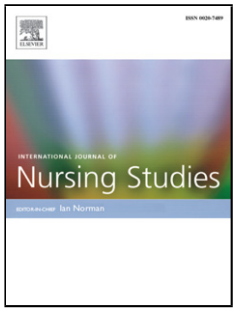

Title: A necessary evil? Nurses and the use of physical restraints in the care of older people

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Editorial

A necessary evil? Nurses and the use of physical restraints in the care of older people

Use of restraints is one of the most frequently reported quality indicators for nursing home care (Spilsbury et al., 2011) and a frequent topic of publication for nurse researchers and others in this journal and elsewhere. The implication of this quality indicator and the tone of most research is very clear. The use of restraints is viewed as a bad thing, an intervention that should be avoided either because it is intrinsically bad or because it is only necessary when other strategies have not been properly implemented. A rapid search of the contents of the IJNS over the past two years illustrates the scale of the issue. Researchers from across Europe, Asia and the USA have discussed restraints, exploring attitudes, interventions or simply using it as an indicator of quality e.g. (de Rooij et al., 2012, Gulpers et al., 2012, Jeon et al., 2012, Milisen et al., 2013, Zwijsen et al., 2012). In this issue of the journal we publish a major systematic review on nurses' attitudes to restraint use which reflects the persistent global nature of the challenge (Möhler & Meyer, 2013). .

Reduction of the use of restraints is a stated goal of national policies on improving quality of care for older people(e.g. (Hjaltadóttir et al., 2012)). But the use of restraints in care homes and elsewhere persists. In a recently published paper in the IJNS we also published a study that found that nearly 12% of hospital patients in Germany had at least '*one physical restraint in place'* (Krüger et al., 2013). The measures used most often were full bed rails but 3% of patients were subject to wrist restraints with smaller numbers restrained with belts or by a fixed table in a chair. It is clear that the decision to use restraints is not taken lightly, without feeling or care, but nonetheless, sometimes it is done as a matter of routine (Goethals et al., 2013). It is a moot point whether the use of physical restraint can ever be justified, although in some rare circumstances it may appear to be the only option. However, the wide variation between different hospitals observed in the recent survey in Germany clearly suggests that local practice may influence decision making more than variation in patient need. Lack of knowledge has been identified as a key driver of decision making in one recent study (Parke et al., 2013).

Mohler and Meyer's review emphasises that if the problem of avoidable restraint use is to be addressed, a better understanding of the attitudes and beliefs of nurses is required. While it is clear that restraints are often viewed negatively and cause many nurses considerable discomfort they are sometimes regarded as what I would term *'a necessary evil'*. In some of the studies reviewed nurses expressed positive attitudes to restraints because of the sense of security they provided. One of the main positive motivations for using restraints was to protect patients from harm. However, this was tied with a clear indication that the reason for use of restraints was often required because the staffing was insufficient to protect the patient while meeting the needs of others. Nurses also expressed concerns about legal liability resulting from a perceived increase in risk, for example of falls.

With this in mind, it is notable that while a recent systematic review found that higher levels of registered nurse staffing in nursing homes was associated with improved quality in many measures, it was associated with a higher use of restraints (Spilsbury et al., 2011). The issue does not appear to be a simple one of resources, although surely this is of relevance. It is also notable that Möhler and Meyer did not note any substantial changes in attitudes over time in the studies they found. Despite strong advocacy of restraint free environments in many nursing guidelines, scientific publications

and national legal frameworks the use of restraints persists and nurses' attitudes to them seem largely unchanged.

So is the use of restraints really a necessary evil? Perhaps, in some rare circumstances, it can be. But in preparing this editorial I was struck by the volume of research on reducing restraint use while I did not notice any well controlled studies demonstrating their positive effects. My searches were cursory and there may well be evidence. I would challenge any advocates of appropriate use of restraints to undertake a high quality systematic review of such evidence, or perhaps simply respond to this editorial by pointing it out. However, in the absence of such a review it seems to me that the use of physical restraints should be classified as being of uncertain effectiveness with a real potential for harm. In the absence of evidence showing that the benefits exceed the harm surely such an approach to treatment should only be considered in the context of a well-designed research study? This is one of the basic tenets of evidence based practice.

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Executive Editor

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