and usual routines:** e.g., toileting, eating, and personal hygiene care.

ORGANIZATIONAL STRUCTURE TO SUPPORT RESTRAINT-FREE CARE

- Establish an interdisciplinary Restraint Reduction Committee
- Review the organization's mission statement, policies; assure committed leadership
- Use geriatric advanced practice nurses, physicians, and interdisciplinary team consultation for complex patient presentations
- Provide staff education; consistent staff assignment; access to supportive equipment; technology to support reliable admission data and communication of care strategies
- Review pain evaluation and treatment protocols
- Review Intensive Care Unit sedation and intubation protocols
- Test patient interventions through continuous quality improvement (CQI)
- Provide for transfer of care between and among staff, units, and healthcare settings

MORE ON THE TOPIC:

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