# ID NOTES FOR INITIATION OF SECLUSION/RESTRAINT

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<th>Date/Time</th>
<th>Unit</th>
<th>Problem #</th>
<th>M.D. Order</th>
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**Behavioral criteria for release**

Time of initiation of seclusion/restraint intervention: ______________________

Name of physician notified: ___________________________ Time of notification: ______________

1. Circumstances that led to use of seclusion or restraint: ________________________________________________________
   ________________________________________________________
   ________________________________________________________
   ________________________________________________________

2. _____ ID Note for Crisis Model Intervention (#275A) Completed

3. The patient’s trauma history was considered prior to the initiation of S/R  Yes ___  No ___  NA ___

4. Describe patient behaviors during seclusion which led to application of restraints. If not applicable, write N/A. _________
   __________________________________________________________________________________________

5. Describe patient behaviors during restraint process which led to seclusion. If not applicable, write N/A. _______________
   __________________________________________________________________________________________

6. Interventions provided:  7. Discussed with patient:
   _____ Privacy during physical intervention  _____ Reason for seclusion or restraints
   _____ CO initiated at ________ am/pm  _____ Right for review with Human Rights Advocate and LHRC
   _____ VC initiated at ________ am/pm  _____ Criteria for release
   _____ Checked for harmful objects; objects retained:  Patient response __________________________
   Patient response __________________________
   Patient response __________________________
   Patient response __________________________

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ID NOTES FOR INITIATION OF SECLUSION/RESTRAINT

Valuables retained, envelope # ____________________________

Others: ____________________________

________________________

Was Family /LAR notified? yes ___  No ___

Family / LAR Response / Suggestions for things that have helped in the past ____________________________

________________________

*Social Worker / Nsg. Supervisor signature ______________

Date / Time of notification ____________________________

*RN to notify Social Worker / Nsg. Supervisor

A. Names of staff involved in seclusion/restraint intervention:

____________________________________________________________________________________________________

____________________________________________________________________________________________________

8. MD Evaluation: ____________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

MD Signature ______________

Date ______________ Time ______________

9. Assessment for physical injury:

_____ Patient was asked about physical discomfort. Response ____________________________

_____ Patient was observed for physical discomfort. Observation/interventions ____________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

RN Signature ____________________________

Attending MD Signature ____________________________

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ID NOTES OF RN ASSESSMENT WHILE IN SECLUSION/RESTRAINT

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RN ASSESSMENT #________ via _______ SR window
________ Face to face (at least hourly)

To be performed minimally every 15 minutes

1. Psychological Assessment in relation to criteria for release:

   A. Behavioral Observation. Check all that apply.
      
      ____ Alert
      ____ Relaxed body posture
      ____ Reality based conversation
      ____ Kicking/striking out
      ____ Restless pacing
      ____ Rapid pressured speech
      ____ Suspicious
      ____ Anxious
      ____ Tearful
      ____ Mute
      ____ Poor eye contact
      ____ Using profanity
      ____ Clenched fist
      ____ Unable to respond to direction/support
      ____ Threats to harm self/others
      Other: ____________________________

   B. Speech Pattern. Check all that apply.
      
      ____ Coherent
      ____ Incoherent
      ____ Tangential
      ____ Circumstantial
      ____ Blocking
      ____ Pressured
      ____ Loose associations
      ____ Flight of ideas
      ____ Hyper verbal
      ____ Hypo verbal
      Other: ____________________________

2. Physiologic Assessment/Interventions. Check all that apply.

   B. Nutrition/Hydration: _____Need assessed
      
      ____ Meal offered
      ____ Meal accepted
      ____ Percent consumed
      ____ Fluids offered (minimally every hour)
      ____ Fluids accepted
      ____ ml consumed

   C. ADLs: _____ Need assessed
      
      ____ Bathroom/toileting offered (minimum every 2 hours)
      ____ Bathing/mouth care (minimum every 24 hours)
      ____ Other: ____________________________

   C. Exercise/physical activity: _____ Need assessed
      
      ____ ROM (minimally every 2 hours if in restraints)
      ____ Promote/suggest body repositioning
      ____ Walking around in immediate area
      ____ Stretching of limbs
      ____ Other: ____________________________

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ID NOTES OF RN ASSESSMENT WHILE IN SECLUSION/RESTRAINT

D. Vital signs: _____ Need assessed
   _____ VS taken (minimally every hour): BP ________  P ________  R ________  T ________

E. Injury/illness (i.e. skin color, skin integrity, complaints of pain or discomfort, level of consciousness)
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   Interventions provided: __________________________________________________________________

3. Review of criteria for release with patient:
   _____ From seclusion
   _____ From wrist restraints
   _____ From ankle restraints

4. Patient response indicating progress toward criteria for release. Check all that apply.
   _____ Able to rest
   _____ Relaxed body posture
   _____ Direct eye contact
   _____ Able to listen
   _____ Participates in formulating strategies towards release
   _____ Non-verbal/Verbally indicates understands criteria for release
   _____ Able to give commitment to safety of self/others
   _____ Other: ______________________________________________________

5. Additional interventions utilized: _____ N/A
   _____ Wrist restraints
   _____ Ankle restraints
   _____ Seclusion
   _____ Other: _______________________________________________________

ID Note: ____________________________________________________________________________________
   _______________________________________________________________________________________
   _______________________________________________________________________________________
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RN Signature _____________________

MD Signature ____________________________________________

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ID NOTES OF RN ASSESSMENT FOR RELEASE FROM SECLUSION/RERAINT

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1. RN evaluation of current behaviors in relation to criteria for release: Check all that apply.
   - _____ Alert
   - _____ Related body posture
   - _____ Reality based conversation
   - _____ Follows staff direction
   - _____ Non-verbal/Verbal commitment to safety of self/others
   - _____ Patient asleep

2. Released:
   - Seclusion
   - Wrist restraint
   - Ankle restraint

3. Transitional support offered:
   - _____ Quiet time
   - _____ Diversionary activities
   - _____ Area of access reviewed
   - _____ Patient identification band applied
   - _____ Belongings returned
   - _____ Opportunity to discuss experience
   - _____ Other: ___________________________________________

4. Patient chose to utilize:
   - _____ Quiet time: Room/Open Quiet Room
   - _____ Diversionary Action: Describe _________________________________________________________
   - _____ Other: Describe _________________________________________________________________________________

ID Note: _______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

RN Signature ____________________________________
MD Signature ____________________________________
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Seclusion
Wrist restraint
Ankle restraint

Alert
Related body posture
Reality based conversation
Follows staff direction
Non-verbal/Verbal commitment to safety of self/others
Patient asleep

Quiet time
Belongings returned
Opportunity to discuss experience
Other: ___________________________________________

Quiet time: Room/Open Quiet Room
Diversionary Action: Describe _________________________________________________________
Other: Describe _________________________________________________________________________________

Alert
Related body posture
Reality based conversation
Follows staff direction
Non-verbal/Verbal commitment to safety of self/others
Patient asleep

R N Signature ________________________________
MD Signature ________________________________
ADDRESSOGRAPH
ID NOTES FOR SECLUSION/RESTRAINT DEBRIEFING  
(COMPLETE WITHIN 24 HOURS OF SECLUSION/RESTRAINT INCIDENT)

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1. Does the patient want family or other caregivers present for discussion of the incident?  _____Yes  _____No

2. What does the patient remember about the events which led to restraint or seclusion? If the patient is unable to recall the event, review the incident & clarify misperceptions. ______________________________________________________
   ___________________________________________________________________________________________________________
   ___________________________________________________________________________________________________________

3. _____ Discuss how patient’s behavior met criteria for release.

4. A. Discuss what could have been handled differently: _______________________________________________________
   _______________________________________________________________________________________________________

   B. Discuss alternatives to avoid seclusion room or restraint in the future: ________________________________________
   _______________________________________________________________________________________________________

5. A. _____ Review with patient if patient rights (physical/psychological well-being, right to privacy) were addressed during seclusion or restraint.  
   Patient response: ______________________________________________________________________________________

   B. _____ Advised patient of opportunity to discuss issues with the Human Rights Advocate.

6. Address physical / emotional trauma that may have occurred as a result of the seclusion/restraint incident: _____ Yes  _____None
   _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________

7. _____ Treatment plan modified to include the above information.

ID Notes: _______________________________________________________________________________________________
   _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________

Patient Signature: _______________________________ Date: __________________

MD Signature: _______________________________ Date: __________________

RN Signature: _______________________________ Date: __________________

Other: _______________________________ Date: __________________

Other: _______________________________ Date: __________________

ADDRESSOGRAPH
ID NOTE FOR CONTINUING SECLUSION/RESTRAINT WHEN CRITERIA FOR RELEASE NOT MET

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Face to face evaluation completed by: ____________________________ Name of MD

________________________ Name of RN

A. Behavior posing a danger to self or others requiring continued need for seclusion or restraint intervention:

____________________________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________________________

B. Alternative interventions considered and rejected:

____________________________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________________________

C. Interventions to promote release:

____________________________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________________________

RN Signature: ___________________________ Date: ___________ Time: ___________

MD Signature: ___________________________ Date: ___________ Time: ___________

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