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

Rev 1/31/18 **PART II – NURSING OBSERVATION**

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

[ ] Addiction Services Division

[ ] General Psychiatry Division **SECLUSION/RESTRAINT START DATE: _____ TIME: _____am/pm**

.**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: _____

**Note: The 15 minute RN assessment is documented 15 minutes after the initiation of physical, mechanical or seclusion use.**

**Hourly Assessment:**

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: _____

| **TIME** *q 15 min* | **INIT MHA/ FTS** | **DESCRIPTION OF PATIENT BEHAVIOR** **Instructions: Staff assigned to Continuous Observation, initial below & complete signature log. Removal from Seclusion/Restraint is based on meeting discontinuation criteria in the MD Order.** | **INTERVENTION** (*Use Codes Below*) |
|---|---|---|---|
| * | | | |
| | | | |
| | | | |
| 1 | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| 2 | | | |

**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: |

| **Signature Log** | **Init** | **Signature Log** | **Init** | **Signature Log** | **Init** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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

**DISCONTINUATION OF SECLUSION/RESTRAINT**
CVH-480b (*side 2*) Rev. 1/31/18

Patient Name _____ MPI# _____

**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:_____

**Nursing Supervisor Assessment:** Any patient remaining in seclusion/restraint for more than 45 minutes requires an assessment by the RN Supervisor within the next 30 minutes.
I have reviewed the patient's status and determined in concert with the Assessing RN that the patient:
Has met behavioral release criteria ☐ Yes ☐ No
Continues to require the use of restraint/seclusion ☐ Yes ☐ No

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

**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<br>If no, explain: | **Patient Community Meeting:**<br>[ ] 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