

SCHOOL OF NURSING

**CASE STUDIES IN RESTRAINT USE IN AN ACUTE TEACHING HOSPITAL:
A FOUCAULDIAN APPROACH**

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ABSTRACT

This thesis reports the outcomes of research into the use of restraint in the care of patients in an acute teaching hospital in Australia. The literature review undertaken for the study revealed much research into restraints showing evidence of the harm they cause, and their ineffectiveness as a safety measure. The literature indicates that the prevalence of restraint use is high - about a third of all hospital patients over the age of eighty-five years may be restrained at some time during the period of their admission.

The main emphasis in my investigation was to uncover an understanding of how the use of restraints has remained possible, despite negative reports on their efficacy and questions about their possible abuse of human rights. Primarily, I set out to provide an understanding of restraint practice, and of how it is maintained and legitimised in a metropolitan teaching hospital.

The study was guided by a Foucauldian approach to discourse analysis. The study reports on in-depth case studies of three patients. The case studies extend beyond observations of the patients to include interviews with members of the multidisciplinary team: nurses, doctors, occupational therapists and physiotherapists. Medical and nursing notes were another source of data.

A discursive formation was identified by which restraint use is justified, and legitimised by the health professionals who use it. Five discourses were established, constituting: inability to 'self govern'; an appropriate environment; treatment; duty of care; and marginalisation.

The study concludes that restraint use can be understood as a complex discursive practice. Through this discursive practice we can understand how staff maintain a monopoly over the truth and perpetuate claims about the inevitability of restraint use. Knowledge of these discursive practices enables an understanding of how the current educational approaches to restraint reduction are likely to have little immediate or sustained impact. With these understandings, we are hopefully better placed to change practice in a way that does not substitute one undesirable approach for another. If this is so, the value of this thesis will lie in its influence on practice as much as in its contribution to scholarship.

CHAPTER ONE

INTRODUCTION

*What we call the beginning is often the end.
And to make an end is to make a beginning.
The end is where we shall start from...
We shall not cease from exploration.
And the end of all our exploring will be to arrive where we started.
And know the place for the first time.
T.S. Eliot 1888-1965.*

This chapter serves to introduce the study. It presents my motivation for conducting research on restraint use, sets out the aims and objectives of my investigation, and describes the overall significance of my research. I take the opportunity to present my assumptions and describe the context in which the study took place, paying particular attention to the difficulty of researching restraint use. In this chapter I also make reference to a point prevalence study on restraint use that I conducted in order to enable the case studies that are described. The final section of this chapter presents a précis of the thesis to guide the reader.

According to the Australian Bureau of Statistics (2000) the Australian population is getting older (the median population age has increased by 5.8 years in the last twenty years). Older Australians are more likely to be treated in hospital. There is a high incidence of behavioural problems with older patients (Cohen-Mansfield, 1989; Inouye, 1994; Ignatavicius, 1999; Flick & Foreman, 2000; Rateau, 2000). Hospital staff often respond to these behaviours by using restraints: as many as twelve and a half percent of elderly hospitalised patients receive physical and chemical restraints (Whitehead, Finucane, Henschke, Nickalson & Nair, 1997). There are many documented negative sequelae including physical and emotional harm (Molasitotis, 1995; Mcshane et al, 1997; Strumpf, Patterson Robinson, Stockman Wagner & Evans, 1998). There are also ethical arguments against the use of restraints. The preservation of individual autonomy in sick or dependent people is a fundamental principle of modern healthcare-ethics (Rosin & Sonnenblick, 1998). Elderly patients in Australian hospitals are vulnerable to the indignity of restraint; although their numbers are large and their advocates few. Conversely, large numbers of nurses face physical abuse from patients, and are frustrated because they commonly believe that they are let down by a system in which restraint use has become institutionalised. As

the body of research demonstrating the harm caused by restraint increases, there is no clear indication that restraint use is declining in Australian hospitals.

A look at the history of restraint use finds a natural starting point in the French Revolution and the work of Philippe Pinel. Although controversial, (Levine, 1996) it is held that Pinel was a humanitarian responsible for supervising the removal of chains from the insane in the last decade of the Eighteenth Century. Deprospero-Rogers and Bocchino, (1999) suggest that in the mid to late Nineteenth Century restraining patients became common, but in Britain at this time restraints were deemed undesirable and were eliminated to a large extent. North America and apparently Australia made no such reforms. By the Nineteen Eighties restraints became a subject of debate in North America (Difabio, 1981; Gillick, Serrel & Gillick, 1982; Blakslee, 1988; Strumpf & Evans, 1988). Restraint rates were high according to the available literature from North America during this time (Frengley & Mion, 1986; Mion, Frengley, Jakovcic & Marino, 1989a). Such cross-cultural disparities have been pointed out by Strumpf et al, (1998) who has made the point that it is hard to justify the high prevalence of restraint in some countries when there are others with a markedly lower prevalence. This historical background evidences the cultural nature of restraint use rather than supporting the proposition that it is a necessary intervention.

Although there is no shortage of studies investigating the lack of justification of restraints, the research literature is less clear on the reason for the continued use of restraints in the light of their ill effects. I chose research methods that would address the issue of the long-standing use of restraints. This study is an empirical investigation informed by Foucault's work. The research utilises case studies with the aim of grounding the research in the context in which restraint takes place. The emphasis will be on the complex, socially bound power relations involved in the use of restraints. The thesis as a whole provides an alternative view on restraint and aims to point to ways of managing change in this area.

The Problem

The use of restraints in acute hospitals is a common but ineffective way of managing behavioural phenomena in elderly patients with dementia (Strumpf et al, 1998). The ramifications of restraint use include: psychological harm, social isolation, and physical harm, such as skin trauma and even death by asphyxiation

(The American Food and Drug Association, 1992). The continued use of restraints has caused negative outcomes for patients and subsequent legal, ethical, economic and personal dilemmas for hospital staff, especially nurses (Evans & Strumpf, 1990). Although research evidence supports the move towards restraint free care, change has happened inconsistently and in isolated centres. Current approaches to restraint reduction are mainly educational, although the most successful attempts have paid careful attention to more complex issues of change management (Quinn, 1996). Therefore, the particular problem addressed in this thesis is resistance to restraint reduction, and its maintained use in many acute hospitals.

Significance

This study is significant because of high restraint use and the serious effects of its use. Furthermore, restraints are typically used on the most frail of hospital patients, who could be considered the most vulnerable to abuse (Blakslee, 1988). Restrained patients have few advocates and, whilst physical harm can be measured objectively, it is more difficult to know what psychological damage is caused during a period of restraint. There is, however, a compelling logic, as well as much empirical evidence, behind the proposition that restraint does cause psychological harm. Thus, this research is significant to nursing practice. It is apparent that, in addition to staff knowledge deficits with regard to restraint, further impediments stand in the way of restraint free care. An understanding of restraint practices is therefore significant to nursing practice, so staff can appreciate the way in which they assist in the maintenance of restraint use. The study is also significant to nursing education and management so that these disciplines can be appropriately tailored to address restraint issues in a meaningful way.

Aims and Objectives

Change in restraint use seems to defy a straightforward educational approach. Thus, there is a need to develop an understanding of the factors inhibiting restraint reduction. One explanation, based on an understanding of the work of Michel Foucault, is that restraint use is socially bound in the complex discourse, and culture of nursing. Therefore, the aims of this study were to investigate:

- What explanations do nurses give in respect to the use of restraint?
- What social explanations (discourses) underpin these explanations?
- How do such discourses function to legitimise, justify and maintain the practice of restraint?

The purpose of addressing these questions is to offer an understanding of restraint from the perspective of a practising nurse. The implications of such an understanding are directly relevant to practising nurses and those involved in nursing management and education.

Motivation for the Study

My motivation in undertaking this study was stimulated by being party to restraining a patient, and finding the practice shocking as well as ineffective in terms of what I saw the goals of nursing as being. I believe the goals of nursing are to provide comfort, maintain independence, and show respect to individuals in the delivery of care, which is sensitive to the needs of the individual. When patients pleaded with me to not use restraints, I could not ignore them, and neither could I ignore the disastrous effects restraints had on them. Therefore, I could not be party to their use, and resolved to investigate the use of restraints as my PhD topic.

I have written this thesis from my perspective as a practising nurse. It is not my intention to undermine or discredit the views of the clinical staff who participated in this study. I am aware that the majority of nurses do not like the practice of restraining patients. However, I am concerned with why alternative practices have been slow to emerge to replace restraint use. I hope that through examining what will later be described as discourses about restraint, it will be possible to understand its social meaning and to encourage change.

I have a very strong belief in the importance of providing nursing care in a restraint free environment. As a nurse educated in Britain, I was surprised at the variety and extent of restraint use in Australia. I found it incredible that my nursing colleagues in Britain seemed not to rely on the practice of restraint, while my Australian colleagues seemed, from my perspective, to take the practice for granted. I do not believe that my British nursing colleagues have any additional skills to those possessed by my Australian colleagues. Neither do I think that the patients cared for in Australia are in any way more difficult to nurse. However, I am surprised to find that patients with similar needs who present similar management problems are routinely restrained in Australia, while this is not the case in Britain. My experience of nursing in Britain has taught me that restraint free environments are possible and that restraints are, in the main, unnecessary. My experience of nursing in Australia

has brought these beliefs into question. Hence my motivation to understand why the practice of restraint in Australia is so readily taken for granted.

Assumptions

I guide my interactions with patients by the principle of respect for individuals, and throughout the research I attempted to keep the notion of courtesy in the foreground. I also believe that the principle of respect extends towards hospital staff executing the unarguably hard task of caring for patients such as those in my study. However, I acknowledge that substantial changes to my value system occurred during the study.

Initially, I proposed to find interventions that could be used by nurses as an alternative to restraints. However, it became apparent to me during the early stages of my research that this focus on alternative interventions was ill advised. In observing a patient during the pilot study who was sitting on a soiled pad, hungry and thirsty, I was convinced that these factors would increase the patient's agitation, and could not understand why the ward nurses could not see this too. As a result, I decided to focus my study on why nurses do not always use their skills to avoid the use of restraints. It had become apparent to me that there are no major new techniques for nurses to learn, but that it is essential that knowledge and skills which nurses already have are employed so as to make it unnecessary to engage in the use of restraints. Therefore, my focus sharpened to consider the reasons why patients are restrained. This focus also brought into view the need to understand what it is in the way nurses think about restraint that perpetuates the practice.

Terms

Throughout the thesis, I refer to patients by pseudonyms or collectively as subjects. Although staff and patients, as much as myself, are subjects of the research in as much as we are subjects of discourse, I refer to them as participants and to myself as researcher, or in the first person, in order to make clear to whom I am referring. When I use the word 'case' I do so in the methodological sense and not with the implication that the subjects or participants are 'cases'. In a study such as this where people diagnosed with dementia, or their families, may feel stigmatised, I attempt to use non-discriminatory, non-ageist language. Such technical terms as are used are defined in the glossary in Appendix A. Another challenge was the problem of studying Foucault through translation, in that, many of his terms do not translate

easily into English and we are left with some awkward sounding words such as problematisation and subjectification. I have endeavoured to include all such Foucauldian terms in the glossary. The spelling of such words follows the Australian English spelling with an 's' rather than a 'z'. Furthermore, the term 'restraint', being central to the thesis, requires clarification.

Restraint definitions are applied in two categories: physical or mechanical restraints; and chemical or pharmaceutical restraints. Various definitions of restraint are found in nursing literature and practice. It is necessary to have a definition of restraint which is both applicable and workable in research and in practice. Several studies use a narrow definition for restraint, and limit physical / mechanical restraints to include custom made belts, vests and other devices, but not bedrails or other implements used or modified, such as blankets (Moss & La Puma, 1991; Castle, 2000) Moss et al (1991 p.22) use the following definition:

Mechanical restraints are leather or cloth devices, bedrails, or geri-chairs, used to modify the behaviour of an individual through the limitation of physical movement.

This definition causes no problem in data collection. However, bedrails are not always used to restrain patients, and this definition does not help to identify other interventions which constitute inappropriate restraint. It should be acknowledged that this limited definition might not reflect the full extent of inappropriate restraint use. The following is an example of a more inclusive definition which focuses on the patient's control over an intervention.

A physical restraint is any device used to inhibit a person's free physical movement...A restraint whether it is mechanical, chemical or environmental is defined as such when the individual has no control over the application or use of the device. An individual is restrained when s/he cannot remove a belt, refuse a medication or leave a locked facility. (Ewart, 1997 p.27)

Caution is necessary in accepting the above definition because there are a number of reasons why a person may not be able to control their surroundings, and these are not all caused by nurses. Whereas it is of concern if a patient cannot control their immediate environment, it is important for nurses not to add to that lack of control. Thus, the definition of restraint used in this study involved the notion of interventions from the nurse's perspective. There is a clear analogy with how chemical restraint is sometimes understood.

Chemical restraint is defined by Powell (1989 p.156) as follows:

Any pharmaceutical given with the specific and sole purpose of inhibiting specific behaviour or movement.

Drugs used to treat a sense of anxiety are not considered restraints, but if the anxiety manifests itself in behaviours such as pacing / pulling on IV equipment, and drugs are given to prevent these behaviours, it is restraint. The key factor is whether a compound is being used to prevent a specific behaviour. This definition is similar to the definition of restraint in this study:

Any physical or chemical treatment carried out with the intention of limiting the mobility of a patient for any reason other than during a medical procedure.

A criticism of this definition is that some treatments such as, intravenous infusion pumps, skin traction or external fixators, can *constrain* movement. The difference is that such *constraint* is an unwanted side effect of a medical intervention and is not directly *intended*.

It is not difficult to define restraint using the effect of an intervention or the ability of a patient to choose an intervention but these definitions do not help to identify those incidences of restraint which are ethically problematic. There is a thin line between appropriate restraint, when the patient asks for a bedrail to be placed on the bed or when a doctor prescribes a drug to treat an anxiety disorder, and inappropriate restraint where the patient's rights are violated. Car seatbelts could be considered a restraint, but one would not suggest they were unethical in the same way a strait jacket may be considered unethical. It needs to be clear to all care providers that there is a mode of restraint which is problematic, and it is this type of restraint that should be addressed in research and practice. Thus, any definition of restraint should facilitate the identification of inappropriate restraint, not merely count the number of patients who are taken to be restrained according to some pre-specified criteria. Therefore, throughout this study the term restraint is used to mean any physical or chemical treatment carried out with the intent of limiting the mobility of a patient for any other reason than during a medical procedure.

Approval and Access

The topic of restraints is a contentious and emotive one, and I had some difficulty in gaining access to an acute hospital to study restraint. Several hospitals had to be

approached before I could gain access - even then major changes to the research protocol had to be made to satisfy the sensitivities of various committees. Hospital committee members were not familiar with the work of Michel Foucault and, as such, were sceptical of its relevance to the issue of restraints or clinical research per se. There were certain pressures which made it necessary to drop several of my original research questions and concentrate upon the three questions on page 11. As a result this research has a political agenda, to the extent that, what I studied was shaped by restraint education initiatives in the hospital making it impossible to measure the extent to which restraint use declined as a result of my input. However, with careful explanation of the relevance of a Foucault influenced approach to the relevant hospital ethics committee, I was able to maintain the philosophical scaffolding of my study.

Restraint Practices in the Research Setting

In Australia, the nursing literature is virtually silent on the extent of restraint use. Hence, it seemed logical to examine the patterns of restraint in the Australian teaching hospital where the research took place. I undertook a point prevalence study as the first phase of the research and I will report the findings in brief here. The importance of this phase of the research was threefold. Firstly, it was important to demonstrate that there was substantial restraint use, so the resources invested in the second phase of the study were justified. Second, this phase was to provide me with information about which wards used restraint and were likely to have patients suitable for the case studies. Thirdly, it provided a general insight into patterns of restraint use, such as, the reasons for restraint, and modes of restraint. The report of this point prevalence study can be found in Appendix B. What follows is a brief synopsis of the findings of this phase of the study.

The study was conducted over 18 hours in a 253 bed Australian teaching hospital. The results showed that 9.4%, of the adult population, were restrained at the time of the study. The period of restraint ranged from one day to one-hundred and four days. The use of restraint increased in the oldest age category. Bedrails (62% of restraints) were the most common mode of restraint followed by chemical restraint (17%) and posey vests (9%). Staffing levels were not clearly related to increased restraint use. The majority of restrained patients were admitted from home (67%) and were commonly suffering multiple morbidities including, cerebrovascular accident (CVA),

ischaemic heart disease, diabetes, arthritis and infections. The most common reason for restraint given by nurses were to prevent falling (59%), and secondly to control agitation (21%).

These results indicate a significant problem in the hospital and reinforce the need for the current study into the discourses that support and maintain restraint use as a mode of care.

Framework

I have structured the thesis as follows: In Chapters Two to Four the literature on restraint use is reviewed. In Chapter Two I consider the prevalence of restraint use and the literature on attempts to reduce or eliminate restraint use. Chapter Three, discusses four behavioural phenomena associated with restraints and strategies which have been investigated in response to these behaviours. In Chapter Four, I discuss the ethical and legal issues involved with restraint use. I conclude that, despite a considerable amount of research on restraint, the literature has little effect on its prevalence.

Chapter Five outlines the theoretical rationale for merging two methodologies: discourse analysis and case study; to answer the research questions. The main focus of this Chapter is to demonstrate an understanding of the two methodologies and their relevance to the research topic. I also describe data collection and analysis.

Chapter Six is a full presentation of the research findings for each case study. Each account commences with the subject's clinical details and a description of the behaviours the nurses cited as reasons for using restraints. Observational data, interview data, and field notes are combined to present chronological accounts of the use of restraints on the three subjects.

In Chapter Seven, I reconsider the findings reported in Chapter Six with reference to the literature reviewed and the theories of Michel Foucault, and present a discursive formation with respect to the use of restraints. Chapter Eight summarises the thesis and presents my conclusions. The research questions posed in this chapter guide my summary.

Summary

This introductory chapter has described the importance of the study, my motivations, aims and assumptions. I have also referred to the framework of the

thesis and described its structure. In the next chapter, I review the literature on restraint.

CHAPTER TWO

LITERATURE REVIEW

There are no prescriptions...Do whatever your ingenuity and your heart suggest. There is little or no hope of any recovery of his memory. But man does not consist of memory alone. He has feelings, will, sensibilities, moral being- matters of which neuropsychiatry cannot speak. And it is here, beyond the realm of an interpersonal psychology, that you may find ways to touch him and to change him.
Oliver Sacks 1933-.

Introduction

This chapter aims to place the problem of restraints clearly within a broad framework of nursing and related literature. The prevalence of restraint use in a wide range of predominantly non-psychiatric health care settings is described. The specific concerns about the use of restraints will be reviewed. Behavioural phenomena associated with restraint use will be discussed, and approaches to restraint reduction will be critically examined. Restraint has been a 'hot' topic in the past two decades and it is to be expected that there is a comprehensive body of research into restraint. What is clear, and will be discussed, is that the practice remains prevalent in today's hospitals and nursing homes, both in Australia and abroad. The current review seeks to take a critical view of the picture of restraint presented in the literature and identify what has been overlooked in research. Behavioural and ethical aspects of restraint use will then be explored. Taken as a whole, the points made in these two chapters justify the approach I adopted in my investigation of restraint use.

Global Patterns of Restraint Use

Having examined definitions of restraint in Chapter One, it can be appreciated that prevalence reports on restraint are complicated not only by the difficulty in identifying what can be taken to be use of a restraint, but also by the different methods used to measure restraint use. The prevalence of restraint in North America, where most figures exist will be discussed first, followed by other international patterns and, finally, figures for Australia. It should be noted that many of the reports on prevalence and restraint reduction do not identify the author's definition of restraint, thus, making straight forward comparisons impossible.

North American teaching hospitals

Several policies pertaining to restraints in North America have been published, including the Omnibus Budget Reconciliation Act (OBRA) 1990 and the Joint Commission on the Accreditation of Healthcare Organisations (JCAHO). U.S. federal regulations are clearly set out:

- The patient has the right to be free from restraints, of any form, that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
- A restraint can only be used if needed to improve the patient's well-being and less restrictive interventions have been determined to be ineffective
- The use of restraint must be... in accordance with the order of a physician ... and never written as a standing order.
- The condition of the restrained patient must be continually assessed, monitored, and re-evaluated. (Health Care Financing Administration, 1998 p. 36070)

Before these regulations, in the mid to late Eighties, North America saw a rise in restraint rates, and early studies in teaching hospitals suggest figures were as high as 18 – 22% for patients aged over 65 years (Frenley & Mion, 1986; Robbins, Boyko, Lane, Cooper & Jahnigen, 1987; Lofgren, Mcpherson, Granieri, Myllenbeck & Sparafka, 1989; Mion et al, 1989a). Many of the patients in these studies were recipients of more than one restraint, for example, wrist and vest restraint. Generally, the most common reason for restraint was to prevent falls (up to 77%), followed by preventing disruption to therapy (up to 40%).

One rigorous contemporary study which claims an inclusive definition of restraint examines restraint in three North American teaching Hospitals (>49,000 patient observations) and found 799 patients restrained, a restraint rate of 5.8% and 3.4% for non-intensive care patients (Minnick, Mion, Leipzig, Lamb & Palmer, 1998). It is important to note that a direct comparison cannot be made between these figures and those in the paragraph above, since the former show restraint use per person aged over 65 years, rather than for the hospital population as a whole. As non-intensive care patients are the focus of the current research, the pattern of restraint use among this group in the above mentioned study will be clarified. Staff cited prevention of disruption to therapy in 42.8% of all incidents of restraint in this group and, fall-prevention in 20% of the observations of restraint. Despite the liberal definition of restraint used in this study, bedrails were not included as restraints since there is no mention of them in the report. The most common type of restraints used were wrist

restraints (bilateral 59%) followed by vest restraints, (16%). Other restraints such as geri chairs and waist restraints were noted in less than 1% of restraint use. The most likely people to be restrained were men aged over 65 years, closely followed by women in the same age group.

In Canada a study including both chemical and physical restraint was carried out (156 patients' documentation reviewed), (Kow & Hogan, 2000). Of the total 18 (11.5%) patients who were restrained, 7.7% were physically restrained and 10.3% were chemically restrained (the Powell definition of chemical restraint (p. 15) was used. However, physical restraints such as geri chairs and bed rails were not counted as restraints.

Europe

International research other than that carried out in North America is limited and this may reflect either a lack of concern or a less profound problem. In Britain, for example, there appears to be little use of restraint. In one hospital, (686 observations) fifty-six (8.4%) of the patients had bedrails raised; no other restraints were found in use (O'Keeffe, Jack & Lye, 1996). No distinction was made between the use of bedrails for support and their use as a restraint, and a number of the patients were reported to have asked for their bedrails to be put up. Evans and Strumpf (1989), found similar results on a visit to Scotland. Although research is limited, it can be inferred that the problem of excessive bedrail use is not extensive. It should be noted that inappropriate bed rail use is problematic, as bedrails have been implicated in a number of deaths (Miles, 1996; Parker & Miles, 1997; Miles & Parker, 1998). The most common reason for the use of bedrails given by O'Keeffe (1996) was fall prevention (52 patients). It should also be noted that the observations were conducted at night when most, if not all, of the patients were in bed. Hence, daytime restraint use may be less frequent. In the above study a stepwise logistic regression on data for 668 patients with seven independent variables found: agitated confusion; an age of 70 years or more; and stroke to be the best predictors of the use of bed rails. Patients on the geriatric wards were significantly less likely to have bedrails in place. Whilst patient behaviours and increasing age are correlated with restraint use, the phenomenon of restraint may have more to do with skills or attitudes of staff. One would expect a high concentration of patients with all the

associated correlates of bedrail use on geriatric wards. More will be said about this in the section on restraint reduction.

A small-scale comparative study of hospital nurses in the United Kingdom and Greece showed that 43.6% (N=17) of the U.K. nurses stated that restraints were used on their ward and all of the Greek nurses (N=11) stated that restraints were used on their wards (Molassiotis & Newell, 1996). This study had a very broad definition of restraint, including withholding privileges, verbal threats and the use of geri chairs to prevent falls. The Greek nurses were more likely to use verbal threats and withhold privileges, whereas the United Kingdom nurses were more likely to use medication. A specific definition of chemical restraint is not given in the report, so it is unclear how the authors asked the nurses to determine chemical restraint.

In a large scale cross cultural study of restraint prevalence in acute hospitals, rates of between 15% and 17% were seen in France (N=35), and Italy (N=167), while Spain showed almost 40% (N=210) (Ljunggren, Phillips & Sgadari, 1997). An excellent study in Polish psychiatric hospitals was conducted which compared restraint use between 1989 and 1996, controlling for staff-patient ratios, diagnostic rates, patient demographics, chronicity of illness, global pathology level in each ward and ratio of beds needed to actual beds (Kostecka & Zardecka, 1999). The study involved a one-month period of observation. Significantly more episodes of restraint occurred in 1996, but the average duration of each episode decreased, the number of episodes per patients fell, and the proportion of episodes due to patient aggression increased. This type of quality data is laudable and should be addressed in the general nursing context as it enables the global community to evaluate restraint reduction attempts and make relevant comparisons in data sets. A study in Swedish hospitals put the restraint prevalence in Sweden at 17% (N=122), but Denmark (N<308) and Iceland (N<69) were found to have restraint prevalences of less than 9% (Ljunggren et al, 1997).

Asia

In Hong Kong a study in 1995 found that about 10% of elderly patients in an acute geriatric and psycho-geriatric ward were subject to physical restraint (Chien, 1999). It should be noted that this is 10% of elderly patients not 10% of the hospital population, as in the hospital studies presented above. One cross cultural study found the prevalence of restraint in Japan to be less than 9% (Ljunggren et al, 1997).

Australia

In 1996 The Australian Society for Geriatric Medicine's (ASGM) position Statement on Physical Restraint Use in the Elderly was issued (Flicker, 1996). This provided guidance on the conditions under which restraints could be used and these stressed the importance of consent from the patient or next of kin/surrogate. ASGM also issued directives on how often to check and release restraints. The guidelines state that patients should be restrained for a defined period of time only, and that a registered nurse's signature to indicate that the patient was reviewed prior to restraint should be supplemented by a physician's signature within 24 hours. Retsas (1997a p.34), provides a comprehensive critique of this position statement claiming that:

...whilst the statement is underpinned with beneficent motives it has a number of problematic areas.

Retsas states that the laws in most States are more stringent than the position statement in their need for prescription of restraints by a doctor, unless in an emergency, in which case, the doctor must document the intervention "as soon as is practicable". Hence, he argues for reconsideration of the standard.

Australian teaching hospitals

Few research studies on the prevalence of restraint use in Australian hospitals existed before the 1990s. Two research studies in Australian teaching hospitals were identified. The most comprehensive examined the medical wards of four teaching hospitals in three states (408 observations) and found a restraint rate of 8.5% - 18.5% (12.5% overall), (Whitehead et al, 1997). Inclusive definitions of chemical and physical restraint were used. However chemical restraints were defined as being sedating or neuroleptic drugs in the report, and this may well be an over inclusive definition of chemical restraint. The study was rigorous, in that it validated case notes and direct observations. As this is the only comprehensive research on restraint patterns in Australian teaching hospitals it is worthy of detailed consideration.

An age related increase in restraint prevalence rates was found (8.1% of people aged under 60 years, 11.4% aged 60-79 and 19.4% people aged over 80). The restrained patients were slightly more likely to be female. The majority had been in-patients for more than 10 days. The most common principal diagnosis on admission was stroke (37%), followed by cardio-respiratory disorder (16%) other neurological

disorders excluding stroke (14%) musculo-skeletal disorders and sepsis (both 8%) and 18% with varied diagnoses. A total of 54 restraints were used on 51 patients. In the cases of forty-five patients (83%) the restraints were physical, and in nine (17%), chemical. Bedrails accounted for the majority of restraints (52%, 28 patients) followed by tilting chairs (13%, 7 patients) and seatbelts and posey vests, 9 % each (5 patients). The study showed there was confusion in the definition of restraints in the clinical workplace. When a senior nurse was asked to identify restrained patients she correctly identified patients restrained in only 27% of cases. This nurse did not include bedrails as restraints. Impaired consciousness, confusion and impaired mobility were the reasons for restraint stated implicitly rather than explicitly in the documentation (43%), impaired mobility alone (24%), confusion alone (14%) and in 20% of the cases no rationale for restraint was noted or implied.

A study conducted in an Australian teaching hospital analysed incident forms to review how many patients were restrained following an incident (Gaebler, 1994). An incident is described as an accident, incident or error of any untoward event involving a patient regardless of whether an injury had occurred. Of the 100 patients sampled, 25% had restraint orders subsequent to one or more incidents. These results cannot be compared easily with the previously stated studies because the percentage of patients is of those who were involved in a reportable incident and not a percentage of a comparable group. However, some additional characteristics were found among the restrained population. Patients were more likely to be restrained if they suffered visual or auditory impairment or were identified by the nurses as having an altered mental state. There was no significant association between place of origin (home / nursing home / hostel) but discharge destination was significant. Nearly half of the unrestrained patients (49%) were discharged home, compared to only 16% of the restrained patients. One cannot claim however that restraints are predictive of discharge to a nursing home as this may show that the most heavily dependent patients are restrained. Of those patients who were restrained, 88% were involved in multiple falls and only three of the single fallers were restrained following a fall. Although this result was statistically significant, the association should be interpreted with care because it does not follow that the restraints caused the multiple falls. Following 211 of the falls, restraints had been ordered but were not in place in 25 cases, and falls happened despite restraints in eight cases.

Australian Nursing Homes

The problem of restraint use in Australian nursing homes has been studied almost exclusively by Retsas, who conducted a series of surveys in Queensland, New South Wales, Western Australia, Victoria and South Australia examining the rates and patterns of restraint use. The results are valuable, as the standardised data collection methods enable comparisons. Data collection involved administering a 48-item questionnaire by post to nursing home directors of nursing (DON's). This enabled a wide coverage and range of nursing homes. However, the validity of self-reports in such a contentious matter may well underestimate restraint rates. Retsas used an inclusive definition of restraint and the study is comparable to the other existing comprehensive prevalence figure of 27% from 42 nursing homes in Melbourne (Koch, 1993). Retsas results are as follows: Western Australia-26% (Retsas, 1997a), South Australia-30% (Retsas, 1997b), Queensland-24% (Retsas & Crabbe, 1997), New South Wales-15% (Retsas & Crabbe, 1998), Victoria-25.5% (Retsas, 1998). Although NSW has lower rates than the other States, Retsas cautions that the DON's from the largest nursing homes in this State often did not indicate their restraint rates. These results do not display a downward trend in restraint rates in most nursing homes in Australia. Although centres of restraint free care have been documented these serve as exceptions rather than the norm.

The commonest reason for restraints given by the DON's was "to prevent falls" and the second most offered explanation was "because no alternative exists". Generally, with controls to enable direct comparisons, restraint rates showed a weak correlation between gender and size of nursing home. Most nursing homes had specific written policies about restraint (96% in Western Australia). The most common type of restraint used in most States was bedrails. However, in New South Wales, restraint vests were the commonest. Other restraints were, belts, lap trays, reclining chairs and straps. These surveys did not examine the issue of chemical restraint.

In addition to the 1996 Australian Society for Geriatric Medicine's position statement, several parts of the 1988 report 'Living in a nursing home: outcome standards for Australian Nursing Homes (Australian Government, 1988), stated that physical and other forms of restraints are to be used appropriately. Conformity with this requirement is determined by whether the need for physical restraints is assessed,

whether residents and doctors are informed, whether the types of restraint used are appropriate, and whether their use is reviewed and documented as to type, duration, reasons and circumstances of restraint use. We have yet to learn whether the 1996 position statement will have any effect on the use of restraints. Indeed the results of Retsas' surveys show there has been no immediate change in restraint use. The Outcome standards take for granted the possibility of an "appropriate" type or duration of restraint use. This assumption is questionable when the negative effects of restraint which will be reviewed next are considered.

Taken as a whole, the studies reviewed show that figures on restraint use are patchy internationally, and do not facilitate comparison as they rely on different definitions of restraint and methods of measuring it, such as nurse reports, documentation review and direct observation. The current research advocates a standardised definition of restraint, which incorporates all practices intending to limit a specific behaviour or general movement at any time, other than during a medical procedure. A clear picture has emerged from this review: Restraints are more likely to be used on the most elderly, physically frail and cognitively impaired individuals regardless of health care setting or global geographical situation. No single country which has produced any figures thus far can claim that it makes no use of restraints, although studies indicate China, Japan, Iceland, Denmark and the United Kingdom may not demonstrate to the same extent the problem which is evident in Spain, Greece, the USA and Australia. However, this conclusion should be regarded with caution because the research literature is not comprehensive, and care needs to be taken not to over generalise from small numbers of studies.

Problems Associated with Restraint

Restraint has an inconsistent prevalence internationally and the following section will demonstrate that the lowest possible prevalence is the most beneficial to quality care. This section will systematically review the literature on the negative sequelae following restraint including the physical and psychosocial aspects and the ethical and legal misgivings associated with using restraint.

Physical and Emotional Effects of Restraint

Researching physical and emotional factors is complicated because of the difficulty in claiming cause and effect between restraint use and physiological and psychosocial effects. Causal relationships are even more difficult to determine

because the typical patient under restraint has multiple health problems and self care deficits. However, there is a large and growing body of empirical research which supports the proposition that tying patients up will cause problems. Yet it needs to be mentioned that researchers with the volition to study restraints also seem to aspire to restraint free care. I found no research study which set out to identify the benefits of restraint use which may, to some extent, bias the findings of the studies that have been conducted. An additional problem arises in investigating psychological factors in patients with dementia as the existing knowledge pertaining to understanding or measuring psychology with this group is primitive. Nevertheless, it is difficult to conceive how restraining a patient would have a beneficial effect on their emotional well being. The position that everything has to be evidenced through scientific method before we can accept a claim as 'true' is questionable, given the difficulties that objective science has in dealing with dementia. Every attempt will be made here to present the findings in an objective fashion. The strengths and weaknesses of study designs will be emphasised.

A cohort study of 102 physically restrained hospital patients showed that these patients suffered extraordinarily high rates of in-hospital death (21%) and morbid events including falls (4%), new urinary and faecal incontinence (29%), infusion thrombophlebitis (13%), new pressure sores (22%) and nosocomial infections (12%) (Lofgren et al, 1989). Patients restrained for longer than four days developed significantly more nosocomial infections and pressure sores compared to those restrained for a shorter period. The high mortality rate may reflect the severity of illness in the restrained patients. However, the study reports that the clinical characteristics of the patients were similar. With logistic regression the researchers attempted to adjust for difference in severity of illness, although they acknowledge the possibility of subtle differences in assumed pathology. The study did not use a control group, and the researchers did not claim causal inference between restraints and negative sequelae, but their findings demonstrated an important dose effect: those patients restrained for longer periods had more adverse outcomes.

A longitudinal study of 71 people with dementia living in the community found that the use of neuroleptic drugs was associated with an increased rate of cognitive decline in dementia (Mcshane et al, 1997). This study did not use control groups and did not exclude the possibility that the patients treated with neuroleptics were on a steeper trajectory of cognitive decline. As this study was a longitudinal study, it was

possible to trace the patient's previous rate of decline. The findings showed that in almost all cases, the downward trajectory started at the same time as treatment with neuroleptics, implying the decline in cognitive function was related to the commencement of the drug.

The American Food and Drug Association attributed one hundred and thirty one deaths to the use of restraints between 1987 and 1996 . There are many studies which stress the damaging effects of restraint on, impaired mobility, incontinence, eating difficulty, altered nutrition, skin breakdown and nosocomal infections (Evans & Strumpf, 1989; Gillick, Serrel, & Gillick, 1982; Lofgren, McPherson, Granieri, Myllenbeck, & Sparafka, 1989; Sullivan-Marx, 1994).

The evidence in the above studies on the prevalence and the harm associated with restraints, validates the significance of the current study in its attempt to address the reasons for the long standing use of restraint despite the evidence of harm. However, a limited number of studies have reported on attempts to reduce restraint use and these will be discussed next.

Strategies for Restraint Reduction

Much restraint reduction research has been conducted in nursing homes (Kallman, Denine-Flynn & Blackburn, 1992; Sloan, Papougenis & Blakeslee, 1992; Kramer, 1994; Bradley, Siddique & Dufton, 1995; Levine, Marchello & Totolos, 1995; Dunbar, Neufeld, Libow, Cohen & Foley, 1997; Kenedy Weeks, 1997; Williams & Finch, 1997; Middleton, Keene, Johnson, Elkins & Lee, 1999; Myint, Neufeld & Dunbar, 1999). However, more recently there are a number of documented restraint reduction initiatives in hospital units (Powell et al, 1989; Quinn, 1996; Sullivan-Marx & Strumpf, 1996; Chalifour, 1997; Jensen et al, 1998; Johnson & Bendea, 1998; Gilbert & Counsell, 1999; Winston, Morelli, Bramble, Friday & Sanders, 1999b; Morrison, Fox, Burger & Goodloe, 2000). It should be noted, that each one of these successful restraint reduction reports originated in the USA. In a review of all the Australian journals in both Medline and CINHALL no report on restraint reduction in either nursing homes or hospitals was found.

Conditions in the fast paced environment of acute care hospitals differ from those in nursing home settings, but many alternative interventions and all of the guiding principles can be transferred. In one innovative demonstration project, a "functional intensive care unit" was adapted from one patient room, and staffed by a nursing

assistant for those patients on the ward in need of restraint. It had a day room focus, where patients could interact and be supervised. In addition to lower restraint use, these patients experienced a lower incidence of complications, and their care was associated with reduced costs and shorter stays than a comparison group (Maddens, Clark & Fraza, 1994).

Another study, in an acute neurological ward involved alternative modes of care including inter-disciplinary assessment, sensor alarms, rocking chairs and recliners, structured daily routines, and physical exercise programmes. Unfortunately the report gave no indication of the extent of restraint reduction but informed us that there was no increase in patient injury (Gilbert & Counsell, 1999).

A further restraint reduction programmes took an inter-disciplinary approach to forming a protocol and supporting restraint documentation (Winston et al, 1999b). An institutional “buy-in” session held to gain support of all levels of hospital management was followed by carer education on all aspects of restraint, including risks and alternatives. The report claimed that there was a strong commitment to restraint reduction and that restraints were reduced but, again, no figures were reported. The report concluded that the key factors in restraint reduction were: development of a restraint reduction program, implementation of educational strategies, and a continuous evaluation programme.

Johnson and Beneda (1998), report a restraint reduction of 18.9% to less than 1%. This was achieved through the establishment of alternatives, culture change emphasising prevention, appropriate restraint use and use of alternatives (and staff education of alternatives), reconstruction of hospital policies, and producing a workable evaluation tool to evaluate the need for restraint. Alternatives to restraint are discussed in the next chapter, Chapter Three.

A study by Morrison et al (2000), used a nurse led approach in conjunction with weekly multi-disciplinary restraint reduction rounds, during which the team discussed alternatives for the restrained patients. The program was evaluated by a week-long audit on restraint use (observational) and found restraint use over the week to have fallen from fifteen cases before the initiation to just one.

Quinn (1996), states that common elements shared by successful restraint reduction programs include administrative support, a strong educational component, participation of all persons involved in the continuum of care, and individualised care of the older person. Strumpf (1992b), states that highlighting the myths about

restraint and orientating nurses to the realities of caring for older people are the keys to reducing restraints. The current research takes a more critical view of the problem of restraint use. If lack of education was the sole reason for high restraint use then restraint reduction would be a significantly easier task, and there would not be the need for the intricate “buy in” strategies described in a report above. Some studies have focused on nurses’ ‘attitudes’ to both the elderly and to restraint use, and I review this literature next.

Nurses’ attitudes and knowledge

There has been significant interest in the state of nurses’ knowledge and attitudes to restraint, and the implications of these factors on restraint use. The existing research is, in the main, contradictory which may reflect changing attitudes over time, a general diversity of sentiments about restraints among carers, or the current fragmented approach to restraint reduction which is apparent from the prevalence figures. The contradiction may also represent inadequacies in the research documents designed to measure nurses attitudes.

Studies report that between 33% and 40% of nurses do not agree with decisions to use restraints (Holzworth & Wills, 1999; Lamb, Minnick, Mion, Plamer & Leipzig, 1999). Bryant (1997), indicates that nurses in long term care settings use fewer methods of restraining patients and more alternatives. However, the prevalence cited in this chapter does not support this proposition and this may highlight a problem with the use of self report measures in determining the prevalence of restraint.

Matthiesen (1996), reported that in a population of 281 nurses and health care workers, where 50 represented the strongest endorsement of the patient’s right to autonomy and risk taking and less inclination towards the use of physical restraints, and 0 represented no endorsement, the average score was 33. Attitude scores differed significantly between practice settings, with the subjects in the geriatric and medical units having higher scores than subjects in the gero-psychiatric settings. There were no significant differences between registered and non-registered nurse groups. However, other studies found large differences between nursing assistants and registered nurses, with registered nurses supporting patient autonomy to a greater extent (Mattiasson & Anderson, 1995; Sullivan-Marx & Strumpf, 1996; Wu, Wu, Lui & Lin, 1999). Fifty-nine percent of registered nurses reported that they felt upset if a patient became disturbed after restraints were applied, yet only 28% of the

registered nurses in the study thought that patients might become more disorientated when restrained (Matthiesen et al, 1996). Personal or professional contact, age, years of experience, and educational preparation were not associated with high knowledge, practice or attitude scores, where higher scores indicate less likelihood of restraint use (Matthiesen et al, 1996). A major point made by Matthiesen et al (1996), was that contact with older patients and educational opportunities do not necessarily reflect competence in restraint use. However, it is apparent in one study that restraint reduction programs had a favourable effect on employee attitudes towards not using restraint (Sundel, Garrett & Horne, 1994).

Sullivan-Marx, in a recent study, found that restraints were significantly more likely to be used when there was a high proportion of skilled nursing staff on duty (Sullivan-Marx, Strumpf, Evans, Baumgarten & Maislin, 1999). Mattiasson (1995), found that support for patient autonomy was higher from an individual point of view than when nurses were asked to gauge the unit's perspective. A study in a psychiatric setting states that nurses respond differently to chronic mental illness, being then more likely to use restraints (Roper, 1987).

Some studies have highlighted conflict in emotional responses to restraint (Difabio, 1981; Marangos-Frost & Wells, 2000). Nurses in another study described a lack of feelings about the use of restraints. The following quotation from one of the nurses captures this emotional indifference.

...I have no feelings (long pause), there are many patients who are wearing the restrainers. (Lee, Chan, Tam & Yeung, 1998 p.156).

The authors of the study from which this quotation is taken go on to argue that emotional indifference may reflect a ritualisation of restraint. Another study reports that very few respondents felt guilt or embarrassment when using physical restraints (Lamb et al, 1999). Furthermore, studies have shown that nurses have inadequate knowledge of restraints in two particular areas knowledge: the harm restraints cause, and knowledge of the alternatives. Between 45% and 56% of nurses cannot identify the dangers associated with restraints (Maruschock, 1996; Lee et al, 1998; Lamb et al, 1999), and between 39% and 65% fail to provide any alternatives (Strumpf & Evans, 1988; Hardin et al, 1994). In the study by Lee (1998), nurses identified further restrictive devices as alternatives, such as bedrails and Geri chairs. A study of Israeli student nurses showed that some students continued to restrain patients despite the fact that they had negative attitudes toward doing so, and gained good

theoretical knowledge during their clinical experience (Fradkin, Kidron & Hendel, 1999). The students simply imitated the actions of the nursing staff on the ward.

Marangos-Frost (2000), considered nurses decision making to be an important factor in restraint use and concluded that decisions are based more on internalised morals, values and emotions than on information gathering. This finding brings into question the validity of the argument that nurses will use fewer restraints if they are educated about restraints. The study by Marangos-Frost indicated that the solution might be more complex than a mass education campaign.

Finally, little has been written about relatives' attitudes to restraints. One study found that relatives were very ill informed as to their rights and patients' rights, and this study demonstrated the importance of addressing family concerns and anxieties (Kanski, Janelli, Jones & Kennedy, 1996). In another study between 60% and 70 % of respondents reported that chemical and physical restraints were a source of disagreement between hospital staff and families (Lamb et al, 1999). It would appear that there is a role for patient advocates here, as nurses may experience conflict between the need to support medical and nursing decisions and their need to inform relatives.

Summary

This chapter has highlighted widespread ambivalence in nurses' feelings about the use of restraint and inadequacies in their knowledge of restraint use. It is questionable whether any of the factors identified as influencing restraint use can affect the future use of restraints. I will argue that due to the difficulties in accurately measuring attitudes (Polit & Hungler, 1995), and attitude change, a focus on nurses' attitudes may not be helpful in promoting restraint reduction. Attitudes are socially constrained and thus, an understanding of the social systems, which the current system aims to provide, is more helpful in the case of restraints. Furthermore, restraint reduction cannot be investigated precisely without more stringent and standardised definitions of restraint.

Moreover, it is important to recognise that restraints are commonly used in response to specific patient behaviours. Therefore, a broad understanding of these behaviours is necessary in order to anticipate the discourse analysis presented in Chapter Six. The next chapter reviews the literature on behavioural phenomena associated with restraint use, and discusses studies which report on least restrictive

measures in response to these behaviours. Taken together, these two chapters, Chapter Two and Chapter Three, present the literature which provided the point of departure for my investigation of restraint use. The combination of discourse analysis and case study methodology I used was developed as a complementary approach to these dominant approaches to research into the use of restraints.

CHAPTER THREE

BEHAVIOURAL PHENOMENA AND RESTRAINT

Asneezia – a hitherto unrecognised psychiatric symptom...A new disease, 'asneezia' is described...The disease is characterised by the absence of sneezing or the inability to sneeze... Some 'asneezics' have been cured by electroconvulsive therapy. (Shukla, 1985 p 565)

Four behavioural phenomena commonly associated with restraint will be discussed in this chapter: agitation, falls, wandering, and aggression. Prevention of restraint lies in managing these behaviours by less restrictive means. There is an assumption in caring for patients with these behaviours, that the behaviour of patients with dementia is purely idiosyncratic. This view is based on unfounded opinion, and many nursing scholars, (Rogers, 1961; Cohen-Mansfield & Billig, 1986; Evans & Strumpf, 1990; Ryden, Bossenmaier & Mclachlan, 1991b; Mion & Mercurio, 1992; Strumpf et al, 1992b; Frengley, 1996; Capezuti, Talerico, Strumpf & Evans, 1998b), have sought to correct it. As with normal psychology, behaviour in dementia is influenced by stimuli in the psychosocial and environmental domains. The strategies to address problematic behaviours are fundamental, as they are often regarded as essential nursing care. They include: adequate pain management, comfort provision, continence and hygiene maintenance, and adequate dietary intake (Mallett & Dougherty, 2000). A quote from Florence Nightingale reminds us of the centrality of these issues to nursing in a section called "What nursing ought to do":

I use the word nursing for want of a better. It has been limited to signify little more than the administration of medicines and the application of poultices. It ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet – all at the least expense of vital power to the patient. (Nightingale, 1859/1946 p 16).

Stress is placed here on those aspects of essential nursing care which are our best weapons against restraint use. For people with dementia or acute confusion these fundamental needs have to be met with additional rigour, as it is often the case that expression and interpretation of these needs is difficult. Thus, meeting the needs of people with dementia and related behavioural problems is much more difficult than it appears.

Agitation

Agitation in patients with dementia is common, (Taft, 1989), but traditionally few studies have addressed therapeutic interventions for agitation (Marx, Werner & Cohen-Mansfield, 1989). Research exists to show that physical and chemical restraints may confound the behaviour of a confused patient (Strumpf & Evans, 1988). However, agitation continues to be a common reason for institutionalisation (Young, Muir-Nash & Ninos, 1988), and occupational burnout (Struble & Silverstein, 1987). Agitation has been defined as:

...A broad behavioural term connoting excessive motor activity, which is often non-purposeful in nature and commonly associated with feelings of internal tension, irritability, hostility, and belligerency. (Barnes & Raskind, 1980 p.111).

Another author defined agitation as:

Vocal or motor behaviour that is either disruptive, unsafe, or interferes with the delivery of care in a particular environment. (Rosen et al, 1994)

The negative focus on the problems caused by agitation or the purposelessness of the behaviours in these definitions is not helpful to nurses trying to care for patients creatively. This is not to deny that agitation can be severely disruptive, but to point out that these definitions represent an extremely distorted view of agitation because they arise from an institutional context. One study in Sweden (Johansson, Zingmark & Norberg, 1999), showed that the majority of nurses found the agitated behaviours of clients to be meaningful expressions of the dementia sufferers' inner world. They interpreted the behaviour as meaningful fragments of common activities of the patients' pasts. It is clear that this insight will be far more helpful in the search for alternatives to restraints than seeing agitation as a problem to be curbed.

Manifestations of agitation are classified into three syndromes: aggressive behaviour (hitting kicking, cursing); physical non-aggressive behaviour (general restlessness, pacing and disrobing inappropriately, resisting care); and verbally agitated behaviours (repetitious sentences, requests for attention, complaining, negativism) (Cohen-Mansfield, Marx & Rosenthal, 1989). Agitation has been categorised based on the severity of behavioural manifestations (Patrick, 1986). An example of a less severe agitation would be the inability to sit still for long while the other end of the spectrum is evidenced by continual wandering.

Causes

Although agitation probably results from a combination of needs and confusion, these antecedent conditions are not always apparent (Cohen-Mansfield & Billig, 1986). Correlates of agitation in the literature include, confusion and delirium (Taft & Cronin-Stubbs, 1995), impairments in activities of daily living (Spector & Jackson, 1994), sleep disturbance (Cohen-Mansfield & Marx, 1990), a tendency to fall (Marx & Cohen-Mansfield, 1990), and an absence of emotional intimacy in social networks (Cohen-Mansfield & Marx, 1992). These correlates may be either causative of agitation, or result from agitation, and the research evidence is inconclusive on this point.

Delirium (a term used interchangeably with acute confusion) occurs in 14% to 56% of elderly hospitalised patients and is associated with hospital mortality rates of 10% to 65%, longer and costlier hospitalisations, and increased rates of nursing home placement (Inouye, 1994; Flick & Foreman, 2000). Delirium may be manifested by hyper vigilance or inattentiveness; disorientation; memory impairment; illusions, hallucinations or misperceptions of stimuli. The severity of these symptoms varies during the day and is typically worse when the patient is fatigued (Foreman, Mion, Lark & Fletcher, 1999). Classically delirium develops shortly after admission and lasts less than five days. Cases of delirium lasting longer than seven days are rare (Foreman et al, 1999).

Work has been done in identifying the presence of 'sundown syndrome' which was first identified over fifty years ago (Ebersole & Hess, 1998). It gives rise to increased agitation or disorientation after the sun goes down. Conflicting research exists as to the relationship between circadian rhythms and agitation such as would support a 'sundown syndrome'. However, studies not supporting the presence of a syndrome are smaller studies, such as that by Cohen-Mansfield (1989), who found that four out of eight patients were more agitated in the morning. These results are not however, sufficient to dispel the possibility of a sundown syndrome, the notion of which has considerable support in the care of the aged literature (Weinrich, Egbert, Eleazer & Haddock, 1995).

Consequences

Disturbed sleep patterns associated with agitation may also have a confounding effect on the condition (Gerdner & Buckwalter, 1994). Researchers have shown that

deprivation of rapid eye movement (REM) sleep results in symptoms of irritability, apathy, decreased alertness and increased sensitivity to pain (Brewer, 1985). Evidence also exists that disruptions in sleep cycle may also alter other biological rhythms, such as the release of adrenal hormones (Hayter, 1980). Consequently, the sleep-deprived individual may have less tolerance to stress (Lerner, 1982). Extremely agitated patients may exhaust their body's stores of vitamins, especially the B complex vitamins affecting energy release (Green & Harry, 1987). Another consequence of agitation is increased falls (Marx & Cohen-Mansfield, 1990). Alternatively, authors have reported that agitation is an adaptation that offers stimulation and exercise, and chances to engage in help seeking behaviours (Weinrich et al, 1995).

Alternatives: Assessment

Capezuti et al (1998b), presents a thorough patient assessment tool, which was successfully used to help eliminate bed rail use in a hospital without increasing incidents. Tools such as these could become standard practice for all patients at risk of falling while in a state of agitation. A study which evaluated the outcomes of a multi-disciplinary approach to assessment resulted in increased functional independence and a dramatic reduction in behavioural and cognitive problems (Holm et al, 1999). Holm attributed this to effective treatment of co-morbid psychiatric illness, and believed that behaviour improvements were secondary to cognitive gains rather than a primary effect of the prescribed treatments.

A comprehensive look at the antecedents of agitation in hospital patients should start with an assessment of the patient's cognitive status (Gerdner & Buckwalter, 1994). Delirium and dementia are the two most common organic brain syndromes associated with agitation (Cohen-Mansfield & Marx, 1989). Definitions of these two distinct problems can be found in the glossary in Appendix A. Despite variability in the etiological basis of delirium, consensus exists about the most common causes, described by Foreman as medication- either under or over doses; infection, particularly urinary and chest infections; dehydration and electrolyte imbalance; and metabolic disturbances. Ignatavicius (1999), reports the following as risk factors for delirium: advanced age, hypoxia, immobilisation, relocation, impaired vision or hearing, recent surgery, multiple diseases, trauma, alcohol, and sleep deprivation. A model for predicting factors for delirium was found to be clinically and statistically

significant in identifying individuals with a high risk of delirium (Inouye & Charpentier, 1996). Delirium can be more complicated to identify when superimposed on dementia and research suggests that delirium is often untreated in these cases (Flick & Foreman, 2000). Jacobson (1997), gives a detailed report of the laboratory tests which can help in the diagnosis of delirium. However, it is not the intent of the current review to present the medical management of agitation. Nevertheless, it is important to treat the primary causes of agitation. Many of the causes of delirium are to a greater or lesser extent, reversible and tools such as the one reported by Inouye (1996), can speed up response time, so that care becomes more proactive, thus preventing the need for restraints. Evidence shows that the use of restraints during periods of delirium is often counterproductive (Sullivan-Marx, 1994; Ignatavicius, 1999).

Drug therapy

Previous psychiatric problems were identified in 57% of 731 patients with dementia in one study (Zimmer, Watson & Treat, 1984). As shown in the study by Holm, (1999) when psychiatric conditions are correctly identified and treated, significant improvements can be seen in behaviour and cognition. Some studies have shown that many medications will actually precipitate agitation in the elderly (Patrick, 1986; Cohen-Mansfield & Marx, 1989). Drug toxicity especially from levodopa, corticosteroids, anticholinergics and barbiturates and drug withdrawal (especially from central nervous system depressants) may cause agitation (Shamoian, 1988). Whilst many studies advocate minimal use of psychotropic drugs, the Holm study shows marked increases in prescribing anti-psychotics, anti-depressants and mood stabilisers but a decrease in anti-anxiety drugs such as benzodiazepines. What appears to be fundamental in the latter study is the attention to assessment of individuals rather than a ritualised approach.

Responding to sensory problems to prevent agitation

Sensory impairment and communication losses may also precipitate agitation (Gerdner & Buckwalter, 1994), and the implication is that nurses should ensure continuing access to sensory aids such as spectacles and hearing aids. Pain is a common fact of life for many elderly individuals and some common pain related diagnoses are arthritis, hip fracture and cancer (Harkins, 1988). Non-verbal, cognitively impaired individuals may communicate pain through behaviours which

are not included in standardised pain assessment tools such as vocalisations or crying out, facial expressions such as grimacing or wincing, wrinkling of the forehead in response to movement, increased restlessness, rocking, rubbing or guarding of a body part, increased irritability, and aggressive behaviours or resistance to personal care (Ryden & Feldt, 1992). These behavioural manifestations may cause pain to be interpreted as agitation and thus go untreated. Some research indicates that verbal cognitively impaired individuals may give equally reliable pain reports as cognitively intact elderly, but no consensus has been reached in the literature on this point (Feldt, Warne & Ryden, 1998).

Three recent studies were found on pain assessment in cognitively impaired individuals. The first found that over a third of all patients believed to have pain by a family member received no analgesia during the month prior to data collection. Of the subjects known to have at least one diagnosis known to cause pain, 60% had not received analgesics in the month prior to data collection. Fifty-nine percent of subjects whose medical records indicated they had arthritis had received no pain medication in the previous month. Although this study was conducted in a nursing home and included only 38 patients it is clear that further research extending these question to hospitals would aid insight. A hospital study asked nurses to describe pain behaviour in the cognitively impaired and found that the behaviours associated with pain in the literature were identified (Galloway & Turner, 1999). However, even if nurses know how pain is expressed in cognitively impaired elderly patients, it should not be assumed that they adequately administer medications for pain. One study addressed nurse ratings for pain and corresponding administration of pain medication for 83 nursing home residents. This study found that registered nurses' ratings of pain and the administration of pain medications were not significantly correlated. In addition, cognitively impaired residents were prescribed significantly less scheduled or 'as required' medication than cognitively intact residents (Kaasalainen, Middleton, Knezacek & Hartley, 1998).

Environmental management

The environment has been put forward as an aspect that may have an effect on agitated behaviour. One study correlated a range of agitated behaviours with a range of environmental factors and found that units with the poorest global environmental scores on areas such as cleanliness, maintenance, stimulation, lighting, attractive

views and evidence of personal mementos in the room experienced significantly less agitated behaviours from residents. Furthermore, the quality of human relationships between carers and residents exerted strong influences on agitation levels. The study reports that the physical and human environments were so inter-related they could not be separated analytically (Sloane et al, 1998). Specifically designed environmental adaptations for agitation include, increased personal space (Marx et al, 1989), a wanderers lounge (Mc Growder-Lin & Bhatt, 1988), and a reduced stimulation unit (Cleary, Clamon, Price & Shullaw, 1988). Some disagreement in the literature over the necessary amount of stimulus is evident. However, it is clear that both over and under stimulation can be detrimental and what is important is individualising the amount of stimulation based on the reactions of the person (Jacobson & Schreibman, 1997).

Psychosocial approaches

Various therapies have been tested to see if they have a beneficial effect on confusion and agitation including music therapy, validation therapy, and reality orientation. Literature suggests that the choice of therapies will be most beneficial if health care professionals understand the stages of dementia (Matteson, Linton & Barnes, 1996). Matteson suggested that Piaget's developmental stages happen in reverse in dementia of the Alzheimer's type. Certain therapies need language skills and therefore, would not be beneficial to patients with end stage dementia. It should be stressed that these therapies are not one off interventions, rather programmes running over weeks. Patients may not be in hospital for long enough to complete a programme. In addition the agitation that usually results in restraint in hospital, such as danger of a fall, could not wait for an improvement over ten weeks. Therefore, it is clear that interventions with immediate results are the most beneficial and these are more likely to be interventions such as pain relief and comfort provision. However, what may be relevant to hospital nurses is that aspects of the therapies can be adopted as standard interpersonal techniques.

Reality orientation (RO) can be both an individual and a group therapy. The basic assumption of RO is that it disrupts cognitive decline by stimulating the confused individual with repetitive activities (Scanland & Emershaw, 1993). It is an attempt to reinforce name, date, time and other facts of orientation or reality. RO studies have revealed no significant improvement in mental status or social behaviour and

activities of daily living (Holden & Sinebruchow, 1978; Hogstel, 1979). Some studies found improvement in orientation and behaviour (Harris & Ivory, 1976; Citran & Dixon, 1977). One reason for disparate results is the varying backgrounds of persons conducting programmes, and the lack of existing guidelines for structuring an RO program (Spector, Davies, Woods & Orrell, 2000). In a systematic review of RO in dementia, six studies met the criteria for randomisation and control, and although trial varied in length of intervention and outcome measure results, all showed that RO had a significant positive effect on both cognition and behaviour (Spector et al, 2000). Results such as these, show that further work into the efficacy of RO are justified. RO has been criticised as an intervention to reinforce the clinicians' reality onto a person rather than understanding the patients' reality. An alternative seeks to validate the person's own reality and is called validation therapy.

Validation therapy (VT) can be delivered one-on-one or in a group setting. A basic premise is that the therapist must have empathy and unconditional positive regard for the person they are working with (Rogers, 1951). VT consists of a number of verbal and non-verbal communication techniques designed to stimulate communication, tune into and empathetically validate the communications of an elderly person with dementia. It is held that this has a calming effect on agitation (Feil, 1993). Again clinical studies show mixed results and lack rigour when trialing the effectiveness of VT. However, one large study with a control group, randomisation and blindness among the nursing staff as to which group the patient was in, showed that VT did not reduce the use of psychotropic medications, physical restraints or nursing time devoted to intervening in problem behaviours (Toseland et al, 1997). It would seem that there is not a lot of support for VT as an intervention for agitation. However, a qualitative study of clinical nursing assistants' techniques in reducing agitation showed that the most important techniques were looking to their personal and family values and having respect for elderly people (Anderson, Wendler & Congdon, 1998), values similar to the principles of VT.

Gerdner (1993), was the first to systematically investigate the use of music with agitated individuals with dementia during the 30-minute presentation of music and the 60 minutes immediately following. She found a statistically and clinically significant reduction in agitation. Devereaux (1997), supports these findings. Gerdner suggests that music therapy (MT) is relatively inexpensive and requires

minimal time. She presents a comprehensive protocol for the choice of music, duration and conditions of listening (Gerdner, 1999). MT appears to be one intervention that could be followed in the acute care setting. However, hearing difficulties have been identified as a risk factor of restraint (Gaebler, 1994), and this may limit the usefulness of MT.

Several studies have found the use of rocking chairs and modifications to furniture to increase comfort helpful in alleviating agitation (Mion & Mercurio, 1992; Missildine & Harvey, 2000). Where medical device removal is a problem, the consensus appears to be to rationalise the use of any invasive device as soon as possible, but if this is not possible the device should be made as comfortable and secure as possible.

Although there is a lack of hard scientific evidence for many of the alternatives, it is essential to the success of interventions that they are individualised, and as such blanket interventions on randomised groups may hide the benefits seen in individual case study research. Hence, this section will be concluded with the proposition that interventions should be made by nurses with a full appreciation of all the options, and a detailed knowledge of the patient's context in order to choose an appropriate intervention in the treatment of agitation.

Falls

Prevention of falls is the major reason given for nurses initiating restraint use, but restraints have also been implicated in causing serious falls. Like restraint research, studies on falls are difficult to compare as researchers use different definitions of a fall. Some researchers do not count falls that are a result of CVA, myocardial infarct (MI) or seizure and some institutions report all falls while others only report injurious falls. The discussion that follows concentrates on in-hospital falls, as these are more relevant to the current research.

Causes

Similar risk factors are associated with falls and restraints. For convenience these risks can be divided into intrinsic and extrinsic factors. Intrinsic factors which increase the risk of falls are age, history of previous falls and gait problems, (Johnson, 1986; Gross, Shimamoto, Rose & Frank, 1990), cognitive, visual or sensorimotor impairment, urinary and bladder dysfunction, (Moris, Rubin, Moris & Mandel, 1987; Tinetti, Williams & Mayewski, 1987; Tobis et al, 1990), confusion,

depression and agitation (Gluck, Wientjes & Rai, 1996; Oliver, Britton, Seed, Martin & Hopper, 1997). Polypharmacy, substance abuse and some pharmacological agents have also been identified as risk factors (Lamb, Miller & Hernandez, 1987; Mion et al, 1989a; Grant & Hamilton, 1997). Barbieri (1983), produced a patient profile by interviewing patients who had fallen and found that people with a strong desire for independence, those dealing with a life crisis, and those not likely to seek help were at high risk of falling.

Extrinsic risk factors include inappropriate footwear, misuse of ambulation devices, (Wasson, Gal & McDonald, 1990; Robbins, Gouw & Mcclaran, 1992), unstable furniture, elevated bed position, shiny floors, and dim lighting (Whedon & Shedd, 1989). Falls appear to have no significant relationship to time of day, day of the week, month or season (Devinchenzo & Watkins, 1987), but there is some evidence that in-patient falls occur most frequently in the first and last week of hospitalisation (Tack, Ulrich & Kerh, 1987).

Consequences

Eighty-four percent of all adverse in-patient incidents are fall-related (Tideiksaar, 1993). Falls compromise the quality, increase the cost of hospitalisation, and account for many lengthy hospital stays and permanent disabilities (Raz & Baretich, 1987; Tobis et al, 1990). A Western Australian Teaching Hospital (680 beds) found 578 falls were reported from 382 patients over 6 months (Gaebler, 1993). It was found that 52% of patients who fell in hospital had subsequent multiple falls. Forty percent of the single fallers sustained no injury and there was a similar non-injury rate for multiple fallers on the first fall (42%). However, the rate of injury per fall climbed to 85% for the fourth fall. Overall, only 18% of multiple fallers escaped injury in all their falls. Eight percent of the multiple fallers sustained a fracture while no single fallers sustained fracture, with moderate abrasions and lacerations being more common. Whereas this can be considered a low percentage the implications to the patients are far reaching, including increased physical and emotional stress, prolonged hospitalisation, and significantly more feelings of dependency and isolation (Baker & Harvey, 1985; Johnson, 1986).

In-patient falls have negative effects on nurses such as stress, guilt and self-doubt, (Brians, Alexander, Grotta, Chen & Drumas, 1991), which have implications for staff morale.

Falls and restraints

As stated earlier, despite being the most commonly cited reason for restraints there, is no evidence that falls happen less frequently when restraints are used. In fact, various researchers have shown that between 10% and 47% of falls happen despite use of restraints (Weiman & Ovear, 1986; Mion et al, 1989b; Gross et al, 1990; Tinetti, Lui & Ginter, 1992). Providing evidence for the converse hypothesis (that restraints increase the number and seriousness of falls) is difficult. For instance, are the restraints leading to further falls or are multiple fallers being restrained more frequently because they are exhibiting an increased propensity to fall? There are ethical problems with restraining a group of patients and comparing their falls to an unrestrained control group, but a number of researchers designed studies to avoid this problem. Arbesman (1999), used a randomised case controlled study design with 252 patients and 250 controls, in a large metropolitan hospital, to test three hypotheses:

- A mechanical restraint was used before the day of the fall (or the selected day) significantly more often for the cases than for the controls.
- The cases were significantly more likely than the controls to have participated in occupational therapy, physical therapy or cardiac rehabilitation prior to the day of the fall (or the selected day)
- Nursing adequacy, as defined by the provided-to-expected nursing ratio, was significantly lower for the cases than for the controls.

Cases were matched for length of stay to day of the fall and age. This could be considered crude matching criteria, however, the large numbers offset this problem to some extent. Data were analysed using conditional logistic regression. The study revealed that individuals who were mechanically restrained at any point prior to the fall (for the cases) or selected day (for the controls) had approximately twice the risk of falling compared with patients who had not been restrained, although the figures only approached statistical significance. The risk of falling was highest soon after a patient had been restrained. Cases and controls showed no significant differences in their participation in therapies and staffing adequacy.

Neufeld, (1999) conducted a 2-year prospective study of an educational intervention for physical restraint reduction to describe how removing physical restraints affected injuries in nursing home settings. At the onset of the intervention

859 residents were restrained and their injury rate studied after restraint removal, serious injuries declined significantly. In the second part of the study 2075 patients in 16 facilities showed a restraint reduction of 41% to 4%. The decrease in the percentage of injuries of moderate to serious severity was significant (7.5% to 4%). This author concluded that a substantial decrease in restraint use occurred without an increase in serious injuries, although minor injuries and falls increased.

A number of studies have investigated falls rates and injury rates during attempts at restraint reduction, but the results are varied. However, these studies cannot be directly compared without thorough evaluation of the actual restraint reduction programme. Nevertheless, three studies have reported a decrease in fall rates with restraint reduction (Suprock, 1990; Bloom & Braun, 1991; Cuchins, 1991). Four studies reported no change in serious injuries when restraints were reduced (Powell et al, 1989; Capezuti, Evans, Strumpf & Maislin, 1996; Evans et al, 1997; Capezuti, Strumpf & Evans, 1998a). Two studies reported decreases in serious injuries after restraint reduction (Suprock, 1990; Ejaz, Jones & Rose, 1995). One study reported an increase in serious injuries (Read, Bagheri & Stricklan, 1991). It should be noted that the studies most successful in reducing restraint have in common a comprehensive network of support and education for the staff effecting change in their restraint practices, along with a unified multidisciplinary approach.

Alternatives

Risk identification is central to fall prevention, and various tools have been evaluated for this purpose. Two of these tools were evaluated (Morse Fall Scale and Functional Reach Test) against nurses' clinical judgement in predicting those in-patients who were most likely to fall. The results showed that the tools were time consuming and nurses' judgements were just as reliable for prediction (Eagle et al, 1999). This finding suggests that such tools need to be much more sensitive to be clinically useful. Fall prevention programs can reduce fall rates and fall injuries (Rogers, 1994; Mccollum, 1995). Once risk is determined, various interventions have been identified. Brady (1993) identifies quality improvement as essential for fall prevention including greater awareness of patients needs to toilet, seek rest, or obtain nutrition and hydration. Staff teaching on risks and fall prevention was highlighted by Morse (1993) as being an effective factor in fall reduction. Commonly cited fall prevention strategies are listed in Table 1.

Table 1

Table to demonstrate approaches to preventing falls

Fall prevention strategy	Research evidence
Multi-disciplinary assessment of: <ul style="list-style-type: none"> • Mobility • Cognition • Falls risk 	Henrich, 1988; Cuchins, 1991; Close, Ellis, Hooper & Glucksman, 1999; Sullivan & Badros, 1999; Alcee, 2000 Rogers, 1994; Mccollum, 1995
Education: <ul style="list-style-type: none"> • Staff, patient and family about fall prevention • Train in transfer skills (staff) • Gait balance and strength training 	Brady et al, 1993; Lord, Ward, Williams & Strudwick, 1995; Schnelle et al, 1996; Patrick, Leber, Scrim, Gendron & Eisener-Parsche, 1999 Morse, 1993
Environmental adaptation: <ul style="list-style-type: none"> • Lighting • Aids • Stabilise furnishing • Quality measures (call bell, toileting, nutrition and hydration needs etc) • Exit alarms 	Cuchins, 1991; Brady et al, 1993; Strumpf et al, 1998
Treatments: <ul style="list-style-type: none"> • Hip protectors • Reduce restraints • Reconsider medications • Optimise sensory aids (clean glasses and hearing aids) 	Evans, Strumpf & Williams, 1992; Lauritzen, Petersen & Lund, 1993; Strumpf et al, 1998; Cameron et al, 2000

Wandering

In one study wandering was found to be a common reason for the decision to place a relative with dementia into residential care (Armstrong, 2000). It has been suggested that subjective classifications of wandering has led to ambiguity on the subject of wandering (Thomas, 1995). One such subjective definition involves the proposition that wandering is defined by its aimlessness and an example is as follows:

Moving about aimlessly in a disoriented fashion. (Snyder, Rupperecht, Pyrek, Brekhus & Moss, 1978 p.272).

Thomas (1995), contends that the terms “aimless or “purposeless” should be excluded from any definition of wandering. The use of these words implies that the wanderer has no intent or goal for moving about. Thomas holds that if the patient is viewed within their contextual world then wandering behaviours can be understood as purposeful, although the planning and actions may be short lived and spontaneous. Furthermore, if behaviours are seen as purposeless, it leaves very little hope as to

possible creative interventions for that behaviour (Thomas, 1997). Several writers have examined the habits and patterns of wandering patients, and have suggested and tested possible interventions for maintaining their safety and dignity (Hussian & Brown, 1987; Algase, Kupferschmid, Beel-Bates & Beattie, 1997; Algase, 1999; Roberts, 1999).

Patterns of wandering have led to objective classifications of wandering, such as time spent in efficient and inefficient travel (Marino-Saltzman, Blasch, Morris & Mcneal, 1991). Classifications have also focused on perceived intent, for example “exit seeking” or “self stimulators” (Hussain, 1985). Thomas (1995), suggests an alternative classification of “time in motion” to distinguish two broad categories of wanderers, continuous and sporadic. Continuous wanderers are characterised by being on the move for over 50% of wakeful time, having greater cognitive disability and wandering until literal exhaustion. This group seems unable to sit down even when they were reoriented to their chair or bed. Thomas (1995), describes sporadic wanderers as those who ambulate for less than 50 % of their wakeful time and have only an occasional desire to move about in the need to satisfy a particular need. This group showed a greater ability to express their needs and engage in social interaction. An awareness of the difference between individuals who wander may be useful in efforts to assist them. Furthermore, an awareness of the needs associated with wandering makes the use of restraints to tackle the problem even more negligent of the patients’ rights. Algase (1999), suggests that wandering can be examined in term of its pattern. Patterns identified are direct movement, lapping, pacing, or random. According to Algase, direct movement between two points is not considered to be wandering. She also states that analysis of lapping, pacing or random movement can be examined for clues to the meaning of an individual’s wandering pattern. A previous study by Algase (1997), indicated that, over twenty-four hours, wandering is less of a night-time phenomenon and most wandering peaks between 1700 and 1800 hours apparently confirming reports of “sundown syndrome” (Evans, 1987).

Causes

Studies have shown that wanderers have a higher level of cognitive impairment than non-wanderers, and these neuro-cognitive factors were summarised in relation to wandering in a literature review by Algase (1999). Algase reports that wandering tends to manifest late in the dementia process and if present, is associated with a

faster rate of cognitive decline. Compared with ambulatory non-wandering individuals with dementia, wanderers have poorer neuro-cognitive abilities. Individuals who wander have deficits in tasks requiring spatial skills. Algate holds that both the ability to keep in mind the route to a destination (a function of the hippocampus), together with the ability to use spatial information as it is confronted (frontal lobe function), is necessary for effective way finding. Algate refers to studies which have shown the hippocampus to be implicated in the amount of locomotion a wanderer displays. Language deficits, particularly of an expressive nature are also poorer in those who wander, than in controls (Edgerly, 1995). Such deficits may contribute to wandering behaviours.

Consequences

Coltharp, Ritchie and Kass (, 1996) claim that there may be several benefits derived from wandering behaviour, such as, adaptation to stress, continuity of behaviours from earlier pre-morbid times, and the physical benefits of regular activity. In addition, wandering is beneficial to the individual when it fulfils a particular need (Thomas, 1995). One study found that wanderers are in motion 55% of the time (Cohen-Mansfield, Werner, Marx & Freedman, 1991). Wandering is often associated with negative outcomes which have been classified as either “safety” or “nuisance” related. A significant safety issue results from patients absconding from a unit. A group of wanderers attempted to leave the unit 557 times in one study (Gaffney, 1986). The risk of falling is high among wanderers (Kiely, Burrows & Lipsitz 1998; McConnell, 1998). Weight loss is also a problem for wanderers who do not sit down long enough to eat a full meal and have high calorie expenditure through constant activity (Singh, Mulley & Losowsky, 1988). Legal and ethical problems are associated with wandering as some successful escapes by patients have resulted in deaths of a horrific nature such as death by falling from a high window (Meiner, 2000) and a drowning (Anonymous, 2000). Restrictive measures have not been well received by the legal profession and one court judged it was mistreatment to barricade a patient who was known to wander in his room (Anonymous, 1997). Nuisance related problems have been described such as entering others’ rooms and exploring their personal possessions (Hirst & Metcalf, 1989).

Alternatives

Psychosocial

Physiological aspects of caring for patients who wander have been discussed in the section on agitation and are important, as agitation may be one of the underlying causes of wandering. Hence, the fundamentals of comfort, pain relief, hydration, nutrition and elimination need to be addressed first. Integral to the success of using appropriate alternatives is the comprehensive assessment of the wanderer's previous lifestyle, likes and dislikes, meaningful activities and roles and this can be done with a significant other (Thomas, 1995). Algase (1999), suggests psychosocial interventions are particularly relevant in the case of patients who wander in a pacing manner, as this may be a result of anxiety and stress. The use of validation can be effective in creating a climate of trust (Feil, 1982). As sporadic wanderers may have intact social skills this group may be open to increased social interaction in the form of activity or reminiscence groups. The focus of these groups should be on strengths not weaknesses, and on engagement not entertainment (Sevier & Gorek, 2000). The latter study states that a multi-disciplinary approach is necessary and the programme showed an increased relatives' satisfaction with care, and the residents' functional independence. Exercise programs showed mixed results with one study finding a significant decrease in wandering behaviour, (Holmberg, 1997) and another showing no change (Gillogly, 1991). The latter study was the more rigorous of the two but claims that longer periods of intervention (>12 weeks) should be trialed before exercise is ruled out as an intervention. It should be stressed that while these interventions may be applicable to the hospital environment, the higher frequency of acutely unwell individuals may reduce their relevance.

Designing sensory tables, tactile boards and "activity barrels" using familiar items to attract a wanderer may compel them to stop (Gaffney, 1986), and this may be important for continuous wanderers. Rocking chairs have been shown to have some success in reducing wandering perhaps as a substitute movement (Algase, 1999). Music therapy was tested against reading to patients and after a week of sessions both groups significantly reduced wandering but other measures of cognitive function such a mini mental tests, pre and post intervention showed no change.

Drug therapy

Weiner (1999), suggests that wandering behaviour is not amenable to drug therapy. However, this may be an over simplification of the problem in light of the research into different types of wandering behaviour. Wandering is associated with high levels of stress and anxiety and this may be particularly relevant when patients display pacing (Algase, 1992). Therefore, it is appropriate to consider pharmaceutical management with anti-anxiety drugs such as benzodiazepines as one of the possible interventions (Maletta, 2000). However, there are notable side effects and as a result the use of these drugs should be carefully monitored and kept to a minimum (Philips, Hawes & Fries, 1993). One small but clinically relevant piece of research found wandering initially increased and then decreased over a 12 week period of sedation rationalisation (Heal & Mccracken, 1998). I do not wish to support the use of chemical restraint, but recognise that medication can have a role in behaviour management when used skilfully.

Environmental management

Environmental answers to the wandering problem include avoiding excessive noise or disruptions (Cleary et al, 1988), decorating the room with familiar objects and visual aids, and disguising doors and windows as other objects (Roberts, 1999). Roberts tried placing mirrors in front of exits and found this distraction to be highly effective in cases with severe dementia. Camouflaging the door with cloth panels was moderately effective, as were floor patterns, which were most effective with patients with Alzheimer's disease rather than other dementias (Hewawasam, 1996). Structured days with regular schedules for toileting, eating (finger foods) and sleeping, music, clocks and calendars in view proved most successful with those who were less severely demented or sporadic wanderers.

Emerging technologies

There has been a move to increase the amount of technology to ease the burden of caring for patients who wander. There is now a range of products specifically designed to prevent patients from wandering out of units, such as, door alarms and perimeter alarms. The best of these involves a portable receiver that alerts the caregiver when a patients walks past a certain predetermined point. A comprehensive overview of products can be found in the following article (Devereaux Melilo & Futrell, 1998).

Aggression

Aggression is a significant problem for nurses working in all areas of health care and one study found that nearly 40% of the nurses had had at least one violent patient experience (Rosenthal & Edwards, 1992). Aggressive behaviours have been defined by Ryden (1988) as a hostile action directed toward other persons or objects or toward oneself. She includes physical, verbal and sexual aggression in this definition. Patel and Hope (1993 p.458) define aggression as

...an overt act, involving the delivery of noxious stimuli to (but not necessarily aimed at) another object, organism or self, which is clearly not accidental.

Causes

Several researchers have explored the characteristics of elderly persons who manifest aggressive behaviours. Despite disparities in research settings and data collection, several consistent findings emerged. Aggressive elderly persons tend to be more cognitively impaired than non-aggressive persons (Ryden, 1988; Marx, Cohen-Mansfield & Werner, 1990; Patel & Hope, 1992), and more functionally dependent (Marx et al, 1990). A poor quality of family relationships correlates with aggression (Hamel et al, 1990; Marx et al, 1990), and males are more likely to be aggressive than females (Ryden, 1988; Hamel et al, 1990; Marx et al, 1990; Ryden, Bossenmaier & McLachlan, 1991a). Verbal aggression has also been associated with depressed affect and physical pain (Marx et al, 1990), and poor physical health (Cohen-Mansfield, Marx & Werner, 1992). Caution should be taken in interpreting some of these findings. For example, quality of relationship and aggressive behaviours can be explained by the negative effect of an aggressive behaviour on interpersonal relationships or, the poor relationship may precede the aggressive behaviour.

Given that not all persons suffering from dementia manifest aggression, it is important to understand what specific neurological damage or pre-morbid tendency, frustration, discomfort or other cues are related to aggression. There is much still to be understood about the causes of aggressive behaviour and further research is needed in this area (Cohen-Mansfield & Werner, 1998).

Consequences

As with all behavioural phenomenon, carers may become bewildered and frustrated if they do not know how to deal with aggressive behaviours. As a result some may endure abuse as they work with combative patients, some may give minimal care, some may respond in a patronising or intimidating manner, and others may physically abuse aggressive patients (Ryden & Feldt, 1992). Aggressive behaviour has been found to contribute to carer burnout, increased staffing needs, and increased staff turnover (Heine, 1986).

Alternatives

Ryden (1992), describes a goal directed approach to caring for aggressive patients where the goals are promoting a feeling of safety, physical comfort, a sense of control, pleasurable experiences for the patient, and optimal stress. Ryden advocates that carers should view aggression as meaningful behaviour to be explored and understood, rather than as disruptive behaviour to be controlled, so that carers may find it more of a challenge and less of a threat (Ryden et al, 1991a).

With regard to safety, most aggression (72%) is in response to invasion of space, for example, during activities of daily living. Ryden suggests patients may misperceive their environment, and may act inappropriately in response to feelings that are evoked. The individual may not be able to draw on past coping experiences because of poor memory, and may lack judgement to select alternative actions. As a result strong feelings may be evoked, such as fear.

A tool which measures aggression has been designed specifically for the elderly by Ryden (1988) and has been used to measure the success of, or need for, interventions. There is a need to expand the body of knowledge concerning the treatment of aggressive behaviour in patients with dementia. These patients pose special challenges distinct to mental health nursing and learning disabilities, due to the usual loss of memory, and sometimes lack of verbal communication skills.

Psychosocial interventions

Development of verbal and non-verbal communication skills which enhance feelings of trust and safety are critical to preventing aggressive behaviours (Ryden et al, 1991b; Feldt & Ryden, 1992). Importantly, individuals may differ in what provokes feelings of fear. Therefore, an individualised assessment of cues and patterns of behaviour is necessary (Ryden & Feldt, 1992).

One non-pharmaceutical short-term method for managing aggression is to allocate a specific person, often called a 'special' or one to one nursing. It should be recognised, however, that this may be intrusive to that patient's privacy, and may cause increased violence if the 'special' is not skilled in de-escalation techniques (Fenton, Bowers, Jones, Lakeman & Morrison, 2000). The importance of a sense of control to the elderly has been well established, and there is no logic to suggestions that it is less relevant to persons with dementia (Meddaugh, 1990). Although decisional capacity may be reduced, freedom of action can be maintained in many spheres of life.

Aggressive and angry behaviour is known to escalate in a more or less predictable manner, thus, there are opportunities for health care professionals to assess and intervene. Fenton (2000), suggests that de-escalation techniques include observing for signs and symptoms of anger and aggression, approaching patients in a calm manner, avoiding confrontation, giving choices, and maintaining dignity. De-escalation techniques also emphasise the therapeutic use of self i.e. using the nurse's own personality and relationship with the patient as one method to interact therapeutically with the patient (Stevenson, 1991). This therapeutic use of the relationship implies there is a pre-existing relationship with the patient and, frequently, this may not be the case. Nurses need to be aware that they may need to re-establish the relationship at each interaction with the patient, as memory of previous interaction may not be available to the patient with dementia. Caring for people with dementia is not the same as caring for adults with learning disabilities or psychiatric patients. However, it is appropriate to draw on these disciplines as they too, on a regular basis, manage patients who display aggression.

The literature on learning disabilities highlights one approach called natural therapeutic holding (Stirling & Mchugh, 1997). This approach is pro-active and has clear therapeutic goals rather than being an arbitrary and reactionary approach for the sole purpose of controlling undesirable behaviour. Caution must be used in the light of the importance of physical touch and aggression, however, natural therapeutic holding is a sensitively applied method of physical interaction in which a nurse listens and physically responds to the individual using touch as a therapeutic medium. It may be more effective in conveying positive regard and trust where verbal de-escalation is not entirely appropriate due to communication disabilities. It may be appropriate to use this method instead of physical restraint with patients who

are in immediate danger, however persons delivering this care would be in the immediate danger themselves and thus, need to be properly trained in delivery and appreciate the appropriate situations for its use. No literature on how this intervention might work on patients in hospital with dementia was found but it is apparent that research into this technique should be conducted in the absence of any techniques other than physical restraint.

Ryden (1992), suggests that patients need to experience pleasure. When loss of memory or anticipation of the future are difficult or impossible to experience, what is left is the ability to experience pleasure in the immediate moment. Aggression is a common reaction to an invasion of personal space, thus pleasurable experiences using touch need to be individualised, as blanket use of interactions may increase aggression in some cases. Pain is discussed in detail in the section on agitation and will not be repeated here however it should be stressed that pain may trigger aggression especially when aggression occurs on movement (Ryden & Feldt, 1992).

Environmental adaptation

Environments which are flexible will provide an arena for choice in the care of patients with dementia (Ryden & Feldt, 1992). It should be stressed that the majority of Ryden's work has been done in nursing homes, which may offer a more flexible environment than in acute care situations. However, this assumption is not a reason for hospital nurses not to reflect on the need for flexibility in nursing care and the possible role of the organisation in perpetuating aggressive behaviours. The environment and interpersonal relationships have been implicated in optimising the amount of stress experienced by patients (Cleary et al, 1988).

Restraint use and aggression

One study found nursing home residents who were chemically restrained were three times as likely to engage in verbally aggressive behaviour, while residents who were physically restrained were three times as likely to engage in physically aggressive behaviour (Kolanowski, Garr, Evans & Strumpf, 1998). However, the restrained and non-restrained patients in the latter study were not case matched so the research may simply show that the most aggressive patients were restrained. A certain compelling logic cannot be escaped: that if aggression is often an expression of fear or feelings of threat to safety, then restraining a person will do nothing to alleviate those feelings and may make the problem worse.

When discussing alternatives to restraint, clinicians generally say that alternatives have to be 100% successful in preventing the behaviour or harm resulting from that behaviour. This assertion seems reasonable on the surface. However, in light of the physical harm which restraints cause, and the fact that they are not a panacea against all harm, if less restrictive alternatives are as good as restraints in preventing harm they are considerably more desirable than restraints. Although the research on alternatives is not highly developed it is clear that alternatives to restraint do exist. It could be argued that research needs to be carried out to identify under what conditions various alternatives should be tried. However, it may be that, due to the individual life histories and experiences, this task is impossible. Researchers who have investigated alternatives to restraint use have generally found that nurses' creativity in making interventions particular to the patient are important in avoiding the need for restraining (Mion & Mercurio, 1992; Snyder, Egan & Burns, 1995; Stolley, 1995; Cohen, Neufeld, Dunbar, Pflug & Breuer, 1996; Bryant & Fernald, 1997; Kenedy Weeks, 1997; Counsel, Gilbert & Wagner, 1998; Gerdner, 1999; Winston, Morelli, Bramble, Friday & Sanders, 1999a).

Summary

Taken as a whole the literature on agitation, falls, wandering, and aggression, indicates that there are interventions possible which prevent or treat these four behavioural phenomena. It will be shown in Chapter Six that nurses are, to varying degrees, aware of these interventions, but that many such interventions are ruled out as inappropriate to the patients in this study. The literature indicates that these four behavioural phenomena are common and important problems for hospital staff. Rather it will be shown in Chapter Six and Chapter Seven, that patients who are restrained are treated as exceptional cases, and thus marginalised from certain therapies. This marginalisation and other ethical concerns are so important to discussions of restraint that, in fact, they permeate through this thesis. The next Chapter will discuss the ethical and legal implications of restraining a patient in hospital.

CHAPTER FOUR

ETHICAL AND LEGAL CONSIDERATIONS

One task for “critical thought” is thus to expose [the costs of our self-constitution], to analyze what we did not realize we had to say and do to ourselves in order to be who we are... The experience of critical thought would start in the experience of such costs. Thus, before asking, or at least when asking, what we must do to behave rationally, this kind of thinking would ask: “What are the forms or rationality” that secure our identity and delimit our possibilities? It would ask what is “intolerable” about such forms of reason. (Rajchman, 1991 p 11)

Ethical views on restraint

When nurses talk about restraints they allude to the ethical principle of ‘beneficence’ (Matthiesen et al, 1996) and seem to support the view that restraints are protective and inevitable in the care of confused elderly patients (Mattiasson & Anderson, 1995). They also argue that a special relationship exists between patients and nurses who have responsibility for patient’s care. This special relationship gives rise to a moral duty on the nurses’ part to protect those in their care from harm (Lee et al, 1998). However, most of the literature on restraints alludes to the principle of non-maleficence and autonomy and seems to indicate that, to a large extent, restraints are unnecessary, harmful, and overused (Moss & La Puma, 1991; Press, 1991; Hopton, 1994; Dodds, 1996; Frengley, 1996; Davis, Laker & Ellis, 1997; Mohr, Mahon & Noone, 1998; Rosin & Sonnenblick, 1998).

The preservation of individual autonomy of sick or dependent people is fundamental to the rhetoric of empowerment that has permeated nursing, from Orem’s self care model to almost every philosophy of nursing on any ward today. Davis et al (1997), in a literature review suggest considerable academic interest in the area of autonomy and independence. Autonomy is defined by Beauchamp and Childress (1989) as complex and contextually bound. These authors suggest three defining attributes to autonomy: voluntariness, individuality and self direction. Davis et al, group the substantive evidence on autonomy into four categories: systems of care delivery which promote individualised assessment and care; attempts to encourage participation in care; patterns of communication which avoid exerting

power or control over patients and finally environmental modification to promote independence and reduce risk. These moves aim to promote autonomy in academic and clinical nursing, and un-consenting use of restraints can be positioned in direct conflict with them. Elderly people have been made the subjects of this ethical debate since they are seen as vulnerable due to physical and cognitive losses that they face in large institutions.

The research on restraints points to the fact that there is no beneficence to be claimed by using restraints, for there is no evidence that they provide protection and, conversely, that they are maleficent, as seen in the above section on problems with restraints. This section does not intend to debate the benefits versus the harms of restraint. It is accepted here that restraints are a non-validated therapy, which pose a threat to the dignity and human rights of elderly hospital patients, and the discourse of beneficence should not hold the status that nurses give it. However, despite little academic support for restraints, and much support for increasing autonomy of elderly patients, the practice of restraint continues without a substantial change in clinical discourse. It is this apparent stagnation of the ethical discourse which is important in the present research. Here the work of Foucault in linking ethics, power and practice crucial in interpreting the debate.

Although it appears clear that restraints are not justifiable on a basis of prevention of harm, it should be noted that restraints can be justified ethically if there are real and immediate concerns about patient or staff safety (Moss & La Puma, 1991 p.24).

When another identifiable individual is at risk of serious morbidity or mortality, or the public welfare appears to be in jeopardy, we believe that overriding the refusal of restraints by a competent patient or his proxy is ethically permissible. The ethical principle of preventing harm to identifiable others supersedes the patient's right to refuse.

Unclear delimitation of what constitutes real or immediate danger may contribute to the failure of the autonomy discourse to prevail over restraint use. To illustrate, serious risk of morbidity or mortality could refer to an episode of patient violence - one of the reasons given for restraint use. How determined aggression has to be before restraints are used is questionable. Clearly nurses have a right to use restraints *before* they have been injured, but patients can be unpredictable. The question is - when does potential danger become real danger? Some work has been done on predicting patients who pose a risk to nurses and other patient's safety (Hamel et al,

1990; Cohen-Mansfield & Werner, 1998). However, this work is embryonic and there is a need for greater understanding of the relevant issues. The ramifications of lack of clarity about immediate risk and restraint, is evident in the first case study on Joe (presented in Chapter Six).

The problem is to determine the most appropriate response in any given situation. Traditionally health experts have claimed expertise in the diagnosis and management of mental distress. Others have dismissed this claim as nonsensical, especially in mental health settings (Lindow, 1990; Masson, 1990). Notably, Rogers et al (1993), have attacked the very idea that it is possible to develop professional expertise in the classification of people's mental distress. However, given the complexities in interpreting acts of aggression, it would be difficult to sustain an argument in reality from either of these perspectives. It could be argued that the use of restraint is inherently oppressive, and that the aggressive behaviour of a restrained person is not irrational. Instead the behaviour might represent the expression of justifiable anger at interventions which are intended to be therapeutic, but which are experienced by the restrained person as a threat to their safety. In the current research we can see how silence on this point adds to the discourse on constituting the patient as unable to 'self govern'. However, although there may be situations where a person's aggression may be the consequence of oppression, there are clearly situations where aggressive and violent behaviour against staff is unprovoked. There is a belief in mental health nursing that outbursts of aggression may be beneficial to individuals and that there should be viable alternative responses to the use of restraint (Hopton, 1994).

Nurses also report using restraints, to prevent the patient from harming him / her self, and this presents a different ethical problem. From a utilitarian point of view, the calculation is straightforward: as long as the force used to restrain the person (and their resistance) is less injurious than the target behaviour, restraint of the individual is ethically correct (Gillon, 1986). According to the empirical research on the problems with restraints presented above, it is suggested that restraint use should be understood as an application of an investigation or non-validated therapy and should be governed by a primary ethical principle, that of informed consent, (Moss & La Puma, 1991). Consent here is referred to as an ethical principle as opposed to a legal one, which will be addressed in a separate section. Patients with full decision making capacity must understand and volitionally accept a detailed disclosure of the

potential benefits and risks of restraints together with their therapeutic goals. Herein lies a problem, for there has been much debate over the degree to which a person with dementia is accountable for their actions (Davis et al, 1997). Dodds (1996 p.161) states

There is no reason to believe that when people become older and less able to live fully independently, they lose all interests beyond protection of their health.

The elderly patients of today have survived many risks within and outside their control such as, marriage, mortgage and, world war. Some risk is inherent in valuing life and health and within these are the ideals of freedom and independence. It is a justifiable claim that autonomy develops by degrees and so too diminishes in degrees. Patients at the lowest end of the decision making capacity spectrum should have well-intentioned proxies, who meet the same high standard (Press, 1991). Finding such proxies should be taken seriously as freedom and autonomy are highly valued in our society and underpin many approaches to improving quality of care (Dodds, 1996; Rosin & Sonnenblick, 1998).

The Universal Declaration of Human Rights 1948 implies that restraint of a severely distressed person is justifiable as long as it does not involve “inhuman or degrading treatment”. This statement appears to raise questions, such as; are restraints inhumane even if they limit the harm which an individual can cause? Deontology is the theory that certain moral duties are binding regardless of the consequences and that all people have dignity and intrinsic worth and deserve unconditional respect. Interfering with an individual’s freedom and ability to make choices is disrespectful and violates human dignity and, in line with the provisions of the Human Rights Act, this is a strong ethical argument against the use of restraints.

The following example illustrates the clinical point of view on this subject. Real and immediate danger may be claimed in the case of a patient with a dense hemiparesis and little or no insight into their disability. At the time just before they attempt to get out of the chair they are in real and immediate danger of harming themselves. The limited insight may be part of the pathology of CVA or dementia. Is it justifiable to be paternalistic in this instance? Nurses claim that since they can not predict when a patient will get up and can not observe them 24 hours a day, restraints have to be used. A letter to The American Journal of Nursing (Patient Restraints, 1997 p.16) makes this point:

The majority of the patients are total care and I can't be with them as much as I would like to. Many are confused. We can't get families to stay nor can they afford to pay a sitter... So when we encounter a confused patient who tries to get out of bed, we have no choice but to use a vest restraint... I would rather my patient have on a vest restraint and be safe than try to do all I have to do while constantly worrying is a patient is trying to get out of bed. I worry and have enough stress the way it is – I don't need more.

We see here how compelling the argument is. The nurse depicts the situation and the patient as hopeless, and overtly states that she has no choice – thus distancing herself from the infringement on the patient's autonomy. No comment on the issue of consent is made, here the nurse perceives safety and her peace of mind as the most important principles.

There is a further ethical conundrum when we consider there may also be a justifiable ethical claim in being paternalistic in the short term so that autonomy can be restored in the long term. An example of this may be a patient with a recent hip repair who has dementia. The argument is that if the bones are allowed to heal then the patient will be able to walk again and will thus have greater independence and autonomy in the future. However, there is no research to show that restraints are validated in this situation and again as such should be administered with consent. Furthermore, the ethical principle is that restraints should be consistent with the overall goals of therapy (Moss & La Puma, 1991). For example, restraining a patient in a chair in the name of rehabilitation appears inconsistent with the ethos of rehabilitation.

A discussion regarding the ethics of restraint would not be complete without mention of the realities of providing health care within an increasingly managed care environment. Although studies have shown that staffing levels and skill mix need not be altered to achieve reduction in restraint use, it has been pointed out that the way in which nursing staff are organised, can affect nurses' ability to provide individualised care to frail elderly persons (Frengley & Mion, 1998). Individualised care is central to eliminating restraint use according to Strumpf (1998). Systems to determine clinical staffing numbers and mix should be sensitive to the special requirements of the older ill patient. Indeed, extra staff with no further knowledge of how to deal with the behavioural phenomena that result in restraint will not help, and studies have shown that education is crucial to the reduction of restraints (Strumpf, Evans, Wagner & Patterson, 1992a; Schoenfelder & Van Why, 1997).

It ought to be asked what conditions need to prevail in order for nurses to prioritise individual freedom at least as highly as safety. When nurses make decisions of priority such as safety over freedom and dignity, the decision reached may have some connection with nurses' fear of the legal ramifications of injury. Legal aspects of restraint use will be covered next. The conditions leading to the current prioritisation of safety over freedom are of central concern to this thesis.

Legal Consequences of Restraint Use

There have been court decisions, which have found health providers negligent for not using restraints, (Nava, 1996; Richman, 1998; Wilkinson, 1998); negligent for using restraints, (Lambert, 1992; Annas, 1999; Langslow, 1999); and not negligent for not using restraint (Anon, 1999; George, Quattrone, Goldstone & Woodbury, 1999). In one case the provider was found not negligent for not using restraints after serious injury resulted to a patient after a fall (Fiesta, 1991). The reason given for the decision was that the physician testified that restraints were contraindicated because of the patient's mental status. However, in a further case, where the patient was also combative and confused, a jury found the hospital liable for negligence and awarded almost (US) \$1.5 million to the patient's family. Thus, on legal precedents alone we are no closer to a universal truth of how legal restraint is.

Legal discussions of restraint focus on two fundamentals; the law in relation to the autonomy and integrity of persons, and the duty of care that nurses have to protect vulnerable patients from harm. Common law remedies which may be relevant to restraint are false imprisonment, assault and battery and negligence (a short glossary definition of these terms is offered in Appendix A). Defences may be, consent and necessity.

As front-line health care professionals nurses are especially vulnerable to being named in a malpractice lawsuit (Wilkinson, 1998). Evans (1990), states that exposing the myth of protection at all cost from liability is necessary in the care of frail elderly patients. A patient who falls and receives an injury is not automatically compensated in the litigation system and hospitals are not insurers of patient safety per se (Fiesta, 1991). Fiesta however, controversially claims that nurses are more likely to be held liable for failing to restrain a patient who should be restrained than for restraining a patient who should not be restrained. This position potentially severely damages the restraint reduction movement. In the face of empirical

evidence on the problems with restraint, and the ethical arguments heard so far, this position is decidedly uncertain, and some suggest the opposite is true (Strumpf et al, 1992b). George (1999 p.34), based on a case where a provider was found not negligent for not using restraint suggests that a health provider is:

...not liable for an error of judgement if, in arriving at that judgement, the health care provider exercised care and skill, within the standard of care the health care provider was obliged to follow

Furthermore, he suggests that decisions to restrain are a matter of medical judgement with which courts should not interfere, and the courts should not attempt to substitute hindsight for the judgement of the nurse on the spot. This support for the deviation from accepted practices, such as restraint, is important for nurses striving towards restraint free environments. Judgements concerning when patients should be restrained, should be based on patient assessment, and policies should permit staff to formulate professional judgement (Fiesta, 1991).

Lawful justifications of restraint

Consent is one lawful justification of restraint. If a patient gives fully comprehending consent for a restraint then false imprisonment cannot be claimed. Retsas' (1997a), view of the Australian Standards is that a relative cannot adequately provide consent. Cox Hayley (1996), defended this argument and indicated that in respect of the provision of information, the standard of care is a matter of medical judgement (which should be measured against an average medical practitioners decision in that case). Occasionally, reference is made to representatives holding powers of attorney or other forms of authority from the patient. However, while having power to handle property and financial affairs, people with power of attorney do not have power to make decisions regarding the treatment of their appointer (Stuart, 1996). This decision is a medical one, preferably made in conjunction with family members, as there is evidence that, in most situations, the elderly person's trust in family outweighs the need for accurate medical decisions (High & Turner, 1987). Stuart (1996), states that mere acquiescence to restraining measures may not be enough to establish consent. It is common in nursing practice that the patients whose behaviour is identified as needing restraint may be incapable of giving consent because of their confused mental state. Advance directives (living wills) are formal written documents designed to guide medical care when an individual

becomes unable to make medical decisions. The decision need not be 'wise' in medical opinion but has to be respected when it is made by a competent adult. Retsas (1997a), states that consent after the fact of restraint is legally suspect as it fails to recognise that only under the Mental Health Act are staff authorised to do anything to another person without that person's consent.

Risk Management

The more complex and demanding health care becomes the greater the focus on ethical and legal aspects of the work. Such issues, as mentioned above, include the ability to provide adequate individualised care, staff shortages, lack of resources and the question of risk and its management is beginning to receive wide spread attention.

It is suggested that public consciousness of risk and its reverberations in all areas of life have perhaps never been higher (Kaufman, 1994). Kaufman goes on to establish risk awareness as both a function and expression of medicine, which is now firmly embedded in understandings of the role of medical care in late twentieth century. In the context of expanding knowledge about what constitutes risk, and our awareness of ever greater exposure to risk, we are forced to minimise the risk that health professionals and the public feel older people are exposed to, or that their functionally limited bodies, selves, and lives apparently embody. Patterson (1998), warns, however, that an over reliance on scientific absolutism although usually well intentioned, has frequently been exposed as unstable by unforeseen events, of sometimes catastrophic proportions.

There is a parallel with restraints here in the 125 deaths by restraint in the last decade (Langslow, 1999). Some maintain that we have moved from crisis to complacency, (Hogwood, 1987), and this may hold some truth in the case of restraints, as the negative effects unfold and the prevalence of their use remains high. One of the pressures on the risk management issues is that we cannot wait for science to conduct the many necessary research projects in order to refine its models and there comes a time when we have to accept a proposition as a 'truth'. There may be times where economics impose deadlines, and pressure to reach this stage is intense. The law copes with this change by considering what the average practitioner would have done at the time (Diamond, 1995). Patterson suggests that while law has traditionally focused on actual as opposed to potential harm, there are increasingly

systems of risk management in place of detailed regulation and this, he suggests, will focus negligence on the adequacy of those systems and their operation.

In an Australian case involving a death caused by restraint, the coroner concluded that the case should not necessarily be used to limit the use of restraint, but to assist with the recognition of the level of risk management systems that are needed to reduce the risk (Langslow, 1999). The best way to prevent asphyxiation from physical restraint however, is by primary prevention – that is by not using restraints (Miles, 1996). Frengley (1996), discusses the rapid swing that medicine has made to legal and financial risks as the overarching decision-making framework, and questions whether this will lead to the provision of care lacking in ‘kindness’. He suggests that the law has no philosophical construct for kindness and is unable to provide for the logical incorporation of kindness into its formulations. In the care of the aged we are often faced with situations where there is little that can be done but be kind.

This literature clearly points to the conclusion that restraints are difficult to justify according to research, ethical principles, or legal precedents. It will be shown in Chapter Six that in the current study, to accommodate this difficulty, the participants have established an elaborate justification system, which successfully stonewalls the arguments put forward against restraint and for alternatives in the previous chapter.

Summary

Chapters Two, Three and, Four have demonstrated that restraint is a significant global as well as local problem with a high prevalence in Australian hospitals which is a cause for concern. Many negative ramifications of restraints including, physical and emotional, ethical and legal considerations have been demonstrated. Research has been presented which claims that restraint has only limited success in preventing both the target behaviours and harm from those behaviours. Alternative interventions which have been trialed have had a beneficial effect on behaviours and fewer ethico-legal problems. It has been demonstrated that with education, a multidisciplinary approach and manager support, restraints can be eliminated or substantially reduced without increasing patient or staff problems.

Despite this evidence, change is limited to isolated centres and the majority of restraint reduction attempts are found in nursing homes and not in hospitals. The approaches to restraint reduction presented in the literature, focus on the individual

nurse as a change agent. For example, education and attitude research is aimed at as the preferred method for influencing an individual nurse's views about restraint. The current study breaks with this tradition by attempting to identify the social practices which legitimise restraint use. The intention is to offer a more contextually bound understanding of restraint use, with the aim of illuminating a socially sensitive transformation of practice. This work is not an emancipatory project, in that it does not seek to liberate either patients or nurses. However, I cannot relinquish all transformatory ambitions. Through attention to Foucault's work on power/knowledge, my hope is that restraints can be seen at face value, rather than as historically constructed realities. This approach takes care to ensure that new dominations will not consume the space that restraints leave behind. Consequently, my aim is to break the silence surrounding restraints in contemporary nursing practice in order to identify how restraint use is legitimised in a teaching hospital. This issue will be investigated by seeking answers to the following questions:

- What explanations do nurses give in respect of the use of restraint?
- What social explanations (discourses) underpin these explanations?
- How do these discourses function to legitimise, justify and maintain restraint use?

The value of answers to these questions depends upon the understanding they bring to practises. The potential value of this perspective will rely heavily on the Foucauldian scaffolding I present in Chapter Five. I will seek to establish the benefits of discourse analysis in Chapter Eight.

CHAPTER FIVE

METHODOLOGY

There are more ideas on earth than intellectuals imagine. And these ideas are more active, stronger, more resistant, more passionate than politicians think. We have to be there at the birth of ideas, the bursting outward of their force; not in books expressing them, but in events manifesting this force, in struggles carried on around ideas, for or against them. Ideas do not rule the world. But it is because of ideas... that it is not passively ruled by those who are its leaders or those who would like to teach it, once and for all, what it must think.
Michel Foucault 1926-1884

This Chapter will introduce the theoretical scaffolding of the study, and demonstrate the benefits of this approach to nursing research, and specifically the study of restraint use. Two methodologies, discourse analysis and case study are united, thus, enabling a critical analysis of restraint use grounded in the context of the hospital ward. Secondly, this chapter describes how the study was undertaken in a practical sense, explaining the methods of data collection and analysis.

Foucauldian scaffolding

I will try to present a straight-forward account of how Foucault's ideas informed the study. It is with some caution that I call this section 'a methodology', as authors have argued that Foucault's approach was so unmethodical that a presentation of his ideas as a method is contradictory (Megil, 1985). Nevertheless, I have attempted to incorporate some basic themes of Foucault's work into an empirical study of the use of restraints. The use of the word scaffolding in the heading rather than framework is deliberate as it implies the temporary structure that has been built for the purposes of understanding restraint use. A scaffold has the advantage over a framework in that it can be dismantled and rearranged to tackle a different problem. This is in keeping with post modernism's rejection of overarching theories. The main themes to be covered in this section are archaeology, genealogy, power/knowledge, governance and discourse.

Kendall and Wickham (1999 p. 3) suggest two techniques for helping one stay close to Foucault's ideas, looking for contingencies not causes, and having a healthy

scepticism in regard to all political arguments and historical interpretations. These two techniques are discussed next.

Contingency

Looking for contingencies, in relation to restraints, we are able to see that they emerged, not because they are necessary, but because they are one possible result of a series of complex events between other events. This is not the same as saying that anything could have happened or did happen. There were definite pressures, which meant that restraint eventually became seen as 'humane' and necessary, but these did not unfold in a linear cause and effect pattern. One way of looking at this, favoured by the present study and directly influenced by Foucault, is that restraints resulted from an unpredictable pattern of knowledge that did not, through 'progress', prevail in the contemporary setting as immeasurably superior to other modes of care. Restraints are just one way of dealing with behaviours. Other contingencies for dealing with these same behaviours can be seen in health care settings where restraints are not used.

Scepticism

Scepticism involves the suspension of judgement to allow problems to be seen in a new way. Kendall and Wickham (1999) suggest that the suspension of judgment should involve a genuine attempt to escape all judgments other than those you accept as your own and it is this *process* that is of importance rather than the *outcome* of each attempt. I have attempted to avoid judgments that draw on authority from another investigation. This other knowledge is put in a separate category and the appearances of a subject are appreciated at face value. An example pertinent to restraints is, rather than arguing that restraint has come about because of the relationship between an emphasis on safety and reduced staffing levels, I consider that restraints are apparent and have certain continuities with some practices but also represent discontinuity with some existing knowledge, such as the move towards partnerships in care (Keegan, Guzzetta & Gooding Kolkmeier, 1995). The discontinuities are not voids between events, but transformations. What is important about these transformations is not the events before and after them, but the circumstances that make possible these events. Whether the claims about safety and staffing levels are true or false is beside the point and necessarily limits the scope of investigations into restraint. What is important is to remain sceptical about such

claims. With these two techniques in mind, we now move on to a discussion of archaeology and how it has informed the study.

Archaeology

Foucault points out that archaeology is a tool that is concerned with ‘the analysis of the statement as it occurs in the archive’ (Foucault, 1972) and, thus, it offers a historicist view. It can be said that the Foucauldian approach uses history, not of a period but of a problem. In this way, Foucault (1975/79 p. 30-31) refers to a ‘history of the present’ recognising that time does not stop at a point of a sensible or desirable present. In addition, Foucault is not concerned with total history of overarching principles that govern an era, but rather with describing ‘differences, transformations, continuities, mutations and so forth’ (Foucault, 1972 p.9-10).

Hence, rather than researching the hospitals of the twentieth century, the method would involve looking in micro detail at a particular aspect of the hospital system, looking at the history as it relates to that aspect. Foucault terms the attention to problems rather than historical periods, problematisation (Gutting, 1994). Problematisation involves subjectification of people. Subjectification is what Foucault refers to as how one constitutes oneself and is constituted as the subject of control. Subjectivity is considered a complex product rather than a pre-existent condition. Foucault argues that investigation into codes of moral behaviour must pay careful attention to the forms of moral subjectification, how we constitute ourselves as moral subjects of our own actions. Pertinent questions are: Why does behaviour become an object of moral concern? What are the forms of problematisation? What are the practices involved in their formation? What are the ways the players in the game see themselves as acting ethically? Foucault indicates four important aspects of a problematisation:

- The ethical substance; the part of one’s self which is taken to be the relevant domain for ethical judgment – what we seek to govern in others and ourselves.
- The mode of subjection; the way in which the individual establishes his or her relation to moral obligations and rules
- The self forming activity or ethical work that one does to transform one’s self into an ethical subject
- The telos, the aims of behaving ethically or grand designs of the ethical work. (Gutting, 1994 p.118)

Problematisation does not assume progress or regression, so it is not relevant to talk as if we have reached a stage of higher insight that we can look back on what has

happened with the greatest wisdom. The most important challenge is to understand how and why we hold something as knowledge, some procedures rational and some not, therefore, addressing what is usually considered essential or natural. This said, I acknowledge that my attitudes to restraint are as much a part of the complex of power and knowledge as the culture that supports their use.

Archaeology helps us to map the networks of accepted concepts, legitimised subjects, taken for granted objects and preferred strategies, which yield truth claims. We are not interested in the truth of those claims, but how some of them have come to constitute knowledge within those networks. For example, in his discussion of the birth of the prison, *Discipline and Punish* (Foucault, 1975/79 p.191) we are shown how the prison is a form of visibility that produces statements about criminality, while statements of criminality produce forms of visibility that reinforce prison. With reference to restraints, we can see a direct analogy: restraint is a form of visibility (a visible thing), which is part of the production of statements about the patient, their behaviour and restraints, and these statements reinforce the use of restraints. Statements and visibilities mutually condition each other and the relationship between the sayable and the visible is important to the present study. Consequently, one reveals something of the visible in opening up statements, and something of the statement in opening up visibilities. These relationships are important as they formulate rules for the repeatability of statements, in other words, condition what can be said of the use of restraints. In looking at why particular debates and controversies are current, Foucault directs us to the ‘episteme’, which he explains is:

...the general system of thought whose network, in its positivity, renders an interplay of simultaneous and apparently contradictory opinions possible. It is this network that defines the conditions that make a controversy or problem possible, and that bears the historicity of knowledge. (Foucault, 1972 p. 75).

This quotation is particularly relevant to the study of restraint as there are many statements both for and against restraint, which nurses may use simultaneously when they talk of restraint use. There are rules, which allow these statements to exist simultaneously and allow the establishment of certain truths to exist about restraint practice or the restrained patient.

Genealogy

Genealogy concentrates on the strategic use of power; indeed Foucault offers this version of the distinction between genealogy and archaeology:

If we were to characterize it in two terms, then 'archaeology' would be the appropriate methodology of this analysis of local discursives, and 'genealogy' would be the tactics whereby, on the basis of the descriptions of these local discursives, the subjected knowledges which were thus released would be brought into play. (Foucault, 1980 p.85).

Hence, genealogy is considered here a development of the archaeological system where in the former attention is drawn more to issues of power. Prado (2000 p.33) states that Foucault makes three crucial inversions in his projects:

- The significance of the marginal over the ostensibly central.
- The constructed over the supposedly natural.
- The originative importance of the accidental over the allegedly inevitable.

These inversions are fundamental concerns in the genealogical method. We can expand on genealogy if we consider Foucault's particular notion of power and its distinction from, and interplay with, knowledge.

Power/Knowledge

The term, power/knowledge is central to the Foucauldian notion of power. We shall consider power first and its interplay with knowledge second. The arrangement of power is important: it is not a hierarchical, regimented distribution, where those at the top have the most power and those at the bottom very little. It not only works from the top down, but from the bottom up and horizontally too. To make this a little clearer Foucault describes power as a capillary like arrangement, indicating that the mechanisms of power are actually minute and functioning on every level. It is necessary to understand power as a dispersed and pervasive force. Foucault described his understanding of power thus:

When I think of the mechanisms of power, I think of it's capillary form of existence, of the extent to which power seeps into the very grain of individuals, reaches right into their bodies, permeates their gestures, their posture, whatever they say, how they learn to live and work with other people. (Foucault, 1975/77 as cited in Sherridan, 1980 p217)

Put like this, no one is ever 'outside' of power, there are no social spaces devoid of relations of power. Critics have interpreted this dispersed view of power as

undefined and non-specific. However, writers have claimed that this view of Foucault's conceptualisation ignores his emphasis on the relational character of power (Barrett, 1991 p.136).

Hindess (1996) suggests that as power is dispersed and available to everyone, it follows that power is unstable and reversible. Contrary to other conceptualisations where power involves the removal of liberty, Hindess (1996) suggests that the exercise of power in Foucauldian terms requires a degree of freedom, as where there is no possibility of resistance there can be no relations of power. Those who are subject to the effects of power are free as they are themselves in a position to act on the actions of others, thus engaging in power on their own account. Foucault makes the following reference to this point:

We must distinguish the relationships of power as strategic games between liberties – strategic games that result in the fact that some people try to determine the conduct of others. (Foucault, 1988 p.19)

Another function of power is that it does not corrupt or negate, causing closures in the way conspiracists may think of power, it is productive and active. Hunt and Wickham (1994) make Foucault's view of power distinct by describing it as 'the perpetual process of keeping the process going'.

We must cease once and for all to describe the effects of power in negative terms: it 'excludes, it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production. (Foucault, 1975/79 p.194)

Thus it appears it is relevant only to ask how power works rather than what it is, not who possesses it, but how is it practiced. Whether resistance then is a source of celebration or of despair is beside the point, what is important for this study is to examine and describe the way in which resistance operates as part of power, not to seek to approve or oppose it. Through these resistances we can point to power and its operations.

A closely related but not synonymous term, knowledge has a mutually conditioning effect on power. Foucault understood knowledge as:

The field of coordination and subordination of statements in which concepts appear, and are defined, applied and transformed...; Lastly, knowledge is defined by the possibilities of use and appropriation offered by discourse. (Foucault, 1972 p.182).

It has been argued here that power is a series of relations between forces and knowledge forms, such as visibility and statements. Foucault leads us to a mutually conditioning understanding of power/knowledge, for instance, power supports certain types of knowledge and knowledge supports certain types of power.

Power produces knowledge....power and knowledge directly imply one another; ...there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations. These 'power-knowledge relations' are to be analysed, therefore, not on the basis of a subject of knowledge who is or is not free in relation to the power system, but on the contrary, the subject who knows, the objects to be known and the modalities of knowledge must be regarded as so many effects of these fundamental implications of power-knowledge and their historical transformations. (Foucault, 1975/79 p.27)

Foucault's work examined the rise of formal knowledge complexes and traces the ways they have come to inform widely used techniques of power in the modern world such as knowledge generated by medicine being used in the governance of deviance (Foucault, 1963/73). Alternatively, an example in the present research would be knowledge generated by frail aged care being used in the governance of behavioural phenomenon and justifying the use of restraints.

Governmentality

Technologies of the self are concerned with Foucault's view of governmentality, which like power, is seen as more dispersed than the traditional conception of government, where the work of a sovereign power is founded on, and operates through, the consent of its subjects. Foucault suggests that the word refers to less spontaneous exercises of power over others and to the use and invention of technologies for the regulation of conduct. Government aims to regulate the conduct of others or oneself (technologies of the self) and acts on the manner in which individuals regulate their own behaviour. Restraint can be thought of as a regulation of conduct in the absence of the ability or willingness to self regulate. It is, therefore, a social practice that serves as a proxy technology of the self.

It is important to consider another formation, 'subjectivity', (discussed earlier). Subjectification functions as a process by which individuals position themselves and others as 'subjects' of a debate and the way in which they speak of their relationships and roles in the debate. Some subjects are made 'authorities of delimitation', those

within a given society who are granted the authority to delimit, define, label, and discuss the objects of the discursive formation. Foucault writes:

my objective ...has been to create a history of the different modes by which, in our culture, human beings are made subjects.
(Foucault, 1982 p.208).

Subjects are the product of power and the 'sites' for technologies of the self. Objectification is the way in which the spoken or written word becomes an object to be analysed, debated or discussed. Both of these formations make a surface of emergence, places within which objects, including people who have restraints applied to them, are designated and acted upon.

Discourse

Discourse theory, as understood from a Foucauldian perspective, involves recognition that, in relation to knowledge, there is a structural formation which conditions what can be said, who can say it, and when it can be said. Also important is the view that what can be defined as knowledge, or truth, is defined within specific discursive relations, which is to say that whatever counts as knowledge, whether true or false, is produced by and within given discourses (Jose, 1998). One may say that nothing exists outside of discourse. An obvious counter argument may involve the natural world: it did indeed exist before and outside of discourse. The point here is that before discourse it is not possible to think or talk about the natural world, we have no representations of it. Our representations come from science, literature and many other disciplines. We need to understand the relationship between linguistic processes and socio-cultural practices. We then see that language is not exhaustive or transparent but strategic and directed toward a desired end. In talking of the natural world, does one draw more heavily on discourses of science? Of literature? Or, perhaps, religion? Each would give one a very different representation. Without attention to these discourses, we are trapped within certain forms of thinking, unable to reflect upon the ruling categories of a certain discourse. These discursive formations act like a set of rules which make discourse malleable in that they make possible the inclusion, or exclusion, of discussion of elements or possible points of view.

Discourse transmits and produces power; it reinforces it, but also undermines it and exposes it, renders it fragile and makes it possible to thwart it. ...There is not on one side, a discourse of power, and opposite it, another discourse that runs counter to it.

Discourses are tactical elements or blocks operating in the field of force relations: there can exist different and even contradictory discourses within the same strategy; they can, on the contrary, circulate without changing their form from one strategy to another, opposing strategy (Foucault, 1976/84 p.101-102).

The discursive formation is made possible by a group of relations established between authorities of emergence, delimitation and specification. These relations constitute discursive practices that Foucault describes as historical rules determined in the social, economic, geographical or linguistic context of a period that outline what will be taken seriously and what are valid points for discussion.

Hence, we can see the contextual nature of any problematisation, and this has been a point of critique by many commentators. Traynor (1997) examines the claim that postmodernism fails to offer authoritative explanations for social phenomena that might provide a scientific basis for policy formation. However, he also highlights the weakness of this criticism, by concluding that postmodernism is a mandate for causing trouble for those groups who are currently having their say, not as a place from which to champion the cause or view of any particular group. Not every problem has a compact and neat solution. In the matter of restraint, there is no quick fix, as evidenced by its longstanding use. However, by developing an understanding of the social practices involved in restraint use we can possibly get closer to addressing the problem in a lasting and effective way.

One further term must be explained in this methodological section, and that is the term, constitute. In this study the word 'constituting' is used to describe the end product of the subjectifications and objectifications of the case studies. Foucault (in translation) frequently uses the word when describing the results of discursive processes. The word implies a composition of parts rather than a cause and effect, linear process and this is distinctly Foucauldian. An example of Foucault's use of the term in *Discipline and Punish* where Foucault elaborates on the constitution of a corpus of knowledge through, the examination, normalising judgement, and hierarchical observation:

The old form of inspection, irregular and rapid, was transformed into a regular observation that placed the patient in a situation of almost perpetual examination. This had two consequences: in the internal hierarchy, the physician, hitherto an external element, begins to gain over the religious staff and to regulate them to a clearly specified, but subordinate role in the technique of the examination; the category of the 'nurse' then appears; while the

hospital itself, which was once little more than a poorhouse, was to become a place of training and of the correlation of knowledge; it represented a reversal, therefore, of the power relations and the constitution of a corpus of knowledge [emphasis added].
(Foucault, 1975/79 p.186)

Constituting also implies that there is a product of technologies of power, and this is in keeping with the position that power does not form closures. Power is productive, it produces new knowledge, it produces resistance and, importantly to this thesis, it produces subjects who can be spoken about; practices which can be debated – in fact all those processes that together produce a particular constitution of reality. It is in this way that the term, constitution is used in this thesis.

Having discussed the broad themes of archaeology, genealogy, power-knowledge, discourse and constitution, it is necessary to comment in practical terms on how this theoretical scaffold has influenced the study as a whole. The attention to Foucault's themes has directed the study of restraint use to the context and rules that govern what can and cannot be said, and to the rules, which create spaces in which new statements can be made. It is essential to make clear that the study is attempting to create a thorough understanding of restraint use without the delimitation of identifying a cause and effect. Therefore, principles of contingency and scepticism are the keys to this study.

In sum, the basic units of analysis of discourse are not merely words, but meanings, that can be identified in all structures, physical, organisational, political and spoken. This guided the study to a broad base of data collection involving an examination of physical environments, social environments and organisational environments. Discourse analysis has been critiqued as a deconstructive methodology, which gives rise to a hopeless outlook on problems, as it does not reconstruct or provide solutions. The aim for this research is that Foucault influenced discourse analysis will develop a reflexivity which will continue to unsettle the taken for granted aspects of nursing care thus making it possible to challenge and reshape the dominant discursive framework impacting on restraint use. Attention now turns to the second methodological strategy chosen to undertake this investigation, the case study.

Case study

Two Authors, Yin and Skate, have lent much authority to the domain of case study research through application of the methodology in a number of research studies and texts (Becker, 1967; Rothney, 1968; Kaufman, 1981; Feagin, Orum & Sjoberg, 1991; Stake, 1994). Case study research has been marked by fluctuating popularity over the last century. The Chicago Department of Sociology had much to do with the popularity of the case study method early in the 1900's. This interest contributed a wealth of information during a period of increased immigration in North America. Different aspects of immigration, such as, poverty, and unemployment, were ideally suited to case study methodology. Whyte's *Street Corner Society* in 1943 (1955/43) is an example of this early case study work. However, case study methods suffered denigration within the movement to make sociological research more scientific. Quantitative measurements, objectivity and rigour were to take the place of observation, participation and interpretation.

The common stereotype of case study research such as, 'it is a method of last resort' has been reinforced by many social science texts; however, paradoxically case studies are now appearing with increasing frequency (Yin, 1994). The case study as a research strategy has grown in authority over the last decades to a large extent because of the work of social scientist, Robert Yin. In addition, Yin's book on case study research (Yin, 1994) is beginning to stand the test of time with several editions and numerous reprints. As a result, empirical research methodology is increasingly being considered from a pluralistic rather than an hierarchical perspective, and for its ability to best address the particular kinds of research questions.

One reason for the choice of a case study design for the present study was that the problem of restraint is not limited to one professional group, an approach that takes account of the complexity of the issues involved was, therefore, required. Decisions to restrain are not a straightforward matter. They may be made, influenced by, or acquiesced to by a whole multi disciplinary team. Therefore, the use of restraint needs to be understood within the context in which it occurs. The central focus must be on the practice of restraint in the specific setting in which the use of restraints becomes a practical option. Hence, a case study was adopted as a research methodology that offers the potential for capturing the complexities that attend restraint practice. Furthermore, the case study methodology has the advantage of

fluidity, thus allowing me to consult with the different 'subjects' involved in restraint use. Moreover, the case study enables the practice of restraint to be considered within the context of the discourses that make it possible. Central to these discourses is the ability to consider the place of the powerless and voiceless in the process. Here it is significant to note that the patients who were the subjects of the case studies that will be presented were, in a sense, powerless and voiceless in the process. They were nevertheless able to resist domination by the continuation of their problematic behaviour.

Case study was considered the most viable research strategy for the following three reasons:

- the type of research question posed
- the degree of control the investigator had over the behavioural events
- and the degree of focus on contemporary as opposed to historical events

Yin (1994 p.3) states that a case study:

...investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident

This is particularly true of the problem of restraints, for instance, restraints are used because of patient behaviours, but also because of the nursing culture, and perhaps because of a knowledge deficit among nurses. All these factors are inseparable from the environment. Furthermore, it can be argued that restraint is used for particular behaviours, but that some of the same behaviours are caused by restraint.

The fundamental strength of the case study is its ability to cover contemporary phenomena and their context. Hamel (1992) asserted that the criticisms of the methodology display the immaturity of sociology rather than the pitfalls of case studies. Despite, and because of these criticisms, much has been done over the last decade to clarify and improve the methodology.

Consequently, case studies have been denigrated on the basis that they are the soft option, which have no basis for generalisation. Therefore, Yin (1994 xiii) states in his preface;

The case study has long been stereotyped as a weak sibling among social science methods.

Such statements arise from the common misconception that research strategies have and should be viewed hierarchically. A hierarchical perspective is inherent in emulation of logical positivist principles in some attempts to justify the case study as a legitimate research method. It will be argued in the section on discourse analysis that developing inadequate explanation of a phenomenon, in this case restraint practice is a valid way of ensuring scientific rigour.

Another traditional prejudice is concerned with the lack of accuracy of case study research. Yin (1994) admits that there are a number of sloppy investigations, which have allowed equivocal evidence, or biased views, to influence the direction of findings and conclusions. It should be recognised that bias can slip into any research; Yin (1994) suggests that in case studies these problems may have been more frequently encountered and less frequently overcome.

Case study is a term common in many different contexts. For instance, medical doctors frequently use case studies as a teaching tool for their students. However, the need for rigorous detailed and complete presentation of the events is not necessary in these case studies, and events may even be deliberately manipulated to make a point. This is far removed from the process of case study research where every effort must be made to represent the case evidence fairly. However, the fact that the two different techniques share the same name is possibly responsible for some of the ambiguity. Likewise many disciplines use the term case histories which should also be identified as a documentation method and not blurred with a category of research methodology.

The arguments for the use of discourse analysis, within a case study design, have been presented in this section. The following section will discuss the methods used to collect and analyse the data.

PRACTICAL RELEVANCE AND METHODS

The purpose of this section is to discuss the specific strengths that discourse analysis brought to the study. This research is distinct from previous restraint research as it recognises that a simple accumulation of so called “unvarnished positivist facts” about restraint has had on inconsistent and limited effect on its prevalence. This study stresses that there are a number of reasons for this, and that these reasons lie in the social meanings surrounding restraints in the ward culture.

In case study and discourse analysis alike, what is achievable, and desirable, is to develop an adequate theoretical understanding or interpretation of the use of restraints, and in this way the methodologies can merge comfortably. Rather than taking the findings as a way of seeing further into a range of feelings, behaviours, or attitudes, the discourse analysis findings will be taken at face value. What is important is that all language serves a range of social purposes over and above the mere relay of information. Hence the questions of interest are how the discourse is put together and what purpose this serves.

The main reason for taking this approach is that two decades of traditional research has failed to lead to any sustained and unified change in the practice of restraint. This failure to change leads me to consider other research options to perhaps give a new understanding of the problem

A postmodern approach to research has been criticised for leading to a state of “intellectual paralysis” (Anderson, 1996). In other words the technique provides a critique but no solutions to the problems. The current research is, however, practical in nature, and through adherence to this practical relevance of the analysis clues to practical solutions can be found. Importantly for practice, the effects of the ‘truths’ about restraints are to directly suppress change. Take, for example, the ethical ‘truth’ of the greater good for the patient if they are restrained. In fact, the identification of the interests behind this particular ‘truth’ reveal that it may not be in the patients interests to be restrained, but it may be a significant advantage for the nurse. This is hidden behind the professional hegemony of the claim of restraints providing safety.

The current research makes no claims to studying objectively the restraint issue. The inevitability of the theoretical position being context and observer specific is acknowledged, and this is made explicit. Through discourse analysis the findings in the case studies take on a higher function. They are not mere corroborators of issues arising from the text, but identifiers of social patterns and meanings. This could be seen as a deviation from the essential form in case study research of generalising to pre-existing theory. However, what is also recognised in case study methodology is that it is evolving. This is why Yin (1994) calls case study research an “on-going craft”. The challenge for this study was to merge case study design and discourse analysis for the specific needs of researching the phenomenon of restraint.

What theory there is on restraint is certainly utilised in the analysis, in that I was aware of discourses in the literature and the effect that they may have on my

discourse, and that of the participants. The existing theory on discourse was also used in structuring the recognition of discursive formations about restraint use. However, an existing theory that was both specific enough to the problem, and elaborate enough to explain the phenomenon was not found. Therefore, discourse analysing the text and conversations with the participants, helped form the understanding of restraint use that this study achieves. The two methodologies complemented each other and enabled a pragmatic look at the previously methodologically restrained approach to restraint.

Research Design

A research design is the logic that links the data to be collected (and the conclusions to be drawn) to the initial questions of a study. (Yin, 1994 p.18).

In this study the design phase took one quarter of the research time, which shows the importance given to this phase. Study propositions helped to guide the research and further ascertain where to look for the relevant evidence. The proposition of the study was that certain discourses in practice prevent the move to a restraint free environment. A rival proposition from the literature was that restraints are surrounded by myths and if staff had knowledge of these myths this would promote moves to restraint free environments. This led me to observe and interview staff about their feelings and thoughts on restraint, enabling me to document discursive practices, and analyse their social functions.

Because the unit of analysis was the 'meaning' behind interactions with, and descriptions of the patient, observations and discussions were focused on the individual patient. Not only did this focus interview questions, it also kept the participants grounded in the reality of caring for that patient. The participants talked about a real patient, to someone with experience of caring for him/her. This meant I could challenge inconsistencies in the participant's discourse, and indeed the participants could challenge me. This common ground was an important part of the design.

A major literature review was undertaken in the planning phase of the study to improve specific knowledge. I am a registered nurse so many of the circumstances are familiar. I attempted to increase my awareness of the surrounding so that I could be objective and not take for granted what an outsider would think unusual. To

achieve this I kept a reflective journal, before, during, and after the data collection phase of the research, and many interesting observations arose from this.

Yin (1994) states that for case studies, theory development is an essential part of the design. This theory is not equitable with grand theory, merely sufficient blueprint for the study. Various social factors were identified in the literature as central to explaining the continued use of restraints (legal, ethical, economic etc discourses). However, these were not considered complete enough to explain the continued use of restraint and it was hoped that an alternative explanation would arise from the discourse analysis. The work of Foucault, specifically his work on power/knowledge, discourse and ethics was used to guide the development of a discursive formation.

Yin (1994) states that an important step is to identify a format for the final report. It was decided at this stage that each of the cases would be reported on singly with a final cross case analysis. Another detail was that the cases would follow a chronological order, so that the reader could appreciate the emerging discourse within its context.

Pilot Study

I chose to pilot the proposed research because of the unpredictability of the patient's behaviours and my developing skills as a researcher. There was no previous research on which to draw experience, so I conducted two pilot studies before I commenced the case studies presented in Chapter Six.

The first pilot study was carried out with a lady named Peggy who had a history of slow onset dementia, and had been recently admitted with a severe stroke. Peggy continually wanted to get out of her chair but did not have the ability to stand unaided. She was verbally demanding and had suffered frequent falls since she had been admitted.

The pilot study helped finalise the focus on why restraints were used rather than what alternatives were possible. This was influenced by the observation that whilst the nurses claimed they did not know what to do to eliminate restraint they certainly were not doing all that they could. During each observation, I noticed that Peggy was on a wet pad, an uncomfortable chair, or was complaining of thirst. I decided there may or may not be alternatives to restraint which needed discovering but that

they would only be relevant at such times as the patient was receiving essential measures of nursing care, such as comfort provision.

A second pilot study confirmed the observations of the first. This study was with Sid who had been admitted in an acute confusional state. He was deaf and his hearing aid had been lost. This posed problems that also arose in the final case study reported in Chapter Six.

These pilot case studies were essential to gaining an appreciation of how I could best collect and analyse data. Without the pilot studies there would have been significant problems in data collection and analysis.

Subject selection

The subjects were patients in an acute general hospital who was being restrained for the majority of the day. Subjects were selected when the nurses identified the patients as being the highest priority, and the most complex in terms of removing the restraints. The nurses would say, "Have a go [at removing the restraints] but you've bitten off more than you can chew with this one". This lack of hope from the nurses was a substantial part of my inclusion criteria. The subjects but they were chosen because they were substantially different in specific respects as gender, dementia state and diagnosis (they all had dementia but of different types and aetiology's).

The selection of staff participants only started following the initial observation of the patients, so that I could assess which staff members were interested in talking, and which had close involvement in the care of the patient. Subjects were chosen initially on the grounds of who was having extensive contact with the patient but then followed a snowball sampling logic by asking the interviewee explicitly who they thought was important to talk to, or by following a logical path as issues arose. This type of snowball sampling was useful as it identified people of key importance who may not otherwise have been interviewed (Polit & Hungler, 1995). The process of snowball sampling is a linear process and, therefore, appears to contradict the Foucauldian principle of non-linearity. However, the notion of a discursive formation makes no presupposition about linearity. Therefore, the analysis here is not a linear one although the methods used to explore it had some linear characteristics. No staff members refused to be interviewed, and all were generous with their time when they saw the high level of involvement I had with the subjects.

Data Collection

Data collection procedures were not routinised or mechanistic and broadly they involved taking on the different roles of interpreter and evaluator, as well as those associated with more structural techniques such as interviews, and observations. What should be mentioned here is that the research steps did not proceed in a chronological manner, rather data collection was interspersed with preliminary data analysis, an approach that was essential in order to focus data collection efforts on relevant emerging issues.

Yin (1994) stresses the importance of the researcher enhancing their skills for data collection. Contingencies should include: questioning, listening, flexibility, understanding of the issues, and personal awareness of bias and preconceived ideas. Improving my questioning and listening has been a focus for my personal and professional development for the past decade. I practiced my interview skills before undertaking data collection and completed a formal course at master's level in qualitative research. Remaining flexible in my interpretation of solutions is a skill I prepared for by anticipating seemingly predictable events and imagining other possible scenarios.

There were to be several foci for research questions. First, about the patient or subject: What were his/her behaviours in the context of his environment? Data collection included a family history, and mini mental tests, field observations of behaviour with and without restraints, analysis of behavioural logs filled in by the nurses, physiological and pharmaceutical factors in his care, and examining in particular issues of his/her comfort or lack thereof.

Secondly, my focus was on the patient's experience of care as well as that of the staff members involved. Data collection methods included observation and conversations with the subjects in conjunction with analysis of the nursing and medical plans of care. These activities led to interviews with individual staff members. When the opportunity arose I played devil's advocate by demonstrating to the nurses alternatives to the use of restraints. Continual attention to the research questions helped to contain the research. However, the questions I began with were refined as issues came up. An example of question development is presented in Appendix D.

Each issue as it emerged was cross referenced or triangulated from different viewpoints. Multiple sources were important so that the discursive formation could be based on a convergence of information. This principle enabled me to look at multiple realities, i.e. different views from people with different roles in the care of the subjects. In this respect, case study data collection enabled the research to be truly context bound. In addition, through methods of triangulation of data sources among different participants convergent lines of inquiry are likely to be much more complex and interesting, and to draw on a full range of discursive practices.

Several modes of data collection were employed, including, documentation, interview, participant, and non-participant observation. No single source had complete dominance over the others. Rather, the sum of the parts contributed to the strength of the data collection techniques as a whole.

Creating a study database was a time consuming, but necessary part of the data collection. In the current research it was kept in a strict chronological order with separate computerised files for each data source (diaries and field notes were not computerised but followed the same format).

Documentation

I transcribed all documentation for the hospitalisation of the subjects accurately from the multi-disciplinary notes. Usefulness of this documentation was not based on its accuracy or lack of bias, but on its ability to corroborate or contradict an argument, and produce discourse to be analysed. Contradictory evidence from the notes gave a reason to investigate further and produced new questions. Yin (1994) notes that documents are not written specifically for case research, and that the researcher should always be aware of the intended audience so as to more fully understand the intended message or, in discourse analysis terms, the social function served by the text.

Interviews

The reason the interview method played such a significant role in the conduct of the study was because I wished to corroborate observations of specific events and interpretations by asking the same question of different individuals. Questions were formulated during periods of observation, so that a specific event could be brought into question. It should be noted I became well known to the participants through both the interviews that were conducted, and the long periods of participant

observation undertaken on the wards. As I was well known, there was no need to engage subjects in a drawn out process preparing them for interviews. What I call 'interviews' were often brief casual conversations, which were integral to the research, despite their apparent informality. I did not wish to accurately reveal an unbiased set of opinions from the informants, which is the concern of traditional social scientists. In traditional techniques researchers ask open-ended non-leading questions, however, discourse analysts see the interviewer as an active participant in the conversation. Thus, the questions asked set the functional context for the answers, to a large extent. With this in mind the whole interview was transcribed and analysed.

Secondly, discourse analysis does not seek to bury variation in response by processes of pre-coding or categorisation. Consistency in patterns of language use rather than in content is of concern to the discourse analyst. However, diversity in the verbatim is valued by discourse analysts because it shows the informants are drawing on a full range of interpretive repertoires (Potter & Wetherell, 1989).

Finally, to allow for the full exploration of interview data I created a kind of confrontative arena in which I could contest that which the participants wanted me to accept as a shared reality. This is not to say that I was argumentative, but that I encouraged participants to reflect on what they were saying during the interview. One technique, described by Potter and Wetherell (1989), was to approach the same issue more than once in an interview- thus enabling the analysis of the function of the discourse to become clearer.

Interviews took place on the ward in a separate study room. I interviewed as many participants as the snowball sample indicated. In one case study, six participants were interviewed. Four participants were interviewed in each of the other two case studies. The snowball sample determined who was important to talk with not a regimented sampling structure as with other social science methodologies. The length of an interview depended on how much the participant had to say. All interviews were longer than half an hour. The longest took an hour and ten minutes. Several interviews generally took place with each informant.

Observation

Observation was in the main participatory, and I was at times fully responsible for the care of the subjects. This technique had advantages and disadvantages that can

be discussed (Mays & Pope, 1995) in terms of insider/outsider issues. First, I was able to accurately empathise with the nursing staff as to what it was like to care for a particular subject. Secondly, I was able to act as a relativist in that I was exposed to the circumstances and interpersonal relationships that the nurses have and personal awareness of thoughts and feelings provided further clues to how nurses feel (later to be corroborated in interviews and observations). The issue of restraints is highly stressful especially in conjunction with violence as in the first case study. This involvement helped me to understand this stress. As the nurses knew that I appreciated their situation they were, I think, more open in their dealing with me.

I chose to become an insider in the care of the subjects for ethical and methodological reasons. I was aware that the subjects were very likely to get less nursing time because the nurses knew that I was watching their interactions. If I had not been permitted to intervene the subjects may have gone without care. Moreover, I removed restraints from the subjects in order to observe their unrestrained behaviour (permission was first gained from the nursing staff). Therefore I had a duty to maintain the safety of the subjects, which at times meant constant interaction with them.

However, being one of the nursing team posed difficulties. I had to work hard to remain objective. This was achieved by keeping a reflective journal, and regular meetings with my supervisor to account for the progression of each case study. The purpose of the journal was to chronicle as many happenings in the case as possible during data collection. It also aided my attempt to challenge the 'taken for granted' by heightening my awareness of what I was taking for granted in the data collection. The journal allowed me record initial ideas and plot the rise of those ideas throughout the discourse. The journal was filled in on each day of data collection and each day of writing the initial draft.

Non participant observation

Non-participant observation was useful in cases such as nursing hand-over, directly observing the site for aspects of the environment, assessing the interactions with staff and the patient.

Life histories

Life histories were built up from family interviews and conversations with the subject. Life histories were a vital part of each case study as they increased my

understanding of the subjects' behaviours, and at times gave insight into the meaning of their comments.

Data analysis

Data analysis proceeded with the consideration of data from each case study in chronological order. Again, methods of discourse analysis and case study analysis were combined to build a contextual understanding for restraint practices with respect to each individual. The verbatim account of the interviews was subjected to discourse analysis and these findings were incorporated into the case study to provide further evidence of emerging issues.

Data analysing case studies consists of examining, or recombining the evidence to address the initial study questions. The work of Foucault with respect to discourse, power/knowledge and ethics are strong scaffolding for the case descriptions. The questions are fore-grounded but the descriptive framework and chronological array of the data organises the case study analysis. The descriptive approach helps to identify the appropriate pattern of complexity; this ultimately is used to provide an understanding of the possibility of the long standing use of restraints.

Chronologies permitted me to determine events over time. My analytic goal was to compare the chronology of practices with the discursive practices. My endeavour was to show that the results relied on all the relevant evidence. Practically, the analysis involved mapping out the broad stages of the subject's care, with the focus on the research questions. This array was mainly descriptive and enabled further exploration, and finally, explanations to be made of the complex discourses that legitimised the use of restraints.

Analysing Discourse

Spoken or written discourse is not simply a channel for the flow of transparent information but a potent action orientated medium. Discourse analysis is an emerging methodology and there is no structured format for how it should proceed.

Following the data collection and formation of the case study database, a huge body of discourse needed to be broken down and structured in a way that made the data manageable for analysis. The first stage was to relate the discourse to the chronological descriptions of each subject. This involved scanning the data as inclusively as possible for discourse relating to each time phase. The inclusiveness was important, as this stage had a pragmatic rather than analytic goal. The aim was

to collect together instances for examination, however figurative or only vaguely related to the questions. During this phase many ideas for analysis occurred and careful note of these was taken, however, I was careful that this did not affect the inclusiveness of the coding process.

Potter and Wetherell (1989 p 168) use the analogy of analysis of discourse being like riding a bicycle, while analysis of survey data is like baking a cake from a recipe. As such it is very difficult to put into words the mechanisms of the analysis of data. It involved careful reading and re-reading of texts but it also involved specific reading skills. Rather than reading in order to produce a summary I was interested in the detail of the passage, its inherent contradictions and vagueness.

Discourse analysis is concerned with looking for pattern, that is differences or consistencies and function and consequence of the accounts. At this stage propositions were formed about these functions and effects and linguistic evidence was sought from the multiple data sources.

Potter and Wetherell (1989) suggest there is no analytic method in the standard sense. There is however, a firm theoretical framework focusing attention on construction, function and effect of the data. This is not to say that the reader should merely trust the results, as there are several stages of validation that will be discussed next. Potter and Wetherell, (1989 p 169) identify four analytic techniques used to validate the findings of discourse analysis, coherence, participant's orientation, new problems, and fruitfulness. I will discuss these next in addition to their application to the current research.

Coherence

The first premise is that a set of analytic propositions should give coherence to a body of discourse. It should be stressed here, that much of the validity of discourse analysis lies in the clarity with which the reader can assess and evaluate the researcher's interpretations. This premise is shared with case study research. In other words, the reader should be able to see if there are loose ends or broad patterns, which do not hang together within the research. Discourse, which lies outside the explanatory framework, is often revelatory and, as such, the explanatory scheme should be broad enough to encompass such examples. Potter and Wetherell (1989 p.170) state that:

If there are no special features which plausibly explain difference, the exclusive nature of our scheme should be questioned.

Participant's orientation

Participant's orientation lends validity to discourse analysis as the phenomena of interest had consequences for peoples working lives. Hence, we are not concerned with dictionary definitions, but what sense participants actually make of their interactions. As readers we can say what we perceive as consistent, or otherwise, but what is important is the subject's interpretation of such. The interviewer may ask a question, but this may be interpreted as an accusation. If the subject treats it as an accusation, the analyst is justified in interpreting it this way too. Likewise, if the researcher claims that restraints are justified from two incompatible standpoints and the informants have a third standpoint oriented at justifying the first two then the researcher can claim some authenticity for this view.

New problems

The production of new problems and solutions to them in the analysis provides evidence, that the linguistic resources are being used effectively.

Fruitfulness

The final criterion, fruitfulness is in many ways the most powerful. This refers to the ability of the new theoretical scheme to make sense of the discourse and generate new kinds of discourse. In this way discourse analysis can provide a language for new discursive practices and thus new nursing practices.

Texts have referred to discourse analysis, as with case study research as the arena for hypothesis development, these hypotheses then to be tested rigorously by experiment. From the previous discussion of the under-pinnings of discourse analysis we know that infallible criteria for assessing research lie only within positivist thinking. The premise that is important to this study is that developing an adequate theoretical understanding is at least as important as perfecting and performing rigorous methodology.

Ethical Considerations

There were ethical considerations that reflected the multiple data sources and these will now be considered.

The subjects

The research proposal was submitted to Curtin University of Technology Ethics Committee. Once approval to undertake the study was given, I sought approval from the hospital's ethics committee. After a number of significant changes to the research proposal ethical approval was granted.

The patients I proposed to study were doubly vulnerable as they were experiencing altered mental capacity and were part of a potentially stigmatised group, the elderly. I justify conducting research with this doubly vulnerable group of people, by emphasising the need to improve the care of patients who are restrained. The research questions posed in this study could only be answered by involving members of this vulnerable group in the research. Only when vulnerable groups receive appropriate research attention can their standard of care and the quality of their lives improve.

No potential risks to the subjects were anticipated or eventuated, as the removal of restraints only took place at times when I was working individually with the subject. I have experience in aged care, and felt I was well able to recognise the need to adapt or cease data collection.

One problem occurred when I saw practices from an agency registered mental health nurse that I felt strongly were abusive. I discussed this with the nurse at the time. He was unconcerned about his behaviour and thought it rational. The subject was in direct danger so I discussed the issue with the nurse coordinator for that shift who intervened and moved the nurse to 'special' another patient. I discussed the appropriate action with my supervisor who recommended the incident should be documented and a copy given to the ward manager. No further incidences caused ethical dilemmas.

The patients in the prevalence study were not approached for consent. However, access to their notes was required for the collection of defined information.

The subjects in the case studies were not asked for written consent as in all cases it was inappropriate because of their cognitive state or sensory impairment. It was, however, assumed that their view was central, and I attempted to explain the research in such terms as I thought appropriate in order to gauge the extent of their cooperation. In no case did I, or the nurses, feel the subject would have asked not to be part of the research, as the alternative was to be restrained, and all these subjects

expressed frustration or anger at being restrained. It was anticipated that the subjects may have had the legal capacity to give consent, but may not have been in a position to give full, informed consent due to expressive or cognitive difficulties. Next of kin were approached for written consent, and in no instance was there any hesitation on their part when the study information and opportunity for questions was provided. The consent form is presented as Appendix C. It states that the subject is a voluntary participant in the study, that the study will not affect their medical treatment, they understand the purpose of the study, and they may withdraw from the study at any time without explanation. Signed consent forms were kept in a locked filing cabinet at Curtin University.

I had to be careful that I was not being used as a 'special' for the subjects, and that my presence did not alienate the subjects from the ward nurses. I limited data collection periods to four hours, at times not coinciding with the start of the shift in order to prevent this. If relatives arrived during data collection periods I did not prevent their visit but used the time to talk to them and see to observe how the subjects reacted to them.

The subjects and their families were given a written guarantee of privacy and confidentiality and made aware that pseudonyms would be used in any published report.

The participants

Following approval of the study by Curtin University of Technology Human Research Ethics Committee and the teaching hospital's ethics and scientific committee, I sought permission from the level three managers, and clinical nurses from the particular wards involved. This was particularly important, as I needed cooperation from the nurses in order to interview subjects and staff. Every effort was made to fully inform the nurses as to the data collection techniques and the purpose of the study. I spent most of the initial research weeks providing as much information to the nurses as I could.

The study aimed to collect potentially sensitive information that the nurses caring for the subjects could have felt protective about. I made it clear to all the nurses that the research was not intended to criticise nursing staff, but to facilitate positive change. A newsletter was sent to all staff on the wards involved, informing them of the study and its objectives.

An information letter was given to all nurses directly involved in the case studies, and their right to withdraw from the study at any time without consequence to their employment was stressed. The nurses involved were given time to discuss any concerns they may have had with me.

Field notes were written immediately after periods of observation. Pseudonyms were used in all raw data and only I had access to this material. Participants received a written guarantee of privacy and confidentiality incorporated in the information sheet that they were given (see AppendixC).

Data collection was planned with nurses so as to cause as little disruption as possible to the staff. However, as stressed earlier, it was important that the wards did not rely on my visits to care for the subjects. At the end of all visits the relevant staff were informed that I was leaving the ward. At the same time, the staff were asked whether they would like me to replace the restraints. This ensured that a misunderstanding of responsibility never compromised the care and safety of the subjects.

Data

The research data were maintained according to the National Health and Medical Research Committee (NHMRC) guidelines for research data. I was the only person with access to the data. The audiotapes, transcripts and field notes were kept in a locked filing cabinet at Curtin University and will be destroyed after a period of five years (audio tapes after confirmation of contents with subjects). All identifying data and consent forms were also placed in this locked filing cabinet. I personally typed all of the transcripts so there were no issues of debriefing a typist. Notation from the medical and nursing notes was transcribed within the hospital and de-identified during transcription so no medical notes linked to the identity of staff or patients left the hospital.

Summary

In this chapter, discourse analysis and case study have been described as methods of gaining a contextual understanding of the practice of restraint in a teaching hospital. The first part of the chapter deals with the theory related to the two methodologies, and the rationale for uniting them in the search for contextual understanding. The second half of the chapter deals with the methods employed in gathering the data using these two approaches, and how that data has been analysed.

As with any research process there are ethical concerns that must be considered to ensure the safety of the participants and the investigator. The pertinent issues have been discussed in this chapter. In Chapter Six the findings from the three case studies on restraint practices are presented.

CHAPTER SIX

CASE STUDIES: THE FINDINGS

There is one great difficulty with a good hypothesis. When it is completed and rounded, the corners smooth and the content cohesive and coherent, it is likely to become a thing in itself, a work of art. It is then like a finished sonnet or a painting completed. One hates to disturb it. Even if subsequent information should shoot a hole in it, one hates to tear it down because it once was beautiful and whole.
J Steinbeck 1902-1968

This Chapter presents information on three case studies, Joe, Elsie and Ted. The aim of each section is to provide clear descriptions of the person, the clinical space, and the restraint practices employed by staff during the subjects' hospital admission. In the descriptions I am not concerned with what could, or might have been, but with what actually 'was' - attempting to answer the sufficiently difficult question of how restraints are used and justified. Inevitably, I will refer to why restraints are used but this is not my primary focus. The descriptions generated in this study draw on evidence from observation, documentation and interviews. I make a deliberate attempt to maintain chronological order in these descriptions so as to remain faithful to what actually took place. The purpose of the case studies that follow is to identify what Foucault would call, discursive practices that serve to maintain restraint as a method of controlling behaviour. I start with a case study of Joe, a pseudonym to protect the identity of the subject.

Case Study One: Joe

Background

It can be difficult when a writer attempts to show demented or any other abnormal behaviour, and I try not to fall into the trap of presenting a hopeless dialogue or mawkish picture. I was privileged to see sides to Joe's character during the period in which the case study was conducted that some other staff may have missed. Joe is a catholic working class man of Irish decent. His wife said proudly "He always put food on the table for his family. He'd never accept dole." I believe I could see this pride and single mindedness in his mood swings. His wife described him as a quiet man and his good friend, Pete, said; "...sometimes you didn't even know he was there". This is in marked contrast to what the nurses in the ward said about him. Joe

had been a keen fisherman and worked mainly as a shearer and wool store worker. His friend talked of him as a champion shearer. Sid said, "He sheered more than us and he's only a little fella". Sid was Joe's best friend and never failed to make him smile. As he walked in the room Joe would say "Sydney or the bush [Australian colloquialism]". They would tell me stories of their mustering days together. Joe has a loving wife, who describes herself as having "nerves". They have two daughters and three grand children. Joe's wife was always close to tears when she spoke with me.

It is very difficult to describe Joe's behaviour - the only sure thing was that it could change as fast as you could describe it. At times he was light hearted, orientated and joking (especially with Sid). Within seconds he could be tearful, angry or hallucinating. Joe could be violent, displaying behaviours such as, squeezing wrists, hitting, punching, pushing, or shoving. He directed violence towards the staff but never at another patient. The most determined violence he directed at me was squeezing my wrists. Joe was verbally threatening more often than physically violent. Common precursors to these violent behaviours were invasion of his personal space for toileting or hygiene care, or asking him to repeat himself, which was problematic as he was at times difficult to hear. At times it appeared Joe did not hear or understand my speech, but repeating myself often irritated him too. It would appear that he had less difficulty in comprehension than he did with putting together a response. Joe's need for privacy caused a problem as he was not always safe to be unsupervised in the bathroom and he had a problem with visuo-spacial skills. Therefore without help, dressing and washing were difficult and time consuming.

First Impression

The following passage is taken from the first day of my field notes. It provides a general overview of the daily situations nurses looking after Joe found themselves in. It also highlights my beginning dilemma with chemical restraint. I subsequently spent many hours of observation with Joe in a semi-conscious state.

This was morning shift. At hand over there was gossip about the evening before: Joe had been aggressive. The coordinator warned me I had taken a lot on, and I thought I probably had. There was some gossip about him; one nurse laughing at another's running away from him when he became violent. She was stating proudly that she just told him to come back inside and stop misbehaving,

and he did. The other nurses laughed. The thought crossed my mind that they were trying to intimidate me. I admitted to feeling very apprehensive.

Joe was still asleep when I went into the room. I took off the posey vest and took down the bed rails. He roused and he became conscious of someone in the room. He sat up with his eyes closed. He did not open his eyes to see who I was. He was struggling to free his legs from where they had become tangled in his sheets. He looked heavily sedated and I checked his drug chart. He had had 5mg of intra muscular diazepam. I reached to untangle his legs from the sheets and he took a swing at me. I dodged his arm and sat back quietly in the chair by his bedside. He settled down and went to sleep again.

Figure 1 - Clinical details
Admitted: 06/02/00 Discharged: 29/04/00
Case study start: 29/02/00
Admission diagnosis: Acute confusional state for management.
Age: 74 Marital status: Married
Residence: Home
Past medical history:
Ischaemic heart disease (CABG). 8 year history of Parkinson's disease however, the diagnosis following MRI scan is diffuse Lewy Body Dementia.
Drug history:
Sinemet, Zocor, Asprin, Tenomin
Psychiatric history: 3-4 year history of night time hallucinations worsening in the last year. Relieved with reduction of Sinemet. Admitted with altered mental state following violence towards his neighbour and running away down a busy road. MMSE: 17 on admission
Functional status: Fully independent on admission

Clinical Details

Figure 2 - Restraint History
Target behaviour: aggressive outbursts with risk to self and others. Possibility to abscond
1st restraint: Bedrail: 08/2/00 Posey vest: 08/2/00 Chemical: 08/02/00 Special: 09/02/00
Psychiatric special nurse: 10/3/00
Pattern of restraint: Varied
This admission: Joe expressed fluctuating behaviour, was physically and verbally aggressive at times and tried to leave the ward. He was restrained since the day after admission. He had numerous falls during his admission, none of which were formally documented. He never received a serious injury from a fall. He left the ward several times and was brought back from the car park or street.

Figure 1 summarises Joe's clinical details. The information was collected from Joe's wife, nursing notes and medical notes. Where conflicting data were found the sources were compared and the notation with the strongest of evidence was taken to be most accurate. The data sources included nursing and medical notes, a prolonged interview with the next of kin, my field notes and observations, nurses' verbal reports to me

and during handover, and my interviews with participants. There were several differing accounts as to the medical term for Joe's condition. I use, Diffuse Lewy Body Disease, the term used by the consultant neurologist, a definition of which can be found in the Glossary in Appendix A.

Restraint History

Figure 2 summarises Joe's restraint history. One previous delirious episode in August 1999 appears to have been precipitated by a bad chest infection. Joe was hospitalised and although his behaviour was difficult, his wife said it was nothing like now, and he had never been restrained. Joe was discharged home and continued with only slight increased confusion. He was admitted again in February 2000 (the current admission) after an episode of violence towards his neighbour. Joe's wife says she is frightened to see him, as he has been aggressive with her. She said she knows he is frustrated and has said to her "Let's go!" When she said they could not, he said, "That's what's making me so savage". This last comment highlights how plausible Joe could be and what insight he had into his situation at times.

Clinical space

The following section will present the details of the clinical space in which Joe was nursed. The clinical floor plan of the ward Joe was in is presented in Figure 3, so that the reader may appreciate the effect, which the nurses claim, impacted on their ability to care for Joe. P1 signifies Joe's position on the ward.

From the Diagram in Figure 7 (Appendix E), it is obvious that there are many exits leading to areas of danger, such as car parks and first floor balconies. There is a communal day room but it is not easily visible from anywhere on the ward. The ward layout is suited to those who are capable of 'self governance', but does not promote surveillance of patients with behaviours that put them at risk, unless they are under a nursing 'special'.

Table 2 presents the biographical data on the participants for this case study and their role in Joe's care.

Table 2

Pseudonym	Experience	Current role	Experience in current role
Peter	20 years	Clinical Nurse (UK)	10 years
Amber	7 years	Senior Registered Nurse	3 years
Julie	31 years	Manager, Non-clinical involvement	10 years
David	4 years	Psychiatric Liaison Doctor	6 months
Rebecca	9 months	Graduate Nurse	5 months
Heath	10 years.	Agency Psychiatric Nurse	3 years

Restraint reduction is a major focus of attention in nursing literature. In this case, attention was on the challenging and burdensome work of day-to-day nursing and running the ward. To many of the staff, the notion of a 'restraint free' environment was an abstraction more than a little removed from reality. In one interview Peter says:

...Our emphasis is on making sure (and my own very much) if they're clean and tidy, fed and watered, and leave here with no other physical signs of hospitalisation, like skin trauma, malnutrition or other injuries. I think we do a pretty good job of that but I'd like to think that there's a bit more that we could do.
(Peter)

Restraint free care calls for improved patient assessment and use of interventions such as, therapeutic touch, reality orientation, and validation therapy. But what consumed the energy of the shift was more mundane, keeping track of the patients, ensuring nutrition and hydration administering medication. The ward seemed like any other, busy with lots of people. The orange floors were shiny and the H block corridors were littered with bath chairs, linen skips and hoists. I noted that the man in the next bed to Joe had Cheyne-Stokes breathing and wondered to myself how appropriate it was to have Joe next to him. The room had an adjoining bathroom shared with another room occupied by two ladies. The room was close to the nurses' station but none of the rooms were visible from the station. There were two verandas both with ramps leading down to major car parks. The ward had exits seemingly everywhere- nine in all.

The Practices

Each case study will be structured chronologically. I describe the behaviour of each subject on admission under the heading Admission behaviour. This leads onto a discussion of the subsequent behaviours that resulted in the use of restraints. The term Problematization (see p. 66) will be used to capture the discourse that justified the use of restraint, seen from the point of view of nursing and medical staff. Nursing notes and medical notes as well as my field notes and observational notes will be used to elucidate this process. In the first case study only, restraint behaviours are then considered under the heading of Extraordinary interventions and External interventions. The term extraordinary is used here to emphasise that the use of restraint is regarded as an inappropriate, if frequently used, nursing practice. Finally, in all case studies, attention will turn to the Deproblematization of the

behaviour of each subject – a necessary process for the reduction of restraint or alternative placement that will be described.

Joe's was the first case study I completed, and in many ways the most difficult for a combination of reasons, including his at times extreme behaviour, and my developing skills in case study research. The following is an overview of the major happenings in Joe's care. Although the care Joe received has been sub-divided into a series of phases for ease of discussion, it is important to note that they are not distinct phases but a process in a constant state of flux. The first stage is admission behaviour and is characterised by Joe's entry into the clinical space. (The left hand side of Tables 3-6 show Joe's behaviour; the middle the staff reaction to the behaviour, and the right hand side demonstrates some of the discourse common at this phase.) The second stage denotes the first incidence of maladaptive behaviour and the first use of restraint in Joe's hospitalisation.

Table 3

ADMISSION BEHAVIOUR		
Behaviour	Practice	Discourse
Admitted 06/02/00. Aggressive towards neighbour. Calm behaviour on ward for shift after admission.	Parkinsonian medication ceased.	Confused, agitated resistive aggressive Patient requires full supervision
MALADAPTIVE BEHAVIOUR		
Behaviour	Practice	Discourse
08/02/00 First physical aggression shown towards the nursing staff	First physical restraint used in response	Attempting to throw furniture about Down right violent

Problematization, the third phase, as described in the methodology, denotes the collection of discursive and non-discursive practices that make something enter into the play of the true and the false in a way that constitutes it as an object of thought, such as moral debate or scientific knowledge. The problematization phase can be seen in Table 4 (pg. 97).

Several key things in this case study were made subjects of debate and subsequently problematized: Joe's behaviour, the use of restraints, the environment and the staffing levels / skill of the nursing staff, with the effect of making restraint seem an inert, benevolent or necessary act.

Table 4

PROBLEMATISATION		
Behaviour	Practice	Discourse
08/02/00 Continuation of aggression and violence directed towards staff. Attempting to leave the ward. 02/03/00 faecal incontinence later diagnosed as Clostridium difficile. Becomes less functional, spends much time sleeping. Behaviour remains unstable, however, and Joe continues to have aggressive outbursts. Behaviour marked by severe peaks and troughs	Beginning of many debates about his care. Referred to the liaison psychiatrist who referred to the psycho-geriatrician. 09/02/00, PCA special commences 17/02/00 Plans being formed for discharge to nursing home. 21/2/00 Parkinsonian drugs re-started 24/2/00, seen by psycho-geriatrician, described as manageable. 29/02/00 Notation by responsible doctors re-takeover Joe's care by the psycho-geriatricians. 29/02/00 First research observation.	Special, posey belt insitu PRN. Confused and unsettled getting more unsettled

In order to use restraints Joe's behaviour, or Joe himself, had to be made the subject of debate. Very quickly after the first episode of aggressive behaviour, the nurses refer Joe to the doctor for sedation and the first physical restraint is used, documented in Nursing Note 1 (opposite).

No doubt Joe was a real problem to the staff on the ward. However, it is interesting to note that his behaviours are not put into context. This disables anyone reading the notes from being able to see if there was a precursor to his behaviour and what it was; if it

was lack of ability on behalf of the graduate nurse we are given no chance to appraise this. We saw his problematic behaviours divorced from his context, a very powerful way of depicting his behaviour as if it was purely something from within him and not something we can have an effect on. Thus the only thing to do is control it as best we can (with chemical and physical restraints).

Nursing note 1

8/2/00 14 40 assisted with ADL'S requiring constant supervision becoming aggressive violent and extremely agitated lashing out pacing ++++. Haloperidol given 1mg given IMI as ordered. Dr is aware. May have 1-2mg 8/24, placed in posey as bashing self into the walls continues to be agitated. Graduate RN

15 00 pt extremely agitated still trying to break posey, chair or himself. 2 mg haloperidol given. Graduate RN

Medical note 1

8/2/00 12 15 ATS re-:agitation. Patient apparently violent, agitated -needs 4-5 people to restrain-freed himself from posey-walking all over the place-very aggressive on being approached. D/W and S/B neuro, plan - 1-2mg haloperidol 8/24-RMO to be called if agitated despite haloperidol-higher doses of sedation/ haloperidol risky as pt has diffuse Lewy body disease (clinical working diagnosis)

Nursing note 2

Pt became aggressive when told to go back to room he grabbed next patient's razor out of locker and slashed at my arm when registered nurse and I tried to clam him down he then grabbed my two wrists and squeezed them till they hurt then he pulled at my blouse and would not let go until male CN calmed him down. Agency EN

Medical note 2

0702/00 Thankyou for referring Mr M. Plan- assess cognition and function once mental state improves / plateaus. (Occupational Therapist)

The doctors write about the first incident of violence as shown in Medical Note 1 (above). This account demonstrates how extreme Joe's behaviours were and again fails to put them into context. The crucial question is, what was he doing to need four to five people to restrain him; presumably he was restrained and he had freed himself. However, the restraint is not called into question as a cause of his behaviour. Instead, more restraint (chemical) was used to control his behaviour.

Another example of the problematisation of Joe happened on the first day of my observations: one of the nurses at the 'handover' referred to Joe as "Houdini". She'd been caring for him the night before and he had escaped from a posey restraint. It was an apt nickname and one that made the other nurses laugh, myself included. However, on reflection the remark had the effect of 'demonising' Joe. One could have referred to the incident as happening due to poor equipment design, or skill in the person applying it, but the nurse chose to refer to the incident as happening because of extraordinary skills on Joe's part. Although jovial, this label could be as damaging as any other. Even Joe's abilities are a problem to the staff as in the following example.

Joe was at times quite frightening... He might be an elderly gentleman but he's quite physically strong and able. And he was certainly past the term of being described as aggressive- that's an understatement, he was down right violent. (Peter)

One of the forms of Problematisation was "opting out" or opting someone else in. In other words bringing into the moral argument the question of, who is responsible for Joe? This opting out can be demonstrated in the discourse as inter and intra-disciplinary. Highlighting this practice is not to condemn it – merely to appreciate that it happened, and to understand that it had an effect on how Joe was perceived and subsequently how his conduct was governed.

In Nursing Note 2 (p. 97) the female enrolled nurse refers to help from a male member of staff when help from another female nurse had already failed to "calm him [Joe] down". This demonstrates the delegation of care to another more suitable person within the nursing team. Even within the nursing team there were attempts made to define Joe's care as outside the ability of the female nurses. This had a far-reaching effect, as there was only one male member of staff on the ward.

It is interesting that the care of this subject was delegated to an agency-enrolled nurse: the ward nurses were very aware how difficult he was to manage as the

nursing and medical notes on p. 97 indicate. When asked why the coordinator utilised the agency nurse for Joe's care, practical reasons were given such as giving the ward's staff a break.

When you've got perhaps on the you know maybe one shift at a time but to come back and do it a couple of days in a row I think that is it's just too... too taxing and erm it's just too much for our regular staff to handle that on a regular basis (Amber)

I have sympathy with this comment. However, the effect of this allocation was to make Joe less of a problem to the ward, and if there were further incidents the regular staff could be free from rebuke. It was predictable that there would be further incidents. Joe's care plan at this time states he has a falls risk, and he had already displayed several violent outbursts.

All members of the inter-disciplinary team 'opted out' in some way from his care. Opting out by the occupational therapist, for example, can be seen in Medical Note 2 (p. 97). The occupational therapist makes Joe's behaviour sound transitional and in this way avoids any input in the near future. When I talked to the occupational therapist I said it was a shame he was not having therapy as I thought he would benefit from the contact. She replied that she did not feel he was capable of any new learning so her involvement would not see any improvement in his functional ability.

The physiotherapist also states that she plans a full assessment of function once Joe was mentally stabilised and cooperative, similarly opting out of immediate responsibility. This also gives the impression that these dementia behaviours negate the need for her involvement, as they are so exceptional. In fact, the prevalence of behaviours resulting in restraint in the hospital is high, as indicated in the introduction to the study. The physiotherapist writes nothing further in the notes for his admission. Although Joe, in a lucid moment told me that the physiotherapist had been and said she would come back. He said she had not come back, and he did not know why because that was what he needed, a good work out. He often hung around outside the gymnasium that is part of the ward, but was never invited in.

The doctors also opted out by referring to other teams of doctors. It is normal practice to seek a second opinion from a psychiatrist. However, this practice also defines the problematic behaviour as outside the sphere of the responsible doctor's expertise. Subsequent to this, the psychiatrist states his plan as "continue supportive

nursing interventions”, thereby handing responsibility for Joe’s care back to the nurses.

The nurses speak of the psychiatrists as the experts in the care of this patient, and clearly have high expectations as to their ability to care for patients such as Joe:

Erm I think they do seem to be well experienced and thoughtful in their use of medication to control behaviour and if that’s the only task that they’re involved in I think that’s worth while and erm because the thing that alienates this sort of patient from nurses is nurses fear of getting hurt. (Peter)

Later (16/02/00) again the medical doctors recommend takeover by a further team, the psycho-geriatric doctors, after a period of continued complaint by the nursing staff that Joe was “uncontrollable” and “unmanageable”. This solution to his care is not a solution for Joe but it is certainly a solution for the responsible doctors, who, at this point are under continued pressure from the nursing staff to do something. The psycho-geriatrician makes no response to the request to takeover Joe’s care, and states that his behaviour is “manageable”. She offers to take over the follow up of the care once Joe was discharged. In stating that she also frees herself of immediate responsibilities of care. She took twelve days to see Joe after his referral from the psychiatric liaison doctor. The slow response and the eventual disinterest of the psycho-geriatrician was a source of anger for several of the nurses I interviewed.

I think that these things were allowed to go on far too long before we got any input I think it’s a bit of discrimination because they don’t let people needing specialist referrals for any thing else wait two weeks ...If they’re not up in a couple of days the doctors are on the phone and giving them a hard time... I think that they stitched us up pretty badly ...Maybe erm it wasn’t their fault but they do seem to take a long time to come from when they was referred to but that’s an on going problem... And the self-fulfilling thing in this hospital is you know when you do a psych-geri referral you’ll be waiting for ages. (Peter)

So erm and there was a great mix up with his management he was you know palmed off by the psycho-geriatrics. (Julie)

I’ve noticed, even medical staff would, didn’t seem as interested when issues were raised it would be like a quick in and out Hi how are you doing today? Erm and talking over his head. (Amber)

The function of this ‘opting out’ discourse, intentional or not, is to suppress the notion that these participants can do more themselves. I offer the above comments as support for the assertion that no individual or group, took responsibility for Joe’s care, and that this had a notable effect on restraint use. The presumption in these excerpts is that something can be done of real benefit by the alternative individual or group, and that little of benefit can be done meanwhile. Thus, removing personal responsibility for improving care. This may or may not be true but it is effective in handing on the responsibility of Joe’s care to some nebulous ideal place or person. Peter qualifies this assertion by referring to the hole in the system for Joe:

I think these are patients with specialist needs that the current system doesn't fit (Peter).

Amber referred to the need to create another team whose responsibility Joe’s behaviour did fall within:

Well I'm not too sure (laughs) what their role is because whenever they come over [the psycho-geriatricians] they seem to say that everything is not their job... Erm and fair enough if there's a problem so maybe there needs to be somewhere in between psycho-geriatrics and erm medical geriatrics that people you know will have the time to manage people (Amber).

Researcher: So what is the answer for these patients?

Julie: Obviously to you know have them all in one place so in a way I mean a dedicated area for these care awaiting problem patients...

The doctors who rely on ‘scientific knowledge’ could not agree on a course of treatment. It is clear that the care of this patient was not an exact science and this further allowed the doctors to argue who was best versed to take responsibility for Joe.

Well I personally was of the view that he should have had his Parkinsonian medication stopped straight away... But I can understand that the neurologists were reluctant to do that because they were concerned that he was going to become immobile as a result of that... I think that at least some of his symptoms were to some extent reversible by withholding the Parkinsonian drugs...(David)

Amber referred to this debate of responsibility as putting Joe in the “too hard basket”. It is apparent that this basket may be a dangerous, if convenient, place for an elderly patient with dementia to be.

The use of restraints is in itself a part of problematisation, as it focuses the care around the current debate on restraints, making the care of a patient into a moral issue. The discourse shows different definitions of restraint, from a liberal or inclusive definition to a conservative definition of restraints as only custom made devices (Heath). During an interview, a graduate nurse Rebecca brings my attention to how normal tables are sometimes used as a restraint when they are put behind the front legs of the patient's chair: a liberal definition of restraint. Amber brings to my attention, the use of barriers as restraints to confine a patient to one area. The effect of this is to categorise restraints as more or less effective, and as more or less ethical.

*Erm I think (Pause) the first thing really you do is either tie them down or when they become agitated and aggressive, or chemically erm so they sleep and I think the chemical sedation is probably erm (long pause) over used in some in a lot of circumstances...My err conflict is really with things like erm mittening hands and things like that erm that's what really gets me more than anything else.
(Amber)*

We can see how certain restraints are projected as more or less ethical than others and Amber puts mittening in the foreground. Not having a fixed definition of restraints also causes problems for evaluating how much restraint is used on the ward, which may be beneficial to the staff as restraints have been intensively problematised in the literature (see p. 12-13 Chapter One), and by the hospital under study in a restraint working party. The timing of restraint use is also open to problematisation. Nurses describe how it is difficult to know when restraints are needed and when not. It is apparent that it matters little to the patient if he has a restraint on when he is asleep. However, this is when Rebecca feels restraint should not be used:

So you could have taken the jacket off while they were asleep or you know they've had their medication and it's kicked in half an hour later and they've still got their restraint on. (Rebecca)

In the following quote Rebecca establishes her moral role to protect the patient.

Erm (pause) I (pause) I think that erm (pause) you need to sometimes protect the patient (Rebecca)

Amber relates the need to justify not using restraints rather than using restraints:

Erm it's not I think it's not so much management but it's more sort of erm if you think this person should be poseyed or restrained or

whatever erm, if you're not going to restrain then I think have a better have a pretty damn solid plan in place because if anything happens it's going to be your head on the chopping block. (Amber)

In light of all the bad press and the specific problems with restraining this patient, one would imagine more need to justify using restraints than not. Here Amber makes *herself* the subject of control by the people who will have her head on the chopping block, presumably nurse managers. Conversely the agency nurse when asked if he felt responsible for reducing restraint use said:

I think it's my total responsibility. I think it's part of my every minute of every of every five minutes of every hour of my shift. (Heath)

Heath is internalising the moral obligation for assessing the need for restraint and in so doing establishing his relationship to the morals involved with using restraints, making himself a subject of his own moral code.

One interesting insight was the obvious contradiction in the ward about restraints and safety. Rebecca points out this contradiction by describing a situation where she had restrained Joe to prevent him from falling or wandering off the ward. She describes how he had got up and walked around with the chair on his back despite the restraint. She was clearly aware of the lack of safety in this situation:

Rebecca: But it used to like heaps like he used to like stand up with the whole chair and the jacket on him and try to walk around with that on.

Researcher: So it wasn't really effective or safe at the times when he was very aggressive?

Rebecca: No! No not at all

Researcher: So what do you think about it [restraint] being used anyway?

Rebecca: Well (long pause)... I don't know it's hard to say coz there's that thing like you're protecting them from themselves.

Rebecca points out the lack of safety in the intervention she then uses a paternalistic argument to justify restraints as a benevolent intervention to prevent harm. The contradiction here is striking but Rebecca, and others, actually uses this as an argument for restraint continuation. Many of the nurses describe the devastating effects that restraints had on Joe's care:

I think erm and I've seen it before that when people do become restrained they actually deteriorate and that's a belief of mine... When they're restrained their mobility deteriorates and then once their mobility deteriorates you have all other things erm problems after that. (Amber)

The psychiatric doctor also agrees:

I think that erm a restraint does affect the care their mobility erm their mobility and their freedom as well Erm personally I feel that restraints, where possible should never be used... Erm it's really a matter of the patient's safety being compromised (David)

In this extract the get out clause is used “where possible”. This indicates that in David’s opinion some instances of restraint use promote safety. The function of this discourse is to justify restraints by arguing the purpose they serve, not on the consequences that result from their use.

The use of ethics to argue the role of restraints in contemporary care was ubiquitous throughout the case study. However, there were other arguments as to why alternative interventions were not used. As Peter points out, the restraints were a practice of opting out of other forms of care for whatever motivation.

I think that for long periods of time it [restraint] was used as a method of opting out of other methods of care by nurses...(Peter)

One factor that impacted on the nurses not using alternatives to restraint was the environment:

But I don't know I'd be more inclined to just like if you had the room and just let them go like wander like if you had a room to stick them in or something they could like wander around and I don't know... Yeah where they could wander around and like trash things or whatever and get it out of their system or I don't know (Rebecca).

Rebecca’s last comment seems to reflect images of the padded cell, this may indicate some of the feelings the staff have towards this patient and their hope for any meaningful interaction. The manager, Julie and psychiatrist, David also comment on the environment:

Well because it's got too many exits oh it's got nine yes and then and it's too small... Erm and they feel responsible we've got to balconies you know with roads out there it's really busy... Erm and besides all that I mean you just don't want people disappearing you know and err, err so it's, it's an extremely bad ward for patients like this. (Julie)

...I think certainly you would have taken him from an environment which was providing concerns and the environment down there [psycho-geriatric unit] wouldn't have provided as much concern...(David).

The environment was causing great concern for the staff and making the trial of alternatives unsafe. We can also see the problematisation of the nurse's skills and time. Peter comments on how he believes restraints are the first option in these cases.

Unfortunately the culture tends to be that restraints are the first option and in my opinion that's what people tend to think about and that is for the the supposed pressures people think they have upon themselves to get their work done (Peter)

David, the psychiatrist goes on to support Peter:

Erm and I would say that erm I guess in my experience of ordering restraint it's issued after hours when the usual medical team aren't there and whether that's an issue of the people covering the ward may be busy and it could be an issue of management of the ward staff I'm not sure erm but I'm sure that in the majority of cases probably not every option is tried. (David)

David supports Peter's assertion that economies of time, or at least perceived economies of time, may be important in preventing the trial of alternatives. Amber introduces the notion of peace of mind for her self while she did her other work. It is notable that she also pointed out the devastating effect that restraints had on Joe (p. 124) but claims to use restraints as a paternalistic intervention to safeguard the interests of the patient.

Yer it's much easier to tie someone down and know that they're going to be okay there and get along with the rest of the work than it is to err perhaps sort it out... (Amber)

Who takes responsibility for restraints has been a subject of review of late in the hospital, and the policy is changing to make it the doctor's job. When I asked Amber, who makes the decision to restrain, she told me that until recently it was the nurses' decision, usually an experienced nurse:

Yeah more so it would tend to be someone who's a bit more experienced who will say, "look this is what we've got to do". Erm I don't think younger ones tend to have the knowledge or experience or the confidence to decide to tie someone down or whatever they choose, so it's usually when someone has been out a couple of years and they've seen that this is the norm. (Amber)

The manager explains how she is trying to implement the new policy.

Well I mean it hasn't it hasn't really been brought in fully as such; you know the requiring the doctors signature and that wasn't actually happening. What I'm doing is trying to put parts of it in like informing the relatives so they're not going to get shocked when they see them... (Julie)

Given the above mentioned arguments on how the responsibility for restraining a patient can be pushed to others, it could be that a pre-occupation with informing relatives may result in the nurses owning the decision to restrain a patient even less than they do. It can be suggested that relatives will be made the gatekeepers of restraint without, in many cases, experience or knowledge of possible alternatives. Rebecca is prepared to give an example of this in her practice:

Yes and erm when err when you ask the family weather it's okay like to posy them or whatever erm they often will say yes, straight away "Oh yes yes yes whatever's best for them" but then they'll go what do you mean like what do you actually have to do to them like do you have to tie them down or you know I think I don't know weather they think it's like straight jackets or (laughs) I don't know but yes and then they often want to know how long they've been in a restraint for how erm long like when visitors come in when people have got their hands mittened... (Rebecca)

It was common to see the nurses chasing the doctors down to get a restraining order for a patient. The use of the term "restraining order" implies the nurses are under some duress to restrain as in fact they are if an order is in place. However, this seems to be a wanted duress as the nurses go out of their way to make sure they have it. The dispersion of responsibility appears damaging to the removal of restraints here. During the study period, I frequently heard nurses referring to discussions with the relatives as gaining consent or permission for restraint. Julie, the ward manager stated that relatives should be informed of restraint use, but the nurses on the floor interpret this as 'consent'. It may not be a coincidence that the semantic difference, between informing relatives and gaining their permission or consent removes some of the nurses' anxiety and conflict about the measure.

This stage of problematisation continues with no sign of any grand plan for Joe other than to get him admitted to a nursing home. The catch is no nursing home will take him in his state. The nurses do not know what to do with Joe, but feel he should

be taken over by the psycho-geriatricians. They refuse to take him stating that he does not require admission to their unit.

The end of this stage is characterised by an event that is beyond the ordinary in that it was unexpected and uncommon, and thus called for the 'extraordinary' intervention seen in Table 5 below.

Table 5

EXTRAORDINARY INTERVENTION		
Behaviour	Practice	Discourse
04/03/00, Joe punched a pregnant nurse.	04/03/00 request for psycho-geriatric take over again. 05/03/00 psychiatric nurse special. Consideration of a form one, pressure on psycho-geriatricians. 07/03/00 response from psycho-geriatrician will not take over care (no beds).	Restless afternoon, became aggressive towards staff. Upended meal tray. Up and talking to the nurse then punched her in the stomach. Nurse too distressed to write in notes.

Joe's problematisation escalates when he punches his nurse, who is eight months pregnant. Numerous times before this event Joe had struck a member of staff, and Peter points out:

His behaviour had been equally bad if not worse for some time period some period before that and I'd reported aggression and I've got smacked a few times and it was almost (pause) funny. I think that if there are anxieties like that they should be listened to and sedation used if required... correctly. (Peter)

The psychiatrist, David was prepared to admit that Joe's care and well being was not always in the foreground for decision making.

[Joe's care] was complicated by a lack of team communication by different medical teams with slightly different agendas erm and different opinions... The outcomes could have been improved if there was more direct communication with the different people involved...I think that things got diverted from that sort of the focus of erm the staff concerns about his behaviour, which is fair enough because I mean risks to the staff and the patient weren't always at heart all the time. (David)

The nurses commented on how they felt a decision had been made not to take Joe over to psycho-geriatric care. The nurses felt that this decision was inappropriate, and thought that the psychogeriatric team realised this but would not back down on their decision. Even when real harm had been caused to a member of staff, they made the decision to allocate a psychiatric nurse to Joe rather than move him to the psycho-geriatric unit. One could discuss why a pregnant nurse was assigned to Joe's

care under the circumstances, perhaps he was considered a light load as he was mobile. The devastating results of this episode caused the staff some concern, and also heightened the nurse's fear of caring for Joe. For the next two days Joe was heavily sedated, became immobile and communication with him was very difficult. He slept for the majority of the day, became dehydrated, and lost three kilograms in weight. The nurses were worried that he was at risk of pressure damage and chest infection. Finally, the psycho-geriatric doctors agreed to put Joe on the waiting list for the psycho-geriatric ward. This stage was underlined by much inter-professional communication. Peter talks about how he felt about the psycho-geriatric team:

...but they wouldn't listen erm I appreciate that some of what they were saying was that it's not a psychiatric illness you know dementia is the cause of his behaviour and they couldn't alter that but I don't think they had any right to say those things without an accurate assessment erm and I think they spent a lot of time just coming and going without actually doing anything. (Peter)

In an attempt to convey how difficult Joe's behaviour was the nurses chronicle every event which is either dangerous for them or Joe and his nursing notes read like a school report, with comments like "aggressive x5, resistive x10". The nurses now have a 24-hour a day psychiatric nurse 'special' to care for Joe. On the second day the psychiatric nurse 'special' walked out of the ward before completing his shift or documenting anything in the notes. The ward nurses stated that he was "unhappy with the situation". Another psychiatric nurse informed me that he walked off the shift because he was never relieved for a break. I interviewed this nurse about this situation.

Erm I have been in situations on a nine-hour shift where I've worked eight hours without having a break. I've been in situations where I constantly had to speak to the coordinator about getting medications supplied to me or having a meal break. (Heath)

It appears that having the 'special' in with Joe allowed the regular ward nurses to distance themselves from Joe's care. Often the agency nurses I spoke to said that they were left for long periods of time before anyone came to see if they were okay. I also experienced this, and while I felt marginalised, it occurred to me that this also helped to marginalise Joe. I talked to Julie the manager about this and she was concerned about the problems with bringing in "out of ward specials".

Julie: But I think that the coordinators should have supported the specials rather than Oh! I've got a special, he's safe I don't need to worry.

Researcher: Do you think that he might have become slightly marginalised?

Julie: Well that's my understanding of what happened, you know he didn't get continuity of care and that is dangerous, that is my understanding.

Heath, the agency psychiatric nurse, said he believed that although 'specials' from an agency can work well, in this case the communication was hampered between him and the staff. He explained this by suggesting the unqualified staff, whom 'specialled' Joe when the agency could not provide a qualified nurse did not communicate well, and that there was some stigma regarding mental health nurses and their patients.

What should be stressed here is that even with the 'special' nurse, Joe continued to be restrained for long periods of time. Most nurses claim that they would need to be able to keep an eye on a person for 24 hours if they were not going to restrain them. Here we see that such a measure was indeed unsuccessful in eliminating restraint use. Julie the manager has this to say of the marginalisation of Joe through the inclusion of 'specials':

Julie: Well it was you know, you know, it came to nearly a thousand dollars a day and I which, I mean, I don't mind keeping specials but as long as they're being used but I came up here one day and the coordinator did not have a clue what was going on because he [Joe] was being 'specialled'.

Researcher: I'm wondering to what extent you think the specials allowed the ward nurses to distance themselves from the care of this patient?

Julie: Well they did but I felt it was too much you know just the fact that every day there was a different coordinator and they didn't have a clue what was going on and they are it's a very busy ward and I understand what happens. I can understand where they're coming from, they would think there was just one less patient they had to worry about especially when you've got time restrictions... err they still have to concern themselves and they concerned themselves too little I think.

It appears that although engaging the 'special' was universally thought of as a benevolent act, it did not eliminate the use of restraints and allowed the ward staff to feel blameless for restraining Joe.

There were discourses between nurses over the appropriateness of the care they provided. The nurses were putting pressure on the medical doctors to 'do something' with Joe to make him manageable, and the medical doctors were putting pressure on the psycho-geriatric doctors to take over responsibility for Joe. Amber was aware of this process and called it the game of "Chinese whispers".

Several days after Joe punched the pregnant nurse the medical doctors considered putting Joe under a section in order that he could be kept in hospital involuntarily (see Medical Note 3 opposite). This also coincided with several attempts Joe made to leave the ward. I note the threatening nature of the quote in Medical Note 3, apparently using Joe's voluntary status as leverage to get rid of him.

The following day the psycho-geriatric registrar was contacted and she informed the doctor, who documented that there were no beds available, and that a Form One was inappropriate (Medical Note 4 above). She restated that Joe should have his levodopa dose reduced, as advised a week ago in a consultation. The following day, despite the previous day's thorough assessment by the registrar, the psycho-geriatric consultant came to meet Joe. He assessed the notes and said that Joe's behaviour had improved at times when his levodopa had been stopped, and worsened when it was restarted, and evidenced this with examples from the notes. I assessed the notes, and found it was equally possible, to prove the reverse situation was true. Despite this, Joe's levodopa dose was halved and eventually stopped. My observational notes from this time show that Joe hallucinated both on and off the levodopa. If the hallucinations were worse on the levodopa then the resulting immobility from its cessation caused additional problems. If immobile, Joe was no longer able to self care, and greatly resented any invasion of personal space occurring when the nurses tried to fulfil his self care deficits. The situation was certainly not black and white,

Medical note 3

Intermittent behaviour unmanageable on medical ward could psycho geriatric team transfer to their care; otherwise we will have no option but to use Form One.

Medical note 4

Behaviour has improved, more cooperative, still resistive but with less power however we will have to cope with this. Plan – continue olanzapine, please pursue N/H placement and we will support in the community as we have no beds and no bed is likely to come available in the foreseeable 7-10 days.

Nursing note 3

Pt grabbed locker and almost tipping it on to him had to be dragged away from it. Pt quiet in lounge room but resistant when required to come back to his room

as the psycho-geriatric doctors would have us believe. It would seem that objective science let Joe down rather badly.

One may ask, what was the reason for the psycho-geriatric consultant's rationalisation of Joe's condition. Had the reduced levodopa had the desired effect on Joe's cognition and behaviour then he would no longer be a problem from a psychiatric point of view. He may well have been worse off for the reasons pointed out above, but the medical staff could not argue that his mobility was the concern of the psycho-geriatricians. I discussed the difficulty in nursing Joe when he was immobile with the psycho-geriatric registrar, and she said at least if he were aggressive while he was immobile, he would be less capable of doing harm to anyone. She agreed that in this case not giving the levodopa was a form of chemical restraint. On this point she writes in the notes about Joe (Medical Note 4 p. 110). Here too, discourses are established as running counter to each other, on the one side keep him immobile and keep staff safe and on the other put staff at risk but maintain Joe's freedom. This manipulation of the choices silences an alternative discourse that might provide basic human rights to Joe, and maintain staff safety. Nurses would commonly say that this situation could not exist. However, at all times during my observation I used no restraints and I was never hurt. I have no special training in dealing with anger or violence. I would argue the alternative contingency is possible in practice, but was not possible within the discursive formation of the staff involved in Joe's care.

Nurses also make a dichotomy of chemical verses physical restraint as Amber shows:

Erm I think (pause) the first thing really you do is either tie them down physically or when they become agitated and aggressive chemically so they sleep. (Amber)

Amber's depiction of how you deal with agitated behaviour shows a striking lack of imagination in the care of agitated patients and it would appear that there are in fact only two interventions for agitation, physical or chemical restraint. The literature discussed in Chapter Three gives examples of many different interventions that could be employed in response to the type of behaviours Joe was displaying.

It is relevant now to turn to the assessments that the above decisions are based on and in so doing we will move onto the final two stages of Joe's hospitalisation, external intervention and de-problematisation. It is important to concentrate on the

practices of assessment at this stage, these are considered rational and objective. Nursing and medical students are educated to make assessments upon which decisions can be made. One of the ways of justifying restraints is by the assessment of the subject's behaviour. Although the notes detail objective assessments, they are not comprehensive and what is considered noteworthy is motivated, in this instance, by strong feelings about the inappropriateness of caring for Joe on a medical ward. Needless to say, if Joe shows cooperation in eating his breakfast but later threatens a nurse it is likely that what will be considered noteworthy will be the verbal threats not the cooperation. One could give many reasons for this, eating breakfast is not likely to have legal ramifications, but assault on a nurse may, or the most important thing for the next nurse caring for Joe is to be aware that he can be verbally aggressive not that he ate his breakfast. All these points may be valid, however, this necessarily gives the worst picture possible in the notes of Joe's behaviour. In addition the language used to show Joe's behaviour is quite shocking. For example words like "lashing out". A patient care assistant, who was in charge of Joe one shift, wrote the text in Nursing Note 3 p. 110. The language gets increasingly controlling at this point.

Another phase seems to take place when the regular nurse manager, Julie returns to work on the ward. The stage of external intervention is characterised by a cessation of the extraordinary measures in Joe's care and a certain amount of determination to "get to the bottom of the problems". This stage makes way for a deproblematization of Joe's behaviour and these stages are inseparable so will be dealt with next in Table 6.

Table 6

EXTERNAL INTERVENTION		
Behaviour	Practice	Discourse
Joe's behaviour remained unstable. Functionally dependent for many activities of daily living	16/03/00 Parkinsonian drugs ceased 20/03/00 Regular nurse manager returned, psychiatric nurse special ceased.	15/03/00 Confusion, irritability and attempting to hit staff still prominent
DEPROBLEMATISATION		
Behaviour	Practice	Discourse
Joe remained dependent on the nurses for maintaining activities of daily living, behaviour remains unstable however the peaks and troughs appear a little less marked. Less able to perform catastrophic demonstrations of anger because of his immobility in part due to the cessation of his levodopa	20/3/00 Onwards, decreased use of restraints, decreased violence towards staff, looked after by team members or agency but not as a special.	21/03/00 Once you've looked after him for a while and particularly since his mobility's not so good and he's kind of lost a bit of weight, become a bit frail. 21/03/00 He's not so bad, you get to know him

Julie, in the next quote comments on her disapproval of what had been happening in Joe's care in her absence.

I don't think the coordinators looked at the week as a whole or the patient as a whole they just thought you know there's a psych special and that's you know we've done our bit. So the last time it happened I came back on the Monday and nothing had been done again and I said to the coordinator I want you to ring up his team the psycho-geriatric team and I want them to come and review the need for a special and that's when [the special] it all stopped (Julie).

She felt that the 'special' had served its purpose; a thorough assessment of Joe's behaviour, but that his behaviour was now much more manageable. So overnight, Joe went from requiring a 'special' nurse to not requiring a 'special' nurse. No observations, in the notes or in my journal display a sudden change in Joe's behaviour. Over the admission he did seem less aggressive in addition to being less capable of catastrophic demonstrations of aggression due to the cessation of his levodopa. However, he was just as exhausting to care for in my observation times after the 'special' as before the 'special'. So while the 'special' was packaged as a benevolent intervention, again we see that it was more to control and contain Joe, not to fulfil the burden of care that he created. Joe still frequently tried to leave the ward and still became aggressive and resistive at times. However, there was a collective attitude change towards Joe's management.

Once the 'special' had stopped, and reams of notes could no longer be kept on his behaviour there were less negative reports of Joe's behaviour. Having only one nurse to care for Joe and four other patients meant that notation was limited. So, too, was the contact with Joe, and therefore, the chance for him to feel aggressive towards another person. One nurse commented that patients like him always take a month or so to 'settle'. She said that eventually the nurses got to know the patient, and the patient got to know the hospital, and in the end they all adapt. Amber shows some learning which helped her care for Joe in the following comment.

Nursing note 4

Good diet and fluid in-put, took medications, sitting in lounge, family visited today.

Medical note 5

No chloral hydrate last night, awake eating breakfast, resistive yesterday pm but no physical aggression, U & E normal continue care.

I mean I've noticed with him when he gets all stroppy and he has four people grab his arms that doesn't help him and myself I know that if you leave him alone and just say right Joe what are you doing and if you don't start pulling at him he reacts very differently, he calms down a lot and you don't get that violent outburst (Amber).

Joe was near the top of a steep decline when he was admitted, and by this stage he was dependent on the nurses for activities of daily living. Perhaps his cognition declined to the point that he no longer felt the insecurity of the insight he had originally had into his condition. However he still had moments of extreme clarity and insight even at this stage.

It is impossible to say why exactly the nurses began to care for Joe without a 'special' and reduced restraint but that is what happened over night. This was doubly notable as even during periods of being 'specialed' some of the nurses would claim to need to use restraints in addition to their presence. One explanation is that there was a realisation that the only way to dispose of the problem was to a nursing home. No nursing home would take him according to their previous accounts of his behaviour. However, with a different approach to his behaviour he could seem quite manageable. It is probably a combination of all these reasons that contributed to Joe's deproblematization.

Peter talked, about how these long staying patients become part of the ward community, and how that is beneficial to their care, as everyone knows their foibles. There was certainly a delay in Joe becoming part of the ward community, as he was 'specialed' by an agency nurse for almost a month. What is said of Joe's behaviour now becomes routine, such as in Nursing Note 4 (p. 113). The medical notes also echo this matter of fact tone in Medical Note 5 (p.113).

The master plan, for what would eventually happen to Joe, was decided on the ninth of February, two days after his admission, when the doctors asked the Aged Care Assessment Team to assess his suitability for nursing home placement. It was clear that an assessment based on his behaviour at that time would lead to the decision that he needed placement in a nursing home and this is what happened.

Case Study Two, Elsie

Background

Elsie's case study will be discussed in this section following the same format as Joe's case study giving, a description of the person, the clinical space, and the practices employed by the nurses as they relate to restraint use.

Elsie had been a busy person. Up to the age of eighty-three she was involved in bowls and the Women's League and had delivered meals on wheels for elderly people in her neighbourhood. Until she was seventy-nine she did the accounts for a small business. She was widowed at fifty after looking after her husband for ten years, who had severe depression. After his death Elsie began to travel and do things that were impossible for her before. Her daughter described her relationship with her mother as very close. Her daughter was devastated by the loss of her mother as the person she knew, the matriarch, and strong woman but with a kind and gentle nature.

Elsie had an advanced stage of dementia. She had very little verbal communication skill. She displayed scratching and picking behaviours, which had left her skin very badly damaged. She had been mobile before admission but did not seem interested in mobilising now. She did get up occasionally from the bed and on these occasions she generally needed to go to the toilet. She got up continually from the chair and these attempts seemed aimed at getting back to bed. She did not seem to have any interest in her world; she would eat very little (quarter of a banana a meal), she did not watch events happening in her environment, and she no longer seemed to recognise family or friends. She rarely tried to speak, but expressed a range of emotions through her eyes and gestures. Elsie's social graces were still intact and with guidance she could join in with her activities of daily living.

First Impression

The following passage is taken from my field notes. It presents the general picture of Elsie's abilities and habits. This passage introduces Elsie as a gentle person, whose manners, despite her lack of verbal skill, were still intact. Elsie's vocabulary consisted of, "Good morning, dear", "please" and "thank you" and rarely anything other than these words.

Elsie was a strikingly small lady who appeared extremely frail and underweight. She was asleep when I walked in the room and I sat by her bed. She must have noticed someone's presence in the room as she awoke and stared at me with alert eyes. I shook her hand

(mitten) and said hello, she replied “Hello dear” and continued a sentence of varying intonation but only one word, “dear, dear dear”, and so it went on for a couple of seconds. She left her mittened hand in mine but closed her eyes and burrowed into the pillow with her cheek. Although she appeared restful in the timing and depth of her breathing her mittened hand was never still as she rubbed and fidgeted with the skin on her arms and legs. The nurses made reference to her uncanny ability to ‘escape’ the posey and mittens simultaneously. They said with a hint of affection, “she’s a little devil that one”.

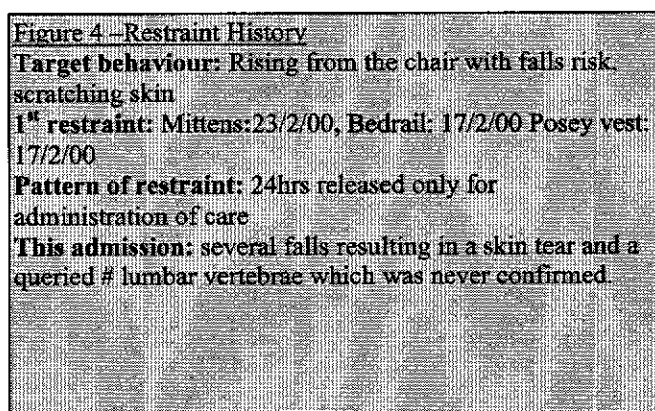
Clinical Details

Figure 3 presents Elsie’s clinical details. Again, the information has been corroborated with multiple data sources. Elsie contracted Methycillin Resistant Staphylococcus Aureus (MRSA) during her hospital stay. Overall, her hospitalisation was characterised by very little change in her physical condition.

Figure 3 – Clinical Details
 Admitted: 17/2/00 Discharged: 13/04/00 Case study start: 13/3/00
Admission diagnosis: Fall with resulting # pubic rami, for analgesia and mobilisation.
Age: 89 **Marital status:** *Widowed*
Residence: *Hostel*
Past medical history:
 Gastric Cancer resulting in partial gastrectomy 60 years previous, type two diabetes, and slow onset dementia.
Drug history:
 Allergic to haloperidol, iron tablet only admission medication
Psychiatric history:
 Six-year slow progressive memory loss. Five years ago persuaded to sell car due to worries about her safety, shortly after this her daughter thought she was still unsafe and encouraged her to move to sheltered accommodation. Four years ago forced to move to a dementia hostel as the sheltered housing were no longer able to cope with her. No history of other psychiatric illness. MMSE: unable to assess – did not answer questions
Functional status: Able to walk previous to admission, but dependent for all activities of daily living. On commencement of case study, chair/bed-fast, doubly incontinent when not regularly toileted, totally dependent on carers for activities of daily living.

Restraint History

Figure 4 presents Elsie's restraint history. Elsie had never before been an



inpatient, and had never been restrained, to her daughter's knowledge, before this admission. The hostel had not been using restraints, but had not been managing her picking and itching habit. Her skin was in poor condition on admission.

The Clinical Space

In this section Figure 8 (Appendix E) shows the clinical floor plan of the ward. Position one shows Elsie's position in the clinical space. It is clear that there was no attempt to make Elsie more visible from the nurses station. In fact, she was placed at the furthest point from the nurses' station. Much was said in the literature review of the effect the environment has on the use of restraint. The nurses seem to agree with the literature and are prepared to say that if they had the appropriate environment they would not need to use restraint. The environment is problematised quite extensively in this case and will be discussed at length in the section on problematisation.

Table 7 shows the roles and responsibilities of the participants in Elsie's case. These informants were Elsie's main carers and therefore made up a significant part of the clinical space.

Table 7

Pseudonym	Experience	Current role	Experience in current role
Alison	20 years	Nurse manager, partial clinical involvement	7 years
Jo	6 months	Graduate Nurse	3 months
Beth	10 years	Enrolled nurse	2 years
Wendy	xxxxxxxxxxxxxxxxxxx	Elsie's daughter	xxxxxxxxxxxxxxx

The Practices

Although Elsie generated less data to analyse, in a sense, that is as interesting with respect to what was not said. Again the practices as they relate to restraining Elsie will be described in chronological order. Once again there is no real time phase distinct from another but it aids descriptions to use the phases to present the case study. The first phase involved Elsie's entry into the clinical space and Table 8 (below) presents her behaviour and condition on the left hand side and the staff response on the right.

Table 8

ADMISSION BEHAVIOUR		
Behaviour	Practice	Discourse
Admitted 17/02/00 following a collapse of unknown origin, found to have a # pubic rami. Had severe skin abrasions from scratching on admission.	Admitted for pain management and mobilisation.	Unable to give any history Agitated

This stage is brief and soon moves into the stage of problematisation, which is the major stage of Elsie's admission. The meaning of the term problematisation as it relates to this study has been described on p.66. Table 9 presents an overview of this phase.

Table 9

PROBLEMATISATION		
Behaviour	Practice	Discourse
No great improvement seen. Continues to scratch skin on arms and legs. 20/02/00 First fall recorded. 07/03/00 MRSA +ive.	17/02/00, Doctors made decision not to treat Elsie with life prolonging measures. 23/02/00 First restraint used. 23/02/00. Mittens used to prevent scratching. 27/02/00 name down for rehabilitation ward. 08/03/00 transferred to rehabilitation ward. 14/03/00 Physiotherapist decides Elsie will always need assistance with mobility, therefore, needs nursing home rather than hostel.	Patient normally a wanderer Scratches constantly at her skin

The environment had some effect on how the nurses were able to care for Elsie. According to Jo this was very important in the following way:

The hospital's an unnatural environment and it sometimes can make people more uncomfortable and I guess more unstable...It's

not their home...I mean, if they come from a nursing home that they've been in for a long period of time or they've come from their home and it's new territory they're not aware of where things are, or where they should be, or their role. You know, their routine they interrupt, they might have a normal routine at the nursing home or at home, but the hospital routine is completely different for them, you know they get up at different times, they get meals at different times. Yes, exactly, they may have their chair at a different spot... I mean, they might get up out of a different side of the bed (Jo)

Alison the manager also makes comment on the environment.

Alison: unfortunately we'd probably be able to manage without restraint if we had a safe environment but we don't have a safe environment.

Researcher: What to you makes an environment safe?

Alison: Well I think we need some sort of device err either on the door or err a tagging device on the patient so that when they actually do go out you're at least aware because some of the patients are fine, are quite happy if they can just get up and wander around... There's a huge number of exits leading to car parks and roads and that's an issue.

Beth also seems to think the environment is important but is a little unclear about exactly why.

Beth: Yes and sometimes like people like Elsie, this isn't the right environment for them with dementia and all that... If she was on like, a dementia ward or, you know Alzheimer's they're designed for people like that...

Researcher: Yes. How do you think they design them? What is different about that environment?

Beth: Erm there's a lot of room in them like really wide walking corridors erm there's one lady who

Medical Note 6

Daughter believes that her mother would refuse any treatment if she could voice her own opinion and would choose to remain immobile therefore not for resuscitation not for medical interventions aimed at prolonging life...Mrs H looks comfortable sitting in chair but daughter feels that she would like to go back to bed. Daughter also expressed a wish for Mrs H to receive stronger analgesia i.e. morphine if necessary.

Nursing note 5

4/3/00 ...Able to participate in dressing and showering. 2 hourly toileting successful...
11/03/00 Max assistance with ADL's tried to help but still required max assistance.

Medical Note 7

27/02/00 Co-operating with ambulation D/W Physiotherapist I will put her name down for (rehabilitation ward) to get her back to independent ambulation.

09/03/00 Ambulates with 2 and frame, very strong guidance for direction needed. (Physiotherapist)

Nursing note 6

04/03/00 Pt is able to ambulate comfortably with frame and stand-by.

Nursing note 7

Continues to pick at skin tears continually

used to wear a helmet, they put a helmet on her and she used to walk around the ward.

Researcher: But you could have those on any ward couldn't you?

Beth: Yeah and just safety aspects or it you know nothing that's going to erm hurt them (pause) sharps bins and things like that.

In essence what the nurses seem to be saying is they're not sure what the right environment is but it's definitely not here. In my field notes I made mention of the chair in which Elsie was sitting. The chair's legs were adjustable to fit any height, however, her feet were not touching the ground, and the chair was about four inches too tall. During observations it occurred to me that it was the immediate environment that was of most concern to Elsie since she did not mobilise very far. What was important was that she was comfortable and happy in her immediate surroundings, not that she needed a totally different ward. While the participants acknowledge the effect the environment had on Elsie and her behaviour, they do not use their creativity to adapt the environment they have. In fact their manipulation of the environment appears to be in conflict with her comfort. For example, although she seemed to like to sleep a lot, they would place emphasis on her need for stimulation, sitting her in the chair in the corridor by the birdcage. Beth gives the reason given for this movement of Elsie to the corridor:

Beth: So erm the patient gets to see a bit more of the world not so they're stuck in their bed all the time even if it's just seeing another face or the birds in the cage or to hear different voices.

Researcher: And what was the need for that stimulation?

Beth: Oh err just so they don't become bored.

Beth and other nurses did not accept the view that Elsie had regressed and wanted to sleep a lot and certainly did not accept the view that it was her right to sleep if she wanted to. They saw Elsie's disinterest in her surroundings evidenced by her sleeping as a problem to be solved, a disinterest in a life that could be enhanced. Despite the ward's claims of individualised care the nurses did not feel that it was a normal progression of her condition to sleep for large periods of the day. The daughter on the other hand did not want to "get her going again". She expressed a strong feeling that her mother would not want to get going again if she had the

choice and thought the staff's choice to send her to rehabilitation was unethical. In a prolonged interview with Elsie's daughter she told me that she believed in euthanasia and that she thought it would be the only fair way to care for her mother. She said she had not told the doctors, who she said had become oppositional when she had suggested that it was a waste of time trying to rehabilitate Elsie. After this conversation with the daughter the doctor writes (see Medical Note 6 p. 119).

The fact that Elsie was receiving little simple analgesia made the suggestion of morphine seem inappropriate to the doctor who actually cancelled the order for morphine. There is a strikingly silent discourse on euthanasia here. I take no position on the ethics of euthanasia but it is interesting to note that whilst it is a valid and appropriate issue for discussion at Elsie's stage in life, it is not possible to discuss within the medical framework and certainly not without some tangible pathology to justify its discussion. The absence of this discourse, despite its high priority for the daughter, shows the way in which a position can be eliminated from a discourse. Following this, restraints are easier to justify because they are not as bad as the unspeakable, illegal and unethical practice of euthanasia. The doctors thought that the daughter was unethical in her view and, who is right is a difficult question. However, what is clear is that Elsie herself chose to sleep for about 90% of the day, but for much of that time had to sleep among the discomfort of a noisy corridor and an uncomfortable chair. Adaptations, such as a more comfortable chair were not beyond the scope of her current situation.

An interesting point on the assessment of Elsie was that although her behaviour was to a great extent homogenous for the whole admission, the opinions of the assessing nurses varied greatly according to the descriptions they gave and the excerpts in Nursing Note 5 (p. 119) from the documentation demonstrate this. The doctor on the surgical ward writes the third entry in Medical Note 7 (p. 119) putting a positive bent on Elsie's abilities. However, the physiotherapist on the rehabilitation ward writes the second entry in Medical Note 6 (p. 119). The nurses on the surgical ward had written, however, that Elsie could ambulate comfortably with a frame (Nursing Note 6 p. 119). Despite claims of comprehensive objective assessments, we can see that each member of the team has a very different opinion of Elsie's abilities. It is possible that her abilities fluctuated to that extent, but my observations led me to believe that her abilities were quite stable during hospitalisation, and that she presented with slow cognitive decline rather than dramatic fluctuation like Joe.

One explanation is that her abilities fluctuated depending on the skill of the assessor to initiate and interest Elsie in activities. I do not make these points to suggest that the unequal assessment of Elsie caused her to become restrained. The point here is that the disparity in the assessments may be a symptom of the extent to which Elsie is subject to the assessment competence of the nurse looking after her. The fact that some days she helps to wash herself, and some days she receives total care is evidence of her passive role in the interaction. As a passive recipient of health care, the nurses can do as they please with her and this includes sitting her out in her chair, tying her to the chair, and mittening her hands.

Only three times is there any mention of pain assessment in the nursing notes, although Elsie was admitted to hospital with a painful condition for pain management according to the doctors' notes. On the 20/02/00 the nurses note that Elsie appeared to be in pain when mobilising. The doctors suggest paracetamol and dyhydrocodine tartrate before mobilisation, but the nurse's report states that she refused oral analgesia. From the interview with Elsie's daughter I found out that she hated to take medications and would always avoid taking them if possible. Elsie's daughter tells the doctor on the 17/02/00 that her mother would refuse any treatment if she could, and would choose to remain immobile. On the strength of this conversation, at least in part, the doctor decides to make Elsie "not for resuscitation".

Elsie's daughter also doubts her mother's ability to remobilise and return to the hostel according to the doctors' notes. The doctors agree not to mobilise her if she is in pain, from which one can assume the daughters problem is with an aggressive plan to get her mother going again. However, the family are insistent that Elsie not be in pain and actually request that she be given morphine. Other nurses manage to administer analgesia to Elsie but do not record if this has any effect on her pain behaviours. Overall, the prescription of analgesia is sporadic and some days just a week after admission she receives no analgesia at all despite her painful condition.

On 22/03/00 the nurse's remark in the notes that Elsie seems to be in pain and she is reluctant to mobilise. On 3/4/00 the nurses say that she is "*in pain +++ when mobilising*". On the 25/03/00 the doctors note that she is reluctant to mobilise despite regular analgesia. It is possible that pain was contributing to Elsie's agitated behaviour. However, no attempt was made to investigate this and Elsie's pain is only referred to in terms of its effect on her mobilisation. Once again, Elsie is a passive recipient of the care system. When she does exhibit pain behaviour the

nurses express this as either a dementia trait or a personal habit from before the dementia. One nurse went to great lengths to explain to me that there was nothing that could be done about Elsie's scratching behaviour, as it was a throwback from her busy life before the dementia. This may be true, but I found that if Elsie's comfort level was improved, she very quickly went to sleep and there was little need for controlling her behaviour.

Assessment of Elsie's skin seems to preoccupy much of the nursing notation. The striking thing about these notes is the lack of imagination or problem solving associated with the assessment of Elsie's scratching behaviour. It is accepted in the notes that the scratching predates the admission to hospital, and perhaps this is the reason. Maybe it is assumed that everything has been done before. On admission the nurses describe Elsie's scratching as agitated behaviour and ask for a mild sedative for her. This shows the routine nature of chemical restraints in the emergency department. This behaviour was not new, as Elsie had broken skin and old wounds. The behaviour was not directly related to the admission problem, but despite that the nurses felt justified in treating it, writing the entry in Nursing Note 7 (p. 119).

The nurses suggest that Elsie is constipated, and this may cause the agitation and picking. However, when the constipation is resolved, the behaviour continues. The nurses treat the skin with emollients, as it is very dry, but it takes the suggestion from the daughter that it would be a good idea to cut Elsie's nails. Over the course of the admission, Elsie's skin did improve its integrity and Beth was keen to point this out to me. What is not mentioned is the cost at which her skin improved? The cost in question was the cost of her basic human right to freedom. Especially as the difference to the condition of her skin was marginal.

When people talked about restraints it usually provokes use of strong language such as 'conflict' 'inappropriate', 'prisoner like' or 'unfair' but when the nurses looking after Elsie talked about restraint it rarely provoked such language. The following extract from my interview with Beth showed a distinctly ambivalent feeling towards restraint in this case.

It was good and bad. The other thing, too, was that she couldn't really communicate clearly. Well I think it's sad in a way, but I think if her skin has to get better, then things have to be done.
(Beth)

Later on she adds that she actually seemed more settled with the restraints on but earlier had said in some ways it made her more agitated. Jo, when asked how restraints affected Elsie, said she was not walked as much, she then said:

She didn't seem very frustrated with them she was just, it kept her occupied it kept her hands occupied picking at the mittens or playing with the mittens...but erm we had to take them off quite a bit and they were drying her hands out but I don't think psychologically they affected her as much as the fact her hands were dry. (Jo)

A short while before Elsie was discharged to the nursing home there was a stage of deproblematization. This stage was less marked than with Joe as she was less fervently problematized in the first place. In fact Elsie's case seemed to be characterized by a lack of discourse. Nevertheless there was a feeling that if rehabilitation had failed they were less justified in their attempts to stimulate her. As a result Elsie was left in bed for longer periods where she was less of a problem to the staff for a number of reasons. She attempted to get up less often from the bed as compared to the chair. At this stage her skin had improved and she was scratching less often.

Table 10

DEPROBLEMATISATION		
Behaviour	Practices	Discourse
No significant improvement, no change to picking or scratching behaviour.	11/04/00 On wait list for four nursing homes. 13/04/00 Discharged to Nursing Home	Pleasantly demented Await Nursing home There wasn't much we could do, she didn't respond.

Elsie did not seem to provoke the emotive response as the other case studies did and this was an observation I reflected on in my diary. Elsie was a passive recipient of all the care the nurses chose to subject her to. She rarely resisted care, and even when she became a little difficult in the shower it was not difficult to encourage her to comply. Elsie posed no threat to the smooth running of the ward. When Elsie managed to escape the posey it did not cause a sensation. Despite the fact that the rehabilitation ward uses fewer restraints than other wards in the hospital, and, therefore, restraints are more of an exception, their use with Elsie did not seem exceptional.

It may also be pertinent that despite her advanced state of cognitive decline, and her severely limited language skills, she was perceived as worthy of rehabilitation on a specialised ward. Joe and Ted (the following case-study) both suffered catastrophic effects on their mobility during their stays and did not receive physiotherapy. On a cognitive level, Joe had a greater potential for improvement if one considers his cognitive level alone. However, receiving rehabilitation or not, Elsie still got restrained. The difference was that there was no chance that Joe would be accepted on the rehabilitation ward –there was no way he would get through the screening, so the staff had to concentrate their efforts to get him transferred elsewhere. In Joe's case this was the failed attempt to get him under psycho-geriatric care, Elsie went to rehabilitation and eventually to a nursing home. I would argue that while these decisions to move patients apparently are made on pragmatic grounds such as 'probability of improvement' the real decision may be 'probability of compliance' or 'probability of being able to make that patient someone else's problem'.

As with all the cases studied an early problematisation of discharge destination is present. What the daughter wishes is that Elsie dies and does not go elsewhere, but the medical staff can not see any immediate prospect of this so start to make plans for the future. The physiotherapist decides on the 15/03/00 that she believes Elsie will not walk again safely on her own, and this rules out the possibility of going back to the hostel. So quietly, and without much interdisciplinary discussion, the daughter with the social worker's help, choose a selection of nursing homes. Two days after the nursing home is chosen Elsie is discharged to it. This does not cause much discussion or debate, she just moves out of the ward, still with mittens and posey in place. Two days after the discharge I returned to the ward to interview the manager and few of the nurses remembered Elsie. She had not left her mark. She had not been exceptional in any way.

Case Study Three, Ted

Background

Ted's is the final case study for which I will present a case description and commentary. Again the description will focus on the person, the clinical space, and the practices used to care for Ted.

Ted had a short psychiatric history; for the last two years he had experienced hallucinations and paranoia, and had previously been admitted to the study hospital under a section because of these problems. Ted had been discharged back to his home following this previous episode but his daughter had been worried about him. The following is a passage from my observations:

Ted was a very easy person to get on with. He liked to talk, to tell you about his life and his achievements. Ted, unlike Joe was easily distracted from his hallucinations. He responded well to having company and would tell me how lonely he got at times. He liked to draw and did a couple of sketches for me. Ted had a daughter who would grow exasperated with his repeated worries about his money and house. He felt threatened, and had frequent paranoid ideas about theft of his belongings and money. These paranoid ideas had been apparent when Ted first presented at the hospital with an altered mental state a year ago. He responded well to validation of his fears and distraction during these paranoid episodes. At times the validation and distraction could take thirty minutes but at other times he would respond more quickly.

First Impression

This passage demonstrates the problems communicating with Ted because of his hallucinations and his severe hearing difficulty. It also introduces some of Ted's agitated behaviours which feature heavily in the nursing assessments discussed later.

Ted's room was half way down the corridor. There was classical music coming from the room but inside he seemed unaware of it. It was a single room; he was sitting in his chair, straining forwards against the vest restraint. I noticed he had very swollen ankles and he'd kicked one of his slippers off. The other was digging into his oedematous foot. He barely seemed to acknowledge my presence in the room until I shook his hand. It became obvious he was hard of hearing and the medical notes confirmed this... He asked me if I was a long way from home and I thought he might be referring to my English accent (he sounded English too). I explained who I was and where I was from in as simple terms as I could but he seemed to loose attention and proceeded to use his slipper, which he took off his foot, as a telephone to talk to someone in an authoritative manner. He struck me as someone who'd had responsibility.

Around him on the floor were the complete set of buttons, which he'd pulled off his pyjamas and scraps of his all in one pad that he had pulled apart. I touched his hand and said his name – he looked at me and said "You've got spots all over your face and you've taken all my money".

Compounding Ted's confusion was his poor hearing and the fact that his hearing aid had been lost.

Clinical Details

Figure 5 presents Ted's clinical details. The information was collected from multiple data sources and corroborated for discrepancies so that the most accurate information is displayed here. Ted is of English decent, but had lived in Australia since the Second World War. He'd become a managing director of a large dairy farm and enjoyed a good income and life style according to his daughter.

His daughter said he had

enjoyed and outlived two happy marriages. His second wife died four years ago.

My contact with Ted led me to believe he was a reasonable man who responded to explanation when he could hear it. He was however impulsive and forgetful, and therefore, needed explanations about every ten minutes. He became agitated when left alone and expressed loneliness several times to me when I went to see him. He had been aggressive in the first week of admission but all I saw of him was mild manners with the most assertive behaviour directed to the physiotherapist when she was trying to mobilise him. He simply refused therapy and resisted all attempts at passive movement. It later transpired that he was probably in a considerable amount

Figure 5 Clinical Details	
Admitted:	3/4/00
Discharged:	16/05/00
Case study start:	5/5/00
Admission diagnosis:	Confusion and Aggression no obvious cause for investigation.
Age:	88
Marital status:	Widowed x2
Residence:	Hostel
Past medical history:	Ischaemic heart disease, angina, atrial fibrillation, deafness in left ear, rectal carcinoma (excised one year ago), Chronic oosteoarthritis particularly affecting his knees
Drug history:	Haloperidol, 0.5 mg bd Diclofenac 50mg bd Frusemide 40mg bd Ramipril 5mg od Cloxy1 and senna x2 nocte (Olanzapine ceased the day before)
Psychiatric history:	Confusion post op 2 years ago. Admitted under section one year ago due to paranoia and unsafe behaviour recently placed in hostel. MMSE: unable to assess – hearing difficulty.
Functional status:	Able to walk on admission, mainly self-caring but recent decline occasionally incontinent of urine. On commencement of case study, chair-fast, doubly incontinent when not regularly toileted, totally dependent on nurses for activities of daily living.

of pain at this time. He appeared to find it very difficult to express his needs, and it was a very complicated process of trial and error to find out what was impacting on his agitation. His moods changed from day to day having good and bad days. The most striking thing about Ted for me was the speed with which he had declined since admission as seen in the section on functional status Figure 5.

Restraint History

Figure 6 gives a short overview of Ted's restraint history. Ted had some

Figure 6 – Restraint history
Target behaviour: Initially aggression but falls risk and agitation after transfer to the ward.
1st restraint: Chemical: 3/4/00 Physical: Bedrail 3/4/00 Poscy vest 9/4/00
Pattern of restraint: 24hrs released only for administration of care until 5/5/00 several attempts made to rationalise after this, longer periods of restraint free on commencement of case study
This admission: Admitted due to aggression and altered mental state. Treated for a urinary tract infection and altered mental state. No investigations into slow irregular heart beat undertaken on daughters request. Was given atropine in ED but it was documented that this measure would not be undertaken again as the daughter did not want any measures to prolong his life. Suffered drug induced Parkinsonism, contractures and decline in muscle strength during hospitalisation.

experience of restraint in several previous admissions. The first time was during an anaesthetic induced confusion, post operatively and was for a very short period about two year ago. Subsequent to this he was detained in hospital under a section one, involuntary stay, in response to paranoid behaviour, such as packing furniture into his car and driving to the police

station to tell the police that he had the suspects in his car. The medical notes indicated he felt aggrieved about his involuntary status, but he was cooperative and the section was not renewed the following day. He was discharged with psychiatric nurse support. Ted's cognitive state decreased over the next year.

The Clinical Space

Figure 9 (Appendix E) shows the clinical space in which Ted was nursed. It shows the exit from the ward into the main lift area, this is irrelevant to Ted's case as he was not ambulant over this distance. P 1 shows Ted's first position on the ward on admission. Despite the fact that Ted was brought in with an acute confusional state, he was placed half way down the ward, away from the nurses' station. P 2 represents an attempt to move Ted into a four-bedded bay. This move failed as Ted was reported to be too disturbing to the other patients. Later, he was moved into the observation ward next to the nurses' station. Despite being called the observation ward and being in close proximity to the nurses' station, it was not actually visible from anywhere on the ward. Position 3 would, however, be more audible from the central area of the ward. This section is designed to introduce the clinical details of the space in which Ted was cared for. During Ted's admission we can see that the nurses tried to use the clinical space to best care for Ted.

Table 11 presents the details and professional roles of the participants in Ted's case.

Table 11

Pseudonym	Experience	Current role	Experience in current role
Lisa	4 years	Graduate nurse (New Zealand)	6 months
Michelle	9 months	Graduate nurse	5 months
Sue	13 years	Nurse manager. Not clinically based	5 years
Ben	5 years	Medical Registrar (UK)	5 months
Celeste	9 months	Graduate nurse	5 months

Michelle talked about Ted's move into a four-bedded bay.

I don't think he had much idea of what was going on around him anyway. (Michelle)

And Lisa:

Yes and also things like moving him back into a four bedded bay if it's appropriate because he's a lot calmer than when he came in...there's more chance of somebody to go into a four bedded room constantly than a single room (Lisa).

And Celeste.

Celeste: Erm I wouldn't I don't like seeing them something that gets me is seeing them in their rooms by themselves. Alone and restrained and just with a table in front of them.

Researcher: But there's not dayroom on this ward, a communal place for him to sit...

Celeste: No but perhaps that's an idea (laughs).

Sue the nurse manager gives us a 'classic example' of when the environment impacts on a patient's behaviour.

...I was doing an agency shift a couple of years ago at another teaching hospital and this is a classic example I was 'specialing' a man with two chest drains and I said 'would you like a cup of tea' and he said 'I'm not having anything until I'm out of this prison' so I thought well I'm 'specialing' him so I'll take the restraint off so I did and he drank his tea and just slept quietly for the remainder of the shift. (Sue)

The above reference to the nurse's discourse demonstrates their awareness of the impact of the environment on patient care. They had tried individualised music selection (the classical music I heard in my first encounter with Ted. The music, however, was ineffective because his hearing aid had been lost and he could not hear it.

The Practices

As with the previous two case studies, Ted's care seemed to follow a series of phases, which although are not distinct in space and time, are evident and predominant at certain times. Again the first of these stages involves Ted's entry into the clinical space and is presented in Table 12.

Table 12

ADMISSION BEHAVIOUR		
Behaviour	Practice	Discourse
Admitted 04/04/00.	Given haloperidol 10mg	Aggressive and a danger to himself
Aggressive towards staff in emergency department	intravenously in three doses	
Temp 37.1	Given Midazolam and settled	
Remained agitated	Catheterised	
Self-removal of catheter		
balloon intact with trauma.		

As with the previous two case studies the next stage is characterised by some maladaptive behaviour that is not easily controlled or solved. This phase is presented in Table 13.

Table 13

MALADAPTIVE BEHAVIOUR		
Behaviour	Practice	Discourse
05/04/00 found on floor by bed – required 2 sutures to head. 08/04/00 becomes unwell not eating or drinking pyrexial, hallucinating, and continuing to pose a falls risk	Restrained with bedrails. Referred to PG team. 06/04/00 decided not to treat UTI “in line with NFR status”. 07/04/00 reviewed by PG team and advised to treat organic cause for confusion. 09/04/00 Restrained with posey vest.	Delirious

Following the realisation that the behaviours are not going away, there comes a period of intense problematisation of the person and the practices used to care for Ted. The phase of problematisation is characterised in Table 14.

Table 14

PROBLEMATISATION		
Behaviour	Practice	Discourse
Heightening of agitated behaviours, 09/04/00, Physically much better apyrexial and eating and drinking again Begins to rip buttons off pyjamas and shredding incontinence pad 15/4/00 Ted fell despite restraint – no injuries noted 28/4/00 Ted falls again after no restraint trial – no injuries. 03/05/00 severe Parkinsonian syndrome evident	Nurses not giving haloperidol due to worries about sleep apnoea 11/04/00 daughter agrees to nursing home care. Nurses get a nursing assistant to help with care. Seen by ACAT who advised reassessment by PG team. 13/04/00 hands mittened in response to ripping up all in one pad. 18/04/00 increased haloperidol despite reports of decreased mobility and request for physiotherapist. 21/04/00 further increased haloperidol. 29/04/00 further increased haloperidol. 28/04/00 Dr’s request trial without posey haloperidol dose halved.	Calling out Very demanding Spontaneous unpredictable Unsettled

The nurses based their judgments of appropriate treatment upon assessments. There are two aspects important to the assessment of patients for a Foucault-influenced study. First, what staff chose to assess and second, how they did the assessing. What we choose to assess and comment on is by no means all that we could assess and the major points of assessment can be seen as contingencies. They

may be based in part, on nursing research, or tradition, or personal preference that may appear logical and obvious, but serve a very definite social function.

In the nursing notes the major points of assessment are functional abilities, including ability to communicate, continence, and other activities of daily living, state of consciousness or mental state including, agitated to drowsy, asleep or awake, aggression or hallucinations, mobility including wanted and unwanted movement, observations of vital signs such as blood pressure or temperature and amount of food and fluid intake. If we now look at the details of the assessments, rather than their 'gist', we can make some points of interest.

From admission to the ward the nurses describe Ted's level of functional ability as "requiring full assistance and [incontinence] pad and pants". Despite documentation in the medical notes that Ted was only occasionally incontinent of urine two days ago before admission no mention of this is made in the nursing notes which focus very much on the here and now. In sixteen out of 44 day entries written, mention is made of Ted's incontinence such as "incontinent this morning" or "PU in bed". The nurses seem to use continence as a criterion for assessing Ted's global state of confusion along with; compliance with medication; trying to climb out of the bed or rise from the chair; and how much 'sense' he is talking (See Nursing Note 8 p. 133). The nurse could have said that Ted's communication was difficult to understand but she chose to say that he was talking nonsense. One could argue that this difference is semantic only, but nurses' abilities to decipher what patients with communication difficulties are saying are undoubtedly varied. The imaginary line between sense and nonsense, which this registered nurse believes Ted had crossed, is not as black and white as it appears in Nursing Note 8 (p. 133). I argue the use of this discourse has a powerful effect on how Ted was perceived, and therefore treated. It certainly gives a clear indication of how this nurse perceived him.

The nurses also mention incontinence whilst under chemical and physical restraints, including mittens and posey vest, which would make continence impossible for any individual (see Nursing Note 8 opposite). The nurses at no time refer to the pressure on their time or any other reason why Ted was not aided to go to the toilet regularly. During observations when I had the luxury of time, I found it was indeed possible to assist Ted every four hours and maintain full continence. Not once was Ted's incontinence or need for the toilet described as a cause for Ted's agitation in the nursing notes, but it is usually expressed as a symptom of his confusion. The nurses also make frequent mention of Ted's ripping his incontinence pad up as a symptom of confusion (see Nursing note 9 opposite).

Nursing note 8

Restless this am ripping all in one +++ hard table positioned in front of chair, which seems to be effective. Posey remains in situ and observed frequently. Very confused this PM. Calling out "fire" (no fire in the room) and tipping cups 2 of h₂O on floor. Haloperidol given as charted. Incont of urine in all in one. Sat out of bed with restraints from 10 00 to 12 00 fed lunch and put back to bed at 13 00 talking nonsense

Nursing note 9

Posey restraint in situ due to pt restlessness (pt trying to get out of chair) and removing all clothes and nappy. Tolerating small d&f. BO checked every 2/24 as per protocol and PAC given, all in one changed x2 due to pt pulling nappy apart continually talking and pulling off clothes and nappy since 1630 hrs given 2 mg haloperidol at 1930 at time of report sleeping comfortably. EN

Nursing note 10

Pt restless this shift obs remain stable full assist with ADL's haloperidol given as charted. Pt woke up panicking T 37 at 0130 unable to measure BP and out-put as pt was very shaky. Pt looked confused. Paracetamol and haloperidol given as per chart. RN Pt very erratic trying to climb out of bed. Medication given as per chart no effect. Dr notified and interim order of larger dose haloperidol given. Pt moved to nurse's office for safe nursing.

Nursing note 11

Pt went back to bed after sitting out of bed. Reg checks with posey. After back wash pt settled and went to sleep at 1900hrs EN.

Another striking thing about the discourses which the above sections underline is the paternal linguistic style using words like 'put back to bed', 'restless', 'settled', 'fed lunch'. In all these examples the subject is objectified and has things 'done to him'. This linguistic style has the effect of dehumanising Ted and rendering him personality-less. At least it seems to give the impression of a baby-like approach and many nurses talked of him affectionately as "poor Ted" in the tone one might talk of a baby. During an interview Michelle makes mention of this while talking about the use of restraints:

Michelle: ...I think everyone's torn between right and wrong.

Researcher: Yes that must be quite stressful?

Michelle: Yes I mean it's all sort of stressful really, especially when you start finding out things about their history like their lives...Then it makes it more difficult...So it just sort of gives you new values like.

The doctors use a professional discourse when assessing Ted and name his agitated hand behaviour, 'picking'. On no occasion during observation did Ted display this behaviour at times of restraint free care. Ted's so called 'picking' behaviour involved exploration of anything around his waist or torso. While 'picking' one time at the start of an observation I asked him what he was doing and he replied: "getting this off. I have to get this off". Ted showed no signs of purposeless picking or pill rolling behaviour. On all occasions during observation Ted's pad ripping appeared to be a planned attempt to release himself from the restraint. Likewise, his habit of ripping the buttons off his pyjamas was a visible sign of agitation, which reinforced the need for restraint but could also be perceived as a rational, if impulsive, reaction to restraint. Michelle agreed with my observation and makes specific mention of this ambiguous qualification of Ted's confusion:

With his care I think like he's quite... like he pulls and pulls it that he err gets quite agitated that it's on [vest restraint] and I have heard him say sometimes that it's really tight. (Michelle)

On admission to the ward the nurses use the term 'settled' to describe Ted's state of consciousness. Ted's state of consciousness is rarely referred to without mention of the administration of haloperidol (Nursing Note 10 p. 133). In an interview, Lisa makes mention of this dependence on medication in the treatment of agitation noting that daily needs may cause Ted to be agitated but the agitation is then treated with haloperidol (see Nursing Note 10 p. 133).

Researcher: Do you think he gets out of the chair as a habit or for a reason?

Lisa: It's hard to say but probably boredom...And he does want to move he might want to go to the toilet, he might be in pain, there's a lot of things and it's hard to gauge when somebody can't communicate or they're confused... And then there's the other aspect if they give him haloperidol for agitation and it may well not be agitation it may just be a pure daily need that we do without thinking because it's subconscious... I guess it's a process of elimination...Erm moving them round, pain relief, toileting, food...

Infrequently nurses refer to care that they have administered such as back washing and re-positioning and the success this has on 'settling' Ted (see Nursing Note 11 p. 133). Despite this success the majority of nurses continue to describe Ted's agitation in relation to the administration of haloperidol. Once more we can observe this false dichotomy of discourses that are so powerful in silencing other discourses as a result, the nurses can think of no alternatives to caring for Ted, other than to use a 'special'.

During the interviews, the nurses consistently make note of the un-predictability of assessing Ted. Here Celeste makes this point:

... it's because of his dementia his behaviour changes a lot like I didn't want to posey him this morning because he was quite calm and and sort of contented but then a little while later he slipped from his chair so that sort of I though well maybe I should have poseyed him all the whole morning. (Celeste)

Medical Note 8

ATSP re inc temp

36-38 in 3 hours, tachycardic, normotensive O/E alert remains confused – able to answer questions but disorientated. Denies chest pain or other. Catheter preformed, urine looks clear. UA –ive wbc's nitrites. D/w nurse – disruptive +++ over night. Sleeps all day then disruptive over night...Alert but not OTPP. Note ripping incontinence pad. Restless overnight, still requires posey.

Medical Note 9

Mr P is delirious. He has a variable conscious state from being alert and responsive to drowsy and unaware of his surroundings. He has picking behaviours and is reacting to unseen stimuli. He is febrile, tachycardic and probably has a UTI.

Nursing note 12

Pt restless and attempting to get up. Pt had a fall yesterday and I feel he needs restraint for own safety. Remains confused trying to climb out of bed several times. Pt's condition unchanged. Requiring two to transfer but very heavy to lift. Pt not putting much weight on feet when standing.

Medical note 10

Nursing staff report incr stiffness making transfer difficult. +ive glabella tap parkinsonism evident

Lisa also makes reference to his spontaneity:

I guess that one of the hard things about the assessment is that he can be very spontaneous and unpredictable so it's not always easy to know how long his lucid period will last so that's difficult even if you can get him calm it's no guarantee. (Lisa)

The doctor's assessment concentrates on the objective or measurable aspects of Ted's case for example in Medical Note 8 (p. 135). When the medical doctors make mention of Ted's state of consciousness they frequently: refer to discussions with the nurses; use the professional discourse of not orientated to person place or time; or when they are forced by the new policy to evaluate the need for restraint each day, they resort to mentioning Ted's habit of ripping his incontinence pad as in the second entry in Medical Note 8 (p. 135).

The psycho-geriatric team (Medical Note 9 p. 135) makes use of the term "delirious" to describe Ted's behaviour, and use his 'picking' behaviour as a qualification of this. There are several effects of naming Ted's behaviour in this way. It reduces Ted's behaviour to the irrational and meaningless, caused by physiological disorder. In this way any discourse, which assumes that the behaviour is a reaction to the restraint, the most rational reason for the behaviour, is effectively silenced. Here we see the reduction of Ted's person to a brain disorder despite the fact that this does not help the treatment in any way. In fact, this might be to Ted's detriment.

Ted's mobility is never mentioned in the nursing notes until it causes a problem that needs some nursing management. There are two types of problem the nurses have with Ted's mobility (see Nursing Note 12 p. 135). The first is his ability to stand and his high risk of falling, and the second develops as his inability to stand increases and the nurses find they can no longer easily administer essential nursing care. These diverging ends of the mobility problem are characterised in the quotations from the nursing notes and the fourth from the medical notes in Nursing Note 12 (p. 135).

Ted's mobility is one of the criteria used in the aged care assessment team's assessment of whether he can go back to his former residence. It is interesting to note the person most concerned with mobility, the physiotherapist, sees Ted on 26/04/00 and says he has not made any improvements re mobility in the last two weeks, his confusion has probably worsened, he is awaiting nursing home placement and the plan is to discharge from physiotherapy. The physiotherapist makes her assessment of Ted's mobility on whether improvement has taken place. In this assessment it is not assumed or even considered that no improvement has occurred because Ted has been restrained, or because she has had no input with him, or that the physiotherapy resource is spread too thinly to provide physiotherapy to meet

Ted's needs. Ted's decline in physical function is consistently used to further marginalise him from the physiotherapy resource. It is true that we live in an economic world and services have to be rationalised, however, we should do this in the knowledge of the effect it has on restraint use. If we were to apply the participant's own dichotomous argument and argue that either Ted gets physiotherapy, or he will have his human rights infringing with restraints, we may not be so keen to prioritise Ted out of the resource. As the physiotherapist sees no improvement as a criterion for her dis-involvement in addition to level of confusion, she must see her role as exclusively aimed towards recovery. This delineation of her role successfully silences the importance of preventing decline. The other aspect of her assessment is Ted's discharge destination of nursing home. This underlines the generally accepted assumption that in an economic world priority must be assigned and what happens here as a result of his discharge destination is that Ted is given a low priority for the resource of physiotherapy.

One immediately encounters problems when trying to say anything objective about restraints and this emphasises the complex nature of the practice. The most important aim of this section is to present a description of the meaning of restraints to the people who use them and to describe how they are used or justified. Lisa has some strong feelings about using restraints that she shares with me after I ask her how important restraint reduction is:

Oh I think it's huge I mean in my practice I would prefer not to use patient restraint because I think it adds to their confusion and aggression especially if they've been used a bit before. And it's a way of modifying our patients so they remain safe but it's not it doesn't seem natural because they've already got some degree of neurological deficit. (Lisa)

She goes on to justify, however, that restraints are only used on her ward because of a lack of time. Later she adds on the subject of restraints the discourse of economy of time.

I think really that there are a lot of nurses who would really rather not use restraints to be honest often we'll say oh I hate doing this to people, I find it really over powering to do that and it's almost like going back to like corporal punishment you know going back to something so ancient that erm...(Lisa)

Celeste also says about restraints:

To me even though I'm a grad nurse I feel that it's very like sort of prisoner like... and because it's our fault that we don't have the staff resources we don't have, we've got staff shortages so we have to we have to erm use restraint but we shouldn't I don't really believe in them myself because it's quite unkind. (Celeste)

Celeste makes an interesting point about the dispersed responsibility of restraints:

Researcher: and who is responsibility is it to reduce restraint?

Celeste: Probably the Doctors and Nurses because doctors are the ones that order them but we decide to. I suppose we assess them.

Celeste compares Ted to another patient with more cognitive function:

She was frustrated I think because she didn't know why she was poseyed. Ted's a bit more, sometimes he doesn't even know the posey's on. (Celeste)

This point of view is in direct conflict with my observations which document Ted saying, in response to restraint, "Please don't put those on they're a devil to get off, please don't, I don't need those, please don't I'm breathing up to my eyeballs".

Finally Ted's care goes through a phase of deproblemtisation, where perhaps, the practices have to be seen to be effective so all improvement has to be highlighted.

This phase is overviewed in Table 15.

Table 15

DEPROBLEMATISATION		
Behaviour	Practice	Discourse
Continues agitated behaviours	15/05/00 seen by consultant who states no complaints from nursing staff and that a Nursing home has accepted him and has a bed ready. Daughter against this decision but is reminded that she has signed hospital policy that he be place in the first nursing home on the list with a bed. 16/05/00 Ted discharged to Nursing home	Awaiting nursing home

This stage does not go on for long as Ted is placed in a nursing home the day after his daughter selected one. As seen in Table 15, there is some resistance to the placement from Ted's daughter, but the social worker constitutes herself the subject of the hospital policy, and informs her that once a nursing home is selected, Ted can be moved at the earliest opportunity. Ted moves to the nursing home without any consultation on his part.

Summary

In this chapter I have presented the discourses involved with the practice of restraint as they occurred in the three case studies. More importantly, we have seen the ways in which the subjects were portrayed, both in notation and in verbal communication, as people so diminished that even their behaviour that could be understood as rational is deemed to be irrational. The full significance of these discourses will be explained in Chapter Seven. Using the heading “constituting the person as unable to self govern”.

We have also seen the problematisation of the physical environment by the participants. This discourse contributes to restraint use by forming the notion of an ideal environment distant from the one they practice restraint in. In Chapter Seven I will discuss how this discourse contributes to the implausibility of trying interventions other than restraint. This discourse will be discussed under the heading “constituting an appropriate elsewhere”.

In the three cases, debates over the ‘correct’ treatment are evident. Through this discourse we can see the dichotomy established by the participants between biomedical and psychosocial approaches to caring. This discourse contributes to restraint use by introducing the notion that there was an ideal treatment for the subjects. It was generally conceived that this treatment should be highly skilled and, thus, obvious and basic solutions to the care of these three subjects were marginalised. I discuss this discourse as “constituting an appropriate treatment” and discuss its function in Chapter Seven.

The discourse discussed under the heading “Constituting an appropriate duty of care” will deal with the participant’s establishment of their powerlessness in reducing restraints as they establish themselves as subjects of the profession, of ethics and of management.

Finally, we have seen evidence that the subjects were marginalised in several different ways and how this indirectly led to continued restraint.

The overall purpose of the next chapter is to describe the functions of these five discourses as a discursive formation, and expand on how it contributes to restraint use. In this way we will come to understand why restraint use is practiced in spite of its disadvantages and nurses knowledge of alternative interventions.

CHAPTER SEVEN

THE DISCURSIVE FORMATION

*I shall be telling this with a sigh,
Somewhere ages and ages hence,
Two roads diverged in a wood, and I-
I took the one less travelled by,
And that has made all the difference.
Robert Frost 1874-1963*

In Chapter Six I have presented case studies of, Joe, Elsie and Ted and demonstrated the discourses that surrounded the practice of restraint. I will now delineate five discourses of restraint and show how they are embedded in a discursive formation. I will then explain how this discursive formation sustains the practice of restraint. Each of the three subjects is distinct in as much as Joe, Elsie and Ted are individuals, but there are many similarities in the way the nurses delivered their care. The common factor was the use of restraint. Therefore, I shall describe how the discursive formation I have identified can be considered more or less strategic, in the Foucauldian sense.

Dichotomous Discourse on the Humane

The discursive formation that I shall describe is that I have come to regard as the ‘dichotomous discourse on the humane’. I will explicate five discernable discourses within this discursive formation, but before I do, some preliminary remarks about the nature of the task that I undertake here. As always, I start from an arbitrary place in Foucauldian discourse.

We need to constantly probe the way in which views about patients’ behaviour of any kind are constructed. Foucault refers to this never ending vigilance, thus:

“My point is not that everything is bad but that everything is dangerous, which is not exactly the same as bad. If everything is dangerous, then we always have something to do. So my position leads not to apathy but to a hyper and pessimistic activism. I think that the ethico-political choice we have to make everyday is to determine which is the main danger. (Foucault, 1984/86 p. 262)

That said, this section will present the discursive formation, I have identified by breaking it down into sections. These sections aid the discussion of the different permutations of the discursive formation. I give examples of the discourses that

follow by referring back to Chapter Six to support of my arguments. Many of the examples could fit into multiple sections of more than one of the discourses. This highlights again, how complex the practice of restraint is, and how engrained it has become in everyday language that seeks to justify and maintain its long survival as a technique of care. The first discourse is “constituting the person as unable to self govern”. An explanation of my specific meaning of the word ‘constituting’ can be found on p. 72.

I – Constituting the person as unable to ‘self govern’

I start with a discussion of this discourse, as it was the most universally and extensively called upon in the three case studies. The other discourses in the framework were used to differing degrees and will be presented in no particular order. Some discourses have moulded and created meaning that has gained the status and currency of ‘truth’. One powerful way of legitimising restraint was to establish certain truths about the individuals seen as needing restraint. These truths rule out the appropriateness of other modes of care or constitute extreme behaviour that call for extreme intervention; the participants had a range of ways of establishing these truths. One potent means was to describe the behaviour of the subject in isolation from the context in which it took place.

For Joe, this involved presenting in full and graphic detail the nature of his behaviour as exemplified in Chapter Six, but ignoring the possibility that, to some extent, restraint use reinforced these behaviours. In Joe’s case, words such as ‘non-co-operative’ and ‘resistive’ reinforce how he thwarted the best efforts of the staff to treat him humanely. These truths are then used to perpetuate more truths, such as that he is to blame for the extreme measures that ensued.

Similarly, Elsie had been brought into hospital with a painful fracture for analgesia and despite the fact she received very little analgesia, pain was never considered to be a cause of her behaviour, rather her behaviours were constructed as idiosyncratic, dementia behaviours.

Yet again, Ted was constituted as unable to ‘self govern’, and this was marked by the way his picking behaviour and his incontinence were divorced from the effect of the restraints he was subjected to (see p. 133-134).

Once Ted was constituted as ‘at risk’, he was then easily ‘treated’ with a range of restraints that were justified under the circumstances. Ted is probably not

exceptional in that even the most newly qualified nurses can recount more than several experiences of caring for similar patients. However, Ted needs to be defined as 'an exceptional case', in order to justify restraint use. Through the construction of Ted as 'an exceptional case', he had little chance of significant recovery. If he was mobile he was restrained to maintain his safety. If he was immobile he was restrained because his lack of compliance with the expectations of the nurses was taken as a global measure of his state of consciousness. If Ted did not make sense he was given haloperidol, which had a negative effect on his cognition. Following treatment in hospital, there was only one 'sensible' outcome for Ted and that was to transfer him to a high dependency nursing home. This in turn affected the type and intensity of care that Ted was eligible for. The nurse's assessments of Ted had social functions, which were not obvious at first reading. One of these functions was to make Ted's case appear 'hopeless' or, more accurately perhaps 'hopeless without haloperidol'. It was interesting that, what the nurses referred to as 'basic nursing care needs' for Ted were often neglected, despite the obvious discomfort this caused and the effect this discomfort had on his behaviour. Ted's behaviour was construed as not only unpredictable and idiosyncratic, but also as caused by his dementia rather than by his specific health problems: in Ted's case severe arthritis pain. Even when Ted's pain was pointed out to the staff, they are unwilling to restart analgesics for various medical reasons that were apparently more important than the effect of pain on his behaviour. This position is not logical, yet it was accepted by the participants. Even the cause and effect between the restraints and Ted's 'picking' behaviour was ignored by the nurses in their documentation. If we can suspend the assumption that general medical wards can cope and correct any problem that does not fit into another specialty: if we can suspend the assumption that hospitals exist to cure people: importantly, if we suspend the assumption that pharmacology has an array of products on offer that with skilful application can effectively control behaviour, things may have been a little different for Ted. Although many of the staff did not explicitly support these beliefs, it is evident that they were the assumptions on which many of their decisions were made. The nurses made the judgment that haloperidol was beneficial despite there being no evidence that this in fact was the case. In fact, it appears that Ted's disorganised and difficult behaviour was directly proportional to the increasing doses of medication he received. However, the judgment had been

made, and if we consider the effect that this 'truth claim' had on the 'reality' of Ted's conduct, it was perhaps, not insignificant.

One way of looking at Ted's care is to say that the above assumptions are merely contingent. Was it a contingency that safety became the predominant consideration and moral obligation of the nurses? Nurses claim the inevitability of safety and its position in the hierarchy, and seem to assume that if it is not the highest priority, it has to be the lowest. A closely related argument, is that of: if not restraint, then a fractured neck of femur. Which again is not an inevitability. By putting notions of safety and of freedom in antithesis to each other, staff can safely avoid the argument that safety and freedom may exist together, both in less extreme forms. This discourse sets up the issues on opposite sides of the fence, and is powerful because of its emotive nature. This discourse dictates that if you do not want the patient to be safe you must want the opposite, which would be frail elderly patients falling over and causing untold damage and suffering to themselves. The other aspect of this discourse is that it powerfully and silently packages restraints as humane and caring, despite the obvious contradiction this represents. A contradiction that is all too implicit in the interview discourse.

The nurses legitimise restraint by their portrayal of Ted as hopeless and exceptional, and their construction of restraints as both inevitable and humane. This helps to ease the guilt of restraint use by dispersing the responsibility for its use to the doctors, the managers and increasingly the family. By establishing nurses as subjects of these different agencies the task of restraining a patient who is pleading and imploring not to be restrained is overcome.

There is a certain problematisation of what the person is, how they behave, what their needs are in relation to how a person should behave and the needs prescribed by tradition and education, and this can be called an ontology. The ontology of the patient in hospital is not based on the average patient with dementia and places unrealistic expectations on how these patients should behave. Importantly, these patients do not get better as patients are supposed to do, and hence, they are already exceptional. This includes the assumption of what behaviours are amenable to nursing, and how nurses exist as ethical subjects.

This ontology is governed by a deontology or set of 'rules' that set out the appropriate intervention under specific circumstances such as the use of restraints in exceptional cases. This in turn conditions the ontological construction of the 'what

is' of the patient because in order to use restraint certain conditions must be present, and the nurses, through their assessments, must prove these circumstances. Also in operation is an aesthetic or a sense of the look and feel of an intervention, and this too must be manipulated to legitimise restraints. There is a need for a general impression of progress towards a more aesthetically pleasing patient so as to legitimise the role of the hospital. The ward should appear in control and clean, and elderly patients wandering around, or calling out, threaten this aesthetic value.

Finally, there is a teleology in action or need for a grand design, either a cure or a disposal of the patient to somewhere out of sight and responsibility of the hospital. There is much talk of a dedicated area for 'these patients' implying an altruistic feeling towards their care. In effect this argument seems to legitimise less than appropriate care here by constructing an 'elsewhere appropriate environment'. Whether this other environment exists anywhere is beside the point the most important thing is it was not assumed to exist in the here and now of the research setting. This necessitated a grand design that was to contain the patient until he could be moved to a more appropriate environment. We can see how the plan to move all three subjects to nursing homes conditions the rules about how they will be treated.

This examination of abnormal behaviours is what Foucault would call a 'technology of normalisation'. The examination as an exercise of power is given much attention in *Discipline and Punish* (Foucault, 1975/79 p. 184) where Foucault points out that the function of the examination is that it "...transforms the economy of visibility into the exercise of power" (Foucault, 1975/79 p 187). The accessibility of the subject to be seen maintains the disciplined individual in his subjection. Foucault explains that it holds the subject in a mechanism of objectification. It reaffirms the presence and coherence of the normal and homogenous. Is it not possible to make Joe, Elsie or Ted more happy as they are, so they have to be made more like some ideal of an elderly, retired, responsibility-less person. These assertions are not merely theoretical subtleties; they have operational functions. The terming of Ted's behaviour as 'picking' represents a total marginalisation or even obliteration of Ted's narrative. It forms the basis for the ideology that views Ted as irrelevant, irrational or deviant. His behaviour is neatly packaged as a symptom of illness and the legitimacy of his actions is denied.

Foucault also says of the examination that it "...introduces individuality into the field of documentation." (Foucault, 1975/79 p. 189) Foucault goes on to argue that the examination:

...places individuals in a field of surveillance also situates them in a network of writing; it engages them in a whole mass of documents that capture and fix them.

The case notes are not an adjunct to the selfhood of the patient, but for the staff using them they actually become part of the patient's 'self'. Therefore, the examination makes possible two functions. First, it makes the person describable in his individual features and secondly; it makes comparisons possible, and hence opens up the possibility of measuring the gaps between individuals.

The patients have no immediate rights or access to medical and nursing notes. The use of highly technical language in the notation and abbreviations precludes all but the initiated from comprehending what is said. For example, the notation of a 'positive glabella tap' means very little even to many of the staff, but to the initiated, perhaps just the doctors and the occasional nurse, it means there is considerable drug induced Parkinsonism. One can imagine why this particular symptom should hide behind a professional façade. The notation focuses on the nurse's communication to the patient, or the doctor's communication to the nurses, but rarely communication between the two. This produces an, 'us' and 'them' situation between the doctor and the patient. This projection of the different disciplines as on different sides brings about the possibility of the nurses discourse that claimed the doctors 'stonewall' suggestions the nurses make about the psycho-geriatricians taking over Joe's care.

Despite the presence of 'causivity' in many of the participant's discourses, it is notable by its absence in this discourse.

The examination, surrounded by all its documentary techniques, makes each individual a 'case': a case which at one and the same time constitutes an object for a branch of knowledge and a hold for a branch of power. The case is no longer, as in causivity or jurisprudence, a set of circumstances defining an act and capable of modifying the application of a rule; it is the individual as he may be described, judged, measured, compared with others, in his very individuality; and it is also the individual who has to be trained or corrected, classified, normalized, excluded etc. (Foucault, 1975/79 p. 191)

The cause of the behaviour is constituted as beyond the possibility of adaptation as it lies in the dementia process, beyond medical cure or understanding. The

discourse in which this is evident is the naming of the subjects as “end-stage” or as having “dementia behaviour”. The participants also portray the behaviours as lifetime habits. For example, one nurse tells me that Elsie had been a busy person all her life, and there is no reason to suspect that she would stop her busy behaviour (such as picking) now she has dementia. It follows that it is, therefore, hopeless to try to break habits of a lifetime. In fact, what Elsie seemed to want to do most is sleep. However, the claims of the lifelong busy person are at first hearing, convincing, and effective in precipitating accepted truth. These truths are little more than varying degrees of well-founded opinion. In this instance we see all the subjects are caught in a catch twenty-two: the patients are seen as lacking insight, therefore, the staff override their wishes and restrain them in their own “best interests” based on the principles of beneficence and duty of care. In order to demonstrate ‘insight’ and competence the patient has to accept the restraint positively and be seen as a good patient. In which case the nurses can claim that the intervention does not bother the patient so it might as well stay in place. This problematisation of when restraints are ‘okay’ gives rise to the possibility of restraint use and one can see evidence of this in Rebecca’s argument about Joe being restrained when he was asleep not being a problem (see p. 102). This presumed lack of competence to make informed decisions is providing the possibility for staff to become paternalistic and create ‘docile bodies’. I will say more of the production of docile bodies in the section on marginalisation.

The other crucial point of this discourse is that it functions to negate the trial of alternative modes of care, it internalises the behaviour and dispensates external intervention as futile or ill informed. My field notes refer to nurses laughing at my attempts to adapt Elsie’s behaviour as young misguided enthusiasm.

The second part of this discourse is the demonisation that runs alongside the absent cause of behaviour. In this instance Joe, Elsie and Ted are portrayed in ways that give their behaviour exceptional qualities. Joe, for instance was labelled ‘Houdini’ after his ability to escape the restraining vest, which is on the surface just a funny name for him. Implicit in this nickname however is an image that is, beyond comprehension, slightly disturbing, somebody who is extraordinary at resisting control. This image bears little relation to the person presented in the introduction to Joe (p. 91-93).

Ted was portrayed in a different way that was equally damaging. Ted was referred to as baby like and hopeless. This powerful metaphor of Ted as a baby maintained a disabling sympathy for Ted. The more sympathy that was felt for Ted, the more hopeless his case was characterised to be. Furthermore, because his case was so hopeless, there was more need for sympathy, and so on, ad infinitum. Ted did not have a nickname but I would hear the nurses say “poor old Ted” a phrase that sums up the paternalistic feelings they had towards him. This infantilisation of Ted reinforces the dichotomy of the ‘us’ and ‘them’ distancing of the subject from the perception of a human being with the same rights as the person applying or ordering the restraint.

Elsie on the other hand was nick named “Little Devil” (p. 116). This name portrayed her as mischievous and playful, again an image far removed from the one I presented in the background on Elsie. Despite the cognitive loss her dementia had caused, she too was able to escape the posey. In fact, it is not a rare occurrence for patients to escape their restraints, and there is nothing particularly exceptional about it, except perhaps, that posey vests are badly designed. These labels, however, served alongside the discourse on the behaviour that had no cause, to stigmatise Joe, Elsie, and Ted as unpredictable, irrational, out of control, disturbed and disturbing. In short, as unable to ‘self govern’, and therefore, in need of outside governance by the hospital staff.

This discourse on governance is evident in every notation of the subject and every interaction with the subject, and its visibility, gives it status as a universal truth statement on the individual, undermining alternative possibilities or approaches. These discourses contribute to the continued perceived need for the use of restraint, but they also account for the weak and sporadic nature of any opposition to restraint. Gutting quote’s Foucault on this point:

care for the self is ethical in itself, but it implies complex relations with others, in the measure that this ethos of freedom is also a way of caring for others...Ethos implies a relation with others, to the extent that care for the self renders one competent to occupy a place in the city, in the community... whether it be to exercise a magistracy or to have friendly relationships (Gutting, 1994 p. 161).

By establishing that the subject is unable to ‘self govern’ the he or she is disqualified from the usual human rights. The person who can ‘self govern’ has rights and has to be treated according to an elaborate moral code. By the packaging

of the subject as an amoral being they no longer have need for this treatment. For instance, Joe is disqualified from the right to leave the ward, Elsie is disqualified from the right to sleep in comfort, and Ted is disqualified from the right to choose his environment and seek company when he is lonely. These negated rights preserve the currency of the need for control in dementia care, which is crucial to justification of restraint. Also in action is a discourse aimed at the unsuitability and unaccommodating nature of the environment, and the ways in which this contributed to restraint use will be discussed next.

II Constituting an appropriate elsewhere.

This discourse functioned to alter the responsibility for the restraint in as much as the environment placed certain pre-existing realities on the staff. I call this practice of discussing the environment a 'problematization', a term I have discussed earlier and will now elaborate on. Foucault displays an interest in contrast and difference but this does not imply commitment to an underlying unity. The following quote shows how problematisations function to displace questions.

The freeing of difference requires thought without contradiction, without dialectics, without negation; thought that accepts divergence; affirmative thought whose instrument is disjunction; thought of the multiple – of the nomadic and dispersed multiplicity that is not limited or confined by the constraints of similarity...What is the answer to the question? The problem. How is the problem resolved? By displacing the question.
(Gutting, 1994 p. 142)

It is not a criticism that aspects of the case studies' care were problematised. Problematizations make way for new ways of behaving but can equally delimit what can be said and done. For example, the structure of the ward is ideally designed for patients who can use a nurse call buzzer, for none of the rooms are visible from any of the communal places on the ward. This presumption of ability to appropriately use the nurse call system is somewhat anomalous if we consider the proportion of patients accommodated on this ward who, like Joe, remain unable to use the nurse call system. The presence of numerous exits with no barriers also demonstrates the assumption that all patients are obedient and stay in their appropriate place. This is not a presumption based on reality. In Joe's case we can see that both these structural factors bring about a situation where the staff are asking pears of apple trees. In other words, we are setting both the patient and the nurses up to fail in their

reciprocal tasks of receiving and providing humane care. Possibly because of these inherent structural obstacles the nurses are aware that there might be an 'elsewhere' more appropriate for their "problem care-awaiting patients" as Julie called them.

For Joe this discourse was extensively problematised until the pursuit of an alternative place became the goal of care for some time. A range of people were dispensated from the responsibility of caring for Joe as a result. This discourse is closely tied in with the discourse over the most appropriate treatment for Joe, and the marginalisation of Joe. It was the skills of the staff on the psycho-geriatric ward, which the general nurses seemed to think they lacked, and thus, this argument adds to the discourse on the most appropriate treatment for Joe. The effect of bringing into question the psycho-geriatric ward was to constitute an elsewhere, geographically distant from the current ward. It had the effect of diminishing the possibility of delivering humane care in the current environment. On the other hand, removal of the subject removes the problem for the ward, and in this way this discourse adds to the discourse on marginalisation.

This discourse has one assumption at heart, which I argue is fundamentally flawed. The assumption is that there is a right place for Joe, Elsie and Ted; that there is a space in which their care is unproblematic, or at least so much less problematic that they no longer require restraint. Without arguing contrary to the literature review, that environment has an effect on behaviour; the function of this discourse is to render the nurses helpless in their current situation, thereby contributing to the legitimisation of restraint use. In Elsie's case it also seemed to cause a certain lack of inspiration to do much with the current environment, such as, move her close to the nurses station, or make her chair legs the correct height. As a result these subjects end up in what Amber terms the "too hard basket" and Peter terms the "hole in the system", which inevitably ends in nursing home placement.

Elsie is similarly packaged as more or less appropriate for the rehabilitation ward and is subsequently moved and perhaps unsurprisingly does not receive any different care in terms of restraint when she arrives on this ward. Eventually, Elsie is placed in a nursing home.

The hospital is treated as a kind of warehouse for these subjects. This is implied in the nurse's discourse such as "problem care awaiting patient". It also implies that there is a particular trajectory in dementia care, i.e. an expectation that there can be no recovery, and that there, necessarily, must be decline. This again appears normal

and natural, but if one considers the effect of this on the subject, it is not negligible. Not least it defines the subject as requiring a nursing home, even when this assessment is done on the second day of admission for an acute confusional nature (p. 97 Table 4). We will return later to the particular marginalising effects identification as 'nursing home material' has on the subject's access to services.

It is becoming apparent that there are certain rules governing the use of restraints. One of these rules is that there must be a lack of clarity in deciding the 'proper course of events'. This lack of direction is contributed to by the first discourse, which demonstrates the unpredictability of the subject, the second, which demonstrated the unsuitability of the environment and by the next discourse which demonstrates the difficulty in deciding on a course of treatment.

III Constituting an appropriate 'other' treatment.

This discourse is particularly dichotomous as it deals with chemical and physical restraint as therapies. The nurses seem to identify two approaches to caring for the subjects, the psychosocial or the biomedical. There is tension between the two that can create conflict for individual nurses. We saw how Lisa recognises the over-reliance on the biomedical model and she offers some resistance to it, identifying when Ted's behaviour may have a physical discomfort cause, such as, needing the toilet or being hungry (p. 134-135). The chemical restraint problematic was most obvious with Ted and Joe and involves the debate over how best to treat them. The most obvious dichotomy here is made by the participants and involves the acceptance of medication as the proper way to resolve the behaviour. This approach is apparently reasonable to the participants, after all they have established that what is going on is a physiological process that they can only refer to in medical terms. As a result this medical process can be treated with medication, and that is the only way one can resolve the problem.

This is a way of packaging the solution as standard, and it is important that treatments are seen to be standard or protocol. At the same time it is obvious that the medications for either Joe, or Ted, are not having a predictable, standard or desirable effect on their behaviour. Just as there was a perception of a good or desirable space in which to care for these subjects, there is an illusion that there is a good or desirable way to control their behaviour. It constitutes another treatment regime under which, Joe for example, becomes manageable and is still treated humanely.

This is plausible in theory, but it is quite possible that there just is no perfect way of controlling behaviour perhaps some of the behaviours just have to be tolerated. The psycho-geriatric doctor suggests that supportive nursing interventions are the most appropriate treatment in Joe's case, but we are no closer to uncovering these. The doctors in Elsie's case refused to entertain the idea of euthanasia, but are quite happy for restraints to be applied indefinitely. The suggestion of euthanasia provides an epistemological challenge to medicine and as such brings about a resistance from the doctors to discuss it. This prescription of restraints and packaging Elsie as 'suitable for rehabilitation' makes a striking conflict that is hard to ignore. This conflict may be evidenced in the changing nature of Elsie's assessments, which are at one time indicative of decline and at another of improvement (p. 120 Text Box).

If Ted was treated to the most skilled and resourced care available would he still have become immobile and been a source of numerous accident forms? Underlying these discourses is the assumption that, hospitals are places people go to for cures and that the hospital can deal with what ever is thrown at it from nursing homes, hostels or homes in crisis from carer burn out. There is the strong expectation that the hospital will always be of benefit to a person. This, in fact, is a contingency that has been present in recent years only. A century ago people went in hospital to die and it was generally accepted that few people came out alive.

This discourse involving the use, or non-use, of restraints in specific cases produces the dichotomy, which for nurses is a source of great conflict prompting them to invoke language such as 'prison like', 'inappropriate' and 'unfair'. The nurses seem all too aware of the dangers of using restraints. They are aware that patients can escape and that in Joe's case he can walk around with the chair strapped to his back by the posey (p. 103). At the same time, they are forced to justify restraint, as it is the only accepted, visible method they are familiar with, that is legitimate for use in such cases. Likewise there is resistance to chemical restraint for similar reasons but the visibility of haloperidol provides little possibility for alternative interventions to immerge. The restrained patient reinforces the legitimacy of the non-restrained patient in so much as his behaviours are so divergent from the non-restrained and visa versa. By problematising the need for control the possibility of using chemical restraint is introduced. My question is why techniques such as back washing became subordinate to haloperidol and, thus, were perceived as less effective? (p.135 Nursing Note 11 and p. 133). It seems that these alternative

strategies suffer the serious drawback of being too basic for the behaviours that have already been constituted as 'extreme'. The effects of this 'truth' and its dominance in the discourse are evident in their ability to delimit other treatments and interventions. This discourse is an example of the way it can determine and limit the range of possibilities by which reality is constructed. This discourse creates only marginal opposition from several of the nurses notably Peter and Lisa who both have direct experience of nursing in non-restraint environments (Lisa is from New Zealand and Peter the UK).

Chemical restraint is also interesting as its availability and the responsibility for its use is somewhat dispersed. Although the doctors prescribe it the nurses may exercise an amount of discretion in the administration because it is frequently prescribed as an 'as required' medication. 'As required' medications are available, quick and legitimate. No other measures are written down as possibilities for intervention. The visibility of the 'as required' medications as opposed to other measures here reinforces chemical restraint, which in turn increases the visibility of chemical restraint as a measure of care. In the discussion of the next discourse the nurses further problematise their relationship to responsibilities and duties.

IV Constituting an appropriate duty of care

The participants refer to this discourse commonly, and dramatically, to show how they, as individuals, are subjects of forces beyond their control. The nurses imply directly that they have moral obligations to the profession to withhold. Indirectly they imply a duty to the management. Amber invokes the metaphor of the head on the chopping block if she does not restrain and anything goes wrong (p. 103). As in Foucault's example of the panopticon (see glossary p. 186), the nurses have become self-policing in the protection of patients from harm with the bureaucracy of forms to fill in, and the hierarchal surveillance of these forms. I suggest that this emphasis on patient safety adds to nurse's perception of their need and responsibility to prevent harm, and thus, the use of legitimate interventions to this end. In addition, Foucault asserts that the consequence of such scrutiny and surveillance is the production of the 'docile body' (Foucault, 1975/79 p. 135). I am talking here of the nurses as docile bodies and later I will discuss the production of the patients as docile bodies, however, in this case the consequence of this production is to maintain the nurses'

perception of their lack of control over the situation. I argue that it is a mere contingency, although deeply entrenched, that nurses have this responsibility.

Logically, the self identified specialists in the musculo-skeletal and locomotion processes, the physiotherapists, might be better placed to shoulder this responsibility, especially if the patient is at risk of falls. Indeed, the doctors with their array of medications that can cause dizziness or hypotension could be held accountable too in the ramifications of patient's falls. As it stands the physiotherapists are able to defer all responsibility to the nurses and even, as I will discuss in the section on marginalisation, choose to have no involvement in this type of work.

The doctors and managers on the other hand, establish their duty to the safety of the nurses caring for the subject, and informed me of their powerlessness. I had an interesting conversation with Ted's doctor who implied his powerlessness when nurses ask for restraining orders. He was asking me what alternatives were possible, so I explained that regular toileting and comfort measures were the best place to start. With a sarcastic laugh he said "...and how well do you think it would go down if I suggest that to the nurses?"

The other people with an interest in the care of the subjects were the relatives and on p. 106, I problematise how the relatives are, with the introduction of the new policy, being called on to give 'permission' for restraints. This measure is intended to limit the amount of restraint use as well as decrease the impact that it has on the family. However, this is a good example of one discursive identity changing for another, and in the process, creating a new oppression. Furthermore, while once, as Amber points out, nurses had total say on who was restrained, now there are many others involved in this decision. This makes restraint look altogether more liberal, but it has really involved new forms of maintenance of old power relations. Rebecca points out the relatives say yes straight away to restraint without understanding it, so the surface liberalism works to further cover and entangle the use of restraint in the nursing culture. In Foucauldian terms the effects on power that the change of policy brings about causes a counter movement, that is, a form of resistance on the nurses part to maintain the practice.

V Discourse on marginalisation

One further ideological force at large is perhaps the most unintentional and is possibly a by-product of the previous four although it too serves definite social

functions. This discourse produces and is symptomatic of the marginalisation of Joe Elsie and Ted.

As already mentioned through the machinations of the discourses the nurses have constituted the three subjects as unable to 'self govern', irrational and nonsensical. They did this through their highly ritualised examinations that aimed to classify and categorise the subjects. I will deal with Joe and Ted first as the methods of their marginalisation differs from Elsie's.

In Joe and Ted's case the physiotherapists and the occupational therapists are supported in making some far-reaching truth claims, namely that Joe and Ted are not eligible for physiotherapy or occupational therapy. This is buttressed by their professional assertion that these patients are not capable of new learning, therefore, they would not benefit from their services (Medical Note 2 on p. 98). There is a nexus that seems fairly obvious to me, but for the participants, they find these views rather standard. The first assumption implicit in these claims is that there is no use in therapy unless one can see improvement. I find the marginalisation of preventing decline total.

The second assumption here is that unless they can improve in a cognitive or physical sense, Ted and Joe, can do nothing useful. Joe himself pointed out that he needed a good workout and my observations certainly concur with his view that he was calmer and more relaxed when he had expended an amount of energy walking round the ward with me. The catharsis involved in men doing physical exercise and its effect on violence is well documented. The third assumption is that specialist services are limited, and that physiotherapists and occupational therapists have to treat the most deserving patients, or the ones most capable of measurable recovery. This discourse is, again, widely accepted by all the participants, but for me causes huge conflict. The effect that having no access to the services of the multidisciplinary team has on Joe and Ted is huge. Ted for example, made a rapid transmission to a chair-fast faller from a man who could walk with a stick with no history of falls.

Despite this he had two sessions with a physiotherapist one of which was aborted as she found Ted uncooperative. The major reason for Ted being restrained was his falls risk, and yet the person most qualified to limit this risk is wholeheartedly committed to having nothing to do with him. Ted has no right to access this service because he is incapable of learning or improvement, and because he is going to a

nursing home where he will not need to be independent. The staff should be making the decision of who has access to the limited services, with an awareness that the priority system at present is contributing to the use of restraints. Perhaps it is less easy to marginalise Joe and Ted from their right to physiotherapy or occupational therapy when this resistance is brought to bear. Perhaps then another patient's improvement will not be prioritised over Joe or Ted's human right to freedom.

Elsie on the other hand did receive physiotherapy. She was even sent to a rehabilitation ward to recover her mobility. This could be seen as benevolent, that despite all her lack of cognition, the staff are still prepared to try for best quality of life. However, it is also possible to view Elsie's move as one more attempt to get rid of a patient to somewhere else, another place geographically removed from the current situation. Indeed this passing on of problems characterises all case studies and ends for all the subjects in nursing home placement.

Joe was too hard to pass on for a number of reasons, not least because he was in the 'too hard basket'. However as Peter pointed out he was still marginalised by not being able to become part of the ward community as a single nurse from an outside agency was assigned to his care. This was packaged as a benevolent favour. The participants acknowledged their kind manager for allowing this level of nursing care and were very happy with the situation. However, what was then possible was very little standardisation of the quality or type of care Joe receives. Julie the manager acknowledges this problem when she says there was no continuity of care. The social function this also served was to marginalise Joe from the ward, and to render any problems he caused, less of a problem for the ward. It again allowed a blurring of the responsibility for Joe.

The other aspect to this discourse is the production of the subjects as docile bodies. I discuss in the section of constituting the subject as unable to 'self govern' how hierarchical observation, normalising judgements, and ritualised examination, produce docile bodies and this applies to both the nurses and the patients. I would like to concentrate now on the effect the subject as a docile body has on their marginalisation. As discussed earlier the subjects narrative is easily dismissed as irrelevant and likewise their behaviour. This enabled the nurses to ignore Ted's pleas for freedom. No matter how rational they were, Ted and his pain were ignored because nothing Ted said or did was considered rational. In Elsie's

case the doctors could ignore her daughter's wish to discuss euthanasia; and so this discourse remained silent.

Therefore, the care delivered was no longer gauged on the needs of the subject, it was dependent on the availability of services. And, despite this causing palpable problems in caring for these three subjects, there was little awareness of this. The subjects were pawns in the hospital's battle to keep beds open for more patients; Their human subjective narratives were not heard because they were not perceived capable of having them, at least none that could be regarded as rational and, therefore, nothing that could be regarded as legitimate.

Conclusion

Discursive formations stand to discourse in the way that categories stand to objects. That is, discursive formation is an abstract term that relates to a set of discourses. However, the concept discourse is itself an abstract term and there are no rules of thumb for determining how many discourses it makes sense to describe with respect to a particular set of social practices. For convenience, arbitrary decisions have been made about the discourses that make sense of restraint use. In practice, I have found it helpful to distinguish among discourses concerned with constitution of the subject as a person who is unable to 'self govern', problematisation, the use of restraints as realistic and sensible, the duty of care, and marginalisation. Although there are other ways in which the relevant constitutions could have been described, these seem to me to make sense. Moreover, they are likely to be readily understood by registered nurses because they are firmly grounded in the way that nurses talk about restraint and about patients. Whereas the concept, discourse may be an abstract one, the intelligibility of discourses are readily accessible to prior understandings of practice. Therefore, it is possible to recognise a number of discourses within a discursive formation. This implies that individual discourses in a set are neither contradictory nor complementary per se. The value of this interpretation is demonstrated in Chapter Eight in which I bring the thesis to an end by returning to my research questions and by answering them in light of the conclusions supported here and by the study as a whole.

CHAPTER EIGHT

CONCLUSION

One cannot over-emphasise the fact that everything- meaning and value as well as appropriateness of individual conduct to the energy state of an atom – depends upon the thing itself and its environment.

Cyril Stanley Smith 1903-1991

This Chapter will firstly give an account of the way in which Foucault has influenced the current study. Secondly, it will discuss the limitations of this study, followed by a brief response to these limitations. Thirdly, I will address the three research questions posed at the start of the thesis and give a brief summary of my conclusions. Finally, I will present the implications of the research for nursing practice, research, scholarship, education, and Foucauldian scholarship.

In the Chapter Seven, I offered an understanding of the social processes that maintain restraint as a visible and legitimate practice. These are my own views influenced by the work of Foucault. Those reading the study, depending on the time and space they occupy, will judge the legitimacy of my claims, but I make no claim to the “truth” of my findings. I have been aware of a reflexivity causing a discomfort with my own role of moral judge in this project. My cause is not to privilege an alternative view but to make trouble for those who are currently having their say about restraints, to challenge those who currently seduce others with their construction of reality.

In Chapter Five, I introduced a technique that I call scepticism. I go as far as to say that I endeavoured to remain sceptical about my claims throughout the research process. The truth value of this thesis is that it is sensitive to the natural or overlooked practices that maintain the legitimacy of restraint. It pays attention to the ruling categories, the fundamental linguistic practices that we take for granted, but which I have argued are more socially motivated than is usually thought. Therefore, my approach is sensitive to the context in which restraint takes place. I am claiming that single small acts such as these described in Chapter Six, represent a general technique of power that maintains the use of restraints. Ultimately, the certainty with which I make this claims is context bound. To be more specific than this is to oversimplify a practice that is complex.

Foucauldian description

The influence of Foucault's 'methods' is fundamental in this study in that it directly informed the nature of the research questions. My interest in restraint use stemmed from my practice, and the gaps in understanding expounded in the literature review. However, the particular focus on the role of discourse and power/knowledge as a focus of inquiry are borrowed from Foucault's texts and understandings of a range of social phenomenon such as prisons (Foucault, 1975/79) and modern clinical medicine (Foucault, 1963 /73). It is with this frame and lens that the whole thesis has been designed, conducted, developed and concluded.

More specifically a Foucault influenced approach focused the study on power relations and importantly the function of that power, seeking to expound the mechanisms and working of power rather than the causes of or reasons for it. In this way the study has concentrated on the social functions of what can be said, and what is not, or cannot be said. It has focused on the face value of discourse, not seeking to uncover a deeper understanding of the psychology of a practice, but to uncover how a practice functions.

One of the most fundamental influences of Foucault on this thesis is that it diverted the study from a search for a solution for restraint use. My understanding was that the complex nature of the use of restraints belied a solution and I support this stance by the argument that the existing research base, although plentiful, has not changed the use of restraints dramatically in the last ten years. In this way, this thesis is unusual compared to all other reviewed articles on restraint use. Conducting research does not change practice but the current study focuses on the contextual nature of social practices such as restraint use, adding a new understanding that has direct implications for those working in nursing practice, nurse education and or nursing scholarship.

Limitations of the study

There are certain philosophical limitations including classical arguments about the position of postmodernism and specifically the ideas of Michel Foucault as opposed to other philosophy's ability to make sense of the world, a phenomena or a problem.

Postmodernism has been condemned as ultimately flawed in its rejection of overarching theories or unifying standpoints on a subject. This rejection is said to leave us faced with a multiplicity of incommensurable world-views. Postmodernism

has been criticised and characterised as a group of ideas, which lead to a paralysis when its foundations are taken to their extreme. How then can it identify anything that will not fold in on itself as soon as it is said? Critics would argue that this rejection of ultimate foundations is deeply problematic and gives rise to a moral chaos, which is politically and theoretically damaging. In other words this fragmented approach may miss the issues, and focus on the particular whim of the researcher. This lack of a claim to authority is the basis of the postmodern critique.

Critics could point to the danger of not starting the study with a preordained structure as imposing my own 'en route' leads to a manipulation of the data from my point of view. Other qualitative research methods include methods that attempt to transcend the present and the subjective. For example 'bracketing' is a term common to phenomenologists who attempt to set aside their individual subjectivity through self reflection to make clear their thoughts and feelings to enable them to act like an empty vessel in the research process, an agent who does not change the final product. Because no attempt is made to deny, or compensate, for individual bias in the current research, it could be argued that the research gives a severely narrow personal view of the subject of restraint and, as such, is of little use to nursing practice or scholarship.

Finally, the postmodern research approach can be criticised, as it does not offer clear steps for change. This work does not point directly to what should be done to change practice with regards to restraint use. It is all very well to understand a thing, knowing the reasons for a problem but if this does not actually lead to a change in practice then is there any point in understanding?

This thesis could be criticised on grounds of validity, sample size, randomisation or reliability, however, all such criticisms stem from the logical positivist approach to research. This thesis is informed by a totally different paradigm than the principles of scientific research and does in no way try to emulate its particular types of rigour.

A Brief Response

In reply to the first point of critique posed above, it is possible to see the lack of overarching theories referred to as an advantage rather than a flaw. Falzon (1998 p. 4) suggests that the alternative to overarching world-views is not fragmentation but an opening up.

By freeing ourselves from the illusion that there is some absolute standpoint, and recognising that all our concepts of knowledge, truth and right action are 'local' or historically specific, we will help open up a space for diversity, for otherness, for other forms of life.

The dependence on unified grand theories is a striking contradiction that encourages us to cast futile and simplistic webs of logic over a fundamentally illogical and complex world. The passage of time between the arrival of an anti-restraint discourse in the 1970's, and their continued use in the year 2000, shows us that mere knowledge of the damage restraints cause, does not change practice. In a logical world, identification of best practice results in a change in that practice. However, change in restraint use has been notable by its absence. I argue, that because of the complex and static social discourses that surround restraint use, their continuance is possible, and only an examination of these discourses will comment on an appropriate way forward. I would argue, in the shadow of many great philosophers, such as, Foucault, Deluze, Derrida, and Lyotard that the existing discursive formation has opened up the illusion of an absolute standpoint. We can open up a space for diversity, and 'local', or historically specific understanding of the phenomena of restraints.

Moving to the second point of critique, that of bias, it is not denied that another researcher making the same observations and from the same data sources may have arrived at different findings and conclusions. For example, I have acknowledged that a feminist may have examined the role that gender stereotyping and gender roles had on the use of restraints. My findings neither negate this point nor silence it. At any one time there may be a multitude of possible explanations. The challenge with this research was to take one approach to understand restraint use and fully explore it, so as to offer a coherent and cohesive explanation. My argument is that this approach is more informative to nursing practice than one that imposes false structures from the beginning. This approach implies the need for never ending attention to the ways we conduct ourselves, as history does not stop at some logical point, but continues to service the present in its language and design. The alternative view of bias seems to neglect the argument that language is not a total and innocent representation of consciousness, and that the hospital staff are speaking subjects positioned within a socio-political context. For this study, attention was given to both these points of

view, and it is that which makes my approach different to that found in the literature on restraint.

Thirdly, it is true that there are no clear steps forward with which to make the move to restraint free care as a result of this thesis. However, I argue again that a simplistic search for solutions without understanding the problem is a fundamental flaw of the previous research into restraint use. The current research attempts to uncover a contextual understanding of the issues. Rather than paralysing change, this can give sophistication to restraint reduction attempts, as it takes into account the factors influencing restraint use more fully. It is clear that in order for alternative points of view to be heard, the language needed to express them must be available for reflection and analysis. Through carrying out research such as this it is possible to make available to nurses who feel uncomfortable about restraint use, points of view and ways of expressing them which undermine the commonly perceived inevitable necessity of restraint use.

As discussed in the chapter on methodology, this type of research has validity that is tested in different ways from logical positivist research. The coherence and fruitfulness of my argument will be judged by the reader. The thesis has succeeded in producing new problems as discussed in the sections on the implications of the research. I claim validity with respects to my orientation as a participant. Frequently participants use discourse in response to their own discourse. For example, the problematisation of patients can be evidenced by the need to deproblematised them again before discharge and this is vital to the plan of discharging all three subjects to a nursing home. In all three case studies it can be seen that deproblematisation was a linguistic construction despite little change in the behaviour of the subjects.

Discussion of research questions: Nurses' explanations

I do not intend to give a definite answer to the questions I posed for myself. However, some points can be made in response to the questions that I believe are vital for an understanding of the long standing use of restraints.

As pointed out in Chapter Two, there are myths about elder restraint use (Evans & Strumpf, 1990), and nurses have a comprehensive system of explanations for using restraints. Evans and Strumpf, (1990) approach these explanations but stop short of how they function socially. In the present study I found that there was one predominant reason given for the continued and long standing use of restraints, and

that was an ethical one – to save the patient from themselves, the paternalistic argument. The other explanations or myths pointed out are explanations, which rule out the trial of alternatives and do not appear to be central to the justification of restraints.

One striking thing about these explanations is they seem to be almost static in their expression. Although there is an amount of professional academic space given to restraints and their associated problems, this has not apparently forced a change in the explanations for restraints among nurses. Nurses can simultaneously argue for and against restraint about the same person about the same incident. This is possible because of the intense problematisation, identified in the findings and analysis of this project.

Legitimation of restraint

The above two questions will be answered together as they are intimately connected. Five discourses were identified in the discursive framework, constituting the subject as unable to ‘self govern’, constituting and appropriate elsewhere, constituting an appropriate treatment, constituting an appropriate duty of care, and finally, a discourse on marginalisation of the subject.

The first discourse, constituting the subject as unable to ‘self govern’ is discussed next. This discourse can be manipulated but often includes unpredictability, and hopelessness as a key theme. These discourses are so powerful and damaging to the subject that their existence seems to infer that the subject now has no rights to any of the normally expected services or options. Patients are no longer allowed to make choices about small things such as how much or when to eat, much less as to where they will be discharged. Not only are these attributes established as facts, these truths establish a number of other truths about the subject, which further serve to support the original truth that the subject is unable to ‘self govern’. There is at work the social rule that one is eligible for certain rights if one respects the rights of others. One of these rules is that of ‘self governance’ so that one can react appropriately according to social norms. By constituting these subjects as unable to ‘self govern’ the staff were able to withhold their rights and to justify a number of extreme measures to govern how the subjects should govern themselves in the absence of self-government.

Secondly, the discourse involved an intense problematisation of the environment with the effect of making restraint use seem inevitable. This discourse also had the effect of constituting another environment distant from the present where care can be given appropriately, where staff would be free from the physical manifestations of their inappropriate environment. The participants frequently knew very little about how this environment would differ from the current one. In fact for all but one of the nurses who identified significant features, this ideal environment seemed to be almost mythical and with this magical slight of mouth, fools the spectator into the view that there is little that the current staff can do to eliminate restraint use in their environment. Thus the responsibility for restraint use is shifted to a somewhat ephemeral group of people who designed the building in the first place or those who do not pull it down now and start again.

The third discourse of importance involves constituting restraints as the only treatment that is realistic and sensible. These include the discourses on economy of time, ethics, and legalities. This discourse includes traces of the last discourse in that it includes reference to an ideal treatment, which is not easily pinned down by those who espouse it. This discourse also systematically rules out the trial of alternatives by a number of persuasive and emotive arguments such as the lack of time the overworked nurses get to care for individuals and the risk they are at of getting injured if they do not restrain. It has been identified how these discourses seem rational but under close scrutiny prove to be little more than varying degrees of well founded opinion which are damaging to the identification of alternatives to restraint use.

Fourthly, the participants made explicit reference to their appropriate duty of care. This discourse was particularly persuasive and emotive. Through this discourse participants establish themselves as behaving ethically and as being accountable to their managers or to their profession. The discourse functioned as an extension of the constitution of an appropriate treatment as it provided further, more weighty, reasons for the inappropriateness of risk taking behaviour. This discourse totally silences the view that one is behaving professionally by upholding patient's fundamental human rights, and it is possible for these subjects to be characterised as not entitled to these rights as they are 'non-self governing' individuals. This discourse relies in part on the establishment of dichotomies, which are an over simplification of reality, for instance, 'restrain and protect' verses 'do not restrain

and harm'. By manipulating discourse to suggest that if one does not do a thing another thing will necessarily happen, the staff make easy choices about what they want to happen. It does not matter that these choices do not reflect reality, only that there is a chance that the negative outcome could happen in which case it can be used to justify making the hard decision to restrain a patient. This manipulation has the compelling effect of silencing other discourses, which are also legitimate, such as, there is a fundamental right to freedom, nurses are not fulfilling their duty of care if they use restraints and it is inhumane to subject elderly patients to the humiliation of being tied to a hospital bed. In this thesis alternative discourses are seen as legitimate, but within the discursive framework in the hospital wards they are unsaid, or qualified with a 'but' clause which neutralises their potency.

Fifth, there was significant evidence of marginalisation of restrained subjects. This is particularly interesting as it can be viewed in juxtaposition to the above discourse, which seeks to problematise the subjects' behaviour and make it the subject of debate. This discourse, however, functions to keep the subject out of the realms of the discussed, the problematic and the visible. The participants had a number of ways of eliminating the subjects from their responsibility. For example, the nurses used outside agencies to care for the subjects when possible. The physiotherapists and occupational therapists immediately identified the subjects as outside their sphere of expertise, and the doctors focused on the issue of which specialty was most well suited to take responsibility for the subjects, to the extent that in one case moving the subject to another area unashamedly became the medical plan of care.

All these discourses functioned independently and simultaneously; they were emphasised by some and backgrounded by others. Some were essential to maintaining restraint use while others appeared ancillary. They do not fit into a neat scheme but form a network or capillary system whereby one does not need, in a hierarchical sense, to have power to contribute to the longstanding use of restraints. The next section aims to make clear how the work of Foucault has influenced this thesis.

Summary of the major findings

While practical reasons were given for the use of restraints, few of these were logical or practical in terms of managing the three people in this study. There was a

striking disjunction between the academic or research based discourse on restraints and the discourse of the staff on the wards. It was shown that in terms of what happens to patients with regards to restraint, the ward based discourse was more influential than the academic discourse.

The most influential practice that legitimised restraint was constituting the person as unable to 'self govern'. One may argue that patients with dementia are not able to 'self govern', and therefore, the staff are realistic in this claim. However, once the person was categorised in this way, their rights were so totally obliterated that even rational behaviour could be seen as irrational, and, thus, could be used to justify restraint. This discourse was bolstered by ethical arguments about the safety of the patients, which apparently justified doing almost anything to the patients. It was found that participants could discursively conjure up other environments and treatments where care was unproblematic. These euphemisms were never pinned down to specifics and were offered by the participants as reasons for the continued use of restraints. What they did in effect was to paralyse the staff from using basic and available solutions to the behaviours of the subjects, such as, providing pain relief and comfort. Another major finding was the extensive marginalisation of all three subjects, which had the effect of either silencing any discussion of restraints, or disqualifying subjects from the services that it was generally accepted would do them no good. Again we see the divergence from the research findings presented in the literature review, which advocate a multidisciplinary approach to restraint reduction.

The emphasis on managed care in the literature was echoed by participants in this study, who made claims to nurse shortages to justify the need for restraints. What is clear is that staff shortage debates necessarily confuse the issue of restraints. I am not suggesting that there are not shortages or that there are. I am suggesting that it is a totally separate issue, as restraints do not add safety to an understaffed ward. However, my attention to the need to find the causes of behaviours would seem to entail the need for more staff, as does the attention to marginalisation from therapy services. What this study achieves is to make staff aware of the lines along which they prioritise or characterise certain patients as not needing some services. Essentially this thesis challenges the notion of the 'objective assessment' and highlights the functions it serves which are perhaps not objective but orientated to very specific socio-political goals.

This research has implications for both scholarship and practice and these will be discussed in the next section. Implications for scholarship include nursing scholarship, Foucauldian scholarship, and implications for practice include, nursing practice, education and research.

Nursing scholarship

Attention to the work of Michel Foucault throughout this thesis aims to fill a knowledge gap within the restraint literature, and offer a new understanding of the issues. This thesis exposes the political nature of the discursive formation of restraint use, and highlights the existence and role of relations of power in the maintenance of restraint. In particular, it has led to a thoroughly context bound explanation of how nurses continue to use restraints. I have attempted to escape imposing judgements on their practices in order to focus on an understanding of the function of the practices as they are. Understanding practices leads us to new questions rather than answers. It leads specifically to questions about the social and political role of the nursing assessment and how it is neither comprehensive nor objective as it claims. The discourses exposed above present a way of viewing restraint use and point paths for the elimination of restraints.

Use of Foucault's ideas in this thesis adds to an emerging trend in nursing research to pioneer new methodologies, which may inform nursing more fully than traditional scientific research. New methodologies can be moulded to fit the discipline of nursing rather than nursing questions being made to fit methodologies. Through the repeated application of discourse analysis future nurse researchers can put an additional arrow in their methodological quiver with which to take aim on problems in nursing practice.

Foucauldian scholarship

This thesis demonstrates the utility of this approach in understanding contemporary issues in nursing. It is important that the limitations of the methods utilised in this thesis are set out by conducting studies, which apply it to a range of issues, and not by theoretical delimitation.

Foucault did not claim a fixed or limited theory. His work needs to be made sense of with each new application. Hence, the reference to scaffolding in the introduction to Foucault's principles in the methodology. This study provides an interpretation of

a Foucauldian influenced method with which to compare future and past interpretations.

Nursing practice

This thesis is relevant to nursing practice as it provides an interpretation of an issue that is entirely practical in its nature. The central issue is, how to deal with large numbers of patients admitted to acute hospitals with behaviours beyond those we understand, or find it easy to conduct ourselves around. My hope for this thesis is that it may provide an alternative language and perspective from which to understand and talk about restraint use. This may free staff involved in restraining patients from certain constraints of a limited view of the possible or the ethical. The literature review uncovered the fact that many nurses find restraint use troubling. However, these nurses do not seem to have the vocabulary with which to oppose the practice or make sense of their thoughts and feelings.

Discourse analysis enables the expanding of possibilities for the framing and shaping of practices by making visible the invisible power relations embedded in texts. In so doing it offers the opportunity for those in health care to conceive of other possibilities. (Lupton, 1992 p. 149)

Nursing practice may also benefit by this thesis' exposure of the way in which the staff are complicit in the maintenance of restraint as a form of care. This thesis achieves this by attention to the proposition that no aspect of existing social reality can be seen as authentic, natural or normal. From this point of view, it is easier to observe the unobserved, the taken for granted which lies outside of the tight scheme of scientific rigour from which it is easy to be near-sighted or far-sighted, suffer tunnel vision and colour blindness. These imperfections cause holes in the system of which the research subjects talk and maintain the status of truth of any issue that may service the present. Nursing practice can be made aware of these blind spots and so can create new forms of behaviour, new modes of self-understanding and new codes of moral conduct. In this manner this thesis has the potential to unsettle the taken for granted nature of the current practice of restraining elderly patients.

This thesis should encourage those involved in practice to be vigilant about the acceptance of practices that cause a conflict of ethics. This research uncovers a deeper understanding of the life of patients subjected to restraint and as such is relevant to any nurse who is using restraint in their practice.

Nursing education

This thesis holds important messages for nursing education in that it informs a more appropriate mode of care giving for those teaching skills to nursing students. For example, this thesis has demonstrated how the objective and ritualised patient assessment that is so deeply entrenched in nursing vernacular, can add to the marginalisation and disempowerment of the elderly, frail patient.

Education of student nurses is one avenue to change practice. By making educators aware of the political nature of the rituals and procedures they teach, it may be possible to temper the teaching with a more humane approach to care.

Through the understandings of restrained patients life and opportunities contained in this thesis, educators can make students aware of their responsibility to question the practices they see.

Further research

This study has shown that there are misunderstandings about restraint, despite much research in the area of restraint use. These misunderstandings highlight the need for research that appreciates the nature of the nursing context and the implications it has on practices. Further research attention may be required in the area of appropriate staffing levels for aged care and appropriate assessment skills for all staff in the multidisciplinary team.

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APPENDIX A

GLOSSARY

The glossary contains definitions and explanations of technical terms used in the thesis in the following categories, medical terms, medications, Foucauldian terms, ethical terms, nursing terms and legal terms. The glossary that follows draws on a number of sources such as medical texts, the British National Formulary, texts on Foucault, and a number of ethical, nursing and legal dictionaries.

Alzheimer's Disease (AD):

The most common cause of dementia in Western countries. First described in 1907 by Alois Alzheimer. Clinically, AD presents with subtle onset of memory loss followed by a slowly progressive dementia affecting all functions.

Lewy Body Dementia:

Often known as diffuse Lewy body disease, but can only be differentiated from diffuse Lewy body type of Alzheimer disease on autopsy when neurofibrillary tangles are present in conjunction with Lewy bodies. Neurologically has features of both, Parkinson's and Alzheimer's disease. There is evidence of a characteristic clinical syndrome. These patients often have Parkinsonian features, frequent fluctuations in mood, behaviour, cognitive ability and level of alertness with episodic confusion and lucid intervals suggesting delirium. The fluctuating pattern persist over a long time however unlike typical delirium. There is an unusual sensitivity to neuroleptic medications and benzodiazepines, with exaggerated adverse responses in standard doses.

Vascular Dementia:

Commonly connected with stroke and heart disease or other manifestations of diffuse atherosclerosis and can involved multiple infarcts or diffuse white matter dementia. Clinically the disease progresses in a steplike decline.

Glabella Tap:

Repetitive tapping (at about 2 hertz) over the glabella produces a sustained blink response (Myosin sign) in contrast to the response of normal subjects who override the primitive reflex to blink.

Mini mental state examination (MMSE):

Designed by Folstein (Folstein, Folstein & Mchugh, 1975). These are tests designed to evaluate attention, orientation, memory, insight, judgement, and grasp of general information. Responses to a series of questions and commands are scored to give an overall figure for global mental state. The test is valid and reliable but the test should be interpreted in the context of a comprehensive assessment.

Problematizing (-ation):

The designation of a particular concept or issue as constituting a problem of thought. Importantly for a Foucault influenced study it involves going beyond this definition to establish the conditions of possibility of a 'problematic'. To do this one must examine the ensemble of discursive and non-discursive practices that make it possible for a concept to be integrated into the various knowledge claims about truth and falsity.

Deproblematization:

The linguistic ability to propose a solution or talk of a problem as solved. Can also be evidenced by the absence of certain discursive practices or the failure of a former problem to constitute an issue worth of discussion any longer.

Subject (-ification):

The term subject is used with several different meanings in this thesis, firstly, the research subject or participant, either patient or staff member. Secondly, the process by which a person is made the topic and focus of problematisation or ethical debate.

Discourse

The systematic ordering of linguistic signs or signifiers in a meaningful arrangement. In Foucault's view, however, discourses encompassed more than just words and what those words might signify; they include the very acts of speaking, writing or articulating words (or signs or structures) such that they systematically created the objects of which they spoke.

Empiricism:

An epistemological view that what counts as knowledge claims are justified by appeals to sense experience.

Genealogy:

A term used by Foucault, deriving from Nietzsche. The goal was to record shifts in the knowledge-power nexus in the development of particular discourses.

Modern (-ism, -ity):

Marks a particular historical period but the beginnings of this period are debatable. For philosophy as opposed to architecture, literature, politics and so on, Rene Decartes is usually taken as signalling the beginning of the modern era. The range of philosophies spawned by the enlightenment is seen as characteristic of modernity.

Postmodernism (-ity):

Reflects a shift in philosophical thinking since then and Foucault's thought is both indicative and representative of this shift. Postmodernism rejects the idea that there is any perspective from which one can claim a purely objective view. All perspectives are partial and hence the knowledge claims cannot be treated as indicating universal truths.

Structuralism:

A kind of inquiry or theory predominantly concerned with the description of structures. Linked to the work of philosophers such as Piaget, Levi-Strauss. Structures can be linguistic, social or literary. The approach is often linked to an assumption that structures – relationships between particulars- not particulars themselves are basic to human knowledge. The influence reached its zenith in the 1960's.

Poststructuralism:

A move away from the conception of structures as autonomous determinants of social practices. Claims that thought is constituted by the codes, conventions, and discourses that make up a given cultural order.

Pluralism:

The view that there are multiple realities that cannot be reduced to one single reality.

Panopticon

Referring to the physical structure of Bentham, where prisoners were always visible but were not aware of when they were being watched. This provided a form of discipline that did away with heavy locks and security measure previously evident. Also used by Foucault as a metaphor for modern society that has become increasingly surveyed through its institutions.

Levodopa:

A dopaminergic drug indicated in Parkinsonism. Side effects; can cause anorexia, nausea, insomnia and agitation amongst others. (Start dose-SD 125-500 mg daily).

Antipsychotics:

Also known as neuroleptics and generally tranquillise without impairing consciousness and without causing paradoxical excitement. Extrapyramidal symptoms are most troublesome causing Parkinsonian features. Examples include, **haloperidol** (SD, 1.5-3mg 2-3 times a day), **oxazepam** (SD, 10-20 mg 3-4 times a day). An example of an atypical antipsychotic is **olanzapine** (SD, 10mg daily) extrapyramidal effects may be less marked with this drug and there is some evidence it may be safer for use with the elderly.

Benzodiazepines:

Are indicated for the short term relief of anxiety but long term use is not recommended. Dependence and tolerance can result from long term use with a marked withdrawal syndrome. Paradoxical effects can be seen with an increase in aggression or hostility. They may be long acting such as **diazepam** (S.D, 1mg x3 per day for elderly patients), **temazepam** (SD 10 mg at bedtime), or short acting such as, **oxazepam** (SD 10-20 mg 3-4 x per day), **nitrazepam** (SD 2.5-5mg at bedtime) or **midazolam** (recommended only for medical procedures).

Beneficence:

Well doing; the activity of benefiting others.

Non-Maleficence:

The opposite of **Maleficence**, which is ill-doing; the activity of doing evil to others.

Autonomy:

A person's capacity for self-determination; the ability to see oneself as the author of a moral law by which one is bound. Displayed when a person freely decides, out of respect for a moral demand, to act morally independent of any external incentives

Deontology:

Moral theories according to which the rightness or obligatoriness of an action is not exclusively determined by the value of its consequences, but where other considerations can also be relevant. For instance, that the action fulfils a promise, or complies with a divine command, are deontological. Opposite of **teleological** thinking where the goodness or badness of an action is determined by its consequences

Posey Vest:

Custom made waistcoat-type device that crosses over at the front and clips with tapes attached to the device. Can be used with the aim of preventing rising from either a bed or a chair. Contraindicated in cases of extreme agitation due to possibility of asphyxiation.

Bedrail:

Fixture on the side of a bed that can be raised to form a barrier to prevent a patient falling out of bed. Not advised for restraint as patients may attempt to climb over the bedrail.

Geri Chair:

Custom made chair used to aid positioning or prevent rising. Usually with a lap table which attaches to the front of the chair that cannot be removed by the patient. Can also be bucket shaped which deters but does not totally prevent rising for some patients.

Mittens:

Can either be custom made or ad hoc devices with the purpose of immobilising the fingers to prevent picking or plucking behaviours to prevent dressing or device removal by agitated patients.

'Special':

The allocation of a single nurse to a single patient for the length of a shift usually when that patient requires more care, either physical or psychological than can be provided by a nurse with other responsibilities. Can also be used to control the movement of patients who wander or are at risk of falling (sometimes called a guard).

False imprisonment:

The restriction of an individual's liberty by another, without legal justification.

Assault:

An approach by one person that leads to the fear in another of physical harm.

Battery:

Actual physical approach by one person that leads to physical harm.

Consent:

An agreement about future conduct. Needs to be made by a competent individual, who is fully aware of the consequences of the agreement.

Necessity:

This is a defence to battery. It requires that the action complained of occurred as a result of fear of the safety of oneself or another.

Negligence:

There are three elements:

- A duty of care must be owed by the person alleged to be the negligent
- There must have been a breach of that duty
- As a consequence of the breach there must have been a damage of a type recognised by law

Power of Attorney:

This enables a person holding it to act for another in certain circumstances. Enduring power of attorney gives the individual the ability to act for another in many more sets of circumstances.

O/E: On examination

S/B: Seen By

UA: Urine analysis

D/W: Discussed with

OTPP: Orientated Time Person Place

UTI: Urinary tract infection

Pt: Patient

ATSP: Asked To See Patient

ACAT: Aged Care Assessment Team

PG: Psychogeriatric

NFR: Not For Resuscitation

BO: Bowels Opened

RN: Registered Nurse

GRN: Graduate Registered Nurse

CN: Clinical Nurse

EN: Enrolled Nurse

RMO: Registered Medical Officer

ADL's: Activities of Daily Living

Incr: Increased

APPENDIX B

A PRELIMINARY INVESTIGATION INTO THE USE OF RESTRAINTS IN THE HOSPITAL UNDER STUDY

Aims

The aims of the first phase were to:

- Identify the use of restraints in the acute teaching hospital under study.
- Gain an understanding for the feelings and attitudes of staff towards restraints and their removal.
- Identify a patient profile of a typical restrained patient.

Definition of restraint

I identified working definitions of restraint from a review of the literature and by discussion with nursing and medical colleagues. The definitions of chemical and physical restraints adapted for the purposes of the study were (see literature review):

***Physical:** any physical treatment used with the sole intention of limiting mobility, where that lack of mobility was not an undesirable constraint of a medical intervention such as a plaster cast or infusion pump were included as restraints. Thus restraints were not limited to posey vests or bed rails, if blankets or tables had been used in such a way to prevent movement this was included as a restraint.*

***Chemical:** any pharmaceutical product given with the sole and specific purpose of inhibiting specific behaviour or movement (Powell et al, 1989). Drugs used for anxiety states were not included but if the anxiety manifested itself in behaviours such as pacing or pulling on IV equipment and a drug was given to prevent these behaviours it was included.*

Research Setting

The study was conducted in a 450-bed metropolitan teaching hospital in Australia. Data were obtained in a period of 14 hours on the same day and 254 patients were observed. The hospital has all major specialties and an emergency department. Emergency department, intensive care and paediatric departments were not included in the study.

Procedure

None of the wards were told of the survey prior to the visits of the author. Wards were selected for participation in the study if they admitted medical or surgical

patients and were visited in a random order at random times. Each patient in the participating ward was observed to determine whether they were restrained and their medication charts reviewed for psychotropic drugs. All possible uses of restraint were documented. Interventions that could have constituted restraint were clarified with the nurse caring for the patient. Clarification focused on determining the purpose of the intervention. The period of restraint was calculated from the last time the patient was restraint free. For a patient to be regarded as restraint free, a period of at least 24 hours free of restraint was required. Explanations for the use of restraint were crosschecked with the medical and nursing notes. The use of chemical restraint was verified with the responsible medical officer. To qualify as an example of chemical restraint the reason for the prescription of a psychotropic drug had to conform to the above definition of chemical restraint. Information was collected on the ward staffing levels and patient demographics. It took between ten minutes and two hours per ward to establish restraint use.

Results

The results showed that on the selected day 9.4% (24) of the population were restrained according to the study definitions for physical and chemical restraint. The use of restraint increased with age - no patient under sixty-two years was restrained. All patients who were restrained had some cognitive impairment.

The period of restraint ranged between 1 and 104 days, the mean period was 17.6 days, median, 4.5, and the mode, 4. In general these restraints had been in place for the length of admission without a break of at least 24 hours so the mean period of restraint in days actually reflects the mean length of stay to a great extent.

Table 1
Prevalence of the Use of Restraint by Age Group

(ALL WARD POPULATIONS)

Age group	Patients N	Restraint N	% of patients restrained	Mean period of restraint (days)	Mean period of restraint (hours)
< 65	100	1	1	8	8
65-75	49	3	6.1	13	17.3
75-84.99	78	11	14.1	20.8	32.4
85+	29	9	31	13	11.6

It should be noted that the number of patients in the 85+ age range in the hospital was 29, therefore, there is a need for repeated prevalence studies on this age group.

Modes of restraint

Bedrails (22 - 62%) were the most frequently used mode followed by chemical restraint (6 - 17%) and posey vests (3 - 9%). There was one incident each of mittens, a geri chair and two patients being physically restrained by a patient care assistant 'guard'. Of the restrained patients, 25% (6) had multiple restraints in place.

Staffing levels and restraint use

Table 2 shows the relationship between the percentage of patients aged under 65 years restrained by ward and nurse to patient ratios.

Table 2
Staffing levels, proportion of elderly patients and restraint use

Ward Number	% of patients restrained	P:N ratio *	% patients > 65
1	0	4.6:1	43
2	3	4.9:1	40
3	3	4.3:1	54
4	3	3.2:1	55
5	4	4.5:1	52
6	8	5:1	66
7	11	4.6:1	86
8	18	4.8:1	66
9	25	4.1:1	88

* Patient to nurse ratio

The patient to nurse ratios vary from three to five patients per nurse and appear to be unrelated to the percentage of patients restrained. It is apparent that the percentage of patients over 65 has a greater influence on the restraint use. The wards with the lowest and highest proportion of patients over sixty-five were associated with the lowest and highest restraint rates respectively. As the number of patients aged over 65 years increases as a percentage of patients in a ward, the use of restraint increases. The rate of restraint is highest when more than 80% of patients are aged 65 years, even when the patient to nurse ratio is nearer to 4: 1 than 5: 1.

Profile of Restrained patients

Identifying a profile of a typical restrained patient was important for the case selection. The majority of restrained patients came from home (17 - 67%), the smallest group from a nursing home (3 - 12.5%) and the remainder from hostels. All the restrained patients who were admitted from home came in when their carer

reached a point of crisis and could no longer go on caring for the individual at home. Of the twenty-four patients who were restrained, sixteen were medical (67%) and eight were surgical patients (33%). The rate of restraint was not significantly different for males and females in any age group hence this criterion was not considered important for case selection. In the vast majority of cases the patients had a known dementia and two other pathologies. Commonly these were neurological and CVA and Parkinsons featured heavily. Ischaemic heart disease, diabetes, oosteoarthritis and infections were also very common.

Reason for restraint

The most frequent reason nursing staff gave for the use of restraint was to prevent falls, among patients with little insight into their lack of mobility (59%). The second most common explanation was to control agitation (21%) prevent wandering (7%) and preventing injury to staff or others (7%). Therapy disruption was given as a reason for restraint in 4% of cases and 2% of the cases the nurse could not identify why the restraint was in place. In the case of wandering nurses often said, they would be happy to remove restraints if they could offer a safe environment. If injuring staff or others was given as an explanation the patients always had multiple restraints in place. Interestingly 85% of the nurses spoken to during the data collection did not consider bedrails to be a restraint. In five cases of restraint by bedrails (23%) the nurses said they could be removed without any increased danger to the patient and they did not need to be up. Much of the bedrail use was not considered 'restraint', as it did not satisfy the study definition, often bedrails were used on patient request or to prevent post-operative, semi-conscious patients and CVA patients from rolling out of bed.

Limitations

Before discussing the results of this phase, its limitations should be highlighted. It is possible as in all point prevalence studies that the restraint use captured in the study is atypical. Data was collected in February and it is possible that mid winter restraint figures would differ in that hospitals tend to have more admissions from the elderly population. The survey was conducted on a Monday, and no routine operations take place on Sunday therefore there were few post-operative patients in the study. In addition the number of restrained patients was not large enough to test hypotheses.

Inappropriate definition of restraint by nurses led to the use of bed rails as a benign intervention. Bedrails and chemical restraint were the most prevalent restraints and the most insidious in that they were less clearly and quickly identifiable as restraint. Bedrails have been associated with a number of cases of death by strangulation (Parker & Miles, 1997; Miles & Parker, 1998). However a patient restrained with bedrails would not be included as a case because of the focus on the patients who were the most complex in terms of restraint removal. These patients were generally those with posey vests and chemical restraints. In order for restraint reduction to proceed consistently it is fundamental for nursing research and practice to establish a universal definition of restraint. The definitions proposed here seem adequate for the purpose of both clinical nursing and research. This finding led to a focus on how nurses defined restraints, as this inclusion or exclusion clearly shaped some of the discourse on restraints.

The prevalence of restraint seems high and although the number of patients was small in the 85 years plus age group prevalence of 33% restraint indicates a disquieting trend. It was intended that the cases in the second phase of the research should represent a patient within this older age group as they could be seen as the most vulnerable group to the damaging effects of restraint.

The current research shows that the nurse's primary reason for using a restraint was to improve patient safety. A common patient profile included diagnoses of stroke or dementia hence it was decided that cases with these medical conditions should be represented in the research. The nurses described an unsuitable environment for example wandering patients on wards with easy access to stairs, roads and car parks. This early focus on the environment in which the care took place was important to the case studies.

Importantly, restraints are often used for prolonged periods of time, in one case 104 days (17.6 days mean). This indicates that restraints are not a crisis intervention; they are an accepted mode of care, which is perhaps the most disconcerting result. Patients were restrained from admission to the day of observation, which raises the question; do patients usually get discharged to a nursing home still in restraint? A longitudinal study of restrained patients would be interesting to answer this question.

The results correspond with previous studies that find increasing age and decreased cognitive ability the strongest predictors of restraint use and staffing levels less strongly predictive. This phase did not find higher staffing levels predictive of

lower restraint use. However, nursing skills and education as to how best to deal with typically restrained patients are traditionally poor. It is likely that additional staff will not influence restraint use where knowledge and skills are the inhibiting factors. It may be the case that with increased skills staffing levels become critical and this is an area that will be investigated during the case studies. Most of the studies arguing for reduced restraint without increased staffing levels are conducted in nursing homes and it is the researchers belief that the two environments are sufficiently different to require separate study in this issue. Practical issues, such as the time take to perform an intervention, were crucial to the second phase of the research.

This section identified a working definition of restraint. The patterns of restraint use within the study hospital have been described. The rates of restraint use are high and should be a cause for concern. Increasing staffing levels may not be effective in reducing restraint but environmental adaptation would seem to be important. Based on the findings of this phase the investment of further resources in the form of case studies seems appropriate.

APPENDIX C

CONSENT FORMS AND INFORMATION: A, FOR STAFF INVOLVED IN THE STUDY AND B, FOR PATIENTS AND THEIR GUARDIANS

CONSENT FORM
(For patients and their relatives)

TO BE USED IN CONJUNCTION WITH THE INFORMATION SHEET

An Investigation into Patient Restraint

Patient's Name:..... Date of Birth:
.....

Legal Guardian's Name:..... Date of Birth:
.....

1. I agree entirely voluntarily to take part in / for my relative / legal friend to take part in "*an investigation into patient restraint*".

I am over 18 years of age.

2. I have been given a full explanation of the purpose of this study, of the procedures involved and of what will be expected of me. The research nurse has explained the possible problems which might arise as a result of my participation in this study.

I agree to inform the supervising doctor of any unexpected or unusual problems I may have with the new interventions.

4. I understand that I am entirely free to withdraw from the study at any time and that this withdrawal will not in any way affect my future standard or conventional treatment or medical / nursing management.

5. I understand that the information in my medical records is essential to evaluate the results of this study. I agree to the release of this information to the research nurse on the understanding that it will be treated confidentially.

6. I understand that I will not be referred to by name in any report concerning this study. In turn, I cannot restrict in any way the use of the results which arise from this study.

7. I have been given and read a copy of this consent form and information sheet.

Signature by patient / relative / legal guardian
nurse

Signature by research

Signed.....

Signed:.....

Date:.....

Date:.....

INFORMATION SHEET
TO BE USED IN CONJUNCTION WITH THE CONSENT FORM
Research proposal
An Investigation into Patient Restraint

I invite you to participate in a clinical research study to design new interventions for nurses to use when patients would normally be restrained. This study has been approved by the Fremantle Hospital Ethics Committee.

If you decide to take part in this research study, it is important that you understand the purpose of the study and how it will affect you. Please read the following pages which will provide you with information about the study and what it involves.

Nature and Purpose of the Study

We have asked you to participate in this study as you work on a ward where restraints are occasionally used.

The aim of this study is to decrease the need for restraint in hospitals by studying restrained patients and trialing new interventions other than restraint.

Although restraints are only used as a last resort to protect patients, most nurses would rather see alternative interventions used as restraints can cause some distress to the patient.

What the Study Will Involve

The researcher will be visiting wards for a number of purposes. Firstly she will be trying to establish who is restrained, why, how and for how long. She may approach you if you are looking after a patient under restraint to clarify some of those points. The researcher will make every attempt to gather information without inconveniencing the nursing staff and these clarifications will take no longer than five minutes.

Secondly, the researcher will be performing in-depth case studies with six restrained patients. During these times she may remove the restraints but only after consultation with the registered nurse and at times when she is working one on one with the patient. If the researcher finds an intervention which successfully controls the patient's behaviour she will feed this back to the staff caring for the patient who can then choose to try the new intervention or ask the researcher to replace the restraints.

If you decide to participate in this study, you may also be asked to give an hour of your time to be interviewed about your feelings, concerns or ideas about restraint. You are also invited to be part of an interest group to whom feedback will be given by the researcher on what new interventions she has found useful. This will give nurses a chance to add thoughts about the difficulties of clinical application of the suggested interventions. The interest group will meet when any meaningful results have been established which will be no more than once a month.

Benefits

A potential benefit of this study is certain patients you are caring for under restraint will have additional times during the day when they are unrestrained and have supervision. In addition should you choose to be part of the interest group or interviews you will get a chance to have some input about the direction of the

research so that the results are clinically meaningful and helpful to you as nurses. As there is a move away from using restraints in nursing, alternative interventions, which work are increasingly important if we are to care for our patients appropriately.

Discomforts and Risks

No risks to the patients are anticipated as a result of the data collection. Your contributions in the interviews are strictly confidential. There will be no use of names in any subsequent write up or publication of the results.

Voluntary Participation and Withdrawal from Study

Your participation in this study is entirely voluntary. If you decide not to participate in this study, you will not be treated with any prejudice in present or future career prospects in this hospital.

You may withdraw from this study at any time, for whatever reason. Such withdrawal will not in any way influence decisions regarding future career in this hospital.

CONSENT FORM
(For staff involved in the study)

TO BE USED IN CONJUNCTION WITH THE INFORMATION SHEET

Research proposal
An Investigation into Patient Restraint

Patient's Name:.....

Date of Birth:

.....

1. I agree entirely voluntarily to take part in "*An investigation into patient restraint*".

I am over 18 years of age.

I have been given a full explanation of the purpose of this study, of the procedures involved and of what will be expected of me. The research nurse has explained the possible benefits and risks of the study to me, and the patients in my care.

I understand that I am entirely free to withdraw from the study at any time and that this withdrawal will not in any way affect my future prospects at this hospital.

4. I understand that I give information to the research nurse on the understanding that it will be treated confidentially.

6. I understand that I will not be referred to by name in any report concerning this study. In turn, I cannot restrict in any way the use of the results that arise from this study.

7. I have been given and read a copy of this consent form and information sheet.

Signature by Registered Nurse
Nurse

Signature by Research

Signed.....

Signed:.....

Date:.....

Date:.....

APPENDIX D

EXAMPLE OF THE DEVELOPMENT OF ISSUES: CASE STUDY ONE:

Why has he so easily and unanimously been identified by nurses as requiring restraint?

To the extent that his behaviours / choices put him at risk why does he so choose / behave?

How did the environment impact upon these behaviours?

Did the nurses lack knowledge of how to communicate with him to assess his needs?

Did the nurses lack motivation to communicate with him? Why?

How did nursing care /management impact upon him?

How did medical care / management impact upon him?

What explanations or justifications for the use of restraints are put forward by the staff? (Multiple realities)

Later these became:

Why did the nurse believe that restraint was a valid way of dealing with these behaviours – if they did! If they didn't why were they used anyway?

Why was inter or intra team communication such an impediment to his care?

In what way were resources directed to his care?

What was it like to care for him? Experienced nurses and grad nurses (multiple realities)

What would be a helpful environment for his care?

How realistic was restraint elimination under the circumstances?

And later

Is this patient being marginalised? Why?

What effect does this have on the reality of restraint reduction?

What discourses or social explanations underpin the continued use of restraint?
(Addressed through analysis rather than data collection)

Was nurses' fear and lack of confidence an inhibiting factor in his care?

APPENDIX E

CLINICAL FLOOR PLANS

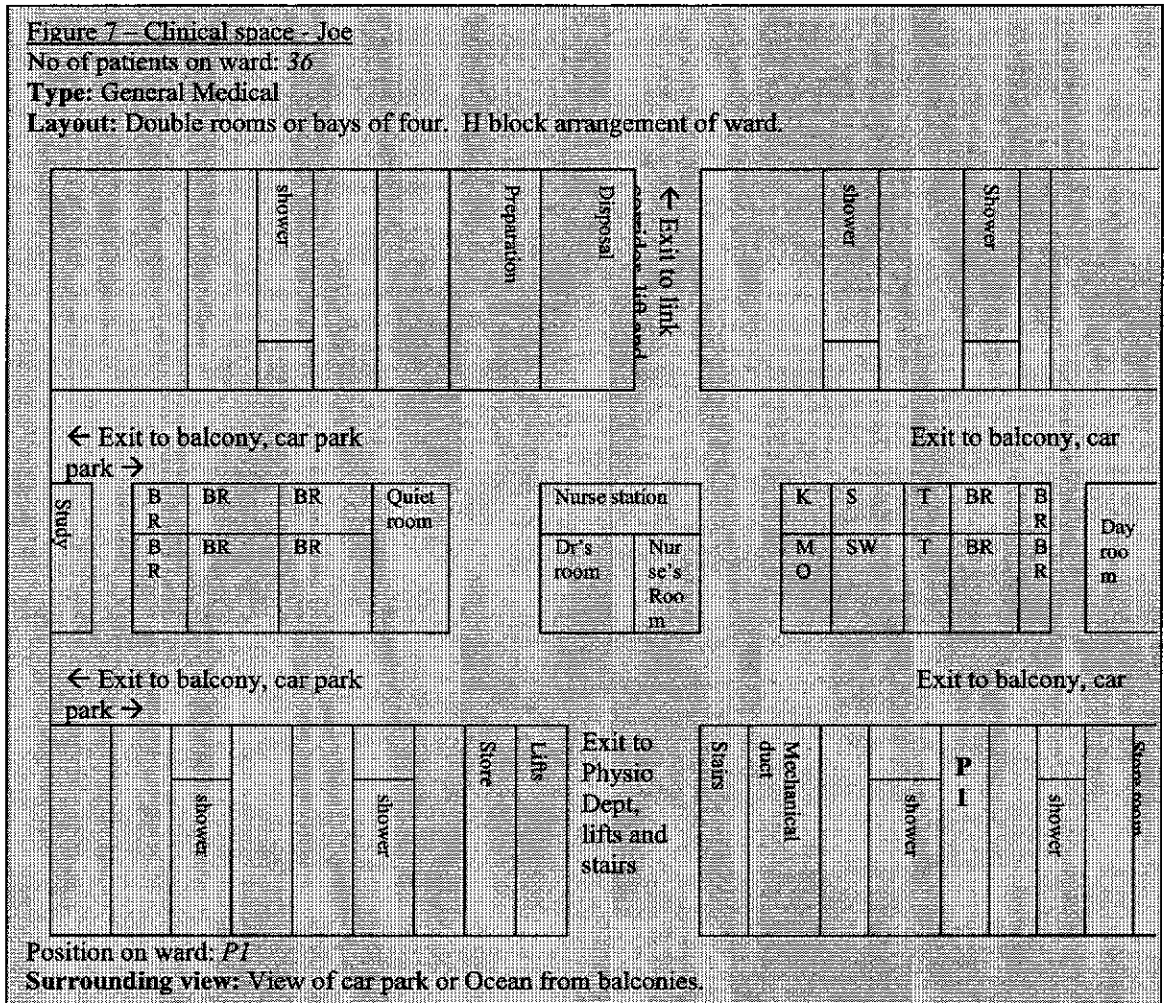
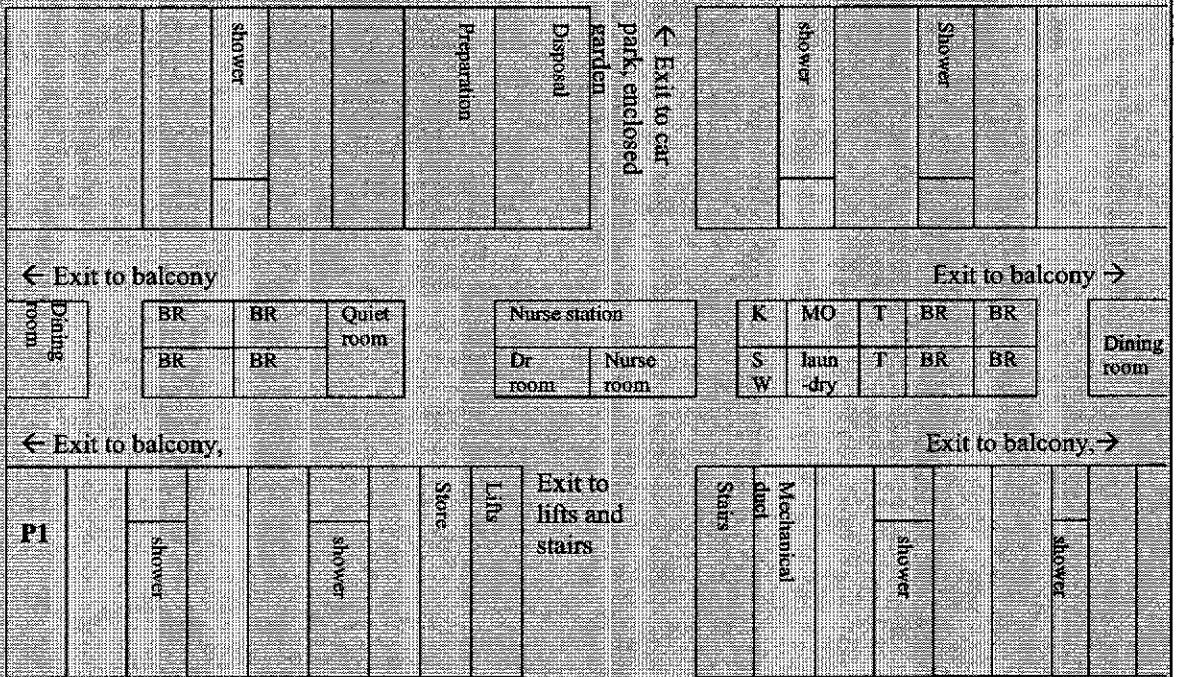


Figure 8 – Clinical Space - Elsie

No of patients on ward: 36

Type: Medical rehabilitation

Layout: Double rooms or bay of four. H block arrangement of ward.



Position on ward: *PI*

Surrounding view: View of car park from balconies.

Figure 9 – Clinical space- Ted

No of patients on ward: 32

Type: Medical haematology and oncology

Layout: Single rooms or bay of four. Central corridor with rooms to left and right

