CVH-480b CONNECTICUT VALLEY HOSPITAL

PART II – NURSING OBSERVATION

AND CARE OF THE PATIENT

Patient Name: ____________________________

MP1# ____________________________ 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.

<table>
<thead>
<tr>
<th>Initial</th>
<th>15 min* Date: _________ Time: _______ AM/PM</th>
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<tbody>
<tr>
<td>Behavioral Assessment: ____________________________</td>
<td></td>
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<tr>
<td>Physical Assessment: ____________________________</td>
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<tr>
<td>Circulation: [ ] Adequate [ ] Other: ______________</td>
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<tr>
<td>Skin Integrity: [ ] Intact [ ] Other: ______________</td>
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<td>RN Signature: ____________________________</td>
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<tr>
<th>Initial</th>
<th>30 min Date: _________ Time: _______ AM/PM</th>
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<tr>
<td>Behavioral Assessment: ____________________________</td>
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<td>Physical Assessment: ____________________________</td>
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<td>Circulation: [ ] Adequate [ ] Other: ______________</td>
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<td>Skin Integrity: [ ] Intact [ ] Other: ______________</td>
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<td>RN Signature: ____________________________</td>
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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: ______________

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<thead>
<tr>
<th>TIME</th>
<th>INIT MHA/FTS</th>
<th>DESCRIPTION OF PATIENT BEHAVIOR</th>
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<tr>
<td>15 min</td>
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<td>Instructions: Staff assigned to Continuous Observation, initial below &amp; complete signature log.</td>
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<td>Removal from Seclusion/Restraint is based on meeting discontinuation criteria in the MD Order.</td>
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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:

<table>
<thead>
<tr>
<th>Signature Log</th>
<th>Init</th>
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DISTRIBUTION: Original - Chart (file behind corresponding Part I or Part III) Photo Copy (both sides) – Data Entry
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
- [ ] Continues to require the use of restraint/seclusion

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:  

Signature (Assessing RN)  Print Name  Date  Time

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

If no, explain:  

Signature (Assessing RN)  Print Name  Date  Time

**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: 

Signature (Assessing RN)  Print Name  Date  Time

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

Signature (Nursing Supervisor)  Print Name  Date  Time