Region ___

HOSPITAL RESTRAINT/SECLUSION DEATH REPORT WORKSHEET

A. Regional Office (RO) Contact Information:

RO Contact's Name: ____

Date/Time of Report to RO: ________________ (Date) RO Contact's Phone: ______________
________________ (Time)

B. Provider Information:

Hospital Name: ___________________ CCN:________________ NPI Number:____________
Address: ____________________________________ State: ___________ Zip Code: _______

Person Filing the Report: _______________________ Filer's Phone Number: ______________

C. Patient Information:

Name: ____________________________________ Date of Birth: _______________________

Admitting Diagnoses: ____

Date of Admission: _______________________ Date/Time of Death: ____________________

Cause of Death: ____

Did the Patient Die: (**check one only, then circle "restraint," "seclusion," or "both" as applicable for the line checked)**

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 _____

Circumstances Surrounding the Death: ____
____
____
____
____
____
____
____

D. Hospital-Reported Restraint/Seclusion Information:

1. Type: Physical Restraint _______ Seclusion _______ Drug Used as a Restraint________

1a. Restraint Type(s) Details:____

For Drug Used as Restraint: Drug Name___________________ Dosage_________________

Number of Doses Given_________________ Adverse Reaction? Yes_____ No______

2. Most Recent Restraint/Seclusion Order Date & Time: ________________________________

2a. Date & Time Restraint/Seclusion Applied: ____

2b. Total Length of Time in Restraint/Seclusion: ____

2c. Date & Time Last Monitored: ____

2d. If simultaneous restraint & seclusion was ordered, describe continuous monitoring

method(s):____

____

____

3. Reason(s) for Restraint/Seclusion use: ____

____

____

4. Was restraint/seclusion used to manage violent or self-destructive behavior? Yes___ No ___
   (If No, Skip Questions 5 – 6)

5. If used for violent/self-destructive behavior, was 1 hour face-to-face evaluation documented?
   Yes ___ No ___

5a. Date/Time of Last Face-to-face Evaluation: ____

6. If used for violent/self-destructive behavior, was the order renewed at appropriate intervals based on the patient's age? Yes ___ No ___

   Note: orders may be renewed for up to a total of 24 hours, at the following intervals:
   > 18 years – every 4 hours
   9 – 17 years – every 2 hours
   < 9 years – every hour

E. RO Action(s):

Was a survey authorized? Yes ___ No ____

If yes, date SA received authorization for investigation: ________________________________

If no, brief rationale: ____

Date RO contacted P & A: ________________ or other agency(ies) __________________________

In the past two years, has a survey related to restraint/seclusion death at this hospital resulted in finding condition-level patients' rights deficiencies? Yes ___ No ___

F. State Agency Action(s):

Date of receipt of restraint/seclusion death report from RO: ________________________________

Date of Survey: ____________________ Date the completed 2567 forwarded to RO: ________

Recommended Conditions Out? Yes _____ No _____

If yes, list condition tag number(s):

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ ____

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ ____

Name and telephone number of SA contact: ____

G. Central Office (CO) Action(s):

Date of receipt of initial restraint/seclusion death report: __________________________________

Date of receipt of initial restraint/seclusion death report worksheet: ________________________

Date of receipt of complete restraint/seclusion death report worksheet ______________________

Additional Information/Comments:

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