

# Showing restraint

**Les Bright** discusses the sensitive topic of restraint and its links to human rights



**E**nabling people to make choices and exercise their rights, while also keeping them safe, captures one of the most frequent daily practice dilemmas facing staff involved in care homes. The Commission for Social Care Inspection (CSCI) has published a thoughtful report on the topic that re-starts a very necessary debate (CSCI 2007).

Once again protecting and promoting human rights is a central part of the concern that emerges from the evidence presented. How many more times must we look in on accounts of poor practices that deny older people their dignity, and compromise their freedom before some decisive action is taken?

## Findings not well received

The report has not been well received in all quarters, being seen by some as yet another attack on an over-worked and under-resourced sector. This is to be expected when so much negative publicity abounds – but protests about unfairness cannot be allowed to deflect valid criticism or mask appalling practices.

This report is not a prevalence study, rather an attempt to flush out the key issues that need to be resolved in order to arrive at a better situation than at present. The RCN has repeatedly confronted this issue, publishing and revising guidance for nurses on a number of occasions (RCN 2004).

The examples recounted in the report draw on up-to-date information derived from a number of methods:

- an online survey on the CSCI website
- a series of group discussions with older people and their families
- follow-up questionnaires with some of the above
- an analysis of inspection reports and complaints data
- meetings with inspectors.

More than 600 reports of inspections in the calendar year 2006/07 contained references to restraint; and 337 complaints were received – from a total of more than 57,000, over a

three-year period – mentioning practices that could be viewed as restraint.

Sadly, the level of participation by older people in the survey was low, with less than 10 per cent of the respondents being drawn from that group. However, responses from care staff, home managers, relatives, trainers, NVQ assessors, and home carers, did provide a fairly representative cross section of those engaged in such care.

The term restraint may be considered to

while falls are common among care home residents, the incidence of serious injury is small – becoming more serious when restraint is used (Gallinagh 2001).

A key message, drawn from an international evidence base, is that restraint is less effective in reducing the incidence of falls and consequent injuries than falls prevention programmes. Excessive and inappropriate medication may also cause falls and harm to the individual.

## Definitions of restraint

■ **Physical restraint:** a physical restriction to moving around by the use of belts or cords, sheets or blankets, purpose designed equipment such as bed rails, and strategic positioning of furniture

■ **Physical intervention:** use of techniques to ‘manhandle’ people either by keeping them in a chair or by stopping them from moving, or forcibly moving someone to another place

■ **Chemical restraint:** the use of drugs and prescriptions to change behaviour, especially use of PRN medications

■ **Environmental restraint:** designing buildings so as to limit people’s ability to move around by use of electronic keypads and baffle locks

■ **Electronic surveillance:** closed circuit television monitoring movements within buildings, door alarms, and electronic tagging of individuals

■ **Medical restraint:** various procedures such as catheters and feeding tubes impinge on people’s lives. Sometimes they try to remove them and actions are taken to prevent this.

lack clarity and so causes confusion. So it is helpful that the report sets out a broad understanding of restraint, and identifies the wide variety of forms it can take.

Nurses may take the view that there is a significant difference between steps to ensure that a patient’s health needs are met by fixing a drip in such a way that it is difficult for the person concerned to remove it, and ‘forced care’ – where an individual is made to eat, take medication or receive some other care associated with their personal hygiene.

The report provides accounts of relatives who wanted to see their loved one leading a more restricted life, by use of belts, bed rails, electronic tags, and locks – all in the belief that such action is in the interest of the older person concerned. Indeed the most frequently cited reason for taking any form of restraining action is safety and protection. However,

What’s needed now is a period of calm reflection so that best practice can be shared, policies redrafted, and their implementation monitored to continue the process of respecting individual rights and preserving people’s dignity. A copy of the report is available at [www.csci.org.uk/PDF/restraint](http://www.csci.org.uk/PDF/restraint) ■

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## References

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- GallinaghR et al (2001) Side rails as physical restraints: the need for appropriate assessment *Nursing Older People* 13, 7, 22-27
- Royal College of Nursing (2004) *Restraint Revisited – Rights, Risk and Responsibility: guidance for nursing staff*. London, RCN