GUIDELINES FOR COMPLETING SECLUSION/RESTRAINTS FORMS

ID NOTES FOR INITIATION OF SECLUSION/RESTRAINT


1. Circumstances that led to use of seclusion or restraints – Information documented should include circumstances that led to the use of seclusion or restraint, the location, antecedent behaviors (significant behaviors occurring prior to the event).
2. ID Note for Crisis Cycle Intervention Completed – Indicate completion by a check mark. Include the least restrictive interventions utilized or why they were not utilized.
3. Describe patient behaviors during seclusion which….. – During the seclusion process, describe the behaviors that explain the need for the application of restraints. If behaviors do not indicate a need for application of restraints, write NA.
4. Describe patient behaviors during restraint process which….. – During the restraint process, describe the behaviors that explain the need for the use of seclusion. If the behavior did not indicate a need for seclusion, write NA.
5. Interventions provided – Check or document interventions provided to the patient. Document the time CO or VC was initiated; circle am or pm. Document belongings retained and valuables envelope number as applicable.
6. Discussed with patient – Check each area as reviewed with patient. Include patient response to discussion.
7. Names of staff involved in seclusion/restraint intervention – List names of staff members involved in the application of seclusion/restraint intervention. Use first initial and last name only.
8. Assessment for physical injury – Ask patient about any physical discomfort or pain; document patient’s response. Observe patient for any physical discomfort/injury; document observations and interventions provided.

ID NOTE OF RN ASSESSMENT WHILE IN SECLUSION/RESTRAINT

Document date and time, unit, problem number. After “RN Assessment” write the number which indicates which RN assessment is currently being performed, i.e., if it is the second assessment since seclusion or restraint, then write “2”, if it is the third, write “3”. Document how assessment is being performed, either through the seclusion room window or face to face.

1. Psychological Assessment in relation to Criteria for Release – Check all that apply under behavioral observation and speech pattern. Under “other”, document descriptions not included on form.
2. Physiological Assessment – Check all that apply during assessment. Address each physiologic need.
A. Nutrition/hydration: Document assessment of need for nutrition and hydration. Document percentage (%) of food consumed and amount (cc) of fluid accepted.

B. ADLs: Document assessment of need for hygienic measures. Check all that apply and document additional care provided under “other”.

C. Exercise/physical activity: Document assessment of need for exercise/physical activity. Check each item as applicable. Document additional care provided and/or relevant assessment data under “other”.

D. Vital signs: Document assessment of need for vital signs every 15 minutes, i.e. observation of difficulty breathing, sweating, etc., and include vital signs as often needed, but at a minimum every hour.

E. Injury/illness: Assess patient for any signs of injury or illness. Document the assessment of skin integrity of restrained limbs. If skin is not warm dry, and intact, include description. Document assessment and any interventions provided. Include any notifications made to MD.


4. Patient response indicating progress toward criteria for release – Check all that apply. If there are other or additional patient responses to interventions, include in space marked “other”.

5. Additional interventions utilized – If assessment/evaluation of patient behaviors indicate need for additional restrictive interventions, check the intervention utilized. If no additional interventions utilized, check NA. Document new MD order and criteria for release in ID Note section provided.


ID NOTES OF RN ASSESSMENT FOR RELEASE FROM SECLUSION/RESTRAINT

Document date and time, unit, problem number.

1. RN evaluation of current behaviors in relation to criteria for release – Identify the patient behaviors that meet the criteria for release. Check all that apply and document additional behaviors not identified on form under “other”.

2. Released – Document the time of the release of interventions.

3. Transitional Support Offered – Check all interventions provided to patient at the time of release. Document additional support offered under ”other”.


5. Include additional comments in designated ID Note section.

ID NOTES FOR SECLUSION/RERAINT DEBRIEFING

Document date and time, unit, problem number.
1. Does the patient want family or other care givers present for discussion of the incident – Record patient response.
2. What does the patient remember about the events which led to restraints or seclusion? If the patient is unable to recall – Ask the patient what he or she remembers about events which led to seclusion/restraint, record response. If patient is unable to recall the event, review and discuss the event. Clarify any misperceptions. Record discussion.
3. Discuss how patient’s behavior met criteria for release - Review the patient’s behavior that demonstrated readiness for release. Place check mark after completion of discussion.
4. Discuss what could have been handled differently – Review with patient how things might have been handled differently. Get patient’s input. Document patient’s response. Discuss alternatives to avoid seclusion room or restraints in the future – Discuss with patient what alternatives can be used in the future to avoid further use of seclusion/restraints. Document alternatives discussed.
5. Review with patient if patient rights – Discuss with patient if physical/psychological needs and right to privacy were addressed during seclusion/restraint. Document response. Advised of opportunity to discuss issue – Advise patient of opportunity to discuss issues with the advocate as needed.
6. Address any trauma that may have occurred as a result of the incident – Ask patient about any physical or emotional trauma experienced during the incident. Document discussion with patient.
7. Treatment plan modified to include the above information – Update nursing care plan as needed, based on additional information.
8. Sign form after completion.

ID NOTE FOR CONTINUING SECLUSION/RESTRAINT WHEN CRITERIA FOR RELEASE NOT MET

Document date and time, unit, problem number. Document name of MD and/or RN involved in face to face re-evaluation of patient.
1. Behavior posing a danger to self or others requiring – Document behavior of patient indicating danger to self or others. Be very descriptive regarding the specific behaviors the patient is demonstrating that requires a continuation of seclusion or restraints.
2. Alternative interventions considered and rejected – Document interventions considered and discussed, but not implemented. Reflect discussion in documentation.
3. Interventions to promote release – Identify the interventions that will be utilized to promote release of the patient from seclusion or restraints.