



Appendix

Sample Forms and Checklists

- **Patient Debriefing Tool Following Restraint/Seclusion** provided by Stone Institute of Psychiatry, Northwestern Memorial Hospital, Chicago, IL
- **Core Skills and Knowledge for Direct Care Staff** provided by Ardent Health Services—Behavioral Health Group, Nashville, TN
- **Competency Test: Care of the Patient in Restraints or Seclusion** provided by Stone Institute of Psychiatry, Department of Psychiatric Nursing, Northwestern Memorial Hospital, Chicago, IL
- **Patient Reported Therapeutic Interventions Survey** provided by the Milwaukee County Mental Health Division, Milwaukee, WI
- **De-Escalation Tips** provided by the Milwaukee County Mental Health Division, Milwaukee, WI
- **Checklist for Using Seclusion and Restraint** from Melonas, J. (2000, December 1). Seclusion and restraint. Dos and don'ts. *Psychiatric News*, pp. 9, 47.
- **Restraint/Seclusion Assessment and Physician Order Set (MC 1156-41 and MC 1156-42)** used at Mayo Medical Center and copyrighted by © Mayo Foundation for Medical Education and Research (MFMER)

Provided by Stone Institute of Psychiatry
Northwestern Memorial Hospital
Chicago, IL

Patient Debriefing Tool Following Restraint/Seclusion

(to be completed within 4–24 hours after release from restraint/seclusion (r/s) by assigned RN)

1. Is there anything staff could have done to assist you with regaining control prior to going into R/S?
2. Were you attempting to give others cues that you were in need of special assistance or beginning to feel “out of control”?
3. Do you know why staff determined that you needed to be in seclusion and/or restraints?
4. In your estimation, was the length of time spent in R/S appropriate? Yes No *(circle one)*
Do you think you could have returned to the unit sooner? Yes No *(circle one)*
5. You were in restraints/ seclusion for _____ hours. How did that time pass for you?
6. How do you feel regarding the care that was provided to you?
Were your needs met? Yes No *(circle one)*
Were you treated with respect? Yes No *(circle one)*
Was your privacy maintained? Yes No *(circle one)*
7. What was the most helpful regarding the intervention?
What was least helpful?
8. How could we have made re-entry (your return to the unit, group, your peers) easier for you?

Provided by Ardent Health Services
Behavioral Health Group
Nashville, TN

Core Skills and Knowledge for Direct Care Staff

This organization has identified the following *core skills and/or knowledge* that they believe *direct care staff* should have in order to be more successful with psychiatric patients.

Skills include the ability to:

- Involve patients and family members.
- Assess and acknowledge the *patient's point of view*.
- Optimize the patient's role in treatment from initial assessment to treatment planning to daily and shift-by-shift goal setting related to the treatment plan. Staff members need to genuinely ask the question: "How can I best help you?"
- Involve patients in identifying what has worked, or not worked, before — by others and by us.
- Assess the patient at the point of intake, in the nursing assessment, and at the beginning of every shift.
- Develop rapport with patients. This includes skills such as how to talk with patients, how to listen, and how to work with patients with whom there is a negative countertransference.
- Teach patients the coping, communication, de-escalation, and self-soothing skills they require to be successful in managing their behavior.
- Identify when a patient may encounter a "trigger" and ways to intervene at the beginning of the experience. Give the staff many intervention strategies/tactics and the power to use them. Teach staff to see the escalation coming and give them skills to help the patient be successful in managing it.
- All therapists must communicate with the team about significant events and potential triggers, especially when the patient moves from one setting/staff to another. It is the responsibility of all staff to be sure essential information is communicated.
- Give directions in ways that positively engage the patient in the interaction.
- Set limits in ways that maximize the patient's sense of control and involvement.
- Implement time-outs in an individualized way.

- Identify and avoid power struggles. Power struggles often result from a demand for compliance or an effort by staff to “gain control.” Body language and tone of voice communicate a message as much as words. Avoid “you vs. me!” conflict. Power struggles often result from staff’s goal that patients follow the rules vs. individualization of treatment.
- Use natural and logical consequences.
- Use psychopharmacology effectively.

Staff should have knowledge about:

- Normal development and developmental stages throughout the life span.
- Psychiatric disorders (including which diagnoses present behaviors that, while disturbing, are not dangerous).
- Communication techniques to use with individuals at various stages of crisis when rational abilities are compromised, in ways that can be heard and responded to.
- The meaning of behaviors. For example, staff should be able to identify the difference between impulsive and intentional behaviors.
- How to allow the patient to appropriately and safely experience frustration and anger.
- When to call the M.D., therapist, or a clinical leader for help long before the patient reaches a trigger — certainly long before seclusion or restraint is considered.
- How to identify and deal with their own “triggers;” how to seek supervision to help deal with issues; and how staff attitudes and behaviors have tremendous influence on the patient’s perspective of a hostile or safe milieu.
- How to use natural timeframes (certainly much shorter than 24 hours) when setting up goals with patients. It is better to think in terms of shift-to-shift or even meal-to-meal or activity-to-activity and to evaluate the effectiveness of the plan frequently.
- How to assist non-psychiatric staff (e.g. lab techs, consultants) who come in contact with patients to set up a successful interaction.

 The unique pattern of a child’s escalation and the ability to focus on interrupting the pattern.

Provided by Stone Institute of Psychiatry
Department of Psychiatric Nursing
Northwestern Memorial Hospital
Chicago, IL

Competency Test: Care of the Patient in Restraints or Seclusion

Written test passing score = 90%

Name: _____ Date: _____

Answer each question with T (true) or F (false) unless otherwise indicated.

- _____ 1. Alternatives to restraints/seclusion DO NOT need to be considered and/or attempted before initiating and do not need to be documented afterwards.
- _____ 2. You do not need to explain to the patient who you are and what you are going to do when the patient is non-communicative, disoriented, or upset.
- _____ 3. Seclusion is less restrictive than restraint and is to be used instead of restraint unless the patient is unable to be contained safely and is at risk for harm to self and/or others.
- _____ 4. It is not necessary to offer a bedpan or urinal to a patient in seclusion because the door to the bathroom is unlocked.
- _____ 5. A good way to check for adequate circulation is to observe extremities for normal color and temperature, good capillary refill, and a palpable radial or pedal pulse.
- _____ 6. When assessing the four limbs of a restrained patient for adequate circulation, the restraints should be checked at least every hour to be sure they are secure and intact.
- _____ 7. In some circumstances, if it is determined to be beneficial and comforting to the patient, a family member or significant other may be allowed to spend time with a patient in restraints.
- _____ 8. If a secluded patient is demonstrating increased impulse control and insight, a staff member may enter the seclusion room alone.
- _____ 9. All initial adult restraint/seclusion orders are limited to 4 hours but may be renewed for another 4 hours after a face-to-face reassessment by a RN and a MD order.
- _____ 10. Only clinical staff who have successfully completed Crisis Prevention Training and passed this competency can continuously monitor a patient in restraints and/or seclusion.

11. Maintaining a patient's dignity and privacy while in restraints and/or seclusion includes which of the following: *[circle correct answer(s)]*
- Covering the patient with a sheet while toileting
 - Keeping the outer door to the seclusion room closed or only slightly ajar
 - Having a staff member of the same sex assist with personal hygiene
 - All of the above
- _____ 12. A patient in restraint needs a routine assessment for adequate hydration and requires fluids to be offered at least every 2 hours while awake.
- _____ 13. "Time-out" is defined by JCAHO as when the patient is restricted for 30 minutes or less from leaving an unlocked room AND when this intervention is consistent with the patient's treatment plan.
- _____ 14. Abnormal vital signs of a restrained patient may be due to inadequate hydration, psychotropic medications or agitation and must be reported to the RN.
- _____ 15. Patients should NOT be downgraded to 2-way restraints, which are unsafe.
- _____ 16. The patient's readiness for release can be assessed if he/she is able to cooperate during meals or ADLs when one arm is released briefly.
- _____ 17. Before a restraint and/or seclusion order can be renewed (8 hour maximum) a face-to-face assessment must be made of the patient by a MD.
- _____ 18. A physician's order must be obtained within one hour following an emergent intervention with restraint or seclusion AND a face-to-face assessment must be done by the physician.
19. Circle behaviors that indicate a patient might be ready to be released from restraints.
- Ability to follow and comply with simple directions
 - Benefitting from use of medication
 - Willingness to use staff redirection
 - Willingness to remain in unlocked seclusion room for limited time after release
 - All of the above
20. First choice interventions in dealing with a patient who is getting out of control should be "non-physical" in nature and be part of the individualized treatment plan for that patient. Examples of these include the following: *[circle correct answer(s)]*
- Verbal De-escalation
 - Mediation
 - PRN Medication
 - Redirecting patient's focus
 - All of the above

End of test for MHWs & CNAs. RNs only continue.

- _____ 21. Patients with a history of respiratory disease or seizures should have the head of the bed elevated while in restraint.
- _____ 22. Behavioral criteria for release from restraint/seclusion should be individualized to meet the patient where he/she is at and reflect attainable goals.
- _____ 23. The patient debriefing after an incident of restraint/seclusion must be done within the 24 hour period following the patient's release.
- _____ 24. It is not necessary to offer PRN medication to patients in restraints as long as they are physically contained and their safety maintained.
- _____ 25. Releasing a patient from restraint/seclusion prior to the expiration of the physician order of 4 hours may be a clinical decision made by a RN.
- _____ 26. If the patient has authorized notification, has consented to have the family kept informed regarding his or her care, and the family has agreed to be notified, staff should promptly attempt to contact the family informing them of the restraint or seclusion episode.
- _____ 27. When restraint/seclusion is continued, the registered nurse should reevaluate the efficacy of the patient's treatment plan and work with the patient to identify ways to help him/her regain control.
- _____ 28. Clinical leadership must be immediately notified of any patient who remains in restraint or seclusion *for more than 12 hours* or experiences two or more separate episodes of restraint and/or seclusion of any duration *within 12 hours*.
- _____ 29. Physician orders should be reviewed by the assigned RN for adequate standing and PRN orders for psychotropic medications to reduce the patient's agitation.
- _____ 30. It may be more difficult to assess for EPS in a patient in restraints.

NOTE: This test provides an example of the types of questions that facilities may want to develop based on their own policies. Because specific accreditation and regulatory requirements may change from time to time, "answers" to these questions are not provided.

Provided by the Milwaukee County Mental Health Division
Milwaukee, WI
Patient Reported Therapeutic Interventions Survey

A: Welcome to unit _____. It is helpful for us to be aware of the things that can help you feel better when you're having a hard time. Have any of the following worked for you? We may not be able to offer all these alternatives but your Treatment Team would like to work with you to figure out how we can best help you while you're here. Please check or write in any that apply. If you would like assistance, please let us know. Thank you!

- | | |
|---|---|
| <input type="checkbox"/> voluntary quiet time in your room | <input type="checkbox"/> listening to music |
| <input type="checkbox"/> voluntary quiet time in the quiet room | <input type="checkbox"/> reading a newspaper or book |
| <input type="checkbox"/> sitting quietly with a staff member | <input type="checkbox"/> watching TV |
| <input type="checkbox"/> talking with another patient | <input type="checkbox"/> calling a friend/family |
| <input type="checkbox"/> talking with staff | <input type="checkbox"/> calling your therapist |
| <input type="checkbox"/> writing in a diary or journal | <input type="checkbox"/> exercising |
| <input type="checkbox"/> deep breathing exercises | <input type="checkbox"/> using cold ice or an ice pack |
| <input type="checkbox"/> going for a walk with staff | <input type="checkbox"/> punching a pillow |
| <input type="checkbox"/> taking a hot shower | <input type="checkbox"/> wrapping self up in a blanket or sheet |
| <input type="checkbox"/> putting hand under cold water | <input type="checkbox"/> drinking a cup of tea or warm milk or eating a snack |
| <input type="checkbox"/> lying down with a cold facecloth | <input type="checkbox"/> other: _____ |

B. What are some of the things that make it more difficult for you when you're already upset? Please check or write in any that apply.

- | | |
|---|--|
| <input type="checkbox"/> being touched | <input type="checkbox"/> being isolated |
| <input type="checkbox"/> bedroom door closed | <input type="checkbox"/> people in uniform |
| <input type="checkbox"/> loud noises | <input type="checkbox"/> yelling |
| <input type="checkbox"/> television | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> particular time of day (when?) _____ | <input type="checkbox"/> particular time of year (when?) _____ |

C. Is there anything else you would like us to know? Please describe:

D. Patient declined to complete survey.

**Milwaukee County Mental Health Division
Patient Reported Therapeutic Interventions Survey**

Patient Signature	Date
Staff Signature	Date

Original: File in TX Plan section/Medical Record

Yellow Copy: QI Department

Pilot A 10/25/99
Pink Copy: Patient

Provided by the Milwaukee County Mental Health Division
Milwaukee, WI

De-Escalation Tips

1. Always identify yourself.
2. Talk and think calm.
3. Ask patients how they are doing, or what's going on.
4. Ask patients if they are hurt (assess for medical problems).
5. Ask patients if they were having some difficulty or what happened before they got upset.
6. Remember why the patient is in the hospital.
7. Find a staff member that has a good rapport/relationship with the patient and have him or her talk to the patient. Let the patient know you are there to *listen*.
8. Offer medication if appropriate.
9. Help patients remember and use coping mechanisms they identified on the Patient Reported Therapeutic Interventions Survey.
10. If a patient screams and swears, reply with a calm nod, okay, don't react.
11. Use team or third-party approach. If patient is wearing down one staff, have another take over (10 minutes of talking might avoid a restraint incident).
12. Reassure patients and maintain professional boundaries (tell patients you want them to be safe, that you are here to help them).
13. Allow quiet time for patients to respond — silent pauses are important.
14. Ask the patient if she/he would be willing, could try to talk to you (repeat requests, persistently, kindly).
15. Respect needs to communicate in different ways (recognize possible language/cultural differences as well as the fear, shame, and embarrassment the patient may be experiencing).
16. Empower patients. Encourage them with every step towards calming themselves they take.
17. Make it okay to try and talk over the upsetting situation even though it may be very painful or difficult.
18. Acknowledge the significance of the situation for the patient.
19. Ask the patient how else we can help.
20. Ask the patient's permission to share important conversations with other caretakers for on-going discussion.

Adapted from Dr. Gudeman's interaction with patient on interventions with de-escalating patient 10/99

Provided by the Milwaukee County Mental Health Division
Milwaukee, WI

Interventions to Assist Patient to Cope

- a. Listen to the patient's concern even if you don't understand.
- b. Ask the patient to tell you what the problem is, and *LISTEN* sincerely.
- c. Recognize and acknowledge the patient's right to his/her feelings.
- d. Sit down if possible (maintain safety) and invite the patient to do likewise.
- e. Invite the patient to talk in a quiet room or area where there is less of an audience and less stimulation.
- f. Apologize if you did something that inadvertently upset the patient. Acknowledge *feelings* (not reasons) and state that it was unintentional.
- g. Let the patient suggest alternatives and choices.
- h. To maintain patient and staff safety, have adequate personnel available for crisis situations.
- i. Speak in a calm, even, non-threatening voice. Speak in simple, clear, and concise language.
- j. Use non-threatening non-verbal gestures and stance.
- k. Be aware of language, hearing, and cultural differences.
- l. Assure the patient that she/he is in a safe place and we are here to help.
- m. Recognize your personal feelings about violence and punishment and how it affects you when a patient is violent.
- n. Be aware of how other staff positively interact with angry patients and model their interventions.

Source: Melonas, J. (2000, December 1).
Seclusion and restraint:
Dos and don'ts. *Psychiatric News*, pp. 9, 47.

Checklist for Using Seclusion and Restraint

Below are some tips for decreasing the risks associated with using seclusion and restraint.

- Know your state's statutes and regulations regarding the use of seclusion and restraint.
- Know current interventions and professional standards regarding seclusion and restraint use.
- Understand your facility's philosophy about the use of seclusion and restraint.
- Expect and support clear policies, procedures, and training for all staff.
- Ensure that staff receives orientation, training, and reviews about seclusion and restraint use.
- Know how staff implements seclusion and restraint.
- Know the staffing patterns of the facility or unit.
- Individualize treatment involving seclusion and restraint to each patient.
- Ensure seclusion and restraint are ordered for a specific time, not "as needed."
- Participate in staff discussions of each use of seclusion and restraint.
- Provide leadership regarding the use of seclusion and restraint.
- Provide education of patients and their families about seclusion and restraint.
- Expect and support clear policies and procedures for responding to questions or concerns about seclusion and restraint.

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- **Restraint Assessment and
Physian Order Set RAPOS (MC1156-41)**

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- **Restraint/Seclusion Assessment and
Physician Order Set MPPTC (MC1156-42)**

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Restraint Assessment and Physician Order Set - RAPOS

Name: _____
Clinic Number: _____
Room: _____

Section I:

Must Complete This

Section **FIRST**

to determine if

restraint is

Medical/Surgical

or Behavioral

↓

Complete the following questions 1-3 to determine if Section II OR Section III of this form is to be completed.

Differentiating Behavioral Restraint From Medical/Surgical Restraint

Is this Medical/Surgical or Behavioral Restraint? To assess, answer the following three questions.

1. Does the patient currently have altered consciousness or cognition (the patient is not fully alert, not awake, having difficulty attending to or engaging in conversation, or is disoriented, etc.)?
 Yes No
2. Could there be medical/surgical reasons for the altered consciousness or cognition?
 Yes No
3. Is the restraint to prevent injury to self?
 Yes No

If 3 YES responses, this is a Medical/Surgical Restraint. Complete Section II.
If any NO responses, this is Behavioral Restraint. Complete Section III.

Section II: Medical/Surgical Restraint

RN Assessment

4. Patient Behavior/Reason for application of Restraint is Danger to self as evidenced by (must check at least one of the following):

- Physically threatening self harm
- Potential for dislodging lines/tubes
- Other (specify): _____

5. Less Restrictive Measures Attempted Prior to Restraint Application (check all that apply):

- Calming techniques
- Positioning
- Exercise
- Other (specify): _____
- Adjust lighting in room
- Diversional activities
- Family visits
- Reorientation
- Bed exit alarm
- Active listening

6. Patient Communication/Information

- Patient provided explanation about need for restraint:

Comments/responses: _____

7. Family Communication/Information (check one):

- Family available and provided explanation about need for restraint
- Family not available at this time

Comments/responses: _____

8. RN Signature: _____

Date: _____

Time: _____

Hospital Orders: Patient Restraint

Note: Restraint Order Expires in Time Limit Indicated

- CANNOT BE A VERBAL OR PRN ORDER -

- 9. I have examined the patient and:
 Agree with above RN assessment - Restrain patient
- Restraint not indicated at this time (describe): _____

10. Time limit 24 hours; specify if less:

11. Type of restraint (check all that apply):

- Cloth limb restraints (soft restraints for limiting limb movement)
- Body holder (vest with ties)
- Padded mitt (full padded mitt with and without finger separation)
- Vinyl limb (strong durable limb holder used to limit limb movement)
- Other (specify): _____

12. Physician signature: _____

13. Page #: _____

Date: _____

Time: _____

- CANNOT BE A VERBAL OR PRN ORDER -

Part 1 - Chart Part 2 - Quality Information Resource Center 2018Aug 300

MED/SURG RESTRAINT

MED/SURG RESTRAINT

Section III:

Behavioral Restraint in Medical/Surgical

RN Assessment

4. Patient Behavior/Reason for application of Restraint (must check all that apply):

- Danger to self (must check at least one)
- Physically threatening self harm
- Potential for dislodging lines/tubes
- Other (specify): _____
- Danger to others (must check at least one)
- Physically/threatening violence
- Coercive
- Other (specify): _____

5. Less Restrictive Measures Attempted Prior to Restraint Application (check all that apply):

- Calming techniques
- Positioning
- Exercise
- Other (specify): _____
- Adjust lighting in room
- Diversional activities
- Family visits
- Reorientation
- Bed exit alarm
- Active listening

6. Patient Communication/Information

- Patient provided explanation about need for restraint:

Comments/responses: _____

7. Family Communication/Information (check one):

- Family available and provided explanation about need for restraint
- Family not available at this time

Comments/responses: _____

8. RN Signature: _____

Date: _____

Time: _____

Hospital Orders: Patient Restraint

Note: Restraint Order Expires in Time Limit Indicated

- CANNOT BE A VERBAL OR PRN ORDER -

- 9. I have examined the patient and:
 Agree with above RN assessment - Restrain patient
- Restraint not indicated at this time (describe): _____

10. Maximum time limit for orders is automatically:

- 4 hrs for patients 18 years of age and older
- 2 hrs for patients 9 to 17 years of age
- 1 hr for patients 8 years of age and under

11. Type of restraint (check all that apply):

- Cloth limb restraints (soft restraints for limiting limb movement)
- Body holder (vest with ties)
- Hand mitt (full padded mitt with and without finger separation)
- Vinyl limb (strong durable limb holder used to limit limb movement)
- Other (specify): _____

12. Physician signature: _____

13. Page #: _____

Date: _____

Time: _____

- CANNOT BE A VERBAL OR PRN ORDER -

Part 1 - Chart Part 2 - Quality Information Resource Center 2018Aug 300

BEHAVIORAL RESTRAINT

BEHAVIORAL RESTRAINT

mayo *Restraint and/or Seclusion Assessment and Physician Order Set MPPTC*

Name _____
 Chart Number _____
 Room _____

Hospital Orders:

Patient Restraint and/or Seclusion

Note: Restraint and/or Seclusion Order Expires in Time Limit indicated CANNOT BE A VERBAL OR PRN ORDER

7. I have examined the patient and:
 Agree with RN assessment
 Restraint and/or seclusion not indicated at this time
 Additional assessment: _____

8. Check all that apply:
 Restrain patient Seclude patient Body search

9. Maximum time limit for orders is automatically:

- 4 hours for patients 18 years of age and older
- 2 hours for patients 9 to 17 years of age
- 1 hour for patients under 9 years of age
- Indicate if it should be less (specify time): _____

10. Type of restraint (check all that apply):

- Cloth limb restraints (soft restraints for limiting limb movement)
- Body holder (vest with ties)
- Hand mitt (fully padded mitt with and without finger separation)
- Wrist limb (stronger, durable limb holder used to limit limb movement)
- Mat (soft tubular body restraints)
- Other (specify): _____

11. Physician Signature: _____

CANNOT BE A VERBAL OR PRN ORDER

12. Page #: _____ Date: _____ Time: _____

Physician completes 7 - 12

RN Assessment

1. Patient Behavior/ Reason for Application of Restraint and/or Seclusion _____

Check all that apply:

- Danger to self (must check at least one):
- Physically threatening self harm
- Potential for choking/lines and/or tubes
- Other (specify): _____
- Danger to others (must check at least one):
- Physically threatening violence
- Combative
- Other (specify): _____

2. Less Restrictive Measures Attempted Prior to Restraint Application _____

Check all that apply:

- Calming techniques Reorientation Active Listening
- Family visits Diversional activities Positioning
- Exercise Adjust lighting in room Bed exit alarm
- Patient suggested method (specify): _____
- Other (specify): _____

3. Patient Communication Information _____

Must complete both:

- Patient provided explanation/information about need for restraint and/or seclusion
- Comment/Response: _____

- Discontinuation criteria discussed with the patient (specify criteria): _____

4. Family Notification/Information _____

Family of patient notified (check one):

- Yes Attempted, unable to reach No release of information

If yes is checked above, complete the following:

- Notification included explanation/information provided to the family about need for restraint and/or seclusion.

Complete only if applicable:

Conservator of patient notified

- Yes Attempted, unable to reach

Comment/Response: _____

Complete only if applicable:

Guardian of patient notified

- Yes Attempted, unable to reach

5. Notification of Clinical Leadership _____

Fill in the blanks to determine if clinical leadership should be notified:

- Hours of restraint and/or seclusion used prior to this order _____ → if • 12 hours, nurse manager or nursing supervisor notified: Yes
- Number of episodes of restraint and/or seclusion used prior to this order _____ → if • 2 episodes in 12 hours, nurse manager or nursing supervisor notified: Yes

Signature: _____

Date: _____ Time: _____

RN or Physician completes 13 - 15

Restraint and/or Seclusion Postvention Summary

To be completed when restraint and/or seclusion is discontinued

13. Efficacy of restraint and/or seclusion: _____

14. Debriefing (check those participating and describe outcome):

- Patient Family Staff Other (specify): _____

15. Signature: _____ Date: _____ Time: _____

Part 1 - Chart Part 2 - Quality Information Resource Center, 201 Bldg 330

RESTRAINT/SECLUSION

RESTRAINT/SECLUSION

RESTRAINT/SECLUSION

RESTRAINT/SECLUSION

MPPTC Behavioral Restraint/Seclusion Flow Sheet

Date: _____

Codes for Type of Restraint/Seclusion

- 1 = Cloth limb restraint x 2
- 2 = Cloth limb restraint x 3
- 3 = Cloth limb restraint x 4
- 4 = Body holder (vest)
- 5 = Hand Mitt
- 6 = Vinyl limb restraints x 2
- 7 = Vinyl limb restraints x 4
- 8 = Seclusion
- 9 = Other (specify): _____
- 10 = Hand Mitt

Activity Codes

- A = Activity completed
- D = Activity discontinued

Codes for Ongoing Assessments

- ✓ = meets acceptance criteria
- ▲ = does not meet acceptance criteria, requires supporting documentation

Codes for Outcome of Assessment

- 1 = Continue restraint
- 2 = Discontinue restraint
- 3 = Continue seclusion
- 4 = Discontinue seclusion
- 5 = Try less restrictive intervention

Ongoing Activities	Time	Type of Restraint/Seclusion (use codes)	Activity Codes	Ongoing Assessments	Outcome of Assessment	Comments
Using Ongoing Assessment Codes Complete and document using Activity Codes		In-person Observation, (document hourly)				
		Restraint continuous in-person observation throughout restraint episode- continuous video monitoring remainder of episode. Restraint release (complete and document every hour when awake) Ambulation or ROM (complete and document every hour when awake) Skin care/repositioning (address and document every hour) Toileting (address and document every hour) Meals/Fluids (address and document every hour) Bathing/Hygiene (address and document every hour) Provide assistance in meeting criteria for discontinuation of restraint/seclusion (complete and document every hour)				
Using Ongoing Assessment Codes Complete and document every 15 minutes		Nutrition/Hydration Receiving and administering nutritional intake. Fluid intake appropriate for patient status. Physical status and comfort Free of observable signs of physical distress/discomfort related to restraint/seclusion. Vital signs done as clinically indicated Psychological status and comfort Patient's dignity is protected and respected. Patient not actively resisting restraint/seclusion. Circulation Extremity warmth, color and sensation is not affected by restraint and appropriate for patient status. Injury: Patient free of injury related to episode of restraint/seclusion				
		Determine need to continue restraint/seclusion or try less restrictive intervention (Complete and document every hour using Codes for Outcome of Assessment. Include Supporting Comments below).				
INITIALS Supporting Comments for Outcome of Assessment: Documentation of behavior/mental status that supports continued need for restraint/seclusion or supports discontinuation of restraint/seclusion To be completed every one hour following initial assessment						

Signature	Initials	Signature	Initials	Signature	Initials	Signature	Initials

RESTRAINT/SECLUSION

RESTRAINT/SECLUSION

RESTRAINT/SECLUSION