Psychiatric Nurses' Attitude and Practice toward Physical Restraint

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ABSTRACT

Aim: This study was to assess psychiatric nurses' attitude and practice toward physical restraint among mentally ill patients.

Methods: A descriptive research design was used to achieve the study objective. The present study was carried out in three specialized governmental mental hospitals and two psychiatric wards in general hospital. A convenient purposive sample of 96 nurses who were working in the previously mentioned setting was included. The tool used for data collection was the Self-Administered Structured Questionnaire; it included three parts: The first comprised items concerned with demographic characteristics of the nurses, the second comprised 10 items measuring nurses' attitudes toward physical restraint, and the third was used to assess nurses' practices regarding use of physical restraint.

Results: There were insignificant differences between attitudes and practices in relation to nurses' sex, level of education, years of experience and work place. Moreover, a positive significant correlation was found between nurses' total attitude scores, and practices regarding use of physical restraint.

Conclusion: Psychiatric nurses have positive attitude and adequate practice toward using physical restraints as an alternative management for psychiatric patients. It is important for psychiatric nurses to acknowledge that physical restraints should be implemented as the last resort. The study recommended that it is important for psychiatric nurses to acknowledge that physical restraints should be implemented as the last resort.

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In psychiatric hospitals, patients' violence and threats of violence constitute serious emergencies that may be difficult to handle by staff. Physical restraints (PRs) refer to any physical methods of restricting a person's freedom of movement, physical activity or normal access to his or her body (Martin, 2002). Moreover it is used in psychiatric health care settings as one of the psychiatric management to reduce the risk of harm among psychiatric patients whether it is directed toward self or toward others (Gelkopt Roffe, Behrbak, Melamed, Werbloff et al., 2009). The use of PR as an intervention in the care of psychiatric patients goes back to the beginning of the science of psychiatry. However, it is still one of the challenging questions in the psychiatric services and has always been considered as a moral argument (Iversen, 2009; Steinert, Lepping, Bernhardsgrüter, et al., 2010). Physical restraint includes devices designed to limit a patient's physical movements such as limb holders, safety vests and bandages. It is used to handle violent and maladaptive behaviors, manage patients with severe mental disorders, prevent injury and reduce agitation and aggression (Capezuti, 2004; Chien, Chan, Lam, & Kam, 2005; Akansel, 2007).

Nurses are closely involved in caring for restrained patients. The common absence of medical orders for starting or removing physical restraints indicates that the nurses mostly make these decisions. Their roles start with the selection of the least restricting arm restraint device available, followed by ones responsible and ending with modifying the patient care plan based on an hourly assessment of the patient’s response and physical condition (De Jonghe et al., 2013).

Several attempts have been made to reduce the integration of restraints in the clinical practice, as most studies used educational approaches in order to encourage nurses to use alternative measures instead of physical restraint. All studies delivered intensive training sessions and introduced a nurse specialist as a consultant; however, the success rate of these interventions in different countries has been variable; for example a successful educational intervention applied on nurses working in the USA proved to be ineffective in The Netherlands (Huizing, Hamers, Gulpers, Berger, 2006; Becker, Koczy, & Klie, 2007; Capezuti et al., 2007).

In general, research findings revealed that patients as a result of being restrained reported that they felt angry, helpless, sad, and powerless, punished, embarrassed, and that their right to autonomy and privacy has been violated, in addition to a feeling of loss of self worth, degradation, demoralization and humiliation while they are restrained (The American Psychiatric Nurses Association, 2001; The JOANNA Briggs Institute, 2002; Elgamil, 2006). Most of the patients' subjective experiences highlight the negative impact of physical restraint on the patients. These experiences were summarized in two themes: restriction and discomfort. Restriction relates to loss of freedom and control over what is happening during hospitalization, while discomfort is....

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caused by enforced immobility, i.e. from patient narrative comment: “I felt like a dog and cried all night, it hurts me to have to be tied up, and I’m in a jail stuck, I couldn’t even bring my hands together” (Sailas and Wahlbeck, 2005; Suen et al., 2006).

A study about psychiatric staff’s thoughts and feelings about restraint use, found that the risk of harm and the use of restraint conflicted with nurses’ role to protect. Nurses did not want to use restraints as a first option (Aschen, 1995; Hennessy, McNeely, Whittington, Strasser, & Archea, 1997; Karlsson, 2000; Hantikainen & Kappeli, 2000). In most of the studies the nursing staff reported a range of emotional reaction felt while doing restraint procedure, including anxiety, anger, feeling bored or distressed, crying, inadequacy, hopelessness, frustration, fear, guilt, dissatisfaction, isolation, being overwhelmed, feeling drained, vengeance and repugnance (Kamel, Maximos, & Gaafar, 2007).

In another study the nursing staff described how they had come hardened to the experience of restraint. Some of them reported that they had no emotional reaction and many reported automatic responding during restraint event in which they did not feel any emotion. This lack of feeling among nurses might be due to the fact that the practice had become so ritualized that it does not provoke any reaction (Sequeira & Halstead, 2004). Nurses’ attitudes toward physical restraints described as ambivalent, characterized by respect for a person’s dignity and by anxiety and the responsibility for the resident’s safety. Nurses described feelings of frustration and guilt when they used physical restraints against the will of a resident (Hantikainen & Kappeli, 2000; Karlsson, 2000).

Attitudes toward physical restraint can affect on nurses’ performance and behavior, especially psychiatric patients who already confronting and discrimination, which may express also by professionals and the general public (Emrich, Thomson, & Moore, 2003). Getting in touch with psychiatric patients and getting knowledge can help in replacing the myths with facts, decreasing stigma and affecting attitudes positively (Halters, 2004).

Physical restraints are a common practice in psychiatric hospitals, with prevalence rates ranging between 33% and 68% in hospital settings (Hamers & Huizing, 2005). Since nurses’ attitude and practice play an important role in psychiatric health care setting, it was deemed important to develop a restraint policy and educate nurses how to implement it because hospitals in Sudan do not have policies and there are illegal uses of restraint recorded.

AIM OF THE STUDY

The Aim of This Study Was to

Assess psychiatric nurses’ attitude and practice toward physical restraint among mentally ill patients.

Objective of the Present Study Was to

• identify psychiatric nurses attitudes toward restrained patients.
• evaluate psychiatric nurses practices regarding physical restraint.

SUBJECTS AND METHODS

Research Design

A descriptive research design was used in the study.

Setting

The present study was carried out in Khartoum-Republic of Sudan hospitals. It included three specialized governmental mental hospitals (Abdalal Aledrecee, Tahai Bahser and Altegani Almahi) and two Psychiatric wards in two general hospitals (Alselal Aliti and Khartoum Teaching Hospital).

Subjects

The study was conducted on a convenient purposive sample consisting of nurses who were working in these hospitals in the time of data collection according to following criteria: from both sexes and working in different psychiatric departments. Any deviations from these criteria were excluded. The questionnaire was distributed to all nurses with mentioned criteria, and the response rate was 63% with 96 nurses from all respondents.

Tools of Data Collection

Data Were collected through

Self-Administered Structured Questionnaire, which aimed to assess nurses’ attitude and practice regarding use of physical restraints. It was adopted from Janelli, Kanski, Scherer, and Neary (1992) and adapted by researchers in Arabic format in order to have a suitable language to suit the nurses’ level of understanding. Then, it was revised by using of panel of experts for the content validity. It included three parts as follows:

The first part:

It comprised items concerned with demographic characteristics of the nurses such as age, sex, qualifications, educational level, years of experience and work place.

The second part:

It comprised 10 items measuring nurses’ attitudes toward using of physical restraint, rated on a 4-point Likert scale in which four = ‘strongly agree’ and one = ‘strongly disagree’. Thus, high scores with cutoff point 24–40 reflected positive attitudes and low scores with cutoff point 10–23 reflected negative attitudes (potential range: 10–40).

The third part:

It was used to assess nurses’ practices regarding the use of physical restraint, which comprised 18 items assessing the issues in nursing care provided to patients immediately, before or during restraint such as ‘explain procedures to patient and significant others.’ The items reported to be done were scored “1” and the items not done were scored “0”. For each area, the scores of the items were summed-up and the total divided by the number of the items, giving a mean score for the part. These scores were converted into a percent score, and means and standard deviations were computed. The nurses’ practice was considered adequate if the percent score was 60% or more and inadequate if less than 60%.

The Cronbach’s alpha coefficients of parts two and three were 0.73 and 0.78.

Pilot Study

A pilot study was conducted after the development of the tools and before starting the data collection. It included 10% from nurses’ works in the previously mentioned settings and then excluded from the study sample. The purpose of the pilot study was to test the applicability, feasibility and clarity of the tools, and it served to estimate the time needed to complete the tools. Simple modifications of the tools were done.

Field Work

The data were collected from 20 February to 30 July 2014. Two days per week were specified for data collection. The days were Sunday and Thursday from 9.30 to 12.30 p.m. The investigator interviewed, observed and filled in the tools from each nurse individually. The approximate time spent with each nurse during the interview was 30 to 45 min; nurses interview number ranged from 1 to 6 nurses per day.
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