THIS FORM IS TO BE COMPLETED FOR ALL THERAPEUTIC HOLDS/SECLUSIONS/RESTRAINTS AND PLACED IN THE PATIENT'S CHART

Date: ________________________ Unit: ______________________________________ □ Acute □ RTC

Was the patient exhibiting behavior that was potentially dangerous to him/her? □ **Yes** □ **No**
Was the patient exhibiting behavior that was potentially dangerous to others? □ **Yes** □ **No**

If the answer to either of the above questions is **Yes** – Please briefly describe the patient's behavior and precipitating events: _
____
____
____

Contra-indications addressed: ____ Benefit Outweighs Risk: □ **Yes** □ **No**

ALTERNATIVES TO MANAGING AGGRESSIVE BEHAVIOR:

Check each less restrictive alternative attempted, and the describe patient's response to the less restrictive interventions attempted in the section below.

□ Processed with patient □ Brought in Alternative Staff Person □ Encouraged Use of Coping Skills Identified on ICP □ Channel Feelings into Activity
□ Diversion/Redirect Attention □ Encourage Self-Time Out □ Staff Directed Time Out □ Encourage Patient to Engage in Relaxation
□ Medication □ Remove from Stimuli □ Unable to draw upon less restrictive alternatives due to sudden onset of dangerous patient behavior.

Please briefly describe the progression of the hold and the patient's response to the therapeutic intervention: ______________
____
____
____

Please check all that apply: Physical Restraint: □ Standing □ Sitting □ Lying □ Seclusion □ Chemical Restraint
Time restraint was initiated: ________________ Time restraint was discontinued: ____________________ Total Minutes: ___________
Time seclusion was initiated: ________________ Time seclusion was discontinued: ____________________ Total Minutes: ___________

Location of Hold: ____

Exact Location of Seclusion: ____

Criteria for removing patient from Restraint or Seclusion:
□ "No self harm" agreement made □ "No harm to others" agreement made □ Other: ______________________________

____ ____
Staff Member Initiating Hold Print Name and Sign **Staff Assisting in Hold (if Assisted) Print Name and Sign**

Name(s) of Additional Staff Witnesses: ____

POST NURSING INTERVENTION ASSESSMENT:

Were other patients cleared from area? □ Yes □ No
Was patient cleared from area? □ Yes □ No
Was the need for intervention explained to the patient? □ Yes □ No
Was the behavior expected for release explained to the patient? □ Yes □ No
Was staff injured during the process? □ Yes □ No

Medication given (type, dosage, how administered- IM/PO and time administered): ______________________________
____

Name of Physician providing order: ___________________________________Date/Time order received: _______________

LIP Notification of Order **Date**: __________________ **Time**: ________________

Custodian Notification: □ Parent □ Guardian □ DHS □ OJA □ ICW **Date**: _________ **Time**: ________________

Date: ________________ **Time:** _____________________ **RN Signature:** ______________________________________

LABEL

LIP Assessment (within 1 hour):

Does a need exist to continue the restraint? □ **Yes** □ **No** If **Yes**, explain: ______________________________

Does a need exist to continue the seclusion? □ **Yes** □ **No** If **Yes**, explain: ______________________________

What caused the incident? ______________________________

Physician notified of assessment results @ ______________(time)

Physician/LIP Signature/RV: ______________________________ Date: ____________ Time:

MEDICAL ASSESSMENT:

Was patient oriented to person/place/time? □ **Yes** □ **No** If **No**, describe below.

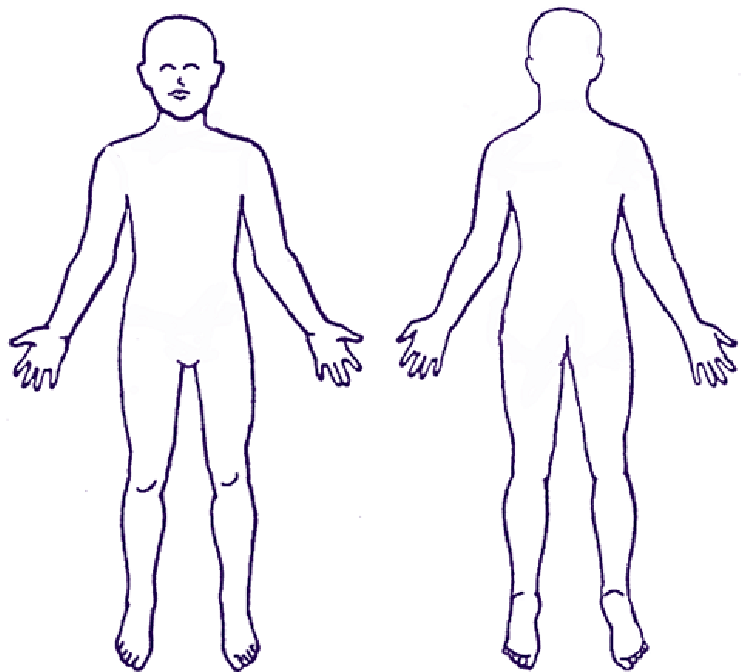
Upon questioning, does patient report any injuries? □ **Yes** □ **No** If **Yes**, describe below.

Upon physical examination, were there any observable injuries? □ **Yes** □ **No**

If **Yes**, indicate on the diagram below all body marks by placement of number from legend below on proper body location.

Additional comments, including any recommendations for review of Treatment Plan: ______________________________

Levels of Injury / Legend for Body Marks	
1	**2**
▪ Abrasions ▪ Carpet Burns ▪ Reddened Area	▪ Patient Complaint of tenderness/pain ▪ Swelling ▪ Bleeding
3	**4**
▪ ER Visit ▪ Fracture/ Dislocation/ Break ▪ Concussion	▪ Hospitalization due to physical injury ▪ Permanent injury/ Disability ▪ Death



Reviewed By Date

PATIENT'S CONDITION AND BEHAVIOR: (Use the coding below to fill in the chart for 15 minute checks.)	
1. Yelling Screaming	2. Crying
3. Cursing	4. Laughing
5. Singing	6. Biting
7. Standing still	8. Walking / Pacing
9. Lying or sitting	10. Sleeping
11. Quiet	12. Disrobing
13. Threatening Self	14. Threatening Others
15. Able to Process	16. Hitting
17. Sexual Acting Out	18. Mumbling Incoherently
19. Head banging	20.

	1st Hour				2nd Hour				3rd Hour			
Time												
Code												
Staff Action												
Staff Initials												

STAFF ACTIONS: (Use the coding below to fill in the chart for 15 minute checks.)	
1. Meal Served & Refused	2. Meal Served & Accepted
3. Fluids Offered & Refused	4. Fluids Offered & Accepted
5. Toilet Offered & Refused	6. Toilet Offered & Accepted
7. Continuous Visual Monitoring	8. Encourage Patient to Calm
9. Medical Treatment Offered	10. Counsel
11. Vital Signs/Circ./Skin Check	12. Range of Motion/Position
13. Door Locked	14. Door Unlocked
15. Containment (Physical Hold)	16. Released to Time-Out

Staff Signature(s)

"Visit" by Therapist or Nurse: (must be conducted each hour of seclusion)	
Time	**Credentialed Personnel Signature**

LABEL