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Extended Research Article

The use of restrictive practices in the everyday care of people living with dementia in hospital settings: an ethnographic study

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Disclaimer: This report contains transcripts of interviews conducted in the course of the research, or similar, and contains language which may offend some readers.

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Scientific summary

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Scientific summary

Research aims

To examine the use of restrictive practice in the care of people living with dementia (PLWD) during a hospital admission. To explore what forms these practices take, the rationales for their use, and the experience of these practices from the perspectives of PLWD, their families, and ward staff and identify alternative strategies that are achievable, safe and transferrable across hospital settings.

Background

The Department of Health and Social Care estimate that between 25% and 50% of all acute hospital admissions are patients who are also living with dementia, making them one of the largest patient populations by diagnostic category. PLWD are also a highly vulnerable group within the hospital, at increased risk of deterioration, physical and cognitive decline, avoidable harm and adverse outcomes, including delayed discharge and institutionalisation.

Recent UK government enquiries and reports have repeatedly identified institutional cultures of restrictive practices (containment, restriction and restraint) as key features of the care inequalities PLWD experience during a hospital admission. To date, no UK research has systematically examined the use of restrictive practices, the forms it takes, rationales for its use, and its impacts on PLWD, carers and staff within NHS hospital wards. While there is a range of guidance across the NHS to inform its use for other patient populations and care settings, there are no best practice guidelines for its appropriate use, or training to support acute staff in using alternative approaches in the care of patients admitted with a diagnosis of dementia.

Our public consultations identified that use of restrictive practices in hospitals as a pressing research priority and PLWD coproduced this research. Many have direct experience of these practices in their care.

Objectives

In response, this in-depth ethnographic study examined the everyday cultures of restrictive practices in the care of PLWD during a hospital admission, exploring what forms these practices take, the rationales for their use, and the experience of these practices from the perspectives of PLWD, their families and ward staff. With a goal to identify evidence-based (and alternative) strategies in the care of PLWD that are achievable, safe and transferrable across care settings. Our objectives were to:

1. Provide a detailed examination of the social and organisational context in influencing the everyday care of PLWD to understand the (a) nature of restrictive (and alternative) practices within wards, (b) circumstances and contexts of use, (c) care practices when PLWD are perceived as at risk, or when their behaviour is perceived as ‘challenging’, ‘disruptive’ or ‘aggressive’.
2. Examine the recognition, understandings and experiences of restrictive (and alternative) practices during an admission from the perspectives of PLWD and their families.
3. Examine staff perspectives (a) their understandings and recognition of restrictive practices, (b) the formal frameworks and informal rationales drawn on to inform the care of PLWD.
4. Translate the findings into evidence-based strategies to support best practice and alternative approaches to feasibly improve the care of PLWD at ward level.

Methods

This ethnographic study drew on symbolic interactionist traditions to provide a detailed contextual interpretive understanding of the social world of the ward. This supported a detailed examination of how the organisational processes influence social actors within them to work in particular ways when caring for PLWD. It also allowed us to examine taken-for-granted practices that have over time become part of the everyday ward cultures and the consequences of these ways of working PLWD.

This study was carried out across nine NHS hospital wards (six acute and three specialist mental health settings) within six NHS trusts (working in dyads in three towns and cities) across England. Sites were purposefully selected to represent a variety of hospital types, geographical locations and socioeconomic catchments (we were not able to access proposed sites in Wales). We conducted 225 days of ethnographic observation fieldwork within general acute medical wards, Medical Assessment Units (and variants thereof), older people's medicine wards and specialist mental health settings. Overall, we collected approximately 500,000 words of observational fieldnotes, transcribed, cleaned and anonymised by the research team. To obtain contextual understanding of the events and practices with these settings, we conducted 1116 in-depth in situ interviews with healthcare professionals, PLWD and care partners.

Research Ethics Committee (REC) approval for the study was granted by the NHS Research Ethics Service via the London – Bromley REC (22/LO/0448) and given approval by the Health Research Authority on 15 July 2022 [Integrated Research Application System (IRAS) 313618]. The research project was approved for the purposes of the Mental Capacity Act 2005 (section 31).

Results

Analysis of data provides understandings of the complex social and organisational interactions that occur in these settings, revealing how the everyday use of restrictive practices occurs in a complex set of wider institutional relations, expectations and priorities with consequences for PLWD admitted to these settings. For purposes of this report and considering the scope of the study, our analysis revealed eight themes: (1) everyday routine use of restrictive practice; (2) cultures of containment; (3) patterns of intensification and 'tightening'; (4) low tolerance of risk; (5) deprivation of liberty and everyday rights; (6) legal frameworks; (7) the impacts and consequences of the use of restrictive practices in the care of PLWD and (8) good practice and de-escalation.

The nature of restrictive practice

We identified the use of restrictive practice in the care of PLWD was an embedded aspect of everyday routine ward care, within all shifts observed within the acute wards, regardless of the ward, time of the day and day of the week. The restrictive practices used within these ward settings took a wide range of forms, with use of raised bedside rails, ward furniture and verbal commands, the most frequently used. These practices were typically carried out swiftly, and at pace, to contain and restrict the movements of PLWD at the bedside. What is of significance is that their use was embedded within timetabled care and viewed by staff as routine; thus, these forms of restrictive practices were typically unrecognised and unrecorded. We identified that ward staff found defining and identifying what constituted restrictive interventions in their routine practices as challenging.

Cultures of containment

Reflecting the international literature, our conceptual framework for defining restrictive practice is expansive, taking in practices that appear very different in their application and impacts, from the routine use of bedside rails and verbal commands, through to the non-consensual sedation of a person living with dementia. Our analysis demonstrates how these apparently diverse range of practices cannot be understood in isolation, but, instead, were utilised multiply in the care of both individuals and cohorts of PLWD within acute wards. The pervasive use and acceptability of these practices meant that escalation to the use of other and multiple forms of restrictive practice became acceptable features of ward care. In turn, this also shaped and normalised wider ward cultures of control, becoming routine aspects of everyday care, informing what patient behaviour was viewed as acceptable and also legitimised staff routine practice in response to perceived risk of falls and 'absconding', or behaviour understood by staff as 'wandering', non-compliance and resistance to care.

Patterns of intensification and 'tightening'

Concerns over safeguarding, staffing and patient safety meant PLWD were required to conform to the expectations of the ward, rather than receiving a formal assessment of risk and consideration of returning home. Should the patient become distressed, lash out, or try to leave the ward, over an admission, this could quickly intensify the restrictive practices used in the care of a patient in the moment and over time. We observed patterns of intensification in the use of restrictive practices, the routine use of raised bedside rails and furniture, escalating to the consideration and use of one-to-one enhanced care, to restricted movement to the bedside. In turn, these practices could generate further patient distress or responses that included attempts to leave the bedside and the ward, which were met by the ward with increased 'tightening' of restrictive practices in their care, and ultimately this could inform the use of sedation. A key impact was the further limiting of an individual's potential pathways from the ward and increasing risk of institutionalisation.

Low tolerance of risk

A key focus for staff in utilising these approaches to restrict patients' movement or contain them at the bedside was as an immediate solution to a key quality assessment metric (falls prevention, a legitimate concern in the care of PLWD) for these wards and the wider institution. Other key identified risks included PLWD 'wandering' within the ward or 'absconding' from the hospital. Ward staff routinely applied restrictive practice not just to increase safety and reduce risk, but also to eliminate these risks for the population of PLWD, without accompanying risk assessment practices, informing powerful ward cultures of containment and low tolerance of risk. Ward staff often explained their actions and applications of restrictive practice interventions as being in the best interest of the patient and as a means of safeguarding and protecting the patient rather than a form of restraint. Yet legally, protective duties do not confer unfettered authority or powers on staff to restrict patients. These approaches had significant impacts on the personhood, dignity and independence of this patient population.

Deprivation of liberty and everyday rights

People living with dementia within these acute wards were likely to be deprived of their liberty. As we have already seen, PLWD were often contained in bed for most of the day with the bedside rails raised. This had the effect of almost completely restricting the persons' liberty of movement. PLWD were not able to leave their beds at will. We did not see any patients successfully lowering the bed rails themselves (although some tried to climb over the raised bed rails, posing significant injury risk). We did not observe ward staff offering to lower them, nor regularly offering PLWD opportunities to leave their beds with support. The intention and impact of the bedrails were that PLWD were effectively *confined* to their beds. These 'informal' restrictions may not involve the kinds of hands-on contact and direct use of force associated with physical restraint, but these environmental restraints significantly impacted on people's well-being and their everyday rights and freedoms – interfering with Article 8 of the European Convention on Human Rights.

Legal frameworks

There was significant variation across and within the acute wards in the application and assessments of the legal frameworks deprivation of liberty safeguards (DoLS) and the Mental Capacity Act. We found that PLWD classified as at risk of falls, 'wandering' or absconding, were more likely to have DoLS instituted. The use of these legal frameworks in a patient's care was recognised as a sign that patient was, or could be, restrained, particularly allowing for the use of sedative medication such as lorazepam or haloperidol. It was common for these interventions, once put in place, to remain in place for the duration of the person's admission, rather than for the specific period of review. We identified that these measures were often used despite patients' repeated requests to be released from these wards.

The impacts and consequences for people living with dementia and ward staff

The use of restrictive practice had significant impacts on PLWD and staff in these settings. For PLWD, we identified increased emotional impacts including verbal and physical expressions of fear and distress. The use of restrictive practice meant some patients described their admission as a form of imprisonment or being held hostage. Cumulatively, the use of restrictive practice across an admission was usually accompanied by increasing the person's emotional distress and their visible physical and cognitive deterioration. The use of restrictive practices also informed impacts on ward cultures, fostering the experience of an admission as one of loneliness, isolation and disconnection and increased the inequalities in care experienced by PLWD within these wards. The use of restrictive practice during admission was also highly distressing for care partners and families.

Ward staff were aware that the strategies they were institutionally expected to draw on and use neither reflected the needs or desires of the patient, nor how they wished to engage with and care for their patients. The lack of agency felt by ward and hospital staff meant these cultures of containment also meant high levels of distress and isolation for all within them. Ward staff often described feeling inadequate by not being able to provide appropriate care and recognised they lacked the skills to support distressed PLWD, also experiencing significant emotional impacts from using restrictive practices in patient care.

Good practice and de-escalation

Our analysis of mental health wards identified good practice potentially transferable to the acute setting. They all fostered cultures of care that minimised the use of restrictive practice in the care of PLWD through (1) the promotion of flexibility in the organisation and delivery of routine care; (2) supported staff in approaches to care that prevented and reduced patient distress by recognising and responding to individual need; (3) staff attuned to relational ways of working and to the emotional needs of their patients living with dementia; (4) ethos of promoting ‘positive risks’ to support mobility and independence; and (5) the legal frameworks governing patients and their admissions were explicitly discussed and recorded. Examples of individual good practices were also seen within the acute sites. Good practice focused on engagement with the patient’s needs, including supporting patients’ mobility, utilising ward resources such as day rooms and tablets, using YouTube (YouTube, LLC, San Bruno, CA, USA) to provide tailored entertainment, and supporting patients with hair and beauty treatments.

Conclusion

Our findings demonstrate that, while there was significant variation between sites in the types of restrictive practice most commonly employed and the use of legal frameworks within them, cultures of containment were in operation in the care of PLWD across these settings. Containment (in bed, at the bedside, within the bay) was both a requirement and expectation as part of the organisation and delivery of care. Any challenge to containment was met with restrictive practice, starting with raised bedside bars, placement of furniture, supervision, and escalating should the person continue to challenge containment practices. These cultures were driven by genuine staff fears over personal and professional reprisals, and enabled by a culture in which family visitors, volunteers and engagement have disappeared from ward settings, creating challenging environments of ennui and isolation.

Study registration

This study is registered as ISRCTN11797465.

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