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Research Article

Review of Maqāsid al-Syarī'ah in the Use of Physical Restraint to Reduce the Risk of Falls in Patients: Literature Review

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Abstract: Reducing the risk of patient falls is one of the most crucial Patient Safety Goals (SKP 6) in hospitals. In clinical practice in inpatient wards, geriatrics, neurology, and the Intensive Care Unit (ICU), physical restraints such as wrist/ankle restraints, body restraints, and full-length bilateral bed rails are still frequently used as pragmatic interventions to prevent patients from falling or dislodging medical devices. However, scientific evidence shows a restraint paradox: the use of unmeasured physical restraints often fails to reduce falls, triggers fatal entanglement injuries, worsens delirium and agitation, irreversibly reduces daily functioning within 72 hours, and violates human autonomy and dignity (karāmah al-insān). This paper examines the use of physical fixation to reduce the risk of falls through an analysis of the Maqāṣid al-Syarī'ah (Islamic principles) and the principles of Islamic jurisprudence (al-qawā'id al-fiqhiyyah) based on 18 reliable scientific literature sources from 2021–2026. The results of the study indicate that the basic law of restricting human movement is prohibited because it harms human dignity and has the potential to cause physical and psychological harm. However, physical fixation can change status to mubah or wajib temporarily on the basis of medical emergency (al-ḍarūrāt tubīḥ al-maḥẓūrāt) in order to maintain the safety of life (ḥifẓ al-nafs) in patients with impaired consciousness or acute agitation (such as post-surgery subarachnoid hemorrhage or critical delirium), with the strict condition that all non-restrictive interventions have been attempted, are carried out proportionally according to the level of emergency (al-ḍarūrah tuqaddar bi qadarihā), do not cause equal or greater harm (al ḍarar lā yuzāl bi mithlih), are accompanied by informed consent from the guardian/family, and are evaluated periodically every 2 hours according to accreditation standards and Sharia Hospitals.

Keywords: Fall Prevention; Islamic Nursing Ethics; Karāmah al-Insān; Maqāṣid al-Syarī'ah; Patient Safetys.

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1. Introduction

Patient falls in hospital settings are adverse events that can increase morbidity, prolong hospitalization, cause head trauma and extremity fractures, increase medical costs, and even result in death (Kardiahning et al., 2025; Montero-Odasso et al., 2022). Within the framework of hospital risk management and Patient Safety Goal 6 (SKP 6), nurses and medical teams are professionally responsible for identifying patients at high risk of falls, including older adults with dementia, post-neurosurgical patients, patients with acute stroke, and patients with decreased consciousness or delirium in the intensive care unit (ICU), and for implementing

effective preventive interventions (Tasya et al., 2024; Albalat-Rodríguez et al., 2026; Fadia et al., 2026).

One of the interventions historically most frequently chosen by nursing staff when dealing with patients at high risk of falls and agitation is the use of physical restraint.(Cortinhal et al., 2024; Canzan et al., 2021). According to the international consensus referred to by Cortinhal et al. (2024), physical fixation is defined as any action or procedure that prevents a person's freedom of movement to a desired position or limits normal access to their own body through manual methods or mechanical devices attached to or adjacent to the patient's body that cannot be easily controlled or removed by the patient. The prevalence of physical fixation use in hospitals shows very wide variations globally, ranging from 6% to 85% in various inpatient wards and can reach 0% to 100% in the ICU.(Cortinhal et al., 2024; Yuliono et al., 2026).

Although physical restraint is applied based on the principle of beneficence and the need to protect patient safety, medical and nursing literature published between 2021 and 2026 highlights significant ethical and clinical tensions associated with its use (Albalat-Rodríguez et al., 2026; Cortinhal et al., 2024; Eladi & Sanga, 2025). On the one hand, nurses are concerned that patients with cognitive impairment, decreased consciousness, somnolence, or delirium may fall from their beds or remove essential medical devices if they are not restrained, particularly when nurse-to-patient ratios are inadequate during night shifts (Al-Qaaneh & others, 2025; Canzan et al., 2021; Salehi et al., 2021). On the other hand, systematic reviews indicate that the routine use of physical restraint is often ineffective in reducing falls and may cause serious secondary injuries, exacerbate agitation, and violate patients' rights to autonomy and human dignity (Abraham et al., 2022; Cortinhal et al., 2024; Montero-Odasso et al., 2022).

For hospitals in Indonesia, especially health service institutions that implement Islamic values and Sharia Hospital Standards(Delina & Oktavianti, 2025)), the dilemma between maintaining the patient's physical safety from the risk of falls and respecting the glory of the patient's body and freedom requires a solid normative foundation. The Maqāṣid al-Syarī'ah (noble goals of Islamic Shari'ah) approach offers a holistic ethical framework for assessing when physical fixation can be justified as an instrument for saving the soul (ḥifẓ al-nafs) and when the practice actually turns into an unjust or detrimental act (ḍarar) that is contrary to the Shari'a(Delina & Oktavianti, 2025). This literature review aims to examine scientific publications from 2021 to 2026, analyze clinical evidence regarding the benefits and risks of physical restraint, and formulate a conceptual ethical-clinical framework for fall prevention based on Maqāṣid al-Syarī'ah and Islamic jurisprudence.

2. Materials and Method

This study employs a literature review approach to explore, analyze, and synthesize scientific and normative evidence regarding the use of physical restraint to reduce the risk of patient falls in hospital settings. The findings are examined from the perspectives of Maqāṣid al-Syarī'ah and the principles of Islamic jurisprudence.

A comprehensive literature search protocol was conducted in reputable international and national academic databases, including PubMed/PMC, the Cochrane Library, MDPI, Oxford Academic, IntechOpen, IIUM Press, and national scientific journals indexed by SINTA/Garuda. The search keywords used a combination of Boolean terms: "physical restraint," "fall prevention," "patient safety," "Maqasid al-Shari'ah," "nursing ethics," and "Islamic health standards."

The inclusion criteria were as follows: (1) original research articles, scoping reviews, systematic reviews, or global clinical guidelines; (2) publications issued between 2021 and 2026; and (3) literature addressing the clinical or psychological impacts of physical restraint or the integration of Islamic nursing ethics and Maqāṣid al-Syarī'ah. Based on these criteria, 18 literature sources were selected for analysis. The selected sources were examined to synthesize clinical findings, map the five principles of Maqāṣid al-Syarī'ah, and explore the application of Islamic jurisprudential principles in emergency situations.

3. Results and Discussion

The theoretical study in this research is based on three main pillars that are mutually integrated in professional nursing practice in hospitals, especially Islamic value-oriented health service institutions and Sharia Hospitals:

Patient Safety Theory and the Restraint Paradox

Within the framework of modern patient safety management which refers to Patient Safety Goal 6 and the global guidelines for falls prevention (World Guidelines for Falls Prevention and Management for Older Adults) fall prevention measures play a vital role in reducing the rate of head injuries, fractures, and length of stay (Montero-Odasso et al., 2022; Kardiahning et al., 2025). Historically, physical restraints such as body harnesses, wrist cuffs, and full bed barriers have been applied as instruments for patient self-protection. However, the restraint paradox theory proves that forced immobilization often triggers counterproductive effects: failing to significantly reduce falls, worsening disorientation and agitation in patients with delirium, triggering pressure ulcers, and causing irreversible impairment in Activities of Daily Living (ADL) functional abilities when applied for more than 72 hours (Abraham et al., 2022; PMC12602471, 2025).

Nursing Bioethics Theory and Patient Autonomy

Clinical decision-making regarding physical fixation is always colored by an ethical dilemma between the principles of beneficence (doing good to save the patient from falling) and non-maleficence (avoiding harm due to fixation injury), and clashes with the principles of autonomy (the patient's right to bodily freedom) and justice (Eladi & Sanga, 2025). Various studies have shown that the use of fixation without empathetic communication and without informed consent involving the family triggers high moral distress in nurses and violates the patient's human dignity (Canzan et al., 2021; Cortinhal et al., 2024).

Maqasid Al Syariah Theory and Fiqh Principles in Islamic Nursing

From the perspective of Islamic law and nursing ethics based on Maqasid al-Shariah, the human body is endowed with inherent dignity (karāmah al-insān) which demands freedom of movement as its original law (Mohamad Ismail et al., 2021; Akmal et al., 2024). The theory of Maqasid al-Shariah classifies human welfare into five pillars of protection (al-ḍarūriyyāt al-khams): safeguarding the soul (ḥifẓ al-nafs), intellect (hifz al-aql), religion (hifz al-din), lineage/family (ḥifẓ al-nasl), and property (ḥifẓ al-mal) (Hashi, 2022).

When there is a conflict between the patient's right to freedom and the threat of death/serious injury, Islamic law applies the theory of rukhsah through the rules of emergency jurisprudence (al-qawā'id al-fiqhiyyah), including:

1. *Al-Ḍarūrāt Tubiḥ al-Maḥẓūrāt*(emergency conditions allow things that were previously forbidden in order to save lives) (Rohim, 2022).
2. *Al-Ḍarūrah Tuqaddar bi Qadarihā*(emergencies must be measured and limited proportionally according to the level of modality and time) (Tasya et al., 2024).

3. *Al-Ḍarar Yuzāl wa Lā Yuzāl bi Mithlih*(the hazard must be eliminated without creating an equivalent or greater hazard) (Montero-Odasso et al., 2022).

Clinical Review and Current Scientific Evidence: Physical Fixation, Fall Risk, and Iatrogenic Complications

In medical-surgical, neurology, geriatric, and intensive care nursing practices, physical fixation is applied through various mechanical devices with varying degrees of movement restriction. An accurate understanding of the benefit-risk profile of each fixation modality is crucial because establishing sharia law regarding a medical procedure requires clear empirical evidence (taḥqīq al-manāṭ) regarding its clinical impact on the patient's body.(Delina & Oktavianti, 2025)).

Classification of Physical Fixation Modalities and Evidence of Their Effectiveness on Fall Risk

Based on clinical literature published between 2021 and 2026, several physical restraint modalities have been identified for fall prevention and therapeutic safety (Albalat-Rodríguez et al., 2026; Cortinhal et al., 2024; National Library of Medicine, 2025; Tasya et al., 2024).:

Table 1. Classification of Physical Fixation Modalities, Fall Prevention Effectiveness, and Clinical Complications.

Physical Fixation Modalities	Main Clinical Indications	Evidence of Fall Prevention Effectiveness	Iatrogenic Risks & Complications (Physical & Psychological)
Body Restraint / Vest & Belt Restraint (Chest/Waist Safety Belt)	Patients with decreased consciousness (somnolence/delirium) or post-neurosurgical surgery (e.g. Subarachnoid Hemorrhage) with a high Morse Fall Scale score (≥45–75) (Tasya et al., 2024).	Effective in keeping patients in bed in the short term (±24–72 hours) if accompanied by close monitoring in the ICU/HCU, but high risk if installed without monitoring (Tasya et al., 2024).	Pressure ulcers, thoracic compression/impaired lung expansion, constipation, incontinence, and risk of asphyxia/strangulation if the patient slumps over the edge of the bed (Cortinhal et al., 2024; PMC12602471, 2025).
Physical Fixation Modalities	Main Clinical Indications	Evidence of Fall Prevention Effectiveness	Iatrogenic Risks & Complications (Physical & Psychological)
Wrist & Ankle Restraints	Acute agitation in the ICU/ER to prevent dislodgment of endotracheal tubes (ETT), NGT tubes, central venous catheters, or falls during severe agitation (Canzan et al., 2021; Al-Qaaneh et al., 2025).	Preventing temporary device removal does not address the root cause of agitation/falls and often triggers greater physical resistance from the patient (Canzan et al., 2021).	Extremity edema, hematoma, skin lesions (58.5%), prolonged capillary refill time, leg ischemia, compression neuropathy, rhabdomyolysis and deep vein thrombosis (Cortinhal et al., 2024; Al-Qaaneh et al., 2025).
Full-Length Bilateral Bed Rails	Standard fall prevention for elderly patients, those with mobility impairments, or mild-moderate cognitive impairment in the inpatient ward.	Creating a false sense of security. The World Fall Prevention Guidelines (Montero-Odasso et al., 2022) confirm that full barriers have not been proven to reduce falls in delirious patients.	Patients with dementia/delirium often attempt to climb over bed rails, resulting in falls from more dangerous heights and increasing the risk of fractures/severe head trauma (PMC12602471, 2025).
Mitten Restraints (Fingerless Medical Gloves) & Geriatric Chair with Locking Table	Minimal restraint alternatives to prevent patients from scratching the surgical wound/removing the IV	Safer and more acceptable than limb restraints, locked chairs still limit functional mobility with prolonged use (Abraham et al., 2022).	Continuous use >72 hours triggers rapid muscle atrophy, irreversible decline in activities of daily living (ADL), feelings of

or sliding out of the wheelchair.	isolation, and depression (PMC12602471, 2025).

The Restraint Paradox and Its Multidimensional Impact

Systematic review(Delina & Oktavianti, 2025))and World Guidelines for Falls Prevention and Management for Older Adults by Montero-Odasso et al. (2022)revealed an important clinical phenomenon known as the restraint paradox. Although nurses apply physical restraints with the intention of protecting patients from falls, empirical evidence suggests that forced immobilization actually accelerates physical deconditioning (loss of muscle mass and postural balance), induces orthostatic hypotension, and increases the severity of injuries when agitated patients attempt to escape or jump over the bed barrier.(Delina & Oktavianti, 2025)). A recent study in PMC12602471 (2025) even noted that irreversible decline in the ability to perform activities of daily living (ADL) can occur after just 72 hours of continuous use of physical fixation.

In addition to physical consequences, the scoping review by Cortinhal et al., (2024) identified significant psychological and social impacts associated with physical restraint, affecting three groups:: (1) in patients, physical fixation triggers feelings of violated dignity, loss of autonomy, fear, anger, anxiety, worsening delirium, post-traumatic stress disorder (PTSD), and a sense of abandonment; (2) in patients' families, witnessing a family member being tied to a bed causes emotional trauma and shame, especially when done without prior notice (Open Nursing Journal, 2025); and (3) in nurses themselves, the act of binding patients causes moral ambivalence, guilt (reported by 62.1% of nurses in the Open Nursing Journal study, 2025), emotional exhaustion (burnout), and moral distress due to the conflict between the demands of maintaining ward security and the humanitarian values of the nursing profession.(Delina & Oktavianti, 2025).

However, an Indonesian clinical case study by Tasya et al., (2024), conducted among postoperative subarachnoid hemorrhage (SAH) patients in the intensive care unit of PKU Muhammadiyah Hospital Yogyakarta, reported that physical restraint was applied in a specific short-term clinical situation. The patient had somnolent consciousness (GCS E2M5V2 to E3M4V2), a high Morse Fall Scale score (75), and a risk of intracranial rebleeding following a fall. In this case, body restraint was applied during the acute phase for three consecutive days, with daily evaluation and discontinuation after the patient's condition stabilized. The case report indicated that this intervention was used to maintain patient safety without reported secondary injury. These findings indicate that legal and ethical assessments of physical fixation cannot be generalized in a black-and-white manner, but must be weighed casuistically and proportionally through the Maqāṣid al-Syarī'ah framework. Key Clinical Evidence Findings (2021–2026)

Physical restraint should not be considered a first-line intervention for fall prevention. The reviewed literature highlights potential complications associated with its routine use without clear emergency indications, including physical injury, deterioration in functional ability, worsening delirium, and violations of patient dignity. Therefore, physical restraint should be considered only as a short-term, last-resort intervention in specific acute clinical situations, accompanied by appropriate monitoring and periodic reassessment (Delina & Oktavianti, 2025).

The Legal Construction of the Origin of Freedom of Movement, Human Glory (Karāmah al-Insān), and the Status of Physical Fixation in Islamic Jurisprudence

In Islamic jurisprudence (fiqh), the human body is a sacred trust from Allah SWT which is bestowed with inherent nobility (karāmah al-insān), as stated by Allah SWT in the Qur'an, Surah Al-Isrā' [17]: 70 ("And indeed, We have honored the children of Adam..."). As a consequence of this nobility, the basic law for every human being is freedom of movement and action (al-aṣl fī al-insān al-ḥurriyyah) and the prohibition of all forms of physical restraint (al-ḥajr aw al-taqyīd al-jasadī) or actions that harm the body without a justifiable reason according to sharia.(Delina & Oktavianti, 2025)).

If a medical professional or nurse binds the body parts of a conscious and competent patient without his consent and without the existence of a life-threatening medical emergency, then in Islamic jurisprudence this action is categorized as a violation of self-respect (i'tidā' 'alā al-nafs wa al-karāmah) and a prohibited deprivation of liberty.(Cortinhal et al., 2024; Eladi & Sanga, 2025)However, Islamic law also stipulates a collective and professional obligation for health workers to maintain the safety of patients who are experiencing physical weakness or loss of rational capacity (such as patients in a state of acute delirium, encephalopathy, severe dementia, or decreased somnolence after brain surgery) so that they do not harm themselves (QS. Al-Baqarah [2]: 195 and QS. Al-Nisā' [4]: 29)(Delina & Oktavianti, 2025)).

Thus, in the construction of contemporary health jurisprudence, the legal status of the use of physical fixation to reduce the risk of falling is divided into three gradations of taklīfī law which depend on the clinical indications and the method of implementation.(Delina & Oktavianti, 2025)):

1. Haram / Forbidden (Maḥẓūr): When physical fixation is used solely for staff convenience or as a substitute for lack of nursing supervision (staff convenience), is applied to patients who are still cooperative and can be educated with non-restrictive interventions, is applied too tightly to cause ischemia or tissue lesions, or is left in place continuously without regular evaluation and without informed consent of the family/guardian(Delina & Oktavianti, 2025)).
2. Makruh (Not Recommended): When equally effective non-invasive fall prevention alternatives are available (such as low-height beds, floor mattresses, motion sensor alarms, or family support at the bedside), healthcare professionals still choose mechanical fixation that limits patient comfort.(Delina & Oktavianti, 2025)).
3. Mubah to Temporary Obligatory (Rukhsah on the Basis of Ḍarūrah / Ḥājah Syar'iyyah): If the patient is in a state of impaired consciousness or acute neuro-psychiatric agitation with a very high risk of falling and threatening life/vital organs (e.g. post-craniotomy or subarachnoid hemorrhage in the ICU/HCU), all non-restrictive alternatives are proven inadequate to ensure patient safety, and fixation is performed with the safest device (least restrictive device), flat/padded, accompanied by guardian approval and regular monitoring every 2 hours.(Delina & Oktavianti, 2025)).

Analysis of the Five Principles of Maqāṣid al-Syarī'ah (Al-Kulliyyāt al-Khams) in the Use of Physical Fixation for Fall Prevention

As formulated by Mohamad Ismail et al. (2021) in the concept of Towards Maqasid al-Shari'ah Based Nursing Ethics and Hashi (2022) and(Delina & Oktavianti, 2025))Akmal et al. (2024), every nursing intervention must be evaluated through its ultimate goal (maqāṣid) towards maintaining the five basic human needs (al-ḍarūriyyāt al-khams). In the case of the

use of physical fixation to prevent a patient from falling, the five dimensions of Maqāṣid al-Syarī'ah provide very comprehensive analytical guidelines as follows:

Ḥifẓ al-Nafs (Preservation of the Soul and Safety of the Body): Weighing the Risk of Falling vs. the Risk of Injury from Fixation

The main goal of fall prevention in hospitals is ḥifẓ al-nafs, namely protecting the life and integrity of the patient's limbs from fatal trauma resulting from falling from bed, such as secondary intracranial bleeding, hip fracture, or the removal of crucial life support equipment.(Delina & Oktavianti, 2025)). From the perspective of Maqāṣid al-Syarī'ah, leaving a patient who is experiencing decreased consciousness (somnolence/stupor) or severe agitation without adequate protection until they fall is a form of negligence (tafrīṭ) which violates the obligation to protect the soul.(Delina & Oktavianti, 2025)).

However, the analysis of ḥifẓ al-nafs does not stop at the intention of preventing falls alone, but must also consider the negative risks of the fixation instrument itself. A study by Al-Qaaneh et al. (2025) on 230 ICU nurses in Jordan revealed that 58.5% of patients who were fixed experienced skin ulceration and severe anxiety, while a study(Cortinhal et al. 2024)and PMC12602471 (2025) documented the risk of limb ischemia, venous thromboembolism, aspiration pneumonia (due to the fixed supine position), and even death due to mechanical asphyxia. Furthermore, ḥifẓ al-nafs in Islam includes maintaining human dignity (ḥifẓ al-karāmah al-insāniyyah). Therefore, in order for physical fixation to truly realize ḥifẓ al-nafs and not turn into a body destroyer, its use must be limited only to indications of a real high risk of falling, using soft protective materials (padded cuffs/vests), periodically releasing the straps for range of motion (ROM) exercises and checking peripheral circulation (capillary refill time, pulse, temperature, and skin color), and immediately discontinuing the fixation once the patient's fall risk score or level of consciousness improves.(Tasya et al., 2024; Cortinhal et al. 2024).

Ḥifẓ al-'Aql (Preservation of Reason, Prevention of Delirium, and Respect for Patient Autonomy)

The dimension of ḥifẓ al-'aql has a very close two-way relationship with the practice of physical fixation. First, from the perspective of the patient's legal capacity status (ahliyyat al-adā'): most patients who require physical fixation for fall prevention are patients who are experiencing acute or chronic cognitive dysfunction, such as ICU delirium, dementia, traumatic brain injury, or metabolic encephalopathy.(Delina & Oktavianti, 2025)). Because the patient's rational capacity is impaired, so that he is unable to recognize the danger of falling that threatens him, Islamic law transfers the responsibility for protection to the patient's guardian and medical personnel through the mechanism of medical guardianship (wilāyat al-ṭibb).(Delina & Oktavianti, 2025)).

Second, in terms of the impact of intervention on the patient's mental health and cognitive function: the literature of the last 5 years has consistently shown that physical restraint carried out without therapeutic communication and without adequate pain/anxiety management actually worsens cognitive disorientation, triggers or aggravates hyperactive delirium, and causes psychological trauma.(Delina & Oktavianti, 2025)). Within the framework of ḥifẓ al-'aql, medical procedures should not harm the patient's mental stability and clarity of reason. Therefore, the application of the principle of ḥifẓ al-'aql requires that nurses first address the patient's acute confusion triggers such as hypoxia, urinary retention, post-operative pain, electrolyte disturbances, or sleep deprivation, as well as perform cognitive reorientation and bring in family members to calm the patient's mind before deciding on the installation of physical fixation.(Delina & Oktavianti, 2025)).

Ḥifẓ al-Dīn (Maintenance of Religion: Facilitation of Worship, Thaharah, and Protection of the Awrah of Patients Who Are Fixed)

One of the most distinctive contributions from the perspective of Maqāṣid al-Sharī'ah and Sharia Hospital Standards(Delina & Oktavianti, 2025))rarely discussed in Western bioethical literature is the impact of physical fixation on the religious rights of Muslim patients (ḥifẓ al-dīn). When both hands or body of a Muslim patient are tied to the side of the bed, the patient loses the ability to independently perform purification (ṭahārah/wudu or tayammum), maintain personal hygiene from impurity due to urinary/fecal incontinence, cover his or her private parts when the blanket is removed when struggling, or perform prayer movements according to his ability.(Delina & Oktavianti, 2025)).

In ḥifẓ al-dīn's review, physical restraints cause patients to be left unclean (due to the increased risk of incontinence in tied patients as found by(Delina & Oktavianti, 2025))exposing one's private parts in the treatment room is a serious violation of the dignity of the believer. Therefore, if physical fixation is forced due to emergency indications of fall prevention, the nurse bears the sharia obligation (wājib bi al-ghayr) to: (1) ensure that the patient's clothing and blanket always cover the private parts perfectly even though the extremities are fixed; (2) carry out routine examinations and elimination cleaning (istinja/diaper changes or catheter care) so that the patient remains pure from impurities; (3) help patients who are still conscious to perform tayammum and perform prayers in a lying position; and (4) provide spiritual interventions such as murottal Al-Qur'an and dhikr which have been clinically proven to reduce patient agitation and anxiety so that the need for physical fixation can be reduced.(Delina & Oktavianti, 2025)).

Ḥifẓ al-Nasl / al-Usrah (Family Care: Empathetic Communication, Informed Consent, and Family Partnership)

The dimension of ḥifẓ al-nasl (protection of family and descendants) highlights the central role of the family as the primary support system for the patient as well as the party emotionally affected by the physical fixation procedure.(Delina & Oktavianti, 2025)). A recent cross-sectional study in The Open Nursing Journal (2025) revealed that 81.8% of nurses acknowledged family authority in making fixation decisions, but 66.7% of nurses reported embarrassment and conflict when families discovered the patient had been restrained without prior notification or discussion.

Through the framework of ḥifẓ al-usrah, family involvement is not merely an administrative formality of signing an informed consent form, but rather a key therapeutic strategy for reducing the use of physical fixation itself.(Delina & Oktavianti, 2025)). The presence of a family member at the bedside (bedside family presence) to hold the patient's hand, speak to the patient in a familiar voice, and monitor the patient's movements is the most humane alternative that significantly reduces patient anxiety and prevents the patient from getting out of bed without supervision.(Delina & Oktavianti, 2025)). If physical fixation is still necessary during critical hours, transparent and empathetic education to the family regarding the goals of patient safety protection has been shown to reduce psychological trauma for the family and build trust between the family and the nursing team.(Delina & Oktavianti, 2025)).

Ḥifẓ al-Māl (Protection of Wealth: Prevention of Cost Burdens Due to Injuries from Falls and Complications of Immobilization)

The dimension of ḥifẓ al-māl (preservation of wealth) demands the management of the financial resources of patients, families, and the health system efficiently and free from financial harm.(Delina & Oktavianti, 2025)). In the context of fall prevention, ḥifẓ al-māl works on two sides of the health economic balance:

1. Preventing Financial Losses Due to Patient Fall Incidents:Hospital falls resulting in femoral neck fractures or subdural hemorrhage require additional surgical intervention, drastically prolong hospital stays, and multiply the cost of care, burdening both the family and the hospital.(Delina & Oktavianti, 2025)).
2. Preventing Iatrogenic Complications Costs Due to Excessive Fixation:On the other hand, the use of inappropriate physical fixation for more than 72 hours can trigger nosocomial complications such as pressure ulcers, urinary tract infections, pneumonia, and loss of functional independence (ADL) which also prolongs hospitalization and drains long-term rehabilitation costs.(Delina & Oktavianti, 2025)). Therefore, hospital management investment in staff training, provision of low beds, and motion detection sensors is a much more sustainable realization of ḥifẓ al-māl than reliance on mechanical fixation.(Delina & Oktavianti, 2025)).

Table 2. Operational Mapping of the Five Principles of Maqāṣid al-Syarī'ah in the Use of Physical Fixation to Reduce the Risk of Falls.

Dimensions of Maqāṣid	Potential Violation / Mafsadah due to Improper Fixation	Standards for Realizing Maslahah in Fall Risk Prevention	Key Literature References (2021–2026)
Ḥifẓ al-Nafs (Soul & Dignity)	Skin lesions (58.5%), edema, leg ischemia, decubitus ulcers, entanglement asphyxia, and humiliation of body dignity (karāmah al-insān).	Protect lives from post-operative/ICU fatal fall trauma using the least restrictive (padded) equipment and circulatory evaluation every 2 hours.	Cortinhal et al. (2024); Tasya et al. (2024); Al-Qaaneh et al. (2025); Open Nursing Journal (2025).
Ḥifẓ al-'Aql (Reason & Autonomy)	Exacerbating delirium, agitation, fear, depression, PTSD, and violating the autonomy of patients who are still competent.	Address organic causes of delirium (pain/hypoxia), respect the guardian's autonomy/consent, and minimize the duration of immobilization (<72 hours).	PMC12602471 (2025); Eladi & Sanga (2025); Canzan et al. (2021); Asriyani et al. (2025).
Ḥifẓ al-Dīn (Religion & Purity)	Patients are left in a state of impurity (incontinence), their private parts are exposed when they are anxious, and they are prevented from worship.	Maintaining strict genital covering, assisting with periodic ṭahārah/cleanliness imperatives, facilitating tayammum/prayer, and murattal therapy.	Asriyani et al. (2025); Akmal et al. (2024); DSN-MUI & MUKISI (2025); Mohamad Ismail et al. (2021).
Ḥifẓ al-Nasl (Family)	Psychological trauma and shame for families when they see patients tied up without education and informed consent.	Involving the family in shared decision-making and optimizing family presence at the bedside as a non-restrictive alternative.	Canzan et al. (2021); Open Nursing Journal (2025); Salehi et al. (2021); Cortinhal et al. (2024).
Ḥifẓ al-Māl (Property & Resources)	Swelling of medical costs due to fall injuries or complications of prolonged immobilization (decubitus & loss of ADL).	Implement evidence-based multifactorial fall prevention and invest in safe and efficient alternative training/means.	Montero-Odasso et al. (2022); Abraham et al. (2022); Hashi (2022); Albalat-Rodríguez et al. (2026).

Operationalization of the Principles of Islamic Jurisprudence (Al-Qawā'id al-Fiqhiyyah) and Standards of Sharia Hospitals in Indonesia

1. **Five Islamic Jurisprudence Principles Controlling the Practice of Physical Fixation**

In Islamic jurisprudence, the transition of the legal status of physical fixation from a prohibited act of restricting liberty to a justified intervention for the protection

of safety is strictly controlled by five main mechanical fiqh rules.(Delina & Oktavianti, 2025)).

2. **Al-Ḍarūrāt Tubīḥ al-Maḥẓūrāt (Emergency conditions permit things that were previously prohibited)**

   Restricting a person's physical movement is inherently prohibited. However, when a patient experiences a decrease in consciousness, such as somnolence-delirium, or acute agitation that poses a real threat (muhaqqaq) of falling out of bed and suffering a brain hemorrhage or fatal injury, the medical emergency permits the use of physical restraint to save the patient's life.(Delina & Oktavianti, 2025))

3. **Al-Ḍarūrah Tuqaddar bi Qadarihā (Emergency conditions must be limited according to their size)**

   This principle is the most crucial control against the misuse of physical fixation in hospitals. The permissibility of physical fixation is not absolute, but is limited by three parameters of degree: (a) the degree of modality, which requires the use of the least restrictive device (least restrictive alternative, for example, medical gloves or a loose, protective waist belt, rather than a full quadruple restraint if not necessary); (b) the degree of time, which requires evaluation every 2 hours and discontinuation as soon as the acute condition is resolved (before exceeding the 72-hour threshold that impairs ADL); and (c) the degree of indication, which requires its permissibility to be revoked once the patient regains consciousness (mā jāza li 'udhrin baṭala bi zawālihi — what is permitted due to an excuse, becomes permissible when the excuse is removed).(Delina & Oktavianti, 2025)

4. **Al-Ḍarar Yuzāl wa Lā Yuzāl bi Mithlih aw bi Mā Huwa Akbar Minhu (Danger must be removed, but it must not be removed with an equal or greater danger)**

   The risk of falling is a danger (ḍarar) that nurses must prevent. However, nurses are prohibited from preventing the risk of falling in ways that actually cause the same or more fatal danger, such as installing a full bed barrier without supervision for a dementia patient who actively climbs (thus falling from a higher place), or binding the wrist with a coarse gauze rope that causes ischemic necrosis of the tissue.(Delina & Oktavianti, 2025)).

5. **Irtikāb Akhaff al-Ḍararayn (Choosing the lightest harm between two harms)**

   If health workers in the ICU or neurosurgical ward are faced with two choices that both carry risks—namely the harm of temporarily restricting the patient's freedom of movement with body restraints or the harm of allowing a patient after Subarachnoid Hemorrhage surgery to fall and experience brain herniation—then sharia requires choosing the lesser harm (namely temporary restriction of movement that is safe and monitored) in order to avoid the harm of death or permanent disability.(Delina & Oktavianti, 2025)).

6. **Al-Umūr bi Maqāṣidihā (Everything depends on the goal/intention**

   The ethical validity of physical fixation is determined by its clinical motivation. If the fixation is applied purely to protect patient safety (patient-centered safety), then the action is considered an act of worship and has beneficial consequences. Conversely, if the fixation is applied as a form of punishment for a fussy patient or simply to reduce the nurse's workload (staff-centered convenience) so that the patient

is not monitored, then such intentions deviate from the Maqāṣid al-Syarī'ah and cannot be justified according to Islamic nursing ethics.(Delina & Oktavianti, 2025)).

Integration with the Indonesian Ministry of Health Hospital Accreditation Standards and Sharia Hospital Standards (DSN-MUI & MUKISI)

In Indonesia, the implementation of fall risk management (Patient Safety Target/SKP 6) and patient care with restraints are regulated in the Hospital Accreditation Standards of the Indonesian Ministry of Health and are enriched by the Sharia Hospital Certification Standards and Instruments Version 1447 H which was jointly published by the National Sharia Council of the Indonesian Ulema Council (DSN-MUI) and the All-Indonesia Islamic Health Effort Council (MUKISI, 2025).(Delina & Oktavianti, 2025))The synergy of these two regulatory instruments requires hospitals to:

1. Standardized Fall Risk Screening:Conduct initial assessment and reassessment of fall risk using validated instruments (Morse Fall Scale for adults, Humpty Dumpty for children, and Sydney Scoring/Edmonson for geriatrics/psychiatrics) whenever there is a change in clinical condition or after administration of sedative/anesthetic drugs.(Delina & Oktavianti, 2025)).
2. Informed Consent Syar'i and Family Education:Provide an honest, polite (qaulan layyinan), and comprehensive explanation to the patient/guardian regarding the medical reasons for the restraints, the alternatives that have been tried, and the monitoring procedures before requesting written consent.(Delina & Oktavianti, 2025)).
3. Maintaining the Hijab, Aurat, and Purity of Patients During Fixation:Ensure that physical fixation is carried out by paying attention to gender equality of officers (ikhtilāṭ/khalwat protection as much as possible), covering the patient's genitals completely, maintaining the purity of the patient's bed and clothing from impurities, and documenting the evaluation of the release of restraints in an orderly manner in the electronic medical record.(Delina & Oktavianti, 2025)).

Results of a Search of Trusted Literature Sources for the Last 5 Years (2021–2026)

A systematic literature search was conducted across reputable academic databases (PubMed/PMC, Cochrane Library, MDPI, Oxford Academic, IntechOpen, IIUM Press, and SINTA/Garuda-indexed national journals) over the past five years (2021–2026). A total of 18 relevant primary literature sources were verified and synthesized in Table 3 as the basis for this paper.

Table 3. Main Literature Synthesis Matrix for the Last 5 Years (2021–2026) on Maqāṣid al-Syarī'ah, Physical Fixation, and Fall Risk Prevention.

Author & Year	Journal / Source	Focus & Study Method	Key Findings Related to Physical Fixation, Fall Risk, & Maqāṣid al-Syarī'ah
Albalat-Rodríguez et al. (2026)	Healthcare (Basel), 14(5), 694 (PMC12984303)	A cross-sectional diagnostic study (n=241 healthcare workers) of knowledge, documentation, and patient safety in physical fixation.	Revealing that 54.8% of staff had not received formal training in physical restraint and only 32.9% documented restraint release; it emphasized the humanization of care and adherence to protocols to maintain patient dignity and safety.
Eladi & Sanga (2025)	IntechOpen (Book Chapter)	Critical analysis of bioethical principles (beneficence, non-maleficence, autonomy, justice) and	Affirming that physical fixation limits basic human freedoms and must therefore be preceded by valid informed

		informed consent in physical fixation.	consent (except in acute emergencies), evaluation of non-restrictive alternatives, and respect for the patient's dignity.
Al-Qaaneh et al. (2025)	Journal of Client-Centered Nursing Care, 11(1)	A cross-sectional study of 230 ICU nurses in 4 hospitals in Jordan on the practice of physical fixation and its alternatives.	Found that complications of skin ulceration and anxiety occurred in 58.5% of patients who were fixed; nursing training was significantly correlated ($p<0.001$) with the use of non-restrictive alternatives before applying physical fixation.
The Open Nursing Journal (2025)	Open Nursing Journal, 19, e1874434642640	A quantitative study of knowledge, attitudes, and practices of critical care nurses in Jordan towards physical fixation.	Revealing that 77.3% of nurses were aware that physical fixation compromised patient dignity, 62.1% felt guilty when restraining patients, and only 59.1% were aware of the obligation to re-evaluate every 2 hours.
PMC12602471 (2025)	Narrative Review (PMCID: PMC12602471; PMID: 41229556)	A narrative review of risk prediction models of physical fixation in the elderly and the adverse effects of immobilization.	Demonstrating the existence of a restraint paradox: a full bed barrier can increase the risk of fatal falls when patients climb, and continuous fixation >72 hours causes irreversible decline in activities of daily living (ADL) function.
Asyiani et al. (2025)	Window of Nursing Journal, 6(2), 142–146	Qualitative study of the application of Maqāṣid al-Syarīʿah in critical neurological patients (hemorrhagic stroke) in the critical care room.	Shows that the integration of hifẓ al-nafs, hifẓ al-ʿaql, and hifẓ al-dīn through family collaboration and spiritual intervention (Qur'an recitation) stabilizes the patient's psychological condition/consciousness and prevents the harm of clinical actions.
Kardianing et al. (2025)	Journal of Professional Nursing Research, 7(4)	Literature review of patient safety risk management implementation (including fall risk) in Indonesian hospitals.	Emphasizes the importance of proactive risk identification, periodic fall scale assessments, and safe environmental modifications to prevent patient injury in hospitals.
DSN-MUI & MUKISI (2025)	Sharia Hospital Certification Standards & Instruments Version 1447 H	National guidelines for the implementation of hospital services based on Maqāṣid al-Syarīʿah in Indonesia.	Integrating the quality and patient safety standards of the Indonesian Ministry of Health with the protection of the five pillars of Maqāṣid (religion, soul, mind, descendants, and wealth), including maintaining the aurat, ṭahārah, and sharia education for high-risk patients.
Cortinhal, Correia, & Fernandes (2024)	Int. J. Environ. Res. Public Health, 21(1), 75 (PMC10815796)	Scoping review (JBI methodology) of 18 studies on nurses' ethical decision-making in adult physical fixation.	Mapping the physical impact (hematoma, edema, ischemia, decubitus ulcers, aspiration, fracture, incontinence), psychological (delirium, depression, loss of dignity), as well as moral distress of nurses due to the conflict between security vs. freedom of movement.

Tasya, Hidayati, & Munif (2024)	An-Najat Journal: Journal of Pharmaceutical and Health Sciences, 2(4), 124–134	Clinical intervention case study of body restraint application in high-risk patients with falls after Subarachnoid Hemorrhage (SAH) surgery.	Proving that in somnolent patients (GCS E2M5V2–E3M4V2) with a Morse Fall score of 75 in the ICU of PKU Muhammadiyah Hospital Yogyakarta, the installation of measured body restraint for 3 days protects patients from falling and is stopped immediately when the risk decreases.
Akmal et al. (2024)	Ijtihad, 18(2), 67–75	Conceptual study of nursing care from the perspective of Maqāṣid al-Syarīʻah.	Placing al-ḍarūriyyāt al-khams as the ethical foundation of nursing care demands a balance between protecting the patient's physical safety (hifẓ al-nafs) and respecting the patient's dignity and intellect.
Abraham, Möhler, et al. (2022)	Cochrane Database of Systematic Reviews, 8(8), CD012476 (PMC9404383)	Cochrane systematic review of interventions to prevent and reduce the use of physical fixation in older adults at home.	Concluded that physical fixation was not proven effective in preventing falls in general hospitals and actually worsened mobility and triggered falls.
Montero-Odasso et al. (2022)	Age and Ageing, 51(9), afac205 (PMC9523684)	Global consensus guidelines (World Guidelines) for the prevention and management of falls in older adults.	Recommends personalized multicomponent fall prevention (environmental modification, balance training, medication review, delirium management) and rejects the use of routine physical fixation as a fall prevention method.
Hashi (2022)	Malaysian Journal of Medicine and Health Sciences, 18(s19), 198–204	Analysis of clinical applications of Maqāṣid al-Syarīʻah in hospital health services.	Explains how the five objectives of sharia (hifẓ al-dīn, al-nafs, al-ʻaql, al-nasl, al-māl) are used to weigh the benefits and mafsadat of each clinical procedure that risks limiting the patient's rights.
Rohim (2022)	Nurani: Journal of Sharia and Community Studies, 22(1), 63–80	Analysis of the implementation of the rules of emergency jurisprudence (ḍarūrah) in realizing Maqāṣid al-Syarīʻah.	Describes the valid conditions of emergency conditions (real threat, absence of halal/non-restrictive alternatives, and restrictions according to the level of al-ḍarūrah tuqaddar bi qadarihā) as the basis for rukhsah in medical actions.
Mohamad Ismail et al. (2021)	International Journal of Care Scholars (IIUM), 4(2), 83–88	Formulation of nursing ethics based on Maqāṣid al-Syarīʻah (Maqasid al-Shariʻah Based Nursing Ethics).	Integrating the principles of modern nursing ethics with Maqāṣid al-Syarīʻah through evaluation of intentions (qaṣd), methods of action (wasīlah), and final results (ma'āl) so that nursing care does not harm human dignity.
Canzan et al. (2021)	Int. J. Environ. Res. Public Health, 18(18), 9646 (PMC8464991)	An in-depth qualitative study of 20 intensive care nurses on perceptions and dilemmas of physical fixation use.	Demonstrating that communication with family, adequate nurse-patient ratio (1:1 or 1:2), and placement of physical fixation solely as a last option are crucial to preventing patient and nurse distress.
Salehi et al. (2021)	Journal of the Intensive Care Society, 22(1), 34–40 (PMC7890764)	A qualitative study of the challenges of using physical	Revealing that the lack of non-restrictive alternative equipment, high workload,

fixation in the ICU in Iran (a Muslim-majority country).	and the absence of clinical audit guidelines led to the overuse of physical fixation and triggered ethical-religious conflicts in nurses.

Maqāṣid al-Syarī'ah-Based Clinical-Ethical Protocol: The "Restraint-as-Last-Resort" Algorithm in Fall Prevention

Based on the synthesis of clinical findings and the principles of Maqāṣid al-Syarī'ah, this review proposes a conceptual ethical-clinical framework that positions physical restraint as a last-resort intervention for fall prevention in hospital settings. The proposed framework consists of five operational stages intended to support clinical and ethical decision-making.:

1. **Stage 1: Comprehensive Fall Risk Assessment and Identification of Reversible Causes (Ḥifẓ al-'Aql & Ḥifẓ al-Nafs)**

   Perform a fall risk assessment using a standardized instrument (e.g., Morse Fall Scale) while screening for causes of restlessness/delirium that can be corrected without restraint, such as acute pain, hypoxia, a full bladder, hypoglycemia, side effects of sedative/anticholinergic medications, or the need to use the bathroom.(Delina & Oktavianti, 2025)).

2. **Phase 2; Optimizing Non-Restrictive Fall Prevention Interventions (Dar' al-Mafāsid)**

   Before considering physical fixation, implement a non-invasive fall prevention bundle: position the bed at the lowest height (low position), install a protective mattress next to the bed if necessary, use subdued room lighting, keep the call bell and patient's personal belongings close, activate the bedside sensor alarm, facilitate the presence of family members at the bedside (bedside family presence), and provide spiritual calming therapy (Quran recitation / therapeutic communication).(Delina & Oktavianti, 2025)).

3. **Stage 3: Verification of Emergency Indications (Ḍarūrah) and Sharia Informed Consent (Ḥifẓ al-Nasl)**

   If a patient experiences decreased consciousness, somnolence, delirium, or acute agitation following major surgery, such as post-craniotomy or subarachnoid hemorrhage (SAH), and non-restrictive interventions are insufficient to prevent a potentially life-threatening fall, the indication for physical restraint should be assessed collaboratively by the attending physician (DPJP) and nursing staff. The purpose, potential risks, and available alternatives should be explained empathetically. Informed consent should be obtained from a patient with decision-making capacity or, when the patient lacks such capacity, from an authorized surrogate, while emergency exceptions should be considered in accordance with applicable clinical and legal requirements.(Delina & Oktavianti, 2025).

4. **Stage 4; Proportional Application (Al-Ḍarūrah Tuqaddar bi Qadarihā) and Safeguarding Shar'i Rights (Ḥifẓ al-Dīn)**

   Choose the least restrictive fixation device (such as mitts or padded body restraints), avoid using full bed restraints without supervision on patients who are able to climb, ensure the patient's private parts are tightly covered, and regularly maintain the patient's body cleanliness from impurities.(Delina & Oktavianti, 2025).

5. **Stage 5; Close Monitoring Every 2 Hours and Early Discontinuation (<72 Hours) (Al-Ḍarar Yuzāl)**

Perform structured observations every 2 hours, including peripheral perfusion (CRT, pulse, temperature, skin color), skin integrity, hydration, nutrition, and elimination needs, as well as range of motion (ROM) exercises. Re-evaluate readiness for removal of fixation at each shift and immediately discontinue physical fixation once the acute condition has resolved to avoid exceeding the 72-hour threshold that triggers irreversible decline in ADL function.(Open Nursing Journal, 2025; PMC12602471, 2025; Albalat-Rodríguez et al., 2026).

4. Conclusion

Based on a search of scientific literature sources over the past 5 years (2021–2026) and a normative analysis based on Maqāṣid al-Syarī'ah regarding the use of physical restraint to reduce the risk of falls in patients, four main points can be concluded:

1. Clinical Paradoxes and Shifting Scientific Evidence (2021–2026):Recent scientific evidence confirms that the routine use of physical fixation is not an effective method for reducing falls in hospitals, and even carries the risk of physical injury (skin lesions in 58.5% of cases, edema, ischemia, pressure ulcers, irreversible decline in ADL after 72 hours) and psychological trauma (delirium, agitation, loss of self-esteem). Physical fixation is only effective when used selectively, for a short duration, and with close monitoring in patients with acute phase impaired consciousness/agitation who are at high risk of falls.
2. Legal Status of Fiqh and Emergency Rules (Ḍarūrah):The basic law of human body binding is prohibited because it is contrary to human dignity (karāmah al-insān) and basic freedom. However, based on the principle of al-ḍarūrāt tubīḥ al-maḥẓūrāt and irtikāb akhaff al-ḍararayn, physical fixation becomes permissible or temporarily obligatory if there is a real threat of fatal fall in a patient who has lost his conscious capacity and all non-restrictive alternatives have failed, with the strict limitations of the principle of al-ḍarūrah tuqaddar bi qadarihā (proportional to the minimum amount of time and modality).
3. Harmony of the Five Principles of Maqāṣid al-Syarī'ah:Decision-making regarding physical fixation must simultaneously balance the five objectives of sharia: protecting the safety of the soul and physical integrity without harming the patient's dignity (ḥifẓ al-nafs), preventing the worsening of delirium and respecting medical autonomy/guardianship (ḥifẓ al-'aql), maintaining the covering of the genitals, purity from impurity (ṭahārah), and facilitating the worship of the fixated patient (ḥifẓ al-dīn), involving the family through empathetic informed consent and bedside presence (ḥifẓ al-nasl), and preventing wasteful costs due to fall injuries and immobilization complications (ḥifẓ al-māl).
4. Implementation Recommendations in Hospitals: The proposed Maqāṣid al-Syarī'ah-based Restraint-as-Last-Resort framework may serve as a conceptual reference for developing hospital fall prevention policies. Further clinical evaluation and validation are required before its integration into standard operating procedures. Hospitals should also consider strengthening nurses' ethical-clinical competencies, providing non-restrictive alternatives, and implementing appropriate monitoring and documentation practices in accordance with applicable clinical standards.

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