RELATIVES PERCEPTION ON THE USE OF PHYSICAL RERAINTS IN THE CARE OF THE ELDERLY
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ABSTRACT

The perception of relatives of elderly patients on the use of physical restraint was explored. A literature search was conducted and a paucity of published work on the topic was revealed. A pilot interview and six semi-structured interviews were conducted in one of the hospitals under the Health Services Executive.
A descriptive design was used and themes were identified with the Miles and Huberman (1994) framework. The three themes that emerged were:
• Perceived meaning of physical restraints.
• Participants perceived alternatives to physical restraints.
• Participants perceived advantages and disadvantages of physical restraint.
The findings suggest that the relatives have mixed perceptions towards the use of physical restraints in the care of elderly. It was apparent that as much as the relatives emphasized safety as the reason for the use of physical restraint, they also had concerns about the disadvantages of its usage. It was also revealed that as much as the relatives would have loved to be involved in the decision-making process on the use of physical restraints, they were not involved neither were they educated about the use.

INTRODUCTION

The impact of an increased ageing population is focusing attention on the quality of services for the older people. Commonly accepted clinical practices, such as restricting the older patient’s freedom under the premise of safety, are now being subjected to increased scrutiny. Accordingly, physical restraints, which is believed to be a form of preventive measure against falls in the elderly, is now considered to be a form of abuse rather than a way of preventing falls (Gallinagh et al., 2001; Gallinagh et al., 2002; Hamers et al., 2004; Huizing et al., 2007; Moore and Haralambous., 2007; Chuang and Huang., 2007).
Several studies have been carried out over the years on the care of the elderly, resulting in a vast number of publications, including those on the use of physical restraints on the older patients. However, information is scarce on the perceptions of relatives of these elderly patients on long-term care on the use of physical restraints on some of these patients. As efficient carers, nurses have a crucial role in providing excellent and efficient care, as well as educating patients and relatives on the need and relative importance of some decisions about their patients.
BACKGROUND

This topic was chosen because the area of research is of particular interest to the researcher who has worked in a gerontology unit in the past ten years. The interest on this topic also arouse because of the researcher’s personal and observed experiences during the course of discharging her duty. Although nurses provide the majority of patient's care in hospitals, it is important to stress that family members are also involved to a certain extent. It is imperative to note therefore, that nurses cannot replace the functions of family members who wish to participate in the physical and emotional care of their elderly relatives (Li et al., 2004).

SIGNIFICANCE OF THE STUDY

The study, which is particularly orientated towards exploration and discovery of a Phenomenon of reality, explored the knowledge, understanding and the feelings of relatives of elderly patients on the reasons for the use of physical restraints. It is therefore, believed that the findings of this study will improve family and health professionals’ relationships on ways to enhance practice towards the patients and contribute greatly to the knowledge of how to deal with physically restrained patients, particularly with reference to the Irish healthcare context. The study will provide insight into the perception of relatives' of elderly patients in long term setting on physical restraints. The importance of educating the relatives of the patients and nurses on how to go about the use of physical restraints when necessary is of relative importance and will without doubt reduce the conflict that nurses experience during ethical decision making regarding the use of restraint.

OBJECTIVES

The study objectives are:
1. To explore participants understanding of physical restraints in care of the elderly.
2. To increase older peoples family’s knowledge and awareness of physical restraints use and alternatives.
3. To improve practices in restraints assessment and usage.

LITERATURE SEARCH

The literature search for this study was based on the strategy suggested by Polit et al., (2001) and it involves consultations with librarians when doing literature searches. Therefore, the first part of the literature search of this study was done in consultation with the Librarian at the Health Services Executive (HSE) library in Dublin. To answer relevant questions, the search focused on publications in English language, which appeared between year 2000 and 2008. It is the belief of this researcher that this period will reflect a lot about what is known on the subject. Initial searches were done using various electronic databases of
Psychinfo, Ovid, Medline and Cumulative Index of Nursing and Allied Health (CINAHL). The keywords used were physical restraint, aged/elderly, long term care, nursing homes and family perception. From the initial searches, relevant articles on the subject were selected. This was then followed by a search of the references in the selected articles. A manual search was also carried out using various combinations of the keywords. In total 41 articles were found to be relevant to the study.

**LITERATURE REVIEW**

The use of physical restraints in the care of the elderly is a controversial and emotive issue in nursing, which has received increased attention from researchers, institutions, and government in recent years. Commonly accepted clinical practices, such as restricting the older people’s freedom under the premise of safety are now being subjected to increased scrutiny (Frengly, 1999 as cited by Gallinagh, 2001). Questions are being raised about the reasons and effectiveness of the use of restraints and its consequences on patients. Despite the extensive body of literature debunking the myths of physical restraints and initiatives to raise the awareness of patient autonomy, this practice is still very common in residential care settings (Evans et al., 2002; Hamers et al., 2004; Cheung and Yam., 2005; Moore and Haralambous, 2007; Chuang and Huang, 2007).

Physical restraint can be defined as any device, material or equipment attached to or near a person’s body, which cannot be controlled or easily removed by the person and which deliberately prevents or is deliberately intended to prevent a person’s free body movement to a position of choice and or a person’s normal access to their body (Gallinagh et al., 2001; Gallinagh et al., 2002; Mott et al., 2005; Gastmans and Milisen, 2006).

Physical restraint includes, but not limited to bedside rails, screw-on table tops, bed clothes, tipping chairs, wheelchair belt when not in transit, manipulation of furniture, limb and wrist restraints, applying break to wheelchair against patients will, putting walking stick out of patients reach and putting wheelchair out of the reach of a wheelchair bound patient (Gastmans and Milisen, 2006). On the other hand, chemical restraints are medications used as part of the treatment of a patient's condition in order to control the patient's behaviour.

According to Wilson, (2000) the use of physical restraints is widespread in various nursing homes and hospitals. Anecdotally, it has commonly been reported that restraints are used to prevent patients’ harm (Gallinagh et al., 2001; Gallinagh et al., 2002; Harmers et al., 2004; Chuang and Huang, 2007; Moore and Haralambous, 2007; Huizing et al., 2007), but this therapeutic function is still a subject of controversy. Various modalities of physical restraints have so far, been reported in the literature, with bilateral and unilateral bedrails and belts being the most frequently used (Hammers et al., 2004; Moore and Haralambous, 2007)
FACTORS RELATING TO THE USE OF PHYSICAL RESTRAINTS

Several factors relating to both residents' clinical conditions and the resources of the nursing facilities have been suggested to promote restraint use (Pekkarinen et al., 2006). In all the literature reviewed, a major reason cited for the use of physical restraints by nurses in the care of the elderly is falls prevention. (Gallinagh et al., 2001, Gallinagh et al., 2002; Hamers et al., 2004; Huizing et al., 2007; Moore and Haralambous, 2007; Chuang and Huang, 2007; Tilly and Reed, 2008). However, this justification has been researched extensively, and presently, is no longer considered the main motivating factor underlying nursing decisions to initiate restraint. In fact, certain authors have shown that restraint devices do not prevent incidences such as patient falls (Arbesman and Wright, 1999 as cited by Gallinagh et al., 2002). Rather, untoward events, including deaths caused by asphyxia are believed to be major consequences of restraint use.

Non-compliance with therapy is believed to be a more accepted rationale for the use of physical restraints, than falls prevention. This is reinforced by greater acuity in conditions, and increasingly invasive character of therapies (Minnick et al., 1998 as cited by Gallinagh et al., 2002).

Another major factor relating to restraints use is the patient's proximity to the nurses' station. Patients who are not easily seen from the nurses' station due to the size of the ward and location of the patient, when the nurses' are in a sitting or standing position would be more likely restrained (Gallinagh et al., 2002; Moore and Haralambous, 2007).

It was also found out from the literature that decrease in staffing levels is related to increase in restraints use (Castle, 2000; Gallinagh et al., 2002; Pekkarinen et al., 2006; Moore and Haralambous, 2007; Huizing et al., 2007). Majority of patients usually restrained are those mainly dependent on nursing staff for their care (Hamers et al., 2004; Huizing et al., 2007; Moore and Haralambous, 2007). Patient confusion has also been suggested to be a significant reason for the implementation of physical restraint in the elderly patients (Gallinagh et al., 2002; Hamers et al., 2004; Huizing et al., 2007). Anxiety, agitation or aggressiveness both verbal and physical, wandering and resistance to direction are other factors that have been shown to be related to the use of physical restraints (Moore and Haralambous, 2007).

The use of physical restraints in the care of the elderly has been suggested in some studies to be gender related (Gallinagh et al., 2002; Hamers et al., 2004; Huizing et al., 2007). Past studies (Gallinagh et al., 2002; Hamers et al., 2004; Huizing et al., 2007) indicated a trend that restraints were more used in women than in men. Gallinagh et al., (2002) found 35% of men and 65% of women had restraints applied in their study. The study of Huizing et al., (2007) also showed 21.4% of the patients restrained were male and 78.6% were female.

There was also an association in the age of patients restrained. Restrained patients tend to be older than their unrestrained counterparts. The study of Gallinagh et al., (2002) showed the average age of the restrained patients was 77 years and unrestrained patient 75 years. Hamers et al., (2004) in their study
carried out in two Nursing homes in Netherland also found that restrained residents were older than unrestrained ones. Pekkarinen et al., (2006) were of the opinion that physical restraints are used more frequently in units where heavy jobs demand coincides with lack of control for nursing staff. This is in agreement with other findings (Gallinagh et al., 2002; Wang & Moyle, 2005; Moore and Haralambous 2007; Huizing et al., 2007) where it was found out that decrease in staffing levels is related to increase in restraint use.

Furthermore, it was asserted that restraint practices could be influenced by many other factors such as physical environment, institutional policy, nursing staff's knowledge about restraint and attitudes towards the use of physical restraints (Karlsson et al., 2000; Gallinagh et al., 2002; Pekkarinen et al., 2006; Moore & Haralambous, 2007).

**EFFECTS OF PHYSICAL RESTRAINTS ON THE ELDERLY PATIENTS**

Many psychological and physiological consequences of restraint use are documented in the literature. In general, the use of physical restraints does not reflect the rationalised nursing care since the preventative function of therapeutic restraint mechanism has not been proven. Accordingly, their use may result in the very problems that they are supposed to overcome (Gallinagh et al., 2002; Evans and Fitzgerald, 2002; Hamers et al., 2004; Pekkarinen et al., 2006), with those who have their freedom limited by a physical restraint more likely to be chemically restrained.

In the literature, two categories of physical injury were identified to be associated with physical restraints. The first category is associated with the direct impact of the restraint device on the patient. These injuries include laceration, bruises, nerve damage, ischemic injury, asphyxiation and sudden death from strangulation. The second category is related to the injuries as a consequence of the enforced immobilization. These include reduced functional ability, loss of muscle tone and contractures (Evans et al., 2002; Evans et al., 2003; Bourbonniere et al., 2003; Morh et al., 2003; Capezuti, 2004; Cotter, 2005; Mamun and Lim, 2005; Demir, 2007).

Other adverse effects of physical restraint are catecholamine rush due to escalating agitation and thrombosis due to prolonged immobile period (Morh et al., 2003). The repercussions of the second group of injury are more profound in older people because it can lead to extended period of hospitalization, development of pressure ulcers, falls, incontinence and longer hospital stay (Evans et al., 2002). It has also been reported that the morbidity and mortality rates are eight times greater in restrained patients than those unrestrained (Cheung and Yam, 2005).

In addition to physical injuries, many restrained patients also suffer from psychological harms. Reactions like anger, fear, denial, demoralization, humiliation, confusion, depression, agitation and regressive behaviours are often expressed by patients who have been restrained (Evans et al., 2002; Evans et al., 2003; Morh, 2003; Mamun and Lim, 2005; Moore and Haralambous, 2007; Huizing et al., 2007; Demir, 2007).
NURSES ATTITUDE TOWARDS THE USE OF PHYSICAL RESTRAINTS

Different researchers reported that nurses' attitudes have an influence on the use of physical restraints in the care of the elderly (Gallinagh et al., 2001; Huizing et al., 2007). Gallinagh et al., (2001) in their study carried out on the relatives' perception of side rail use on the older person in the hospital described the use of side rails as a ritualised common practice in gerontology care. Gallinagh et al., (2002) further described the use of restraints in the care of the elderly as a routine, traditional and reactive approach. Moore and Haralambous, (2007) found out that nurses' reported not knowing enough about alternative approaches to restraint use. They perceived that harm from restraint only occurred if the restraint was incorrectly applied or the patient's assessment was not thorough. Furthermore, it was observed that nurses' reported that family members sometimes insist on the use of restraints, especially side rails (Gallinagh et al., 2002).

Hantikainen and Kappeli, (2000) found resident safety as the justifiable reason for restraint use. Most nurses agreed that there were both negative and positive aspects of restraint, and many saw physical restraint as a protection of staff members from liability. Restraint use was also seen as a legitimate means of controlling aggressive or disrupting behaviour and maintaining the peace and harmony of the environment for the well-being of all residents. Nurses were broadly in agreement that the decision to apply restraint was one for the nurse handling the situation rather than an institutional policy. Because restraint was understood in a variety of ways, decisions were often based on routines, emotions and attitudes rather than empirical facts.

Karlsson et al., (2000) were of the opinion that it was unclear whether nurses were confronted with the dilemma of ethics or merely absenting themselves from the decision-making process. They believed that nursing staffs should read a clinical vignette to measure their reasoning in a hypothetical situation. They were of the opinion that nurses found 'caring' to be a complicated task and requested more contextual detail before making a decision to apply restraint.

The decision to apply restraint is in most cases, associated with a disease perspective, for example, if a resident had dementia and did not comprehend what was good for him or her. Nurses usually found the decision-making process of applying restraint to be complicated and the majority would change the decision under different circumstances. Consistent with other studies (Karlsson et al., 2000; Hantikainen, 2000; Werner and Mendelsson, 2001; Kock et al., 2006), Chuang and Huang, (2007) indicated that nursing staff members would use more physical restraints in situations where the safety of the older person was at stake.

The decisions of nursing staff to use or not to use physical restraints with older people are usually accompanied by the feeling of ambiguity, frustration, powerlessness and unease. In spite of the internal struggle, nurses' still use restraints, believing that their use would prevent falls and other fall-related problems (Karlsson et al., 2000; Koch et al., 2006; Pekkarinen et al., 2006). In order to move forward, nurses as individuals must carefully reflect on practice and re-appraise the stance to counteract these benefits.
Lai, (2007) found out that nurses expressed dissatisfaction with hospital management regarding the pressure placed on them to reduce fall rates and restraint use. This finding is in line with that of Chuang and Huang, (2007) where nurses demanded managers and hospital policy-makers to give their strong support if they use physical restraints properly or create a restraint-reduction environment. Hantikainen, (2001) questioned nurses caring for older people with physical frailties and/or moderate cognitive impairments. Rank-ordered reasons for restraint use were protection and safety; preventing injury and harm to other residents; restlessness, aggressiveness, resistance to treatments and confusion. Furthermore, the application of restraint was to control a situation perceived by nurses to be unacceptable behaviour, or a deliberate attempt to cause distress to staff members. Nurses held differing views on restraint use and what it involves and exhibited both positive and conflicting attitudes toward its use. They likened the decision-making task of restraint use to walking a moral and ethical tightrope. Yet, often restraint decisions were largely based on nurses rights and environmental considerations rather than the wellbeing of residents. As a way of absolving themselves from the responsibility of decision-making, staffs believed that resident’s behaviour would need to change before they could limit restraints use.

Chuang and Huang, (2007) in their study in Taiwan on nurses’ feelings and thoughts about using physical restraints on hospitalized older patients reported how nurses struggled between patients’ autonomy and practice of care. Thus nurses’ personal thought may influence their decisions on physical restraints use as not all published data till date supported the use of restraints. Given increased emphasis on efficacy of nurses’ practice, there is the need to underpin their work with a rationalized evidence based approach.

Because of this development, the Irish Nurses Organisation (INO, 2003) produced guidelines on the use of restraints in the care of the older person to help with clinical governance. The guidelines suggested that those who use restraint should justify their actions and that restraints should only be used when all other nursing interventions have failed.

In support of these findings, Moore and Haralambous, (2007) in their study on barriers to reducing the use of restraints in residential elder care facilities in three care of the elderly homes in Australia, explored staff, families and residents perception about why restraints are used and the barriers to removing them. Most of the families perceived that reducing restraints will increase potential harm rather than with the restraints. Although family members recognised the emotional distress that restraints can cause, they felt without restraints, serious physical injuries were likely to occur and these were considered to be of greater concern than emotional distress. Relatives also reported that when nurses applied restraints for the purpose of resident safety (as opposed to staff convenience); this was best practice available although they have no knowledge of alternative to restraints.

Another challenge in the care of the elderly and the use of physical restraints is the growing number of care assistants working in long-term care (Werner & Mendesson, 2001; Wang & Moyle, 2004), whose limited health education
encourages a focus on reaction rather than the assessment and evaluation of care as a means of preventing residents agitation. While it is essential that all levels of staff must be involved in restraint education, it is ultimately the registered nurse who must be accountable for both assessment and evaluation of restraint use. In most of the literature reviewed, it was evident that nurses' use restraints for fear of litigation and negligence (Moore and Haralambous, 2007; Chuang and Huang, 2007).

From a legal perspective, Dimond, (1995) ascertains that the impedance of a person's freedom is unlawful; exceptions being temporary protection of individuals from themselves or others.

**RESTRAINT USE FROM A LEGISLATIVE AND ETHICAL PERSPECTIVE**

The use of restraints in long-term care facilities is believed to be a method of decreasing the risk of falls and wandering, and to control inappropriate behaviours. There is now a trend away from the use of restraints towards alternative methods. However, when no alternatives are available, to decrease the risk of harm to the resident or others, restraints may be used. To ensure residents' rights and the safe use of restraints, nurses and other caregivers must understand the need to balance the risks of possible harm and their legitimate use. Restraints use is often accepted and justified by beneficence, the ethical principle that conveys the intention to promote good and avoid harm to another person (Ellerton, 2002).

The use of restraints has always been an ethical dilemma. Keating and Smith (2000) defined ethical dilemma as a situation in which the most ethical course of action is unclear, when there is strong moral reason to support each of several positions, or when a decision must be made based on the most right or the least wrong choice of action. To determine if restraints usage is ethical requires consideration of ethical principles of autonomy, non-maleficence, beneficence, fidelity and veracity outlined by Keating and Smith, (2000). To these is added justice by Beauchamp and Childress, (2001).

When speaking of quality of life, one can speak of a resident's condition as being unbearable due to an illness or pain and this can also be said of a patient that is restrained (Blais, 2004).

**Autonomy:** The principle of autonomy asserts that a capable and competent individual is free to determine and to act in accordance with, a self chosen plan and can rightfully, decide their own destiny and should be allowed to make their own evaluations, choices and actions, so long as these do not interfere with the liberty or freedom of others (Keating and Smith, 2000).

Beauchamp and Childress, (2001) described autonomy as self-rule that is free from both controlling interference by others and from limitations that prevent meaningful choice. It is important to keep in mind that competent patients are allowed to make their own autonomous decisions and that an incompetent person still has rights that endure after decision making capacity had ended. When a resident is not competent, the next of kin is expected to make decisions on their behalf with full disclosure of the likely risks and benefits and informed consent obtained before physical restraints is used (Long, 2004; Blais, 2004; Cheung and Yam 2005).
In principle, a patient should receive treatment only after consenting to it. Consent as rooted in the Irish constitution guarantees bodily integrity (INO, 2003). The use of a restraint, therefore, runs contrary to the principle of consent. However, the Irish law also recognises that in many cases restraints are necessary to ensure a right even higher than the right of consent which is the right to life. Although many institutions often ask family members to consent to the restraint of an incompetent or unwilling adult patient, such consent has little legal effect. In law, only the adult individual can give a valid consent (INO, 2003). Beauchamp and Childress, (2001) also assert that being a person with dementia, does not necessarily imply that a resident is incapable of making his own decision and consent treatment, as people with dementia may have periods when they are lucid and competent. Loss of mental functioning should not be taken as a reason to limit a person’s responsibilities about his affairs. It does not follow that people with reduced capacity to exercise their autonomy should loose it completely. Their autonomy should always be respected although their ability to understand or retain information before making complex decisions may be slow. Unless a third party is at risk of serious injury or public welfare is in jeopardy, overriding a refusal of restraint is ethically wrong. There is no ethical justification for the application of restraints as a punitive measure when caregivers are distressed, angered or threatened by a patient, as such practice could be dimmed abusive (Cheung and Yam, 2005).

The ability of human beings to make choices must always be respected in the context of physical restraint (Cheung and Yam, 2005; Weiner et al., 2003). From this derives the ethical norm that caregivers, when considering the use of physical restraint, should inform competent older persons and their relatives as fully as possible about the various options. They should provide information as objectively as possible and in a way that is understandable to older persons and their relatives, about the various treatment possibilities, their nature and aim, their pros and cons, as well as effects and risks. Caregivers, older people and their relatives should attempt to arrive at a wellconsidered choice on the basis of this information (Gastmans and Milisen, 2006).

When making decisions about physical restraints, not only the physical well-being of the older person should be taken into account, but also the social, psychological and moral dimensions of their well-being (Weiner et al., 2003; Gastmans and Milisen, 2006). Physical restraint is justified only if the benefits outweigh the shortcomings. The benefit can be physical, psychological or social in nature; therefore physical restraint methods should be considered only if older people’s health, integrity or living and caring environment would be seriously damaged by not using them. There should be a reasonable or proportionate relationship between the physical restraint and the harm it intends to avoid (Gastmans and Milisen, 2006).

**PHYSICAL RESTRAINTS USE AND THE OLDER PATIENTS’ RELATIVES**

Very few studies have explored the family’s perception on the use of physical restraint on older patients in long-term residential care. Gallinagh et al., (2001) investigated relatives perceptions on the use of side rail; which has been found to be the most commonly used restraint method in the care of the older person in
the hospital (Hamers et al., 2004). In the study, relatives revealed mixed perceptions towards the use of side rails. Some relatives highlighted that if nurses feel secured by using them, they are also contended, as it is a precautionary measure. They believe that side rails aid movement in bed and around the bed, although they are not specifically designed for this purpose. Others see the use of side rails as a tradition in the care of the elderly. However, none of the relatives in the study could suggest any alternatives to the use of restraints, but feel side rails should be modified like padding or mesh.

In a study carried out in Israel, Hendel et al., (2004) found 92% of participants supporting the patients’ right to participate in the decision to restrain, with 67% of the participants believing in the patients’ right to refuse restraint. About 40% of participants were of the opinion that care providers have no right to restrain patients’ against their will. Most of the participants believed in the family’s right to refuse restraining a family member, while 70% believed families should participate in decisions concerning restraining, as also indicated in the studies of Koch and Lyon, (2000) and Nay and Koch, (2006). However, in spite of the perceptions regarding the negative effects of restraining patients, most respondents supported occasional restraint use when needed to prevent patients’ from harming themselves and or others.

Frequently, family members express concerns and distress about physical restraints use and potential risks. Nurses should be prepared to include family members in their decisions and explain the policies and alternatives. Sometimes, persuading family members to spend additional time with the patient may eliminate the need for restraints. Preparing clearly written policies and materials aimed at giving information and answering common questions about restraints and their alternatives is another way of developing families trust and confidence in the staff and increasing family member’s involvement. This may also increase family member’s satisfaction with the care provided to their relatives (Hendel et al., 2004).

On the other hand, Koch and Lyon, (2001) found out that it was difficult to convince some older people and/or their family that restraint should not be used because they see bedrails and seatbelts in use in other institutions and as such did not see anything bad in it. Nay and Koch, (2006) revealed that some family saw a secure environment as one without risks, and as such the efficacy of restraint use and the emotional and physical effect it may exert on an individual, as well as the legal requirements of the facility, should be discussed with the residents and their families.

**REMOVAL, REDUCTION AND ALTERNATIVES TO RESTRAINT USE**

Although several alternatives to restraints have been proposed in the literature, the efficacy and safety of these interventions have not been evaluated prospectively for their individual contribution to fall reduction and injury prevention among high-risk older people (Capezuti, 2004).

Restraints are used mostly to reduce fall and injury, which often has multiple causative factors. Optimal resolution therefore will require multiple interventions that rely on coordination by means of interdisciplinary dialog and action (Capezuti, 2004). Comprehensive assessment, coordinated care management, and individualised intervention plans targeting identified risk factors have been
found to be the most successful strategies to reduce restrictive devices and approaches to implementing these strategies such as staff education, consultation with individual patient and relative and institutional models of care (Koch and Lyon, 2001; Capezuti, 2004).

Moore and Haralambous, (2007) in a study in three care of the elderly homes in Australia on barriers to reducing the use of restraints in residential elder care facilities, explored staff members, families and residents’ perception on why restraints are used, and the barriers to removing them. Most families perceived that reducing restraints will increase potential harm rather than with its use. Although family members recognised the emotional distress that restraints can cause, they felt without restraints, serious physical injuries were likely to occur and these were considered to be of greater concern than emotional distress. Relatives also reported that when nurses applied restraints for the purpose of residents’ safety (as opposed to staffs’ convenience); this was best practice available although they have no knowledge of alternative to restraints.

Lai, (2007) in his study found out that nurses expressed dissatisfaction with hospital management with regard to the pressure they felt was placed on them to reduce fall rates and restraint use. Nurses expressed doing their best and emphasized that better communication among all stakeholders will be significant in resolving the use of restraints. This opinion is in line with that expressed in the study of Chuang and Huang, (2007) where nurses demanded strong support from managers and hospital policy-makers if they use physical restraints properly or create a restraint-reduction environment. Nurses also requested that specific workable and supportive protocols and guidelines should be provided as a supportive practice environment that will give them more confidence in their care and more freedom to try out alternative methods of restraints.

Several studies (Capezuti, 2004; Wang and Moyle, 2005; Pekkarinen et al., 2006, Chiang and Hang, 2007; Knox, 2007; Ludwick et al., 2008) indicated the need for employers to support on-going education in restraint use, including creative alternatives. Such education will encourage staff to consider different behaviour patterns of residents’ agitation, rather than to act upon it when it occurs. Staff education in encouraging the use of alternatives to restraints has demonstrated reductions in usage in both the nursing home and acute care settings (Capezuti, 2004; Wang and Moyle, 2005).

The most significant results however, have been shown with a combination of staff education and interdisciplinary team or advanced practice nurse consultation (Wagner et al., 2007). Regardless of intervention type, several authors (Koch and Lyon, 2001; Capezuti, 2004; Nay and Koch, 2006; Darcy, 2007) recommended strong administrative support to ensure long-term restraints reduction.

Nay and Koch, (2006) and Knox, (2007), emphasized the need for support ‘from the top’ i.e. the Director of Nursing must be seen supporting the idea in principle and in practice. This will assist in overcoming barriers such as initial extra costs, different models of care, and lobbying of relatives and other health professionals. Nay and Koch, (2006) highlighted that existing institutional culture is a major obstacle to restraint minimization. For this culture to shift, staff at all levels must
adopt different work ethics. It was indicated that restraint minimization practices were most effective when implemented within an organizational context that stated a clear philosophy, had well-developed policies, implemented comprehensive client focussed assessments and incorporated programme evaluation. Best practice related to minimal restrain use was seen as optimal when all staffs were aware of the policies and philosophy, liaison with families, and interdisciplinary collaboration and evaluation encouraged.

Koch and Lyon, (2001) asserted that with the provision of alternative care, physical restraints could be safely and drastically reduced. Successful removal was grounded in staff’s education, commitment of staffs’, residents and families and in alternative equipment. They also acknowledged that physical restraints are not able to neither guarantee against nor prevent serious injury. In a restraint free environment, care plans should become more individualised and lead to increased communication and interaction between staff and residents. Information gained from family members and their cooperation will assist greatly in the removal of restraints, and the development of a new and individualised care plan that will focus on relaying issues of concern to management.

Koch and Lyon, (2001) also found most alternatives were inexpensive and additional staffs were not required when physical restraints use was removed. They argued that success for a restraint-free environment was facilitated through the commitment of senior members of staff. However, in spite of the commitment to be restraint-free, they discovered that over 65% of residents remained restrained in some way, mainly by the use of bedrails. In response to its use, staffs’ perceive that bedrails were necessary for the maintenance of residents’ safety.

Broadly speaking, the perspective adopted by researchers as reported in the literature included, nursing staffs with inadequate knowledge about restraint reduction or restraint alternatives on the one hand (Koch and Lyon, 2001; Capezuti, 2004; Nay and Koch, 2006; Darcy, 2007; Lai, 2007; Ludwick et al., 2008), and those who opt to maintain their own sense of comfort and security over the autonomy and dignity of patients (Cheung and Yam, 2005). Nurses seem to have been identified as the crux of the problem in restraint use. However, it needs to be understood that nursing staff may be victims in the system. More often that not, discussions in the literature fail to note that management might be one of the possible obstacles to restraint reduction because of too much bureaucracy in place and with a stance that placed great emphasis on the consequences of falls. It was also found out that registered nurses have a significantly higher level of awareness of the negative effects of restraint than nursing staff that are less highly educated, as the less highly educated staffs were unable to identify physical injury, depression, skin trauma, and humiliation as probable consequences of restraint, thus affecting the minimization of restraint use.

Darcy (2007) in her study found out that most staff members felt that management and families expected them to protect the resident at all costs for fear of litigation, but the focus has changed from the type of restraint to be used to the intention behind the use of restraint. If the reason is for risky behaviour,
then the use of restraint can be minimised, because with the support of management and family, staffs can take risks instead of restraint use. The commitment to provide quality care and quality of life for residents in long-term care facility is evident. But it is important that the concept of risk taking is seen as an integral part of life, and is not denied to the older person. If risk taking is denied, then the holistic nature of nursing is affected (Koch et al., 2006).

Hantikainen (2000) found out that nursing staffs could be overly protective and not take and accept more risks from older people in spite of possible unwanted consequences. Excessive interference in the lives of older people should be avoided as much as possible, and they should be allowed to express themselves. This in turn may help to uncover the motives for and possible consequences of their behaviour.

**METHODOLOGICAL ISSUES**

From the studies reviewed, different research approaches were used, including qualitative, quantitative and mixed research tools. To identify the most appropriate research methodology for this study, there is the need to review the research methods and perspectives in the reviewed studies. Sample sizes in the studies ranged widely. Although there is no simple formula for sample size in qualitative studies, it is however, acknowledged that the larger the sample size, the better for representativeness of the total population, and that small sample sizes create sampling error (Polit et al., 2001). Qualitative studies adopted a phenomenological approach with an appropriate sample size of between 9-20 participants as observed in the work of some authors (Gallinagh et al., 2001; Hantikainen, 2001; Ludwick et al., 2008).

Sample settings involved mostly long-term care facilities and few gerontology units in acute hospitals. The study populations included a mixture of residents, registered nurses, care staff and families of residents. Most of the studies used physically restrained residents (e.g. Gallinagh et al., 2001; Bourbonniere, 2003; Mamun and Lim, 2005; Koch et al., 2006). Very few studies included an explicit statement regarding inclusion and exclusion criteria.

Lai (2007) conducted focus group interview to determine the perspective of nursing staff on the use of physical restraints and participants were staff who volunteered to be interviewed. Dunn (2001) subjects consisted of all the elderly residents residing in a long-term care facility except one resident who is less than 65 years of age. Participants involved those who were restrained and those that were not. Some studies did not discuss inclusion and exclusion criteria at all; in for example, Koch et al., (2006) and Ludwick (2008) while others provided few details (Gallinagh et al., 2001; Mamun and Lim, 2005). Gallinagh et al., (2001) and Lai (2007) used semi-structured interviews. Unstructured interview was used by Koch et al., (2006) and structured interview by Kirkevold and Engedal (2004), while Dunn (2001) used incident reports from case notes. Mamun and Lim, (2005) and Wagner (2007) reviewed medical records of residents. Karlsson et al., (2000), Werner and Mendelsson, (2001), Weiner et al., (2003) and Hamers et al., (2004) employed the use of questionnaires.
A longitudinal observational approach was used by Gallinagh et al., (2002) and descriptive cross-sectional study by Demir (2007). Majority of the researchers discussed issues of reliability and validity but only a few addressed the issue of study limitations. Identified limitations of study designs included two data points, which may not have provided a refined test of characteristics associated with increasing and decreasing use of physical restraints (Castle, 2000). Hantikanen (2001) employed the use of an interpreter because the participants do not speak researcher’s language. The tension between subjectivity and objectivity during data collection and analysis may have an impact on neutrality. Gallinagh et al., (2001) and Dunn (2001) identified small sample size and exclusively focusing on one care of older person/rehabilitation ward.

The time chosen for data collection may have effect as observed in the work of Dunn (2001) as staffs were aware that reduction and/or elimination of physical restraints was the focus. Secondly, the data collection tool did not identify what total percentage of residents in the facility had physical restraint during the period because data were obtained only from incident report records.

The sample design limited the result of the study of Hendel et al., (2004) because in convenience sampling, participants might be atypical of the population. Another limitation was that the study instrument was created for the study. Thirdly, the study did not explore in depth the cultural factors influencing public attitudes of Israeli citizens towards physical restraint. Chuang and Huang, (2007) identified their study limitation as having all participants as female nurses, while in Ludwick et al., (2008) participants were mainly nurses from the medical surgical unit, with a relatively small number from other different shifts, and of different ages and background.

The aim behind this research is because no study of such has been conducted in Ireland in the past. Gallinagh et al., (2001) did conduct a similar study in the United Kingdom; however, the focus was only on bedside rail. From the definition of physical restraints, it is clear that focussing on one type of restraint will not adequately explore what families perception on the use of physical restraint is.

**POPULATION, SAMPLE AND SAMPLING**

The term population connotes the entire number of participants that meet the inclusion criteria for a particular study (Polit and Hungler, 1999). The target population for this study are the relatives of elderly patients who have or are experiencing physical restraints use.

A sample on the other hand, is a subset of the units that make up the population (Polit and Hungler, 1999). The sample for this study consisted of eight relatives. Purposive sampling was used for this study on the premise that the participants possessed certain unique knowledge and experiences about the phenomena to be studied as suggested by Polit and Hungler, (1999).

The sampling involves selecting people from the accessible population to form the representative of the entire population (Polit et al., 2001). The appropriateness of the sample will be assured by the use of nonprobability (not every person will have a chance to be selected). They should be those that are willing to disclose their in-depth feelings and thoughts about their experiences, in order to facilitate the understanding of the phenomena.
In collaboration with the gatekeeper, twenty relatives who met the inclusion criteria were recruited. The use of a gatekeeper generally facilitates the smooth running of the study and can enhance the willingness of the participants to cooperate (Holloway and Wheeler, 2002). The participants were handed an information pack each containing the participants information guide explaining the research topic and formally inviting them to the study (see appendix 2), a consent form to be endorsed (see appendix 3), and a copy of the interview guide (see appendix 4). Among the twenty recruited relatives, seven showed their willingness to participate in the study and signed the consent form.

**SAMPLE SIZE**

There are no rigid established rules, which determine the size of the qualitative sample (Holloway and Wheeler, 2002). Qualitative researchers tend to study smaller samples but in-depth (Holloway and Wheeler, 2002). Cohen (1999) supports this by stating that sample size in phenomenological studies is usually small. According to Streubert and Carpenter, (1999) sample size does not matter as long as it can reach a point of saturation in which no new information appears forthcoming on the same topic using the same participants. Kitzinger (1996) suggested a sample of four to eight. Burns and Grove, (2001) do not give a definite number but emphasize that recruiting a small sample size is not uncommon in studies meant to examine a phenomenon into its depth.

**INCLUSION AND EXCLUSION CRITERIA**

The inclusion and exclusion criteria were formulated with the inputs from the literature review. Inclusion criteria require that participants must be:

- Relatives of elderly patients who have had a recent or ongoing experience of physical restraint use in a long-term ward.
- Eighteen years of age or over as only these are recognised in the society as adults.
- A regular visitor to the patient and have the ability to comprehend the purpose of the study and able to communicate their feelings on the subject.
- Have a close relationship with the patient, such as next of kin or person named on the patient’s chart. Only one member of the family will be invited to participate in the study.

Exclusion criteria require that the following groups of people will be excluded from participating in the study:

- Relatives who seldom visit
- Relatives of residents who are less than sixty-five years of age.
- Individuals who are not relatives
- Relatives whose culture forbids probing into personal life.

**STUDY SETTING AND ACCESS**

The study site is one of the hospitals under the Health Services Executives (HSE) in Dublin. It consists of six care of the elderly ward, two Alzheimer’s care wards, one day-care centre, two young adult chronic disabled wards, one drug detoxification ward and one Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) ward; with each of the wards accommodating twenty-four patients at any point in time either as respite or as long-term care. At the time of conducting this research, the study site had no
research ethics committee, thus approval to conduct the study was obtained from
the Research Ethics Committee, Royal College of Surgeons in Ireland, (Appendix
1). Thereafter, the application requesting access to the study site was forwarded
to the Director of Nursing of the Hospital (Appendix 5). After the approval of the
Director of Nursing, the gatekeeper, a Clinical Nurse Manager 2 in one of the
care of the elderly wards was consulted on the ways and modalities of the
research.

DATA COLLECTION

Data collection in qualitative research involves gathering narrative data from the
participants through interactive processes, for example interviews and
observation and the researcher is considered part of the data collection
instrument (Burns and Grove, 1997). Data collection describes the process
whereby information relevant to the study research questions are systematically
gathered (Burns and Grove, 2005).

Consistent with the qualitative approach, semi-structured interviews were used.
Polit and Beck, (2004) suggested that in the semi-structured interview, the
researcher has a list of topics to cover rather than specific questions to ask.
Semi-structured interviews are especially effective in exploring relatively new or
uncharted areas such as the perception of patients’ relatives to physical
restraints in the care of the elderly. They facilitate the identification of the
prevalent basic issues, opinions and behaviours (Polit and Beck, 2006).

Semi-structured interviews in a relaxed atmosphere are seen as ideal to
facilitate the researcher to probe participants with questions (Parahoo, 1997).
This methodology gives some amount of freedom to the interviewees to define
and concentrate on the areas they wish to cover and yet provides road map for
the interviewer to limit risks of derailment in the course of the interview. The data
for this study was generated through a pilot interview and six semi-structured
interview.

PILOT STUDY

Before the research proper, a pilot study was carried out on 03/04/09. This took
the form of a small scale trial of the research method, to ensure that the design is
feasible (Cormack, 1998). A pilot study is necessary prior to the commencement
of the main study to test the ability of the researcher to obtain accurate data
(Cormack, 1998). Participant for the pilot interview was selected from the target
population thus its findings are likely to be a good indicator of what will emerge in
the main study (Bailey, 1997).

The pilot interview was done in the same setting proposed for the main study.
This helped to determine a variety of practical questions and to assess potential
problems within the setting. As a young researcher, the pilot interview enhanced
my development of effective interview skills (Wimpenny and Gass, 2000). One
participant was allocated to the pilot study because if too many participants are
allocated to the pilot study, the main study may be rendered with insufficient
sample (Bailey, 1997).

Following the data collection and data analysis of the pilot study, the researcher
became familiar with the process; the pilot study also gave the researcher the
chance to assess her communication skills and the recording equipment (Burns
and Grove, 1999). From a review of the findings of the pilot interview, I
discovered the need to speak more slowly and clearly as my African accent was a bit difficult for my European participants to understand. It is very important to also state here that the pilot interview also equipped me with some practical interviewing skills, the absence of which could have destroyed the quality of this study. Thus, the findings of the pilot interview were important to me and so they were included in the study in order to boost the number of participants and more importantly, disregarding the pilot interview would have deprived the study of some valuable data (Teijlingen and Huntley, 2002).

**SEMI-STRUCTURED INTERVIEW**
Six semi-structured interviews were conducted after the pilot interview. According to Polit and Beck, (2006) semi-structured interviews involve the use of topics or broad questions and are not as controlled or fixed as the structured interview. Interviewers normally have a list of trigger or guide questions (Appendix 4); there is space for dialogue and for the participant to offer responses that are not predetermined.

Interviews allow the participants to be in control with partnership interaction between the interviewer and interviewees so that the meanings will eventually be a joint effort of both parties (Polit and Beck, 2006).

Research interviews according to Wimpenny and Gass, (2000) are the most appropriate data collection strategy, which provides access into the deeply seated human experiences. The practicalities of data collection through interviews were planned for ahead of time and the equipment needed was re-checked as suggested by Rose, (1994). Reflection, clarification and conveyance of a sustained interest through active listening are skills recommended by Jasper (1994) for effective qualitative interview.

On the day of the interview, an additional informed consent form (Appendix 7) was given to each participant for signature. The first interview was conducted on the 10/04/09 at the proposed interview room in the hospital. The researcher and the participant sat across to each other, with the recorder at the centre on a round table. The interview was tape recorded to capture an accurate description of what transpired (Parahoo, 1997). The semi-structured interview also allowed a more flexible approach to be gained (Ogier, 1999).

**DATA ANALYSIS**
The function of qualitative data analysis is to uncover the essence of the data and the meaning lying behind it. The researcher has the dual task of presenting the story from the participants’ perspective and also of analysing the story so that its wider meaning is brought to light (Green and Thorogood, 2005). Data analysis in qualitative research is particularly challenging due to the vast amount of data to be analysed and the challenge of reducing the data for reporting purposes (Polit and Beck, 2004).

A major feature of qualitative research is that data collection and analysis occur simultaneously (Bailey, 1997). The use of digital tape recorder was of benefit as it contains more than just words, but the feelings and emphasis of the participants. It also captures their perception on the use of physical restraints on their patients. The tape recorded interview was listened to several times in order to compare participants’ statements and becoming immersed in the data. Thus, the focus was eventually shifted from looking at experiences of individuals to
perceiving the collective experience (Gladden and Cook, 2003) without compromising the unique experiences of the individual participants, (Robinson, 2000). All the data collected were adequately managed and meanings were formulated from a good understanding of the transcripts. To ensure a good degree of anonymity pilot interview was coded PL, while the semi-structured interviews were coded SS1, SS2, SS3, SS4, SS5 and SS6. A good comprehension of the data was obtained through the use of eidetic (that is visibly detailed form) process of data management. After rigorous and repeated readings and reflections, meanings do emanate gradually from the phenomena being studied (Robinson, 2000). The researcher took analytical memos in which thoughts and ideas regarding the data and also the rationale behind the coding of sections was documented. This helped in the later stages of data analysis when there was to-ing and fro-ing between the codes and the themes (Holloway and Wheeler, 2002). Miles and Huberman (1994) framework was employed in managing the data. This framework goes as follows: **Data reduction** - this involves coding and processing, requiring a detailed reading and re-reading of transcripts and then coding the data to identify key issues. **Data display** - recognising and re-presenting codes now allows the scrutiny of texts and the display of data in tables, charts or matrices to facilitate comparison. This enables a fuller thematic description to emerge. **Conclusion drawing** - further analysis and theorising – this involves further interrogation of data and the identification of links between themes and categories resulting in the formation of possible theories that explain relationships in the data. After becoming immersed in the data through several readings and reflections on the data, some of the extracted words and phrases include the following samples of significant words and phrases:

“They will have a belt on to make sure they do not get up or fall …”
“I’ve seen patients tied physically, to chair; I’ve seen patients needing to be restrained and secluded …”
“They have them for patients to keep them safe …”
“I think restraints are a necessary precaution …”
“They need to have the rails up just in case they fall and do some damage …”

The above quotes are some of the ways the participants described how they perceived physical restraints in the care of the elderly based on their experiences. Efforts were made to prevent premature description of what the participants said when meanings were been formulated to each of the significant statements and phrases.

**RIGOUR AND TRUSTWORTHINESS**

Trustworthiness refers to the soundness and robustness of the methodology of a study (Holloway and Wheeler, 2002). The trustworthiness of this study was based on the criteria of the framework used for establishing the rigour in qualitative studies, which include transferability, dependability, credibility and conformability (Polit et al., 2001). The importance of rigour in qualitative study
cannot be over emphasised; Morse and Field, (1996) confirmed that rigour is very important to qualitative studies in the sense that it prevents methodological errors. In accordance with the suggestion of Byrne (2001) a research journal was kept, including all the initial data, interpretations, analyses, report and peers comments. The audit trail is for readers of a study to track how the researcher arrived at the findings. In this study to assure validity, all the original transcripts of the pilot interview and semi-structured interviews were kept under lock and key and the transcript were kept on my personal laptop computer, which has a password so nobody can access it. While both the participants and the researcher are interested in presenting accounts that represent a fair description of their experiences, conflict may still arise on what a fair account is all about (Sandelowski, 1993). The keys to enhance rigour in qualitative studies included fundamental issues such as transferability, dependability, credibility and conformability (Sandelowski, 1986), but Mays and Pope, (1996) criticised these as research biases and non-generalisation.

**ETHICAL CONSIDERATIONS**

It is essential that the researcher examine all aspects of the research approach used from an ethical point of view (Polit and Hungler, 1999). In qualitative research studies, ethical consideration begins with the identification of the study topic and continues through to the publication of the study. A direct relationship between the researcher and participants is very important throughout each step of the research. As this research involves human subjects, there was careful consideration to protect their rights. Anonymity and confidentiality are two of the many ethical issues that were considered for the rights of the participants not to be compromised. The principles that guided the approach on ethical issues included beneficence, human dignity and justice.

**PRINCIPLE OF BENEFICENCE**

While the principle of non-maleficence places an obligation upon the research to do no harm, beneficence requires the promotion of good, and imposes a duty on the researcher to minimise harm and to maximize benefits. To avoid possible psychological consequences, areas of participants’ weaknesses were not explored. I deliberately caution myself not to intrude into psyches of the participants. Despite this I made provision for debriefing sessions by inviting the Chief Social Worker of the hospital to be within reach on each interview session (Appendix 6). However, all the interview sessions went well and there was no need for debriefing session. To avoid exploitation the participants were all given information guide (appendix 2) as suggested by Polit et al., (2001) explaining what the study entails, that it is voluntary and that they can pull out at any time if they wish to.

**PRINCIPLE OF HUMAN DIGNITY**

This principle includes the right to self-determination and the right to full disclosure (Polit et al., 2001). The right to self determination was achieved by stating in the participants information guide (Appendix 2) that participation is voluntary and refusal to participate has no risk of incurring any sanction, penalty or prejudicial treatment to either the potential participants or their sick relatives.
The right to ask questions, to refuse giving certain information and to terminate their participation at any time during the course of the interview was stated in the information pack. All potential participants were given informed consent (Appendix 3) to sign before participating in the study and those that consented were given additional informed consent (Appendix 7) on the day of the interview to assure them of their power of free choice and voluntary participation.

**PRINCIPLE OF JUSTICE**

This principle includes participants’ right to fair treatment and their right to privacy. To achieve fairness and equity, I selected the study participants based on the research inclusion and exclusion criteria and not on their vulnerability or compromised position (Polit and Beck, 2006). To assure the right to privacy, all the data collected were kept in strictest confidence and interviewees were pseudo-named. I made myself accessible to the participants through my mobile phone and email.

**PRESENTATION AND DISCUSSION OF FINDINGS**

**PERCEIVED MEANING OF PHYSICAL RESTRAINT:**

It is amazing that none of my participants was able to give a definite meaning of physical restraint; instead all of them laboured to describe the uses or types of physical restraints using the words that may suggest lack of knowledge of the topic as most of what was said could be from experience. When I inquired about their perceived meaning of physical restraint the following were excerpts of their responses: “They’ll have a belt on to make sure they don’t get up or fall … SS5”

“The person in bed should always have the rail up just in case they fall and do some damage … SS6”

These participants were able to give the types of physical restraints they see in use in the hospital and the reasons why they are used. They could not give their perceived meaning of exactly what physical restraints were. According to the literature, one of the difficulties in researching restraint use is the lack of consensus about what constitutes physical restraints (Nay and Koch, 2006). In this study, participants described physical restraints as safety measures; with the belt related to using a safety belt in the plane or in a car, and side rails described as protective devices but not described physical restraint.

Another participant described the extreme case of physical restraint which could have been from the type of experience he has had in the past.

“I’ve seen patients tied up to chairs; I’ve seen patients needing to be restrained … SS4”

Some of the participants saw restraints as safety devices and necessary precautions in the care of the older people. This belief was confirmed in the literature, where the main reason given for the use of physical restraint is to prevent falls and harm (Gallinagh et al., 2002; Hamers et al., 2004; Chuang and Huang, 2007).

“They use them for patients to keep them safe … SS3”

“Restraints are a necessary precaution … PL.”

Many of the participants admitted to not knowing the meaning of physical restraint.
This did not show a good reflection on the attitude of the nursing staff in the unit concerning educating the relatives of the patients on the use of physical restraint. This study did not involve any of the health professionals and so the reason for the lack of education could not be explored.

“I don’t know enough … SS1”

“Em … not very much … but I won’t be in favour of them … SS2”

“There wasn’t an awful lot that I knew about them … PL”

“The only thing I know about physical restraint is that … they will need them … SS4”

“Not a lot, except that they are necessary … SS6”

Even the very person who claimed to have known much about physical restraint stated:

“I would have a lot of knowledge … I work in a caring profession … I would have encountered restraints, they could be in form of straight jacket or been tied up to the chair or secluded…SS4

It appears that the decision to use physical restraint on their family members are imposed, no serious family education took place thus no informed consent was obtained. This could be a strong enough reason to generate family resistance to the use of physical restraints. It is obvious that the relatives have poor understanding as to what physical restraints means. Their poor understanding and knowledge of what physical restraints are, might have affected their feelings and misgivings.

Physical restraint according to the literature, is any device, material or equipment, attached to or near a person’s body, which cannot be controlled or easily removed, and which deliberately prevents or is deliberately intended to prevent a person’s free body movement to a position of choice and access to their body (Gallinagh et al., 2001; Gallinagh et al., 2002; Mott et al., 2005; Gastmans and Milisen, 2006).

I would have expected the participants to mention that physical restraint deny patients their freedom, which would be the reason why they were classified as forms of abuse in the literature. It is also claimed that the use of physical restraints does not reflect their rationalised nursing care since the preventative function of therapeutic physical restraint has not been proven (Hamers et al., 2004).

Defining restraints is not straight forward. For example not all healthcare workers consider bedrails to constitute restraints (Koch, 1994; Harmers et al., 2004) and nursing staff in the study of Black and Haralambus, (2005) expressed differing opinions regarding whether recliner and tub-chairs or wheelchair feet flaps could be forms of restraints. In this study, physical restraint includes, but not limited to bedside rails, screw on tabletops, bedclothes, tipping chairs, wheelchair belt when not in transit, manipulation of furniture, limb and wrist restraints. Others are applying breaks to wheelchair against patients’ will, putting walking stick out of patients reach and putting wheelchair out of the reach of a wheel chair bound patient (Gastmans and Millison, 2006).
It is a common belief that the knowledge one has about a phenomenon would affect one’s feelings and subsequently one’s relationship with the phenomenon. It is obvious that the participants used the years of experience in which their relatives were physically restrained to describe the types and feelings of acceptance or rejection of physical restraints. Knowledge is required to make unbiased decision and such knowledge can influence feelings and decision-making.

**HOW PERCEIVED MEANING HAS AFFECTED THE FEELING ABOUT PHYSICAL RESTRAINT**

The findings of this study revealed that the participants feeling on the use of physical restraint can be divided into three categories: Acceptance, Rejection and Ambivalence.

**Acceptance:** Almost a half of the participants, accepted the use of physical restraint on their relatives. Some samples of statements made to suggest this are:

“…Well, he has to be restrained …it’s acceptable, it doesn’t seem to cause him any discomfort … He’s happy enough with it….SS3”

“I feel good about it; they put the rail up only when she is in bed…SS6”

“Well, because it’s for their own safety, I don’t mind, it’s good…SS2”

The participants quoted above described their feelings about the use of physical restraints as acceptable and good based on how it has been used on their relatives but not on their own personal feeling about it. One can sense the tune of the use as necessary e.g. “…well he has to be restrained… its acceptable… he is happy enough…SS3. This participant appears reluctant to reject because he did not indicate his personal feeling but the feeling of the patient.

**Rejection:** The participants that have negative feelings about physical restraint based their comments on their personal experience, observation and patients perceived feeling, their comments are outlined below:

“I won’t agree with it at all, I would be totally against it, it is much undignified … SS1”

“I wouldn’t be in favour of them … SS3”

“… Very, very sad, I feel very sad…. He is not aware of his situation that is the only peace of mind I have … PL”

“Oh horrified, totally horrified … It would be upsetting unless if he is aggressive or Violent … SS4”

**Ambivalence:** The participants that are ambivalent about the use of physical restraint still believe the devices have safety value.

“It doesn’t bother me at all, the belt, the bar or the little buzzer, no, that won’t upset me too much … SS1”

“It’s ok, the cot side and the belt I suppose, and it’s protective in case she topples out of the wheelchair … SS5”

From the responses of all the participants, it is clear that they all expressed concerns for patients’ safety by mentioning the need to protect patients from falling. Concern for safety took precedence over their feeling for the use of physical restraint. This finding is in accordance with the study of Moore and Haralambus, (2007) where family members recognised the emotional distress
that restraints can cause, but still felt without restraints, serious physical injuries were likely to occur and these were considered to be of greater concern than their emotional distress.

**INVolVEMENT IN DECISION MAKING**
The majority of participants of this study expressed feelings that suggest they were not involved in the decision to use physical restraints on their relatives. Participants made categorical statements to show this when asked if they were involved in the decision to use physical restraint.

“No, nobody told me, I was not involved, I was neglected … SS3”
“No, I can't remember it being an issue … SS5”
“No. not really, I'll say no, but I would have loved to be involved … SS1”
“No, but I'll have no problem with that, as long as he is not tied-up in bed, arms or Legs … SS4”

The education process in terms of falls reality should start at the time of admission so that residents and their families do not enter the long-term facility under the false impression that they would be kept fall-free throughout their stay. According to Feinsod et al., (2005) the expectations on admission should match the care plan approach of reducing but not eliminating falls and reducing injury from inevitable falls. These authors believed that patients and their relatives should be educated about the meaning, indications, risks and potential benefits of physical restraint use in order to understand the indication and purpose of the use of physical restraint.

“Yes one of the nurses explained to me when he needed it the very beginning… she said it was becoming necessary but I didn't understand anything about it … PL”
“I can't recall now, but they may have because my mother is restrained a long time…”
“I am sure they mentioned it, but I can't recall when… SS2”

Hendel et al., (2004) found that relatives worry about the care of their family members. They believe staff members treat all elderly patients alike, with little individualization of treatment regimens. These authors believe family members became involved in the decision-making process regarding restraints only when the nursing staffs viewed family members as impediments to either restraints placement or removal.

When families do not get information concerning the reasons for restraint use, a misconception related to their use may occur. Castle, (2000) found that a lot of the families indicated that they were not informed before their loved ones were restrained. The study of Gallinagh et al., (2001) also concur with this finding, a study they carried out on hospitalized older adults found that relatives were not consulted in the decision to restrain the patient.

According to Gastmans and Millisen, (2006) the ability of human beings to make choices must always be respected in the context of physical restraint. From this derives the ethical norm that when physical restraints are being considered, caregivers should inform competent older persons, and educate their relatives as
fully as possible, about the various treatment possibilities, their nature and aim, their pros and cons and effects and potential risks. According to Cheung and Yam, (2005) the society places high value on personal autonomy, this is considered to be the dominant ethical principle in Western culture. Within caring context, respect for autonomy and integrity is utmost important when dealing with the well-being of another person. Even after a person ceases to be legally competent, healthcare providers should continue to respect the autonomy of the person, and their decision respected. When a resident is declared incompetent, a substitute decision maker e.g. next of kin should be involved in the decision making process (Blais, 2004), especially when it relates to the use of physical restraints (Hendel et al., 2004).

**PHYSICAL RERAINT: A COMMON PRACTICE**
The use of physical restraint has been associated with hospitalized older people. The comments of majority of the participants confirmed the perception of the relatives on physical restraint as ritualized accepted practice. Because majority of the participants were not involved in the decision to use physical restraint, prompted me to ask how often they come to visit their patients, and why they did not bother to query the nurse’s action on their patients. Some of their responses were:

“Its common in hospitals, they could be asleep….have their wits alright with them and still have the bed rails up … SS3”
“I think that’s the procedure with older people … SS2”
“… Elderly people in hospitals….you’ll see they are always put in bed with rails up … SS6”
“… They just automatically put up the two side rails; it’s only when she is not in bed that the two rails are down… SS4”

Hammers et al., (2004) found out that physical restraint use is a common procedure with cognitively impaired residents in nursing homes. They are in most cases used as routine procedures. These views are similar to those expressed by relatives of elderly patients in the study of Gallinagh et al., (2001), where participants saw safety and ritualized accepted practice as being the reasons for bed rails use. A study by Bakker et al., (2002) also indicated that bedrails and belts are commonly used in nursing homes.

The prevalence of restraint use reported in the literature ranges between 15% and 66% in nursing homes and between 8% and 68% in hospital settings (Hamers et al., 2005).

Although the use of various physical restraints had been reported in the literature, bilateral and unilateral bedrails and belts are the most used restraints in the care of the elderly (Hamers et al., 2005).

One of the participants who tried to justify the ritualized use of physical restraints stated that:

“…They are used when patients get agitated but long after the agitation diminished; they become everyday use … SS4”

Another participant stated that healthcare workers use physical restraint because they see it as a cheaper option hence it is commonly used
“… Restraining patients I think is a cheaper option, when they get agitated, so its used always ...SS5”

SAFETY ISSUES
All the participants interviewed justified the use of physical restraint in terms of their safety function, which is to prevent falls. Falls has been found to be a major problem in residential aged care (Shanley, 2004). Dunn (2001) asserted that, falls are responsible for more than one third of the deaths from unintentional injury in people’s age 65 years and older. When asked why they think physical restraints are used in the care of the elderly, all the participants in this study focused their statements on the anticipated preventive function of physical restraint.

“...he could slip down or may even roll over in a bed or something, and the restraint; I feel in this case it is for his protection ... PL”
“I think well, to keep patients safe, in case they fall out or hurt themselves or hit the table....it will be more for their safety ... SS2”
“I suppose the most important thing is safety for the patient. Restraints are obviously there to help the patients ... SS3”
“... for instance, if the person actually falls out of the bed she could do some damage...she can also fall out of the chair if she doesn’t have the belt on ... SS6”

A major reason cited in the literature for the use of physical restraint in the care of the elderly is falls prevention, (Capezuti, 2004; Hammers, 2004, 2007). Falls are associated with major morbidity, functional decline and increased healthcare expenditure (Tinetti et al., 1994). Half of those aged 75 years and above who fracture their hips because of a fall die within one year (Rawskey, 1998).

The physical impact on the patient especially that of discomfort, injury, increased morbidity, psychological implications, decreased self-confidence and fear of further falls culminates in a significant reduction in quality of life (Mitchel and Jones, 1996). With all the consequences of falls in mind, especially that a patient’s fall reflects the quality of care by the nurses, and that nurses experience fear of blame, anxiety, guilt and distress following a fall by a patient in their care thereby want to prevent falls by all means (Fitzgibbon and Roberts, 1988). However, this justification for the use of physical restraints has been extensively researched, and falls is no longer considered the main factor underlying the decision to use physical restraint as it has been found that they do not prevent falls (Gallinagh et al., 2002).

Some participants also related the use of physical restraint to the prevention of harm among confused and agitated patients, especially patients with dementia and Alzheimer’s disease who may harm themselves, other patients or the healthcare workers. Anecdotally, it is a common belief that restraints are to prevent patients' harm (Lee et al., 1999).

“Well in most cases I think it’s to try and avoid risk of harm, more harm to the patient or the others ... SS5”
“To prevent harm, yeah patients who are at risk of absconding or assaulting other people ... SS4”
“… The patient is agitated and confused; they can harm themselves or the care workers … SS3”

It has been found out that the incidence of falls and harm in residents with dementia is higher than those without dementia (Shanley, 2003). Numerous characteristics of elderly patients have been related to the use of physical restraints e.g. cognitive status, psychosocial performance, past history of falls, wandering etc (Hamers et al., 2004).

This study confirmed the study of Gallinagh et al., (2002) that physical restraints were applied to prevent unsteady and cognitively impaired patients from falling.

Dementia is associated with a variety of behavioural and psychological symptoms (Lyketsos et al., 2000). Delusions, hallucinations, aggression and depression are highly prevalent in long-term care residents (Brodaty et al., 2001) and these addressed the issue of self-harm in long-term patients with dementia and Alzheimer’s. Simeon and Favazza, (2001) defined self harm as any intentional or deliberate act that results in organ or tissue damage, regardless of motivation or mental state. Some of the characteristics of a patient with dementia that can lead to the use of physical restraint are aimless repetitive behaviour and apathy, aggressive behaviour e.g. hitting oneself, banging head, banging one’s fist against objects or somebody else’s hair, pushing oneself back and forth leading to injury among others (Jonghe-Rouleau et al., 2005).

**PARTICIPANTS PERCEIVED ALTERNATIVES TO PHYSICAL RESTRAINTS**

Despite the disadvantages stated by the participants, none of them was able to suggest in reality any form of alternatives to the use of physical restraint. None of the participants could envisage a restraint free environment in the care of the elderly unit.

In Ireland, apart from the Mental Treatment Act (1945) cited by Irish Nurses Organisation (INO, 2003), there is no law authorising the restraints of an adult and thus depriving them of a fundamental human right. In addition to this, there is increasing evidence advocating restraint free care. Avoiding restraints involves an element of risk and nurses are always the victim. Strumpf and Evans (1991) believed that restraint free care should be established as the standard of care for older adults in all settings. Quinn (1994) suggested that all care staff and nurses should consider the use of the following ‘four A’s’ of restraint reduction.

**Attitude** - Development of the attitude of ‘last result’ not first choice.

**Assessment** - The careful systematic assessment of patients’ mobility, mental status and behavioural cues.

**Anticipation** - The application of knowledge of treatment, interventions, therapeutic goals and the needs of older people.

**Avoidance** - Implementation of alternative nursing measures to accomplish treatment goals without physical restraints.

According to Koch and Lyon, (2001) restraint free environment is defined as, the non-use of bed rails, Posey vests, geriatric chairs, chemicals or lap belts for the sole purpose of restricting an older persons freedom to move.

Hamers et al., (2005) asserted that reducing the use of physical restraint in health care is a complex process because there must be a paradigm shift in clinical practice regarding the interpretation and response to behaviour
concerning physical restraint. Change in the standard of practice depends on breaking established myths and assumptions on the use of physical restraints. When asked if they can think of alternatives to the use of physical restraint, some of the responses were:

“No, I honestly don’t think there is anything else … PL”

“I don’t know, I can’t see how you can keep her safe without using the belt or the buzzer, I can’t think of anything … SS1”

“… I don’t think there are any alternatives, I can’t see anything else, I can’t see any other method … SS3”

One of the participants suggested modification in the use of physical restraint:

“The only thing I think you can do is put her bed against the wall, using one side rail instead of two… SS6”

Modification of physical restraints is not an alternative to the use but can reduce potential injuries. The adoption of any new intervention or change in care practice in nursing homes depends largely on administrative support and on evidence that the interventions are cost effective (Wagner et al., 2007). The interventions to reduce physical restraint use may require significant upfront spending in purchasing some equipment, and this may be a capital investment for the nursing homes.

Another participant also suggested reduction in the use:

“I can only say they don’t need to be restrained all the time, may be during the day most of them are perfectly OK during the night … SS4”

It is important to state here that most patients are restrained during the night, because that is when the staffing level is usually very low. Gallinagh et al., (2002) concur with this in their study where they found out that decrease in staffing levels is associated with increase in the use of physical restraint.

Another participant suggested that padding the side rails to prevent injury to the patients when in bed is the only way out since there is no alternative in sight; this is in accordance with the study of Gallinagh et al (2001) where some of the participants in their study suggested modification to side rail as alternative. This procedure is standardised, legalised and recommended when using side rails for aggressive and restless patients.

“If the bed rails are not padded with cushion or blanket, it can cause harm, because when he gets agitated he can bang his head or arm or leg off the bed rails….its only the modification I can think of, no other thing … SS2”

When the participants were asked how often they see their patients been restrained, they all stated “all the time, both day and night” although one of them said she will not count side rail as being restrictive.

“Yes, all the time, she has the belt on, all the time, but I wont bother about the side rail she uses at night, I don’t see them as being restrictive because she needs them … SS2”

A large number of patients that are restrained in the care of the elderly are due to agitation, confusion, aggression and other behavioural problems, but it has been found out that prolonged restraint use in care of the elderly units may actually increase the incidence of agitation, confusion, aggression and other behavioural
problems (Mamun and Lim, 2005). When choosing alternatives for the elderly, emphasis should be on individualized and the uniqueness of the patients and their unique problems (Hendel et al., 2004).

**STAFFING LEVEL**

When the participants were asked if they could think of a way of reducing or eliminating the use of restraints, the issue of low staffing level in the care of elderly emerged. Some of the quotes that emerged were:

“The patients having a one to one or closer observation from staffs can prevent some of the use … SS4”

“… You can’t keep an eye on them for 24 hours; you can’t be there all the time … SS2”

“I am afraid for nurses, as they get busier and busier; they’ll be pushed to use more restraints … SS3”

“… if we are talking purely based on best care, I think more staff can prevent the use of restraints … SS5”

The majority of my participants mentioned the inadequate number of nurses to support a reduction or elimination of restraints use. One participant suggested that:

“There is nothing much that nurses can do except one to one care is implemented; there might be absolutely nothing the nurses can do … SS6”

In a situation where there is a nurse and two healthcare assistants to look after twelve residents who are aggressive, wanderers, confused and a lot of time prone to falls, that will put the nurses under pressure to use physical restraints (Pekkarinen et al., 2006).

This concurred with the study of Lai (2007) on why nurses initiate physical restraints use. Nurses seem to have been identified as the crux of the problem in restraint use.

However, it needs to be understood that nursing staff may be victims in the issue of restraint use. More often than not, discussions in the literature fail to note that using physical restraint might be out of their power.

One of the participants mentioned, “Talking purely based on best care”. It has been reported that a lot of time, the decision to restrain created conflict among the nurses between the need to protect and their professional values (Lai 2007).

In as much as nurses will like to give their patients the best care, they will need a lot of support from the management concerning the pressure placed on the rates of fall and falls reduction.

**SOCIAL CONTACT: COMMUNICATION**

Another important subject that emerged when participants were asked to suggest possible alternatives to the use of physical restraint is that communicating more with the patients can reduce the use of physical restraints. Almost half of them claimed that reducing boredom by encouraging the patient to talk will reduce the use of physical restraint. For those who are able for it, even those that are cognitively impaired, like to talk about their past and when they do they are more relaxed, less agitated and a lot of them actually enjoy it.
“Have a little talk with them and be more interactive with them ... give them a bit of stimulus, the ones that are able for it ... SS3”
“I think communication ... depending on how they communicate with her ... When she gets agitated, you can see that it has a very calming effect on her ... SS5”
“Yeah ... boredom, I think agitation can come from boredom and frustration ... I think communication does negate the effect and the amount of times that she gets frustrated ... SS4”
Many elderly patients are unable to communicate directly their needs or concerns, the most common way such patients can make their concerns known is through the behavioural medium. With dementia patients, understanding their needs can be very challenging as they are not able to learn new behaviours or sometimes remember instructions. The only strategy for nurses to understand what their needs are is through effective communication.
Because all behaviour has meaning, the challenge for the healthcare professionals, is to decipher the message displayed by a particular behaviour. In the care of the elderly, this process becomes more complicated because often, there is more than one reason for the behaviour. The difference will then be explored one by one until the cause of the behaviour; either agitation or aggression is revealed.
Communicating with the patient when agitated, confused or aggressive brings calming effect on them most times and thereby, might reduce the use of physical restraint. This idea on communication is consistence with the study of Koch and Lyon, (2001) that to have a restraint free environment, there must be improved communication and effective interaction between staffs and residents.

RESOURCES: OBSTACLE TO ALTERNATIVES
It is estimated that there are 452, 200 persons aged 65 years and above living in the Republic of Ireland, representing 11.5% of the total population of 4.57 million in 2002 (Central Statistics Office as cited by Nursing and Midwifery Planning and Development Unit 2004). The population of the older people in Ireland will grow to 14% of the total population by the year 2011. Healthcare of the older people in the past was more of a family affair, but this is no longer the case. Due to continued participation in the workforce by women and changes in the family structure, there is now greater reliance on formal health and social care structures.
The Human Rights Commission (2003) stated that older people should be able to live in dignity and security and be free of exploitation, physical and mental abuse. They should be treated fairly, regardless of age, gender, racial or ethnic background, disability, financial situation or any other status and be valued independently of their economic contribution.
According to the Nursing and Midwifery Planning and Development Unit (2004), more than 35,000 people in Ireland have dementia, of which Alzheimer’s is the most common form. The incidence of Alzheimer’s disease in the over 80s’ is 25% and this is on the rise. The question now is whether healthcare delivery system in Ireland is able to supply all the necessary needs of the older people in relation to person centred care. Ageing is a normal process of time related changes that
begins at birth and continues throughout life (Fitzgerald 2004). It occurs through every seconds and minutes of the day.

According to Fitzgerald (2004) older people have not been beneficiaries of the economic boom in Ireland. It is widely acknowledged that the provision for age related diseases such as stroke and dementia are under-developed. Des O’Neil (2004) argues that treatment options can be seen to become limited in advancing years and older people appear to be easily excluded from clinical trials on the basis of co-morbid conditions.

Nursing home residents who are cognitively impaired, or have conditions such as impaired mobility, increased risk for injury, nocturia or incontinence, and sleep disturbances, are at greatest risk for physical restraint use (Wagner et al., 2007). The best alternative way to keep this category of patients safe is that they are nursed individually or create a safe environment for them which might mean the purchase of new equipments to improve their quality of life.

Reducing the use of physical restraint in healthcare is a complex process (Hamers et al., 2005). However, as complex as it is, the removal or reduction of physical restraints improves quality of life (Mamun and Lim, 2005). In support of this claim, Shanley (2003) asserted that implementing programmes to improve clinical practice and quality of life, especially in care of the elderly, depends on getting optimal management and resource support. When the participants were asked for any suggestions towards improving the use and reducing the use of physical restraint, the following were some of the quotes from participants in support of the above claim.

“Resources in general, like snooze room, equipments to monitor them when they are put in a room to prevent harm to themselves and yet be free, obviously is a resource issue … SS5”

“Lack of resources of cause will increase the use of physical restraint ... especially with the economic recession and cut backs on healthcare staff … SS6”

It should be noted that the findings of Werner et al (1994) indicating that the removal of physical restraints and implementation of restraint alternatives has a complex and costly process, is consistent with the study of Black and Haralambous (2005) where they found out that perceived shortage of staff, time and insufficient resources and concerns for legal implications are still listed as barriers to minimizing restraint. Nay and Kock (2006) also identified funds as being a deficient resource. Restraint reduction is perceived to be associated with increased workload and stress and that the safest and most expedient option considered is physical restraint.

**PARTICIPANTS PERCEIVED ADVANTAGES AND DISADVANTAGES OF PHYSICAL RESTRAINTS**

**ADVANTAGES**

The Irish Nurses Organisation (INO; 2003) stated that the Irish law recognises that in many cases restraints are necessary to ensure a right even higher than the right of consent - the right to life. As such anyone who uses chemical, physical or psychological restraints must ensure that the restraints are necessary to prevent patients from harming themselves or others. The decision to use restraint should be made in consultation with multidisciplinary team and the
patients’ families and it should only be used when all other nursing interventions have failed. Without doubt, the main reason to use physical restraints in health care is the prevention of falls (Hamers et al., 2004), the risk of which is a predictor of restraint use (Hamers et al., 2004).

Assisting in the nursing care management in situations of patients’ confusion, wandering and insufficient staff and prevent disrupting therapies are other reasons cited for the use of physical restraints (Hendel et al., 2004). When the participants were asked if there are any benefits in the use of physical restraints, majority stated that they are used for both the staff and the patients’ benefits:

“I think it’s 50/50 … the staff can’t sit there watching her all the time…with the belt on, it frees them to do something else … SS1”

“… You can’t keep an eye on them for 24 hours, so its for the nurses benefit but by the same token its for the patients’ benefit, it’s a bit of both really … SS2”

“It’s just to make sure everybody is safe both the patients and the staff … SS6”

One of the participants who believed the use of physical restraint is totally to the patients’ advantage stated that:

“… He could hurt himself badly if there were no restraints, the cot sides and the seat belts in his chair … SS3”

Two of the participants who believed that the use of physical restraint is just for the nurses’ benefit stated that:

“Oh definitely, the restraints are to the nurses and care workers advantage. I’d say that it’s solely the benefit of the care workers and the nurses … SS4”

“I am afraid for nurses, as they get busy and they are going to get busier, they will be pushed to use more restraint … they will want to prevent litigation because if a patient falls the family are going to complain and also the management, so they use restraint for their benefit … SS5”

These findings suggest that the participants in this study have mixed perceptions towards the use of physical restraint in the care of the elderly. It was apparent that as much as they emphasized safety as the reason for the use of physical restraint, they also have concerns about the disadvantages that the use might bring. It was also revealed that as much as the relatives would love to be part of the decision making process, none of them were actually involved as they would have preferred though a relative claimed that she was merely notified after the procedure had been initiated.

The participants were only referring to side rails and seat belts most of the time as the types of physical restraint. However, according to the literature, physical restraints can be anything from screw-on tabletops, bedclothes, tipping chairs, wheelchair belt when not in transit, manipulation of furniture, limb and wrist restraints, applying break to wheelchair against patients will, putting walking stick out of patient’s reach to putting wheelchairs out of the reach of a wheelchair bound patient (Gastmans and Milisen, 2006).

In spite of their perceptions regarding negative effects of restraining patient, most participants supported occasional restraint use to prevent patients from falling and or harming themselves. Relatives’ perception on the use of physical restraints and the need to support its use may be made possible by the
understanding or experience that in certain circumstances a better alternative for assuring a patient’s safety does not exist. Sometimes, the reason why physical restraint use is not supported is lack of information concerning its risks and implications as evidenced by more positive responses to its use.

Ethical and legal issues on the use of physical restraint may explain why nurses resist the reduction of restraint use. The use of physical restraints may threaten the three cardinal principles of ethics i.e. beneficence, non-maleficence and autonomy. Nurses are morally obligated (non-maleficence) to protect patient from evil or harm (beneficence) while simultaneously maintaining respect for their right to autonomy.

An ethical dilemma may occur when a nurse has to decide whether to use a physical restraint as an intervention to prevent injury, knowing the consequences of decreasing an older person’s mobility and freewill. The commitment to provide quality care and quality of life for residents in the care of the elderly is very important and highlights the concept of calculated risk taking which is an integral part of life that should not be denied older people.

**DISADVANTAGES**

Despite the participants in this study agreeing that physical restraint is mainly used to prevent patients from falling or harming themselves, they nonetheless stated their feelings on the types of risk involved in the use of physical restraints. When asked what they think are the disadvantages to the use of physical restraints, only one out of all the participants stated that there is no disadvantage to its use.

“No, I can’t think of any disadvantage; it is for their good … SS6”

Following are some of the quotes of the participants on the disadvantages of the use of physical restraints.

“When they get agitated, they might use the side rail as the lever to get out, that can be dangerous … SS1”

“For a patient who is agitated, using the cot sides can increase the risk to the patient … SS5”

“My fear about cot sides would be that she would fight and climb up on them and eventually topple over from them … SS4”

It is of note here that many of the participants referred to side rails. This is in accordance with the study of Gallinagh et al (2001) where it was shown that side rails are the most commonly used physical restraint in the care of the elderly and the one associated with most common adverse effect. In a study by Hangar (1999) bed rails were identified as particular risks to patients. The study suggested that bed rails could be reduced without increased risk to older people. Lee et al., (1999) suggested that bed rails have the potential for the occurrence of more serious accidents because the patient may fall from a greater height. Watson (2001) concurs with this and states that patients’ can receive injuries if they put their limbs between the bars. If patients or their relatives choose to have bed rails as a measure of security, it is advisable that the reason be documented in the patient’s care-plan.

Some of the participants also raised the issue of lack of proper training for the nursing staff in relation to the use of physical restraints as a disadvantage. They
contended that if staffs are well educated on the use of physical restraints, the risk might be minimized. Some of the quotes stated are:
“If people aren’t properly trained to use them, they can cause pain … SS3”
“The restraint could be abused, that is a grave disadvantage … PL”
“If nurses are not properly trained to implement, check and make sure that procedures are followed, it can cause harm to the patient … SS1”

Ludwick et al (2008) indicated the need for employers to support on-going education in the use of physical restraint. They are of the opinion that staff education in physical restraint use will also encourage the use of alternatives to restraints and reduction in the usage.

One of the participants also mentioned the need to monitor and supervise patients when they are physically restrained.
“If patients are not well monitored or supervised, the restraints can cause injury … SS3”

When staffs are at hand to monitor and supervise patients that are restrained, they can always save the situation of patients doing more harm to themselves. Another participant suggested padding the side rails to prevent injury to the patients when in bed:
“If the bed rails are not padded with cushion or blanket, it can cause harm, because when he gets agitated he can bang his head or arm or leg off the bed rails … SS5”

This is in accordance with the study of Gallinagh et al., (2001) where some of the participants in that study suggested modification to side rails as alternative. One of the participants focussed on the psychological effect of physical restraints use on the patient:
“There would be harm, nobody wants to be restrained, imagine … What is going on in their mind … SS4”

Gallinagh et al., (2000) reported negative feelings like humiliation, demoralization, indifference and low self worth in elderly patients who experienced restraints. This is consistent with the study of Hamers and Gulpers (2004) in which four caregivers were voluntarily restrained for 24 hours. They reported very unpleasant experiences like the complete absence of privacy, freedom of movement and independency.

**SUMMARY**

As much as the participants recognised the expertise of the professionals, the failure to involve them in the decision making process relating to the use of physical restraint was clearly shown in this study. Establishing partnership with the relatives of the elderly patients, in form of communication and involving the patient where possible will give the relatives the opportunity to ask questions and to identify with the need of the nurses in providing care for these elderly patients. The need to educate relatives on the types, indication, alternatives and potential risks involved in using physical restraint emerged in this study, as protection appears to be the ultimate aim of using physical restraints.
The study shows that despite the fact that relatives are aware that physical restraints have disadvantages, majority of them still accepted the use and could not suggest a realistic alternative to its use. The relatives also identified lack of funding to employ more hands as an impediment in the care of the elderly. It was a consensus among the participants in this study that when there is increased number of staff on duty there may be a reduction in the number of physical restraint use.

LIMITATIONS OF THE STUDY

Reflecting upon the overall aim and the objectives of the study, certain limitations were identified which were recognised while evaluating the study findings. The sample population was taken from one hospital with six care of the elderly wards; two Alzheimers care wards and one care of the elderly day care unit. This contributed to the limited generalisability of the findings to similar care of the elderly Units. The small sample size consistent with phenomenological qualitative study has equally contributed to my ability to explore the understanding of the participants through which the rich data were obtained (Fielding, 1994). Choosing purposive sampling also limited the findings of the study. The use of nonprobability sampling, such as the purposive makes the findings of a study liable to bias which further reduces the credibility and generalisability (Polit et al., 2001). To overcome some of these weaknesses, after the pilot interview, I conducted six one to one semi-structured interviews.

This study was done in partial fulfilment of the award of a Master’s degree; therefore, the stipulated timeframe could have placed certain restrictions on the study. Thus, the timeframe coupled with my limited experience in qualitative research restricted the credibility of the study. To overcome these weaknesses I conducted the study with adherence to the college regulation and I worked under the supervision of my academic supervisor who was able to competently bridge the gaps.

DISSEMINATION OF FINDINGS

The focus of nursing researchers is to strive and disseminate their findings to their colleagues and other healthcare providers (Polit et al., 2001). The findings of this study will not fall into the category of some other nursing studies, which have no effect on practice, this is against the principle of a high quality study hence the findings will be extensively disseminated to enhance possible utilisation.

A copy of this study will be presented to the Director of Nursing services of the study site and will be circulated to the care of the elderly units at the local level. I also intend to present the findings of this study at a care of the elderly seminar and a wider national forum. The findings of this study will also be submitted for
publication in reputable journals of nursing studies, such as the International Nursing Journal of Gerontology and the Journal of Advanced Nursing.

**IMPLICATIONS OF THE STUDY**

The need for research in nursing has been on the increase probably because nurses are expected to provide evidence-based practice from research findings to inform their decisions, actions and interactions with their clients (Polit et al., 2001). The implications of this study will be discussed under these three headings:

1. Implications for nursing practice
2. Implications for nursing education
3. Implications for nursing management.

**Implication for Nursing Practice**

A lot of studies have been carried out over the years on the care of the elderly, resulting in a vast number of publications, including those on the use of physical restraints on the older people. However, information is scanty on the perceptions of relatives of elderly patients in long-term care on the use of physical restraints. Though the finding of this study is from one hospital out of many of its kind in the Republic of Ireland, the rich data will help improve nursing practice in Ireland and the global community.

This study has revealed the need for nurses as professionals to establish partnership and work more collaboratively with patient’s relatives. An ideal partnership in form of communication involving the nurses, the relatives and the patients where possible is necessary. This will afford the patients and their relatives, the opportunity to ask questions and to identify their role in the provision of residents care. Apart from educating the relatives, through communication, these might bring reduction in possible litigation. There is also the need for nurses to review their professional role as patients advocate which Parsons (2004) claims professionals were to play.

Although it is not practical to consider eliminating falls to eliminate the use of physical restraints, an interdisciplinary team focussed approach that concentrates on reducing falls risk is an achievable goal when caring for frail elderly resident in long-term care facilities. Multiple co-morbid conditions as well as discomfort and environmental issues contribute to the risks associated with falls. When approached in a coordinated manner, these conditions can be identified and interventions designed (Feinsod et al., 2005). Each member of the interdisciplinary team has a specific expertise that should be utilised when creating therapeutic approaches. Realistic care plan, staff in-service training and flow of information from the nursing care plans to the healthcare assistants will help to coordinate approaches to reduce fall risk thereby reducing the use of physical restraints.
Implications for Nursing Education

The importance of life-long learning (Experiential Learning) cannot be overemphasized in a profession like nursing, as there are innovations everyday in the world of science. If nurses will have to educate the families of elderly people they will have to be well informed and educated as ‘you can only give what you have, what you don’t have you can’t give’. The Report of the Commission on nursing (1998) has identified Care of the elderly as a key area for development within nursing.

The Report of the Commission on nursing (1998) highlighted the need to develop and strengthen the availability of professional development for all nurses and midwives. It recommended that nursing education in Ireland should evolve to ensure the continued development and progression of nursing practice in keeping with international trends and developments in best practice. Nurses will need to engage in personal and professional development through further education and in-service training.

Continuing Professional Education is linked to providing and improving quality of patient care in the code of Professional Conduct (An Bord Altranais, 2000). According to this code each nurse is accountable for improving professional knowledge and competence. Continuing education also underpins the expansion of nursing practice as outlined in the Scope of Professional Practice document (An Bord Altranais 2000).

In-service education in the care of the elderly should include fall-risk assessment and prevention programme; and there should be education on the management of the confused, aggressive and wandering patients. There should also be ongoing education to unravel creative alternatives to the use of physical restraint. The inservice education centre of the hospital is urged to introduce training nurses and the other disciplines in the hospital on the issue of physical restraint and alternatives.

Implications for Nursing Management

The nursing management unit plays a vital role in designing policies and evaluating nursing practice in general. The findings of this study will equip the nursing management in providing its vital role in health care. To overcome the barriers such as initial extra costs, introducing new models of care, there should be lobbying of relatives and other health professionals to be involved in the course to improve nursing practice concerning the use of physical restraint. In order to find a realistic alternative to the use of physical restraint, the Director of Nursing and the other Nurse Managers must support the idea in principle and in practice. For existing institutional cultures to shift the nurse managers will need to state clear philosophy and well-developed policies focusing on assessment and incorporated evaluation on the use of physical restraint. Management is also advised to balance the pressure put on the staff concerning falls prevention and the use of physical restraint.

Introduction of new care plans is advocated that will be more individualised and lead to increased communication and interaction between staff, residents and family members. The development of new individualised care plan will focus on
relaying issues of concern to nursing management. Guidelines developed by professional nursing organisations like the Irish Nurses Organisation (2003) on the use of restraint in the care of the older person would be beneficial to healthcare administrators who may have to compile local directives.

**RECOMMENDATIONS FOR FUTURE RESEARCH**

Believing that both research and practice in the care of the elderly should devote more attention to the relationship between older people’s family and the healthcare staffs, this study has indicated that there is need to explore the issue of involving family more in the care of their patient. Making the family’s care giving role more realistic and qualitative might reduce agitation, confusion, and aggression in the older people and hence reduce the use of physical restraint. I would also recommend further studies on this research topic, using a larger sample size collected in several locations across Ireland. This, I believe, will give a broader view, deeper understanding and a more generalised finding on the subject. The use of triangulation may also be considered as a better option to generate more credible data for future research on the topic. This is because of a common belief among nurse researchers that the use of multiple research approach in a sample study can ascertain obtaining and understanding of the phenomena under investigation (Denzin, 1989).

**CONCLUSION**

This study has revealed that the relatives of patients in the care of the elderly units have little or no knowledge of the meaning of physical restraint. Although they have the knowledge of the types of physical restraint, it is a common belief that the way one understands and the knowledge one has about something will affect the perception one will have about it. The findings have shown that although majority of the participants accepted the use of physical restraint, they still want to be involved in the decision to use or not use physical restraint for their patients. It appears therefore that they accepted the use of physical restraint for safety reasons and the belief that it is common practice in the care of the elderly.

Although the participants are aware of the risks involved in the use of physical restraint, yet they could not give a realistic suggestion on the alternatives to physical restraint use. It was revealed also that lack of resources and low staffing level might have constituted to physical restraint use. This study did not fail to highlight the importance of management support for nursing staff on the use of physical restraint, both in implementing the reduction or finding alternatives and also in reducing the pressure on the nursing staff to prevent falls by all means. This study therefore suggests that when nurses are faced with inescapable need to restraint elderly patients, they should adhere strictly to the INO (2003) guidelines on the use of restraint in the care of the older people. If a patient is protected from injuring himself or herself, or the others and he is provided with
the most thoughtful nursing care, then one has satisfied her conscience and guard against any legal liability.
REFERENCES


Irish Nurses Organisation (2003) Guidelines on the Use of Restraints in the Care of the Older Person. Focus Group From the Care of the Older Person Section.


Appendix 2
Participants Information Guide

Research Title: Relatives perception on the use of physical restraints in the care of the elderly.

Researcher: Grace A. Oduwole (RGN)
Supervisor: XXXX

Purpose: The aim of this study is to examine the perceptions of the relatives of elderly patients on admission in geriatric units on the use of physical restraints on the patients.

Background: The study, which is particularly oriented towards examining and discovery of a phenomenon of reality, will address the following objectives:
- To ascertain the knowledge and understanding of relatives of elderly patients on the reasons for the use of physical restraints.
- To ascertain their feelings about the use of physical restraints on the elderly patients

Procedure: If you take part in the study, you will be interviewed between 20 and 30 minutes in a quiet separate room within the hospital.

Risk: There are no known risks associated with this study. However, should any issue arise during the course of the interview which can cause distress, the hospital counselling service will be at hand to help.

Confidentiality: Your identity will remain confidential. Your name will not be used; instead, codes will be used to identify participants. The identity of individual participants and the hospital will not be revealed in the report or any other published material arising from the study.

Voluntary Participation: You have volunteered to participate in this study. You may quit at any time. If you decide not to participate, or if you quit, you will not be penalised and will not give up any benefits that you had before entering the study. If you do agree to take part, you will be requested to sign a consent form.

Ethical Approval: Ethical approval has been granted by the Ethical Committee of the Royal College of Surgeons Ireland, Dublin. If you have any concern about this study, you can contact them in confidence on Tel: (01) 4022934; Fax: (01) 4028550; email: recadmin@rcsi.ie.

Additional contacts: If you have any concerns or wish to ask any questions on the above points, please contact me on my e-mail address: or on my mobile phone No: 087 XXXX. You can also contact me through my supervisor on e-mail address:
Thank you for taking the time to participate in this study.
Appendix 3

Participant Consent Form

Research Title: Relatives perception on the use of physical restraints in the care of the elderly.

Researcher: Grace A. Oduwole

Supervisor: XXXX

I understand that I have been invited to take part in a research study on the above subject in Cherry Orchard Hospital, Ballyfermot, Dublin 10, Ireland. I understand that the result of the study may benefit me and/or other relatives. I understand the benefits and risks involved in taking part in this research study. I am aware that I will be interviewed for approximately 20 – 30 minutes in a private room within the hospital. The interview will be tape-recorded and the researcher may also take brief notes throughout the period of the interview. When the interview is transcribed, my identity will not be made known but the information may be published in nursing journals or presentations. I understand that I am free to refuse to participate or withdraw from the study at any time with or without a reason and it will not affect me in any way. I have been encouraged to avail of the confidential hospital counselling service; the details of which I have received. I am satisfied that this study has been explained to me. I have thoroughly read this consent form and I am happy that I comprehend it. All my queries concerning the study have been answered and I agree to participate.

--------------------------------------------------- -------------------------
Signature of Participant Date
--------------------------------------------------- -------------------------
Signature of Researcher Date
Appendix 4

Interview Guide Sheet

1. Tell me what you know about physical restraints?

2. Do you feel there are any advantages or disadvantages to the use of physical Restraints?

3. How do you feel when you visit and see your patient physically restrained?

4. Has anyone explained to you why physical restraint is used?

5. How often do you come in and see your patient physically restrained?

6. Can you tell me what you would like to see improved with regard to physical Restraint or what can be used as alternative?
Appendix 5

Grace A. Oduwole,
Faculty of Nursing & Midwifery,
Royal College of Surgeons in Ireland,
Dublin 2,
Ireland.
9 February, 2009

Ms.XXXX,
Director of Nursing,
Address,
Dublin,
Ireland
Dear Ma,

Application requesting access to the hospital ward to carry out a research on the relatives’ perception on the use of physical restraints in the care of the elderly

I am a registered nurse currently undertaking a Master of Science degree programme in Nursing Studies in Royal College of Surgeons in Ireland. As part of my study, I am required to carry out a research investigation. With the approval of my supervisor, Ms. XXXX I have chosen to conduct a study on the above subject. I am through this memo requesting your permission to gain access to the hospital and the care of the elderly wards. I intend to hold a semi-structured interview in relation to the topic. The interview will last between 20 and 30 minutes for each participant in a quiet private room on the ward and I will be using a gatekeeper for this purpose. To this end, I have contacted Ms. XXXX, and she has shown her interest in the study and her willingness to act as the gatekeeper.

Please, be informed that, relatives who volunteer to participate in this study will be given adequate information about the nature and procedures involved. They will be required to complete an informed consent form. Participants have the right to withdraw from the study at any time without this affecting their legal or ethical rights.

The interview will be tape-recorded and participants’ names will not be disclosed; as codes will be used for identification purpose.

I will be guided by my research supervisor during the course of the study. All ethical considerations will be duly addressed for the purpose of the study. I have applied to the Ethical Committee of the Royal College of Surgeons Ireland, Dublin requesting for the permission to carry out the study.

I will therefore, be grateful if you will afford me the access to the hospital. If you need more information or have any questions regarding the nature of this study, please do not hesitate to contact me on my mobile phone (087 XXXX).

I look forward to hearing from you soon.

Yours faithfully,
Grace A. Oduwole
Appendix 6

Grace A. Oduwole
Faculty of Nursing & Midwifery
Royal College of Surgeons in Ireland
Dublin 2
Ireland.

The Chief Social Worker,
Social Work Department,
Address,
Dublin,
Ireland.

Re: Invitation to Participate in a Research Study

Dear Madam,

I am a Master’s Degree student of the Royal College of Surgeons in Ireland. In Partial fulfilment of the award of M.Sc. in Nursing Degree, I am undertaking a research study on the Perceptions of the relatives of elderly patients on the use of physical restraint in long term care.

If accepted, your expected role will be to provide debriefing services to any of the research participants who may possibly have emotional trauma in the process of data collection.

I would appreciate it if my application is considered.

Thanks.

Yours faithfully,

Grace A. Oduwole
Appendix 7

Additional Informed Consent to be signed on the day of the Interview
Research Title: Relatives perception on the use of physical restraints in the care of the elderly.

Researcher: Grace A. Oduwole
Supervisor: XXXX

Please circle the correct response from the question below:

Do you understand that you have been asked to participate in a study?  Yes/No

Have you received and read a copy of the information sheet?  Yes/No

Do you understand the benefits and risks in taking part in this research study?  Yes/No

Would you like further time to ask questions and discuss this study?  Yes/No

Do you understand that you are free to withdraw from the study at anytime, with or without reason and it will not affect you in any way?  Yes/No

Has the issue of confidentiality, anonymity and privacy been adequately explained to you?  Yes/No

I agree to take part in this study  Yes/No

Signature of Participant
Name
Date

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate

Signature of Researcher Date