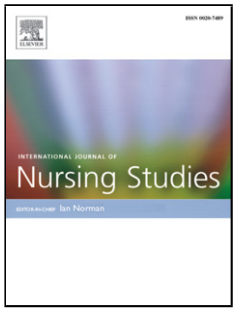

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GUEST EDITORIAL

Beyond restraint: raising awareness of restrictive practices in acute care settings

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Restrictive practices, attitudes, behaviours and consequent interventions such as restraint, remains an emotive subject internationally and across all fields of nursing. It is especially highlighted within mental health nursing, learning disabilities and elderly care settings (Bowers 2007, Gulpers *et al* 2012, Griffiths 2013, Scheepmans *et al* 2017). The problem with restrictive practices in healthcare in general, and in acute care settings in particular, is not new but it has persisted over the years despite attempts to contain it. In this Guest Editorial, we advance three key reasons for the lack of progress in this important area of international nursing practice: conceptual ambiguity, inadequate research attention, and fluctuating awareness.

Conceptual ambiguity

In our view, one of the most significant challenges in this field is a misunderstanding over what restrictive practices represent. This is confounded by a widespread confusion between restrictive practices and restraint: the two are often used synonymously but are fundamentally different, the latter being a symptom of the former. While this challenge relates to all fields of nursing, nurses in general acute care settings are especially affected.

Restrictive practices are essentially about making someone do something they do not want to do or stopping someone from doing something they want to do (Department of Health 2014). In this sense, the notion of restrictive practice extends beyond restraint, encompassing more subtle aspects of restrictive attitudes, behaviours and organisational culture. The term covers a wide range of restrictive activities, only some of which may be

deliberate. Examples of restrictive practices in healthcare may be obvious such as "ward rules" (e.g. waking everyone up at a certain time, rigid visiting hours), or subtle, such as authoritarian attitudes of staff. Excessive restrictive practice often engenders disproportionate use of specific restrictive interventions, such as restraint and seclusion.

Restrictive practices and interventions are commonly encountered when individuals display, or are deemed to be at risk of displaying, 'challenging' behaviour that could lead to physical or psychological harm for them or others. However, challenging behaviour is often the result of unmet needs, communication difficulties or indeed a reaction to restrictive practice itself. Nurses often resort to excessive use of restrictive interventions to manage challenging behaviour, especially in settings where a culture of 'control' is adopted as opposed to one of 'structure', with 'zero tolerance' being a symptom of this.

Inadequate research attention

There is a paucity of international research literature regarding how health professionals interact with patients, and the wider adoption of restrictive practices in general care settings, although the specific issue of physical restraint has received significant research attention. For example, an evidence-based synthesis of staffs' experiences of caring for people with dementia in acute care settings (Houghton *et al* 2016) found that physical restraint was used because staff claimed to be too busy and so did not have sufficient time to care for people with dementia; and that restraint was often deemed justified in terms of patient and staff safety. Examples of physical restraint vary in the international literature, with some being more commonly found in certain countries and practice domains. Bed-rails, fixed tables and wrist restraints are evident in elderly care in Germany, Holland and France (Kruger *et al* 2013, Scheepmans *et al* 2017). Physical, chemical, and in some cases mechanical restraint feature in mental health nursing and learning disabilities in England (NICE 2015), while the use of mittens and chemical restraint is not unusual in intensive care units internationally (Kruger *et al* 2013).

Beyond restraint, the bulk of international research to date focuses on specific examples of restrictive interventions relating to violence, aggression and de-escalation. However, there is little attention paid to precipitating factors and to prevention. Aggressive and violent behaviour may be prevented if symptoms of challenging behaviour are recognised and planned for early in the admission process. Within mental health nursing, for example, use of positive behavioural support plans have recently been found to reduce the need and use of restrictive interventions, as well as incidents of challenging behaviour (Clark *et al* 2017), but further research is needed to validate their use in general acute care settings.

Research initiatives examining restrictive practices in the wider sense are few and far between, especially in general care settings. Indeed, much of the existing research largely centres on mental health, learning disability, elderly and dementia care services (Gulpers *et al* 2012, Goethals *et al* 2013, Bowers *et al* 2015, Price *et al* 2018). This is a cause for concern given the increasing acuity and complexity of general acute care wards, especially medical

assessment and clinical decision units, which cater for a growing number of patients with potential for exhibiting challenging behaviour often, but not always, because of underlying mental health problems, learning disabilities, dementia and other cognitive disorders.

Fluctuating awareness

Internationally, awareness around restrictive practice is variable between countries, settings and levels. The issue does occasionally come into focus, but the problem remains. In the United Kingdom (UK), for example, awareness of the need to reduce restrictive practice in all forms and care settings has been increasing steadily over the past few years driven in part by a rise in the use of prone restraint (Department of Health 2014). The Care Quality Commission (2017), as the independent regulator of all health and social care services in England, recently brought restrictive practices into the policy limelight by stressing the need for health care providers regardless of setting to take reasonable steps to ensure use of the least-restrictive strategies possible when managing challenging behaviour. The Care Quality Commission will intervene when a health care provider has not managed challenging behaviour effectively, not audited and monitored the number of challenging behaviour incidents, not implemented positive behavioural support plans where needed, or when staff are not suitably competent or skilled in managing challenging behaviour in a way that minimises use of restrictive interventions.

Acute care nurses often have limited training in their pre-registration and continuing professional development programmes about care of patients with challenging behaviours, mental health problems or cognitive impairments (Clark 2006). Transfer of their limited knowledge to actual inpatient care can therefore give rise to multiple challenges. For example, it has been shown that nurses in mental health care settings fear the potential for assault (both physically and verbally), which may lead to feelings of vulnerability resulting in excessive 'limit setting' and restrictive practice (Salzmann-Erikson 2014). Restrictive practice in turn may result in patient frustration, challenging behaviour, stigmatisation and further acts of violence and aggression necessitating restrictive intervention. Insight into these phenomena from an acute care setting perspective is currently limited, but it is reasonable to infer that similar issues arise to a same or even greater degree.

Closer regulatory attention to the use of restrictive practices in healthcare is likely to grow, which will require pre-registration and continuing professional development nursing programmes incorporating a more holistic, supportive and less restrictive approach to managing challenging behaviour (Clark & Clarke 2014). Raising awareness among nurses at all levels and settings about restrictive practices, and the potential of positive behavioural support planning, could help improve the quality of patient experience as well as reduce the need for costly one-to-one care especially within general acute care settings.

Conclusion

Internationally, excessive use of restrictive practices and interventions for patients with challenging behaviour across different care settings is likely to continue unless prompt action is taken. Knowledge, skills and attitudes of those who care for these patients, whatever their field of nursing or care setting, may be improved only through sustained and systematic educational and research effort. Further work is needed to advance our understanding of: the nature of restrictive practices in acute care settings; staff perceptions and use of restrictive interventions; implications for patients; and practical means of reducing restrictive practices within different care contexts.

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