CVH-480a **CONNECTICUT VALLEY HOSPITAL**

Rev. 1/31/18 **Seclusion/Restraint**

PART I - Initial Assessment by RN and MD/DO

Patient Name: _____

Division **Shift:** _____

[ ] Addiction Services Division **Unit:** _____ **Date:** _____ MPI # _____ *Print or Addressograph Imprint*

[ ] General Psychiatry 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 (*Not Used*)	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 1st (*i.e.* Secure Guide Escort) should be the start time of the second (*i.e.* Seclusion). (*Check all applicable interventions*)

Seclusion	Date	Start Time	Stop Time	Total Time In:
[ ] Locked		AM/PM	AM/PM	Hrs. Min.
[ ] Unlocked		AM/PM	AM/PM	Hrs. Min.
Physical Restraint √ *all that apply*	Date	Start Time	Stop Time	Total Time:
[ ] Secure Guide Escort [ ] Third Person Assist [ ] Take Down		AM/PM	AM/PM	Min.
[ ] Physical Hold				
Mechanical Restraint	Date	Start Time	Stop Time	Total Time In:
[ ] 4 Point		AM/PM	AM/PM	Hrs. Min.
[ ] Mittens		AM/PM	AM/PM	Hrs. Min.
[ ] 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**

[ ] Posey Net COPS/DON Authorization Required – MD/DO Completes CVH-618 – Date of Response:_____

Authorized? [ ]Yes [ ]No RN Initials: ___		AM/PM	AM/PM	Hrs.	Min.

[ ] Other Non-Standard Mechanical Restraint Device: _____
COPS/DON Authorization Required – MD/DO Completes CVH-618 – Date of Response: _____

Authorized? [ ]Yes [ ]No RN Initials: ___		AM/PM	AM/PM	Hrs.	Min.

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

_____ _____ _____ _____am/pm
Signature (Assessing RN) Print Name Date Time

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.*):

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:

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*):

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

Psychotropic Medication Status PRIOR to Seclusion/Restraint

[ ] Routine psychotropic medication ordered and taken
[ ] Routine psychotropic medication ordered and NOT taken
[ ] No routine psychotropic medication ordered
[ ] PRN psychotropic medication ordered
[ ] STAT/emergency psychotropic medication administered: [ ] PO [ ] IM

Physical Restraint required for Medication Administration?

[ ] No [ ] Yes – If yes, for:
[ ] Emergency Medication
[ ] Court Ordered Medication

Attending MD/DO Consulted at: Time _____ AM/PM Date: _____ [ ] N/A – *If N/A explain*: _____

_____

Notification of Conservator/Family (*completed by Attending Psychiatrist/designee OR On-Call MD/DO/designee)*
Does the Patient have a Conservator of Person?

[ ] No [ ] Yes - If Yes: Name of Conservator: _____

Relationship to Patient: _____

Conservator notified by: _____

Conservator's response: _____

Was family notified? (*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.*)

[ ] Family member is the Conservator (*Record notification and response above*.)

[ ] Yes - Family notified by: _____ Name of Family Member: _____

Family's response: _____

[ ] No, patient unable to give permission

[ ] No, patient prohibits notification

[ ] Other directive: _____

_____	_____	_____	_____ am/pm
Physician Signature	**Print Name**	**Date**	**Time**

I have reviewed this seclusion/restraint episode for appropriateness and completeness of documentation.

_____	_____	_____	_____ am/pm
Signature (Nursing Supervisor)	Print Name	Date	Time