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The decision-making process leading to the use of home physical restraints: A qualitative study

Elisa Ambrosi [a,*], Virginia Poli [b], Michela Filippi [a], Federica Canzan [a], Anna Brugnolli [c]

[a] Department of Diagnostics and Public Health, University of Verona, Italy
[b] Azienda Sanitaria Universitaria Integrata del Trentino, Trento, Italy
[c] Center for Medical Sciences (CISMed), University of Trento, Trento, Italy

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ABSTRACT

Background: Physical restraint is used in residential care despite not being recommended. Decision is influenced by patient characteristics, healthcare provider attitudes, with families often viewing it as a protective tool. Limited research on home care underscores the need for awareness and informed, collaborative decision-making to balance safety, autonomy, and quality of life.
Methods: . A qualitative descriptive study was conducted in a primary care setting in northern Italy, to explore the use of physical restraint and the decision-making process that led to its use in home care. Twenty-five nurses employing in the involved department were recruited via convenience sampling. Data were gathered through face-to-face interviews using a semi-structured guide. Data were analysed using thematic analysis.
Results: . Use of physical restraint in home care aims to ensure patient safety, autonomy, and support caregiver respite. Decision to use physical restraint are influenced by 1) meanings and purposes of restraint, (2) patient-related factors, (3) caregiver role and needs, (4) nurse–caregiver negotiation, and (5) balancing risks, benefits, and alternatives.
Conclusion: . The study highlights the complexity of physical restraint use in home care, where professional responsibility must balance with family roles and patient well-being. Supporting nurses through training, guidelines, and communication is essential to ensure patient safety and family well-being.

What is already known

- Restraint use has been widely examined in institutional care settings, whereas it remains comparatively underexplored in home care.
- Patient safety, caregiver burden, and autonomy are recognised determinants of restraint use in older adult care.
- Ethical concerns surrounding restraints focus on balancing risk prevention with the protection of dignity and human rights.

* Corresponding author at: Department of Diagnostics and Public Health, University of Verona, Mailing address: Strada Le Grazie, 8, 37134, Verona.
E-mail address: elisa.ambrosi_01@univr.it (E. Ambrosi).

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What this paper adds

- In home care, restraint use emerges as a negotiated, relational, and context-dependent practice shaped by family involvement and environmental conditions.
- Restraints may be perceived not only as safety measures but also as pragmatic tools to support caregiving and enable individuals to remain in their home environment.
- Nurses act as ethical mediators in distributed decision-making processes, highlighting the need for context-responsive and internationally relevant guidance for home-based care.

1. Introduction

The use of physical restraints (PR) is a well-recognized issue in long-term care, with well-documented consequences for patients, families, and healthcare providers (Palese et al., 2021; Scheepmans et al., 2020, 2018; Thomann et al., 2021). Although extensively studied in institutional settings such as nursing homes—where prevalence reaches a median of 26.5% (interquartile range [IQR] 16.5%–38.5%) (Ambrosi et al., 2021)—the use of PR in home care remains less explored, despite presenting distinct ethical, clinical, and relational challenges. In this study, "home care" refers to healthcare services delivered in the individual's usual place of residence, outside institutional settings, typically involving both formal healthcare professionals and informal (family) caregivers. The term "patient" is used broadly and does not refer to a specific clinical population; rather, it encompasses individuals requiring home care assistance across a wide range of conditions, including psychiatric disorders, dementia or cognitive decline, and other complex care needs, and is therefore not limited to older adults.

Physical restraint is defined as any action or device that restricts a person's freedom of movement or access to their body, through methods or materials applied to or positioned near the individual, that cannot be easily controlled or removed by the person themselves (Bleijlevens et al., 2016). Commonly used methods include bilateral bed rails, belts for limbs or trunk, fixed tables on chairs, or containment sheets (Scheepmans et al., 2018).

Evidence consistently shows that PR do not reduce falls or fall-related injuries and are associated with adverse outcomes such as pressure ulcers, incontinence, psychological distress, reduced mobility, and social isolation (Capeletto et al., 2021; Scheepmans et al., 2014; Sze et al., 2012). PR use has also been linked to loss of dignity, increased agitation, and deterioration in therapeutic relationships (Scheepmans et al., 2018; Thomann et al., 2021). These findings indicate that poorly informed or low-quality decisions regarding restraint use may result in significant physical, psychological, and relational harm. However, most evidence derives from hospital and nursing home settings, with limited data available in home care.

Studies conducted in home care have primarily examined prevalence, reasons for use, and associated factors (Andres et al., 2024; Capeletto et al., 2021; De Veer et al., 2009; Hamers et al., 2016; Kunik et al., 2010; Kurata and Ojima, 2014; Nakanishi et al., 2018; Scheepmans et al., 2019, 2017; C. C. Weng et al., 2025; Zanetti et al., 2018), identifying both restrictive and supportive purposes (Palese et al., 2021). In this setting, PR are used to prevent falls, manage behavioural symptoms, or avoid interference with medical devices, with prevalence ranging from 5% to 24.7%, reaching up to 38% among patients with cognitive impairment (Andres et al., 2024; Scheepmans et al., 2018; Weng et al., 2025).

Decision-making around PR in home care involves multiple actors, including informal caregivers, nurses, and general practitioners, who contribute at different stages of the process (Andres et al., 2024; Capeletto et al., 2021; De Veer et al., 2009; Hamers et al., 2016; Kurata and Ojima, 2014; Mengelers et al., 2019; Scheepmans et al., 2017; Zanetti et al., 2018). This process is dynamic and context-dependent, shaped by the interaction between clinical needs, family dynamics, and available resources. Informal caregivers often play a key role due to their continuous presence, while nurses contribute through clinical assessment, professional judgement, and implementation of care. Patient involvement remains limited (Scheepmans et al., 2017).

The home environment places nurses in a particularly complex position, requiring them to balance clinical responsibility, patient safety, and family expectations. Decision-making is frequently influenced by caregiver burden, limited supervision, and resource constraints (Andres et al., 2024; Möhler and Meyer, 2014). Recent evidence indicates that PR in home care involves multiple actors such as stress, fatigue, and lack of training or professional support (Weng et al., 2025) which may contribute to the normalization of restraint use as a "practical" solution in demanding care situations.

Despite the involvement of multiple actors, existing research has largely focused on prevalence and associated factors, with limited attention to how restraint-related decisions are experienced and managed in practice. In particular, the perspective of home care nurses remains underexplored. Given their role in clinical assessment, care planning, and ongoing interaction with both patients and families, nurses are well positioned to provide insight into how these decisions are negotiated and enacted in everyday home care practice.

Addressing this gap may inform clinical practice and support more informed, family-inclusive, and ethically grounded decision-making processes that respect patient safety, autonomy, and quality of life.

2. Methods

2.1. Study design

A descriptive qualitative study was conducted through semi-structured interviews(Sandelowski and Barroso, 2002) to explore the

use of physical restraint (PR) in the home context, the decision-making process leading to the use of restraint, and the experiences of nurses, patients, and caregivers.

2.2. Participants

Twenty-five nurses working in primary care settings within a defined municipality in northern Italy were recruited through convenience sampling between January and May 2025. Participants were eligible if they had at least six months of experience in home or palliative care settings and provided informed consent to participate in the study. Participants were excluded if they had less than six months of relevant experience, were not directly involved in patient care in the home care setting at the time of the study, or were unable or unwilling to provide informed consent. To maximize variability and enrich the data, researchers selected nurses with different characteristics in terms of age, experience, and educational background.

2.3. Data collection

Informed consent was obtained from the participants, after which the researcher scheduled one-on-one interviews at convenient times and locations. Interviews were conducted in a quiet room after work shifts. All interviews were audio-recorded and transcribed verbatim, with each participant assigned an anonymous identification code.

The interview questions are synthesized in Table 1.

Each open-ended question allowed the interviewees to share their experiences freely. Following the interview, participants were asked to provide demographic details, including age, gender, and tenure. The interviews were conducted by experienced healthcare professionals with a Master's degree in Nursing and Midwifery Sciences, all of whom had undergone specific training in qualitative research methods and interview techniques. This background ensured methodological rigor, consistency in data collection, and sensitivity in approaching participants. The interviews lasted an average of 30 min and continued until data saturation was achieved. In qualitative research, data saturation refers to the point at which additional data collection no longer yields new information, themes, or insights relevant to the research question (Rahimi and Khatooni, 2024; Saunders et al., 2018).

Saturation was considered not as a single moment but as an iterative and ongoing process, consistent with its conceptualization as context-dependent and shaped by both the characteristics of the study and the researchers' analytic approach (Rahimi and Khatooni, 2024; Saunders et al., 2018).

In this study, saturation was operationalized during concurrent data collection and analysis. Interviews were analysed progressively, and recruitment continued until successive interviews did not generate new codes or contribute additional insights to existing categories and themes. At this stage, redundancy in the data was observed, indicating that the dataset was sufficiently rich to address the study aim and that further data collection was unlikely to add meaningful information.

This approach ensured that data collection was guided by analytic sufficiency rather than a predetermined sample size, thereby supporting the depth, completeness, and credibility of the findings.

2.4. Data analysis

The interview transcripts (approximately 150 pages in total) were independently analysed by two female researchers, both with a background in nursing and extensive expertise in qualitative research. One researcher holds a Master's degree, while the other holds a PhD with specific training in qualitative research within the nursing discipline. Both are university professors with recognized expertise in the study topic.

The analytical process followed the phases of thematic analysis as outlined by Sandelowski and Barroso (Sandelowski and Barroso, 2002) and was further guided by Braun and Clarke's framework (Clarke and Braun, 2018; Sandelowski and Barroso, 2002). The analysis was conducted following Braun and Clarke's six-phase thematic analysis, providing a systematic and transparent framework. This included familiarisation with the data through repeated readings, inductive generation of initial codes from meaningful units of text, and an iterative process of constant comparison, refinement, and condensation of codes. Codes were then organised into sub-categories and broader categories, and subsequently grouped into themes based on patterns of shared meaning. Themes were reviewed, defined, and named to ensure internal coherence and clear distinctions, and the final analytic narrative was developed using illustrative data extracts.

The coding process captured both explicit content and underlying meanings related to restraint use, including safety concerns,

Table 1
Semi-structured interview guide.

What do you think about restraint?
Does restraint use occur in home care settings?
Could you think of a situation when you recently used the restraint?
What decision-making process did you use to decide on restraint?
How did you feel about using restraints?
What was the patient's reaction to the use of restraints? How did he/she experience the application of restraints?
What was the behaviour of any family members present regarding the use of restraints? How did they experience the situation?
Could the restraint have been avoided by using any other strategies?

patient characteristics, caregiver roles, and relational dynamics. This process led to the development of five overarching themes describing the decision-making process in home care. The progression from codes to sub-categories, categories, and themes reflects a hierarchical and interpretative structure that ensured a close connection to participants' experiences. The full coding framework is presented in Supplementary Table S1.

To enhance credibility and dependability, two researchers independently coded the data and regularly compared and discussed their interpretations, resolving discrepancies through consensus.

2.5. Trustworthiness

To ensure the rigor and trustworthiness of the study, several strategies were applied throughout the analytical process in line with Lincoln and Guba's criteria (Lincoln and Guba, 1985), and tailored to this study.

Credibility was enhanced through independent coding of all transcripts by two researchers with expertise in qualitative research, followed by regular meetings to compare coding, discuss discrepancies, and agree on the final coding structure and themes. In addition, member checking was conducted by sharing a summary of the findings with a subset of participants, who confirmed that the interpretations reflected their experiences.

Dependability and confirmability were supported by maintaining an audit trail documenting the main analytical steps, including coding decisions, theme development, and subsequent revisions. Reflexive notes were kept during the process to record methodological choices and to reflect on potential researcher influence on data interpretation.

Transferability was addressed by providing detailed descriptions of the study context, participants, and home care setting, along with the inclusion of illustrative quotations that represent the range of participants' perspectives.

These strategies ensured that the findings were grounded in the data and that the analytical process was transparent and consistently applied.

3. Ethical considerations

The study was conducted according to the guidelines of the Declaration of Helsinki, and approved by the Institutional Review Board of the University of Verona (Cod. 2017_13, 18 July 2017). Informed consent was obtained from all subjects involved in the study.

4. Results

Twenty-five nurses participated in the study (mean age 39.7 years, SD ±8.7), with an average of 7.1 years of experience in primary care (SD ±5.1). Eleven nurses (44%) had completed postgraduate education.

The analysis generated five themes describing how decisions about restraint use are shaped in home care: (1) meanings and purposes of restraint, (2) patient-related factors, (3) caregiver role and needs, (4) nurse–caregiver negotiation, and (5) balancing risks, benefits, and alternatives. These themes reflect the relational and context-dependent nature of decision-making in home care. The relationships between these themes are illustrated in Fig. 1. A detailed overview of the coding structure is provided in Supplementary

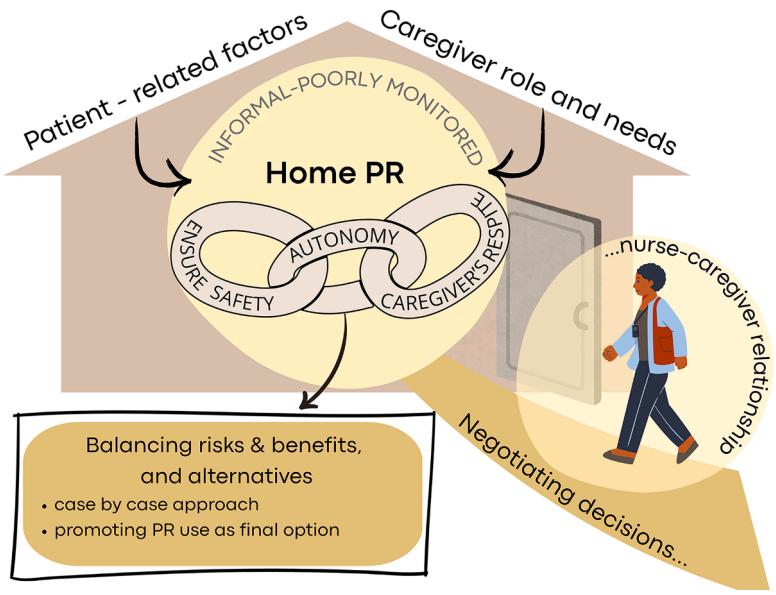

Fig. 1. Nurse's care shapes the decision-making process of restraint use in home care, balancing context-specific factors and the needs of the family unit.

Table S1.

4.1. Meanings and purposes of restraint in home care

Nurses described restraint in home care as a practice that differs from institutional settings, often perceived as less explicit and more context-dependent. As one nurse explained, "It is a more humane form of restraint" (N19), highlighting how its meaning is shaped by the home environment and the presence of caregivers.

Restraints were commonly understood as tools to ensure safety, particularly at night: "Restraint is mostly applied at night… patients feel safer" (N12). At the same time, they were also described as supporting caregiver needs, especially when continuous supervision was not feasible: "Caregivers need to rely on something… they cannot be there constantly" (N16). In some cases, restraint was even seen as supporting patient autonomy, for example when bed rails facilitated mobility: "Supporting oneself on a rail becomes a stimulus to preserve independence" (N6).

However, nurses also emphasized that restraint use in home care is often informal and poorly monitored: "They decide when and how long to restrain… there is no monitoring" (N12), reflecting the unstructured nature of care in domestic settings.

4.2. Patient-related factors influencing restraint use

Decisions about restraint were strongly influenced by patient characteristics, particularly cognitive impairment and risk behaviours. Nurses frequently referred to dementia and agitation as key triggers: "With dementia… it becomes a way to manage the patient at night" (N17).

Restraints were also used in situations involving high risk, such as self-harm or interference with medical devices: "Restraint was used to protect him… during seizures he could not be managed" (N6).

At the same time, nurses highlighted variability in how patients experienced restraint. While some accepted it or perceived it as protective, others reacted negatively: "Like a 'cage'… it is unnatural" (N12). These contrasting experiences contributed to the complexity of decision-making.

4.3. Caregiver role and needs

Caregivers emerged as central actors in restraint-related decisions. As one nurse noted, "At home, the caregiver acts as they see fit" (N16), reflecting the autonomy of the home context. Restraint use was often linked to caregivers' need to manage care demands and ensure safety in the absence of continuous supervision: "They cannot be there constantly keeping watch" (N16).

Emotional factors, such as fear of falls and anxiety about patient safety, also influenced decisions. In addition, nurses highlighted that limited awareness contributed to the normalization of restraint use: "Restraint is often seen as a convenience… lack of awareness" (N3).

Education was described as a key strategy to address this issue: "It is important to educate the caregiver… to reduce risk without restraints" (N9), suggesting a need for greater professional support.

4.4. Negotiating decisions within the nurse–caregiver relationship

Decision-making was described as a negotiated process between nurses and caregivers, often requiring collaboration and compromise. Nurses emphasized the importance of partnership: "Create a partnership that allows a shared process" (N2).

However, this process was not always straightforward. Nurses described the need to balance professional recommendations with caregiver preferences: "A fair compromise with the caregiver is essential" (N17). Maintaining trust was considered a priority, even when disagreements arose: "If it does not cause harm… I try not to confront caregivers" (N22).

These accounts highlight how decision-making is embedded in relational dynamics, where preserving the therapeutic relationship may influence clinical choices.

4.5. Balancing risks, benefits, and alternatives

Restraint was consistently described as a measure to be used only after careful evaluation of risks and alternatives. As one nurse stated, "Restraint is never my first choice" (N19), emphasizing a case-by-case approach.

Nurses reported using alternative strategies, particularly environmental adaptations: "Using the bed on the floor to prevent falls" (N14). However, such alternatives were not always feasible, often due to resource constraints and caregiver burden: "Alternatives can be costly in terms of energy" (N3).

In this context, restraint was sometimes perceived as an unavoidable option, reflecting the tension between ideal practices and real-world constraints.

5. Discussion

This study explored how nurses in home care navigate decisions regarding restraint use, highlighting the relational, contextual, and ethical dimensions that shape these practices. The findings show that restraint use is not solely a clinical or safety-driven intervention

but a negotiated process influenced by patient characteristics, caregiver needs, and the dynamics of the nurse–caregiver relationship. Across themes, decision-making emerged as iterative and context-dependent, requiring continuous balancing of risks, benefits, and available alternatives.

Our findings provide additional insight into restraint use in home care, a context that remains comparatively underexamined. In contrast to institutional settings—where restraint use is often governed by formal regulation and protocol—home care practices appear more fluid and negotiated, shaped by relational, cultural, and spatially intimate environments. This study contributes to the literature by offering a more nuanced account of how restraint practices are constructed in everyday home care contexts.

Consistent with prior research, patient safety concerns, caregiver burden, and respect for autonomy emerged as key determinants of restraint use (Scheepmans et al., 2018; Weng et al., 2025) . This is in line with evidence from home care studies showing that restraint use is influenced by both clinical factors (e.g., cognitive impairment, reduced mobility) and caregiver-related conditions, including supervision capacity and perceived burden (Capeletto et al., 2021; De Veer et al., 2009; Scheepmans et al., 2018; Weng et al., 2025). Our findings extend this body of work by describing how these determinants are dynamically mediated by contextual factors such as housing conditions, resource availability, and professional discretion. Similar observations have been reported in studies showing that restraint use in home care may serve both restrictive and supportive purposes depending on situational demands (Andres et al., 2024; Palese et al., 2021; Scheepmans et al., 2018).

Importantly, restraint was not always framed solely as a risk-containment strategy but, in some cases, as a pragmatic means of supporting continued care at home. This perspective, while less frequently emphasised in the literature (Palese et al., 2021), aligns with findings from home care studies where restraint is described as serving both protective and enabling functions (Andres et al., 2024; Palese et al., 2021; Scheepmans et al., 2018). In this context, the concept of caregiver sustainability—understood as the capacity of caregivers to maintain their role over time without excessive physical, emotional, or psychological strain—becomes particularly relevant. In settings where informal caregiving represents a primary source of long-term support, restraints may be perceived as tools to manage risk while preserving caregivers' ability to continue providing care.

Decision-making in home care was characterised as a distributed and relational process involving both nurses and caregivers. In this study, shared decision-making refers to the collaborative process between nurses and caregivers, in which clinical expertise, experiential knowledge, and contextual constraints are negotiated. This approach is particularly appropriate in home care, where caregivers are directly responsible for daily care and professional oversight is intermittent. However, this model also introduces complexity, as nurses must balance respect for caregiver autonomy with their professional responsibility to ensure patient safety, dignity, and human rights. This finding aligns with evidence indicating that informal caregivers are primary actors across key phases of restraint use—particularly in requesting and decision-making—while nurses contribute through assessment, advice, and coordination (De Veer et al., 2009; Scheepmans et al., 2020).

The findings also highlight the importance of caregiver education and structured professional support. Consistent with previous research (Andres et al., 2024; Möhler and Meyer, 2014), education was identified as a key strategy to reduce reliance on restraint and promote alternative approaches. Environmental adaptations, assistive technologies, and risk-reduction strategies emerged as viable alternatives to restrictive measures (Scheepmans et al., 2020); however, their feasibility depended on socioeconomic resources, housing design, and service infrastructure. These findings emphasise the need for restraint-reduction initiatives that are sensitive not only to individual clinical factors but also to broader structural and cultural determinants of care.

From an ethical perspective, the study illustrates a tension between relational autonomy and the protection of individual rights. While restraints may be perceived as necessary in specific high-risk situations, their use entails potential harms—including physical injury, psychological distress, and erosion of self-determination (Scheepmans et al., 2018; Vandervelde et al., 2021). These adverse outcomes have been extensively documented in hospital and nursing home settings (Scheepmans et al., 2018; Vandervelde et al., 2021), whereas evidence in home care remains comparatively limited. In home care, this tension is intensified by the central role of caregivers and the comparatively diffuse nature of regulatory oversight. Across contexts, transparent communication, ethical reflexivity, and collaborative decision-making therefore emerge as essential components of responsible practice.

Finally, it is important to clarify that this study refers to care provided in individual's homes, meaning non-institutional domestic environments where care is delivered by informal caregivers alongside community-based health professionals. Within these settings, restraint use should be understood as a situated and negotiated practice embedded within nurse–caregiver relationships and shaped by system-level conditions.

Overall, restraint use in home care can be understood as a complex, context-sensitive practice that reflects an ongoing balancing of risk management, caregiver burden, patient dignity, and relational trust. Nurses play a pivotal role as mediators and ethical stewards, working to minimise restriction while maintaining safety and supporting autonomy within diverse care contexts.

5.1. Strengths and limitations

This study addresses a significant international gap by focusing specifically on restraint use in home care, an area that remains underexplored. The qualitative design enabled in-depth examination of ethical tensions and relational processes that are highly relevant across diverse healthcare systems. By moving beyond binary categorizations of restraint use, the findings contribute a nuanced conceptual framework applicable to community-based care. However, the study was conducted within a specific national and organisational context, which may limit direct transferability to settings with different welfare regimes, regulatory structures, or cultural norms regarding family caregiving. Perspectives of patients and family caregivers were not directly included and should be incorporated in future cross-national research. Additionally, social desirability bias may have influenced participants' accounts of ethically sensitive practices. Comparative international studies are warranted to explore how structural, cultural, and policy

environments shape restraint-related decision-making in home care.

5.2. Implications for practice and policy

Given the global expansion of home-based care, the development of internationally relevant, context-responsive guidance on restraint use is urgently needed. Policies should acknowledge the relational and environmental realities of home settings rather than relying exclusively on institutional paradigms. Training programmes should strengthen nurses' competencies in ethical deliberation, negotiation, and culturally sensitive family engagement.

At a systems level, investment in caregiver support, environmental modifications, and accessible assistive technologies may reduce reliance on restrictive practices. International collaboration in developing best-practice frameworks could promote consistency while allowing adaptation to local cultural and structural contexts.

5.3. Implications for research

Future research should prioritise cross-national comparative studies to examine how cultural norms, welfare regimes, regulatory environments, and resource distribution influence restraint practices in home care. Longitudinal and mixed-methods approaches could provide a more comprehensive understanding of how decision-making unfolds over time, capturing how caregivers' perspectives, priorities, and constraints shift across different stages of caregiving trajectories and disease progression, while also integrating quantitative patterns with qualitative insights into the underlying motivations and contextual factors shaping these decisions. Participatory research involving patients and family caregivers across diverse settings may further strengthen person-centred and rights-based approaches to risk management and contribute to a deeper understanding of how shared decision-making is enacted in real-world home care contexts.

6. Conclusions

Restraint use in home care represents a context-sensitive and relational practice shaped by the interplay of family responsibility, professional judgement, and system-level conditions. As care increasingly shifts from institutions to individual's homes across diverse healthcare systems, restraint-related decisions become embedded within everyday family life, where ethical tensions between safety, autonomy, and caregiver burden must be actively negotiated rather than procedurally resolved.

This study highlights the pivotal role of nurses as mediators within these negotiations and underscores the need for internationally relevant, context-responsive guidance that acknowledges the distinctive realities of home-based care. Strengthening caregiver support, fostering shared decision-making, and promoting feasible alternatives to restrictive measures are critical steps to ensure that remaining at home is consistent with principles of dignity, proportionality, and rights-based care.

By conceptualising restraint in home care as a negotiated and socio-contextual phenomenon, this study contributes to a more nuanced understanding of restrictive practices in community settings and provides a foundation for future comparative and policy-oriented research.

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Declaration of generative AI and AI-assisted technologies in the manuscript preparation process

During the preparation of this work the author(s) used ChatGPT in order to improve language and readability. After using this tool/service, the author(s) reviewed and edited the content as needed and take(s) full responsibility for the content of the published article.

Data availability statement

The data are not publicly available but may be obtained from the corresponding author upon reasonable request.

CRediT authorship contribution statement

Elisa Ambrosi: Writing – review & editing, Writing – original draft, Validation, Supervision, Methodology, Investigation, Formal analysis, Conceptualization. **Virginia Poli:** Writing – review & editing, Investigation, Formal analysis. **Michela Filippi:** Writing – review & editing, Methodology. **Federica Canzan:** Writing – review & editing, Supervision, Methodology. **Anna Brugnolli:** Writing – review & editing, Methodology, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.ijnsa.2026.100564.

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