



Visionary Leadership for Psychiatric-Mental Health Nurses Around the World

INTERNATIONAL SOCIETY OF PSYCHIATRIC-MENTAL HEALTH NURSES

POSITION STATEMENT, NOVEMBER 1999

The Use of Restraint and Seclusion

Following is the International Society of Psychiatric-Mental Health Nurses' (ISPN) position on the use of restraint and seclusion in treatment settings with vulnerable populations across the lifespan.

- ISPN believes that all patients have the right to be treated with dignity, concern and high quality competent care. In any aspect of care, registered nurses must advocate for and protect the rights of patients. In all settings, the Patient's Bill of Rights (on how to access organizational, legal and/or advocacy resources) is to be prominently posted in language that all can understand.
- Patients have the right to appropriate and respectful treatment delivered or presented in the least restrictive manner to ensure positive clinical outcomes. ISPN acknowledges that seclusion and restraint is an emergency clinical intervention employed only as a last effort when less restrictive alternatives have failed to ensure safety for patients, staff and families. The definition of restraint as defined by the Health Care and Financing Administration states "restraint is any physical method of restricting a patient's freedom of movement, physical activity or normal access to his/her body".
- ISPN advocates for patients' rights to be cared for in developmentally appropriate ways by competent staff members who have salient experiences in working with diverse populations across the life span. Professional nurses with twenty-four hour responsibilities for care of patients must demonstrate critical thinking skills, anticipate learning needs, and competently apply therapeutic interventions to redirect or repattern behavior. In behavioral healthcare units, advanced practice psychiatric nurses are the best-qualified professionals to make assessments and decisions to restrain.
- ISPN recommends that all patients receive thorough and ongoing assessments of their presenting behavioral problems, identification of biologic precipitants to the behavior and other environmentally specific triggers. Other target areas for initial assessments include identification of patients' developmental levels, screening for any history of trauma (physical or sexual and other traumatic events), particular cultural needs which may affect the delivery of care and those baseline behaviors, which promote healthy coping with stress. It is imperative that providers concurrently screen and assess for co-morbid illnesses (including the possibility of substance intoxication or withdrawal) to ensure that emergent physiologic issues are addressed first.
- ISPN endorses the systematic investigation and utilization of alternatives to mechanical and chemical restraint. Flexibility in adapting the environment of care (physical setting, functional equipment, provider response) is mandatory to ensure safe and effective care for the least amount of time necessary to help patients regain control over their behavior.
- ISPN recommends that all provider staff members have specialized training in behavior assessment, age-appropriate medication, safe monitoring, and follow up. Staff education should include mandatory content regarding assessment and intervention in the cycle of aggression, symptom recognition, verbal intervention skills, and the critical thinking strategies designed to select the least restrictive intervention best suited to the presenting needs of patients. Further training should also address agency specific zero tolerance policies and the organizational responses to the needs of staff involved in incidents of aggression.

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- ISPN acknowledges that the use of seclusion and restraints is a clinical emergency and requires prompt coordinated attention. For psychiatric patients, physicians or licensed independent practitioners (LIP) (an advanced practice nurse, Masters prepared in the specialty of psychiatric mental health nursing) must perform a face-to-face assessments within **one hour of initiation of restraint**. The Health Care Financing Administration defines a LIP as “any individual permitted by law and by the hospital to provide care and services, without direction or supervision, within the scope of the individual’s license and consistent with individually granted clinical privileges”. Renewal of orders must occur at least every 24 hours with a concurrent face-to-face re-evaluation of the patient. Individual orders should specify the duration of restraint (adults 4 hrs; adolescents ages 9-17 maximum of 2 hours, and children under 9 years old maximum of 1 hour). Behavioral reassessments must be performed.
- ISPN believes that advanced practice registered nurses are best qualified to perform reassessments. This facilitates a focus on accurate recording and monitoring of patterns of use for the patient in restraint and/ or seclusion. In addition, attention is paid to activities of daily living, efforts at trial release and the continuous evaluation of less restrictive interventions that may support and eventually substitute for the use of restraint and seclusion.
- ISPN opposes all punitive measures. **As with adults, the heads and faces of children must never be obstructed.** Any medication administered to children must be ordered by physician or advanced practice nurse with prescriptive privileges and administered by a licensed professional. **Children should never be left alone while in restraint or while secluded.** The duration of physical restraint of any kind should extend only until children are sufficiently in control to no longer pose a threat to themselves or to others. Adults and children must be removed from restraints every 2 hours at a minimum. They should be offered fluids and toileting and vital signs should be taken.
- For acute medical-surgical patients, ISPN endorses the active evaluation of patients’ needs and utilization of alternatives to restraint in order to ensure safe delivery of medical and nursing treatments. Physicians or LIPs **must be informed within 1 (one) hour** of the initiation of a restraint. Any major change in patients’ behaviors necessitates immediate notification and communication with physicians and LIPs. Further evaluation and prescribing are on the same schedule as for patients with primary psychiatric illnesses.
- ISPN recommends that all patients, family members or identified significant others be informed immediately about any use of restraint and/or seclusion and receive written information (i.e. family education pamphlet). For all patients, professional judgement is needed to prevent the intervention from becoming a deterrent to visitation by families. As much as possible, families should be given the opportunity to be included in patients’ plans of care. All patients have the right to individualized treatment plans that are developed in collaboration with providers of all disciplines. Treatment plans should be monitored for appropriateness and patients’ progress with their participation on a specified, regular basis.
- ISPN suggests that following any use of restraint and /or seclusion, patients should receive debriefing in clear words that they can understand from their primary caregivers. This intervention facilitates the following: symptom recognition, earlier de-escalation, and promotion of problem solving and conflict resolution skills. Debriefing is necessary to minimize negative effects related to patients’ experiences of being restrained and/or secluded.

- ISPN recommends that each organization collect specific data on the clinical endpoints of restraint and seclusion in order to identify patterns of use. Such data should be used to refine approaches that demonstrate best practice outcomes for the particular populations at risk. In order to further refine evidenced based practice data, ISPN suggests that provider staff members engage in long term review of the efficacy and effectiveness of the current clinical guidelines for restraint and seclusion.
- While the goal of becoming restraint-free is laudable, ISPN suggests caution in a blanket endorsement of zero tolerance policies. Serious adverse consequences can be a potential byproduct in such instances (i.e. insidious escalation in use of medication management).

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