

# Restraints for Residential Aged Care Facilities

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## **Policy Statement**

Residential Aged Care Facilities aim to maximise the well being and safety of residents/clients and ensure they retain their individuality and sense of control over their environment for as long as possible. Restraint can be physical, including waist ties, locked doors, water chairs, recliners and tables positioned to restrict or prevent movement. They can also be chemical, including intentional use of medication to control behaviour or sedation for convenience or discipline.

## **Policy Guidelines**

- The least restrictive option is to be used, with restraint viewed as an undesirable and unnecessary “last resort”.
- Alternative approaches, such as behaviour management, should be used, including effective communication, consideration of physical and emotional needs, changes to the environment and the use of personally relevant activities to promote personhood and provide distraction.
- Before using any form of restraint, a risk assessment should be completed and all alternatives exhausted.
- Before using any form of restraint, the person’s family, and GP must be consulted and, where possible, a geriatrician or psychogeriatrician and the Guardianship Tribunal consulted.
- The person responsible cannot approve restraint but needs to be involved in decision making (as the restraints may be seen as abuse).
- Physical restraint requires consent by a guardian to approve restraint as appointed by the Guardianship Tribunal.
- Chemical restraint is a “special treatment” and requires an application to the Guardianship Tribunal for consent to administer.

- There is provision for “emergency care” or use of restraints without consent. The emergency must be described by the health care practitioner involved.

## **Management Strategy Options**

- Medical review to rule out physical or psychological cause of behaviour.
- Personal history to assess personal preferences, stressors, coping mechanisms etc.
- Behaviour charts to identify behaviours, triggers and assist in management planning.
- Include a range of evidence-based , good practice strategies in the service and support / care plan as listed below.
- Communication techniques, including eye contact, direct statements and verbal reassurance.
- Music therapy, including dancing and singing. It is hard to be angry when you are singing.
- Behaviour Modification, including positive reinforcement or the reward of desirable behaviour.
- Environmental manipulation, eg. round paths or restriction of mirrors, if the PWD sees strangers in them.
- Recreation, including walking and exercise.
- Cognitive Orientation Therapy, including Reality Orientation, particularly in early stage dementia.
- Social Therapies, including day care.
- Emotion Orientated Therapies, including Validation and reminiscence.
- Simulated Presence Therapy e.g. playing taped messages from family about cherished memories.
- Educate the carer and include in planning, by phone or in person.
- Pleasant Events Schedule, including activities that are person-centred, appropriate and fulfilling in the daily and weekly routine.
- Recreational activities and distractions, including the use of pets, dolls and familiar aromas from their past.
- Document what works and tell everyone!

This is not an exhaustive list and professional advice should be sought as required.

Call Commonwealth Care Link, 1800 052 222 for local resources.

Call the National Behaviour Advisory Service, 1300 366 448 for respite services.

## **References**

Adrian, A 2003, ‘Consent clouded by dementia.’, *NRB Board Works* (11) May. Nurses Registration Board of New South Wales.

*Agitation in the older person with dementia: A guide for families & caregivers* 2003.[www.psychguides.com](http://www.psychguides.com)

Haddard, A. 1999, 'Ethics in action.', *Acute Care Decisions* (62) 5. May

*Reducing Behaviours of Concern: A hands on guide*, National Dementia Behaviour Advisory Service Alzheimer's Australia, 2003.