UNIVERSITY OF VIRGINIA HEALTH SYSTEM

1100000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

PSYCHIATRY SERVICES DOWNTIME INTERDISCIPLINARY TREATMENT PLAN
COMPREHENSIVE TREATMENT PLAN

Comprehensive Treatment & Discharge Plan		
Planning Date:	Estimated length of stay:	Coordinator:
Integrated Assessment Summary		
Inventory of Patient's Strengths & Assets		Target Symptoms & Identified Needs
Patient's Input - preferences & needs		

DMS Diagnosis	
Axis I	Axis III
	Axis IV
Axis II	Axis V

Problem List / Identified Needs

Initiation Date	Priority #	Problem/Need: **Not safe to be outside the hospital due to:**	As evidenced by:		
		Long Term Goals / Discharge Criteria:		Target	Achieved

Initiation Date	Priority #	Problem/Need: **Ineffective coping related to:**	As evidenced by:		
		Long Term Goals / Discharge Criteria:		Target	Achieved

Initiation Date	Priority #	Problem/Need: **Not caring for self related to:**	As evidenced by:		
		Long Term Goals / Discharge Criteria:		Target	Achieved

Initiation Date	Priority #	Problem/Need: **Fall Risk:**	As evidenced by: ☐ History of falling and/or history of fall associated with injury ☐ Dementia, delirium and/or depression ☐ Altered gait and balance ☐ Other (specify) _____		
		Long Term Goals / Discharge Criteria:		Target	Achieved

Initiation Date	Priority #	Problem/Need:	As evidenced by:		
		Long Term Goals / Discharge Criteria:		Target	Achieved

Problems deferred to outpatient setting after discharge

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Prob. #	Date /Init.	Short Term Goals / Measurable Objectives	Target	Achieved
		Patient contracts with staff to seek help before acting on harmful impulses (against self / against others)		
		Patient states strength and frequency of harmful thoughts / impulses and reveals details of plan, if any.		
		Patient states absence of suicidal / homicidal thoughts or urges.		
		Patient accepts help from staff with ____ verbal prompt(s).		
		Patient demonstrates _____ ways to cope with harmful / disturbing thoughts.		
		Patient takes medications as prescribed with ____ verbal prompts.		
		Patient verbalizes his / her perception of environmental and internal reality.		
		Patient performs _____ self care activities with _____ prompts.		
		Patient consumes nutritious food / drink at least ___ times a day.		
		Patient tolerates hygiene care and assists as possible.		
		Patient communicates comprehension of the plan to address his/ her pain, i.e.: ☐ pain consult ☐ continue current regimen ☐ titrate to alternative regimen ☐ assess etiology ☐ Other: _____		
		Patient's lab values: ☐ improve to WNLs ☐ stabilize ☐ return to patient's norm ☐ reach therapeutic levels ☐ Other:_____		
		Patient's physical exam findings: ☐ improve to WNLs ☐ not deteriorate further ☐ Other: _____		
		Patient has CIWA scores of 8 or less for 24 hrs.		
		Patient makes contact with community resource support: _____		
		Patient remains free of injury from falls.		
		Patient will state _____ coping strategies for dealing with:		
		Patient will sleep at least _____ hours at night.		
		Patient verbalizes _____ strategies that can improve overall wellness.		
		Patient communicates _____ strategies that can improve his / her management of daily living.		

Prob. #	Date /Init.	Responsible	Short Term Goals/ Measurable Objectives	Therapeutic Interventions	Target Date	Achieved

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Prob. #	Date /Init.	Therapeutic Interventions	Responsible	D/C'd
		Precautions: ☐ Suicide precautions ☐ Fall precautions ☐ Seizure precautions ☐ Violence precautions ☐ Elopement precautions ☐ Sexual precautions ☐ Medical Isolation, Type:	ALL STAFF	
		ECT Care - See Plan of Care Flowsheet Addendum (Form 090303)		
		Provide for safe environment through milieu management and modeling of effective coping and communication.	ALL STAFF	
		Provide for special needs by:		
		Assist patient to participate meaningfully in own treatment.		
		Implement physician orders per PTP	ALL STAFF	
		Titrate / taper medications to achieve therapeutic effect: (list names)		
		Provide education groups re: ☐ Coping skills x_____ ☐ Healthy Living x_____ ☐ Life management x_____ ☐ Illness management x_____ ☐ Other: _____ ☐ Communication/Relationships ☐ Anger management ☐ Leisure Education ☐ Exercise		
		Provide individual education re: ☐ Individual responsibility ☐ Pt's rights ☐ Medications and side effects ☐ Dx/ illness ☐ Substance abuse/addiction ☐		
		Provide for basic needs: ☐ **Hydration**: ☐ push fluids to _____ ☐ IV fluids ☐ **Encourage po intake**: ☐ set up meals ☐ feeding assistance ☐ monitor intake ☐ **Promote sleep**: ☐ maximize amount of sleep x ___ ☐ at night ☐ **Toileting assistance**: ☐ provide reminders ☐ take to BR q ____ & hs ☐ **Hygiene assistance**: ☐ provide reminders ☐ provide support ☐ perform prn ☐ Ambulation ☐ Diversion ☐ Recreation ☐ Rest periods ☐ Leisure time ☐ Other: _____		
		Maximize independent functioning through:		
		Further evaluate:		
		Consult with other services: ☐ Psych OT ☐ Medicine ☐ Cardiology ☐ Neurology ☐ Nutrition ☐ Other: _____		
		Behavior Management strategies:		
		Prevent Falls: ☐ Glasses ☐ Shoes ☐ Timed voiding ☐ Bed alarm/Personal alarm ☐ Constant observation ☐ 15 minute checks ☐ Ambulation assistance ☐ Reorientation ☐ Video monitoring ☐ Orthostatic vital signs ☐ Patient/decision maker education ☐ Floor and/or hip pads ☐ Increased observation ☐ Low bed ☐ Other (specify) _____		

Prob. #	Date /Init.	Responsible	Short Term Goals/ Measurable Objectives	Therapeutic Interventions	Target Date	Achieved

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Involvement of Others

Legal status: ☐ Voluntary ☐ Temporary Detention Order issued: ___/___/___ ☐ Committed on ___/___/___

☐ Patient is assessed to be capable of informed consent.

☐ Patient's capacity to consent in question, 2nd opinion determination sought on ____/____/___

- ☐ Patient determined to lack capacity to give consent on__/___/___ as documented in patient record
- ☐ Patient seeking independent capacity determination due by:____/_____/____
- ☐ Authorized representative (AR)_____ appointed on___/____/___(date)
- ☐ Patient or AR objects to proposed treatment,_____ to contact Human Rights Advocate.
- ☐ Emergency treatment initiated at: ____:_____ ____/____/_____(time /date)
- ☐ Judicial order for treatment over objection ☐ Seek ☐ Obtained on____/____/____(date)

Other:

☐ Pt requested / gave permission for involvement of the following:

- ☐_____ to contact **Family / significant other** : _____
  - ☐ To obtain collateral data ☐ collaborate on Tx needs ☐ arrange meeting ☐ family education
- ☐_____ to contact **Case manager** : _____
  - ☐ To obtain collateral data ☐ collaborate on Tx needs ☐ arrange meeting
- ☐_____ to contact **Outpatient provider** : _____
  - ☐ To obtain collateral data ☐ collaborate on Tx needs ☐ arrange meeting
- ☐_____ to contact **Authorized representative**:_____
  - ☐ To obtain collateral data ☐ collaborate on Tx needs ☐ arrange meeting
- ☐ Other:

☐ Pt declined other involvement

Role of other agencies ☐ No other agency involvement indicated

Identified agency:_____

☐ Provide collateral data ☐ Collaborate on treatment ☐ Assist with placement issues

☐ Provide follow up care ☐ Assist with discharge planning ☐ Other:_____

Other agency involvement:

Referral to Community Resources:

Discharge Plan

Patient Input:

☐ Return to prior living situation ☐ Return to work /school ☐ Pt declines follow up

☐ Arrange placement: _____

☐ Refer to CSB:_____ ☐ Recommending PACT

☐ Psychiatric f/u:_____

☐ Outpatient therapy: _____

☐ Chemical dependency f/u: _____

☐ Medical f/u:_____

☐ Home health: _____

☐ Transfer to other facility_____ ☐ at patient's request ☐ for longer term care

☐ Refer to social services: _____

☐ Refer to community resources: _____

☐ Other:

Care Providers

PRINT NAME	SIGNATURE	TITLE	INITIALS	DATE/TIME

Attending psychiatrist approval of plan:

I have participated in the development of this plan and give my informed consent to this treatment.

Patient signature: _____ **except:**