Guide to Good Nursing Practice
Physical Restraint

Preamble

The application of physical restraint in nursing involves the curtailment of the freedom of clients. The intervention could be viewed by clients as a form of assault, battery or even false imprisonment. However, it is also acknowledged that physical restraint would sometimes be necessary as a last resort to prevent imminent danger of physical harm or protect the safety of the clients or others when less restrictive options of treatment have failed. This paper serves as a reference to support safe and professional nursing practice in the use of physical restraint as well as the ways that the best interest of the client is safeguarded in its application. Alongside this guideline, nurses should also make reference to related policies and guidelines of individual healthcare organizations.

Definition

Physical restraint (refers to "restraint" below) is commonly defined as any device, material or equipment attached or adjacent to an individual's body that he/she cannot easily remove, thus immobilizes or reduces the ability of the individual to move his/her body parts freely and/or to have normal access to his/her own body (Centers for Medicare & Medicaid Services, 2006; Retsas, 1998).

Principles

To develop a good practice in restraint, the nurse needs to consider the following aspects:

1. Restraint is considered only out of protection of the safety and well-being, and in the best interest of a client or others.
2. The nurse should take legal considerations in regard to the source of authority of applying the restraint and observe the policies and guidelines set by the institution in which he/she is practising before any decision made on applying restraint.
3. The nurse should take ethical considerations by ensuring that there is a genuine need to restrain and the safety, comfort, dignity and physical and psychosocial needs of a client on restraint are maintained.
4. The practice of restraint should be minimized and be applied only as the last resort where there is no other viable option or where other options fail in the circumstances.
5. Safety of the client, staff and others should be ascertained and balanced when applying restraint.
6. Restraint is applied in the least restrictive form and over the shortest duration to achieve the purposes as mentioned in the preamble above.
7. Restraint device should be used appropriately, properly, correctly, reasonably and safely with reference to the circumstances of the case.
8. The client with restraint has to be put under close observation and scrutiny and regular assessments.
9. The client and/or his/her family members or guardian should be informed of the needs, risks and benefits of restraint before the possible use of restraint. Debriefing should be done to them as soon as practicable after restraint.
10. The use of restraint should be properly documented for record and inspection purposes.
11. The nurse should explore viable alternatives to minimize the application of restraint.
12. The nurse should maintain updated knowledge and skills in restraint.

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Responsibilities of the Nurse

1. The nurse assesses the need for restraint. Restraint is applied only when the safety and well-being of the client or others is being threatened.
2. The nurse applies restraint as a last resort when less restrictive viable alternatives have been considered, tried or proved to be insufficient, ineffective or inappropriate. Various potential alternative measures can be considered, e.g., additional supervision and observation, decreased sensory stimulation, active listening, appropriate outlets for anxious behavior, relaxation techniques and companionship of a family member or friend, etc.
3. The nurse communicates with the client and/or his/her family members regarding the needs, risks and benefits of the possible use of restraint prior to the application.
4. The nurse complies with institutional policies and guidelines for restraint and being aware of the source of authority. The expertise from other healthcare team members may be solicited as a reference to the decision.
5. The nurse explains to the client the reason for the restraint and attempts to enlist his/her cooperation when restraint is applied.
6. The nurse arranges adequate assistance from competent staff before carrying out the restraint procedure to ensure safety of all involved parties including the client.
7. The nurse applies the least restrictive, reasonable and appropriate devices to restrain the client. The devices should be secured in a proper manner to maintain the client's safety and comfort. While restraining, the nurse pays attention to the client's fragile body parts. Any force used and/or any restriction of the client's freedom of movement must be justifiable and appropriate.
8. The nurse arranges the client under restraint in a place with easy observation and the client is protected from exposure to the public unless it is not practicable or feasible in the circumstances of the case.
9. The nurse maintains close and regular observation on the client with restraint paying particular attention to his/her safety, comfort, dignity, privacy and physical and mental conditions.
10. The nurse attends to the client's biological and psychosocial needs during restraint at regular intervals according to the condition of the client.
11. The nurse reviews the restraint regularly, or according to institutional policies. The nurse considers the earliest possible discontinuation of the restraint once the condition of the client is justified in the reviews.
12. The nurse debriefs the client, his/her family members and staff if indicated as soon as reasonably practicable after the restraint.
13. The nurse documents the use of restraint for record and inspection purposes.
14. The nurse explores interventions, practices and alternatives to minimize the use of restraint, e.g., by comprehensive assessment of clients, reviews on the care provided, modification of the environment, education of staff and collaboration with family members and other healthcare professionals, etc.
15. The nurse maintains his/her competence in the appropriate and effective use of restraint through continuous education. The nurse educates healthcare assistants in up-to-date knowledge and skills in the use of restraint.

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