CRENSHAW COMMUNITY HOSPITAL

Special Services Patient Safety Education

Patient Rounds - Patient Rounding Log and Policy Overview

1. Rounds shall be made at least 15 minutes per hour day unless patient is on 1:1 observation.
2. Alternating rounds will be done on each patient between the fifteen-minute rounding times, **but not on the fifteen-minute time frame**.
3. If you are scheduled for 1:1 observation, you are not to be doing alternating rounds as well

Maintenance Log/ Environmental Safety Rounds - Introduction of Maintenance Log and edits to Environmental Safety Rounds

1. The designated MHT will inspect the entire unit once a shift using the Environmental Rounding Checklist and report any issues to the Special Services Unit Manager and/or Charge Nurse. The Unit Manager and/or Charge Nurse will determine if the findings create an immediate safety issue. If the issues found during the environmental safety round do create an immediate danger the Special Services Unit Manager and/or Charge Nurse should notify the maintenance department immediately for repair.
2. Once these issues are reviewed by the Special Services Unit Manager and/or Charge Nurse a Maintenance Work Order should be completed and logged into the Maintenance Log within the Special Services Unit.
3. The Environmental Safety Rounds Checklist will be placed in the Safety Rounds binder with a copy of the Maintenance Work Order attached.
4. Inspection will include all areas of the unit
5. Any contraband, to include, but not limited to: sharps, wire hangers, lighters, cords, bottles, personal items (perfume, makeup, plastic bags, medicines including over the counter medications) will be removed immediately and labeled.
6. Any extra linens, clean or used, need to be removed and placed in the soiled utility bin.
7. Any other deficiencies, such as housekeeping issues, maintenance problems, or needed supplies, must also be noted. That includes any work not performed by another staff member affecting the general well-being of the unit.
8. Please note that the environmental safety rounds have been edited to add "Are lights working and illuminating?" "Are light fixture covers intact and not broken?" "Are the exterior glass windows intact and not broken or cracked?" "Are all vents secure and clean?" "Are bed mattresses intact with no cracks or tears?" "Are beds secured to floor?"", and "All unoccupied beds checked and linens have been removed, with linen checked for tears or strings.

Multidisciplinary Care Plan – Individually tailoring care plans to fit the problems and goals for patients

1. A multidisciplinary care plan is to be completed on any patient admitted to the Special Services Unit for more than 72 hours.
2. Care plans need to be individualized to each patient with specific updates completed. (i.e. If a patient has an anti-social type disorder or diagnosis, then the goal should not be "pt will attend 2 groups a day." This patient should have a specific goal of "individualized counseling for ______ days and increase psychotherapeutic therapy leading up to 2 groups a day.") If a patient refuses any therapy session or changes in observation status, the care plan needs to be updated to show the change.
3. All care plans should be reviewed and updated for accuracy at least every 24 hours and more as needed.

Comprehensive Admission Skin Assessment

1. Make sure all gowns are free from rips/tears. Please document on the Comprehensive Admission Skin Assessment once you have ensured that gowns are psych appropriate.

Activity Note

1. Individualized activity notes are to be completed if and when a patient refuses an activity.

Group Therapy/Counseling

1. Group Therapy sessions are extremely important to a patient's wellbeing. Patients need to attend these meetings. Please continue to encourage patients to attend therapy sessions. Nurses, please document regarding encouraging patients to attend and their response to the conversation.
2. Counselors have a therapy form to include an individualized counseling session. These forms are completed daily.
3. If a patient refuses group therapy, an individualized therapy note needs to be completed.
4. Counseling sessions will occur at a minimum of twice weekly and may include family, individual, or group sessions.

Community Shower and Laundry Room Process/Kitchen

1. Showers are to be cleaned after each patient use. The Charge nurse will be responsible for assigning which MHT throughout the day will be responsible for the shower. A log

has been placed in the log book for the assigned MHT to write what patient is taking a shower, time in, time out and that the shower is cleaned.
2. Patients are to pick up after themselves once they have finished showering.
3. MHT should ensure that the washing machine is cleaned every Wednesday with bleach and water. Please ensure that when you are assigned to clean the Laundry Room, that the exterior of the washing machine and dryer and cleaned as well. This includes the inner top part of the washing machine that contains compartments.
4. Lint traps on the dryer should be changed after **EVERY** use!
5. Please remember when making tea and lemonade to place a prepared date and an expiration date on label.

Patient Rooms

1. There will be no eating or drinking in patient's rooms
2. Patients need to be encouraged to keep rooms neat and tidy.
3. Rooms will be inspected when safety rounds are completed on every shift and as needed.

Suicide Education

1. **Suicide Risk Assessment Overview**
   a. Risk Factors
      i. Previous suicide attempt
      ii. Chronic Pain
      iii. Central nervous system disorders
      iv. Mental disorders, particular mood disorders, schizophrenia, anxiety disorders (PTSD) and certain alcohol and other substance use disorders; personality disorders (Borderline PD, Anti-social PD and OCD)
      v. Anhedonia, severe anxiety/panic attacks, insomnia, command hallucinations, intoxication and impulsivity
      vi. Impulsive and/or aggressive tendencies
      vii. Hx. of trauma or abuse
      viii. Family history of suicide
      ix. Feelings of humiliation shame or despair. Loss of relationships and poor financial stability.
      x. Lack of social and/or family relationships (No support systems)
      xi. Legal difficulties or problem

   b. Suicide Inquiry: Thoughts/Plan/Intent/Access to Means:
      i. Most of the time a patient is not going to just come out and tell you that they are suicidal or having suicidal ideations. It is your job to ask the right questions that are direct and not open ended. For example, have you ever thought about killing yourself? **NEVER ASK**: You're not thinking of suicide, are you?

ii. Ask: Have you tried to kill yourself before?
iii. Always get as much information possible while the patient is talking to you about any suicidal actions or thoughts, especially if the patient has tried to commit suicide in the past and he/she had a plan to arm themselves. Try in every way to determine the extent to which the patient expects to carry out his/her plan. (See Attached Education Module).

c. Assess Protective Measures

i. Most of the time protective factors do not assist in counterbalancing a High-Risk suicidal patient but usually does help a patient that may be a moderate to low risk. For example, if a patient is suicidal and has responsibility to his/her family members (spouse and children) you can play off if this responsibility in order to hopefully increase his/her coping skills. Some other protective factors may be to their religious faith, problem-solving skills, job responsibilities, and other multiple strong therapeutic relationships.

d. Clinical Judgement

i. Although it can be a challenge to determine the level and/or risk of harm a patient is experiencing, there are specific questions that will help staff to determine the risk level.

e. Documentation

i. Suicide Leveling Assessment Tool: This tool has been created to ask specific questions related to suicide or self-harm using a point system to determine the level of risk per patient. This assessment must be performed on admission and at a minimum of every 24-hour period to reassess. However, if at any time the Nurse and/or MHT determine that the patient has had changes, then the Suicide Leveling System should be done to assess for the need to increase the patient's level or need for one-to-one observation.
ii. A patient's suicide history should always be assessed and taken into consideration. While completing the Suicide Leveling System Assessment, take in to consideration the following: History of suicide of family/close friend, One or more serious attempts within the past 12 months, Serious attempts with actual or potential life-threatening injury.

Suicide Leveling System Assessment and Documentation Process

1. Process

a. All patients will be assessed for suicidal ideations and precautionary measures by using the Suicide Leveling System Assessment Tool on admission and at a minimum of every 24 hours. This does not limit the need to reassess the patient more during your shift or as the patient's need changes throughout his/her stay.
b. Once the nurse finishes assessing the patient's suicide risk and completing the

Suicide Leveling System Tool the nurse then assigns a level and informs the Physician or LIP of the need to increase the patient's observation status. After notification of the MD and/or LIP the nurse will inform the assigned MHT of the patient's observation status and of any increased observation (i.e. One-on- One).

c. There are 3 different observation categories: **15 Minute Checks** (Routine Checks), 1:1 LOS (one-to-one in line of sight) and **1:1 WAL** (one-to-one within arm's length).
d. **Policy** AHW.600.0020

Additional Alternating Rounding Process

1. **Assignment of Alternating Rounds and Documentation**
    a. The Charge Nurse will assign this task to a Nurse and/or MHT every shift.
    b. If one of the assigned staff members has to leave the unit (i.e. lunch or break) the Nurse and/or MHT will give the receiving Nurse/MHT a concise report on his/her patient and turn care of this patient over to this employee until they return to the unit. Once the Nurse/MHT returns to the unit this employee will give a complete and concise report to him/her and relinquish care back to the assigned employee.
    c. The employee assigned to this rounding process will do alternating rounds at different times between the q15 minute checks done by the assigned MHT. This means that this employee may do a rounding time on a patient at 0905, 0908 or 0911 between the 0900-0915 routine. This alternating rounding assignment will make it harder for the patient to learn the routine of the unit in regards to rounding and has an additional staff member monitoring all of the patients for safety.
    d. This monitoring rounding sheets will switch over at 0900 every am after the patient is assessed by the assigned nurse.

Crenshaw Community Hospital Policies and Procedures	Policy Number 015-510	Effective Date 07/01/2014
	Revision Date 09/11/2017	Review Date 09/11/2017
Manual: Special Services Title: Psychiatric Educational Group and Therapeutic Activities	Chief Of Staff Administrator	

Purpose:
Crenshaw Community Hospital's Special Services Unit promotes group and individualized therapy for the psychiatric patient to improve his/her psychiatric health and wellness. We encourage patients to participate in the Special Services group and individualized therapy program. Our programs are designed to support and patient's recovery and help them acquire knowledge and skills that will help them manage the issues that are important. Therapeutic group work also provides support and validation of an individual's feelings as they are given a platform to share their experiences and thoughts with others.
Groups are an essential part of a patient's treatment at Crenshaw Community Hospital. Groups are led by licensed counselors, social workers, and nurses. Below is a listing of some of the groups that we offer.

AA: Alcoholics Anonymous
Anger Management
Self-esteem Building and networking
Discharge Planning Group (Outside Resources to Increase Functioning)
Assessment Group (Value Clarification)
Coping with daily stressors and anxiety issues
Communications Group (Use of Verbal and non-verbal clues)
Coping Skills with Recovery and Substance Abuse
Conflict Resolution Group
Group Goals
Individualized Family and Patient Goals
Medication Group
Other group or individualized sessions as needed per patient's diagnosis

Policy:
To provide educational, spiritual, physical, intellectual and social information related to the patient's needs.

1. All patients are provided an initial Psychosocial Assessment and individualized counseling session within the first 72 hours of admission to ensure that the patient's needs are addressed in collaboration with the psychiatric team members.
2. CCH's counseling team provides two group sessions during the day Monday through Friday at 1000 and 1100. Individualized counseling sessions will be provided on a case by case basis.
    a. All patients will be encouraged to attend Group Therapy sessions as scheduled
    b. If the patient's diagnosis, behaviors, or patient is not willing to attend group therapy sessions then the patients assigned counselor will be provided an individualized therapy session, appropriate for the patient's

psychotherapeutic needs. All group or individualized therapies will be documented within the patients chart using the Group and Individual Therapy note.

c. Counseling sessions will occur at a minimum of twice weekly and may include family, individual, or group sessions.

3. The Activities Coordinator provides a psychiatric appropriate activity opposite to each of these groups for any patients that are not participating in one of these groups. After lunch, weather permitting; the patients are taken outside for the afternoon activities from 1300-1430.
    a. An Activities/Recreational Assessment will be performed on each patient admitted to the special services unit with 72 hours.
    b. All patients will be encouraged to attend psychiatric appropriate activity in a group setting to encourage socialization with others. If the patient refuses to attend scheduled activities the Activities Coordinator or his/her designee will provide individualized activities appropriate to the patient's needs and provide documentation within the patient's chart.
    c. A daily schedule of all activities will be posted on the unit for every patient to visualize. If a patient is not willing or able to attend group activities then individualizes activities will be provided to the patient and documented within the activity.
    d. Therapeutic activity will be conducted daily to focus on each patient's individualized goals to meet the need and interest of patients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.
    e. Assignment of Personnel
        i. Therapeutic activities will be under the direction of the Activities Director. The Director will be on the unit Monday through Friday during the daytime activities schedule.
        ii. Mental Health techs will implement planned therapeutic activities during the evenings and weekends. The mental health tech is under the supervision of the Activities Director. The mental health tech will be oriented and educated to the scheduled therapeutic activities by the Activities Director.

<table>
<tr><td rowspan="2">Crenshaw Community Hospital
Policies and Procedures</td><td>Policy Number
015-455</td><td>Effective Date
08/2017</td></tr>
<tr><td>Revision Date
09/11/2017</td><td>Review Date
09/11/2017</td></tr>
<tr><td>Manual: Special Services

Title: Environmental Safety Rounds</td><td colspan="2">
Chief Of Staff

Administrator</td></tr>
</table>

Policy:
The Charge Nurse will assign the MHT to do a safety round every shift to inspect the entire unit to ensure a safe environment free of any contraband or objects that will allow a patient to inflict self-harm or harm to others. Any issues or objects found will be taken to the Special Services Unit Manager and/or Charge Nurse to review and determine if the issue creates an immediate danger and needs to be taken care of by maintenance department member.

Procedure:

A. The MHT will inspect the entire unit once a shift using the Environmental Rounding Checklist and report and issues to the Special Services Unit Manager and/or Charge Nurse. The Unit Manager and/or Charge Nurse will determine if the findings create an immediate safety issue. If the issues found during the environmental safety round do create an immediate danger the Special Services Unit Manager and/or Charge Nurse should notify the maintenance department immediately for repair.
B. Once these issues are reviewed by the Special Services Unit Manager and/or Charge Nurse a Maintenance Work Order should be completed and logged into the Maintenance Log within the Special Services Unit.
C. The Environmental Safety Rounds Checklist will be placed in the Safety Rounds binder with a copy of the Maintenance Work Order attached.
D. Inspection will include all areas of the unit
E. Any contraband, to include but not limited to: sharps, wire hangers, lighters, cords, bottles, personal items (except for patient clothing or bed linens, perfume, makeup, plastic bags, medicines including over the counter medications found in the patient areas) will be removed immediately and labeled.
F. Any other deficiencies, such as housekeeping issues, maintenance problems, or needed supplies, must also be noted. That includes any work not performed by another staff member affecting the general well-being of the unit (i.e. not cleaning showers, wiping tables, emptying soiled laundry bags)

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Suicide Leveling System Assessment

Assessment Parameters	No Risk	Low Risk/ Level 3	Moderate Risk/Level2	High Risk/Level 1
1. Current Ideation, Plan and Intent				
A. Suicidal Thoughts	_____ None Present (0)	_____ Infrequent or passive thoughts without plan or intent (1)	_____ Frequent or Passive with vague plan with no intent (3)	_____ Continuous and/or contain specific plan and/or stated intent (5)
B. Suicidal Plan	_____ None Present (0)	_____ Unrealistic low lethality with an intent; unavailable means (1)	_____ Vague but realistic plan; available means (3)	_____ Specific realistic plan with available means (5) *
C. Suicidal Intent	_____ None Present (0)	_____ Passive desire to die without self-injuries actions or intent (1)	_____ Expresses vague intent without consideration of plan (3)	_____ Active intent to develop and/or carry out plan (5)
D. Contract for Safety	_____ Able & Willing (0)		_____ Ambivalent (3)	_____ Unable/Refused (5)*
2. History of Suicidal Behavior				
A. History of Suicide Attempts	_____ No previous history (0)	_____ 1-2 low lethality attempts or non-suicidal self-injuries acts in the past two years (2)	_____ One or more serious attempts more than 12 months ago >2 low lethality attempts or non suicidal self-injurious acts in the past year (3)	_____ History of suicide of family/close friend (4) _____ One or more serious attempts within past 12 months (5)
B. Lethality of past self-injurious behavior (If more than one, score most severe).	_____ None Present (0)	_____ Superficial or non suicidal self injurious act without injury requiring treatment (1)	_____ Non suicidal self injury or serious attempt with non life-threatening injury requiring treatment (3)	_____ Serious attempts with actual or potential life threatening injury (5)
Psychological Factors				
A. Depression	_____ None Present (0)	_____ mild; feels "slightly down" (1)	_____ Moderate; moody, sad (2)	_____ Overwhelmed; hopeless; sudden change in demeanor (4)
B. Anxiety	_____ Little or None (0)	_____ Low; denies episodes of intense anxiety (3)	_____ Moderate; Infrequent episodes of intense anxiety (3)	_____ High; frequent episodes of intense anxiety; PTSD or panic symptoms (4)
C. Psychosis	_____ None (0)	_____ Some mild delusions but reality testing intact (1)	_____ Paranoid delusions or ideas of reference, with poor reality testing (3)	_____ Command hallucinations for self-harm, severe unremitting delusions (4)
D. Alcohol/Drug Use	_____ None (0)	_____ Infrequent or past use only, no excessive use (1)	_____ Frequent use, not excessive or occasional use (3)	_____ Frequent, excessive or indiscriminate use, or recent increase (4)
E. Anger/Impulsivity	_____ None (0)	_____ Low; rare outbursts, few impulsive acts (1)	_____ Moderate; occasional outbursts, occasional impulsive acts (2)	_____ High; frequent or severe outburst, frequent or aggressive impulsive acts (4)
4. Medical Factors	_____ None (0)	_____ Acute but short term no disruption in ADL (1)	_____ Chronic or acute, with mild disruption of ADL (2)	_____ Chronic, or severely debilitation (3)
5. Resources or Support	_____ Adequate family/social resources (0)	_____ Limited family/social resources (1)	_____ Marginal family/social resources (2)	_____ Absent or hostile family/social resources (3)
6. Situational	_____ Non-contributory (0)	_____ 1-2 Stressors (2)	_____ 3 Stressors (3)	_____ 4+ Stressors (%)

risk: 0-7 Low Risk/Level 3: 8-18 Moderate Risk/Level 2: 19-34 High Risk/Level 1: 35+, or any with indicator *

Patient Score and Risk ______________________ Observation Level: _____ Q15min checks _____ 1:1 LOS _____ 1:1 WAL

Nurse's Signature ____ Date/Time________

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Question No.	Item	Questions/Criteria	Met	Not Met	Comments *(if "Not Met", what actions did you take?)*
		Common Area Environmental Safety Rounds			
		Entire Unit			
1	Floors	1a. Are hallways and dayrooms free from tripping hazards?			
		1b. Are floor tiles secured to the floor?			
2	Electrical Outlets	Are electrical outlets covered by plates or child-proof plugs?			
3	Vinyl Baseboards	Are vinyl baseboards secured to the wall so they cannot be easily removed and used as a weapon?			
4	Ceilings	Are ceiling tiles intact?			
5	Light Fixtures	Are light fixtures secured to the wall and/or ceiling?			
		Are light fixture covers intact and not broken?			
		Are lights working and illuminating?			
6	Access Point for Wireless Computers	Are all access points for wireless computers secured to the ceiling?			
7	Windows	Are the lexan window glass panes in place?			
		Are the exterior glass windows intact and not broken?			
8	Furniture	Is the furniture intact?			
9	Keypads	9a. Is the main entrance (outside unit) keypad working? (does is unlock and lock)			
		9b. Is the Counselors door (inside unit) keypad working? (does is unlock and lock)			
		9c. Is the seclusion hallway door keypad working?(does it unlock and lock)			
		9d. Is the Courtyard door (inside unit) keypad working? (does is unlock and lock)			
		9e. Are the nursing station keypad working? (does is unlock and lock)			
		9f. Is the keypad at the Med Room working? (does is unlock and lock)			
		9g. Is the keypad at Physician door entrance keypad working?(does it unlock and lock)			
		9h. Is the nourishments room keypad working? (does is unlock and lock)			
10	Staff Offices	Are the doors to staff offices locked when unoccupied?			
11	Showers	Are the shower doors locked when not in use?			
12	Contraband	No contraband found on unit			
13	Fire Extinguisher Key	Are the 2 fire extinguisher keys properly located in the nursing station?			
14	Video Surveillance	Is the video surveillance monitor in the nursing station working?			
15	Courtyard	17a. Are there rocks, dirt, or other things that can be used to throw at others?			
		17b. Is the furniture intact?			

Signature of employee conduction round ______________________ Date ____________

Signature of Charge Nurse ______________________ Date ____________

Signature of Unit Manager ______________________ Date ____________

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High Risk Identifiers/Patient immediately removed from the room and the room closed until Maintenance Depart. Repairs

This list acts as an example of High Risk Identifiers and is not and all inclusive list

- Any compromised showerhead, faucet or fixture that may serve as a ligature point
- Any cracks or breakage of lexan or outer windows
- Damaged or missing parts of door frame window in patient's room
- A steady water leak that causes puddles in floor
- Any electrical covers that have been breached or removed
- Any tamper resistant screw removed from the Lexan
- Cracked or broken bathroom tile
- Broken light fixture
- Mattresses with cracks, holes or zippers
- Large holes in the wall
- Missing ceiling tiles

Low Risk/Remove any potential objects that may cause harm to a patient of staff. Place a work order for Maintenance Depart.

- Soiled ceiling tile
- A small leak that does not cause any immediate danger to the patient
- Blown Light Bulb (Replace if bulb is available)
- A small area of missing paint
- If a patient write/marks on the wall

CRENSHAW COMMUNITY HOSPITAL

Instructions: If criteria is "met", place a "X" in the box. If criteria is "Not Met", place an "O" in the box.

Date: ____________

Item	Criteria	160-1	160-2	161-1	161-2	162-1	162-2	163-1	163-2	164-1	164-2	165-1	165-2	166-1	166-2	170-1	170-2	171-1	171-2	172-1	172-2
Floors	Are floor tiles secured to the floor?																				
Vinyl Baseboards	Are vinyl baseboards secured to the wall so they cannot be easily removed and used as a weapon?																				
Electrical Outlets	Are electrical outlets covered by plates or child-proof plugs?																				
	No electrical cords are a ligature risk?																				
Windows	Are the Lexan window glass panes in place?																				
	Are the exterior windows intact and not broken or cracked?																				
Ceilings	Are ceiling tiles intact?																				
	Are all vents secure and clean?																				
	Are ceiling tiles in place and secure?																				
Beds/ Matresses	Are bed mattresses intact with no cracks or tears?																				
	Are beds secured to floor?																				
Linens	All unoccupied beds checked and linens have been removed. Linens checked for tears or strings (are in good repair)																				
Pillows	All pillows on beds accounted for?																				
Bathrooms	Shower head intact and no space between the walls?																				
	No broken or missing tiles?																				
Ligature Points	Doors and door hinges/ paper towel, soap and toilet paper dispensers are checked for ligature risk?																				
Call Bells	Are call bells intact and in working order?																				

Comments *(If any item was "partially met" or "not met", what actions did you take to correct the issue? See back of form for a list of High and Low Risk Identifiers* ____________

____

____

Signatures: Employee Conducting Round ____________ Charge Nurse ____________ Unit Manager: ____________

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MHT Rounding Log 7A/7P

Date________________________________

Patient Label

Patient's Observation Status

O 15 Minute Checks______________________

O 1:1 Line of Sight (LOS)______________________

O 1:1 Staff within arm length (WAL)___________________

AM Nurse __________________________

Patient Activity Codes

1. 1:1 LOS	7.Socializing	13.Treatment Team	19.Appears asleep	25.______________
2. 1:1 Arm Reach	8.With visitor	14.With _________	20.Awake	26.______________
3. Bathroom	9.Eating	15. Quietly Resting	21.Bathroom door open	27.______________
4. Group	10.Drinking	16.Mumbling	22.Outside	
5. Bedroom	11.Watching TV	17.Isolative	23.Shower	
6 .Dayroom	12.Hallway	18. Tearful	24.______________	

Time	Activity Code	Initials	Time	Activity Code	Initials	Time	Activity Code	Initials	Comments
0700			1200			1700			
0715			1215			1715			
0730			1230			1730			
0745			1245			1745			
0800			1300			1800			
0815			1315			1815			
0830			1330			1830			
0845			1345			1845			
0900			1400						
0915			1415						
0930			1430						
0945			1445						
1000			1500						
1015			1515						
1030			1530						
1045			1545						
1100			1600						
1115			1615						
1130			1630						
1145			1645						

□ Gown placed on 1:1 patient checked for holes, tears, strings or threads ________________ ________________

Signature Time

Initials	Signature

CRENSHAW
COMMUNITY HOSPITAL

MHT Rounding Log 7P/7A

Date______________________________

Patient Label

Patient's Observation Status

O 15 Minute Checks_____________________
O 1:1 Line of Sight (LOS)_____________________
O 1:1 Staff within arm length (WAL)_____________________

PM Nurse _________________________

Patient Activity Codes

1. 1:1 LOS	7.Socializing	13.Treatment Team	19.Appears asleep	25.___________
2. 1:1 Arm Reach	8.With visitor	14.With ________	20.Awake	26.___________
3. Bathroom	9.Eating	15. Quietly Resting	21.Bathroom door open	27.___________
4. Group	10.Drinking	16.Mumbling	22.Outside	
5. Bedroom	11.Watching TV	17.Isolative	23.Shower	
6 .Dayroom	12.Hallway	18. Tearful	24.___________	

Time	Activity Code	Initials	Time	Activity Code	Initials	Time	Activity Code	Initials	Comments
1900			0000			0500			
1915			0015			0515			
1930			0030			0530			
1945			0045			0545			
2000			0100			0600			
2015			0115			0615			
2030			0130			0630			
2045			0145			0645			
2100			0200						
2115			0215						
2130			0230						
2145			0245						
2200			0300						
2215			0315						
2230			0330						
2245			0345						
2300			0400						
2315			0415						
2330			0430						
2345			0445						

□ Gown placed on 1:1 patient checked for holes, tears, strings or threads ________________ ________________
Signature Time

Initials	Signature

CRENSHAW COMMUNITY HOSPITAL

Alternating MHT Rounding Log 7A/7P

Date_______________________________

Patient Label

Patient's Observation Status

O 15 Minute Checks______________________

O 1:1 Line of Sight (LOS)________________________

O 1:1 Staff within arm length (WAL)____________________

AM Nurse ____________________________

Patient Activity Codes

1. 1:1 LOS
2. 1:1 Arm Reach
3. Bathroom
4. Group
5. Bedroom
6. Dayroom
7. Socializing
8. With visitor
9. Eating
10. Drinking
11. Watching TV
12. Hallway
13. Treatment Team
14. With _________
15. Quietly Resting
16. Mumbling
17. Isolative
18. Tearful
19. Appears asleep
20. Awake
21. Bathroom door open
22. Outside
23. Shower
24. ______________
25. _______________
26. _______________
27. _______________

Time	Time Rounded	Activity Code	Initials	Time	Time Rounded	Activity Code	Initials	Time	Time Rounded	Activity Code	Initials	Comments
0700-0715				1215-1230				1730-1745				
0715-0730				1230-1245				1745-1800				
0730-0745				1245-1300				1800-1815				
0745-0800				1300-1315				1815-1830				
0800-0815				1315-1330				1830-1845				
0815-0830				1330-1345				1845-1900				
0830-0845				1345-1400								
0845-0900				1400-1415								
0900-0915				1415-1430								
0915-0930				1430-1445								
0930-0945				1445-1500								
0945-1000				1500-1515								
1000-1015				1515-1530								
1015-1030				1530-1545								
1030-1045				1545-1600								
1045-1100				1600-1615								
1100-1115				1615-1630								
1115-1130				1630-1645								
1130-1145				1645-1700								
1145-1200				1700-1715								
1200-1215				1715-1730								

Initials	Signature

Alternating MHT Rounding Log 7P/7A

CRENSHAW COMMUNITY HOSPITAL

Date_______________________________

Patient Label

Patient's Observation Status

O 15 Minute Checks_______________________

O 1:1 Line of Sight (LOS)________________________

O 1:1 Staff within arm length (WAL)____________________

PM Nurse ____________________________

Patient Activity Codes

1. 1:1 LOS	7.Socializing	13.Treatment Team	19.Appears asleep	25.______________
2. 1:1 Arm Reach	8.With visitor	14.With _________	20.Awake	26.______________
3. Bathroom	9.Eating	15. Quietly Resting	21.Bathroom door open	27.______________
4. Group	10.Drinking	16.Mumbling	22.Outside	
5. Bedroom	11.Watching TV	17.Isolative	23.Shower	
6 .Dayroom	12.Hallway	18. Tearful	24.______________	

Time	Time Rounded	Activity Code	Initials	Time	Time Rounded	Activity Code	Initials	Time	Time Rounded	Activity Code	Initials	Comments
1900-1915				0000-0015				0500-0515				
1915-1930				0015-0030				0515-0530				
1930-1945				0030-0045				0530-0545				
1945-2000				0045-0100				0545-0600				
2000-2015				0100-0115				0600-0615				
2015-2030				0115-0130				0615-0630				
2030-2045				0130-0145				0630-0645				
2045-2100				0145-0200								
2100-2115				0200-0215								
2115-2130				0215-0230								
2130-2145				0230-0245								
2145-2200				0245-0300								
2200-2215				0300-0315								
2215-2230				0315-0330								
2230-2245				0330-0345								
2245-2300				0345-0400								
2300-2315				0400-0415								
2315-2330				0415-0430								
2330-2345				0430-0445								
2345-0000				0445-0500								

Initials	Signature

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Maintenance Log

Month________________________

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Shower Log

Date____________ MHT Assigned______________________

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Date____________ MHT Assigned______________________

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

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Multidisciplinary Care Plan- Adult

Patient Strengths:
- ☐ Insight into illness
- ☐ Compliance with treatment
- ☐ Support of significant people in life
- ☐ Stable residence
- ☐ Employment
- ☐ Insurance
- ☐ Relationship with treating professional
- ☐ Other:______________________

Patient Limitations:
- ☐ Homeless
- ☐ Lack of insight in to illness
- ☐ Non-compliant with treatment
- ☐ Little social support
- ☐ Unemployed/financially insecure
- ☐ No health insurance
- ☐ Has no treating professional
- ☐ Other:______________________

Circumstances of Admission:

____

____

____

Short Term Goals:
- ☐ Patient will comply with unit rules as reviewed upon admission
- ☐ Patient will participate in assessment and treatment planning as evidenced by the signature below
- ☐ Patient will be seen individually within 72 hours of admission for completion of psycho-social history
- ☐ Patient will participate in groups and therapies, as tolerated and beneficial, beginning with individual therapy on Day 1 and 2, with participation increasing, as therapeutic, to ________ daily with goal of participation in all programs activities increasing to ________ by discharge.
- ☐ The patient's psychiatric symptoms that necessitated hospitalization will be eliminated, submerged, or decreased by discharge date.
- ☐ ____

Long Term Goals:
- ☐ Patient and/or significant other(s) will verbalize understanding of diagnosis, signs of relapse, management of illness, and identify community mental health resources
- ☐ Patient will work with counselor, social worker, and discharge planner to develop the best possible discharge plan given each patient's individual circumstances
- ☐ The patient will agree to comply with the follow up care that will be arranged
- ☐ Patient will agree to compliance with prescribed medications upon discharge
- ☐ ____

Patient Participation in Treatment Planning:

☐ Contributed to objectives ☐ Unable to Participate due to:______________________

☐ Aware of care plan and objectives ☐ Refused to participate

______________________ ____________
Signature of Patient/Guardian Date/Time

Interdisciplinary Treatment Team Member's Signatures

______________________	____________	______________________	____________
Physician	Date/Time	Registered Nurse	Date/Time
______________________	____________	______________________	____________
Nurse Practitioner	Date/Time	Counselor	Date/Time
______________________	____________	______________________	____________
Unit Manager	Date/Time	Discharge Planner	Date/Time

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Multidisciplinary Care Plan- Adult

	1. Psychiatric Issues Interfering with Ability to Function: A. □ Hallucinations □ Auditory □ Visual □ Other: ____ B. □ Paranoid Thinking, Other delusional beliefs C. □ Depression D. □ Mood Unstable E. □ Anxiety F. □ Sleep Disturbance G. □ Treatment Noncompliance H. □ ____	____Patient/Family will describe reason for hospitalization ____ Patient will identify areas of strength and weaknesses ____Patient will take medication as prescribed ____Patient will not injure self or others ____Patient will report symptoms to staff ____Patient will participate in therapeutic activities ____Patient will experience reduction in symptoms precipitating admission ____Patient will demonstrate capacity to cooperate with outpatient/ home treatment after discharge	Within 24 hrs of admission Ongoing Ongoing Ongoing By day 2 By day 5 Day 3-5 By discharge	____Assess on admission and pm ____ Monitor for: □ Symptoms of Psychosis: ____ □ Thoughts of suicide or injury to self or others: ____ □ Symptoms of mania: ____ ____Monitor and encourage participation in therapeutic activities ____Medication as ordered/ prescribed ____Nursing education ____Social support & resource services ____Behavior Management ____Group therapies ____Individual therapies □ As Needed ____Family Therapy □ As Needed ____Other	A B C D E F G H Entire Goal Met:
	2. Safety Issues: A. □ Self-injurious behavior B. □ Assaultive behavior C. □ Elopement risk D. □ Fall-risk E. □ History of seizures F. □ ____ G. □ ____	____ Patient will comply with safety measures ____ No injury to self/ others ____ Patient will report thoughts of self-injury, homicidal or suicidal ideation to staff	Ongoing Ongoing Ongoing	____ Educate patient/ family about fall safety ____ Pharmacist/ nurse/ physician review medications ____ Patient monitored at physician ordered frequency ____ID bands maintained on patient ____Precautions ordered by physician ____Restraints/ Seclusion as ordered	A B C D E F G Entire Goal Met:
	3. Alteration in Neurocognitive Status A. □ Delirium B. □ Dementia C. □ Abnormal Movement D. □ ____ E. □ ____	____ Patent will regain/ maintain usual neurological status ____Patient will not experience injury due to falls	By discharge Ongoing	____ Admission baseline assessment ____Reassess mental status q shift ____Initiate precautions as ordered ____Observation at level ordered	A B C D E Entire Goal Met:

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Multidisciplinary Care Plan- Adult

	4. Potential for Withdrawal A. □ Alcohol B. □ Sedative C. □ Mixed D. □ Nicotine ________ ________ ________ ________	____ Patient will not experience complications of untreated withdrawal ____Patient will not experience injury due to symptoms of withdrawal ____Patient will verbalize understanding of symptoms and dangers of withdrawal ____Patient will report symptoms of withdrawal to staff ____Patient will be free of symptoms of withdrawal	Ongoing Ongoing Ongoing Ongoing By discharge	____ Complete substance history assessment psychosocial ____ Monitor vital signs for withdrawal ____Medication as ordered/prescribed ____Provide comfort measures ____ Transfer to medical unit, as needed ________ ________	A B C D Entire Goal Met:
	5. Noncompliance with treatment due to: A. □ Little or no insight B. □ Family lacks understanding of illness C. □ Unable to afford medication D. □ Family dysfunction interferes with access and/or compliance E. □ Other ________	____Patient will be engaged in an individual/ group therapy to educate patient regarding illness and encourage recovery ____ Family or significant others will be involved in treatment designed to provide education and increase understanding of the importance of significant others to recovery ________ ________ ________	Ongoing	____ Patient will be assigned individual/ group therapy appropriate treatment ____ Staff will administer assigned therapeutic activities from treatment ________ ________ ________	A B C D E Entire Goal Met:
	6. Chronic or new onset of acute medical conditions requiring treatment: A. □ Seizure Disorder B. □ Hypertension C. □ Diabetes D. □ Other: ________ ________ ________ ________	____ Chronic and/or acute medical condition(s) which may or may not contribute to patient's psychiatric condition will be identified ____Medical problem will not prevent participation in or provision of psychiatric treatment. ________	24-48 hours Ongoing	____ Initial physical assessment and reassessment PRN ____Medical consults as ordered: ________ ________ ________	A B C D Entire Goal Met:
	7. Impaired ADLs A. □ Unable to perform due to mental illness B. □ Unable to perform due to cognitive impairment C. □ Unable to perform due to less than functional mobility ________ ________ ________ ________	____ ADLs will be completed daily in a timely manner ____ Patient will maintain or increase level of performance of ADLs ________ ________ ________	Ongoing	____ Assist with ADLs as needed ____ Provide direction and assistance with ADLs to patients with cognitive impairment ____PT/OT consult if needed ____Obtain recommended implements to increase independence	A B C Entire Goal Met:

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	8. Acute Stress: A. ☐ Suicidal Thoughts B. ☐ Anger C. ☐ Irritability D. ☐ Substance Abuse E. ☐ Avoidance F. ☐ Difficulty concentrating G. ☐ Muscle Tension H. ☐ Sleep disturbance I. ☐ Impaired Social Skills J. ☐ Hyper vigilance K. ☐ Motor restlessness __________ __________	____ Patient will identify major life conflicts from past and present ____Complete physical evaluation for medications ____ Patient will increase daily social and vocational involvement	First 72 hours Ongoing By discharge	____Counselor will complete the psychosocial assessment ____Counselor will work with patient/family ____Counselor will conduct family session to deal with issues of DC as ordered by physician ____Nurse education regarding diagnosis follow up care and relapse prevention	A B C D E F G H I J K Entire Goal Met:
	9. Psychosocial needs and discharge planning: A. ☐ Court ordered B. ☐ Return to current residence C. ☐ Homeless D. ☐ Alternative placement E. ☐ Lack of support system F. ☐ Nursing Home __________ __________ __________ __________	____Psychosocial assessment will be completed within 72 hours ____ Patient/Family will be familiarized with community resources as needed ____Discharge plan will be in place ____Patient/Family will verbalize understanding of discharge plan	First 72 hours Ongoing By discharge By discharge	____Therapist will complete the psychosocial assessment ____Counselor will work with patient/family ____Counselor will conduct family session to deal with issues of DC as ordered by Physician ____Nurse education regarding diagnosis, follow-up care and relapse prevention __________ __________ __________	A B C D E F Entire Goal Met:
	10. Potential Altered Nutrition/ hydration: A. ☐ Nausea/Vomiting B. ☐ Anorexia/ Bulimia C. ☐ Impaired due to Psychosis __________ __________ __________ __________	____ Patient will maintain adequate nutrition requirements for weight gain/weight maintenance ____ Patient will not purge __________ __________ __________	Ongoing to discharge	____ Screen nutritional status ____ Dietary consult as needed ____ Monitor and record dietary intake ____ Snacks as recommended by dietician ____ 1:1 Observation for 90 minutes after each meal as ordered ____Present sealed foods if paranoid	A B C Entire Goal Met:

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	11. Infection A. ☐ Infection B. ☐ Actual C. ☐ Potential R/T: ☐ Wound ☐ Post Surgical/ Invasive ☐ Post-Intubation ☐ Bacterial or viral infection ☐ Fungal infection ☐ Immunodeficiency ☐Other:____________	____ Infection, if present will be recognized early to allow for prompt treatment requirements for weight gain/ weight maintenance ____________ ____________ ____________ ____________	Ongoing	____ Monitor vital signs as ordered ____Monitor for signs of infection ____Administer antibiotics and anti-infective as ordered ____Instruct patient in signs and symptoms of infection ____Assess for presence and/or history of risk factors such as open wounds, abrasions ____Monitor white blood count ____Assess nutritional status ____Assess for history of drug use or treatment modalities that may compromise immunity ____Assess immunization status	A B C Entire Goal Met:
	12. Pain Management/ Comfort A. ☐ Acute Pain B. ☐ Chronic Pain C. ☐ Lack of Mobility ____________ ____________ ____________ ____________	____Patient will communicate level of pain according to a nonverbal scale or 10 point scale ____Patient will be reassessed and communicate relief of pain	Ongoing	____Assess for pain with appropriate tool and document ____Reassess as indicated ____Administer prescribed ____Assess for effectiveness of medication	A B C
	13. ____________ ____________ ____________ ____________ ____________ ____________ ____________ ____________	____________ ____________ ____________ ____________ ____________ ____________ ____________ ____________		____________ ____________ ____________ ____________ ____________ ____________ ____________ ____________	

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Multidisciplinary Care Plan- Adult

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