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| **Provider Information** | |
| Report Date: *Click here to enter text.* | Program/Facility License #: *Click here to enter text.* |
| AHCCCS Provider ID: *Click here to enter text.* | Program/Facility Name: *Click here to enter text.* |
| Contact Person Phone #: *Click here to enter text.* | Provider Address: *Click here to enter text.* |
| Contact Person and Title: *Click here to enter text.* | |
| Name/Credentials/Title of Person Authorizing the Event: *Click here to enter text.* | |
| Name/Credentials/Title of Person Re-Authorizing the Event: *Click here to enter text.* | |

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| **Member Information** | | | |
| Member Name (Last, First, M.I.): *Click here to enter text.* | | | |
| Date of Birth: *Click here to enter text.* | Age: *Click here to enter text.* | | Gender: *Click here to enter text.* |
| AHCCCS ID: *Click here to enter text.* | |  | |
| TXIX/XXI Eligible:  Yes  No | | Member Behavioral Health Category (SMI, GMH/SA, Child): *Click here to enter text.* | |
| DDD: *Click here to enter text.* | | CHP: *Click here to enter text.* | |
| Court Ordered Treatment (COT):  Yes  No | | ALTCS E/PD: *Click here to enter text.* | |
| Name of member’s legal guardian/Health Care Decision maker (HCDM) (if applicable): *Click here to enter text.* | | | |
| Phone number of member’s legal guardian/HCDM (if applicable): *Click here to enter text.* | | | |

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| **Current Diagnoses** | |
| **Code** | **Name** |
| *Click here to enter text.* | *Click here to enter text.* |
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| **Current Medications** | | | |
| **Medication** | **Dosage** | **Frequency** | **Method of Administration** |
| *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* |
| *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* |
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If a Seclusion and/or Restraint occur, complete all that apply. If the member is secluded and/or restrained, complete **BOTH** the seclusion and restraint sections.

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| **Event Information** | | |
| Type of Event: | Seclusion  Personal Restraint  Chemical Restraint  Mechanical Restraint | |
| Did Member have medical condition(s) that placed them at greater risk for poor outcomes? | | Yes, describe: *Click here to enter text.* |
| No |
| Was the reason for seclusion/restraint and the conditions for release explained to the member? | | Yes, describe: *Click here to enter text.* |
| No |

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| **De-escalation Methods and All Less Restrictive Measures Attempted** | |
| Select de-escalation methods and all less restrictive measures attempted prior to seclusion and/or restraint: | Removing member from stimuli |
| Encouraging member to express feelings in appropriate manner |
| Conflict resolution |
| Re-directing the member |
| Offering prn medication, when necessary |
| Allowing member to pace and vent |
|  | Other (e.g. humor, distraction, 1:1, snack) |

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| **Personal Restraint (check box)** |
| Date of Administration: *Click here to enter text.* |
| Type of Restraint (e.g. Physical Hold):*Click here to enter text.* |
| Time (24-hour clock)  Start time: *Click here to enter text.* End time: *Click here to enter text.* |
| Duration of Restraint: *Click here to enter text.* Hours: *Click here to enter text.* Minutes: *Click here to enter text.* |
| Name/Credentials/Title of Primary Individual involved in the Restraint: *Click here to enter text.* |

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| **Mechanical Restraint (check box)** |
| Date of Administration: *Click here to enter text.* |
| Type of Restraint: *Click here to enter text.* |
| Time (24-hour clock)  Start time: *Click here to enter text.* End time: *Click here to enter text.* |
| Duration of Restraint: *Click here to enter text.* Hours: *Click here to enter text.* Minutes: *Click here to enter text.* |
| Name/Credentials/Title of Primary Person involved in the Restraint: *Click here to enter text.* |
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| **Medication used as Restraint** | | | | | |
| **Date of Administration** | **Time of Administration** | **Medication** | **Dosage** | **Frequency** | **Method of Administration** |
| *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* |
| *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* |
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| *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* |

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| Seclusion |
| Date of Administration: *Click here to enter text.* |
| Time (24-hour clock): *Click here to enter text.* Start time: *Click here to enter text.* End time: *Click here to enter text.* |
| Duration of Restraint: *Click here to enter text.* Hours: *Click here to enter text.* Minutes: *Click here to enter text.* |
| Name/Credentials/Title of Primary Person involved in the Restraint: *Click here to enter text.* |

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| Reason for Restraint/Seclusion | |
| Include relevant information to describe facts/behaviors justifying the use of seclusion or restraint. Be descriptive (e.g. ‘hitting and kicking staff’ instead of ‘physically aggressive toward staff’). | |
| Danger to Self (DTS) | Member Behaviors: *Click here to enter text.* |
| Member Quotes: *Click here to enter text.* |
| Danger to Others (DTO) | Member Behaviors: *Click here to enter text.* |
| Member Quotes: *Click here to enter text.* |
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| **Monitoring** | | | | |
| The member must be personally examined at a minimum of every 15 minutes to ensure the member’s comfort and safety and to determine the member’s need for food, fluid, bathing, and access to the toilet. If the member has any medical condition that may be adversely affected by the restraint or seclusion, the member shall be monitored every five minutes, until the medical condition resolves, if applicable. Attach internal documentation of face-to-face monitoring for all episodes that require such documentation per A.A.C. R9-21-204, A.A.C. R9-10-225, or A.A.C. R9-10-226. Addendum content must include requirements contained in AMPM Policy 962, Seclusion and Restraint Requirements. | | | | |
|  | Date | Time (24-hour clock) | Name of Primary Individual involved in the Restraint | Credentials/Title of Primary Person involved in the Restraint |
| Start | *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* |
| End | *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* | *Click here to enter text.* |

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| Face-to-Face Assessment | | |
| The member must receive a face-to-face assessment of physical and psychological well-being from the Psychiatrist or Registered Nurse (with one year of behavioral health experience) within one hour of initiation of the restraint or seclusion. | | |
| Name/Credentials/Title of Primary Person involved in the Restraint: *Click here to enter text.* | | |
| Date of Assessment: *Click here to enter text.* | | |
| Time (24-hour clock) of Assessment: *Click here to enter text.* | | |
| Description of Member Condition (orientation, mood, affect, behavior per R9-21-204 (physical and psychological wellbeing)): | | |
| *Click here to enter text.* | | |
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| Clinical Justification to Discontinue Seclusion or Restraint | | |
| No risk for danger to self | |
| No risk for danger to others | |
| Improvement of mental status | |
| Medication administration completed | |
| Able to follow verbal commands | |
| Meets all criteria for release | |
|  | |
| Injuries | | |
| Was the member physically injured DURING (not prior to) the seclusion and/or restraint? 🞎 Yes 🞎 No | | |
| If yes, explain the nature of the injury and complete an Incident, Accident, and Death (IAD) Report: |  | |
| *Click here to enter text.* |
| Explain the level of medical intervention needed (e.g. first aid, physician, hospitalization, death): *Click here to enter text.* | | |

**This section MUST be completed if a member was injured during**

**a seclusion and/or restraint procedure**

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| Incident, Accident, and Death (If Applicable) |
| (The Contractor, TRBHA, or Tribal ALTCS, must ensure timely and accurate reporting of incidents, accidents, and deaths involving members to AHCCCS/Quality Management. |
| Date of Incident, Accident, and Death Report completed: *Click here to enter text.* |
| Name/Credentials/Title of All Individuals involved in the Seclusion/Restraint procedure:  *Click here to enter text.* |
| Member Debriefing |
| Date of debriefing: *Click here to enter a date.* |
| Time (24-hour clock) of debriefing: *Click here to enter text.* |
| Name/Credentials/Title of primary individual involved in the Debriefing: *Click here to enter text.* |
| Other participants involved in the debriefing: *Click here to enter text.* |
| Information discussed during the debriefing: *Click here to enter text.* |

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| Staff Debriefing | | | |
| Date of debriefing: *Click here to enter a date.* | | | |
| Time (24-hour clock) of debriefing: *Click here to enter text.* | | | |
| Name/Credentials/Title of all staff in attendance in the debriefing: *Click here to enter text.* | | | |
| Identified intervention opportunities that may have prevented the incident: *Click here to enter text.* | | | |
| Things that were done well and/or team strengths: *Click here to enter text.* | | | |
| Ways the team could strengthen their response to future incidents: *Click here to enter text.* | | | |
| Information discussed during the debriefing: *Click here to enter text.* | | | |
| Procedures that can be implemented to prevent recurrence: *Click here to enter text.*  Systemic changes: *Click here to enter text.*  Alternatives for this member: *Click here to enter text.* | | | |
| Outcome of debriefing (including actions taken to avoid future use of seclusion or restraint and identification or alternatives to seclusion and restraint on individual and systemic levels): *Click here to enter text.* | | | |
| **Follow-Up** | | | |
| Was the treating provider notified? | Yes, Name of provider: *Click here to enter text.* | | Date of Notification:  *Click here to enter text.* |
| No (If no, explain): | |
| Was the family/guardian/health care decision maker notified? | Yes, Name and relationship of the person notified:  *Click here to enter text.* | | Date of Notification:  *Click here to enter text.* |
| No (If no, explain): *Click here to enter text.* | |
| Were the findings of face-to-face monitoring and nursing assessment discussed? | Yes, with whom: *Click here to enter text.* | | Date of Discussion:  *Click here to enter text.* |
| No (If no, explain): *Click here to enter text.* | |
| Was the need for other interventions or treatments reviewed? | Yes, with whom: *Click here to enter text.* | | Date of Review:  *Click here to enter text.* |
| No (If no, explain): *Click here to enter text.* | |
| Were revisions made to the treatment plan or scheduled? | Yes, describe revisions: *Click here to enter text.* | | Date of Revisions: *Click here to enter text.* |
| No (If no, explain): *Click here to enter text.* | |
| Were Seclusion and Restraint orders completed? Check all boxes that apply and attach orders when submitting Seclusion and Restraint form. | | Initial Order | |
| Continuation Order | |
| Discontinuation Order | |
| Were monitoring sheets completed (every 15 minutes or every 5 minutes)? Attach monitoring sheets when submitting Seclusion and Restraint form. | | Yes, Date(s) of Completion: | |
| No (If no, explain): | |

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| Final Sign-Off |
| Name of Director of Nursing or Designee reviewing Seclusion and Restraint Documentation: *Click here to enter text.* |
| Director of Nursing or Designee Phone Number: *Click here to enter text.* |
| Date of Sign-off: *Click here to enter text.* |
| Time (24-hour clock) of Sign-off: *Click here to enter text.* |