Restraints in ICU

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Introduction

This isn’t actually about restraints; it’s about the ethos of ICU units in a country emerging from a particular history....

The fractures and tensions in society are mirrored in the clinical area – especially because it is ‘cutting edge’.
South African Illness Context

• **Patient acuity** $\uparrow$ (HIV/AIDS, TB, violence, accidents & multiple trauma, chronic diseases (e.g. Cardiac & Diabetes), acute infectious diseases)

• **Resource constraints** – financial, ICU beds, equipment, personnel
  – “Haemorrhage” of medical and nursing staff across the board

  • Registered ICU nursing staff $\downarrow$ - increased use of non CCR/N & non R/N staff
Problem

Personal observation: physical restraints are routinely used in certain intensive care units and less so in others.

- “Safety” given as explanation but..

- Clinicians *morally* responsible to ensure patient dignity, autonomy and protection from harm?

  ? Dichotomy
Methodology

Multi-method design:

- **Quantitative: observational study**
  - Site – 3 intensive care units in a public, academic-affiliated hospital in Johannesburg, South Africa
  - **Instrument: Checklist**
    - no & % patients restrained
    - type & measurement of restraints
    - duration of restraint
    - sedation & analgesia prescribed & administered
    - staff patient ratio
## Patients restrained in ICUs

<table>
<thead>
<tr>
<th>Category</th>
<th>ICU 1</th>
<th>ICU 2</th>
<th>ICU 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of patients (beds occupied)</strong></td>
<td>132</td>
<td>55</td>
<td>32</td>
<td>219</td>
</tr>
<tr>
<td>Patients restrained</td>
<td>93</td>
<td>3</td>
<td>10</td>
<td>106</td>
</tr>
<tr>
<td></td>
<td>(70%)</td>
<td>(5%)</td>
<td>(31%)</td>
<td>(48%)</td>
</tr>
<tr>
<td>Patients not restrained</td>
<td>39</td>
<td>52</td>
<td>22</td>
<td>113</td>
</tr>
<tr>
<td></td>
<td>(30%)</td>
<td>(95%)</td>
<td>(69%)</td>
<td>(52%)</td>
</tr>
<tr>
<td>Patients sedated / on analgesia</td>
<td>36</td>
<td>1</td>
<td>10</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>(27%)</td>
<td>(31%)</td>
<td>(31%)</td>
<td>(21%)</td>
</tr>
<tr>
<td>Restrained &amp; not sedated/ on analgesics</td>
<td>57</td>
<td>2</td>
<td>0</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>(61%)</td>
<td>(31%)</td>
<td>(0%)</td>
<td>(56%)</td>
</tr>
</tbody>
</table>
# Days restrained in ICU and range

<table>
<thead>
<tr>
<th>Category</th>
<th>ICU 1</th>
<th>ICU 2</th>
<th>ICU 3</th>
<th>Total Av. in 3 ICUs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average</strong> number of days in ICU with restraints in situ</td>
<td>9</td>
<td>12</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td><strong>Range</strong> of days in ICU with restraints in situ</td>
<td>1-54</td>
<td>11-13</td>
<td>1-21</td>
<td>1 - 54</td>
</tr>
</tbody>
</table>
### Daily Registered Nursing Staff: Patient Ratio (Average)

<table>
<thead>
<tr>
<th>Category</th>
<th>ICU 1</th>
<th>ICU 2</th>
<th>ICU 3</th>
<th>Total in 3 ICUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average no. nursing staff on unit per day</td>
<td>11</td>
<td>7</td>
<td>10</td>
<td><strong>9</strong></td>
</tr>
<tr>
<td>Average staff patient ratio</td>
<td>1:1</td>
<td>1:1</td>
<td>1:1</td>
<td><strong>1:1</strong></td>
</tr>
</tbody>
</table>

“Registered nursing staff” includes CCRN, ICU students (R/N) and R/N not registered in the specialist capacity.
Methodology (contd)

Qualitative study:

- **In depth interviews** with medical & nursing clinicians;
  - Audio-taped & transcribed or written recording (n=1) & thematically analysed
  - Themes & sub-themes extrapolated
- ‘Specialist’ Peer FGD of emerging themes
- **Observation** (unstructured) and field notes
- Journaling
Population & Sample (Clinicians)

Purposive sampling:

- Medical and nursing practitioners registered in or experienced in ICU practice
- Currently working, teaching or supervising students in ICUs (public and private)

• Ethical requirements:

- University HREC, Provincial Directorate, Hospital Management and Unit Medical & Nursing Management permission obtained. Consent obtained from all participants for voluntary inclusion.
Participants

• Medical participants x 5
  – All specialist practitioners and 3 with ICU as a sub-speciality

• Nursing participants x 15
  – 11 registered ICU Nurses 3 – 20 years experience
  – 1 area /section manager (not ICU registered)
  – 3 ICU experienced R/N (1 a student in ICU course)

• FGD = specialist focus group discussion x 5
  – All registered ICU nurses with experience in clinical practice, clinical supervision and education
Themes

• **Restraint – a balancing (and contested) act**
  • Judicious diagnosis & management needed
  • Weaknesses and dangers conceded

• **Benefits**
  • Patients’ benefit
  • Clinicians’ benefit

• **Communication**
  • Among the doctor/nurse team
  • Nurse / patient and family

• **Team experience**
  • Lack of communication, cohesion and collegiality
    *(Leading to restraint?)*
Restraint – a balancing ( & contested) act

• There’s ways of doing things without having to restrain, talk to them, increase the oxygen – what is the need to restrain? They’re unnecessarily restrained a lot. (Nurses 5 & 7)

• You have to establish a balance, limit ventilation to prevent VAP. In government hospitals the pressure is on the beds; but the patient is confused, it’s hard to judge. We probably use them too frequently but we don’t have much of an alternative (Doctor 4)

• ..one on one! What are they doing? (Nurse 3)
Restraint – a balancing (& contested) act

• We don’t have a problem (with restraining); we limit sedatives, they delay discharge from ICU and prolong ventilation (Doctor 1)

• So what do they do? They tie them down! (Doctor 3)

• There are instances when restraints are appropriate (Specialist nurse FGD nurse 2)

• Patient rights yes; but apply those rights judiciously (Doctor 4)
Conclusion

All participants agreed there is a place for restraint in ICU

• Difference in the reasons
  – Experienced & specialist nurses & 3 doctors – nuanced: need to assess the reason for patients agitation/distress, examples given and alternative methods of managing patient posited
  – Others: ‘Scope of Practice’ and patient safety cited as reason for restraining patients

Literature:

60% restrained pts self extubate
Restraint has significant side effects (Evans et al 2002; Bray, Hill et al, 2004)
Theme: Benefits

Patients’ benefit:

• You see this tube it’s very irritating, they pull them out!! You must protect the airway! What about the cricoid? Recurrent intubation is not good. (Nurses 1, 6 and 10)

• Increased hospital acquired pneumonia and also the more they thrash about and pull their ET tubes out, the higher the incidence of tracheo-oesophageal fistula (Doctor 1)

• Your patient needs to be safe. It’s the scope of practice. (Nurses 1, 6, 12, 14, 15)
Theme: Benefits

Nurses’ Benefit

• ..for the benefit of the patient – I doubt it! ..it’s the benefit of the nurse! More for staff convenience than patients’. .. you can get fat very quickly in ICU – always in the tea room! (Nurses 4, 5 and 7)

• It’s usually because the nurse can leave the patient. They’re used without adequately assessing the patients to leave them unattended (Specialist Nurses 2 and 3).
Theme: Benefits

• Nurses’ Benefit

• Often not well thought through. Very often its done from an ease of nursing rather than the doctors or nurses thinking about it. (Doctor 3)

• Most of the time they’re used for nurses’ benefit – it’s easier to restrain than it is to sit next to his bed and talk to him and help them through (Nurse 8)
Conclusion

Conflicting answers (and a lot of anger and scepticism) expressed

– Nurses: Yes: 6 No: 5 Neutral: 4
– FGD: Yes: 1 No: 3 Neutral: 1
– Doctors: Yes: 1 No: 2 Neutral: 2
Theme: Communication: documentation

• Must be prescribed, we prescribe, it’s pretty strict (Doctor 5)

• The doctors will never give you a restraining order... very wary; they won’t prescribe - they know what’s going to happen; have you ever seen injuries from restraints? They won’t prescribe but if the tubes come out they shout! (Nurses 5, 6 and 7)

• No, the staff put them on (Doctor 1)

• ...written prescription. Um... often you can just ask them to prescribe it after, just to make it legal (Nurse 8)

• No, no prescription or protocol, um.. verify it on the ward round, I suppose we need to pick up on it (Doctor 4)
Yes, there is a policy but they’re not prescribed – we’re covered by (Drs name). No, doctors don’t prescribe, we (nurses) prescribe, they don’t ratify it but they’ll ask “is the patient restrained”? I feel OK about that. (Nurse 10)

There is a policy, we looked at it because we thought we might need to change it (Doctor 2)

The doctors prescribe, I’ll diagnose the problem and he’ll prescribe.. they trust me to be on top of things and I’ll tell them what is wrong, liaise and discuss the problem. They trust me... (Nurse 9)
Communication – patient communication

• Communicate, sedated is not deaf. Explain repeatedly, they get amnesia. If they’re restrained then I know the nurses haven’t been talking to the patient, and they haven’t told me what the problem is. (Doctor 2)

• Usually there’s some biological problem, treat it. If you can explain then you don’t have to restrain. (Nurse 9)

• The patient needs an explanation and this needs to be constantly repeated and the person and the family reassured. (FGD nurse 2)
Communication – patient communication

• "we had really good nurses, streets ahead of the doctors! They took it as normal to liaise with families, explain to the patient, sit with them. We don’t have that anymore. (Doctor 3)

• Talk to them, explain to them, reassure them; then you don’t have to restrain. Nurses don’t talk to the patients; it’s a problem. (Nurses 2 & 8)

• I would be horrified (to see a relative restrained). Nurses used talk to patients... but now, um, a lot of the time it’s ... in the culture you don’t complain, ..a far less challenging culture. (Doctor 4)

• If patient is unconscious then it’s the family that needs you to talk. (Nurse 4)
Communication - Team experience

• Window dressing—smart and fancy (*re private ICUs*) but the care is just as bad! Used to be total nursing care. You were independent, proud of what you did. It’s just a job, everyone knows that you get paid more. (Nurse 7)

• 50 to 60% of ICU nurses are agency. The standard of care is poor. To say “because of safety” means you’re not sensitive to the problem. Inadequate sedation or a new physiological disturbance, relieve his pain! Nurses aren’t equipped, current training is a problem; equally the doctors, the current number of well trained doctors is small. (Doctor 2)

• ..need to have knowledge ..what it does to the patient, physically, emotionally, legally! (Nurse 12)
Team experience

• ..the whole ethos of nursing has changed ..many patients are badly handled medically as well. (Doctor 3)

• There’s no team any more. Team, we had it! We were passionate, they trusted us! ..we knew how, adjusting, weaning patients – now you come on and they’ve turned them back – they’re too lazy or don’t know.. (Nurse 2)

• Nurses - they’re defensive, they don’t want you to help them, even if they obviously don’t know; they think that you’re criticising them. (Nurse 7)
Researcher Observation

- **Patient/Nurse communication**
  - Patients in cubicles – high level of acuity
  - 1:1 allocation nurse/patient
  - Monitored via TV screens from nurses’ station
  - Nurses in cubicles when effecting patient care only
  - No nurse/patient interaction noted
  - Projection of hostility

- **Hierarchical organisation**
  - Very little collaboration, multidisciplinary interaction in the unit
  - Ward rounds – doctors accompanied by MIC, not primary nurses; no inter-disciplinary discussion
  - Attempts to encourage nursing team cohesion by MIC of units noted
  - Hostility, mistrust, defensiveness, passivity
Conclusion: Team

Factors impinging on team cohesion & collaboration:

– **Social** - gender, class, economic & professional status (profession/union); professional/sub professional (increasingly)

– **Educational** – university/college; Continuing education /ad hoc in service education

– **Organisational** management & supervisory - revision to hierarchical form; executive/management/worker status

– **Situational** - mistrust, hostility, defensiveness, burnout

– **Language** – scientific western/traditional; English/vernacular

– **Tension** - responsibility & accountability vs. autonomy

– **Economic** - resource constraints – beds, skills, personnel
Ethical reasoning:

- **Nurses**
  - generally - legalistic and rigid
  - experienced – nuanced: care, principle based, utilitarian, virtue, ‘golden rule’

- **Specialist Nurses** (focus group discussion)
  - Experience and knowledge evident – more flexible

- **Doctors**
  - principle based
  - 1 ‘golden rule’ & rights based
Interaction in the unit tense and defensive. Very little trust evident between the disciplines.

Trust, collegiality, communication, team cohesion and respect need to be actively fostered to ensure that interventions employed are used judiciously and with care for therapeutic reasons and not to perpetuate vertical oppression and violence.
Thank you
Recommendations

• **Increase professional & interdisciplinary Interaction**
  
  • Inter-disciplinary clinical and ethical ward rounds; encourage nuanced ethical reasoning by means of values clarification, discussion, case studies
  
  • Reinforce need for communication - written, collegial, inter-disciplinary, patient & family
  
  • Team building
    • Encourage social and professional collaboration
    • Inter-cultural learning
    • Mandatory multi-disciplinary clinical ward rounds
  
• **Enforce policy regarding prescribing, monitoring & documenting restraints**

• **Encourage family involvement**

• **Reinforce patients’ rights; emphasise human dignity**
References


References


Legislation & Policy

Restraint (Mental Health Act No 18 of 1973; no explicit guidelines in new Mental Health Act No 17 of 2002)

Patients’ Rights Charter – Everyone has right to be free from the use of unauthorised force to restrain their movement