NHI

This is a draft document.

WDHB: Go To Plan **PRELIMINARY**

Date

—

People who helped develop this plan:

—

People I will share this plan with:

—

Clinicians involved in my care (e.g., Doctors, Keyworkers etc).:

—

Needs and strengths

—

Summarise needs, strengths and progress across domains of wellbeing:
o Hinengaro (the capacity to communicate, to think and to feel): e.g., mental health, substance use or other addictive behaviours
o Tinana (the capacity for physical growth and development): e.g., medical issues; relevant lifestyle factors
o Whnau (the capacity to belong, to care and to share): e.g., relationships, dependent children
o Wairua (the capacity for faith and wider communication): e.g., confidence, beliefs, values
Also consider needs related to: education / work / occupation, finances, accommodation.

Goals

—

Goals for service intervention, of the person, whanau, and service which are Specific, Measurable, Achievable, Realistic, Time-bound.
"What matters to you?" across domains of wellbeing:
o Hinengaro (the capacity to communicate, to think and to feel): e.g., mental health, substance use or other addictive behaviours
o Tinana (the capacity for physical growth and development): e.g., medical issues; lifestyle factors, smoking cessation
o Whnau (the capacity to belong, to care and to share): e.g., identity, family relationships
o Wairua (the capacity for faith and wider communication): e.g., self-confidence, beliefs, values
Also consider goals related to: education/work/occupation; finances; accommodation.

Actions that support the goals

—

Identify interventions that support goals identified by the person, whnau, and service across domains of wellbeing including:
o Hinengaro (the capacity to communicate, to think and to feel): e.g., educational material; self-help; psychological interventions; psychopharmacology; planning regarding medication run
o Tinana (the capacity for physical growth and development): e.g., treatment of medical conditions; has the smoking cessation intervention been completed?

o Whnau (the capacity to belong, to care and to share): e.g., family interventions; education of significant others; COPMIA planning
o Wairua (the capacity for faith and wider communication): e.g., interventions which impact on self-confidence, beliefs, values
Also consider interventions related to: education/work/occupation; finances; accommodation.

Monitoring the effects of medications on my physical health (Metabolic Monitoring)
No

RELAPSE PREVENTION/COPING PLAN

Triggers and Warning Signs
—

Advanced Directive

What I want to happen if I get unwell?	No

Dependents

Plan for people /animals who are dependent on me	No

People that I can contact who will support me:
—

Has a copy of the Go To Plan been given to the person and/or their family?	—

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WDHB: MH Risk Assessment **PRELIMINARY**

Additional Patient Information

Ethnicity

Ethnicity
—

Assessor details

Assessor Name
—

Assessor Title
—

Assessor Service/Unit
—

Assessor Telephone
—

After Hours Acute Management Plan

Date
—

Time
—

Date of expiry (max 3 months)
—

Reason for Review
—

Clinical Concern
—

Current Diagnosis
—

Legal Status
—

Supporting Parents, Healthy Children Screening

Are there any children / young people who may be affected by mental health and / or addiction issues? —

Full names and DOBs of children /young persons potentially affected

Children

Name and Date of Birth

Name — DateofBirth —

Referral

Has a referral been made to MH and wellbeing support?

—

Has a referral been made to other agencies? Which agencies?

—

Declined referral for support at this time

—

Education about Supporting Parents, Healthy Children given?

—

FV

FV question asked —

Statement in clinical notes —

Document Current and / or Potential Risks

Risk to who? Means?

—

Static factors of importance (e.g. History of substance abuse, childhood abuse, etc.)?

—

Internal dynamic factors of importance - what are they?

—

Who noticed the changes first - patient/family/whanau/others? Is victim notification required?

—

What are the early warning signs, or triggers of these internal dynamic risk factors? Are there other relapse factors?

—

What can be done to influence and manage the early warning signs, triggers or relapse indicators?

—

What situational dynamic factors may affect the risk (e.g. substance abuse, living conditions, relationship problems, not taking medication, access to weapons, etc.)?

—

What interventions help address the situational dynamic factors?

—

Risk Behaviours

Document here if the risk behaviour is reinforcing (e.g. self harm reducing tension, violence or threats being effective?). What interventions help the patient learn other ways of expressing themselves?

—

Which staff / family / friends, etc. are involved in the treatment and care of the patient?

Name	Relationship	Contact details
—	—	—

Protective factors (e.g. insight into illness, supportive family, stable accommodation, etc.)

—

Acute interventions required

—

Risk Statement, After Hours & Acute Management Plan

Risk assessment copied to

—

Copy sent to

—

Alert to MHAHT / Keyworker (enter name)

—

Designation of MHAHT

—

Plan completed in collaboration with

—

If not completed in collaboration, why (e.g. patient unable or unwilling)?

—

Signature:

_____

_____

NB: Have you put enough information in this form to help a colleague treat and care for this patient in an emergency?

Psychoeducation given to client on the potential for increased risk to self and others when under the influence of alcohol and/or other substances?

—

Transition Referral Checklist

WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Name:

NHI:

Hub RC/SMO:

Hub case manager:

GP:

NGO or other services involved:

Diagnosis:

Current Medications:

Last updated Risk assessment:

Last updated HONOS / ADOM / HONOS 65+:

Client has consented:

<u>Transition criteria Checklist</u>

- ☐ Discussed with client
- ☐ Consult with whanau and/or significant care providers.
- ☐ Pre-planning, including consideration regarding potential extenuating circumstances, risk response, client awareness of requirements such as attending at GP surgery.
- ☐ Commitment to treatment & medication compliance (including contact for re-script if relevant, attending on time for IMI)
- ☐ If with SMO notes should evidence discussion at previous clinic and again at transition.
- ☐ Current paperwork as required.. Eg: Honos, Risk Assessment, Comprehensive Assessment, Transition and Recovery Plan
- ☐ Case discussed with transition clinician prior to hub meeting presentation.
- ☐ Where criteria checklist unable to be met this should be reflected in notes and discussed with transition clinician.
- ☐ Must be discharged from secondary Mental Health services (excludes AOD)
- ☐ Consideration of other care packages which may present as barrier to transition: eg- medication oversight from WCLT, Pathways Enhanced Mobile.
- ☐ Client cannot be on Relprevv (if on clozapine extra consideration of compliance is required)
- ☐ MHA informal

Checklist is not exhaustive, there may also be circumstances were criteria cannot be fully met, for discussion with transition clinician.

TRANSITION RECOVERY PLAN

Tangata whaiora Name (or place label here) NHI DATE HUB # Presenting Health Care Professional:	Tick or cross below to evidence areas discussed in transition meeting and add comments where appropriate.
1. Reason for transition meeting presentation (circle one) • Initial assessment • Routine review/ update • Treatment planning/ change in circumstances (includes risk) • Transition planning	
2. Tangata whaiora goals and presenting problem relevant for presentation - Goal 1. - Goal 2. - Goal 3.	
3. Physical –medications (and its effectiveness/ tangata whaiora adherence), health conditions, head injury, metabolic monitoring, diet etc	
4. Environmental – housing, social circumstances/ influences, financial, employment etc	
5. Family/Whānau – family dynamics, separation from family, violence, abuse, supportive family, additional supports etc - *Parent? –how are the children doing?* - *VIP Q's*	
6. Mental health and Addiction – depression, anxiety, addiction, suicidal ideation etc	
7. Protective factors –what is going well? Strategies utilised? Strengths?	
8. Treatment progress/ plan (include measures) • Include HONOS/ADOM/K10 or other	
9. Outcome of transition meeting • k/w follow up (note urgency) • NGO referral request • Rehab • Detox • COPMIA • MHAHT alert • Dr review • Psychology referral • Transition from service • Other (specify)	
10. Safety plan – client directed - Warning signs: - People I can contact: - Places I can go: - Brief tool I can use: - Validating statement:	Does the client have a copy?
11. transition plan (from secondary to primary care) – client directed - I achieved ... - I am still working on... - I plan to... - If I relapse I will... - Validating statement...	Does the client have a copy?
12. Signed by presenting clinician:	Co-signed by: signature: