HARDIN COUNTY GENERAL HOSPITAL
HOSPITAL-WIDE POLICY

Title: RESTRAINT AND SECLUSION **Effective Date: 5/11/2006**
Policy Number: 125 **Med Staff:**
Regulation: IDPH, CAH **Admin:**

I. POLICY

1. Confinement of patients by seclusion is not practiced at this facility.
2. Confinement of patients in physical restraints will not be used except under limited medical circumstances to prevent injury to the patient or to others, and then only when alternate measures are not sufficient to accomplish maximum safety for the patient and to prevent serious disruption of the provision of care to the patient or others. When they are indicated, a systemic and gradual process will be initiated toward reducing their use.

II. DEFINITIONS

1. Physical restraints – Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that the patient cannot remove easily which restricts freedom of movement or normal access to ones body. The following are examples of physical restraints:
   a. Leg and/or arm restraints (soft or leather),
   b. Hand mittens,
   c. Soft ties or vests,
   d. Lap cushions and trays that the patient cannot remove,
   e. Bed rails used to keep patient from voluntarily getting out of bed as opposed to enhancing mobility while in bed,
   f. Tucking in a sheet so tightly that a bed bound patient cannot move,
   g. Wheelchair safety bars to prevent patient from rising out of a chair, placing a patient in a chair that prevents rising, and
   h. Placing a patient who uses a wheelchair so close to a wall that the wall prevents the patient from rising.
2. Chemical restraint – A psychopharmacological drug that is used for discipline or convenience and not required to treat medical symptoms.
3. Discipline – Any action taken by the hospital for the purpose of punishing or penalizing patients.
4. Convenience – Any action taken by the hospital to control patient behavior or maintain patients with a lesser amount of effort by the hospital and not in the patient's best interest.

III. RESPONSIBILITY

Physicians, nurses and patient's representative.

IV. EQUIPMENT

Consent for restraints
Appropriate restraint of least restriction
Appropriate forms

V. PROCEDURES
INFECTION CONTROL: CATEGORY II

1. The physician and/or nurse will assess and document the medical symptoms that warrant the use of the restraint, and initiate or update the *Nursing Care Plan* and the *RN Restraint Assessment Flow Sheet,* to begin the systematic and gradual process toward reducing the need for the restraint. This documentation will include the alternatives that have been attempted, as outlined in the hospital Fall Risk Plan, to prevent the use of the restraint.
2. A written order is made by the physician for the appropriate restraint and is time limited to not more than 24 hours each episode. A new order is written every 24 hours while restraint is in use. When the physician responsible for the patient's care is not immediately available to assess the patient and determine the need for restraint, the RN in charge may initiate the use and obtain the physician's telephone or verbal order which is countersigned according to hospital policy.
3. The patient, or a representative in the case the patient is incapable of making a decision, must sign a consent for the restraint. The informed consent includes the negative outcomes of restraint use including incontinence, decreased range of motion, decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact. The hospital may not use restraints solely because a representative has requested them. They may only be used when it is necessary to treat the patient's medical symptoms.
4. If the patient or representative refuses the restraint, a refusal for restraint form must be signed and placed on the patient record.
5. When restraints are applied:
    a. The patient is placed as close to the Nurse's Station IN ROOM 20, 21, OR 22.
    b. The patient is periodically monitored and his/her needs are attended to. The following observations and interventions will be documented by the nursing staff on the *RN Restraint Assessment Flow Sheet and the Restraint Flow Sheet*:
        A. Assessment of justification for use at least every shift by the Charge Nurse;
        B. Observation of circulation, motion, and condition of skin and limbs every 1 hour (every 15 minutes with leather restraints);
        C. Removal and exercise of extremities and ambulation, if possible, every 2 hours.
        D. Offering of fluids every 2 hours and nutrition and meals given per order and/or routine.
        E. Assistance with toileting every 1 hour, if needed.
6. Dignity and respect are maintained at all times by maintaining a safe, clean environment where they are able to participate in their care and are kept warm and covered as appropriate.

7. A restraint key will be in the possession of all nursing and patient care staff assigned for the duration of their shift when leather restraints are used.
8. The patient's rights, dignity and well being are protected by maintaining a safe, clean environment where the patient is shown respect, able to participate in their own care and is kept warm and covered as appropriate.
9. Restraints cannot be used to permit staff to administer treatment to which the patient has not consented.
10. They may be used for brief periods to permit medical treatment for emergency care unless there has been notice of refusal of the treatment previously by the patient.

VI. DOCUMENTATION

All documentation will be completed on the following forms:

1. Physician Orders
2. Physician Progress Notes
3. RN Restraint Assessment Flow Sheet
4. Restraint Flow Sheet
5. Consent for Restraints