SAFE AND SUPPORTIVE OBSERVATIONS OF RESIDENTS
Guidelines for Healthcare Staff in Mental Health Treatment Facilities

1. **Purpose.** This operating procedure describes guidelines for observing individuals who are at risk for harming themselves or others. Procedures related to seclusion and restraint are not governed by this operating procedure. For seclusion and restraint, follow the requirements in CFOP 155-53 (Suicide and Self-Injury Prevention), CFOP 155-20 (Use of Seclusion), and CFOP 155-21 (Use of Restraint).

2. **Scope.** This operating procedure applies to:
   
   a. Residents hospitalized in state mental health treatment facilities, whether operated by the Department of Children and Families or private entities; and,

   b. At the Florida Civil Commitment Center:
      
      (1) Those residents housed on the Residential Mental Health Units;

      (2) Any resident evaluated by a psychiatrist as meeting criteria for Residential Mental Health but not yet housed on the unit; and,

      (3) Any resident who has been evaluated by a psychiatrist as being an imminent danger to self or others and the behavior is secondary to a mental health disorder/mental health crisis.

3. **References.**


   b. Chapter 394, F.S., “Florida Mental Health Act.”

   c. Chapter 916, F.S., “Forensic Client Services Act.”

   d. Chapter 65E-20, Florida Administrative Code, Forensic Client Services Act Regulation.

   e. CFOP 155-29, Management of Minimum Staffing in State Mental Health Treatment Facilities.


   g. Rule 65E-5.602, Florida Administrative Code, Rights of Residents of State Mental Health Treatment Facilities.
4. **Definitions.** For purposes of this operating procedure, the following definitions apply:

a. **Clinician.** A Physician licensed pursuant to Chapter 458 or Chapter 459, F.S.; an Advanced Practice Registered Nurse (APRN) licensed pursuant to Chapter 464, F.S.; a Physician Assistant licensed pursuant to Chapter 458, F.S.; or, a Clinical Psychologist licensed pursuant to Chapter 490, F.S.

b. **Clinical Risk Assessment Guide (CRAG).** A guide (Appendix A to this operating procedure) which provides some basic areas to consider and report on when assessing a resident’s risk of harm to self or others in the facility. The CRAG also includes some items related to medical risks. The guide is an adjunctive tool which, in some cases, may assist clinicians in developing a more broad-based review of a resident’s status. The tool may also assist with tracking issues related to risk which need to be in recovery plans. The CRAG is employed at the discretion of clinicians or as directed in facility-based policy. Facilities may use their versions of clinical risk assessment instruments if their procedures are adequate to address needs of the resident.

c. **Direct Care Staff.** Includes all positions classified as care providers, i.e., Human Service Workers (HSW), Unit Treatment and Rehabilitation Specialists (UTRS), Therapeutic Security Technicians (TST), and Mental Health Techs (MHT). Such staff can also be referred to as Ward Staff.

d. **Key Indicators.** Signs or symptoms associated with, but not limited to, aggression, assault, suicidality, self-injury, homicidal ideation or behavior, arson, escape/elopement, seizures, falling, and difficulty swallowing. The indicators direct staff toward the need to implement special observation and precautions. When either suicidality or self-injury is a key indicator of concern, staff will employ CFOP 155-53, Suicide and Self-Injury Prevention.

e. **Registered Nurse.** Per section 464.002(22), F.S., any person licensed in Florida to practice professional nursing. This does not include a Licensed Practical Nurse.

f. **Recovery Team.** An assigned group of individuals with specific responsibilities identified on the recovery plan including the resident, psychiatrist, guardian/guardian advocate (if resident has a guardian/guardian advocate), community case manager, family member and other treatment professionals as determined by the resident’s needs, goals, and preferences. Other treatment professionals may include, but are not limited to, psychologists, behavior analysts, and social workers.

g. **Resident.** A person who receives services in a state mental health treatment facility. The term is synonymous with “client”, “consumer”, “individual”, “patient”, or “person served”.

h. **Observation and Precautions.**

   (1) Observations consist of:

   (a) Routine Observation (30 minute checks); and

   the following special observations;

   (b) 15 Minute Checks;

   (c) Group Observation, up to 3 residents in line of sight;

   (d) Continuous Visual Observation (CVO), resident in line of sight;

   (e) One-to-One (1:1) Observation, resident within arm’s reach of one sitter; and

   (f) Two-to-One (2:1) Observation, resident within arm’s reach of two sitters.
(2) Precautions consist of any actions needed to maintain safety during observations. Examples of precautions are:

(a) Searching a bed area for harmful items;
(b) Searching a resident for harmful items;
(c) Restricting a resident to a ward;
(d) Determining the number of staff needed to observe a resident;
(e) Establishing the proximity of staff to a resident; and,
(f) Following a Personal Safety Plan (form CF-MH 3124, available in DCF Forms) to employ calming strategies.

i. Trauma-Informed Care. Trauma-informed care is mental health treatment directed by a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on an individual, and an appreciation for the high prevalence of traumatic experiences in persons who receive mental health services. Trauma-informed care is based on an understanding of the vulnerabilities and triggers of trauma survivors that traditional service delivery approaches may not recognize and may exacerbate.

5. Levels of Observation. There are circumstances when an enhanced level of observation is warranted to ensure the safety of residents and staff. There are also times when situations may warrant a staff member leaving their assigned post to respond to an emergency. If a staff member assigned to provide special observation observes an emergency that requires immediate intervention to protect residents or staff from serious injury, they may take the necessary steps to assist and then return to their previously assigned post to continue their observation.

a. Routine Observation. This level of observation consists of visual observation which is not the result of a special written order in a resident’s medical record. It involves at least thirty (30) minute face checks completed by direct care staff in settings which residents generally occupy such as bedrooms, wards, pods, restrooms, dining rooms, activity rooms, classrooms, and enclosed yards attached to buildings. Supervisors will ensure that staff members are vigilant and aware of each resident’s whereabouts and status. Exceptions for some residents occur at times as they accept greater responsibilities, gain unrestricted grounds access, and have time away from routine observation. Each facility will maintain Residential Area Coverage Sheets (Appendix B to this operating procedure or equivalent documents) daily.

b. 15 Minute Check. This level of observation requires staff to monitor and document a resident’s condition, location, and/or behavior every 15 minutes. This level of observation must be reviewed and renewed at least every seven (7) days.

c. Group Observation (GO). This level of observation requires a staff member to remain within visual contact of up to three (3) designated residents for the physical, medical, emotional or security needs of the residents to be met. The assigned staff maintains visual contact with the assigned residents at all times. If a resident needs to separate from the group observation, additional staff assistance will be required to maintain the observation. Documentation of behavior, activity, and location is required every 15 minutes. Authorization for GO is by clinician order as defined in this operating procedure. This level of observation must be reviewed and renewed at least every seven (7) days.
d. **Continuous Visual Observation (CVO).** This level of observation requires that staff watch a resident and document condition, location, and/or behavior every 15 minutes. The resident is continually watched. CVO will occur in settings residents generally occupy such as bedrooms, wards, pods, restrooms, dining rooms, activity rooms, classrooms, and enclosed yards attached to buildings. CVO consists of visual observation which is the result of a special written order in a resident’s medical record. Supervisors will ensure that staff members are vigilant and aware of each resident’s whereabouts and status. Authorization for CVO is by clinician order as defined in this operating procedure. This level of observation must be reviewed and renewed at least every seven (7) days and include a face-to-face examination by a clinician. The clinician and/or Registered Nurse will document the justification for continuation or discontinuation of an order.

e. **One-to-One (1:1) Observation.** This level of observation requires one staff member to maintain uninterrupted visual contact of a resident while remaining within arm’s length at all times, unless within arm’s length creates a danger to staff members or is not therapeutic for the resident, in which case the order may indicate a variance from this requirement. If it is determined by a clinician that “within arm’s length” creates a danger to staff members or is not therapeutic for the resident, the clinician may write an order indicating a variance from this requirement. One-to-one observation requires documentation at least every 15 minutes. Authorization for One-to-One Observation is by clinician order as defined in this operating procedure. This level of observation must be reviewed and renewed at least every 24 hours and include a face-to-face examination by a clinician and/or Registered Nurse, who will document justification for continuation or discontinuation of an order.

f. **Two-to-One (2:1) Observation.** This level of observation requires two staff members to maintain uninterrupted visual contact of a resident while remaining within arm’s length at all times, unless within arm’s length creates a danger to staff members or is not therapeutic for the resident, in which case the order may indicate a variance from this requirement. If it is determined by a clinician that “within arm’s length” creates a danger to staff members or is not therapeutic for the resident, the clinician may write an order indicating a variance from this requirement. Two-to-One observation requires documentation at least every 15 minutes. Authorization for Two-to-One observation is from a clinician as defined in this operating procedure. This level of observation must be reviewed and renewed at least every 24 hours and include a face-to-face examination by a clinician and/or Registered Nurse, who will document justification for continuation or discontinuation of an order.

6. **Trauma-Informed Care.** All direct care staff and treatment professionals will be trained in Trauma-Informed Care. Staff will review each resident’s Personal Safety Plan (form CF-MH 3124, available in DCF Forms) in his or her assigned area. Staff will work to reduce trauma when employing alternative solutions for residents in crisis or in potentially harmful situations. Staff will use calming strategies and avoid triggers when possible, as indicated on the Personal Safety Plan, when residents are in danger of harming themselves or others. Staff will encourage residents at risk to participate in evidence-based and promising practices to increase skills for self-modulation of emotions.

7. **Key Indicators of the Need to Employ Special Observation and Precautions.** Key indicators that special observation and precautions may be needed include but are not limited to:

a. **Suicidal/Self-Abuse.** Residents who display or who have a significant potential for suicidal or self-injurious behavior. When either suicidality or self-injury is a key indicator of concern, staff may employ CFOP 155-53, Suicide and Self-Injury Prevention, for assessments.

b. **Homicidal/Assaultive.** Residents who display or who have a significant potential for assaultive behavior toward others.

c. **Arson.** Residents who threaten to or have deliberately attempted to set fires.
d. **Escape/Elopement.** Residents who have significant potential for leaving hospital grounds without authorization.

e. **Medical.** Residents who have significant medical problems which require special monitoring and documentation (e.g., seizures, choking, falling, special diets, grabbing food from others, excessive drinking of fluids, interfering with medically necessary treatments such as IVs or PEG Tubes, etc.).

8. **Assessment of Risk and Orders for Special Observation and Precautions.**

   a. Clinicians may order observation and precautions for individuals who are estimated to be at increased levels of risk to demonstrate harm against themselves or others. Orders for observation may also be related to the collection of information for diagnostic purposes. Observation and precautions may be ordered for medical, psychiatric, or behavioral concerns following a face-to-face examination. Orders for special observations and precautions are generally provided after a clinical assessment, and to the extent possible, assessment should involve members of the recovery team.

   b. If a situation exists where special observation and precautions must be initiated, renewed or discontinued after hours, during the weekend or on state approved holidays, a Registered Nurse may, after a face-to-face assessment, seek verbal authorization from a clinician. All verbal authorizations (orders) must be signed by a clinician within 48 hours or the next business day.

   c. All written orders for special observation and precautions, at a minimum, shall:

      1. Identify and describe key indicators or other problems;
      2. Delineate type of observation and precautions needed to maintain safety;
      3. List evaluation or treatment goals aimed at lifting the observation and precautions;
      4. Include the time limit of the order; and,
      5. Include signature, credentials, date, and time.

   d. At the end of the specified duration, a new order must be written to continue the special observation and precautions (if continuation is warranted). The order itself includes justification for the decision to continue the special observations and precautions. Separate notes are not needed. A Registered Nurse can do the face-to-face assessment in communication with a clinician to discontinue the order and document evidence of the resident’s improvement in a progress note.

   e. Observers will use either the Clinical Observation Progress Note sheet in Appendix C to this operating procedure or the Special Observation Flow Sheet in Appendix D to this operating procedure, or equivalent documents in accordance with facility procedures.

9. **Longer-Term Use of Special Observation or Precautions.** In rare cases where an individual requires observation on a longer term or chronic basis (defined as two months or longer) to ensure safety of the individual or others, an order for longer-term observation may be written. Before implementation, the Medical Executive Director or designee of the facility must approve this intervention. This intervention must be part of the recovery plan and must be reviewed by the recovery team on a weekly basis. Once implemented, the clinician’s order must be renewed on a weekly basis.
10. **Discipline Responsibilities for Special Observation and Special Precautions.**

   a. **Responsibilities of Clinicians and Registered Nurses.**

      (1) Assess and evaluate the status of residents’ risk to self or others.

      (2) Assess and evaluate the resident for need to implement, continue or discontinue special observation and precautions.

      (3) Clinicians sign orders to initiate, continue, or discontinue special observations and precautions, in consultation with Registered Nurses (RNs).

      (4) RNs and/or clinicians conduct face-to-face examinations within the frequency required by the observation or precaution.

      (5) RNs and/or clinicians document justification for initiation, continuation or discontinuation of an order.

      (6) RNs notify the Recovery Team leader of the resident’s status.

   b. **Additional Responsibilities of Registered Nurses.**

      (1) Evaluate and document the resident’s behavior and/or condition on initiation of special observations and at minimum each shift, while the resident is on any special observations as defined in this operating procedure.

      (2) Notify the clinician of any changes in behavior and/or health status of the resident as the resident’s condition warrants.

   c. **Direct Care Staff Responsibilities.**

      (1) Observe the resident for changes in behavior and/or condition.

      (2) Immediately report any worsening of a resident’s behavior and/or condition to the unit nurse or the most senior recovery team member available.

      (3) Document observations as instructed by the unit nurse or superior.

      (4) Report changes, interventions, or preventative measures utilized during each change of shift report.

   d. **Recovery/Treatment Team Responsibilities.**

      (1) Meet with residents who are on special observation or precautions; assess the need for continuation; and document the review in the clinical record.

      (2) During normal business hours, the recovery team leader shall notify members of the Team of the resident’s status. The team will decide whether to meet with the resident to determine any additional needs for individualized treatment planning.

      (3) A designated treatment team member will ensure that the resident’s Personal Safety Plan is complete and up-to-date.
SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL

Expanded paragraph 2 to include the Florida Civil Commitment Center in the scope of this operating procedure; added references to Chapter 464, F.S., Part I, and CFOP 115-29 in paragraph 3; throughout the operating procedure, changed the professional title Advanced Registered Nurse Practitioner (ARNP) to the professional title Advanced Practice Registered Nurse (APRN); in paragraph 4, added definitions to Direct Care Staff and Registered Nurse, and added a more detailed description of observation and precautions in the definition for Observation and Precautions; in paragraph 5, revised the description of the various levels of observation and added the 15 Minute Check; in paragraph 6, added language to encourage at risk residents to participate in evidence-based and promising practices programming; in the second sentence in paragraph 7a, changed “will” to “may”; in the second sentence in paragraph 8b, added the phrase “or the next business day” to the end of the sentence; revised paragraph 8d; revised paragraphs 10a, 10b and 10c; and, in Appendix B, “Day” and “Date” were added to the Residential Area Coverage Sheet.
Clinical Risk Assessment Date: _______________  Most Recent/Previous CRA Date: _______________

**Purpose:** This assessment documents the Recovery Team’s collective professional judgment about level of behavioral risk with potential for impact on the health, safety, or security of resident or others, with links to services on Recovery Plan intended to decrease or manage risk.

**Reason for Assessment:**

<table>
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<tr>
<th>RISK CATEGORIES</th>
<th>RISK RATING (Low, Moderate, High)</th>
<th>Recovery Plan Issue Number(s) &amp; Status</th>
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<td>1. VIOLENCE/AGGRESSION TO OTHERS</td>
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<td>2. SUICIDALITY</td>
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<td>3. NON-SUICIDAL SELF-INJURY</td>
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<td>4. ESCAPE/ELOPEMENT</td>
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<td>Date last occurred:</td>
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<td>5. VULNERABILITY TO HARM OR EXPLOITATION</td>
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<td>6. BEHAVIOR THAT ALTERS SAFETY OF THE ENVIRONMENT</td>
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**SUMMARY & RECOMMENDATIONS:**
Overall, the current risk state compared to most recent CRA is (circle one):  **Increased**  **Decreased**  **Unchanged**

Signature/Title of Risk Rater: ___________________________  Signatures/Titles of Members in Attendance: ___________________________

________________________________________________________
Recovery Team Leader Signature  Date: ______________

Psychiatrist Signature/Date: ___________________________  Check one:  [ ] Present at Team Meeting, or  [ ] Reviewed

**INSTRUCTIONS:** Maintain the five (5) most recent Clinical Risk Assessment Instruments in the active chart.
**CLINICAL RISK ASSESSMENT WORKSHEET:** Use each block below to document support for ratings of low, medium, or high

1. **RISK FOR INTERPERSONAL VIOLENCE:**
   - Use HCR results if available; if not, complete B & C Source: ____ Records ____ Interview ____ Both
   A. Refer to HCR-20 dated:____________________, or
   B. Mark the following 7 items as “Present” or “Absent”:  __ Irritability, __ Impulsivity, __ Unwillingness to follow directions, __ Sensitivity to perceived provocation, __ Easily angered when requests are denied, __ Negative attitudes, __ Verbal threats
   (Dynamic Appraisal of Situational Aggression, 2006) Count number of “P”s. Zero suggests the risk of violence over next 24 hrs is very low, 1–3 suggest that the risk is moderate, 4 or more suggest that risk is high, 6 - 7 suggest that risk may be imminent, and:
   C. Consider & describe below other potential contributors (e.g., hx of physical injury to others, hx of exploitation/predation, homicide ideation past/present, Axis I symptom prompts such as command hallucinations, hx of instrumental/proactive aggression, hx of reactive/defensive aggression, threats/intimidation, property destruction) or any Protective Conditions/Strengths:

2. **RISK FOR SUICIDE:** Complete all four categories Source: ____ Records ____ Interview ____ Both
   A. Key factor: _____Lifetime history of 2 or more suicide attempts with intent to die (Dates, or age at time:____________) and Circumstances: Person’s perspective on outcomes of past attempts:
   B. Static/stable/enduring factors (check all that apply): _____History of self harm; _____Seriousness of perceived suicidality; _____Previous hospitalization; _____History of mental disorder (esp. schizophrenia, mood, or eating disorder); _____History of substance use disorder; _____Personality disorder/traits (esp. borderline pd); _____Childhood adversity; _____Family history of suicide; _____Age/gender/marital (older, male, single elevates risk) and
   C. Dynamic risk factors (check all that apply):  _____Lifetime Hx of one attempt with intent to die; _____Suicide thoughts ( ___none ___ weekly ___ daily) ( ___past 24 hrs ___ past week ___past year ___lifetime); _____Suicide plans ( ___access to preferred means – if checked, describe: ___ ); _____Suicide intent ( ___strong ___weak ___fluctuating); _____Perception of being a burden; _____Perception of not belonging/not contributing; _____Hopeless/trapped; _____Active psychological symptoms; _____Treatment adherence; _____Psychosocial stress; _____Problem-solving deficits; _____Impulse control deficits and
   D. Protective conditions and strengths: _____Religious/spiritual beliefs; _____Social connection; _____Willing to communicate; _____Willing to learn/use coping behaviors

3. **RISK FOR NON-SUICIDAL SELF-INJURY:** Check all that apply Source: ____ Records ____ Interview ____ Both
   - History of self-injury: If checked, describe frequency/severity/types:
   - Personality disorder dx; ___command hallucinations ___responsive to peer influence; ___responsive to cultural or setting norms
   - Protective conditions and strengths:

4. **RISK FOR ESCAPE/ELOPEMENT:** Check all that apply Source: ____ Records ____ Interview ____ Both
   - History of escape/elopement/absconding. Describe:
   - Precursor behaviors (e.g., escape tools, hiding, attempts, rehearsals, threat, plan, ideation, perceived need to get away). Describe:
5. **RISK FOR VULNERABILITY TO HARM OR EXPLOITATION**: Check all that apply. Add others if applicable.

- Impaired cognition that affects orientation, sense of time, sense of location, or awareness of safety hazards;
- Active symptoms that affect judgment and impulse control;
- Significant trauma history;
- Potential for repeat victimization;
- Physical disabilities;
- Potential for falls/fractures;
- Limited control of seizures;
- Limited blood glucose control;
- Heightened risk for allergic reaction or infection;
- Potential for choking/aspiration;
- Decreased alertness and response time;
- Other:

Describe:

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6. **RISK FOR BEHAVIOR THAT ALTERS SAFETY OF THE ENVIRONMENT**: Check all that apply. Add others if applicable.

- Property destruction history;
- Potential for non-compliance with medical precautions;
- Potential for sexual predation;
- Potential to access contraband/weapons/substances;
- Documented pattern of noncompliance with written rules of living environment (Note: Limitation on grounds access in civil units cannot be based solely on minor behavior or contraband violations irrelevant to safety and security.)

Describe:

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***CONFIDENTIAL & PRIVILEGED INFORMATION***
**RESIDENTIAL AREA COVERAGE SHEET**

**INSTRUCTIONS FOR COMPLETING RESIDENTIAL AREA COVERAGE SHEET:** Enter day, date and circle shift hours. Each ward coverage staff must sign their name in the observer block, and enter the time when receiving the board, and enter the time when the board is relinquished to the next staff (lunch & breaks included). Midnight shift observer enters resident names for the next shift’s ward coverage sheet. Observer #1 should record hour (e.g., 0900) in blank square with 30 blocks indicative of half-hour intervals (e.g., 0930). Enter appropriate codes for the resident’s Area/Status (all codes are on page 2). Supervisor signs ward coverage at end of shift after review of form for completeness and submits to UTRSSIII or equivalent for further review and filing.

Unit: _____  Ward/Pod: _____  7--3:30  3--11:30  11:00--7:00  11:00--7:30  11:15--7:15

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<th>Observer # 1</th>
<th>Observer # 2</th>
<th>Observer # 3</th>
<th>Observer # 4</th>
<th>Ward/Pod Supervisor</th>
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<td>Time Begin _____ End _______</td>
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Office of Primary Responsibility:  SMF

Facility Name: ________________________________

**RESIDENTIAL AREA COVERAGE SHEET**

Appendix B to CFOP 155-26
February 15, 2019

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<tr>
<th>Unit</th>
<th>Ward/Pod</th>
<th>7--3:30</th>
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Observer # 1
Time Begin _______ End ________
Time Begin _______ End ________
Time Begin _______ End ________

Observer # 2
Time Begin _______ End ________
Time Begin _______ End ________

Observer # 3
Time Begin _______ End ________
Time Begin _______ End ________

Observer # 4
Time Begin _______ End ________

Ward Supervisor
DAY:____________________

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CODES FOR AREAS/BEHAVIORS:
Evacuation Symbols (H=Hearing Impaired, W=Wheelchair or Other Mobility Limitations, B=Blind or Impaired Sight, S=difficulty speaking English, ? = e.g., confusion, difficulty following instructions)

Areas
1-Bedroom
2-Day Room
3-Quiet/Comfort Room
4-Bathroom
5-Shower
6-Dinning Room/Area
7-Therapeutic Area on Ward/Pod
8-Therapeutic Area Off Ward/Pod
9-Yard
10-Community Medical Setting
11-Medical Setting Off Ward in the Facility
12-Legal Setting on Campus
13-Visitor’s Area
14- Seclusion Designated Area
15- Restraint Designated Area
16-Hallway
17-Treatment Mall
18-Patio
19-Recreation/Gym
20-Religious Services
21-Administration
22-Security Office
23-Beauty/Barber Shop
24-On grounds (e.g., freedom of movement)
25-Off Campus (Authorized, e.g., Town Pass, Furlough)
26-Off Campus (Unauthorized, e.g., elopement/escape)
27-Out of Facility (LOA)
28-Other

Areas (Continued)

Status
A-Awake and no appearance of mental, emotional, behavioral, or physical distress (no need for urgent professional care)
B- Awake and some appearance of mental, emotional, behavioral or physical issues (no need for urgent professional case)
C- Awake and an appearance of mental, emotional, behavioral, or physical distress (in need of urgent professional care, notify appropriate discipline and specify concerns in at least one progress note or more frequently as needed each day)
D-Appearance of sleep or resting, no appearance of distress, check for breathing at least hourly on midnight shift
E-Other observational note (enter progress note and notify disciplines as appropriate)
## Clinical Observation Progress Note

**Office of Primary Responsibility:** SMF

---

**Instructions:**

Chart the location and behavior of persons requiring documented clinical observations.

All clinical observations, with the exception of Seclusion/Restraints, will be documented on this form. At the end of each shift, staff will document an end of shift summary.

Incidents requiring more detailed documentation will be documented on Progress and Event Notes form.

To be filed in the Flow Sheet section of the resident’s chart.


---

### Recovery Service Plan Number ________

**Date On Which Observation Began:** _____________

**Reason/Physician:** ___________________________

**Checks:** Q 15 min.

---

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<th>Time Checked</th>
<th>Observational Status</th>
<th>Location/Behavior Observed</th>
<th>Checked By: (Signature)</th>
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**Addressograph:**

**Confidential & Privileged Information *** For Professional Use Only **

Facility Name, Location, FL ZIP Code

---

**CLINICAL OBSERVATION PROGRESS NOTE**

Page 1 of 2

Appendix C to CFOP 155-26
**INSTRUCTIONS:** Chart the location and behavior of persons requiring documented clinical observations.

All clinical observations with the exception of Seclusion/Restraints will be documented on this form. At the end of each shift, staff will document an end of shift summary.

Incidents requiring more detailed documentation will be documented on Progress and Event Notes form.

To be filed in the Flow Sheet section of the resident’s chart.


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**CONFIDENTIAL & PRIVILEGED INFORMATION *** FOR PROFESSIONAL USE ONLY **
### SPECIAL OBSERVATION FLOW SHEET

Document Every 15 Minutes

**Date:** __________________________

Check Level of Observation:
- [ ] Continuous Visual Observation (CVO) @ _______ am/pm;
- [ ] One-to-One @ _______ am/pm;
- [ ] One-to-One with Additional CVO Coverage @ _______ am/pm;
- [ ] Two-to-One Observation @ _______ am/pm

Check Reason for Special Level of Observation:
- [ ] Elopement/Escape
- [ ] Seizure
- [ ] Suicidal Precautions
- [ ] Suicidal Precautions
- [ ] Falls
- [ ] Withdrawal
- [ ] Assautilve/Comitative/Violent Behavior
- [ ] Other (Specify) ___________________________________________________________

**Serious Medical Condition:** Identify: ___________________________________________

**Florida Department of Children and Families**
**Mental Health Treatment Facilities**

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**February 15, 2019**

**CFOP 155-26**

**Appendix D to CFOP 155-26**
CODE EXPLANATION (Must include the individual’s location/activity and behavior/general status) List at least one code from each category:

|------------------|-----------|-------------|------------|-------------|-----------|------------|------------|---------------|------------|-------------------|---------------------|---------------|-------------|-----------|---------|--------|------------------|---------------|-----------|-------------|--------------|--------------|--------------|----------------|---------------|----------------|-------------|-----------------|----------------|---------------|----------------|-----------------|-----------------|-----------------|-----------------|

TRANSFER OF INDIVIDUAL RESPONSIBILITY

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<th>STAFF INITIAL TRANSFER TO:</th>
<th>TIME</th>
<th>NURSE DESIGNEE APPROVAL</th>
<th>CODE*</th>
<th>STAFF INITIAL TRANSFER FROM:</th>
<th>STAFF INITIAL TRANSFER TO:</th>
<th>TIME</th>
<th>NURSE DESIGNEE APPROVAL</th>
</tr>
</thead>
</table>

*Code: 1 = Break  2 = Reassignment during Shift  3 = Change of Shift

Initials: ___________________________ Full Signature: ___________________________ Title: ___________________________

Resident’s Name: ___________________________ Hospital Number: ___________________________

Reference CFOP 155-26