

College of Registered Psychiatric Nurses of British Columbia

THE USE OF PHYSICAL RESTRAINT & SECLUSION AS PSYCHIATRIC NURSING INTERVENTIONS



Position Statement

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INTRODUCTION

The mandate of the College of Registered Psychiatric Nurses of B.C. is to serve and protect the public. The College is responsible through self-regulation to assure a safe, accountable and ethical level of psychiatric nursing practice. The College is accountable to the public through government regulation under the Health Professions Act.

The practice of psychiatric nursing is guided by a set of values and beliefs that are included in the Code of Ethics, the Standards of Psychiatric Nurses and the Expected Competencies.

At the core of psychiatric nursing practice is the therapeutic relationship between the client (individual, family, group and/or community) and the individual Registered Psychiatric Nurse. Establishing and maintaining a professional therapeutic relationship is the responsibility of the Registered Psychiatric Nurse.

Registered Psychiatric Nurses practice in a variety of settings where physical restraint and seclusion are accepted intervention techniques. Both kinds of interventions have a long history of use in psychiatric treatment. Physical restraint and seclusion have been used to effect therapeutic outcomes. Regulation of the safe, therapeutic use of these interventions has been inconsistent and the potential for misuse still exists.

DEFINITIONS

Physical Restraint involves the use of devices to restrict the client's movement either partially or totally.

Seclusion is the placement of a client in a designated locked room.

- The client presents a physical danger to others in the area and is no longer responding to reason
and
- All other interventions have failed to control the behaviours

Therapeutic relationship is the basic premise of the nurse-client relationship and is based on the needs of the client, on trust and respect.

A therapeutic relationship refers to a relationship intended to gain an understanding of the client's need for care, to assist clients to set and implement goals for themselves, and to evaluate the outcome.

GUIDING PRINCIPLES

The purpose of physical restraint or seclusion is to protect the individual and/or the immediate environment including other persons in the environment.

1. The least restrictive and clinically effective measure or approach will be used when a client is at risk of/or is harming self or others. When all less intrusive alternatives have been unsuccessful or are considered clinically inappropriate, the decision to use a physical restraint or seclusion may be taken.
2. Only restraints approved for use at a specific treatment centre may be used.
3. A physician assessment followed by a written order is required specifying type of physical restraint, reason, circumstances for use, duration and conditions for discontinuation.
4. The use of restraints or seclusion must be monitored and documented including an evaluation of the outcome.
5. It is not acceptable to use any type of neck restraint.
6. The decision to use restraints or seclusion will be made by the attending physician in consultation with the interdisciplinary team.
7. In emergency situations, the RPN can initiate the use of restraints or seclusion pending a physician's order.
8. Where possible, the reason for the use of physical restraint or seclusion will be explained to the client and/or family.
9. Continued need for use of physical restraint or seclusion requires clinical assessment and evaluation of the outcome by the RPN in consultation with the physician and interdisciplinary team.
10. RPNs are expected to apply the same standards to the use of physical restraint and seclusion as to any other psychiatric nursing intervention.

CRITERIA FOR THE USE OF PHYSICAL RESTRAINT AND SECLUSION AS PSYCHIATRIC NURSING INTERVENTIONS

The purpose of these criteria statements is to provide direction for the Registered Psychiatric Nurse in clinical decision making related to the use of physical restraint and seclusion as psychiatric nursing interventions. The intent is that RPNs would use physical restraint and seclusion only when these criteria have been met.

1. Assessment

The RPN completes an assessment of all components of the clinical situation to identify:

1.1 The presence of some or all of the following client behaviours:

- self injurious behaviours (e.g. biting, scratching, tearing, hitting)
- other directed aggressive/violent behaviours (e.g. pushing, hitting, biting, scratching, throwing)
- environmentally destructive behaviours (e.g. throwing, smashing, breaking, tearing inanimate objects)
- verbal threats of violence or aggression
- persistent uncontrolled motor activity that puts the client or others at risk
- persistent and/or loud verbal utterances
- persistent behaviours which constitute a safety risk for medically compromised clients (e.g. falling, climbing out of bed, pulling out tubes, sutures, etc.)

1.2 The environmental situation at the time of the assessed behaviours which include mitigating factors such as:

- the amount of stimuli present in the immediate environment (e.g. noise level, number of conversations, number of other individuals, presence of computer, T.V., radio, etc.)

- the status of the other clients in the environment (e.g. level of anxiety, level of disturbance, vulnerability)

1.3 The existence of organizationally - approved statements regarding the use of physical restraint and seclusion which includes:

- clearly defined criteria for the use of physical restraint and seclusion which do not conflict with these criteria
- clearly described responsibility and accountability of the RPN
- clearly described procedures for implementation of physical restraint and seclusion
- clearly described procedures for documentation and communication related to these interventions
- clearly described procedures for evaluation and follow-up

1.4 The existence of medical orders for the use of physical restraint and seclusion for the specific client which includes:

- the type of intervention prescribed
- the duration of the intervention
- the nature of the orders (e.g. P R N ., implement after consultation , etc.)

2. **Planning & Implementation**

The RPN plans and implements psychiatric nursing interventions for the safe, therapeutic use of physical restraint and seclusion to meet the following criteria:

2.1 An analysis of priorities for nursing actions which includes:

- identification of all components of the situation (e.g. behaviour, staffing, environmental)

- discussion of priorities with colleagues
- discussion of priorities with the client, as appropriate
- identification of target behaviours for intervention

2.2 Selection of appropriate intervention which includes:

- Use of alternate interventions to reduce unwanted behaviour (e.g. discussion with client, distraction, reduction of stimuli, removal from stimuli, P.R.N. medication)
- Use of physical restraint based on approved procedures (e.g. informing client, holding, lifting, securing limbs, use of belts, vests and other safety devices)
- Use of seclusion based on approved procedures (e.g. informing client, transport procedures, nature of seclusion space, duration of seclusion, monitoring procedures)
- Use of appropriate communication channels to inform administrative, nursing and medical staff as required
- Use of psychiatric nursing interventions as alternatives to physical restraint and seclusion (use of staff, use of family, education, close observation, constant attention, reality orientation, recreational diversion, emotional defusing, medications)

3. **Evaluation**

The RPN uses an evaluation process for the use of physical restraint and seclusion which meets the following criteria:

3.1 Maintains a record of the use of physical restraint and seclusion which includes:

- Written assessment, nursing diagnoses, care plan, outcome criteria and evaluation for the incident

- Documentation of nursing actions and client behaviours
- Documentation of incident in all designated places (e.g. unusual occurrence reports, nursing service reports)

3.2 Carries out an analysis of the incident which includes:

- Discussion of all components of the incident with health team members
- Discussion of all components of the incident with the client as appropriate
- Recommendations to prevent the need for physical restraint and seclusion in similar situations
- Recommendations to correct problems/deficiencies in the implementation of these interventions
- Recommendations regarding further or continued use of physical restraint/seclusion as interventions for the same client or similar situations

REFERENCES

1. Riverview Hospital Policies & Procedures on the Use of Physical Restraint and Seclusion.
2. Position Statement on the Use of Physical Restraint & Seclusion as Psychiatric Interventions, RPNABC, November 1980.
3. Health Professions Act.
4. Standards of Psychiatric Nursing in British Columbia, CRPNBC.
5. Code of Ethics, CRPNBC.
6. Competencies Expected of the Beginning Practitioner of Psychiatric Nursing, CRPNBC.
7. Registered Psychiatric Nurses: Competency Profile for the Profession in Canada, 2001.