Physical Restraints and their Avoidability in German Long-Term-Geriatric Care Homes

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Main topics covered in the next 20 minutes

- Facts & figures on physical restraint in Germany
- Legal basis for restraint in Germany
- Reasons given by the long-term care (LTC) industry for why restraints are needed
- Examination of some of these reasons
- The decision-making process and its outcome: physical restraint
- Alternatives and solutions
- The ratio of care and the use of technology
- The role of management in LTC facilities

Development of restraint 1998-2011

Figures for applications approved and refused by German Guardianship Judges

(Source: Bundesjustizamt June 2012; own calculations U. Brucker)

	1998	2002	2008	2009	2010	2011	Changes 1998-2010	Change 2010- 2011
Applications for use of restraints	40,337	71,914	98,299	103,578	106,021	96,788	> two-and-a-half-times +262.8 %	
Approved restraints	38,846	66,888	91,823	96,062	98,119	89,074	> two-and-a-half-times +252.6 %	9.2% drop
Refused restraints	1,491	5,026	6,476	7,516	7,902	7,714	fivefold increase 530 %	
Refusal rate	3.7	7.0	6.6	7.26	7.45	7.97	doubled	

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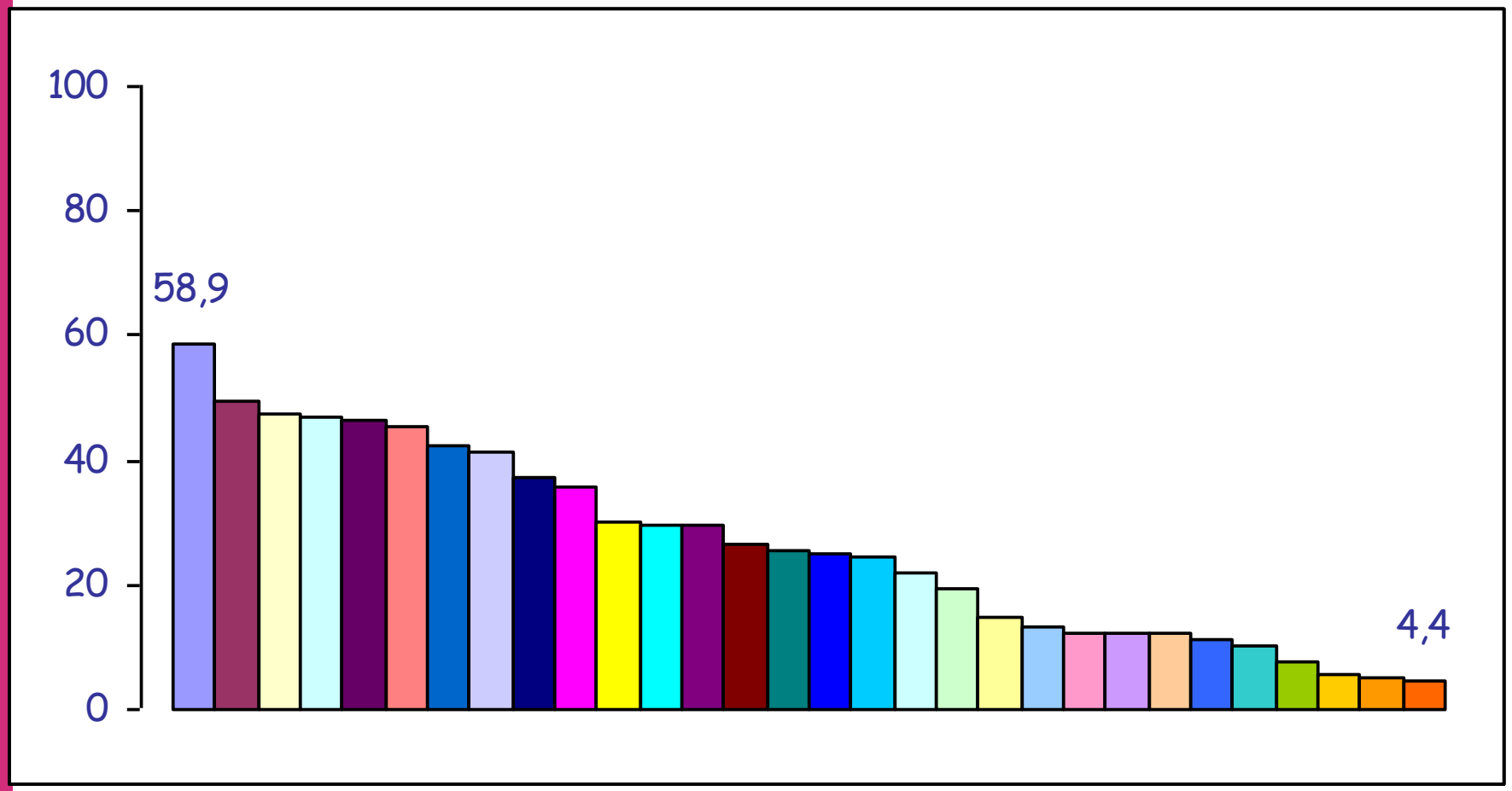
Physical restraints in Hamburg LTC homes

(Meyer G., Köpcke, S. et al., 2008)



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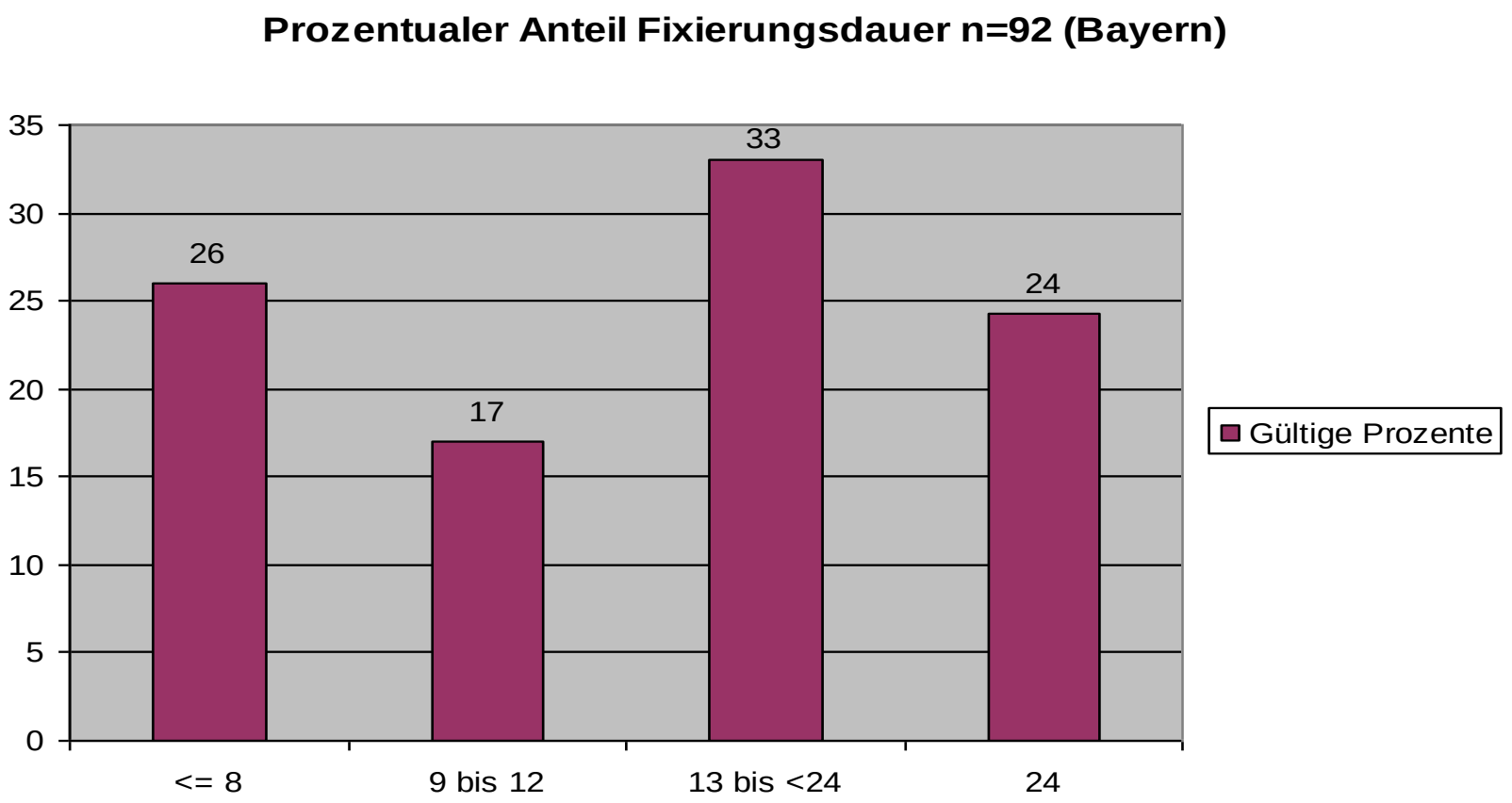
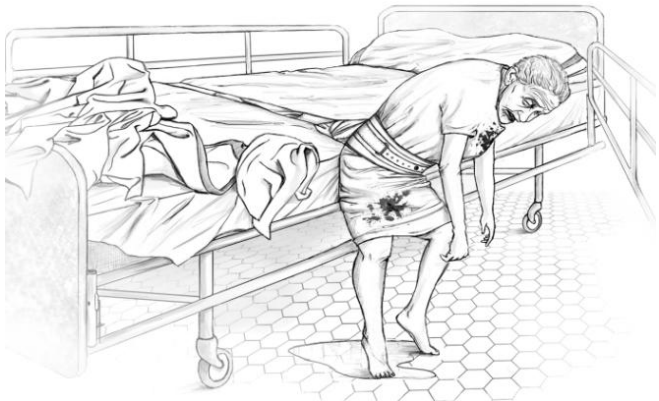
Length of time of daily physical restraints

MDK Bavaria 2011, Dr. rer. medic. A. Herold-Majumdar



Physical restraint is violence towards persons in need of care

Legally mandated force: for the person affected it remains violence



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Reasons for physical restraint
- supplied by the staff of LTC homes

- Staff fear of being held liable
- Restlessness & agitation (persons with dementia)
- To prevent falls
- Internal factors in the home: professional treatment of persons suffering from dementia
- Ignorance of alternatives among judges, GPs, guardians and carers
- Force of habit
- “Community spirit”: identification of “responsibility” and “use of restraint”
- Personal attitude and opinion
- Care “philosophy”

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Reasons for restraint

- Impression: restraint suggests staff has problems in assessing actual needs of residents. Gulpers M.J.M., Bleijlevens, M.H.C., van Rossum, E., Capezuti, E., Hamers, J.P.H., Belt restraint reduction in nursing homes: design of a quasi-experimental study. BMC Geriatr. 2010; 10:11. Published online 2010 February 25. doi: 10.1186/1471-2318-10-11
  - Caring professionals may have problems in decoding the behaviour of persons with dementia: they do not understand the information being communicated
  - They do not understand “Dementish”
  - Non-comprehension of a situation leads to inappropriate conclusions and actions

Reason 1: The staff's fear of being held liable

- **In recent years hordes of lawyers**
- **Spread of fear and scare stories in homes**
- **LTC: "With one foot in prison"**
- **Selective reading of the law on liability**
- **Fear of claims being made by healthcare insurance companies in case of falls and injuries incurring hospital charges**

The staff's fear of being held liable is rarely addressed in studies

What we do not know: realistic estimation and exaggeration

Staff's fear of being held liable creates a frame of mind

Favourable attitude of judges: an application to a judge to allow use of restraints implies:

- **we, the carers, want to prevent residents having falls.** The judicial response is that by allowing restraint, the residents will suffer fewer falls – a perfect solution
- The logic: if an injury occurs, somebody must be responsible. No restraints = residents falling
- The message: no restraints = irresponsible
- Use of restraints (in case of doubt) = a sense of responsibility

Reason 2: Restraint as a means of preventing falls

- **Studies have found no evidence that restraints prevent falls**
- **There is evidence that restraints are not suitable for preventing falls** Capezuti, E., et al., Relationship between physical restraint removal and falls and injuries among nursing home residents. J of Gerontology 53A, M47–M52 (1998)
- **Restraints can lead to more falls and to balance & coordination problems among residents** Evans, D., Wood, J., Lambert, L., Patient injury and physical restraint devices: a systematic review. J Adv Nurs 2003, 41 (3); S. 274-282
- **Restraints involve an increase in mortality risk, in the risk of serious injury and in the duration and frequency of hospital stays** Evans et al. (2003)

Reason 3: Restraints and dementia

- Incorrect care: care is not adapted to the needs of persons suffering from dementia ⇒ chronic stress
- Restricting freedom of movement - above all using physical restraints - intensifies the feeling of being at the mercy of others and of helplessness
- It complicates understanding of the situation
- Immobilization may also foster the development of psychotic disorders
- After just a few hours of restraint, hallucinations and delusions are observed, often associated with significant agitation and aggressiveness (Wojnar, J., 2007)
- Restraint thus risks becoming a “self-fulfilling prophecy”

(From MDS: Principal Statement Dementia, Essen, 2009)

Relation between professional expertise, ethical conduct and the law

- Stress-free care of demented persons: identification of the reasons for challenging behaviour
- From this: deduce alternatives to restraint
- If the outcome of this professional analysis is that no alternatives are available, physical restraint is the *ultima ratio* for the judge/guardian (following the principles of necessity and proportionality)
- Applied professional care thus forms the ethical basis for the legal decision
- **Not** the other way round

What happens in care homes with no or few restraints? What makes the difference?

Solution strategies

- Change in attitudes towards restraints
- Belts removed & bedrails fixed with cable ties
- More care staff
- Strategies involving volunteers
- Staff training in preventing falls and in communicating with persons with dementia
- Consultation with relatives
- Case conferences
- Individualized day reception structures

From Meyer and Köpcke (2008)

Pathway to the decision: restraint

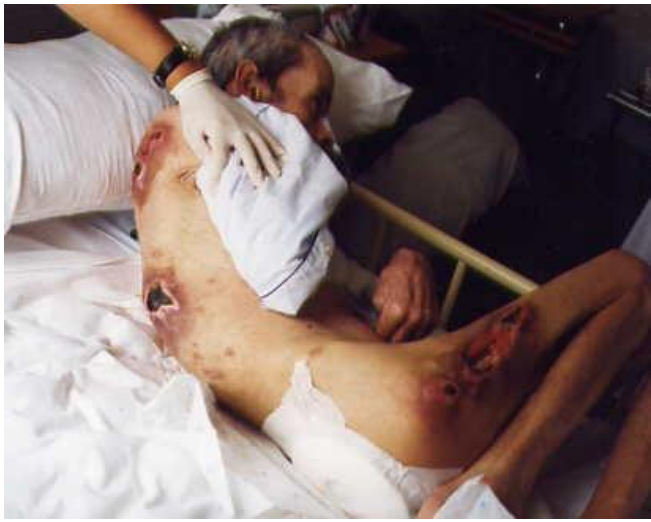
- **Legal guardian consults the nurse**
- **Judge approves restraints: decision depends on information and nurse's assessment**
- **Guardianship authority: information for its opinion comes from the nurse**
- **GP: must rely on information from the nurse**
- **Procedural curator = professional lawyer**

Thus all participants consult the NURSE: her information forms the basis of the decision

Decision network for or against restraints

?

Potential consequences of restraints (1)



- Reduction in body functions
- Circulatory disorders
- Cardiovascular load
- Incontinence & infections
- Muscle loss & pressure sores
- Agitation & social isolation
- Psychiatric diseases
- Severe injuries & death
- Sudden death by acute stress (Laposata, 2006)
- Older adults with dementia have the highest risk of all patients of being restrained when hospitalized

Potential consequences of restraints (2)

- **No** evidence that restraints reduce the risk of falls. **Quite the reverse**: consistent evidence of increased risk of falls and injuries

  (Feinsod, Moore, Levenson, 1997; Bredthauer, 2002; Rubenstein, 2002; Evans, Wood, Lambert, 2003; Berzlanovich, 2008)

- Increased requirement for clinical observation and increased need for assistance in the activities of daily life

- Reduced quality of life (Holweg, 1997; Haut, Böther, Hartmann, 2007)

- Statistically proven: increase in manpower requirements of 67–75%! (Phillips, Hawes, Fries, 1993)

Death by restraints and bedrails

(Berzlanovich, 2010 http://www.fh-fulda.de/index.php?id=9017)

N=33; 82% of them persons with dementia

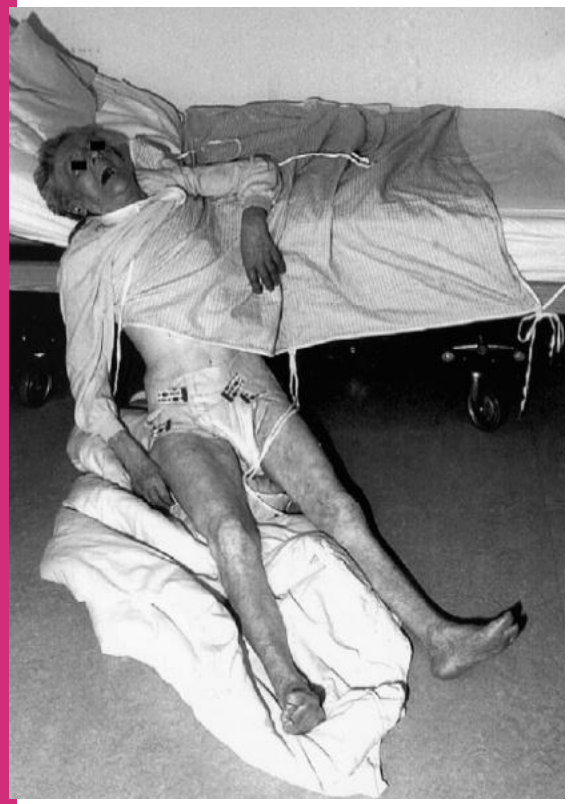
Time between last contact alive & time of death

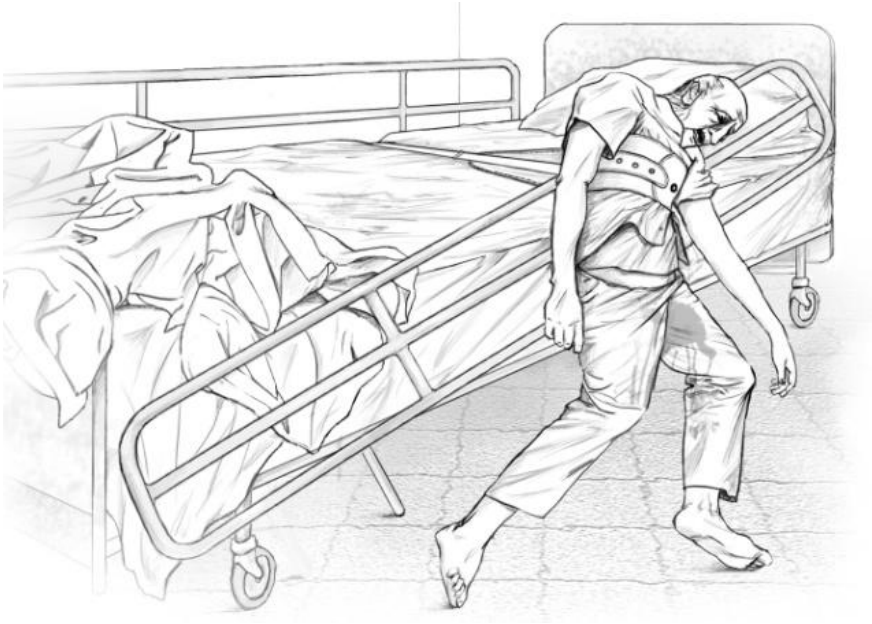
Nursing home: 3-4 hours; hospital: 1 hour 40 minutes

Causes of death:

- Strangulation: 8-10 minutes (19)
- Thorax compression: 20-25 minutes (3)
- Head-down position: 30-45 minutes (11)

Implications for the frequency with which restrained patients are visited





Solutions: Technique. Caring. Management

- Interventions (education and training & technical aids): ⇒10-20% reduction in restraints (redufix et.al.)
- Interventions + authority: 85% reduction in restraints: X-belt study (Gulpers, Bleijlevens, Capezuti J Am Geriatr Soc 2011)
- Time of restraints/medication “on demand”: at night, at the weekend, over public holidays (Supervisory Authority of Munich, 2012)
- Training: are all employees bound to follow what they learn?
- Or is it merely an interesting contribution to the diversity of opinions?

The central role of management

- Labour law gives the director of a nursing home authority
- He/she is able to prohibit the threat or use of restraint and “medication on demand”
- In Bonn (Germany) bedrails are fixed using cable ties and there has been no increase in the incidence of falls and injuries

Procedural variation in the courts

- No hearing that seeks approval for restraints can take place without a court-appointed **special advocate**
- Traditionally: Special advocate = lawyer
- Now: Special advocate = LTC professional looking after the interests of the patient
- Training arranged by the guardianship and supervisory authorities using experts in LTC

“Yes, we can”

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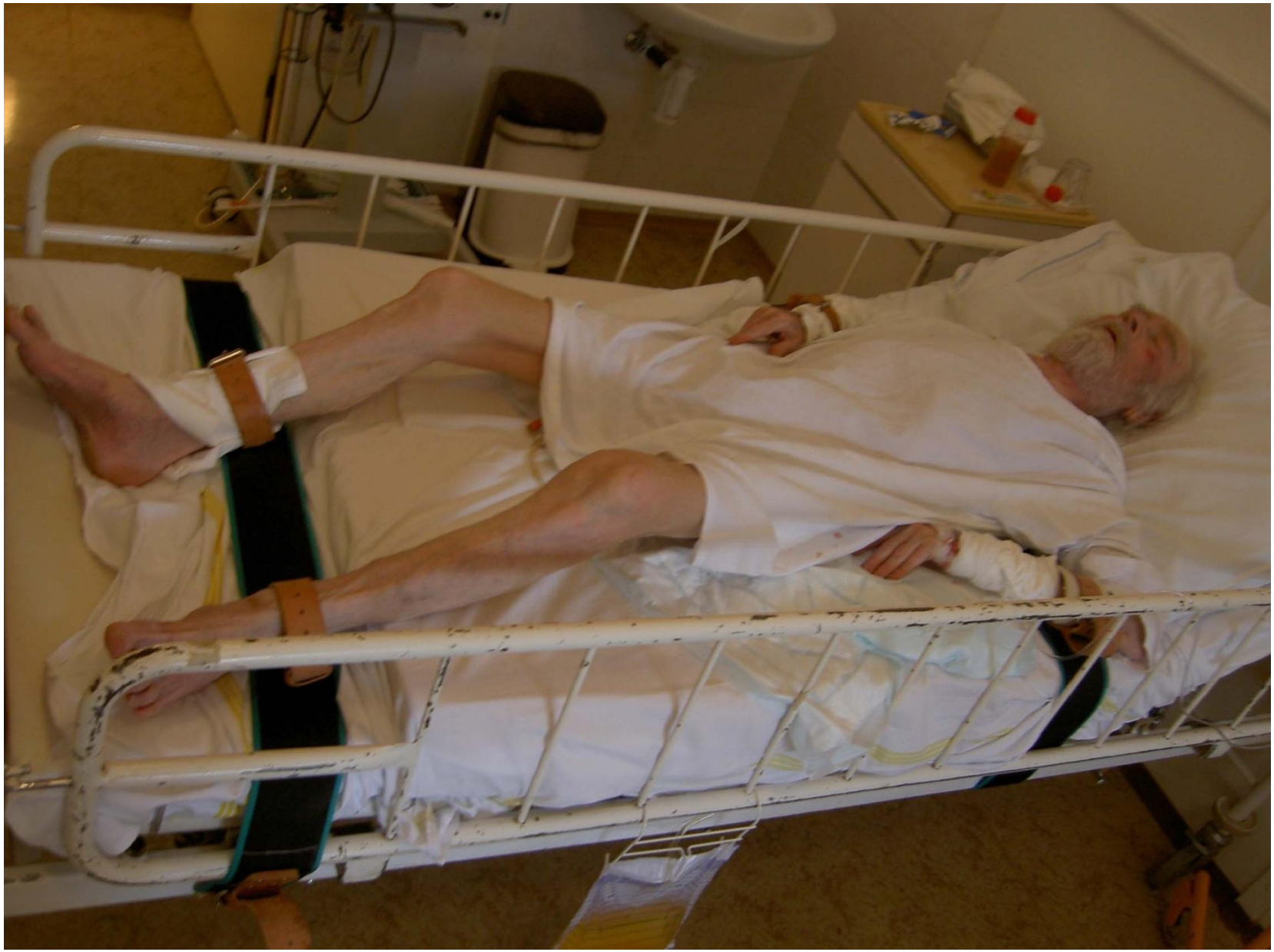

Thank you for your attention

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