CVH-480b **CONNECTICUT VALLEY HOSPITAL** Patient Name: _____

Rev 1/10 **PART II – NURSING OBSERVATION**

Side 1 **AND CARE OF THE PATIENT** MPI# _____ *Print or Addressograph Imprint*

[ ] General Psychiatry Division

[ ] Whiting Forensic Division **SECLUSION/RESTRAINT START DATE: _____ TIME: _____am/pm**

[ ] Addiction Services Division **Unit: _____**

RN ASSESSMENT AND PROGRESS NOTE: Initial Orders - RN documents a Behavioral/Physical Assessment at 15 min., 30 min., 1 hour and hourly thereafter. Reorders - RN documents hourly.

NOTE: *Physical restraints of less than 15 minutes requires completion of only the starred (*) sections below.

Initial 15 min* Date: _____ Time: _____AM/PM

Behavioral Assessment: _____

_____

Physical Assessment: _____

Circulation: [ ] Adequate [ ] Other:_____

Skin Integrity: [ ] Intact [ ] Other: _____

RN Signature: _____

Initial 30 min Date: _____ Time: _____AM/PM

Behavioral Assessment: _____

_____

Physical Assessment: _____

Circulation: [ ] Adequate [ ] Other:_____

Skin Integrity: [ ] Intact [ ] Other: _____

RN Signature: _____

Hourly/Reorder:

1 Behavioral Assessment:

Physical Assessment:

Circulation: [ ] Adequate [ ] Other:_____ Skin Integrity: [ ] Intact [ ] Other:_____

Date: _____ Time: _____*am/pm* P: _____ R: _____ BP: _____ RN Signature: _____

2 Behavioral Assessment:

Physical Assessment:

Circulation: [ ] Adequate [ ] Other:_____ Skin Integrity: [ ] Intact [ ] Other:_____

Date: _____ Time: _____*am/pm* P: _____ R: _____ BP: _____ RN Signature: _____

3 Behavioral Assessment:

Physical Assessment:

Circulation: [ ] Adequate [ ] Other:_____ Skin Integrity: [ ] Intact [ ] Other:_____

Date: _____ Time: _____*am/pm* P: _____ R: _____ BP: _____ RN Signature: _____

TIME *q 15 min*	**INIT MHA/ FTS**	**DESCRIPTION OF PATIENT BEHAVIOR** **Instructions: Staff assigned to Continuous Observation, initial below & complete signature log.**	**INTERVENTION** (*Use Codes Below*)
*			
1			
2			
3			

INTERVENTION(S) ATTEMPTED TO DISCONTINUE SECLUSION/RESTRAINT:

R	Use to indicate any intervention attempted but Refused	PE	Review of precipitating event with patient
REL	Offer patient & demonstrate/practice relaxation strategies	ER	Review emotional response with patient
ACT	Offer patient distracting/calming activities (e.g. reading, story telling, music, etc.)	AR	Offer/discuss alternative actions/responses with patient
MED	Offer patient medication	DC	Discontinued Procedure
SEN	Sensory Modalities	OTH	Other:

DISTRIBUTION: **Original - Chart** (*file behind corresponding Part I or Part III*) **Photo Copy** (*both sides*) – **Data Entry**

DISCONTINUATION OF SECLUSION/RESTRAINT Patient Name: _____

CVH-480b (*side 2*)

Rev. 1/10 MPI#: _____

Signature Log	Init	Signature Log	Init	Signature Log	Init

NEEDS ATTENDED TO:

Fluids Offered at least Every Hour: Amount:_____ Amount:_____ Amount:_____ Initials:____

Range of Motion at least Every 2 Hours: Time:_____ *am/pm* Time:_____ *am/pm* Time:_____ *am/pm* Initials:____

Temp Every 2 Hours: Time:_____ *am/pm* Time:_____ *am/pm* Time:_____ *am/pm* Initials:____

Meals Offered: [ ] Yes [ ] N/A Initials:_____ **Toileting Offered as Needed**: [ ] Yes [ ] N/A Initials:_____

Skin Care, Hygiene, Shower at least Every 24 Hours: [ ] Yes Time:_____ *am/pm* [ ] No Initials:_____

NOTE: *Physical restraints of less than 15 minutes requires completion of only the starred (*) sections below.

***DISCONTINUATION:**

Procedure is: [ ] Seclusion [ ] Physical Restraint [ ] Mechanical Restraint

End Date of Seclusion/Restraint: _____ Time: _____ am/pm **Total Time of Seclusion/Restraint Episode:** Hours _____ Min.____

Patient met criteria for discontinuation as outlined in MD order? [ ] Yes [ ] No – If no explain: _____

_____

***Patient Debriefing:** [ ] Yes [ ] No

If no, explain:

_____

_____

Patient Community Meeting:

[ ] Yes [ ] N/A

RN Summary Progress Note –Include patient's behavioral and physical condition, response to procedure, recommended alternative strategies to prevent recurrence. Include patient's and staff's perspective*. **RN to record "Stop Time" and "Total Time In" on Seclusion/Restraint Part I – form CVH-480a – Side One.**

_____

_____

_____

_____

_____

Physical Assessment:_____

Vitals: [ ] Stable [ ] Other: _____

Circulation: [ ] Adequate [ ] Other:_____

Skin: [ ] Intact [ ] Other:_____

***Was the patient injured:** [ ] No

[ ] Yes:[ ] On initiation of seclusion/restraint *Date & Time:* _____

[ ] While in seclusion/restraint *Date & Time:* _____

_____ _____ _____ _____am/pm

Signature (Assessing RN) 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