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Physical and mechanical restraint in psychiatric units: Perceptions and experiences of nursing staff

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ABSTRACT

Background: Physical restraint in psychiatric units is a common practice but extremely controversial and poorly evaluated by methodologically appropriate investigations. The cultural issues and professionals' perceptions and attitudes are substantial contributors to the frequency of restraint that tend to be elevated.

Aim

In this qualitative study, we aimed to understand the experiences and perceptions of nursing staff regarding physical restraint in psychiatric units.

Method: Through theoretical sampling, 29 nurses from two Brazilian psychiatric units participated in the study. Data were collected from 2014 to 2016 from individual interviews and analyzed through thematic analysis, employing theoretical presuppositions of symbolic interactionism.

Results: Physical restraint was considered unpleasant, challenging, risky, and associated with dilemmas and conflicts. The nursing staff was often exposed to the risks and injuries related to restraint. Professionals sought strategies to reduce restraint-related damages, but still considered it necessary due to the lack of effective options to control aggressive behavior.

Conclusions: This study provides additional perspectives about physical restraint and reveals the need for safer, humanized and appropriate methods for the care of aggressive patients that consider the real needs and rights of these patients.

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Introduction

Physical and mechanical restraint are techniques utilized to immobilize or reduce the patient's movements to prevent destructive behaviors and preserve safety and integrity of the patient or others (Knox, Holloman, & Jr., 2012; National Institute for Health and Clinical Excellence, 2005; Perkins, Prosser, Riley, & Whittington, 2012). Mechanical restraint in the Brazilian context occurs predominantly by the use of cloth bands on the ankle and wrist that fasten the patient to his or her bed (Braga et al., 2016). In Brazil, restraint can be considered a contested but frequent practice (Mantovani, Migon, Alheira, & Del-Ben, 2010). It is also described as a common and accepted procedure strongly related to local traditions and health team preferences and poorly reported on patient medical records (Braga et al., 2016; De Araújo, Martins, Adams, Coutinho, & Huf, 2010).

There is much controversy regarding definitions, legal standards, preferences, and the use of restraints in different countries. Additionally, empirical research concerning restraints to guide clinical decisions is scarce, and there is a lack of empirical studies to justify the differences among countries in the use of restraint measures (Bergk, Einsiedler, Flammer, & Steinert, 2011; Knutzen et al., 2013).

Evidence regarding effective risk management recommends proactive and non-coercive strategies of prevention or the de-escalation of aggressive behavior (Duxbury & Wright, 2011; Knox et al., 2012; Knutzen et al., 2014; National Institute for Health and Clinical Excellence, 2005).

Physical restraint is a coercive and traumatic procedure that is permitted only in very specific circumstances as a last resort and can be used only when other methods have failed (Perkins et al., 2012). Therefore, it is characterized as a safety intervention and not as a therapeutic resource (Allen & Currier, 2004).

The treatment of patients with aggressive behavior is a challenge (Bergk et al., 2011). Safety is a relevant issue in mental health services, and staff members are committed to preventing patients from injuring themselves or assaulting others (Knutzen et al., 2013). Mental health nurses appear have increased exposure to higher risks of workplace violence than other professionals (Knox et al., 2012) and are therefore more involved in restraint episodes.

Restraint is associated with an increased incidence of physical and psychological injuries to both patients and staff (Knox et al., 2012; Knutzen et al., 2013, 2014; Simpson, Joesch, West, & Pasic, 2014). It also promotes negative emotional states and has detrimental implications for the patient and the professional's relationship (Knox et al., 2012; Ling, Cleverley, & Perivolaris, 2015).

Studies performed in psychiatric hospitals of two Brazilian cities estimated that physical restraint was used in 13%–36% of admissions and was more common in patients presenting agitation/aggressive behavior (Braga et al., 2016; De Araújo et al., 2010; Migon et al., 2008). If permitted, physical restraint in psychiatric services tends to be used excessively, necessitating a better understanding as to why this happens for future prevention (Paterson, Mcintosh, Wilkinson, Mccomish, & Smith, 2013).

Qualitative studies about nurses' perspectives regarding the use of physical restraint in psychiatric settings showed that restraint is a challenging subject and can be perceived as an acceptable tool and procedure with multiple purposes, such as control, auxiliary treatment, therapeutic measure, and to prevent damage (Fereidooni Moghadam, Fallahi Khoshknab, & Pazargadi, 2014). Decisions regarding restraint involve complex dilemmas (Marangos-Frost & Wells, 2000) and the organizational culture plays a role in the development of the excessive use of restraint, especially through the legitimatization of coercion (Paterson et al., 2013).

Nonclinical factors such as cultural biases, perceptions, and attitudes are substantial contributors to the frequency of restraint (Knox et al., 2012). Restraint is a common practice but extremely controversial and poorly evaluated by methodologically appropriate investigations (Knutzen et al., 2014; Mantovani et al., 2010). Thus, a need exists for studies that can contribute to the development of ethical and evidence-based guidelines and practices (Bergk et al., 2011). Considering that very little research has been done in Brazil regarding physical restraint, this qualitative study aimed to understand the experiences and perceptions of nursing staff about physical and mechanical restraint in psychiatric units.

Method

The research question of this study was: what are nursing teams' experiences and perceptions regarding physical and mechanical restraint in psychiatric units? This qualitative study employed symbolic interactionism (SI) as a theoretical framework. SI provides a basis for understanding how meanings are developed and the nature of meanings that are constructed in interactions among human beings. This theoretical perspective presupposes that behavior (observable external action and internal experience) is guided by an individual's definitions of reality. In turn, these definitions are derived from the social interactions in which active individuals exert mutual influence (Blumer, 1969).

This study was carried in two psychiatric units from a general hospital in a municipality in the state of São Paulo, Brazil. The groups and sites were chosen because of their ability to reveal the phenomenon. These were the only two psychiatric units in one general hospital in the municipality and had a total of 24 beds: 15 in unit A and 9 in unit B. The site is a large public teaching hospital that is used as a reference for the treatment of many specialties, including people with impulsivity and aggressiveness. At the study site, there was no monitoring indicators or statistical data about physical and mechanical restraint. An institutional policy for reduction of restraint use did not exist.

Members of nursing staff from the organization were eligible if they were working at the institution during the period of data collection. The exclusion criteria were an age younger than 18 years. In this service, the nursing team was composed of nurses (graduated) and nursing assistants (had a technical course and work under the supervision of a nurse). The nursing assistants represent the majority of the nursing workforce in Brazil and are authorized to perform various activities regarding nursing care. They often have longer contact time with patients compared to nurses, who are also responsible for management activities in the units. Regarding restraint, the Brazilian Federal Nursing Council states that nursing assistants may only employ mechanical restraint under the direct supervision of the nurse, except in emergency situations (COFEN, 2012). The maintenance of the restraint also needs to be prescribed by a physician (Federal Council of Medicine, 2000).

Initially, a list of professionals employed at the study sites was obtained. All listed nursing professionals eligible for this study were invited confidentially and individually (without the presence of non-participants) to participate voluntarily in the study. These invitations were made while the researchers were visiting the study sites (at different times and days of the week). Eligible participants were asked to take part in a study investigating experiences and perceptions toward physical and mechanical restraint among nursing professionals who work in psychiatric units. Participants were informed about the scope and the purpose of the study and provided written informed consent.

According to information provided by the study place over the data collection period, there were 38 professionals on the nursing staff. Four professionals were excluded because they were on sick leave and five people refused to participate in the study due to lack of availability.

The study included 29 nursing staff members: 8 registered nurses and 21 nursing assistants. Thus, the saturation point was obtained by methodological exhaustion (all the people who met the selection criteria were approached) and theoretical exhaustion (the objective was reached and the data became repetitive and did not add relevant information about the phenomenon). Data saturation was obtained until the objective of the study was reached and the additional data did not increased relevant information about the phenomenon under study