My Plan – shared care planning

Te Whatu Ora
Health New Zealand
Hauora a Toi Bay of Plenty

Name: **NHI:**

MY PLAN – kaupapa of shared care planning

This is collaborative record of my **Recovery Journey** and the actions that I and my health team, supports, and whānau have agreed to do to help promote my wellbeing, resilience, and quality of life.

This includes my **Wellbeing Plan**, a summary of what I know I need to keep well and a roadmap for others to support me in the way that is helpful when I need it.

This document has been developed in partnership with my team, and the goals stated are the stepping-stones I need to support my wellbeing and to achieve what is a **Good Life** for myself and my whānau.

MY WELLNESS TEAM – the key people working alongside me on this plan		
Name	**Service / Role in my wellbeing plan**	**Contact**
MY PLAN COORDINATOR		
This nominated person will be responsible for organising future My Plan hui and inviting attendees		

SIGN OFF – this plan has been agreed by the named key people		**Date:**
Tangata Whaiora / Whānau	**Support / NGO provider**	**Clinical Team / NASC**
My Plan will be next reviewed on:	*When:*	*Where:*

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Name: **NHI:**

WELLBEING PLAN **What I need to do daily or regularly and the resources I need to stay well and build my resilience**	
Taha Hinengaro – coping with distress, using treatment, mindfulness, being creative	**Taha Tinana –** self-care, rest & relaxation, sleep, being active, looking after my physical health
Taha Whānau – being with family, friends, and social groups, talking with others, volunteering	**Taha Wairua –** expressing my identity, beliefs, and spirituality, feeling connected, being in nature

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Name: **NHI:**

ADVANCED CARE PLAN **What I need to do when I'm becoming unwell, and how others can support me**	
Becoming vulnerable – early warning signs	**Action Plan –** practical steps to address these

CRISIS PLAN – when I'm unwell, what is needed and what others can do to help		
What others may notice:		
Whānau & Social Support:	**Community & Peer Support:**	**Clinical Team Interventions:**

POST-CRISIS RECOVERY – what is needed immediately after a crisis event to help my return to wellness

My Plan – shared care planning

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Name: **NHI:**

WHAT A GOOD LIFE LOOKS LIKE FOR ME – My description of a positive future I have for me, the life that I am hoping for, and what I am working towards with my Care Team, Supports and Whānau

My Goal to Help Achieve This		
Actions to help achieve my goal	**Who will do this / when**	**What happened / progress**

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Name: **NHI:**

My Goal to Help Achieve This		
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Actions to help achieve my goal	**Who will do this / when**	**What happened / progress**

My Goal to Help Achieve This		
Actions to help achieve my goal	**Who will do this / when**	**What happened / progress**

Name: **NHI:** **Address:** **Phone:** *Please attach sticky label if available*	**In-Patient Treatment Plan** BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI *MENTAL HEALTH & ADDICTION SERVICES*

MULTIDISCIPLINARY TEAM (MDT)		***Contact***
Case Manager:		
Psychiatrist:		
Nurse/ Whai Neehi:		
Psychologist:		
Social Worker:		
Occupational Therapist:		
Pou Kokiri		
A & D Counsellor		

Start Date		**End Date**	

Discharge Criteria *(goals of service identified on admission)*
)

ACUTE PLAN *(to be completed with client at start of treatment plan)*	
Triggers / Early Warning Signs	**Actions to be taken / Supports that can accessed**
Non compliant with medication Not attending to ADL	

Name:	NHI:
Address:	Phone:
Please attach sticky label if available	

In-Patient Treatment Plan

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

MENTAL HEALTH & ADDICTION SERVICES

DATE	IDENTIFIED GOAL *(include risk/safety)*	PLANNED ACTIONS / INTERVENTION	PERSON RESPONSIBLE	REVIEW DATE	REVIEW / OUTCOME

Add further treatment plan sheets as needed / following MDT reviews

SIGNED **Clinician:** _____ **Client:** _____ **Other:** _____

Name:	NHI:	In-Patient Treatment Plan	BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI *MENTAL HEALTH & ADDICTION SERVICES*
Address:	**Phone:**		
Please attach sticky label if available			

DATE	IDENTIFIED GOAL *(include risk/safety)*	PLANNED ACTIONS / INTERVENTION	PERSON RESPONSIBLE	REVIEW DATE	REVIEW / OUTCOME

Add further treatment plan sheets as needed / following MDT reviews

SIGNED **Clinician:** _____ **Client:** _____ **Other:** _____

Name:	NHI:	In-Patient Treatment Plan	BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI *MENTAL HEALTH & ADDICTION SERVICES*
Address:	**Phone:**		
Please attach sticky label if available			

DATE	IDENTIFIED GOAL *(include risk/safety)*	PLANNED ACTIONS / INTERVENTION	PERSON RESPONSIBLE	REVIEW DATE	REVIEW / OUTCOME

Add further treatment plan sheets as needed / following MDT reviews

SIGNED **Clinician:** _____ **Client:** _____ **Other:** _____

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI In-Patient **48 Hour Initial** Care Plan	Patient Label	**Admission date:**
	Staff at Te Whare Maiangiangi will promote mental wellbeing by providing client- centered care based on the Recovery model	**Legal Status on admission:**

Identified risks

Mental Health Care Needs	**Action**	**Variation**	Outcome recorded in N/N **Day 1**	Outcome recorded in N/N **Day 2**
Maintain safety in the least restrictive manner	• Assess current risks and update risk assessment • Institute congruent level of observation			
Monitor mental state	• Assess mental state and document observations through 24 hr cycle • Inform clinicians of significant changes to mental state			
Psycho-pharmacy appropriate to condition	• Administer medication as prescribed • Monitor and report efficacy			
Collaboration and partnership	• Maintain authentic therapeutic presence based on trust, warmth, empathy and immediacy • Utilise micro-counselling strategies as appropriate			
Physical Care needs	**Action**	**Variation**		
Physical well-being	• Baseline recordings as indicated • Management of Falls Risk • Physical examination and daily recordings • Medications/physical care appropriate to condition			
Healthy & balanced nutritional intake	• Monitor nutritional status and encourage healthy eating • Dietician referral as appropriate			
Healthy & balanced sleep/rest pattern	Monitor sleep pattern and encourage sleep hygiene			
Social Care Needs	**Action**	**Variation**		
Maintenance of personal autonomy	Encourage independence in activities of daily living			
Maintain links with significant others	Facilitate visits from significant others as indicated by client			
Limit economic or occupational harm 2˚ to hospitalisation	Ensure relevant medical certificates/SW benefit applications are provided			
Cultural safety	Individual cultural beliefs are respected and accommodated			
Spirituality	Facilitate access to spiritual advisors as appropriate			

Signed- **Clinician**: _____ **Client**: _____

[[pgname_P]] [[psname_U]] [[padd1_P]] [[padd2_P]] **[[padd4_U]]**	**NHI:** [[pnhi_U]] **DOB:** [[pbdate_L]] **PH:** [[ptelep_U]]	**TREATMENT PLAN** Te Whatu Ora Health New Zealand Hauora a Toi Bay of Plenty *MENTAL HEALTH & ADDICTION SERVICES*

MULTIDISCIPLINARY TEAM (MDT)	
Case Manager:	
Psychiatrist:/Paediatrician	
Nurse/ Whai Neehi:	
Psychologist:	
Social Worker:	
Occupational Therapist:	
Pou Kokiri	
A & D Counsellor	

Start Date		**End Date**	

Summary of Needs / Issues *(identified in Comprehensive Assessment)*

DISCHARGE PLAN

Discharge / Exit Criteria	**Discharge Need(s)** *(identified at final review)*	**Responsibility / Referred to**	**Date**
	•	•	

[[pgname_P]] [[psname_U]] [[padd1_P]] [[padd2_P]] **[[padd4_U]]**	**NHI:** [[pnhi_U]] **DOB:** [[pbdate_L]] **PH:** [[ptelep_U]]	**TREATMENT PLAN** Te Whatu Ora Health New Zealand Hauora a Toi Bay of Plenty *MENTAL HEALTH & ADDICTION SERVICES*

DATE	IDENTIFIED NEED / GOAL	ACTIONS / INTERVENTION	SIGNED	Date Reviewed Changed
				•

[[pgname_P]] [[psname_U]] [[padd1_P]] [[padd2_P]] **[[padd4_U]]**	**NHI:** [[pnhi_U]] **DOB:** [[pbdate_L]] **PH:** [[ptelep_U]]	**TREATMENT PLAN**	Te Whatu Ora Health New Zealand Hauora a Toi Bay of Plenty *MENTAL HEALTH & ADDICTION SERVICES*

				•
				•
				•

Client Copy: **Accepted** ☐ **Declined** ☐ **if declined, give reason:** _____

Name: **NHI:** **Address:** **Phone:** *Please attach sticky label if available*	**TREATMENT PLAN** BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI *MENTAL HEALTH & ADDICTION SERVICES*

[[pgname_P]] [[psname_U]] **DOB: [[pbdate_L]]** **NHI: [[pnhi_U]]**

ADDRESS: [[padd1_P]] [[padd2_P]], [[psubrb_P]], [[padd4_P]]

Date reviewed	**MULTIDISCIPLINARY TEAM (MDT)**
	Case Manager:
	Psychiatrist:
	Nurse/ Whai Neehi:
	Psychologist:
	Social Worker:
	Occupational Therapist:
	Pou Kokiri
	A & D Counsellor

Start Date		**End Date**	

Summary of Needs / Issues *(identified in Comprehensive Assessment)*

-
-
-

DISCHARGE PLAN

Discharge / Exit Criteria	**Discharge Need(s)** *(identified at final review)*	**Responsibility / Referred to**	**Date**
	•	•	
	•	•	
	•	•	

Name: **NHI:** **Address:** **Phone:** *Please attach sticky label if available*	**TREATMENT PLAN** BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI *MENTAL HEALTH & ADDICTION SERVICES*

	Relapse Prevention Plan *(completed by)*		

Name: **NHI:** **Address:** **Phone:** *Please attach sticky label if available*	**TREATMENT PLAN** BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI *MENTAL HEALTH & ADDICTION SERVICES*

DATE	IDENTIFIED NEED / GOAL	ACTIONS / INTERVENTION	SIGNED	Date Reviewed Changed
			Clinician: *Client / Family:*	
			Clinician: *Client / Family:*	
			Clinician: *Client / Family:*	

Client Copy:

Accepted ☐ **Declined** ☐ **if declined, give reason:**

_____

Patient Label

MULTI DISIPLINARY GOALS

AND CARE

MANAGEMENT PLAN

- This care plan is a guide to all staff who are involved in patient care
- Detailed interventions are noted as documented on other forms e.g. Wound Care plan, Restraint Care plan, Adult admission care plan
- Evaluation of patient progress against goals will be documented in clinical notes
- Care plan should be reviewed and updated when there are changes in patient status

No.	DATE	**NEED FOR CHANGE:** (identify any current problems / difficulties which require intervention and/or treatment during admission)	**GOALS:** (Achievable positive outcome following intervention)	**INTERVENTIONS:** (methods, techniques, procedures etc. used to achieve goals)	**EVALUATION:** (Review of interventions and goal outcomes)	**EVALUATION:** (Review of interventions and goal outcomes)	**EVALUATION:** (Review of interventions and goal outcomes)
	Signature:	Safety & Risk i.e. to self or others;-self neglect, self-harm, suicide & behavioural risk.			Date: Sign:	Date: Sign:	Date: Sign:
	Signature:	**Mental Health Symptoms** :i.e. low mood, anhedonia, amotivation /volition, mania , vegetative state, ineffective coping , altered cognition & thought processes, impaired judgement, spiritual distress , altered nutrition , altered self esteem , social isolation.			Date: Sign:	Date: Sign:	Date: Sign:
	Signature	**Mental Health Symptoms** i.e. Sensory /perceptual changes-hallucinations , altered thought processes , delusions , Catatonia impaired communication, negative symptoms			Date: Sign:	Date: Sign:	Date: Sign
	Signature:	**Mental Health Symptoms** i.e. increased anxiety-autonomic signs , somatic symptoms sensory/muscular , panic attacks- , poor coping mechanism, , social isolation, poor impulse control –obsessive compulsive behaviours			Date: Sign	Date: Sign	Date: Sign

		Dementia & BPSD Symptoms i.e. cognitive disturbance memory ;Apraxia, aphasia agnosia, , poor self-care poor sequencing , perceptual disturbance , motor function.		ABC/ Agitation Chart to be completed (note on chart any changes in meds or behavioural approach)			
	Signature				Date: Sign	Date: Sign	Date: Sign
		Dementia & BPSD Symptoms Aggression & agitation, Non-compliance to medication, anxiety mood disturbance personality changes, altered sleep.		ABC/ Agitation Chart to be completed (note on chart any changes in meds or behavioural approach)			
	Signature :				Date: Sign :	Date: Sign	Date: Sign:
		Other .i.e. EPS, noncompliance to medication substance abuse. Eating disorder , delirium, pain					
	Signature:				Date: Sign :	Date: Sign:	Date: Sign:

Discussed with client/ family/EPOA : Yes ☐ No ☐

Client or Family member signature: _____

Print Name: _____

Date:

Name:		***NHI:***	
Address:			
DOB:		***Ethnicity:***	
Responsible Clinician:			
Legal Status:			
Attach patient label			

WELLNESS PLAN
MICAMHS YOUTH TEAM

To be completed with Young Person/Whanau

Date:	**For:**		Admission		Review			Discharge

IMPORTANT CONTACTS & SUPPORT PEOPLE:

During work hours MICAMHS 0800333061 and after hours 0800 800508; Tauranga Police: 111	Family/Whanau:
GP:	
Clinician:	Other:
Psychiatrist:	Other:

I know I am well when I am [WELLNESS] – *school, work, home, social, health and wellbeing*

The situations and things that have caused me to become unwell are [TRIGGERS] – *situational: school, work, home, family, relationships, social, substance use*

Signs I am becoming unwell are [EARLY WARNING SIGNS] – *feelings, thoughts (what goes through your head), sleep, delusions/hallucinations, eating habits, behaviour (social withdrawal, snapping at others etc.), physical sensations (breath quickens, dizzy etc.)*

If I feel I am becoming unwell I can [RELAPSE PREVENTION] - *medication compliance, reduced stress, family/social support, environmental strategies, spiritual & cultural support, lifestyle*

What I can do:
Distraction/relaxation activities/coping statements:
1.
2.

What other people can do to help me:
1.
2.

What can be done to support my family:
1.
2.

MEDICATION PRESCRIBED

Clinician Name: _____ Clinician Signature: _____

Name of Young Person/Whanau: _____

Young Person/Whanau signature**:** _____

Mental Health and Addiction Service – Child and Youth
Tauranga Hospital
Cameron Road, Private Bag 12024
Tauranga NEW ZEALAND

PARTNERSHIP

KEYWORKER: DATE:

NAME NHI

Developmental History:

Pregnancy:

Birth:

Neonatal Period (1st four weeks):

Maternal Health:

Infancy: *(First Year, Feeding, Sleeping, Motor Behaviour, Temperament)*

Milestones: *(Smiling, Sitting, Standing, Walking, Crawling, Talking, Toileting, Puberty)*

Significant Events: *(Separations, Bonding, attachment etc)*

Relevant Medical/Psychiatric History:

Medical:

Psychiatric:

Personality and Temperament:

Family History:

Family Structure/Genogram:

Family Psychiatric History:

Family Medical History:

Social Situation: *(Living circumstances, financial situation, supports, significant stressors)*

Cultural Factors:

Personal History

Peer Relationships:

Hobbies and Activities:

Cultural Identification:

Spiritual Beliefs:

Self Esteem:

Any other relevant information about the client/family:

Assessor Name: **Signed:** **Date:**

Consent forms ☐

Care Plan ☐

Risk Assessment ☐

HONOSCA ☐

RISK ASSESSMENT & TRANSITION PLAN (R.A.T.)

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

Name:
NHI:
DOB:

Risk Assessment (Risks and Risks factors):

Date of Risk Assessment:	Assessor Name and Designation:	
Domains	Current: 0-8 weeks	Historical: >8 Weeks
RISK TO SELF: Consider: Suicidal ideation, plans, intent, previous attempt, access to means, self-harm, drug/alcohol use, truancy, self cares (sleep, appetite, physical conditions/ chronic illness), relationship break up, cognition, low self-esteem, mood, hopelessness, impulsivity, mental health disorder, social disengagement, school failure.		
RISK TO OTHERS: Consider: Violence, aggression, bullying, sexualised behaviour, conduct, criminal activities, damage to property, availability of weapons		
RISK FROM OTHERS: Consider: Bullying, physical/sexual/emotional abuse, Neglect, Peer pressure.		
FAMILY/ENVIRONMENTAL RISKS: Consider: Family violence/dynamics, parental conflict/divorce, carers mental/physical health, Living environment (overcrowding/exposure to drugs/alcohol/gangs/guns/ violence/ sexual activity etc), death, loss, grief, financial situation. Family history suicide. Court/Police issues.		

Strengths and Protective Factors (Consider: Locus of control, self-esteem, parental presence and connectedness, connected to school, peers and other adults):

Risk Formulation: (Use 5P's; Presenting, Predisposing, Precipitating, Perpetuating, Protective factors):
Presenting:

Predisposing:

Precipitating:

Perpetuating:

Protective:

OVERALL LEVEL OF RISK: ☐ **LOW** **MEDIUM** ☐ **HIGH**

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

HONOSCA SCORE: _____ Date_____

Youth Wellness Plan

Ideally this plan is to be completed by the young person and their legal guardian (parent/carer). The young person and their legal guardian are responsible for ensuring that this young person and others around them remain safe.

Triggers

List situations or events that increase your risk of engaging in unhelpful behaviours.

1. .
2. .
3. .
4. .
5. .
6. .
7. .
8. .
9. .
10. .

Unhelpful Behaviours

List behaviours that do not help your wellbeing:

1. .
2. .
3. .
4. .
5. .
6. .
7. .
8. .
9. .
10. .

Youth Support Team

List the people and organisations helping you stay well.

Name: _____
Phone: _____
Name: _____
Phone: _____
Name: _____
Phone: _____
Name: _____
Phone: _____

Mental Health Crisis Team (24/7): 0800 800 508
Youthline: 0800 37 66 33, free txt 234
Child/Adolescent Mental Health: 5798380 or 0800 333 061

If an emergency call '111'

Helpful Behaviours

List behaviours that help you to stay safe and well.

1. .
2. .
3. .
4. .
5. .
6. .
7. .
8. .
9. .
10. .

Client Objectives, Plan, Engagement (COPE)

My Choice Goal (s):	
Things I have been working on:	
The things I have achieved since I first came here:	
Things that have supported my wellbeing:	
Things I can keep doing to support my wellbeing:	

My Medications:

Medication Name	What it does	Dose	When and how to take it

Signature _____ Date _____