Mental Health and Addiction Services

Orientation Introduction

WELCOME

Name: _____

Program: _____ Date: _____

Introduction to Mental Health and Addiction Services

Congratulations on completing our general hospital orientation. Welcome to the next component of your learning journey. You will be assigned one of our MH & A Staff Members to orientate you, but anyone in our team will be able to answer your questions.

The staff member assigned to orientate you is: _____
In addition to your hands-on clinical area orientation, this booklet has been designed to assist you with other aspects of your new role.

This booklet contains:

Overview of Mental Health and Addiction Services

We provide Schedule 1 Services for Brant and Norfolk Counties which includes: Crisis Service; Inpatient Service; Day Hospital; Outpatient Program and Consultative Services.

We are an Acute Care General Adult Psychiatry service, providing treatment to individuals 16 years of age and older.

MH & A Services is located in E Wing:

- Lower 2 (L2): Private offices of Dr. Book, Dr. Briskin, and Dr. Prayaga
- Lower 1 (L1): MH & A Inpatient Unit and Gymnasium
- Main: Crisis Services and Outpatient Counselling, Dr. Olejarova; CMHA Brant and H-N Office; Concurrent Disorder Office
- 1 level: Acute Day Treatment, Middle and Late Recovery, Anxiety, Relaxation and Medication Clinic. This makes up the Mental Health and Addiction Group Program.

MH & A Service Mission

The dynamic interdisciplinary teams of the Mental Health and Addiction Services are dedicated to the provision of a comprehensive range of acute care assessment and treatment services to adult residents of Brant who have a new and/or serious and persistent mental illness. Our inpatient care is also extended to the residents of Haldimand-Norfolk Region.

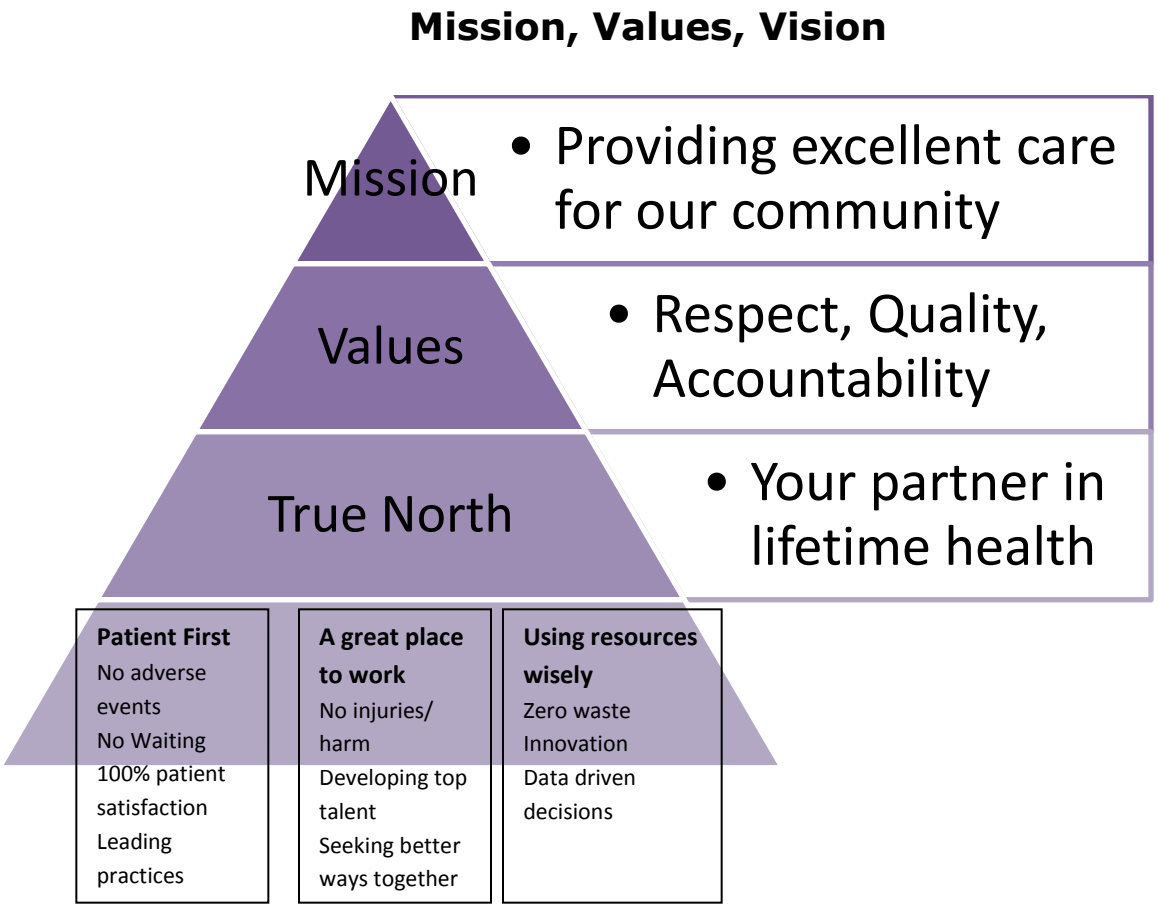
Exemplary care ensures that our consumers realize their full potential to participate as active citizens in our community.

BCHS Corporate Priorities:

We strive to meet the priorities of the BCHS in everything we do:

- Patient's First
  Some areas this priority includes:
  - Patient Safety indicators
  - Compliments and Complaints
  - Patient Flow
- A Great Place to Work
  Some areas this priority includes:
  - Attendance (sick time)
  - LEAN principles
  - Staff Safety
  - Performance Appraisals (Halogen)

- Financial Sustainability
  Some areas this priority includes:
  - Budgets (overtime, supplies, etc.)

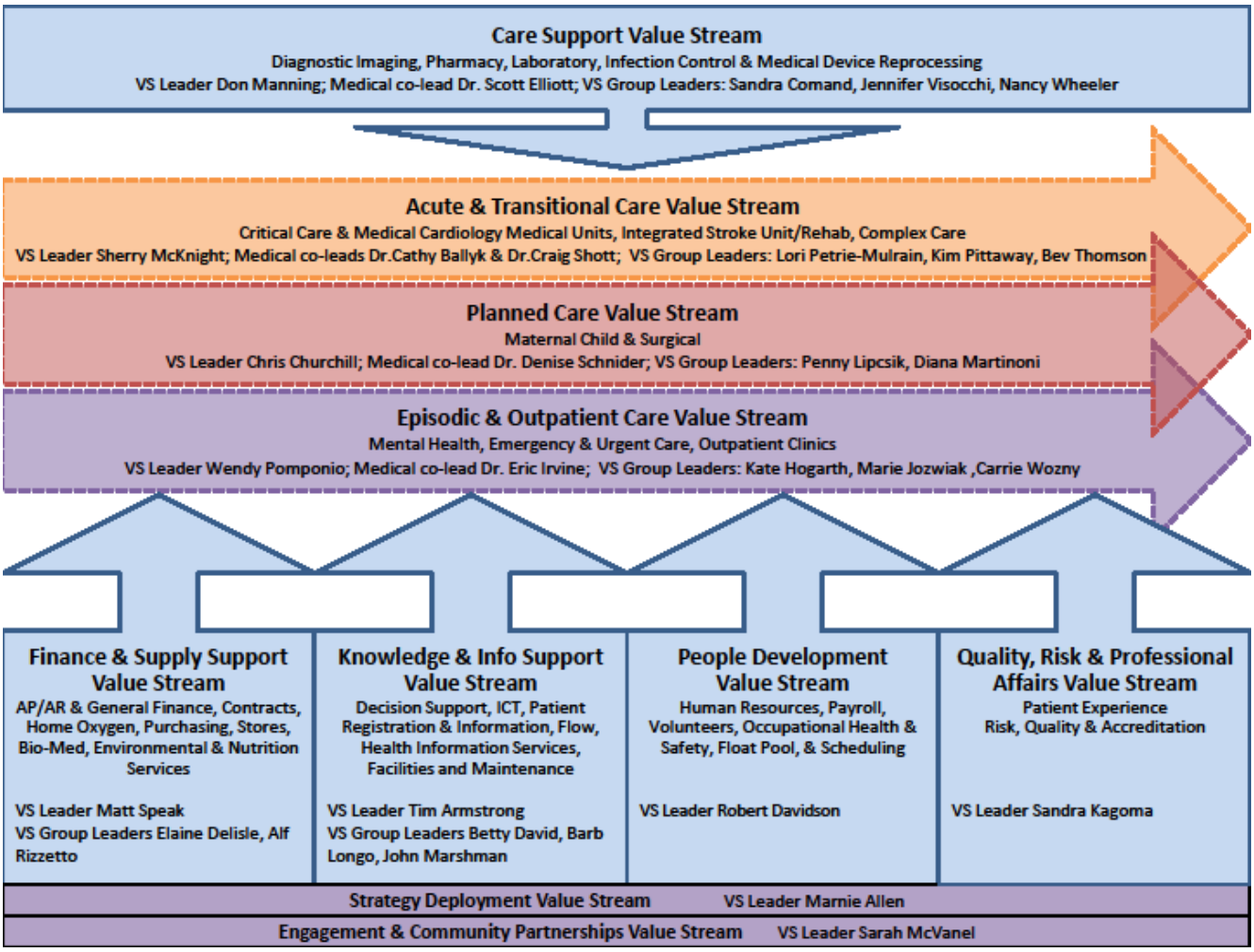


Every one, every minute, every day

Value Streams at the BCHS

Value Streams are a non-traditional organizational structure. The goal is to reduce silos within the organization to provide a seamless journey for our patients from admission to discharge where all actions are value added for the customer.

At the Brant Community Healthcare System, Mental Health and Addiction Services is part of the Episodic Care Value Stream.



Local Health Integration Network (LHIN) – Mental Health and Addiction Priorities:

Our LHIN is called the Hamilton, Niagara, Haldimand, Brant (HNHB) LHIN. It is also known as LHIN 4. While Norfolk is not specifically in the name of our LHIN, it is included.

All Hospitals in this area have accountability agreements with our LHIN. Our community partners also have accountability agreements with our LHIN.

Since 2011, our Mental Health and Addiction LHIN leaders have given us the following priorities:

- To reduce Mental Health and Addiction visits to Emergency Departments
  What we are doing:
  - Tracking of visits, dispositions, type of service, etc.
  - Providing comprehensive assessments at off-site locations (diversion from ER) that have processes in place to access hospital service without going to the ER.
  - Reporting to the LHIN number of visits per month
- To reduce wait times for Mental Health and Addiction individuals in the Emergency Departments
  What we are doing:
  - Tracking of time intervals: registration in ER; and time for MH & A service (time from order for service until time service received). This also includes Norfolk General Hospital Emergency Department.
- To increase access to Mental Health and Addiction service
  What we are doing:
  - Creating off-site access points (i.e., St. Leonard's Community Services; Brant Medical Center)
- To increase and/or enhance working relationships/partnerships with other agencies
  What we are doing:
  - We have a 'What's Out There?" program that brings our community partners into the building to education the individuals we serve
  - Addictions Counsellor from St. Leonard's Community Services comes to the Inpatient Unit once/week as well as to our Acute Day Treatment Program
  - Consumer Survivor Program (HOPE) comes to the Inpatient Unit once/week, and is also available on an ad hoc basis
  - We have entered into a partnership with St. Leonard's Community Service to create an Early Psychosis Program for Brant
  - We are working with St. Leonard's Community Service to create a Detox/Withdrawal Management Program for Brant.
- To reduce recidivism of Mental Health and Addiction individuals in the Emergency Department
  What we are doing:
  - Tracking of repeat visits to the Emergency Department within 30 days

- Tracking of visits to the Emergency Department for individuals seen at one of our off-site locations
- Tracking dispositions of MH & A clients from the ER (discharge/transition planning)
- Community Agency/care provider notification of individuals under their care that present to the Emergency Department. This also includes our own internal outpatient programs.

- To reduce inpatient admission recidivism of Mental Health and Addiction individuals
  - Tracking of repeat admissions to the MH & A Inpatient Unit within 30 days
  - Notification to CMHA case management when one of their clients is admitted to ensure discharge/transition planning
  - Weekday interdisciplinary team conferences to address care planning, which includes discharge planning

Our community partners and internal outpatient services are also working to meet these LHIN priorities.

Big Dot Indicators and Scorecards:

Our Hospital has had a focus on 'Big Dot Indicators' for the past three years.
In 2011.2012, our Big Dot Priorities were:

- Customer Service: this consisted of the completion of e-learning for customer service. MH & A Services ended the year with 98%
- Performance Appraisals: this consisted of the completion of performance appraisals in Halogen. MH & A Services ended the year with 74% of past PA's and 100% of current PA's.
- Hand Hygiene: this consisted of the outcomes of Hand Hygiene Audits. MH & A Services have two individuals who complete these monthly audits. This is to allow us to audit both Inpatient and Outpatient practice. MH & A Services ended the year with 100%.
- Inventory % Reduction: the goal was to reduce the cost of supplies by at least 5%. We did not meet this target. Our overall supply cost reduction was by 3%.

In 2012.2013, our Big Dot Priorities were:

- Total Margin: This was in respect to financial variances. The target was a positive % and MH & A Services achieved a 10%
- % of Rapid Improvement Events (RIE) facilitated by Leadership. The target was 25% and the overall hospital by March 2013 was 45.5%
- ER Wait Times: This was the 90th percentile for ER Wait Times. The overall average 90th percentile for the hospital was 26.91 hours. MH & A Services 90th percentile was 7.79 hours; 50th percentile was 0.44 hours.
- Patient Experience: A survey was developed and addressing client's anxieties and fears was measured. MH & A Services had an overall average of 80.2%.

- The Big Dots of the previous year became Big Dot Priorities 2 and 3

In 2013.2014, our Big Dot Priorities were:

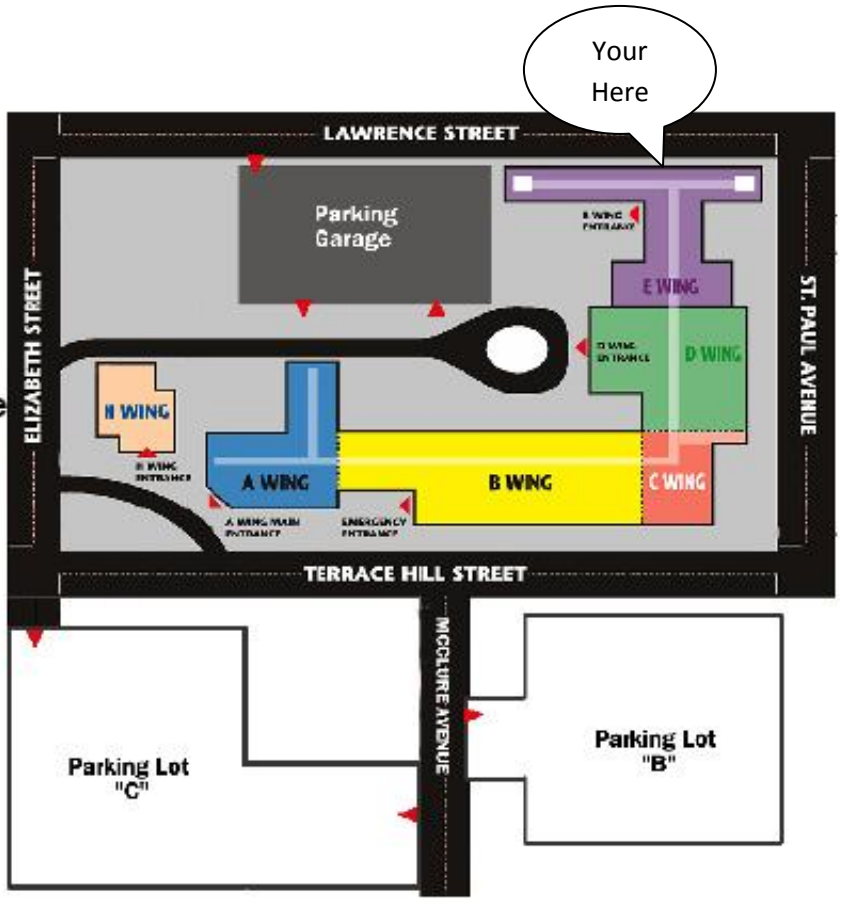
- Reduction in Falls Injury Rate: This consists of measuring the number of total falls and of those falls was there an injury.
- Inpatient Surveys: This consists of measuring the percentage of survey returns for Inpatient and Outpatient. MH & A Services also has an added survey to meet the standardization of client experience within our LHIN. These are also measured.
- Value Stream Flow: This metric looks as bed turnover and occupancy. While the hospital is to show an increase by 10%, MH & A Services has a LHIN priority to reduce Inpatient admissions and length of stay.
- Capacity Building: This consists of measuring the percentage of staff from a value stream who have attended the hospital Skills Building Series or Emerging Leaders.
- Business Intelligence Tool
- Previous years Big Dot priorities became Big Dot Priorities 2 and 3.

Each year our Board of Governors will determine new 'Big Dot Indicators'. Staff were asked to make suggestions for the Strategic Planning of our Big Dot Indicators for 2014.2015.

Patient Flow continues to be a high priority within the hospital. Our target is to have individuals who are admitted through the Emergency Department wait no longer than 1 hour to reach the inpatient Unit.

Brant Community Healthcare System

Brantford General Site



A Wing

Level 8——Asthma Clinic (Puffer Club)
Level 2——Chapel
Pastoral Care
Level 1——Tim Horton's
Gifts Plus
Cashier
Volunteer Lounge
Patient Services
Dialysis Clinic
Main——Health Records
Environmental Services
Organizational Health
Document Source (Xerox)

B Wing

Level 8 ——Paediatrics
Surgical
Level 7 ——Medical A
Level 6 ——Medical B
Level 5 ——Surgical
Level 4 ——Labour & Delivery
Level 3 ——Obstetrics & Constant Care Nursery
Level 2 ——Inpatient Rehabilitation
Level 1——Emergency Department
Discharge Planning
Orthopaedic Fracture Clinic

C Wing

Level 2,4,7 —Complex Continuing Care
Level 6 ——Laboratory
Main ——Cafeteria

D Wing

Level 5 ——Critical Care
Level 3 & 4 —Heating, Ventilation, Air Conditioning
Level 2 ——Rehabilitation Services
Speech Pathology (Adults)
Level 1 ——Imaging (X-Ray, CT Scan, Fluoroscopy, Nuclear Medicine, Mammography, Special Procedures, Ultrasound)
Main ——Ambulatory Care
Cancer Clinic (Oncology)
Patient Registration
Pre-op Clinic
Laboratory Services
Cardiac Diagnostics
Tim Hortons
Business Cashier
Lower Level 1 —Operating Suites
Day Surgery
Post Anaesthetic Care Unit
Lower Level 2 —Stores/Receiving
Pharmacy
Mortuary
Central Sterile Supply

E Wing

Level 5 ——Financial Services
Mohawk School of Nursing
Level 4——Human Resources
Dr. Dickson
Level 3——Orthopaedic Surgeons offices
Level 2——Speech Pathology (Children)
Information Technology
Level 1—— Community Mental Health program
Staff Development
Main —— Mental Health
Women's Health Clinic
Diabetes Education & Outpatient Nutritional Counselling
Lower Level 1 Project Management Office
Lower Level 2 --Mental Health Program
Lower Level 3 --Boardroom
Materials Management
Home Oxygen
Kiwanis Lifeline
Lower Level 4 - Healing with Crafts

H Wing

Level 2 ——Administration Offices
Level 1 ——Foundation
Community Relations & Marketing
Main ——Engineering & Maintenance

Who's Who

The Executive of the Brant Community Healthcare System

- Jim Hornell, CEO
- Lina Rinaldi, Chief Operating Officer and Chief Nursing Executive
- Dr. David Cameron, Director of Medical Affairs and Medical Staff

The Brant Community Healthcare System now operates within a Value Stream Model. There are three clinical value streams: Acute and Transitional Value Stream; Planned Care Value Stream; and Episodic Care Value Stream. Mental Health and Addiction Services is in the Episodic Care Value Stream.

Mental Health and Addiction Services

- Wendy Pomponio, Value Stream Leader, Episodic Care. Wendy's office is located in B Wing 1.
- Dr. Eric Irvine, Value Stream Medical Leader, Episodic Care. Eric's office is located in B Wing 1.
- Dr. Shreekant Sharma, Chief of Psychiatry. Dr. Sharma's office is off-site at the Brantford Medical Centre.
- Kate Hogarth, Value Stream Group Leader, Mental Health and Addiction Services. Kate's office is located in E Wing Main.

Mental Health and Addiction Services Clerical Support

- Inpatient Unit (L1): Lisa Bakker, Unit Clerk
- Outpatient Counselling (Main): Cindi Browne, Secretary
- Group Programs (1): Debbie Haines & Susan Forsyth, Secretaries

Psychiatrist's Secretaries

- Dr. Book and Briskin: Carolann Oliver
- Dr. Prayaga: Deb Fowler
- Dr. Olejarova: Susan Forsyth
- Drs. Sharma: Joan Mersereau

We have one psychiatrist in the community with only courtesy hospital priviledges. Dr. T. Clarke who is in private practice.

The Team

Population health needs are complex and diverse, and it is increasingly recognized that these needs are best met by teams of health providers working in collaboration with each other, and with patients. You will find that we have integration throughout our programs.

There is a growing consensus that interdisciplinary collaboration will contribute to:

- Improved patient care and outcomes
- Improved recruitment and retention of health providers;
- Improved communications among health providers
- More efficient and effective employment of health human resources; and
- Improved satisfaction among patients and health providers (Health Canada, retrieved April 14, 2005).

In addition to promoting better health outcomes for patients, research has shown that interdisciplinary collaborative work provides opportunities for informal education across disciplines and enhances skills and knowledge of other professions, as well as a sense of understanding and respect amongst health care professionals (Paquette-Warren et al. 2004).

In Mental Health and Addiction Services, our core team is made up of:

- Psychiatrists
- Registered Nurses
- Registered Practical Nurses
- Occupational Therapists
- Social Work
- Therapeutic Recreation
- Clerical
- Environmental Service Aides
- We also have Hospitalists who work with our Crisis Service and for our Inpatient Service

Additional members to our Core Team who provide on-site care are:

- Pastoral Care/Music Therapist
- Dieticians
- Pharmacist
- Addiction Counsellor (St. Leonard's Community Services)
- Consumer Survivor Group (Brant Vocational Training Association)
- Canadian Mental Health Association (Brant and Haldimand-Norfolk)
- Right's Advisors (Patient Advocate Office)
- Participants in our 'What's Out There' program component

We also have partnership agreements with Social Services (ODSP and OW) to assist individuals with transportation to outpatient treatment programs.

Program Descriptions:

You will learn about your respective programs in further detail during your orientation period.

Crisis Response Network:
In November 2011, The Brant Mental Health Crisis Response System of the Brant Community Healthcare System and the Mental Health Crisis Support Service of St. Leonard's Community Services joined together to create the Brant Crisis Network. Since then the Network has been joined by the Dementia Alliance (Alzhiemer's Society) with 2 geriatric crisis workers and Woodview Children's Services. The team works in partnership with other community services and supports, as well as serving as a resource to other services within the community at large.

All aspects of our system provide coordinated entry and linkage for clients to the larger mental health system and to other community resources.

Components of MH & A Services of the Crisis Network are:

- Emergency Mental Health
  - 24/7 nursing consultation to the Emergency Department
- Mental Health at the Brantford Medical Clinic
  - 8/5 crisis assessments from 1000 - 1800 hours
  - the Walk-in is closed on holidays
  - individuals requiring this service must ask for the mental health workers specifically
- Crisis Counselling
  - 8/5 short-term crisis intervention in E Wing Main. Length of service is 1 month.
  - The Family Health Teams assist this team with physician orders.
  - Closed on holidays
- Crisis Service at St. Leonard’s Community Services
  - 8/6 crisis assessments from 1100 - 1900 hours. This staff member has the ability to assist ER MH in the Emergency Department when there are clients waiting.
  - There is no physician at this site.
- Hospitalists
  - There is a roster of some of the Hospitalists who provide medical back-up and/or provide physician orders for the hospital component of the Crisis team.
- Emergency Mental Health Crisis Line

- The primary Crisis Line for Brant County is the St. Leonard's Crisis Line (24/7). The hospital line is for emergency crises (24/7).

MH & A Inpatient Unit:

The Mental Health Inpatient Unit is an Adult General Psychiatry short-term stabilization unit. This unit is staffed with an interdisciplinary team that provides 24 hours/day nursing care and 5 day a week Therapeutic Treatment Program from our Mental Health Group Programs.

Treatment goals and plan of care are formalized in the daily Interdisciplinary conferences, in conjunction with the Clinical Assessment Protocols (potential problem domains) identified at the time of Unit assessments.

Admission to the Unit is via the Brant Crisis Network (BCHS staff) or direct via psychiatrists. We provide Psychiatric Inpatient stay for individuals in Haldimand-Norfolk as these Counties do not have a Schedule 1 facility. Individuals in the H-N Emergency Rooms are the same priority as individuals in the BCHS ER.

There is a Transition Facilitator Role within the Unit to assist with seamless transition planning to enhance the patient experience. This is a Unit Nurse who focuses on ensuring that transitions from Inpatient to Outpatient or Community care are informed and seamless.

Acute Day Treatment (Day Hospital):

ADT is an intensive psychiatric outpatient treatment program that provides 12 (twelve) hours of daily care that is designed to provide clients with severe or acute mental health conditions an individualized and attentive treatment program that is not typically provided in a regular outpatient setting.

The ADT option is not limited to people who are ending a hospital stay; it also meets the needs of admission diversion for those who need a higher level of care without the services of overnight, 24-hour nursing.

ADT provides group and individual treatment to assist individuals in the early stage of Recovery. Individuals who do not meet the admission criteria will be discharged and referred to more appropriate services.

Admissions are from Emergency Mental Health, Mental Health Urgent Care, Crisis at St. Leonard’s Community Services and Mental Health Inpatient Unit and/or direct by Psychiatrist with admission priviledges. We may also receive admissions from family physicians.

Middle Recovery Program

Individuals who have been in our Acute Day Treatment Program and are now in the action stage of recovery are involved in the group milieu that focuses on cognitive-behavioral therapy, relapse prevention and some on-going skill building. This program runs for 28 days.

Late Recovery Program

Once Middle Recovery has been completed, individuals who have completed the evening Middle Recovery Program may continue therapy to maintain their recovery in the Late Recovery Program. This is a weekly cognitive therapy group in the early evening.

Therapeutic Skills Program

We work to assist individuals to gain the ability to enhance their sense of well-being through education and skill-building.

Anxiety Education is 10 weekly closed educational group sessions to assist in understanding and managing your symptoms.

Assertiveness is 10 weekly closed educational group sessions to assist clients in skills of assertiveness.

Relaxation/Body Mindfulness is a continuous weekly program to assist individuals in developing the skills to address their anxiety state.

Medication Therapy Program

The Mental Health Medication Therapy Program focuses on medication administration, adherence, monitoring, education and symptom management.

Individuals receiving medication therapy may also receive assessment and treatment within the MH & A Group Programs (i.e., functional assessments, cognitive assessments, life skills, etc.).

Mental Health Counselling

Mental Health Counselling is a program for individuals who are seeking assistance in the acute phase of their mental health and addiction problem. The professional therapists offer individual counseling to meet the clients' unique needs. The program believes that people can be helped to effectively enhance their own mental well-being through counseling. People can be helped to increase their self-esteem, improve their coping skills, enhance the ways that they communicate and relate to others and effect change within the social system in which they live.

A referral is required by a family doctor, psychiatrist or nurse practitioner to access this service.

Community Treatment Coordinator

The role of the Co-ordinator is:

- To provide training/education to these stakeholders of Brant, Haldimand and Norfolk
- To establish strong working relationships with necessary mental health and social service providers
- To monitor and gather the necessary information related to the creation and effective implementation of CTO's
- To develop protocols and relationships with local police, within hospital emergency and mental health departments and other key groups as needed
- To be familiar with Right's Advice capacity locally
- To ensure that a CTO be practical and have good potential for success.
- To organize discharge planning activities with the physician and appropriate community services.

Early Psychosis Intervention Program (B.H.N. - Begin Healing Now)

The Begin Healing Now program is a regional program for Brant, Haldimand and Norfolk Counties. The team is comprised of a Registered Nurse, Occupational Therapist, Registered Practical Nurse, Masters in Social Work and the B.H.N psychiatrists.
Again this is an integrated program with staff from both MH & A Services and St. Leonard's Community Services.
This team provides individual, client and family groups, and community education.
It is an intensive case management program.

Concurrent Disorder Outreach Program

Another integrated program between MH & A Services and St. Leonard's Community Services. This program provides specialized outreach assessment and treatment to individuals who are experiencing a concurrent disorder.
The team has partnerships with Family Practices, Methadone Clinic and Holmes House.

Coping Skills Group

This program should be starting shortly. This will be a 20 week closed group that provides treatment for individuals who are experiencing emotional dys-regulation; interpersonal conflicts, and distress intolerance.
Individuals meeting the criteria for this group may not have a diagnosis, but rather experiencing crises.
This type of group will also be provided by our community partners and is coordinated for staggered start dates to decrease wait times.

Dialectic Behavioural Therapy

This is also a program that should be starting shortly. The program is developed through the partnerships of St. Leonard's Community Services, Canadian Mental Health Association - Brant, Grand River Community Healthcare Center, Family Counselling Center of Brant and MH & A Services at the BCHS.

Each agency has one or two individuals with enhanced training to provide Dialectic Behavioral Therapy to individuals with a diagnosis of Borderline Personality Disorder. This program consists of weekly individual and group therapy for individuals who have accepted the terms of the program.

Global MH & A Service Practices

Model of Care

A system for the distribution of health care provider care in which care of one patient is managed for the entire 24-hour/12 hour/day or contact/visit from admission to discharge by one healthcare provider who directs and coordinates the other care team members, coordinates the schedule of tests, procedures and daily activities for that patient, and cares for that patient personally when on duty.

In practice, mental health and addiction care is a collaborative venture in which a high level of communication and cooperation is required between all team members. At no time should a patient wait unnecessarily for decisions affecting their freedom or achievement of goals because the primary care provider is unavailable – colleagues should make the necessary decisions (including amending and updating) with reference to the integrated service care plans.

Huddles

A Huddle is time each day or certain days on a weekly basis that the team comes together to work through the PDSA (Plan, Do, Study, Act/Adjust) cycle. The team may plan for the day or next day, as well as checks the results from the previous day/week/month and problem solves what can be done more effectively. Finally, it is a chance for the team to make adjustments and improvements to their daily work practices such as new processes, etc

Staff Meetings

Global Team meetings play a vital role in the healthy functioning of Mental Health and Addiction Services and the MH & A staff.

The purpose of Team Meetings is to provide an opportunity for:

- Information sharing and program updates between staff
- Development and review of strategic plan (program planning) in regards to mandates, priorities and legislation
- Review of MH & A policies, guidelines and clinical guidelines
- Accreditation readiness
- Developing teamwork and support for one another
- Identification and discussion of service issues

We endeavor to have 1 or 2 meetings per month. Staff are paid to come into team meetings on their own time.

Staffing

Posting of Rota:

The rota, of scheduled staff, will be posted four weeks in advance of the commencement of the schedule. A master rota will be used as a guide in completing the schedule; although, adjustments may be made by the Program Manager to allow for changing needs of the program, e.g., Christmas, vacation, conferences, availability of staff.

Inpatient, and Emergency Mental Health

Requests prior to the posting of the new rota will be emailed to the Unit Clerk (schedmh) at least 1 (one) week prior to posting. The Program Manager will be copied on all requests.

All other areas

Requests prior to the posting of the new rota will be emailed to the Program Manager. The requests will be sent via email at least 2 (two) weeks prior to the posting date.

Sign-In Sheets:

- It is the responsibility of the individual staff member to sign-in for actual hours worked. Tours scheduled may be entered for the entire seven day sign-in sheet, but the initialing of attendance must be done on the actual day of the tour.
- Staff can not initial attendance for another staff member.
- Any hours worked on other units/areas will be noted on the sign-in sheets.

Vacation Planners

Vacation Planners are an electronic Excel Workbook in Mental Health, and are always available for viewing. These planners consist of two worksheets, December 15th to June 14th and June 15th to December 14th.

There are two Vacation Planner files, one for Inpatient and Emergency Mental Health Nursing; and another for all other programs under Mental Health.

All requests for pre-approved vacation must be emailed to the Program Manager, who will enter this into the planner. The Program Manager will reply to the individual that the request has been entered into the planner for pre-approval via email. It is the staff member's responsibility to check that vacation request has been entered accurately.

Requests for pre-approved vacation are accepted until September 15th for the Dec.-June time frame, and March 15th for the June-Dec. timeframe. These will be entered in red in the planners with final approval being electronically indicated by October 15th and April 15th respectively.

For 24/7 services, two individuals of the same discipline may be off at one time (i.e., 1 FT and 1 PT; or 2 FT; or 2 PT, etc.).

For other programs, other than scheduled program closures, 1 individual will be approved to be off at one time.

On-Call Psychiatrists

The on-call schedule for Psychiatrists is created by the Psychiatrists and each area receives a copy (Inpatient, Crisis, and Acute Day Treatment), as well as the Emergency Department.

Non-violent Crisis Intervention

The Crisis Prevention Institute (CPI) provides a non-violent crisis training program that is recognized by many as a standard for violence prevention in the human service industry.

Mental Health and Addiction Services ensures that the service has two certified CPI trained instructors for the service.

Non-violent Crisis Intervention certification is a mandatory working requirement in Mental Health and Addiction Services for all staff. The focus is on ensuring the Care, Welfare, Safety and Security of those involved in a crisis situation.

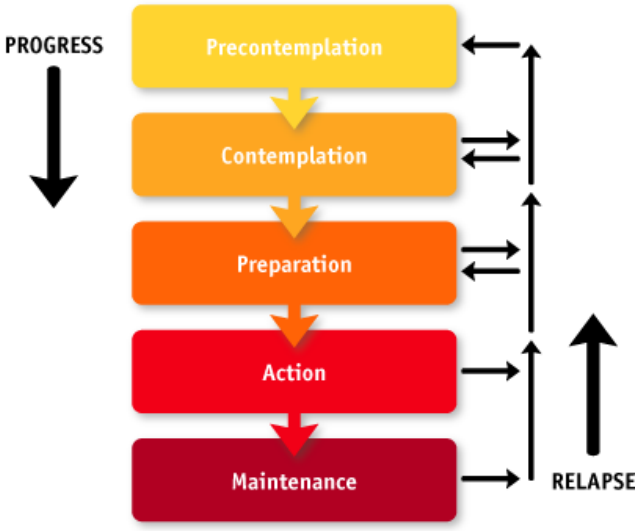
Initial training occurs as needed and as well as annual recertification.

Recovery/Readiness for Change Model

The Transtheoretical Model of Behavior Change assesses an individual's readiness to act on a new healthier behavior, and provides strategies, or processes of change to guide the individual through the stages of change to action and maintenance.
In the Transtheoretical Model, change is a "process involving progress through a series of stages"

- Pre-contemplation – "people are not intending to take action in the foreseeable future, and are most likely unaware that their behaviour is problematic"
- Contemplation – "people are beginning to recognize that their behaviour is problematic, and start to look at the pros and cons of their continued actions"
- Preparation – "people are intending to take action in the immediate future, and may begin taking small steps towards change"
- Action – "people have made specific overt modifications in their life style, and positive change has occurred"
- Maintenance – "people are working to prevent relapse," a stage which can last indefinitely"
- Termination – "individuals have zero temptation and 100% self-efficacy... they are sure they will not return to their old unhealthy habit as a way of coping"

In addition, the researchers conceptualized "relapse" (recycling) which is not a stage in itself but rather the "return from action or maintenance to an earlier stage."



Recovery is often called a process, an outlook, a vision, a conceptual framework, a guiding principle. There is no single agreed upon definition of recovery. However, the main message is that hope and restoration of a meaningful life are possible, despite serious mental illness (Deegan, 1988, Anthony, 1993). Recovery is: "both a conceptual framework for under- standing mental illness and a system of care to provide supports and opportunities for personal development. Recovery emphasizes that while individuals may not be able to have full control over their symptoms, they can have full control over their lives. Recovery asserts that persons with psychiatric disabilities can achieve not only affective stability and social rehabilitation, but transcend limits imposed by both mental illness and social barriers to achieve their highest goals and aspirations."

Customer Service:

BCHS

Heart and Soul

You are what people see when they arrive here.

Yours are the eyes they look into when they're frightened and lonely.

Yours are the voices people hear when they ride the elevators and when they try to sleep and when they try to forget their problems. You are what they hear on their way to appointments that could affect their destinies. And what they hear after they leave those appointments.

Yours are the comments people hear when you think they can't.

Yours is the intelligence and caring that people hope they'll find here.
If you're noisy, so is the hospital. If you're rude, so is the hospital.
And if you're wonderful, so is the hospital.

No visitors, no patients can ever know the *real* you, the you that *you* know is there—unless you let them see it. All they can know is what they see and hear and experience. And so we have a stake in your attitude and in the collective attitudes of everyone who works at the Brant Community Healthcare System. We are judged by your performance. We are the care *you* give, the attention *you* pay, the courtesies *you* extend.

Thank you for all you're doing.

Brant Community Healthcare System
The Willett, Paris
The Brantford General

Service Excellence by Wendy Leebov, Ed. D

The Cab Ride

Twenty years ago, I drove a cab for a living.

When I arrived at 2:30am, the building was dark except for a single light in a ground floor window.

Under these circumstances, many drivers just honk once or twice, wait a minute and then drive away. But I had seen too many people who depended on taxis as their only means of transportation. Unless a situation smelled of danger, I always went to the door. This passenger might be someone who needs my assistance, I reasoned to myself.

So I walked to the door and knocked. "Just a minute" answered a frail, elderly voice. I could hear something being dragged across the floor. After a long pause, the door opened. A small woman in her 80's stood before me. She was wearing a print dress and hat with a veil pinned on it, like somebody out of a 1940's movie.

By her side was a small nylon suitcase. The apartment looked as if no one had lived in it for years. All the furniture was covered with sheets. There were no clocks on the walls, any knickknacks or utensils on the counters. In the corner was a cardboard box filled with photos and glassware.

"Would you carry my bag out to the car?" she said. I took the suitcase to the cab then returned to assist the woman. She took my arm and we walked slowly towards the curb. She kept thanking me for my kindness. "It's nothing", I told her. "I just try to treat my passengers the way I would want my mother treated."

"Oh, you are such a good boy", she said.

When we got in the car, she gave me an address, and then asked, "Could you drive through town?" "It's not the shortest way," I answered quickly. "Oh, I don't mind," she said. "I'm on my way to a hospice."

I looked in the rear-view mirror. Her eyes were glistening. "I don't have any family left," she continued. "The doctor says I don't have very long."

I quietly reached over and shut off the meter. "What route would you like me to take?" I asked.

For the next two hours we drove through the city. She showed me the building where she had once worked as an elevator operator.

We drove through the neighbourhood where she and her husband had lived when they were newlyweds. She had me pull up in front of a furniture warehouse that had once been a ballroom where she had done dancing as a girl. Sometimes she'd ask me to slow in front of a particular building or corner and would sit staring into the darkness, saying nothing.

As the first hint of sun was creasing the horizon, she suddenly said, "I'm tired. Let's go now."

We drove in silence to the address she had given me. It was a low building, like a small convalescent home, with a driveway that passed under a portico.

Two orderlies came out to the cab as soon as we pulled up. They were watching her every move. They have been expecting her. I opened the trunk and took the small suitcase to the door.

The woman was already seated in a wheelchair. "How much do I owe you?" she asked, reaching for her purse. "Nothing" I said.

"You have to make a living," she answered.

"There are other passengers," I responded.

Almost without thinking, I bent and gave her a hug. She held onto me tightly. "You gave an old woman a little moment of joy," she said. "Thank you."

I squeezed her hand, and then walked into the dim morning light. Behind me, a door shut. It was the sound of the closing of a life. I didn't pick up any more passengers that shift. I drove aimlessly lost in thought. For the rest of that day, I could hardly talk. What if that woman had gotten an angry driver or one who was impatient to end his shift? What if I had refused to take the run, or had honked once, then driven away?

On a quick review, I don't think that I have done anything more important in my life.

We're conditioned to think that our lives revolve around great moments….

But great moments often catch us unaware, beautifully wrapped in what others may consider a small one.

People may not remember exactly what you did or what you said…BUT…

They will always remember **HOW YOU MADE THEM FEEL.**

Beware of Garbage Trucks™

by David J. Pollay

How often do you let other people's nonsense change your mood? Do you let a bad driver, rude waiter, curt boss, or an insensitive employee ruin your day? Unless you're the Terminator, you're probably set back on your heels. However, the mark of your success is how quickly you can refocus on what's important in your life.

Sixteen years ago I learned this lesson. And I learned it in the back of a New York City taxi cab. Here's what happened.

I hopped in a taxi, and we took off for Grand Central Station. We were driving in the right lane when all of a sudden, a black car jumped out of a parking space right in front of us. My taxi driver slammed on his brakes, the car skidded, the tires squealed, and at the very last moment our car stopped just one inch from the other car's back-end.

I couldn't believe it. But then I couldn't believe what happened next. The driver of the other car, the guy who almost caused a big accident, whipped his head around and he started yelling bad words at us. How do I know? Ask any New Yorker, some words in New York come with a special face. And for emphasis, he threw in a one finger salute, as if his words were not enough.

But then here's what really blew me away. My taxi driver just smiled and waved at the guy. And I mean, he was friendly. So, I said, "Why did you just do that!? This guy could have killed us!" And this is when my taxi driver told me what I now call, "The Law of the Garbage Truck™." He said:

Many people are like garbage trucks. They run around full of garbage, full of frustration, full of anger, and full of disappointment. As their garbage piles up, they look for a place to dump it. And if you let them, they'll dump it on you.

So when someone wants to dump on you, don't take it personally. Just smile, wave, wish them well, and move on. Believe me. You'll be happier.

So I started thinking, how often do I let Garbage Trucks run right over me? And how often do I take their garbage and spread it to other people at work, at home, or on the street? It was then that I said, "I don't want their garbage and I'm not going to spread it anymore."

I began to see Garbage Trucks. Like in the movie "The Sixth Sense," the little boy said, "I see Dead People." Well now "I see Garbage Trucks." I see the load they're carrying. I see them coming to dump it. And like my taxi driver, I don't take it personally; I just smile, wave, wish them well, and I move on.

One of my favorite football players of all time is Walter Payton. Every day on the football field, after being tackled, he would jump up as quickly as he hit the ground. He never dwelled on a hit. Payton was ready to make the next play his best. Over the years the best players from around the world in every sport have played this way: Tiger Woods, Nadia Comaneci, Muhammad Ali, Bjorn Borg, Chris Evert, Michael Jordan, and Pele are just some of those players. And the most inspiring leaders have lived this way: Nelson Mandela, Mother Theresa, Ghandi, and Martin Luther King.

See, Roy Baumeister, a psychology researcher from Florida State University, found in his extensive research that you remember bad things more often than good things in your life. You store the bad memories more easily, and you recall them more frequently.

So the odds are against you when a Garbage Truck comes your way. But when you follow The Law of the Garbage Truck™, you take back control of your life. You make room for the good by letting go of the bad.

The best leaders know that they have to be ready for their next meeting. The best sales people know that they have to be ready for their next client. And the best parents know that they have to be ready to welcome their children home from school with hugs and kisses, no matter how many garbage trucks they might have faced that day. All of us know that we have to be fully present, and at our best for the people we care about.

The bottom line is that successful people do not let Garbage Trucks take over their lives.

What about you? What would happen in your life, starting today, if you let more garbage trucks pass you by?
Here's my bet: You'll be happier.

Telephone Practice

Reference for

Service Excellence

To achieve our values of respect, quality and accountability, we must be courteous and commit to a culture of compassion and customer service excellence in all our day-to-day activities. This includes interactions with our patients ,family members, members of the general public, community partners, coworkers, physicians, BCHS members in other departments, volunteers, and students. (i.e., external and internal customers).

Below are the standards and expectations of all BCHS members.

Our focus for 2011-2012 is:

I will live this by:	I will show this by:
Treating others how they want to be treated	Speaking directly to the person, and acknowledging their presence. **"Hi, My name is _____, I am a (role) in (area). I am here to..."**
Actively listening	Paraphrasing what the customer is saying or asking. **"So, if I understand you correctly..."**
Displaying a service orientation	Using a standard telephone greeting. **"Hello, (name) speaking, I am a (role) in (area). How may I help you?"**
Displaying empathy	Using Sad but Glad rules: **"I am sad this is happening to you but am glad to help you by..."**
Providing information and explaining processes	Giving a timeline and follow-up at the right time or when the status changes. **"The information I have for you is.... I will check back in once I have an update."**
Empowering customers to make choices & take action	Making it right as best I can. **"I will _____ for you."**

Michael Efthimiakopoulos (above), a McGill commerce graduate, suffered from depression and took his own life. Now, his father, John Efthimiakopoulos, hopes to launch a website to rally support among others who would like to change laws and attitudes toward mental illness. He would also like to see Quebec review laws governing mental illness to allow family members more say when a loved one is in distress.

Photograph by: Courtesy of the Efthimiakopoulos family, .

MONTREAL - It was a little after midnight on July 4 when Michael Efthimiakopoulos went for a walk on the Jacques Cartier Bridge.

A McGill commerce graduate, Efthimiakopoulos loved Pink Floyd, reading and mountain climbing. Summer nights, he had been known to hike up Mount Royal to watch the sunrise with friends. Winter afternoons, he might hang out in a café reading the newspaper or meet pals for a beer.

But for the last four years, the 47-year-old banker had been struggling with a deepening depression. When his illness began to affect his work, his employer offered to put him on medical leave, providing he enrolled in therapy.

“He refused, because of the stigma,” his father recalls. “He didn’t want others to know. He was a very proud boy.”

As his condition worsened and he still refused treatment, the bank let Efthimiakopoulos go.

John Efthimiakopoulos, who retired from the restaurant business last winter, tried to persuade his older son to seek help. “ ‘If you were a little boy, I would do what has to be done. But now, it’s up to you. I have always been proud of you. And I would be so proud of you the moment you take the first step.”

“Give me time,” Michael told his father. “I’m not ready yet.”

Michael didn’t want to see other people, not even his brother Peter, on a visit home from his job overseas. Michael’s illness wasn’t something the family discussed with others.

“When a loved one has a problem with mental illness, even the family does not want to spread it around. In our case, we kept it between us. Why? Because of that stigma,” his father says.

“It’s so hard when you are there to help your children and you know there is nothing you can do.”

On the Jacques Cartier Bridge that July night, Efthimiakopoulos was carrying a knapsack in which he had packed a small stepladder. Stopped by police patrolling the bridge, Efthimiakopoulos said he was out for a stroll on a beautiful night. When they asked about

the ladder, he said he was moving and had borrowed it from a friend. Suspicious, the officers decided to take Efthimiakopoulos to Notre Dame hospital for observation.

Over the next six hours, Efthimiakopoulos would see three psychiatrists. According to his father, the medical team concluded he was depressed, but did not appear suicidal. Michael Efthimiakopoulos wanted to leave and told the hospital not to call his family. By law, they had no right to keep him.

That evening, Michael met his parents, a Monday ritual John and Anna Efthimiakopoulos had begun after their son became ill. He said nothing of his stroll on the bridge, or his visit to Notre Dame.

“To us, he was the same as every other time,” his father recalls.

Unlike other meetings, when they might make small talk about the stock market, Michael had little to say. He didn’t stay long.

Early on the morning of July 12, Michael Efthimiakopoulos climbed to a precipice on Mount Royal, and jumped off. He was alive and able to speak when Urgences Santé brought him to the Montreal General just after 3 a.m.

On his way to the operating room, he told hospital staff not to call anybody. He died a few hours later.

In his wallet was a slip of paper with two phone numbers, his own and his parents. Yet it would take a full day before his parents received the call telling them their son was dead.

“I’ve faced mountains in my life. Nothing bothered me. But this is not the same. This is the worst thing that can happen to a father or a mother,” John Efthimiakopoulos said.

“When my son was born, I was 20 years old and a waiter at the Queen Elizabeth Hotel. And when Michael was born, I felt so rich. … To me, wealth is what you are, not what you have. Family is a very important thing. When Michael died, I felt like I had lost half of my world.”

He would like to see Quebec review laws governing mental illness to allow family members more say when a loved one is in distress.

“When doctors realize that the person is mentally ill, depressed, there must be an exception. There are always exceptions in life.”

More urgent, he argues, is greater education, awareness and sensitivity in our society toward people who are suffering from mental illness.

“I’m not an expert. I’m nobody. The only thing I know is that I’m a father whose son committed suicide because of the stigma,” said John Efthimiakopoulos, who hopes to launch a website to rally support among others who would like to change laws and attitudes toward mental illness.

"We live in 2011. We have to stop calling these people crazy, erratic, twisted. We have to accept it as a disease of the brain. Condemnation does not liberate. It oppresses," he said.

"My wife said there is nothing we can do. Yes, there is nothing we can do for Michael. But if I can do something to save other lives, other sons and daughters, sisters and brothers, fathers and mothers, that would be a consolation for me."

Mental Illness and Stigma

You Tube:
Labels: http://www.youtube.com/watch?v=PdvfVqv6usw&NR=1&feature=endscreen
Mental Illness Stigma: http://www.youtube.com/watch?v=Dw_I-G1smoo
What if I Told You?: http://www.youtube.com/watch?v=AGYseZ0OrvQ&feature=related
Mental Health Public Information:
http://www.youtube.com/watch?v=UeU0B2ZfOEg&feature=rellist&playnext=1&list=PL6BF2C793A6806F52

What is the problem?

Stigma is a major barrier preventing people from seeking help. *Many people living with a mental illness say the stigma they face is often worse than the illness itself.* Mental illness affects people of all ages and from all walks of life. It can take many forms including depression, anxiety and schizophrenia.

What is Stigma?

Stigma is made up of two parts: negative and unfavorable attitudes, and negative behaviours that result from those attitudes. People living with a mental illness often experience stigma through:

- Inequality in employment, housing, educational and other opportunities which the rest of us take for granted.
- Loss of friends and family members (the social and support network).
- Self-stigma created when someone with a mental illness believes the negative messages.

2011 - Mental Health Commission of Canada

Recognizing the problem
Use the **STOP** criteria to recognize attitudes and actions that support the stigma of mental illness. It's easy. Just ask yourself if what you hear:

- **S**tereotypes people with mental illness (that is, assumes they are all alike rather than individuals)?
- **T**rivializes or belittles people with mental illness and/or the illness itself?
- **O**ffends people with mental illness by insulting them?
- **P**atronizes people with mental illness by treating them as if they were not as good as other people?

1993 – Canadian Mental Health Association

The words we use can hurt:

Acceptable Words/Phrases	Words we should never use
- Person with a mental illness	- Crazy, insane, mental patient - Short of a loaf
- Person with schizophrenia	- Schizophrenic
- Person with a diagnosis of a disability/mental illness	- Mentally retarded - The disabled - Mentally ill
- Person with a diagnosis of a disability/mental illness	- Normal or abnormal
- Living with	- Suffering from
- Diagnosed with	- Victim of
- Person with an alcoholic addiction	- Alcoholic
- Person with a drug addiction	- Addict, junkie, crackhead
- Mental Health assessment room (in ER)	- Bubble room

What is LEAN?

Lean thinking is not a manufacturing tactic or a cost-reduction program – **BUT A WHOLE SYSTEM MANAGEMENT STRATEGY.** Lean thinking starts at the customer value then works toward designing processes to deliver that value.

A lean organization understands customer value and focuses its key processes to continuously increase it. The ultimate goal is to provide perfect value to the customer through a perfect value creation process that has zero waste.

To accomplish this, lean thinking changes the focus of management from optimizing separate technologies, assets, and vertical departments to optimizing the flow of products and services through entire value streams that flow horizontally across technologies, assets, and departments to customers.

Lean, in any setting, is a customer-focused management philosophy. In healthcare, lean means focusing on the patient as the primary customer. A heightened patient focus means implementing new lean methods for ensuring patient safety and quality of care, such as checklists and error proofing methods. Patient focus also means designing processes and physical spaces with the patient in mind, minimizing wait times and travel distances. Simply put, many lean hospitals describe their goals as follows: **"No waste, no waiting, zero harm."**

Traditional Culture vs LEAN Culture

Traditional	LEAN
Functional Silos	Interdisciplinary Teams
Benchmarking to justify not improving - "just as good"	Seek the ultimate performance, the absence of waste
Blame people	Root cause analysis
Rewards: individual	Rewards: group sharing
Supplier is enemy	Supplier is ally
Guard information	Share information
Volume lowers costs	Removing wastes lowers costs
Internal focus	Customer focus
Expert driven	Process driven

LEAN Terminology

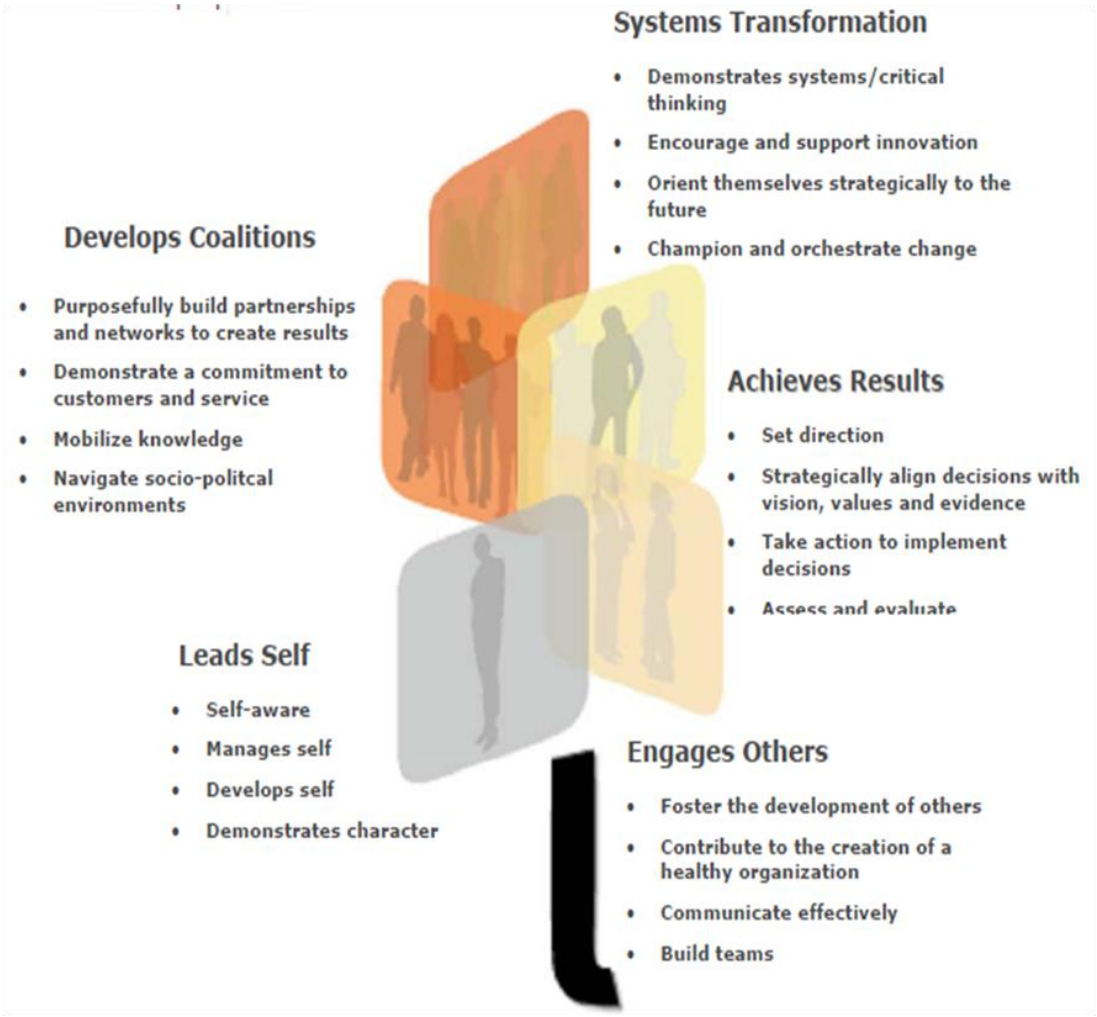
Term	Definition	Examples
Andon	- a call for HELP - a signal to stop	- Code White - Code Nurse STAT - an Andon email
Gemba	- going to see the work actually done	- visiting another clinical area to see what is happening - visiting a community partner
Kata	- the act of practicing a pattern so it becomes second nature - An improvement kata is a routine for moving from the current situation to a new situation in a creative, directed, meaningful way	- developing Action Rounds - developing Huddles - developing processes and failing forward
Kanban	- a visual signal that triggers an action	- clean and dirty cards on equipment - 5S tape markings
Kaizen	- an evolving improvement from the previous condition	- Kaizen event ▪ an organized 3-5 day event to look at a specific problem and identify solutions to implement ▪ also called Rapid Improvement Events (RIE) - outcomes from Huddles
5 S	- A solution for being organized in the workplace	- our Inpatient Unit (communication center and supply room both have been 5S)
5 Whys	- Asking "Why?" enough times to get to the root cause of the problem.	- The basis for any Root cause Analysis.
Pareto	- Analyzing a problem with a large number of factors involved. Factors are grouped according to importance, similar to the 80/20 rule.	
Value Stream Mapping	- A tool to identify material and flow through a process in an organization.	

Term		Definition	Examples
Standardized Work	-	The current best method for doing a task. The same way, every time, by everyone. Account for change based on new best practice.	
Value Added Activity	-	An activity that improves the process or result.	

Achieving LEAN Methodology

Everyone in our organization is a leader in achieving excellence in customer service (Patient First). The Brant Community Healthcare System utilizes the LEAD model in our Emerging Leaders program.

LEADS Model



What is 5S?

A series of step that helps create a better workplace by organizing, cleaning and reducing waste.

What are the 5 Steps?

Sort – separate out what is needed from what is not needed, keep only what is needed, only in the amounts needed and only when it is needed. Restore unnecessary items.

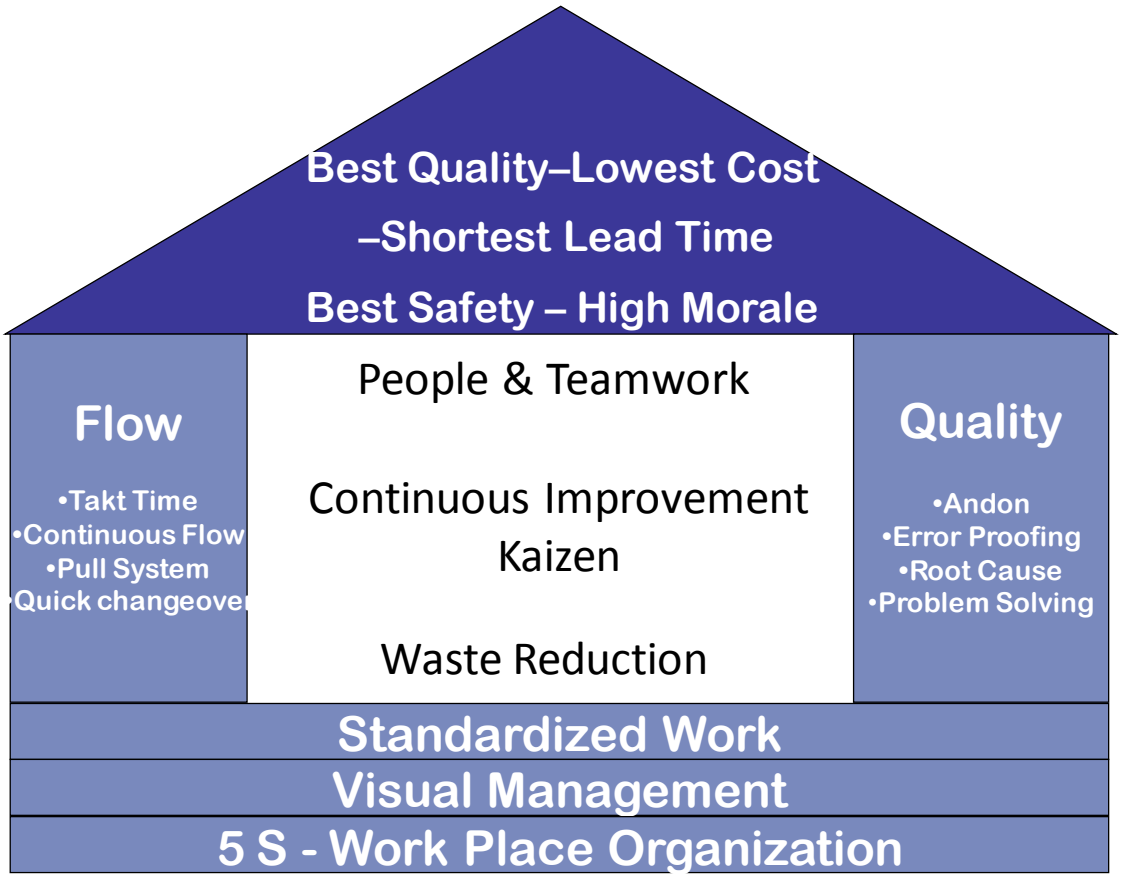
Set – arrange items so they are easy to find and use. Label items so that their storage sites are easily understood by anyone. Implement visual control.

Shine – Clean the work area.

Standardize – make sure that organization, orderliness and cleanliness are being maintained and incorporated into everyday activities.

Sustain – properly maintain correct procedures. Use audits and standard operating procedures. Continuously improve workplace conditions.

Our LEAN House



Finding Resources

Mental Health 'N' Drive
Mental Health and Addiction Services has a specific drive that is not accessible to other areas. In this drive you will find folders that contain forms utilized by MH & A Services; discipline specific folders that contain college documents; folders for meeting minutes; schedules for outpatient services; as well as folders for clinical resources.

Mental Health and Addiction Program Manual
The electronic Mental Health and Addiction Program Manual can be found in our Mental Health drive. This is the most accurate version of the Manual. There are also binder paper copies in each area. The manual contains policies and procedures, guidelines and protocols.

Clinical Assessment Protocols
This document is electronic and can be found on-line in the folder for the Mental Health Program Manual.

Supplies
There is a supply cupboard on Main. Extra brochures can be found in this cupboard. On the West end of Main, there is a Patient Activity Supply Room.

Work Orders
There are three computers in MH & A Services that have the Megamations software. The areas are: Inpatient, Main and Level 1. This software enables staff to enter work orders for maintenance repairs.

Wellness Toolkit
The Wellness Toolkit which was developed internally is a patient centered document that assists clients through their journey to recovery. The package is developed with the client at his/her own pace. Not all sections are relevant for each client. When the client is discharged, the toolkit goes with him/her.
The toolkit can be found in the folder 'Clinical Tools'.

Clinical Tools
We have attempted to create a folder as a resource for staff. This contains research documents, articles, and patient teaching materials. It is available to all MH & A staff.

Electronic Documentation
You will have electronic documentation (PCS) training during your hospital orientation. This typically occurs on the Friday.

Our Community Partners

Canadian Mental Health Association – Brant Chapter (CMHA)

The Brant County Branch of the Canadian Mental Health Association contributes to the mental well-being of the community through support services for persons with a serious mental illness and educational initiatives for the general public. CMHA promotes a positive approach to mental health through leadership, education, advocacy and support services. This is done in partnership with consumer/survivors of mental health services and their families.

Programs:

- Community Support Services
  Community Support Services offers short and long-term community support (also known as Case Management) for adults with a serious mental illness. Community Support Workers are available to assist individuals to set goals in a variety of areas, including those on Community Treatment Orders, to maintain stability in the community.
- Mental Health Court Support
  Mental Health Court Support Services provides diversion and court support services for persons with serious mental illnesses in Brant County. Services are provided to persons who are 16 years of age or older. These services assist individuals with accessing treatment and support services, in order to maintain a healthier lifestyle and avoid further contact with the criminal justice system.
- Vocational
  Vocational Support Services assist employment disadvantaged persons with a serious mental illness to obtain and maintain employment, education and volunteer opportunities.
  Vocational Support Workers in the **Works for Me** and **Sustainable Employment Initiative** programs are available to help clients establish and pursue their vocational goals, using the psychosocial rehabilitation and recovery approach.
- Supportive Housing
  Rent geared-to-income housing for men and women with serious mental illnesses is provided in Brantford.
  Lyons Avenue is a cooperative, home-like setting for 8 adults.
  Affordable housing is available at **Phoenix Place** in one-bedroom and two-bedroom apartments for adults with a serious mental illness, who are homeless or at risk of being homeless. Rent is set at the maximum allowed by Ontario Works or O.D.S.P.
- Social Recreation
  Life Skills sessions are offered in a formal group setting. Each group is time-limited, usually totaling 8-12 weeks of three-hour sessions. Eligible group participants are 16 years or over, have a serious mental illness, are committed to attending all sessions and have met with the facilitator for a pre-screening assessment. Life Skills helps individuals in their recovery.
- Alternatives Activity

The **Alternatives Activity Centre** provides a range of social and recreational activities that assist consumers to develop personal resources and/or skills. Activities follow the principles of psychosocial rehabilitation and promotes the empowerment of each consumer, through participation in the planning and implementation of activities.

- Family Support
  Family members and friends providing support and other types of assistance to someone with a mental illness are also in need of information and support. Families are often in the position of providing assistance with daily living, emotional support, crisis support, finding services and information, financial assistance.
- Families for Mental Health
  This committee is comprised of family members of persons with serious mental illness, who have first-hand knowledge of the challenges of living with mental illness.

St. Leonard's Community Services (SLCS)

- Mental Health Crisis Support
  Professionally trained Mental Health Crisis Support Counsellors will assess the crisis situation and intervene. Intervention may include:
  - Further telephone counselling
  - An on-site visit from the crisis counsellor
  - Access to a peer support worker
  - Referral to other community services
  - Involvement of other emergency services.

  Walk-in service is six evenings a week (Sun-Fri) from 1100 hours to 2000 hours. Mental Health and Addiction Services has a Crisis Worker on site from 1100 to 1900 hours six days a week with remote access to the MH & A Services electronic system.
- Case Management
  Short-term, up to four months post-release from custody mental health case management services, as a transitional support for offenders released from correctional custody back to the community, either at the completion of incarceration or under some form of community supervision.
- Concurrent Disorders
- Short-term, up to four months intensive short-term case management services for individuals with mental illness and substance use concerns who are at risk of becoming involved in the criminal justice system or as a component of a court diversion treatment plan. Also as a support for offenders being released from correctional custody or under some form of community supervision.
- Parent Adolescent Support (Positive Parenting Program)
  Triple P™ is a parenting and family support strategy that aims to prevent severe behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents. Triple P is designed and tailored to the needs of parents.
  Triple P™ 8-week program offered in partnership by Woodview, St. Leonard's Community Services, Family Counselling Centre and Ontario Early Years Centre.

Weeks 1 – 4: Parents only group sessions.
Weeks 5 – 7: Individual phone consultations with a practitioner.
Week 8: Group session.

There are two streams: parents of children 0 – 12 and parents of children 13 – 16 years of age

- Stop Now & Plan (SNAP)

  SNAP™ is for families. Both parents and children are expected to participate. Children that demonstrate any of the following behaviours will benefit from participating in SNAP™. Children from the age of 9 – 12 years of age.
  - Displays aggressive behaviour.
  - Has personal or family encounters with the police, or is at risk of doing so.
  - Demonstrates negative or anti-social behaviour.

  SNAP™ is an 8-week program held afterschool (each session is 1.5 hours) to help children regulate their angry feelings and to stop and think before they act, avoid fighting, handle peer pressure, stop stealing and play fairly.
  The parenting group helps parents learn how to reduce the frequency and intensity of their children's behaviour problems and to monitor, encourage, reward and consequence fairly and according to their child's developmental level.
- Mother Voice

  MotherVoice is a counselling service for mothers with substance abuse issues. The program focuses on expectant mothers and mothers with children 0-6
- Adult Groups

  OASIS

  This ongoing support group for individuals struggling with mental health and substance abuse issues is offered every Thursday afternoon from 1:30 p.m. to 3:00 p.m. and is held at Grand River Community Health Centre

  STEPS TO CHANGE

  Co-ed and Women only groups are offered. Steps to Change is a 10-week treatment group for individuals seeking drug and alcohol education, alternative coping strategies and relapse prevention skills. Clients must be referred through an addictions counsellor to attend this program.

  REFLECTIONS

  Co-ed and Women only ongoing support group for individuals attempting to make changes or maintaining changes to their drug and/or alcohol use.
- Youth Groups

  STEPS TO CHANGE

  This is a co-ed 7-week substance abuse treatment group for individuals under the age of 18.

  REFLECTIONS

  This is co-ed ongoing support group for youth looking for assistance to help maintain changes to substance use.

<u>Family Counselling Center of Brant (FCC)</u>

The Family Counselling Center promotes the well being and social inclusion of individuals and families through counselling, support, education and advocacy.

- *INDIVIDUAL, COUPLE, FAMILY AND GROUP COUNSELLING*

Counselling services are offered by a team of Masters level therapists committed to providing a responsive, creative, compassionate and healing service to the community and treatment to individuals, couples and families in distress
Family Counselling Centre of Brant, Inc. is also a provider under the Frist Nations & Inuit Health Branch, offering fully funded short term counselling services to eligible persons, with a valid status card.

- *CREDIT COUNSELLING AND CONSUMER EDUCATION SERVICES*
  Credit Counselling and consumer education services provide counselling and repayment programs for over-indebted individuals and families. Budget counselling is available for those experiencing difficulty in managing their living expenses.
- *DEVELOPMENTAL SERVICES*
  The staff and volunteers of Developmental Services are committed to the universal acceptance of persons with a developmental delay. The staff believe that this mission will be achieved by assisting these persons to grow towards their fullest potential by providing support and access to community services.
- *HAMILTON BRANT BEHAVIOUR SERVICES*
  Hamilton Brant Behaviour Services is a community-based service for children, adolescent and adults with developmental disabilties with significant behavioural/emotional problems. Under the supervision of a registered psychologist, our Behaviour Consultants work with individuals and their primary care and/or service providers, teaching practical ways to promote healthy behaviours.

Brant Assertive Community Treatment Team (Brant ACTT)

Assertive Community Treatment is an evidence-based program that provides intensive community-based treatment, rehabilitation and supports (including peer support) to the most seriously mentally ill for improved quality of life and independent living. ACT also supports individuals by assisting with medication, housing, finances, employment and life skills. Treatment is considered assertive because staff work with individuals in their home, place of work and other personal environments.

HOPE (Helping Ourselves through Peer and Employment)

A mental health consumer/survivor organization providing peer support and employment opportunities to people with mental health problems

Orientation Documents
New Mental Health & Addiction Service Team Member Checklist

EMPLOYEE INFORMATION			
Name:	Start date:		
Position:	Manager: Kate Hogarth		
FIRST DAY			
☐ General Hospital Orientation. ☐ Occupational Health and Human Resources meetings			
POLICIES			
☐ Review key MH policies.	• Documentation • Code White • Dress code	• Workplace Violence • Confidentiality • Patient Identifiers	
ADMINISTRATIVE PROCEDURES			
☐ Review general administrative procedures.	• Keys • Admission and Discharges • Mail (incoming and outgoing) • Maintenance Requests • Time changes/scheduling	• Desk phone/voicemail • Building Lock down • Orientation Checklist • Halogen	
INTRODUCTIONS AND TOURS			
☐ Give introductions to department staff and key personnel during tour.			
☐ Tour of facility, including:	• Fire Alarms • Fire Hoses/Tanks • Inpatient Unit • Outpatient Areas	• Crisis Response • ADT Program • Inpatient T. Team • Group Programs	• Med Clinic • Laundry Facilities • Supply Cupboard • Parking
POSITION INFORMATION			
☐ Introductions to team. ☐ Review Orientation objectives. ☐ Review Mental Health 'N' drive.	☐ Review job schedule and hours. ☐ Review payroll timing, time cards (if applicable), and		
COMPUTERS			
☐ Hardware and software reviews, including:	• E-mail	• Microsoft Office System	• Databases

Mental Health and Addiction Services – Orientation Checklist

Levels: Satisfactory (S); Needs Improvement (NI); Unsatisfactory (U); Not applicable (NA)

Item	**Preceptor Initials**	**Self-Assessment** **(Date & Level)**	**Date Completed**
Locates performance competencies in Halogen			
Discusses and understands the mission, vision, values, and strategic directions of the organization			
Tour of Department (Inpatient Unit, Outpatient, MH Group Program Area, Medication Clinic, Multipurpose Room)			
Keys to the Department			
Fire Extinguishers, Pull Stations, Fire Exits			
Safety: Code White buttons, WHIMIS products, PPE, hand hygiene, eye wash stations, etc.			
Clerical Support: Unit Clerk/Secretaries			
On – line MHA and HCCA forms, clinical tools			
On – line MH Program Manual			
Staff mail slots			
Pamphlet/Hand – outs/Binder Cupboard – Supply Cupboard			
Dress Code			

Item	Preceptor Initials	Self-Assessment (Date & Level)	Date Completed
Email Access			
Time Requests (Vacation Planner, Sick Calls)			
Hospital Documents (including bnet)			
Service Specific Documents (referral forms, Policies, etc.)			
Engages in interprofessional Collaborative Practice and LEAN principles. For example, but not limited to: ▪ Daily Huddles ▪ Standard Work ▪ 5 S			
Demonstrates responsibility to own learning by assessing their own learning needs and seeking out activities and resources to meet identified needs.			
Uses self-reflection in practice and seeks resources accordingly • Aware of own role and responsibility within unit, organization and profession • Seeks and accepts assistance and feedback as necessary • Seeks resources and clarification during decision-making and problem solving situations			
Recognizes ethical issues and seeks assistance in addressing them • IDEA framework • Ethics consultation team			

Item	Preceptor Initials	Self-Assessment (Date & Level)	Date Completed
Demonstrates sensitivities to need of other team members • Ensures the right care provider for patient care needs by demonstrating and applying the knowledge, skill and judgement related to the different roles of the interprofessional care team members • Collaborates with interprofessional care team when a patient's care needs have changed in order to identify the human resources required to meet the change in patient status • Shares knowledge and experience • Shows willingness to support other team members			
Attends and completes mandatory in-service orientation education and e-learning For example but not limited to: • WHMIS • Hand Hygiene • Code Red • Code Blue • Code Green • Code White • Respectful Workplace • Customer Service Excellence • Patient Confidentiality • Dress Code • AODA • Domestic Violence • Injury Reporting • Donning and Doffing • FIPPA			

Item	Preceptor Initials	Self-Assessment (Date & Level)	Date Completed
Participates in on-going educational initiatives For example but not limited to: • Pulse staff meetings • Service specific meetings • Educational rounds • In-services • Interprofessional rounds/huddles			
Maintains certificate in CPR if applicable			
Familiar with emergency procedures in real or simulated situation, and able to locate policies and procedures for each • Code Blue • Code Pink • Code Yellow • Code White • Code Red • Code Burgundy • Code Purple • Code Black • Code Green • Code Orange • Code Brown • Code Grey			
Locates and adheres to relevant medical directives and unit specific policies and procedures. For example but not limited to: • Code of Conduct policies			

Item	Preceptor Initials	Self-Assessment (Date & Level)	Date Completed
Describes the procedure for reporting patient incidents, near misses and medication errors using RiskPro			
Describes the procedure for reporting staff incidents or injury			
Understands the role of Accreditation Canada and the Required Organizational Practices (ROP) relevant to their practice/unit			
Communicates significant patient information to appropriate team members in the circle of care in a timely manner through: For example but not limited to: • TOA unit to unit, shift to shift and facility to facility where appropriate (SBAR) • Verbal communication • Written/electronic documentation • Telephone • Participation in interprofessional rounds			
Operates unit specific communication equipment For example but not limited to: • Call bell response system • Code Blue response • Telephones • Physician paging/notification • Notification of other staff			
Documents care according to BCHS and regulatory body standards • Documents and updates all information as soon as possible without compromising patient safety • Applies BCHS principles of charting by exception and the DAR format • Maintains professional accountability of charting			

Item	Preceptor Initials	Self-Assessment (Date & Level)	Date Completed
Performs an integrated initial assessment For example but not limited to: • Admission to the unit • Code status • Allergy status • Smoking status • Identify interprofessional consultation needs (e.g. SW, nurse, DCP, SLP, PT/OT) • HOBIC/RAI if applicable • Patient orientation to the care plan			
Provides care based on the principles of patient and healthcare safety For example but not limited to: • Least restraint use • Falls risk assessment • Minimal lift • Mandatory reporting of child and elder abuse, domestic violence • Wound care prevention			
Maintains infection prevention and control standards For example but not limited to: • Universal precautions • Donning and doffing PPE • Appropriate isolation signage • FRI tool compliance • Patient and family education			

Item	Preceptor Initials	Self-Assessment (Date & Level)	Date Completed
Establishes priorities for patient care in collaboration with the patient For example but not limited to: • Identifies existing or potential health problems • Documents care plan • Develops acceptable outcomes • Uses evidence-based principles to select and individualize interventions			
Collaborates with patient, family and health care team to implement a plan of care that will achieve a positive health outcome for the patient For example but not limited to: • Initiate BPMH where appropriate • Processes physicians orders appropriately • BMV where appropriate • Notifies and communicates with physicians and members of the health care team as necessary (lab values, changes in patient condition, abnormal assessment findings)			
Promote positive self concept and the principles of AODA (Accessibility for Ontarians with Disability Act) For example but not limited to: • Support cultural identity • Adapt plan of care to support cultural health beliefs while in hospital			
Identification, treatment, prevention and documentation of allergic responses to food, medications, contrast material or other substances			

Item	Preceptor Initials	Self-Assessment (Date & Level)	Date Completed
Operates equipment in a safe manner specific to the delivery of patient care For example but not limited to: • Glucometer • IV pumps • Automatic vital signs machine • Thermometers • Suction • Oxygen • Stretchers • Mechanical lifting devices • Beds • Wheelchairs/walkers			
Engages in safe mediation administration according to regulatory college standards via the following routes as appropriate: • Oral • Topical • Rectal • Vagina • Subcutaneous injection • Intramuscular injection • Intravenous • Intravenous below the drip chamber • Inhalation • Intestinal tube			

Item	Preceptor Initials	Self-Assessment (Date & Level)	Date Completed
Engages in appropriate narcotic procedures For example but not limited to: • Counting and documentation • Receiving from pharmacy • Wasting • Responsibility for the key			
Collaborates with health care team in discharge planning with the patient For example but not limited to: • Predictive discharge • Referral to appropriate internal and external resources for support • Facilitate transition of patient from hospital to discharge destination • Other (please specify)			
Performs thorough respiratory assessment, implementation and evaluation of care For example but not limited to: • Respiratory assessment • Use of oxygen (nasal prongs, masks and Ambubag and portable) • Oral/nasopharyngeal suctioning • Insertion of orpharyngeal and nasopharyngeal airway • Care and maintenance of chest tubes • Care for and suctioning of a patient with a tracheotomy • Prevention or minimization of risk factors in the patient at risk for aspiration • Other (please specify)			

Item	Preceptor Initials	Self-Assessment (Date & Level)	Date Completed
Performs thorough cardiovascular assessment, implementation and evaluation of care For example but not limited to: • Cardiovascular assessment • Promotion of maximum functional activity level for a patient with impaired cardiac function • Promotion of arterial and venous circulation • Reduction of the risk and/or limitation of complications of developing thrombus formation • Other (please specify)			
Performs thorough gastrointestinal assessment, implementation and evaluation of care For example but not limited to: • Abdominal assessment • Nutrition assessment • Oral care • Swallowing assessment • Accurate monitoring and documentation of elimination patterns • Insertion of nasogastric tube • Assessment, care and maintenance of nasograstic tube • Assessment, care and maintenance of gastrostomy/jejunostomy tubes • Delivering nutrients and water through a gastrointestinal tube • Assessment and care of ostomy • Other (please specify)			

Item	Preceptor Initials	Self-Assessment (Date & Level)	Date Completed
Performs thorough genitourinary assessment, implementation and evaluation of care For example but not limited to: • Genitourinary assessment • Accurate monitoring and documentation of output • Insertion and/or removal of Foley or in and out catheter • Care and maintenance of urinary drainage equipment • Improving bladder function/ maintenance of optimum elimination pattern • Perform bladder scan • Closed system intermittent or continuous bladder irrigation • Urostomy care and maintenance • Other (please specify)			
Performs thorough neurological assessment, implementation and evaluation of care For example but not limited to: • Neurological assessment • Assessing and developing a plan of care regarding seizure activity • Canadian Neurological Scale • Initiate the Stroke Alert Protocol • Cognitive screening (e.g. MMSE, MoCA) • 3 Ds (delirium depression and dementia screening) • Other (please specify)			

Item	Preceptor Initials	Self-Assessment (Date & Level)	Date Completed
Performs thorough musculoskeletal assessment, implementation and evaluation of care For example but not limited to: • Musculoskeletal assessment • Lifts and transfers • Early mobilization • ROM • Positioning • Other (please specify)			
Performs thorough integumentary assessment, implementation and evaluation of care For example but not limited to • Integumentary assessment • Braden Scale • Prevention of pressure ulcers • Wound care • Other (please specify)			
Performs thorough pain assessment, implementation and evaluation of care. For example but not limited to: • Pain assessment • Pharmological interventions • Non-pharmological interventions • Other (please specify)			

Item	Preceptor Initials	Self-Assessment (Date & Level)	Date Completed
Performs thorough endocrine/metabolic assessment, implementation and evaluation of care. For example but not limited to: • Endocrine/metabolic assessment • Diabetes management • Preventing and treating hyperglycemia and hypoglycemia • Other (please specify)			
Performs psychosocial assessment, implementation and evaluation care based on For example but not limited to: • Psychosocial assessment • Social support system • Life course changes • Spirituality • Analysis and prioritization of risk reduction strategies for individuals or groups (e.g. shelter, finance, supports) • Other (please specify)			
Accurate interpretation of • Blood gasses • Blood and urine tests • Biochemistry • Culture and sensitivity			

Item	Preceptor Initials	Self-Assessment (Date & Level)	Date Completed
Promote adequate fluid balance and monitoring: For example but not limited to: • Initiate peripheral IVs • Regulate/maintain/change and hang peripheral IV fluids • Hypovolemia management • Hypervolemia management • Initiate blood transfusions/blood products • Regulate and maintain blood transfusions/blood products • Removal of IV catheter • Conversion to saline lock • Flushing/accessing and de-accessing CVADs • Care and maintenance of CVAD • Administering TPN • Managing TPN			
Promotion of physical comfort and psychological peace in the final stages of life For example but not limited to: • Stages of grief • After death care of the body • Providing support to the family • Accessing internal and external resources for patient and family support • Other (please specify)			
Provide instruction and learning experiences to individuals, families or communities to: • facilitate voluntary adaption to behaviour conducive to optimal outcomes • increase their knowledge base regarding their health condition			