# POLICY 962, ATTACHMENT A, SECLUSION AND RESTRAINT INDIVIDUAL REPORTING FORM

| PROVIDER INFORMATION | |
|---|---|
| Report Date: | Program/Facility License #: |
| AHCCCS Provider ID: . | Program/Facility Name: |
| Contact Person Phone #: | Provider Address: |
| Contact Person & Title: | |
| Name/Credentials/Title of Person Authorizing the Event: | |
| Name/Credentials/Title of Person Re-Authorizing the Event: | |

| MEMBER INFORMATION | | |
|---|---|---|
| Member Name *(Last, First, M.I.)*: | | |
| Date of Birth: | Age: | Gender: |
| CIS ID: | AHCCCS ID: | |
| TXIX/XXI Eligible: ☐ Yes ☐ No | Member Behavioral Health Category: | |
| DDD: | CMDP: | |
| CRS: | ALTCS E/PD: | |
| Name of member's legal guardian (if applicable): | | |
| Phone number of member's legal guardian (if applicable): | | |

| CURRENT DIAGNOSES | |
|---|---|
| CODE | NAME |
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| CURRENT MEDICATIONS | | | |
|---|---|---|---|
| MEDICATION | DOSAGE | FREQUENCY | METHOD OF ADMINISTRATION |
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## EVENT INFORMATION

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.

| EVENT INFORMATION | | |
|---|---|---|
| Type of Event: ☐ Seclusion ☐ Restraint | | |
| Date: | Time (24-hour clock): | Evaluation/Initial face to face Assessment: |
| Did Member have medical condition(s) that placed them at greater risk for poor outcomes? | | ☐ Yes, describe: |
| | | ☐ No |
| Was the reason for restraint/seclusion and the conditions for release explained to the member? | | ☐ Yes, describe: |
| | | ☐ No |

| 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 (i.e. humor, distraction, 1:1, snack, etc.) |

| PERSONAL RESTRAINT (CHECK BOX) | | |
|---|---|---|
| Date of Administration: | | |
| Type of Restraint (i.e. Physical Hold): | | |
| Time (24-hour clock): | Start time: | End time: |
| Duration of Restraint: | Hours | minutes |
| Name/Credentials/Title of Primary Person involved in the Restraint: | | |

| MECHANICAL RESTRAINT (CHECK BOX) | | |
|---|---|---|
| Date of Administration: | | |
| Type of Restraint: | | |
| Time (24-hour clock): | Start time: | End time: |
| Duration of Restraint: | Hours | minutes |
| Name/Credentials/Title of Primary Person involved in the Restraint: | | |

**MEDICATION USED AS RESTRAINT**

| DATE OF ADMINISTRATION | TIME OF ADMINISTRATION | MEDICATION | DOSAGE | FREQUENCY | METHOD OF ADMINISTRATION |
|---|---|---|---|---|---|
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## SECLUSION

| SECLUSION | | |
|---|---|---|
| Date of Administration: | | |
| Time (24-hour clock): | Start time: | End time: |
| Duration of Restraint: | hours/ | minutes |
| Name/Credentials/Title of Primary Person involved in the Restraint: | | |

## REASON FOR RESTRAINT AND/OR SECLUSION

| REASON FOR RESTRAINT/SECLUSION | |
|---|---|
| Include relevant information to describe facts/behaviors justifying the use of seclusion or restraint. Be descriptive (i.e., 'hitting and kicking staff' instead of 'physically aggressive toward staff'). | |
| ☐ Danger to Self (DTS) | Member Behaviors: |
| | Member Quotes: |
| ☐ Danger to Others (DTO) | Member Behaviors: |
| | Member Quotes: |
| | |

## MONITORING

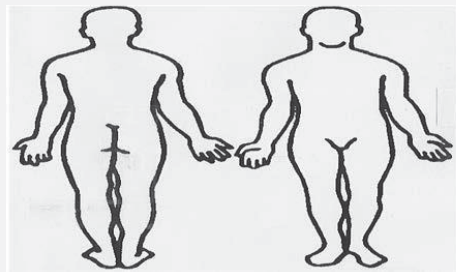
| MONITORING | | | | |
|---|---|---|---|---|
| The member must be personally examined at a minimum of every 15 minutes to ensure the behavioral health member's comfort and safety and determining the client's need for food, fluid, bathing and access to the toilet. The member must be checked every five minutes if the member has a medical condition that places him/her at a greater risk, as determined by the facility, by the restraint and/or seclusion. 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 AHCCCS Policy Exhibit 960-3, Seclusion and Restraint Requirements. | | | | |
| | Date | Time (24-hour clock) | Name of Primary Person involved in the Restraint | Credentials/Title of Primary Person involved in the Restraint |
| Start | | | | |
| End | | | | |

| FACE-TO-FACE ASSESSMENT |
|---|
| The member must receive a face-to-face assessment of physical and psychological well-being from the Psychiatrist, Registered Nurse (with one year of behavioral health experience) within one (1) hour of initiation of the restraint or seclusion. |
| Name/Credentials/Title of Primary Person involved in the Restraint: |
| Date of Assessment: |
| Time (24-hour clock) of Assessment: |

| CLINICAL JUSTIFICATION TO CONTINUE RESTRAINT OR SECLUSION |
|---|
| ☐ Continues at risk for danger to self |
| ☐ Continues at risk for danger to others |
| ☐ No improvement of mental status |
| ☐ Unable to follow verbal commands |
| ☐ Medication administration not completed<br>○ |

| CLINICAL JUSTIFICATION TO DISCONTINUE RESTRAINT OR SECLUSION |
|---|
| ☐ 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

| INJURIES | |
|---|---|
| Was the member physically injured DURING (not prior to) the restraint and/or seclusion? ☐ Yes ☐ No | |
| If yes, explain the nature of the injury and complete an Incident, Accident, and Death report: |  |
| | |
| Explain the level of medical intervention needed:<br><br>(e.g. first aid, physician, hospitalization, death) | |

**THIS SECTION MUST BE COMPLETED IF A MEMBER WAS INJURED DURING A SECLUSION/RESTRAINT PROCEDURE.**

| INCIDENT, ACCIDENT, AND DEATH (IF APPLICABLE) |
|---|
| (The Contractor or TRBHA must ensure timely and accurate reporting of incidents, accidents, and deaths involving members to AHCCCS Clinical Quality Management. |
| Date of Incident, Accident, and Death Report completed: |
| Name/Credentials/Title of All Persons involved in the Seclusion/Restraint procedure: |

## DEBRIEFING

| MEMBER DEBRIEFING |
|---|
| Date of Debriefing: |
| Time (24-hour clock) of Debriefing: |
| Name/Credentials/Title of Primary Person involved in the Debriefing: |
| Other participants involved in the debriefing: |
| Information discussed during the debriefing: |

| STAFF DEBRIEFING |
|---|
| Date of Debriefing: |
| Time (24-hour clock) of Debriefing: |
| Name/Credentials/Title of *all* staff in attendance in the Debriefing: |
| Identified intervention opportunities that may have prevented the incident: |
| Things that were done well and/or team strengths: |
| Ways the team could strengthen their response to future incidents: |
| Information discussed during the debriefing: |
| Procedures that can be implemented to prevent recurrence:<br>Systemic changes:<br>Alternatives for this member: |
| Outcome of Debriefing (including actions taken to avoid future use of seclusion or restraint/ identification or alternatives to seclusion and restraint on an individual and systemic levels): |

## FOLLOW-UP

| FOLLOW-UP | | |
|---|---|---|
| Was the treating provider notified? | ☐ Yes, Name of provider:<br>☐ No (If no, explain): | Date of Notification: |
| Was the family/guardian notified? | ☐ Yes, Name and relationship of the person notified:<br>☐ No (If no, explain): | Date of Notification: |
| Were the findings of face to face and nursing assessment discussed? | ☐ Yes, with whom:<br>☐ No (If no, explain): | Date of Discussion: |
| Was the need for other interventions/treatment reviewed? | ☐ Yes, with whom:<br>☐ No (If no, explain): | Date of Review: |
| Were revisions made to the treatment plan or scheduled? | ☐ Yes, Describe revisions:<br>☐ No (If no, explain): | Date of Revisions: |
| Were Seclusion and Restraint orders completed? Check all boxes that apply and attach orders when submitting Seclusion & Restraint form. | | ☐ Initial Order<br>☐ Continuation Order<br>☐ Discontinuation Order |
| Were monitoring sheets completed (every 15 minutes or every 5 minutes)? Attach monitoring sheets when submitting Seclusion & Restraint form. | | ☐ Yes, Date(s) of Completion:<br>☐ No (If no, explain): |
| Were the findings of the assessment discussed? | | ☐ Yes, Date(s) of Completion:<br>☐ No (If no, explain): |

| FINAL SIGN-OFF |
|---|
| Name of Director of Nursing or Designee reviewing Seclusion and Restraint Documentation: |
| Director of Nursing or Designee Phone Number: |
| Date of Sign-off: |
| Time (24-hour clock) of Sign-off: |