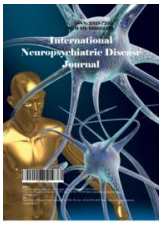

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Restraints and Restrictive Interventions during Essential Personal Care in Elderly People Living with Dementia in Care Homes

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Authors' contributions

This work was carried out in collaboration among all authors. Author MC wrote the initial draft with Authors LB and MC led the project. Author IAJ provided consultation on subsequent drafts, and undertook the revisions. All authors provided advice and feedback throughout the process and read and approved the final manuscript.

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ABSTRACT

Care home staff are frequently required to provide invasive personal care for their residents, and on occasions need to use restraint and restrictive practices with people with dementia. This often occurs in situations where the residents no longer have the insight that they require help and may misperceive the personal assistance as an assault. On a practical level, a significant number of people with dementia are currently being admitted to inpatient units due to their level of resistance around essential personal care. Often these same people are settled at all other times. This paper provides practical advice on how to support residents and their caregivers, and gives clinical, legal and ethical guidance. Previous work undertaken by the present authors have shown that care staff require supervision and coaching on this topic.

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The paper includes training materials used by the authors. This includes a composite, fictitious case example that illustrates approaches that are compliant with UK guidelines. It addresses the training of staff working in care homes.
As such this paper provides a review and practical example of the appropriate use of restraint for residents unable to consent to the 'intimate' care they are receiving. It describes a method delivered in a person-centred manner and within a legal framework. Having read this paper, care home staff should feel more confident, competent and secure in the assistance they are providing in this contentious area.

Keywords: Geriatrics; forced care; residential care; assault cycle; formulation; care plan.

1. INTRODUCTION

Physical restraint is defined as "any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person" [1]. While this definition may appear clear, the concept of restraint in legal terms is ambiguous. Hantikainen and Kappeli [2] for instance, found differences in how nurses interpreted the term restraint, and the conditions for justifying its use. For example, if the nurses thought they were using 'hands-on' care for the benefit of the residents, the nurses were less likely to consider their actions to be 'restraint' [3].

Current UK guidance suggests that caregivers must consider the possibility that they might need to employ physical restraint when "essential" personal care is required [1]. This is care that would lead to significant harm to a person's health or dignity if the health concern was left unattended for any significant length of time [4].

In dementia care, restraint is most commonly employed when caregivers are required to provide invasive personal care (assisting with bathing, continence related issues), but it can also apply to other aspects of care (e.g. changing dirty clothes, re-dressing wounds, cutting toenails etc.). Intimate care is often provided by staff in residential settings who receive little or no training, are poorly paid, and work under tight time pressures [5]. In contrast, NHS staff receive regular training in Prevention of Management of Violence and Aggression (PMVA) training. Typically this training provides staff with the knowledge and skills to employ de-escalation skills, breakaways techniques, disengagement tactics, and control and restraint interventions for their patients and clients [6].

Some people living with dementia who require essential personal care may be unaware of their care needs and resist staff attempts to support them. Such people may perceive themselves as being attacked or molested and become very distressed [7]. Almvik, Rasmussen and Woods [8] found that 20% of all challenging incidents in dementia care settings involved bathing or showering. Subsequently, a high proportion of referrals to specialist teams working with Behaviours that Challenge (BtC) are linked to difficulties providing personal care. Hence, evading personal care can be understood as the person communicating their need for wanting 'safety and control' within their environment [4].

Current best practice guidelines [9] advise that detailed assessments and needs-led care plans are developed to address BtC [7]. Often these behavioural difficulties can be resolved by such standard care plans, however, a number of people remain resistive and attempt to physically fend off care, misperceiving the 'best interest' intent of the carers. It is these situations that potentially warrant the use of physical restraint (i.e. in situations where the individual is deemed to lack capacity to make the decision to refuse care they require).

Alzheimer's Australia [10] estimates the prevalence of the use of restraint varies between 12-49% for people living with dementia, depending on setting. The Commission for Social Care Inspection [1,11,12], identified restraint associated with the delivery of personal care as a significant problem, and initially referenced the concept of 'forced care' when identifying situations where the use of force is used to deliver care.
In England the lawful use of restraint with people deemed to lack capacity is governed by the Mental Capacity Act (MCA) [13]. If a person is formally assessed as lacking capacity, then restraint is only lawful if it is deemed to be in the person's 'best interest' [5,14]. Clinical experience, however, informs us that capacity assessments relating to the use of force for essential personal care tasks within care homes

are rarely undertaken [5]. Most of the legal framework around the use of restraint is either unknown or ignored by those providing hands-on care. The current situation in this area is unsatisfactory, yet surprisingly it appears to operate under the governance radar.

A range of guidelines from different organisations, both nationally and internationally, have been developed to address the broad issue of restraint [1,6,10,15]. Evidence about the use and impact of restraint practices on residents suggests it can be associated with greater risk of injuries such as pressure ulcers, aspiration and breathing difficulties, falls and death [16]. There is general agreement that restraint should only ever be used as a last resort [17], where the benefits outweigh costs [10], and when there is a possibility of harm to the person or others [1]. The national guidelines, however, currently tend to focus mainly on (i) restraint of 'intended actions' (e.g. stopping someone leaving the building, preventing them hitting out), or (ii) the delivery of vital medical treatment or interventions (e.g. intravenous injections, medication and naso-gastric feeding [18,19]). Research by Howarth et al [4] who surveyed care home staff about the use of restraint suggest that it is used routinely by staff and sometimes involves physical restraint, particularly when supporting residents to wash and change continence products. Further, staff indicated they required more practical training in approaches to restraint. This work resulted in the development of a practical framework [14,20]. Key features of this framework are outlined below:

- Prior to using restraint, standard biopsychosocial interventions should be attempted [9,21]. If these interventions do not resolve the difficulties, and the delivery of personal care is essential, then consider updating the care plan to include restrictive interventions.
- A formal capacity assessment regarding the resident's ability to make decisions regarding their personal care should be completed.
- If the resident lacks capacity, a 'best interest' decision should be made which clarifies if restrictive interventions are in the person's 'best interests'. Family and all relevant professionals should be involved in this process.
- Further guidance must be sought if there are any concerns highlighted about the impact of using restrictive interventions with the individual (e.g. medical, physiological, emotional, including breathing problems, proneness to falls, etc.).
- Training session(s) should be delivered to care staff and provided by specialists who are accredited in PMVA training as part of the resident's care. This session will provide generic training in PMVA and information about restraint 'holds' (Table 1).
- Care plans should be updated in collaboration with the care staff. Key safety points from the restraint techniques identified should be emphasised in the care plan. Further points to highlight include: the legal framework; the use of de-escalation skills [22]; the staff should have a strong focus on reassurance following interventions.
- Staff should be asked to sign-off on a register that they have received training on restraint practices, but only if they feel competent and confident to go ahead and use the approaches described in the care plan, including any PMVA techniques.
- The use and success of the restrictive interventions should be reviewed over a period of 6-8 weeks.

2. METHODOLOGY

Caregivers require support and training to deliver the above guidance in a competent, confident and legal manner. The remainder of this article addresses this issue, describing features of a training programme that has been carried out for the last five years in one of the largest Mental Health Trusts in the UK (Cumbria, Northumberland and Tyne and Wear NHS Foundation Trust). The article provides a fictitious case example that the authors use for training purposes. It illustrates the comprehensive nature of a care plan, and the detailed nature of the behavioural instructions. However, prior to presenting the case example a range of restraint techniques typically taught during the authors' training courses will be discussed (Table 1).

3. TRAINING MATERIALS

3.1 Examples of Restraint Techniques

Table 1 provides descriptions of the types of 'hands on' care taught and coached by a NHS clinical team that supports care homes in the delivery of restraint in the North East of England.

Table 1. Examples of common and less common restraint techniques

	Level of physical contact associated with technique	Description of the restraint holds and manoeuvres
Common Techniques	No contact or gentle physical guidance and redirection	Graded approach using cues and prompts - Always consider if physical contact is needed. - Use of verbal prompts, gestures and gentle physical prompts (e.g. soft touch to the back of the arm or gently holding someone's wrist and elbow and guiding them somewhere).
	Low level of restriction (1 staff member to hold, 1 to attend to care)	Use of low level restriction holds - Rear elbow hold (looks like staff member has put their arm around the person) or; - Double forearm hold (more restrictive and staff member tucks in and raises both of the person's arms while aligning bodies closely).
	High level of restriction (minimum 3 staff: 2 to hold, 1 to attend to care)	Use of higher level restriction holds - Forearm hold and figure of four hold (e.g. to allow staff to hold the person safely during essential care). Both are highly restrictive holds and focus on holding the persons forearms. Staff members stand either side of the person, align bodies closely then tuck in and raise both of the person's arms to restrict movement. - Seated restraint/de-escalation in chairs (holding someone in a seated position during care with staff facing either to the front or rear of the person in either a seated or kneeling position).
Less Common and Adapted Techniques	High level of restriction (2 or more staff to hold, 1 to attend to care)	Use of higher level restriction (less common) holds - Holding someone on a bed (three adapted options for holding and turning someone who is in a recumbent position on a bed) - Planned approach from behind the person in order to assist them into a seated position (e.g. hold them in a shower-chair) - Assisted stand (allows staff to move someone from the floor or a seated position when other options are not available and without equipment). At no time is pain used to gain compliance from the person and any movement of limbs is done in line with that which is comfortable and natural for the person.
Further sources [23,24].		

It is worth noting that restraint is seen as the 'last resort'. Hence, prior to using restraint staff need to be aware of – and be trained in - alternative strategies that will help prevent the premature use of restrictive practices. These strategies are well illustrated in the assault cycle [25], which shows the five phases of a BtC: a wellbeing/content phase; triggering phase; escalating phase; high-arousal phase; calming phase (Fig. 1) [22]. It is suggested that a clinician's choice of intervention is linked to the person's state of arousal. Hence, knowing how to keep the person in a state of wellbeing should be viewed as key in the management of someone's BtC. Being aware of, and shielding from, potential triggers are also important strategies. Further, knowing how to de-escalate growing agitation is also an important skill. By intervening with suitable techniques when the arousal level is still relatively low, the skilled carer may be able to avert a 'full-blown' BtC. However, when the person with dementia is in a high-

arousal phase there may be a requirement to use restraint as a last resort in order to keep the person, or others, safe [26].

Another example from the training programme is the case of 'Bob'. This is a fictitious case and has been developed for teaching purposes and does not describe details of any specific residents known to the authors.

3.2 Case Example: Bob

Bob, 82, had Alzheimer's disease and had resided in a care home for four years. He was referred to the community mental health team because he was physically aggressive during personal care and took three carers to support him following episodes of incontinence. Staff reported that Bob would 'lash out', punch, kick, become vocal, swear and attempt to head butt them. To understand more about Bob, a formulation was completed using the Newcastle Formulation Model. The Newcastle Model is the most popular biopsychosocial approach in the management of BtC in the UK [27]. It is one of the few formulations that has an evidence base, having been used in the FITS randomised controlled study [28]. The descriptive features of the formulation is illustrated in Fig. 2, and the actual process used to employ it are well described in James and Jackman [29].

The formulation enabled the staff to identify the triggers to the behaviour. Due to the level of distress and agitation displayed by Bob, the team's Consultant Psychiatrist carried out a medication review. Owing to the large number of psychotropic medications already prescribed, it was decided not to alter Bob's regimen further. Also, because Bob was not aggressive when not being touched invasively, it was felt that it would be better to employ a nonpharmacological intervention.

The formulation was produced with the help of a number of staff who knew Bob well, all of the information was then shared with the wider group of staff in a meeting; such meetings are typically known as 'information sharing sessions' [29]. The resulting discussion enabled everyone to understand why Bob was behaving in an agitated manner. This process also supported the production of a comprehensive care plan (Table 2). Staff at this stage were advised to update Deprivation of Liberty Safeguards (DoLS) and complete a 'best interest decision' regarding the interventions they were using when physically holding Bob.

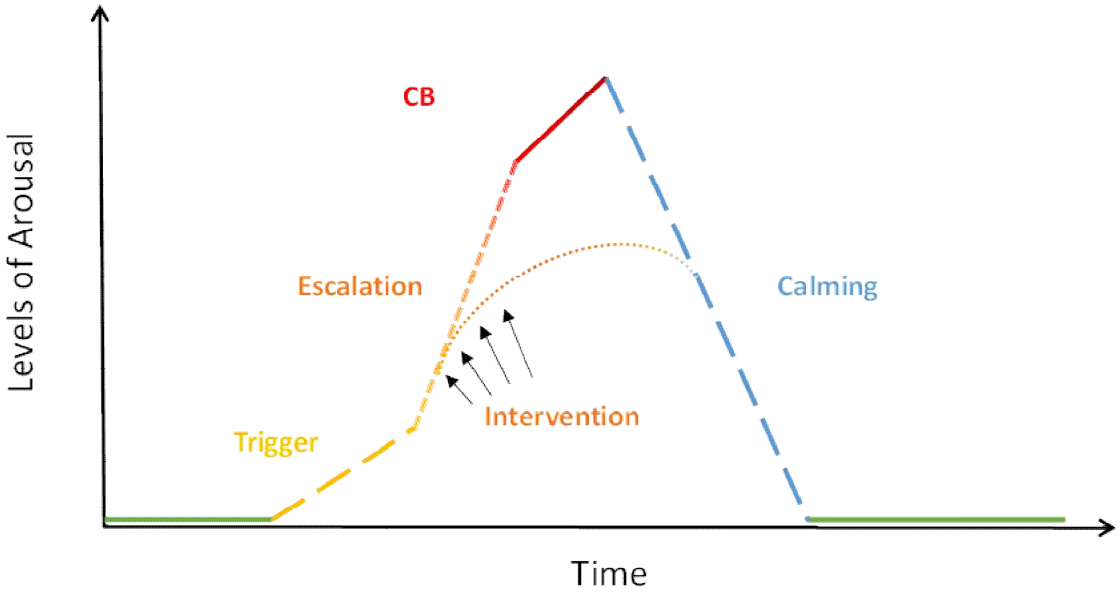

Fig. 1. The assault cycle

Legend: solid light line/green – wellbeing; light dotted line/yellowy orange – primary prevention & de-escalation; solid dark line/red – behaviours that challenge (CB); dark long dotted line/blue – calming

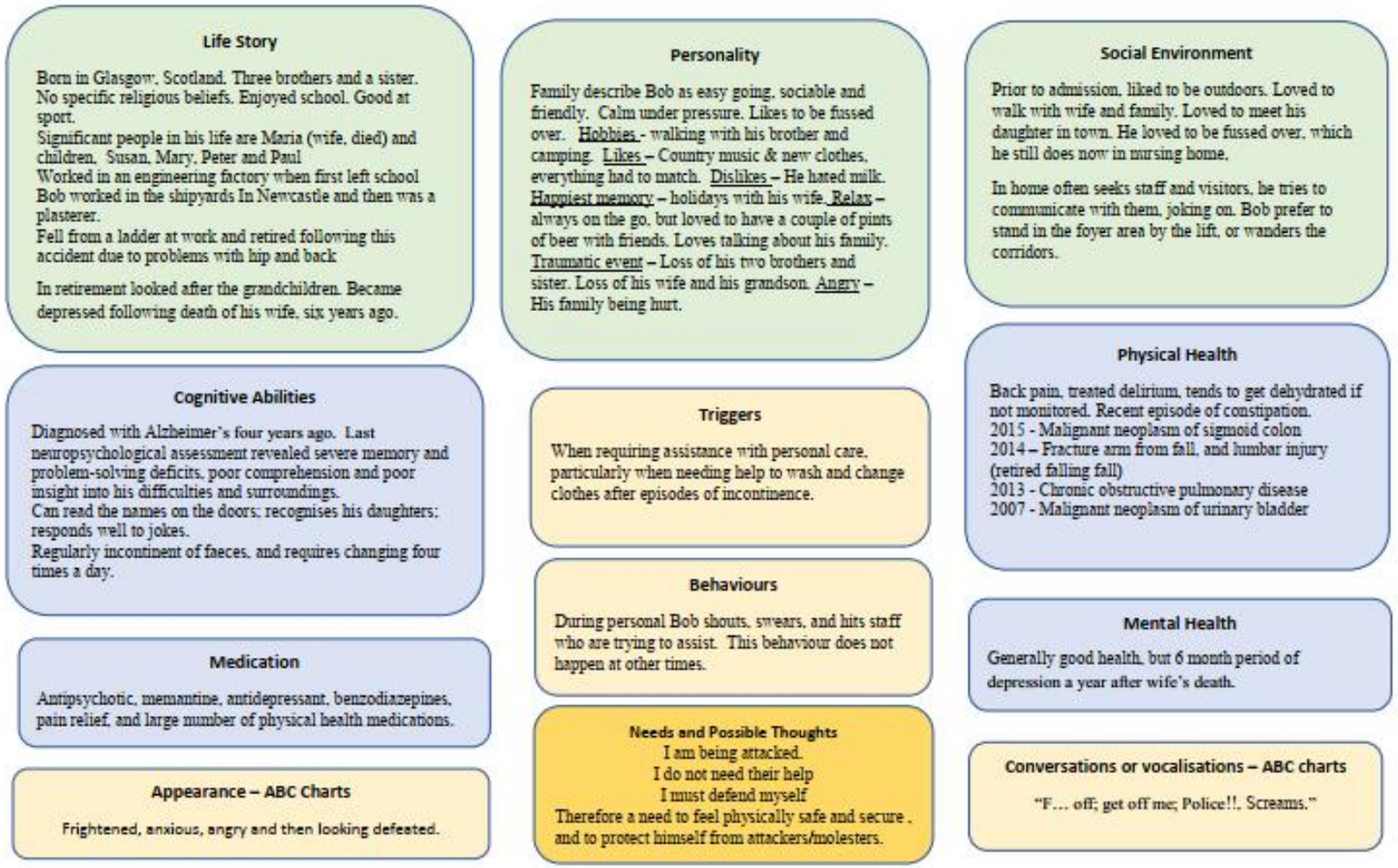

Fig. 2. Newcastle model - formulation of Bob[29]

Table 2. Comprehensive care plan

1. Target behaviour:

- Bob can be resistive to staff when they are attempting to assist him with essential personal care. This tends to be following episodes of incontinence. Bob will attempt to push staff away and hit out at these times.

2. Aim of interventions:

- To ensure Bob's essential care needs are met in a timely fashion.
- To ensure that any restraint interventions used are the most appropriate in order to complete the task quickly and safely.
- To ensure that Bob's health and dignity needs are maintained.
- To ensure that both Bob and staff remain safe.

3. Interventions (to be used only with the person identified)
It is essential that this plan is treated as a last resort option and that the existing medication plan continues to be followed to ensure that every step is taken in an attempt to avoid the need for the use of restraint.
The following intervention was discussed with staff and was felt to be the least restrictive, safe and effective option for meeting Bob's needs.
Once staff notice that Bob has been incontinent, they should attend to him within the following time scales:

- Urinary incontinence and clothing soiled: respond in 30 minutes (staff to approach at least 3 times within this time frame).
- Faecal incontinence and clothing soiled: respond in 5 minutes (approach at least once within this time).

Should existing approaches fail to meet Bob's needs, the following intervention should be undertaken:

- This intervention is to offer a strip wash only. In this instance restraint must not be used to offer a shower/bath (you cannot safely hold someone who is soaking wet!). Should a shower or bath become essential, and restraint necessary to complete the task, then an alternative care plan should be considered and further training delivered.
- Ensure the room is fully prepared.
- Guide Bob to enter a spacious bathroom or the bedroom.
- Once in the room, 3 staff to attend.
- 1 staff member to attend to care and 2 to hold him.
- 2 staff members to take hold of Bob's arms at the same time. Use figure of four arm holds as demonstrated. Ensure bodies are closely aligned in order to restrict movement.
- 1 staff member to attend to care. Give clear and simple prompts/instructions throughout. Use hand signals and model what you are asking Bob to do if necessary as this may help with communication.
- Give him time to process this information.
- Same staff member to undo Bob's clothing while standing behind him. Ensure that they are standing side on while doing this as Bob may kick back or stamp.
- Try and keep Bob covered for as long as possible (he may hold a sheet/towel in front of him or around himself). It is felt that embarrassment is still a significant trigger for Bob's distress.
- Once clothing is undone, it should be removed as quickly as possible. Adapted clothing will help with this as it can be removed very rapidly and with the minimum of fuss.
- Attend to personal care as a strip wash of lower half at

this point.
- Remaining staff member to kneel down and approach Bob from the side as demonstrated (staff should not be directly in front of Bob at any point).
- Once completed, staff to assist Bob to get dressed (allow him to do as much for himself as possible).
- Staff to leave the room as soon as the intervention is complete with one staff member remaining to continue to offer reassurance if necessary and give Bob space to calm.
- Keep Bob under observation for at least the next 60 mins (minimum of every 15 mins) and offer reassurance as required. When he is settled again offer a drink, something nice to eat or attempt to engage in an activity that he may find soothing (refer to activity plan).
- Retain on general observations after this point.
- Complete a body map at first available opportunity after the interventions completed and if any marks are noted then report to relevant parties (family, care manager, GP if necessary etc.) and take appropriate action if any pain or discomfort is evident.

This care plan should be reviewed and evaluated on a regular basis and at least monthly.
It is the responsibility of the home to ensure that staff maintain the skills required to deliver the intervention detailed above.

4. Things for staff to be aware of:

Staff must ensure that an up to date Mental Capacity and Best Interest decision have been completed in relation to this element of Bob's care.

A DoLS (Deprivation of Liberty Safeguards) must also have been applied for that identifies that restrictive physical interventions are being used to deliver essential personal care.

Rationale for use of the intervention:

- To be used when proactive and reactive measures have failed and care is deemed essential.
- In this instance "essential care" means attending to personal care following an episode of incontinence which requires clothing/bedding or incontinence pads to be changed.
- Bob has been assessed as lacking Mental Capacity to make an informed decision pertaining to his personal care needs following an episode of incontinence.
- Following discussion with staff and family members, a best interest decision has been completed in relation to delivering this intervention.
- It has been agreed that should Bob refuse to allow staff to assist him or become resistive during the intervention, then it is in his best interests to have the task completed by utilising the physical interventions/use of restraint as described above.
- Bob's clothing could be altered to make removal easier (e.g. soft backed Velcro in place of buttons or clothing being cut along seams and stuck back together). In this case, ensure that any seams are covered so that the Velcro lining is not in contact with the skin.
- By briefly restricting Bob's freedom to move during these interventions the likelihood of potential harm to both himself and staff is reduced.

Non-essential care:

Non-essential care does not mean that care tasks do not have to be done. It simply suggests there is

a limit to how far we can go and that it is unlikely that we could ever justify using more restrictive interventions to 'force' the person to receive the care.

We should consider the degree of distress that the person experiences when we attend to their care when considering what might be essential and non-essential. It is very difficult to justify causing someone very significant distress if all we are doing is combing their hair or changing clothing that is not overtly soiled. However, we may be able to justify removing someone's clothing and washing them against their will if they have been incontinent of faeces and they lack the capacity to understand the associated risks to their health and dignity.

The following are examples of interventions for personal care that might be viewed as non-essential and can therefore be attended to in an opportunistic manner:

- Washing hair
- Combing hair
- Brushing teeth
- Clipping nails
- Getting changed from nightwear to day wear and vice versa

Essential care:

Essential care is that which could result in significant harm to a person's health or dignity if left unattended for any significant length of time. For the purposes of this care plan, we are thinking about personal care that needs to be delivered following an episode of faecal or urinary incontinence, or after a prolonged period of not having received any intimate care and there are significant concerns about health and wellbeing.

Ensure all staff are familiar with the following safety points:

- Ensure no pressure is placed directly on to the back, chest, head or neck at any time.
- Any forced movement of Bob's arms must be done in line with the natural movement of his limbs and within the scope of what he finds comfortable, while taking into account any other relevant physical impairments. Bob has been observed to have full range of arm movement.
- At no time should pain be used to gain compliance.
- As far as is reasonably possible, the organisation providing care to Bob should ensure that the correct number of trained staff required to deliver the intervention identified in this care plan are available at all times.
- As discussed in the initial care planning training, staff must keep in mind the risks associated with positional asphyxia. It is the responsibility of the person attending to the care to monitor Bob's breathing throughout (the person standing to the right must always be doing this but all staff should maintain a high level of awareness throughout the intervention). Any indication that he is having respiratory difficulties then staff must release immediately and reassess.
- Any marks or injuries that might be sustained during interventions should be body mapped, recorded and the necessary people informed (family, care manager, GP etc.).
- If at any time the interventions appear to be causing Bob prolonged distress, then the care plan should be re-evaluated and further guidance sought.
- It is the responsibility of the care provider to ensure that staff member's skills remain up to date and that they continue to be competent to deliver the care interventions detailed above. It is suggested that a period of no more than 18 months should elapse between training updates.

Due to the high levels of aggression, it was agreed that staff would be trained in Prevention Management of Violence & Aggression (PMVA) techniques [23,24]. The techniques selected were deemed to be appropriate, serving to protect Bob and the care staff at times of high levels of physical confrontation. In the longer term, it was felt that the PMVA techniques were a less restrictive option than the use of sedating and/or tranquilising medications. Indeed, it was felt that the latter would further reduce his ability to self-care and therefore potentially increase the level of distress that both he and staff experienced during interventions.

The use of the care plan supported Bob to be able to remain at the nursing home because staff now felt that they could confidently and competently care for him while minimising the levels of distress and aggression. These interventions protected staff and Bob from any further injuries during episodes of aggression.

4. DISCUSSION

The training material outlined in Table 1 and the case example are resources aimed at improving the confidence and competence of care staff. These materials share similarities with other multicomponent training approaches delivered in care homes to reduce restraint [30]. The training elements outlined above are incorporated within a clinical pathway to ensure clarity of delivery. An empirical assessment of the approach is ongoing, but early monitoring suggests that the quality of the leadership in the care homes impacts on outcome. This is consistent with previous studies were more supportive leadership was related to the use of less restraint [30,31].

The article demonstrates the level of detail and sophistication that is required within the care plans in order to deliver good ethical care in this contentious area. The training, coaching and writing of the care plans often require a lot of resources initially, and this frequently includes specialist external help (eg. NHS staff accredited in PMVA coaching). However, with experience and training many care homes can develop their own expertise relatively quickly.

Part of this expertise will require the setting-up of criteria of what actually constitutes restraint in a specific setting. While some examples are unequivocally forms of restraint (safety belts, arm holds), others are more debateable (eg. bed rails and cot sides). An aspect of the growing competence of a member of staff trained in this area will be their ability to identify alternative responses to the use of restrictive practices (eg. the use of verbal de-escalation techniques [7]). James and colleagues have identified 40 different de-escalation techniques [22].

Managers, staff and family carers should also be given the opportunity to be open and honest about their current practices, which must be labelled unequivocally as ‘restraint’ where force is being used. They also need to be confident in applying restraint when needed without fear of recriminations as part of their duty of care in relation to their residents, selves and colleagues [5].

Staff training is a crucial feature of the comprehensive approach described above [30,32]. Staff need to be offered good quality training that provides them with the knowledge and skills required to deliver the ‘best’ possible care. There should also be the development of a best practice training package [33]. Such a package would highlight: (i) the law relating to this area of care; (ii) how to be person-centred within a lawful framework; (iii) basic de-escalation skills; and (iv) and training in decision-making processes about ‘when and how’ to undertake restrictive interventions. There should be some basic training in how to breakaway safely when feeling threatened and how to safely hold someone to stop them causing harm to themselves and/or others during essential care interventions [34]. The training should also give carers a set of skills they can use immediately which improves their ability to assist residents’ appropriately [31]. Some of the details provided in this paper give practical examples of relevant training resources.

National guidance specifically for caring for those with a dementia is required in relation to this topic; some countries already have guidelines established in this area [3,32].The development of some clear and specific guidelines for staff in the UK would be of great assistance. While there is lots of guidance on how to conduct a mental capacity and best interests assessment for instance [1], there is much less available to assist care staff to manage an agitated person who frequently resists personal care [30,31,34]. It is important that whatever guidance is produced can be easily understood and used by everyone involved in providing care for others. The approaches recommended need to be utilisable in ‘the moment’ and at the point a carer is making a very difficult decision about a person’s essential care.

This article has dealt with a relevant topic within care homes, however, similar problems exist in hospital settings (both acute and mental health). If the paper had addressed NHS settings additional legal guidance would be required 14], placing extra conditions on the use of restraint in inpatient settings. The use of restraint is also a highly relevant topic in ‘home care’ settings. Guidelines have been developed for families and patients living at home, although the implementation of these guidelines is often challenging. A good review of the development and evaluation of a multicomponent training program in ‘home care’ settings is described by Vandervelde et al. [34]

5. CONCLUSION

This article has demonstrated practical approaches to the management of people who become agitated during personal care interventions. It is a common reason why people with dementia are admitted to mental health inpatient units, and a problem in terms of obtaining successful discharges from these units because of an inability to find care settings able to provide help with intimate care tasks. A case study illustrated the comprehensive nature of the care plans needed in the area. Such care plans require extensive training to support the interventions.

In addition to the training, there is a need for further research, as there is a lack of robust evidence that focuses specifically on resistance to personal care amongst people with dementia living in care homes. Steps should be taken to address this, which could serve to underpin a call for changes to statutory and mandatory teaching. It continues to be a struggle to get the issue openly acknowledged by care home managers who remain understandably fearful of the consequences of acknowledging such problems occurring in their units.

Unfortunately, without an overt recognition of this problem from the private and public sector alike a longer term drive to change things nationally seems unlikely to occur. This may be changing gradually with the publishing of national reports and guidance [1,9,14,35] and perhaps staff will now begin to receive adequate training in both the assessment and the delivery of essential personal care. Once this becomes a standard expectation with regards to statutory and mandatory staff training then the situation may improve and ultimately it will be a safer workplace for everyone.

CONSENT

It is s not applicable.

ETHICAL APPROVAL

It is not applicable.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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