Introduction

Problem Statement: The physical and chemical restraint of patients, despite being often applied with no real scientific basis, has always been part of nursing practice in caring for the ill people.

Research Questions: What is the level of knowledge over in nursing about physically and chemically restraining?

Purpose of the Study: Evaluate the level of knowledge of nurses on physical and chemical restraint of patients.

Methods

The cross-sectional descriptive study was conducted by collecting data using a survey on the knowledge that physically and chemically restraining patients. To this end, a sample was assessed consisting of 156 nurses aged between 24 and 57 (average being 35.11), 79.2% of which were female and 20.8% were male.

Results

Participants’ knowledge regarding the patient’s safety: Most participants (92.3%) believe that physical restraint is a protective practice of patient’s safety; Consider appropriate to apply physical restraint in patients: with psychotic disorders (91%); with disorders related to substances (68.6); with personality disorders (59.6%); with mood disorders (55.1%).

Participants report that the curricula of the attended courses did not include content on the restraint of patients (59.6%), saying to have acquired this knowledge in hospital practice (58.3%). As most significant conclusions we point out that 46.9% of professionals have good knowledge, 6.2% reasonable knowledge and 46.9% reveal insufficient knowledge. On the other hand, 79.5% found that physical restraint carries risks for the patient and 82.1% shows to have correct knowledge identifying it as one of the potential risks for developing pressure ulcers.

For the physical restraint of the patient, appropriate designed strips must be used (Portugal 2007). In contrast, participants report that the materials most used for this purpose are bandages, sheets and cotton, which may be explained by the absence of specific materials for this purpose. Considering the parts of the body to immobilize, the participants highlight the wrists and chest, and the literature reports that the placement of the strips should take into account the importance of the situation and that the 5th strip (chest) should only be placed after the immobilization of the arms and legs. Most participants (94.2%) revealed that physical restraint should apply when all the other measures fail.

Most participants (69.2%) expressed that physical restraint is not an indicator of quality of care, and we concluded that when it is applied, they use first alternative procedures, with the aim of providing proper care. However, 76.9% of the participants considered physical restraint as a good health practice, if necessary to safeguard their safety and not only regarding patients at risk of falling.

Most participants (84.0%) have preference to verbal and chemical restraint approaches instead of physical restraint.

Conclusion

Since the application of restraint is still a frequent and daily practice in hospitals, health centers, nursing homes and other health institutions, in order to better understand and explain this problem, the following questions remain unanswered: What is the best decision maker algorithm for the application of restraint measures? When to apply the physical restraint at the expense of chemical restraint and vice versa? Given the results, there arises the concern to include training on the physical and chemical restraint of patients in the study plan, as well as implementing the training and simulated practice of restraining measures, giving future nurses the transferable skills needed in clinical practice.

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References
