How to use the “four-quadrant” approach to analyse different restraint situations

Ethical issues in patient restraint

In this article...

- The use of restraint in nursing practice
- The four-quadrant approach to analysing ethical dilemmas
- Using this model to analyse different restraint situations

These comments suggest how challenging the issues are; the head of patient safety at the National Patient Safety Agency acknowledges that there are situations when nurses have to intervene to prevent harm to a patient (Healey, 2010). However, according to Healey, vests, as well as belt and cuff devices are unacceptable and have resulted in deaths and serious harm.

As well as an ethical imperative to prevent unjustifiable restraint, there is also a legal framework that includes: Offences Against the Person Act 1961; the Mental Capacity Act 2005; Adults with Incapacity (Scotland) Act 2000; Human Rights Act 1998; and the Mental Health Act 1983 (see Royal College of Nursing, 2008).

Types of restraint

Let’s Talk about Restraint: Rights, Risks and Responsibility (RCN, 2008) identified five types of restraint: physical, chemical, mechanical, technological and psychological. Physical restraint involves holding patients down or physically intervening to stop them from leaving an area. Chemical restraint is when a restless patient is sedated as a form of restraint.

The posey vest described earlier is a form of mechanical restraint. Other examples include bedrails and baffle locks, but furniture, such as tables and chairs, positioned in such a way as to restrict freedom of movement are also forms of mechanical restraint.

Technological developments have resulted in more sophisticated forms of restraint such as tagging, door alarms and closed-circuit television. What is called technological surveillance amounts to restraint.

These comments suggest how challenging the issues are; the head of patient safety at the National Patient Safety Agency acknowledges that there are situations when nurses have to intervene to prevent harm to a patient (Healey, 2010). However, according to Healey, vests, as well as belt and cuff devices are unacceptable and have resulted in deaths and serious harm.

As well as an ethical imperative to prevent unjustifiable restraint, there is also a legal framework that includes: Offences Against the Person Act 1961; the Mental Capacity Act 2005; Adults with Incapacity (Scotland) Act 2000; Human Rights Act 1998; and the Mental Health Act 1983 (see Royal College of Nursing, 2008).

Types of restraint

Let’s Talk about Restraint: Rights, Risks and Responsibility (RCN, 2008) identified five types of restraint: physical, chemical, mechanical, technological and psychological. Physical restraint involves holding patients down or physically intervening to stop them from leaving an area. Chemical restraint is when a restless patient is sedated as a form of restraint.

The posey vest described earlier is a form of mechanical restraint. Other examples include bedrails and baffle locks, but furniture, such as tables and chairs, positioned in such a way as to restrict freedom of movement are also forms of mechanical restraint.

Technological developments have resulted in more sophisticated forms of restraint such as tagging, door alarms and closed-circuit television. What is called technological surveillance amounts to restraint when the technology results in people being prevented from leaving an area or having their movement controlled.

Psychological restraint deprives patients of choices and involves them...
being told they are not permitted to do something; setting limits on what they can do, such as times to go to bed; and depriving them of the means to be independent. This can include keeping them in nightwear and not letting them have outdoor clothing, walking or visual aids.

**Restraint in nursing practice**

The following three scenarios, drawn from anonymised practice examples, show the complexity of this issue in everyday practice. Put yourself in the position of the nurse then respond to these questions:

- Can the nurse’s actual or expected intervention be described as restraint?
- If so, what type of restraint?
- What ethical arguments can be presented for and against the intervention?
- What alternatives are there?

**Scenario 1**

Charlotte Morgan is an inpatient on an acute mental health unit and has a diagnosis of bipolar disorder. She is experiencing psychotic symptoms and is refusing oral medication, fluids and nutrition. Ms Morgan is overactive, appears dehydrated and has not slept for at least three days. Nurses are concerned her physical health will deteriorate further and are considering whether they should restrain her and give her medication without her consent.

**Scenario 2**

Ronald Freeman has been admitted to hospital after a stroke. He has been assessed and it is agreed that his swallowing is impaired. He is restless and has communication difficulties. His family agree with healthcare professionals that he should have enteral feeding via a nasogastric tube. Mr Freeman pulls out the first two tubes so nurses are now considering whether they should use mittens or a nasal loop or bridle to hold the tube in place.

**Scenario 3**

Cora Jamison recently moved from her home to a nursing home. She has a diagnosis of dementia and is becoming increasingly frail. She wanders continuously around the home and repeatedly goes to the front door and says she wants to go home. One of the staff tells her: “You cannot go home today. It’s Sunday and there is no transport.” Mrs Jamison accepts this and continues to wander from room to room.

Staff discuss how to manage Mrs Jamison. Her husband is particularly anxious that she remains safe; he tells staff when she was at home he had to ensure doors were locked and she had a table fixed on her chair to prevent her from getting up so she could rest. He suggests staff might use a tracking device that will sound an alarm if she attempts to leave the home.

**Scenario analysis**

Each of the scenarios is analysed using the four-quadrant approach in Figs 1-3 (Jonsen et al, 1992). This is used in clinical ethics and is outlined by the UK Clinical Ethics Network (2011) as a “series of questions that should be worked through in order”:

1. **Indications for medical intervention**
   - What is the diagnosis? What are the treatment or intervention options? What are the probabilities of situations happening again?

2. **Preferences of the patient**
   - Is she willing or unwilling to cooperate with care and treatment? Why? Is her autonomy respected?

3. **Quality of life**
   - What distress is Ms Morgan experiencing? Will her quality of life after intervention be acceptable to her? Or might intervention compromise the success of future care? What interventions will enhance her quality of life? How can intervention benefits be maximised and harms minimised? After the acute episode, how can nurses collaborate with her to minimise the chances of such situations happening again?

4. **Contextual features**
   - What family issues might influence decision-making? Is there a staff member, family member or friend Ms Morgan trusts who could help to gain her cooperation? What religious, cultural or legal issues need to be taken into account? Are there conflicts of interest? What interventions, for example, are in her best interests if she lacks capacity? Are staff working within the law?

**5 key points**

1. There are five types of restraint: physical, chemical, mechanical, technological and psychological.
2. Restraint is not a panacea and can present significant risks to patients.
3. The four-quadrant approach is a helpful framework for ethical analysis of situations involving restraint.
4. Understanding the legal requirements of healthcare practice is necessary to protect patients from unjustifiable restraint.
5. Restraint should be considered as a last resort and practitioners should consider alternative interventions to promote safety and respect the dignity of the person.

The nurse then responded to these questions:

- **Medical indications**
  - What are the goals of care and treatment for Ms Morgan? Is her diagnosis of bipolar disorder correct?
  - What are the probabilities of different interventions (least coercive first) achieving the goals of treatment and care?

- **Patient preferences**
  - Does Ms Morgan have capacity? If so, what does she want? If not, has she expressed preferences in an advance directive (Atkinson, 2011)? Is she willing or unwilling to cooperate with care and treatment? Why? Is her autonomy respected?

- **Quality of life**
  - What distress is Ms Morgan experiencing? Will her quality of life after intervention be acceptable to her? Or might intervention compromise the success of future care? What interventions will enhance her quality of life? How can intervention benefits be maximised and harms minimised? After the acute episode, how can nurses collaborate with her to minimise the chances of such situations happening again?

- **Contextual features**
  - What family issues might influence decision-making? Is there a staff member, family member or friend Ms Morgan trusts who could help to gain her cooperation? What religious, cultural or legal issues need to be taken into account? Are there conflicts of interest? What interventions, for example, are in her best interests if she lacks capacity? Are staff working within the law?

The nurse then responded to these questions:

- **Medical indications**
  - What are the goals of care and treatment for Mr Freeman? Is his swallowing disorder correct?
  - What are the probabilities of different interventions (least coercive first) achieving the goals of treatment and care?

- **Patient preferences**
  - Does Mr Freeman have capacity? If so, what does he/she want? If not, has he/she expressed preferences in an advance directive (Atkinson, 2011)? Is he/she willing or unwilling to cooperate with care and treatment? Why? Is his/her autonomy respected?

- **Quality of life**
  - What distress is Mr Freeman experiencing? Will his quality of life after intervention be acceptable to him? Or might intervention compromise the success of future care? What interventions will enhance his quality of life? How can intervention benefits be maximised and harms minimised? After the acute episode, how can nurses collaborate with him to minimise the chances of such situations happening again?

- **Contextual features**
  - What family issues might influence decision-making? Is there a staff member, family member or friend Mr Freeman trusts who could help to gain his cooperation? What religious, cultural or legal issues need to be taken into account? Are there conflicts of interest? What interventions, for example, are in his/her best interests if he/she lacks capacity? Are staff working within the law?
and there is a question as to what he is communicating (is he, for example, refusing feeding or demonstrating irritation and a lack of understanding about the purpose of the tube?) and how to proceed ethically. Also under consideration is what can be described as mechanical restraint in the form of mittens or a nasal loop or bridle to keep or hold the tube in place.

Hand-control mittens make it more difficult for patients to pull out their nasogastric tube. Williams (2010) concluded that mittens “have a place in clinical practice” but their use should be in accordance with a clear protocol and decision-making process, and that older people and their next of kin must be informed about the use of mittens and involved as fully as possible in the decision-making process.

Nasal loops or bridles involve securing a nasogastric tube to a patient’s septum with a tape. This can also be labelled mechanical restraint and is ethically more problematic as it involves an invasive and uncomfortable procedure. Analysing Mr Freeman’s situation using the four-quadrant approach suggests asking the questions in Fig 2.

Psychological restraint and technological surveillance in dementia care

Mrs Jamison’s case suggests psychological and technological restraint. Staff try to deter her from attempting to leave the home by saying: “You cannot go home today; it’s Sunday and there is no transport.” This may appear innocuous but is nonetheless deceptive and dishonest. The second consideration relates to technological surveillance, in the form of a tracking device that will sound an alarm should Mrs Jamison attempt to leave the home.

The Nuffield Council on Bioethics (2009) states: “These technologies may also be of significant benefit to carers in terms of reassurance as to the wellbeing and state of health of the person for whom they care.” The focus of the report is on supporting people with dementia, promoting their autonomy and wellbeing, and also considering the interests of carers.

In relation to Mrs Jamison, the questions in Fig 3 should be considered.

Conclusion

Sara Morgan’s views about UK nurses’ reluctance to embrace restraint in care stimulated much-needed discussion about this contentious issue. As responses to her piece highlighted, restraint is not a panacea and can present significant risks to patients. It should always be considered a last resort as it presents a significant threat to human rights, dignity, autonomy and wellbeing. Nurses must guard against choosing restraint, particularly when staff resources are limited. It may be the easiest option but it is rarely the most ethical. Restraint represents a compromise as it has the potential to undermine the values of nursing. More creative, collaborative and respectful responses to care are required.

References


Healey F (2010) UK nurses do care deeply about patient safety – which is why they don’t use restraining vests. Nursing Times. tinyurl.com/care-patient-safety


