

WHITING FORENSIC 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

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 (WFH-171, Section F and WFH-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 WFH-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 WFH-469 as indicated during the patient debriefing.
3. The RN ensures that the patients 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 WFH-469 will be filed in chronological order as the last document in the Assessment section of the chart.

IV. Exception
WFH