ORIGINAL RESEARCH

Restraint Practices in Incapable Wandering Patients During COVID-19: Ethics and Best Practice Recommendations

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ABSTRACT

Patients who wander as one of their psychological and behavioural symptoms of dementia are often unable to follow or recall Infection Prevention and Control precautions, putting them at risk of contracting or spreading COVID-19. Physical and chemical restraints have been used to limit the risk of transmission to wandering patients and their care providers, but restraints are not the standard of care for wandering behaviour in non-pandemic scenarios. Although provincial policies on restraint use are available, their guidance may not provide the context-dependent information necessary for individual patient decisions. To address this knowledge gap, we reviewed the medical, ethical, and legal considerations through an interdisciplinary approach including nurses, physicians, ethicists, hospital leadership, risk management, and legal counsel. We present an ethical framework that front-line health-care workers can use to create a balanced patient-centred care plan for incapable wandering patients who are at risk of contracting or spreading COVID-19.

Key words: COVID-19, bioethics, dementia

INTRODUCTION

Decision-making during a pandemic such as COVID-19 necessitates balancing the utilitarian principle of protecting the largest number of people while not placing overly burdensome restrictions on individuals. However, this balance of individual rights with the rights of others is particularly challenging in the case of cognitively impaired patients who cannot follow infection prevention and control (IPAC) precautions, putting them at risk of contracting or spreading COVID-19. It is not clear from existing policies whether chemical and physical restraints are permissible in these circumstances to mitigate harm to self and others, given that such restraints are not the standard of care in non-pandemic times.(1) The inherent moral distress from providing care that seems to conflict with a patient's autonomy and dignity can result in moral injury to health-care workers.(2) While provincial policies provide guidance,(3,4) they do not help clinicians weigh the ethical and medical concerns for individual patients. To this end, we conducted a review of the medical and ethical literature and sought legal counsel to develop a comprehensive policy for clinicians. A hypothetical case scenario is used to illustrate the critical points of this report. This work is intended to help health-care workers maintain patient-centred care despite pandemic circumstances requiring prioritization of utilitarian principles.

CASE SCENARIO: PART I

Mr. GB is an 82-year-old man with Alzheimer's dementia awaiting placement in long-term care following an admission for delirium. He is known to wander as one of his behavioural and psychological symptoms of dementia (BPSD). He is easily redirectable and enjoys sitting by the nursing station. During a COVID-19 outbreak, he develops a dry cough and rhinorrhea. His COVID test returns positive. Mr. GB continues to wander without a mask and frequently tries to enter the nursing station as he did previously. Hospital staff are concerned he will spread COVID to other patients on the ward and health-care workers.

METHODS

Medical Considerations

A non-systematic literature search of MEDLINE (1946-January 2021) was conducted using the terms "restraints", "dementia", "wandering", "antipsychotics", and "COVID-19". Relevant

studies were selected, and their references manually searched for additional papers.

Ethical and Legal Decision-Making Process

An interdisciplinary team of physicians, nurses, ethicists, and hospital leadership engaged in an ethical decision-making process grounded in reflective practice.[5] This standardized process provided a foundation for ethical decision-making while allowing for clinical flexibility to apply to individual patient scenarios. In the first stage, ethical issues were identified. In the second stage, the team gathered perspectives of relevant stakeholders, including risk management/quality of care, corporate restraints committee, external legal counsel, the Canadian Medical Protective Association (CMPA), and an insurer. A team approach grounded in non-maleficence and dignity was used to review the relevant legislation, standards of practice, and institutional policies. Contextual features and resource implications were also considered. The third stage was dedicated to generating possible recommendations. In the fourth stage, recommendations were evaluated based on the team's core values and duties. The final stage consisted of integrating an addendum into the existing institutional policy, receiving corporate approvals, and communicating the changes to the interprofessional staff involved in patient care.

RESULTS

Medical Considerations

More than 20% of patients with dementia exhibit wandering behaviours.[6] As cognitive impairment is associated with increased age and frailty—both risk factors for severe COVID-19 infection—it is all the more crucial to mitigate risk of infection in this population.[3,7]

A literature search identified very few papers relevant to the medical care of wandering patients in the context of COVID-19, of which most were reviews or policy documents. Provincial public health guidelines identified the need to follow IPAC measures to limit the spread of communicable diseases,[4,8] which is challenging in patients with dementia who may not remember or follow instructions. Generally, best practices to curtail wandering patients begin with a thorough assessment identifying any modifiable triggers for wandering.[3] Non-pharmacological strategies must be exhausted before considering chemical and physical restraints.[3,9,10] However, there has been a statistically significant increased use of antipsychotics and benzodiazepines since the onset of the COVID-19 pandemic, both locally in Ontario[11] and globally.[12,13] Use of restraints has been associated with increased delirium,[14] adverse events in nursing homes,[15] and COVID-19 mortality.[16] The available recommendations ultimately highlight the need for a combined principles-based and context-based approach to each individual's care,[9] but no practical approach exists to support clinical decision-making.

Ethical and Legal Considerations

The ethical issues were identified as reflecting a dialectic between individual autonomy and collective safety, summarized by four primary ethical principles (Figure 1).[3,17] The clinical team is tasked with maintaining the dignity of patients who wander while honouring their responsibility of safety to other patients, the staff, and the community. These issues generated strong emotions, as decision-making needed to occur rapidly yet mindfully, balancing multiple factors.

The principle of utilitarianism—protecting the greatest number of people without overly burdensome restrictions on individuals—underpins public health decisions during emergencies like pandemics. In direct conflict with these utilitarian values, physicians have a fiduciary duty to care and advocate for their individual patients. Fiduciary conflict arises when physicians are charged with caring for both wandering COVID-positive patients and other patients at risk of contracting COVID-19 on the same ward. A

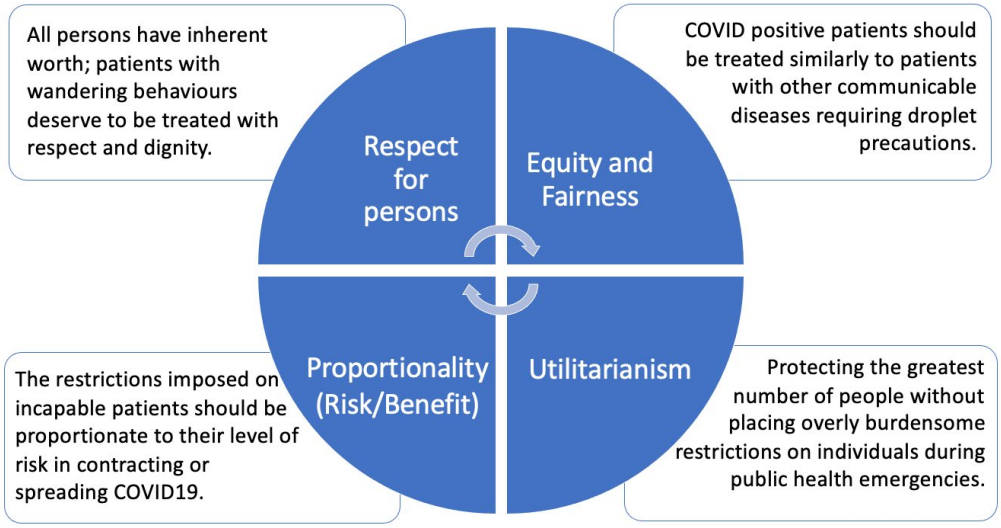


FIGURE 1. The ethical considerations when considering restraint practices in incapable wandering patients during COVID-19[3,17]

potential solution is cohorting COVID-positive patients on a single ward. When not feasible, the ethical principle of proportionality can mitigate this fiduciary conflict; the restrictions imposed on an individual should be proportionate to the level of risk in contracting or spreading COVID-19. Therefore, individual risk assessment is crucial in resolving the moral distress that is elicited when balancing patient autonomy and collective safety.

Consultations with stakeholders strongly suggested early communication with families concerning the potential need for restraints and to minimize their use. At the time, there was no specific guidance on whether the substitute decision-maker (SDM) for an incapable patient was required to give consent before restraints could be used. Ontario legislation stipulates the use of restraints is permissible in an emergent situation to prevent serious bodily harm to self or others.[18] Ultimately, our ethical decision-making process determined that it was reasonable to consider COVID-19 an emergent situation. As such, SDMs should be advised of the potential need for restraints, and their consent should be sought but was not required.

CASE SCENARIO: PART II

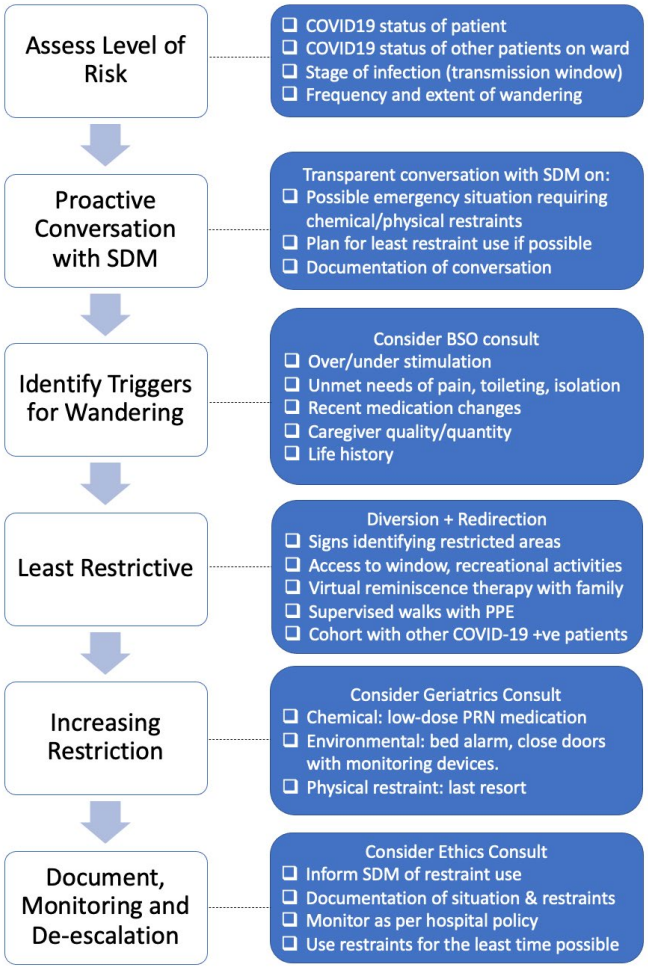
Despite initial success with least restrictive methods, Mr. GB developed hyperactive delirium due to his COVID-19 infection. He was no longer easily redirectable and became physically aggressive to the health-care team when prompted to leave the room of a COVID-negative patient. He received a one-time emergency dose of haloperidol 0.5mg intramuscularly. He was then guided back to his room where limb restraints were applied. His SDM was notified prior to haloperidol administration, and the conversation was documented. Due to staffing shortages, least restrictive measures, such as 1:1 companionship to address bed-exiting, were not possible. When reassessing his restraints every 12 hours, the medical team weighed the risks to the collective safety of the other patients and hospital staff and determined Mr. GB needed to remain in restraints as he continued to have bed-exiting behaviour. Three days later, Mr. GB was transferred to a cohorted COVID-19 ward. Mr. GB was able to wander within limited areas in the hallway and his restraints were removed. His delirium slowly cleared, and he was eventually transferred to his new home in long-term care.

DISCUSSION

We identified the pertinent medical, ethical, and legal factors involved when caring for incapable wandering patients at risk of contracting or spreading COVID-19. Caring for such patients can be morally distressing to health-care workers when core ethical principles of medical practice—autonomy, fiduciary duty, beneficence, and non-maleficence—conflict with pandemic ethics of utilitarianism. Recognizing the ethical dilemma is integral to understanding why clinicians feel moral distress. Added to this complicated picture are the medical considerations of wandering patients who are often at risk for serious complications from COVID-19 due to age and medical comorbidities, but who are at increased risk of harm associated with chemical and physical restraints. The findings of the interdisciplinary working group were incorporated into our institution's hospital policy on restraint use as an addendum to the existing policy; it now sets the standard of care for practitioners at our institution. These findings have been synthesized into a decision-support framework (Figure 2) to help clinicians navigate cases at their own institutions.[19,20]

Strengths of this report include the interdisciplinary approach used to address this ethical dilemma. Furthermore, we outline the principles and processes that health-care institutions can use to create ethical decision-making frameworks in novel situations where there is a paucity of literature to inform practice.

Limitations of this report include the relative scarcity of literature on this topic, particularly in acute care or inpatient settings. Most best practices and recommendations were extrapolated from long-term care or nursing home settings.



SDM = substitute decision maker
BSO = Behavioural Supports Ontario
PE = personal protective equipment
PRN = taken as needed

FIGURE 2. Decision-support tool when managing incapable wandering patients during the COVID-19 pandemic[19,20]

This highlights a needed area of research in studying the experiences and outcomes of wandering inpatients during COVID-19 to inform future policies.

CONCLUSION

The COVID-19 pandemic has posed many challenges across all ages and health-care sectors. Clinicians caring for incapable patients at risk of contracting or spreading COVID-19 are encouraged to follow an approach that balances medical, ethical, and legal considerations.

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CONFLICT OF INTEREST DISCLOSURES

We have read and understood the *Canadian Geriatrics Journal's* policy on conflicts of interest disclosure and declare no conflicts of interest.

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