One hour face to face

By
Debra McGuire, MSN, RN

OBJECTIVES

AT THE END OF THE PRESENTATION, PARTICIPANT WILL BE ABLE TO:

- LIST ELEMENTS OF THE 1 HOUR FACE TO FACE ASSESSMENT.
- IDENTIFY AT LEAST 3 THINGS TO CONSIDER WHEN CONDUCTING A 1 HOUR FACE TO FACE ASSESSMENT.
- DEFINE EXCITED DELIRIUM AND IDENTIFY AT LEAST 2 POSSIBLE CAUSES.

TRIGGERS

Drug Therapy

Anxiety Disorder

Pain

Mood Disorder

Delirium

BEHAVIORAL SYMPTOMS

Psychosis

Interpersonal Stressor

Environmental Stressor

WARNING SIGNS

- SUDDEN UNEXPLAINED CHANGES IN AFFECT OR MOOD
- INCREASED RESTLESSNESS
- PACING
- CHANGE IN SPEECH PATTERN AND TONE
- THREATENING BODY LANGUAGE
- LESS RESPONSIVE TO REDIRECTION
- REFUSING MEDICATION AND/OR CARE
- PHYSIOLOGIC CHANGES: DIAPHORETIC, FACIAL GRIMACING, FLUSHED SKIN, DISTENDED NECK VEINS, DILATED PUPILS

EXCITED DELIRIUM

- It is a condition of extreme mental or motor excitement characterized by aggressive activity with confused and unconnected thoughts, hallucinations, paranoid delusions, and incoherent or meaningless speech.
- **Possible causes: drug induced; adverse drug reaction, fever/sepsis; head trauma**
- Cardiac arrhythmia is the likely cause of unexplained deaths of restrained individuals with agitated delirium.

REGULATORY REQUIREMENTS

- WHEN RESTRAINT OR SECLUSION IS USED FOR THE MANAGEMENT OF VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR THE PATIENT MUST BE SEEN FACE-TO-FACE WITHIN 1 HOUR AFTER INITIATION OF THE INTERVENTION.
- AFTER 24 HOURS, **BEFORE** WRITING A NEW ORDER, A PHYSICIAN OR OTHER LIP RESPONSIBLE FOR THE CARE OF THE PATIENT MUST SEE AND ASSESS THE PATIENT.

ONE HOUR FACE TO FACE

- CONDUCTED WITHIN ONE HOUR OF INITIATING SECLUSION OR RESTRAINT.
- CONDUCTED BY: PHYSICIAN, LIP, OR RN OR PA WHO HAS BEEN TRAINED IN ACCORDANCE WITH REGULATORY REQUIREMENTS.

ELEMENTS OF FACE TO FACE ASSESSMENT

EVALUATION OF:

- THE PATIENT'S IMMEDIATE SITUATION
- THE PATIENT'S REACTION TO THE INTERVENTION
- THE PATIENT'S MEDICAL AND BEHAVIORAL CONDITION; AND
- THE NEED TO CONTINUE OR TERMINATE RESTRAINT OR SECLUSION.

PATIENT'S IMMEDIATE SITUATION

- IS THE PATIENT SAFE?
- ARE RESTRAINTS APPLIED APPROPRIATELY?
- WHAT LED TO SECLUSION/RESTRAINT EPISODE?
- WERE THE LEAST RESTRICTIVE MEASURES ATTEMPTED? DOES DOCUMENTATION SUPPORT CLINICAL JUSTIFICATION?
- IS THE PATIENT BEING MONITORED APPROPRIATELY?

PATIENT'S REACTION

- WHAT DOES THE PATIENT LOOK LIKE AT THE TIME OF THE ASSESSMENT?
- IS THE PATIENT CALMING DOWN?
- DID THE PATIENT RECEIVE A PRN?
- HAS PATIENT EDUCATION BEEN DONE RE: DISCONTINUATION CRITERIA? IS IT DOCUMENTED?
- CAN PATIENT VERBALIZE D/C CRITERIA?

MEDICAL/BEHAVIORAL CONDITION

WHAT ELSE COULD BE CONTRIBUTING TO THE PATIENT'S BEHAVIOR:

- UNREPORTED DRUG USE
- NEW MED CHANGES WITH POTENTIAL ADVERSE REACTIONS…..REVIEW MAR
- INFECTION…..PROGRESSING TO SEPSIS
- RECENT FALL WITH HEAD TRAUMA
- BLOOD SUGAR: EXTREMELY HIGH OR LOW
- OBTAIN VITAL SIGNS

THE NEED TO CONTINUE OR TERMINATE

- HAS THE PATIENT CALMED DOWN ENOUGH TO DISCONTINUE THE RESTRAINTS?
- DOES PATIENT RESPOND TO DIRECTION/RE-DIRECTION?
- IS THE PATIENT ASLEEP?

MEDICAL EMERGENCIES

- EXCITED DELIRIUM
- DIABETIC : INSULIN SHOCK, DIABETIC KETOACIDOSIS
- RESPIRATORY DISTRESS
- SEIZURES
- CHEST PAIN, CARDIAC DISTRESS
- DISLOCATED/FRACTURED JOINTS, LIMBS
- BLEEDING

TERMINATE RESTRAINTS IMMEDIATELY FOR S/S PHYSIOLOGIC DISTRESS

FACE TO FACE FOLLOW-UP

- IF THE FACE-TO-FACE EVALUATION IS CONDUCTED BY A TRAINED RN OR PA, THE RN OR PA **MUST** CONSULT THE ATTENDING PHYSICIAN OR OTHER LIP WHO IS RESPONSIBLE FOR THE CARE OF THE PATIENT **AS SOON AS POSSIBLE** AFTER THE COMPLETION OF THE 1 HOUR FACE-TO-FACE EVALUATION.

***DOCUMENT PHONE CONSULTATION ON FACE TO FACE SHEET**

- MONTHLY REVIEW/REPORTING OF SECLUSION/RESTRAINT HOURS/EPISODES
- REVIEW OF RESTRAINT CHARTS
- CORRECTIVE ACTIONS FOR DEFICIENT FINDINGS