Case report

The use of direct coercion during the management of a patient with paranoid schizophrenia – case report

Zarządzanie opieką nad pacjentką ze schizofrenią paranoidalną a przymus bezpośredni – opis przypadku

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Słowa kluczowe: schizofrenia paranoidalna, pacjent, przymus bezpośredni, opieka.

Abstract

In a situation of increased aggression from a patient, which creates a danger and a threat to their own health and to other patients and staff, direct coercion is used. Such intervention is undertaken when it is necessary to protect the patient's life or health. The aim of this study is to show the specifics of care for a patient in whom an assessment of mental health during the period of intensification of symptoms of paranoid schizophrenia indicated the legitimacy of the use of direct coercion. The paper describes an individual case of a mechanically immobilized patient. To collect data about the patient, the following research techniques were used: interview, observation, measurement, and documentation analysis. The following research tools were also used in the work: interview questionnaire, a card for the application of direct coercion against a person staying in a psychiatric hospital or other medical institution or in an organizational unit of social assistance, the Modified Explicit Aggression Scale – MOAS, and the Courtauld Emotional Control Scale (CECS). Mechanical immobilization is unpleasant for both the patient and the staff. Nevertheless, it is indispensable in certain cases. Compliance with the law makes it impossible to commit abuses against a patient who has been mechanically immobilized.

Streszczenie

W sytuacji nasilonej agresji pacjenta, stwarzającej niebezpieczeństwo i zagrożenie dla własnego zdrowia, innych pacjentów i personelu, stosuje się przymus bezpośredni. Taką interwencję podejmuje się w razie konieczności ochrony życia lub zdrowia pacjenta i innych osób, kiedy inne interwencje nie zredukowały nasilenia zachowania agresywnego. Celem artykułu jest ukazanie specyfiki zarządzania opieką pielęgniarską nad pacjentką, u której ocena stanu zdrowia psychicznego w okresie nasilenia objawów schizofrenii paranoidalnej wskazała na zasadność zastosowania przymusu bezpośredniego. W pracy opisano przypadek pacjentki unieruchomionej mechanicznie. W celu zebrania danych o kobiecie posłużono się następującymi technikami badawczymi: wywiad, obserwacja, pomiar, analiza dokumentacji. Zastosowano również następujące narzędzia badawcze: kwestionariusz wywiadu, Karta zastosowania przymusu bezpośredniego wobec osoby przebywającej w szpitalu psychiatrycznym, innym zakładzie leczniczym albo w jednostce organizacyjnej pomocy społecznej, Zmodyfikowaną skalę jawnej agresji (MOAS), Skalę kontroli emocji (CECS). Procedura unieruchomienia mechanicznego jest nieprzyjemna zarówno dla pacjenta, jak i dla personelu. Pomimo to w określonych przypadkach okazuje się niezbędna. Przestrzeganie przepisów prawa uniemożliwia popełnienie nadużyć w stosunku do pacjenta, u którego zastosowano unieruchomienie mechaniczne.

Introduction

The sudden onset of symptoms indicating a mental disorder or exacerbation of a diagnosed mental health disorder, including aggressive behaviour, may be an indication for hospitalization.

The causes of aggressive behaviour of patients towards health care professionals may be environmental, mental, or physical [1]. Physical aggression includes situations involving bodily damage, i.e. from pushing back, hitting, or twitching. Mental aggression manifests itself in threatening gestures, a raised voice, shouting, or body posture [2]. According to Barziej *et al.*, the causes of aggressive behaviour in mental illness may be psychoses or manic syndromes [3, 4]. External environmental factors including vari-

ous hospital stimuli, the number of patients in a room, and interpersonal relations between patients contribute to the occurrence of aggressive behaviours [5]. Understaffing or inadequate care can also contribute to aggressive behaviour. The risk of aggression is greater if the patient is stressed, frustrated, has an inability to deal with emotions, or notices aggressive behaviour from other patients [1].

The behaviour of people with mental disorders sometimes forces health care workers to take special measures of direct coercion. Direct coercion is an auxiliary technique that is sometimes necessary for the protection of the patient's life or health [6–8]. In medicine, it is an action aimed at protecting the patient from him/herself and protecting others from the patient undergoing direct coercion. Patients who feel various forms of direct coercion are unjustified often accuse the staff of abuse [9–11]. In Polish law, the Mental Health Protection Act minimizes the risk of abuse in the use of direct coercion on patients and ensures that all patients' rights are respected [12–14]. Procedures of immobilization including methods of application and documenting the application of direct coercion and assessing the legitimacy of its application for a person with a mental disorder are clearly defined in the Mental Health Protection Act as regulated by the Minister of Health [8, 15]. Customarily, the use of direct coercion is understood as a violation of a patient's bodily inviolability. It should be emphasized that limiting the personal freedom of a person with a mental disorder may only apply to situations where it is necessary to ensure a successful course of treatment and for the safety of other people. In any case, the patient's dignity should be respected under all circumstances, and the application of strict legal rules is necessary so that compulsion does not evolve into violence [16–19].

Managing violence is an essential component of working with potentially aggressive patients. With the help of a list of experimentally confirmed risk factors, medical personnel can monitor a patient's behaviour to prevent outbreaks of aggression [20, 21]. In nursing care, several main goals in caring for an aggressive patient can be distinguished. The main goal is to have the ability to inhibit arousal and control unsafe behaviour. The second goal is to be able to identify symptoms (such as agitation, anger) and inform staff. The final goal is to reduce the risk of aggressive behaviour [22].

Aim of the research

The purpose of this work is to present a case study involving the legitimate use of direct coercion on a patient with paranoid schizophrenia during a period of severe symptom manifestation.

Case report

The paper describes an individual case of a patient mechanically immobilized due to aggressive behaviour at the General Psychiatry Clinic of the Frederic Chopin Provincial Clinical Hospital No.1 in Rzeszow. After obtaining the consent of the director of the facility, a 3-day observation of the patient was carried out from 3rd March to 5th March 2019. To collect patient data, the following research techniques were used: interview, observation, measurement, and documentation analysis.

The following research methods were used in this work:
- Interview questionnaire,
- A card for the application of direct coercion against a person staying in a psychiatric hospital or other medical institution or in an organizational unit of social assistance,
- The Modified Explicit Aggression Scale (MOAS),
- The Courtauld Emotional Control Scale (CECS).

The patient was in the process of getting a divorce and had 2 children aged 8 and 4 years, who were under her mother's care. She had completed a 2-year post-graduate study in tax consulting. She worked as a cashier and was not entitled to an invalidity pension. Her husband left her about 3–4 months prior to hospitalization. She had been undergoing psychiatric treatment since 19 years of age at the Mental Health Clinic. She stated that "they found my brain cancer in the Admissions Room, but I signed out at my own request". She began to drink herbal teas to cure herself. She showed us her left ear stating that "there was a cuticle epithelium and water poured out". She was in a psychiatric hospital for the first time in April this year, "because she wanted to". She signed off at her own request after a few days. Recently, she had called the hospital herself and stated "now I'm fine, I don't have voices, delusions, or psychoses". She said she had heard voices ordering her to commit suicide, and she stated "I said yes, but I don't know why". She saw no need for psychiatric treatment, stating "nothing is therefore ... all good. There was none of it, I said yes, but none of it, I wanted to see how it was in the ward". She confirmed drinking alcohol "rarely, every 3–4 days". She did not take psychotropic drugs regularly because "I can't hear voices".

Due to the above-mentioned symptoms, the patient was determined to pose a direct threat to her own life, and she was admitted for further treatment without consent. Based on the data from the medical records and the results of the currently conducted psychiatric examination, the patient was diagnosed with paranoid schizophrenia.

Assessment – mental state. On the day of admission, the patient was in psychomotor anxiety, in an elevated mood, with affective maladjustment. Auto- and allopsychic-oriented correctly, and consciousness was clear. She showed dissimulated psychotic symptoms with delusional interpretation of the surrounding reality and actions of the environment. She had anxiety and distraction tendencies. At night, she slept

intermittently. Her personality had features of unstable structure. She conveyed fanciful delusions, with confirmed commentary and imperative auditory hallucinations, and claimed she had a brain cancer that she had cured by drinking herbs. She confirmed that she could hear voices that were calling her and stated "they say I am a rag, a whore, that I would hang myself. They threaten my hair will fall out and fall out, that's really it. Now they make me leave, I have to listen to them." She had previously withdrawn her consent for treatment in a psychiatric hospital. She was still under the influence of acute psychotic symptoms – delusional, persecutory delusions, subject to imperative auditory hallucinations persuading her to commit suicide, distracted, restless, and in fear.

Due to the above-mentioned symptoms, the patient was deemed to be a direct threat to her own life, and a decision was made to continue psychiatric treatment without her consent. The respondent had no sense of mental illness, she was uncritical about her mental health and the need for treatment. In addition, under the influence of psychotic sensations, she could not control her behaviour, which was bizarre and maladjusted. In a state of exacerbation of a mental illness, the above-mentioned patient was completely unaware of her behaviour and psychotic sensations and there was a real risk of suicide. She required treatment in a psychiatric hospital under the conditions of Article 23 of the Action Mental Health Protection. In the clinic she was restless, tense, maladjusted, made distracted statements, uttered delusions, and denied hallucinations. Mechanical protection in the form of seat belts was required 4 times due to agitation, active resistance, aggression to the environment, sexual inhibition, and auto-aggressive behaviour (Tables 1–3).

Discussion

The use of direct coercion for this patient was preceded by careful observation and evaluation of her behaviour and was performed by a therapeutic team. The professional team (6 people) was trained in dealing with patient aggression. The coordinator (in this case the doctor) supervised the procedure. Each nurse was trained in the use of direct coercion.

A 5-step care model (ADPIE) was used to care for the patient – comprehensive patient-cantered care. The five stages were as follows: assessment, diagnosis, planning, implementation, and evaluation. The

Table 1. Observation card for the use of coercion

Time/day	Determinants of the state of health indications for coercion (Codes)	Form of coercion used	Total time of coercion used	Results of examinations carried out by a nurse	The effects of direct coercion on the health of an immobilized person
II day	1.1*, 1.2*, 1.3*, 1.4*, 1.9*, 2 MOAS – 28 points	Safety belts	6 h 45 min	Vital signs: RR, heart rate, temperature, breathing within normal limits. The patient does not report pain.	None
III day	1.11*, 1.2*, 1.1* MOAS – 28 points	Safety belts	3 h 15 min	Vital signs: RR, heart rate, temperature, breathing within normal limits. The patient reports the pain of "existence."	None
III day	1.11*, 1.10*, 1.3*, 2 MOAS – 28 points	Safety belts	2 h	Vital signs: RR, heart rate, temperature, breathing within normal limits. The patient reports a headache.	None
IV day	1.11*, 1.2*, 1.1* MOAS – 28 points	Safety belts	1 h 45 min	Vital signs: RR, heart rate, temperature, breathing within normal limits. The patient does not report pain.	None

**Codes: 1) Behaviour: 1. Twitching (hitting), 2. Shouting, 3. Crying, 4. Laughing, 5. Singing, 6. Mumbling, 8. Calm, 9. Eats a meal, 10. Drinks liquid, 11. Removes medical/diagnostic equipment, 12. Disorganizes the work of the ward, 13. Sleeps, 14. Other (please specify); 2) Release from immobilization to change position or meet physiological and hygienic needs (Annex 3 to the Regulation of the Minister of Health of 21 December 2018. (poz. 2459).*

Table 2. Causes and duration of the use of direct coercion in a patient

Time	Narrative of the patient behaviour, (statements)	Clinical assessment	Nursing diagnosis
II day 7 am – 10.45 am	The patient is under mechanical immobility. To the question: How do you feel? she says, "no thanks ... whatever you want ... I'm not going anywhere ...." When trying to drink - she drinks greedily and shouts: "give beer, beer ... what is it ..." She spits, squeaks, tugs. Blood pressure measurement is difficult, the patient removes the medical equipment: "I will give you ... get out of my house ... where is Paweł?"	Aggressive patient, psychomotor stimulated, ridiculous statements, with temporary release (RR measurement), attempts to destroy medical equipment. Attention and concentration disturbed by acute psychotic sensations.	Expressing active and verbal aggression towards the environment as a result of frustration and psychotic experiences.
II day 11 am – 11.15 am	The patient is released from the seat belt. She laughs, tears her shirt, tries to run naked out of the room. She doesn't respond to commands, spits, tries to kick nurses, calls men, conducts self-talks. "Come on! I'll go to the store anyway ... for an apple, a brush, shoes. " He's crying ... "I'm nobody ... this is how the queen looks ... what you stare at ... I'll be right back".	Sick in psycho-motor anxiety, multi-threaded, aggressive towards the staff, ridiculous when trying to talk. Talks with obscene content. Seems to be subject to hallucinations.	Lack of adequate assessment of reality and risk of casual sexual contact.
II day 11. 30 am – 1.45 pm	Anxious patient, "I talk to Paweł," he will arrange you ... go and kill them ... kill you hear! Paweł, you have a knife. Cut off these cords for me ... you hear! ". - she eagerly drinks, reports physiological needs. When trying to release temporarily, she tries to hit her head against the bed rails and bite the nurse.	The patient still requires direct coercion. She does not make logical contact and is not able to calm down. At the doctor's order, injections were given with great resistance. She has a hallucinatory dialogue.	Possibility of physical injury to the patient or staff due to auto – and allo-aggressive behaviour.
III day 4.30 pm – 7.45 pm	Sick in a dysphoric mood, in clear awareness and autopsychic orientation preserved, with abolished allopsychic orientation. "I'm lost, devils consumed me to hell, my heart burns". She smells burning. Where are they ... family, damn family!" She goes out on the windowsill, jerks the door handle, strikes the window with her fists.	There is a real threat to the patient's life. Does not respond to commands, required intervention. Immobilized with great resistance with the participation of 6 people. The patient was strongly agitated, vulgarizes.	Risk of direct health or life loss as a result of an attempt to jump out the window.
III day 9.30 – 11.30	The patient spoke English to herself so that nobody would understand her. She is convinced that someone is lying next to her. During a conversation with the nurse, the patient "saw changes in her eyes ... they were unnaturally large black. She asked her about it, panicked, claimed that "she hypnotizes people." She started screaming, she was restless. "She wanted to get to this nurse ... it was unnatural behaviour." She threatened the staff. "First I was shocked and then you will be!"	He is subject to psychological hallucinations, delusions of influence, influence, delusional interpretation of the surrounding reality. Personality with features of unstable structure. Without a sense of mental illness, criticism of your behaviour and spoken content reduced. Active aggression observed.	Perception disorders and interpreting reality as a result of psychotic symptoms (delusions).
IV day 8.30 am – 10.15 am	The patient threatens other patients, is aggressive to the environment, spits and pushes nurses. Because of active and verbal aggression – she kicked, hit the staff, and cursed.	The respondent has no sense of mental illness, she is uncritical of her behaviour and the need for psychiatric treatment, under the influence of psychotic experiences manifesting as aggressive behaviour. In a state of exacerbation of a mental illness under the influence of psychotic symptoms, it threatens the health and life of others and requires absolute mechanical re-protection.	Displaying active and verbal aggression towards the environment as a result of frustration due to unrealized intentions (unsuccessful manipulations of people from the environment) and psychotic experiences.

Table 3. The course of direct coercion used in selected immobilization stages

Time	Nursing diagnosis	Nursing interventions	Implementation	Evaluation
II day 7 am – 10.45 am	Expressing active and verbal aggression towards the environment as a result of frustration and psychotic experiences.	– Taking action to control emotions and aggressive behaviour of the patient, – Assessment of the patient's mental state, the risk of an attack of aggression, an emergency situation, predicting the patient's response, – Recognizing the type of agitation and keeping a distance from offensive words on the part of the patient (not to be provoked), – Keeping a safe distance from the patient (physical distance), – Participation in pharmacological treatment, – Talking – calmly but loudly enough, without shouting, responding to demands – (meet those that must be met, others postpone) – Isolating the patient from excess stimuli, informing her about wanting to help her in order to gain self-control, – Disapproval of the patient's provocative behaviour.	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	The patient is calmer, still jerks and exclaims. She responds briefly to commands. The patient did not cause physical harm to herself or anyone from the medical staff.
II day 11 am – 11.15 am	Lack of adequate assessment of reality and risk of casual sexual contact.	The patient is not at all calmer, does not have a hallucinatory dialogue, the objectification of the patient's mental state indicates the calmness of obscene thoughts.		The patient is not at all calmer, does not have a hallucinatory dialogue, the objectification of the patient's mental state indicates the calmness of obscene thoughts.
II day 11.30 am – 1.45 am	Possibility of physical injury to the patient or staff due to auto- and allo-aggressive behaviour.	– Raising the head to prevent choking, – Loosening seat belts from time to time (on each limb separately), – Avoiding pressure on the neck, chest, pelvis, and back, – Close observation of the patient, – Gaining trust in the patient through therapeutic contact – patience, tact, empathy, authenticity, creating an atmosphere that gives a sense of security, through her presence, establishing contact and understanding the patient's experiences, creates a sense of security, stimulates faith in recovery, – Learning the patient's life situation, her premorbid past, the course of the disease and her current life situation, – Observing the patient in terms of the occurrence of psychotic symptoms, learning about and interpreting them in order to be able to predict her behaviour and prevent dangerous situations, – Hearing the patient (do not deny, confirm, or discuss delusions and hallucinations), – Facilitating the verbalization of the content of psychotic experiences – encouraging their description, – Applying the technique of making it real and expressing doubts – Avoiding touching the patient without notice, – Avoiding laughter, whispers, quiet conversation, – Help in directing the patient's attention and awareness to reality – conversation about real events, things, people, – Being present and keeping calm and understanding, – Complicity in pharmacotherapy, observing side effects of used drugs.	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	No injuries were observed in the patient. There were no adverse events.

Table 3. Cont.

Time	Nursing diagnosis	Nursing interventions	Implementation	Evaluation
III day 4.30 pm – 7.45 pm	Difficulties in making and maintaining relationships with the surroundings caused by the lack of presence of loved ones and anxiety.	– Mental support, – Avoiding excessive guardianship, – Conversation focused on learning about fears, using elementary and supportive psychotherapy, – Enabling contact with the family and implementing her to care for the patient, – Enabling contact with a psychologist, – Sedative medication given on medical order and anxiolytic (Haloperidol, Relanium) on the orders of a doctor, – Providing professional answers to questions.	✓ ✓ ✓ ✓ ✓ ✓ ✓	
III day 9.30 am – 11.30 am	Perception disorders and interpreting reality as a result of psychotic symptoms (delusions)	– Demonstrating acceptance of the patient, – Establishing individual therapeutic verbal and non-verbal therapeutic contact, – Calm and controlled behaviour with the patient, – Identifying the causes of communication disorders, – Informing the patient about the activities performed and research, – Applying therapeutic silence, clarifying, summarizing, certifying, building hope, reflecting, and identifying strengths in conversation with patient.	✓ ✓ ✓ ✓ ✓ ✓	The patient copes with psychotic sensations much more easily and is more critical towards them.
IV day 8.30 am – 10.15 am	Displaying active and verbal aggression towards the environment as a result of frustration due to unrealized intentions (failed manipulations of people from the environment) and psychotic experiences.	– Assessment of the patient's mental state, risk of aggression attack, emergency situation, – Predicting patient response, recognizing agitation, – Identifying the causes of aggression and eliminating them (e.g. people who provocatively affect the patient), – Isolating the patient from excess stimuli, – Ensuring the patient is willing to help to gain self–control, – Not showing superiority due to the function performed, avoiding judgmental attitude, – Not showing an advantage resulting from the use of coercive measures, – Keeping a distance from offensive words on the part of the patient (do not succumb to provocation), – Expressing disapproval of the patient's provocative behaviour, – Avoiding prolonged eye contact with the sick person, dangerous faces, attitudes, excessive gestures, – Talking – calmly but loudly enough, without shouting, – Responding to demands – meet those that must be met, postpone others, – Raising neutral topics in conversation, not touching topics that are sensitive to the patient, – Keeping a safe distance from the patient (physical distance), – Participation in pharmacological treatment.	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	The patient does not show aggressive behaviour; the problem requires further, careful observation.

nursing process is a method of staged decision-making based on critical thinking. The first stage in the nursing process is evaluation related to carrying out a sound nursing assessment based on scientific evidence. The diagnosis is made by diagnosing the patient with the use of critical thinking. Planning consists of writing and formulating the obtained results from care that can be measured, as well as identifying appropriate interventions based on current scientific evidence. The next stage is related to implementation, i.e. the implementation of appropriate interventions. The last element of the process is evaluation, which consists of assessing the obtained results [23, 24].

In the presented case report, immobilization in the form of seat belts required objectification and updating the patient's mental state. Therefore, the duration of coercion was different and depended solely on the patient's current condition. Thanks to careful observation of the patient's mental and somatic state, the seat belts were used for the shortest possible time.

Immobilization requires the use of straps, handles, straitjacket, or sheets and can be embarrassing to the patient. In addition, the patient is placed in a single room alone, and when conditions do not allow for this, the patient should be protected from the eyes of other patients in the room to ensure privacy [8]. The first step in applying immobilization to a patient is to take away objects that may pose a threat to his or her environment. A doctor may order this form of direct coercion for a maximum of 4 h. After examination, the patient may extend this time for a further 2 periods, up to a maximum of 6 h. Further multiple extensions of immobilization for periods not longer than 6 h may be applied only after personal examination by a physician and obtaining the opinion of another psychiatrist. The duration of the use of direct coercion is dictated by patient behaviour.

According to Lisowskiej *et al.*, it is important to partially or totally release the patient at least once every 4 h to ensure the possibility of changing positions or meeting physiological needs [13, 25]. The patient's attempts at temporary dismissals are much more frequent, and result from a patient's temporary "emotional calm down". Nurses can predict the development of events and skilfully communicate with aggressive and agitated patients. Neu indicates that the use of direct coercion has unpleasant consequences because it is a great psychological burden for the patient and the personnel participating in it. The implementation of this procedure is not in line with the intuitive help and treatment identification of the nursing profession. Often, patients who are immobilized exchange aggression and anger for despair with frequent crying. Because of this behaviour, nurses can feel guilty [26, 27]. Research by Riahi *et al.* indicated that in the opinion of many psychiatric nurses, the use of direct coercion is necessary to keep everyone safe [7]. In this case study, safety belts were the least onerous tool to ensure patient safety. Lanthen *et al.* argued that it is unacceptable to leave a patient unattended. Such irresponsible behaviour can have short- and long-term consequences for a vulnerable "victim" [28, 29]. Nursing care during the whole period of mechanical protection should include careful observation of not only the mental state, but also the somatic state. Nurses in contact with an aggressive patient must have certain skills, such as a calm approach to the patient, a gentle and calm way of speaking, avoiding long eye contact, keeping a safe distance from the patient, and showing control over the situation. Ezeobele states that it is important to speak and act in a way that will not be perceived by the patient as a threat [30]. In an emergency situation, the nurse should use the help of other employees and act in accordance with the procedures in force at the facility (if available), and if necessary, administer medication and isolate the patient. An experienced and competent nurse knows that coercion should not be used as a form of punishment because direct coercion is a therapeutic and not a repressive intervention (e.g. it is intended to regain self-control) [28]. Kontio *et al.* indicates that during the observation of a patient, symptoms of anger, nervousness, or aggression are visible, and these emotions constitute a call to patience, forbearance, and new communication strategies with a sick person. Losing freedom and being subjected to strong psychotic sensations should in no way diminish the dignity of a given human being. The most important thing for the nurse is to assume that the immobilized patient is not bad but is in a difficult situation and is suffering. Such an approach will indicate the direction of advanced psychological and psychiatric diagnostics [31, 32].

According to Karcz *et al.*, ethical aspects should be considered in the analysis of the legitimacy of using direct coercion. Many authors attempt to solve problems related to the benefits of using direct coercion for patients showing aggressive behaviour. One should always answer the question as to what extent coercion will be useful for the patient's condition and whether it is possible to replace it with other techniques, i.e. reducing the patient's aggressive behaviour [33, 34].

Fąfara and Trąd also drew attention to the fact that the need to comply with the law in the field of mechanical immobilization results from the need to ensure that the entire procedure does not turn into staff violence towards the patient [35]. Neu emphasizes that after the immobilization procedure is completed, only a small number of people should remain in the room, which is to protect the patient from excessive discomfort. The patient should be informed about the treatment and given medication [26].

According to Neu, one person should be with the immobilized patient at all times for supervision and monitoring of vital signs. Any situation in which immobilization has occurred should be discussed with the patient (after immobilization). Patients should be given

sufficient time to prepare for such conversations due to the effects of sedatives or reluctance to talk to their physician. At the latest, it may take place before the collateral that was used to immobilize. The patient should be made aware again of the reasons for immobilization. The attitude of the staff should be respectful and empathic, and at the same time firm. The standard should be to discuss the performed immobilization with the entire staff (called debriefing) [26]. According Kontio, conditions and circumstances of using coercion may lead to sudden events and unexpected errors requiring a quick response. The experience gained and the teamwork connected with it result in flexibility of reaction in these situations. Debriefing aims at early identification and definition of mistakes and avoiding them in subsequent situations involving direct coercion measures. In addition, the procedure of immobilizing the patient burdens the medical staff mentally. Debriefing gives them the opportunity to express their feelings about carrying out the procedure [28, 31].

To reduce the use of direct coercion measures, special procedures are implemented in the professional work of medical personnel in New Zealand, Germany, and Australia [9]. Norvoll *et al.* argue that following a code of ethics may have a significant impact on improving the quality of direct coercion practices used, as well as in avoiding its application [19]. According to the researchers, such actions influence moral decisions. In terms of the justification for using direct coercion, ethical behaviour contributes to an increase in awareness of violations towards the patient, which in turn minimizes moral stress. The staff have the sense of being consistent when taking appropriate action with a code of ethics [36, 37]. On the other hand, in Scandinavian countries, the USA, and the Netherlands, the subjects of discussion are issues related to the reduction of coercive practices and the improvement of their quality [38]. These considerations particularly concern the aspect of resignation in isolation psychiatric care [18, 32]. Examples of activities that contribute to reducing the use of direct coercion can be the following: pharmacological interventions, patient monitoring, integration and education of staff, monitoring patient isolation, improving the treatment plan, changing the therapeutic environment, and treating patients as active participants in the treatment process (to avoid forced isolation, integrating staff, improving the treatment plan) [19, 33]. One should remember ethical determinants of direct coercion and ask oneself who it is really intended for – the environment or the patient. Will it be beneficial for the patient, and are there other methods to prevent aggressive behaviour of the patient? [33].

Conclusions

The priority task in the care of a mechanically immobilized patient is to prevent immobilization complications. The mechanical immobilization procedure is unpleasant for both the patient and the staff. Despite this, it is essential in certain cases. Compliance with legal regulations prevents abuse of a patient who has been subjected to mechanical immobilization. Medical staff should always remember to refer to the patient with respect as a human being and be aware of their suffering. When dealing with an aggressive patient, behaving calmly, speaking gently, showing control over the situation, not provoking the patient, and taking care of personal safety are necessary. Prevention of unexpected and undesirable events is possible through constant updating of knowledge on the correct management of an aggressive patient and learning appropriate techniques, including the use of tools to assess the risk of aggression.

Conflict of interest

The authors declare no conflict of interest.

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