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By Lois K. Evans, PhD, RN, FAAN, and  
Valerie T. Cotter, MSN, CRNP, FAANP

# Avoiding Restraints in Patients with Dementia

*Understanding, prevention, and management are the keys.*



Ed Eckstein

**Overview:** Older adults with dementia are at higher risk than other patients for being placed in restraints, despite numerous negative physical and psychological outcomes associated with their use. Many nurses continue to believe that restraints are necessary to control behavioral symptoms and prevent falls or the disruption of life-sustaining therapies in patients with dementia. Reducing the use of restraints depends on interpreting patient behavior to identify unmet needs; regular assessment for changes in mental or physical status; individualized care focused on communication, consistency, surveillance, and appropriate environments; and a flexible team approach based on dialogue among staff members and respect for patients' needs and rights. For a free online video demonstrating the use of the practice guide, go to <http://links.lww.com/A231>.



### Web Video

Watch a video demonstrating the use and interpretation of the practice guide, *Avoiding Restraints in Older Adults with Dementia*, at <http://links.lww.com/A231>.



### A Closer Look

Get more information on why it's important for nurses to reduce restraint use in patients with dementia, as well as why *Avoiding Restraints in Older Adults with Dementia* is the right approach for the job.



### Try This: Avoiding Restraints in Older Adults with Dementia

This is the practice guide in its original form. See page 45.



### Online Only


Unique online material is available for this article. URL citations appear in the printed text; simply type the URL into any Web browser.

**B**ill Hawthorne, an 83-year-old widower, was hospitalized for pneumonia three days ago. (This case is a composite based on our experience.) He'd been receiving care in a nursing home after a stroke left him with weakness on his right side. Although Mr. Hawthorne has had 14 recorded falls—one of which resulted in a hairline pelvic fracture—all of them occurred in the first few days after his stroke, when he was in a hospital-based skilled nursing facility. For more than a year he has been cared for without restraints and without injurious falls in his current nursing home. He arrived at the hospital with previously diagnosed hypertension, moderate dementia, mild depression, and hearing and vision loss. He had had coronary bypass surgery 30 years ago and prostate cancer treated with brachytherapy (radium implantation) 10 years ago; he has a history of long-term vertebral compression with back spasm.

He was admitted with the following medications: albuterol inhaler (AccuNeb and others), pantoprazole (Protonix), clopidogrel (Plavix), diltiazem (Cardizem and others), isosorbide dinitrate (Dilatrate and others), lovastatin (Altoprev, Mevacor), venlafaxine (Effexor), and donepezil (Aricept). He was started

on iv antibiotics and continuous oxygen by nasal cannula. Full-length side rails and bilateral wrist restraints were used because of his "restlessness and irritability," persistent efforts to get out of bed without assistance, and pulling at the iv site and oxygen tubing. He needed help to safely transfer; reminders to use his walker; and moderate assistance with bathing, grooming, dressing, toileting, and eating. Although he was aware of his need to urinate, he was occasionally incontinent because of urgency and an inability to use the call bell. He drank sufficient amounts of fluids, and his respiratory condition continued to stabilize.

#### AN APPROACH TO AVOIDING RESTRAINT USE

When restraints are used frequently and clinicians view them as necessary, they may become the rule rather than the exception. As described in *Avoiding Restraints in Older Adults with Dementia*, page 45, there are two keys to avoiding restraints in this population: understanding, preventing, and responding to a patient's behaviors and working toward organizational change, regardless of setting. (For more on the latter, see *Best Practice Comes Through Organizational Change*, at <http://links.lww.com/A391>. )



## Why Is Restraint Use in People with Dementia a Problem?

*Immobilization in a bed or chair can result in functional decline and injury.*

Some of the problems arising from immobilization by forced bed rest or restraint in a chair are difficulties with balance, strength, and gait; loss of bone and muscle mass; a decline in cognitive function; skin breakdown; urinary tract infection; incontinence; pneumonia; cardiovascular stress; depression and other psychiatric and psychological sequelae such as delirium, posttraumatic stress, and anxiety; and even death.<sup>1-5</sup> Once released from restraint, older adults are at greater risk for falls and fall-related injuries because of the deconditioning from immobilization.<sup>1</sup> Further, in one prospective study of frail nursing home residents who were restrained in the hospital, their ability to perform activities of daily living after discharge was worse than that of their counterparts who were not restrained.<sup>4</sup>

Increased awareness of the poor outcomes associated with restraint use and of the depth and range of the unmet needs of patients in restraints has led to a gradual shift in understanding and practice. According to data from the Centers for Medicare and Medicaid Services' Minimum Data Set Repository, an average of 5% of residents in U.S. nursing homes are restrained on a daily basis,<sup>6</sup> in stark contrast to the rate of more than 25% seen in the late 1970s.<sup>7</sup>

In all settings, the challenge is to balance patients' rights and their safety. Current federal

Any behavioral symptom in a patient with dementia should not be dismissed but rather viewed as a clue to unmet needs (such as for food or water, comfort, or interaction) or as a sign of a change in health status (such as infection, myocardial infarction, or pain). Regular assessment is crucial, as is nurses' ability to address problems, on a patient-by-patient basis, with input from the patient, family, and caregivers. (For more information on behavioral assessment in patients with dementia, see "Behaviors Associated with Dementia," *A New Look at the Old*, July 2005.)

The current standard is providing safe care without using restraints of any form, whether physical or chemical.<sup>8, 17</sup> (For more on current regulations and standards, see *Why Is Restraint Use in People with Dementia a Problem*, at right.) Achieving this standard requires making sense of the patient's behavior. Behavioral symptoms arise from neurochemical changes, as well as from comorbidities, pain, medication toxicity, unmet needs, or environmental factors.<sup>18</sup> When behavioral symptoms are evident, the nurse can use the following questions in order to gather crucial information for the plan of care.

**Can the patient communicate what she or he needs and wants?** Often, it's possible to determine the needs of a person with dementia simply by asking what she or he needs—an approach that's often overlooked. Many such patients can communicate through speaking, gesturing, nodding, or making eye contact. Questions requiring yes or no answers are best.

*Ask family, friends, or staff from the previous care setting* about the patient's history; usual communication style and cues to indicate pain, fatigue, hunger, or a need to urinate or defecate; abilities in activities of daily living; and daily routines ("Is he often awake at night or an early riser?" "Does she prefer breakfast before dressing? Take an afternoon nap? Have a routine for dressing?").

**Do disruptive behaviors signal unmet physiologic or psychosocial needs?** For example, a patient who tries to get out of bed without help may be trying to reach the toilet. A toileting schedule will help to curtail such attempts and prevent incontinence. In critical care, the patient emerging from sedation may be alarmed at a sudden inability to speak or the presence of inserted lines and tubes. Consider how treatments feel to the patient and pay attention to gestures, actions, and words to ascertain their meaning. It may also help to reflect back to the patient what you perceive, as in the following examples:

- "Mr. Jones, I see you holding your belly and moving toward the edge of the bed. Do you need to go to the bathroom?"
- "Ms. Lee, you have a worried look. It must be frightening not to be able to speak. You have a tube in your throat to help you breathe, and that's why you can't speak. Let me show you in this mirror what it looks like." (The caregiver shows the patient the tube in the mirror, then helps her feel the tube with her hands.) "If it hurts, I can adjust it. We'll take it out when you're breathing better on your own, and then you'll be able to talk."
- "Ms. McIntyre, you're reaching toward the halo in your scalp. Is your head itching? I know your hair hasn't been shampooed for several days, and

guidelines state, "A hospital must protect and promote each patient's rights. . . . All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time."<sup>8</sup> Despite federal rules and new research-based standards of practice intended to limit the use of restraints, administrators and health care personnel succeed in widely varying degrees. A recent randomized study of 40 U.S. hospitals in six metropolitan areas revealed a range of restraint use across all types of units from 4.7 per 1,000 patient days to 94 per 1,000 patient days.<sup>9</sup> Perhaps unsurprisingly, ICUs had the highest rates: accounting for only 16% of patient days, they were the site of 56% of restraint use. More research is needed to explore in detail the reasons for the high rate of restraint use in ICUs and determine safe, practical alternatives.<sup>10, 11</sup>

**Older adults with dementia** are at high risk for being restrained. Memory and judgment are compromised, limiting patients' ability to participate fully in their care. When admitted to a new setting, they often don't recognize where they are and can't make sense of the environment. They may attempt to get away, go home, or protect themselves against intrusive care from unfamiliar providers. These patients may not understand what's explained to them or be able to communicate their needs. According to a 2007 report from the Alzheimer's Association, 47% of nursing home residents and 50% or more of older adults in assisted living have a diagnosis of dementia, while in hospitals about 25% of older adults have some form of dementia.<sup>12</sup> Degenerative brain changes from dementia also place these patients at high risk for developing delirium. Characterized by agitation, restlessness, and confusion—and too often unrecognized in patients who already have dementia—delirium often indicates a dangerous underlying condition such as infection, dehydration, electrolyte imbalance, pain, drug toxicity, or psychological trauma.<sup>13</sup> (Even in older adults without dementia, an acute

change in cognitive function or confusion can be the first sign of urinary tract infection, pneumonia, medication interaction, dehydration, congestive heart failure, myocardial infarction, or pain, appearing even before more traditionally heeded physical signs and symptoms such as fever, cough, or complaints of chest pain.)

Staff in all clinical settings may feel that designing and delivering care safely to these patients without the option of restraints is a burden and a challenge. A descriptive study by Minnick and colleagues found that acute care nurses most often cited concern about the disruption of therapy—particularly of life-sustaining treatments such as ventilation or intubation—as a reason for using restraints.<sup>9</sup> In both acute and long-term care, perceived fall risk and behaviors such as wandering, agitation, or aggression may also lead caregivers to consider using restraints.<sup>14, 15</sup>

To avoid restraint use, staff often look for alternatives. In hospitals, the use of constant observation (the one-to-one assignment of nursing assistants or special attendants to patients) has risen, despite its costs. The use of electronic devices to monitor residents' or patients' location in facilities is widespread. New protective devices heralded as "nonrestraining"—such as bed nets, wedge cushions, lap huggers, and laptop trays that affix to a chair—are becoming more widespread. The poor outcomes associated with immobilization or reduced mobility, the costs of constant observation, and the disturbance to patients with dementia when alarms are attached to their bodies necessitate a new approach. What is normative in one country may be seen as unnecessary and even unethical in another. Martin and Mathison, in an observational study comparing the use of restraints in three ICUs in the United States to their use in two Norwegian ICUs, found that restraints were used in 39 of 100 patient observations in the U.S. ICUs and not at all in the Norwegian ones. Reasons given by the authors for the absence of restraint use in the Norwegian ICUs include greater respect for older adults and their rights and a far more open physical layout, permitting direct visual observation.<sup>16</sup>

I see that the scalp areas around the metal prongs are crusty. I'm going to gently shampoo your hair, and we'll see if that makes you more comfortable."

Use a *behavioral log* like the one found at [www.nursing.upenn.edu/centers/hcgne/gero\\_tips/PDF\\_files/Behavior\\_Log.pdf](http://www.nursing.upenn.edu/centers/hcgne/gero_tips/PDF_files/Behavior_Log.pdf) to help discern the roots of a patient's behavioral symptoms. Around-the-clock documentation—of when a behavior occurs, the circumstances, and the resolution—engages all staff in problem solving. When a behavior change is noticed, begin screening immediately for any of the previously described disorders or conditions.

Use *standardized screening instruments* to measure and document even subtle changes in function throughout a patient's stay. Screening instruments

include the Mini-Cog (see "The Mini-Cog," December 2007) and the Mini-Mental State Examination<sup>19</sup> for general cognitive function, the Confusion Assessment Method (see "Detecting Delirium," December 2007) for acute confusion and delirium, and the Geriatric Depression Scale: Short Form (see "The Geriatric Depression Scale: Short Form," October 2007) for affective function. Activities of daily living can be assessed using the Katz Index of Independence in Activities of Daily Living (see [www.hartfordign.org/publications/trythis/issue02.pdf](http://www.hartfordign.org/publications/trythis/issue02.pdf)), and instrumental activities of daily living can be assessed using the Lawton Instrumental Activities of Daily Living Scale (see [www.hartfordign.org/publications/trythis/issue23.pdf](http://www.hartfordign.org/publications/trythis/issue23.pdf)).



### Watch It!

Go to <http://links.lww.com/A231> to watch a nurse use the practice guide for avoiding or eliminating restraints in older adults with dementia.

View this video in its entirety and then apply for CE credit at [www.nursingcenter.com/AJNolderadults](http://www.nursingcenter.com/AJNolderadults); click on the How to Try This series link. All videos are free and in a downloadable format (not streaming video) that requires Windows Media Player.

For patients who can't speak well, a range of observational rating scales—most of which focus on facial expression, behavior, and gesture—have been developed or are being tested. For example, van Herk and colleagues conducted a literature review of 13 observational pain-rating scales and found that while a few showed promise, “psychometric evaluation is not uniform” among them.<sup>20</sup> “Until a reliable and valid observation scale has been developed,” they concluded, “patients with one or more probable painful diagnoses who are not able to communicate should be treated as if they are in pain.” (To view the portion of the online video discussing assessment of the patient and working to remove restraints, go to <http://links.lww.com/A232>. 📺)

#### MANAGING RISK

**Fall prevention.** Brain damage from any source—dementia, stroke, or Parkinson's disease, for instance—may predispose older adults to injury because they may not recognize their limitations. Depending on the setting, staff may judge certain behaviors to be unsafe and consider restraints—despite the risk of deconditioning from immobility, which can increase the risk of falls and the danger of injury if the patient struggles to get free of the restraints. *The focus should be on preventing injurious falls, not on preventing falls at any cost.*

The nurse should develop an *individualized plan of care*, and all staff should be aware of its implementation; nursing assistants are especially critical to its success. Helping patients maintain gait, balance, and muscle strength is also crucial. Involving occupational and physical therapists in the hospital and in a restorative-care program in the nursing home will help forestall decline. Judicious use of adaptive aids, such as properly fitted walking frames and canes, is also essential.

High-risk patients require close *observation and surveillance*. Meade and colleagues found that hourly

rounds that are focused on anticipating and meeting patients' needs may help prevent falls resulting from unassisted ambulation.<sup>21</sup> Move the person closer to the nurses' station, ask friends and family to visit, improve observation of patients, use electronic warning devices (those that sound at the nurses' station but not near the patient are less likely to cause agitation), and incorporate environmental safety measures such as proper lighting or nonskid mats.<sup>22</sup> In Europe, surveillance is sometimes enhanced by use of open wards; however, even in settings where privacy is the norm, there are many ways to help staff observe and interact with the patient: using glass windows to the hallway, using video monitors, including all staff (even housekeeping) in the safety plan, and storing supplies in the rooms. Fearful patients or those with delirium may require constant surveillance, at least until the underlying cause of the patient's behavior is determined and treated. The observer should be trained to orient the patient through conversation and physical touch and to stay alert for changes in behavior or communications of basic needs.

To reduce the patient's risk of falling from bed, use a bed that can be lowered nearer to the floor and place padded mats on the floor at the side of the bed. Remove side rails, unless the patient uses them to reposition herself or himself in bed, in which case a half rail should be used. For transfer, a trapeze is preferable to side rails. Bed bumpers (a concave mattress, or a swimming pool noodle or rolled blankets placed under the edge of the mattress) can be used to demarcate the bed perimeter and may help prevent the patient from accidentally rolling out of bed.<sup>23</sup> Bed alarms may be useful on a temporary basis. Individualized approaches, based on answers to the following questions, may reduce the need for restraints, including side rails<sup>23,24</sup>—is the patient trying to get out of bed to use the toilet; because she or he is uncomfortable, bored, or hungry; or because it's just her or his usual “time to get up”?

The patient's motivation should likewise be the focus when she or he tries to get out of a chair unassisted. Also make sure the chair properly supports a patient who is weak or partially paralyzed. Portable chair alarms can be useful, although like bed alarms they may be ignored by staff when their use has become too common. Fixed tray tables can be a safety risk when the patient tries to escape and becomes trapped. Sitting in the same position for hours on end is neither comfortable nor healthy, so patients should be helped to engage in periodic weight-bearing exercise and move between chairs.

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Managing Editor: Sherry A. Greenberg, MSN, APRN, BC, GNP  
New York University College of Nursing

## Avoiding Restraints in Older Adults with Dementia

By: Valerie T. Cotter, MSN, CRNP, FAANP and Lois K. Evans, DNSc, RN, FAAN  
University of Pennsylvania School of Nursing

**WHY:** Use of physical restraints in older adults is associated with poor outcomes: functional decline, decreased peripheral circulation, cardiovascular stress, incontinence, muscle atrophy, pressure ulcers, infections, agitation, social isolation, psychiatric morbidity, serious injuries, and death. Older adults with dementia have the highest risk of all patients for being restrained when hospitalized. Impaired memory, judgment, and comprehension contribute to the difficulty these patients have in adapting to the hospital. Patients may feel 'lost' and afraid, and try to escape or 'resist' care, yet language deficits associated with dementia limit their ability to clearly express these concerns. Brain damage associated with dementia also places these patients at risk for delirium or acute confusional state, further increasing disorientation and confusion.

**TARGET POPULATION:** Older adults admitted directly from home, nursing home or other non-hospital setting. At particular risk for restraint use are patients whose behavior (agitation, confusion, exiting the bed unassisted) is judged to be 'unsafe,' e.g., contributing to falls or interfering with treatment and medical devices.

**BEST PRACTICE:** Best practice supports individualized care that permits **nursing the person safely** and without physical or chemical restraint. There is no single instrument to assess the meaning of behavioral communication in hospitalized older adults with dementia. Knowledge about the patient's usual behavior and function is critical to individualizing care. Standardized screening of cognition should be done at admission and periodically to detect delirium (See *Try this*: Mini Cog; Confusion Assessment Method).

### ASSESS COMMUNICATION AND BASELINE BEHAVIORS; ASSESS RESTRAINT RISK

- **Assess the message in the patient's behavior:**
  - Ask the patient what she or he needs: Many patients with dementia can still communicate needs.
- **Consult knowledgeable others:** Ascertain the patient's personal and medical history, typical communication style, behavior, daily routines, and abilities.
- **Assess for unmet needs and behavioral changes:**
  - View increased confusion and agitation as a trigger to assess for changes in the patient's health status.
  - Assess for hunger, fatigue, sleep deprivation, pain, need to urinate or defecate, infection, obstruction, fear, or hallucinations. Listen "beyond the words" to understand the emotions behind what the patient is trying to communicate.
- **Use standardized screening instruments on admission and periodically; Use any change from baseline to trigger further assessment:** Screen for cognitive function (e.g., Mini Cog), delirium (e.g., Confusion Assessment Method-CAM), and mobility and transfer performance (ADLs). (See *Try this*: Mini Cog; CAM; Katz ADL).
- **Assess behavior that places a patient at risk for restraint use:**
  - Fall risk (**NOTE: restraints do not prevent falls or fall-related injuries**).
  - Interference with treatment devices (feeding tubes, intravenous lines, sensors and monitors, urinary catheters, dressings, oxygen catheters or mask, ventilators) .
  - Agitation, restlessness, bed exits.

### USEFUL INTERVENTIONS TO PREVENT AND RESPOND TO PATIENT BEHAVIORS

#### Match specific interventions to the individual patient and his/her needs

- **Communicate clearly, slowly, calmly:** Face the patient; always call the patient by the preferred name; use gestures; relax and smile.
- **Remove bedside rails or use only half rails; remove restraints**
- **Understand the patient's reason for attempting bed exit:** Most often, it is a need to toilet. Anticipate and meet

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- needs by individualized elimination routine based on the patient's history.
- **Attend to bed safety:** Lower height, alarms, bed-boundary markers, trapeze or transfer enabler.
    - Remember, an alarm system is merely an alert for a potential emergency
    - Identify all patients on each shift that have bed alarms
  - **Attend to chair and wheelchair safety:** Use portable chair alarms
  - **Protect against falls and injuries:**
    - Provide night light in bathroom
    - Preserve function with daily weight-bearing, comfortable seating, ambulation devices at the bedside
    - Provide non-skid slippers
    - Place fall risk "alert" on the bed or door frame
    - Be especially alert at change of shift times
  - **Modify the immediate environment:**
    - Reduce excessive noise and activity (TV off unless patient requests)
    - Provide for interaction with and visualization of and by others
    - Provide appropriate light levels
    - Remove confusing art or other objects
  - **Provide surveillance:** Move patient closer to nursing station or to a room with a window to the hallway; use monitors.
  - **Reassess need for invasive treatment devices:**
    - Use the least invasive method to deliver care
    - Repeatedly use verbal explanation, guided exploration and a mirror: Help the patient understand what is in place and why
    - Provide comfort care to the site: Oral/nasal care, anchoring of tubing
    - Use camouflage: Clothing or elastic sleeves, temporary air splint
    - Provide diversionary activities: Something to hold and squeeze; favorite music in a headset
    - Discontinue invasive treatments as early as possible
  - **Provide for 'familiarity':** Encourage use of family photographs, favorite personal mementos, audiotapes of family members. Assign the same staff to the extent possible.
  - **Encourage family and familiar others to participate in care:** Frequent visiting, ADL assistance, and remaining at the bedside around the clock for 1-2 days post admission and/or during the evening.
  - **Strive for consistency of personnel, normal function and usual routines:** e.g., toileting, eating, and personal hygiene care.

#### ORGANIZATIONAL STRUCTURE TO SUPPORT RESTRAINT-FREE CARE

- Establish an interdisciplinary Restraint Reduction committee
- Review the organization's mission statement, policies; assure committed leadership
- Use geriatric advanced practice nurses, physicians, and interdisciplinary team consultation for complex patient presentations
- Provide staff education; consistent staff assignment; access to supportive equipment; technology to support reliable admission data and communication of care strategies
- Review pain evaluation and treatment protocols
- Test patient interventions through continuous quality improvement (CQI)

#### MORE ON THE TOPIC:

Best practice information on care of older adults: [www.ConsultGerIRN.org](http://www.ConsultGerIRN.org).

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## Online Resources

For more information on this and other geriatric assessment tools and best practices, go to [www.ConsultGerRN.org](http://www.ConsultGerRN.org), the clinical Web site of the Hartford Institute for Geriatric Nursing, New York University College of Nursing, and the Nurses Improving Care for Healthsystem Elders (NICHE) program. The site presents authoritative clinical products, resources, and continuing education opportunities that support individual nurses and practice settings.

Visit the Hartford Institute site, [www.hartfordign.org](http://www.hartfordign.org), and the NICHE site, [www.nicheprogram.org](http://www.nicheprogram.org), for additional products and resources.

Go to [www.nursingcenter.com/AJNolderadults](http://www.nursingcenter.com/AJNolderadults) and click on the *How to Try This* link to access all articles and videos in this series.

*Bathrooms and bedrooms* are the sites of most falls. A night light can help a patient get to the toilet safely. A portable toilet at the bedside, especially in acute care, can help preserve function and prevent falls. Water or urine spills can be dangerous; nonskid slippers or posted fall alert warnings can help prevent falls.


**Treatment interference.** Any patient with dementia can disrupt invasive therapies. Some devices that patients with dementia find troublesome are IV lines, feeding tubes, sensors and monitors, urinary catheters, dressings, oxygen catheters or masks, and ventilators. Staff should continually ask these questions:

- Can the treatment be administered in a less intrusive way?
- Is the treatment needed any longer?
- What measures might help the patient tolerate continued short-term use of a treatment?

Again, the key here is *assessment of motivation*: is the person “interfering with” the device because of curiosity? Because the device is uncomfortable or painful? Because she or he doesn’t understand the source of the discomfort? Is the discomfort great enough to warrant discontinuation of the particular treatment? In fact, patients often may know before staff when they no longer need an intrusive device—a literature review by Maccioli and colleagues cites studies showing that between 63% and 89% of patients who extubate themselves are not reintubated.<sup>25</sup>

Use the least invasive method to deliver care. Explain to the patient what is happening (such as the insertion of a feeding tube), why it’s happening, and when the device can be removed. Guided exploration—using a mirror to show patients what is being done to them or placing the patient’s hand on the device and helping her or him to feel it—may be particularly helpful in soothing the fears of a patient with dementia. Provide comfort care at the site of insertion, such as anchoring or adjusting a feeding tube so that it doesn’t pull on sensitive nasal–oral tissue or providing nasal and mouth care to help the person tolerate short-term use of the device. Camouflage the insertion site with clothing or elastic sleeves, a temporary air splint, or bandaging. Provide diversionary activities such as something to hold and squeeze or favorite music in a headset.

Discontinue invasive treatments as early as possible. Because interrupting treatment in ICUs can be life threatening, the risks and benefits of restraint use and sedation must be weighed. The wide variability of restraint use among ICUs reflects differences in the use of anesthetics and sedation as well as in administrative style and nursing practice.<sup>9,16</sup> Attention by the interdisciplinary team to patients’ behavioral cues;

early identification and treatment of the underlying cause of delirium, when it’s present; and appropriate use of analgesic, anxiolytic, and antipsychotic medications can result in greater comfort, less agitation and resistance, and better outcomes.<sup>25</sup> (To view the segment of the video in which an expert discusses best practices regarding the prevention of restraint use in older adults with dementia, go to <http://links.lww.com/A233>. )

### STRATEGIES TO EASE AND COMFORT THE PATIENT

**The environment.** Reducing noise levels and removing art or other objects that frighten the patient can help reduce disruptive behavior, and music or pleasant aromas can have a relaxing effect.<sup>26,27</sup> Ensure appropriate light levels, including soft directional lighting at night. Move the patient closer to the nursing station. Promote confidence and trust with clear and consistent routines. Provide a sense of familiarity, even in acute care, by encouraging frequent family visits and the introduction of something from home—such as photos of loved ones, a clock, a memento, or audiotapes of family members—that reminds patients who they are and that they’re cared for.

Pay special attention to the end of the day as staff go home: older adults with dementia may become insecure and fearful during these periods and attempt to leave. Continuity and consistency in staff assignments are critical; when people with dementia become familiar to one caregiver, it is much less likely that behavioral symptoms will be inappropriately managed.<sup>28</sup> Minnick and colleagues found that keeping more supplies and services within the room increases the number of people who observe and interact with the patient and gives nurses more time to focus on the patient’s needs.<sup>29</sup>

Encourage family and friends to assist with activities of daily living and to remain at the bedside around the clock for one or two days after admission or during the evening to assure the patient that

she or he is safe. Cultural differences may influence the behavior of the person who has dementia; actions that may seem unusual or inappropriate (lying on the floor instead of the bed, pushing an aide away during personal care because of a closely guarded

*The focus should be on preventing injurious falls, not on preventing falls at any cost.*

sense of physical privacy) may have logical explanations when the person's culture or background is taken into account. (To view the video segment discussing the coordination of care and maximizing health status, go to <http://links.lww.com/A234>. 📺)

### MR. HAWTHORNE, UNRESTRAINED

Mr. Hawthorne's nurses called the nursing home for information on his baseline physical and cognitive function and usual behaviors. They learned that, in the nursing home, he used a low bed and a bedside commode. Also, he took a low-dose nonsteroidal antiinflammatory drug regularly for chronic back pain; this information had not been included on his hospital transfer form. They learned that Mr. Hawthorne valued his independence and cleanliness and that urinary incontinence was especially distressing to him. Irritability and restlessness were not common before he had pneumonia.

After the nurses discussed the new information with the medical staff, Mr. Hawthorne's antibiotics were given orally instead, and the IV line and continuous oxygen therapy were discontinued. A bedside commode was provided, and a toileting schedule was developed. The physical restraints were removed, and his irritability decreased. Further, his low bed (without side rails) was placed against one wall, and family visited during the night. Mr. Hawthorne engaged in physical therapy to improve his strength and balance and ensure that he was using the walker more safely. These measures resulted in fewer episodes of incontinence, fewer unaccompanied trips to the bathroom, no injurious falls, and the elimination of physical restraints. ▼

*Lois K. Evans is the van Ameringen Professor in Nursing Excellence and director of the Psychiatric Mental Health Advanced Practice Program at the University of Pennsylvania*

*School of Nursing in Philadelphia, where Valerie T. Cotter is an advanced senior lecturer and program director in the Adult Health Nurse Practitioner Program. Contact author: Lois K. Evans, [evans@nursing.upenn.edu](mailto:evans@nursing.upenn.edu). Avoiding Restraints in Older Adults with Dementia is reproduced with permission of the Alzheimer's Association, Chicago.*

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Routine use of Try This approaches or tools may require formal review and approval by your employer.

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