British Association of Critical Care Nurses position statement on the use of restraint in adult critical care units

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SUMMARY

• Critical care nurses in the United Kingdom have become increasingly concerned about the use, potential abuse and risks associated with physical restraint of patients.
• Restraint in critical care is not only confined to physical restraint but can also encompass chemical and psychological methods.
• There are concerns regarding the legal and ethical issues relating to the (ab)use of physical restraint techniques in critical care.
• The aim of this article was to present the British Association of Critical Care Nurses (BACCN) position statement on the use of restraint in adult critical care units and to provide supporting evidence to assist clinical staff in managing this process.

Key words: Chemical • Critical care • Ethical • Evidence • Legal • Physical • Restraint

BACCN position:

• The purpose of restraint is to facilitate optimal care of the patient.
• Use of restraint must not be an alternative to inadequate human or environmental resources.
• Restraint should only be used when alternative therapeutic measures have proved ineffective to obtain the desired outcome.
• Decisions regarding use or non-use of restraint must be made following a detailed patient assessment, by the interdisciplinary team.
• Critical care areas must develop and implement protocol/guidelines in order to assist nurses and others in this process.
• Whatever form of restraint is used there must be appropriate, continual assessment tools used and the findings acted upon.
• Clear, concise documentation of decisions, plans and treatment must be held within the patients’ record.
• The patient and their family should be engaged within discussions to inform them of the reason for choice of the restraint method.
• Education for all staff regarding chemical, physical and psychological restraint must encompass training and competency programmes in critical care units.

BACKGROUND AND INTRODUCTION

The BACCN as one of the main national organisations for critical care nurses in the United Kingdom (UK), with over 3600 members, considers that, it is the association’s responsibility to provide support to the
membership through the formulation of various position statements. Increasingly, BACCN members have been voicing their concern over the increased use of physical restraints in practice. This was noted through a growing number of requests for professional advice on this subject. The use of physical restraint in critical care is not normally accepted in the care or management of critically ill patients.

When examining the subject of restraint in health care, chemical, physical, and psychological aspects are always included. In the UK, physical restraint is neither widely accepted nor widely used, whereas in the United States of America (USA), Australia and mainland Europe, it is a more conventional practice. In the UK, it is argued that chemical restraint is used as a more accepted alternative. (Van Norman and Palmer, 2001; Maccioli et al., 2003; Royal College of Nursing, 2004).

A group of experienced critical care nurses with an interest and expertise in the area of restraint were invited via BACCN regions to form a working party. The information included in this statement refers only to adult patients, and implications for paediatrics have not been addressed.

**METHODOLOGY**

A wide range of available databases was searched to gather evidence and facilitate the evolution and development of the position statement. The databases searched included: Medline, CINAHL, Cochrane database, Department of Health and the National Research Register. Before conducting a comprehensive search of the literature, the following terms were used: restraint, physical, chemical, critical care, intensive care, education, relatives, agitation, sedation, delirium, complementary therapies, alternative therapies, legal, ethical and outcomes. Parameters included English language, articles relating to human subjects and articles restricted to the last 15 years. The literature was then reviewed through the following categories:

- Legal and ethical issues
- Alternative therapies
- Chemical restraint
- Physical restraint
- Risk management issues
- Educational issues
- Department of Health: policy and other professional documents
- Views of patients and their families

With regard to ‘restraint in critical care’, the majority of available literature emanated from the USA and Australia, with few examples from the UK, and is mainly focused on physical restraint. Similar to other guidelines regarding restraint (Maccioli et al., 2003; Evans et al., 2002), the working group found the available evidence, to be focused on individual cohort studies, case series and qualitative studies. The group set out to construct a document as a resource for critical care staff, based on the best current available evidence, to qualify the points of the position statement and act as a resource for critical care staff when considering restraining therapies in any form.

**LEGAL AND ETHICAL CONSIDERATIONS**

Critically ill patients depend upon nursing staff to attend to all their basic and complex needs (Reigle, 1996). During confusion or delirious states, patients may inadvertently remove their endotracheal or tracheostomy tube, dislodge their vascular access or arterial line or remove dressings and expose a surgical wound, thus jeopardising their well-being. Preventing and protecting the patient from harm are central nursing responsibilities for individuals who are temporarily incapacitated. Jacobi et al. (2002) suggest that 80% of intensive care unit (ICU) patients may experience some degree of agitation during their stay; the causes of this are numerous and are covered in another section of this article. The use of physical and chemical restraint may be seen as a simple solution to this problem; however, it is complicated by a professional obligation to ensure that patient freedom, dignity and autonomy are maintained (Reigle, 1996) and enshrined in the Code of Conduct (Nursing and Midwifery Council, 2002). Physical restraints are associated with risk and are a drastic intervention, so it follows that patient consent must be sought (Department of Health, 2001). However, when discussing restraint in general, professionals may consider the need to obtain consent for physical restraint, yet if a decision is made to administer chemical restraint for critically ill person consent is rarely sought (Van Norman and Palmer, 2001).

Everybody has the right to be free from the use of an unauthorized force to restrain their movements, unless they are subject to legal detention (Human Rights Act, 1998). In addition, no one should be subjected to torture or degrading treatment (Human Rights Act, Article 3, 1998). However, The Mental Health Act of 1983 (Department of Health and Welsh Office, 1999) notes five common reasons for the use of restraint, of which non-compliance with treatment, self-harm and risk of a physical injury by an accident, being the two most relevant in the critical care setting. The Mental Health Act (Department of Health and Welsh Office, 1999) also points out that ‘Restraints may take many
forms. It may be both verbal and physical and may vary in degree from an instruction to seclusion.’ Moreover, Happ (2000) suggests that when a patient believes he is restrained, he is, psychologically.

Patients in critical care environments may undergo changes to their normal behaviour, due to their underlying illness and pathology. Carers in critical care units face difficult decisions about identifying strategies to prevent the patients from harming themselves. The Department of Health, (2001) guidelines on consent are clear, and it adds that no one is able to give consent on behalf of another; however, the need to communicate and work closely with the patient and relatives is stressed. These guidelines emphasize that consent is not a one-off process, but ongoing and encompasses treatment, physical investigation and personal care for patients. In Scotland, the Adult with Incapacity Act (Scottish Executive, 2000) states that guardians may be appointed to help with decision making on behalf of the adult with incapacity. Many interventions used within critical care environments can impair the patient’s ability to make such decisions, i.e. medication, illness, language barriers and emotional distress. The need to respect patient autonomy is widely upheld as a measure of professional practice, but it implies that the individual is competent or that there is an elected guardian to represent their best interests. When consent cannot be obtained it is recognized that the ‘reasonable person’ rule can be applied. This enables a professional to act in the best interests of the patient according to approved accepted standards of care. It is reasonable to assume that a ‘reasonable person’ would wish to be treated for life-threatening conditions when not able to give consent. (Dimond, 2002). The Department of Health (2001) advises that if clinical staff are unsure of the legal implications of an intervention, then expert advice should be sought from the associated legal department.

Critical care staff have a moral obligation to do no harm, non-maleficence and to promote good, beneficence (Beauchamp and Childress, 1994). This implies that health care professionals need to balance the risks and benefits associated with all forms of restraint. This is confounded with patients who lack the capacity to consent, and rapid decisions are needed to ensure that patients do not harm themselves. In such cases, actions need to be justified, and for the purpose intended (Reigle, 1996), introducing guidelines for staff to follow will aid in such judgements when they have to be made (Vance, 2003).

Balancing the best interests of the patient to ensure safety and promoting the patients well-being and safeguard their interests may be difficult, but is the responsibility of the nurse who must adhere to their Code of Professional Conduct (Nursing and Midwifery Council, 2002). Happ (2000) felt that the nurse’s presence at the bedside was a crucial element in the reduction of the use of restraints and that the environment and use of other diversional therapies should also be considered. In the USA, legislation from the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission on Healthcare Organizations (JCAHO), 1996) and malpractice claims have led to a review of practice regarding the overuse of physical restraints (Kapp, 1996). As cited in Vance, (2003), the JCAHO standard for physical restraint must be limited to be ‘clinically appropriate, adequately justified and used only after all other non-restrictive and innovative alternatives have failed’ (p.87). The Joint Commission on Healthcare Organizations (JCAHO), (1996) also suggest monitoring the amount of physical restraint used as a quality indicator. Changing the practice and culture in the USA in reducing the use of physical restraints has presented challenges to nursing staff trying to explore alternative methods whilst maintaining patient safety (Vance, 2003).

When all other alternative therapies have failed, and as a last resort, in the UK there are situations when it would be seen as lawful to use reasonable force and to restrain a patient (Dimond, 2002). These are:

- To prevent self-harm or risk of physical injury,
- Where staff are in immediate risk of physical assault,
- To prevent dangerous, threatening or destructive behaviour.

However, nurses need to ensure that this is reasonable and proportionate to the circumstance, otherwise they may face allegations of assault (Department of Health, 2001; Royal College of Nursing, 2004) or breach of the Human Rights Act, Article 3 and 5. (Human Rights Act, 1998). Consensus needs to be reached between the health care professionals, patient and relatives where possible. (Department of Health, 2001; Royal College of Nursing, 2004).

**RISK MANAGEMENT ISSUES**

The majority of evidence on physical restraint comes from the USA where restraint techniques have been used in many clinical settings. However, there is little substantial evidence to support restraint in reducing patient self-harm and injury (Kapp, 1996; Mion, 1996; Martin, 2002; Maccioli et al., 2003). Evidence from the USA suggests that physical restraints were not consistent in preventing self-extubation, indeed such interventions may aggravate and increase the
incidence of patient agitation. Anecdotal reports suggest that restraint of patients has led to death and injury (Robinson et al., 1993). It is further reported that injuries have occurred when staff have neglected to monitor and adjust restraints (Kapp, 1996). Other effects of physical restraint are expanded on elsewhere in this article. Reports from the USA evidence claims of negligence and battery made when patients have been restrained. The result of which has led to the need for physical restraints being a prescribed device and written standards being produced (Joint Commission on Healthcare Organizations (JCAHO), 1996), as a means to limit overuse in institutions (Kapp, 1996). Further studies suggest that reduced nurse:patient ratios may increase the use of both physical and chemical restraints (Mion, 1996; Leith, 1998; Heffner, 2000). There is a growing evidence to suggest that higher nurse:patient ratios are associated with better patient outcomes (Doering, 2003). Nurse:patient ratios must be considered, and lack of nursing staff is not a rationale for utilizing restraint therapies (Royal College of Nursing, 2004).

Whilst clinical practice in the UK may not rely on physical restraint techniques, chemical restraint is used as a means of sedating patients (Heffner, 2000; Van Norman and Palmer, 2001). The potential adverse effects and risks of sedation overuse and an increased duration of mechanical ventilation is expanded on elsewhere in this article. In order to undertake risk assessment for the use of restraint in critically ill adult patients a number of factors need to be taken into consideration (see Table 1).

### Agitation, confusion and delirium

Patients who are delirious or agitated may require some form of restraint. As stated earlier, when patients become agitated or confused they may remove their invasive lines, life-saving equipment, become aggressive and even expose themselves (Maccioli et al., 2003). Jacobi et al. (2002) suggest as many as 80% of patients in critical care have agitation and delirium, which they define as: ‘an acutely changing or fluctuating mental status, inattention, disorganized thinking and an altered level of consciousness that may or may not be accompanied by agitation’ (p 131).

Despite the high incidence of delirium it is often under-recognized and may be under-treated (Truman and Ely, 2003). Delirium in critical care has been identified as an independent risk factor for prolonged hospital stay (Ely et al., 2001). Sedation scales provide information about the level of consciousness or arousal but do not assess the subtleties of consciousness. (Truman and Ely, 2003). The Society of Critical Care Medicine guidelines recommend that critically ill patients be monitored for their level of sedation and for the risk of developing delirium (Jacobi et al., 2002).

Assessment tools such as the Confusion Assessment Method (CAM–ICU) can be used to assess for delirium (Truman and Ely, 2003). Treatment of delirium should first involve prevention, by trying to re-orientate patients, minimizing noise and regular analgesia and include a review of the patients’ current drugs. Truman and Ely (2003) argue that benzodiazepines and narcotics that are often used in critical care to treat confusion/delirium actually ‘worsen cognition and exacerbate the problem’ (p. 34). Clonidine has been used to augment the effects of sedation in agitated patients and may be useful in patients who are agitated, where the possible cause may be drug withdrawal syndromes (Ip Yam et al., 1992; Spies et al., 1996). Jacobi et al. (2002) recommend that Midazolam or Diazepam be used for rapid sedation of acutely agitated patients and Haloperidol as the preferred agent for the treatment of delirium in critically ill patients.

### Table 1 Risk issues

- The decision to restrain an individual should be informed through a multidisciplinary collaborative forum, the purpose of which is to ensure that a global professional perspective is sought
- Where possible, the consent of the patient or preferred patient choice should be gained. If this is not feasible, assent of the next of kin should be attempted
- A mechanism for staff to voice concerns if they disagree with a decision should be supported
- The decision to restrain should not be influenced in any way by the degree or lack of staffing levels within the ward area
- The discussion, beforehand should address the method of restraint to be used, when and for how long, with this agreement being clearly documented in the patient’s plan of care
- Guidelines/policies need to be available to guide staff and to standardize the use and application of restraint techniques within the clinical environment
- A risk assessment model should be adopted by the organization to ascertain the need, choice and type of restraining technique
- Clear documentation of the decision to restrain should be made within the patient’s medical notes. Further to this, documentation should state when the restraint is released for clinical assessment or removal
- The adoption of any restraint technique needs to be accompanied by a recognized training programme
- Physical restraint should never be used in a manner that may be considered indecent or undignified
- Where possible, a sufficient number of staff that are trained and confident in safe and appropriate techniques and in alternatives to restraint should be ensured
- Equipment used for physical restraint is accepted commercially evidenced based and adheres to national guidelines
- Audit of restraining techniques should be implemented to inform practice
Considerations for managing delirium are listed in Table 2.

Pre-disposing factors of agitation, confusion and delirium
Agitation has treatable causes including pain, sleep deprivation, hypoxia, mechanical ventilation, fear, myocardial ischaemia and altered cell metabolism (Powers, 1999). Anxiety can cause a patient to be agitated and render them vulnerable to self-injury. This can escalate to confusion and agitation and, if not addressed, can lead to full-blown delirium (Marshall and Soucy, 2003). Anxiety and stress are influenced by a number of factors including an inability to communicate and frustration, unfamiliar surroundings (Barr and Donner, 1995), frequent procedures, loss of control over self, anticipation of real or imagined danger, noise, irregular sleep and wake patterns (White and Zellinger, 2001).

Critical care personnel should aim to minimize negative effects of the physiological response to stress (Epstein and Breslow, 1999), which can be triggered by pain, anxiety, fear and sleep deprivation (Hooper and George-Gay, 1997). Physiological stress response causes the release of catecholamines, which in turn causes impaired cellular metabolism, myocardial ischaemia, myocardial ischaemia and increased oxygen consumption. It is important to control anxiety and agitation to improve tolerance to endotracheal or tracheostomy tubes to enhance ventilator synchronisation with the patient (Egerod, 2002).

Physical and psychological causes for delirium and ICU syndrome result from organic and metabolic effects, patient’s personality, age and emotional conditions at onset of illness. Environmental factors include isolation, impersonal environment, sensory overload and sleep deprivation (Granberg et al., 1996). Other pre-disposing factors include: drugs, infection, stress, lack of sleep or too much or too little stimulation. Advanced age brings additional challenges, as the elderly are more sensitive to changes to hypoxia (Marshall and Soucy, 2003). Precipitating factors include stress, difficulty communicating, reduced mobility, altered body image, altered identity, isolation and loneliness.

Pain and general discomfort
This can be caused by the underlying disease and is a common reason for agitation. It is a significant cause of anxiety in patients and contributes to the stress response. Analgesia is vital in achieving optimal sedation (White and Zellinger, 2001); however, difficulties arise in critical care in assessing pain levels in patients who are not able to communicate (Slomka et al., 2000). Strategies must be used to assess and manage pain in critically ill patients. (Shannon and Bucknall, 2003).

Under-sedation
Under-sedation occurs in patients with increased metabolic states and history of drug and alcohol abuse, resulting in an increased tolerance. It is easily recognized as agitation, anxiety and sometimes attempts by the patient to remove invasive devices such as intravenous lines, endotracheal tubes and attempts to get out of bed or aggressive movement towards staff in the unit. Under-sedation can cause adverse cardiovascular effects such as tachycardia, hypertension, increasing metabolic rate and oxygen requirements and lead to inadequate ventilation (Carrasco, 2000).

Noise
Noise is a significant stressor for patients. Contributory factors are inappropriate alarm settings, suction equipment left on after use and telephones (Dyer, 1996). Staff conversations have been regarded as a significant source of noise and confusion for patients. Patients have remembered hearing parts of conversations during bedside ward rounds, which led to misinformation and fear and contributed to persecutory delusions (Russell, 1999).

Inadequate sleep
Sleep is needed for the healing process and, if inadequate, can contribute to increased morbidity and mortality (Krachman et al., 1995). Sleep is necessary for patients to prevent ICU psychosis (Ollevaet et al., 1998) and can be helped by sedation. Nursing interventions can disturb sleep and cause a vicious cycle resulting in reversal of sleep-wake cycle. Lack of natural light, noise, pain, separation, communication, immobilization all contribute to disturbed sleep.

Alcohol withdrawal
The prevalence of dependence on alcohol in the UK overall is 74 per 1000:119 per 1000 in men and 29 per 1000 in women (Singleton et al., 2001). These figures
are higher in the younger adults: currently there are 150,000 alcohol-related hospital admissions per year. Potentially, critical care units will be caring for more patients with alcohol dependence in the future. Complications of alcohol abuse are common. Alcohol withdrawal syndrome (AWS) includes symptoms of delirium, pancreatitis, seizures, aspiration syndromes, acute respiratory distress syndrome, sepsis and multiple metabolic disorders. Delirium tremens (DTs) will develop in 5% of those hospitalized for AWS and rise to 15% if not treated. AWS develops when levels of alcohol fall after prolonged or excessive consumption. This is due to reduced alcohol levels in the brain, which create an imbalance and excessive neuronal activity (Satiz, 1998).

Watling et al. (1995) suggest that an alcohol withdrawal protocol can co-ordinate care for patients dependent on alcohol. This allows for staff to measure signs of withdrawal objectively, to administer drug doses based on withdrawal symptoms and allows flexibility in administering appropriate doses. Substitution of the drug that has been abused with another one having a similar pharmacological profile is the general approach to treatment of physical drug dependency (Crippen, 2000). The choice of drug should be one such as midazolam, which can give as a continuous infusion that can be altered rapidly if required. Haloperidol is beneficial in the treatment of restlessness and aggressive agitation especially in combination with benzodiazepines (Crippen, 2000). Other medications include chlorodiazepoxide, chlormethiazole and occasionally alcohol orally. Benzodiazepines are easily titrated for controlled withdrawal and less toxic to organ systems and are favoured over the use of ethanol infusions to treat DTs. Propofol can also be used when sedation alone is insufficient because of its progressive dose dependent continuum of anxiolysis, hypnotic, sedation and finally anaesthesia. In critical care, these medications are not given as a method of curing the addiction but to control the symptoms of withdrawal, during the critical illness phase and help compliance with treatment as a supportive measure. (Honisett, 2001).

**Nicotine withdrawal**

This can cause delirium, which is reversible (Mayer et al., 2001). Patients admitted to intensive care are subjected to enforced nicotine withdrawal, as nicotine is addictive. Smokers have been shown to be more likely to self-extubate than non-smokers (Atkins et al., 1997). It is normally noted on admission or from the patient’s family, whether and how much a patient smokes. This is called the fifth vital sign (Fiore and Jorenby, 1992). Honisett (2001) suggests nicotine replacement therapy has a place in treating symptoms of withdrawal and can reduce length of stay in ICU. It is reported by Balfour et al. (2000) that nicotine replacement therapy is well known and is now standard treatment for people who stop smoking. Nicotine patch alleviates symptoms of withdrawal including cravings, changes in heart rate and improvement of delirium. There is uncertainty about the efficacy and safety of nicotine patches especially with cerebrovascular disease, e.g. post-myocardial infarction or cerebrovascular accident due to the possible increase in thrombogenic potential of cerebral endothelium (Mayer et al., 2001).

**Other drug withdrawal**

This can be managed with replacement therapy of sedation with benzodiazepines or propofol. Replacement with fentanyl, morphine or methadone can be used for narcotics. (Mayer et al., 2001).

A summary of managing factors associated with agitation and confusion are listed in Table 3.

**ALTERNATIVE NON-RESTRAINT METHODS/CONSIDERATIONS**

**Complementary and alternative therapies**

Evidence regarding complementary and alternative therapies varies in quality and quantity, though, for specific conditions the evidence base is more robust (Kreitzer and Jensen, 2000). Patients in critical care have complex physiological and psychological needs, and there is currently little substantive evidence overall; however, the use of such therapies can be considered if thought beneficial for the individual patient (Kreitzer and Jensen, 2000). In reviewing the evidence related to critical care settings, the following was found with regard to specific therapies:

**Massage**

Richards et al. (2000) found this could be beneficial for patients, in promoting relaxation and reducing pain. More robust research is required with regard to reducing anxiety in critical care patients (Richards et al., 2000).

**Music therapy**

Wilkins (2003) demonstrated that music reduced agitation in confused patients, improved mood and facilitated communication. Music therapy is easy to administer, relatively inexpensive, non-invasive intervention that can reduce anxiety and pain. (White, 2000).

**Acupuncture**

Acupuncture and acupressure are commonly used to reduce anxiety in the Orient but infrequently within Western medicine. (Cohen and Abraham, 2002).
Table 3 Management of predisposing factors for the agitated patient

<table>
<thead>
<tr>
<th>Are any of the following conditions present?</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol/nicotine addiction</td>
<td>Determine amount, frequency, type of consumption and administer appropriate alternative drug therapies</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Investigate previous history of such and potential treatment to alleviate problem</td>
</tr>
<tr>
<td>Central nervous system disorders</td>
<td></td>
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<tr>
<td>Psychological or emotional disturbances</td>
<td></td>
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<tr>
<td>Personality type</td>
<td></td>
</tr>
<tr>
<td>Chronic renal, hepatic, cardiac, pulmonary dysfunction</td>
<td>Monitor condition, address alterations in blood chemistry</td>
</tr>
<tr>
<td>Advanced age (i.e. &gt;65 years)</td>
<td>Be aware of multiple aetiologies and medications</td>
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<tr>
<td>Reduced nutrition</td>
<td>Check electrolytes/fluid balance</td>
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<tr>
<td>Vitamin deficiency</td>
<td>Vitamin and mineral screen, trace elements</td>
</tr>
<tr>
<td>Dehydration</td>
<td>Involve dietician</td>
</tr>
<tr>
<td>Brain trauma</td>
<td>Monitor and report changes in conscious level</td>
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<tr>
<td>Possible drug reaction/interactions</td>
<td>Review drug prescription chart</td>
</tr>
<tr>
<td>Hypoxia/dyspnoea</td>
<td>Check for side effects interactions, and incompatibilities</td>
</tr>
<tr>
<td>Pain</td>
<td>Check arterial blood gas, oxygen saturation, ventilator settings and function, and adjust to optimise patient’s condition</td>
</tr>
<tr>
<td>General discomfort</td>
<td>Assess and monitor pain levels, and ensure adequate analgesia is administered</td>
</tr>
<tr>
<td>Anxiety/fear/stress</td>
<td>Change of position</td>
</tr>
<tr>
<td>Communication difficulties</td>
<td>Check for urinary retention</td>
</tr>
<tr>
<td></td>
<td>Bowel/incontinence evaluation</td>
</tr>
<tr>
<td>Under sedation</td>
<td>Reassurance and explanation of procedures</td>
</tr>
<tr>
<td>Environmental factors</td>
<td>Provision of appropriate communication aids</td>
</tr>
<tr>
<td>Sleep deprivation</td>
<td>Minimise isolation as far as possible</td>
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<td></td>
<td>Allow participation of family/friends</td>
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<tr>
<td></td>
<td>Consider alternative/diversional therapies</td>
</tr>
<tr>
<td></td>
<td>Consider anxiolytics</td>
</tr>
<tr>
<td>Environmental factors</td>
<td>Reduce noise levels to promote comfort</td>
</tr>
<tr>
<td>Sleep deprivation</td>
<td>Maximise sleep/minimise interventions</td>
</tr>
<tr>
<td></td>
<td>Encourage day/night lighting and rest periods. Assess environmental conditions e.g. temperature and adjust accordingly</td>
</tr>
</tbody>
</table>

**Communication**

Efforts to communicate with the patient via a non-verbal route are frequently unsuccessful, causing patients to feel frustrated, depersonalized and insecure. Verbal communication with the patient is often impossible due to the presence of an endotracheal or tracheostomy tube (Hewitt, 2002). Studies of patient’s recollections of ICU demonstrate that staff in often fail to acknowledge a sedated patient’s presence when discussing physiological condition and treatment plans (Russell, 1999). Comments on poor prognosis increases their fear of impending death and disability, contributing to anxiety confusion. (Russell, 1999, Rotondi and Chelluri, 2002).

**Therapeutic touch**

Expressive touch can enhance communication with a sedated patient. Its use informs the patient that the nurse is focused on them. There is evidence that touch has a comforting and calming effect on patients (Mclnroy and Edwards, 2002).

**Involvement of relatives**

Relatives and friends are a support in sustaining orientation of the patient. Their inclusion with planning care should be valued (Hewitt, 2002). Human beings provide an important part of the sensory environment for most patients.

**Melatonin**

Small short-term studies (Bonn, 1996) have suggested that melatonin can improve sleep quality by co-ordinating biological and circadian rhythms. Further research needs to be carried out into this area.

If ICU staff are considering the introduction of complementary and alternative therapies to critical care practice, it is recommended that the following are considered: collating the evidence base with regard to
safety and efficacy, consent from the patient, appropriateness of the therapy, developing and utilizing protocols, use of qualified therapists, education, training and audit (Kreitzer and Jensen, 2000; Royal College of Nursing, 2003).

CHEMICAL RESTRAINT
Traditionally chemical restraint within critical care settings is used in the following ways:

- Sedation, most commonly, involves continuous intravenous sedation given to patients being mechanically ventilated.
- Neuromuscular blocking agents or paralysing drugs, sometimes used to prevent patients breathing themselves whilst on mechanical ventilation, or to prevent raised intracranial pressure in head-injured patients.
- Anxiolytics Drugs used specifically to manage agitated, acutely confused, delirious patients. This includes sedation and antipsychotic drugs.

Sedation
Sedation is most commonly in critical care for patients who are being mechanically ventilated and is given for the following reasons: comfort, reduction of anxiety, amnesia, to facilitate care such as ventilation and to reduce myocardial oxygen demands (Ball, 2002). Woodrow (2000) claims that there are sound humanitarian arguments for the use of sedation, which include the reduction of discomfort from the endotracheal tube and ensuring that the patient is synchronous with the ventilator. Accepting that there are sound humanitarian arguments for the use of sedation in critical care, there does, however, appear to be a tendency to over-sedate patients (Heffner, 2000), and sedation can have significant unwanted side effects, such as:

- Hypotension, producing increased need for inotropic drugs.
- Detrimental effects on the pulmonary vasculature increasing V/Q mismatch.
- Reduced rapid eye movement (REM) sleep. No sedatives provide REM sleep, and a lack of REM sleep can be a common cause of ICU psychosis.
- Accumulation leading to delayed weaning and increased length of ICU stay.
- Reduced intestinal motility which can impair the establishment of enteral feeding. (Intensive Care Society 2003 www.ics.ac.uk/downloads/sedation.pdf).

Park (2002) highlights that in the UK the medical approach to sedation is one that focuses on sedation first, with pain relief considered as an adjunct therapy. This approach argues Park (2002), can lead to over sedation. The Society of Critical Care Medicine guidelines for the sustained use of sedatives in the critically ill (Jacobi et al., 2002) states that the optimal sedation level will be influenced by the patient’s illness and the supportive treatments they require. Many of the sedation assessment tools aim for an optimal sedation level where the patient receives the minimal amount of sedation that enables them to be aware but calm and tolerant of treatments such as mechanical ventilation. Some patients however, may require deep levels of sedation to facilitate mechanical ventilation (Jacobi et al., 2002). The Society of Critical Care Medicine guidelines (Jacobi et al., 2002) state: ‘The desired level of sedation should be defined at the start of treatment and re-evaluated on a regular basis as the clinical condition of the patient changes.’ (p. 124). In the UK, sedation is commonly given by continuous infusion. This method may prolong the duration of mechanical ventilation, length of stay in critical care and may increase the need for tests such as computed tomography (CT) scan to assess alterations in mental status.

In a randomised controlled trial, Kress et al. (2000) demonstrated that stopping continuous sedative infusions once per day reduced the time spent on mechanical ventilation. In the control group where sedation was stopped at the discretion of a doctor, the median duration of mechanical ventilation was 73 days, whilst in the intervention group, who had a daily sedation hold it was 4.9 days. Duration of ICU stay was also shorter in the intervention group and they required fewer tests such as CT scans to assess changes in their mental status. This practice of sedation holds is now being promoted by the Modernization Agency as part of a ‘care bundle’ for ventilated patients (Berenholtz et al., 2002; Fulbrook and Mooney, 2003).

Jacobi et al. (2002) recommend that a validated sedation assessment scale be used. There are a number of Sedation Scales that have been validated for use in critically ill patients such as the Motor Activity Assessment Scale (Devlin et al., 1999) and the Ramsey scale (Ramsay et al., 1974). Many of the scales define categories of sedation but do not guide the titration of therapy. In the UK, the following are commonly used for sedation:

- Anaesthetics induction agents
- Hypnotics
- Opioids
- Benzodiazepines

Less common drugs include Remifentanil and Clonidine. Remifentanil is a new type of analgo-sedation, with a
more predictable action. It has a rapid onset and rapid offset (Park, 2002). Lane et al. (2002) described the use of remifentanil in 17 patients. Patients sedated with remifentanil received less propofol or midazolam, and eight of the patients were able to be sedated using remifentanil alone. Further research needs to be done on using remifentanil in critical care involving larger numbers of patients, but this approach of treating pain first and then using hypnotics if required may mean that patients are able to remain more awake whilst on intensive care and may therefore require less chemical restraint. Recommendations for the use and management of sedation are listed in Table 4.

**Neuromuscular blocking agents**

The use of neuromuscular blocking agents to paralyse patients could be considered the most hazardous kind of chemical restraint used in intensive care, especially in view of the potential risk that the patient may be insufficiently sedated (aware) and paralysed. The Society of Critical Care Medicine guidelines (Murray et al., 2002) state that neuromuscular blocking agents should only be used as a last resort, in the following circumstances – an increased intracranial pressure, muscle spasms and to decrease oxygen consumption, but only after all other treatments to improve the clinical situation have been tried. The guidelines also state that neuromuscular blocking agents should be stopped daily and only restarted if the patient’s condition requires them. Recommendations for the management of neuromuscular blocking agents are listed in Table 5.

**PHYSICAL RESTRAINT**

In a systematic review of evidence regarding physical restraint in acute and residential settings, Evans et al. (2002a) found that between 7% and 17% of hospital patients are subject to physical restraint. There are reports of the adverse effects of physical restraint, which can culminate in death (Miles and Irvine, 1992; Ruben et al., 1993; Parker and Miles, 1997). The Food and Drug Administration (FDA) estimated that at least 100 deaths occurred annually from improper use of restraints (Milliken, 1998). Evidence demonstrates that the use of physical restraint can lead to: skin trauma, pressure sores, muscular atrophy, nosocomial infection, constipation, incontinence, limb injury, contractures, depression, anger, a decline in functional and cognitive state and increasing agitation (Evans et al., 2002a; Royal College of Nursing, 2004). It is reported that there are negative effects on patients and their families, with patients feeling disgraced and embarrassed in remembering the experience (Strumpf and Evans, 1988; Kanski et al., 1996). The negative effects on patients and their families in critical care are described in another part of this article.

Harm associated with physical restraint is usually explored in terms of physical or psychological injury, rather than in terms of patient’s rights. It is suggested that benefits of physical restraint increase a patient’s vulnerability to neglect and harm, are unproven, have no scientific basis and no clinical trials have evaluated the effectiveness of restraints (Reigle, 1996). In critical care, two studies demonstrated that the incidence of self-extubation in already restrained patients exceeded 60% (Cappolo and May, 1990; Grapp et al., 1995). Where physical restraint has been traditionally used and accepted, such as the USA, there are increasing concerns about it’s use, aiming to balance this intervention with the rights of the individual, providing humane care and ensuring patients come to no harm (Reigle, 1996). Efforts are now concentrating on reducing restraint in areas where it has been traditionally used, and have been more successful in residential settings than acute care (Evans et al., 2002a). Different programmes and approaches are required depending upon the setting but have demonstrated success in the ICU (Vance, 2003). Considering the physical, psychological and ethical aspects of physical restraint, it is advocated that such is only used when all other...
methods of managing the problem have failed, employed with caution and as a last resort (Royal College of Nursing, 2004; Joint Commission on Healthcare Organizations (JCAHO), 1996; Reigle, 1996).

Recommendations when using physical restraint are included with risk issues as summarized in Table 1.

**PATIENT AND RELATIVES PERSPECTIVES ON PHYSICAL RESTRAINT**

Little evidence pertaining to patient and relatives perceptions on the use of physical restraints in critical care was found. Most of these articles originate from USA, Australia and one from Italy where the use of physical restraints is widely recognized and accepted within their culture as an agreed method of practice. In these countries, there is currently little or no critical care follow-up provision and therefore their findings and patient numbers are limited, as is their use of chemical restraint.

Minnick et al. (2001) concluded that ‘patients do not remember great distress specifically related to the use of restraints, but the overall situation leading to the use of restraints is disturbing if remembered’. Six patients (40%) in this study did remember being restrained, and the behaviour which led to this (pulling intravenous and ventilator tubing). Although they reported knowing that they needed to stop, they were unable to do so. Four of these six patients remembered having visitors whilst restrained. None indicated any embarrassment or distress that their relatives witnessed this restraint. Two key themes, which should be taken into consideration, highlight the therapeutic use of physical restraints. Firstly, those patients who remembered restraints being used believed that they were used for the patients’ own safety, that nothing else could be done and the restraints were removed once the patients were no longer agitated. Secondly, and of equal importance, was that the patients may have accepted restraints because they remembered at least one nursing action that enhanced the acceptability of restraints.

Another study (Simini, 1999) researching into patient’s perceptions of ICU found six patients of 55 interviewed remembered being ‘tied to the bed’, which is a small number if common practice is to physically restrain all patients.

Completely juxtaposed to this, Bower and McCullough (2000); Rotondi and Chelluri (2002) and Russell (1999) indicate that studies over the past 20 years, have found that patients had ‘negative feelings and described the event as very unpleasant’. Feelings such as anger, fear, resentment and not knowing the rationale for being restrained were noted.

The evidence from the studies previously described demonstrate how patients and families perceive restraint and highlights that the latter are upset seeing their loved ones restrained and want to know more about the consequences of such policies. Few seemed to understand the rationale for using restraints and many were worried about the physical and psychological harm arising from these interventions on the patient. Involving the families in patient care was found to be a helpful way to reduce restraint use (Evans et al., 2002), this is a theme highlighted by Hewitt (2002), who recognizes that relatives and friends can provide support by assisting with orientation and should be valued as a resource.

**Evidence from the UK**

During the last decade, more research has developed into the follow-up of critical care patients, focusing on their physical and psychological outcomes. (Eddleston et al., 2000; Hayes et al., 2000; Skirrow et al., 2001; Jones et al., 2003) Such studies have started to describe the physical and psychological problems encountered by critical care patients, during and after their stay in critical care. These studies do suggest that both environmental factors and chemical therapies in critical care contribute to delusional behaviour of the critical care patient. As recommended by Skirrow et al. (2001), the aim for future enquiry is to investigate further the causes of disorientation and psychotic episodes in our patients, to enable critical care staff in managing and preventing them.

A follow-up service is an excellent way to seek out both patient and relatives experience and feelings of their critical care admission (Griffiths and Jones, 2002) and to evaluate restraint practice in general. Developing such a service is now recommended for critical care units (Audit Commission, 1999; Department of Health, 2000) and can act as a valuable forum to evaluate the effects of clinical practice. Recommendations with regard to involving patients and their relatives are summarized in Table 6.

**Table 6 Inclusion of patients and families**

- The important role of the family as a resource to support the patient and reduce restraint therapies should be made explicit. Inclusion of patients, families and intensive care unit staff in discussions prior to the use of physical restraints
- Recognition of a multicultural population means available translations/translator are necessary to discuss this issue
- If units are to adopt physical restraint therapies, this must be included in all patient and relative information booklets
- Information from any ‘follow-up’ service should be fed back to the critical care unit to inform future practice
- Further research to include the patient and relative perspective is necessary to provide best practice guidelines.
Education and training

Educational programmes in critical care should address all types of restraint therapies. The USA and Australia are now addressing a reduction in physical restraint (Evans et al., 2002; Martin, 2002; Vance, 2003), by developing educational programmes aimed at enhancing understanding of:

- patients rights and autonomy;
- ethical aspects of restraining patients;
- legal aspects;
- impact and dangers of physical restraint;
- restraint alternatives.

Such initiatives need to be developed in the UK, but also encompass creating greater awareness of chemical restraint as well as ways of preventing or minimizing these approaches (Heffner, 2000). Recommendations to assist in education and training are summarized in Table 7.

Current research

The European Society of Intensive Care Medicine Nursing Section is currently undertaking a study on Physical Restraint in Intensive Care in Europe (PRICE study) The purpose of this study is to establish the incidence and reasons for physical restraint in adult intensive care units in Europe. The research will also be addressing any differences in the use of physical restraint and any relationship between nurse:patient ratios.

Dr Christina Jones and Professor Richard Griffiths are co-ordinating a study regarding ‘Psychological recovery from critical illness’ between the Whiston Hospital Liverpool (UK), Ferrara Hospital (Italy), Norrkoping and Gothenburg (Sweden) and Bergen (Norway). The Italian group is collecting data on the patient’s memory of restraint and any later symptoms of Post Traumatic Stress Disorder.

The results of these studies will be disseminated internationally and added to the body of research within this field of practice.

It is recognized that further research needs to be undertaken to explore the practices, physical and chemical restraint and reflections of patients/relatives concerned with their experiences of restraint within critical care.

CONCLUSION

This position statement was constructed following requests from members of the BACCN to explore the issues regarding all types of restraint therapies in critical care. It was perceived to be an important area of practice to review. Therefore, the international and national evidences available were critiqued by the working party and the statement formulated. The publication of this work aims to provide health care professionals and managers with the meaningful position of the BACCN. It is not intended to be explicitly prescriptive but to highlight to members, areas to be considered in order to inform their practice. The essence, core beliefs and values of the BACCN are withheld throughout this position statement, which centres on the needs of the critically ill patient and family to receive the highest standard of care available.

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REFERENCES


APPENDIX
Definitions of restraint

**General**
‘In broad terms, it means restricting someone’s liberty or preventing them from doing something they want to do.’ (Royal College of Nursing, 2004)

**Physical**
‘Any physical or mechanical method of restricting a person’s freedom of movement or physical activity to his or her body’ (This includes the use of four bed rails in the upright position)

Devices which do not constitute restraint are those customarily used in conjunction with medical diagnostic procedures, treatments, or movement/transfer of patients and are considered a regular or usual part of treatment (Joint Commission on Healthcare Organizations (JCAHO), 1996 www.jcaho.org)

**Chemical**
‘A drug used as a restraint to control behaviour or to restrict the patient’s freedom of movement, and is not standard treatment for the patient’s medical or psychiatric condition. [Centers for Medicare and Medicaid Services www.cms.hhs.gov cited in Martin, (2002)]

**Psychological restraint**
‘If the patient believes he is restrained, he is at least psychologically restrained.’ (Happ, 2000)