



**Connecticut Valley Hospital  
Nursing Policy and Procedure**

**SECTION B: THE NURSING PROCESS  
CHAPTER 6: ADMISSION, NURSING  
ASSESSMENT, NURSING REASSESSMENT**

**POLICY AND PROCEDURE 6.2.4: PATIENT  
PERSONAL SAFETY PREFERENCE**

Authorization:  
Nursing Executive Committee

Date Effective: May 1, 2018  
Scope: Connecticut Valley Hospital

**Standard of Practice:**

The RN will review and document with each patient his/her Personal Safety Preferences within 24 hours of admission, annually, and with a significant change in condition.

**Standard of Care:**

The patient can expect to have his/her personal preferences incorporated in his/her care. The patient will discuss his/her Personal Safety Preferences with a RN within 24 hours of admission, annually, and with a change in condition.

**Policy:**

The Patient Personal Safety Preference Form is intended to assist the patient and the treatment team to plan for safe and therapeutic interventions based on a collaborative approach between the RN and the patient. It is to be utilized in planning the patient's care as a treatment planning tool, whenever the patient requests a modification, has a significant change in condition, or requires psychiatric intervention.

**Procedure:**

**I. Nursing Assessment**

1. The RN collaborates with the patient during the Nursing Assessment and Annual Reassessment to document the patient's Personal Safety Preferences (CVH-171, Section F and CVH-171a). This is completed within 24 hours of admission. If the patient is unable to complete, the assigned nurse should address weekly and complete as soon as the patient is able to cooperate.
2. In collaboration with the treatment team, the RN ensures that the patient's personal preferences are included in the Patient's Plan of Care.
3. The RN modifies the patient's Personal Safety Preferences by initiating a new CVH-469 form whenever the patient requests a modification in his/her preferences.

**II. Psychiatric Intervention**

1. The RN ensures that the patient's personal preferences are utilized during efforts to engage the patient in problem-solving, conflict resolution and de-escalation as necessary.

2. If Seclusion/Restraint intervention occurs, the RN discusses personal preferences with the patient and updates form CVH-469 as indicated during the patient debriefing.
3. The RN ensures that the patient's personal safety preferences are included for review during a Focus Treatment Plan Review following a restraint or seclusion episode.
4. When a patient is placed on continuous or one-to-one observation, the RN uses the Special Observation Communication Sheet to provide information on the patient's preferences to the staff member assigned to monitor the patient.
5. The RN ensures that the patient's personal preferences are brought in for review during the Focus Treatment Plan Review following continuous or one-to-one observation.

### **III. Filing**

1. All revisions of CVH-469 will be filed in chronological order as the last document in the Assessment section of the chart.

### **IV. Exception**

In the Addiction Services Division, due to the low incidence of seclusion and/or restraint intervention, CVH-469 will be completed on an individual patient basis depending on the patient's history, presenting behavior, and behavior of the patient during the course of hospitalization.