Restraint use in an acute setting:
A nursing student's perspective

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I stood at the foot of the stretcher and I watched a team of police officers, nurses, and security staff fighting to detain an agitated young woman. She was brought into the emergency department due to abnormal behaviour and substance abuse. As the team tried to restrain her, she began to flail, kick, and spit at anyone within arm's reach. After she had been secured to the stretcher, she threatened us by promising that she would remember our names, find our homes, and kill our families. Five milligrams of Haldol and two milligrams of Ativan later, she was heavily sedated. For the next four hours, she remained secured in a five-point restraint as we monitored her vital signs and circulation.

The use of mechanical, physical, and chemical restraints to control patients has always carried ethical controversy.[1] Chemical restraints are typically psychoactive medications, while physical and mechanical restraints are designed to limit a client's mobility.[2] The major consequences of restraint use in an acute setting include psychological distress, physical injury, and damage to therapeutic relationships between patients and staff.[3] In Ontario, legislations such as the Mental Health Act, the Patient Restraint Minimization Act, and the Health Care Consent Act have guided the development of multiple initiatives supporting the use of minimal restraint.[4,5,6] With this approach, all alternative measures available to control a patient should be exhausted before resorting to restraints.[3] If restraint is deemed necessary, the least restrictive method should be implemented.[3]

In this situation, the use of multiple restraints was effective in protecting the patient and staff from harm. However, there is a need to evaluate whether these control interventions were necessary for care, or simply reflexive and convenient. In keeping with the minimal restraint approach, the least coercive interventions should have been considered first.[3] Currently, evidence strongly suggests that verbal de-escalation can be effective and should be attempted before employing any form of coercive control intervention.[3] In fact, coercive control interventions, such as involuntary medication and mechanical restraints, have been demonstrated to escalate aggression.[7] The team failed to choose the least restrictive option when there was an opportunity to do so. Rather than simply calming the patient, she was sedated and physically restrained with the five-point restraint for four hours. Alternatives such as soft-tie restraints were not considered.

Individuals who are more likely to receive control interventions in a hospital setting include those who have a substance addiction, a mental health diagnosis, and/or a history of abuse.[7] Evidence suggests that patients are less likely to attend prescribed follow-up mental health treatments after being physically or mechanically restrained.[8] Given the cyclic nature of this issue, we should be asking ourselves: does the short-term benefit of using control interventions outweigh the long-term costs?

As a student nurse, it can feel uncomfortable to challenge the decisions made by experienced healthcare professionals. However, it is imperative to advocate for the conservative use of restraints on behalf of patients who cannot do so themselves. As the paradigm continues to shift away from the traditional practice of routine restraint use, advocating in favour of a minimal restraint approach should be a responsibility shared by every healthcare professional.[3]

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