

CF OPERATING PROCEDURE
NO. 155-26

STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, September 15, 2021

Mental Health/Substance Abuse

SAFE AND SUPPORTIVE OBSERVATIONS OF RESIDENTS
Guidelines for Healthcare Staff in Mental Health Treatment Facilities

1. Purpose. This operating procedure describes guidelines for observing individuals who are at risk for harming themselves or others. Procedures related to seclusion and restraint are not governed by this operating procedure. For seclusion and restraint, follow the requirements in CFOP 155-53 (Suicide and Self-Injury Prevention), CFOP 155-20 (Use of Seclusion), and CFOP 155-21 (Use of Restraint).
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 464, Florida Statutes (F.S), Part I, "Nursing Practice Act."
 - b. Chapter 394, F.S., "Florida Mental Health Act."
 - c. Chapter 916, F.S., "Forensic Client Services Act."
 - d. Chapter 65E-20, Florida Administrative Code, Forensic Client Services Act Regulation.
 - e. CFOP 155-29, Management of Minimum Staffing in State Mental Health Treatment Facilities
 - f. Jennings, A. (2004), The Damaging Consequences of Violence and Trauma: Facts, Discussion Points, and Recommendations for the Behavioral Health System, Alexandria, Virginia, National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning.
 - g. Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-specific Services. National Center for Trauma-Informed Care (NCTIC). January 2008
 - h. Rule 65E-5.602, Florida Administrative Code, Rights of Residents of State Mental Health Treatment Facilities.

This operating procedure supersedes CFOP 155-26 dated February 15, 2019.

OPR: SMF

DCF Tracker Assignment Number: A21-004117.

4. Definitions. For purposes of this operating procedure, the following definitions apply:

a. Clinician. A Physician licensed pursuant to Chapter 458 or Chapter 459, F.S.; an Advanced Practice Registered Nurse (APRN) licensed pursuant to Chapter 464, F.S.; a Physician Assistant licensed pursuant to Chapter 458, F.S.; or, a Clinical Psychologist licensed pursuant to Chapter 490, F.S.

b. Clinical Risk Assessment Guide (CRAG). A guide (Appendix A to this operating procedure) which provides some basic areas to consider and report on when assessing a resident's risk of harm to self or others in the facility. The CRAG also includes some items related to medical risks. The guide is an adjunctive tool which, in some cases, may assist clinicians in developing a more broad-based review of a resident's status. The tool may also assist with tracking issues related to risk which need to be in recovery plans. The CRAG is employed at the discretion of clinicians or as directed in facility-based policy. Facilities may use their versions of clinical risk assessment instruments if their procedures are adequate to address needs of the resident.

c. Direct Care Staff. Includes all positions classified as care providers, i.e., Human Service Workers (HSW), Unit Treatment and Rehabilitation Specialists (UTRS), Therapeutic Security Technicians (TST), and Mental Health Techs (MHT). Such staff can also be referred to as Ward Staff.

d. Key Indicators. Signs or symptoms associated with, but not limited to, aggression, assault, suicidality, self-injury, homicidal ideation or behavior, arson, escape/elopement, seizures, falling, and difficulty swallowing. The indicators direct staff toward the need to implement special observation and precautions. When either suicidality or self-injury is a key indicator of concern, staff will employ CFOP 155-53, Suicide and Self-Injury Prevention.

e. Registered Nurse. Per section 464.002(22), F.S., any person licensed in Florida to practice professional nursing. This does not include a Licensed Practical Nurse.

f. Recovery Team. An assigned group of individuals with specific responsibilities identified on the recovery plan including the resident, psychiatrist, guardian/guardian advocate (if resident has a guardian/guardian advocate), community case manager, family member and other treatment professionals as determined by the resident's needs, goals, and preferences. Other treatment professionals may include, but are not limited to, psychologists, behavior analysts, and social workers.

g. Resident. A person who receives services in a state mental health treatment facility. The term is synonymous with "client", "consumer", "individual", "patient", or "person served".

h. Observation and Precautions.

(1) Observations consist of:

(a) Routine Observation (30-minute checks); and
the following special observations;

(b) 15 Minute Checks;

(c) Group Observation, up to 3 residents in line of sight;

(d) Continuous Visual Observation (CVO), resident in line of sight;

(e) One-to-One (1:1) Observation, resident within arm's reach of one sitter; and

(f) Two-to-One (2:1) Observation, resident within arm's reach of two sitters.

(2) Precautions consist of any actions needed to maintain safety during observations. Examples of precautions are:

- (a) Searching a bed area for harmful items;
- (b) Searching a resident for harmful items;
- (c) Restricting a resident to a ward/dorm/pod;
- (d) Determining the number of staff needed to observe a resident;
- (e) Establishing the proximity of staff to a resident; and,

(f) Following a Personal Safety Plan (form CF-MH 3124, available in DCF Forms) to employ calming strategies.

i. Trauma-Informed Care. Trauma-informed care is mental health treatment directed by a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on an individual, and an appreciation for the high prevalence of traumatic experiences in persons who receive mental health services. Trauma-informed care is based on an understanding of the vulnerabilities and triggers of trauma survivors that traditional service delivery approaches may not recognize and may exacerbate.

5. Levels of Observation. There are circumstances when an enhanced level of observation is warranted to ensure the safety of residents and staff. There are also times when situations may warrant a staff member leaving their assigned post to respond to an emergency. If a staff member assigned to provide special observation observes an emergency that requires immediate intervention to protect residents or staff from serious injury, they may take the necessary steps to assist and then return to their previously assigned post to continue their observation.

a. Routine Observation. This level of observation consists of visual observation which is not the result of a special written order in a resident's medical record. It involves at least thirty (30) minute face checks completed by direct care staff in settings which residents generally occupy such as bedrooms, wards, pods, restrooms, dining rooms, activity rooms, classrooms, and enclosed yards attached to buildings. Supervisors will ensure that staff members are vigilant and aware of each resident's whereabouts and status. Exceptions for some residents occur at times as they accept greater responsibilities, gain unrestricted grounds access, and have time away from routine observation. Each facility will maintain Residential Area Coverage Sheets (Appendix B to this operating procedure or equivalent documents) daily.

b. 15 Minute Check. This level of observation requires staff to monitor and document a resident's condition, location, and/or behavior every 15 minutes. This level of observation must be reviewed and renewed at least every seven (7) days.

c. Group Observation (GO). This level of observation requires a staff member to remain within visual contact of up to three (3) designated residents for the physical, medical, emotional or security needs of the residents to be met. The assigned staff will maintain visual contact with the assigned residents at all times. If a resident needs to separate from the group observation, additional staff assistance will be required to maintain the observation. Documentation of behavior, activity, and location is required every 15 minutes. Authorization for GO is by clinician order as defined in this operating procedure. This level of observation must be reviewed and renewed at least every seven (7) days.

d. Continuous Visual Observation (CVO). This level of observation requires that staff watch a resident and document condition, location, and/or behavior every 15 minutes. The resident is continually watched. CVO will occur in settings residents generally occupy such as bedrooms, wards, pods, restrooms, dining rooms, activity rooms, classrooms, and enclosed yards attached to buildings. CVO consists of visual observation which is the result of a special written order in a resident's medical record. Supervisors will ensure that staff members are vigilant and aware of each resident's whereabouts and status. Authorization for CVO is by clinician order as defined in this operating procedure. This level of observation must be reviewed and renewed at least every seven (7) days and include a face-to-face examination by a clinician. The clinician and/or Registered Nurse will document the justification for continuation or discontinuation of an order.

e. One-to-One (1:1) Observation. This level of observation requires one staff member to maintain uninterrupted visual contact of a resident while remaining within arm's length at all times, unless within arm's length creates a danger to staff members or is not therapeutic for the resident, in which case the order may indicate a variance from this requirement. If it is determined by a clinician that "within arm's length" creates a danger to staff members or is not therapeutic for the resident, the clinician may write an order indicating a variance from this requirement. One-to-one observation requires documentation at least every 15 minutes. Authorization for One-to-One Observation is by clinician order as defined in this operating procedure. This level of observation must be reviewed and renewed at least every 24 hours and include a face-to-face examination by a clinician and/or Registered Nurse, who will document justification for continuation or discontinuation of an order.

f. Two-to-One (2:1) Observation. This level of observation requires two staff members to maintain uninterrupted visual contact of a resident while remaining within arm's length at all times, unless within arm's length creates a danger to staff members or is not therapeutic for the resident, in which case the order may indicate a variance from this requirement. If it is determined by a clinician that "within arm's length" creates a danger to staff members or is not therapeutic for the resident, the clinician may write an order indicating a variance from this requirement. Two-to-One observation requires documentation at least every 15 minutes. Authorization for Two-to-One observation is from a clinician as defined in this operating procedure. This level of observation must be reviewed and renewed at least every 24 hours and include a face-to-face examination by a clinician and/or Registered Nurse, who will document justification for continuation or discontinuation of an order.

6. Trauma-Informed Care. All direct care staff and treatment professionals will be trained in Trauma-Informed Care. Staff will review each resident's Personal Safety Plan (form CF-MH 3124, available in DCF Forms) in his or her assigned area. Staff will work to reduce trauma when employing alternative solutions for residents in crisis or in potentially harmful situations. Staff will use calming strategies and avoid triggers when possible, as indicated on the Personal Safety Plan, when residents are in danger of harming themselves or others. Staff will encourage residents at risk to participate in evidence-based and promising practices to increase skills for self-modulation of emotions.

7. Key Indicators of the Need to Employ Special Observation and Precautions. Key indicators that special observation and precautions may be needed include but are not limited to:

a. Suicidal/Self-Abuse. Residents who display or who have a significant potential for suicidal or self-injurious behavior. When either suicidality or self-injury is a key indicator of concern, staff may employ CFOP 155-53, Suicide and Self-Injury Prevention, for assessments.

b. Homicidal/Assaultive. Residents who display or who have a significant potential for assaultive behavior toward others.

c. Arson. Residents who threaten to or have deliberately attempted to set fires.

d. Escape/Elopement. Residents who have significant potential for leaving hospital grounds without authorization.

e. Medical. Residents who have significant medical problems which require special monitoring and documentation (e.g., seizures, choking, falling, special diets, grabbing food from others, excessive drinking of fluids, interfering with medically necessary treatments such as IVs or PEG Tubes, etc.).

8. Assessment of Risk and Orders for Special Observation and Precautions.

a. Clinicians may order observation and precautions for individuals who are estimated to be at increased levels of risk to demonstrate harm against themselves or others. Orders for observation may also be related to the collection of information for diagnostic purposes. Observation and precautions may be ordered for medical, psychiatric, or behavioral concerns following a face-to-face examination. Orders for special observations and precautions are generally provided after a clinical assessment, and to the extent possible, assessment should involve members of the recovery team.

b. If a situation exists where special observation and precautions must be initiated, renewed or discontinued after hours, during the weekend or on state approved holidays, a Registered Nurse may, after a face-to-face assessment, seek verbal authorization from a clinician. All verbal authorizations (orders) must be signed by a clinician within 48 hours or the next business day.

c. All written orders for special observation and precautions, at a minimum, shall:

- (1) Identify and describe key indicators or other problems;
- (2) Delineate type of observation and precautions needed to maintain safety;
- (3) List evaluation or treatment goals aimed at lifting the observation and precautions;
- (4) Include the time limit of the order; and,
- (5) Include signature, credentials, date, and time.

d. At the end of the specified duration, a new order must be written to continue the special observation and precautions (if continuation is warranted). The order itself includes justification for the decision to continue the special observations and precautions. Separate notes are not needed. A Registered Nurse can do the face-to-face assessment in communication with a clinician to discontinue the order and document evidence of the resident's improvement in a progress note.

e. Observers will use either the Clinical Observation Progress Note sheet in Appendix C to this operating procedure or the Special Observation Flow Sheet in Appendix D to this operating procedure, or equivalent documents in accordance with facility procedures.

9. Longer-Term Use of Special Observation or Precautions. In rare cases where an individual requires observation on a longer term or chronic basis (defined as two months or longer) to ensure safety of the individual or others, an order for longer-term observation may be written. Before implementation, the Medical Executive Director or designee of the facility must approve this intervention. This intervention must be part of the recovery plan and must be reviewed by the recovery team on a weekly basis. Once implemented, the clinician's order must be renewed on a weekly basis.

10. Discipline Responsibilities for Special Observation and Special Precautions.

a. Responsibilities of Clinicians and Registered Nurses.

- (1) Assess and evaluate the status of residents' risk to self or others.
- (2) Assess and evaluate the resident for need to implement, continue, or discontinue special observation and precautions.
- (3) Clinicians sign orders to initiate, continue, or discontinue special observations and precautions, in consultation with Registered Nurses (RNs).
- (4) RNs and/or clinicians conduct face-to-face examinations within the frequency required by the observation or precaution.
- (5) RNs and/or clinicians document justification for initiation, continuation, or discontinuation of an order.
- (6) RNs notify the Recovery Team leader of the resident's status.

b. Additional Responsibilities of Registered Nurses.

- (1) Evaluate and document the resident's behavior and/or condition on initiation of special observations and at minimum each shift, while the resident is on any special observations as defined in this operating procedure.
- (2) Notify the clinician of any changes in behavior and/or health status of the resident as the resident's condition warrants.

c. Direct Care Staff Responsibilities.

- (1) Observe the resident for changes in behavior and/or condition.
- (2) Immediately report any worsening of a resident's behavior and/or condition to the unit nurse or the most senior recovery team member available.
- (3) Document observations as instructed by the unit nurse or superior.
- (4) Report changes, interventions, or preventative measures utilized during each change of shift report.

d. Recovery/Treatment Team Responsibilities.

- (1) Meet with residents who are on special observation or precautions; assess the need for continuation; and document the review in the clinical record.
- (2) During normal business hours, the recovery team leader shall notify members of the Team of the resident's status. The team will decide whether to meet with the resident to determine any additional needs for individualized treatment planning.
- (3) A designated treatment team member will ensure that the resident's Personal Safety Plan is complete and up-to-date.

BY DIRECTION OF THE SECRETARY:

(Signed original copy on file)

JACQUELINE A. YOUNG
Director, State Mental Health Treatment Facilities, Policy and Programs

SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL

Addition of a reference; addition of the words dorm and pod to 4h(2)(c); grammatical editing; and changed word ADDRESSOGRAPH to read DEMOGRAPHIC INFORMATION on attachments.

RESIDENT'S NAME & IDENTIFICATION NUMBER:

CLINICAL RISK ASSESSMENT WORKSHEET: Use each block below to document support for ratings of low, medium, or high

1. **RISK FOR INTERPERSONAL VIOLENCE:**
 Use HCR results if available; if not, complete B & C Source: ___Records ___Interview ___Both

A. Refer to HCR-20 dated: _____, or

B. Mark the following 7 items as "Present" or "Absent": ___ Irritability, ___ Impulsivity, ___ Unwillingness to follow directions, ___ Sensitivity to perceived provocation, ___ Easily angered when requests are denied, ___ Negative attitudes, ___ Verbal threats
 (Dynamic Appraisal of Situational Aggression, 2006) Count number of "P"s. Zero suggests the risk of violence over next 24 hrs is very low, 1-3 suggest that the risk is moderate, 4 or more suggest that risk is high, 6 - 7 suggest that risk may be imminent, and:

C. Consider & describe below other potential contributors (e.g., hx of physical injury to others, hx of exploitation/predation, homicide ideation past/present, Axis I symptom prompts such as command hallucinations, hx of instrumental/proactive aggression, hx of reactive/defensive aggression, threats/intimidation, property destruction) or any Protective Conditions/Strengths:

2. **RISK FOR SUICIDE:** Complete all four categories Source: ___Records ___Interview ___Both

A. Key factor: ___ Lifetime history of 2 or more suicide attempts with intent to die (Dates, or age at time: _____) *and* Circumstances:
 Person's perspective on outcomes of past attempts:

B. Static/stable/enduring factors (check all that apply): ___ History of self harm; ___ Seriousness of perceived suicidality; ___ Previous hospitalization; ___ History of mental disorder (esp. schizophrenia, mood, or eating disorder); ___ History of substance use disorder; ___ Personality disorder/traits (esp. borderline pd); ___ Childhood adversity; ___ Family history of suicide; ___ Age/gender/marital (older, male, single elevates risk) *and*

C. Dynamic risk factors (check all that apply): ___ Lifetime Hx of one attempt with intent to die; ___ Suicide thoughts (___ none ___ weekly ___ daily) (___ past 24 hrs ___ past week ___ past year ___ lifetime); ___ Suicide plans (___ access to preferred means – if checked, describe: _____); ___ Suicide intent (___ strong ___ weak ___ fluctuating); ___ Perception of being a burden; ___ Perception of not belonging/not contributing; ___ Hopeless/trapped; ___ Active psychological symptoms; ___ Treatment adherence; ___ Psychosocial stress; ___ Problem-solving deficits; ___ Impulse control deficits *and*

D. Protective conditions and strengths: ___ Religious/spiritual beliefs; ___ Social connection; ___ Willing to communicate; ___ Willing to learn/use coping behaviors

3. **RISK FOR NON-SUICIDAL SELF-INJURY:** Check all that apply Source: ___Records ___Interview ___Both
 ___ History of self-injury: If checked, describe frequency/severity/types:
 ___ Personality disorder dx; ___ command hallucinations ___ responsive to peer influence; ___ responsive to cultural or setting norms
 ___ Protective conditions and strengths:

4. **RISK FOR ESCAPE/ELOPEMENT:** Check all that apply Source: ___Records ___Interview ___Both
 ___ History of escape/elopement/absconding. Describe:
 ___ Precursor behaviors (e.g., escape tools, hiding, attempts, rehearsals, threat, plan, ideation, perceived need to get away). Describe:

5. **RISK FOR VULNERABILITY TO HARM OR EXPLOITATION:** Check all that apply. Add others if applicable.

- Impaired cognition that affects orientation, sense of time, sense of location, or awareness of safety hazards;
- Active symptoms that affect judgment and impulse control; Significant trauma history; Potential for repeat victimization; Physical disabilities; Potential for falls/fractures; Limited control of seizures; Limited blood glucose control; Heightened risk for allergic reaction or infection; Potential for choking/aspiration;
- Decreased alertness and response time; Other:

Describe:

6. **RISK FOR BEHAVIOR THAT ALTERS SAFETY OF THE ENVIRONMENT:** Check all that apply. Add others if applicable.

- Property destruction history; Potential for non-compliance with medical precautions; Potential for sexual predation; Potential to access contraband/weapons/substances; Documented pattern of noncompliance with written rules of living environment

(Note: Limitation on grounds access in civil units cannot be based solely on minor behavior or contraband violations irrelevant to safety and security.)

Describe:

*****CONFIDENTIAL & PRIVILEGED INFORMATION*****

<p>Florida Department of Children and Families Mental Health Treatment Facilities</p> <p>SPECIAL OBSERVATION FLOW SHEET Document Every 15 Minutes</p> <p>Date: _____</p>	<p>DEMOGRAPHIC INFORMATION</p> <p>NAME: RESIDENT NUMBER: DOB: DOA: FACILITY: UNIT: WARD OR POD:</p>
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Check Level of Observation: Continuous Visual Observation (CVO) @ _____ am/pm; One-to-One @ _____ am/pm;

One-to-One with Additional CVO Coverage @ _____ am/pm; Two-to-One Observation @ _____ am/pm

Check Reason for Special Level of Observation: Elopement/Escape Sexual Precautions Suicidal Precautions Falls Withdrawal

Seizure Assaultive/Combative/Violent Behavior Other (Specify) _____

Serious Medical Condition: Identify: _____

TIME 12M-5:59A		STAFF INITIALS	SUPERVISORY MONITORING	TIME 6A-11:59A		STAFF INITIALS	SUPERVISORY MONITORING	TIME 12N-5:59P		STAFF INITIALS	SUPERVISORY MONITORING	TIME 6P-11:59P		STAFF INITIALS	SUPERVISORY MONITORING
CODES				CODES				CODES				CODES			
12:00-12:14				6:00-6:14				12:00-12:14				6:00-6:14			
12:15-12:29				6:15-6:29				12:15-12:29				6:15-6:29			
12:30-12:44				6:30-6:44				12:30-12:44				6:30-6:44			
12:45-12:59				6:45-6:59				12:45-12:59				6:45-6:59			
1:00-1:14				7:00-7:14				1:00-1:14				7:00-7:14			
1:15-1:29				7:15-7:29				1:15-1:29				7:15-7:29			
1:30-1:44				7:30-7:44				1:30-1:44				7:30-7:44			
1:45-1:59				7:45-7:59				1:45-1:59				7:45-7:59			
2:00-2:14				8:00-8:14				2:00-2:14				8:00-8:14			
2:15-2:29				8:15-8:29				2:15-2:29				8:15-8:29			
2:30-2:44				8:30-8:44				2:30-2:44				8:30-8:44			
2:45-2:49				8:45-8:59				2:45-2:49				8:45-8:59			
3:00-3:14				9:00-9:14				3:00-3:14				9:00-9:14			
3:15-3:29				9:15-9:29				3:15-3:29				9:15-9:29			
3:30-3:44				9:30-9:44				3:30-3:44				9:30-9:44			
3:45-3:59				9:45-9:59				3:45-3:59				9:45-9:59			
4:00-4:14				10:00-10:14				4:00-4:14				10:00-10:14			
4:15-4:29				10:15-10:29				4:15-4:29				10:15-10:29			
4:30-4:44				10:30-10:44				4:30-4:44				10:30-10:44			
4:45-4:59				10:45-10:59				4:45-4:59				10:45-10:59			
5:00-5:14				11:00-11:14				5:00-5:14				11:00-11:14			
5:15-5:29				11:15-11:29				5:15-5:29				11:15-11:29			
5:30-5:44				11:30-11:44				5:30-5:44				11:30-11:44			
5:45-5:59				11:45-11:59				5:45-5:59				11:45-11:59			

CODE EXPLANATION (Must include the individual's location/activity and behavior/general status) List at least one code from each category:

Location/Activity

- 1. Sitting
- 2. Standing
- 3. Resting
- 4. Sleeping
- 5. Talking
- 6. Reading
- 7. Writing
- 8. Watching TV
- 9. On Phone
- 10. With Physician
- 11. With Therapist
- 12. With Nurse
- 13. With Rehab
- 14. Team
- 15. Group
- 16. Meds
- 17. Personal Room
- 18. Dayroom
- 19. Hallway
- 20. Bathroom
- 21. Laundry
- 22. Fresh Air
- 23. Lobby
- 24. Meal on Unit
- 25. Meal off Unit
- 26. Gym
- 27. Quiet Time
- 28. Seclusion
- 29. Restraints
- 30. Appointment
- 31. Visitors
- 32. Tx Mall
- 33. Off Unit with Staff
- 34. On Unit Activities

- 35. Outside Activities
- 36. Snacks
- 37. Eating
- 38. Walking
- 39. With UTRS or MHT
- 40. Bathing
- 41. School/Work Therapy

If individual is off unit while on Line-of-Sight or One-to-One Obs., FLOW SHEET must accompany the individual.

Behavior/General Status

- A. Agitated
- B. Angry
- C. Anxious
- D. Apologetic
- E. Assaultive
- F. Calm
- G. Cooperative
- H. Crying
- I. Demanding
- J. Guilty Thoughts/Feelings
- K. Happy
- L. Hearing Voices
- M. Hyperactive
- N. Interacting with Others
- O. Isolating Self
- P. Intrusive
- Q. Pacing
- R. Paranoid
- S. Resting
- T. Restless
- U. Seeing Things
- V. Self-Harm
- W. Self-Harm Thoughts/Feelings
- X. Uncooperative
- Y. Ventilating Feelings
- Z. Withdrawn

TRANSFER OF INDIVIDUAL RESPONSIBILITY

STAFF INITIAL TRANSFER FROM:	STAFF INITIAL TRANSFER TO:	TIME	NURSE DESIGNEE APPROVAL	CODE*	STAFF INITIAL TRANSFER FROM:	STAFF INITIAL TRANSFER TO:	TIME	NURSE DESIGNEE APPROVAL	CODE*

*Code: 1 = Break 2 = Reassignment during Shift 3 = Change of Shift

Initials

Full Signature

Title

Resident's Name: _____

Hospital Number: _____