STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, November 4, 2016

CF OPERATING PROCEDURE
NO. 155-20

Mental Health/Substance Abuse

USE OF SECLUSION IN MENTAL HEALTH TREATMENT FACILITIES

1. Purpose. This operating procedure provides standards for the use of seclusion in state mental health treatment facilities. The operating procedure addresses the use of seclusion for behavior management purposes.

2. Scope. This operating procedure applies to:

a. Residents hospitalized in state mental health treatment facilities, whether operated by the Department of Children and Families or private entities; and,

b. At the Florida Civil Commitment Center:

(1) Those residents housed on the Residential Mental Health Units;

(2) Any resident evaluated by a psychiatrist as meeting criteria for Residential Mental Health but not yet housed on the unit; and,

(3) Any resident who has been evaluated by a psychiatrist as being an imminent danger to self or others and the behavior is secondary to a mental health disorder/mental health crisis.

3. References.

a. Chapter 394, Florida Statutes (F.S.), Mental Health.

b. Chapter 916, F.S., Mentally Deficient and Mentally Ill Defendants.

c. Rule 65E-20, Florida Administrative Code (F.A.C.), Forensic Client Services Act Regulation.

d. Rule 65E-5, F.A.C., Mental Health Act Regulation.

e. Rule 59A-3, F.A.C., Hospital Licensure.

f. Code of Federal Regulations, Title 42 – Public Health, Chapter IV – Centers for Medicare and Medicaid Services, Department of Health and Human Services, Subchapter G – Standards and Certification, Part 482 – Conditions of Participation for Hospitals, 482.13 Conditions of Participation: Patients' Rights, Final Rule, Amended May 16, 2012, [42CFR482.13]. Centers for Medicare and Medicaid Services, Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Revision 105, 03-21-14.

4. Definitions. For the purposes of this operating procedure, the following terms shall mean:

a. Assessment. The systematic collection and integrated review of resident-specific data. Assessment specifically includes efforts to identify key medical and psychological needs, competency

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to consent to treatment, patterns of co-occurring mental illness and substance abuse, as well as clinically significant neurological deficits, traumatic brain injury, organicity, physical disability, developmental disability, need for assistive devices, physical or sexual abuse or trauma, and antecedents to violent behavior.

b. Behavioral Emergency. A situation where a resident's behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the resident, other residents, staff, or others.

c. Comfort Room. A room that has been physically designed to provide sanctuary from stress, and/or can be a place to experience feelings within acceptable boundaries. The Comfort Room is used voluntarily, though staff members may suggest its use.

d. PRN. An individualized order for the care of a resident which is written after the resident has been seen by a physician/Advanced Registered Nurse Practitioner (ARNP)/Physician's Assistant (PA), which sets parameters to attending staff to implement according to the circumstances set out in the order.

e. Personal Safety Plan. A document containing information regarding calming strategies identified by the resident as being helpful in avoiding a crisis, such as the use of seclusion or restraint. This document is completed by the resident, with assistance from facility staff, if needed. It is used as a guide to increase awareness of strategies that can be used with each individual to de-escalate situations before a crisis arises. For each individual, the plan identifies calming strategies; actions that are "triggers" to a potential crisis situation; personal signs or signals of distress; individual preferences regarding staff interactions during a pre-crisis situation and the type of emergency intervention used; medications which the resident has found to be helpful in emergency situations; and information regarding past traumatic experiences. This plan is reviewed by staff upon initial admission to the facility, after each seclusion or restraint event and is updated at least annually.

f. Resident. An individual receiving services in a state mental health treatment facility. The term is synonymous with "client", "consumer", "individual", "patient", or "person served."

g. Restraint. A physical device, method, or drug used to control behavior. A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the individual's body so that he or she cannot easily remove the restraint and which restricts freedom of movement or normal access to one's body.

(1) A drug used as a restraint is a medication used to control the person's behavior or to restrict his or her freedom of movement and is not part of the standard treatment regimen of a person with a diagnosed mental illness who is a client of the Department. Physically holding a person during a procedure to forcibly administer psychotropic medication is a physical restraint.

(2) Restraint does not include physical devices, such as orthopedically prescribed appliances, surgical dressings and bandages, supportive body bands, or other physical holding when necessary for routine physical examinations and tests; or for purposes of orthopedic, surgical, or other similar medical treatment; when used to provide support for the achievement of functional body position or proper balance; or when used to protect a person from falling out of bed.

h. Seclusion. The physical segregation of a person in any fashion or involuntary isolation of a person in a room or area from which the person is prevented from leaving. The prevention may be by physical barrier or by a staff member who is acting in a manner, or who is physically situated, so as to prevent the person from leaving the room or area. For the purposes of this procedure, seclusion does not refer to isolation due to a resident's medical condition or symptoms, or the confinement, in forensic facilities, to bedroom areas during normal hours of sleep when there is not an active order for

seclusion. Securing residents in areas or rooms temporarily in order to respond to unusual circumstances (for example, in response to resident's or staff safety during another resident's behavioral emergency, riots, hostage situations, or natural disasters) is not considered seclusion for clinical behavior management purposes and is excluded from this operating procedure.

i. Recovery Plan. A written plan developed by the resident and his or her recovery team. This plan is based on assessment data, identifying the resident's clinical, rehabilitative, and activity service needs, and the strategy for meeting those needs. This plan documents treatment goals and objectives, criteria for terminating the specified interventions, and documents progress in meeting specified goals and objectives.

j. Recovery Team. An assigned group of individuals with specific responsibilities identified on the recovery plan including the resident, psychiatrist, guardian/guardian advocate, community case manager, family member, and other treatment professionals as determined by the resident's needs.

k. Seclusion and Restraint Oversight Committee. A group at an agency or facility that monitors the use of seclusion and restraint at the facility. The purpose of this committee is to assist in the reduction of seclusion and restraint use at the agency or facility. Membership includes, but is not limited to, the facility administrator/designee, medical staff, quality assurance staff, and a peer specialist or advocate, if employed by the facility or otherwise available. If a peer specialist or advocate is not employed by the facility, an external peer specialist or advocate may be appointed.

l. Continuous Visual Observation. Requires staff to remain within constant view and close physical proximity of a designated resident to ensure the physical, medical, emotional, and security needs of the resident are observed. The assigned staff maintains uninterrupted visual contact of the resident at all times. At no time should a staff be assigned to more than one resident for Continuous Visual Observation. The physical proximity for staff (e.g., within arm's length, within same room, etc.) will be specified in the physician's order for restraints. Continuous Visual Observation is related to the management of seclusion and restraint.

5. Standards.

a. Each facility will provide a therapeutic milieu that supports a culture of recovery, individual empowerment, and responsibility. Each individual will have a voice in determining his or her treatment options. Treatment will foster trusting relationships and partnerships for safety between staff and individuals. Facility staff will be particularly sensitive to individuals with a history of trauma and use trauma informed care. Seclusion and restraint practices shall be guided by the following principles of trauma-informed care: assessing trauma histories and symptoms; recognizing culture and practices that are re-traumatizing; processing the impact of a seclusion or restraint with the individual; and addressing staff training needs to improve knowledge and sensitivity.

b. The health and safety of the resident shall be the primary concern of state mental health treatment facilities at all times. Therefore, when a resident demonstrates a need for immediate medical attention in the course of an episode of seclusion, medical priorities shall supersede psychiatric priorities, including the immediate discontinuation of the use of seclusion, if medically necessary. Contraindications to the use of specific seclusion or restraint techniques due to medical conditions will be documented in the individual's medical record as part of the individual's admission and subsequent physical examination or psychiatric evaluation. Staff shall be informed of any contraindications as determined by the physician or Advanced Registered Nurse Practitioner (ARNP) and shall utilize other techniques as indicated on the individual's personal safety plan.

c. Seclusion shall be employed only in an emergency, with intent to prevent a resident from seriously harming or continuing to harm others, and when less restrictive techniques have been tried

and failed; or if it has been determined that the danger is of such immediacy that less restrictive techniques cannot be safely applied and would not afford adequate protection to others.

d. Seclusion shall not be used as punishment, for the convenience of staff, or as a substitute for treatment programs.

e. The criterion for release of a resident from seclusion is achievement of the objective, i.e., that the resident no longer represents an imminent danger to others, rather than the passage of a time period. Every secluded person shall be immediately informed of the behavior that caused his or her seclusion and the behavior and conditions necessary for release. The individual shall be released from seclusion or restraint as soon as he or she is no longer an imminent danger to self or others.

f. Seclusion use shall not be based on the resident's seclusion history or solely on a history of dangerous behavior. Dangerous behaviors include those behaviors that jeopardize the physical safety of oneself or others.

g. De-escalation and physical management techniques sanctioned and taught by the state mental health treatment facility staff shall be employed. Only the minimum amount of force necessary shall be used in initiating the use of seclusion.

h. Seclusion and restraint may not be used simultaneously for children less than 18 years of age. For adults age 18 and over, simultaneous seclusion and restraint is only permitted if the individual is on Continuous Visual Observation by an assigned, trained staff member. Staff providing this monitoring must be in close proximity to the individual.

i. Each facility utilizing seclusion or restraint procedures shall establish and utilize a Seclusion and Restraint Oversight Committee.

j. Seclusion is never to be used for residents who actively engaged in self-injurious behavior, and staff are to consider the resident's proclivity to engage in self-harm.

6. Training Requirements.

a. Staff must be trained on the use of seclusion and this operating procedure, including items (1) – (7) below, within 30 days of assignment, and at least annually thereafter as part of orientation and subsequently on an annual basis or more frequently. Staff responsible for or participating in the following actions will demonstrate relevant competency in the following areas before participating in a seclusion event or related assessment, monitoring or provision of care during an event:

(1) Strategies designed to reduce confrontation and to calm and comfort people, including the development and use of a personal safety plan;

(2) Use of nonphysical intervention skills as well as bodily control and physical management techniques based on a team approach;

(3) Observing for and responding to signs of physical and psychological distress;

(4) Monitoring the physical and psychological well-being of the person who is secluded, including any special requirements specified by facility policy associated with the one hour face-to-face evaluation;

(5) Clinical identification of specific behavioral changes that indicate that seclusion is no longer necessary;

(6) The use of first aid techniques; and,

(7) Certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

b. The frequency of training for cardiopulmonary resuscitation will be in accordance with certification requirements, notwithstanding paragraph 6a of this operating procedure.

c. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address residents' behaviors.

d. The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed.

7. General Procedures.

a. De-escalation and Resident's Advance Preference.

(1) Less restrictive verbal de-escalation interventions/calming strategies shall be employed before physical interventions, unless physical injury is imminent.

(2) A Personal Safety Plan (see Appendix A to this operating procedure for a recommended form) shall be utilized for the purpose of guiding individualized intervention techniques. The form shall be completed upon admission or as soon as the resident is stable enough to complete the form with staff assistance, filed in the resident's medical record and reviewed at least every 12 months based on admission date to determine if changes are necessary.

(a) Review of the personal safety plan shall be documented by the recovery team within 2 working days of a seclusion event, and updated if necessary;

(b) Specific intervention techniques from the personal safety plan that are offered or used prior to a seclusion event shall be documented in the individual's medical record after each use of seclusion; and,

(c) All staff shall be aware of and have ready access to each individual's personal safety plan.

(3) In determining the appropriate intervention for a specific resident in response to an emergency situation that may warrant seclusion, any preferences or recommendations provided by the resident must be considered and documented in the medical record. The personal safety plan shall include the following inquiries, to be used as clinically appropriate:

(a) What behaviors, situations or circumstances upset you?

(b) What techniques, methods, or tools help you control your behavior and prevent crisis situations?

(c) What methods help you regain control when you are experiencing loss of control?

(d) What can staff do to assist you? What should staff not do?

(e) As a last resort in a crisis situation what might you find helpful? Examples would include such things as medication/injection/oral, going to a quiet place.

(4) The information obtained from the personal safety plan form will ensure awareness of circumstances and actions that may serve as triggers for a resident's aggressive behavior and the measures that may help prevent or deescalate them.

(5) The seclusion process shall evidence consideration that the resident's choice alternatives as identified on the personal safety plan form have been considered. Any preferences expressed by the resident regarding the gender of the observing staff person shall be honored when possible and clinically appropriate.

b. Initiating Seclusion.

(1) Seclusion may be implemented pursuant to an order by a physician or other licensed independent practitioner (Advanced Registered Nurse Practitioner (ARNP) or Physician's Assistant (PA)), if permitted by the facility to order seclusion and stated within their protocol. Seclusions may be initiated prior to obtaining a written order if the physician is not immediately available. The attending physician must be consulted as soon as possible if the attending physician did not order the seclusion.

(2) An examination of the resident will be conducted within one hour by the physician or may be delegated to an Advanced Registered Nurse Practitioner (ARNP) or Physician's Assistant (PA) if authorized by the facility and stated within their protocol. A Registered Nurse (RN) may conduct the examination within one hour if authorized by the facility and trained according to paragraph 6 of this operating procedure. If the face to face evaluation is conducted by a trained Registered Nurse, the attending physician who is responsible for the care of the person must be consulted as soon as possible after the evaluation is completed. This examination shall include:

(a) A face-to face assessment of the resident's mental status and physical condition;

(b) A review of the clinical record for any pre-existing medical diagnosis and/or physical condition which may contraindicate the use of seclusion;

(c) A review of the resident's medication orders, including an assessment of the need to modify such orders during the period of seclusion;

(d) A determination of whether to continue or terminate the seclusion; and,

(e) A determination that the risks associated with the use of seclusion is significantly less than not using seclusion.

(3) Documentation of the examination required by paragraph (2) above, including the time and date completed, shall be included in the resident's medical record.

(4) The written order shall:

(a) Be written on the Order Sheet and included in the resident's medical record;

(b) Specify the facts and behaviors justifying the intervention and identify the time of initiation and expiration of the authorization;

(c) Specify the type of intervention to be used;

(d) Include any special care or monitoring instructions; and,

(e) Include the criteria for release.

(5) Each written order for seclusion of individuals age 18 and over is limited to four hours. A seclusion order may be extended every four hours (up to a total of 24 hours) after consultation and review by an ARNP or physician, as defined in s. 394.455(21), Florida Statutes, in person or by telephone with an RN who has physically observed and evaluated the resident. The original order may only be renewed up to a total of 24 hours, in accordance with these limits.

(6) When the original order has expired (after 24 hours), the resident must be seen by a physician, ARNP, or PA and his/her assessment of the resident documented before a new order for seclusion can be written. After 24 hours, a new order for seclusion must be written in accordance with paragraphs 7b(1)-(4). For individuals age 9-17, the order is limited to 2 hours. All verbal orders for seclusion must be signed within 24 hours after the initiation of seclusion by the authorizing physician (for civil) or physician/ARNP/PA (for forensic).

(7) Seclusion use exceeding 24 hours requires the notification of the Hospital Administrator or his/her designee by the next business day.

(8) Seclusion may be initiated prior to obtaining the written order of a physician/ARNP/PA only if the resident presents an immediate danger to others and a physician is not immediately available to perform a face-to face examination. A Registered Nurse or highest level staff member who is immediately available and who is trained according to paragraph 6 of this operating procedure may initiate seclusion in an emergency, given the following directives:

(a) If seclusion is initiated by a staff member other than an Advanced Registered Nurse Practitioner or a Registered Nurse, an Advanced Registered Nurse Practitioner or Registered Nurse shall assess the need for seclusion and document that need in the resident's medical record within 15 minutes of initiation.

(b) A physician/ARNP/PA must conduct a face-to-face examination (as described in paragraph 7b(2) above) and authorize seclusion use within one (1) hour of initiation. The face-to-face examination may be delegated to a trained RN (as described in paragraph 7b(2) above).

(9) Prior to placing a resident in seclusion, staff shall check the seclusion room to ensure it is safe and free of unsafe items and a staff member of the same gender shall search the resident for potentially dangerous objects. Any potentially dangerous objects shall be removed and documented in the resident's medical record.

(10) Upon the initiation of seclusion, the registered nurse/physician (or in their absence, the initiating staff person) shall inform the resident of the behaviors that precipitated the seclusion, and the criteria, in specific behavioral terms, necessary for release. Release criteria shall reflect that the individual is not an imminent danger to self or others. This information will be recorded in the physician's order.

(11) The resident must be clothed appropriately for temperature and at no time shall a resident be placed in seclusion in a nude or semi-nude state.

(12) Seclusion and restraint may not be ordered simultaneously, unless the resident is continually monitored face to face by an assigned staff member.

(13) Seclusion shall not be used for residents exhibiting behaviors which preclude the safe application of this modality, based upon the clinical judgment of the ordering practitioner.

(14) PRNs for the use of seclusion are not permitted.

c. Monitoring Residents in Seclusion.

(1) Observation of a secluded resident must be an ongoing process with observation and documentation of the resident's condition documented at least every 15 minutes by trained staff for behavior, potential injury, and respiration. Staff shall document their observations, their name, date and time of the observation on a seclusion/restraint form developed by the treatment facility. At least one time per hour, the observation must be conducted by a nurse.

(2) Residents in seclusion shall be monitored to ensure that his/her physical needs, comfort, and safety are properly cared for. Residents must be offered the opportunity to drink and toilet, as requested. Staff assigned to monitor shall be trained and competent to assess physical and psychological signs of distress.

(3) For each use of seclusion, the following shall be documented:

(a) The emergency situation resulting in the seclusion event;

(b) Alternatives or other less restrictive interventions attempted, as applicable, or the clinical determination that less restrictive techniques could not be safely applied;

(c) The name and title of the staff member initiating the seclusion; the date/time of initiation and release;

(d) The individual's response to seclusion, including the rationale for continued use of the intervention; and,

(e) The individual was informed of the behavior that resulted in the seclusion and the criteria necessary for release.

(4) This documentation will be in the resident's medical record and in a facility registry maintained for this purpose.

d. Resident Release from Seclusion.

(1) A resident shall be released from seclusion as soon as he or she no longer appears to present an imminent danger to others and meets the behavioral criteria for its discontinuation written in the physician's order.

(2) Upon release from seclusion, a nurse shall observe, evaluate, and document the individual's physical and psychological condition.

(3) After a seclusion event, a debriefing process shall take place to decrease the likelihood of a future seclusion or restraint event for the individual and to provide support.

e. Review of Seclusion Event.

(1) Each facility shall develop policies to address:

(a) A review of the incident with the individual who was secluded. The individual shall be given the opportunity to process the seclusion event as soon as possible but no longer than within 24 hours of release. This debriefing discussion shall take place between the individual and either the recovery team or another preferred staff member. This review shall address the incident within the framework of the individual's life history and mental health issues. It shall assess the impact of the event on the individual and help the individual identify and expand coping

mechanisms to avoid the use of seclusion in the future. The discussion will include constructive coping techniques for the future. A summary of this review should be documented in the individual's medical record.

(b) A review of the incident with all staff involved in the event and supervisors or administrators. This review shall be conducted by the close of the next business day after the event and shall address: the circumstances leading to the event; the nature of de-escalation efforts; alternatives to seclusion attempted; staff response to the incident; and ways to effectively support the individual's constructive coping in the future and avoid the need for future seclusion. The outcomes of this review should be documented by the facility for purposes of continuous performance improvement and monitoring. The review findings will be forwarded to the Seclusion and Restraint Oversight Committee.

(c) Support for other individuals served and staff, as needed, to return the unit to a therapeutic milieu.

(2) Within 2 working days after any use of seclusion, the recovery team shall meet and review the circumstances preceding the event and review the individual's recovery plan and personal safety plan to determine whether any changes are needed in order to prevent the further use of seclusion. The individual who was secluded shall be provided an opportunity to participate in this meeting. The recovery team shall also assess the impact the event had on the individual and provide any counseling, services, or treatment that may be necessary. The recovery team shall analyze the individual's clinical record for trends or patterns relating to conditions, events, or the presence of other persons immediately before or upon the onset of the behavior warranting the seclusion, and upon the individual's release from seclusion. The recovery team shall review the effectiveness of the emergency intervention and develop more appropriate therapeutic interventions. Documentation of this review shall be placed in the individual's clinical record.

(3) If an individual has had multiple seclusion events, the recovery team shall conduct a thorough clinical review, including a medication review, to determine if any changes to the recovery plan or overall treatment and services are needed.

f. Seclusion and Restraint Oversight Committee. Each facility utilizing seclusion procedures shall establish and utilize a Seclusion and Restraint Oversight Committee that includes medical staff to conduct at least weekly reviews of each use of seclusion and monitor patterns of use, for the purpose of assuring least restrictive approaches are utilized to prevent or reduce the frequency and duration of use with residents. The review committee shall include a consumer resident or external advocate if employed or whenever possible, and shall employ an analysis and countermeasures approach.

8. Reporting a Death That Occurs During Seclusion.

a. All facilities that are subject to the Conditions of Participation for Hospitals, part 482 under the Centers for Medicare and Medicaid Services (CMS), must report to CMS any death that occurs in the following circumstances:

(1) While a person is secluded or restrained;

(2) Within 24 hours after release from seclusion or restraint; or,

(3) Within one week after seclusion or restraint where it is reasonable to assume that use of the seclusion or restraint contributed directly or indirectly to the person's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.

b. Each death described in paragraph 8a(1), (2) and (3) above shall be reported to CMS by telephone, (404) 562-7435, no later than the close of business the next business day following knowledge of the persons' death. A report shall simultaneously be submitted to the Mental Health Program Office headquarters in Tallahassee, FL. The report on Agency for Healthcare Administration (AHCA) form #3031-8007 should be sent within 24 hours to the CMS regional office in Atlanta and to the AHCA office in Tallahassee.

c. All facilities will notify the Director of Mental Health Treatment Facilities within one (1) hour of knowledge of a death described in paragraph 8a.

9. Reporting Seclusion Data. Each facility will report seclusion data to the Department's designated data system monthly, no later than the 15th following the end of the reporting month. This data will be reported according to the requirements contained in Chapter 14: Seclusion and Restraint Events – SANDR (see http://www.dcf.state.fl.us/programs/samh/publications/155-2-v11-1-2/C14SANDRv11-1-2.pdf).

BY DIRECTION OF THE SECRETARY:

(Signed original copy on file)

WENDY SCOTT
Director, Policy and Programs

SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL

Routine updating with no substantive changes. In paragraph 4h, “such as” was deleted and replaced with “for example.” In addition, the term “staff safety” was added to the same paragraph.

Personal Safety Plan

Name:_____ Date:_____ Facility:_____

You can document on this form suggested calming strategies IN ADVANCE of a crisis. You can list things that are helpful when you are under stress or are upset. You can also identify things that make you angry. Staff and individuals receiving services can enter into a *"partnership of safety"* using this form as a guide to assist in your treatment plan. The information is intended only to be helpful; it will not be used for any purpose other than to help staff understand how to best work with you to maintain your safety or to collect data to establish trends. This is a tool that you can add to at any time. Information should always be available from staff members for updates or discussion. Please feel free to ask questions.

1. Calming Strategies: It is helpful for us to be aware of things that help you feel better when you're having a hard time. Please indicate five (5) activities that have worked for you, or that you believe would be the most helpful. If there are other things that work well for you that we didn't list, please add them in the box marked "Other". We may not be able to offer all of these alternatives, but we would like to work together with you to determine how we can best help you while you're here.

	Listen to music		Exercise
	Read a book		Pace in the halls
	Wrapping in a blanket		Have a hug with my consent
	Write in a journal		Drink a beverage
	Watch TV		Dark room (dimmed lights)
	Talk to staff		Medication
	Talk with peers on the unit		Read religious or spiritual material
	Call a friend or family member		Write a letter
	Voluntary time in the quiet room/comfort room		Hug a stuffed animal
	Take a shower		Do artwork (painting, drawing)
	Go for a walk with staff		Other? (Please list below)

2. What are some of the things that make you angry, very upset or cause you to go into crisis? What are your "triggers"?

	Being touched		Called names or made fun of
	Security in uniform		Being forced to do something
	Yelling		Physical force
	Loud Noise		Being isolated
	Contact with person who is upsetting		Some else lying about my behavior
	Being restrained		Being threatened

3. Signals of Distress: Please describe your warning signals, for example, what you know about yourself, and what other people may notice when you begin to lose control. Check those things that most describe you when you're getting upset. This information will be helpful so that together we can create new ways of coping with anger and stress:

	Sweating		Clenching teeth
	Crying		Not taking care of self
	Breathing hard		Running
	Yelling		Clenching fists
	Hurting others:		Swearing
	Throwing Objects		Not eating
	Pacing		Being rude
	Injuring self: (Please be specific)		Other? (Please list below)

Personal Safety Plan (page 2)

4. Preferences Regarding Gender and Others: Do you have any preferences or concerns regarding who serves you when you are upset or angry?

☐ Women staff ☐ Men staff ☐ No preference

☐ Language (specify):_____ ☐ Ethnicity (specify):_____

☐ Culture (specify):_____ ☐ Particular religion(specify):_____

5. Preferences Regarding Physical Contact: We would like to know about your preferences regarding physical contact. For example, you may not like to be touched at all or you may find it helpful to have a hug or be touched *appropriately* when you are upset.

Do you find it helpful to be hugged or touched appropriately when you are upset? ☐ Yes ☐ No

Comments:_____

6. Seclusion and Restraint: This facility is trying to eliminate the use of seclusion and restraints. Therefore, it would be helpful to know if you have ever been placed in a seclusion room or been restrained. This information will be used only for collecting data and for training purposes, not to predict any future behaviors.

Have you ever been placed in a seclusion room? ☐ Yes ☐ No

Have you ever been restrained? ☐ Yes ☐ No

7. In Extreme Emergencies: In **extreme** emergencies seclusion and restraint may be used as a last resort. Is there anything you find helpful in emergency situations that could prevent them from being used?

Alternative physical spaces such as: ☐ Comfort Room ☐ Quiet Room

Other alternatives such as: ☐ Exercise ☐ Medication by mouth ☐ Emergency injection

☐ Other:_____

8. Medical Conditions: Do you have any physical conditions, disabilities, or medical problems such as asthma, high blood pressure, back problems, etc., that we should be aware of when caring for you during an emergency situation?

_____

_____

_____

9. Helpful Medications: We may be required to give medications if other measures do not help you to calm down. In this case, we would like to know, what medications have been especially helpful to you? Please describe.

_____

_____

10. Not Helpful Medications: Are there any medications that are not helpful? What and why?

_____

_____

11. Room Checks: Room checks are done at night to make sure you are okay. In order to make room checks as non-intrusive as possible is there anything that would make room checks more comfortable for you?

_____

_____

_____

(continued on next page)

Personal Safety Plan (page 3)

12. Trauma History:

Do you have any issues regarding abuse such as sexual or physical abuse that you would like to talk about with staff, or with a counselor? ☐ Yes ☐ No

Would you like more information on these issues in classes or support groups? ☐ Yes ☐ No

13. Anything Else? Is there anything else that would make your stay easier and more comfortable? For example, do you have any special issues like cultural, diet, sexual preference, appearance, etc. that you think could contribute to misunderstandings or cause problems for you? Please describe:

The Personal Safety Form Information should be presented to the treatment team and incorporated into the treatment plan for this individual. Each individual shall receive a copy. This form has been adapted from an original form created by the Massachusetts Department of Mental Health.

See s.394.453, and 394.459(4), Florida Statutes