Swedish Policy

• Swedish supports the use of the least restrictive alternative to the use of restraint and/or seclusion

• When restraint and/or seclusion are necessary, they are to be discontinued at the earliest possible time

• Staff, patient, and visitor safety are priorities at all times
Least Restrictive Alternative: Why?

- **Mandated by**
  - State WAC
  - TJC, CMS

- **Evidence Based** - least restrictive alternatives to restraint and seclusion
  - Decrease incidences of restraint and seclusion
  - Avoid traumatizing and/or re-traumatizing patients
  - And prevent violence in healthcare

- **Best Practice** - prevention and reduction of restraint and seclusion leads to
  - Fewer injuries
  - Shorter lengths of stay,
  - Decreased recidivism/re-hospitalization
  - Less medication
  - Increased positive outcomes/discharge or higher level of functioning at time of discharge
# Least Restrictive Alternatives

## How?

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of patient’s name and maintaining eye contact</td>
<td></td>
</tr>
<tr>
<td>Use of age appropriate explanations of treatment</td>
<td></td>
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<tr>
<td>Engaged listening</td>
<td></td>
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<tr>
<td>Development of therapeutic rapport (includes tone, facial expressions, soothing conversation, hand holding)</td>
<td></td>
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<tr>
<td>Use of de-escalation techniques</td>
<td></td>
</tr>
<tr>
<td>Involvement of patient’s support systems</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offering of sensory interventions such as relaxation/calming activities, self-soothing</td>
<td></td>
</tr>
<tr>
<td>Activities, distracting activities, and environmental modifications</td>
<td></td>
</tr>
<tr>
<td>Use of PRN medications</td>
<td></td>
</tr>
<tr>
<td>Use of a patient safety attendant (PSA)</td>
<td></td>
</tr>
<tr>
<td>Implementation of a Health Care Agreement (HCA)</td>
<td></td>
</tr>
</tbody>
</table>
Tips to Help Avoid Power Struggles

• Maintain a calm demeanor
• Use patient centered communication:
  “What will help now?”
  Open ended questions
  Reflective listening
• Use empathy
• Redirect
• Engage but don’t crowd- give patient space
• Offer choices
• Give patient time to think
• Allow venting
• Allow pacing
• Avoid “you must”
• Use positive limit setting
• Be clear and use simple language
• If others are in the area, remove the audience
Personal Safety Attendant (PSA)

Who might need a PSA?

• Suicidal
• Epilepsy Monitoring (without aura)
• High-risk for causing injury to self
• Behavior is unpredictable or difficult to manage

What are my responsibilities as a PSA?

• Constant monitoring of the patient to ensure safety
• Sometimes also “regular” duties of your role, when appropriate (such as ADLs)

Safety

Patient

Environment

Yourself!
Expectations of a PSA

Report:
- On-coming
- Off-going
- Breaks

Of Distractions:
- Cell phones
- Headphones/ Earbuds
- Computers

Of Inappropriate Discussions
Of patient verbalizing intent to harm or leave
Expectations of a PSA

> As your attention should be on the patient at all times, use of cell phones is not allowed, and computers are for charting on patient care only
  • A distracted PSA is considered “negligent” if an adverse event were to occur.

> When you arrive on the unit, check in with the charge nurse and get report from the patient’s nurse. It is important that you understand what the patient’s needs are before assuming care

> Locate and read “PSA Job Aid” on the Swedish intranet
  • Your care should be specifically tailored to the patient and their diagnosis
  • The PSA Job Aide outlines tips and strategies for working with different kinds of patients requiring a PSA
PSA for Patients with Delirium

Strategies for Working with a Patient with Delirium/Acute Confusion:

• Identify yourself with each interaction
• Ensure the patient has glasses and/or hearing aids to maximize sensory perception
• Explain interventions, procedures, and equipment simply and clearly
• Provide frequent orientation cues (e.g., clock, calendars, verbal cues)
• Frequently re-orient the patient to the situation
• Provide reassurance to patient
• Maintain an accepting, calm manner by using a reassuring and gentle tone of voice
• Reduce noise level as able
• Encourage visits from family and friends
• Place familiar objects in room
PSA for Patient with Dementia

Strategies for Working with a Patient with Dementia:

- Identify self with each interaction
- Approach the patient slowly from the front while telling him/her what you are going to do
- Keep voice volume appropriate for distance and ability to hear
- Use a normal speech rhythm. (Speaking too fast or in an irritated, excited manner may cause agitation)
- Use a reassuring and gentle tone of voice
- Maintain an accepting, calm manner
- Use gestures or cues when possible, in addition to verbal communication
- Attempt to distract or re-direct when patient begins to become agitated over an issue
- Consider the use of diversionary activities
  - Towel-folding and stacking
  - Card game, shuffling, sorting
  - Video/DVD movies (appropriate to the patient)
  - Exercise ball
  - Provide soothing music
  - Ambulate with patient as tolerated
PSA for Patient with Nighttime Difficulties

Strategies for Working with a Patient with Nighttime Difficulties:

• Lower lighting, darken the room
• Re-orient to time of day
• Soothing music (no loud music)
• Turn off the TV
• Warm, non-caffeinated beverages
• Back rub
• Limited number of visitors, especially near bedtime
• Consider ambulating with the patient if he/she is up and awake at night
PSA for a Violent Patient

Strategies for Working with a Violent Patient:

• Make sure you always stand between the patient and the door in order to get out safely if necessary
• Speak clearly, calmly, and in a matter-of-fact way; do not raise your voice
• Do not attempt to engage in discussion regarding reasons for restraint. Simply state the reason for the restraint (ask the RN first)
• Do not respond to verbal attacks
• Re-orient the patient as needed
• Reassure the patient that you are there to provide for his/her safety and well-being
• Do not assume that because the patient has calmed that he/she is in full control of his/her behavior
• Keep yourself safe. Maintain at least an arm’s (punch) and leg’s (kick) length of distance from the patient unless the RN has instructed to maintain a greater distance. Buddy with another staff member, as necessary, for closer care
• Coordinate with RN for more frequent breaks, as needed
Suicide Precautions

Patients on Suicide Precautions must **always** be in your line of sight

- You must be able to see your patient when they are in the bathroom. If they refuse, consult with your RN.

- **There is NEVER** a situation where a suicidal patient can be unsupervised in the bathroom
Suicide Precautions

Remove all belongings and equipment that can potentially be used for harm. This may include:

- All sharps
- Breakable and sharp objects
- Belts
- Phone cords
- Medications
- Plastic bags
- IV Pole & Pump
- Cell phones (Remove initially, then care team will make the decision to keep or remove)
  - Consult with RN when it may be appropriate to keep or use a phone of any kind
  - Electronic devices (Care team decision to keep or remove)

Even though the patient is being constantly watched, these items must be removed!

Any items brought in and left by visitors must be searched
Suicide Precautions, cont.

• If your patient tries to leave, do not physically stop them
  • If patient is violent or homicidal, call a Code Grey.
  • If patient leaves, provide a description of the patient and a direction of travel- now a Code Purple
• If patient is in a seclusion area, use security or a team of caregivers for all interactions, such as delivery trays or going to the bathroom. Patients in seclusion may be stopped if trying to leave.

• Suicidal patients may walk in the halls if:
  • The RN/ Charge Nurse states that they can
  • They are with the PSA at all times
  • They do not leave the unit, even with the PSA
  • They are not a flight risk
Paper Service

- Request Paper Service trays when ordering food from the cafeteria.
- If there are any items on the tray that are sharp or can be sharp if broken, do not bring them into the room!
- Visitors cannot bring in sharps or silverware.
  - If food items need to be cut, they can do so outside of the room.
Clinical Procedure

**PATIENT SAFETY ATTENDANT (PSA):**
HIGH SAFETY RISK PATIENT MONITORING

<table>
<thead>
<tr>
<th>Clinical Procedure</th>
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<tbody>
<tr>
<td><strong>Approved:</strong> January 2018</td>
</tr>
<tr>
<td><strong>Clinical Area:</strong> All inpatient units and emergency departments</td>
</tr>
<tr>
<td><strong>Population Covered:</strong> All patients requiring a PSA</td>
</tr>
<tr>
<td><strong>Campus:</strong> Ballard, Cherry Hill, Edmonds, First Hill, Issaquah, Mill Creek, Redmond</td>
</tr>
</tbody>
</table>

**Related Procedures, Protocols, and Job Aids:**

- Alcohol Withdraw Management
- Confused Patient Management: Delirium Encephalopathy
- Restraint or Seclusion Management
- Suicide Precautions: Patient Management

**Purpose**

The purpose is to outline guidelines for the initiation, continuation, and discontinuation of a Patient Safety Attendant (PSA).

**Responsible Persons**

Registered Nurse (RN), Assigned Patient Safety Attendant (PSA): A nursing assistant-certified (NAC), ED tech, nursing tech, licensed practical nurse (LPN) or registered nurse (RN) may be assigned the role.

**Prerequisite Information**

A PSA may be required if a patient is an acute risk of harm to self or others, requires violent restraints or seclusion, or requires close observation for treatment interference or fall prevention.

An appropriately oriented NA-C, ED Tech, Nursing Tech, LPN, or RN may be assigned the role of patient safety attendant. The primary RN and primary NA-C continue to provide all necessary nursing care in collaboration with the PSA. Appropriate orientation includes review of PSA role and responsibilities.

Direct observation by a PSA may be utilized as a least restrictive alternative to the use of restraint or seclusion.

If a PSA is assigned to monitor more than 1 patient, in the same room or in separate rooms, the PSA must be positioned to maintain an unobstructed view of all assigned patients. Additional staff must be provided if patient activity (e.g., patient ambulating in the hall, in the restroom, or transported off the unit) prevents the simultaneous monitoring of both patients.
<table>
<thead>
<tr>
<th>Responsible Person</th>
<th>Steps</th>
</tr>
</thead>
</table>
| RN                 | 1. Consider the cause of the patient’s behavior by assessing the following as applicable to the patient condition:  
  - Attempt to determine and address causal factors in the patient’s behavior, as appropriate:  
    - Have toileting needs been met?  
    - Consider a toileting schedule or the potential for urinary retention or constipation  
    - Assess for pain and take measures to alleviate pain  
    - Assess for neurocognitive disorder (e.g. delirium, dementia)  
    - See [Agitated Confused Patient-Management Guidelines: Adult](#)  
    - Consider history or new onset of psychiatric conditions  
  - Determine if there is a medical cause for confusion:  
    - Review lab results and medications  
    - Evaluate oxygenation  
    - Rule out UTI and assess for possible sepsis  
  - Assess for neurologic deficits:  
    - Does the patient have any motor/sensory deficits (including hearing, vision, speech, language)?  
    - Ensure that the patient has access to any assistive devices (glasses, hearing aids, walker, etc.)  
  - Assess primary language and/or literacy:  
    - Arrange for interpreter services as needed  
    - Tailor communication and education as needed for the individual patient  
  - Assess for episodic confusion (“sundowning”):  
    - Use distraction or diversion techniques  
    - Decrease stimulation at night  
  - Review patient’s medication in partnership with LIP:  
    - Could a new medication or adjusted dose be the cause of confusion or agitation?  
    - Is sedation medication at the appropriate dosing to ensure safe medical management?  
    - Are medications and dosages adequate to manage delirium?  
    - Are additional medications or dose adjustment needed to manage agitation?  
  2. Utilize all appropriate least restrictive alternatives to restraints and assess the patient response to the intervention. See the [Alternatives to Restraints](#) resource guide for suggested nursing interventions.  
<table>
<thead>
<tr>
<th>RN</th>
<th>4. Reassess patient response to all attempted alternatives to restraint/seclusion. If patient safety warrants close observation, consider assigning a PSA to provide direct observation.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INITIATION OF PSA</strong></td>
<td><strong>NOTE:</strong> Notify Charge Nurse of the need for a PSA and develop a unit based plan to staff the role.</td>
</tr>
<tr>
<td>5.</td>
<td>Review with the PSA the role requirements appropriate to the assigned patient.</td>
</tr>
<tr>
<td>6.</td>
<td>Provide nursing bedside report (as appropriate) or patient handoff report to the PSA.</td>
</tr>
<tr>
<td><strong>PSA</strong></td>
<td>1. Report to the charge nurse on arrival to the unit and be oriented to the PSA role and responsibilities. Participate in nursing bedside report (as appropriate) or receive patient handoff report as provided by the RN or previous/off going PSA.</td>
</tr>
<tr>
<td></td>
<td>2. Maintain direct line of sight to the patient(s) at all times:</td>
</tr>
<tr>
<td></td>
<td>• PSA must be able see the patient(s) at all times.</td>
</tr>
<tr>
<td></td>
<td>• The PSA is not to engage in activities that take their attention away from the patient such as excessive use of a computer, cell phone, or distracting reading materials.</td>
</tr>
<tr>
<td></td>
<td>• Patient will be observed while in the bathroom.</td>
</tr>
<tr>
<td></td>
<td>• Maintain an unobstructed view of restraints, if applicable.</td>
</tr>
<tr>
<td></td>
<td>3. Create a safe environment. See High Safety Risk Patient Room Checklist:</td>
</tr>
<tr>
<td></td>
<td>• Ensure the bed is in working order and furniture in good condition; de-clutter room.</td>
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<tr>
<td></td>
<td>• Keep the bed in low position with wheels locked.</td>
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<tr>
<td></td>
<td>• The patient wears yellow double-sided socks if identified as high risk for falls.</td>
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<tr>
<td></td>
<td>• Use best judgment when calling for help, use call light or leave patient to find help.</td>
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<tr>
<td></td>
<td>• The patient wears a purple gown if identified as an elopement risk.</td>
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<tr>
<td></td>
<td>• Pediatric patients wear a HUGS security tag if identified as an elopement risk.</td>
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<tr>
<td></td>
<td>4. Remove any dangerous items from the patient and the room. Items must be documented in the chart. Behavior management patients require all below steps. In the case of treatment interference, use clinical judgment in consultation with the bedside RN.</td>
</tr>
<tr>
<td></td>
<td>• Sharps such as scissors, razor, clippers, metal nail file</td>
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<tr>
<td></td>
<td>• Breakable and sharp objects such as CD and DVDs, glassware</td>
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<tr>
<td></td>
<td>• Belts, phone with cord and other electrical appliance cords:</td>
</tr>
<tr>
<td></td>
<td>o Long cords can be zip-tied shorter to reduce ligature risk</td>
</tr>
<tr>
<td></td>
<td>o Do not remove the call light. This can be built into the bed, or zip-tied for a shorter cord length</td>
</tr>
<tr>
<td></td>
<td>• Matches or lighter</td>
</tr>
<tr>
<td></td>
<td>• Jewelry</td>
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<tr>
<td></td>
<td>• Medication- including medication kept in clothing or purse</td>
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<tr>
<td></td>
<td>• Decisions regarding appropriate access to electronic devices will be made with the care team.</td>
</tr>
</tbody>
</table>
5. Offer fluids as appropriate. Behavior management patients require the following steps (in the care of treatment interference, use clinical judgment in consultation with the bedside RN). Ask for a Safety Tray when ordering meals; plastic utensils (fork and spoon) and paper plates and cups (no aluminum cans). Inventory all items when removing the tray from the room.

6. Complete and document all aspects of ADL’s for patient as appropriate. This includes but is not limited to the following: vital signs, bathing, ordering meals and assist with feeding, or toileting. Additional staff may be needed for some care activities.

For patients on a toileting schedule:

- a. Assist to bathroom or bedside commode (BSC) according to schedule (obtain additional assistance as needed).
- b. Stay with patient while using the bathroom or BSC.
- c. Keep track of output volumes

7. All ancillary staff and visitors must first check in with the RN or RN’s designee prior to entering the patient’s room. The RN needs to screen visitors and all items in their possession.

8. While on duty, obtain RN approval and relief prior to discontinuing direct observation.

9. **If the patient has restraints in place:**

   - Ensure restraint is properly and safely applied (e.g., one finger space between cuffs and patient). Notify the RN immediately if the patient complains of discomfort or attempts to loosen or remove the restraint. **In case of an emergency** (such as a fire or Code Blue), the PSA is expected to be able to release the restraints.

   **Restraints for Violent Behavior**
   Perform safety checks and document every 15 minutes in the restraint flowsheet, including:
   - Skin integrity
   - Circulation, motion and sensation in restrained extremities
   - Respiratory rate
   - Psychological status

   **Restraints for Medical Interference**
   Perform safety checks and document every 2 hours in the restraint flowsheet, including:
   - Skin integrity
   - Circulation, motion and sensation in restrained extremities
   - Respiratory rate
   - Psychological status
   - Check with the RN regarding the every two hour range of motion interventions for the patient

   - Ensure that essential care needs are addressed
   - *Always* obtain RN approval before removing or loosening a restraint.
   - Document according to the restraint policy. See Restraint or Seclusion Management.

10. Respond as trained if the patient experiences a medical emergency; report any other emergency immediately to RN staff.
11. Accompany the patient for any clinical tests or procedures off of the unit. Remain within an arm’s length distance of the patient unless otherwise directed by the person performing the test or procedure. (Patients in restraint for violent behavior are not transported off the unit except in an emergency situation.)

12. Notify the RN if the patient is not cooperating with treatment or is threatening to leave. If the patient is aggressive or insists on leaving the unit, call a Code Gray, See Code Gray: Violent or Self-Destructive Behavior.

13. If the patient leaves the unit, immediately notify the patient’s RN or the charge nurse (who may call a Code Purple or Code Amber Alert as indicated). Be ready to describe the patient to Security, including what the patient looks like, their clothes and that the patient may be a danger to self or others.

14. Provide handoff to the PSA on-coming shift.

<table>
<thead>
<tr>
<th>RN</th>
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<tbody>
<tr>
<td><strong>CONTINUATION AND DISCONTINUATION</strong></td>
</tr>
<tr>
<td>1. Assess and document the presence of a patient safety attendant at least every 4 hours.</td>
</tr>
<tr>
<td>2. Frequent rounding on the PSA by the RN. Adjust care plan as needed based on PSA report.</td>
</tr>
<tr>
<td>3. Assess the patient’s response to close observation and document in the shift summary.</td>
</tr>
<tr>
<td>4. Collaborate with the multi-disciplinary team to determine the appropriate time to discontinue the direct observation of the PSA.</td>
</tr>
</tbody>
</table>

**Definitions**

*Direct Observation.* A competent observer in direct line of sight of one or more patients. Observer is in close proximity, with no physical barriers preventing easy access to the patient.

*Patient Safety Attendant (PSA).* A nursing assistant-certified (NAC), ED tech, nursing tech, licensed practical nurse (LPN) or registered nurse (RN) may be assigned the role to provide direct observation for one or more patients.

**Supplemental Information**

The PSA role is part of the healthcare team and any patient information is confidential per the HIPPA guidelines.

Attire is consistent with the *Personal Appearance* policy and name badge is visible.

The PSA follows policies regarding use of personal electronic devices and breaks. Computers are to be used for work-related activities only. See *Personal Electronic Device While on Duty*.

**Regulatory Requirement**

None.

**Addenda**

*Engagement and De-escalation: Strategies for Patient Care (Confused and/or Agitated Patient)*  
*High Safety Risk Patient Room Checklist*  
*Understanding and Preventing Delirium: A Guide for Family and Friends*
STAKEHOLDERS

Author/Contact

Elizabeth Wierman MSW, CDP, Psychosocial Clinical Specialist

Expert Consultants

Pediatric Quality and Safety Committee (June 2017)
Swedish Restraint Compliance Governance Committee (September 2017)

Sponsor

Margo Bykonen, RCNO Swedish/CNO First Hill, Swedish Administration
## Engagement and De-escalation Strategies for Patient Care (Agitated and/or Confused Patient)

### Strategies for Working with an Escalated Patient
- Make sure you always stand between the patient and the door in order to get out safely if necessary.
- Speak clearly, calmly, and in a matter-of-fact way; do not raise your voice.
- Do not attempt to engage in discussion regarding reasons for restraint. Simply state the reason for the restraint (ask the RN first).
- Do not respond to verbal attacks.
- Re-orient the patient as needed.
- Reassure the patient that you are there to provide for his/her safety and well-being.
- Do not assume that because the patient has calmed that he/she is in full control of his/her behavior.
- Keep yourself safe. Maintain at least an arm’s (punch) and leg’s (kick) length of distance from the patient unless the RN has instructed to maintain a greater distance. Buddy with another staff member, as necessary, for closer care.
- Coordinate with RN for more frequent breaks, as needed.

### Strategies for Working with a Patient with Delirium or Acute Confusion
- Identify yourself with each interaction.
- Ensure the patient has glasses and/or hearing aids to maximize sensory perception.
- Explain simply and clearly all interventions, procedures, and equipment.
- Provide frequent orientation cues (e.g., clock, calendars, and verbal cues).
- Frequently re-orient the patient to the situation.
- Provide reassurance to the patient.
- Maintain an accepting, calm manner by using a reassuring and gentle tone of voice.
- Reduce noise level as able.

### Strategies for Working with a Patient with Nighttime Difficulties
- Lower lighting, darken the room.
- Re-orient to time of day.
- Soothing music; no loud music.
- Turn off the TV
- Warm, non-caffeinated beverages

### De-escalation Strategies
- Ask them to cooperate
- Explain the situation/rationale
- Present options/choices
- Confirm choices
- Act/follow through with choices

### Verbal Intervention Tips and Techniques

<table>
<thead>
<tr>
<th>DO:</th>
<th>DON'T:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remain calm</td>
<td>Overreact</td>
</tr>
<tr>
<td>Isolate the situation</td>
<td>Get in a power struggle</td>
</tr>
<tr>
<td>Enforce limits</td>
<td>Make false promises</td>
</tr>
<tr>
<td>Actively Listen</td>
<td>Fake attention</td>
</tr>
<tr>
<td>Be aware of non-verbals</td>
<td>Be threatening</td>
</tr>
<tr>
<td>Be consistent</td>
<td>Use jargon</td>
</tr>
</tbody>
</table>
**Clinical Procedure**

**Approved:** July 2019  
**Next Review:** July 2022

<table>
<thead>
<tr>
<th>Clinical Area:</th>
<th>All clinical areas except inpatient psychiatry</th>
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<tbody>
<tr>
<td>Population Covered:</td>
<td>All patients</td>
</tr>
<tr>
<td>Campus:</td>
<td>Ballard, Cherry Hill, Edmonds, First Hill, Issaquah, Mill Creek, Redmond</td>
</tr>
<tr>
<td>Implementation Date:</td>
<td>October 2008</td>
</tr>
</tbody>
</table>

**Related Policies, Procedures, and Job Aids:**
- Involuntary Psychiatric Commitment, Boarding, and Treatment
- Mental Health/Psychiatric Consultations: Inpatient
- Patient Safety Attendant (PSA): High Safety Risk Patient Monitoring
- Restraint or Seclusion Management
- Search and Seizure: Patient
- Telesitter Continuous Patient Observation (Adult Acute Care): Low Severity Suicidal Patient
- Nursing Minimum Documentation Reference

**Go directly to:**
General Information about Suicide Risk

**Addenda:**
- Suicide Precautions: Patient Management Level of Observation (Edmonds ED Pilot Only)
- Suicide Precautions Observation Algorithm (Edmonds ED Pilot Only)
- Suicidal Ideation/Homicidal Ideation Approved Activity List for Pediatric Patients
- High Safety/Ligature Risk Patient Room Checklist
- Suicide Precautions RN Checklist
- Suicide Prevention and Crisis Plan (patient and family education)
- What to Expect During Your Pediatric Inpatient Behavioral Health Stay

**Purpose**

To outline steps for the identification, assessment, and prevention of self-harm or attempted suicide during hospitalization and immediately following discharge.

**Policy Statement**

None.

**LIP Order Requirement**

No order is required.

**Responsible Persons**

Licensed Independent Provider (LIP), Registered Nurse (RN), Charge Registered Nurse (CRN), Social Worker (MSW), Behavioral Health Assessment Team Clinician (BHAT Clinician)
Prerequisite Information

All patients are screened for risk of harm to self (including suicidality) or others. Screening questions may vary based upon patient population and/or care area (e.g. Emergency Department).

All staff providing clinical care are responsible for identifying patients at risk for suicide as well as identifying environmental safety risks for such patients and taking steps to mitigate these risks.

Level of observation includes: 1:1 via PSA, 2:1 via PSA, direct remote continuous monitoring via telesitter.

The use of standard suicide precautions allows caregivers to prevent the patient from inflicting self-harm while utilizing the least restrictive level of patient observation. If the lesser restrictive alternative is ineffective, a more restrictive level of observation may be considered by the care team in order to maintain safety of the patient and others. Suicide Precautions are not synonymous with nor contradictory to Seclusion; Seclusion is when a patient has been directed to remain alone in a care area or defined space or perceives that they will be physically prevented from leaving, in accordance with the Center for Medicare and Medicaid Services (CMS) regulations [CMS 482.13(e)(1)(ii)]. Calling a Code Gray to prevent elopement is considered a measure that physically prevents the patient from leaving (Isolation restriction is not considered in this regulation.) See Restraint or Seclusion Management.

The hospital setting provides access to items that can be used to attempt suicide and opportunities for the patient to be alone to make an attempt. Awareness of contributing and suicide risk factors and recognition of warning signs are important to ensure appropriate safety and that treatment measures are implemented.

General Information about suicide risk

Suicide risk is influenced by biological, psychological, social, and cultural factors. These factors interplay to raise or lower the risk of suicide.

Factors which are associated with increased suicide risk for patients:

- Mental or emotional disorders- particularly depression and bipolar disorder.
- Previous suicide attempts or self-harm.
- History of trauma or loss.
- Serious illness, or physical or chronic pain or impairment.
- Alcohol and drug use problems.
- Social isolation.
- Discharge from inpatient psychiatric care, within the first year after and particularly within the first weeks and months after discharge.
- Access to lethal means coupled with suicidal thoughts.
- Family history of suicide.
- Feelings of hopelessness.
- Barriers to accessing mental health treatment.
- Unwillingness to seek help due to stigma attached to mental health and substance use disorders of to suicidal thoughts
- Impulsive of aggressive tendencies
- Cultural and religious beliefs (e.g. belief that suicide is a noble resolution of a personal dilemma
- Local epidemics of suicide

Protective factors that buffer suicide risk:

- Effective clinical care for mental, physical, and substance use disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Family and community support (connectedness)
- Support from ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes
• Culture and religious beliefs that discourage suicide and support instincts for self-preservation

**Key symptoms:**

• Current suicidal ideation, plan, intent
• Anxiety/panic or agitation
• Impulsivity
• Lack of ability to feel enjoyment/pleasure
• Feelings of hopelessness, despair, worthlessness
• Global insomnia
• Command hallucinations
• Giving away possessions
• Precipitants: triggering events leading to humiliation, shame or despair, ongoing medical illness, history of abuse or neglect, intoxication

### PROCEDURE

<table>
<thead>
<tr>
<th>Responsible Person</th>
<th>Steps</th>
</tr>
</thead>
</table>
| RN                 | 1. Screen all patients for suicide risk and document patient response. See *Nursing Minimum Documentation Reference*. **NOTE:** Edmonds Emergency Department continue to Level of Observation Job Aid *Suicide Precautions: Patient Management Level of Observation (Edmonds ED Pilot Only)*  
2. Initiate interventions to mitigate risk for suicide in the hospital based upon screening results and patient needs. **NOTE:** In perianesthesia/procedural in the case of positive C-SSRS screen, notify charge nurse/manager/nursing supervisor and LIP. This may result in additional consultation with a mental health professional. |
| RN                 | 1. Initiate Suicide Precautions when a patient has been admitted for treatment of self-inflicted injury with suicidal intent and the psychiatric consultant has not evaluated and determined appropriate level of supervision, or if comments or behaviors of the patient raise concern about self-harm. See the *Suicide Precautions RN Checklist*.  
2. Initiate direct continuous observation. See *Patient Safety Attendant (PSA): High Safety Risk Patient Monitoring*. Edmonds Emergency Department initiate observation per Level of Observation Job Aid  
• Initial level of observation is determined based upon patient presentation and environment.  
• Initial level of observation may be 2:1 in the case of ligature free care space and ligature free attire.  
3. Place the patient in the purple paper scrubs. If purple paper scrubs are not appropriate (e.g. due to incorrect fit or patient preference) place patient in purple gown. **NOTE:** Purple cloth gown is a ligature risk requiring safety mitigation.  
4. Create and maintain a safe environment. See *High Safety Risk Patient Room Checklist*.  
5. Contact Security Services to conduct a search of the room and/or belongings remaining with the patient to ensure safety. **Do not leave belongings that need to be searched with the patient.** See *Search and Seizure: Patient*. |
• For patients admitted from the ED, a new search is required after transfer.
• Instruct patient’s visitors that all items being brought to the patient must first be cleared by staff.

6. Request Dietary to use “paper service” with comment “safety tray.”
• Dietary will deliver to nursing staff all food/fluid orders using disposable/paper dinnerware, plastic utensils, NO knives.
• Glass or china dinnerware, cups, soda cans, glass bottles and knives of any kind are not allowed.
• Nursing staff will deliver items directly to the patient after removing hard plastic covers or metal plate warmers.

7. Inform the attending LIP of patient comment or behaviors that indicate suicide risk.

8. Notify Social Work/BHAT and request referral for further assessment of suicide risk and discharge planning. See Mental Health/Psychiatric Consultations: Inpatient
9. Recommend a referral for psychiatric consultation if not already initiated. See Mental Health/Psychiatric Consultation: Inpatient. (See below for psychiatry consult in the ED.)
10. Notify the unit manager and/or administrative supervisor of patient with identified suicide risk.
11. Contact the psychosocial clinical specialist for assistance with nursing care planning and management as needed.
12. Patient is to remain on the unit, but with access to the common patient areas when accompanied by the PSA. In the case of a required medical procedure, first determine if the procedure can be done on the unit and make arrangements. If the patient is required to leave the unit for a medical necessary procedure:
   a. First assess risks to the patient’s safety as it pertains to leaving the unit. (For staff safety, a patient who must leave the unit is to be accompanied by two staff members, i.e., a transporter and PSA.)
   b. Alert Security that the patient is leaving the unit accompanied by staff.
   c. If safety cannot be assured and the procedure must be carried out, discuss with the LIP the need for restraint based on the patient’s behavioral presentation, obtain and implement the appropriate restraint orders, and instruct the PSA to perform monitoring as required and to complete documentation upon return to the unit. See Restraint or Seclusion Management.

13. Continue direct continuous observation (e.g. 2:1, telesitter). Level of observation may change based upon patient severity and in consultation with MSW/BHAT Clinician and LIP. Change in level of observation requires:
   2. Patient care team huddle consisting of at a minimum the patient’s LIP, primary RN, and MSW/BHAT Clinician. Huddle may be completed by proxy in the case of not all members of the team available in person. Primary RN to facilitate.
   3. All members of the patient care team must be in agreement to change the level of observation. If level of observation changes, outcome of huddle is documented in the EMR.

NOTE: Direct observation may be discontinued if a determination has been made that this is not necessary for patient safety by the LIP in consultation with the patient’s RN, MSW/BHAT clinician, and/or psychiatrist. In the ED this consultation decision is made by the MSW/BHAT clinician conducting the suicide risk assessment, the ED LIP and charge nurse or primary RN.
14. Document assessment, interventions and patient behavior as reported by PSA and/or observed by RN in ED notes, shift summary or unexpected event notes.

**MSW, BHAT Clinician**

1. Complete an assessment:
   - **ED MSW/BHAT Clinician:** Complete a comprehensive psychiatric assessment, including complete suicide risk assessment.
   - **Inpatient MSW on all campuses except Edmonds**
     See [Mental Health/Psychiatric Consultation: Inpatient](#).
     - Complete suicide risk assessment if social worker sees patient prior to the consulting psychiatrist.
     - Complete brief psychiatric assessment if assessment not already completed by ED social worker or psychiatry.

3. Immediately convey concerns to the attending LIP.
4. Confer with the primary RN regarding the assessment and safety needs of the patient.
5. Recommend a psychiatric consultation (requires LIP to LIP contact) if not already initiated.
6. Collaborate with the consulting psychiatrist as needed.
7. Participate in care conferences with other members of the healthcare team to coordinate plan of care.
8. Work with the patient’s family and support system as appropriate.
9. Participate in discharge planning with other members of the healthcare team to ensure that safety needs of the patient are addressed prior to hospital discharge.
10. Upon discharge, provide crisis hotline and suicide risk information to patient and support system. See patient and family education flyer [Suicide Prevention and Crisis Plan](#).

**LIP**

1. Direct the RN to initiate Suicide Precautions unless it has already been initiated. See [Suicide Precautions RN Checklist](#).
2. Request a psychiatric consult (requires LIP to LIP contact) if indicated. See [Mental Health/Psychiatric Consultation: Inpatient](#). Phone consults are available for the ED.
3. Work with the other members of the healthcare team to ensure safety needs of the patient are addressed during hospital stay and in discharge planning.

**Psychiatry Consultant**

1. The Psychiatric Consultation Service is available 24 hours a day for:
   - Prompt emergency patient management by phone to LIP, Social Work, BHAT and/or nursing staff.
   - Face-to-face evaluation for inpatients within 24 hours of phone referral, usually within 12 hours of referral.

2. Participate in ongoing patient care and discharge planning as appropriate.
   - Suicide risk management with visits daily or as otherwise indicated.
   - Facilitate admission to an inpatient psychiatric unit when indicated.
   - Assist MSW/BHAT Clinician and attending LIP to support referral to the Designated Crisis Responder (DCR) for involuntary psychiatric commitment proceedings when appropriate.

**Case Manager (inpatient only)**

1. Guide and direct patient care, work collaboratively with social work, BHAT, nursing, and medical staff to assure that appropriate referrals are made.

**Administrative Supervisor (inpatient only)**

1. Assist the RN to obtain a PSA for direct observation of the patient.
2. Confer with the RN about contacting the DCR as needed after hours.
Definitions

CMS. Center for Medicare and Medicaid Services

Lethal Means. Anything which could be used to inflict serious harm on oneself or another person.

Ligature Risk (Point). Anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulations.

Protective factor. Characteristics and conditions that predispose an individual to experience less physical and psychological distress in response to adverse events.

Risk factor. Characteristics or conditions predisposing an individual to experience negative physical and psychological outcomes in response to adverse events.

Direct Observation. A competent observer in direct line of sight of one or more patients. Observer is in close proximity, with no physical barriers preventing easy access to the patient.

Designated Crisis Responder. County mental health professional with the legal power to detain citizens against their will under the Involuntary Treatment Act. Formerly known as the County Designated Mental Health Professional or DMHP.

Safety tray. Meal trays and individual dietary orders are supplied using disposable paper dinnerware, including bowl, cups, plates, napkins and plastic utensils, NO knives. The following items are PROHIBITED: glass or china dinnerware, cups, soda cans, glass bottles, knives of any kind. Dietary staff delivers the items to nursing staff. Nursing staff is responsible for delivering the diet order directly to the patient after removing any hard plastic covers or metal plate warmers.

Seclusion is any care area or defined space that a patient has been directed to remain alone and the patient perceives that he/she is being prevented from leaving the care area or defined space.

Seclusion offers a selective and limited environment designed to:

- Minimize external stimulation
- Protect patients from the medical and equipment hazards in the emergency department
- Prevent elopement prior to the rule out of urgent medical conditions and/or psychiatric crisis.

Seclusion is initiated when a patient has been directed to remain alone in a care area or defined space, perceives that the consequences of elopement would result in initiation of a Code Gray, and staff have considered less restrictive options. Utilizing a locked door in a dedicated seclusion room is also seclusion. Seclusion occurs in both locked and unlocked environments. Initiating a Code Gray or utilizing a locked door to a dedicated seclusion room constitutes physically preventing the patient from leaving the designated room or space. The patient is also in seclusion if he/she has been directed to remain alone in a care area or defined space and perceives they will be physically prevented from leaving.

The following actions do not directly constitute the use of seclusion:

- A patient held in the emergency department pending psychiatric clearance. Seclusion begins when the patient is confined to a defined space, alone and has been instructed to not leave the defined space (i.e., private treatment room, triage space, etc.).
- The assignment of a PSA to provide direct observation. Multiple patient populations may have a PSA assigned to assist with observation and maintenance of a safe environment.
- Assigning the patient to a private room is not constituted as seclusion if the patient may willingly exit the room or defined space to ambulate or perform ADLs.
Locked Seclusion Room: A room with a lockable door that is specially equipped with simultaneous video and audio monitoring equipment. If the door is locked, the patient must be monitored either in person or with simultaneous use of the video and audio monitoring equipment.

Forms

None.

Supplemental Information

According to the [Centers for Disease Control and Prevention (CDC) WISQARS Leading Causes of Death Reports](https://www.cdc.gov/nchs/wisqars/pdf/LeadingCauseOfDeath2017.pdf), in 2017:

- Suicide was the tenth leading cause of death overall in the United States, claiming the lives of over 47,000 people.
- Suicide was the second leading cause of death among individuals between the ages of 10 and 34, and the fourth leading cause of death among individuals between the ages of 35 and 54.
- There were more than twice as many suicides (47,173) in the United States as there were homicides (19,510).

The Washington State Department of Health adds: “Healthcare professionals are in a unique position to notice depression and suicide warning signs in their patients and intervene early. Suicide is a preventable public health issue. Understanding the stressors and hopelessness that lead people to consider suicide and connecting them to the appropriate help can save lives.”

**Crisis Hotline Telephone Numbers**

**Local:**

King County 24-hour Crisis Line:
(206) 461-3222 or
(866) 427-4747
TDD (206) 461-3219

Snohomish County Care Crisis Line:
(425) 258-1352 or
(800) 584-3578

Teen Link-A Confidential Helpline for Teens:
Evenings 6 – 10 p.m., seven nights a week
(206) 461-4922
(866) TEENLINK
TDD (206) 462-3219

**National:**

1-800-273-TALK
TTY 1-800-799-4TTY

**Regulatory Requirement**

Centers for Medicare & Medicaid Services (CMS). 482.13 – Patient rights. CMS. 482.13(e)(1)(ii).

Det Norske Veritas (DNV). Patient Rights. PR.2 Specific Rights

References

CMS Survey and Certification Memo 18-6 (December 8, 2017)
CMS Quality Safety & Oversight Group 18-21 (July 20, 2018)
Care Quality Commission
CDC in the National Institute of Mental Health
Washington State Department of Health

Addenda

Suicidal Ideation/Homicidal Ideation Approved Activity List for Pediatric Patients
High Safety/Ligature Risk Patient Room Checklist
Suicide Precautions RN Checklist
Suicide Prevention and Crisis Plan (patient and family education)
What to Expect During Your Pediatric Inpatient Behavioral Health Stay

STAKEHOLDERS

Author/Contact

Elizabeth Rubin MSW, LICSW, CDP, Clinical Specialist, Psychosocial

Expert Consultants

Marianne Klaas, MN, RN, CHSP, HACP, CPHQ, CHOP, Regional Director Accreditation, Safety, Injury Management, and Clinical Quality Investigations
Margaret Skoog MSN, ARNP, AGCNS-BC, Emergency Services Clinical Nurse Specialist

Sponsor

Arpan Waghray MD, Executive Medical Director, Behavioral Medicine
Suicide Precautions RN Checklist

☐ Place patient in a room close to and preferably within view of the nurses’ station.

☐ Explain to patient why precautions are being taken (e.g., want to keep safe until he/she/they is feeling less despondent and more in control).

☐ Obtain PSA and review PSA High Safety Risk Patient Room Checklist with the PSA, check in frequently, offer breaks as indicated to maintain alertness.

*NOTE- Direct observation may be discontinued if a determination has been made that this is not necessary for patient safety by the LIP and in consultation with the nursing manager, social worker, and/or psychiatrist. In the ED this consultation decision is made by the social worker conducting the suicide risk assessment, the ED LIP and charge nurse or nurse manager.*

If 1:1 observation is discontinued, verify if remaining suicide precautions need to be continued, if not obtain order to discontinue.

☐ Contact Security to search belongings which will remain with patient. (Do not leave belongings that need to be searched with the patient.)

☐ Remove potential harmful items from patient room and document disposition.

☐ Place patient in purple paper scrubs.

☐ Notify LIP, place a Suicide Precautions order, and consider requesting a psychiatric consultation (requires An LIP-to-LIP request) unless done.

☐ Initiate Social Work or BHAT (Edmonds campus only) referral.

☐ Notify Nurse Manager or Administrative Supervisor.

☐ Contact Psychosocial Clinical Specialist for assistance as needed.

☐ Request “paper service” with comment ”safety tray” and use for all dietary items.

☐ Instruct visitors to check in first with staff and all items brought are to be screened prior to the visit.

☐ Carefully observe patient during administration of oral meds, mouth check may be needed to ensure medication has been swallowed.

☐ Patient remains on the unit (may walk around and go to common areas accompanied by PSA as applicable). If medical procedure is required off unit, see Suicide Precautions: Patient Management for further precautions.

☐ Provide complete handoffs (RN and NAC/PSA)

☐ Document assessments, interventions and patient behaviors as reported by PSA and/or observed in notes (ED note, shift summary or unexpected event note)

10100801_add1.doc(rev.7/08/19)
High Safety/Ligature Risk Patient Room Checklist

Consider removing or securing the items listed below during room prep

*zip ties can be used to help secure cords*

### Patient Equipment

- **Cardiac/Vital Sign monitor**
  - Cords
  - BP cuff and tubing
  - Leads
- **Suction set-up**
  - Tubing
  - Canister
  - Suction regulators
  - Wall mount for canister
- **Chair exit alarm**
  - Power cord
  - Sensing pad cable
- **IV pole mounted on bed**
- **IV Pump on roll stand**
- **Patient ceiling lift (contact Facilities for assistance)**
  - Lift strap retracted as far into housing as possible
  - Control cable removed
  - Consider removing lift frame dependent on patient condition
- **O₂ tank and holder from bed**
- **Miscellaneous tubing, supplies and packaging**
- **Phone**
- **SCD pump and tubing**

### Bathroom/Closet

- **Toilet safety call cord**
- **Shower safety call cord**
- **Hangers in closet**
- **Shower curtain (if needed, call Facilities for assistance)**

### Environmental Considerations

- **Install empty sharps container**
- **Move bed plug-ins to entry side of bed so they are in line of sight**
- **Remove flashlight if present**
- **Remove gloves from wall cupboard**
- **Ensure buckets on WOW are empty or removed**
- **Window blind pull chains secure or risk assessed for blind removal**
RESTRAINT OR SECLUSION MANAGEMENT

**Clinical Procedure**

<table>
<thead>
<tr>
<th>Approved</th>
<th>Next Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2019</td>
<td>June 2022</td>
</tr>
</tbody>
</table>

**Clinical Area:** All inpatient units and emergency departments

**Population Covered:** All patients

**Campus:** Ballard, Cherry Hill, Edmonds, First Hill, Issaquah, Mill Creek, Redmond

**Implementation Date:** October 2007

**Related Procedures, Protocols, and Job Aids:**
- Alternatives to Restraint
- Code Gray: Violent or Self-Destructive Behavior
- ED Precautionary Hold: Behavioral Crisis Triage
- Involuntary Psychiatric Commitment and Boarding
- Face-to-Face Assessment: Behavioral Restraint or Seclusion Role of the Rapid Response Team (Pilot Project: Ballard Campus Only)
- Missing Adult Patient: Code Purple
- Patient Safety Attendant (PSA): High Risk Patient Safety Monitoring
- Prisoner/Forensic Patient
- Restraint or Seclusion Management: Risk Management Process in the Event of Patient Death
- Search and Seizure: Patient
- Suicide Precautions: Patient Management
- Workplace Violence Prevention

**Go directly to:**
- Policy
- Prerequisite Information
- Code Gray: Violent Restraint Track
- Initiation of Restraint/Seclusion
- Patient Monitoring
- Continued Use of Restraint or Seclusion
- Discontinuation of Restraint/Seclusion
- Initiation of Law Enforcement Restraint
- Restraint-Related Death Reporting
- Definitions
- Addenda

**Purpose**

To describe the clinical management of a patient at initiation, continuation and removal of restraint or seclusion.

**Policy**

Indications for restraint are:

- **Non-Violent Track (formerly Medical Interference Track):** To support medical healing and protect patient from self-harm, or restrict patient’s movement to assist with the provision of care.
- **Violent Track:** To restrict a patient’s movement for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff members, or others.
Swedish Medical Center does not support the use of chemical restraint. The treatment of a patient’s symptoms, like anxiety or agitation, is not considered a chemical restraint.

Restraint is never a PRN or standing order.

Restraint is not to be used for a patient with a BiPAP mask in place. The patient needs to be able to remove the mask in event of emesis. The use of a patient safety attendant (PSA) will be in place to monitor patients who require observation with the use of a BiPAP mask. As a safety alternative instead of restraint use for a patient with a BiPAP mask, the patient should be assessed for intubation.

Seclusion is only to be used in the Emergency Departments and Inpatient Behavioral Health Units.

All LIPs and staff providing direct care to patients are required to read and adhere to the Swedish Medical Center standard on the use of restraint or seclusion. Policy information relevant to LIP responsibilities is included in the Medical Staff Services Regulatory Compliance Guide and is required educational reading for biennial re-credentialing.

Staff is required to demonstrate competence in appropriate restraint application. Swedish maintains records of completion of training.

**LAW ENFORCEMENT RESTRAINT DEVICES:** Patients in law enforcement restraint devices are not covered by the Restraint or Seclusion Management Clinical Procedure. Per CMS Interpretive Guidelines §482.13(e) – The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices applied by non-hospital employed or contracted law enforcement officials for custody, detention, and public safety reasons are not governed by this rule. The use of such devices are considered law enforcement restraint devices and would not be considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients. The law enforcement officers who maintain custody and direct supervision of their prisoner (the hospital’s patient) are responsible for the use, application, and monitoring of these restrictive devices in accordance with Federal and State law. However, the hospital is still responsible for an appropriate patient assessment and the provision of safe, appropriate care to its patient (the law enforcement officer’s prisoner).

When a forensic patient arrives at the hospital in the custody of a law enforcement officer, is physically restrained with law enforcement cuffs or other restrictive device, and the law enforcement officer indicates the patient is to remain in law enforcement restraint device:

- The patient remains in law enforcement restraint device.
- The law enforcement officer is expected to stay with the patient as long as the patient remains in law enforcement restraint device.
- No law enforcement restraint device order or renewal of order is needed as long as the law enforcement officer remains present with the patient. No face-to-face evaluation is required.
- If the patient is in the Emergency Department (ED), care is provided according to the *Emergency Department Care Guidelines*.
- If the patient is hospitalized as inpatient, care is provided according to relevant clinical protocols, procedures, and inpatient standards.
- While patient remains in law enforcement restraint device, the law enforcement officer is oriented to their responsibilities by SMC Security Services (*See Prisoner/Forensic Patient Clinical Procedure*).
- If the law enforcement officer decides to leave because the patient does not need guarding or because the law enforcement office must leave because they are urgently required elsewhere and *discontinues law enforcement restraint device*, the patient is immediately evaluated for the need for continued restraint. If restraint is indicated, an order is initiated for Violent Restraint and this *Restraint or Seclusion Management* standard is followed.

**LIP Order Requirement**

Elements of this procedure require a licensed independent practitioner’s (LIP) order.
Responsible Persons

Any staff member, Licensed Independent Practitioner (LIP), Registered Nurse (RN), ED Tech, Licensed Practical Nurse, Nurse Technician, Mental Health Technician, Nurse Assistant-Certified (NAC), Security staff.

Prerequisite Information

1) LIPs and RNs approved to order restraints and/or complete the face to face assessment are listed as follows:

<table>
<thead>
<tr>
<th>TASK</th>
<th>MD/DO</th>
<th>ARNP</th>
<th>PA-C</th>
<th>RN</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORDER Non-Violent Restraint (formerly Medical</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Interference Restraint)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORDER Violent Behavioral Restraint / Seclusion</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>FACE TO FACE ASSESSMENT for Non-Violent</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Restraint (formerly Medical Interference Restraint)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FACE TO FACE ASSESSMENT for Violent Behavioral Restraint / Seclusion</td>
<td>X</td>
<td>X*</td>
<td>X*</td>
<td>X*</td>
</tr>
</tbody>
</table>

* Completion of the Swedish approved training module is required for all ARNPs, PA-C, and RNs who place orders or conduct face to face assessments. Certificate of completion will be documented in the ARNP or PA’s Medical Staff file or the RN’s employee desk file.

2) The restraint or seclusion chosen is the least restrictive intervention that protects the patient’s or others’ safety and is to be discontinued at the earliest possible time. Restraint/seclusion is initiated only after evaluating the patient and determining that the use of alternatives to restraint or less restrictive measures poses a greater risk than that of using restraint/seclusion. See Alternatives to Restraint.

3) Any device in any combination that restrains four (4) limbs requires a Violent Restraint Track order to support the increased monitoring and patient safety needs.

4) All patients have the right to be free from physical or mental abuse and corporal punishment. All patients have the right to be free from restraint or seclusion in any form imposed as a means of coercion, discipline, convenience, or retaliation by staff.

5) A history of falls, dangerous behavior, a family’s request, or the possibility that the patient’s behavior may place him or her at risk is not sufficient reason to justify the use of restraint or seclusion.

6) The use of non-intended devices (sheets, gauze, tape, bandages) as a restraint is prohibited.

7) Swedish Medical Center provides staff training to ensure safe implementation of restraint or seclusion. Training is targeted to the specific needs of the patient population and is provided during orientation and on a yearly basis. Fire safety training for staff emphasizes the need to remove patients from seclusion or restraint devices as soon as possible to expedite the evacuation process.

8) Be alert for predictors of violence and respond early. See addendum, Early Predictors and Interventions to Reduce Potential for Violence.

9) The Epic System List titled ‘Restraint Status’ is the Swedish Restraint Log for nurse leaders. It tracks all patients with an active Restraint Order.

10) In an emergency situation, the RN may initiate restraint/seclusion.

11) Trial release of restraint or seclusion is not permitted. Restraint or seclusion may be temporarily released in the presence of a staff member for the purpose of providing care. If the patient is released from all restraint or seclusion and left unattended by staff, the restraint or seclusion is considered terminated. Once a patient is removed from all restraint or seclusion, any subsequent need for restraint or seclusion requires a new order.
### CODE GRAY: VIOLENT RESTRAINT TRACK

<table>
<thead>
<tr>
<th>Steps</th>
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</thead>
<tbody>
<tr>
<td>1. Call a Code Gray if patient’s behavior escalates towards violent harm to self, staff, or others.</td>
</tr>
<tr>
<td>2. After calling for a Code Gray, if more staff is needed to assist with patient care, patient hold, and restraint application, staff dials 3000 and requests the call center to re-page overhead the need for additional staff to respond to Code Gray (location).</td>
</tr>
<tr>
<td>3. If patient is transferred directly to an inpatient unit, call 3000 and announce a Code Gray-Transfer to alert Security to immediately deploy to location and assist in the safe transfer of the patient from existing restraint to Swedish restraint.</td>
</tr>
<tr>
<td>4. If patient will be discharged to another facility and is still in four-point restraint, call 3000 and announce Code Gray-Transfer. If the patient is not currently in restraint, but will be placed in restraint on gurney, call 3000 and announce a Code Gray.</td>
</tr>
</tbody>
</table>

### VIOLENT RESTRAINT TRACK: ADDITIONAL DIRECTION

<table>
<thead>
<tr>
<th>Steps</th>
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</thead>
<tbody>
<tr>
<td>1. A security search is performed to ensure patient does not have any potentially harmful items in his/her possession when restraint/seclusion is ordered for violent behavior. Patient’s belongings are to be stored outside of the patient’s room.</td>
</tr>
<tr>
<td>2. Provide only disposable meal trays with paper tray, dishes and plastic utensils, no knives for patient exhibiting violent/suicidal behavior. No hot liquids are allowed. Immediately remove all items and dispose outside of the room after use.</td>
</tr>
<tr>
<td>3. Consider placing patient in a purple gown if there is concern that patient might leave unit.</td>
</tr>
<tr>
<td>4. Emergent Mental Health Hold: See Definitions.</td>
</tr>
</tbody>
</table>

### INITIATION OF RESTRAINT OR SECLUSION

**Seclusion is only allowed in Emergency Departments and Behavioral Health Units**

**NOTE: Simultaneous restraint and seclusion is infrequent. Please see Simultaneous Restraint and Seclusion or Seclusion in Locked Room**

<table>
<thead>
<tr>
<th>Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In an emergency situation, the RN may initiate restraint/ seclusion.</td>
</tr>
<tr>
<td>2. Notify the LIP and obtain an order prior to or immediately after restraint application. A telephone order is permitted if the LIP is not present at the time of restraint/seclusion.</td>
</tr>
<tr>
<td>3. Describe the specific behaviors that must be demonstrated by the patient in order to discontinue the use of seclusion. Explain these behaviors in a manner that the patient/family can understand and reinforce the plan as needed.</td>
</tr>
<tr>
<td>4. Consult with the nurse manager, charge RN or nursing administrative supervisor to determine the level of staff observation required and any need for unit staffing level changes. Assign patient safety attendant (PSA) to provide direct observation and maintain safety of the patient and environment.</td>
</tr>
<tr>
<td>5. Ensure the restraint key is immediately available, if locked restraint used:</td>
</tr>
<tr>
<td>• Charge RN</td>
</tr>
<tr>
<td>• Patient RN</td>
</tr>
<tr>
<td>• PSA for emergency release only</td>
</tr>
<tr>
<td>• Taped to the unit patient reader board at nursing station or designated area</td>
</tr>
</tbody>
</table>
### Restraint Flowsheet:

- Alternatives to restraint/seclusion attempted or considered prior to the application of restraint/seclusion
- Patient’s behavior necessitating restraint/seclusion
- Time the LIP was notified of the need for restraint/seclusion order
- Device(s)/seclusion initiated
- Restraint/seclusion was properly and safely applied, and if any injury to the patient occurred
- Initial monitoring of safety and physical needs

### Restraint order is never a PRN or standing order.

1. Place an order for restraint or seclusion prior to or immediately after restraint application / seclusion.
2. The order must specify:
   - Behavior necessitating restraint/seclusion
   - Restraint track – non-violent (formerly medical interference), violent, or seclusion
   - Limb count for restraint
   - Restraint length in hours
   - Type of restraint device(s)/seclusion to be initiated
3. LIP, or appropriately trained designee, will conduct a face-to-face evaluation of the patient:
   a. *Within one hour* of the initial application of restraint/seclusion for **Violent Behavior.** If a patient’s violent behavior resolves and the restraint/seclusion intervention is discontinued before the LIP, or appropriately trained designee, arrives to perform the one hour face-to-face evaluation, the LIP, or appropriately trained designee, is still required to see the patient face-to-face and conduct the evaluation within one hour after the initiation of this intervention.
   b. *Within 24 hours* of the initial application of restraint for **Non-Violent Behavior (formerly Medical Interference).**
4. Notify attending physician at the time of the face-to-face evaluation if the attending LIP did not order the restraint/seclusion.
5. Document in a progress note (SmartText and .dot phrase is available):
   - Evaluation of the patient’s immediate situation – condition or symptoms necessitating restraint or seclusion
   - Evaluation of alternative measures tried
   - Patient’s medical and behavioral history
   - Need to continue or terminate the restraint/seclusion
   - Notification of attending physician, if applicable
   - Requests for consultations

### PATIENT MONITORING

1. Monitor and document in Restraint Flowsheet patient safety *every 15 minutes* for **Violent** Restraint Track and *every 2 hours* for **Non-Violent (formerly Medical Interference)** Restraint Track.
   - Circulation, motion and sensation, skin integrity
   - Psychological status
| NAC) | RN or delegate (ED Tech, LPN, Nurse Technician, Mental Health Technician, NAC) | 2. Monitor and document in Restraint Flowsheet patient physical needs (comfort, nutritional and hydration needs) *every 2 hours*:
| | | • Observed behavior(s) |
| | | • Fluids offered while awake |
| | | • Range of motion to extremities unless contraindicated; document contraindication reason (not applicable to seclusion) |
| | | • Elimination needs when awake |
| | | • Hygiene needs as needed |
| | 3. Monitor by observation, interaction, and direct examination of the patient. The observer must be able to see the patient fully at all times, i.e. extremities and head, to adequately assess general physical condition. |
| | 4. Monitor the patient for increased anxiety, agitation and/or physical activity that may indicate patient is escalating or attempting to harm self and immediately notify additional staff. |
| | 5. Delegated monitoring staff shall report immediately to the RN any change in condition, any physiological parameters that are outside of normal limits, or any change in the patient’s behavior. |
| | 6. Attempt to provide patient privacy from non-direct care personnel or visitor viewing. |

### CONTINUED USE OF RESTRAINT OR SECLUSION

| RN | 1. Work with the patient to identify ways to regain control to ensure that the use of restraint/ seclusion is discontinued at the earliest possible time. |
| | 2. Assess and document in the Restraint Flowsheet the continued need of restraint for **Non-Violent (formerly Medical Interference)** behavior:
| | • Once per shift or a minimum of once every 12 hours. |
| | 3. Assess and document in the Restraint Flowsheet the continued need of restraint for **Violent** behavior within the time frames below:
| | • Every 4 hours for patients age 18 or older |
| | • Every 2 hours for patients age 9 through 17 |
| | • Every hour for patients under the age of 9 |
| | 4. Notify LIP of need for new order within applicable timeframes if continued restraint use is necessary. |
| | 5. Evaluate Plan of Care effectiveness and revise as needed. |
| | 6. Document any unexpected events related to restraint use in the EMR. This information may be included in the Shift Summary Note. |
| | 7. Complete an eOVR if patient, staff, or provider sustains an injury during while patient is restraint/seclusion. |

### Prolonged Restraint Use / Seclusion

If patient remains in restraint for a prolonged period (see below), the Plan of Care is revised accordingly.

- 72 hours or longer for patients in Non-Violent (formerly Medical Interference) restraint
- 24 hours or longer for patients in Violent restraint/seclusion
- 4 hours for patients in simultaneous restraint and seclusion or locked seclusion

| LIP | 1. **Non-Violent Track (formerly Medical Interference Track):** *Each calendar day*, complete a face to face evaluation & document. Each calendar day, enter new order if continued use of restraint required. |
2. **Violent Track:** *Every 24 hours,* complete a face to face evaluation & document. Enter new order per time frames below if continued use of restraint is required:

- Every 4 hours for patients age 18 or older
- Every 2 hours for patients age 9 through 17
- Every hour for patients under the age of 9

3. Document in a progress note (SmartText and .dot phrase are available):

- An evaluation of the patient’s immediate situation: condition or symptoms necessitating restraint or seclusion.
- Evaluation of alternative measures tried.
- The patient’s medical and behavioral history
- The need to continue or terminate the restraint/seclusion
- Notification of the attending physician, if applicable
- Requests for any consultations

**NOTE:** If patient remains in restraint/seclusion for prolonged period, the Plan of Care is revised accordingly.

---

**DISCONTINUATION OF RESTRAINT/SECLUSION**

1. Discontinue restraint/seclusion as soon as the patient’s behavior no longer places the patient at risk for accidental self-injury, intentional self-harm, interferes with necessary care, or poses a violent threat towards others.

2. Progressive restraint release steps are to be followed for any patient in **violent four-point restraint**:

   **NOTE:** If 5th or 6th restraint is also used, the 6th is removed FIRST in progressive release, followed by the 5th, before extremity restraints.

   - 5th restraint: chest or waist restraint
   - 6th restraint: spit hood

---

**Progressive Release for Patient in Double Locked Restraint**

1. If patient also has fifth or sixth restraint, remove first and observe for 15 minutes.

   
   If patient meets criteria for release stated above, proceed to step 2, below.

   
   If patient meets criteria for release, release other limbs and observe for 15 minutes.

**Manage Orders:**

IF patient behavior during progressive release reduces level of restraint, AND restraint is still necessary (e.g., four locked restraints to two restraints), THEN obtain new order for reduced level.

**Restraints applied to patient must equal restraints ordered.** Document actions taken and rationale.
3. Observe the patient for 15 minutes following release of restraint/seclusion.

**NOTE:** Trial release of restraint/seclusion is not permitted. Restraint/seclusion may be temporarily released in the presence of a staff member for the purpose of providing care. If the patient is released from all restraint/seclusion and left unattended by staff, the restraint/seclusion is considered terminated and any subsequent need for restraint/seclusion requires a new order.

4. RN Document on the Restraint Flowsheet:
   - Patient behavior allowing for release from restraint/seclusion
   - Discontinuation of restraint device(s)/seclusion

5. RN Document “Goals Met” on the restraint/seclusion Plan of Care.

6. RN Click on the “Complete” link next to the restraint/seclusion order in “Active Orders.”

7. Obtain a new order if restraint/seclusion is required again after a patient has been completely removed from all restraint devices/seclusion.

### RESTRAINT-RELATED DEATH REPORTING

1. Complete the [Restraint/Seclusion Death Report Worksheet](#) if patient:
   - Died while in restraint or seclusion.
   - Died within 24 hours after removal from restraint/seclusion.
   - Died within one week after restraint/seclusion.

2. Fax the completed worksheet to Risk Management.

### Definitions

**Devices and alternatives NOT considered restraints:**

- Orthopedically prescribed devices, such as an orthopedic splint
- Surgical dressing, bandages, IV arm board
- Protective helmet
- Other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests
- Positioning the patient during surgery or post-anesthesia care
- Any device used to protect the patient from harm which can be removed by the patient (e.g. Omni belt and torso support).
- Hand mitts may be used as an alternative to restraints. When using mitts:
  - Patient should have free movement of both arms. Mitts should not be tied down and mitts should not be used in combination with any restraint devices.
  - Patient should have free movement of fingers inside the mitts.

- Use of side rails to protect the patient from falling out of bed as long as patient can independently exit the bed.
- Use of side rails/guard rails to protect the patient from falling out of stretcher, crib, or gurney.
- Patients monitored in their room with a staff person (e.g. PSA) and prompted to stay in room (not physically kept from leaving) is considered an alternative to restraint. If a patient will not remain in the room, a Code Gray can be called for possible restraint orders or seclusion.
- Law enforcement restraint device.
**ED Precautionary Hold.** See *ED Precautionary Hold: Behavioral Crisis Triage.*

**Emergent Mental Health Hold.** When, as a result of a mental health disorder a patient presents an imminent likelihood of serious harm to self or others or is in danger due to grave disability that patient may be held in the Hospital/ED until an MSW (or other MHP) is able to assess and facilitate a safe disposition. If the patient’s condition warrants a referral to the Designated Crisis Responder (DCR) the patient will be held until the DCR can evaluate and make a determination about the disposition of the patient. See RCW 71.05.153 for more information.

**ITA (Involuntary Treatment Act) Detention.** The DCR has determined the lawful confinement of a person under the provisions of 71.05 RCW (or 71.34 for juveniles) for not more than seventy-two hours (judicial court days). Detained persons are frequently “boarded” on various floors in the Swedish system awaiting transfer to court and/ or an Involuntary Psychiatric Treatment Facility.

**Law enforcement restraint device.** The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices applied by non-hospital employed or contracted law enforcement officials for custody, detention, and public safety reasons.

**Licensed Independent Practitioner (LIP).** For the purpose of ordering restraint or seclusion, a LIP is any practitioner permitted by State law and hospital policy as having the authority to independently order restraints or seclusion for patients. A resident who is authorized by State law and the hospital’s residency program to practice as a physician can carry out functions reserved for a physician or LIP by the regulation.

**Locked Seclusion Room.** A room with a lockable door that is specially equipped with simultaneous video and audio monitoring equipment. If the door is locked, the patient must be monitored either in-person or with simultaneous use of the video and audio monitoring equipment.

**Prolonged Restraint Use/Seclusion:**

- 72 hours or longer for patients in Non-Violent (formerly Medical Interference) restraint
- 24 hours or longer for patients in Violent restraint
- 24 hours for patients in seclusion
- 4 hours for patients in simultaneous restraint and locked seclusion

**Restraint.** A restraint is considered to be any device, equipment, or method that immobilizes or reduces the ability of the patient to move limbs, body, or head freely. If the patient can freely remove the device, equipment, or method, it is not considered a restraint.

**Non-Violent Restraint (formerly Medical Interference Restraint).** A restraint used to support medical healing and protect patient from self-harm, or restrict patient’s movement to assist with the provision of medical care. Patient immobilization that is a routine component of a procedure (e.g. MRI, surgery etc.) is not considered restraint.

**Violent Restraint.** A restraint used to restrict a patient’s movement for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff members, or others.

**Chemical Restraint.** A drug or medication used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement that is not a standard treatment or dosage for the patient’s condition. For example, giving a medication for treating extreme agitation to sedate a patient would be considered treatment for a condition and, therefore, not considered a chemical restraint. **Chemical restraint is not used at Swedish.**

**Seclusion.** Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others. §482.13(e)(1)(ii).
Seclusion offers a selective and limited environment designed to:

- Minimize external stimulation.
- Protect patients from the medical and equipment hazards in the emergency department.
- Prevent detained patients from eloping prior to the rule out of urgent medical conditions and/or psychiatric crisis.

Seclusion is initiated when a patient is told to remain alone in a care area or defined space and that the consequences of elopement would result in initiation of a Code Gray or utilizing a locked door in a dedicated seclusion room. Seclusion occurs in both locked and unlocked environments. Initiating a Code Gray or utilizing a locked door to a dedicated seclusion room constitutes *physically preventing the patient from leaving* the designated room or space.

The following actions *do not directly* constitute the use of seclusion:

- A patient being detained in the emergency department. Seclusion begins when the patient is confined to a defined space, alone and has been instructed to not leave the defined space (i.e., private treatment room, triage space, etc.).
- The assignment of a PSA to provide direct observation. Multiple patient populations may have a PSA assigned to assist with observation and maintenance of a safe environment.

Assigning the patient to a private room is not constituted as seclusion if the patient may willingly exit the room or defined space to ambulate or perform ADLs.

Seclusion is only used in the ED and Inpatient Behavioral Health units.

**Restraint key.** The key used to release patients from locking restraints. Key is kept in all four locations:

- With patient’s RN
- With Charge RN
- Taped to white communication board at nurses’ unit, where applicable.
- With the PSA for emergency release only

**Time out.** An intervention in which patient consents to being alone in a designated area for an agreed upon timeframe from which the patient is not physically prevented from leaving.

**Forms**

- **Restraint or Seclusion Flow Sheet** (61078) (downtime only)

**Supplemental Information**

LIPs who order restraints receive an annual training document in the requirements of this policy and demonstrate a working knowledge of this policy through ongoing compliance.

Staff is required to demonstrate competence in appropriate restraint application. Swedish maintains records of completion of training. Training may include:

- Review of SMC’s policy on use of restraint and seclusion
- Techniques to identify staff and patient behaviors, events and environmental factors that may trigger circumstances that require the use of restraint or seclusion
- Alternatives to restraint or seclusion and nonphysical interventions
- How to choose the least restrictive intervention based on the patient’s medical or behavioral status
- How to apply restraint or seclusion safely
- How to assess, monitor and document the patient’s physical and psychological condition
• How to recognize and respond to signs of physical and psychological distress, including how to apply first aid, if needed
• Indications that restraint or seclusion is no longer necessary

Regulatory Requirement

CMS. Medicare Conditions of Participation for Hospitals. 482.13(e-g) – Patient Rights.

CMS: Conditions of Participation §482.13(e)(5)

CMS: Conditions of Participation §482.13(e)(12)

DOH MQAC Advisory (October 2015)

WAC-246-320-226 (3)(f)

WAC 246-840-300

DNV. PR.7, PR.8, and PR.9 – Patient Rights.

References

Swedish Medical Staff By-laws/Rules and Regulations

Addenda

Behavioral Health Patients in the ED: Levels of Observation
Care of the Patient in a Law Enforcement (LE) Device Algorithm
Caring for Agitated, Potentially Violent Involuntary Boarded Patients
Documenting Face-to-Face Evaluation for Restraint Order: Medical Interference, Violence, or Seclusion
Early Predictors and Interventions to Reduce Potential for Violence
Hand Mitts
Quick Guide to Restraint/Seclusion Documentation
Restraint Alternatives
Restraint Devices
Restraint Track and Device Algorithm
Restraint/Seclusion Process Workflow
Restraint Log Documentation
Seclusion Process Workflow
Simultaneous Restraint and Seclusion or Seclusion in Locked Room
Hospital Restraint/Seclusion Deaths to be Reported Using the Centers for Medicare and Medicaid Services (CMS) Form CMS-10455, Report of a Hospital Death Associated with Restraint or Seclusion: First Hill and Ballard; Cherry Hill; Issaquah; Edmonds.
STAKEHOLDERS

Author/Contact

Elizabeth Wierman Rubin, MSW, LICSW CDP, Psychosocial Clinical Specialist

Co-Authors

Swedish Restraint Compliance Governance Committee (June 2018)

Expert Consultants

Accreditation Department
Edmonds Medical Executive Committee (April 2017)
First Hill Medical Executive Committee (April 2017)
Issaquah Medical Executive Committee (April 2017)
Workplace Violence Prevention Committee (June 2018)

Sponsor

Marianne Klaas, Administrative Director of Accreditation, Safety, Injury Management, and Clinical Patient Relations
### Clinical Protocol

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<th>Next Review:</th>
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### Clinical Area:
- Medical/Surgical, Pediatrics and Pediatric ICU, Acute Rehab, Critical Care, Emergency Department Observation Units: extension of ED, outpatient status, Adult Pediatric Psychiatry

### Population Covered:
- All patients

### Campus:
- Ballard, Cherry Hill, Edmonds, First Hill, Issaquah, Mill Creek, Redmond

### Implementation Date:
- June 2019

### Related Procedures, Protocols, and Job Aids:
- Advance Directives and CPR Preference
- Critical Care Patient Care Management: Adult
- Epidural Anesthesia in Obstetrics
- Fall Prevention
- Fall Prevention and Safety: Pediatric
- Immunocompromised Patient Management: Adult
- Intermediate Care Unit (IMCU) Patient Care Management
- Ketamine Management for Pain: Adult
- Ketamine Use for Pediatric Procedural Sedation
- Nursing Documentation in the Emergency Department
- Pain Management
- Pain Management: Neonatal
- Pain Assessment Pediatric
- Pain Management: Epidural/Intrathecal Analgesia Management
- Patient Rights
- Postoperative Patient Care Management: Adult
- Postoperative Management Pediatric
- Skin Care: Pressure Ulcer Prevention and Management
- Telemetry Patient Care Management: Adult

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Purpose

To provide guidelines for minimum documentation requirements in the Electronic Medical Record.

Policy Statement

The Registered Nurse (RN) is accountable for the accuracy and completeness of nursing documentation in the patient’s record including those patients whom have been assigned to non-RN staff for delegated aspects of their care (WAC 246-840-705).

RNs complete documentation on each patient as outlined in this procedure. Clinical judgment is used based on the patient’s condition, situation, and complexity to determine the need for additional data collection and/or more frequent monitoring and documentation.

Assessments and interventions are completed before documentation.

LIP Order Requirement

Elements of this (procedure or protocol) require a licensed independent practitioner’s (LIP) order.

Responsible Persons

Registered Nurse (RN)

Prerequisite Information

- LIP orders individualize patient care. LIP orders override the minimal documentation standards. Compare patient’s individualized orders for differences from this policy.

Admission data are objective and subjective data collected from observation, examination, interviews, and written records. Admission assessment includes:

- Vital signs including, temperature (T), pulse (P), respiratory rate (R), blood pressure (BP), height and weight for all patients; and O₂ saturations for critical care, surgical patients, and others as indicated by condition

- Initial head-to-toe assessment and comprehensive pain assessment

- Mental status examination (for behavioral health patients)

- Risk assessments are completed within time frames as indicated for specific ages and include falls, safety, skin breakdown, delirium, suicide risk (not required for adult outpatients unless indicated), bedside swallow screen (patient at risk for aspiration, e.g., TIA/Stroke), latex sensitivity, and pregnancy/lactation screen.

- Initial skin breakdown risk assessment is completed on all patients at point of entry including Acute Care, Critical Care, Family Maternity, Emergency Department for acuity levels 1-2-3, and surgical/Procedural Services.

- Review and validation of prior-to-admission medications, allergies, immunizations, and medical history by LIP

- Focused assessment completed upon assuming patient care from another nurse or receiving nurse from another inpatient unit

- Comprehensive assessment is completed with admission of patients from outpatient areas, ED, and direct admits.

- Inpatient Behavioral Health Units (Edmonds & Ballard Campuses) refer to the medical-surgical column for minimum documentation charting elements unless directed by the department structure or a LIP order.
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<th>Charting Element</th>
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| Vital Signs      | Admission: T, P, R, BP, SpO2 (if indicated by condition) within 4 hrs  
Ongoing: Every 8 hrs or per unit guideline; as condition warrants  
Post-op: T, P, R, BP, SpO2 completed:  
- On arrival;  
- 15 min X 2;  
- 30 min x 1;  
- 60 min x 1hr;  
- At least every 4hrs x 24hrs;  
- Then every 8hrs or per unit guidelines  
Immunocompromised patients (oncology): Every 4hrs and as condition warrants. | In-Patient Pediatric & PICU  
Patient Admission: T, P, R, BP, SpO2 (if indicated by condition)  
Ongoing Pediatrics: T, P, R Q 3 hours on gainers and growers (infants), every 4 hours on routine pediatric patients – unless specified differently by the LIP  
BP’s are done every day or unless condition warrants more frequent  
SpO2 continual monitoring requires an LIP order  
Pediatric Post-op: T, P, R, BP, SpO2 on arrival then every 15 min x 2, every 30 min x 2, then every 1 hr until stable. Once stable VS as per orders.  
PICU and Intermediate Pediatric care:  
*T, P, RR, BP, SpO2 every 1-2 hours or more frequent per LIP orders or as patient condition warrants  
*Temp every 4 hrs or per patient condition  
Post-Surgical (Phase I Recovery or in PICU):  
*T, P, RR, BP, SpO2 every 5 min x 3; every 15 min x 5; every 30 min x 2; every 1 hr x 2 then per LIP orders. | ICU  
Admission: T, P & Rhythm, R, BP, SpO2  
- 15 min X 1hr or until stable, then every 1hr, or more frequently with changes in condition  
- Temp every 4hrs  
Ongoing: certain conditions may necessitate more frequent VS every 5-10 min (e.g., drip titration, shock, active bleeding).  
IMCU  
Admission: T, P & Rhythm, R, BP, SpO2  
- 30 min X 1hr until stable, then every 2 hrs, or more frequently with change in condition  
- Temp every 4hrs  
Ongoing: certain conditions may necessitate more frequent VS (e.g., change in rhythm, shock).  
Telemetry  
Admission: T, P & Rhythm, R, BP, SpO2  
- 30 mins x 1 hr until stable, then every 4 hrs, or more frequently with change in condition.  
- Temp every 4hrs | Arrival: T, P, R, BP, SpO2, pain (see below for directive on pain assess/reassess)  
Ongoing: Vital signs are based on the initial documented patient triage acuity, using the ESI classification system.  
Any abnormal vital signs are recorded, reported and followed up.  
- **Level 1** (Critical): Vital signs every 5-15 minutes PRN and no less frequently than every hr for the first 4 hrs, then every 2 hrs if clinically stable.  
- **Level II** (Emergent): Vital signs no less frequently than every hr for the first 4 hrs, then every 2 hrs if clinically stable.  
- **Level III** (Acute): Vital signs no less frequently than every 2 hrs for the first 4 hrs, then every 4 hrs if clinically stable.  
- **Level IV** (Urgent): Vital signs per acuity and clinical assessment, but no less than every 4 hrs.  
- **Level V** (Minor): Vital signs per acuity and clinical assessment, but no less than every 4 hrs.  
**Disposition:** T, P, R, BP, SpO2 and pain is required within 60 min of discharge, admission or transfer.  
**ANTEPARTUM:**  
Admission: T, P, R, BP, SpO2  
Ongoing: every 4 hrs  
**LABOR:**  
Admission: T, P, R, BP, SpO2  
Ongoing:  
- **Temp:**  
  - Intact: every 4 hrs  
  - >38-C: every 1 hr  
- **ROM:**  
  - 2, 4 hrs  
- **BP’s:** every 2 hrs  
- **PP’s:** every 4 hrs  
- **SpO2:** continual monitoring  
- **FHR:** every 1 hr (EFM)  
- **Doppler:** every 15-30 min  
- **Magnesium Sulfate for Preeclampsia:**  
  - BP, P, RR, SpO2: every 5 min with loading dose, every 30 min during maintenance  
  - Lung sounds: every 2 hrs  
  - DTR’s, clonus, LOC, edema, visual changes, epigastric pain, headache: every 4 hrs  
- **Intake & Output:**  
  - every 1 hr with totals every 8 hrs and 24 hrs  
- **Maternal VS (BP, P, RR, SpO2):**  
  - Latent Labor:  
    - **Low risk:** every 4 hrs  
    - **High risk:** every 2 hrs  
    - **FHR:** every 1 hr (EFM)  
  - **Active Labor:**  
    - **Low risk:** every 2-4 hrs  
    - **High risk:** every 1-2 hrs  
    - **FHR:** every 30 min (EFM); **Doppler** every 15-30 min  
  - **Oxytocin**  
    - **Low risk:** every 2 hrs  
    - **High risk:** every 1 hr  
    - **FHR:** every 30 min (EFM)  
  - **Second Stage Active Pushing**  
    - every 1 hr  
    - **FHR:** every 30 min (EFM); **Doppler:** every 5 min  
  - **Misoprostol/Balloon Catheter**  
    - **FHR:** every 1 hr and/or prior to re-dosing, changes in FHR or tachysystole, or after interventions, SROM  
  - **Magnesium Sulfate for Preeclampsia**  
    - BP, P, RR, SpO2: every 5 min with loading dose, every 30 min during maintenance  
  - **Lung sounds:** every 2 hrs  
  - **DTR’s, clonus, LOC, edema, visual changes, epigastric pain, headache:** every 4 hrs  
  - **Intake & Output:** every 1 hr with totals every 8 hrs and 24 hrs |
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<td>C-Section Delivery Recovery</td>
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<td>BP, P, RR, SpO2: on admit then every 5 min x 3, then BP, HR, RR, SpO2 and fundal tone, location, vaginal flow, pain and sedation every 15 min x 7 (total of 9 in 2 hrs)</td>
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<td>Temp on admit and end of recovery</td>
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<td>POSTPARTUM:</td>
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<td>Normal Newborn: Temp, HR and RR every 30 min x 2 hrs then every 4 hrs until 24 hrs of life, then every 8 hrs until d/c</td>
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<td>Newborn Sepsis Protocol: Temp, HR, and RR every 30 minutes x 2 hrs then every 4 hrs until discharge</td>
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<td>Vaginal Delivery – Postpartum Maternal</td>
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<td>BP, temp, HR, RR, SpO2, fundal tone, location, vaginal flow, and pain every 1 hour x 2, every 4 hours x 2, then twice daily (every AM and every PM) until d/c</td>
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<td>C-Section Delivery – Postpartum Maternal:</td>
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<td>BP, temp, HR, RR, sedation, fundal tone, location, vaginal flow, and pain every 1 hr x 2, every 4 hours x 24 hours, then twice daily.</td>
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<td>SpO2 every 1 hr x 12 hrs, then every 2 hrs x 12 hrs, then every shift until discharge (if patient meets criteria for normal sleep, do not have to awaken)</td>
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<td>EFM= Electronic Fetal Monitoring</td>
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<td>FHR = Fetal Heart Rate</td>
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<td>ROM = Rupture of membranes</td>
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</tbody>
</table>

EFM= Electronic Fetal Monitoring
FHR = Fetal Heart Rate
ROM = Rupture of membranes
<table>
<thead>
<tr>
<th>Charting Element</th>
<th>Medical/Surgical</th>
<th>Pediatrics and Pediatric ICU (PICU)</th>
<th>ICU/IMCU/Telemetry</th>
<th>Emergency Department</th>
<th>Perinatal Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td>Admission: within 4 hrs</td>
<td>Admission: within 4 hrs</td>
<td>Admission: Upon admit</td>
<td>Obtained per patient condition when relevant to care provided</td>
<td>Admission: within 4 hrs of admission (a stated height is acceptable)</td>
</tr>
<tr>
<td>Weight (Wt)</td>
<td>Admission: within 4 hrs</td>
<td>Ongoing: Per unit guideline</td>
<td>Admission: Upon admit</td>
<td>Within the Triage Assessment during visit—stated weight acceptable for Adult patients ONLY when pt condition does not allow for actual weight</td>
<td>Admission: within 4 hrs of admission (Pre-pregnancy weight and prenatal care visits must be documented upon admission)</td>
</tr>
<tr>
<td></td>
<td>Actual not reported</td>
<td></td>
<td>Ongoing: Patients 6 months old or less are weighed on night shift; Patients 6 months old or greater are weighed on dayshift. (Daily Wts are done with LIP order.)</td>
<td></td>
<td>ANTEPARTUM: Per unit routine POSTPARTUM: Per unit routine, if condition warrants NEWBORN: At birth and daily per unit routine</td>
</tr>
<tr>
<td>Prior-to-Admission Medications, Allergies, Immunizations</td>
<td>Admission: Verify within 4 hrs</td>
<td>All Pediatric Patients Admission: Verify within 4 hrs. *Nurse is to create list of PTA medications &amp; allergy data. LIP holds primary responsibility for med rec.</td>
<td>Admission: Verify within 4 hrs. *Nurse is to create list of PTA medications &amp; allergy data. LIP holds primary responsibility for med rec.</td>
<td>Allergies are verified during Triage Assessment prior to treatment as patient condition allows. *LIP holds primary responsibility for med rec.</td>
<td>Allergies: Verify within 4 hrs *Nurse is to create list of PTA medications &amp; allergy data. LIP holds primary responsibility for med rec.</td>
</tr>
<tr>
<td>Charting Element</td>
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<td>Initial Focused Assessment (Admission)</td>
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<tr>
<td>Comprehensive Assessment on arrival and every shift or per unit guideline</td>
<td>focused assessment upon admission. Complete assessment (head to toe)</td>
<td>Complete assessment (head to toe) within 1 hr of admission.</td>
<td>Admission:</td>
<td>A Complete assessment (head to toe) within 1 hr of admission.</td>
<td>A Focused Assessment is completed on every patient.</td>
</tr>
<tr>
<td>Ongoing: Individualized focused assessment as condition warrants</td>
<td>Ongoing and Post-op: full assessment upon assumption of care and with any changes in patient condition.</td>
<td>Ongoing:</td>
<td>Ongoing:</td>
<td>Ongoing:</td>
<td>Ongoing:</td>
</tr>
<tr>
<td>within 30 min of arrival then an individualized focused assessment upon assumption of care and as condition warrants.</td>
<td>full assessment upon assumption of care and with any changes in patient condition.</td>
<td>within 1 hr of shift, and on assumption of patient care.</td>
<td>within 1 hr of shift, and on assumption of patient care.</td>
<td>intermediate per LIP order.</td>
<td>within 30 minutes after procedure. Full assessment upon assumption of care. Individualized, focused assessment as condition warrants.</td>
</tr>
<tr>
<td>Neurovascular checks for Orthopedic postop and as condition warrants:</td>
<td>Neurovascular checks for Orthopedic postop and as condition warrants:</td>
<td>Neurovascular checks for Orthopedic postop and as condition warrants:</td>
<td>Neurovascular checks for Orthopedic postop and as condition warrants:</td>
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<td>Neurovascular checks for Orthopedic postop and as condition warrants:</td>
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<td>For Neuro patients:</td>
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<tr>
<td>Chart Neuro assessment under the Stroke Care tab. The below assessments are in the order of the stroke flowsheet.</td>
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<td>• Pupil Size, Shape, and Reaction</td>
<td>• Pupil Size, Shape, and Reaction</td>
<td>• Pupil Size, Shape, and Reaction</td>
<td>• Pupil Size, Shape, and Reaction</td>
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<td>• Dorsiflexion and Plantar Flexion</td>
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<td>Interventions documented during shift of care as performed based on the CPG/PG and patient condition.</td>
<td>Interventions documented during shift of care as performed based on the CPG/PG and patient condition.</td>
<td>Interventions documented during shift of care as performed based on the CPG/PG and patient condition.</td>
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<td>Initial Focused Assessment (Admission) (cont)</td>
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<td><strong>b. Spine patients</strong></td>
<td><strong>c. Stroke patients</strong></td>
<td><strong>EOM’s</strong></td>
<td><strong>NIH stroke scale BID /with neuro changes and Cranial as above as ordered</strong></td>
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<tr>
<td>• Tongue Signs/Symptoms</td>
<td>NIH stroke scale BID /with neuro changes and Cranial as above as ordered</td>
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<td><strong>b. Spine patients</strong></td>
<td><strong>c. Stroke patients</strong></td>
<td><strong>Sensory Impairment</strong></td>
<td><strong>with neuro changes and Cranial as above as ordered</strong></td>
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<td>• Cognitive</td>
<td>• NIH stroke scale BID /with neuro changes and Cranial as above as ordered</td>
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<td>• Pupils Q4H</td>
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<td>• Face Symptoms</td>
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<td>• Motor Response (if applicable)</td>
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<td>• Tongue Signs/Symptoms</td>
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<td>• Hand Grip</td>
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<td>• Muscle Strength Grading</td>
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<td>• Dorsiflexion and Plantar Flexion</td>
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<td>• GCS</td>
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<td>• Muscle Strength Grading</td>
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</table>
**Plan of Care (On Admission)**

By the end of the shift at least ONE Care Plan Guide (CPG) template should be initiated pertinent to the admission diagnosis, patient assessment, and progression towards discharge. *Co-morbidity CPG is added if the co-morbid condition impacts the admission progression towards discharge.*

**Plan of Care (ongoing management)**

Prior to handover of care (transfer or change of shift):
Document progression of goal(s)/ outcome(s) and summary status every shift.

**Plan of Care (discharge)**

Discharge Documentation:

**Status of each active CPG & goals:**

- For problems in which the goals were not met, document the follow-up services or supports as part of the discharge plan.

Discharge Documentation includes the following:

- Mobility of the patient at discharge, patient teaching including review of the discharge instructions, review of discharge prescriptions, follow up care, and patient’s mode of departure.

**Education**

Prior to handover of care (transfer or change of shift):

Status of educational needs must be updated. Each educational need should be resolved by discharge.

Discharge Documentation:

Status of each active CPG & goals:

- For problems in which the goals are not met, document the follow-up services or supports as part of the discharge plan.

**Education provided at discharge**

Status of educational needs must be updated. Each educational need should be resolved by discharge.

**Pain Assessment Documentation**

NOTE: Some units & campuses require more frequent pain documentation – check with your manager if unsure

(see PCA, Epidural and Ketamine below)

Documentation includes:

- Pain level,
- Sedation if 3 or 4 on POSS scale
- Respiratory assessment if not WDL

**Admission or first contact:**

- Pain assessment with pain location, rating, descriptors & assessment tool.

**On-going**

- Pain assessment with pain location, rating, descriptors & assessment tool.
- Location
- Onset (when did it begin?)
- Duration (how long has it been present?)
- Frequency (is the pain always there or does it come and go?)
- Quality (e.g., throbbing, aching, sharp, dull, stabbing, burning,

**Plan of Care:** Initiate appropriate Pain CPG if pain is an issue for the patient and/or effects hospital course/discharge

**Children's Hospital at Swedish**

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<table>
<thead>
<tr>
<th>Charting Element</th>
<th>Medical/Surgical</th>
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<td>and/or respiratory rate</td>
<td>shooting)</td>
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<td>age 15 and over: 10 or less</td>
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<td>age 5 to 14, 14 or less –</td>
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<td>age 1-5: 20 or less</td>
<td>Plan of Care:</td>
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<td>Initiate appropriate Pain CPG if</td>
<td>pain is an issue</td>
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<td>patient and/or effects hospital</td>
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<td>course/discharge</td>
<td>and/or family</td>
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<td>Plan of Care:</td>
<td>Admit:</td>
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<td>Within 4 hrs</td>
<td>Pain assessment</td>
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<td>with pain rating, descriptors &amp;</td>
<td>assessment tool.</td>
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<td>Acceptable Comfort Level &amp;</td>
<td>effects of pain</td>
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<td>pain on goal</td>
<td>On-going:</td>
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<td>Upon assumption of care and Q4</td>
<td>generally more</td>
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<td>hours more if condition warrants.</td>
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**Newborn:**

**Admission:**

Document any identified pain sources (e.g., fractured clavicle or humerus, cephalohematoma) in the Newborn Admission Database in the electronic medical record. Record baseline N-PASS pain score.

If pain is present at birth or on admission, or at any time during hospitalization, include pain management in the plan of care.

**Ongoing:**

Record N-PASS pain/sedation score with each hands-on vital signs (minimum of every six hours).

Identify actual or potential sources of pain for the neonate (e.g., surgery, heel sticks, fractures).

**Assess response to treatment as follows, documenting:**

- Pain level
- Respiratory rate
- Level of sedation, if receiving medication
- Effects

**Nurse-administered PRN bolus dosing:** Intravenous (IV), Intramuscular (IM)

**Within 30 minutes**

**Oral or rectal medications:** Within 1 hour

**Regularly scheduled bolus dosing:** Every 4 hours

**Non pharmacological interventions for pain scores greater than 3:** Within 1 hour

**PCA and Continuous Opioid Infusions**

Document Pain Assessment to include:

- Pain location & level
- Sedation level of 3 or 4 (Using Pasero Opioid-Induced Sedation scale (POSS))
- Respiratory rate
- SpO₂ (<92% contact LIP):
  - Upon initiation: Within 30 minutes of initiation, every 2 hrs x 4

**Document Assessment Refer to:**

<table>
<thead>
<tr>
<th>Pain Management: Pediatrics</th>
</tr>
</thead>
</table>

**Document Pain Assessment:**

- **Upon initiation:** Within 30 minutes of initiation, every 2 hrs x 4
- **Ongoing:** Every 4 hrs
- **Rate or dose increase:** Within 30 min.

**For Continuous Opioid Infusions, document pain assessment:**

- **Upon initiation:** Within 30 minutes of initiation
- **Ongoing:** with vital signs per protocol

**For patients with patient-controlled analgesia (PCA), continuous opioid infusion IV or SC, and ketamine infusion, document pain assessment:**

- **At initiation,**
- **Within 30 minutes after initiation,** then
- **Every 2 hours for 8 hours,** then
- **Every 4 hours until discontinued,** then
- **Within 30 minutes of a rate or dose increase.**
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</thead>
<tbody>
<tr>
<td>PCA and Continuous Opioid Infusions (cont)</td>
<td>• Ongoing: Every 4 hrs • Rate or dose increases: Within 30 min.</td>
<td>*Respiratory rate if: • 10 or less/min for patients 15 yrs. and over (or over 40 kg) • 14 or less for pts between 5 to 14 yrs • 20 or less for pts between 1 and 5 years ol • Or respirations are irregular, shallow, or noisy</td>
<td>• Ongoing: Every 4 hrs • Rate or dose increases: Within 30 min.</td>
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</tr>
<tr>
<td>Epidural Monitoring</td>
<td>Document Standard Monitoring per Epidural order set • If appropriate include dermatome level/motor strength every 8 hrs</td>
<td>Document Standard Monitoring per Epidural order set • If appropriate include dermatome level/motor strength every 8 hrs</td>
<td>Document Standard Monitoring per Epidural order set • If appropriate include dermatome level/motor strength every 8 hrs</td>
<td>N/A</td>
<td>Vitals to monitor: BP, P, R, SpO₂ • every 5 min x 4, then every 10 min x 4, then every 30 min • Epi Cath LDA assess every 8 hrs • Dermatomes every 2 hrs FHR every 30 min by cont. EFM</td>
</tr>
<tr>
<td>Ketamine Monitoring</td>
<td>Ketamine infusion Per Ketamine Order Set. Refer to Ketamine Management for Pain: Adult as condition warrants (e.g. rate increase, LIP bolus) Ketamine infusion greater than 10 mg/hr: Per Ketamine Order Set plus continuous telemetry &amp; O₂ monitoring <strong>NOTE:</strong> sedation may be assessed using either Modified Ramsay Score or POSS</td>
<td>Ketamine infusion Per Ketamine Order Set. Refer to Ketamine Management for Pain: Adult as condition warrants (e.g. rate increase, LIP bolus) <strong>NOTE:</strong> sedation may be assessed using either Modified Ramsay Score or POSS</td>
<td>Ketamine infusion Per Ketamine Order Set. Refer to Ketamine Management for Pain: Adult as condition warrants (e.g. rate increase, LIP bolus) <strong>NOTE:</strong> sedation may be assessed using either Modified Ramsay Score or POSS</td>
<td>For patients with patient-controlled analgesia (PCA), continuous opioid infusion IV or SC, and ketamine infusion: • At initiation, • Within 30 minutes after initiation, then • Every 2 hours for 8 hours, then • Every 4 hours until discontinued. • Within 30 minutes of a rate or dose increase.</td>
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<tr>
<td>Pressure Ulcer Risk Assessment (Braden or Braden Q Scale)</td>
<td>Admission: within 4 hrs Ongoing: every shift and with assumption of care.</td>
<td>All Pediatric Patients and PICU Patients Admission: within 12 hrs Ongoing: every shift.</td>
<td>Admission within 4 hours Ongoing: every shift and with assumption of care</td>
<td>Any skin impairments are assessed and documented during the visit.</td>
<td>Admission: within 4 hrs Ongoing: every shift</td>
</tr>
<tr>
<td>Disability</td>
<td>Admission: within 24 hrs</td>
<td>All Pediatric Patients Admission: within 24 hrs</td>
<td>Admission: within 24 hrs</td>
<td>Assess for any needs related to hearing, vision, and language during Triage and PRN throughout visit.</td>
<td>Admission: within 24 hrs</td>
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<td>Interpreter Services</td>
<td>Document:</td>
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<tr>
<td>• Patient/family initial request for interpreter</td>
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<tr>
<td>• Number of attempts made to schedule an interpreter, in-person or otherwise</td>
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<td>• Interpreter confirmation time (time confirmed, not time arrived) and agency providing the interpreter</td>
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<td>• Any situation where unable to provide patient/family requested modality and why (e.g., when in-person interpreter is requested but not available)</td>
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<td>• Interim services provided when there is a wait for an interpreter (in-person or otherwise)</td>
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<tr>
<td>• Initial Interpreter arrival/departure.</td>
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<tr>
<td>• Interpreter shift change (e.g., if there are three interpreters to cover a 12-hour shift, document on initial interpreter arrival, document at first shift change, second shift change, and final departure time).</td>
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<td>• Upon assumption of care, document to the exception if the interpreter is not present when EPIC/patient chart indicates otherwise.</td>
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<td>• Document modality change (e.g., from video relay cart to in-person interpreter)</td>
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<tr>
<td>• Each engagement of patient using a video relay cart in absence of in-person interpreter</td>
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<td>• <strong>Do not need to document:</strong> Upon assumption of care if no change in interpreter service/schedule</td>
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<td>• <strong>Do not need to document:</strong> Each time a caregiver engages with patient using scheduled in-person interpreter</td>
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<tr>
<td>Nutrition Risk</td>
<td>Admission: within 24 hrs</td>
<td>All Pediatric Patients Admission: within 24 hrs</td>
<td>Admission: within 24 hrs</td>
<td>N/A</td>
<td>Admission: within 24 hrs</td>
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<td></td>
<td>Ongoing: On transfer, every 4 days &amp; significant change in condition</td>
<td>Ongoing: On transfer, with changes in patient condition and every 4 days</td>
<td>Ongoing: As pertinent to patient status</td>
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<tr>
<td>Bedside Nurse Swallow Screen - for patients age 80 years and greater and those with recent and/or new stroke</td>
<td>Complete on admission prior to any oral intake (including medications), if not NPO or already completed in ED</td>
<td>Pediatric swallow screens completed in radiology with Peds Therapy as condition warrants.</td>
<td>Complete on admission prior to any oral intake (including medications), if not NPO or already completed in ED; and post extubation.</td>
<td>Complete on patients presenting with possible stroke prior to any oral intake (including medications), if not already NPO.</td>
<td>N/A</td>
</tr>
<tr>
<td>Confusion Assessment Method (CAM/ICU CAM)</td>
<td>Admission: within 4 hrs</td>
<td>N/A</td>
<td>Admission: within 4 hrs</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td></td>
<td>Ongoing: RNs with training, every shift and prn with significant change in behavior or condition</td>
<td></td>
<td>Ongoing: Every 12 hrs and with significant change in behavior or condition</td>
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<tr>
<td>Alcohol Use Screening</td>
<td>Admission: within 4 hrs</td>
<td>Social history is to be completed on all pediatric patients upon admission. If it is not age appropriate, document “Never”.</td>
<td>Admission: within 4 hrs</td>
<td>As patient condition warrants.</td>
<td>Admission: within 4 hrs</td>
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<tr>
<td>CIWA-aR Scale Ongoing</td>
<td>PRN per patient condition.</td>
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<tr>
<td>Pregnancy/ Lactation Screen</td>
<td>Admission: within 4 hrs</td>
<td>Patients pregnant are considered emancipated adults and not on pediatric units.</td>
<td>Admission: within 4 hrs</td>
<td>During Triage Assessment prior to treatment (LMP for all females within childbearing age)</td>
<td>Admission: within 4 hrs</td>
</tr>
<tr>
<td>Suicide Risk</td>
<td>Admission: within 24 hrs or per unit standard and PRN</td>
<td>Admission: within 24 hrs and PRN</td>
<td>Patients are screened for the presence of suicidal and homicidal ideation during triage assessment.</td>
<td>PRN</td>
<td></td>
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<tr>
<td>Sepsis Screening</td>
<td>Admission: within 24 hrs</td>
<td>All Pediatric Patients and PICU patients upon admission, coming in the November 2019 upgrade release</td>
<td>Admission: within 4 hrs</td>
<td>Patients are screening for the presence of infection during the triage assessment.</td>
<td>ADULTS: Admission: within 4 hrs</td>
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<td></td>
<td></td>
<td>Ongoing: every 12 hrs or with assumption of care, or with changes in patient condition.</td>
<td></td>
<td>Ongoing: Initiate Intraamniotic Infection Management Standard If condition warrants. Refer to MEWT score throughout labor.</td>
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<td>NEWBORNS: Assess all newborns greater than or equal to 34 weeks gestation for EOS risk within 30 minutes of birth.</td>
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<tr>
<td>Latex Screen</td>
<td>Admission: within 4 hrs</td>
<td>All Pediatric Patients and PICU Patients upon admission</td>
<td>Admission: within 4 hrs</td>
<td>All allergies are documented during the triage assessment</td>
<td>Admission: within 4 hrs</td>
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<tr>
<td>Patient Profile</td>
<td>Admission: within 24 hrs</td>
<td>All Pediatric Patients and PICU patients upon admission</td>
<td>Admission: within 24 hrs</td>
<td>All patients are screened for concerns of abuse during the triage assessment.</td>
<td>Admission: within 24 hrs</td>
</tr>
<tr>
<td>*items: General Information, Current Health, Mutuality/Individual Preferences, Functional Level Prior/Current, Abuse Screen, Values/Beliefs/Spiritual Care</td>
<td></td>
<td>Pediatric Safety assessment within 24 hrs</td>
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</table>
| Fluid Balance                          | Every 8 hrs until 24 hrs after DC of IV or Foley | In-Patient Pediatric: Intake and Output Every 4-8 hrs PICU: Intake: Record PO/Enteral and IV intake at the time of administration. For continuous IV or Enteral administration record intake every 1-2 hrs. Output: Record urine output every 1-2 hours for patients with indwelling catheter, and every void for all others. | Urine output checks ICU every 1 hr; IMCU every 2 hrs, Telemetry every 4 hrs, on unstable patients or those with fluid volume imbalances; others Q4 hrs. | PRN | ADULTS: Every shift
<p>|                                         |                  |                                   |                  | NEWBORNS: Every shift |                  |
| Drainage Tubes &amp; Lines                 | Per scheduled shift of nurse and with significant change in Patency &amp; placement every 4 hrs | Per scheduled shift of nurse and with significant change in connection, Initial: Assessment of all lines and drains present on arrival and placed while in the | At beginning and end of shift, assess and document connection, patency. |                  |</p>
<table>
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<tr>
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<td>connection, patency &amp; placement.</td>
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<td><strong>IV line Documentation:</strong></td>
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<td>patency and condition every shift and PRN.</td>
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<tr>
<td>Record chest tube output every 1 hr</td>
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<td>Drains (NG, JP, etc) – record and documented with routine assessment, as ordered, or as patient condition warrants</td>
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<td>patency &amp; placement</td>
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<tr>
<td><strong>Ongoing:</strong> Assess the condition of all lines and drains as patient condition warrants.</td>
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<td><strong>Disposition:</strong> Ensure all lines and drains are patent if the patient is being admitted/transferred and discontinued as – appropriate if patient is discharged.</td>
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<td>ED.</td>
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<tr>
<td>IV Administration</td>
<td>At time of hanging and ending solution, end of shift, rate changes, &amp; DC solution</td>
<td>At time of hanging and ending solution, end of shift, rate changes, &amp; DC solution</td>
<td>At time of starting and ending infusion as well as any rate changes.</td>
<td>At time of hanging and ending solution, end of shift, rate changes, &amp; DC solution</td>
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<tr>
<td>IV Site Assessment</td>
<td>Per scheduled shift of nurse and as change in condition warrants</td>
<td>Observe IV site hourly for continuous infusions and every 4 hrs for saline locks. Document the assessments every 4 hrs.</td>
<td>Observe IV site hourly for continuous infusions or medication administration. Every 4 hours for saline locks. Document the assessments every 4 hrs.</td>
<td>Document site condition on insertion or arrival (if access present on arrival) and assess site throughout visit documenting abnormal findings if warranted</td>
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<td>ADULT: Observe IV site hourly for continuous infusions. Assess and document with transfer of care, at least every 8 hrs thereafter, and as change in condition warrants.</td>
<td>NEWBORN: Observe IV site hourly for continuous infusions and every 6 hrs for saline locks. Document assessments with initial PCS assessment, prior to and after IV medication administration, and every 6 hrs thereafter.</td>
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<tr>
<td>Critical Value Notification</td>
<td>Medical Record will reflect date/time critical lab results were reported to LIP and/or actions taken.</td>
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<tr>
<td>ADLs</td>
<td>Per scheduled shift</td>
<td>Every 3- 4 hrs,</td>
<td>Per scheduled shift of nurse. See “Early Mobilization for Patients Admitted to the Intensive Care Unit”. and standard of care</td>
<td>PRN</td>
<td>PRN</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Every meal PRN (diabetes or calorie count)</td>
<td>Every meal Every snack Every 4 hrs – Tube Feeding</td>
<td>Every meal Diet type Formula type Formula strength Rate</td>
<td>PRN</td>
<td>ADULT: PRN NEWBORN: Every shift</td>
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<td></td>
<td>• Diet type</td>
<td>• Formula type</td>
<td>• Formula strength</td>
<td>• Rate</td>
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<td></td>
<td>• % eaten</td>
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<td></td>
<td>Every 8 hrs – Tube Feeding</td>
<td>Formula type</td>
<td>Formula strength</td>
<td>Rate</td>
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<td>Restraints</td>
<td>Non-Violent On initiation</td>
<td>On-going:</td>
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<td></td>
<td>• On initiation</td>
<td>• Continued need for restraint once per shift or minimally every 12 hrs,</td>
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<td></td>
<td>• On-going:</td>
<td>• Patient safety aspects of care every 2 hours</td>
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<td>• Physical need aspects of care every 2 hrs</td>
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<td>• At discontinuation</td>
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<td>Violent On initiation</td>
<td>On-going:</td>
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<td></td>
<td>• On initiation</td>
<td>• Continued need for restraints every 4 hrs for patients age 18 or older, every 2 hrs for ages 9-17, every 1 hr for age under 9</td>
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<td>• Patient safety aspects of care every 15 min, physical needs every 2 hrs</td>
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<td>• At discontinuation</td>
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**Note:** Routine checking of tube feeding residuals is not required nor recommended.
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<tr>
<td>Cardiac Monitoring</td>
<td>N/A</td>
<td>Intermediate Care, and PICU:</td>
<td>Admission: Measure (PR, QRS, QT, QTc intervals), interpret &amp; post rhythm strip on admit and with changes in condition.</td>
<td>If placed on cardiac monitoring: Initial rate and rhythm should be documented in Epic. Any change in rhythm is documented.</td>
<td>N/A</td>
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<tr>
<td>Richmond Agitation Sedation Scale (RASS)</td>
<td>N/A</td>
<td>N/A</td>
<td>Admit: Post rhythm strip every 12 hrs and PRN for rhythm changes. Ongoing: Post rhythm strip every 12 hrs and with change in rhythm or symptoms of cardiac event.</td>
<td>ICU and IMCU Patients on sedatives: On initiation, with each titration and every 2 hrs.</td>
<td>N/A</td>
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<tr>
<td>Hemodynamics</td>
<td>N/A</td>
<td>PICU: Assess and document CVP, arterial readings every 1 hr or more frequently as condition warrants. Continuous Sedation: PICU sedation assessment while on IV sedatives occurs every 2 hrs and more frequently PRN.</td>
<td>Arterial, CVP &amp; PA pressures invasive on and non-invasive parameters per policy standard of care, and change in patient condition</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Vasoactive IV Drug Administration</td>
<td>N/A</td>
<td>PICU: BP every 1hr when titrating or per LIP order.</td>
<td>BP and HR every 5-15 min on initiation until stable and then every 1hr or per policy standard of care.</td>
<td>BP and HR every 5-15 min on initiation until stable and then every hour.</td>
<td>N/A</td>
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<tr>
<td>Neuromuscular Blocking Agents – Continuous Infusions</td>
<td>N/A</td>
<td>PICU: Complete a baseline train-of-four (TOF) assessment before initiating NMBAs. All subsequent TOF testing is compared to this baseline reading. Monitor and record TOF response every hour. PRN, and after each dosage change or change in continuous dosage with the parameters as listed above. Titrate NMBA for desired effect as ordered. Monitoring TOF may be less frequent for pediatric patients. Consult with the LIP for frequency preference.</td>
<td>ICU: Baseline neurological assessment, RASS &amp; Train of Four (TOF) Baseline BIS assessment. Titrate sedatives and/or opioids to BIS score per orders. Ongoing TOF and/or parameter assessment (e.g., SpO2) per standard of care BIS score per orders.</td>
<td>N/A</td>
<td>N/A</td>
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<td>Charting Element</td>
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</table>
| Temporary Pacemaker – including Transcutaneous Pacing | N/A | N/A | Assessment of patient’s capture and sensing threshold, and underlying rhythm per scheduled shift of nurse.  
• Pacemaker settings every 12 hours and with each change in pacemaker settings | Assessment of patient’s capture and sensing threshold, and underlying rhythm on initiation, per vital signs protocol above and at time of transfer/admission. | N/A |
| Ventilated Patients | N/A | Pediatric ICU:  
Assessment of lungs upon intubation, with change in condition, transfer or assumption of care, every 2 hrs if stabilized | Respiratory assessment upon intubation, with change in condition, or assumption of care, or every 4 hrs if stabilized | Respiratory assessment upon intubation, with change in condition, transfer, or every 4 hrs if stabilized | N/A |

Definitions

*BIS* - Bispectral index monitoring  
*CAM* - ICU Confusion Assessment Method Intensive Care Unit Patient  
*CVP* - central venous pressure  
*PA* - pulmonary artery  
*RASS* - Richmond Agitation Sedation Score  
*TOF* - Train-of-Four

References


**STAKEHOLDERS**

**Authors**

Clinical Nurse Specialists (CNSs)  
Professional Development Specialists (PDSs) per specialty  
Critical Care Council, June 4, 2019

**Sponsor**

Renee Rassilyer-Boomers, DNP, RN, Director of Clinical Education and Practice