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Residential Care Staff's Knowledge of Reporting Restrictive Practices in Intellectual Disability and Older Persons Care Settings: A Scoping Review

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Scoping Review

Abstract

Introduction: This Restrictive practice is an intentional restriction of an individual's voluntary movement or behaviour. Given the impingement of human rights associated with restrictive practice, many jurisdictions all over the world have advocated for a reduction in their use, highlighting the importance of reporting restrictive practice. However, a paucity of literature exists examining the knowledge of residential care staff regarding reporting restrictive practice.

Aim: To examine the knowledge of residential care staff regarding the reporting of restrictive practices in intellectual disability and older persons care settings.

Methods: A scoping review referenced to JBI and PRISMA guidelines was used. The studies were retrieved from a library multi-search function of various databases. Sixteen studies were included in the final analysis.

Findings: Findings demonstrate that residential staff lack knowledge of what defines a restrictive practice and find the reporting system as unnecessary, time consuming and burdensome. The identified barriers to reporting restrictive practice included: fear, lack of clear guidelines and awareness of the reporting system, lack of time, and staff shortages. While the facilitators included awareness campaigns, availability of appropriate reporting structures, and managerial support.

Conclusion: This review suggests that improvements in terms of residential staff understanding of and reporting of restrictive practice is required. Moreover, this review has the potential to assist policymakers to understand the individual, organisational and regulatory barriers and facilitators to reporting restrictive practice within intellectual disability and older persons care settings.

Keywords: residential care staff, residential care, reporting, incidents, restrictive practices, knowledge, older persons, and intellectual disability

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1. Introduction

Restrictive practices are defined as intentionally restricting an individual's voluntary movement or behaviour (Health Information and Quality Authority (HIQA), 2024) and can be applied using physical, chemical, environmental (Department of Health, 2011), or psychological constraints (HIQA, 2023).

Restrictive practices violates an individual's autonomy and freedom (Hamers et al., 2016; Estevez-Guerra et al., 2017) and consequently can lead to decreased physiological well-being (Muluneh et al., 2024), reduced mobility and cognitive functioning, worsening of non-cognitive symptoms of dementia (Muluneh et al., 2024), injury and/or death from entrapment and asphyxiation (Bellenger et al., 2018).

Older adults and individuals living with intellectual disabilities (ID) are more likely to need support with daily living activities, as they may experience higher rates of life-limiting physical and mental co-morbidities compared to the general population (Cooper et al., 2018).

Many older adults and persons living with an ID rely on care from others, such as long-term care residential facilities (Khan et al., 2024).

The literature has reported that these vulnerable groups may have restrictive practices applied to them as a response to challenging behaviours and some co-existing cognitive conditions (Sheehan et al., 2015; Cooper et al., 2018).

However, the moral, ethical and legal necessities of restrictive practices within healthcare and disability support is much debated (Mcsherry & Freckelton, 2015).

The literature has reported safeguarding concerns in relation to residents' ability to consent to restrictive practices (Dunbar et al., 2022a; Dunbar et al., 2022b). Therefore, examining the knowledge of residential care staff regarding the reporting restrictive practices is paramount.

Given the negative outcomes associated with restrictive practice, many jurisdictions all over the world have advocated for a reduction in their use (Government of Australia, 2022; HIQA, 2023).

Reporting restrictive practices is valuable as a resource for planning, delivering, monitoring, managing and improving care in relation to restrictive practice use (HIQA, 2023).

However, the literature has identified varying degrees of knowledge of reporting restrictive practices amongst health care professionals (HCP's) (O 'Regan et al., 2022) and has questioned whether HCP's knowledge influences the use of restrictive practice in nursing homes (Kassew et al., 2020; Carrero-Planells et al., 2021). With this in mind, this scoping review examines the literature on residential care staff knowledge of reporting restrictive practices within ID and older persons care settings.

2. Material and methods

A comprehensive scoping review was conducted using the Joanna Briggs Institute (JBI) protocol, a nine-step approach and includes: (1) abstract; (2) introduction; (3) methods; (4) review question; (5) inclusion criteria; (6) search strategy; (7) study selection; (8) data extraction; and finally, (9) data analysis and presentation (Peters et al., 2022).

This review also used the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flowchart (Page et al., 2021) for reporting findings.

The PRISMA flowchart was chosen for its usefulness in showing the steps taken in selecting and excluding papers for inclusion in the scoping review.

There is clear evidence of how, why and what studies were selected or rejected.

2.1 Review question

The purpose of this scoping review is to examine residential care staff knowledge of reporting restrictive practices within ID and older persons care settings.

It is important to note that scoping reviews mostly use the JBI's Population, Concept and Context (PCC) approach (Peters et al., 2022). With this in mind, this scoping review examines the following research question:

What is residential services staff (Population) knowledge of reporting restrictive practice (Concept) in older persons and ID care settings (Context)?

2.2 Inclusion criteria

The inclusion criteria included: primary research such as qualitative, quantitative, or mixed-methods studies that focused on and answered the research question; studies published in the English language between 2013 and 2025 (much change in legislation and practice in restrictive practices has occurred within this timeframe); with full text availability; and studies that focused on all forms of restrictive practices in older persons and ID healthcare settings.

2.3 Search strategy

A search of several databases including Cumulative Index to Nursing and Allied Health Literature (CINAHL), EBSCO, Science Direct, Google Scholar and PubMed was undertaken using the multi search function.

In the selection of studies key search terms using the Boolean operators AND/OR were used to search the databases as identified in Table 1.

The decision to use a multi-search approach came from the realisation that some papers, especially those relating to ID services, used terminology from social care and some appeared in social care journals and not just health science sites.

The reference lists of appropriate studies were also hand-searched for additional articles.
Literature was found examining restrictive practices that are in use and discussions on the benefits and disadvantages of restrictive practice use.
Due to unavailability of papers written specifically about reporting restrictive practices, the search included papers on incident reporting systems and medical incident reporting, because some restrictive practices are reported as incidents or through the incident reporting systems (NDIS Quality and Safeguards Commision, 2020).
In Australia, inappropriate use of restrictive practices are reported under the Serious Incident Response System (SIRS) whilst physical and chemical restrictions are reported through the National Aged Care Mandatory Quality Indicator Programme (Government of Australia, 2022).
Reports on medical incidents included reports on chemical restrictive practice use.

2.4 Study selection

The initial search identified 3291 papers (see PRISMA, figure 1).
After excluding a further 1,070 of these papers that examined restrictions such as Covid restrictions and prisons, the final yield of papers was 2,221.
Eight hundred and eighty-nine (n=889) duplicates were identified and removed, and 1,332 were screened of which 1,127 papers were excluded.
These were for example newspaper articles which had been included in the initial results because a library multi-search function was used.
The remaining 205 selected papers were identified for full reading in relation of terms of eligibility.
Some articles referred to restricted medical services like abortions, whilst other papers had no information relating to restrictive practices.
Many papers broadly discussed restrictive practices as a concept without exploring the knowledge or reporting of restrictive practice.
Fourteen primary studies met the criteria for inclusion in the scoping review.
Two reviewers screened the 191 papers rejected by the first researcher and identified four papers that were potentially relevant to the scoping review.
Of these four, two were deemed relevant, resulting in 16 papers finally selected for the scoping review.

2.5 Data extraction

The data extracted from the selected studies is presented in table 2 and presents the study title, authors, publication year, the population, concept and context of the study and the methods utilised within the included studies.
The key findings from each study are also specified.

Table 1: Key search terms

Key search terms	Alternatives/Boolean
Residential services staff	Nurses or Carers or Care assistants or catering staff or Social Care Assistants or Social Care worker or Health care workers or Physicians or Doctors or social workers or Health Care Professionals
Restrictive practices	Restraints or physical restrictions or mechanical restrictions or chemical restraints or psychological restrictions or psychosocial restrictions
Knowledge	Perspectives or attitudes or perceptions or views or information
Reporting	Incidents or Records or Reports or medical incident reports
Older persons	Elderly persons or older adults or later life or geriatric
ID	Learning disability

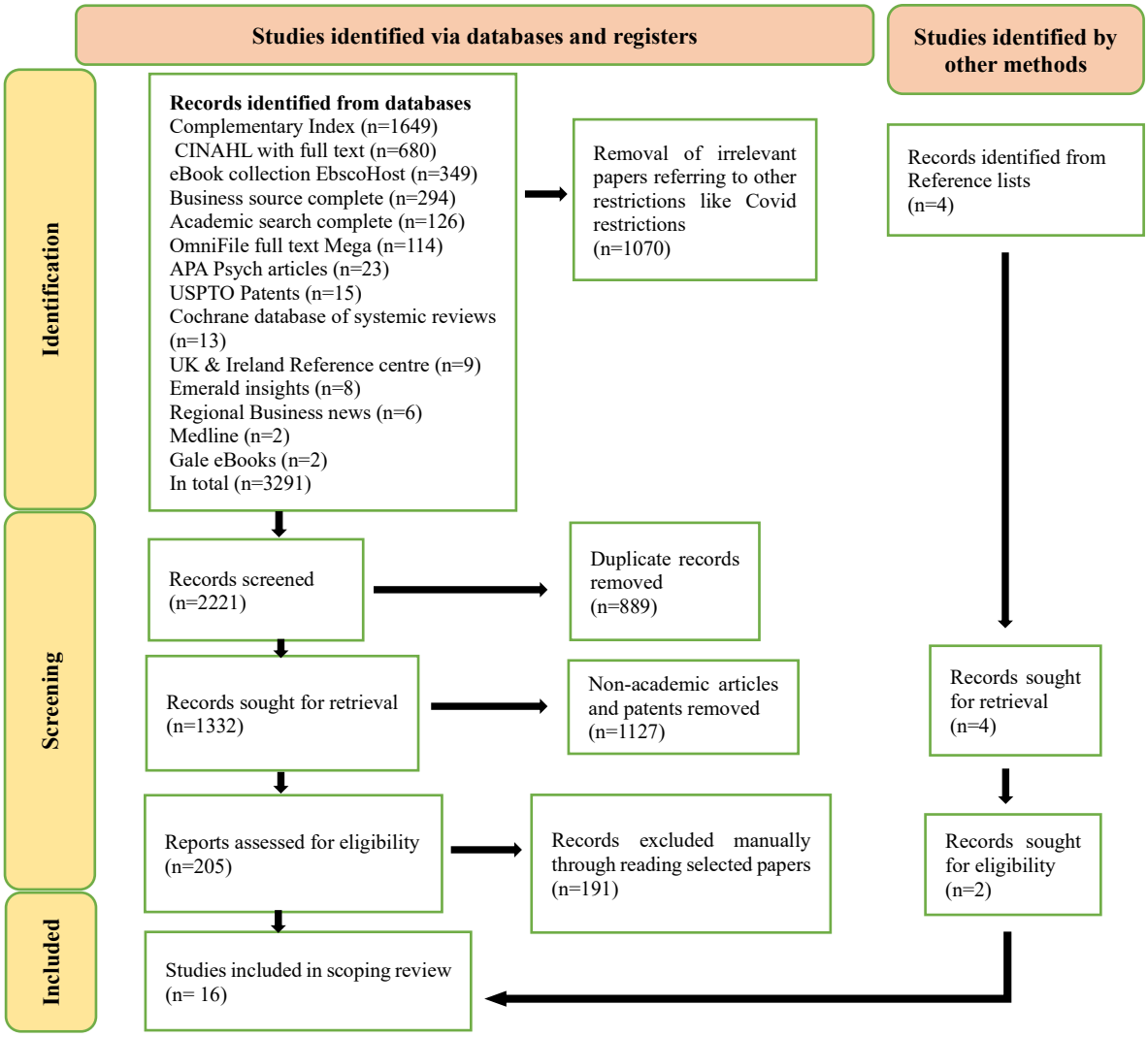

Fig. 1: PRISMA flow diagram

Author/Year	Population	Concept	Context	Methodology	Outcomes	Key findings
Aboshaiqah (2013)	Nurses	Nurses' perceptions on not reporting medication errors	Government hospital in Saudi Arabia	Quantitative design using survey. Analysis by descriptive statistics.	-Nurses identified fear of blame and manager's response as a reason for not reporting. -79% of omitted errors were not reported.	-Focusing on the individual nurse rather than the system. -Blame apportioned to the nurse. -Leadership style and organizational culture affects reporting.
Bahadori et al., (2013)	Nurses	Factors that influence not reporting on medication errors from nurses' viewpoint	A hospital in Iran	Quantitative design using questionnaire. Analysis by both descriptive and inferential statistics	-Respondents identified 3 barriers: fear of consequences of reporting, managerial factors and factors to do with the reporting system. -No significant relationships between the reporting of medication errors and nurses' demographic characteristics such as marital status, types of work shifts, age, and education level.	-Fear of legal consequences. - Leadership style and organizational culture. -Level of education and age did not influence reporting.
Oshikoya et al., (2013)	Paediatric Nurses	Nurses' experience of reporting medication errors	Public hospitals in Lagos, Nigeria	Quantitative design using questionnaire. Analysis by descriptive statistics	- 64% nurses had committed at least one medication error in their career. - Increased workload due to high patient-to-nurse ratio, cited as a major cause of medication error. - 44% of nurses aware of a system for reporting medication errors while 42% nurses were not aware of the system.	-Fear of retribution and punitive action. -Increased workload led to medication errors. -Poor awareness of medication error reporting system.
Tabatabaee et al., (2014)	Nurses	Reasons for medication error underreporting from the nurse's perspective	A private hospital in Iran	Quantitative design using survey. Analysis by inferential statistics	-Fear of job losses, legal consequences and blame for colleagues were highest ranked barriers cited. -Not knowing how to detect a medical error, finding the reporting process time consuming and forgetfulness were ranked lower as barriers	-Individual concerns such as fear of legal consequences and job losses identified as a greater barrier compared to organisational and systematic concerns such as the time-consuming nature of the reporting system.
AbuAlRub et al., (2015)	Nurses & Physicians	Awareness of the incident reporting system and practices.	Accredited and non-accredited Jordanian hospitals	Quantitative design using questionnaire. Analysis by descriptive statistics	-42.2% of nurses compared to 24.6% of physicians completed an incident report in the previous month. -Responses related to reporting practices varied in accredited hospitals versus non-accredited hospitals. -69.6% of nurses versus 48.5% of physicians knew what to do with the completed incident report form. -Staff perceived reporting as pointless	-Nurses had greater awareness of the incident reporting system compared to physicians. -Some jurisdictions give penalties to those at fault, resulting in reduced reporting.

Finlayson et al., (2015)	Adults with Intellectual Disabilities and key carers	Investigating injury incident reporting procedures in relation to injury prevention.	Greater Glasgow area, Scotland	Qualitative design using interviews. Analysis by descriptive analysis	-66.7% of paid carers identified that incident reports are recorded at institutional level. -10.1% of participants reported that incidents are recorded on site. -2.2% of participants were unfamiliar with incident reporting procedures.	-Majority of paid carers were aware of the injury incident reporting procedure. -Future training should pay attention to promoting counter measures for increased risk to exposure.
Chen et al., (2018)	Nurses	Nurses' awareness & attitudes towards reporting medical incidents & factors that affect reporting.	Hospitals in Taiwan	Quantitative design using surveys. Analysis by descriptive statistics	-Managers and those with post-graduate education reported higher intention to report. -Experienced nurses had higher willingness to report medical errors -Anonymity and rewards reduced willingness to report errors.	-Experience, responsibility and education increase willingness to report. -A simplified reporting system can encourage and motivate reporting medical errors.
Øye and Jacobsen, (2020)	Nursing home staff	To investigate the kinds of informal restraints used in nursing homes	Four nursing homes in Norway	Qualitative design using field observations and interviews. Thematic analysis	-Staff used the expression, 'grey-zone restraint' indicating a form of restraint not clearly regulated by legislation. -Staff reported concern for patients' safety as reasons for restraint use e.g. fear of falls and wandering behaviour.	-Staff had problems identifying restrictive practices. -Lying to residents was noted as some of the grey-zone restrictions not fully regulated. -All the informal restraints were not clearly defined and depended on staff interpretation.
Bjӧrne et al., (2021)	Residential services staff	Incident reports contribution to developing quality in ID services.	ID community services in Sweden.	Qualitative design using surveys, interviews. Thematic analysis	-Most incidents were altercations between service users. -Reports did not mention use of restrictive practices that were used. Self-injurious behaviour is mentioned without explaining what led to it.	-Reports are completed in a perfunctory manner, to just comply with regulations.
Bjӧrne et al. (2022)	Staff in group homes and daily activities in Sweden	Strategies staff believe would reduce the use of restrictive measures	Sweden	Quantitative design using surveys, analysis by content analysis	-The different restrictive measures in use were discussed in the responses. -Staff expressed uncertainty on classifying certain measures as restrictive compared to a practice that is not restrictive e.g. locking medication, standing in the way of a service user, or controlling diet.	-The use of restrictive measures was found to be widespread, despite clear legislation and policies forbidding their use. -There is uncertainty on what measures are reported as restrictive.
Dunbar et al., (2022a)	ID services	An overview of all reported restrictive practices in ID settings in Ireland	Ireland	Quantitative design using archival research. Analysis by descriptive statistics	-There were 1387 facilities in operation in the period under study. -Environmental restrictions were most frequent at 28349 for the period under review.	-A large variance in frequency of use of restrictive practices. -Some physical, chemical and environmental restrictions recorded as 'other.' -Non-chemical restraints listed as chemical restraints. -Data is self-reported by persons in charge.
Dunbar et al., (2022b)	Older persons	Overview of the incidence	Ireland	Quantitative design using	-There were 608 nursing homes in operation in the period under study.	-Administering a psychotropic drug may not always equate to chemical restriction.

	residential care centres	and types of restrictive practices used in older persons residential care facilities		archival research. Analysis by descriptive statistics	-70,663 restrictive practices reported in same period. -Environmental restrictions were highest reported at 37,967 -There was a high variance in each category except in physical restraints.	-Environmental restrictions were highest, but less than 50% nursing homes reported their use. -Presence of nil returns dataset may suggest under reporting.
O'Regan et al., (2022)	Long term care facilities for older persons and ID services	Description of the development of an analysable database of statutory notifications.	Notifications from older persons and long-term disability care facilities in Ireland.	Quantitative design using archival research, analysis by descriptive statistics	-Access to database is limited to regulatory staff or available under a data-sharing agreement to external requests. -There are notifications where specific incidents are mandated to be reported in 3 days of the event, or quarterly. -High missing data in earlier years.	-In earlier years, researchers found a degree of missing data, which may have led to the conclusion that notifications increased over time. -Missing data may have been due to inadequate knowledge or lack of reporting guidelines.
Leif et al., (2023)	Behaviour support practitioners in ID services	Experiences of Australian behaviour support practitioners who use restrictive practices	Australia	Qualitative design using open-ended questions by survey. Analysis by thematic analysis	-Participants reported various barriers and enablers in their attempt to limit use of restrictive practices at the individual, organisational and regulatory levels.	-Suggestions were identified for regulatory services and service providers to collaborate and develop guidelines or checklists to assess how specific organisations support reductions in use of restrictive practices.
Oweidat et al., (2023)	Nurses	Assessing nurses' level of awareness of incident reporting.	15 hospitals in Jordan	Quantitative design using surveys. Analysis by descriptive statistics	-94.8% of participants aware of incident reporting -Nurses working in accredited hospitals compared to non-accredited hospitals had higher awareness of self-reporting. -Participants reported a fear of blame and disciplinary actions as a barrier to reporting restrictive practice. -A lack of knowledge was cited as reason for under-reporting.	-Nurses showed a high level of awareness of the incident reporting system. -Accrediting bodies conduct awareness campaigns in Jordanian hospitals. -Facilitators to reporting restrictive practices included: seniority; experience; and organisational culture.
Savage et al., (2024)	Patients in acute settings	To determine and compare the rates of coercive practices across countries	Australia, England, Wales, New Zealand, The Netherlands, Germany, Japan, USA and Ireland	Mixed methods using archival research. Comparative analysis	-All countries differed in the definitions and types of restraints they reported. -Some countries separated mechanical and physical restraint reports. -Durations and rates of coercive measures were highly variable. Japan had the highest rates and duration of coercive measures.	-There is need for universal definitions of restrictive practices for easier international comparisons. -Some antipsychotics might be therapeutic but also restrictive. -The World Health Organisation (WHO) could help encourage other countries to begin tracking restrictive practices.

3. Data analysis & presentation

To better understand residential care staff knowledge of reporting restrictive practices within ID and older persons care settings, this paper focuses on the classification of four themes found from the review of studies reporting on restrictive practices, and other incident reports in nursing homes and acute hospitals. The themes are: (1) residential staff knowledge of reporting restrictive practices; (2) residential staff perceptions of reporting restrictive practices; (3) residential staff attitudes to reporting restrictive practices; and finally (4) barriers and facilitators of reporting restrictive practices at the individual, organisational and regulatory levels.These themes will now be explored.

3.1 Residential staff knowledge of reporting restrictive practices

Residential services staff have varying degrees of knowledge of reporting restrictive practices.

A quantitative study undertaken by AbuAlRub et al., (2015) in seven Jordanian hospitals examined nurses (n=307) and physicians (n=144) awareness of incident reporting.

This study found that nurses had greater knowledge of the incident reporting system (80.8%) compared to physicians (53%).

In addition, nurses have reported more incidents than physicians, with 42.2% of nurses having completed an incident report, compared to 24.6% of physicians.

Participants cited forgetting and fear of disciplinary actions as reasons for not reporting.

While most physicians and nurses knew of the existence of the incident reporting system, only 69.6% of nurses and 48.5% of physicians knew what to do with the form once completed.

Oweidat et al. (2023) conducted a cross-sectional survey to assess nurses' level of awareness and perceptions of the incident reporting system in 15 Jordanian hospitals.

This study found a high awareness of the incident reporting system by nurses (94.8%).

Findings also highlighted that nurses in accredited hospitals had higher awareness of incident reporting compared to nurses in non-accredited hospitals.

A study investigating injury incident reporting in ID services in Glasgow found that a majority of paid carers were aware of the incident reporting procedure, with only 2.2% unfamiliar with the procedure (Finlayson et al., 2015).

This study did not specify any of the carers' qualifications. O' Regan et al. (2022) prepared a database of statutory notifications in Ireland between 2013 and 2019.

Their aim was to describe the development of an analysable database of statutory notifications from older persons and ID care facilities.

They encountered a high degree of missing data and information in earlier years and suggested that this missing data may have been due to inadequate knowledge by health care providers or lack of reporting guidelines.

3.2 Residential staff perceptions of restrictive practices

Findings from the included studies reported that residential services staff have varying perceptions of restrictive practices.

For example, in Sweden, Björne et al. (2022) found that staff had mixed perceptions about what they deemed a restrictive practice with some reporting that they did not know whether locking away medications; controlling diets; or blocking the service user's path deemed as a restrictive practice (Björne et al., 2022).

In a cross-sectional analysis of restrictive practice notifications submitted to the regulator from disability and older person's residential care facilities in Ireland, Dunbar et al. (2022a) found that staff did not record seclusion as a restrictive practice, despite this falling under environmental restrictions. Notifications also showed antibiotics and beta-blockers listed as a chemical restraint (Dunbar, et al., 2022a; Dunbar et al., 2022b).

In addition, there were examples of physical, environmental and chemical restraints reported as 'other', despite the categories being available to select from (Dunbar, et al., 2022a; Dunbar et al., 2022b).

Øye and Jacobsen (2020) conducted a mixed method study in four nursing homes in Norway, from 2012 to 2014, to investigate the types of informal restraints used in nursing homes.

Staff highlighted problems with defining restrictive practices. Staff also used the expression, 'grey-zone restraint' indicating a form of restraint not clearly regulated by legislation. In addition, informal restraints were not clearly defined and were dependent on staff's interpretation.

In a mixed methods study to determine and compare the rates and use of coercive practices in mental health care across nine countries the durations and rates of coercive measures were highly variable with Wales reporting no mechanical restrictive practice use in the period under review and Japan had the highest rates and duration of coercive measures.

In addition, many countries were found to differ in their definitions of restrictive practices (Savage, et al., 2024).

3.3 Residential staff attitudes towards reporting restrictive practices

Chen et al. (2018) conducted a cross-sectional study of nurses in three Taiwanese hospitals and surveyed nurse's attitudes towards reporting medical incidents and factors that affect reporting. Some health care workers found the reporting system burdensome.

Participants in management positions and with post-graduate qualifications reported a higher willingness to report medical incidents compared to those in non-

managerial positions and less qualifications. Björne et al. (2021) conducted a survey among healthcare staff in one Swedish municipality to ascertain if incident reports contribute to improving quality in ID services for those with challenging behaviours. Participants in this study reported completing the reports in a perfunctory manner, just to comply with regulations. Some reports did not include any mention of restrictive practices used in incidents in which altercations occurred between service users.

3.4 Barriers and facilitators to reporting restrictive practice at the individual, organisational and regulatory levels

Some studies highlighted barriers and facilitators to reporting restrictive practice at an individual level. For example, Bahadori et al. (2013) conducted quantitative studies on barriers to reporting medication errors in nursing and found that characteristics such as age and level of education had no bearing on a nurse's knowledge of reporting medication errors. In contrast, Chen et al.'s (2018) study found that nurses who highly rated their professional development were less likely to report errors. Leif et al. (2023) conducted an online survey amongst behaviour support practitioners in Australia working in ID services. The aim was to understand their experiences in designing and delivering behaviour support plans that include restrictive practices. Unwillingness to change was also highlighted as a key finding, with staff expressing unwillingness to use alternatives to restrictive practices and often using what they know best rather than trying different ways of managing challenging behaviours.

At the organisational level, the organisational culture, governance and policies were found to affect staff knowledge of reporting restrictive practices. Numerous quantitative studies explored barriers to reporting medication errors by nurses in Saudi Arabia, Iran, Nigeria and Iran again, respectively and found the reporting system time consuming (Aboshaiqah 2013; Bahadori et al., 2013; Oshikoya et al., 2013; Tabatabaee et al., 2014). Leadership styles and organisational culture were cited as barriers, with nurses reporting that managers focused on individual nurses, blaming them rather than focusing on the reporting system (Aboshaiqah 2013; Bahadori et al., 2013; Oshikoya et al., 2013; Tabatabaee et al., 2014). Awareness campaigns held by Jordanian hospitals to increase their employees' awareness of the incident reporting system is also mentioned as an organisational factor responsible for high awareness of the incident reporting system (Oweidat et al., 2023).

At a regulatory level, O' Regan et al. (2022) recognised that the legal requirement to notify the healthcare regulator of medical incidents forces health care staff to report. In Jordan, a monetary penalty is given to health care staff who are found at fault in a reported incident. This acts as a barrier as it leads to less reporting, for fear of such penalties (AbuAlRub et al., 2015). In four different studies on understanding barriers to reporting medication errors, fear of legal consequences and job losses were cited as reasons for not reporting (Aboshaiqah 2013; Bahadori et al.,2013; Oshikoya et al., 2013; Tabatabaee et al., 2014). In addition, raising awareness of the reporting systems by accrediting bodies was found to be a facilitator of reporting restrictive practice by nurses (Oweidat et al., 2023).

4. Discussion

This section will discuss a summary of findings, and the strengths and limitations of both the primary research and the review itself. In addition, this section will outline what the review adds to existing knowledge and finally the implications for future practice, theory, education, research and policy.

4.1 Summary of findings

Whilst the definition of a restrictive practice is clearly outlined in the literature as intentionally restricting an individual's voluntary movement or behaviour (HIQA, 2024), the findings of this review highlight an inconsistency amongst residential staff of what is deemed a restrictive practice (Øye & Jacobsen, 2020; Björne et al., 2021; Björne et al, 2022). In addition, a lack of awareness in relation to the classification of restrictive practice were identified (Dunbar et al., 2022a; Dunbar et al., 2022b) and this can consequently lead to both inaccurate reporting of restrictive practices and the efforts to reduce their use (Bowers 2000; Roper et al., 2015). Therefore, comparing find¬ings across studies within different health care settings, as well as assessing the effectiveness of interventions, and identifying ways to effectively minimize these practices will be challenging (Muluneh et al., 2024). It has been recommended that clearer examples of how certain procedures meet the definitions of restrictive practices may improve reporting by reducing variability of interpretation by practitioners (Clark et al., 2018).

Findings of this review also highlight that nurses have a greater awareness of incident reporting systems compared to physicians (AbuAlRub et al., 2015; Oweidat et al.. 2023). This suggests a large proportion of incident reporting is completed by nurses despite the fact that residential care facilities are staffed by a multi-disciplinary team which includes amongst others: health and social care assistants, catering staff, occupational therapists, physiotherapists and doctors. In 2023, Ireland's National Safeguarding Office introduced roles for nurses as Clinical Nurse Manager 2, in the different regions (HSE National Safeguarding Office, 2023). However, Ireland's social workers have argued that this can lead to safeguarding being viewed through a clinical lens

instead of a rights-based model (McGarry et al., 2022).

Under/over-reporting of restrictive practices may be influenced not only from lack of knowledge, but by staff perceptions and attitudes of the reporting process as well. This review highlighted that reporting restrictive practices and other incidents such as medication errors, was perceived to be burdensome (Oshikoya et al., 2013; Tabatabaee et al., 2014; Chen et al., 2018) and studies highlighted that residential staff complete reports in a perfunctory manner, and only as a regulatory requirement (Björne et al., 2022). Although environmental restrictions were the highest reported restrictive practice in Ireland in 2020, less than 50% of nursing homes reported on them, suggesting under-reporting (Dunbar et al., 2022b). Dunbar et al. (2022a) posit that the availability of the 'other' categorisation of restrictive practices within the HIQA database may have led to misreporting as there was an option to just identify any restrictive practice, if one was unsure. In Ireland, 18.3% of residential care facilities reported zero use of restrictive practices (Dunbar et al., 2022b). This may mean they adhered to the zero tolerance to restrictive practice use throughout the year, or they did not report, either intentionally, or because they did not know what to report.

The findings of this review have established that staff attributes appear to be directly related to a higher working knowledge of reporting restrictive practice such as self-confidence; higher levels of education; higher management positions; and more years of experience (Chen et al., 2018). Higher management positions enables managers to have access to feedback on reports submitted, arguably therefore encouraging more reporting, whilst higher levels of education and experience may mean one has received appropriate training on reporting restrictive practices. At the organisational level, hospital accreditation in Jordan was found to be a factor in facilitating reporting restrictive practice (Oweidat et al., 2024). The primary differences in accredited and non-accredited hospitals are adherence to quality, patient safety and staff competence standards, with accreditation serving as a marker for excellence (Shaw et al., 2014; Oweidat et al., 2024). The rigorous process that goes into accreditation may account for the higher knowledge of reporting systems by nurses working in accredited hospitals. In other jurisdictions like Ireland however, all hospitals and residential care facilities are regulated and do not operate without accreditation (HIQA, 2022; HIQA, 2023). Staff shortages in nursing homes can result in staff prioritising actual care to residents and neglect other duties such as reporting and documentation (Yang & Zhang 2023; Khan et al., 2024). Caregiving deficiencies lead to adverse outcomes, including caregiver stress and burnout (Khan et al., 2024). At the regulatory level, authorities such as HIQA in Ireland require mandatory periodic reporting of all types of restrictive practices (Government of Ireland, 2013a; Government of Ireland, 2013b), which encourages reporting. In other jurisdictions, legal consequences, such as docking of wages for those found at fault, and potential job losses, may discourage reporting (Aboshaiqah 2013; Bahadori et al., 2013; Oshikoya et al., 2013; Tabatabaee et al., 2014; AbuAlRub et al., 2015).

4.2 Strengths and limitations of this review

The systematic approach presented in this scoping review has provided the ability to explore and synthesize a range of evidence on a topic that has been under-examined. It has contributed to the current understanding of how to promote the wellbeing of older adults and individuals with ID in care settings. However, this scoping review is not without limitations. The paucity of literature on reporting restrictive practices led the author to resort to including papers that reported on medication errors and any incident reporting that involved staff in nursing homes and acute settings, to gain an understanding of the general knowledge of reporting by healthcare workers. While the aim of this scoping review was to examine the knowledge of residential care staff regarding the reporting of restrictive practices in intellectual disability and older persons care settings the majority of studies included in this scoping review only discuss nurses' knowledge, despite nursing homes staffed by a multi-disciplinary team.

Some of the primary research presented in this review acknowledged small and unrepresentative samples (Chen et al., 2018; Leif et al., 2022; Oweidat et al., 2023; Savage et al., 2024) and may have led to inaccurate generalizations and limit the applicability of the research findings. In addition, some studies relied on self-reporting data (Tabatabaee et al., 2014; Finlayson et al., 2015; Dunbar et al., 2022a; Dunbar et al., 2022b; O'Regan et al., 2022) which may result in reporter bias. Øye and Jacobsen (2020) carried out field observations in nursing homes in Norway and this may have led to researcher bias as personal views may influence interpretation of observations. Finally, the search included only studies published in the English language, which increases the risk of study selection bias.

4.3 What this review adds to existing knowledge

While this review has improved the understanding of residential staff knowledge of reporting restrictive practice, it highlights that restrictive practice is a complex concept and lacks clarity. Bearing this in mind, a clear definition of restrictive practice is required in order for all residential staff to understand and report restrictive practice within ID and older care settings. The importance of establishing universal definitions, classifications and reporting standards to

enable consistent and meaningful global comparisons is required.

This review also highlighted the burdensome nature of reporting restrictive practices for residential staff. Macrae (2016) compared the health incident reporting system to the aviation industry and recognised that healthcare sectors encourage large quantity of incidents to be reported whilst the aviation industry only focuses on serious incidents. This poses a question of whether healthcare services should continue reporting all incidents or should they rather prioritise certain incidents?

The negative perceptions of reporting restrictive practice identified in this review can assist regulatory authorities that record restrictive practice notifications, such as Ireland's HIQA to enhance understanding of the challenges associated with reporting. It also has the potential to develop interventions or enhance existing policies that can assist residential care staff to improve reporting restrictive practice.

The reporting of restrictive practices is a regulatory requirement in many but not all jurisdictions. Therefore, there is a need for the World Health Organisation, to encourage countries not currently reporting restrictive practices to do so. The review amplifies the need for further regulatory involvement in staff training on reporting restrictive practices.

4.4 Implications for future practice, theory, education, research and policy

This scoping review highlights that all members of the multi-disciplinary team should be encouraged to interact with the reporting systems as much as nurses do, so that there are no disparities in the working knowledge of reporting restrictive practices between nurses and other residential care staff (Oweidat et al., 2023). According to Liang & Huang, (2023) knowledge of restrictive practices can be improved through multicomponent interventions. Arguably, this has the potential to rectify the under, over and misreporting of restrictive practices.

This review also highlights the need for curriculum changes in future undergraduate and post-graduate healthcare education, to include training on restrictive practices and inclusion of reporting of these as part of routine healthcare duties, to improve practice. The review also has the potential to guide policy changes on how best to implement policies in the regulation of restrictive practices, whilst taking into consideration the perceptions and attitudes that residential staff currently have. This will ensure that policies are inclusive of all members of the multidisciplinary team in residential care, not just nurses, as currently reflected in the studies included in this scoping review.

Given the lack of clarification and understanding in relation to restrictive practice, arguably a concept analysis is warranted to improve our understanding of this complex concept. Future research is required to examine factors to reporting restrictive practice at the individual, organisational and regulatory level. In addition, future research could utilize different research methodologies such as Soft Systems Methodology (SSM) (Checkland 1981) in order to explore the problematic situation related to the use of restrictive practices that can violate an individual's autonomy and freedom. It could also compare real world data and provide changes that can improve not only the use of restrictive practice but also the reporting of restrictive practice. SSM is a collaborative approach and provides dialogue between individuals and groups with contrasting views (Malekijahan et al, 2024). This may provide an opportunity to interrogate the negative perceptions staff currently seem to hold towards reporting restrictive practices.

5. Conclusion

This review is both timely and relevant in relation to examining residential care staff's knowledge of reporting restrictive practices in ID and older persons care settings and how it relates to health policy, service design and delivery. Findings suggest that restrictive practice is a complex concept and improvements in terms of residential staff understanding of and reporting of restrictive practice is required.

This review has the potential to assist policymakers and healthcare leaders to improve residential staff's knowledge of reporting restrictive practice and has identified implications for future practice, theory, education, research and policy.

Conflict of interests

The authors have no conflict of interest to declare.

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6. References

Aboshaiqah, A. (2013). Barriers in reporting medication administration errors as perceived by nurses in Saudi Arabia. Middle-East Journal of Scientific Research, 17(2), 130-136.

AbuAlRub, R. F., Al-Akour, A., & Alatari, N. H. (2015). Perceptions of reporting practices and barriers to reportig incidents among registered nurses and physicians in accredited and non-accredited Jordanian hosiptals. Journal of Clinical Nursing, 24, 2973-2982.

Bahadori, M., R., R., Aghili, A., Sadeghifar, J., Gharsi Mashadi, M., & Smaeilnejad, J. (2013) The factors affecting the refusal of reporting on medication errors from the nurses' viewpoints: a case study in a hospital in Iran. ISRN Nursing (876563).

Bellenger, E. N., Ibrahim, J. E., Lovell, J. J., & Bugeja, L. (2018). The nature and extent of physical restraint-related deaths in nursing homes: a systematic review. Journal of Ageing and Health, 30(7), 1042-1067.

Björne, P., Deveau, R., & Nylander, L. (2021). Passing laws is not enough to change staff practice: The case of legally mandated "incident" reporting in Sweden. Journal of Intellectual & Developmental Disability, 46(2), 186-196. Retrieved from https://doi.org/10.3109/13668250.2021.1873751

Björne, P., Deveau, R., McGill, P., & Nylander, L. (2022). The use of restrictive measures in community services for people with intellectual disabilities in Sweden. Journal of Policy and Practice in Intellectual Disabilities, 19(2), 193-201.

Bowers, L. (2000). The expression and comparison of ward incident rates. Issues in Mental Health Nursing, 21(4), 375-374.

Carrero-Planells, A., Urrutia-Beaskoa, A., & Moreno-Mulet, C. (2021). The use of physical restraints on geriatric patients: Culture and attitudes among healthcare professionals at intermediate care hospitals in Marjoca. A qualitative study protocol. International Journal of Environmental Research and Public Health, 18(14), 7509.

Chen, L., Wang, L., Redley, H., Hsieh, Y., Chu, T., & Han, C. (2018). A study on the reporting intention of medical incidents: a nursing perspective. Clinical Nursing Research, 27(5), 560-578.

Checkland, P. B. (1981). Systems Thinking, Systems Practice. New York: John Wiley.

Clark, L. L., G., H., & Xyrichis, A. (2018). Beyond Restraint: Raising awareness of restrictive practices in acute care settings. International Journal of Nursing Studies, 86, A1-A2.

Cooper, S.A., Hughes-McCormack, L., Greenlaw, N., McConnachie, A., Allan, L., Baltzer, M., . . . Morrison, J. (2018). Management and prevalence of long-term conditions in primary health care for adults with intellectual disabilities compared with the general population: A population-based cohort study. Journal of Applied Research in Intellectual Disabililities, 31(1), 68-81.

Department of Health. (2011). Towards a Restraint Free Environment in Nursing Homes. Department of Health, Dublin.

Dunbar, P., Hazelwood, E., Wang, Q., McMahon, M., Walsh, K., & Keyes, L. M. (2022a). Incident and type of restrictive practice use in residential disability facilities in Ireland. A cross-sectional Study. Health and Social Care in the Community, 30, e6009-e6017.

Dunbar, P., McMahon, M., Durkan, C., Walsh, K. A., & Keyes, L. M. (2022b). Incidence and type of restrictive practice use in nursing homes in Ireland. BMC Geriatrics, 22(802). Retrieved October 31, 2023, from https://bmcgeriatr.biomedcentral.com/articles/10.1186/s12877-022-03450-4

Estevez-Guerra, G. J., Farina-Lopez, E., Nunez-Gonzalez, E., Gandoy-Crego, M., Calvo-Frances, F., & Capezuti, E. A. (2017). The use of physical restraints in long term care in Spain:a multi-center cross-sectional study. BMC Geriatrics, 17(29). https://doi.org/10.1186/s12877-017-0421-8

Finlayson, J., Jackson, A., Mantry, D., Morrison, J., & Cooper, S.-A. (2015). The provision of aids and adaptations, risk assessments, and incident reporting and recording procedures in relation to injury prevention for adults with intellectual disabilities: cohort study. Journal of ID Research, 59(6), 519-529.

Government of Australia. (2022). Restrictive Practices in Aged Care- A Last Resort. Training and guidance. Retrieved from www.health.gov.au

Government of Ireland. (2013a). Care and Welfare of Residents in Designated Centres for Older People Regulations. Dublin: The Stationery Office.

Government of Ireland. (2013b). Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations. Dublin: The Stationery Office.

Hamers, J., Bleijlevens, M., Gulpers, M., & Verbeek, H. (2016). Behind closed doors: involuntary treatment in care of persons with cognitive impairment at home in Netherlands. Journal of American Geriatric Society, 64, 354-358.

Health Information & Quality Authority. (2023). Regulation and Monitoring of Social Care Services. Guidance on Promoting a Care Environment that is free from Restrictive Practice. Older persons and ID Services. Health Information & Quality Authority, Office of The Chief Inspector, Dublin.

Health Information and Quality Authority. (2022). Health and Social Care Standards Strategy 2022-2024. Health Information and Quality Authority, Dublin.

Health Information and Quality Authority. (2024). Lexicon for Social Care. HIQA, Regulation and Monitoring of Social Services. Dublin: HIQA.

HSE National Safeguarding Office. (2023). Annual Report 2023. Limerick: HSE.

Kassew, T., Tilahun, A. D., & Liyew, B. (2020). Nurses knowledge, attitude, and influencing factors regarding physical restraint use in the intensive care unit: a multicenter cross-sectional study. Critical Care Research and Practice, 20(1), 1-10.

Khan, H. T., Addo, K. M., & Findlay, H. (2024). Public Health Challenges and Responses to the Growing Ageing Populations. Public Health

Challenges, 3, e213. https://doi.org/10.1002/puh2.213

Leif, E. S., Fox, R. A., Subban, P., & Sharma, U. (2023). 'Stakeholder are almost always resistant': Austalian behaviour support practitioners' perceptions of the barriers and enablers to reducing restrictive practices. International Journal of Developmental Disabilities, 69(1), 66-82.

Liang, S. H., & Huang, T. T. (2023). The Optimal Intervention for Preventing Physical Restraints Among Older Adults Living in the Nursing Home: A Systematic Review. Nursing Open, 10(6), 3533-3546.

Macrae, D. (2016). The problem with incident reporting. BMJ Quality and Safety, 25, 71-75.

Malekijahan, A., Ghatari, A. R., Shoar, M., & Fard, A. (2024). Utilizing soft systems methodology;Designing a regulatory model in information and communications technology. 11th International Symposium on Telecommunications (IST).

McGarry, S., Donnelly, S., & Geiran, V. (2022). Position Paper on Adult Safeguarding: Legislation, Policy and Practice. Irish Association of Social Workers.

Mcsherry, B., & Freckelton, I. (Eds.). (2015). Coercive Care, Rights, Law and Policy. Routledge.

Muluneh, Z. B., Chavulak, J., Lee, D. A., Petrakis, M., & Haines, T. P. (2024). Variations in definitions used for describing restrictive care practices (seclusion and restraint) in adult mental health inpatient units:a systematic review and content analysis. Social Psychiatry and Psychiatric Epidemiology. 60, 1-24

NDIS Quality and Safeguards Commision. (2020). Unauthorised Use of Restrictive Practices. Questions and Answers. Information session, National Disability Insurance Scheme, Australia.

O'Regan, S., McGrane, N., Dunbar, P., Dunnion, M., Leistikow, I., & O'Connor, L. M. (2022). Public reporting of adverse events from long term care facilities for older persons and people with disability in Ireland 2013-2019: Development of an openly accessible database and descriptive analyses. Journal of the American Medical Directors Association, 23, 1328-1334.

Oshikoya, K., Oreagba, I., Ogunleye, O., Senbanjo, I., & MacEbong, G. (2013). Medication administration errors among paediatric nurses in Lagos public hospitals: an opinion survey. International Journal of Risk & Safety in Medicine, 25(2), 67-78.

Oweidat, I., Atiyeh, H., Alosta, M., Al-Mugheed, K., Alabdullah, A. A., Alzoubi, M. M., & Abdelaliem, S. M. (2024). The influence of hospitals accreditation on nurses perceptions of patient safety. Human Resource Health, 22(1), 36 https://doi.org/10.1186/s12960-024-00920-1

Oweidat, I., Mugheed, K., Alsenany, S. A., Abdelaliem, S. M., & Alzoubi, M. M. (2023). Awareness of reporting practices and barriers to incident reporting among nurses. BioMed Central Nurcing, 22(231). https://doi.org/10.1186/s12912-023-01376-9

Øye, C., & Jacobsen, F. F. (2020). Informal use of restraint in nursing homes: a threat to human rights or necessary care to preserve residents dignity? Health, 24(2), 187-202.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., … Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ, 372(71). https://doi.org/10.1136/bmj.n71

Peters, M. D., Godfrey, C., McInerney, P., Khalil, H., Larsen, P., Marnie, C., . . . Munn, Z. (2022). Best practice guidance and reporting items for the development of scoping review protocols. JBI Evidence Synthesis, 20(4), 953-968. Retrieved November 29, 2023, from https://journals.lww.com/jbisrir/Fulltext/2022/04000/Best_practice_guidance_and_reporting_items_for_the.3.aspx?context=FeaturedArticles&collectionId=5

Roper, C., McSherry, B., & Brophy, L. (2015). Defining seclusion and restraint: legal and policy definitions versus consumer and carer perspectives. Journal of Law, Medicine, and Ethics, 23(2), 297-302.

Savage, M. K., Lepping, P., Newton-Howes, G., Arnold, R., Staggs, V. S., Kisely, S., . . . Noorthoorn, E. O. (2024). Comparison of coercive practices in worldwide mental healthcare: overcoming difficulties resulting from variations in monitoring strategies. BJPsych Open, 10(e26), 1-9.

Shaw, C. D., Groene, O., Botje, D., Sunol, R., Kutryba, B., Klazinga, N.,Wagner, C. (2014). The effect of certification and accreditation on quality management in 4 clinical services in 73 European hospitals. International Journal for Quality in Health Care, 26, 100-107.

Sheehan, R., Hassiotis, A., Walters, K., Osborn, D., Strydom, A., & Horsfall, L. (2015). Mental illness, challenging behaviour, and psychotropic drug prescribing in people with ID: UK population based cohort study. British Medical Journal, 351. h4326, https://doi.org/10.1136/bmj.h4326

Tabatabaee, S. S., Kalhor, R., Nejatzadegan, Z., Kohpeima Jahromi, V., & Sharifi, T. (2014). Barriers to medication error reporting from nurses' perspective: a private hospital survey. International Journal of Hospital Research, 3(2), 97-102.

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K. K., Colquhoun, H., Levac, D.,Strauss, S. E. (2018). PRISMA Extension for scoping reviews (PRISMA-ScR): checklist and explanation. Annals of Internal Medicine, 169(7), 467-473.

Vrbnjak, D., Denieffe, S., O'Gorman, C., & Pajnkihar, M. (2016). Barriers to reporting medication errors and near misses among. International Journal of Nursing Studies, Nov(63), 162-178.

Yang, G., & Zhang, L. (2023). "Relationship between Ageing Population, Birth Rate and Disposable Income per Capita in the Context of COVID-19. PLoS One, 18(8), e028978. Retrieved from https://doi.org/10.1371/journal.pone.0289781