Attachment 1.

Care Plan			
Name:		**NHI:**	**Date Plan Started:**
Inpatient Team	**Nurse:** **Consultant:** **Other Staff:**		
Community Team and contact details:	Keyworker: Consultant:		
Key Support people and contact details:			
GP:			

Action plan for this admission - *Living document*				
Goals	**Actions/Intervention**	**Who will do it**	**By when (date)**	**Achieved (date)**
Test	Test			

Service user's Signature: _____
Date:_____

Family/Whanau Signature: _____
Date:_____

Nurse/Keyworker Signature: _____

Appendix

Date:_____

Attachment 2.

Te Whatu Ora
Health New Zealand

CARE PLAN

Care Plan					
Name **Preferred name**		**NHI**		**Date Plan Started:**	
Community Team and contact details:	*Cornwall House* *Keyworker:* *Consultant:*				
Key Support people and contact details:					
Other services and contact details					
GP:					

Personal Statement:

Action plan for this admission - *Living document* **Te Whare Tapa Whā – Taha Hinengaro** mental wellbeing**, Taha Tinana** physical wellbeing**, Taha Wairua,** spiritual wellbeing belonging and hope. **Taha whānau,** family wellbeing**.**

Date	Goal	Actions/Intervention	Who will do it	By when (date)	Achieved (date)

Early Warning Signs:

Te Whatu Ora
Health New Zealand

Things I will do if I have Early Warning Signs:

Things My Support People and Clinicians will do if I have Early Warning Signs:

[Tangata whaiora] Signature:
Date:

[Family / Whānau] Signature:
Date:

[Nurse/Keyworker] Signature:
Date

[Other support] Signature:
Date:

Tangata whaiora Participation? Yes/No

Te Whatu Ora
Health New Zealand

Goals Completed: When a goal has been removed from care plan please add here so that a record can be kept.

Date	Goal	Action/Intervention	Achieved yes/no	Comment

Attachment 3.

Te Whatu Ora
Health New Zealand

Haumaru Ōrite Care Plan

Name		**NHI**		**Date Plan Started:**	
Preferred name					
Community Team and contact details:	*Community Team:*				
	Key worker:				
	Consultant:				
Key Support people and contact details:					
Other services and contact details					
GP:					

Personal Statement:

Action plan for this admission - *Living document* **Te Whare Tapa whā**
Taha Hinengaro mental wellbeing, **Taha Tinana**, physical wellbeing, **Taha Wairua**, spiritual wellbeing belonging and hope, **Taha whānau**, family wellbeing.

Date	Goal	Actions/Intervention	Who will do it	By when (date)	Achieved (date)

Appendix C

Te Whatu Ora
Health New Zealand

Date	Goal	Actions/Intervention	Who will do it	By when (date)	Achieved (date)

Early Warning Signs:
Things I will do if I have Early Warning Signs:
Things My Support People and Clinicians will do if I have Early Warning Signs:

Te Whatu Ora
Health New Zealand

[Service user's] Signature:

Date:

[Family/Whānau] Signature:

Date:

[Nurse/Keyworker] Signature:

Date:

[Other support] Signature:

Date:

Service User Participation?	Yes / No

Goals Completed: When a goal has been removed from care plan please add here so that a record can be kept.

Date	Goal	Action/Intervention	Achieved yes/no	Comment

Attachment 4

Client Name:
Dob:
NHI:

Date of CHOICE | **Date of Review** | **Number of face to face contacts**

Top Problem as Identified by Service User and Family/Whanau

Partnership Goal #1

Progress towards Partnership Goal #1 Choose an item

Partnership Goal #2

Progress towards Partnership Goal #2 Choose an item

Partnership Goal #3

Progress towards Partnership Goal #3 Choose an item

Current Intervention Choose an item

Secondary Intervention Choose an item

Progress: what has worked and what has not?

Letting Go Plan: Consider homework, websites and community agencies for support

Attachment 5.

Te Whatu Ora
Health New Zealand

Care Plan

Name		**NHI**		**Date Plan Started:**	
Preferred name					
Who am I? (Ko wai ahau?)					
What matters to me (my best hopes, dreams and wishes)?					
What do I find really challenging at the moment?					
How do I know when I need support, (what changes in me)?					
If I need to take time out, what can I do?					
Trusted people that I can turn to (and their contact details)					
My Team and contact details:					
Other services and contact details					
General Practitioner (My doctor)					

Support Plan - Te Whare Tapa whā
Taha Hinengaro (emotional wellbeing), **Taha Tinana (**physical wellbeing), **Taha Wairua (**spiritual wellbeing, belonging and hope), **Taha whānau (**family and social wellbeing), **Whenua (**land/roots)

Date	Focus	Steps/Plan	Who will do it	By when (date)	Done (date)

Appendix F

Clinical Review Meeting Document
Buchanan Rehabilitation Centre (BRC)

Client Name		**Date of Birth**		**NHI**	
Gender		**Ethnicity**		**First Language**	
Address				**Main Contact**	
Date of admission		**Admitted from**		**Last Community Team**	
Mental Health Act		**Date Implemented**		**DHB**	

Care Team:					
Primary Nurse		**Occupational Therapist**		**Social Worker**	
Psychologist		**Psychiatrist**		**Other**	

Clinical Review Date		**Attendees:**		
Date of last Clinical Review		**Date of last Family Meeting**		

Appendix F

Clinical Review Meeting Document
Buchanan Rehabilitation Centre (BRC)

FORMULATION
Identification and cultural background: **Presenting problems:** **Predisposing:** **Precipitating:** **Strengths:** **Perpetuating:**

CLIENT NEED/RECOVERY GOAL: To be client driven					
Need/Recovery Goal	**Intervention** (Cells can be split if more than one intervention is needed for an identified need/goal)	**Who/When** (Cells can be split if more than one intervention)	**Expected outcome** (Cells can be split if more than one intervention)	**Update** (Cells can be split if more than one intervention)	**Specific Plan** e.g. early warning signs, relapse plan State where filed

Appendix F

Clinical Review Meeting Document

Buchanan Rehabilitation Centre (BRC)

SAFETY STATEMENT
A brief description of the persons past and current risk to others, and themselves, including suicide, self-harm, as well as self-neglect.

OUTCOME MEASUREMENT: To include qualitative information in addition to scores	
HoNOS /Other Measure	

DISCHARGE PLANNING

Appendix F

Clinical Review Meeting Document
Buchanan Rehabilitation Centre (BRC)

Expected discharge date:	**Expected discharge location: (*central, north, west, other*)**	**Expected discharge accommodation type:**

BRIEF SUMMARY OF PROGRESS SINCE LAST CLINICAL REVIEW

CLIENT INVOLVEMENT					
Clients comments on care plan:					
If client not involved, reasons for this:					
Signature:				**Date:**	
This plan has been discussed with the Family/Whanau either during the meeting or afterwards?	Yes/No	If no why?		**Date:**	

BRC staff only:	
At the end of the clinical review meeting the primary nurse shall discuss with other team members who shall complete the following;	**Who**
i. Make a clinical note in HCC capturing time and date of meeting and attendees. ii. Using the meeting minutes update the existing clinical review document on HCC and email the finalised version to all team members.	

Appendix F

Clinical Review Meeting Document
Buchanan Rehabilitation Centre (BRC)

iii.	If the formulation and safety statement were done without the client being present then it needs to be shared with the client in the second part of the clinical review meeting or after the meeting by an identified team member. Once formulation and safety statement has been discussed with the client please print off a copy of the updated clinical review document from HCC, ask the client to read and sign it, give them a copy and upload the signed copy as a PDF to HCC documents. (signed PDF of clinical review document should be uploaded to HCC within one week of clinical review date)	
iv.	Update Family/Whanau in regard to details of current clinical review (if not present at the meeting)	
v.	Paste '*brief summary of progress since last clinical review'* section of clinical review document into the 'past mental health history' section of Client Regional History form with dates to reflect period of time summarised. Update all other relevant domains of Client Regional History form.	
vi.	Update risk section of Client Regional History form (including 'risk history', 'risk formulation', and 'strategies known to promote safety').	
vii.	Update any specific management plan that may exist for the client.	
viii.	Update CHIPS 'client rehab goals' tab	
ix.	Update Relapse Plan with client.	
x.	Inform BRC administration staff that whether or not clinical review meeting went ahead and when to book next review.	

Shared Care Snapshot Summary

Patient	D.O.B	Patient ID

Summary - Please click links to view details	
Patient Plan - Personalised Care Plan	Last Modified Date:

Care Team

Name	Designation | Facility | Organisation	Care Team Role	Contact Details

Diagnoses Back to Top

Allergies Back to Top

Prescriptions Back to Top

Recent Measurements Back to Top

Date/Time	Measurement Type	Measurement Value(s)

Patient	D.O.B	Patient ID

Personalised Care Plan

Back to Top

Last modified by:

About Me

What Matters to Me:

My Goal

Things I Will Do

Things My Care Team Will Do

Daily Life

Medication Issues

Te Whatu Ora
Health New Zealand
Te Toka Tumai Auckland

Starship
Child Health

MUST ATTACH PATIENT LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct visit patient label

PA Assessment and Care Plan
Mental Health Fragility

PATIENT ATTENDER (PA) ASSESSMENT AND CARE PLAN MENTAL HEALTH FRAGILITY

Form must be completed by assigned RN prior to Patient Attender arrival.

Authorisation for increased observation for recent suicide attempt/active suicidal ideation or risk of self-harm. (Consult Liaison Team Member or On-call Psychiatric service)			Print name
MHA section			
Date commenced		Date for review	CN/NUM sets date
Authorisation for increased observation for other mental health concerns CN or NUM or CNM (after hours)			Print name
RN completing the form			Print name

Category A – Constant 1:1 observation (within arm's length at all times)	☐	**Category B – Constant visual observation (within sight at all times)**	☐

If you have any concerns or questions at any time – inform the assigned staff nurse
If PPE (Personal Protective Equipment) is required – follow the door signage

☐	**Risk of suicide attempt/active suicidal ideation or Risk of self-harm**	
Remain in the room when parents, relatives or friends are present		
When patient is in the bathroom	Door to remain open (parent can supervise)	☐
	Door can be closed and do 2 minute verbal checks	☐
Limit shower time to a maximum of 10 minutes.	Shower curtain to remain open (can wear swimming suit or parent can supervise)	☐
	Shower curtain can be pulled closed and do 2 minute verbal checks	☐
At bedside	Curtain to remain open	☐
	Curtain can be closed for privacy reason (e.g. changing clothes) and do 2 minute verbal checks	☐
Immediately report and document any of the following concerning behaviour to the staff nurse:	• Pacing • Verbally abusive • Voicing suicidal thoughts e.g. there's no reason to live, I want to die • Climbing on furniture/window sills • Inappropriate discussions with other people about suicide/death • Potential sharp objects e.g. pencil sharpeners, scissors • Any signs of blood or injuries	

☐	**Risk of going absent without leave (AWOL)**
Sit inside the bedroom by the door/exit	
Immediately press the staff assist button if patient is trying to abscond from the room/ward Do not follow the patient off the ward	
Do 2 minute verbal checks, if patient is in the shower, bathroom or behind the bedside curtain for privacy reason (e.g. changing clothes)	
Document description of patient (clothes they are wearing and colour, hair colour, footwear) at the beginning of the shift and with any change on the Patient Attender report (CR4791)	
Immediately report and document any of the following concerning behaviour to the staff nurse:	• Trying to leave the room • Getting out their hop card, money or phone • Putting on shoes • Changing clothes

PA ASSESSMENT & CAREPLAN MENTAL HEALTH FRAGILITY

CR4793

Te Whatu Ora
Health New Zealand
Te Toka Tumai Auckland

Starship
Child Health

MUST ATTACH PATIENT LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct visit patient label

PA Assessment and Care Plan Mental Health Fragility

☐	**Risk of excessive moving/standing**
Do 2 minute verbal checks when patient is in the shower, bathroom or behind the bedside curtain for privacy reason (e.g. changing clothes)	
Immediately report and document any of the following concerning behaviour to the staff nurse:	• Continuous pacing • Exercising • Standing and refusing to sit down • Standing in front of the mirror for more than 3 minutes • Constant moving on bed and in bed space • Constant jiggling/shaking of legs • Going to the bathroom more than once in every 2-3 hours

☐	**Risk of purging/vomiting**
Do 2 minute verbal checks, if patient is in the shower, bathroom or behind the bedside curtain for privacy reason (e.g. changing clothes)	
Limit toilet time to 3 minutes	
Limit shower time to maximum of 10 minutes	
If you hear, see or smell vomit report to the staff nurse	
Immediately report and document any of the following concerning behaviour to the staff nurse:	• Going to the bathroom more than once in every 2-3 hours • Being secretive e.g. hiding containers in the cupboard • Excessive drinking of any fluids e.g. refilling of water bottle

☐	**Risk of tampering with nasogastric (NG) feeds**
Ensure you can see NG tubing connections at all times	
Do 2 minute verbal checks, if patient is in the shower, bathroom or behind the bedside curtain for privacy reason (e.g. changing clothes)	
PA to inform nurse to disconnect NG (nasogastric) feed prior to shower and to inform nurse to reconnect NG feed immediately after shower	
Immediately report and document any of the following concerning behaviour to the staff nurse:	• Tampering with the pump e.g. pausing or turning off • Disconnecting tubing from nasogastric tube, pump or feed bag • Touching or fiddling with the NG tube

Document patient behaviour and activity hourly on the Patient Attender report (CR4791)