
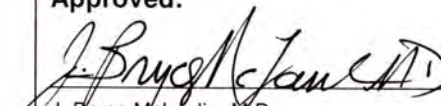
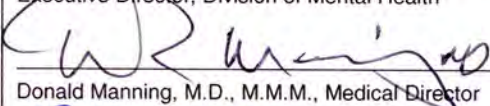
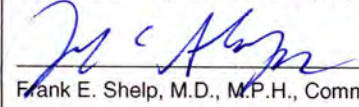


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|  <p>Georgia Department of Behavioral Health & Developmental Disabilities DBHDD</p> | <p align="center">Policy # 03-501</p> <p align="center">Page 1 of 11</p> |
| <p>Chapter: Hospital Operations Subject: Observation of Individuals to Ensure Safety</p> | |
| <p>Applicability: State Hospitals and State Operated Crisis Stabilization Programs</p> | <p>Original Effective Date: <i>Policy was rescinded prior to December 1, 2009 effective date</i></p> |
| <p>References: Official Code of Georgia Annotated (O.C.G.A.) 37-3-160, 37-3-165, 37-4-124</p> | <p>Revision Effective Date: October 15, 2010 Revision #2 Effective Date: November 15, 2010 Full Implementation Date: January 15, 2011 Scheduled Review Date: September 2011</p> |
| <p>Attachments: Attachment A: 24 Hour Observation Sheet Attachment B: Line-of-Sight & One-to-One Observation Flow Sheet</p> | <p>Approved:</p> <p> 11/8/10 J. Bryce McLaulin, M.D. Date Executive Director, Division of Mental Health</p> <p> 11-5-10 Donald Manning, M.D., M.M.M., Medical Director Date</p> <p> 11-10-10 Frank E. Shelp, M.D., M.P.H., Commissioner Date</p> |

OBSERVATION OF INDIVIDUALS TO ENSURE SAFETY

POLICY

State Hospitals and State-operated Crisis Stabilization Programs utilize established procedures for three levels of observation in order to ensure safety in the least restrictive manner that is commensurate with the clinical care needs of individuals being served.

DEFINITIONS

Routine Observation: Maintaining general awareness of the individual's whereabouts and status by visually observing the individual at least every 30 minutes.

Line-of-sight Observation: Maintaining continuous visual observation of no more than three (3) individuals. This is considered "special observation" because it involves increased levels of monitoring, restrictiveness and documentation.

One-to-one Observation: Being within arm's length and maintaining continuous visual observation of no more than one (1) individual. This is considered "special observation" because it involves increased levels of monitoring, restrictiveness and documentation.

Individual: The term "individual" is utilized in this and other DBHDD policies to refer to persons served by DBHDD hospitals or Crisis Stabilization Programs (rather than the previously used terms "consumer" or "client").

APRN: Advanced Practice Registered Nurse

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Licensed Nurse: For the purpose of this policy this phrase refers to both Registered Nurse (RN) and Licensed Practical Nurse (LPN).

Plan of Care: Includes Individualized Treatment Plan, Individualized Recovery Plan, Individualized Service Plan or Individualized Program Plan as applicable for an individual.

Qualified Mental Retardation Professional (QMRP): Individuals designated according to requirements for QMRP as defined by the Centers for Medicaid Services (CMS).

Seclusion: The involuntary confinement of a person alone in a room (or in any area of a room) where the person is prevented from leaving, regardless of the purpose of this confinement. The practice of “restrictive time-out” (RTO) is seclusion and may not be utilized except in compliance with the policy regulating use of seclusion. The phrase “prevented from leaving” includes not only the use of a locked door, but also the use of physical or verbal control to prevent the person from leaving. The word “alone” refers to being separated and apart from all other individuals.

Team: Includes Interdisciplinary Recovery Planning Team for mental health and forensic services and Interdisciplinary Team for developmental disabilities services.

INTRODUCTION

The primary purpose of observation is to provide safety for customers during periods of distress when they are at risk of harm to themselves and/or others. It is essential to ensure that this period is therapeutic; although the individual may perceive such observation as not needed at the time. Staff should also be aware that the process of observation may be distressing to the individual and should try to put the person at ease without compromising safety. Observation can also be used to provide an intensive period of assessment of a person's mental state.

Teams should not hesitate to use increased levels of observation when their judgment indicates it is needed. However they should be clear about its purpose and aware of the wider effects of this decision.

Observation Skills of Staff: In order to protect individuals, staff and others, it is essential that staff have skills in detecting signs of impending aggression or violence. Staff receive training in techniques for the early identification, de-escalation and management of aggression. Staff remain alert for behaviors that may indicate deterioration, or other change in the individual's mental state that may lead to negative outcomes. Observation of individuals who are experiencing acute symptoms of mental illness is a skilled task involving assessment of the individual's mental state, the risks involved, and the potential benefits for the individual and others. Viewing this task as simply 'watching the door' or 'guarding the individual' is insufficient and unacceptable. Observation is an opportunity to develop rapport and build a relationship. This may include engaging the observed person in some constructive and therapeutic activity or intervention and offering support in order to strengthen the therapeutic relationship between the observing staff and the individual.

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PROCEDURES

Assessment of Risk to Determine Observation Level

Assessment of risk is a necessary preliminary to and component of safe and satisfactory observation. A high level of judgment based on training and experience is required to define the risks involved and the potential benefits to the individual and others.

An interdisciplinary approach is used to assess risk. At admission, each individual is assessed by medical and nursing staff. Following the assessment, the level of observation is recorded in the medical record. There may be occasions when a joint nursing and medical assessment may not be possible or practical and decisions must be made solely by nursing staff in response to an immediate situation.

Factors to be considered as part of the assessment process include, but are not limited to, the following recent, known information, which must be documented in the clinical record:

- Threats, stated plan, or attempts to do physical harm to self or others
- Availability of means to do violence or physical harm
- Known patterns of dangerousness to self and others, including present and recent behaviors
- Lack of insight or judgment regarding behavior which is dangerous to self or others
- Lack of control over dangerous impulses
- Unstable mood and affect
- Hallucinations or delusions affecting behavior
- Dangerous compulsive behaviors
- Inability or unwillingness to not cause physical harm to self or others
- Medical conditions necessitating special care
- Elopement or escape risk

Individual Involvement

Where possible the individual, and, as appropriate, other members of his or her support system are involved in decisions related to levels of observation including any limits that are set. Verbal explanations are supplemented by written information explaining the policy on observation. This information is provided to all individuals on admission and is available to relatives (or representatives) when they visit the unit.

Specific Procedures for Each Level of Observation

The physician or APRN orders the level of observation that is needed for each individual based upon their specific and immediate need. In the event the individual's known, observed and/or reported condition or behavior requires immediate implementation of a higher level of observation, a licensed nurse, licensed psychologist, shift supervisor or QMRP may evaluate the individual, implement the appropriate special observation, document in the progress notes, and notify the on-call physician or APRN within one hour.

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a) Routine Observation

- 1) Routine Observation is the minimum level of observation available; it is the least intrusive and restrictive to the individual. Routine Observation is likely to meet the needs of most individuals most of the time. It is the default level, which is planned for and implemented for all individuals who do not require Line-of-sight Observation or One-to-one Observation.
- 2) For every individual under Routine Observation, a designated staff person on duty has knowledge of the particular individual's general location at all times, whether on or off the unit.
- 3) During any time that an individual is expected to be present on the unit or in the treatment mall, visual checks (visual contact with the individual) must be carried out every thirty (30) minutes to confirm the location of each individual.
- 4) Documentation of Routine Observation thirty (30) minute checks is recorded on the **24 Hour Observation Sheet (Attachment A)**. See Documentation requirements for each level of observation section of this policy.
- 5) Each hospital inserts location codes for Routine Observation into the Observation Codes space on the **24 Hour Observation Sheet (Attachment A)** which are specific to that hospital's configuration. The code listing should include areas within the living unit and specific buildings on campus where individuals would be located.
- 6) If an individual on Routine Observation level is away from the living unit and treatment mall to attend other activities or for other approved reasons, staff are not required to verify location every 30 minutes. During these times, staff should note on the **24 Hour Observation Sheet (Attachment A)** the reason why the individual is off the living unit or away from the treatment mall.
- 7) When an individual is on leave, the 24 Hour Observation Sheet should indicate that information.

b) Line-of-sight Observation

- 1) When the assessment results indicate that the individual requires more than Routine observation, Line-of-sight Observation is instituted.
- 2) This level of observation is a clinical decision based on risk assessment that indicates there is a possible, but not imminent, risk of harm.
- 3) If Line-of-sight Observation is to be initiated, the individual should be informed of the restriction and the rationale by the charge nurse or other person or persons designated by the Team. The person initiating the special observation level documents the rationale in the individual's record.
- 4) Documentation of Line-of-sight Observation is completed every 15 minutes on the **Line-of-sight & One-to-one Observation Flow Sheet (Attachment B)**. See Documentation requirements for each level of observation section of this policy.

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- 5) The staff designated as Primary Observer must maintain constant and continuous visual contact with the individual(s).
- 6) **There are two types of Line-of-sight Observation.**
 - (a) **Typically, one (1) staff member is assigned the responsibility as OBSERVER for Line-of-sight Observation of a maximum of three (3) individuals.** During this assignment the primary observer is not responsible for any Routine Observation. This ratio of no more than three individuals for each observer is required for mental health units.
 - (b) **In ICF-MR and Nursing Facilities, it may be appropriate to have one (1) staff member assigned to provide Line-of-sight Observation for one (1) designated Line-of-sight individual, in addition to providing Routine Observation for up to four (4) individuals.** The appropriateness of this “combined assignment” is determined by the QMRP on duty for the shift, nurse in charge, or shift supervisor based on unique circumstances with the one individual who is at higher risk plus the practicality of being able to safely provide Routine Observation at the same time. This “combined assignment” (Line of Sight for one individual plus up to four individuals on Routine Observation) may only be used within ICF-MR and Nursing Facilities.
- 7) During either type of Line-of-sight Observation, the Observer must keep all designated Line-of-sight individuals in his/her sight at all times. To do so, it is necessary to remain in an area that permits the Observer to constantly and simultaneously monitor all of the individuals to whom he/she is assigned. The Observer must be close enough to each designated Line-of-sight individual to intervene quickly to ensure safety.
- 8) The nurse in charge, shift supervisor, or QMRP on duty for the shift must ensure that a back-up is available when the Primary Observer needs assistance. If an individual needs to leave the area and the Observer cannot accompany the individual, a back-up staff person must accompany the individual and maintain Line-of-sight observation. If the Observer or back-up needs to leave, they may do so only after a replacement staff member has assumed responsibility for the observation.
- 9) Whenever responsibility for observation of an individual is transferred from one staff to another, that transfer and the charge nurse/designee’s approval of that transfer are documented on the **Line-of-sight & One-to-one Observation Flow Sheet (Attachment B).**
- 10) During Line-of-sight Observation, an individual may not be kept away from all other individuals or be managed in any other way which meets the definition of seclusion as specified in this policy.
- 11) Any decision to relax observation requirements to respect privacy during bathing or toileting may only be made by the attending or ordering medical staff or by an APRN and must be documented in the clinical record. If observation

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requirements are relaxed by the medical staff in order to respect privacy, the observer is still required to be physically present in the room with the individual.

c) One-to-one Observation

- 1) One-to-one Observation is used for individuals whose assessment indicates that their behavior presents a substantial risk of serious harm to themselves or other people.
- 2) One-to-one Observation is ordered for individuals who pose a serious, significant and immediate risk of suicide, self harm, violence, abuse, or self neglect and who require one-to-one observation at all times in order to prevent harm to self or others.
- 3) If One-to-one Observation is to be initiated, the individual should be informed of the restriction and the rationale. The person initiating the special observation level documents the rationale in the individual's record.
- 4) One-to-one Observation can be perceived as threatening to some individuals. In such circumstances, the medical and nursing staff (in conjunction with the individual when possible) make a judgment concerning both the beneficial and harmful effects of One-to-one Observation, attempting to make the observation as respectful as possible while still maintaining safety.
- 5) Documentation of the decision to provide One-to-one Observation and the reason for the decision is made in the clinical record. See Documentation requirements for each level of observation section of this policy.
- 6) Documentation of One-to-one Observation is completed every 15 minutes on the **Line-of-sight & One-to-one Observation Flow Sheet (Attachment B)**. See Documentation requirements for each level of observation section of this policy.
- 7) A physician may specify that an individual receiving One-to-one Observation remain in or be restricted from a specified area if it is determined that this is necessary to ensure safety. The rationale for this restriction must be documented in the physician's order and progress note. If at any time the restriction(s) placed on the individual meet the DBHDD definition of seclusion, then all requirements for ordering, conducting and monitoring seclusion must be met, in accordance with DBHDD's seclusion policy.
- 8) The staff member providing One-to-one Observation is assigned the sole responsibility of One-to-one Observation of an individual, remaining within arm's length of the individual at all times, to include individual's bathroom breaks and while individual is sleeping. This staff member is the Observer. The Observer may not be assigned to do other responsibilities during the time he/she is providing One-to-one Observation.
- 9) The Observer must not leave the individual until responsibility for the individual is transferred to another staff member.
- 10) Whenever responsibility for observation of an individual is transferred from one staff to another, that transfer must be approved in advance by the nurse in

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charge, shift supervisor or QMRP, or the person designated to be in charge of the unit in their absence. This approval and the transfer itself is documented on the **Line-of-sight & One-to-one Observation Flow Sheet (Attachment B)**.

- 11) Considerations of safety take precedence over privacy. There shall be no physical barriers between the individual and the assigned staff. Same gender staff is used to monitor during activities such as bathing and toileting that would normally warrant greater privacy.
- 12) In some situations, more than one staff member may be required for One-to-one Observation. The use of more than one staff member to provide One-to-one Observation is only used when judged strictly necessary by the physician or APRN, or by other staff when the individual's known, observed or reported condition or behavior requires immediate implementation of a special observation in accordance with details in this policy.
- 13) Both the Observer who is being relieved and the incoming staff about to begin the period of observation must sign the **Line-of-sight & One-to-one Observation Flow Sheet (Attachment B)** at the time of handing over responsibility.
- 14) Hand-off communication serves an important function as a transition and is essential to ensure safety. In order to avoid unnecessary duplication of questioning and improve continuity of care, hand-off communication takes place before and after every period of One-to-one Observation. When appropriate, this communication should involve the individual. Sometimes, due to the nature of the information that must be shared, it may be necessary for another staff member to provide One-to-one Observation while the departing Observer gives a full report to the incoming designated staff member.
- 15) The rationale for One-to-one Observation must be reviewed by the Team within 24 hours of initiation. If the Team will not be available to convene within 24 hours, a registered nurse, shift supervisor or QMRP must review the individual's condition or behavior with the physician or APRN every 24 hours until the Team can meet. This review must be documented and orders must be revised by the physician or APRN at any time that the individual's needs change. Any changes in the plan of care that result from the team review are documented in the medical record.

Longer-term use of Line-of-sight or One-to-one Observation

In rare cases where an individual requires Line-of-sight or One-to-one Observation on a longer-term or chronic basis (defined as two (2) months or longer) to ensure safety of the individual or others, an order for longer-term observation can be written. Before implementation, the Clinical Director must approve this intervention. The intervention must be part of the plan of care and must be reviewed by the involved Team on a weekly basis. Once implemented, the physician's order must be renewed on a weekly basis.

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Roles and responsibilities of staff

- a) There are several expectations of the staff as they work with the individual and provide the designated level of observation.
 - 1) The following features are observed and any changes are reported and documented in the clinical record by the staff who observe the changes:
 - appearance and dress
 - general behavior, level of co-operation, acceptance of help
 - morbid ideas, violent thoughts/fantasies
 - self-blame, hopelessness and suicide intent
 - mood and attitudes
 - orientation, awareness, memory
 - insight into current situations
 - hallucinations or delusions
 - substance misuse
 - change in medical condition
 - 2) Staff intervene with the individual in a manner consistent with **Safety-Care®** in order to reduce the likelihood of harmful outcomes for the individual or other people.
 - 3) If the above fails or it is not reasonable to attempt such an approach, then staff must alert other staff members to help ensure that enough staff are available to prevent an unsafe situation.
 - 4) Staff document their observations.
- b) The nurse in charge, shift supervisor, or QMRP on duty for the shift are responsible to ensure that the level of observation is appropriately maintained at all times.
- c) All nursing and medical staff are responsible to ensure that records contain documentation as specified within this policy.
- d) The nurse in charge, shift supervisor, or QMRP on duty for the shift identifies the specific staff member(s) assigned to care for each individual according to his or her required level of observation, and specifies those staff member(s) who remain available to assist in the care area. The assignment of care is written, discussed in shift report, and posted to identify staff responsibilities for each individual. Time frames for specific assignments and rotation of duties are determined and monitored by the nurse in charge, shift supervisor or QMRP on duty for the shift.
- e) In the event the individual's known, observed or reported condition or behavior requires immediate implementation of a special observation, a licensed nurse, licensed psychologist, shift supervisor or QMRP may evaluate the individual, implement the appropriate special observation, document in the progress notes, and notify the on-call physician or APRN within one hour.

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- f) The physician/APRN must personally evaluate the individual within two hours of notification and write an order for the special observation or discontinue the intervention implemented. Such actions must be recorded in the clinical record.
- g) A licensed nurse or QMRP must assess the individual's behaviors requiring special observation every shift. A progress note must be written at least once per shift by a licensed nurse or by the QMRP.
- h) If a situation arises where medical and nursing staff do not agree on the appropriate level of observation, the individual remains on the higher level of observation until reviewed by the Clinical Director or Chief Medical Officer.
- i) The role of carrying out the agreed upon level of observation usually falls on direct care staff and nursing staff. As necessary and appropriate, other clinical staff members of the Team may also fulfill this role. This is likely to vary and is dependent upon several factors including the level of observation the individual is receiving, the degree of risk defined, the experience and skill of the clinician and the main purpose of the therapeutic interaction with the individual. The basic principle is that any clinical staff or member of the Team may carry out any level of observation if they meet the following criteria:
 - they are familiar with the policy and
 - they are judged as competent to fulfill the role.
- j) If another staff member takes an individual to an office or program area, responsibility is transferred to that staff member and he/she becomes the Primary Observer until responsibility is transferred to another qualified staff member.
- k) It is the responsibility of the nurse in charge or shift supervisor of the unit to appropriately allocate the resources they have at their disposal and contact their supervisor or the Administrator on Duty if staffing resources are insufficient to meet the immediate need.

Documentation requirements for each level of observation

- a) Routine Observation:
 - 1) Every 30 minutes by the assigned staff member on **24 Hour Observation Sheet (Attachment A)**.
 - 2) Completed **24 Hour Observation Sheets (Attachment A)** are maintained by the hospital for a minimum of three (3) years in a manner that facilitates retrieval as needed. Completed forms are filed in a secure area with controlled access.
 - 3) Physician order and progress note are required at initiation of Routine Observation.
- b) Special Observation (Line-of-sight and One-to-one Observation):
 - 1) Documentation must include the behavior or risk for which the individual is being supervised, for example "special observation for elopement risk."

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- 2) Documentation requirements for Line-of-sight and One-to-one Observation are as follows:
 - a. Every 15 minutes by the assigned staff member on **Line-of-sight & One-to-one Observation Flow Sheet (Attachment B)**.
 - b. Completed forms are filed in the individual's record.
 - c. Progress note by Licensed Nurse or QMRP at the end of each shift.
 - d. New physician order and physician progress note:
 - (a) at initiation of Line-of-sight or One-to-one Observations and
 - (b) at least every 24 hours during the period of time that either Line-of-sight or One-to-one Observation is being provided.

- 3) Each transfer of responsibility must be documented on the **Line-of-sight & One-to-one Observation Flow Sheet (Attachment B)**. The flow sheet must include nurse/designee approval as well as the reason for the transfer. The flow sheet is maintained by the Primary Observer at all times.

- 4) Supervisory monitoring to ensure that staff are properly documenting Line-of-sight or One-to-one Observation occurs at random intervals but at least twice per shift, and is conducted by the charge nurse, shift supervisor, or QMRP. This monitoring also ensures that the level of observation is being conducted properly.

Frequency of Review Regarding Observation Levels

- a) Any individual who is on either Line-of-sight or One-to-one Observation is reviewed jointly by nursing or QMRP and medical staff at least once every 24 hours. This review is documented by physician or APRN in the progress notes and includes rationale for continuation or discontinuation.
- b) To allow for weekends/holidays, a review is carried out before the weekend/holiday and a clear statement is written by physician or APRN in the progress notes about how staff will address the individual's needs. This ensures that after-hours covering physicians have the information needed to determine each day whether to continue or discontinue the Line-of-sight or One-to-one Observation.
- c) The nurse in charge or QMRP can request an early review of observation level with the responsible physician if he/she considers it appropriate to do so. Only in exceptional and justifiable circumstances should medical staff decline the request for a review. This request for review is documented in the progress notes by the nurse or QMRP.
- d) Active treatment is maintained regardless of observation level. If Line-of-sight Observation is required beyond five days or One-to-one Observation is required beyond 72 hours, the Team must convene to:
 - review the plan of care and make any necessary changes, and

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- ensure whenever possible and appropriate, the continued implementation of the active treatment interventions/programs identified in the individual's plan of care.

Education and Training Regarding Observation Levels

- The Regional Hospital Administrator is responsible for ensuring that staff members attend training regarding observation levels.
- The assessment of staff competency to undertake the respective levels of observation is the responsibility of the unit nurse manager or other clinical supervisor through performance review and staff development.
- In a situation where a new staff person has joined the Team, local coaching/training programs are initiated at unit level. New staff can only be allocated observation duties when they are competent to do so and the unit manager or other clinical supervisor assesses that competence.

Monitoring and Audits of Observations

- Because of the importance of special observations to the safety of individuals and staff, it is essential that the quality and consistency of the processes be monitored, reported, evaluated, and, whenever possible, improved.
- The first type of monitoring for observation process implementation is completed twice per shift by the nurse, shift supervisor, or QMRP on the unit when Line-of-sight and/or One-to-one Observation are being utilized for individuals. This monitoring is documented on the individual's **Line-of-sight & One-to-one Observation Flow Sheet (Attachment B)**.
- The second level of monitoring is the responsibility of the Nurse Executive or designee who is responsible for auditing compliance with this policy, including ensuring that supervisory monitoring is being performed consistently. Frequency of auditing should be no less than monthly reviews of a representative sample of the **Line-of-sight & One-to-one Observation Flow Sheets (Attachment B)**.

Staffing

The Nurse Executive is responsible for routine monitoring of data in relation to observation practice and interpreting implications for staffing resources.

Attachment A: Hospital Specific Details for Observation of Individuals Policy Implementation

Click on a hospital to view details

[Central State Hospital](#)

[East Central Regional Hospital](#)

[Georgia Regional Hospital – Atlanta](#)

[Georgia Regional Hospital – Savannah](#)

[Northwest Georgia Regional Hospital](#)

[Southwestern State Hospital](#)

[West Central Georgia Regional Hospital](#)

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Unit: _____ Side/Area: _____

Group (if applicable): _____

Observation Codes:

| | | | |
|-----------------------------------|---|-------------------------------------|--------------------------------|
| B=Bedroom | O= Off Campus Activity | EP=Escape Precaution 2 | FP=Fall Precaution |
| C=Campus Activity | P=Program Area | SP=Suicidal Precaution | HTP=Head Trauma Protocol |
| H=Hospitalized at Acute Hospital | V=Visit Off Campus with Family or potential provider | HO=Hold Order, NGRI | IST=Incompetent to Stand Trial |
| L=Living Unit | X=Unable to Locate | NGRI= Not Guilty by Reason Insanity | CR=Conditional Release |
| M=Medical Appt (off or on campus) | | HP=Homicidal Precaution | |

| Individuals | Room # | Noon – 12:29 P.M. | 12:30 – 12:59 P.M. | 1:00 – 1:29 P.M. | 1:30 – 1:59 P.M. | 2:00 – 2:29 P.M. | 2:30 – 2:59 P.M. | 3:00 – 3:29 P.M. | 3:30 – 3:59 P.M. | 4:00 – 4:29 P.M. | 4:30 – 4:59 P.M. | 5:00 – 5:29 P.M. | 5:30 – 5:59 P.M. | 6:00 – 6:29 P.M. | 6:30 – 6:59 P.M. | 7:00 – 7:29 P.M. | 7:30 – 7:59 P.M. | 8:00 – 8:29 P.M. | 8:30 – 8:59 P.M. | 9:00 – 9:29 P.M. | 9:30 – 9:59 P.M. | 10:00 – 10:29 P.M. | 10:30 – 10:59 P.M. | 11:00 – 11:29 P.M. | 11:30 – 11:59 P.M. | |
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| <p>Georgia Department of Behavioral Health & Developmental Disabilities</p> <p>LINE-OF-SIGHT & ONE-TO-ONE OBSERVATION FLOW SHEET</p> | <p>IDENTIFICATION</p> |
|---|------------------------------|

DATE: _____ Document q 15 min. **Circle level of Observation:** Line-of-Sight @ _____ am/pm; **One-to-One** @ _____ am/pm
Circle Reason for Special Level of Observation: ▶ Elopement ▶ Hold Order ▶ Sexual Precautions ▶ Suicidal Precautions ▶ Falls ▶ Withdrawal
▶ Seizure ▶ Assaultive/Combative/Violent Behavior ▶ Other (Specify) _____
▶ Serious Medical Condition: Identify: _____

| TIME 12M-5:59A | | STAFF INITIALS SUPERVISORY MONITORING | TIME 6A-11:59A | | STAFF INITIALS SUPERVISORY MONITORING | TIME 12N-5:59P | | STAFF INITIALS SUPERVISORY MONITORING | TIME 6P-11:59P | | STAFF INITIALS SUPERVISORY MONITORING |
|-------------------|--|--|-------------------|--|--|-------------------|--|--|-------------------|--|--|
| CODES | | | CODES | | | CODES | | | CODES | | |
| 12:00-12:14 | | | 6:00-6:14 | | | 12:00-12:14 | | | 6:00-6:14 | | |
| 12:15-12:29 | | | 6:15-6:29 | | | 12:15-12:29 | | | 6:15-6:29 | | |
| 12:30-12:44 | | | 6:30-6:44 | | | 12:30-12:44 | | | 6:30-6:44 | | |
| 12:45-12:59 | | | 6:45-6:59 | | | 12:45-12:59 | | | 6:45-6:59 | | |
| 1:00-1:14 | | | 7:00-7:14 | | | 1:00-1:14 | | | 7:00-7:14 | | |
| 1:15-1:29 | | | 7:15-7:29 | | | 1:15-1:29 | | | 7:15-7:29 | | |
| 1:30-1:44 | | | 7:30-7:44 | | | 1:30-1:44 | | | 7:30-7:44 | | |
| 1:45-1:59 | | | 7:45-7:59 | | | 1:45-1:59 | | | 7:45-7:59 | | |
| 2:00-2:14 | | | 8:00-8:14 | | | 2:00-2:14 | | | 8:00-8:14 | | |
| 2:15-2:29 | | | 8:15-8:29 | | | 2:15-2:29 | | | 8:15-8:29 | | |
| 2:30-2:44 | | | 8:30-8:44 | | | 2:30-2:44 | | | 8:30-8:44 | | |
| 2:45-2:49 | | | 8:45-8:59 | | | 2:45-2:49 | | | 8:45-8:59 | | |
| 3:00-3:14 | | | 9:00-9:14 | | | 3:00-3:14 | | | 9:00-9:14 | | |
| 3:15-3:29 | | | 9:15-9:29 | | | 3:15-3:29 | | | 9:15-9:29 | | |
| 3:30-3:44 | | | 9:30-9:44 | | | 3:30-3:44 | | | 9:30-9:44 | | |
| 3:45-3:59 | | | 9:45-9:59 | | | 3:45-3:59 | | | 9:45-9:59 | | |
| 4:00-4:14 | | | 10:00-10:14 | | | 4:00-4:14 | | | 10:00-10:14 | | |
| 4:15-4:29 | | | 10:15-10:29 | | | 4:15-4:29 | | | 10:15-10:29 | | |
| 4:30-4:44 | | | 10:30-10:44 | | | 4:30-4:44 | | | 10:30-10:44 | | |
| 4:45-4:59 | | | 10:45-10:59 | | | 4:45-4:59 | | | 10:45-10:59 | | |
| 5:00-5:14 | | | 11:00-11:14 | | | 5:00-5:14 | | | 11:00-11:14 | | |
| 5:15-5:29 | | | 11:15-11:29 | | | 5:15-5:29 | | | 11:15-11:29 | | |
| 5:30-5:44 | | | 11:30-11:44 | | | 5:30-5:44 | | | 11:30-11:44 | | |
| 5:45-5:59 | | | 11:45-11:59 | | | 5:45-5:59 | | | 11:45-11:59 | | |

CODE EXPLANATION (Must include the individual's location/activity and behavior/general status) List at least one code from each category:

Location/Activity

- 1. Sitting
- 2. Standing
- 3. Resting
- 4. Sleeping
- 5. Talking
- 6. Reading
- 7. Writing
- 8. Watching TV
- 9. On Phone
- 10. With Physician
- 11. With Therapist
- 12. With Nurse
- 13. With AT
- 14. Team
- 15. Group
- 16. Meds
- 17. Personal Room
- 18. Dayroom
- 19. Hallway
- 20. Bathroom
- 21. Laundry
- 22. Fresh Air
- 23. Lobby
- 24. Meal on Unit
- 25. Meal off Unit
- 26. Gym
- 27. Quiet Time
- 28. Seclusion
- 29. Restraints
- 30. Appointment
- 31. Visitors
- 32. Tx Mall
- 33. Off Unit with Staff
- 34. On Unit Activities

Behavior/General Status

- A. Confused
- B. Cooperative
- C. Uncooperative
- D. Calm
- E. Agitated
- F. Hyperactive
- G. Hearing Voices
- H. Intrusive
- I. Seeing Things
- J. Isolating Self
- K. Crying
- L. Demanding
- M. Restless
- N. Withdrawn
- O. Self Harm Ideations
- P. Angry
- Q. Anxious
- R. Paranoid
- S. Threatening
- T. Ventilating Feelings
- U. Pacing
- V. Interacting with Others
- W. Happy

If individual is off unit while on Line-of-Sight or One-to-One Obs., FLOW SHEET must accompany the individual.

TRANSFER OF INDIVIDUAL RESPONSIBILITY

| STAFF INITIAL TRANSFER FROM: | STAFF INITIAL TRANSFER TO: | TIME | NURSE DESIGNEE APPROVAL | CODE | STAFF INITIAL TRANSFER FROM: | STAFF INITIAL TRANSFER TO: | TIME | NURSE DESIGNEE APPROVAL | CODE |
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Code: 1 = Break 2 = Reassignment during Shift 3 = Change of Shift

Initials

Full Signature

Title
