

**CONNECTICUT VALLEY HOSPITAL
NURSING ASSESSMENT SUPPLEMENT
PERSONAL SAFETY PREFERENCES FORM**

[] General Psychiatry Division
[] Addiction Services Division

Name _____

MPI# _____ *Print or Addressograph Imprint*

1. While you are a patient at Connecticut Valley Hospital, the staff wants to work with you to provide a safe and comfortable environment for your treatment. In order to do this, we would like to know what you think will help when you are not feeling well or are having a hard time. We may not be able to offer these alternatives under certain circumstances, but we would like to work together to figure out how we can best help you while you are here.

Have any of the following ever worked for you? (*Check all that apply*)

Voluntary quiet time in your room		Drawing	
Voluntary quiet time in the quiet room		Molding some clay	
Resting/napping		Sitting by the nurse's station	
Lying down with a cold face cloth		Watching TV	
Wrapping up in a blanket		Talking to your Primary Nurse Clinician	
Deep breathing exercises		Calling your therapist	
Additional/extra medication		Talking with staff	
A warm or cool drink		Talking with another patient	
Eating something		Talking with a Chaplain	
Taking a hot shower		Calling a friend or family member	
Reading a newspaper, magazine or book		Pacing the halls	
Listening to music		Going for a walk with staff	
Writing a diary/journal/letter		Exercise	
Other (<i>please list</i>):			

2. What are some of the things that make it more difficult for you when you are already upset? Are there particular situations/things/events that you know will cause you to become more upset? (*Check all that apply*)

Being touched		Boredom/lack of activities	
Bedroom door being open		Seeing people in uniforms	
People staring at me		Loud noise	
Not being able to express my opinion		Yelling	
Being criticized		Noise in general	
Being isolated/alone		Particular time of the day (<i>when?</i>):	
Lack of staff availability/attention		Particular time of the year (<i>when?</i>):	
Not having input (<i>explain</i>):			
Other (<i>please list</i>):			

People who are helpful to me are (*please list*): _____

People who are not helpful to me are (*please list*): _____

3 Have you ever been physically/mechanically restrained? [] No [] Yes

If Yes: When? _____

Where? _____

What happened? _____

Have you ever been chemically (with medications) restrained? [] No [] Yes

If Yes: When? _____

Where? _____

What happened? _____

4. We try to provide the safest environment possible without physical violence, but we realize that some people lose control. If you are in danger of hurting yourself or someone else, we will need to use additional interventions to make sure that everybody is safe which may include physical restraint.

We may not be able to offer you these alternatives; but if it becomes necessary, what interventions have been helpful to you in the past? (*Check all that apply*)

Talking to staff		Seclusion room (<i>unlocked door</i>)	
Quiet time in my room		Seclusion room (<i>locked door</i>)	
Quiet time in the quiet room		4 point restraint to the bed	
Time out in the time out room		2 point ambulatory restraint (<i>hands restrained</i>)	
Additional/extra medication		2 point restraint to waist belt (<i>hands & arms restrained to waist</i>)	
Other (<i>please list</i>): _____		4 point ambulatory restraint (<i>arms & legs restrained</i>)	

5. If we need to administer medication along with physical restraint, is there any medication that has been particularly helpful for you? (*please list*) _____

COMMENTS: _____

[] Patient unable to participate

[] Patient refused to participate

RN Signature _____ Date _____