

**PART I - Initial Assessment by RN and MD/DO**

Patient Name: \_\_\_\_\_

☐ General Psychiatry Division

Shift: \_\_\_\_\_

☐ Whiting Forensic Division

Unit: \_\_\_\_\_

Date: \_\_\_\_\_ MPI # \_\_\_\_\_

Print or Addressograph Imprint

☐ Addiction Services Division**NURSING ASSESSMENT:****Behavioral Assessment:** Describe the precipitating factors and the patient behavior(s) resulting in an imminent risk/emergency, the specific interventions used and the patient's response to each intervention prior to initiation of seclusion/restraint.**Describe the patient's specific behavior(s) leading to imminent risk:** \_\_\_\_\_**Describe the antecedents and precipitating factors/circumstances that led to the behavior(s) described above necessitating seclusion or restraint:** \_\_\_\_\_**Physical Assessment:** Include consideration of pre-existing medical conditions, physical disabilities and history of sexual or physical abuse and any special interventions needed: \_\_\_\_\_**Therapeutic Interventions Attempted** – List types of interventions provided and the patient's response to each intervention (*must include description of actual behavior and/or a quote from the patient*). Indicate if the intervention used was obtained from the patient's Personal Safety Preferences (PSP) form CVH-469 or as recorded in the Nursing Assessment/Reassessment).

Personal Safety Preference Interventions	Patient's Response in Behavioral Terms
Other Interventions	
Clinical Interventions Considered ( <i>Not Used</i> )	Rationale

**Justification for Seclusion/Restraint** (*Check all that apply*): ☐ Imminent risk of serious physical assault  
☐ Imminent risk of serious self destructive behavior**"All Available"/Code Called?** ☐ Yes ☐ No**Procedure(s):** Round seconds up to the next minute (*example* 12:20:05 is rounded up to 12:21). When more than one intervention is used sequentially, the stop time of the 1<sup>st</sup> (*i.e.* Secure Guide Escort) should be the start time of the second (*i.e.* Seclusion).(*Check all applicable interventions*)

<b>Seclusion</b>	Date	Start Time	Stop Time	Total Time In:
<input type="checkbox"/> Locked		AM/PM	AM/PM	Hrs. Min.
<input type="checkbox"/> Unlocked		AM/PM	AM/PM	Hrs. Min.
<b>Physical Restraint</b> <i>✓ all that apply</i>	Date	Start Time	Stop Time	Total Time:
<input type="checkbox"/> Secure Guide Escort		AM/PM	AM/PM	Min.
<input type="checkbox"/> Third Person Assist				
<input type="checkbox"/> Take Down				
<input type="checkbox"/> Physical Hold				
<b>Mechanical Restraint</b>	Date	Start Time	Stop Time	Total Time In:
<input type="checkbox"/> 4 Point		AM/PM	AM/PM	Hrs. Min.
<input type="checkbox"/> Mittens		AM/PM	AM/PM	Hrs. Min.
<input type="checkbox"/> Soft Limb Holders		AM/PM	AM/PM	Hrs. Min.

**Distribution: Original – Chart** (*file in date order in the Psychiatric Progress Note Section*) **Photo Copy – Data Entry**

<input type="checkbox"/> Posey Net COPS/DON Authorization Required – MD/DO Completes CVH-618 – Date of Response: _____					
Authorized? <input type="checkbox"/> Yes <input type="checkbox"/> No	RN Initials: _____	AM/PM	AM/PM	Hrs.	Min.
<input type="checkbox"/> Other Non-Standard Mechanical Restraint Device: _____					
COPS/DON Authorization Required – MD/DO Completes CVH-618 – Date of Response: _____					
Authorized? <input type="checkbox"/> Yes <input type="checkbox"/> No	RN Initials: _____	AM/PM	AM/PM	Hrs.	Min.

**Patient notified of criteria for discontinuation, as outlined in the MD/DO order.**

\_\_\_\_\_  
Signature (Assessing RN)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_ am/pm

**Nursing Supervisor:** I have reviewed the imminent need for seclusion/restraint with the Assessing RN as to the necessity of this intervention at: Time: \_\_\_\_\_ AM/PM Date: \_\_\_\_\_.

Signature Nursing Supervisor: \_\_\_\_\_ Print \_\_\_\_\_

## PHYSICIAN FACE TO FACE ASSESSMENT:

**Describe the emergency/imminent risk, that lead to seclusion/restraint usage, also document any noted physical injuries. (If necessary use additional Progress Note sheet(s) and attach.):**

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**Continuation Assessment:** Describe the patient's current condition and justification regarding either the discontinuation of seclusion/restraint or the need to continue use of seclusion/restraint:

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**Review of Systems** for Significant Medical Conditions and or History of Physical/Sexual Trauma (*that may require extra caution when using seclusion and/or restraint*):

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**Applicable Labs** (that would require extra caution when using seclusion and/or restraint or may be contributory to the current behaviors) **Reviewed and Conclusions:**

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<b>Psychotropic Medication Status <u>PRIOR</u> to Seclusion/Restraint</b> <input type="checkbox"/> Routine psychotropic medication ordered and taken <input type="checkbox"/> Routine psychotropic medication ordered and NOT taken <input type="checkbox"/> No routine psychotropic medication ordered <input type="checkbox"/> PRN psychotropic medication ordered <input type="checkbox"/> STAT/emergency psychotropic medication administered: <input type="checkbox"/> PO <input type="checkbox"/> IM	<b>Physical Restraint required for Medication Administration?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, for: <div style="margin-left: 40px;"> <input type="checkbox"/> Emergency Medication  <input type="checkbox"/> Court Ordered Medication         </div>
<b>Attending MD/DO Consulted at:</b> Time _____ AM/PM Date: _____ <input type="checkbox"/> N/A – If N/A explain: _____	
<b>Notification of Conservator/Family</b> <i>(completed by Attending Psychiatrist/designee OR On-Call MD/DO/designee)</i> <b>Does the Patient have a Conservator of Person?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes: Name of Conservator: _____ <div style="margin-left: 100px;">Relationship to Patient: _____</div> <div style="margin-left: 100px;">Conservator notified by: _____</div> <div style="margin-left: 100px;">Conservator's response: _____</div>	
<b>Was family notified?</b> <i>(Check for release of information and directives recorded on the Admission Nursing Assessment - Section VII, Annual Nursing Assessment - Section VI-F or the Personal Safety Preference Form CVH-469.)</i> <input type="checkbox"/> Family member is the Conservator <i>(Record notification and response above.)</i> <input type="checkbox"/> Yes - Family notified by: _____ Name of Family Member: _____ <div style="margin-left: 40px;">Family's response: _____</div> <input type="checkbox"/> No, patient unable to give permission <input type="checkbox"/> No, patient prohibits notification <input type="checkbox"/> Other directive: _____	
<div style="display: flex; justify-content: space-between; border-top: 1px solid black; border-bottom: 1px solid black;"> <span>_____</span> <span>_____</span> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>Physician Signature</b></span> <span><b>Print Name</b></span> <span><b>Date</b></span> <span><b>Time</b> _____ am/pm</span> </div>	
<b>I have reviewed this seclusion/restraint episode for appropriateness and completeness of documentation.</b> <div style="display: flex; justify-content: space-between; border-top: 1px solid black; border-bottom: 1px solid black;"> <span>_____</span> <span>_____</span> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-between;"> <span>Signature (Nursing Supervisor)</span> <span>Print Name</span> <span>Date</span> <span>Time _____ am/pm</span> </div>	