SUBJECT: ASSESSMENT - PSYCHOSOCIAL	REFERENCE #2030
DEPARTMENT: BEHAVIORAL HEALTH UNIT	PAGE: 1 OF: 2
	EFFECTIVE:
APPROVED BY:	REVISED:

PURPOSE:

- Obtain adequate data to identify and understand events and circumstances that led to this hospitalization.
- Identify support systems and resources available to the patient.
- Explore patient's functional level and deficits in mental and physical competency.
- Develop a treatment plan, which addresses the patient's immediate and long-term care needs.

POLICY:

A comprehensive assessment will be completed within three (3) working days. Initial contact will be made with the patient and/or family member within 24 hours of admission, Monday through Friday. A patient admitted between Friday afternoon and Monday morning will be contacted on Monday. An individualized plan of care will be formulated based on the data obtained from the assessment, information obtained from other members of the multidisciplinary team and any additional information that may be available.

PROCEDURE:

- The attending psychiatrist will initiate an order for a psychosocial assessment and participation in group therapy.
- Initial contact will be made with the patient and/or family member the first working day following admission. The assessment will include a demographic profile, presenting problems, family history, financial resources, medical and psychiatric history, social supports and functional status/capacity for activities of daily living and instrumental activities of daily living.
- This comprehensive assessment will be completed and placed in the medical record within three (3) working days. Based on the data obtained, a social work treatment plan will be formulated, including both short-term and long-term goals.

DOCUMENTATION:

- The psychosocial assessment will be dictated, typed and filed in the patient's medical record under the assessments section of the chart.
- Communication with the patient, family or agencies/organizations in the community will be documented in the interdisciplinary progress notes and will meet the standards of confidentiality.

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SUBJECT: “HAND-OFF” COMMUNICATION	REFERENCE #2102
DEPARTMENT: BEHAVIORAL HEALTH UNIT	PAGE: 1 OF: 4
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- "Hand-off” communications will take place whenever there is a change in the patient’s caregivers. Caregivers include all clinical staff and medical staff.
- For 24-hour Behavioral Health Organizations caregivers include clinical staff, program staff and teachers (not all inclusive).
- “Hand-off” communication shall include:
  - Accurate patient information regarding care, treatment and services
  - Current patient’s condition
  - Recent or anticipated changes in the patient’s condition
- All information will be presented in a clear, concise manner.
- Healthcare professionals and ancillary staff shall be allotted the time to “hand-off” patient communication and to ask and answer questions with minimal interruption. It is hoped that this will lessen the amount of information that might be forgotten or simply not conveyed.
- Examples of patient care transitions where “hand-off” communication will take place:
  - At the change of shift between nurses
  - When a nurse leaves the unit for a period of time, such as lunch or to accompany a patient to another area of the facility
    - Temporary responsibility of the patients under the care of the departing nurse is given to another licensed nurse.
  - When a physician transfers complete responsibility for a patient
  - When physicians are transferring on-call responsibilities
  - When physicians and nurses are transferring patients to another level of care
  - Anesthesiologist’s report to the PACU RN and/or to the unit RN
  - Patient transfer to another healthcare facility
  - 24-hour care facilities:
    - Teachers providing information to child care workers
    - Report given between clinical staff and program staff

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<table>
<tr><td>SUBJECT: TREATMENT INTERVENTIONS</td><td>REFERENCE #2111</td></tr>
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<tr><td>EFFECTIVE:</td></tr>
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PURPOSE:

- To establish a therapeutic relationship with the patient that will assist to decrease and/or eliminate acute symptoms of illness that precipitated hospitalization.
- Identify the patient's knowledge of factor(s) contributing to the current hospitalization.
- Implement interventions that provide education, behavioral management, enhance self-esteem and promote a sense of competency.
- Educate and provide support to family members and significant others in maintaining the patient in a community setting.

POLICY:

The primary treatment modality is group intervention. Individual counseling is also utilized with patients that are receptive and functionally able to participate. Individual intervention is provided for patients unable to tolerate the group process.

PROCEDURE:

- Group Intervention:
  - Patients that are functionally competent to participate in group intervention are encouraged to attend on a daily basis. Group modalities include supportive counseling, problem solving techniques, assertion skills training, cognitive-behavioral approaches, social skills building and educationally focused groups.
- Individual Intervention:
  - Individual intervention can be initiated at the request of the patient or at the recommendation of a member of the professional team. The modality of choice is dependent on the presenting problem or request. Crisis intervention, problem solving and supportive counseling approaches are most common.
- Family Intervention:
  - Family sessions may be initiated as identified above. Family counseling may be indicated to clarify the patient's needs, identify the coping skills and care-giving capacity of the significant other, resolve conflicts in the treatment plan, and to provide education and information. These sessions are most frequently related to discharge recommendations and exploring options in long-term care.

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POLICY:

- It is the policy of ___________________ Hospital to minimize the use of seclusion and restraint through preventive measures and use of alternatives. Seclusion and/or restraint should be the selected intervention only when used as an emergency measure to control a patient's unanticipated, severely aggressive, or destructive behavior which places the patient or others in imminent danger and all less restrictive measures have been determined to be ineffective.

- A licensed physician, psychologist or registered nurse (RN) must identify and document the following:

  - Observed threat of harm to self or others
  - Less restrictive interventions attempted and patient's response
  - Appropriate orders from physician
  - Communication to the patient, and as appropriate (with the patient's specific permission) the family of the need for seclusion and/or restraints and criteria for discontinuation of seclusion and/or restraint
  - Patient's behavior during the process of placement in seclusion and restraints

- A patient in seclusion and restraints retains all his/her rights as outlined in Patient Rights. A Denial of Rights Form must be completed when seclusion and/or restraints are used for the patient on the Behavioral Health Unit.

- The organization will ensure:

  - That the type of restraint used is determined by the situation the restraint is being used to address, not by the diagnosis of the patient or his/her treatment setting
  - That the use of behavioral management seclusion and/or restraint will be in accordance with the order of a physician or other LIP permitted by the state and the hospital to order seclusion and restraint
  - That the CMS requirement pertaining to Patient's Rights contained in the Conditions of Participation (Centers for Medicare and Medicaid Services' Interim Final Rule for Patient Rights, effective August 1, 1999) must be met and may be superseded only when state law is more restrictive
  - That policies and procedures regarding use of seclusion and restraint are in compliance with state law

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POSITION DESCRIPTION / PERFORMANCE EVALUATION

Job Title: Behavioral Health Unit RN
Supervised by: Behavioral Health Unit Nurse Manager
Prepared by: ______________________
Approved by: ______________________
Date: ______________________
Date: ______________________

Job Summary: Provides nursing care through physical and mental assessments, laboratory testing, treatment plans and therapeutic treatments. Knowledgeable of a wide range of disorders; cognitive, emotional, developmental, social and behavioral. Performs crisis intervention. Participates in the department's performance improvement and continuous quality improvement (CQI) activities.

DUTIES AND RESPONSIBILITIES:

E = Exceeds the Standard M = Meets the Standard NI = Needs Improvement

Demonstrates Competency in the Following Areas:	**E**	**M**	**NI**
Provides care appropriate to condition and age of patient including, pediatric, adolescent, adult and the geriatric population.	2	1	0
Ability to perform nursing assessments on all patients and reassessments as per policy. This includes pediatric, adolescent, geriatric and the general patient population.	2	1	0
Ability to adequately assess and reassess pain. Utilizes appropriate pain management techniques. Educates the patient and family regarding pain management.	2	1	0
Performs thorough patient psychiatric interviews.	2	1	0
Continuously observes patient's behavior, mental status and activities.	2	1	0
Formulates and implements patient treatment plans; family is included when appropriate.	2	1	0
Ability to revise treatment plans as indicated by the patient's response to treatment and evaluates overall plan daily for effectiveness.	2	1	0
Demonstrates ability to perform treatments and provide services to level of licensure.	2	1	0
Knowledgeable of medications, including psychotropic drugs, and their correct administration based on the age of the patient and their clinical condition.	2	1	0
Follows the five (5) medication rights and reduces the potential for medication errors.	2	1	0
Performs patient care responsibilities considering needs specific to the standard of care for patient's age.	2	1	0
Demonstrates the ability to perform crisis intervention and triage.	2	1	0
Provides psychotherapeutic treatments to patients and families; individual psychotherapy, group therapy, family therapy and educational classes.	2	1	0
Documentation meets current standards and policies.	2	1	0
Coordinates and supervises patient care as necessary.	2	1	0
Communicates appropriately and clearly to the Nurse Manager, co-workers and physicians.	2	1	0
Concurs with members of the treatment team for the benefit of the patient.	2	1	0
Consults other departments as appropriate to provide for an interdisciplinary approach to the patient's needs.	2	1	0
Treats patients and families with respect and dignity; provides emotional support.	2	1	0
Performs all aspects of patient care in an environment that optimizes patient safety and reduces the likelihood of medical/health care errors.	2	1	0

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