

THE SAFETY TOOL
The Massachusetts Department of Mental Health

Client Name _____ Date _____

Do you have a history of:

- | | | |
|--|---|---|
| <input type="checkbox"/> losing control | <input type="checkbox"/> feeling unsafe | <input type="checkbox"/> restraint or seclusion |
| <input type="checkbox"/> assaultive behavior | <input type="checkbox"/> history of trauma | <input type="checkbox"/> self injurious behaviors |
| <input type="checkbox"/> suicidality | <input type="checkbox"/> history of incarceration | |

Describe _____

Staff: Interview patient using tool or provide to patient depending on pt. preference

What are some of the things that

make it more difficult for you when you're already upset?

Are there particular "triggers" that will cause you to escalate?

Being touched	Being isolated	
Bedroom door open	People in uniform	
Particular time of day (when?)	Time of year (when?)	
Loud noise	Yelling	
Not having control/input (explain)	Being around men, women (which?)	
Other: (please list)		

It is important to consider what things might help you to feel better when you are having a hard time and think you might lose control. These are some possible suggestions. We may not be able to offer all of these choices but we would like to work together to figure out how we can best help.

Voluntary time out in your room	Reading (what?)	
Voluntary time out in the quiet room	Watching TV	
Sitting by the nurses station	Pacing the halls	
Talking with another patient	Calling a friend	
Talking with staff	Exercise	
Punching a pillow	Putting hands in cold water	
Writing in a diary/journal	Putting ice on wrists	
Deep breathing exercises	Writing on arm with red marker	
Wrapping up in a blanket	Lying down with cold face cloth	
Listening to music	Other: please list	
Going for a walk with staff (if privileges allow)		

IF PATIENT IS RESTRAINED DURING HOSPITALIZATION, REVIEW TOOL & USE THE PATIENT COMMENT FORM TO REASSESS FOR NEW TRIGGERS AND COPING STRATEGIES

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Have you ever been restrained in a hospital or other setting?
 IF PATIENT IS AT RISK OF RESTRAINT:

	Physically/Mechanically	Chemically
<i>When?</i>		
<i>Where?</i>		
<i>What happened?</i>		

Inform patient of the organization's policy on restraint/seclusion (check) yes no

If you are in danger of hurting yourself or someone else, we may need to use a physical (holding), mechanical (restraining you to a bed), or chemical (giving you medication to calm you down). We may not be able to offer you all of these but we would like to know what you would prefer.

Is there anything that would be helpful to you during a restraint? For ex., gender of staff, talking to someone

Quiet room or area		Open door seclusion	
Closed door seclusion		Chemical restraint	
Walking leg Walking wrist		Hand mittens	
4 point restraint			

during restraint, other. Describe.

We may be required to give you medication if physical restraints aren't calming you down. Would you like to discuss what medication you might prefer with your doctor? (Y/N)

If person engages in serious ongoing self-injurious behaviors (cutting, banging, biting, burning, swallowing objects), refer to team psychologist for extended plan.

Medical conditions or physical disabilities that might place person at greater risk:

Comments/Additions:

 Date

 Patient Signature

 Staff Signature

INCORPORATE INTO THE TREATMENT PLAN
 GIVE COPY OF TOOL TO THE PATIENT