



**DELAWARE PSYCHIATRIC CENTER  
POLICY AND PROCEDURE DIRECTIVE**

**Division of Substance Abuse and Mental Health  
Delaware Health and Social Services**

<b>FUNCTION</b> CARE OF PATIENTS	<b>REVISION/REVIEW DATES</b>	
<b>SUBJECT</b> PAGE 1 OF 14 <b>SECLUSION OR RESTRAINT</b>	June 15, 1990	August 21, 1998 (revised)
	June 5, 1991	December 21, 2000 (revised)
<b>POLICY NUMBER</b> TX 1	June 22, 1992	April 20, 2001 (revised)
	June 2, 1993	June 18, 2001 (revised)
<b>EFFECTIVE DATE</b> June 9, 1989	June 26, 1995	August 27, 2002 (revised)
	September 29, 1995	August 31, 2007 (revised)
<b>MEDICAL DIRECTOR/DESIGNEE</b> DATE	May 9, 1997	October 19, 2007 (revised)
	July 7, 1997	October 26, 2007 (revised)
	July 1, 1998 (revised)	
	<b>HOSPITAL DIRECTOR</b>	<b>DATE</b>
	<i>[Signature]</i>	10/26/07

**DISCIPLINES INVOLVED:**  Dietary  Business Office  Housekeeping  
 Maintenance  Medical  Nursing  Personnel  Pharmacy  
 Psychology  Rehab Services  Risk Management  Security  Social  
 Work  Training Other: PI Dept.

**PURPOSE:**

This policy describes the procedures to be followed whenever the use of seclusion or restraint is required for those situations with adequate, appropriate clinical justification based on the patient's assessed needs and when less restrictive alternatives have been considered and used.

**REFERENCE:** Joint Commission on Accreditation of Healthcare Organizations Standards on Seclusion and Restraint / Centers for Medicare and Medicaid Services (CMS)

**STANDARDS:**

All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

Restraint is used only as a last resort, when clinically necessary, to protect the patient's well being and when other less restrictive measures are determined to be ineffective to protect the patient, staff or others from harm. Accordingly, when determining whether a patient's condition is such that restraint is only viable option, the patient's behavior, at

the time, must pose a greater risk to himself or others, than the risk of using restraint or seclusion.

Patients are assisted and monitored during the use of seclusion or restraint to provide for the patient's well being and to minimize the length of the intervention. A debriefing involving the patient and staff occurs after each intervention. Delaware Psychiatric Center staff review seclusion and restraint protocol with patients and/or their families upon admission and obtain an acknowledgement signature when able, when unable, the reason is documented. Clinical leadership is notified when a patient experiences prolonged or multiple episodes of seclusion or restraint. Data is aggregated on the use of seclusion or restraint in order to monitor risk, create internal benchmarks and prioritize performance improvement initiatives.

**NOTE:** Restraints shall not be used for staff convenience or as a form of punishment. All restraints will be conducted in a humane, safe and effective manner without intent to harm or create undue discomfort to the patient.

**APPLICABLE TO:** All clinical staff

**DEFINITIONS:**

**QUIET ROOM/TIME OUT** – The voluntary separation of a patient in a room from which the individual has a means of leaving and may leave. Quiet room/time out refers to a situation in which a patient willingly goes alone into a room that is left unlocked. Anytime the quiet room is used by an agitated patient, nursing staff must observe the patient at all times and offer support as needed.

**SECLUSION** – The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self destructive behavior.

**RESTRAINT** – (A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or (B) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

**FOUR POINT RESTRAINTS** – The use of leather bracelets or other hospital-approved restraints to restrict the movement of a patient's limbs. The bracelets are attached by means of a belt to a bed frame so that the patient is maintained in a supine position.

**FIVE POINT RESTRAINTS** – The use of a soft belt in addition to leather bracelets when the four limbs are restrained on a highly agitated, aggressive or combative patient who is "bucking" uncontrollably in bed. The soft belt may be utilized on the mid-trunk area and the straps are secured to the bed frame.

AMBULATORY RESTRAINT- The attachment of a wrist to waist restraint device which controls the patient's arm movement. This restraint allows the patient to ambulate but limits arm movement thus preventing assaultive or self harm behavior.

MECHANICAL DEVICES- Includes, but is not limited to: belts, side rails, spit socks, geri-chair with tabletops, hand mittens/mitts and stretchers.

PHYSICAL HOLD- The application of physical force without the use of any device, for the purpose of restraining the free movement of a patient's body. Holding a patient in a manner that restricts his/her movement constitutes restraint for this patient. (Used when administering IM medications, transporting, and prevention of harm to self and others.)

LESS RESTRICTIVE MEASURES – Includes, but is not limited to: verbal intervention to de-escalate the patient; walking with the patient to another area; mediating in disputes; offering the quiet room; offering PRN medication (PO medications should be offered initially)

**PROCEDURES:**

- I. INITIATION OF SECLUSION OR RESTRAINT (The following procedures take place almost simultaneously)
  - A. During a psychiatric emergency, in the absence of a Physician on the unit, a Licensed Nurse may initiate a seclusion or restraint intervention.
  - B. A Licensed Nurse or Physician informs the patient, calmly and concretely, that he/she is being placed in seclusion or restraints and the reason why such an intervention is necessary.
  - C. An attempt is made to elicit the patient's cooperation with the intervention. If the patient is unwilling to ambulate to the quiet room, Nursing Staff will transport the patient by utilizing the facility's standard method / practice based on the current training manual.
  - D. Nursing staff ensure that the environment is safe and secure by:
    1. Removing all bed linens and pillows if the decision has been made to place the patient in seclusion.
    2. Checking the patient's pockets for sharp and other dangerous items and removing them along with other items including, but not limited to money, any belts, shoes, matches, jewelry and eyeglasses. Objects that are removed from the patient are **itemized** on the *Seclusion or Restraint Nursing Assessment* form. The items are safely stored and returned to the patient upon termination of seclusion or restraint. Contraband items are handled in accordance with the contraband policy.

3. Only the ambulatory wrist-waist restraints with locking cuffs may be used in the milieu.

**E. The Licensed Nursing staff, during the psychiatric emergency must:**

1. **Promptly** notify the Physician and receive an order for the use of the intervention.
2. Assign a staff member to:
  - A. monitor a patient in seclusion
  - B. permanently remain with the patient in restraints
3. Inform the patient of the behavior expected in order for the seclusion or restraint to be terminated.
4. Notify a Nursing Supervisor immediately of all episodes of seclusion or restraint.
5. Complete the ***Seclusion or Restraint Nursing Assessment*** form:
  - a. specifics should be documented when “Imminent risk of harm,” “Self-injurious behaviors,” or “Other” is checked under PATIENT BEHAVIOR LEADING TO INTERVENTION. Who was at risk and what the risk was, should be noted as applicable.
  - b. if “Emergency situation precluded the use of less restrictive alternatives” is checked, an explanation is required.
  - c. objects removed from the patient are **itemized** on this form and kept together in an inter-office envelope labeled with the patient’s name. Money is counted and witnessed by another staff. The money is placed in an envelope, sealed and signed by both staff. The sealed, signed envelope is placed inside the inter-office envelope which is secured in the medication room until the patient is removed from the intervention.
  - d. physiological or psychological risk factors that are present in the patient’s medical record (i.e., H&P, psychiatric assessment) are noted on this form and communicated to the Physician who is being contacted for the order. Staff are directed to be sensitive to, and observant of, any behaviors that may be related to pre-existing medical conditions, physical disabilities, history of sexual or physical abuse.
  - e. Licensed Nursing Staff reviews the Advance Directive Query form (located in the Advance Directive section of the chart)

to determine if the patient wants his/her family notified, and whether the family wishes to be notified in the event of a seclusion or restraint episode. The Licensed Nurse notifies the family unless the patient has indicated that family notification should not occur. If the family indicates upon notification that they do not wish to be contacted or prefers to be notified at a specified time, the Licensed Nursing Staff notes this in Section III of the Advance Directive Query form.

6. Completes and signs the first page of the **Seclusion or Restraint Record** sheet.
- F. The Nursing Supervisor monitors the intervention by checking the patient in person and assessing if there are any interventions that can be offered to the staff to shorten the duration of the intervention.
- G. The Physician writes/gives an order for the seclusion or restraints which must include the following:
1. type of intervention (i.e., seclusion, four point restraints, five point restraints)
  2. reason for and/or purpose of the intervention
  3. maximum duration of the intervention (**note**: initial maximum duration and subsequent renewals are **not to exceed 4 hours**)
  4. if seclusion or restraint use needs to continue beyond the expiration of the time-limited order, a new order for seclusion or restraint must be obtained. New orders must not exceed the established 4 hour time limit and may not be renewed if the patient has been in restraints for 24 consecutive hours.
  5. documentation related to endpoint criterion
- H. The Physician, after personally examining the patient **within one hour** after the initiation of the intervention, unless the intervention ended within one hour, writes a progress note which must include the following:
1. The patient's behavior and the intervention used;
  2. The rationale for the use of the restraint or seclusion; and
  3. The patient's response to the use of restraint or seclusion.

Documentation in the patient's record should indicate a clear progression regarding how techniques are implemented with less intrusive interventions attempted or determined to be ineffective prior to the introduction of more restrictive measures.

Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours: 4 hours for adults 18 years of age or older

- I. The Physician signs and dates the order and the progress note at the time that he/she assesses the patient **within one hour** after the initiation of the intervention.
- J. When the seclusion or restraint intervention is terminated before the time-limited order expires, that original order can not be used to reapply the restraint or seclusion. If the patient again becomes an imminent risk of physically harming himself / herself or others, and non-physical interventions are not effective, a physician must be contacted to issue a new order.
- K. If a seclusion or restraint intervention is renewed by a physician after four (4) hours, the Physician must reevaluate the patient in person and write another progress note. The Physician reevaluates the efficacy of the patient's treatment plan and works with the individual to identify ways to help him or her regain control.
- L. End point criteria- The use of restraint/seclusion should be frequently evaluated and ended at the earliest possible time based on the assessment and reevaluation of the patient's condition. Staff should continually assess the patient to ascertain his or her condition and to determine whether restraint or seclusion can be discontinued. The decision to discontinue the intervention should be based on the determination that the patient's behavior is no longer a threat to himself / herself or others.

## II. **MONITORING OF PATIENTS DURING SECLUSION OR RESTRAINT**

- A. Patients in restraints are monitored via 1:1 observation. Patients in seclusion are monitored through ***continuous*** visual or auditory observation. Staff who monitor patients in seclusion are physically stationed directly outside the seclusion room door.
- B. All patients are assessed at least every fifteen (15) minutes or more frequently if clinically indicated. All attempts are made to assess the secluded patient in person, depending on his/her clinical status. In cases where the secluded patient is in crisis without behavioral control and is threatening harm to others, assessment and monitoring may be accomplished by constantly observing and communicating with the patient

through the observation window. If the patient is engaging in behavior that is self-injurious or refuses to move into the line of sight, the door is unlocked under the direction of the Licensed Nursing staff and a minimum of two (2) staff must be present to enter the room.

- C. The staff member assigned to observe the patient in seclusion or restraint explains that he or she will be available as needed to provide for fluids, toileting, or other needs of the patient. Any requests for such needs are to be met promptly. Intake and toileting are to be documented when they occur on the Seclusion or Restraint Record sheet. At all times, the staff must be cognizant of the patient's right to privacy and respectful care that maintains his or her dignity.

### III. ASSESSING AND ASSISTING THE PATIENT IN SECLUSION OR RESTRAINTS

- A. Nursing staff utilize a *Seclusion or Restraint Record* sheet for each occurrence of seclusion or restraints (see attached). **Beginning at the time of the initiation of the intervention**, the assigned staff member documents every 15 minutes on the *Seclusion or Restraint Record* sheet the observed behaviors of the patient along with any needs provided during the intervention. These assessments include:
1. Vital signs (blood pressure, pulse, respiration) and interpreting their relevance to the physical safety of the patient in restraint or seclusion. (**NOTE**: When this is not possible due to the patient's behavior, documentation to this effect is required.)
  2. Recognizing nutritional/hydration needs. (**NOTE**: Meals are restricted to finger foods [no utensils] and the patient is observed continuously while he/she is eating. The Licensed Nursing staff removes one arm restraint to allow the patient in restraints to eat in a semi-sitting position. When this is not possible due to the patient's behavior or refusal, a liquid nutritional supplement can be provided and documented.)
  3. Checking circulation and skin integrity.
  4. Checking range of motion in the extremities by a Licensed Nursing Staff. (**NOTE**: The process of removal and if necessary reapplication is done on one limb at a time. When this is not possible due to the patient's behavior, documentation to this effect must be made in the "Nursing Assessment" section.)
  5. Addressing hygiene and elimination. (**NOTE**: The patient in restraints is offered the use of a urinal or bedpan.)

6. Addressing physical and psychological status and comfort by talking with the patient and addressing complaints of discomfort or distress.
  7. Assisting patients in meeting behavior criteria for the discontinuation of restraint or seclusion.
  8. Recognizing readiness for the discontinuation of restraint or seclusion and communicating this readiness to the Licensed Nursing staff.
  9. Recognizing when to contact Licensed Nursing staff who will contact the Attending Physician or MOD in order to evaluate and/or treat the patient's physical status.
- B. Staff utilize the "Comments" section to elaborate on all areas of assessment that require further clarification so that the patient's condition and needs and services provided are clearly described.
- C. Clinical leadership (Director of Nursing, Medical Director, and Director of Professional Services) are informed on the next regular work day of instances in which patients experience extended, or multiple episodes of restraint or seclusion to include the following:
1. any instance in which a patient remains in seclusion or restraint for more that 12 hours.
  2. two (2) or more separate episodes of seclusion and/or restraint of any duration within 12 hours.
  3. If either of the above conditions continue, the leadership is notified every 24 hours.
- D. This information is reviewed to assess whether additional resources are required to facilitate discontinuation of seclusion or restraint and to minimize recurrent instances.

#### **IV. TERMINATION OF INTERVENTION**

- A. In addition to the Q15 monitoring by Nursing Staff, a Licensed Nurse assesses the status of the patient's condition every hour and documents this assessment on the Seclusion or Restraint Record.
- B. The Licensed Nurse directs the removal of the restraints, assessing the patient's response at the removal of each. If a fifth restraint has been used, it should be removed first. Four point restraints are removed by the following method: four point to three point, three point to two point, and the



last two restraints are removed simultaneously by two staff members (**one point restraint is never utilized**).

- C. If at any time during the restraint removal process, the patient continues to be a threat to self or others, full restraints must not be reapplied. A physician must be contacted for further instruction, up to and including a new order for restraints to be reapplied.
- D. Once seclusion or restraints have been terminated, the Licensed Nurse debriefs the patient regarding the intervention and completes the Seclusion/Restraint Patient Feedback form prior to returning the patient to the unit milieu. If completing the Patient Feedback questionnaire is contraindicated immediately after the event, the questionnaire is completed by a member of the Treatment Team within 24 hours. Counseling is provided for any trauma that may have resulted from the incident. A copy of the Patient Feedback form is forwarded to the Performance Improvement Department where it is incorporated into performance improvement activities. The original form is attached to the seclusion/restraint paperwork and filed in the patient's medical record. This information is used by the Treatment Team to incorporate the patient's feedback into his/her treatment plan.
- E. The Nursing Supervisor reviews all episodes of seclusion or restraint for completeness of the required documentation. The Nursing Supervisor signs, dates, and times the reviewed documentation forms. The Nursing Supervisor ensures that the original documentation remains in the medical record and a copy is forwarded to the Performance Improvement Department.

## V. FOLLOW-UP

- A. All cases of seclusion or restraints are reviewed at each scheduled meeting of the Treatment Team. Recurring issues leading to seclusion or restraint must be addressed on the patient's treatment plan. The discussion and documentation may include, but are not limited to, changing the clinical plan for treatment, other less restrictive alternatives and changing the dose or type of medication prescribed for the patient.
- B. The Treatment Team identifies and explains to the patient the behavior that leads to seclusion or restraints and the requirements for terminating seclusion or restraints. The Treatment Team uses the information contained in the Seclusion/Restraint Patient Feedback form at the first Treatment Team meeting after the seclusion or restraint incident.
- C. The Treatment Team refers to and reviews page 1 of the Advance Directive Query form to ensure that the patient's suggested strategies for dealing with crises have been considered in the less restrictive alternatives attempted by staff. The Treatment Team documents any new information

received from the patient on the Advance Directive Query form for future use.

- D. The seclusion or restraints issues identified on a patient's treatment plan must be reviewed during the regularly scheduled patient treatment plan review.
- E. The death of any patient, for any reason, while in restraint or seclusion must be reported to the CMS Regional Office (RO). Also, any patient's death that occurs after seclusion or restraint has been discontinued and where the patient's death could be reasonably related to that patient having been in restraint or seclusion must be reported to the RO. The Nursing Supervisor will report all patient deaths associated with the use of seclusion or restraint, by telephone (215-861-4140), to their CMS-RO prior to the close of business, the next business day after the patient's death.

## VI. PERFORMANCE IMPROVEMENT

- A. The following data is collected on each episode of seclusion or restraint:
  - 1. treatment unit / shift
  - 2. staff who initiated the intervention
  - 3. length of each episode
  - 4. date and time each episode was initiated
  - 5. day of the week each episode was initiated
  - 6. type of restraint used
  - 7. whether injuries were sustained by patient or staff
  - 8. age of the patient
  - 9. gender of the patient
- B. Particular attention is given to the following:
  - 1. Multiple instances of restraint or seclusion experienced by a patient within a 12-hour time frame
  - 2. The number of episodes per patient
  - 3. Instances of restraint or seclusion that extend beyond 12 consecutive hours
  - 4. Use of psychoactive medications as an alternative for or to enable discontinuation of restraint or seclusion
- C. Licensed independent practitioners participate in measuring and assessing use of restraint and seclusion for all patients in the Hospitals.
- D. The Performance Improvement Department submits regular reports to the Performance Improvement Steering Committee, Medical Staff, and the Governing Authority, regarding its recommendations for improvement.

**VII. STAFF TRAINING**

- A. Staff education and training will be provided both as a part of General Orientation of all new and contract staff and as a part of ongoing in-service training for all staff who have direct patient care responsibilities, responsibilities for application of restraint, or the monitoring or assessment of patients in restraints.
- B. Training content will include the following:
  - 1. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.
  - 2. The use of nonphysical intervention skills.
  - 3. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.
  - 4. The safe application and use of all types of restraint or seclusion used in facility, including training in how to recognize and respond to signs of physical and psychological distress.
  - 5. Clinical identification of specific behavioral changes that indicate the restraint or seclusion is no longer necessary.
  - 6. Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with 1 hour face-to-face evaluation.
- C. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.
- D. Individuals providing the training are qualified as evidenced by education, training and experience in techniques used to address patients' behaviors.
- E. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.

Delaware Psychiatric Center  
**Seclusion or Restraint  
Nursing Assessment**

TIME INTERVENTION BEGAN: \_\_\_\_\_:\_\_\_\_\_ am/pm

SECLUSION     4 POINT RESTRAINTS     5 POINT RESTRAINTS     OTHER: \_\_\_\_\_

Patient's name: \_\_\_\_\_ Unit: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT BEHAVIOR LEADING TO INTERVENTION: (CHECK all specific behaviors that apply)**

<input type="checkbox"/> Threatening harm	<input type="checkbox"/> Destruction of property	<input type="checkbox"/> Biting	<input type="checkbox"/> Hair pulling
<input type="checkbox"/> Imminent risk of harm to: <input type="checkbox"/> self <input type="checkbox"/> patients <input type="checkbox"/> staff	<input type="checkbox"/> Unprovoked aggression i.e., striking out without warning	<input type="checkbox"/> Hitting	<input type="checkbox"/> Spitting
specify: _____	<input type="checkbox"/> Self-injurious behaviors specify: _____	<input type="checkbox"/> Kicking	<input type="checkbox"/> Throwing objects
		<input type="checkbox"/> Shoving	<input type="checkbox"/> Fire-setting
		<input type="checkbox"/> Scratching	<input type="checkbox"/> Other: _____

**EMERGENCY SITUATION** (less restrictive alternatives were not able to be attempted due to rapid escalation of immediately dangerous behavior) explain: \_\_\_\_\_

**LESS RESTRICTIVE ALTERNATIVES UTILIZED: (CHECK all that were attempted relative to this immediate event)**

<input type="checkbox"/> Talked with the patient	<input type="checkbox"/> Set limits with the patient	<input type="checkbox"/> One-to-one observation
<input type="checkbox"/> Addressed patient's need _____	<input type="checkbox"/> Redirected the patient verbally	<input type="checkbox"/> Offered PRN medications
<input type="checkbox"/> Used techniques suggested by the patient as noted in the Advance Directive query form	<input type="checkbox"/> Separated the patient from the area	<input type="checkbox"/> Involuntary administration of medication: _____
specify: _____	<input type="checkbox"/> Verbal contract for safety	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Voluntary quiet room/time out	

**Physiological or psychological risk factors (Determine by reviewing H&P, Psychiatric Assessment):**

Pre-existing medical conditions     Physical disabilities     Hx of sexual abuse     Hx of physical abuse     None  
specify: \_\_\_\_\_

**Physician who gave verbal order:** \_\_\_\_\_

**Physician was notified of risk factors by:** \_\_\_\_\_

**Physician was notified of 1 hour time limit to sign order by:** \_\_\_\_\_

**Patient checked for dangerous objects** (i.e., belts, sharps, shoes, matches, jewelry, money, etc.): \_\_\_\_\_

List of objects removed (exact amt. of money): \_\_\_\_\_

Removed by: \_\_\_\_\_ Location stored: \_\_\_\_\_

**BEHAVIORAL EXPECTATION FOR TERMINATION OF INTERVENTION (Copy onto S/R Record form):**

- 1. Resting quietly, either sitting or lying down for \_\_\_\_\_ minutes (specify – example 5, 10, 15 etc.)
- 2. Patient is able to discuss/interact with staff in a calm manner.
- 3. Patient is calm and able to verbalize a desire for intervention to be discontinued.
- 4. Patient is calm and able to verbalize an understanding of behavior that led to intervention
- 5. Patient is calm and able to contract for safety.

**Patient was informed of behavioral expectation for discontinuation of intervention by:** \_\_\_\_\_

**Licensed Nursing Staff:** \_\_\_\_\_

(Signature and title of individual who initiated intervention)

**DOCTOR ASSESSMENT WITHIN ONE (1) HOUR** : \_\_\_\_\_

**MD Signature** \_\_\_\_\_ Time: \_\_\_\_\_:\_\_\_\_\_ am/pm

**FAMILY NOTIFICATION**

Name of family member: \_\_\_\_\_ Date: \_\_\_\_\_

Name/title of staff person: \_\_\_\_\_ Time: \_\_\_\_\_:\_\_\_\_\_ am/pm

**DATE/TIME INTERVENTION ENDED:** \_\_\_\_\_ / \_\_\_\_\_ : \_\_\_\_\_ am/pm TOTAL TIME: \_\_\_\_\_ hrs \_\_\_\_\_ min.

**Patient was debriefed by:** \_\_\_\_\_ **If no, explain:** \_\_\_\_\_

**Licensed Nursing Staff:** \_\_\_\_\_

(Signature and title of individual who discontinued intervention)

**Nursing Supervisor:** \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_:\_\_\_\_\_ am/pm

(Signature indicates the above information has been reviewed and is accurate and complete)

**SECLUSION OR RESTRAINT RECORD**

PATIENT'S NAME: \_\_\_\_\_ MEDICAL RECORD # \_\_\_\_\_ DATE: \_\_\_\_\_

Document behavioral criteria required for discontinuation (per S/R Nursing Assessment sheet): \_\_\_\_\_

1=Yelling/cursing 3=Struggling/pulling on restraints 5=Lying on bed 7=Sitting on bed 9=Banging/kicking door/wall/bed 11=Refusing to talk to staff 13=Talking with staff  
 2=Verbal threats 4=Pacing 6=Lying on floor 8=Sitting on floor 10=Standing at door 12=Resting/quiet 14=Other (Specify)

Time Q 15 "	Be- havior  See codes above	Patient is Free of Injury  (Y) yes (N)* no	Vital Signs  (list actual readings)  (N)* not obtainable	Toileting accepted by patient  (Y) yes (N) no	Hy- giene (clean)  (Y) yes (N)* no	Hydration/ Nutrition Offered  (Y) yes (N) no  Fluids Meals		Status/ Com- fort (are within normal limits for S/R)  (Y) yes (N)* no  Phys. Psycho- logical		Discon- tinuation Criteria met  (Y) yes (N) no	Init.	COMMENTS  *Explain any "N" that was noted that has an asterisk. Explain what action was taken (injury, hygiene, status/comfort, skin integrity, circulation, or range of motion) or why the assessment could not be completed (vital signs).	To be completed & initialed by the RN/LPN Q15" while patient is in restraints			Init. of RN or LPN
						Skin Integ. WNL (Y) yes (N)* no	Circu- lation WNL (Y) yes (N)* no	ROM WNL (Y) yes (N)* no								

**Licensed Nurse's Hourly Assessment for patient in seclusion and restraint (documented and initialed in line below)**

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Licensed Nurse's Comments: \_\_\_\_\_


**Licensed Nurse's Hourly Assessment for patient in seclusion and restraint (documented and initialed in line below)**

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Licensed Nurse's Comments: \_\_\_\_\_

Initials	Signature	Initial	Signature	Initials	Signature	Initials	Signature

Nursing Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_:\_\_\_\_ am/pm  
 (Note: Signature indicates the above information has been reviewed and is accurate and complete.)

**SECLUSION/RESTRAINT PATIENT/FAMILY AND STAFF DEBRIEFING**

Completed by the House Supervisor (off-shifts, weekends, holidays) and Nurse Manager/designee (day shift – weekdays) with staff who were involved in the event. Completed by the House Supervisor (off-shifts, weekends, holidays) and Nurse Manager/designee (day shift– weekdays) with the patient when the seclusion or restraint is discontinued. If the patient is unable to debrief immediately after the S/R, debriefing must occur within 24 hours. **(Fax within 24 hrs to PI Dept. 54418)** (Attach this form to S/R paperwork for Tx Team review and file in chart)

**Patient's Name:** \_\_\_\_\_ **Unit:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Seclusion**      **Restraint**      **Time intervention began:** \_\_\_\_\_ :

am/pm      **Time intervention ended:** \_\_\_\_\_ : \_\_\_\_\_ am/pm

**STAFF RESPONSES (# 1 – 3 below; debriefing staff signature required\*)**  
**Staff who were actively involved in secluding or restraining patient or events leading up to it:** \_\_\_\_\_  
**\*Signature of staff who debriefed involved staff:** \_\_\_\_\_  
 Date: \_\_\_\_\_ Time: \_\_\_\_\_ : \_\_\_\_\_ a.m./p.m.

**PATIENT RESPONSES (# 1 – 8 below; debriefing staff signature required\*)**  
**\*Signature of staff who debriefed patient:** \_\_\_\_\_  
 Date: \_\_\_\_\_ Time: \_\_\_\_\_ : \_\_\_\_\_ a.m./p.m.

1. What led to the patient being secluded or restrained?

1. What led to you being secluded or restrained?

2. What did staff do to help the pt before he/she was secluded or restrained?  
 Individual attention, talked with patient  
 Addressed patient's need: \_\_\_\_\_  
 Used calming techniques previously suggested by patient or your family: \_\_\_\_\_  
 Suggested other things pt could do: \_\_\_\_\_  
 Contacted trusted staff  
 Contacted family/significant other  
 Offered medication  
 Suggested time out or the Quiet Room  
 Explained that seclusion/restraints may be necessary  
 Other: \_\_\_\_\_

2. What did staff do to help you before you were secluded or restrained?  
 Individual attention, talked with you  
 Addressed your need: \_\_\_\_\_  
 Used calming techniques previously suggested by you or your family: \_\_\_\_\_  
 Suggested other things you could do: \_\_\_\_\_  
 Contacted trusted staff  
 Contacted family/significant other  
 Offered medication  
 Suggested time out or the Quiet Room  
 Explained that seclusion/restraints may be necessary  
 Other: \_\_\_\_\_

3. What could have prevented the patient from being secluded or restrained?

3. What could have prevented you from being secluded or restrained?

**PATIENT RESPONSES**

4. Were your personal dignity and privacy respected?

5. Did you feel safe while you were secluded or restrained?

6. Did being secluded or restrained help you regain control?

7. What were you told that you needed to do in order to stop being secluded or restrained?

8. Did anything happen during the event that may have frightened, injured or made you feel uncomfortable?

**COMPLETED BY TREATMENT TEAM:**

How and by whom were patient's responses or family's concerns addressed with the patient/family:

Treatment Team Signatures:

Physician Signature: