HOSPITAL RESTRAINT/SECLUSION DEATH REPORT WORKSHEET

(Revised 7/08)

A. Regional Office (RO) Contact Information:

RO Contact's Name: _____

*Date of Report to RO: _____ Time: _____

B. Provider Information:

*Hospital Name: _____*CCN: _____

Address: _____City: _____ State: _____ Zip Code: _____

Person Filing the Report: _____ Filer's Phone Number: _____

C. Patient Information:

*Name: _____ *Date of Birth: _____

Admitting Diagnoses: _____ *Date of Admission: _____

*Date of Death: _____Time of Death: _____

*Cause of Death: _____

*Did the Patient Die: *(check one only)*

_____While in Restraint, Seclusion, or Both

_____Within 24 Hours of Removal of Restraint, Seclusion, or Both

_____Within 1 Week, Where Restraint, Seclusion or Both Contributed to the Patient's Death

*Type: Physical Restraint _____ Seclusion _____ Drug Used as a Restraint_____

***Was a Two Point Soft Wrist Restraint used alone, without seclusion or chemical restraint or any other type of physical restraint?** Yes____ No_____

If YES, check "02" below and stop. No further information is required.

If NO, complete the rest of the worksheet.

*If Physical Restraint(s), Type:

_____01 Side Rails
_____02 Two Point, Soft Wrist
_____03 Two Point, Hard Wrist
_____04 Four Point, Soft Restraints
_____05 Four Point, Hard Restraints
_____06 Forced Medication Holds
_____07 Therapeutic Holds
_____08 Take-downs
_____09 Other Physical Holds
_____10 Enclosed Beds
_____11 Vest Restraints
_____12 Elbow Immobilizers
_____13 Law Enforcement Restraints
_____14 Other Physical Holds

If Drug Used as Restraint: *Drug Name_____ Dosage_____

****Mandatory field***

D. Hospital-Reported Restraint/Seclusion Information:

*1. Reason(s) for Restraint/Seclusion use: *(mandatory only if answer to D.4. is "Yes")*_____
_____
_____
_____

2. Circumstances Surrounding the Death: _____
_____
_____
_____
_____
_____

3. Restraint/Seclusion Order Details:

a. Date & Time Restraint/Seclusion Applied: _____

b. Date & Time Last Monitored: _____

*c. Total Length of Time in Restraint/Seclusion: _____

*4. Was restraint/seclusion used to manage violent or self-destructive behavior? Yes___ No___

*a. *If YES, was 1 hour face-to-face evaluation documented? Yes___ No___*

If NO, skip to Section E.

*b. Date/Time of Last Face-to-face Evaluation: _____

*c. Was the order renewed at appropriate intervals based on patient's age? Yes____ No____

Note: Orders may be renewed at the following intervals for up to 24 hours:

> 18 years of age	*every 4 hours*
9 – 17 years of age	*every 2 hours*
< 9 years of age	*every hour*

*5. If simultaneous restraint and seclusion ordered, describe continuous monitoring method(s):
_____
_____
_____

E. RO Action(s):

1. *Was a survey authorized? Yes____ No____

If YES, date SA received authorization for investigation: _____

If NO, provide brief rationale: _____

2. *If answer to E1 is yes, date RO contacted P & A: _____

(Do not contact the P&A unless a survey was authorized)

3. In the past two years, has a survey related to a restraint/seclusion death at this hospital resulted in finding condition-level patients' rights deficiencies? Yes____ No____

****Mandatory field***