Behavioral Management Restraint/Seclusion
Nursing Flow Sheet and Progress Notes

Instructions for Use

1. Check appropriate Division
2. Print or addressograph patient's name and MPI number
3. Describe emergency situation and precipitating factors
4. "All Available/Code Called" – check yes or no
5. Categorize Emergency Situation – check all that apply
6. Procedure
   - check all that apply
   - record MD ordering Restraint or Seclusion
   - record time placed in Restraint or Seclusion
     (record time taken out at termination of procedure)
   - record RN signature, date and time
7. Check all less restrictive interventions attempted, describe specific intervention9s) and patient response
8. Describe behavior(s) which will demonstrate that the patient is no longer imminently dangerous to self/others
9. RN Assessment and progress notes – assess the patient by direct observation and review of documented care and observation by assigned staff
10. Observation and Care of the Patient – assigned staff must document observation and care of the patient every 15 minutes using the Observation and Care codes.
    Requirements include:
    Circulation check every 15 minutes
    Range of motion every 2 hours
    Offer of fluids/toilet every 2 hours
    Recording intake & output
    Temperature every 2 hours
    Blood pressure hourly
    Pulse & respirations every 30 minutes
11. Signature Log – assigned staff must initial and sign
12. Summary Progress Note – the RN will note the patient's mental and physical condition, response to the procedure, and recommended strategies to prevent recurrence
13. Nursing Supervisor review – the RN Supervisor will review the restraint/seclusion episode and flow sheet/Progress Notes for appropriateness, accuracy, and completeness. The RN Supervisor will record signature, date and time as indicated