McLaren Northern Michigan

Behavioral Health RN Orientation Competency

(Adult Inpatient & Geriatric)

Name of Orient		
Name of Preceptors	1.	4.
	2.	5.
	3.	6.
Orientation Time Frame		

Key:
1. Completed
2. In-serviced
3. Observed
4. Provided care with assistance
5. Demonstrates without assistance and can verbalize rationale

Procedure:	**Key Code & Initials of Preceptor**
General Information: 1. Interdisciplinary team: a. Attend and actively participate in care plan meetings. b. Meet with Therapists (Social Workers, Recreational Therapist). c. Attend group activities. 2. Walk through a patient chart and explain use of each form. 3. Aware of Behavioral Health Programs: a. Adult inpatient. b. Partial/Day Program. c. Geriatric Inpatient. 4. Crash cart, suction, oxygen.	

Patient Care:

Key Code & Initials of Preceptor

1. Preadmission screening process for patients in the ER or on the medical floors:

    a. Receives call from ER or medical floor for a patient that needs Behavioral Health treatment. Collect the following information from the caller:

        i. Patient's name, DOB, room #, insurance, the doctor that medically cleared the patient, if there is a petition or cert filled out, and why do they need to be screened for Behavioral Health.

        ii. All patients should be medically cleared with the following labs completed: CBC, CMP, UA, UDS, ETOH, & Pregnancy Health.

    b. Call Bay Arenac Behavioral Health (BABH) at 989-895-2300 and ask to speak with an Emergency Service (ES) worker. Relay the patient information to the ES worker and they will determine who screens the patient.

    c. If it is their screen they will see the patient and call you back with the information. You will then fill out a screen over the phone with them. If it is not their screen then a BH staff will need to go see the patient and complete the screen.

    d. Once the screen is done verify that the insurance company does not need to be called for authorization. If the patient has Medicaid or does not have any insurance at all then BABH will need to authorize days.

    e. Verify that the legal paperwork is filled out correctly. The patient should be read the Voluntary Form before they agree to sign it. The Petition and Cert need to be filled out correctly and dated and timed appropriately.

    f. Present the completed screen to the Psychiatrist for admission or denial orders.

    g. Make 6 front and back copies of the screen. The original stays in the ER if the patient is from the ER, otherwise it goes in the chart. A copy each goes to social work, UR, rec. therapy. One copy is for the admissions nurse. The last 2 copies go in the chart. One copy of the front half of the screen down through the insurance information needs to be sent to admitting with the orders of who the patient is being admitted to, the diagnosis, and the room number.

    h. Call for report for the patient before they are transferred. Receive report in SBAR format. Security will transport the patient to the unit for you.

2. Preadmission screening process for patients outside of McLaren:

    a. Complete the 2-sided screen with the screener over the phone to present to the Psychiatrist.

    b. Outside facilities should fax over their screen, lab work, and legal paperwork.

    c. Ensure that the insurance information is correct and that if the patient has no insurance or if they have Medicaid that a CMH staff did the screen. CMH will have to authorize days for patients with Medicaid or no insurance.

    d. Ensure the patient was medically cleared with appropriate labs completed (CBC, CMP, UA, UDS, ETOH, & Pregnancy Test).

    e. Some insurance companies require staff to call them with the screen for pre-approval/ authorization. You may need to call the insurance company for authorization. This should be done before the patient is transferred to the unit.

    f. Present to the Psychiatrist for admission or denial orders.

	Key Code & Initials of Preceptor
3. Admission Legal Paperwork of Patients: a. Adult Formal Voluntary: It is important that the patient is alert and oriented to person, place, time, and situation in order to sign AFV. They must read and understand the front of the AFV form and understand that they will not be able to sign themselves out. b. Involuntary Patient: A petition needs to be filled out by an adult 18 years or older. A certificate needs to be filled out by a Physician or a Psychiatrist. (PA's and NP's cannot fill out a certificate.) The certificate needs to be dated and timed for the day of admission after 8 am. It needs to be done after 8 am because the Psychiatrist on the BH Unit needs to be able to complete the 2nd certificate within 24 hours. The patient will meet with a lawyer if a 2nd cert is completed on them. The lawyer will give them option to sign deferment or go to a court hearing. c. Deferment: Deferment occurs when a patient was brought to the unit on an involuntary basis and after meeting with the lawyer agrees to treatment. d. ATO/Court Ordered Patients: Ensure that the court order is active and not expired. Some patients become court ordered after they are admitted if they refuse to sign deferment because they do not agree with the ordered treatment. e. Demand for hearing. i. Voluntary or deferment admissions, but the patient is not compliant. We are requesting the court hearing. 4. Admission of patients: a. Petition/Physician Certificates: i. See section on petition and certification. b. Certificates of Service: i. Only for involuntary admissions. It's our proof we gave them a copy of their petition and certification. c. Rights Booklet: i. Remove staples from rights booklet and patient book. d. Written statement of rights. e. Bringing patients onto the unit: i. Ensure petition and certification were completed appropriately before bringing patient on the unit. f. Conducting skin check: i. Always have two staff present. g. Searching patient belongings for safety: i. Check pockets, socks, unfold everything. h. Documentation of patient belongings: i. Document all patient belongings. Specifically note any items that are name brand or expensive.	

Key Code & Initials of Preceptor

i. Storage of patient belongings:

   i. Hygiene products stay locked up until the patient needs them.

   ii. Patients can wear one ring per hand. No other jewelry is allowed.

j. Handling patient's money and valuables:

   i. $20 and over gets locked up in Security t. It's up to the patient if they want expensive jewelry locked up in Security or with their belongings on the unit.

k. Handling patient's medications:

   i. Send to Pharmacy.

   ii. Write medications on Personal Property receipt. You do not have to count the number of pills, but state 1 bottle or 1 empty bottle, etc.

l. Special concerns with patient belongings:

   i. If a patient doesn't want something like a rosary or family picture locked up, a Doctor's order is required stating the patient can have the item on the unit.

m. Treatment care plan-formulation with discharge planning (goals, objectives and intervention):

   i. Paper and Paragon care plan.

n. Explain the different forms to be signed.

5. Appropriately administers an intramuscular injection:

   a. For as needed medications, use deltoid or gluteal. No more than 1 mL should be administered in the deltoid.

   b. For any long acting medication, you must read the medication insert (every medication has different instructions).

   c. Chooses appropriate site for upper arm injection (1-2 inches below the acromion process).

   d. Use an alcohol wipe to clean the injection site in a circular motion, moving away from the site. Allow site to air dry.

   e. With your nondominant hand, stretch or spread the skin flat between the thumb and index finger to create a firm surface and to isolate the muscle stretch.

   f. Using your dominant hand, hold the syringe between the thumb and forefinger as if holding a dart.

   g. Insert the needle at a 90-degree angle (needle should be between 1-1.5 inches in length.

   h. Aspirate syringe (if clear, depress the plunger of the syringe into the skeletal muscle).

   i. After medication injected, removes syringe and deploys safety device.

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6. Appropriately administers a subcutaneous injection: a. Choose appropriate needle size (needle length should be 1/2 to 7/8 inches). b. Chooses appropriate site (deltoid or outer aspect of upper leg). c. Cleanses site with alcohol wipe and allows skin to air dry. d. Using the thumb and first 2 fingers of the nondominant hand, pinch up a fat fold, pulling it away from the muscle underneath. e. If 2 inches of tissue can be grasped or using an insulin pen, use a 90-degree angle to inject. Otherwise, insert the needle at a 45-degree angle. f. Inject medication. g. Remove needle, deploy safety device and discard syringe in appropriate hazardous needle box. 7. Manages full patient assignment. 8. Assesses for potential danger to self and/or others every 15 minutes: a. Assess patient's location and **behavior**. 9. Appropriately applies restraints correctly, including appropriate tightness and ability to release quickly. 10. Appropriately utilizes motivational interviewing. 11. Discharge of patient: a. Return of items from Security and Pharmacy. b. Completion of discharge instructions (RN).	
Miscellaneous: 1. Supports quality improvement activities and monitoring. 2. Contact precautions and contact precautions plus. 3. Environment assessment. 4. Line of sight. 5. Orthostatic hypotension.	

I have read the information provided to me on Recipient Rights and will attend CPI training on this date _____, which is 30 days after hired.

Name: _____

Date: _____

Unit: _____