Cooley Dickinson Hospital

Personal Safety Tool

CDH # 431 Rev. 7/06

Date: _____

Our Mission

Our mission is to create a person-centered system of care that is directed by the principles of recovery & trauma informed care. These principles help create an environment that is free from violence and coercion facilitating increased safety and resiliency throughout the hospital admission and upon return to the community.

Please take a moment to complete the following questionnaire. This information will help us to better understand your unique needs and to provide you with the best possible care.

Triggers: What are some of the things that make you angry, very upset or cause you to go into crisis?

- ☐ Being touched
- ☐ People in uniform
- ☐ Yelling
- ☐ Bedroom door open
- ☐ Darkness
- ☐ Sudden movements
- ☐ Being restrained
- ☐ Auditory and/or visual hallucinations
- ☐ Being ignored/Not listened to
- ☐ Being around men/women (which?)_____
- ☐ Loud noise: _____
- ☐ Particular time of day_____
- ☐ Being isolated
- ☐ Time of year (When?)_____
- ☐ Being threatened
- ☐ Not having control/choices/input (Explain) _____
- ☐ Contact with family or person who is upsetting (Who?)_____
- ☐ Nightmares/distressing thoughts at night. If so, what? _____
- ☐ Other_____

Warning Signs: What are your warning signs when you feel you may lose control?

- ☐ Sweating
- ☐ Crying
- ☐ Being Rude
- ☐ Loud Voice
- ☐ Clenching fists
- ☐ Wringing hands
- ☐ Singing inappropriately
- ☐ Laughing Loudly/Giddy
- ☐ Pacing
- ☐ Rocking
- ☐ Swearing
- ☐ Can't Sit Still
- ☐ Having bad thoughts about myself or others
- ☐ Other:_____

Crisis Prevention Strategies:

It is helpful for us to be aware of things that help you feel better when you are having a hard time. Please indicate if any of the following have ever worked for you.

- ☐ Listen to music
- ☐ Relaxation tapes
- ☐ Warm or cold drink
- ☐ Sound machines
- ☐ Writing a letter
- ☐ Reading (What?)_____
- ☐ Rocking chair/glider
- ☐ Voluntary time in the quiet room
- ☐ Bean bag tapping/brushing
- ☐ Lying down with cold face cloth
- ☐ Wrap up tight with sheet/thin blanket
- ☐ Doing artwork (painting, drawing)
- ☐ Voluntary time in room
- ☐ Pacing in the halls
- ☐ Dark room (dimmed lights)
- ☐ Talking to staff
- ☐ Medication
- ☐ Talking with peers on unit
- ☐ Aromatherapy
- ☐ Calling a friend/family member
- ☐ Hot balls/sour candy
- ☐ Putting hands in cold water
- ☐ Voluntary time in sensory room with staff
- ☐ Deep breathing/mindfulness exercises
- ☐ Using ice (How?)_____
- ☐ Other? (Please list)_____
- ☐ Writing in a journal
- ☐ Exercise
- ☐ Watching TV
- ☐ Use of clay
- ☐ Stress Ball
- ☐ Hugging a pillow
- ☐ A hot/cold shower
- ☐ Weighted blanket/vest
- ☐ Pet Therapy

Medical Conditions:

Do you have any physical conditions, disabilities, or medical problems such as asthma, high blood pressure, back problems, etc. that we should be aware of when caring for you during an emergency situation?
☐ Yes ☐ No Explain if yes: _____
_____

Trauma History:

Do you have a history of sexual abuse or other type of trauma, in childhood? ☐Yes ☐ No
Or as an adult? ☐Yes ☐ No Is abuse still occurring now? _____
What type(s) of abuse or trauma have you experienced? ☐Sexual ☐Emotional abuse ☐Physical abuse
☐War ☐ Incarceration ☐Other? _____
Describe briefly (if able to):_____

Do you have a history of:

☐ Losing control ☐ Feeling unsafe ☐ Suicidality ☐ Self injurious behaviors
☐ Assaultive behavior ☐ Abusive towards other people ☐ Restraint or seclusion
Describe: _____

Seclusion and Restraint:

Have you ever been placed in a seclusion room? ☐ Yes ☐ No
Have you ever been restrained? ☐Yes ☐No If yes? When_____Where?_____
What Happened? _____
Have you ever been given medication as an injection that was forced on you? ☐ Yes ☐ No
If yes? When?_____Where?_____
What happened?_____

In Extreme Emergencies:

How can you help us avoid restraint/seclusion? _____
_____
In emergencies, some things that are utilized include: ☐Sensory room ☐Quiet room ☐Your room
☐Weighted blanket ☐Aromatherapy ☐Talking to staff ☐Medication by mouth
☐Emergency injection ☐Other: _____

Medications:

We may be required to give medications if other measures do not help you to remain safe and in control. In this case, we would like to know what medications have been especially helpful to you. Please describe:
_____
_____

Are there any medications that are not helpful? ☐Yes ☐No If yes, why were the medications not helpful?
_____
Is there anything else that would make your hospitalization better? _____
_____

_____ _____ _____
PATIENT SIGNATURE STAFF SIGNATURE DATE

If not completed on admit, why? _____ Date/Time: _____