Use of physical restraint: ethical, legal and political issues

Layla Hughes and Paula Lane describe the implications of restraint procedure in intellectual disability practice in Ireland, and how policy changes affect nurses

Layla Hughes Intellectual disabilities nursing student. School of Health Sciences, Waterford Institute of Technology, Ireland

Paula Lane Lecturer. School of Health Sciences, Waterford Institute of Technology, Ireland

Correspondence to: 20062176@mail.wit.ie


Published in print: 26 April 2016 Double blind peer review

This article explores the ethicolegal and political factors associated with physical restraint in intellectual disability practice in Ireland.

The primary purpose of physical restraint in intellectual disability care is to prevent injury or
harm to the service user or others, yet research evidence shows it can cause trauma and injury. Physical restraint is a controversial topic and it is important for nurses to remain up to date with clinical governance strategies, regulation and policy developments.

In recent years, there has been debate regarding the use and misuse of the restrictive practice of physical restraint, particularly in care settings where vulnerable clients reside. In intellectual disability services, nurses face difficult decisions in caring for clients when managing challenging behaviour.

The protection and safety of the service user is of utmost importance and includes: legal considerations regarding professional duty of care and consent; political matters of advocacy and power; human rights; and ethical principles.

Ethics require a moral approach that 'first does no harm', engaging in beneficial practices that serve to uphold the best interests of service users and engender public trust.


**Title:** Comparison of restraint data from four countries.

**Citation:** Social Psychiatry and Psychiatric Epidemiology, May 2016, (May 4, 2016), 0933-7954 (May 4, 2016)

**Author(s):** Lepping, Peter, Masood, Barkat, Flammer, Erich, Noorthoorn, Eric O.

**Abstract:** Background: Previous studies comparing restraint data from different countries had to rely on randomly published data and showed wide variance in the prevalence of restraint between countries. Aim: To systematically compare datasets from four similar European countries with regard to restraint prevalence. Methods: We analysed whole country or area datasets on restraint from Wales, Ireland, Germany and the Netherlands systematically, thus excluding selection, patient and setting bias. Learning disability (LD) and forensic settings were analysed separately. Differences in proportions between countries were tested by means of Chi square, with number of admissions, admission days and catchment area as denominator and counts of restraint as numerators. Results: Full datasets were obtained allowing calculations of total admissions, total restraint numbers, numbers of patients involved and total occupied bed days. Data for Ireland is from 2012 and from 2013 for the other three countries. The percentage of patients exposed to restraint varies between 4.5 and 9.4 %. The average number of restraints per patient is stable at around 3 in all countries. Patient numbers affected by restraint per 100 occupied bed days per month vary between 0.095 and 0.200. The Netherlands have the highest use of seclusion (79 %), the longest
restraint times and low use of enforced medication. Wales the lowest use of seclusion (2 %), followed by Ireland (29 %) and Germany (49 %). Events per 100 admissions per month vary between 17 and 21. Patients affected by restraint per 100 admissions per month vary between 5.4 and 7.5. LD services account for a disproportionately high number of restraint events.Conclusion: Patient related restraint data are remarkably similar between countries. Type and length of restraint still vary significantly. (PsycINFO Database Record (c) 2016 APA, all rights reserved)(journal abstract)

Source: PsycInfo