

## Avoiding Excessive Physical Restraints to Reduce ICU Pseudo Delirium

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### Abstract

ICU delirium is a common occurrence, with a wide range of risk factors contributing to its incidence. However, the excessive use of physical restraints as a precautionary measure poses challenges in accurately diagnosing and managing delirium. This paper highlights the practical constraints faced in implementing delirium prevention strategies in China, such as the shortage of medical personnel and the pressure to avoid adverse events. These constraints often lead to the continued use of physical restraints even in conscious patients who have been successfully weaned off mechanical ventilation. Additionally, delays in transferring patients from the ICU to general wards further contribute to the prolonged use of restraints. These circumstances can result in restricted patient autonomy, hinder early rehabilitation efforts, and increase emotional agitation. To address these issues, this paper proposes two recommendations: the establishment of transitional care units post-ICU discharge and the implementation of comprehensive interdisciplinary education. Transitional care units can provide a supportive environment for recovery and focus on early rehabilitation training, while interdisciplinary education programs can prioritize patient-centered care and help healthcare professionals maintain

judgment capabilities and consider individual patient needs. By implementing these recommendations, the aim is to improve delirium prevention and control in the ICU, ultimately enhancing patient outcomes and reducing the use of physical restraints.

### **Commentary**

Due to the prevalence of risk factors such as mechanical ventilation, emergency surgery, advanced age, and sepsis, the incidence of ICU delirium ranges from 11% to 80% [1]. However, it is important to note that a small subset of patients may experience agitation as a result of excessive use of physical restraints, which can be misinterpreted as hyperactive delirium and demands careful consideration. Due to the widespread shortage of medical and nursing personnel in China, the implementation of delirium prevention and control strategies often faces challenges due to practical constraints [2]. Despite the introduction of nonpunitive reporting of adverse events, nurses frequently resort to using physical restraints to avoid incidents such as falls from the bed or unplanned tube extubation, driven by work pressure and strained interpersonal relationships. As a result, even conscious patients who have been successfully weaned off mechanical ventilation may still be subjected to physical restraints. Furthermore, influenced by considerations such as Diagnosis-Related Group (DRG) assessments and average length of stay [3], many general wards are hesitant to accept patients transferred from the ICU. They may require significant improvement in the patients' condition before agreeing to accept them, causing delays in transfers. During this waiting period, patients may be subjected to excessive physical restraint measures.

The aforementioned reasons can result in the following clinical scenarios: awake patients who have successfully been weaned off mechanical ventilation may still be subjected to ongoing physical restraints, which restrict their autonomy and create difficulties in coughing. This, in turn, hampers early rehabilitation activities and contributes to emotional agitation. Additionally, noncompliant patients may be mistakenly diagnosed with hyperactive delirium, leading to an increase in the use of restraints. This cycle continues until nurses resort to requesting the attending physician to excessively administer sedative medications to patients. In severe cases, tracheal reintubation may become necessary. This entire process can sometimes create a hostile atmosphere between nurses and patients.

The observations mentioned above occurred incidentally within the ICU, but their incidence in China lacks sufficient research. Considering the current realities in the Chinese medical market, the following

suggestions can be discussed: (1) Establishing transitional care units post-ICU discharge: The creation of transitional care units that provide a lower level of monitoring and allow for the presence of family members can facilitate a smoother transition for patients. These units can focus on early rehabilitation training and provide a supportive environment for recovery. (2) Comprehensive interdisciplinary education: Implementing education programs that prioritize patient-centered care is crucial. These programs should aim to prevent healthcare professionals, including doctors and nurses, from becoming excessively focused on institutional routines. Instead, they should emphasize the importance of maintaining judgment capabilities and considering individual patient needs. This shift may help healthcare professionals avoid becoming mere tools within the healthcare system.

### **Competing Interests**

The author declares that he has no competing interests.

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