# MY CARE BOARD

**Our goal is to provide you with excellent quality care.**

<table>
<thead>
<tr>
<th>TODAY'S DATE:</th>
<th>MY ROOM NUMBER:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFERRED NAME:</td>
<td>NA02</td>
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</table>

**Adolescent Mental Health Unit Phone Number:**

320-255-5704

**My Care Team**

- **Physician/Provider:**

- **RN:**

- **MHA:**

- **Clinical Social Worker:**

**Additional Members:**

**Family Spokesperson**

**What's Important to Me:**

**About Me:**

**On Unit**

**Off Unit**

**Plan of Care:**

**Pain Scale:** Working together to manage your pain.

- **Pain Rating Scale: Most?**

- **No Pain**
- **1 Mild**
- **2 Moderate**
- **3 Severe**
- **4 Very Severe**
- **5 Most**
- **6 Extreme**
- **7 Unbearable**
- **8 How Most**
- **9 Worst**
- **10 Unbearable**

**Pain Plan:**

**Last Dose:**

**Next Dose:**

**Hourly Rounding**

- **Personal Needs**
- **Pathways**
- **Plan for the Day**
- **Pain (Emotional & Physical)**
- **Pumps**

**Department Nursing Director and Phone Number:**

**Chris Walker - ext. 53228**

For any comments or concerns please contact the Department Nursing Director. Thank you.
UNIQUE TREATMENT PLAN DEVELOPMENT FORM

Date Created: ____________________

Patient Name: ____________________

MRN: ____________________

DOB: ____________________

LABEL

TYPE OF PLAN

☐ New Plan  ☐ Update to existing Plan

☐ Complex Medical (i.e. Non CC HealthCare Home or other Care Plans)
☐ Behavioral/Social Needs without violence
☐ Behavioral/Social Needs WITH Potential For Violence
☐ Medication Contract

UNIQUE NEEDS INFORMATION
(Only use sections needed. You may delete and add external pages as appropriate)

Date: ____________________  Author: ____________________

Background leading to plan:

Individualized Interventions: (when patient is in the Emergency Room)

Additional Individualized Interventions: (when patient is admitted to the hospital)

Goals/strengths/passion:

Target Behavior(s)/Challenges: willful actions – address each action separately

Special Concerns/Fears

Procedures/Food/Activities to be avoided

Family and Support Systems:
Replacement Behavior: expectations are to be measurable and specific

Intervention: consequences of non-conformity

Cheerleading Statement (Behavioral Health Plans only):

Add Sections as needed:

Approval Signatures:

Date:

Reviewed/revised:

**Place completed plan in patient chart (will be scanned at next rounding) or send to HIM Coordinator electronically for entry into EMR.**
DISCHARGE CHECKLIST

1. Psychiatrist
   □ Discharge order

2. Registered Nurse (RN)
   a. Medications/treatment orders
      □ Contact consulted physician(s) for additional discharge orders (insulin, etc.)
      □ Use discharge navigator to review that all parts of discharge are complete. Review discharge medication orders (make sure all bars are green).
      □ Take home medications in lock box reviewed for pt to take home.
      □ Check on any medications that pt may have come in on, bulk meds in med box or refrigerator to take home.
      □ MA pending patients only: a week’s worth of meds can be dispensed through SCH OP pharmacy (55670) until MA is effective.
      □ Review any written prescriptions (right pt name)
   b. Discharge process
      □ Does the pt meet any “Core Measures” criteria? (pneumonia, heart failure, acute MI)?
      □ Review AVS with patient/family/community staff
      □ Call report (if pt discharging to a facility)
      □ Complete discharge documentation

3. Mental Health Associate (MHA)
   □ Help patient pack their belongings. Once all belongings are packed, attach sign to wire basket with your initials.
   □ Retrieve pt valuables from unit safe/hospital safe/cell phone/cigarettes/off unit storage
   □ Patient can get into street clothes 30 minutes before anticipated discharge time.

4. Health Unit Coordinator (HUC)
   □ Write pt name, room number & anticipated discharge time on white discharge board.
   □ Place pt chart, folder, valuables/medication envelopes & discharge checklist(s) in Discharge basket on back shelf behind HUC.
   □ Print IMM (if not already done) & place in discharge folder. Pt must be given a printed Copy at least 4 hours prior to discharge (can be given as early as 48 hours before DC).
   □ Pull used BP cuff from file box.
   □ Taxi voucher for pt leaving by taxi with address information completed. Call taxi one hour in advance of anticipated discharge time.
   □ When pt is discharged to home, add the discharge follow-up call to the AVS. Enter a phone number where the patient can be reached.
   □ If pt has a Unique Treatment Plan (UTP), send most recent copy to Health Information Management (HIM). (Tube 200).
   □ Empty & clean medication box. Send back to pharmacy. Certain meds need to be disposed Of or not ordered for home use. Remove valuables/medication copies from chart.
   □ Remove observation sheet from rounds binder once pt is discharged.
   □ Discharge pt from EPIC.

5. Any staff member (HUC/MHA/SW/RN)
   □ Hand out patient satisfaction survey (Press Ganey)
   □ Confirm that “Managing My Recovery” plan is complete at discharge as well as PHQ-9 (ID label needs to be on these forms).
   □ Escort pt when leaving (hospital standard of practice). Use wheelchair if pt is a fall risk.