LETTER TO EDITOR OPEN ACCESS

Use of Restraints in Health Care Contexts – An Educational Consideration

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Dear Editor,

There has been an ongoing effort to reduce the use of restraints in patients, including older adults with dementia. Education is considered a crucial element of a dedication to achieving this initiative. As an example, continuing education regarding the adverse consequences of physical restraints, specialised education regarding dementia, and training regarding the appropriate implementation of alternative techniques may be viable alternatives (1). Three important considerations are highlighted in this commentary.

The first consideration is related to the way in which restraint is considered and used in clinical settings. This review reported that the prevalence of restraints ranged from 5.1% to 80.0%, depending on the definition of "restraint" (1). In this case, there is a good reason to be concerned that this insight may be doing more harm than good. Physical restraint, for example, is frequently justified when considered a last resort measure. This suggests that healthcare professionals use restraint as a last resort when alternative measures have been unsuccessful and the well-being of a patient is compromised. This may involve a patient who is at risk of causing harm to themselves or others. However, this is not always how things work in practice. The so-called "last resort" can often be a knee-jerk reaction, which means that the restraint, in any form, may be employed for the wrong reasons or in the wrong way.

One study pointed out the impact of nurses' past experiences, the shared, rather than individual, approach that nursing staff adopt, and having to rely on the knowledge and skills of others when using restraint as a "last resort" (2). This suggests that the interpretation of "last resort" can be subtle and complex. Meanwhile, similar concerns were raised with the suggestion that the use of restraints may be a result of nurse understaffing and the inability to monitor at-risk patients (3). They also asserted that healthcare professionals are sometimes reluctant to use restraint, but they often do so without realising it (3). Given this, we must begin by challenging the "last resort" narrative and the arbitrary nature of the use of restraint. To regulate the use of restraint, it becomes necessary to have written policies and guidelines. Additionally, the use of physical restraints must be regulated by high-quality clinical practice guidelines (4).

The second consideration is the disproportionate emphasis on "maintaining patient safety" as the basis for the restraints. That is why it is likely that nurses may have taken additional precautions to safeguard patient safety, notably when the review identified that the most frequently cited justifications for the use of restraints were a history of falls and a high risk of falling (1). The global priority now is to ensure the safety of patients with dementia in acute hospitals (5). Even so, I am not convinced as to whether the use of restraints is morally plausible, particularly in light of the notion that this context suggests a "default" response in the interest of patient safety. The question that must be addressed is whether this perceived safety is a result of the nurses' mistaken assumptions. A study found a significant gap between the expressed needs of individuals with dementia in the hospital and the perspectives of staff members regarding safety (6).

There is also reason to believe that this somewhat defensive and reactive strategy would only serve to undermine the significance of upholding the patient's dignity and personhood, particularly when restraint

is perceived as the only way of preventing them from falling (7). Active educational interventions for nurses on the topics of falls should be prioritised to change this narrative. These interventions should aim to increase nurses' capacity to identify the risks associated with fall incidents and to improve their familiarity with fall prevention guidelines (8).

The final consideration is related to the involvement of families in the team's efforts to reduce the use of restraints. The review reported that the prevalence of restraints was reduced because of interdisciplinary screening for restraints. This reduction was accomplished by consulting with a psychiatrist and implementing a restraint decision flowchart (1). I am incredibly optimistic about the concept of interdisciplinary screening for restraints; however, I am also hopeful that the family's involvement will not be overlooked or undervalued. This is partly because families expressed a desire for honest and transparent communication regarding the necessity of restraints and other critical care decisions (9). The care of patients with dementia could be informed and improved by family engagement, particularly when healthcare professionals are striving to balance patient safety. Furthermore, healthcare professionals should develop the ability to communicate effectively and establish positive relationships with patients and families through empathetic and meaningful communication.

In summary, nurse educators are instrumental in fostering and facilitating a greater understanding of the use of restraints. Continuing education on this topic also serves as a valuable reminder to deliver dignified care with compassion and accountability. The following three essential considerations are offered: the necessity of reflecting on the true meaning or practical application of the term "last resort," the importance of a morally sound justification for the implementation of additional precautions while maintaining patient safety, and the significance of the family role as a component of the interdisciplinary intervention. Last but not least, there is an urgent need to reflect on the critical role and commitment of nursing education in providing healthcare professionals with a clear understanding of restraint in practice, which allows them to continue to strive for the preservation of patient safety and dignity.

Article History:
Submitted: 21 March 2025
Revised: 6 May 2025
Accepted: 10 May 2025
Published: 31 July 2025

DOI: 10.31436/ijcs.v8i2.443
ISSN: 2600-898X

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