Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

POLICY ON THE USE OF PHYSICAL RESTRAINTS IN DESIGNATED RESIDENTIAL CARE UNITS FOR OLDER PEOPLE

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1.0 Introduction

The HSE AND Nursing Homes Ireland are committed to a policy of restraint free environments in residential services for older people. This policy aims to support a person centred approach to care and compliance with the HIQA national quality standards for residential care settings for older people. It proposes a whole systems approach which acknowledges the rights of older people to take risks, in the context of their cognitive and physical ability, in order to maintain their independence and autonomy.

The document has been compiled by an interdisciplinary working group (**Appendix 13**) on a partnership basis between the HSE and Nursing Homes Ireland as a guide to the very limited circumstances where the use of physical restraints are permitted.

The policy is set out in three parts, the policy, procedures and guidelines on restraint use. It is intended for use in all residential care settings where older people live and which are inspected by HIQA.

PART 1

2.0 Policy Statement

It is the policy of the HSE to ensure that restraints are not used in the care of older people in residential care and community hospital settings.
However, it is acknowledged, that in a small number of very exceptional cases and as a last resort, time limited restraint may be considered as part of the residents care plan.

2.1 Purpose

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

2.2 Rationale

The context within which Residential care for older people is delivered is changing rapidly. The Health Information and Quality Authority (HIQA) Standards, and the development of person centred care practices

together with a number of highly publicized adverse incidents have resulted in a greater focus on the rights of older people who live in residential care.

The evidence from research suggests that restraint reduction does not increase the number of falls and may reduce their severity (O'Keeffe 2004, Braun et 2000) The HSE and the Nursing Homes Ireland are committed to a policy of restraint free environments while recognizing the need for procedures to support staff in the small number of cases where restraint is required for a short period of time. It proposes a whole systems approach which acknowledges the rights of older people to take risks, in the context of their cognitive and physical ability, in order to maintain their independence and autonomy. Therefore adverse incident reporting must be seen in this context and support staff to find the right balance between duty of care and respect for an older persons right to freedom of movement.

2.3 Scope

- For the purpose of this document, ***an older person is defined as "any person aged 65 years and over" in residential care setting for community hospital. This applies to all older people admitted for continuing care/short stay, assessment and rehabilitation, respite and palliative care.***
- This policy applies to all staff working in public, voluntary and private residential care settings. It is guided by the National Quality Standards for Residential Care developed by Health Information and Quality Authority (HIQA) and the HSE policy 'Responding to Allegations of Elder Abuse Policy (2007).
- This policy is set within the context of the HSE's Quality and Risk Management Standard 2007.
- For the purpose of this policy, the term interdisciplinary team members refers to staff working within the unit i.e. nursing staff, care staff and those who may provide services to residents on a sessional basis i.e. consultant geriatricians, general practitioners, therapists.

2.4 Legislation/Other related policies

- Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2009
- Trust in Care. Policy for Health Service Employers on upholding the Dignity and Welfare of Patients/Clients and the Procedures for Managing Allegations of Abuse against Staff Members.
- HSE 'Responding to Allegations of Elder Abuse '

The document is set out in three parts outlining the policy, procedures and guidelines on restraint use in accordance with the HSE's Quality and Risk Management Standard – Doc ref: OQR009 20080201 v2.

This policy supersedes all other policies on physical restraint usage that may exist prior to publication of this policy. The policy does not address the issue of environmental restraint or the use of psychotropic medications.

2.5 Glossary of Terms and Definitions

Definition of Restraint

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

It does not refer to equipment requested by the individual for their safety, mobility or comfort. Neither does it refer to drugs used – with informed consent – to treat specific, appropriately diagnosed conditions where drug use is clinically indicated to be the most appropriate treatment. (Nay and Koch 2006).adapted

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

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

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

H.I.Q.A. also offer the following definition of **physical restraint**:

"Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot easily remove that restricts freedom of movement or normal access to one's body"

2.6 Roles and responsibilities

All staff working in residential care settings and community hospitals have the responsibility to comply with this policy.

Those who have responsibility of ensuring compliance with the policy:

National Director, Integrated Services Directorate, Performance & Financial Management

- Ensure that both corporate and local level are aware of their responsibility
- Ensure that management and compliance with this policy is effective in each area within their remit

Regional Directors of Operations

- Responsible for oversight and support of local managers
- Ensure that all relevant managers are aware of their responsibility
- Ensure that management and compliance with this policy is effective in each area within their remit.
- Ensure that training is carried out in accordance with the implementation plan
- Ensure that audit is carried out in line with audit guidelines.

Integrated Services Managers/Local Health Manager

- Ensure that all relevant managers are aware of their responsibility
- Ensure that management and compliance with this policy is effective in each area within their remit.
- Ensure that training is carried out in accordance with the implementation plan
- Ensure that audit is carried out in line with audit guidelines.

Those with responsibility of complying with the policy:

Directors of Nursing

- Ensure that all relevant staff are aware of their responsibility
- Ensure that management and compliance with this policy is effective in each area within their remit.
- Ensure that training is carried out in accordance with the implementation plan
- Undertake Audit of compliance in line with agreed protocol.
- Ensure any statutory requirements for reporting has been carried out

All relevant staff

Each Health Professional/HSE employee is accountable for their practice. This means being answerable for decisions he/she makes and being prepared to make explicit the rationale for those decisions and justify them in the context of legislation, case law, professional standards and guidelines, evidence based practice, professional and ethical conduct (HSE PPPG guidelines) and as outlined in criteria 3.2 of the Quality and Risk Standard.

2.7 Aims of the Policy

The aims of the policy are:

- To promote a restraint free environment
- To ensure that restraint will only be used as a last resort in exceptional circumstances following a comprehensive interdisciplinary assessment.
- To inform and guide all staff on the on the use of Physical Restraint in Residential Care Units.
- To involve the resident, their family and carer in the decision making process with the persons rights safety and dignity at the forefront

- To ensure that organisations at both corporate and local level are aware of their responsibility to ensure that restraint is not utilised as a means of controlling a resident's behaviour, emotions, psychological or social activities

2.8 Principles

The organisations involved are committed to a philosophy of a restraint free environment by adopting a rights based approach. These rights are enshrined in the Irish Constitution, EU Law, the European Commission on Human rights and International conventions and covenants, and clearly outline that older people within residential services have the right to:

- Equality and non-discrimination.
- Right to vindication of the person.
- Right to personal liberty.
- Family rights.
- Right to individual privacy.
- Rights to bodily integrity.
- Right to spiritual and physical integrity.
- Right not to be tortured or ill-treated.
- Rights to effective remedy.
- Social and economic rights including the right to health and social security services.

2.9 The Law and Restraint

The application of restraint to a resident is unlawful, except in very limited circumstances which are permitted by law. Any person using restraint has to be able to justify it in the context of legislation and case law.

2.1 The use of Restraint is not permitted (HIQA SS21.17)

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

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

2.11 Circumstances in which restraint is permitted in a time limited way in a residential care setting

- For behaviour when there is an immediate and significant risk to the resident's safety or the safety of others and the behaviour may result in a significant injury to that resident or others (for example where a resident who repeatedly harms themselves, unprovoked or uncontrollable physically violent/injurious behavior toward self or others).
- For the brief provision of essential personal care when there is an immediate and significant risk to the resident's well being.
- When a resident requires emergency medical care such as the presence of a life-sustaining medical device (e.g., endotracheal tube) that if disrupted would create immediate jeopardy to the resident's health - specifically in a resident who is at high risk for unintentionally disrupting that device (e.g., a delirious resident).
- For risk of falls when the risk of falling is immediate as in severe imbalance (E.g. stroke with severe neglect, gross cerebellar ataxia) or where a person may have suffered a hip fracture or another type of lower extremity fracture in which weight-bearing is restricted.
- A comprehensive, interdisciplinary assessment has been carried out unless when a resident's unanticipated behaviour places him/her or others in imminent danger. In this case short–term, proportionate and non-dangerous physical restraint measures may be taken by staff without prior formal assessment (HIQA 21.9). However an assessment must be conducted within a 12 hour time frame.
- There is clear evidence that an extensive range of measures have been tried, for a reasonable period of time and they have proved unsuccessful in maintaining the safety of the person from causing significant harm to themselves or others

2.12 The following methods of restraint can only be used when a decision to restrain a person has been made and only ever for a specific medical symptom

- Lap Belts
- Hand mitts
- Bed rails (see policy on use of bed rails)
- Chairs. Any chair that has the effect of restraining a person must be individually fitted by an appropriately trained health care professional for his or her requirements. It should allow the resident to engage in eating and drinking and, in other activities such as reading, or manipulating objects with their hands for diversion. Similarly, a chair should not inhibit a resident from being in contact with other people.

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

2.13 The use of all other types of devices or interventions is not permitted and their use is contrary to promoting resident's dignity. These include:

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

2.14 Resident and Family involvement

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

2.15 Consent

The consent of the resident should be gained before any restraint measure is used and during the period of restraint. In order for a resident to be fully informed, the facility must explain, in the context of the individual resident's condition and circumstances, the potential risks and benefits of all options under consideration, including using a restraint, not using a restraint, and alternatives to restraint use. Whenever restraint use is considered, the facility must explain to the resident how the use of restraints would treat the resident's symptoms and assist the resident in attaining or maintaining his/her highest practicable level of physical or psychological wellbeing. In addition, the facility must explain the potential negative outcomes of restraint use.

2.16 Residents who lack capacity to consent

Competent residents must not be restrained without their informed consent. The single exception is that a competent resident may be restrained as an emergency measure if his or her unanticipated violent or aggressive behaviour places him/herself or others in imminent danger.

The Irish Supreme Court definitively states that in law one does not lose the right to autonomy and dignity with the loss of mental capacity, and that the constitutional right of bodily integrity and privacy as well as respect for the person applies in equal measures regardless of their ability to communicate their consent to or refusal of treatment (Madden, 2002). Where a person is incapable of making decisions for themselves others may make choices on their behalf. These choices must be based on the best interest of the person (Madden, 2002). If clarity is required regarding an individual's capacity to give consent nurses should seek expert advice from other members of the multi-disciplinary team.

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

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

Even for those residents who are judged to lack capacity to consent to the use of restraints, restraints should not be used if the resident expresses a clear and consistent preference not to be restrained.
The single exception is the physical restraint of the resident as an emergency measure when his/her unanticipated behaviour places him/ her in imminent danger of serious physical harm. In such circumstances the use of the physical restraint does not exceed beyond an immediate episode.

In the case of a resident who is incapable of making a decision, the appointed legal representative may exercise this right based on the same information that would have been provided to the resident. However, the legal representative cannot give permission to use restraints for the sake of discipline or staff convenience or when a restraint is not necessary to treat the resident's condition.
While family members cannot give consent for the use of restraint, they should be involved in the decision making process.

2.17 Accountability

Clinical Accountability

The decision to restrain is a clinical decision and the decision maker is accountable for that decision.

2.18 Clinical Governance

- The residential care unit must maintain a written record indicating all staff have read and understand the policy. The record must be reviewed and updated monthly to ensure that all existing and new staff are familiar with this policy.
- The record must be available to the inspection authority and/or other designated body upon request.

- Each episode of restraint must be reviewed by the multi-disciplinary team involved in the resident's care and treatment and documented in the resident's clinical file as soon as is practicable. Knowledge gained from the review process must be used to both inform the resident's care and inform future educational needs of staff.
- A residential unit must undertake an audit and/or evaluation which should include patterns of restraint use and relevant incidents and accidents. Such audit should inform local policy, practice and staff education needs.
- Information gathered regarding the use of restraint must be held in the centre and used to compile a report in line with HIQA requirements (30.2) or other statistics on the use of restraint within the residential care setting. This report must be available to the inspection authority or/and any other designated body and may be used to inform the national policy on restraint.

PART 2

3.0 Procedures

1. The resident assessment
2. The care Plan
3. The care of the resident during the period of restraint
4. Restraint procedure in an emergency situation
5. Review procedures

3.1 Resident Assessment

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

- Nurses, medical practitioners, allied healthcare professionals, healthcare assistants and other staff working in the facility.
- Including the person with a cognitive impairment in the process is essential as they still may have the ability to participate in care decisions and communicate their needs.

3.2 Co-ordinating the Assessment

It is important that the assessment is coordinated by a person with the required competencies such as a registered nurse. This comprehensive assessment provides the information that underpins the resident's care needs and should take place over a continuous period sufficient to identify their individual needs. No intervention should be considered unless in an emergency situation, without a thorough and relevant assessment being performed. **(Appendix 1)**

3.3 What the Assessment should consider

- The person's own wishes and preferences
- The person's physical health
- The person's mental, social and psychological health
- The physical and social environment in which the person resides
- Any previous behaviours and how they were responded to in the past
- The presenting behaviours of concern and the risks associated with this behaviour continuing
- Any contributing factors which include how staff respond to behaviours of concern
- The severity and potential consequences of the resident's behaviour for both the resident and others.

3.4 Assessment Outcome

This assessment may reveal the trigger or cause of the behaviour of concern. All behaviours that cause concern should be fully documented and the information used to build up a picture of the behaviour and the context in which it occurs. The action taken as a result of the assessment must be based on the best available evidence. Once the information is collected, the health care team should review and analyse the information to identify any patterns and plan a course of action suitable to meet the individual needs of the resident concerned. All alternatives to the use of restraint should be considered and used as a first resort. Such alternatives may include:

- Correction of any underlying medical condition (use of antibiotics, improved, pain control, etc.)
- Promotion of activities that meet the individuals needs.
- Modifications to the environment (lighting, heating, décor).
- Improved access to outdoors for exercise or other activities. **(See Appendix 2)** for a more comprehensive listing).
- Direct supervision of the resident.

Restraint can increase the level of risk, or add new risks (e.g. aggravate further the behaviour that is of concern, expose a resident to hazards created by other residents' behaviour which they cannot avoid, or confine him or her in such a way that attempts to escape are potentially harmful) (Mental Welfare Commission for Scotland 2006).

When considering the use of restraint it is necessary to consider whether its use causes greater distress than the unmet need. Where the resident is judged to lack the capacity to consent, physical restraint is not used if he/she expresses a clear and consistent preference not to be restrained (HIQA 21.20). Multi-disciplinary discussion should attempt to predict and understand how the resident is likely to feel if their movements are limited. Any reduction in social contact caused by restraint may, in itself, be distressing to the resident, as may the social stigma of 'needing' restraint.

A determination should also be made as to whether the resident is capable of independently removing the device and whether the device restricts the resident's freedom of movement

3.5 Development of the Care Plan to reflect needs/risks identified in the Assessment. This should include:

- The specific symptom to be treated or behaviour of concern to be responded to or prevented
- The steps taken to identify the underlying physical, psychological and/or environmental causes of the symptom.
- The alternative measures that have been taken, for how long; how recently, and the outcomes.
- The risks involved in using the physical restraint. **(See Appendix 3)**.
- The type of restraint, the reason for use, period of restraint, and location of physical restraint.
- The names of the inter-disciplinary team members involved in the decision.
- The conditions or circumstances under which the restraint is to be used

- The time frame under which it will be used and the associated date for review

3.6 Care of the resident during the period of restraint

- In an emergency situation or during periods of extreme behaviour the resident is continuously observed.
- In all other situations where restraint is used, the resident is checked regularly at intervals defined in his/her care plan.
- A record of these checks must be documented, **(See Appendix 4).**
- Opportunity for motion and exercise must be provided for a period of not less than 10 minutes during each two hour period in which restraint is employed and the resident is awake, and a record of such activity must be kept.
- During any period where a resident's movements are subject to restraint one or more staff members must be in direct, continuing visual and verbal contact with the resident.
- Family/carer involvement in the residents care should be encouraged, if it is safe to do so restraints should be removed during visits. Staff should ensure that the family recognises the need to inform staff on their departure to ensure the safety of the resident.
- The resident must be provided with a means for calling for assistance and shown how to use the system (special consideration may need to be given to a person with a cognitive impairment, e.g. staff may need to observe cues from the person that they may need assistance)
- Ensure residents physical needs are met as promptly as possible such as toileting nutrition warmth, comfort and hydration.
- Special consideration should be given when restraining residents who are known, by the staff involved in restraining the resident to have experienced some form of physical or sexual abuse.

3.7 Restraint decisions in emergency situations and in a situation of immediate unplanned need

The decision to restrain an individual must only be made when there is immediate and significant danger to the resident or others. Where a resident's unanticipated behaviour places him/her or others in imminent danger or personal compromise short–term, proportionate and non-dangerous physical restraint measures may be taken by staff without prior formal assessment. Precipitating factors and behaviours, and the actions taken are clearly recorded in a restraint register. If restraint has been applied in an emergency, it is most important that a full explanation and support is offered to the resident. In the event of an emergency situation, continuous observations by a designated person are necessary until the situation is reviewed by the interdisciplinary team. The decision must be reviewed and documented by the interdisciplinary team within 24 hours or as soon as possible but not longer than 48 hours.

All episodes of unplanned 'emergency' restraint must be recorded in the resident's care plan and in the care home/ward's incident reporting procedures.

3.8 Restraint review

The registered nurse arranges a interdisciplinary review of the residents condition linked to the use of restraint as soon as possible (no later than 24 hours) A full review of the decision to restrain is undertaken with the multi-professional team as soon as is practically possible (within 72hrs).

- If the situation improves, discontinuation of restraint should occur and the time and the treatment leading to the improvement recorded in the care plan.
- After the restraint has been discontinued, time should be spent with the resident and family discussing any concerns they may have.
- Time should be spent with care staff discussing any issues of concerns they may have.

PART 3

Guidance to support staff decision making
4.0 Decision Making Tool

This decision making tool aims to assist management and staff to make informed decisions in relation to the use or non use of restraint in responding to behaviours of concern**. (Appendix 5)**

1.1 When responding to behaviours of concern, the assessor must follow the Decision Making Tool in order to ensure the best possible outcome for the older person.

1.2 When a person makes a decision to restrain an older person they are accountable for that decision.

1.3 It is the responsibility of the representative to document the rationale for their decision and their action plan.

4.1 Guidelines on the use of lap belts

A lap belt is a strap that is fastened across a person's waist for the purpose of maintaining them in a safe and comfortable position in a seat. A lap belt is considered a restraint if it limits an individuals freedom of voluntary movement. It is considered an enabler if it is provided to facilitate function. Lap Belts form part of an entire seating system (which includes the chair, cushion and other accessories). Lap belts should always have releasing buckles to allow quick and easy release in the event of an emergency. Lap belts are recommended for safety when moving (either when self propelling or when the chair is being pushed) within the unit or outside.

4.2 Policy for the use of Bed Rails

For the purpose of this policy, the term bed rail will be used. Other terms are often used i.e. cot sides, safety sides, bed guards. The HSE and Nursing Homes Ireland are committed to a policy of restraint free environments in Residential services for Older People. However, it is acknowledged, that in a small number of very exceptional cases, a limited use of bedrails may be considered as part of the residents care plan to reduce the risk of accidentally slipping, sliding or rolling from bed but not to prevent the person leaving the bed.

Bed rails present an inherent safety risk, particularly when the resident is older or disoriented. Even when a bed rail is not intentionally used as a restraint, residents may become trapped between the mattress or bed frame and the bed rail. Disoriented residents may view a raised side rail as a barrier to climb over or may go to the end of the bed to get around a raised bed rail. When attempting to exit the bed by any of these routes, the resident is at risk of entrapment, entanglement, or falling from a greater height posed by the raised bed rail, with a possibility for sustaining greater injury or death than if he or she had fallen from a lowered bed without raised rails.

Thus, bed rails should only ever be used following an individualized assessment, with interdisciplinary team input if needed. All residents who require a special bed, such as an ultra-low bed, or equipment fitted to their bed for the purpose of aiding moving and handling e.g. grab rails, bed levers should be referred to the appropriate service for assessment.

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

Please refer to the following sections regarding resident and family involvement (section 2.14), Consent (section 2.15) and residents who lack capacity to consent (section 2.16).

4.3 Bed rails should not be used:

- For moving and handling purposes, unless they are integrated bed rails, which are deemed by the manufactures information to be suitable for this purpose. In this case a full standard risk assessment must be completed.
- To prevent residents from leaving the bed
- For residents who may be confused or agitated
- To prevent residents from wandering
- Restraint should never be used to cover any deficiency of service, lack of professional skill, or defects in the environment

4.4 Bed rails may be used:

- If a documented, comprehensive, interdisciplinary assessment indicates that bedrails may prevent falls from bed (other than those falls that result from the resident leaving or attempting to leave the bed voluntarily or in the circumstances outlined in 4.2) and
- There is clear evidence that an extensive range of alternative measures (see 4.6) have been tried, for a reasonable period of time and they have proved unsuccessful in maintaining the safety of the person from causing significant harm to themselves or others OR
- At the request of the resident for use as balance/support (e.g. when sitting up in bed) to give a feeling of security, **providing that the Resident is able to:**
    1. Mobilise about the bed
    2. Free any trapped limb themselves
    3. Is fully orientated and aware of their own surroundings and capability

In all circumstances consideration of the resident's mental and physical condition must take place and a documented risk assessment must be completed.

4.5 Bed rails can be classified into two basic types:

- Integral – types that are incorporated into the bed design and are supplied with it or available as an optional accessory
- Third party – types that are not specific to any particular bed model.
- They are intended to fit a wide range of domestic, divan or metal-framed beds from different manufacturers.

Bed rails are medical devices and they should be used in accordance with guidance issued by the Irish Medicines Board and The Medicines and Healthcare products Regulatory Agency (MHRA) UK. Ref ;MHRA (2006) Device Bulletin 2006(06) the safe use of bedrails London: Medicine and Healthcare products Regulatory Agency access at www.mhra.gov.uk

4.6 Alternative measures to prevent falls from bed

Bed rails should only be considered after alternative measures have been tried. Such measures include:

- Nursing the resident on a lowered bed.
- Use of specially made "ultra low beds".
- Placing a crash mat on the floor to soften a fall. (A plan must be in place as to how the resident will be raised off the mattress should they fall onto it. This should include as per manual handling assessment sliding the resident off the mattress and then hoisting them off the floor).
- Using an inflatable bed rail e.g. Safe side or inflatable bed side.
- Using a pressure alarm system to alert carers that the resident has moved.
- Using body-positioning devices.
- Perimeter Mattress or barrier (such as swimming tube)

4.7 If following the use of alternative bed management options for a reasonable period of time or if no suitable alternative is identified, a risk assessment should be carried out which considers the balance of risk of using bed rails with the risk of not using bed rails (See Appendix 6 & 7 for details of Risk Balance Tools)

- Risk balance assessments should be reviewed after each significant change in the resident's condition. The decision to continue to use (or not) the bed rail should then be recorded in the care plan and appropriate documentation. The reassessment strategy should be specified, providing criteria and timescales for reassessment.

4.8 If the initial assessment indicates that the use of bed rails is appropriate, a second assessment must be made to determine if the bed rails to be used are suitable for use in combination with the bed, mattress and resident. This is to reduce the risk of harm to the resident from for eg. Entrapment (See Appendix 8 & 9)

Resident factors:

- Is the bed rail to be used for a small adult
- Is their head or body small enough to pass between the side rail's bars?

- Is their head or body small enough to pass through the gap between the lower bed rail and the mattress?
- Is their head or body small enough to pass through the gap between the bed rail and the side of the mattress?

Bed rails used for resident mobility or turning, repositioning, where alternatives are not available should have a risk assessment completed and a care plan to reflect this. Staff should liaise with the relevant services to source alternatives.

It is the responsibility of the staff member to document rationale for their decision and their action plan.

Relevant discussions about the use of bed rails with the resident/ relative/carers and members of the interdisciplinary team should be documented, including outcome.

When a resident who has been assessed as requiring bed rails, subsequently refuses them, this must be clearly documented and further discussion with the resident, carers and interdisciplinary team as to what steps will be taken to maintain a safe environment.

When a resident or informal carer specifically requests bed rails the implications of both provision and non-provision should be considered. Where there is disagreement further discussion with senior staff involving the interdisciplinary team should occur and be clearly documented, including outcome.

4.9 Safe fitting of a bed rail

The following factors must be assessed when a bed rail is being affixed to a bed:

- Is the bed rail suitable for the bed to which it will be fitted
- Has the bed rail been fixed correctly to the bed
- Is there a gap between the lower rail of the bed rail and the top of the bed which could cause entrapment
- Does the mattress compress easily at its edge, creating an entrapment hazard
- Will any gap between the end of the bed rail and the bed head or wall allow entrapment
- Is there a gap between the bed rail and the side of the mattress that may allow entrapment of the resident's head or body
- Is the bed rail secure – is it possible that it will move away from the side of the bed and mattress when in use, or fall off at one end, creating an entrapment hazard
- All unsafe bedrails [e.g. two-bar bedrails, bedrails with internal spaces exceeding 120mm, bedrails not in matched pairs, and bedrails in poor condition or with missing parts –have been removed and destroyed; see MHRA advice in accompanying document.
- All bedrails or beds with integral rails have an asset identification number and are regularly maintained;
- Types of bedrails, beds and mattresses used within the organisation are of compatible size and design, and do not create entrapment gaps for adults within the range of normal body sizes except for: Mattress overlays

which should be used only with extra-height bedrails. The extra-height bedrails and mattress overlays have fixed highly visible labels indicating this;

- Bariatric bed which must be used with compatible extra-wide mattresses.

Always check with the manufacturer's guidelines regarding the correct use of bed rails.

4.10 Whenever bed rails are used the following checks should be carried out for all types of bed rails

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

4.11 Using bed rails with air mattress or overlays

Special care should be taken when using bed rails with the above mattress's because:

- The reduction in the effective height of the side rails relative to the top of the mattress may allow the resident to roll over the top of it.
- As the mattress edge is easily compressible the risk of entrapment is increased.

4.12 Air mattress and pressure sore prevention overlays

- These mattresses may reduce the overall height of the bed rail, thus allowing the resident to roll over the top. Extra height bed rails may need to be supplied.
- The compression of the mattress may increase the risk of entrapment between the side of the bed rail and the mattress.
- The weight of the mattress may not be enough to keep the assembly in place. This is particularly the case when using third party bed rails, which rely on the weight of the mattress to keep the assembly in place.

4.13 Adjustable or profiling beds

- Most profiling beds feature bed rails that are incorporated into the bed design or are offered as an optional extra by the manufacturer. These types of bed rail are involved in fewer incidents than third party bed rails. The following points should be considered when using this type of bed:

- Many beds have a single piece bed rail along each side of the bed. When the bed is profiled there is an increase risk of the resident toppling over the bed rail.
- To overcome this problem some profiling beds are fitted with split bed rails, one at the head end and one at the foot end. With this type of bed rail there is a further risk of entrapment between the two halves of the bed rail, which needs to be considered.

4.14 Bed rail protectors

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

- **Please refer to the following sections regarding the development of the care plan to reflect needs/risks identified in the assessment (section 3.5) and the Care of resident during the period of bed rail use (section 3.6)**

5.0 Implementation Plan

This policy will be disseminated through the Integrated Services Directorate of the HSE. All relevant staff members must sign a signature sheet to confirm that they have read, understand and agree to adhere to the policy. **(See Appendix 11)**

Responsibility for rolling out the implementation plan will lie with the Assistant National Director of Services for older people.

A training programme to support implementation will be rolled out to support restraint reduction in general however this does not remove responsibility of all staff to comply with the policy in advance of such training.

Each residential unit will identify a restraint champion who would be responsible for the roll out of the policy to all staff and would be both the link and advocate for promoting a restraint free environment.

5.1 Revision and Audit

An initial audit will be undertaken after six months in the context of compliance and any revisions that may be required. Thereafter the policy will be audited annually. There are two levels of audit

1. A national audit led by the Healthcare Audit Team.
2. A local audit by the Director of Nursing in each residential care setting. The results of this should be discussed with the local and regional Quality, Safety and Risk committees.

Any revisions or modifications proposed following audit must be communicated via the regional quality, safety and risk committees to the Assistant National Director of services for Older People who will sign off on any revisions.

References/Bibliography

Capezuti, E., Maislin, G., Strumpf, N., & Evans, L. K. (2002). Side rail use and bed-related fall outcomes among nursing home residents. Journal of American Geriatric Society, 50(1), 90–96.

Commission for Social Care Inspection (2007) Rights, risks and restraints: an exploration in the use of restraints in the care of older people. Commission for Social Care Inspection: London

Commonwealth of Australia (2004) Decision making tool: responding to issues of restraint care in aged care. Available at www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-decision-**restraint**.htm.

Cunningham C (2006) Understanding challenging behaviour in patients with dementia. Nursing Standard. 20, 47, pp.(42-45)

Decision-Making Tool: Responding to Issues of Restraint in Aged Care (2004) Australian Government Department of Health and Aging.

Department of Health OHIO (1996) Restraints and Enablers Requirements for Nursing Homes. Bureau of Healthcare Standards And Quality.

Gastmans. C., Milisen, K, (2007) Use of physical restraint in nursing homes : clinical-ethical considerations. Downloaded from jme.bmj.com www.jmedethics.com

Evan, D., Wood, J. and Lambert, L. (2003) Patient injury and physical restraint devices: a systematic review, Journal of Advanced Nursing, 41(3)pp.274-282.

Health Information and Quality Authority (2007) National Standards of Residential Care Settings for Older People. Available at www.hiqa.ie

Health Services Executive (2007) Responding to Allegations of Elder Abuse Policy Dublin: Health Services Executive

Irish Nurses Organisation (2003) Guideline on the use of Restraint in The Care of Older Person. www.ino.ie

Kitwood, T. (1997). Dementia Reconsidered: The Person Comes First. Buckingham: Open University Press.

Madden D (2002) Medicine, Ethics & the Law. Butterworths Publisher

Mental Health Commission (2006) Rules governing the use of seclusion and mechanical means of bodily restraint Reference no: R-s69(2)/02/2006. Available at www.mhcirl.ie

Mental Welfare Commission for Scotland (2007) Restraints and limits to Freedom: Principles and good practice for practitioners considering restraint in residential care settings. Mental Welfare Commission for Scotland: Edinburgh.

National Patient Safety Agency (2007) Bedrails: Reviewing the evidence, a systematic literature review, National Patient Safety Agency: London

Nay R. & Koch S. (2006) Overcoming restraint use: examining barriers in Australian aged care facilities. Journal of Gerontological Nursing 32, 33–38.

Omnibus Budget Reconciliation Act. (1987). *Public Law 100-203, Section 4201(a) & 4211(a*), Washington, DC: US Government Printing Office.

Park M, Hsiao-Chen Tang,H, (2007) Evidence-Based Guideline. Changing the Practice of Physical Restraint Use In Acute Care. Journal of Gerontological Nursing *February 2007 (pg 9-14)*

Rights,Risks and Limits to freedom (2006) Mental welfare Commission for Scotland.Available at www.mwcscot.org.uk

Royal College of Nursing (2004) Restraint revisited – rights, risk and responsibility. Guidance for Nursing Staff. Available at www.rcn.org.uk/publications

Stokes G (2000) Challenging Behaviour in Dementia: A Person-centred Approach. Winslow Press, Oxfordshire.

Gallinagh R., Slevin E., & McCormack B. (2000) Side rails as physical restraints: the need for appropriate assessment Nursing older people. vol 13, no7 pp.20-25.

MHRA (2006) Device Bulletin 2006(06) the safe use of bedrails London: Medicine and Healthcare products Regulatory Agency access at www.mhra.gov.uk

National patient Safety Agency (2007) Bed rails: Reviewing the evidence, A systematic literature review. London: National Patient Safety Agency. Access at www.npsa.nhs.uk

National patient Safety Agency (2007) Resources for reviewing and developing a bed rail policy. London: National Patient Safety Agency. Access at www.npsa.nhs.uk

National patient Safety Agency (2007). *Slips, trips and falls in hospital* London: National Patient Safety Agency. Access at www.npsa.nhs.uk

National patient Safety Agency (2007). *Safe and effective use of bedrails: Resource set.* Access at www.npsa.nhs.uk

O'Keeffe ST *(*2004), Down with bedrails? The Lancet. 363 9406 pp.343-344

Appendix 1

Assessment of Need

Medical/Nursing/Therapy assessment:

An assessment should be undertaken to rule out any underlying medical condition that may be causing problems for the person (e.g. UTI, RTI, constipation). This assessment should also differentiate between dementia and delirium. When a patient is not feeling well or is "just not right", it is important to do a core assessment of his or her current status. Some of the signs that indicate that something is wrong include: the patient is more confused than usual, not eating, incontinent or unsteady.

The assessment should include and look for the following:

- temperature, pulse and respiration rate
- blood pressure
- urinalysis
- weight loss
- hydration
- infection (chest, urinary tract, ear, systemic)
- Mobility and gait (for example—can the person walk to the toilet or change position when necessary?)
- pain (remember that residents may not always verbalise pain)
- deterioration in hearing and/or vision
- change in eating or toilet habits
- unattended ailments such as dental problems, pressure sores or tinea
- A medication review to consider adverse effects of medication. (e.g. over sedation may increase risk of falls etc)
- hunger and thirst
- Has an assessment of sleep cycle been carried out to establish the person's normal night time routine?
- Has the person had a comprehensive health check recently (sight, hearing, dental etc)
- Unmet Psychosocial Needs (e.g., social isolation, disruption of familiar routines, anger with family members)
- If medication is being used to aid the use of some treatment (urinary catheter) identify other potential form of treatment of consider discontinuing the treatment
- Change in cognitive function

MENTAL STATE AND COGNITIVE FUNCTIONING

Many behaviours that cause concern can be attributed to a change in the resident's mental state. Sudden changes to mental state and cognitive functioning can be caused by conditions that respond to treatment. A resident who has a diagnosis of dementia may also have depression or episodes of acute confusion (delirium). If

either of these conditions is suspected then an assessment should be undertaken by the most appropriate person to consider the following:

- Is the resident depressed?
- Has the level of confusion or disorientation suddenly increased?
- Is the resident overly suspicious?
- Does the resident appear to be responding to hallucinations (auditory, visual or tactile?)
- Does the resident appear to be delusional?
- Could this be a side-effect of medication?

ENVIRONMENTAL ASSESSMENT

After a physical cause of agitation has been ruled out environmental and social factors that trigger behavior disturbances should be considered .It is important to determine: the duration, frequency, and severity of symptoms, the pattern of the disturbance and which activities and caregivers typically precipitate behaviours of concern. Obtaining this information will help to monitor patient status and assess the efficacy of interventions. An environmental assessment to determine if any environmental factors are contributing to the person's sense of ill being (e.g. lighting, heating, noise levels, use of bed rails or other obstructions, are all toilets etc clearly signposted to aid the older person or the person with dementia?). This may include the following:

- Are single rooms or private areas available?
- Is glare from shiny floors or open windows a problem?
- Is there too much clutter which may cause confusing cues
- Noise-loud voices or too many people
- Not enough stimulation leads to boredom or anxiety
- Examine behaviour of roommates or family members.

PSYCHOSOCIAL ASSESSMENT

A psychosocial assessment is needed to establish if the person's life history can explain behaviours that are of concern to staff (fear, events,). This should include collecting information on their lifestyle, communication methods, likes and dislikes, daily routine and abilities. Who is this person? What are his/her longstanding traits, abilities, preferences, experiences, habits? Other areas to consider are:

- Resident's previous ways of handling stress
- Patterns of sleep, exercise and relaxation
- Lifetime habits such as, for example were they shift workers, regular church attendees etc
- Any change in circumstances (e.g. arrival at the facility, death or loss of a loved one or pet)?
- Level of communication by staff: communication that is either too child like or, conversely, is too difficult to understand may cause confusion or frustration
- Need for privacy and/or social contact
- Attitudes, knowledge and behaviour of staff.
- Comfort e.g. too hot/too cold
- Restriction of freedom or movement

- Spiritual needs
- need to communicate in a language other than English

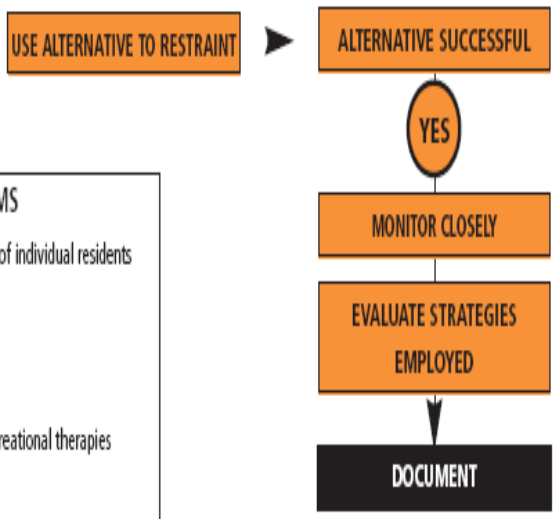
FACILITY ASSESSMENT

Is a person centred approach adopted by all staff in the setting? (Observe staff interactions with a cognitively impaired person)

Is there any element of the hospital routine that might contribute to behavioural problems or falls etc?

Has all the staff received education in the management of behaviours of concerns/ falls prevention?

Has the facility access to other members of the interdisciplinary team?



Alternatives to the use of restraint

ENVIRONMENTAL

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

ACTIVITIES AND PROGRAMS

Develop programs to meet needs of individual residents such as:

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

ALTERATIONS TO NURSING CARE

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

PHYSIOLOGICAL STRATEGIES

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

PSYCHOSOCIAL PROGRAMS AND THERAPIES

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

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

APPENDIX 3

Physical Effects

- Immobility and increased risk of falls
- Pain/Discomfort
- Entrapment and accidental death by strangulation and asphyxiation
- Injuries sustained trying to free themselves i.e. cuts and bruises
- Pressure sores
- Muscle atrophy
- Loss of bone density
- Contractures
- Incontinence
- Constipation
- Dehydration
- Skin irritation
- Hypostatic Pneumonia
- Exacerbation of Hemorrhoids
- Increased morbidity and mortality

Psychological Effects

- Depression
- Cognitive decline
- Increased agitation
- Increased confusion
- Fear
- Anger
- Resistance
- Increased aggressive behaviour to include verbal aggression
- Humiliation
- Feelings of panic
- Lack of understanding
- Social Isolation

APPENDIX 4

RESTRAINT RELEASE & REVIEW CHART

Patient / Resident Name: ____________________________ **MRN** _______________

Date Restraint First Initiated____

In consultation with Doctor ____

Type of Restraint: ____

	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	24 hr review 2 signatures & code
Date	08.00-10.00		10.00-12.00		12.00-14.00		14.00-16.00		16.00-18.00		18.00-20.00		
	20.00-22.00		22.00-24.00		24.00-00.00		00.00-02.00		02.00-0400		04.00-06.00		

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

- ✓ = Assessment completed and still is applicable,
- ⃠ = Change noted, the MDT consulted and the care plan changed
- ✕ = refer to documentation entry in care plan

Review need for Restraint every 24

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

Activities / Behaviour / Mood Comfort / Socialization Circulation / Safety Hydration / Nutrition Range of Motion / Function Toileting	Declines in the resident's physical functioning and/or muscle condition Contractures / Injury Increased incidence of infections Compromised circulation Skin Breakdown / Bruising /	Withdrawal from social activities Agitation / Delirium Depression / Sensory deprivation Decreased appetite Sleeping pattern disturbance Incontinence / Constipation

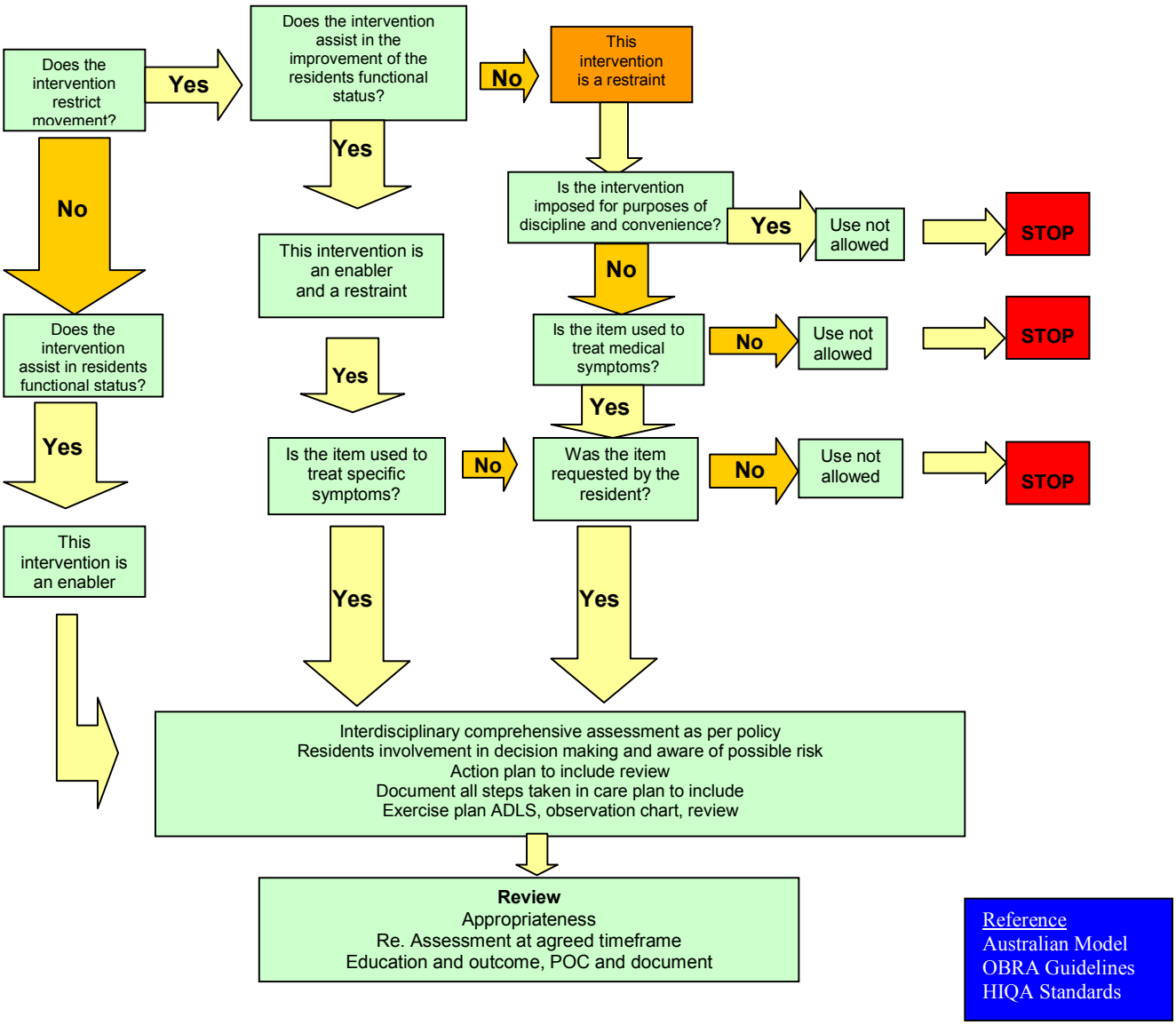
	Abrasions	

APPENDIX 5

DECISION MAKING TOOL WHEN CONSIDERING IMPLEMENTING RESTRAINT INTERVENTION

Initial Assessment

1. Has an assessment of possible underlying physical and psychological causes been carried out and documented in the care plan
2. The alternative measures that have been taken
   (1) For how long
   (2) How recently
   (3) Outcome
3. Evidence that a restraint will benefit the symptoms
4. Risk involved using restraint.
5. Assessment must be documented prior to initiation of restraint.


Does the intervention restrict movement?
Yes
Does the intervention assist in the improvement of the residents functional status?
No
This intervention is a restraint
Yes
No
Is the intervention imposed for purposes of discipline and convenience?
Yes
Use not allowed
STOP
No
This intervention is an enabler and a restraint
Does the intervention assist in residents functional status?
Yes
Is the item used to treat medical symptoms?
No
Use not allowed
STOP
Yes
Yes
Is the item used to treat specific symptoms?
No
Was the item requested by the resident?
No
Use not allowed
STOP
This intervention is an enabler
Yes
Yes
Interdisciplinary comprehensive assessment as per policy
Residents involvement in decision making and aware of possible risk
Action plan to include review
Document all steps taken in care plan to include
Exercise plan ADLS, observation chart, review
Review
Appropriateness
Re. Assessment at agreed timeframe
Education and outcome, POC and document
Reference
Australian Model
OBRA Guidelines
HIQA Standards

APPENDIX 6

1. Brief risk balance tool

Risk balance tools are good at conveying the need to balance an individual patient's multiple risk factors. They also reflect the legal requirement that decisions are made in the patient's best interests when they lack capacity to make their own decisions. However, they rely on staff having a realistic picture of relative risks. Currently, many staff may over-estimate the risk of fatal entrapment and under-estimate the risk of injury from falls from bed.

THE RISK OF NOT USING BEDRAILS	THE RISK OF USING BEDRAILS
How likely is it that the patient will fall out of bed? Patients may be more likely to slip, roll, slide or fall out of bed if they have mobility or eyesight problems or are confused or drowsy. **How likely is it that the patient will be injured in a fall from bed?** Injury from falls from bed may be more likely, and more serious, for patients who are elderly, have osteoporosis, are on anti-coagulants or are very ill. **Will not using bedrails cause the patient anxiety?** Some patients may be fearful even though their actual risk of falling out of bed is low.	**Would bedrails stop the patient from being independent?** **Might the patient climb over the bedrails?** An injury's severity can be increased if the patient climbs over a bedrail and falls from a greater height. **Could the patient injure themselves on the bedrails?** Bedrails can cause injury if the patient knocks themselves on them or trap their legs or arms between them. There is also a very rare risk of postural asphyxiation. **Could using bedrails cause the patient distress?** Bedrails may cause distress to some patients who feel trapped by them.
BEDRAIL USE IS RECOMMENDED IF THE RISKS ABOVE ARE GREATER THAN THE RISKS ON THE RIGHT	BEDRAIL USE IS NOT RECOMMENDED IF THE RISKS ABOVE ARE GREATER THAN THE RISKS ON THE LEFT

APPENDIX 7

2. Detailed risk balance tool

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

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

Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations

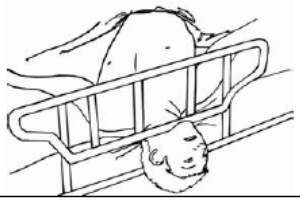
Zone	Dimensional Limit Recommendations
1 Within the rail	<120 mm (< 4 3/4 “)
2 Under the rail, between rail supports or next to a single rail support	< 120 mm (< 4 3/4 “)
3 Between rail and mattress	<120 mm (< 4 3/4 “)
4 Under the rail, at the ends of the rail	<60 mm (< 2 3/8 “) AND >60° angle

APPENDIX E

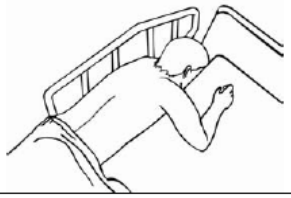
Drawings of Potential Entrapment in Hospital Beds

Zone 1 – Entrapment within the rail

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



Zone 3 – Entrapment between the rail and the mattress

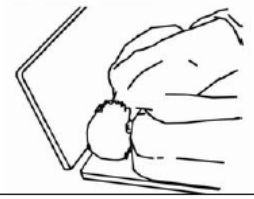


Zone 4 – Entrapment under the rail, at end of rail

Zone 5 – Entrapment between split bed rails

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

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



Residential Restraint Register

Name of Organisation _____

Week Beginning ---------- **200**

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

Residents Name	Date of Birth	Ward/Unit	Type of Restraint	Initiated by	Documentary evidence in care plan of full Risk assessment and plan of care identified	Daily restraint assessment and restraint removal chart completed	Review Date	Signature	Date &Time

Appendix 11

Signature Sheet

Policy Title: **POLICY ON THE USE OF PHYSICAL RESTRAINTS IN RESIDENTIAL CARE UNITS**

I have read, understand and agree to adhere to the attached Policy, Procedure, Protocol or Guideline:

Print Name……

Signature ……

Area of Work……

Date……

Please return this completed form to:

Appendix 12

RESTRAINT DEVELOPMENT WORKING GROUP

NAME	TITLE
Ann Coyle	National Planning Specialist. Office of the Assistant National Director of Services for Older People
Alan Murphy	Quality & Risk Manager, HSE Dublin Mid Leinster
Breda Hayes	Director of Nursing, St Mary's Hospital, Phoenix Park, Dublin
Ciara Hopper	Nursing Homes Ireland
Eilis Carroll	Nursing Homes Ireland
Eleanor Edmund	Patient Advocate, Alzheimer's Society Ireland
Helen Flint	Director of Nursing Research & Development, HSE Dublin Mid Leinster
John Linehan	Care Group Co-ordinator, Services for Older People, North Cork
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Appendix 13

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Mary Culliton	Head of Consumer Affairs, HSE
Martin Devine	Assistant National Director - Environmental Health, HSE
Jane Carolan	National Director - Corporate Planning and Corporate Performance, HSE
Kevin McKenna	Project Facilitator, Working Group on Work related Aggression & Violence
Pat Harvey	Chairman, HSE Working Group on Work related Aggression & Violence
Marion Witton	Chief Inspector of Social Services, HIQA
Ann Carrigy	Director, Serious Incident Management Team, HSE
Leo Strong	Head of Procurement, HSE
Pat Healy	Regional Director of Operations, HSE South
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Jim Gallagher	Manager for Older Persons, HSE West
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Appendix 14

Audit Tool – Policy On The Use of Physical Restraints in Designated Residential Care Units for Older People (HSE, 2010)

Audit tool – development, approval and review details:

Developed by:	This audit tool is adapted with kind permission from the audit tool developed by Dr. S Hughes**,** Team Lead Quality, Clinical Audit and Research, **HSE** Dublin Mid Leinster.
Approved by:	Restraint implementation plan working group
Approval date:	22nd March 2011
Review date:	December 2011
Review details:	This audit tool will be reviewed in conjunction with review of the Policy on the use of physical restraints in designated residential care units for older people HSE 2010 in December 2011

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Audit Tool – Policy On The Use of Physical Restraints in Designated Residential Care Units for Older People (HSE, 2010)

Objective of the Audit tool:

This audit tool is to be used to retrospectively audit the processes used to physically restrain residents in Residential Care Units and to identify if the processes used are in line with the 2010 HSE Policy on the use of physical restraint in designated residential care units for older people.

Type of Audit: This is a retrospective care plan audit

Methodology:

Inclusion Criteria:	All residents who had a period of planned **OR** unplanned/immediate physical restraint during the previous 2 months (since date of previous audit)

Audit:

- **Frequency of Audit of Physical Restraint:** An audit should be carried out after each episode/period of planned or unplanned/immediate physical restraint which
- **Revision and audit of the Policy:** See Page 23 of National Policy (HSE, 2010)

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Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Audit Tool – Policy the use of Physical Restraints in Designated Residential Care Units for Older People (HSE, 2010)

Name Ward/Unit/Area		**Date of Audit**	
Auditor(s) Name(s)		**Auditor(s) Title (s)**	
Resident Identifier (name/ medical card number)	**1.**	**2.**	**3.**
	4.	**5.**	**6.**

Methodology
Please insert **1** for **Yes, if** the criteria is found evidenced in the resident's care record.
Record **0** for **No,** if the criteria is not evidenced

OR

N/A for **Not applicable**

Section A: Non-emergency restrictive intervention during the audit period

A	**Criteria**	**Resident Identifier**					
		1	**2**	**3**	**4**	**5**	**6**
A1	Rationale for use of the restraint are outlined in the resident's care plan						
A2	There is evidence of a assessment as per policy.						
A3	There is evidence of the involvement of the resident/advocate/carer/family member as part of the assessment						
A4	The capacity of the resident was considered as per policy.						
A5	There is evidence that informed consent was obtained						
A6	There is evidence of consideration and application (where appropriate) of alternatives to using restraint.						
A7	There is evidence of decision making process for using restraint and choice of restraint as per policy.						
A8	There is evidence of a Risk Assessment carried out on the use of the chosen form of restraint and identification of risk						
A9	There is evidence of identified control measures to manage any potential risks						

A10	There is evidence that Documentation supports appropriate checks have been carried out on the restraint equipment prior to their use						
A11	Where a resident refuses a required restraint, this is documented in the care plan						
A12	Where a resident refuses a required restraint there is evidence of a risk assessment of this situation and the development of control measures one a restraint is applied.						
A13	The care plan is in place and outlines the circumstances under which the restraint is to be used						
A14	There is a clear strategy outlined in the resident's care plan for; • checks on the resident while restrained as per policy						
A15	• Timeframes for when the restraint is to be applied.						
A16	• Opportunity for motion and exercise for the resident during the restraint period and as per policy.						
A17	• Meeting physical needs of the resident during restraint period						
A18	• The procedure for the resident calling for assistance						
A19	There is evidence of regular observational checks of the resident at intervals defined in the care plan as per the policy						
A20	There is evidence of a reassessment strategy outlined in the resident's care plan (with criteria and timescales)						
A21	There is evidence that the episode of restraint is clearly and accurately recorded on the unit's Restraint Register						
A22	There is evidence that a multidisciplinary review of the resident's condition, linked to the used of the restraint, takes place within 24 hours of the restraint having been applied.						
	Total Scores for Yes						
	Total Scores for No						
	Total Scores for N/A						
	Total % (Total of Yes + N/A as a percentage of Total (22)						

Section B: Emergency intervention (immediate and unplanned) during the audit period

	Criteria	**Resident Identifier**					
		1	**2**	**3**	**4**	**5**	**6**
B1	Rationale for the immediate and unplanned need for restraint are outlined in the resident's care plan						
B2	Evidence supports that the restraint was used where there was an immediate and significant risk to the resident's safety						
B3	Evidence supports that the restraint was used where there was an immediate & significant risk to other residents/ staff/ family/visitors/others **OR** to the safety of others or that the resident's behaviour could potentially have resulted in a significant injury to that resident or others.						
B4	The resident's care plan clearly details; • who made the decision to apply the restraint including						

B5	name/s/grade/area of work. • who actually applied the restraint (Name/grade/title)						
B6	here is evidence in the resident's care plan that the multidisciplinary team were involved in the decision making process.						
B7	There is evidence of consideration and application (where appropriate) of alternatives to using restraint						
B8	There is evidence in the care plan that a risk assessment was carried out on the type of restraint used						
B9	Documentary evidence supports that appropriate checks have been carried out on the restraint equipment prior to their use						
B10	There is a clear strategy outlined in the care plan for checks as per policy.						
B11	There is a clear strategy outlined in the care plan for timeframes for restraint/review as per policy						
B12	There is a clear strategy outlined in the care plan for opportunity for motion and exercise as per policy						
B13	There is a clear strategy outlined in the care plan for meeting physical needs as per policy						
B14	There is a clear strategy outlined in the care plan for calling for assistance as per policy						
B15	There is evidence that observations by a designated person took place until a review of the resident's condition was undertaken by the multidisciplinary team as per policy						
B16	There is evidence of a reassessment strategy outlined in the resident's care plan (with criteria and timescales)						
B17	There is evidence that the resident has been assessed/reviewed by the multidisciplinary team within 12 hours of the restraint having been applied as per policy.						
B18	There is evidence that the decision to continue to apply the restraint is reviewed and documented within 24 hours or as soon as possible (but not longer than 48 hours) and (by whom ie. Person/s responsible documented)						
B19	There is evidence that a full explanation of the situation and the decision to apply the restraint was given to the resident						
B20	There is evidence that the episode of unplanned/immediate restraint was discussed with the relatives/ carers as per policy.						
B21	There is evidence that the episode of restraint is recorded on the unit's Restraint Register						
B22	There is evidence that an incident report form was completed on the immediate and unplanned used of restraint as per policy						
	Total Scores for Yes						
	Total Scores for No						
	Total Scores for N/A						
	Total % (Total of Yes + N/A as a percentage of Total (22)						

Audit Outcomes:

Audit Outcomes	1		2		3		4		5		6	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Restraint processes were appropriately applied at all times												
There were deviations from the correct restraint processes												
Recommendations for improvement are required												

Comments and Recommendations arising from the audit: