Restraint in the Care of People in Residential Aged Care Facilities

2001 revised 2015

1. Preamble

The patient's needs and rights should always be the first consideration when considering the application of restraint. Patients have died or been seriously injured by restraints. On the other hand, patients and staff have been injured by lack of restraint.

The need for restraint should always be based on individual assessment of the issues. These issues span ethical, legal and medical domains. Key to this decision is finding the balance between:

- a patient's right to self determination;
- protection from harm; and
- the possibility of harm to others.

The medical practitioner providing the patient's care is ultimately responsible for the decision to restrain a patient. However, the decision to use restraints should not occur in isolation. It involves a process of request, assessment, team involvement and consent within an ethical and legal framework.

Any decision and plan of care to restrain must be documented and signed by the doctor in the patient's record.

2. Definition

A restraint is a device or medication that is administered for the purpose of restricting the movement and/or behaviour of a person.

3. Principles

Psychotropic drugs may have an important role in the reduction of distressing symptoms and the specific treatment of medical conditions such as delirium, anxiety, depression, psychosis and behavioural and psychological symptoms of dementia (BPSD). Use of these drugs in such a context does not constitute restraint and they should not be withheld.

There are clinical situations where psychotropic drugs may be prescribed for combined purposes of both a degree of restraint and the reduction of distressing symptoms, and/or specific treatment of medical conditions.

Restraints should only be prescribed where any potential risk or harm caused by the restraint itself is less than the risk of the patient not being restrained.

The prime purpose of restraint should be the safety, wellbeing and dignity of the patient and should take into consideration any previously expressed or known values and wishes. In the short term the welfare and protection of others (patients, carers, residents and staff) and the statutory occupational health and safety obligations on employers must also be considered.

Underlying causes of aggressive and/or challenging behaviour particularly associated with a recent change in behaviour or function should be thoroughly assessed by the attending medical practitioner in partnership with the patient's family (and/or formal or informal carers) and staff. Those causes which are medical, such as delirium or pain, or which may respond to medical interventions such as depression, psychosis, anxiety and BPSD should be considered and treated.

The use of restraint must always be the last resort after exhausting all reasonable alternative management options.

The least restrictive form of restraint should be used and it should be viewed as a temporary solution. It must be time limited and subject to regular review. If chemical restraint is used it must be in the lowest effective dose for the minimum necessary period.

A key consideration when making such decisions is the capacity of the patient to consent. Consent should be sought in line with legislated requirements, whenever restraint is used.

Many challenging behaviours can be prevented or minimised through appropriate social and staffing structures and creative, friendly physical environments. When such strategies have failed, and when restraint cannot be avoided, then any restraint should minimise the use of pharmacological or direct physical methods. In practice it is often necessary to manage aggressive and/or challenging behaviours in settings that are less than ideal.

Restraint of a patient for staff convenience or to manage patient workloads is unacceptable.

All health and residential care facilities must ensure mechanisms are in place for timely review and discussion of contentious issues and decisions such as the application of restraint for both the welfare of a patient and the welfare of others.
Patients, families of patients, health care professionals and staff must be informed and have access to mechanisms to complain, anonymously if desired, about the use of restraints.

4. **Education and training**

Education about the issues related to restraints should be a fundamental element of training for health professionals.

Basic education courses and continuing education in restraint issues and the application of restraint should become an integral part of education for health care professionals and those actively involved in the care and treatment of older persons within residential facilities.

Where restraint becomes an issue in domiciliary settings, access to education for formal and informal carers is essential.

Education and training should be developed and delivered in collaboration with the RACF Medical Advisory Committee and should
include:

1. The ethical, medical, and legal issues associated with the use of restraint.
2. Provision of written guidelines for the application of environmental, pharmacological and physical restraint(s).
3. The potential for harm arising from the use or non-use of restraints.
4. Optimal prevention, minimisation, assessment and management of aggressive and/or challenging behaviour.
5. Timely access to medical assessment and treatment of illnesses associated with, and potentially causing aggressive and/or challenging behaviour.
6. Regular audit and clinical review of the use of restraint in the facility including individual case review, critical incidents and near miss monitoring, aggressive and/or challenging behaviours and the subsequent use of restraint(s).
7. Flexible work practices.

Medical practitioners have an educative and mentoring role in minimising the use of restraint.

See also:

AMA Code of Ethics – 2004, editorially revised 2006
AMA Position Statement on Care of Older People 2011
AMA Position Statement on End of Life Care and Advanced Care Planning 2015

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