nbsa Standard for the Use of Restraint

The Nurses Board of South Australia (**nbsa**) is required to act in the public interest. A function amongst others of the **nbsa** is to endorse professional standards. The *Nurses Act 1999* requires the **nbsa** in exercising this function to ensure that the community is adequately provided with nursing care of the highest standard and to achieve and maintain the highest professional standards of competence and conduct in nursing.

In developing and endorsing this standard, the **nbsa** aims to

- clearly describe nursing practice for clients, employers, education providers and nurses
- provide the people who access nursing services with information that will help them make informed decisions about safe, quality health care
- standardise key aspects of nursing practice to promote professional mobility
- make transparent the **nbsa**'s expectations of nursing practice
- clearly articulate the standards the **nbsa** will use in assessing reports of unprofessional conduct or incompetence.

RESPONSIBILITIES OF REGISTERED AND ENROLLED NURSES

Registered nurses and enrolled nurses have different responsibilities in regard to the use of restraint. It is the responsibility of individual registered and enrolled nurses to interpret these Standards in the context of applicable law, codes of practice, other applicable professional standards, and guidelines relevant to the individual practice setting in the delivery of nursing care. Fundamental to this process is the protection of the rights and well being of the client. As members of a profession, registered and enrolled nurses must practice in the best interests of the client which includes assessment of the need, risks, benefits and alternative methods of treatment proposed given the nurses' level of expertise and experience.

RESTRAINT

Restraint is any word or action that interferes with the ability of a client to make decisions or restricts their free movement. Restraint may form a part of nursing practice in some settings and involve different techniques, appliances and strategies. Regardless of the setting or technique, restraint must be understood to impose a form of control such as preventative measures, restraint minimisation strategies and/or chemical restraint. All of these techniques are aimed at limiting the actions of individuals in circumstances in which the individual is at risk of injury or of injuring another person. The application of restraint should occur only where other preventative measures have been considered and deemed not appropriate and is necessary in the circumstances of the individual case.

SECLUSION

Seclusion can be seen as a mode of restraint and is the placement of a client in a room alone and preventing them from leaving. Seclusion also includes isolating a client in other areas. Seclusion should only be used when other strategies to manage grossly disturbed or aggressive behaviour have been exhausted. Involuntary seclusion occurs when a client is placed without their consent in a room from which they are prevented from leaving or are

in other ways deliberately isolated from others. Voluntary seclusion occurs when a client is placed at their request in a room on their own and the client determines the period of seclusion and whether the door is locked. Where seclusion is voluntary, the client can request that the period of seclusion be terminated at any time.

MANAGEMENT OF RESTRAINT

The management of challenging behaviours, violent incidents and the use of restraint are important aspects of nursing practice. The decision to restrain requires consideration of individual, organisational, social, cultural, religious and professional factors and the exercise of professional/clinical judgment. The NBSA has developed a Standard for the use of restraint that

- articulates and documents what the **nbsa** expects as the minimum requirement for the safe use of restraint and seclusion
- identifies restraint as incorporating all associated actions from client assessment to intervention and evaluation
- takes into consideration the increasing complexity and scope of nursing practice, the changes to nursing educational preparation and the accountability and autonomy of nurses in decision making for the delivery of client care
- acknowledges the multidisciplinary and collaborative nature of the management of challenging behaviours.

STANDARD 1

The safety and wellbeing of the client is ensured by restraint practices that reflect current knowledge, applicable law, practice guidelines, codes of practice and organisational policies and procedures.

Nursing practice includes evidence of

a) current knowledge and compliance with human rights conventions, relevant State and Federal Legislation and common law, Professional Standards and Codes and applicable practice guidelines
b) knowledge of and compliance with relevant organisational policies and/or procedures,
c) current knowledge of safe use of physical and chemical restraint[1], and interpersonal interventions aimed at the prevention and management of challenging behaviours
d) familiarity with concepts of accountability, best practice and evidence based practice,
e) consultation in determining the management and care of clients who require support for challenging behaviours
f) recognition that each client requires individualised care
g) implementation of strategies to prevent or minimise challenging behaviours
h) evaluation of interventions and outcomes
i) appropriate action in response to questionable orders, decisions or behaviours of others including members of the health care team.

STANDARD 2

Protection of a client, staff and other parties is the primary focus of the use of restraint.

2.1 Use of restraint

Nursing practice includes evidence of

a) actions to minimise the use of restraint
b) staff preparation and education
c) adherence to relevant policies, procedures and specific care or management plans for individuals
d) systematic approaches to improving practice.

2.2 Consultative decision-making and authorisation

Nursing practice includes evidence of

a) consultation with the client where the person has mental capacity
b) consultation with the next of kin or guardian where the client does not have mental capacity
c) consultation which may include consultation with the responsible medical officer, and or organisational policies and procedures.

2.3 Assessment

Nursing practice includes evidence of

a) respect for the client's dignity, privacy, cultural background and personal rights
b) identification of the client's physical, cultural, psychological, social and safety needs and relevant history
c) assessment of possible causes and consequences of the client's behaviour
d) identification of the potential health and safety risks for the client and for others of not using restraint
e) assessment of the least restrictive type of restraint
f) appropriate assessment and decision making in the initiation of restraint.

2.4 Consent

Nursing practice includes evidence of

a) obtaining informed consent from the client where appropriate
b) obtaining agreement for the use of consent from the next of kin or other legally authorised person.

2.5 Client monitoring during episodes of restraint

Nursing practice includes evidence of

a) ensuring the wellbeing and safety of the client
b) maintaining observations of the client
c) considering the use of alternative solutions where possible
d) providing maximum comfort within the use of constraints
e) interventions aimed at optimising rest, nutrition, hydration and elimination
f) interventions to divert the client's attention to beneficial or therapeutic activities
g) assessment of the continuing need for restraint
h) evaluation of the use of the restraint and outcomes.

2.6 Documentation

Nursing practice includes evidence of

a) nursing assessment including the client's behaviour and health problems leading to the need for the use of restraint
b) consideration of any health problems possibly to be worsened by the use of restraint
c) use of other strategies to manage challenging behaviours
d) consent to restrain
e) the timing and duration of episodes of restraint
f) arrangements for protecting the safety of the client and/or others during the use of restraint
g) maintenance of client confidentiality
h) documentation of who initiated restraint.

STANDARD 3

Protection of the health and safety of the client and/or others guides decision-making about restraint.

Nursing practice includes evidence of

a) multidisciplinary review of incidents related to the use of restraint
b) evaluation of the frequency and duration of episodes of restraint
c) how episodes of restraint were monitored and recorded
d) application of the least restrictive alternative
e) correct use of restraints
f) when each episode of restraint was reviewed and by whom
g) goal setting towards a restraint free environment
h) arrangements for the debriefing and counselling of clients who have been restrained and for the staff involved
i) recognition of the potential risks associated with restraint and actions to minimise those risks.

OTHER ISSUES

Violent Incidents

Clients, nurses and others may be subjected to threats, physical and/or verbal abuse. Nurses are entitled to a safe working environment and are not obliged to put themselves at risk. However nurses also have a duty of care to take all reasonable steps to avoid self-harm of clients, and harm to others. Such situations should be managed in accordance with this Standard and with regard to individual organisational policies and procedures.

ADDITIONAL SOURCES OF INFORMATION

When interpreting Standards of the **nbsa**, it may be helpful to refer to relevant applicable legislation, the common law and others, Standards and Codes of nursing practice.

nbsa Website

Copies of the standards are available on the **nbsa** website at www.nursesboard.sa.gov.au

or from the Board at

200 East Terrace Adelaide SA 5000

Telephone

08 8223 9700

EXPLANATION OF TERMS

Accountability
Accountability is the nurse accepting responsibility for her or his decisions and behaviours as a professional nurse and for the consequences of those decisions. Accountability cannot be delegated.

Autonomous Nursing Practice
Autonomy in practice is the nurse being self-directed in determining appropriate decisions and behaviours.

Best Practice
Best practice is demonstrated by adherence to Standards of Practice endorsed by the nursing profession and described by experts at professional conferences and in relevant journals.

Challenging Behaviours
Challenging behaviours are those behaviours that put clients or others at risk and are behaviours that are likely to cause serious offence or injury to others.

Chemical Restraint
Chemical restraint is the intentional use of medication for the primary purpose of controlling a client's behaviour. Inappropriate use of restraint can constitute assault, false imprisonment or negligence. Hence, consent should be obtained from the client, next of kin or an authorised person for the period the restraint is deemed necessary.

Clients
The term, client is used in these Standards to refer generically to anyone who is the recipient of nursing services hence the focus of nursing practice. Therefore, the term is used not only to refer to those individuals who directly receive nursing care, but also to their family members, significant others and carers.

Competence
The combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a professional/occupational area. *(ANMC)*

Consent
To consent is to give one's permission verbally, in writing or by implication. Consent can only be given by a client who has legal capacity and is competent to do so. Informed consent requires disclosure of sufficient information including risks, benefits, alternatives and consequences of no action so that the client is able to make an informed decision. If a client is not competent, or does not have capacity to consent, then consent can be given by a person who has authority to consent on behalf of the client. Such authority can be conferred by a Court of law or by legislation. To be effective the consent must be voluntarily given, cover the act performed and be given by a person who has legal capacity to consent. In an emergency a client may be unable to consent. In these situations reference should be made to statutory provisions for authorising medical treatment and nursing care. Any next of kin should be notified and where possible agreement to the proposed treatment obtained. In the absence of consent, a nurse may be justified in using restraint and/or seclusion if it is necessary for the client's own health and safety or for the protection of others. The actions taken must be those that a reasonable nurse, acting in the best interests of the client, would take in the circumstances.

Ethical Considerations
Nursing practice is guided by ethical principles that include promoting autonomy for the client, acting only for the client's good (beneficence), avoiding harm to the client (non-maleficence) and respecting the dignity of the client and the client's human rights. This Standard should be read in conjunction with the ANMC Codes of Ethics and Conduct and other statements intended to promote ethical nursing practice.

Evidence Based Practice
Evidence based practice is the process of informing and improving one's professional competence by using expert opinion and the results of systematic reviews to ensure that personal practice is based as far as possible on sound and verifiable evidence.

Human Rights Conventions
Since 1945 the United Nations has developed a framework for human rights that encompasses international instruments, which Australia has ratified. These include the 1948 United Declaration of Human Rights, the 1958 Discrimination (Employment and Occupation) Convention, the 1966 International Covenant on Civil and Political Rights, and the 1975 Declaration on the Rights of Disabled Clients. Such conventions provide an international context for ethical nursing practice. Principles for the Protection of Clients with Mental Illness were adopted by the United Nations General Assembly in 1991 and inform the 1992 Australian National Mental Health Policy.

Nurses
The collective noun nurses is used here to refer to all nurses and midwives who are registered or enrolled by the **nbsa** and practice in South Australia.

Nursing Competence
Nursing competence is the ability of the nurse to act with the knowledge, skills and attitudes that can reasonably be expected of a registered or enrolled nurse in South Australia taking into account the education and experience of the nurse and the particular circumstances of the situation.

Physical Restraint / Mechanical Restraint
Physical or mechanical restraint is the intentional restriction of a person's voluntary movement or behaviour using a device or physical force.

Practice Settings
The use of the term practice settings is inclusive of all settings where nurses practise.

Risk Management
Practising in the best interests of the client requires an assessment of the risks to the client, staff members and others. Whereas it is impossible to eliminate risk entirely, it is the responsibility of the nurse and other members of the multidisciplinary team to minimise the risks to clients to a level agreed to by the client (or the client's representative), wherever possible.

Restraint of Prisoners
In relation to the restraint of prisoners, these Standards should be used in accordance with Prison Regulations and Standing Orders.

Restraint of Clients Accompanied by Police
The restraint of clients accompanied by police should be undertaken in accordance with special powers exercised by the police and with these Standards taking into account the particular circumstances of the situation.

Restraint in Caring for Children, Adolescents and People with Special Needs
Although there are situations that require children and adolescents to be restrained in their own interests, these Standards have been developed so that they can guide the nursing practice of a client of any age. These Standards have also been prepared to guide nursing practice that involves people with a mental disorder or people with a physical disability.

Specialist Services
Specialist services are those that have been developed to provide assistance to clients or clients with complex needs and education and support to health professionals or others involved in their care. Specialist assessment and treatment including forensic services may be of assistance to nurses caring for people with challenging behaviours. In particular, specialist psychiatric, psychological and mental health services including specialist nursing services.

Stakeholders
Stakeholders are all those who have an interest in the duty to ensure the highest Standards of care and include clients and client organisations, relatives and friends of clients and other health care providers.

Standards
Standards are statements on the conduct of nursing practice endorsed by the **nbsa**.

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