

 **try this:**Best Practices in Nursing Care  
for Hospitalized Older Adults  
*with dementia*from The John A. Hartford Institute for Geriatric Nursing  
and the Alzheimer's Association

Volume 1, Number 1, Summer 2003

Series Editor: Cora Zembrzuski, APRN, MSN, CS, PhD (c)

**Avoiding Restraints In Patients with Dementia**

By: Valerie T. Cotter, MSN, CRNP and Lois K. Evans, DNSc, RN, FAAN

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

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

**BEST PRACTICE:** Best practice supports individualized care that permits **nursing the person safely** and without physical or chemical restraint. There is no single instrument to assess the meaning of behavioral communication in hospitalized older adults with dementia. Knowledge about the patient's usual behavior and function is critical to individualizing care. Standardized screening of cognition and to detect delirium should be done at admission and periodically (See *Try This*: Mini Mental State Exam; Confusion Assessment Method).

**ASSESS COMMUNICATION AND BASELINE BEHAVIORS; ASSESS RESTRAINT RISK**▶ **Assess the message in the patient's behavior**

- **Ask the patient what she or he needs:** Many patients with dementia can still communicate needs.

▶ **Consult knowledgeable others:** Ascertain the patient's personal and medical history, typical communication style, behavior, daily routines, and abilities.▶ **Assess for unmet needs and behavioral changes:**

- Use increased confusion and agitation to trigger assessment for changes in the patient's health status
- Assess for hunger, fatigue, sleep deprivation, pain, need to urinate or defecate, infection, obstruction, fear or hallucinations. Listen "beyond the words" to understand the emotions behind what the patient is trying to communicate.

▶ **Use standardized screening instruments on admission and periodically; Use any change from baseline to trigger further assessment:** Screen for cognitive function (e.g., Mini Mental State Exam-MMSE), delirium (e.g., Confusion Assessment Method-CAM), and mobility and transfer performance (ADLs). See The Hartford Institute for Geriatric Nursing website at [hartford.ign@nyu.edu](mailto:hartford.ign@nyu.edu)▶ **Assess behavior that places a patient at risk for restraint use:**

- Fall risk; **restraints do not prevent falls or fall-related injuries**
- Interference with treatment devices (feeding tubes, intravenous lines, sensors and monitors, urinary catheters, dressings, oxygen catheters or mask, ventilators)
- Agitation, restlessness, bed exits

**USEFUL INTERVENTIONS TO PREVENT AND RESPOND TO PATIENT BEHAVIORS**

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

▶ **Communicate clearly, slowly, calmly:** Face the patient; always call the patient by the preferred name; use gestures; relax and smile

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

## **ORGANIZATIONAL STRUCTURE TO SUPPORT RESTRAINT-FREE CARE**

- ▶ Establish a Restraint Reduction committee
- ▶ Review the organization's mission statement, policies; assure committed leadership
- ▶ Use geriatric advanced practice nurses, physicians, and interdisciplinary team consultation for complex patient presentations
- ▶ Provide staff education; consistent staff assignment; access to supportive equipment; technology to support reliable admission data and communication of care strategies
- ▶ Review pain evaluation and treatment protocols
- ▶ Test patient interventions through continuous quality improvement (CQI)

## **REFERENCES:**

- Capezuti, E., Talerico, K.A., Cochran, I., Becker, H., Strumpf, N., & Evans, L. (1999). Individualized interventions to prevent bed-related falls and reduce siderail use. *Journal of Gerontological Nursing*, 25(11), 26-34.
- DeProspero, P., & Bocchino, N.L. (1999). Restraint-free care: Is it possible? *American Journal of Nursing*, 99(10), 26-33.
- Strumpf, N.E., Robinson, J.P., Wagner, J.S., & Evans, L.K. (1998). *Restraint-free care*, New York: Springer.
- Sullivan-Marx, E.M. (2001). Achieving restraint-free care of acutely confused older adults. *Journal of Gerontological Nursing*, 27(4), 56-61.