



# STATE OF IOWA

CHESTER J. CULVER, GOVERNOR  
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES  
CHARLES J. KROGMEIER, DIRECTOR

May 15, 2009

## GENERAL LETTER NO. 3-A-AP-3

ISSUED BY: Office of the Deputy Director of Field Operations

SUBJECT: Employees' Manual, Title 3, Chapter A, Appendix, **MENTAL HEALTH INSTITUTES APPENDIX**, Title page, revised; Contents (page 1), revised; pages 1 through 18, revised; and the following forms:

- 470-0420 *Application for Voluntary Admission – MHI*, revised
- 470-0423 *Application for Voluntary Admission – Substance Abuse Treatment*, revised
- 470-0430 *Authorization to Release Information for Legal Settlement and Assignment of Insurance Benefits*, revised
- 470-0428 *Consent to Treatment*, revised
- 470-4161 *DHS Institution Admission Core Data*, new
- 470-4495 *Hospital Procedures in the Event of Unauthorized Departures*, new
- 470-4317 *Initial Restraint or Seclusion Prescription*, moved and revised
- 470-4516 *Mental Health Institute Discharge Plan*, new
- 470-4498 *MHI Individual Grievance*, new
- 470-4496 *MHI Type 1 Incident Investigation Report*, new
- 470-4497 *MHI Type 2 Incident Review Report*, new
- 470-4322 *Restraint/Seclusion Debriefing: Administrative Review*, moved and revised
- 470-4318 *Restraint/Seclusion Monitoring Checklist and Narrative*, moved
- 470-4319 *Restraint/Seclusion Next Working Day Team Debriefing*, moved and revised
- 470-4320 *Restraint/Seclusion Patient Debriefing*, moved and revised
- 470-4316 *Restraint/Seclusion Same-Day Staff Analysis*, moved and revised
- 470-4321 *Risk, Triggers, Signs and Coping Aids*, moved and revised

### Summary

This new appendix contains revised forms from Chapter 3-A-Appendix and from Chapters 3-D-Appendix Chapter 3-E-Appendix, which are now obsolete, as well as new forms required by new policies.

### Effective Date

Upon receipt.

## Material Superseded

Remove the entire Chapter A from Employees' Manual, Title 3, Appendix, and destroy it. This includes the following:

<u>Page</u>	<u>Date</u>
Title page	November 25, 1980
Contents (page 1)	May 12, 1987
MH-1101-0	11/80
1, 2	November 25, 1980
MH-1102-0	11/80
MH-1103-0	11/80
3, 4	November 25, 1980
MH-1104-3	11/80
MH-1105-3	11/80
5, 6	November 25, 1980
MH-1106-2	11/80
MH-1110-0	11/80
7	November 25, 1980
8	May 12, 1987
MH-2203-0	7/84
MH-2101-0	11/80
9	November 25, 1980
10	May 12, 1987
MH-2201-0	3/87
11, 12	May 12, 1987
MH-4102-0	11/80
13, 14	November 25, 1980
MH-5202-0	11/80
15, 16	November 25, 1980
MR-1101	11/80
MR-1301	11/80
17, 18	November 25, 1980
19	November 25, 1980
MR-1302	11/80
MR-1401	11/80

## Additional Information

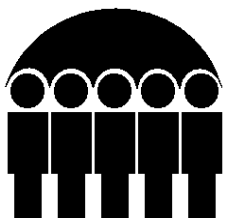
Refer questions about this general letter to the Deputy Director, Division of Field Operations.

Revised May 15, 2009

Employees' Manual  
Title 3  
Chapter A Appendix

# MENTAL HEALTH INSTITUTES

## APPENDIX



Iowa  
Department  
of  
Human Services

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## Application for Voluntary Admission – MHI

### Section A

I, the undersigned, desire to enter the \_\_\_\_\_ mental health institute as a voluntary patient for observation, diagnosis, care, and treatment for mental illness.

If admitted, I agree to abide by the rules and regulations of the mental health institute and to give written notice if I decide to leave the mental health institute against the advice of the medical staff.

If, after a diagnostic evaluation and after being informed of the findings that I am or may be suffering from a condition requiring care and treatment and I am admitted as a patient, I hereby voluntarily consent to such care and treatment based on a standard reasonable course of treatment as indicated by sound medical practice including laboratory and x-ray procedures, as determined by the medical staff in consultation with me.

I also understand that there are further courses of treatment available for me for which my further consent, or that of my parent, guardian, or legal representative, shall be required.

Signature of Patient

Date

Witness

Parent, Guardian, or Legal Representative

### Section B

To the \_\_\_\_\_ County Point of Central Coordination, I, \_\_\_\_\_, by my signature above, hereby make application for voluntary admission to the \_\_\_\_\_ mental health institute under sections 229.2 and 229.42, Code of Iowa.

### Section C

This application has been made through the \_\_\_\_\_ County Point of Central Coordination process and the voluntary admission is  denied  approved.

The applicant has legal settlement in this county of application, or

I agree to comply with the process outlined in IAC 29.4 for legal settlement determination.

CPC Administrator

Date

### Section D

This application is for the admission of an individual determined to be a state case.

Approved  Denied

Deputy Director or Designee, Field Operations

Date

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**Application for Voluntary Admission – MHI, Form 470-0420**

Purpose	<p>Form 470-0420 is used to make application for voluntary admission to a mental health institute and to assure that:</p> <ul style="list-style-type: none"><li>◆ The application has been approved through the central point of coordination process, and</li><li>◆ Legal settlement has been determined or the process for determination is implemented.</li></ul>
Source	<p>Complete this form on line using the template in the public state-approved mental health forms folder on Outlook. Supplies of the form may also be printed or photocopied from the sample in the manual as needed.</p> <p>The county central point of coordination may print the form as above or request copies of the form from the mental health institute.</p>
Completion	<p>Section A of the form is completed in all voluntary applicants, or by the individual's parent, guardian, or legal representative. For private pay and minor applicants, only this section of the form needs to be completed.</p> <p>Section B of the form is completed when the individual or those financially responsible for the individual are unable to pay for the care and the cost of care will be paid in whole or in part at public expense. The adult individual who is seeking admission or the individual's guardian or legal representative completes Section B. Then application submitted to the individual's county of residence's central point of coordination.</p> <p>Section C of the form, when section B has been completed, is completed through the applicant's county of residence's central point of coordination process.</p> <p>Section D of the form is completed by the deputy director for field operations or the director's designee when approval as a state case is requested.</p>

**Distribution**                      The mental health institute receives and retains the original in the individual's record. A copy of the completed application is provided to the applicant and, when the application is through a central point of coordination the central point of coordination may retain a copy.

**Data**                                      When the central point of coordination determines that the individual's legal settlement in a county other than the county of residence or that the individual is a state case, documentation to support the determination shall be attached.

If legal settlement is determined to be in dispute, the central point of coordination shall include information showing that the dispute resolution process has been initiated.

## Application for Voluntary Admission – Substance Abuse Treatment

I, the undersigned, desire to enter the \_\_\_\_\_ mental health institute as a voluntary patient for observation, diagnosis, care, and treatment for substance abuse.

If admitted, I agree to abide by the rules and regulations of the mental health institute and to give written notice if I decide to leave the mental health institute against the advice of the medical staff.

If, after a diagnostic evaluation and after being informed of the findings that I am or may be suffering from a condition requiring care and treatment and I am admitted as a patient, I hereby voluntarily consent to such care and treatment based on a standard reasonable course of treatment as indicated by sound medical practice including laboratory and x-ray procedures, as determined by the medical staff in consultation with me.

I also understand that there are further courses of treatment available for me for which my further consent, or that of my parent, guardian, or legal representative shall be required.

Signature of Patient	Date
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Witness	Parent, Guardian, or Legal Representative
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This application is for the admission of an individual determined to be a state case.

Approved       Denied

Deputy Director or Designee, Field Operations	Date
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Admitted for:

Alcoholism       Substance abuse

Confidential Patient Information  
Unauthorized release of this information is prohibited by law.

**Application for Voluntary Admission – Substance Abuse Treatment,  
Form 470-0423**

Purpose	Form 470-0423 is used for making an application for admission to a mental health institute for voluntary substance abuse treatment.
Source	Complete this form on line using the template in the public state-approved mental health forms folder on Outlook. Supplies of the form may also be printed or photocopied from the sample in the manual as needed.
Completion	The form is completed before admission by the individual seeking admission or the individual's guardian or legal representative. If the individual is seeking admission as a state case, the deputy director of field operations or the deputy director's designee must approve the application.
Distribution	The mental health institute receives and retains the original in the individual's record. A copy of the completed application is provided to the applicant.
Data	The form contains the date the form was completed, the signature of the individual or the individual's guardian or legal representative and the name of the employee witnessing the signing.

**Authorization to Release Information for Legal Settlement and Assignment of Insurance Benefits, Form 470-0430**

Purpose	Form 470-0430 is used to obtain consent from the individual to obtain necessary information to determine legal settlement and for the assignment of insurance benefits.
Source	Complete this form on line using the template in the public state-approved mental health forms folder on Outlook. Supplies of the form may also be printed or photocopied from the sample in the manual as needed.
Completion	The form is completed at the time of admission by the individual seeking admission or the individual's parent, guardian, or legal representative.
Distribution	The mental health institute receives and retains the original in the individual's record. A copy of the completed application is provided to the applicant.
Data	The form contains the date of completion and the signature of the individual, or the individual's parent, guardian, or legal representative and the employee witnessing the signature.

**AUTHORIZATION TO RELEASE INFORMATION FOR LEGAL SETTLEMENT  
AND ASSIGNMENT OF INSURANCE BENEFITS**

TO: The Superintendent of the Mental Health Institute, \_\_\_\_\_, Iowa.

This is your full and sufficient authority to release my name and any other confidential information needed for the expressed purposes of determining legal settlement and obtaining reimbursement for the cost of my care and treatment from any third party payers or funding sources. (This includes MAGELLAN.)

I hereby assign to the Mental Health Institute and the state of Iowa any and all insurance benefits due me to cover the cost of my care in the institute.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

**THIS CONSENT EXPIRES ONE YEAR FROM ABOVE DATE**

Witness

Signature of individual, parent, guardian, or legal representative

If not the individual, your relationship to patient

The information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

MENTAL HEALTH INSTITUTE

STAMP PATIENT IDENTIFICATION IN SPACE BELOW

**AUTHORIZATION TO RELEASE  
INFORMATION FOR LEGAL SETTLEMENT AND  
ASSIGNMENT OF INSURANCE BENEFITS**

Iowa Department of Human Services

## CONSENT TO TREATMENT

MENTAL HEALTH INSTITUTE  
, Iowa

Granted by / or on behalf of:

Date:

The Mental Health Institute provides active treatment to all patients who are in need of acute psychiatric services. While you are here, treatment will be provided including the use of medications, a psychiatric rehabilitation program, school for children and adolescents, discharge planning, and vocational rehabilitation counseling services.

This consent authorizes the staff of the Mental Health Institute to perform such medical interventions as is necessary for evaluation and treatment and to administer such drugs as in their judgment are necessary for evaluation and treatment. If you are on medications at the time of admission, they may be continued and evaluated by the physician. If other medications are needed at the time of admission, education on these medications will be provided. At the time a treatment plan is initiated, your treatment, including medications will be explained to you. During this treatment planning session, the treatment team will also discuss goals and discharge planning with you. No promise has been made of a successful outcome and medication does not always produce the desired effect, and different medications may be added at a later time. In this case, you will be informed of recommended changes or additions.

Restraint and/or seclusion are used as a treatment of last resort only in an emergency situation at this hospital. Should you become a danger to yourself or others and all other interventions including the recommendations suggested when completing the coping aids forms have failed, you might need to be secluded or restrained.

The Mental Health Institute philosophy of treatment and restraint and seclusion policy have been explained to me and I have received a copy of patient rights materials which outline my rights and responsibilities as a patient.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Guardian (if applicable) \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

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**Consent to Treatment, Form 470-0428**

Purpose	<p>Form 470-0428 is used by the mental health institute to confirm that an individual has given consent for treatment while a patient is in the facility. This form also confirms that the patient has been informed of:</p> <ul style="list-style-type: none"><li>◆ The philosophy of treatment of the facility,</li><li>◆ The policy concerning restraint and seclusion, and</li><li>◆ The patient's rights and responsibilities.</li></ul>
Source	<p>Complete this form on line using the template in the public state-approved mental health forms folder on Outlook. Supplies of the form may also be printed or photocopied from the sample in the manual as needed.</p>
Completion	<p>The admission staff shall explain this form to the patient. The patient (or the patient's guardian, where applicable) shall read, sign, and date the form. The patient's signature is required before delivery of treatment other than lifesaving measures.</p>
Distribution	<p>Upon completion, this form is filed in the patient's ward chart while an inpatient in the mental health institute. At the time of discharge, the form is moved to the patient's permanent medical record.</p>
Data	<p>The form contains the patient's name, the date administered, and the signatures of the patient, the guardian, and a witness.</p>

**DHS Institution Admission Core Data, Form 470-4161**

Purpose	Form 470-4161 is used for collecting pertinent information concerning an individual admitted to state mental health institute or state resource center.
Source	This form is generated by the AVATAR medical records system. A sample of the form is in the manual.
Completion	The form is completed by the institution employees for all admissions whose cost of care is payable in whole or in part by the state or a county.
Distribution	The institution retains the original in the individual's record. A copy of the completed form is sent by facsimile or other electronic means to the county of admission by the end of the next working day after the day of admission.
Data	The form contains identifying and background information concerning the individual admitted. The form also provides a means for the determination of legal settlement.

For Internal  
Use Only

**DHS Institution Admission Core Data**

Confidential  
Information

Name: Institution ID:  
Social Security Number: Admit Date/Time:  
County of Legal Settlement: Facility Chart #:

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**A. General Information**

Institution: Patient Phone:  
State ID: Sex/Gender:  
Admission Type: Marital Status:  
Alias Name: Veteran:  
Birthdate: Religion:  
Age: Employment Status:  
Birthplace: Highest Grade Completed:  
Citizenship: Occupation:  
Race:

**B. Hospital Assignment**

Physician:  
Social Worker: Program Code:  
Counselor: Unit:

**C: Legal Status**

Legal Status: Prescreened:  
Effective Date: Court Case #:  
Contact Person: Hold Order:  
Committing County: Hold For:

**D: Authorization**

Consent to Release Information Completed To:  
Voluntary App Signature:  
Tx Consent Signature:  
Co-Signature Required: Co-Signature Obtained:

**E: Background Information**

Admitting County:  
Admitted From:  
Accompanied By:  
Living Arrangement:  
Source of Admission:

Address Information:

Address	County	Yrs/Mo at Address yrs. mo.	Services While at Address	Service Start	Service Start

For Internal  
Use Only

**DHS Institution Admission Core Data**

Confidential  
Information

Name:

Institution ID:

Social Security Number:

Admit Date/Time:

County of Legal Settlement:

Facility Chart #:

***F: Payment Source***

Guarantor:

***G: Resource People***

***H: Patient's Information Issued***

Advanced Directives:

Client Rights Received:

Smoking Policy Received:

Visitors :

***I: CPC Notified***

How notified:

***J: Additional Comments***

Treatment History at This Facility:

# of Admissions:

Last Discharge Date:

For Internal  
Use Only

**DHS Institution Admission Core Data**

Confidential  
Information

Name:

Institution ID:

Social Security Number:

Admit Date/Time:

County of Legal Settlement:

Facility Chart #:

**Response Sheet for Determining Legal Settlement**

*(Please FAX this sheet to State Facility within 3 business days)*

**ACCEPT**

**DENY** Show how you determine Legal Settlement  
Provide any Legal Settlement information you may have  
regarding patient.  
(Attach separate sheet if necessary)

**UNABLE TO DETERMINE LEGAL SETTLEMENT**  
List information needed to determine legal settlement:

**Release of Information Needed:**

**Agency:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Date of Service:** \_\_\_\_\_ **Type of Service:** \_\_\_\_\_

- 1.
- 2.
- 3.
- 4.

**Signature:** \_\_\_\_\_ **County:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*Note: This is not a determination of funding  
This is not a Notice of Decision**

## Hospital Procedures in the Event of Unauthorized Departures

As a voluntary patient, you have the right to request your discharge by submitting a written notice to the Superintendent or Chief Medical Officer. You will then be discharged immediately except when the Superintendent, Chief Medical Officer, or attending physician intends to institute judicial procedures.

If, as a voluntary patient, you leave this hospital without going through the proper discharge procedure, this hospital will then proceed as follows:

If you are found to be unaccountably absent from the ward or assigned therapy, and cannot be immediately located, unauthorized departure (departure without prior authorization) will be assumed. Ward personnel will immediately notify the charge nurse, attending physician, and/or the physician on call. Before instituting any further procedures, hospital personnel will make a thorough search of the wards, building, and grounds. If you are not located, the following actions will be instituted:

1. The responsible physician will probably call your nearest relatives (or correspondents listed) notifying them of the unauthorized departure and outlining the steps proposed they should take (return if you are agreeable, involuntary hospitalization, temporary home visit, discharge, etc.).
2. At the discretion of the hospital staff, law enforcement officials may be informed of the unauthorized departure, if this is considered to be in your best interest. Protected health information will be released according to HIPAA guidelines as outlined in the hospital's Notice of Privacy Practice.
3. In case of a court hold or legal request to notify law enforcement authority, such persons will be notified of the unauthorized departure.
4. Your unauthorized departure will be reported to the Deputy Director, Division of Field Operations.

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Date

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Signature of Patient

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Witness

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Guardian

**Hospital Procedures in the Event of Unauthorized Departures,  
Form 470-4495**

Purpose	Form 470-4495 is used to provide notice to individuals admitted voluntarily to an MHI of the procedures the MHI will follow in any instance where the individual leaves the hospital without proper notice to the hospital.
Source	This form may be printed from the electronic share located at \\Hoovr3s2\DEPDIR.772\Facility Policies\R&S Forms. Supplies of the form may also be printed or photocopied from the sample in the manual as needed.
Completion	<p>The form is completed upon admission. Admission staff will explain the form to the individual or, where appropriate, to the individual's parent, guardian, or legal representative.</p> <p>The individual, or the individual's parent, guardian, or legal representative shall sign the form acknowledging that they were informed of and understand the policy.</p>
Distribution	Upon completion of the form, a copy is placed in the individual's permanent record and one copy is given to the individual.
Data	The form contains the date the form was completed, the signature of the individual or the individual's parent, guardian, or legal representative and the name of the employee witnessing the signing.

### Initial Restraint or Seclusion Prescription, Form 470-4317

Purpose	<p>Form 470-4317 is used to prescribe restraint or seclusion as a last resort to prevent imminent physical harm to either the patient or facility staff.</p> <p>The back of this form is used to continue the restraint or seclusion beyond the initial prescription and describes the specific reasons or behaviors that require the continuation of the restraint or seclusion.</p>
Source	<p>Complete this form on line using the template in the public state-approved mental health forms folder on Outlook. Supplies of the form may also be printed or photocopied from the sample in the manual as needed.</p>
Completion	<p>MHI medical staff or an MHI registered nurse completes this form when restraint or seclusion needs to be prescribed.</p> <p>MHI medical staff or an MHI registered nurse completes the back of this form when restraint or seclusion needs to be continued beyond the timeframes of the original prescription.</p>
Distribution	<p>Distribution shall be as designated by MHI policy and procedures on restraint and seclusion.</p>
Data	<p>Complete all items on each form. The form documents:</p> <ul style="list-style-type: none"><li>◆ The reason for the restraint or seclusion.</li><li>◆ The intervention attempted to de-escalate the emergency.</li><li>◆ Specific instructions based on the patient's history.</li><li>◆ Criteria for the patient's release from restraint or seclusion.</li><li>◆ The physician or physician assistant's face-to-face assessment of the patient.</li><li>◆ Orders for continued restraint or seclusion and the reason for those orders.</li></ul>

### Initial Restraint or Seclusion Prescription

Restraint or seclusion is prescribed for no more than \_\_\_\_\_ hours.

Type of prescription:

- Restraint
- Seclusion

Restraint type:

- Four point
- Five point
- Ambulatory
- Physical hold
- Four point with bicep cuff
- Five point with bicep cuff
- Transport board

Location:

Program/ward:	Room:	Other:
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Where restrained:  Bed Reason for use:  Prevention of self harm  Prevention of harm to others

Restraint/seclusion beginning:

Ending:

Date: _____ Time: _____	Date: _____ Time: _____
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Person assessing the need for emergency R/S:

From: (Doctor/PAC/ARNP)	To:	Read back (if a verbal order):
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Specific reason for prescription:

Interventions attempted to de-escalate the emergency and results (include time and staff names):

Specific instructions based on the patient's medical or psychiatric condition, history of abuse or R&S history:

Specific measurable release criteria:

RN/doctor signature:	Date:	Time:
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Physician/physician assistant face-to-face assessment:

Signature:	Date:	Time:
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### Continuation Restraint or Seclusion Prescription

Continuation order for patient:	Patient ID:
Continuation #:	Date: <span style="float: right;">Time:</span>

Restraint or seclusion is prescribed for no more than \_\_\_\_\_ additional hours.

From: (Doctor/PAC/ARNP)	To:	Read back (if a verbal order):
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Specific reason for continuation:

RN signature:	Date: <span style="float: right;">Time:</span>	Medical staff signature:
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Continuation #:	Date: <span style="float: right;">Time:</span>
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Restraint or seclusion is prescribed for no more than \_\_\_\_\_ additional hours.

From: (Doctor/PAC/ARNP)	To:	Read back (if a verbal order):
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Specific reason for continuation:

RN signature:	Date: <span style="float: right;">Time:</span>	Medical staff signature:
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Physician/physician assistant face-to-face assessment:

Signature:	Date: <span style="float: right;">Time:</span>
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### Mental Health Institute Discharge Plan

Person's Name	Institute Number	<input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary	<input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Abuse
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Reason for Discharge:

### Discharge Plan

Check plan actions required and complete including name of any provider.

Community Living Plan	Plan Action Required	Employee Responsible	Time Fame	In Place
<input type="checkbox"/> Living arrangment				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Nutrition				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Transportation				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Medical care other than psychiatric				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Social supports and activities				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Education and training				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other (specify):				<input type="checkbox"/> Yes <input type="checkbox"/> No

Continued Treatment Plan	Plan Action Required	Employee Responsible	Time Fame	In Place
<input type="checkbox"/> Supervised residential living				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Community living support services				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Outpatient therapy				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Medication management				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Continued inpatient treatment				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other (specify):				<input type="checkbox"/> Yes <input type="checkbox"/> No

**Funding for Required Supports**

Person:

- Does not require assistance with funding       Requires assistance through CPC process       Requires other financial assistance

Describe:

Available community support persons:

Crisis plan:

This plan was developed with my input and assistance. I agree to its implementation and I am responsible to:

My intent is to follow through with those parts of the plan for which I am responsible.

Person's Signature	Date
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Responsibilities of the Mental Health Institute following discharge:

Responsible Employee's Signature	Date
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**Mental Health Institute Discharge Plan, Form 470-4516**

Purpose	Form 470-4516 is used to document the discharge plan developed for an individual.
Source	Complete this form on line using the template in the public state-approved mental health forms folder on Outlook. Supplies of the form may also be printed or photocopied from the sample in the manual as needed.
Completion	The form is completed by the individual's treatment team as the discharge plan is developed.
Distribution	<p>The institution retains the original in the individual's record. The plan is shared with the individual as the plan is developed and a copy is provided if requested.</p> <p>The individual is given a copy of the plan at discharge. With the consent of the individual, a copy of the plan may be provided to a service provider who is identified in the plan or to a family member.</p>
Data	The form specifies the responsibilities of the individual and the institution in developing and carrying out a plan of discharge.

### MHI Individual Grievance, Form 470-4498

Purpose	Form 470-4498 is used by individual's or the individual's designated representative, parent, guardian, or legal representative for the filing of formal grievances and recording and documenting the process and findings of the investigation.
Source	This form may be printed from the electronic share located at \\Hoovr3s2\DEPDIR.772\Facility Policies\R&S Forms. Supplies of the form may also be printed or photocopied from the sample in the manual as needed.
Completion	<p>The individual, or the individual's designated representative, parent, guardian, or legal representative completes the first section of the form providing a statement as to the actions the individual is grieving. The remainder of the form is completed by the employee assigned to try and resolve the grievance and, if the grievance is not resolved, by the human rights committee.</p> <p>Within five business days, the first-line supervisor shall investigate the grievance and try to resolve it at the supervisor's level. If resolution is not possible, the grievance is sent to the director of nursing. Within five business days, the nursing supervisor investigates the grievance and tries to resolve. If resolution is not possible, the grievance is then sent to the human rights committee for investigation, findings, and a recommendation.</p>
Distribution	<p>After the individual completes the statement of the grievance, the original goes to the line supervisor and a copy is sent to the human rights committee. Copies of any collateral information collected as part of the investigation shall be attached.</p> <p>When the investigation is complete, final copies are provided to:</p> <ul style="list-style-type: none"><li>◆ The individual filing the grievance</li><li>◆ The nursing supervisor</li><li>◆ The superintendent</li></ul>
Data	The form contains the name of the person filing the grievance, the statement as to what is being grieved, the findings and recommendations of the investigation, and the final actions taken as a result of the grievance.

## MHI Individual Grievance

### Statement of Grievance

State your concern. Explain the facts as best you understand them. Your parent, guardian, legal representative, family or an employee is a resource for you in advocating for your rights. You may ask any of these persons to help you. We encourage you to contact them to help you with expressing your concern.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Person Assisting (Print Name)

**Findings/Resolution By**

Provide summary of discussion, solutions offered, reasons individual did or did not agree to resolution.

\_\_\_\_\_  
First Line Supervisor

Date received for review \_\_\_\_\_

Date of response \_\_\_\_\_

Resolved:  Yes  No

Signature \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
Director of Nursing

Date received for review \_\_\_\_\_

Date of response \_\_\_\_\_

Resolved:  Yes  No

Signature \_\_\_\_\_

Date \_\_\_\_\_

Grievance has been sent to HRC as of this date \_\_\_\_\_

**Human Rights Committee Worksheet**

Date received copy of grievance \_\_\_\_\_

Date received from director of nursing \_\_\_\_\_

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Grievance Subcommittee Members Assigned

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Work of the Grievance Subcommittee

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Documentation of Investigation and Facts Relied On

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Findings and Conclusion of Investigation  
(To be completed in 10 business days of receipt from director of nursing.)

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Recommended Action and Resolution of the Grievance  
(To be completed within 5 business days of completion of investigation.)

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Date of Human Rights Committee decision \_\_\_\_\_

## MHI Type 1 Incident Investigation Report

This form is to be used by the mental health institute (MHI) investigator to prepare the written report of the investigation into all type 1 incidents and by the Incident Review Committee to determine appropriate actions needed as a result of the investigation. See 3-A-Appendix for instructions.

<b>I. Basic Information</b>	
Investigation Report	
Investigation number	ID number
Name of alleged victim <input type="checkbox"/> Adult <input type="checkbox"/> Child	Ward
Date incident allegedly occurred	Time alleged incident to have occurred
Date/time reported to supervisor	Date/time reported to superintendent
Location of incident	
Date/time reported to DHS	Reported to
Date/time investigation assigned	Date investigation completed <input type="checkbox"/> Check if Addendum
Name and title of primary investigator assigned	
Description of the incident	
Names of alleged perpetrators	
Names of persons reporting the incident	
Immediate protections implemented	
Date/time of medical assessment	
Immediate actions taken with alleged perpetrators	
Names of all witnesses (employees, volunteers, contractors, individuals, others)	

Type of incident (check all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Alleged abuse                      | <input type="checkbox"/> Elopement   |
| <input type="checkbox"/> Physical                           | <input type="checkbox"/> Suspicious injury   |
| <input type="checkbox"/> Sexual                             | <input type="checkbox"/> Injury resulting from restraint   |
| <input type="checkbox"/> Verbal                             | <input type="checkbox"/> Suicide attempt   |
| <input type="checkbox"/> Mental or psychological            | <input type="checkbox"/> Individual physical or sexual assault of another individual   |
| <input type="checkbox"/> Neglect or denial of critical care | <input type="checkbox"/> Other incidents in which an initial Type 2 incident review or clinical or interdisciplinary team review indicates a potential allegation of abuse |
| <input type="checkbox"/> Exploitation                       | <input type="checkbox"/> Other incident assigned for investigation by the Superintendent or Deputy Director  |
| <input type="checkbox"/> Serious injury                     |  |
| <input type="checkbox"/> Death                              |  |
| <input type="checkbox"/> Suspicious                         |  |
| <input type="checkbox"/> Unexpected deaths                  |  |

## II. Investigative Procedure

### A. General Information

1. *List the dates and times the investigator visited the site of the incident.*
2. *List the persons with whom the investigator spoke at that site.*

### B. Collecting Physical Evidence

1. *Describe the manner in which the scene of the incident, if any, was secured.*
2. *List each piece of physical evidence collected and where kept after collection.*
3. *List any pictures that were taken.*

### C. Interview Evidence

1. *List all persons interviewed in chronological order, including name, title, date and time, and type of interview (e.g., face-to-face, telephone).*
2. *Report the questions asked and answers given of all individuals identified in II.C.1.*

3. *List the person or persons, if any, identified as the target or targets of the case.*
4. *Describe the way in which the investigator afforded the target or other witnesses any right to representation if such rights exist by contract or other regulation or by law.*
5. *For any person identified in II.C.3., note whether the person had been suspended pending the investigation, whether any such person was reinstated during the course of the investigation and the reason for the reinstatement. If no one was suspended, please explain.*
6. *List any previous investigations that were reviewed as relevant to determine the circumstances, the veracity of witnesses, or corrective actions to be proposed.*

**D. Documentary Evidence**

1. *List any statements taken from individuals interviewed in the case. (This may be noted, for convenience, on the list identified in II.C.1., above.)*
2. *List any other documents collected in this case.*

### **III. Analysis and Recommendations**

- A. Was the incident as reported? If type modified, explain.**
- B. What impact did the incident have on the health and safety of the individual? Explain.**
- C. Was a cause of the incident identified? Explain.**
- D. Did employees respond appropriately to protect the health and safety of the individual? Explain.**
- E. Was the incident reported in a timely manner? If not, explain.**

**F. Is a corrective action plan required? If no, explain. If yes, describe including:**

1. *The corrective action required.*
2. *Which employee is responsible for developing the corrective action plan.*
3. *Which employee is responsible for implementing the corrective action plan.*
4. *Dates by which corrective action is to be developed and implemented.*

**G. Is this incident a part of a pattern of incidents involving this individual or the employees?**

**H. Other recommendations? Specify.**

\_\_\_\_\_  
Incident Investigator

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

#### **IV. Superintendent Review**

- A. Was the review of the incident appropriate and complete?**
- B. Was appropriate action taken to protect the health and safety of the individual?**
- C. Was the incident reported and the review done in a timely manner? If no, explain.**
- D. Was the determination of need or no need for corrective action appropriate?**
- E. Was a clinical or interdisciplinary team review required? If yes, was it completed?**

**F. Is this incident a part of a pattern of incidents involving this individual or the employees?**

**G. Recommendations for further actions needed.**

\_\_\_\_\_  
Reviewer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

**V. Superintendent's Approval**

- Approved
- Approved as modified (explain):
- Return for further investigation

\_\_\_\_\_  
Superintendent

\_\_\_\_\_  
Date

**MHI Type 1 Incident Investigation Report, Form 470-4496**

Purpose	Form 470-4496 is used to provide the outline and format for investigation and documentation of type 1 incidents at the mental health institutes.
Source	Complete this form on line using the template in the public state-approved mental health forms folder on Outlook. Supplies of the form may also be printed or photocopied from the sample in the manual as needed.
Completion	The institution employee assigned to complete the investigation completes Sections 1, 2, and 3 of the form. The superintendent or the superintendent's designee completes section 4, and the superintendent completes section 5.
Distribution	When sections 1, 2, and 3 are completed, the form is sent to the superintendent or the superintendent's designee for review. If someone other than the superintendent performs the review, then when section 4 has been completed, the form is sent to the superintendent for final approval.
Data	The form contains information concerning the background and findings of an investigation of an allegation of abuse.

**MHI Type 2 Incident Review Report, Form 470-4497**

Purpose	Form 470-4497 is used to provide the outline and format for review and documentation of type 2 incidents at the mental health institutes.
Source	Complete this form on line using the template in the public state-approved mental health forms folder on Outlook. Supplies of the form may also be printed or photocopied from the sample in the manual as needed.
Completion	The institution employee assigned to complete the incident review completes Sections 1, 2, and 3 of the form. The employee designated by the superintendent review type 2 incident review reports completes section 4.
Distribution	When sections 1, 2, and 3 are completed, the form is sent to the superintendent's designee for review.
Data	The form contains information concerning the background and findings of a review of a type 2 incident at a mental health institute.

## MHI Type 2 Incident Review Report

This form is to be used by the mental health institute (MHI) employee assigned to review an incident and prepare the written report for all type 2 incident reviews. See 3-A-Appendix for instructions.

<b>I. Basic Information</b>	
Review Report	
Review number	ID number
Name of individual <input type="checkbox"/> Adult <input type="checkbox"/> Child	Ward
Date incident allegedly occurred	Time alleged incident to have occurred
Location of incident	
Date/time incident reported to supervisor	Supervisor reported to
Date/time review assigned	Date review completed
Name and title of employee assigned to review	
Description of the incident	
Names of employees involved	
Names of persons reporting the incident	
Immediate protections implemented	
Immediate actions taken with employees	
Names of all witnesses (employees, volunteers, contractors, individuals, others)	

Type of incident (check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Accident on or off campus resulting in injury | <input type="checkbox"/> Medication error          |
| <input type="checkbox"/> Adverse drug reaction                         | <input type="checkbox"/> New onset seizure         |
| <input type="checkbox"/> Aspiration pneumonia                          | <input type="checkbox"/> Self injury               |
| <input type="checkbox"/> Assault by an individual to an employee       | <input type="checkbox"/> Significant weight change |
| <input type="checkbox"/> Assault by an individual to a peer            | <input type="checkbox"/> Site infection            |
| <input type="checkbox"/> Bowel obstruction                             | <input type="checkbox"/> Skin breakdown            |
| <input type="checkbox"/> Choking                                       | <input type="checkbox"/> Status epilepticus        |
| <input type="checkbox"/> Elopement                                     | <input type="checkbox"/> Suicide gesture           |
| <input type="checkbox"/> Fall  | <input type="checkbox"/> Other (specify):          |
| <input type="checkbox"/> Injury of unknown origin                      |  |
| <input type="checkbox"/> Medical emergency                             |  |

## II. Review Procedure

### A. General Information

1. List the dates and times the reviewer visited the site of the incident.
2. List the persons with whom the reviewer spoke at that site of the incident.

### B. Information Related to the Incident

1. Describe the incident, impact on the individual, and employee actions or inactions related to incident.
2. Summarize the findings of the record review including, but not limited to, event logs, flow sheets, and case record.
3. Summarize the findings of any environmental review including, but not limited to, bedrails, wheelchairs, floors, etc.

### C. Interview Findings

1. List all the employees and individuals the reviewer interviewed to collect information regarding the incident.
2. Information describing the incident as provided by the employees interviewed. Report based on each employee interviewed.
3. Information describing the incident as provided by the individual involved or other individuals. Report based on each individual interviewed.

### III. Analysis and Recommendations

- A. Was the incident as reported? If type modified, explain.
- B. What impact did the incident have on the health and safety of the individual? Explain.
- C. Was a cause of the incident identified? Explain.
- D. Did employees respond appropriately to protect the health and safety of the individual? Explain.
- E. Was the incident reported in a timely manner? If not, explain.
- F. Is a corrective action plan required? If no, explain. If yes, describe including:
  - 1. The corrective action required.
  - 2. Which employee is responsible for developing the corrective action plan.
  - 3. Which employee is responsible for implementing the corrective action plan.
  - 4. Dates by which corrective action is to be developed and implemented.
- G. Is this incident a part of a pattern of incidents involving this individual or the employees?
- H. Other recommendations? Specify.

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Incident Reviewer

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Date

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Title

## IV. Superintendent's Designee Review

- A. Was the review of the incident appropriate and complete?
- B. Was appropriate action taken to protect the health and safety of the individual?
- C. Was the incident reported and the review done in a timely manner? If no, explain.
- D. Was the determination of need or no need for corrective action appropriate?
- E. Was a clinical or interdisciplinary team review required? If yes, was it completed?
- F. Is this incident a part of a pattern of incidents involving this individual or the employees?
- G. Recommendations for further actions needed.

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Reviewer

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Date

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Title

**Restraint/Seclusion Debriefing:  
Administrative Review**

Patient name	Patient #
Date R/S started	Time
Date R/S ended	Time
Location	

Review team staff present:

(Leader)

- Patient debriefing form reviewed
- Same day staff debriefing form reviewed
- Next working day team debriefing form reviewed (If patient has been in restraint or seclusion more than once in the past 30 days, specifically address the causes and plans to eliminate future episodes.)
- Is there evidence that a rule or policy may have triggered the incident?
  - Yes (Indicate the rule and any changes that may have gone into effect since the event.)
  - None

Training needs identified based on review of information:

Yes

None

Feedback for treatment team based on review of information:

Yes

None

Feedback will be provided by (administrative leader):

- Recommended acknowledged by:  Treatment team       Physicians       Nursing  
 Training       Other:

Date and time of administrative review:

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**Restraint/Seclusion Debriefing: Administrative Review, Form 470-4322**

Purpose	Form 470-4322 is used to document the review by MHI administrative staff of a restraint or seclusion intervention.
Source	Complete this form on line using the template in the public state-approved mental health forms folder on Outlook. Supplies of the form may also be printed or photocopied from the sample in the manual as needed.
Completion	<p>The clinical director, director of nursing, or the superintendent leads an administrative review of all written debriefing materials following each episode of restraint or seclusion.</p> <p>The reviewers will particularly note if there have been multiple episodes of restraint or seclusion required for this patient, as indicated by the team debriefing form. If so, the administrative reviewers will specifically address causes and strategies to reduce or eliminate future episodes.</p> <p>The recommendations of the administrative review will be routed to and acknowledged by the treatment team, the physician staff, nursing staff, training staff and any other applicable departments of the facility.</p>
Distribution	Distribution of form shall be as noted above and as designated by MHI policies and procedures on restraint and seclusion.
Data	<p>Complete all items on each form. The form identifies:</p> <ul style="list-style-type: none"><li>◆ Any evidence that a site or policy may have triggered the incident.</li><li>◆ Any training needs identified based on the review.</li><li>◆ Any feedback for the patient's treatment team based on the review.</li></ul>

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**Restraint/Seclusion Monitoring Checklist and Narrative, Form 470-4318**

Purpose	Form 470-4318 is used to: <ul style="list-style-type: none"><li>◆ Document the names of all staff directly involved in a restraint or seclusion intervention;</li><li>◆ Describe objective release criteria from the restraint or seclusion prescription form to be used in determining when a patient can be released; and</li><li>◆ Document assessments of the patient's physical and psychological well-being during a restraint or seclusion intervention.</li></ul>
Source	This form may be printed from the electronic share located at \\Hoovr3s2\DEPDIR.772\Facility Policies\R&S Forms. Supplies of the form may also be printed or photocopied from the sample in the manual as needed.
Completion	This form is to be completed by MHI staff involved in the restraint or seclusion intervention and subsequent monitoring of the patient.
Distribution	Distribution of form shall be as designated by MHI policies and procedures on restraint and seclusion.
Data	Complete all items on each form.





**Restraint/Seclusion  
Next Working Day Team Debriefing**

Patient name	Patient #
--------------	-----------

Check event that applies:  Restraint  Seclusion

Restraint/Seclusion:

Date	Time
------	------

Location
----------

Persons participating:

Is this the first incident of R/S this admission?  Yes  No If yes, how often in the past 30 days?

1. What events led up to the incident?
2. How did the situation escalate (verbal, non-verbal, physical)?
3. Review of patient input (when possible, have patient read or describe):
4. Review of recommendations and implementation of changes in treatment plan:
5. Notification and debriefing completed with family or significant others by social worker. Persons notified:

No authorization by adult client for notification of family or significant others

Social Worker/Staff Signature	Date
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### Restraint/Seclusion Next Working Day Team Debriefing, Form 470-4319

Purpose	<p>Form 470-4319 is used to assist the treatment team to:</p> <ul style="list-style-type: none"><li>◆ Determine how to more effectively assist the patient and staff in understanding what precipitated a restraint or seclusion event.</li><li>◆ Develop interventions to avoid the need for restraint or seclusion.</li></ul>
Source	<p>Complete this form on line using the template in the public state-approved mental health forms folder on Outlook. Supplies of the form may also be printed or photocopied from the sample in the manual as needed.</p>
Completion	<p>The assigned treatment team completes a team debriefing on the next working day following an incident of restraint or seclusion. The meeting shall include the patient, the physician, the nurse, the social worker, and, when possible, LPNs, RNs, and the RN supervisor.</p> <p>The team members indicate on this form whether or not there have been multiple episodes of restraint or seclusion during this admission and how frequently episodes have occurred within the past 30 days. Recommendations include strategies to eliminate multiple episodes and use alternative interventions.</p>
Distribution	<p>File the completed team debriefing form in the patient's record. Additional distribution of form shall be as designated by MHI policies and procedures on restraint and seclusion.</p>
Data	<p>Complete all items on each form. The form contains:</p> <ul style="list-style-type: none"><li>◆ A list of the staff participating in the debriefing.</li><li>◆ A summary of the events heading up to the incident.</li><li>◆ A review of the patient report.</li><li>◆ A review of the recommendations and implementation of changes in the patient's treatment plan.</li><li>◆ Documentation of debriefing with the patient's family.</li></ul>

### Restraint/Seclusion Patient Debriefing, Form 470-4320

Purpose	Form 470-4320 is used to document information received directly from a patient involved in a restraint or seclusion intervention.
Source	Complete this form on line using the template in the public state-approved mental health forms folder on Outlook. Supplies of the form may also be printed or photocopied from the sample in the manual as needed.
Completion	The RN or designee initiates the patient debriefing process. As soon as the patient is receptive following any incident of restraint or seclusion, staff will ask the patient to complete this form. The patient can complete the form independently or with staff assistance.
Distribution	Place the form in the front of the patient's medical record for reference during the team debriefing. Additional distribution of form shall be as designated by MHI policies and procedures on restraint and seclusion.
Data	The form solicits information on: <ul style="list-style-type: none"><li>◆ The events leading up to the incident.</li><li>◆ The patient's actions and feelings before and after the incident.</li><li>◆ Possible future strategies.</li></ul>

## Restraint/Seclusion Patient Debriefing

Patient name	Patient #
--------------	-----------

Check event that applies:  Restraint  Seclusion

Date	Time
------	------

Location
----------

1. What events led up to the incident?
2. Did I say or do anything that made the situation worse?
3. How did I feel before all of this happened?
4. How do I feel now?
5. What did I want in the first place?
6. What actually happened to me as a result?
7. What could I try next time that might work better?
8. I also want staff to know.

Patient signature	Signature of RN supervisor or designee
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### Restraint/Seclusion Same-Day Staff Analysis

Patient name	Patient #
--------------	-----------

Check event that applies:  Restraint  Seclusion

Restraint/Seclusion:

Date	Time
------	------

Location
----------

First incident R/S this admission:  Yes  No

Primary staff involved in the intervention:

Staff present for analysis:

1. What events led up to the incident?
2. How did the situation escalate (verbal, non-verbal, physical)?
3. What staff actions helped (verbal, non-verbal, physical)?
4. What staff actions didn't help (verbal, non-verbal, physical)?
5. Was a PRN or STAT medication given before or during restraint or seclusion?  
 Yes  No If yes,  PRN or  STAT?

	Time Given	Medication	Dose	Route
1 <sup>st</sup> dose				
2 <sup>nd</sup> dose				
3 <sup>rd</sup> dose				

6. Was staff response time appropriate?  Yes  No
7. Were all needed equipment and supplies immediately available and ready?  Yes  No
8. Were there enough staff to safely manage the situation?  Yes  No
9. Was it clear who was the on-scene leader?  Yes  No
10. Comments and explain any answers of "No" on questions 6 through 9.

11. If there were injuries to patients or staff, indicate who was injured and the type of injuries. Identify staff by job title only and other patients by client ID.

Actions taken to treat injuries (patient or staff).

12. What went well about the emergency response?

13. What could we try next time that might work better?

14. Recommendations for treatment plan or administrative review and other comments.

15. Ensure restraint/seclusion intervention is recorded in the treatment plan.  Yes  No

16. Describe the physical and emotional effects on both the consumer and the staff. Have staff or patients been informed of how to seek psychological services to cope with this event?

Signature of RN supervisor or designee

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**Restraint/Seclusion Same-Day Staff Analysis, Form 470-4316**

Purpose	Form 470-4316 is used to document an immediate post-event analysis and discussion by all primary staff involved in a restraint or seclusion intervention. This form is also to be used in the team debriefing and the administrative review.
Source	Complete this form on line using the template in the public state-approved mental health forms folder on Outlook. Supplies of the form may also be printed or photocopied from the sample in the manual as needed.
Completion	<p>The RN supervisor or designee initiates the same-day staff debriefing process following any incident of restraint or seclusion, after the situation has calmed, orders are written, and the initial paperwork is completed. To the extent possible, all staff directly involved in the incident shall be included in this debriefing.</p> <p>The debriefing for staff is to be a structured meeting in a safe environment, encouraging an open discussion and recording of the facts and what might have been done differently to avoid this and future incidents of restraint or seclusion.</p>
Distribution	Place this form in the patient's record to document the debriefing results and to be used in the team debriefing and administrative review. Additional distribution of form shall be as designated by MHI policies and procedures on restraint and seclusion.
Data	<p>Complete all items on each form. The form summarizes:</p> <ul style="list-style-type: none"><li>◆ The events that led up to the incident.</li><li>◆ How the situation escalated.</li><li>◆ What staff actions helped and didn't help.</li></ul>

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**Risks, Triggers, Signs and Coping Aids, Form 470-4321**

Purpose	<p>Form 470-4321 is intended to identify situations that may lead to agitation of the patient and to identify methods that may be helpful to deescalate a potentially volatile situation.</p> <p>The form is also designed to identify additional self-reported conditions such as medical conditions or history of abuse that should be considered when providing treatment and is to be read and understood by all staff working with the patient.</p>
Source	<p>Complete this form on line using the template in the public state-approved mental health forms folder on Outlook. Supplies of the form may also be printed or photocopied from the sample in the manual as needed.</p>
Completion	<p>This form is to be completed by the patient or with the patient assisted by admission staff upon admission to the MHI or as soon as possible thereafter when the patient is able to answer the questions on the form.</p>
Distribution	<p>Keep this form readily available in the patient's medical record. Additional distribution of form shall be as designated by MHI policies and procedures on restraint and seclusion.</p>
Data	<p>Encourage the individual to complete the form. The form lists:</p> <ul style="list-style-type: none"><li>◆ Things that cause agitation, fear, or panic in the patient.</li><li>◆ Observable early warning signs for the patient.</li><li>◆ Things that may help the patient calm down.</li><li>◆ The patient's history of:<ul style="list-style-type: none"><li>• Restraint and seclusion:</li><li>• Medical conditions and physical disabilities.</li><li>• History of sexual or physical abuse.</li></ul></li></ul>

## Risks, Triggers, Signs and Coping Aids

Patient name	Patient #
--------------	-----------

Date
------

1. During your course of treatment, we try to identify and avoid things that cause agitation, fear, or panic. Tell us what kinds of things may set off actions that may lead to a dangerous situation.

Examples may be:

Being given time limits	Being told what to do	Loud noises or voices	Time of year
Being ignored	Being teased or picked on	Men	Tone of voice
Being told no	Certain people or family members	Time limits	Women
Being touched	Finger pointing	Not having control	Time of the month
Being told to wait	Isolation	Time of day	

2. Are you aware of any observable early warning signs that staff should be aware of that you may exhibit before you start to get upset?

Examples may be:

Sweating	Loud voice	Can't sit still	Hurting others or things
Breathing hard	Sleeping a lot	Being rude	Hurting myself
Racing heart	Sleeping less	Pacing	Not able to care for self
Clenching teeth	Hyper	Crying	Isolating/avoiding people
Clenching fists	Swearing	Squatting	Laughing loudly/giddy
Red faced	Bouncing legs	Eating less	Singing inappropriately
Wringing hands	Rocking	Eating more	Other

3. What are some things that might help you calm down when you start to get upset?

Examples may be:

Board games	Drawing	Play doh	Stuffed animals
Bouncing balls	Exercising	Punching a pillow	Talking with someone
Card games	Jigsaw puzzles	Reading	Tearing paper
Collapsible activity toys	Journaling	Relaxation techniques	Time alone
Coloring	Lego blocks	Sitting by self	Video games
Computer	Looking at pictures	Screaming and yelling	Walking
Crafts	Music - listening or playing	Shower or bath	Watching television
Crossword puzzles	Outdoor games	Silly Putty	Wrapping up in a blanket
Crying	Pacing or walking	Squish pillows	Writing stories or letters
Deep breathing	Phone calls	Stress balls	about feelings

4. Have you ever had to be in restraints or seclusion in previous inpatient episodes?  Yes  No  
If yes, please describe where and when.

5. What happened that resulted in the use of restraint or seclusion?

6. Do you have any medical conditions or physical disabilities?

7. Do you have any history of sexual or physical abuse?

Staff signature	Date
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