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Abstract

Many is the starry-eyed couple who have pledged their unending love for each other, sealed with those infamous words 'til death do us part', tossing the phrase liberally forth with no concept that death will indeed one day sever the bond between them, and facilitate in that remaining, one of the most momentous changes that they may ever have had to negotiate.

That Australian society is a progressively ageing one is an often acknowledged fact, with a predominance of women making very old age overwhelmingly a women's issue (Knapman 1996), with the eighty and over age group representing two women for every man (Australian Bureau of Statistics 1992, cited in Petersen 1994, p.84). Thus fades the stereotypical notion of a silvery-haired couple walking off into the autumnal sunset of their declining years together, enjoying mutual companionship on extended fishing trips and family picnics. This elusive ideal falls well short of the actual experience of a substantial number of Australian women, for whom isolation, aloneness and continual ageing - with their attendant pressures - make up for them their newfound status of widowhood, and all the implications that such a title incurs.

In an attempt to understand those stereotypes of the aged staunchly held by this society, and in order to understand their perpetuation in my own mind, I arranged to visit my eighty year old aunt, hoping through the filter of this one woman's experience to gain a new insight into this unique, extensively varied strata of the population.

It should have come as no great revelation to me that my aunt's life experience of the last thirty years has been not so much a gracious adapting to her ageing process, but a negotiating of her widowhood - the major issue in her life which wound its subliminal influence throughout her every word. Research of the current literature revealed insightful discourse on the somewhat caricatured state of being a widow - an exploration of which forms the basis of this paper.

Death of a spouse is one of the most profound losses experienced by humans (Anderson and Dimond 1995, p.308). It was through the discussion with my aunt that I came to understand the implications of this fact in her life, which struck at the very foundations of her existence. She had been my uncle's wife - the spouse of a well-esteemed Rotarian, who had unsuccessfully run for political office several times, and who had been her support socially and financially, while she remained out of the paid workforce, caring for their three daughters and pursing voluntary charitable works. His untimely death from lung cancer in her fiftieth year plunged her into an early transition involving role and status change in which a widow moves from being married to single (Poncar 1989, p.6). With this change comes a redefinition of her role in the social network. As my
aunt had dealt with such a change at a younger age than the majority of widows, her ageing had not been simultaneous with this status change. As she spoke, however, of her son-in-law, it became apparent that after the second great loss of her life - the death of her thirty-seven year old daughter from breast cancer - she assumed this daughter's role in mothering her grandson and incorporating her son-in-law into her social circle, relying on him for practical needs and for fulfilling a support role in, for example, serving the drinks at dinner parties. Thus she built for herself a new status involving a male beneficiary of her energies, but set herself up for another major loss upon his moving to another city for career advancement.

Widowhood has been described as a process of replacing former roles and activities with new ones (Poncar 1989, p.9), such a process being less common in middle life and therefore a lonelier one than for elderly women (Arber and Ginn 1991, 162). So it was almost a natural consequence that my aunt would slide into the role of support for her son-in-law when he was coping with the loss of his spouse, a dynamic which she had dealt with twenty years before.

In her study of older widows' experience of living alone at home, Porter (1994, p.21) enumerated several distinct phenomenon upon which she postulated that they built a structure for coping with daily living. Reflecting on my aunt's revelations, I could witness these in her experience. The first, most patent strategy she has subconsciously deployed within her experience is that of making her aloneness into a state that is acceptable to her (p.21). I have observed how she has redefined her need for companionship by incorporating not only family but also a network of friends into selected areas of her day. Foundational to this is the liberty to go out - in daylight hours - and to interact and seek the fellowship she is denied at home. Thus of an evening it becomes acceptable to be alone in her familiar surroundings - listening to the radio, enjoying selected television programs or reading a meaty novel. Within the liberty to 'watch what I want' and to bypass the 'trash on TV' is an attempt to make the liberty of aloneness into a positive dynamic.

Crucial to my aunt's adaptation is the unstated notion that she can take care of things her own way, involving a making of her own decisions and considering her own needs first - a concept labelled by Porter (1994, p.21) as 'going my own way' and which women did so by ensuring they fulfilled the responsibilities basic to living alone. Intrinsic to this procedure is the balance between a solo coping with tasks and a level of asking those close and trusted for assistance. A quick review of my aunt's situation exposed how this delicately balanced status quo has been recently disturbed by her son-in-law's moving to Hobart. 'Who will call to change the light bulbs?' - a minor detail for a younger individual, but a major obstacle to independence for one who is climbing up on a chair to reach the offending socket, taking up with her that recalcitrant pelvis and those rebelliously arthritic changes. How fickle it would be for such a menial task to stand between this lady and her remaining in her own home.

Inherent in this self-monitoring readjustment is what Porter (1994, p. 22) described as 'reducing my risks', wherein elderly women performing their daily tasks generally become increasingly concerned for their own safety, with the common result of bringing the world closer to home. Hence the rational behind my aunt's no longer going out a night 'unless your parents take me'. Likewise her needing to deny her penchant for wearing high heeled shoes - 'I just love them' - and surrendering them for sensible, flatter shoes. This may seem a very wise choice, but represents a big adaptation for a woman who has progressed through various eras of fashion clinging to her classic, elegant dress, offset by those flattering heels.
The widows in Porter's (1994) study were doing all that was necessary to 'keep themselves going' because of the overriding imperative to continue living in their cherished homes. There was observed a propensity to compare their own routines and abilities with those of other older women, particularly those who were no longer successful in this staying able. Criteria they subconsciously used included 'just sitting down' and 'minds [that] slip'. These concepts were echoed in my aunt's deliberate choice to keep active by cleaning her house herself - not like acquaintances who have someone to come in and help; and her devouring of cryptic crosswords - to keep her mind active. Foundational to all these noble goals is the hoping to see the 'future that I prefer' (p.23).

Widowhood presents its conscripts with a myriad of changes, involving more than just those of role and status adjustment, but every facet of the woman's life experience up until the point she is plunged into this state of being. These women find themselves having to learn to handle the tasks once done by husbands, with house and car maintenance plus managing of financial affairs all presenting themselves as daunting procedures (Anderson and Dimond 1995, p.311), for which they are often unprepared (Bowling 1982 cited in Poncar 1989, p.8). My uncle would have considered his role of husband to unequivocally include that of breadwinner, provider, administrator of finance and final arbiter following discussion - a noble stance but one which leaves a patent void upon the incumbant's demise. Thus my aunt, having plunged herself into my uncle's terminal care, entered mourning in a somewhat exhausted state and was then obliged to pick up the reins of her situation and learn how to steer. It was through just such a need that she would have instigated her coping strategies of taking care of things her own way and keeping herself going.

Included in this was the momentous decision to surrender the imposing old house on the hills of Trevallyn, with its adornments added by her husband's cabinet-making skills, surrounded by the exquisite prize-winning garden that he had cultivated. It was no light decision to pack up the grand furniture and memories of three daughters, and move to a small, modern house on the other side of town. I suspect that my aunt realised that her hope of reaching that goal of staying in her own home was infinitely more attainable in a revised setting. Enmeshed in this decision was the instant dismissal of any notion of living with family - a concept which would strike at those very foundations of that vital independence.

It was only as I have, as it were, come to know my aunt in a deeper way - or has it been a renegotiation of my relationship with her as adult to adult? - that I understand the monumental changes and choices that beset her upon her husband's untimely death. This widowhood, described by Robinson (1986, p.153) to be a developmental issue for older women, is more accurately reflected by Poncar (1989, p.7) as a dual grieving process - the simultaneous mourning of the one departed and of her role. Such a conjecture begs the question of whether this society recognises the double incumbent nature of the widow's loss, permitting her to fully negotiate the unfolding grieving process on both counts. Whereas for many their immediate response to a spouse's death is usually shock and disbelief (Anderson and Dimond 1995, p.309), I sense that my aunt, by virtue of the living death afforded by carcinoma, began her grieving journey during my uncle's transition from life to death. Opinion differs on the length of a grieving period, with Engel (cited in Poncar 1989, p.7) declaring a 'successful one to take between six and twelve months', whilst others argue that it may take some two or more years to regain interest in the outside world (Silverman cited in Poncar 1989, p.7). However, such time framing would, I suggest, serve to encapsulate a widow's expectation of her emotions and coping, and hinder a healthy outworking and consequent readjustment in the new role in which she is now cast.
Parkes (cited in Turner 1987) points out that the absence of a significant culture of mourning and of funeral rites has made the entire process of death and grieving in today's contemporary society highly problematic, uncertain and unsatisfactory. My personal recollection of my uncle's death is of his body being whisked away to a funeral parlour to be prepared for an impressive funeral at a large local church - a ceremony which my aunt did not attend because of feeling uncomfortable with such a form of burial rite and public mourning.

Thus was her support, confidant, friend and lover (Poncar 1989, p.6) plucked from her, leaving her as one who has lost their supportive crutch, and now must learn to walk unaided. This glimpse into the world of widowhood via the filter of my aunt's life has indeed exposed that state for the unique, individually-experienced phenomenon that it is.

References


Following conversation with an elderly relative or acquaintance, isolate a prominent issue that arose out of your narrative account and analyse, incorporating relevant literature.
Who uses the lab?

Dr P J Martyr, Lecturer
Tasmanian School of Nursing
Nuritinga Issue 1
June 1998

This paper reports the results of a 30-day study involving Nursing Computer Lab M101, Newnham campus, University of Tasmania. The purpose of this study was to gain knowledge in three areas:

- how many students are using the computer lab provided by the school,
- what are the demographics of that student population,
- how much time each student was spending in the lab.

By analysing these three fields, some preliminary findings may emerge as to what factors inhibit or enhance computer access.

Introduction

This study was carried out at the Tasmanian School of Nursing - which, together with the Schools of Medicine, Biomedical Sciences, Rural Health and Pharmacy, make up the Faculty of Health Sciences. The TSON is based at Launceston, in the north-east of the state, with other campuses at Hobart, Burnie, and Launceston General Hospital.

This study is an attempt to establish in part if on-campus nursing student facilities are being used, and what sorts of factors may be assisting or impeding access to computers for nursing students. The Launceston campus of the TSON offers a computer laboratory with 11 terminals for student use. The lab operates on a free-use basis; that is, there is no log-in or password needed to use the facilities. This inhibits tracking of the students’ use of the laboratory, and has shaped the data collection for this study. The lab is also accessible 24 hours a day, seven days a week.

The hardware consisted in 1997 of three Power-Macintoshes (6300/120) and eight Macintosh LCIIIs. All have colour monitors and Ethernet capacity. The software included a range of word-processing programs, the Eudora electronic mail program, the Netscape internet browser and a variety of miscellaneous programs.

Literature Review

Literature on computer use in nursing education is prolific, producing a specialist body of knowledge complete with its own forums for discussion. The literature reviewed for this paper examines the problems and barriers to the integration of computer use in nursing education in the college/university context. There are two major concerns - cost of equipment and student inexperience, which form a problematic nexus for the computer educator in nursing.
Cost of hardware
Hebda (1988) undertook a study of the types of computer assisted instruction (CAI) in baccalaureate nursing schools in the US, which revealed barriers such as high costs, lack of educator time and skill, and lack of quality software (p. 24). Calderone (1994) also noted that the cost of hardware and software has been a strong impediment to the more extensive adoption of interactive technologies, including interactive video instruction.

Student inexperience
Schwirian et al (1989), in a comparative study of the attitudes of nurses and nursing students, found that students did not have as much computer experience as predicted, and that lack of skills would form a barrier to integration. Wilson (1991), who examined the role of computer anxiety, also noted lack of hands-on experience as a key problem in generating this anxiety, and indicated studies which showed that anxiety is reduced with successful computer interaction. Van Dover and Boblin (1991) have noted the importance of experience in computer use for nursing education, as has Burkes (1991). The question of physical access to facilities has been obliquely addressed by Birx et al (1996) in their study of laptop use, which provided nursing students with laptops during the course of the study. The study did, however, note a high level of frustration with troubleshooting and technological failure, which impeded access to electronic resources.

Access
There is also very little literature on the problems of access in nursing student computer use. Researchers begin from the premise that students have access to a computer, or have ensured that students are loaned a computer for the purposes of the study (Birx et al, 1996). What has not been explored is whether students have regular access to computers, and if so, what kind of access.

Method
The study was conducted over 30 days during first semester in 1997, when most of the students were at the Launceston campus. Second-year students attend a four-week practical course after week 10 of each semester, so the study was carried out before this took place in order to allow a maximum diversity of student users.

Sample
The sample was generated originally by the need to introduce a booking system for the computer lab in 1997. Student perceptions were that the lab was in constant use, and that they were thus frequently unable to access this facility. I introduced this system, which was to be self-policied by the students, and which consisted of booking sheets, one for each day, divided into half-hourly periods. As this was to form my means of data collection, I checked that this did not require Ethics Committee approval; subsequent and more detailed studies may involve this.

The students were encouraged, via notices posted in the lab, to fill in the booking sheets, which gave timeslots and the terminal number, with their first initial and surname. These sheets were collected weekly and the data entered on a spreadsheet.
**Who uses the lab?**

*Dr P J Martyr*

**Data analysis**

The data was collated and compared against student lists to ascertain year level and enrolment in Nursing. Only two students who used the lab and filled in the data sheets were not enrolled in the Bachelor of Nursing course. The data was then broken down into three broad categories, the first of which noted the students using the lab, and how often they used it. This was recorded on a daily basis, and so did not take account of multiple use of terminals by the same student throughout one day.

The second category was broken down into individual terminal use, to gain some indication of student preference for particular terminals, and how this may affect access. Finally, the total number of students per day and total number of hours per day the lab was in use were calculated, producing a mean lab use figure for the group.

**Limitations**

This study was intended to gather preliminary data about the amount of use of the lab, and to provide the groundwork for future studies on problems of access and technical support. As such, it has a number of limitations.

Some students persistently entered their initials only, and so this data was discarded. Students also tended to under-use the booking sheets - on several occasions, sheets were collected which bore notes claiming that the lab was being fully used, although only a few students had entered their name and terminal number.

The form of data collection also limited the study; it at best represents an incomplete view of lab use. The short duration of the study will also exercise a limitation on the results.

**Results**

1 & 2. How many students are using the lab, and their profile

The profile of the ‘typical’ lab user was a second-year female pre-registration student, who used the lab 1-4 days out of the 30-day period. From the 96 students recorded, a general breakdown can be generated (Table 1).

<table>
<thead>
<tr>
<th>Table 1.1: Profile of Student Users of Lab over 30 Day Pilot Study</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td><strong>Nursing experience/education</strong></td>
</tr>
<tr>
<td>Pre-registration</td>
</tr>
<tr>
<td><strong>Level in course</strong></td>
</tr>
<tr>
<td>1st year</td>
</tr>
<tr>
<td>Year 2</td>
</tr>
<tr>
<td>Year 3</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
</tbody>
</table>
The first year cohort was not well-represented, as there were only 18 present in the study, which represents 11% of a first year pre-registration enrolment of 159. The Year 2 students had a high representation, which was almost certainly directly influenced by the introduction of an on-line second-year unit, Perspectives in Ageing, in 1997. 75 of the students in the sample were second year level, which represents 68% of the total second year pre-registration enrolment of 110. There was, by contrast, only 1 third-year student, which is understandable given that most third-year classes are held off the Launceston campus.

3. Use of lab and computer preferences
The level of participation for each student during the 30 day pilot study was also calculated, and ranged from 3% (1 day) to 70% (21 days). The mean attendance was 12 days out of the 30, or 40%. Over half of those sampled used the lab only once or twice during the 30 days of the study (Table 2).

<table>
<thead>
<tr>
<th>Days Participated</th>
<th>Number of Students</th>
<th>Percentage of 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>39 (40%)</td>
<td>3%</td>
</tr>
<tr>
<td>2</td>
<td>14 (14.5%)</td>
<td>7%</td>
</tr>
<tr>
<td>3</td>
<td>11 (11%)</td>
<td>10%</td>
</tr>
<tr>
<td>4</td>
<td>8 (8%)</td>
<td>13%</td>
</tr>
<tr>
<td>5</td>
<td>4 (4%)</td>
<td>17%</td>
</tr>
<tr>
<td>6</td>
<td>2 (2%)</td>
<td>20%</td>
</tr>
<tr>
<td>7</td>
<td>4 (4%)</td>
<td>23%</td>
</tr>
<tr>
<td>8</td>
<td>2 (2%)</td>
<td>27%</td>
</tr>
<tr>
<td>9</td>
<td>4 (4%)</td>
<td>30%</td>
</tr>
<tr>
<td>10</td>
<td>2 (2%)</td>
<td>33%</td>
</tr>
<tr>
<td>11</td>
<td>2 (2%)</td>
<td>37%</td>
</tr>
<tr>
<td>12</td>
<td>1 (1%)</td>
<td>40%</td>
</tr>
<tr>
<td>13</td>
<td>1 (1%)</td>
<td>43%</td>
</tr>
<tr>
<td>14</td>
<td>2 (2%)</td>
<td>47%</td>
</tr>
<tr>
<td>More than 14</td>
<td>1 (1%)</td>
<td>70%</td>
</tr>
</tbody>
</table>

The chart below shows a comparison between PowerMac use and LCII use. Given that there were only three PowerMac terminals to eight LCII terminals, PowerMac use over the 30-day period was proportionately heavy, at 282.5 hours of PowerMac use to 340.5 hours of LCII use (Chart 1).
Do students take advantage of the lab’s 24-hour access, or do they integrate lab use as part of their normal routine on their contact days only? The results seemed to indicate that while students who used the lab on the weekend were able to spend more time there, the majority of the lab activity was still confined to Monday-Thursday, which represents the normal bulk of student contact hours in the School (Table 4).
The weekday user tended to use the lab for shorter periods of time, which may be caused by pressure from other students needing to use the lab, or by time limits between classes. On the weekend, fewer students used the lab, and used it for longer periods, which again supports either of the above possible explanations (Table 5).

### Table 4: Patterns of lab use over 30-day period - Weekdays (21 days)

<table>
<thead>
<tr>
<th>Date</th>
<th>Students</th>
<th>Total Hours</th>
<th>Mean per student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thur 27-Mar</td>
<td>2</td>
<td>9.5</td>
<td>4.25</td>
</tr>
<tr>
<td>Wed 9-Apr</td>
<td>5</td>
<td>13.5</td>
<td>2.7</td>
</tr>
<tr>
<td>Thur 10-Apr</td>
<td>7</td>
<td>9.5</td>
<td>1.35</td>
</tr>
<tr>
<td>Fri 11-Apr</td>
<td>8</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
<td>Mon 14-Apr</td>
<td>9</td>
<td>32.5</td>
<td>3.6</td>
</tr>
<tr>
<td>Tue 15-Apr</td>
<td>26</td>
<td>30</td>
<td>1.15</td>
</tr>
<tr>
<td>Wed 16-Apr</td>
<td>25</td>
<td>38.5</td>
<td>1.54</td>
</tr>
<tr>
<td>Thur 17-Apr</td>
<td>16</td>
<td>16.5</td>
<td>1.03</td>
</tr>
<tr>
<td>Fri 18-Apr</td>
<td>9</td>
<td>27.5</td>
<td>3.05</td>
</tr>
<tr>
<td>Mon 21-Apr</td>
<td>22</td>
<td>37.5</td>
<td>1.7</td>
</tr>
<tr>
<td>Tue 22-Apr</td>
<td>12</td>
<td>10</td>
<td>.83</td>
</tr>
<tr>
<td>Wed 23-Apr</td>
<td>10</td>
<td>25.5</td>
<td>2.55</td>
</tr>
<tr>
<td>Thur 24-Apr</td>
<td>12</td>
<td>26</td>
<td>2.1</td>
</tr>
<tr>
<td>Mon 28-Apr</td>
<td>6</td>
<td>10.5</td>
<td>1.75</td>
</tr>
<tr>
<td>Tue 29-Apr</td>
<td>12</td>
<td>11.5</td>
<td>.95</td>
</tr>
<tr>
<td>Wed 30-Apr</td>
<td>12</td>
<td>11.5</td>
<td>.95</td>
</tr>
<tr>
<td>Thur 1-May</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Fri 2-May</td>
<td>2</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Mon 5-May</td>
<td>20</td>
<td>31.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Tue 6-May</td>
<td>27</td>
<td>37.5</td>
<td>1.38</td>
</tr>
<tr>
<td>Wed 7-May</td>
<td>25</td>
<td>70.5</td>
<td>2.82</td>
</tr>
</tbody>
</table>

Mean users = 13, total use = 477.5 hours, mean use = 2 hours
Proportion of total hours = 76.7%
*Students took their Easter intra-semester break between these dates
Proportionately, the weekend use was far lower (Chart 2). From these preliminary results, it can be argued that 24-hour 7-day access is not being utilised by the majority of students. This may be due to lack of awareness of this facility.

### Table 5: Patterns of lab use over 30-day period

<table>
<thead>
<tr>
<th>Date</th>
<th>Users</th>
<th>Total hours</th>
<th>Mean use/student</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-Apr</td>
<td>1</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>13-Apr</td>
<td>3</td>
<td>9.5</td>
<td></td>
</tr>
<tr>
<td>19-Apr</td>
<td>6</td>
<td>16.5</td>
<td></td>
</tr>
<tr>
<td>20-Apr</td>
<td>7</td>
<td>25.5</td>
<td></td>
</tr>
<tr>
<td>25-Apr*</td>
<td>6</td>
<td>23.5</td>
<td></td>
</tr>
<tr>
<td>26-Apr</td>
<td>4</td>
<td>15.5</td>
<td></td>
</tr>
<tr>
<td>27-Apr</td>
<td>4</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>3-May</td>
<td>6</td>
<td>21.5</td>
<td></td>
</tr>
<tr>
<td>4-May</td>
<td>7</td>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>

Mean users = 10, total use = 145.5 hours, mean use = 3.5 hours
Proportion of total hours = 24.3%
*25 April is Anzac Day, a national holiday.

### Discussion

The young female majority is reflected in the overall course enrolment in the Bachelor of Nursing at the School. The fact that all were pre-registration students may support Wilson’s (1991) hypothesis that mature-age nursing students may experience higher levels of computer anxiety, although Burkes (1991) notes that age did not affect the outcome of her study.
Overall, students showed a clear preference for the more powerful Power-Macintosh terminals over the slower, older LCIIIs. Given Jones and McCormac’s study (1992) on the inefficiency of user opinion in evaluating computer-assisted learning, the monitoring of actual equipment use may provide a useful form of evaluating program and hardware preferences (Table 3).

The profile of the ‘typical’ lab user can now be extended to:

- second-year
- female
- pre-registration
- used the lab 1-4 days out of the 30-day period
- used it for about 2 hours
- used a PowerMac if one was available
- used the lab as part of her normal timetable during the week

The data reveals that students prefer faster, more modern hardware, that they tend to integrate computer lab use into their normal contact-hours timetable, and that they do not tend to use the lab every day. A different picture may well emerge if the lab use were charted exclusively when assignments were due in, as lab use may increase dramatically at these times.

This data also highlights the non-lab users, which poses questions for future research. Why were so few first-year students represented? Why were there no enrolled nurse students or registered nurse students using the lab provided in the School? A further complicating factor is student ownership of or access to computers off-campus. At the time of writing, the TSON is undertaking research which may help determine this.

Further studies may also indicate for which tasks the students are using the lab - is it electronic mail collection, word-processing of assignments or internet browsing? Given the restrictions placed upon lab use as part of the current pilot study, we could assume the significant tasks were word-processing and e-mail. My earlier study (Martyr 1997) indicated the popularity of e-mail among students, and the short periods of time spent in the lab may indicate e-mail collection rather than the more time-consuming task of writing and word-processing assignments.

A follow-up study to this would involve more thorough data collection, to overcome the problem of students not participating. A qualitative approach could reveal more about student perceptions of access. A survey of identified heavy lab users is also a possibility. The best means of ensuring accurate data collection is to introduce a log-on system which will record the identity of the student using the terminal. At present, this is not envisioned for the Newnham lab.
Conclusion

This pilot study set out to gain knowledge in three areas - how many students are using the computer lab provided by the School, what are the demographics of that student population, and how much time each student was spending in the lab. Some preliminary findings have emerged as to what factors seem to enhance computer access. But there are still questions of limited access to mature-age, male and off-campus students, which may prove significant in further study. Limitations on access, through lack of technical or financial support, may play an important role in limiting nursing use of computers in their student life and subsequent practice.

References


Restraints: a review of the literature

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Abstract

The use of restraints in nursing home settings has become an important issue today. While nurses are striving to keep residents safe, they may be compromising the autonomy of the residents. This paper will review the literature, looking at the types of restraints used, the prevalence of use in the United States, Canada and Australia; as well as the rationale behind the use, the effects of using restraints, as well as look at some suggested alternatives to restraints.

The two classifications for restraints are physical and chemical. Physical restraints are mechanical devices applied to a person in such a way that free physical movement is inhibited, (Koch, 1993; Braun & Lipson, 1993). Physical restraints include sheets used as ties, gerichairs (chairs with locking lap trays), wheelchair restraints, side rails, Posey vests, belts and wrist and ankle cuffs, (Braun & Lipson, 1993; Koch, 1993; Sloane, Mathew, Scarchourough, Desai & Tangen, 1991).

Sloane et al, (1991) found that chemical restraints are "generally considered to be present when a neuroleptic, anxiolytic or sedative or hypnotic agent is used on a regular basis." Braun & Lipson (1993), discussed how chemical restraints increased in the nursing home settings in the 1960_s after the deinstitutionalisation of mentally ill patients. This in turn lead to these patients being admitted into nursing homes, where the staff did not have the necessary training to handle the complex behaviours of these patients. As a result, the staff became dependant on using psychotropic drugs to control the behaviours of these residents, (Braun & Lipson, 1993). This practice of medicating residents to control their behaviour is still present today.

Sloane et al, (1991) reported that in the United States, between 11%-58% of nursing home residents and 43%-72% of those residents with dementia receive neuroleptics, anxiolytics, sedatives or hypnotic agents, used to control their behavior. The prevalence of physical restraints in the United States seems to vary from 19% to 85%, (Braun & Lipson, 1993; Sloane et al, 1991; Tinette, Marottoli & Ginter, 1991; Koch, 1993). Bradley, (1995), discussed a survey conducted in Canada, covering six nursing homes (2 in Ontario, 4 in Nova Scotia) and it was found that the rate of restraint use was 70%-85%. In 1997, Andrew Restas conducted a study in Australia and found that 29.5% of residents in nursing homes in South Australia were restrained, 15.3% in New South Whales and 23.6% in Queensland. Another study found that 0%-57% of residents in nursing homes in Australia were physically restrained, (Koch, 1993).

Some common reasons given by nursing staff for the use of restraints are to prevent residents from falling, prevent resistance to treatment, wandering and prevention of injury to self or others, (Huffman, 1998; Koch, 1993). Tinetti, Liu, Marottoli & Ginter, (1991) found that unsteadiness (72%), disruptive behavior such as agitation (41%) and wandering (20%) were the most frequently
quoted reasons for restraint use. It was also found "that resident characteristics independently associated with initiation of restraints were older age, disorientation, dependence in dressing and nonuse of antidepressants," (Tinetti et al, 1991).

Braun & Lipson, (1993) commented that the primary reason for restraint use, cited from a 1988 Strumph & Evans article, were residents confused mental status and the fear that the resident would fall if not restrained. Braun & Lipson also revealed that nursing staff stated that restraints help prevent assultive behavior, wandering, falls, poor posture and help with the administration of medication, are used as a method of punishment and as a means easier to staff than supervision. Pressure to avoid litigation, insufficient staff, and employee attitudes supporting restraint use were reasons of restraint use given by Coleman (1993).

In Bradley's article on Canadian studies, (1995) seven arguments were given as factors associated with restraint use and they are: restraints keep people safe; no alternatives to restraints; used only as last resort; insufficient staff, people ask to be restrained and therefore do not mind; restraints keep staff and institution safe from litigation and finally, restraint reduction is not safe without full administrative support. Arguments disputing such rationale for use will be discussed later on in this paper. One of the main reasons cited in the literature for restraint use in nursing homes is to prevent residents from falling and "this is a paradox which is widely recognized in the literature because the act of restraining a resident can jeopardize the future mobility and in no way assures the safety of that resident, (Bell, 1997).

In 1998, G.B. Huffman stated that prolonged use of restraints has been associated with fall-related injuries as well as a decrease in physical and psychological function. Some specific examples of negative physical effects of restraint use are: decreased muscle mass, strength/physical deterioration, orthostatic hypotension, urinary and faecal incontinence, increased risk for nosocomal infections, oedema of lower extremities, changes to body chemistry such as demineralisation and electrolyte loss, increased risk of falls, increased risk for pressure sores, and accidental strangulation, (Bell, 1997;, Huffman, 1998; Koch, 1993; Sloane, Papougenis & Blakeslee, 1992; Tinettie, Marottoli & Ginter, 1991). Restraints can also have negative psychological effects on the resident and these include: reduced communication skills, increased confusion and agitation, loss of self-esteem, loss of trust, loss of self-confidence and loss of autonomy, (Sloane, Papougenis & Blakseele, 1992; Koch, 1993; Braun & Lipson, 1993). Residents often associate restraints with punishment. Braun & Lipson (1993), stated that to avoid the linking of punishment and restraints, staff should avoid removing the restraints when there is an improvement in behaviour. This would only reinforce the resident's belief that he/she is being punished. The use of restraints can also have a negative psychological effect on the nurses implementing the restraints, such as feelings of inadequacy, frustration, dissatisfaction and feelings of guilt, (Bell, 1997).

Seven arguments supporting the use of restraints were mentioned earlier in this paper. Bradley (1995), provided counter arguments for each of the seven points, which will now be discussed. The first argument for restraint use, given by nursing staff, was that restraints keep residents safe from falling. Bradley stated that restraints actually increase the danger to residents, and supported this statement by giving the example that residents often climb over rails, between rails and over the end of the bed, which in turn often results in a fall or injury. One reason the resident may be trying to leave the bed is that they have to go to the bathroom and with the delay of trying to get around the restraint, often incontinence occurs, which increases the risk of the resident slipping in their own urine on the floor, (Bradley, 1993).
The second argument for restraints was that there are no alternatives to restraints and this was counteracted with the statement that education is key to realising that there are indeed alternatives. Studies have shown that education does make a difference; in Nova Scotia after a ten hour educational program on alternatives to restraints, restraint use was reduced by 50%, (Bradley, 1995). Huffman’s 1998 article also supported this when he found that there was an average absolute decline in restraint use of 18% in a nursing home that received education and consultation. He commented that "a combination of staff education and consultation leads to a decrease in the use of physical restraints in nursing homes, without a concomitant increase in staff time, use of psychoactive drugs or injuries related to falls, (Huffman, 1998). Restas (1997) found that the education needs to be adequate, recent and focussed on achieving attitudinal changes and implementing practices that incorporate those changes. Bradley also suggested that some effective alternatives are better pain management, flexibility of care, residents having more independence, subtle environmental changes and it was stressed that the restraint-free alternatives fix or manipulate the environment and not the resident, (Bradley, 1995).

The third argument in Bradley’s 1995 article was that restraints are used only as a last result. Bradley felt that this statement was false and that restraint use was underestimated by nursing staff and one reason for this may be that the act of restraining a resident is very uncomfortable to the staff. Some restraints, gerichairs and bedrails, are used so often that some staff no longer consider them to be restraints, which may also account for the low estimation of restraint use by nursing staff, (Bradley, 1995). Koch (1993) felt that nursing homes need to adopt a philosophy where restraints are advocated only as a last resort and that the staff be limited on the number of restraints available to them.

Inadequate staffing in nursing homes was the next argument given by the nursing staff. Bradely agreed that if there was an improvement in the staff/resident ratio then there would also be an improvement in the quality of care to residents. She also argued that more time is required to look after a resident who is restrained compared to one who is not. Restraining someone requires that the resident be provided with exercise, to try to prevent immobility complications, which takes up a lot more of the nurses time. Toileting would also take up more time as the resident would have to be removed from restraint and assisted to the toilet because of diminished physical strength, (Bradley, 1995).

In some circumstances, residents or the residents family may request for restraints to be used. This is often because they feel more secure and safe, or because they are used to restraints being used. If such is the case, the resident and family may need to be educated on restraint use and the nurse may need to provide the resident with extra attention until such time that they feel safe and comfortable with their environment, (Bradley, 1995). Nurses often believe that by using restraints, they are keeping themselves and the institution safe from litigation if a resident should happen to fall while not restrained. This argument is untrue in that there has been no argued case where an institution has been sued because they did not restrain a resident; Chances are more likely that the institution will be sued if a resident has an accident and sustains injuries while restrained, (Bradley, 1995).

The final argument was that restraint reduction is not possible without administrative support. Bradley, (1995) found this to be true, in that providing just the nurses with education regarding restraint reduction is insufficient, as the administrative staff may advocate restraint. This may in turn influence the effect of the education received. Braun & Lipson, (1993) also noted that restraint use has been endorsed by many disciplines, making it a more acceptable practice. This means that...
efforts to reduce restraint use must be a team effort and take place in a larger restorative framework. Thus, the more staff advocating the reduction of restraint use, the more success is likely.

Molasiotis (1995) felt that the "main alternatives to physical restraints are environmental manipulation, reality orientation and behavioural techniques, adequate staffing and a no-restraint policy training. It was felt that increased light, placing the patient close to the nursing station, mattresses on the floor, a quiet room, accessible call light or other means of communication with nursing staff, and a redesign of furniture would be beneficial to the cognitively impaired resident and decrease the need for restraints, (Molasiotis, 1995). Molasiotis also felt that confusion, agitation or disorientation (the main reasons for restraint use) may in fact be due to medication, a wet bed, electrolyte imbalance or impaired renal function. If the cause of the confused, agitated or combative behaviour is relieved then the nurse may be able to avoid using restraints (Molasiotis, 1995).

In 1993, Coleman found that night-time diversional activities and environmental modifications such as the "wandering loop," locked units or door alarms give residents more independence and freedom while still ensuring their safety. Some strategies to decrease the risk of falling, while maintaining patient autonomy, include lowering beds closer to the floor, making bedside commodes available and moving high risk patients closer to the nursing stations, (Coleman, 1993). Coleman also found that by identifying residents at greater risk of behavioural problems of dementia and implementing a surveillance and preventive strategy, the use of restraints may be reduced.

In 1987, with the movement of "Untie the Elderly", the Omnibus budget Reconciliation Act (OBRA) was passed in the United States. The act states that nursing home residents have a right to be free of restraints and that physical restraints only be used if required for treatment and not for the purpose of punishment or convenience of the staff, (Braun & Lipson, 1993). Since this implementation of the act, restraint use has reduced in the United States to a rate of about 21% in 1995, (Cohen, Neufeld, Dunbar, Pflug & Breuer, 1996). However, it is still felt that many nurses are still unaware of alternatives to physical restraints. The availability of research on alternatives is somewhat limited.

The issue of restraint use is global, as there is a high prevalence rate in a lot of countries, particularly western countries. More awareness of alternatives needs to be implemented into nursing training. A policy introducing restraint reduction gradually into the system may be necessary, as staff are often afraid of change and also fear the program not working. Small successes with may prod the staff on to continue with the program whereas a failure may see failure of the whole program. All in all, the use of restraints is a cause for concern as it damages not only the residents morality but also that of the nurse. Change is required and with change will come improvement in both staff and resident autonomy. A balance between safety and autonomy is what is needed and more policies and support for this type of system are needed.
References


