



# Quality appraisal of clinical practice guidelines on physical restraints in ICU: a systematic review

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**Background:** Physical restraint has been regarded as a protective measure in the intensive care unit (ICU) in order to avoid unexpected events. But a great number of researches have proven that physical restraints can cause bad influences on patients' mental health, such as language delays of children, sense of uncertainty, loss of trust, etc. However, it is unclear whether there are currently high-quality clinical practice guidelines (CPGs) to guide clinical practice in physical restraints. So we aim to analyze available CPGs on physical restraints in ICU with Appraisal of Guidelines for Research and Evaluation II (AGREE II) evaluating methodological quality and Reporting Items for Practice Guidelines in Healthcare (RIGHT) evaluating reporting quality.

**Methods:** We systematically searched PubMed, Embase, Web of Science, CINAHL, CNKI (Chinese database), Wanfang data (Chinese database), relevant websites (GIN, NICE, SIGN, RAO, AHRQ, AACN), and Google from their inception to Nov 21, 2021. Two reviewers independently use the AGREE II tool and RIGHT checklist to evaluate methodological and reporting quality of included guidelines on physical restraints in ICU. The number and proportion of reported items of RIGHT checklist and the scores of each domain of AGREE II were calculated. We also evaluated the consistency among the reviewers via use of the intragroup correlation coefficient.

**Results:** A total of six guidelines were included. The mean AGREE II score for the included guidelines was 39.56% with a range of 30.27–69.85%. No guideline was “high quality”, and only one guideline was “moderate quality” with 69.85% mean AGREE II score. The mean RIGHT reporting score for guidelines was 41.0% with a range of 24.7–77.7%. Only one guideline was “moderate-reported” with a mean reporting score of 77.7%.

**Discussion:** In general, the methodological and reporting quality of physical restraints guidelines is low, and future development or updating of high-quality guidelines to guide clinical practice is needed.

**Keywords:** Clinical practice guidelines (CPGs); quality appraisal; intensive care units (ICUs); physical restraints

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## Introduction

Patients in the intensive care unit (ICU) often require invasive catheters to assist in their treatment due to their condition, such as tracheal intubation, central venous catheter (CVC), and urinary catheters (1). As it is believed to limit the patient's movement (2), physical restraints have long been used as a protective measure for patients in the ICU to ensure that patients' life-support catheters are not accidentally removed (3), which has resulted in physical restraints rate 23.4 times higher in the ICU than in the general wards (4). The rate of physical restraint use varies between countries. In the United States, a study that included 68 ICUs showed that the physical restraints rate in ICUs was 33% (5,6). In China, where several scholars have conducted localized surveys over the past decade, the physical restraints rate fluctuated between 35.1% and 77.2% (7-10). Physical restraints are widely used in ICU around the world (11).

With the establishment of the "biopsychosocial medical model", the care of patients has gradually changed from "disease-centered" to holistic care centered on the physical and psychological health of patients (12). Therefore, when using physical restraints on ICU patients, medical staff should consider the physical and psychological effects of physical restraints. Unfortunately, it has been proven that physical restraints may lead to delirium (13), neurovascular complications (e.g., redness, limb movement, oedema, and colour complication) (14) and worsen agitation (15). Besides, while the main reason for using physical restraints in the ICU is to prevent the extubation (16), some studies (17-19) have pointed out that physical restraints can increase the level of anxiety and irritability of patients, but instead increase the risk of unplanned extubation and falls, which cannot ensure patient safety.

High quality clinical practice guidelines (CPGs) can enhance the health care quality through presenting recommendations to decision makers (20). Nurses are the primary decision-makers in applying physical restraints (3,21). So, reducing the use of physical restraints requires changing nurses' perceptions and increasing knowledge of the proper use of physical restraints, guided by high-quality CPGs (22). Although physical restraints CPGs have been published by different organizations, the quality of available ones remains unknown. Our study aims to evaluate the quality of physical restraints guidelines from methodological and reporting perspective and to inform future practice improvement and guideline development. We conducted the systematic review following the PRISMA

reporting checklist (available at <https://apm.amegroups.com/article/view/10.21037/apm-21-2851/rc>) (23).

## Methods

### *Data sources and search strategy*

On Nov 21, 2021, two reviewers (RL, YL) independently searched MEDLINE (via PubMed), Web of Science, Embase, Cumulative Index to Nursing and Allied Health Literature (CINAHL), China National Knowledge Infrastructure (CNKI), and Wanfang Data since inception using search terms, such as "physical restraint", "intensive care unit", "critical care", "acute care", "practice guideline", etc. The details of the search strategies are shown in [Appendix 1](#). We also searched Google and some relevant websites (GIN, NICE, SIGN, RNAO, AHRQ, AACN) using "physical restraint" as search terms.

### *Inclusion and exclusion criteria*

We included guidelines based on the following inclusion criteria: (I) articles met the definitions of the guidelines proposed by the institute of medicine (IOM) in 1990 or 2011 (24,25). When evidence quality is low or very low, the guideline panels label them as consensus statements (26). So, in this study, we included statements based on evidence; (II) guidelines focus on physical restraint; (III) the settings of guidelines include critical care and acute care settings (general residential care setting were excepted); (IV) guidelines focus on adult patients; (V) guidelines were published between January 2001 and November 2021 in Chinese or English.

Our exclusion criteria were: (I) articles focus on chemical restraints or recommendations of physical restraints cannot be clearly distinguished; (II) previous version of guidelines, if there were two same guidelines by the same group/organization; (III) translated versions, brief versions or interpretations of the guidelines.

### *Study selection*

Two reviewers (RL and YL) independently screened the titles, abstracts based on the inclusion and exclusion criteria through bibliographic software EndNote and then screened the full text. Disagreements were resolved by consensus and discussion with a third reviewer (XJ). Prior to the screening, a pilot test was performed until agreement on the screening process was reached.

### Data extraction

Data were extracted by two reviewers (RL and YL) using a standardized form: organization, publication date, country/region, systematic literature search, recommendation formulation method, evidence quality grading, conflicts, funding.

### Quality appraisal of guidelines

Two reviewers (RL and YL) independently used the Appraisal of Guidelines for Research and Evaluation II (AGREE II) tool (27-30) to assess the methodological quality of the included guidelines. According to the AGREE II manual (27), it contains 23 items in six domains. Each item was rated on a seven-point scale (1-strongly disagree to 7-strongly agree). The domain quality score (between 0 to 100%) was calculated by aggregating the individual scores of the reviewers according to the formula provided in AGREE II handbook, scaled by the percentage of the highest possible score, and averaging the scores of the two reviewers. In addition, the mean scores of the six standardized domains were used to calculate the overall guideline assessment and to classify guidelines (31,32): “high quality” was score >80%; “moderate quality” was score between 50–80%; “low quality” was score <50%.

Two reviewers (RL and YL) independently used the Reporting Items for Practice Guidelines in Healthcare (RIGHT) checklist (33) to assess the reporting quality of the included guidelines. It contains 22 items in seven domains. Items rated as “reported” are scored as 1, items rated as “not reported” are scored as 0. Calculate the percentage of the total score to obtain the overall report assessment is divided into: “well-reported” was score >80%; “moderate-reported” was score between 50–80%; “low-reported” was score <50%.

### Statistical analysis

Using SPSS 25.0 to calculate intra-class correlation coefficients (ICC) of two reviewers in AGREE II scores and RIGHT reporting scores to test agreement among reviewers. ICC >0.75 shows good reliability (34).

## Results

A total of 635 articles were retrieved, and 74 duplicate articles were excluded; 542 articles were excluded after reading the title and abstract. Based on full-text screening,

13 articles were excluded, and six guidelines were included (35-40). The selection process was shown in *Figure 1*.

The ICC values for two reviewers were 0.820 (95% CI: 0.757–0.868) in the AGREE II and 0.837 (95% CI: 0.792–0.873) in the RIGHT checklist, both of which indicate good reliability.

### Characteristics of guidelines

The six guidelines were published in the United States (37,38,40), the United Kingdom (35,36), and Canada (39), with only the guideline developed by The University of Iowa (38), which were updated in 2016 after being published in 2012, and the guidelines developed by the Intensive Care Society (35), which were published in 2021 and are scheduled to be updated in 2024; none of the remaining guidelines have been updated or plan to update. Five guidelines (36-40) mentioned systematic literature retrieval, but only one (39) described the guideline development process and literature search strategies in detail. Three guidelines (37,39,40) formulated recommendations through expert consensus and used the evidence grading system, including Cochrane, SIGN, and self-defined system. The rest guidelines were not mentioned recommendation formulation methods and evidence grading system. One guideline (38) reported no relevant conflicts of interest for the developers, and two guidelines (39,40) reported funding sources. Specific information was shown in *Table 1*.

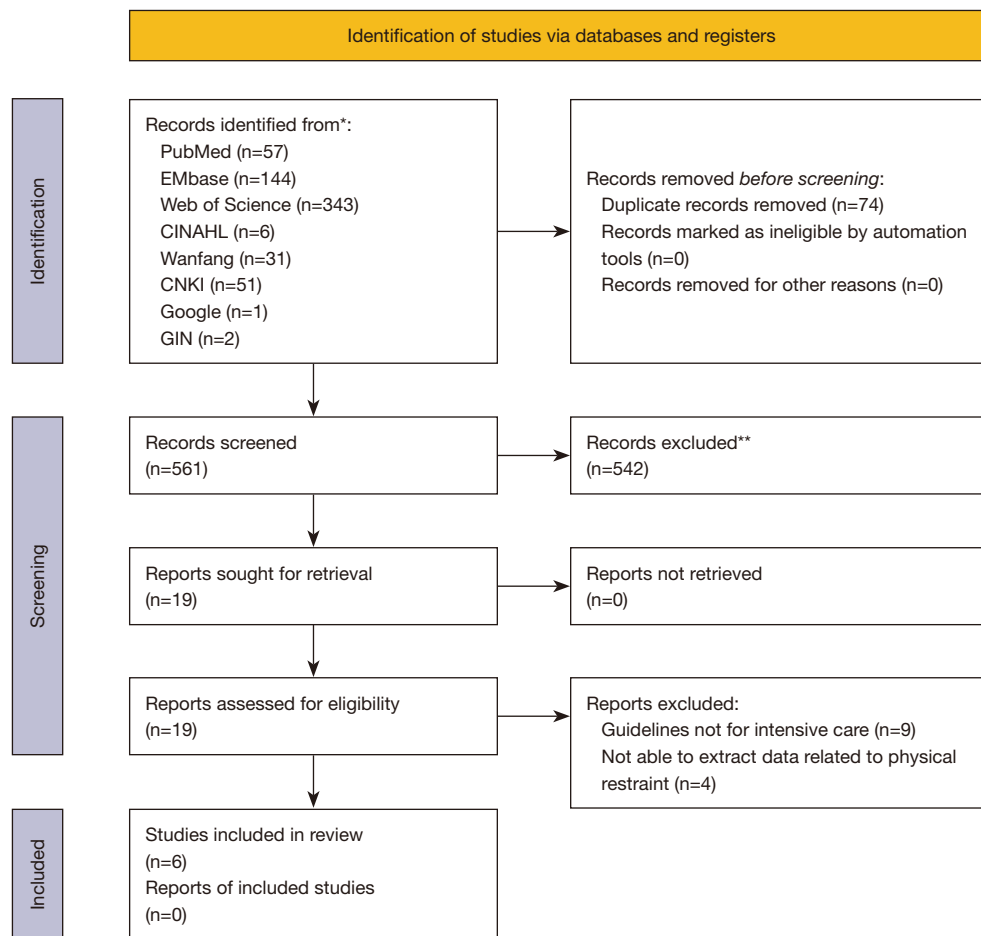
### Quality of included guidelines

#### Methodological quality

The mean AGREE II score of the included guidelines were 41.92% with a range of 31.89–69.50%. No guideline was “high quality”. Only one guideline developed by the Registered Nurses’ Association of Ontario (RNAO) with a mean AGREE II score of 69.50% was “moderate quality”, and the remaining five guidelines were of “low quality”. The overall AGREE II scores (average of six domains) for each guideline were shown in *Figure 2*. “Clarity of Presentation” was the highest score (69.91%), and “Applicability” was the lowest score (21.53%). Each domain AGREE II scores were shown in *Figure 3*. And the scores of all guidelines in six domains were shown in *Table 2*.

#### Reporting quality

The mean reporting rate for guidelines was 41.0% with a range of 24.7–77.7%. Only one guideline developed by



**Figure 1** PRISMA 2020 flow diagram for new systematic reviews which included searches of databases and registers only. \*, consider, if feasible to do so, reporting the number of records identified from each database or register searched (rather than the total number across all databases/register); \*\*, if automation tools were used, indicate how many records were excluded by a human and how many were excluded by automation tools.

RNAO was “moderate-reported” with a mean reporting rate of 77.7%, and the remaining five guidelines were all rated as “low-reported”. The overall reporting rates of six guidelines were shown in *Figure 2*. Among the seven domains, “Information” was the highest reporting rate (66.7%), while “Funding and conflict-of-interest statements and management” was the lowest reporting rate (16.7%). Among 10 key items, the reporting rates of item 14c “other consideration”, item 18b “role of funder” and item 19b “management of conflict of interest” were 0%, with the highest reporting rates of item 12 “evidence quality assessment approach” at 50%. Each domain reporting rates were shown in *Figure 4*. And the reporting rates of all guidelines in seven domains were shown in *Table 3*.

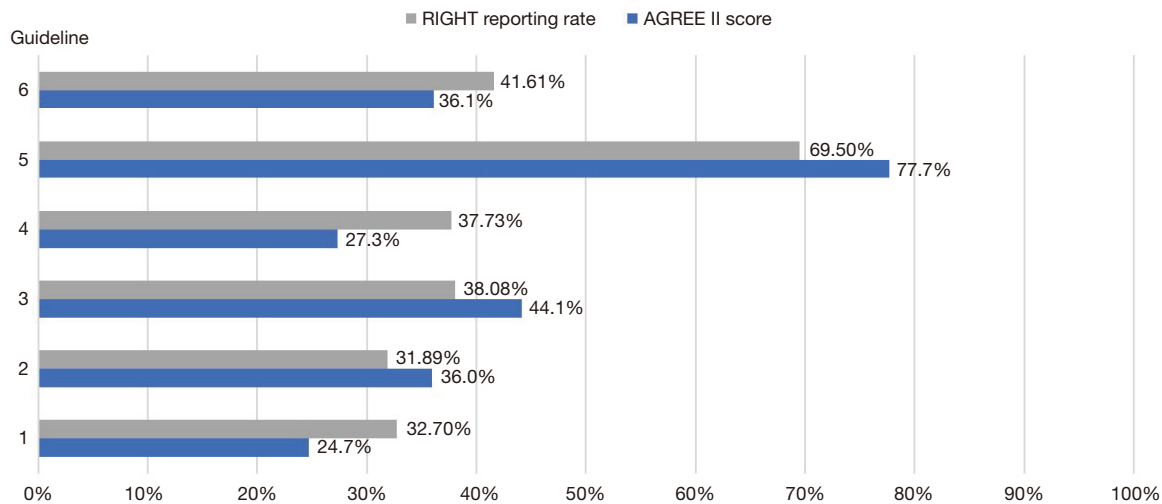
## Discussion

CPGs, developed based on the best research evidence, provide clinicians with clear and comprehensive recommendations and are an important bridge between research evidence and clinical practice (41). AGREE II and RIGHT checklist focus on different aspects of quality, although some items overlap, in general can be a more comprehensive reflection of the quality of a guideline. It has been shown that AGREE II scores and RIGHT reporting rates have a high positive correlation, and writing CPGs based on the RIGHT checklist can improve AGREE II scores and thus improve the quality of guidelines (32,42). Therefore, this study provides suggestions for the future development of high-quality CPGs by evaluating the quality

**Table 1** Characteristics of included guidelines

No. of guideline	Developing organization	Publication date	Country/region	Systematic literature retrieval	Recommendation formulation method	Evidence quality grading	Conflicts	Funding
1 (35)	Intensive Care Society	Mar 2021	UK	Not reported	Not reported	No	Not reported	Not reported
2 (36)	BACCN	Sep–Oct 2004	UK	Yes	Not reported	No	Not reported	Not reported
3 (37)	ACCCM	Nov 2003	USA	Yes	Expert consensus	Cochrane	Not reported	Not reported
4 (38)	The University of Iowa	Feb 2016	USA	Yes	Not reported	No	No	Not reported
5 (39)	RNAO	Feb 2012	Canada	Yes	Expert consensus	SIGN	Not reported	Ontario Ministry of Health and Long-Term Care
6 (40)	HIGN	2012	USA	Yes	Expert consensus	Self-defined	Not reported	The Hartford Institute for Geriatric Nursing, New York University College of Nursing

BACCN, British Association of Critical Care Nurses; ACCCM, American College of Critical Care Medicine Task Force; RNAO, Registered Nurses' Association of Ontario; HIGN, Hartford Institute for Geriatric Nursing.

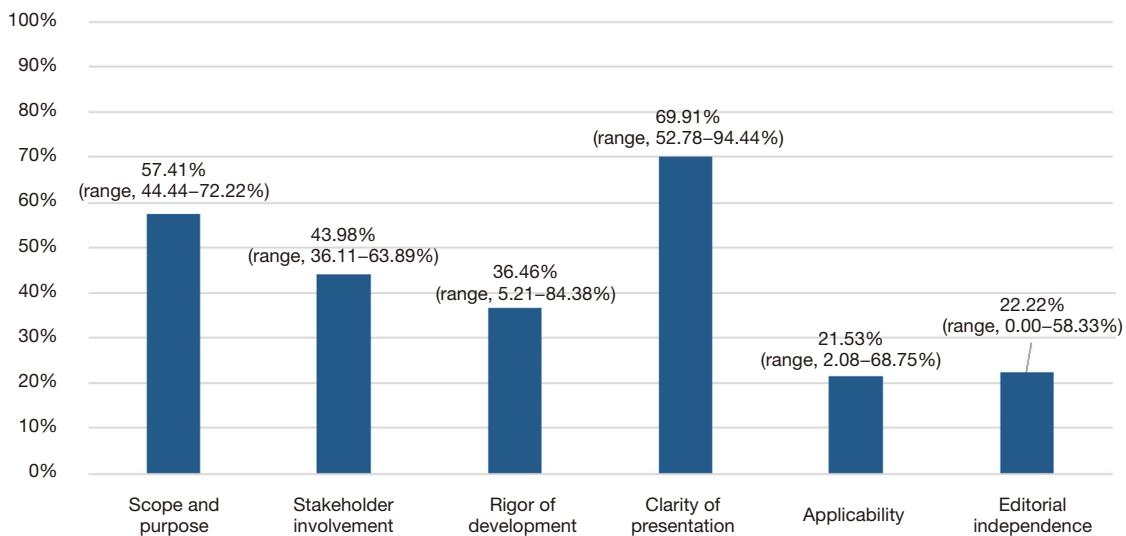


**Figure 2** AGREE II mean scores and RIGHT reporting rates of each guideline. AGREE II, Appraisal of Guidelines for Research and Evaluation II; RIGHT, Reporting Items for Practice Guidelines in Healthcare.

of physical restraints CPGs.

The overall methodological and reporting quality of the six guidelines included in this study was low. Only the guideline developed by RNAO in 2012 were rated as “moderate quality” in terms of methodological and reporting quality. The quality of CPGs affects clinical practice (41), so there is a need to develop high-quality

CPGs in physical restraints to better guide clinical practice. There are two categories of CPGs: evidence-based CPGs (EB-CPGs) and non-EB-CPGs (43). Study found that the quality of EB-CPGs was significantly higher than the quality of non-EB-CPGs (26). If only low-quality evidence is available, EB-CPGs can be developed as well (43). Thus, in the future, high-quality physical restraints CPGs should



**Figure 3** AGREE II mean scores of each domain for all included guidelines. AGREE II, Appraisal of Guidelines for Research and Evaluation II.

**Table 2** AGREE II domain scores

No. of guideline	Scope and purpose	Stakeholder involvement	Rigor of development	Clarity of presentation	Applicability	Editorial independence	Average
1 (35)	50.00%	41.67%	5.21%	63.89%	35.42%	0.00%	32.70%
2 (36)	44.44%	41.67%	26.04%	75.00%	4.17%	0.00%	31.89%
3 (37)	55.56%	41.67%	41.67%	75.00%	14.58%	0.00%	38.08%
4 (38)	50.00%	36.11%	43.75%	52.78%	2.08%	41.67%	37.73%
5 (39)	72.22%	63.89%	84.38%	94.44%	68.75%	33.33%	69.50%
6 (40)	72.22%	38.89%	17.71%	58.33%	4.17%	58.33%	41.61%
Average	57.41%	43.98%	36.46%	69.91%	21.53%	22.22%	41.92%

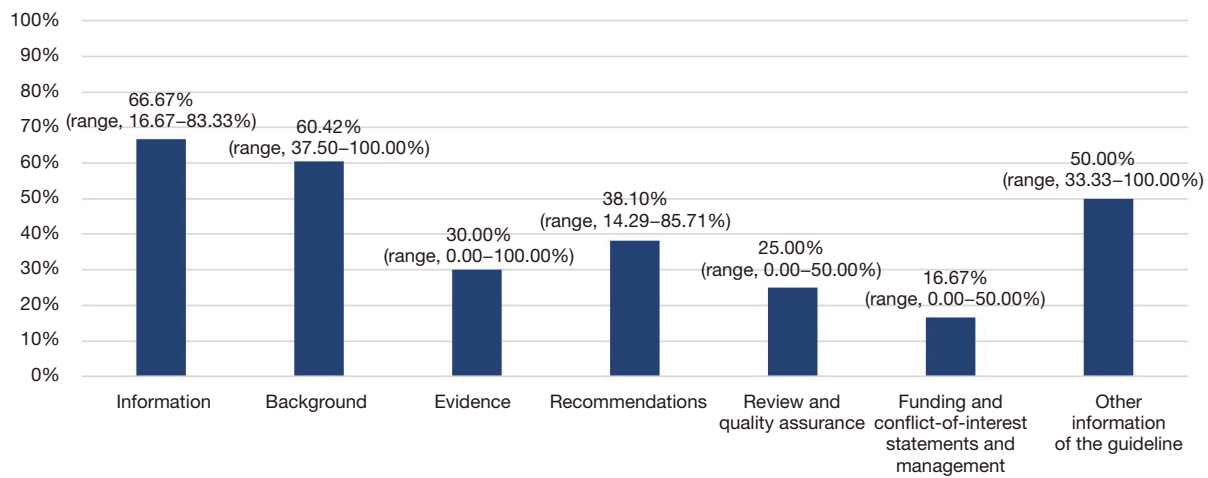
AGREE II, Appraisal of Guidelines for Research and Evaluation II.

be developed based on the best available evidence and in strict accordance with the methodology of evidence-based guidelines.

Applicability of recommendations in clinical practice is a key element of guideline translation (44). The overall mean score for “Applicability” of physical restraints CPGs in AGREE II was only 17.36%, with 4 guidelines (36–38,40) scoring <10%, which was serious neglect of guideline applicability. Studies have summarized facilitators of guideline application (44), including the provision of guideline implementation tools (e.g., executive summaries, brochures), presentation of guidelines in a short format, and presentation of guidelines in a digital format. It is

recommended that future CPGs focus on the evidence as well as the application aspects. In particular, it should pay attention to analyzing what the advantages and disadvantages of applying the recommendations of this guideline, providing supporting tools, potential resource implications of applying the recommendations, and proposing monitoring and/or auditing criterion.

For both funding and conflict of interest statements, physical restraints CPGs scored low quality for both AGREE II and RIGHT checklist corresponding items. Three guidelines (35–37) did not report either financial support or information about conflict of interest. Conflicts of interest are one of the most important factors affecting



**Figure 4** RIGHT reporting rates of each domain for all included guidelines. RIGHT, Reporting Items for Practice Guidelines in Healthcare.

**Table 3** RIGHT reporting scores

No. of guideline	Information	Background	Evidence	Recommendations	Review and quality assurance	Funding and conflict-of-interest statements and management	Other information of the guideline	Average
1 (35)	83.3%	75.0%	0.0%	14.3%	0.0%	0.0%	0.0%	24.7%
2 (36)	83.3%	37.5%	0.0%	14.3%	50.0%	0.0%	66.7%	36.0%
3 (37)	66.7%	62.5%	20.0%	42.9%	50.0%	0.0%	66.7%	44.1%
4 (38)	66.7%	37.5%	0.0%	28.6%	0.0%	25.0%	33.3%	27.3%
5 (39)	83.3%	100.0%	100.0%	85.7%	50.0%	25.0%	100.0%	77.7%
6 (40)	16.7%	50.0%	60.0%	42.9%	0.0%	50.0%	33.3%	36.1%
Average	66.67%	60.42%	30.00%	38.10%	25.00%	16.67%	50.00%	41.0%

RIGHT, Reporting Items for Practice Guidelines in Healthcare.

the reliability of guidelines (24,45). Studies have shown that financial ties exist between guideline authors, panelists, and pharmaceutical companies (46). Therefore, guideline developers should regulate the management and reporting of funding and conflicts of interest, and researchers and administrators need to actively improve management policies and develop corresponding reporting specifications to promote physically binding CPGs toward greater objectivity, fairness, and transparency.

Opinions and preferences of the target population, procedures for updating the guideline, sources and evaluation of evidence were factors that affect the quality of the guidelines. The overall mean score for 14a “Describe whether values and preferences of the target population(s)

were considered in the formulation of each recommendation” of physical restraints CPGs in RIGHT checklist was 33.3%. Few guidelines clearly describe how to consider patients’ perspectives and preferences, but clinical experience suggests that patients’ feelings and perceptions and close collaboration with health care professionals play a critical role in physical restraints practice. Thus, without knowledge of patient preferences, the implementation of the guidelines is definitely affected. Similar to the results of other guideline evaluations (47), descriptions of the updating procedures of the guidelines were poor, with only two guidelines (37,39) mentioning an update schedule. The WHO guideline handbook stated that although there is no maximum duration validity of recommendations, the minimum period for

guideline updates is 2 years, and the maximum period is 5 years (48). Therefore, it is extremely important to update the guidelines in a timely manner. The mean score of “Rigor of development” in AGREE II (36.46%) and “Evidence” in RIGHT checklist (30.00%) were low, which reflect that the guidelines for “sources and evaluation of evidence” are not very good. Inclusion and exclusion criteria for evidence should be clear and strictly implemented, and formal tools or methods (e.g., Jadad scale, GRADE method) should be used to assess the strength of the evidence, clearly state the limitations of the evidence, balance the pros and cons of the available evidence, and give supporting data. A clear presentation and description of the evidence will help clinical staffs make good decisions based on a synthesis of the evidence when applying the recommendations. In addition, attention should be paid to the completeness of guideline reporting. For example, for process of systematic review, the entire process of literature search should be described in detail, and a complete search strategy should be provided in an appendix rather than just a few key words.

### Limitation

This study provided a systematic literature retrieve to comprehensively explore the methodological and reporting quality of physical restraints CPGs and to make recommendations. Our findings provide clinical experts and methodologists with an overview of methodological and reporting quality of physical restraints guidelines, which may contribute to the development and updating of future guidelines and promote standardization of physical restraints practice. However, this study had several limitations. First, we only have two researchers involved in the quality appraisal process, which may have been problematic in terms of the accuracy of the results. Second, we only searched guidelines published in Chinese and English. So, we may not have included all of the guidelines.

### Conclusions

In general, the methodological and reporting quality of physical restraints guidelines were low, and future development or updating of high-quality guidelines to guide clinical practice is needed. The domains of applicability, funding and conflict of interest statement, opinions and preferences of the target population, procedures for updating the guideline, sources and evaluation of evidence still need improvement. In the development of guidelines,

more detailed and specific methodological descriptions are needed.

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### Footnote

*Reporting Checklist:* The authors have completed the PRISMA reporting checklist. Available at <https://apm.amegroups.com/article/view/10.21037/apm-21-2851/rc>

*Conflicts of Interest:* All authors have completed the ICMJE uniform disclosure form (available at <https://apm.amegroups.com/article/view/10.21037/apm-21-2851/coif>). The authors have no conflicts of interest to declare.

*Ethical Statement:* The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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## Appendix 1 Search strategy

PubMed (n=57)

(((((Intensive Care Units[MeSH Major Topic] OR (Critical Care[MeSH Major Topic])) OR (Critical Care Nursing[MeSH Major Topic])) OR ((cardiac[Title/Abstract] OR coronary[Title/Abstract] OR heart[Title/Abstract] OR burn[Title/Abstract] OR respiratory[Title/Abstract] OR surgical[Title/Abstract] OR surger\*[Title/Abstract] OR high dependency[Title/Abstract] OR stepdown[Title/Abstract] OR step-down[Title/Abstract] OR special\* weaning[Title/Abstract] OR postoperati\*[Title/Abstract] OR post-operati\*[Title/Abstract] OR postsurg\*[Title/Abstract] OR post-surg\*[Title/Abstract] AND (unit\*[Title/Abstract] OR centre\*[Title/Abstract] OR center\*[Title/Abstract]))) OR ((intensive care unit[Title/Abstract] OR intensive care units[Title/Abstract] OR ICU\*[Title/Abstract] OR intensive care[Title/Abstract] OR critical care[Title/Abstract] OR acute care[Title/Abstract] OR SICU\*[Title/Abstract] OR CCU\*[Title/Abstract] OR EICU\*[Title/Abstract] OR HDU\*[Title/Abstract] OR SDU\*[Title/Abstract] OR EDSDU\*[Title/Abstract]))) AND (("Restraint, Physical"[Mesh] OR Restraint, Physical[Title/Abstract] OR Physical Restraints[Title/Abstract] OR Restraints, Physical[Title/Abstract] OR Physical Restraint[Title/Abstract] OR Immobilization, Physical[Title/Abstract] OR Physical Immobilization[Title/Abstract] OR Restraint[Title/Abstract] OR Restraints[Title/Abstract])) AND ("Guideline" [Publication Type] OR "Guidelines as Topic"[Mesh] OR "Practice Guideline" [Publication Type] OR "Practice Guidelines as Topic"[Mesh] OR Guideline\*[Title] OR Guidance\*[Title] OR Recommendation\*[Title] OR Statement\*[Title]))

Embase (n=144)

('intensive care unit'/exp OR 'intensive care'/exp OR 'intensive care unit':ab,ti OR 'intensive care units':ab,ti OR icu\*:ab,ti OR 'intensive care':ab,ti OR 'critical care':ab,ti OR 'acute care':ab,ti OR sicu\*:ab,ti OR ccu\*:ab,ti OR eicu\*:ab,ti OR hdu\*:ab,ti OR sdu\*:ab,ti OR edsdu\*:ab,ti OR ((cardiac:ab,ti OR coronary:ab,ti OR heart:ab,ti OR burn:ab,ti OR respiratory:ab,ti OR surgical:ab,ti OR surger\*:ab,ti OR 'high dependency':ab,ti OR stepdown:ab,ti OR 'step down':ab,ti OR 'special\* weaning':ab,ti OR postoperati\*:ab,ti OR 'post operati\*':ab,ti OR postsurg\*:ab,ti OR 'post surg\*':ab,ti) AND (unit\*:ab,ti OR centre\*:ab,ti OR center\*:ab,ti)) AND ('physical restraint'/exp OR 'physical restraints':ti,ab OR 'physical restraint':ti,ab OR 'physical immobilization':ti,ab OR 'restraint':ti,ab OR 'restraints':ti,ab) AND ('practice guideline'/exp OR 'guideline':ti OR 'guidelines':ti OR 'practice guidelines':ti OR 'guidance':ti OR 'recommendation':ti OR 'recommendations':ti OR 'statements':ti OR 'statement':ti)

CNKI (n=51)

( 篇文摘 = 身体约束 + 约束 + 物理约束 ) AND ( 篇文摘 = 重症监护 + 重症医学 + 监护室 + 监护病房 + 加护病房 + 加强医疗病房 + ICU ) AND ( 篇文摘 = 指南 )

Web of Science (n=343)

(TOPIC=(intensive care unit OR intensive care units OR ICU\* OR intensive care OR critical care OR acute care OR SICU\* OR CCU\* OR EICU\* OR HDU\* OR SDU\* OR EDSDU\*) OR TOPIC=((cardiac OR coronary OR heart OR burn OR respiratory OR surgical OR surger\* OR high dependency OR stepdown OR step-down OR special\* weaning OR postoperati\* OR post-operati\* OR postsurg\* OR post-surg\*) AND (unit\* OR centre\* OR center\*)) AND TOPIC=(Physical Restraints or Physical Restraint or Physical Immobilization or Restraint or Restraints) AND TOPIC=(Guideline or Guidelines or Practice Guideline or Practice Guidelines or Guidance or Recommendation or Recommendations or Statement or Statements)

CINAHL Database (n=6)

( (MH "Intensive Care Units+") OR (MH "Critical Care+") OR (MH "Acute Care") ) OR SU ( (intensive care unit OR intensive care units OR ICU\* OR intensive care OR critical care OR acute care OR SICU\* OR CCU\* OR EICU\* OR HDU\* OR SDU\* OR EDSDU\*) OR ((cardiac OR coronary OR heart OR burn OR respiratory OR surgical OR surger\* OR high dependency OR stepdown OR step-down OR special\* weaning OR postoperati\* OR post-operati\* OR postsurg\* OR post-surg\*) AND (unit\* OR centre\* OR center\*)) ) AND (MH "Restraint, Physical") OR SU ( Physical Restraints or Physical Restraint or Physical Immobilization or Restraint or Restraint ) AND (MH "Practice Guidelines") OR SU ( Guideline or Guidelines or Practice Guideline or Practice Guidelines or Guidance or Recommendation or Recommendations or Statement or Statements )

WanFang (n=31)

题名或关键词 :( 身体约束 或 约束 或 物理约束 ) and 题名或关键词 :( 重症监护 或 重症医学 或 监护室 或 监护病房 或 加护病房 或 加强医疗病房 或 ICU ) and 题名或关键词 :( 指南 )