SMOKEY POINT
BEHAVIORAL HOSPITAL

Guide to

Adult Inpatient Care at Smokey Point Behavioral Hospital

Information for Patients, Families, and Loved Ones

We are glad you are here. We are here to help.

Each member of the Smokey Point Behavioral Hospital (SPBH) team strives to achieve our mission of providing a supportive, compassionate, and innovative environment of patient-centered care. Together with you, we will chart a path toward your recovery and well-being.

Our teams will work closely with you to develop an individualized treatment plan to ensure that you receive effective and compassionate care. You will be provided with guidance and tools to help better understand and manage your illness and symptoms, strengthen resilience, and improve your mental health going forward.

This guide provides an overview of what to expect upon arrival at Smokey Point Behavioral Hospital and to address common questions and concerns that you and your loved ones may have.

Thank you for placing your trust in Smokey Point Behavioral Hospital. Your health, comfort, and well-being are our highest priorities.

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What Does The Admission Process Consist Of?

Upon arrival at Smokey Point Behavioral Hospital, you will meet with a clerk from our Intake department who will gather preliminary information. This is the first step before meeting with a clinician, who will provide a thorough, diagnostic, psychological evaluation.

With your approval, two family members/loved ones can stay with you during the admission, except children under the 18 years old. Otherwise, family/loved ones will step out of the room for the assessment so that you can speak freely to the staff.

For your safety and the safety of others, the Intake clerk will check your personal items to ensure there is nothing that would pose a hazard. They will then move your belongings into a safely stored space until you discharge. At this time, an identification wristband are provided and must be worn for the duration of your stay.

A nurse will perform a nursing assessment; take vital signs, obtaining information about current medications, medical conditions, and/or safety concerns.

A clinician will then conduct an initial evaluation, and provide the clinical staff with information to determine which program will best meet your needs and to begin your initial treatment plan. Based on the initial assessment, the clinician may order medication and additional tests.

Finally, an Intake staff member will accompany you to the inpatient unit to be introduced to the nursing staff and assigned to a clinical team; who will address any treatment needs during your stay.

How Long Does The Admission Process Take?

Typically, the process takes two to four hours. Part of this time is necessary to complete the admission assessment, record information about the treatment plan, and enter patient information into our system.

Family members and loved ones with information that is important for clinicians to know should speak to staff if they do not have the opportunity to provide this information during the initial evaluation.

Is Financial Assistance Available?

Smokey Point Behavioral Hospital recognizes that some patients have limited means and may not have access to insurance coverage for all services.

We have a financial assistance program for uninsured patients and underinsured patients with limited financial resources. Please be sure to talk to our financial counselors for more information.

Why Do Different SPBH Staff Ask Me The Same Questions?

Not surprising, you will most be asked to tell us about yourself a few times, one time with each professional, such as a psychiatrist, registered nurse, therapist and potentially a chemical dependency professional if necessary. Each staff will listen to answers for different purposes. We want to be as thorough as possible when developing your individualized treatment plan.

What Releases Will I Be Asked To Sign?

You will be requested to sign a release of information (ROI) form for each family or friend that you authorize SPBH to exchange information. This will also include your current primary care physician, psychiatrist, and/or therapist. These releases are required so we may communicate with your health care providers outside of SPBH.

Later in the process of your treatment, you may be requested to sign additional release of information forms in order for staff to speak with any additional support systems regarding your care.

How Long Should I Expect To Stay At The Hospital?

The length of treatment is different for each patient admitted to the program; however, the typical length of stay is between 5-10 days.

What Do I Need To Bring?

- **Medication List:**
  - Make sure to provide a list of your **CURRENT** prescription and over-the-counter medications, including dosages and frequency. SPBH will provide medications on our formulary only. This may not include medications prescribed for specific medical conditions.

- **Medical Equipment:**
  - You should also plan to bring any durable medical equipment you may need such as a CPAP machine, hearing or visual aids. Any items with cords may need to be kept at the nursing station.
  - ***Please mark your name on all personal care items*.**

- **A Word About Cellphones:**
  - To help promote focused engagement during group therapy and other aspects of treatment, cellphones are NOT allowed. During the admission process, each patient is given a form to write down important phone numbers to keep on the unit, and cellphones will then be securely stored. Cell phones will be returned upon discharge.

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ITEMS ALLOWED AT SPBH

When you arrive on the unit, your personal belongings will be checked in by a mental health technician (MHT). You will be allowed to keep your clothing in your room.

Smokey Point Behavioral has washers, dryers, laundry soap available on each unit. Laundry service is provided for patients and done at night. Dirty clothes are placed in brown paper bags with your name on the bag. Freshly laundered clothes are also returned in brown paper bags.

PLEASE REFER TO "ITEMS NOT TO ALLOWED AT SPBH" (next page) AFTER READING THIS SECTION.

Suggested Items to Bring:

- Insurance card, photo ID, and contact list of current providers.
- **Three to five days** of casual, comfortable clothing (with no drawstrings):
  - Pants
  - Shirts
  - Socks, underwear and bras.
    - Bras with underwire and sports bras are not allowed.
  - Shoes and slippers without laces (we will provide ties).
  - Shorts must be worn under dresses or skirts).
  - Pajamas: Must be worn at bedtime and have a shirt and bottom.
- **Unframed** photos of family.
- **Wire free journals** for writing.
- **Foam earplugs** for sleeping.
- **Medications:** inhalers, birth control pills and antibiotics if needed. We supply all other medication.
  - **Please bring a current, accurate list of your medications, frequencies and dosage times.**
- **Makeup** is limited to **two items**.
  - The items must be in **NON-GLASS** containers with **NO** mirrors, and they must be used under supervision.

***All clothing must provide adequate coverage. Staff may request that clothes be changed if they consider the attire to be inappropriate (too tight, too short, offensive, dirty, etc.) Any inappropriate clothing will be marked with your name and stored for family to pick up or until you are discharged. Socks, shoes or slippers must be worn at all times.

******* Jewelry is limited to a **wedding ring only**. All other jewelry is prohibited and will be securely stored.

******* Exchanging, borrowing, or lending any clothing or personal items is prohibited.

Alcohol-Free Hygiene Toiletries:

- Toothbrush/Toothpaste
- Shampoo/Conditioner
- Hairbrush/Eyeglasses
- Deodorant
- Feminine hygiene products

*Basic hygiene kits can be provided at no cost if patients do not have these items (all toiletries are placed in plastic containers behind the nurse's station).

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ITEMS NOT ALLOWED AT SPBH

We strive to keep our building free of potentially hazardous items. As a result, we have determined what items are considered contraband and not approved for patients admitted to SPBH. The list includes (but is not limited to):

- Alcohol, drugs or illegal substances
- All electronic or battery operated devices: cameras, cell phones, computers, video games, etc.
- Bedding, blankets, pillows, and stuffed animals (for infection control purposes). *We will supply all the linens and pillows you need during your stay.*
- Belts, drawstrings, handkerchiefs, hats, scarves, stockings, pantyhose or tights, any clothing/shoes with ties
- Boots (includes steel toe)
- Cans (aluminum, metal or plastic – such as aerosol cans)
- Cameras, cellphones, computers, gaming devices
- Cigars, cigarettes, e-cigarettes and tobacco products (SPBH is a tobacco and smoke-free campus).
- Clothing with offensive language
- Drawstrings, rope, chains or other corded items
- Ear and facial piercings deemed a safety risk
- Earplugs (wax or plastic)
- Earphones
- Flowers and candy
- Food of any kind outside of SPBH is not allowed on units or patient rooms and will not be delivered.
- Glass, ceramic objects, and picture frames
- Hats or headbands
- Hair dryers, curling irons, straightening irons
- Hairspray
- Hand sanitizer with alcohol
- Hard-backed books (soft cover books are acceptable)
- Jewelry including body piercing and necklaces (except wedding rings)
- Lighters and matches
- Metal items such as combs, metal nail files/nail clippers, manicure sets, and picture frames.
- Mirrors (including make-up compacts with mirrors)
- Mouthwash/gel toothpaste containing alcohol
- Nail polish or polish remover
- Needles, sewing needles, & hooks of any kind
- Paperclips, pencils, & pens
- Perfume & cologne
- Pins (includes straight and safety pins)
- Plastic bags of any type or size
- Purses, luggage, backpacks (*will be stored until discharge*)
- Razors
- Scissors
- Spiral notebooks
- Shoes or slippers with laces (we will provide ties)
- Underwire bras and sport bras
- Weapons of any kind (e.g. guns, knives, mace/pepper spray, etc.)

**We will not allow revealing clothing (spaghetti straps, bare midriffs, short shirts, shorts, overalls, clothing below the belly button/waistline, unbuttoned pants, saggy pants or items with potentially offensive material such as racism, gang related sexual, Satanism, etc. Staff reserves the right to exchange such clothing with scrubs.

INPATIENT CARE AT SMOKEY POINT BEHAVIORAL HOSPITAL

Treatment Philosophy

Our treatment philosophy is centered on a therapeutic milieu that fosters personal growth, integrity, and empathy. Group therapy is the core component of treatment and provides the opportunity to interact with others at your own pace and comfort level. In doing so, contributes to positive outcomes of working within a group experience within a caring, safe, and supportive environment—an essential factor in your recovery.

You will receive a copy of the group program schedule on your unit. Group meeting times and schedules are posted on each unit and are subject to change.

Our goal is to help patients reach their potential by strengthening daily functioning and by accomplishing short-term and long-term treatment goals. Change can be difficult and painful, but growth payoff is beyond worth it. Our staff will make every effort possible to support you and your family to make the necessary changes to lead a fulfilling life. Along with you and your family/loved ones, help and change is possible. By working with you, your family, and as a member of the therapeutic milieu, change IS possible.

Respect and responsible behavior by all members of our therapeutic milieu is an important aspect of our treatment philosophy and we encourage all patients to share their feelings in an open and trusting atmosphere.

Change Process

You have been admitted to the Adult Inpatient program to grow and develop, which can evoke feelings of anger, sadness, loneliness and even fear. Our staff will support you, your family, and friends through the change process so that you and your loved ones will experience positive outcomes.

Our goal is to develop coping skills that are necessary for safety and to achieve success in addressing and completing treatment goals. One of the objectives is to work with your feelings in a constructive and safe manner. Our staff will work to help you understand what healthy expression is about. You will learn how to obtain the support that is both desired and necessary for personal growth. The goal during treatment is to improve abilities to resolve problems and form healthy relationships with others.

Ultimately, we hold you, the patient, responsible for your own behaviors. You will be taught how to connect the decision-making process, the behaviors, and final outcomes. Our staff is here to ensure safety for everybody and to assist patients to take responsibility for their own decision-making.

Assessments, Evaluations and Treatments

The Adult Inpatient Program addresses the biological, psychological, social, spiritual, and physical components of human behavior within the context of a brief hospitalization.

Assessments and Evaluations include the following:

Nursing Assessment:
A registered nurse completes a comprehensive nursing assessment within 8 hours.

Psychiatric Evaluation:
A psychiatrist/ARNP will complete within 24 hours.

History and Physical Assessment (H & P):
A physician or designee will complete within 24 hours.

Psychosocial Assessment:
A therapist will prepare a psychosocial evaluation within 72 hours of your admission.

Recreational Activity Assessment:
A certified recreational therapist will complete within 72 hours.

Other Assessments:
Other assessments will be conducted as ordered, i.e., chemical dependency, dietary, etc.

Group sessions are structured to help better understand your illness and manage symptoms, learn strategies and skills to assist recovery efforts, and work on lifestyle/safety plans to manage recovery and wellness. Treatments include medication evaluation and management, group and family therapy (case-by-case), education, intervention, support, group therapy, and family therapy on a case-by-case basis. In addition, you will have opportunities to meet other patients who may be dealing with similar issues, and can offer valuable wisdom, support and insight that will help in recovery.

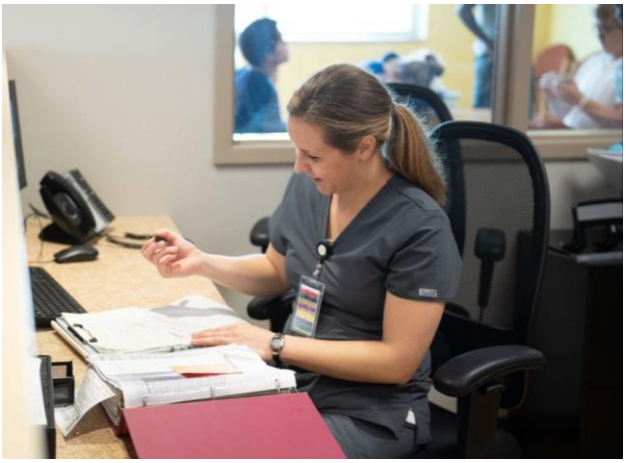
Treatment Planning

An individualized treatment plan will be developed by utilizing the identified problems from completed assessments; taking into consideration bio-psycho-social, spiritual, and physical attributes, as well as your strengths and limitations.

Treatment plans addresses the specific goals and objectives, which define appropriate interventions to be utilized. Ultimately, they document the ongoing efforts necessary to restore you to a higher level of functioning that would either permit discharge from the program or the continued need for inpatient hospitalization.

Treatment Teams

The treatment team includes a range of medical and therapeutic staff responsible for your care during your stay at SPBH. They work together to provide compassionate and effective care, and work with each patient to decide on the best treatment plan that will meet the needs of the patient.



As with all health care, collaboration between you, loved ones, and your treatment team is crucial. We encourage every patient to learn as much as possible about their illness, including symptoms, recovery, resilience, and wellness. The treatment team needs to know about you: the history of the illness, symptoms, behavior, as well as strengths, interests, and abilities. Learning about your illness will help you in your recovery. Please feel free to ask the treatment team if you have any questions or concerns.

The treatment team includes a comprehensive roster of professional who will help develop the treatment plan:

- **Medical Staff:** The medical staff consists of psychiatrists, primary care physicians (PCP's), and advanced registered nurse practitioners (ARNP's).

- **Nursing Staff:** The nursing staff consists of registered nurses (RN) and license practical nurses (LPN) that administer medications, provide support, and help coordinate care, provide information, and answer various questions. Each day and on each shift, a specific nurse is assigned to specific patient's care. Student nurses may assist registered nurses in providing care.

- **Program Therapists:** The program therapists are masters-level clinicians that help coordinate overall care (referred to as "case management"). They communicate with family, loved ones, and caregivers;

lead family meetings, assists in aftercare plans, and arrange for follow-up care. Program therapists also help the patient understand and manage their illness as well as provide support for recovery.

- **Recreational Activity Therapist (Rec Therapist):** This staff is responsible for leading recreational activities, such as art therapy, music, and structured games in a group setting. The groups help learn new skills, gain insights, and provide connection with other patients.

- **Mental Health Technicians (MHT):** The MHT's assist the nurses in monitoring patient symptoms, taking vital signs, supervising meals, organizing activities, leading groups, and maintaining patient safety on the unit.

You can identify staff members by the identification badges that they wear; which display their name, photo, and department. All staff members must always wear Smokey Point Behavioral Hospital photo identification badges. If anyone without an identification badge approaches you, ask that he or she display his or her badge or let a staff member know.

My Attending Psychiatrist is: _____ Assigned on unit

My Program Therapist is: _____ Assigned on unit

Structure of the Program

The key components of the program include the following:

- **Group Therapy**: Group therapy sessions is scheduled each day with a focus on skill development and cognitive behavioral interventions to improve interpersonal, social, and occupational functioning. Each patient will have the opportunity to meet with the therapist in a group setting to address treatment issues in a supportive environment. Issues such as low self-esteem, stress management, relaxation, anger management, anxiety, depression, and mania are included in the focus of this group therapy.

- **Psycho-Educational/Skills Group:** Psycho-Educational/Skills Group sessions is scheduled each day to provide patients with education on mental illness and to improve coping strategies to decrease symptoms.

- **Individual Therapy:** The Program therapist provides individual therapy on an as-needed basis. Group therapy is the primary treatment model.

- **Family Therapy:** With your consent, and at the discretion of the treatment team, family members may be requested to participate in family therapy sessions.

- **Addiction Education**: You will explore the cause and effects of drugs and/or alcohol on physical, emotional, mental, and spiritual wellbeing if you have identified issues with chemical dependency.

- **Recreational Activity Therapy:** The Recreational Activity Therapy group helps structure leisure time while developing new skills. This program encourages the development of motor, cognitive, and social skills.

Program Rules and Guidelines

- Be respectful of yourself and others.
- All patients are expected to talk to a staff person about the any issues that led to admission.
- All patients are expected to follow staff directions.
- **There will be no physical contact between patients.**
- There is a TV for general use and there are rules governing appropriate behavior that will dictate what is played on the television.
- All activities will stop and the television will be turned off for scheduled group sessions; to encourage active participation in the treatment program.
- Patients are responsible for making their own beds and keeping their rooms neat.
- Staff will complete room checks daily to ensure safety.
    - If any prohibited items are discovered they will be removed.
- All room doors will remain locked when you are not in your room, but you may ask staff to unlock the door at any time.
- Mattresses and/or any furniture will not be moved due to hospital safety regulations.

Confidentiality Policy

Privacy and confidentiality of all patients and their families is respected and protected. Personal Health Information (PHI) is available only to staff directly responsible for your care in order to provide treatment. Efforts are enforced to keep confidentiality and to maintain privacy within the treatment setting.

For privacy and the privacy of others, names of clients/patients should never be shared outside of the program. Please do not discuss personal details or information such as addresses, phone numbers, etc., with others. This is prohibited for confidentiality and protection reasons.

Nondiscrimination Policy

Smokey Point Behavioral Hospital does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by Smokey Point Behavioral Hospital directly or through a contractor or any other entity with which Smokey Point Behavioral Hospital arranges to carry out its programs or activities.

This is required in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Regulations of the U.S. Department of Health and Human Services issues pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

Patient Identification Number aka "ACCESS CODE"

While you are a patient at SPBH, both confidentiality and privacy are protected in accordance with state and federal laws.

To assist in preserving confidentiality, each patient will be provided with a four-digit patient identification number upon admission.

This patient identification numbers are referred to as an "**Access Code**" and will be yours for the duration of treatment. These codes are given out to whomever the patient wishes to have them, and must be provided by the patient. If callers want to talk to you and do not have this access code, our reception team cannot confirm nor deny to them that you are a patient at SPBH. **To be very clear: family, loved ones, friends, etc., will not be able to contact you without providing the reception team with the access code.**

My ACCESS CODE is _____

Telephone Calls

You may receive phone calls at SPBH, provided the caller can tell our reception team what your access code is. Please note that phone calls may be limited in duration, due to all patients needing phone time.

Mail

Incoming mail is given out daily. All letters and packages are required to be opened in front of staff. This prevents the possibility of dangerous or restricted items getting into patients' possession.

Meals and Snacks

Each unit has a specific mealtime for breakfast, lunch, and dinner. Each meal will be served in the dining room, unless a written order indicating meals must be provided on the unit. Snacks are also available for everybody on each unit. SPBH's Dietary Services accommodate diets for patients with medical restrictions (i.e. diabetes or food allergies). Dietary Services can also provide meals for vegans, vegetarians, as well as those based on religious principles (i.e. kosher). Restrictions are to be identified during the Intake Assessment. We do not provide caffeinated beverages as these may affect your metabolism.

Food is not allowed in patients rooms.

Outside Food

For safety, sanitation, and dietary management purposes, visitors may **NOT** bring outside food or beverages into the facility. There are various reasons, but one of the most important is that certain foods can pose health risks if a patient is taking specific classes of medications known as MAO inhibitors. The physician and nurse will instruct the patient about food or beverage restrictions related to any medication. We encourage patients to ask the nurses if they have questions or concerns about what items they can or cannot eat.

Secure Units

All inpatient units remain locked and patients are seen by staff at regular intervals to promote a safe environment. Some units allow patients to leave the unit for a supervised visit with family or loved ones. If this is an option, it will be to be set up prior to visitation.

Visitations are held so that family and loved ones can work together on treatment goals.

We understand that regular visitation times my not be conducive to those that have work, family or other obligations. The treatment team will do the best they can to accommodate. Please be sure to reach out to the treatment team prior to any visitations.

Visitation schedules have changed since the COVID19 pandemic. Please contact the hospital receptionists to receive the updated information regarding visitation days and times.

Visitation Guidelines

- **ALL VISITORS MUST OBTAIN THE PATIENT'S ACCESS CODE NUMBER, AS PROVIDED BY THE PATIENT ONLY, PRIOR TO VISITATION. THE CODE IS NECESSARY FOR ENTRANCE INTO THE VISITATION AREA.**
- All visitors should review the "Items Allowed at SPBH" and "Items Not Allowed at SPBH" lists in this handbook prior to any visitations**.**
- Visitors cannot bring personal belongings (i.e. purses, phones, lighters, etc.) into the hospital. These items need to remain in your vehicle or stored in one of the hospital lockers located in the lobby area.
- Weapons of any kind (guns, knives, pepper spray, etc.) are NOT allowed on the premises.
- Smoking is not permitted (we are a tobacco and smoke-free campus).
- All visitors will be scanned for prohibited items.
- Only immediate family members can visit the patients. Any other visitors will need permission from the patient's treatment teams.
- Visitation is limited to two visitors at a time.
- **Minors under the age of 18 may not visit during regular visiting hours. Visitation with minors must be schedule prior with the treatment team.**
- Children cannot be in the lobby without a supervising adult; aged 18 years or older (this cannot be hospital staff).
- There are no pets allowed on campus.
- Any items brought into the hospital must be inventoried and searched by staff members before providing to the patient.
- Patients cannot receive any over-the-counter prescription medication or illicit drugs at visitation.
- Visitors who do not abide by these guidelines, who are disruptive, or appear to be under the influence, shall be required to leave immediately upon staff request.

*****Every patient has the right to refuse any visitation*****

Physical Care

Physical care includes medical evaluation, treatment, and possible consultation regarding physical problems and complications. The medical and nursing staff work together to observe, evaluate, and treat physical, medical, and medication needs. In accordance with your diagnosis, evaluation and treatment plan, the attending psychiatrist/provider will determine and order all medications.

Worship

All patients can practice their chosen religious beliefs and staff will assist them to facilitate the practice of those beliefs in a non-threatening manner.

Property Damage

While the hospital recognizes that many of the patients admitted to SPBH have trouble in managing anger or other emotions, there will be no tolerance for deliberate destruction of hospital property. In instances where this occurs, the cost for repairs will be the responsibility of the patient.

Special Precautions

We have a deep commitment to the safety of all our staff and others. For patients who are at risk for self-injury, assault, running away, or setting fires, or if there is belief that a patient is in danger of harming himself, herself, or others, the use of physical restraint or seclusion (special precautions) may be necessary and **used only as a last resort.** These precautions require clinical justification and only as a means to protect the patient from self-injury or from injuring others.

In conjunction with the nursing staff, any order for physical restraints and seclusion must be given by the attending or on-call provider. The staff implementing the written order must have documented training in the roper application of restraints and seclusion.

Patients that are in physical restraint and seclusion are consistently monitored by the staff, and are provided regular meals, bathing and the use of toilet facilities. If perceived to be a threat to themselves, a staff member will stay with the patient. Sensitivity to the patient's dignity and well-being under these difficult circumstances is critical.

Restrictions

Patients are responsible for their behavior while at SPBH. All patients must adhere to the Rules and Guidelines to maintain a safe and therapeutic milieu. When patients break the rules or conduct themselves in a manner that is destructive to the program, specific consequences for that behavior are given. Restrictions and consequences are set according to the capabilities and limitations of each patient.

A definition of restrictions and consequences are as follows:

- **Time Out:**
  - A “time out” is the removal of the patient from the milieu to a designated area for a specific amount of time. This time will allow the patient to collect their thoughts and to reflect on inappropriate behavior.

- **Close Observation:**
  - This is when a patient may need additional support and monitoring.

- **Unit Restriction:**
  - If communication and cooperation between the patient, other patients or the staff breaks down, patients may be restricted to their unit. Activities and meals take place within the unit during this restriction. Visitation may be limited or unavailable during this unit restriction, but family therapy sessions will not affected.

- **Room Restriction:**
  - Patients may be restricted to or from their room when they cannot control dangerous and destructive behaviors.

- **Association Restriction:**
  - If patients are having relationships with other patients that may be detrimental to their treatment goals, they may be restricted from interacting with those patient(s).

- **Dayroom closure:**
  - The staff may temporarily close the common areas on the unit to help regain a therapeutic environment if individuals engage in disruptive behaviors.

Discharge Planning

Discharge planning is an integral part of the treatment process, beginning with admission and documented throughout the treatment.

During the treatment-plan review session, the discharge plan is reviewed by the entire team. Each patient is also encouraged to participate in the process. The physician and/or treatment team advises the patient of the criteria for discharge and modifications that may occur.

Under the direction of the attending psychiatrist, the treatment team coordinates discharge planning. The goal of discharge planning is to ensure the continuity of care best meets the needs of the patient and facilitates a successful return to the community. Discharge planning activities include linkage with community resources, support, and listings of providers to promote a patient’s return to a higher level of functioning.

Discharge planning is a process that will provide continuing care, treatment, and services after discharge. The discharge plan describes the reason for and conditions under which the patient is discharging. The discharge plan also describes the shifting of responsibility for care following discharge. Prior to discharge, it is essential that the discharge aftercare plan be completed sufficiently to allow connection to appropriate clinicians, programs and services.

The criteria for discharge will vary from patient-to-patient according to each patient’s specific circumstances and needs. The criteria for a patient discharging from the Adult Inpatient Program is as follows:

- The goals of the treatment must be substantially met at this level of care (unless transfer to another treatment facility is indicated) and a discharge plan is in place that meets any continuing needs

- The follow-up goals and treatment plans for a lesser level of care have been established.

- Releasing or transferring the patient to a less intensive level of care does not pose a threat to themselves, others, or property.

Any discharge from the hospital requires the written order of a physician. The order should specify the day of the discharge, the condition of the patient at discharge, and the discharge diagnosis. Aftercare services is defined in the discharge plan.

Discharges are generally scheduled Monday-Friday before noon to ensure a smooth transitions; including reliable transportation, the return of medications that may have been stored in our pharmacy, the return of personal belongings, access to outpatient support resources, and the location of a chosen pharmacy to get prescriptions filled. We will work with you to coordinate your day of discharge plan.

Discharge against Medical Advice (AMA)

Discharges against Medical Advice may occur under the following conditions:

- The Patient / Legal Guardian(s) enters a written request for discharge.

- The Patient / Legal Guardian(s), after being counseled by the attending physician, continues to demand a discharge.

- The Patient is assessed and is no longer a danger to themselves, others or property. If the patient does represent a danger to self or others, the attending physician will seek court-ordered detention of the patient for the safety of the patient or others.

Next Steps

The next step upon leaving the Inpatient Program will be voluntary participation in our Adult Outpatient Services. A staff member will speak to you about this before discharge.

Hospital Address and Phone Number:

Smokey Point Behavioral Hospital
3955 156th St. NE
Marysville, WA 98271
360.651.6400

We are a tobacco and smoke-free facility*

Social Media and Reviews:

www.smokeypointbehavioralhospital.com

PATIENT RIGHTS AND RESPONSIBILITIES

The hospital shows its support of rights by demonstrating how the staff interacts with patients and involves them in decisions about their care, treatment, and services. We are committed to these rights and ensure the privacy of each patient, while striving to meet each patient's culture and individuality with dignity and respect.

Provision of Care

- The patient has the right to reasonable access to care, treatment, and services. The patient has the right to considerate and respectful care, to include the consideration of psychosocial, spiritual, and culture variables that influence the perception of illness.

- The patient has the right to receive adequate information about the person(s) responsible for the delivery of their care, treatment, and services.

- The patient has the right to be free from all forms of mental, physical, sexual/verbal abuse, neglect, and exploitation.

- The patient has the right to expect that, within its capacity, the hospital will make a reasonable response to the request of a patient for services. The hospital must provide evaluation, service and/or referral as indicated by the urgency of the care. When medically permissible, a patient may be transferred to another facility only after another facility has accepted the patient and the patient has received complete information and explanation concerning the need for transfer as well as the benefits and risks associated with it.

- The patient has the right to receive care, treatment, and services in an environment that is safe.

- The patient has the right to expect reasonable continuity of care after discharge, including information on continuing health care requirements, names and contact information for physicians and others who can or do provide ongoing care.

- The patient/family has the right, in collaboration with the physician, to be informed about and to make decisions involving his/her healthcare, including the right of the patient to accept medical care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.

- The patient or his/her designated representative has the right to participate in the consideration of ethical issues that arise in his/her care.

- The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his/her care of treatment. The patient has the right to refuse to participate in such research projects.

- The patient has the right to appropriate assessment and management of pain.

- The patient has the right to be involved in all aspects of their care, treatment, and services; including pain management.

- The patient has the right to freedom from the use of restraints unless clinically required.

- Voluntary patients have the right to request discharge at any time. Patients that are requesting discharge may be referred for an involuntary treatment evaluation if the psychiatric provider has reason to believe the patient may be a risk to themselves or others if released from the hospital.

Provision of Medical Information

The patient has the right to obtain from the physician's complete information, in comprehensible terms, concerning his/her diagnosis, treatment, prognosis, alternatives for care or treatment, and the names of professionals responsible for his/her care. When it is not medically advisable to give such information to the patient, the information can be made available to an appropriate person on his/her behalf.

- The patient has the right to receive from his/her physician, information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include, but no necessarily be limited to, the specific procedures and/or treatment, the medically significant risks involved, alternatives, and the probably limitation during the recovery period.

Provision of Hospital Information

- The patient has the right to examine and receive an explanation of his/her bill regardless of the source of payment.

- The patient has the right to obtain information relevant to his/her care, or any relationship between the hospital and other health care and educational institutions, as well as on the existence of any professional relationships among individuals, by name, who are treating them.

- The patient has the right to information at the time of admission about the Hospitals Patient's Rights policy.

- The patient has the right to obtain information from the Hospital with regard to the Hospitals and the states mechanism for the initiation, review and resolution of complaints concerning the quality of care received.

- The patient has the right to obtain information from the Hospital regarding how he/she can formulate advance directives and to appoint a health care agent to make health care decisions on his/her behalf to the extent permitted by law.

Confidentiality and Patient Records

- The patient has the right to security, personal privacy, and confidentiality of information concerning his/her own medical care programs. Case discussion, consultation, examination and treatment, and all communications are confidential and should be conducted discreetly. Those not directly involved in the care of the patient must have his/her permission to be present.

- The patient has the right to the confidentiality of his/her medical records and to have access to information contained in his/her medical records within a reasonable time frame. The hospital will not 'frustrate the legitimate efforts" of the patient to gain access to their own medical records and will actively seek to meet these requests within the limits of the law.

Patient and Family Responsibilities

Hospital patients and their families also have responsibilities while in the hospital, including the following:

- Provision of Information: The patient/family is responsible for providing, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medication, changes in conditions, and other matters relating to the patient's health.

- Compliance with Instruction: The patient/family are responsible for following the treatment plan developed with the practitioner and should understand that noncompliance may affect outcomes. While the plan is being developed, the patient/family should express any concerns regarding ability or non-ability to carry out the proposed course of treatment. Every effort should be made to adapt the treatment plan to the patient's specific needs and limitations.

- Refusal of Treatment: The patient/family are responsible for the outcomes if treatment is refused or the plan of treatment is not followed.

- Adhering to Hospital Rules and Regulations: The patient/family are responsible for following the hospitals rules and regulations as detailed in the admission packet and as posted on hospital signage.

- Showing Respect and Consideration: The patient/family are responsible for being considerate of the rights of other patients an of hospital personnel. This includes controlling personal noise, cell phone noise, and other distractions.

MENTAL HEALTH ADVANCE DIRECTIVES
Information for Consumers

What is a Mental Health Advance Directive (MHAD)?

A mental health advance directive (MHAD) is a written document that describes your directions and preferences for treatment and care during times when you are having difficulty communicating and making decisions. It can inform others about what treatment you want or do not want, and it can identify a person called an "agent' who you trust to make decision and act on your behalf.

Should I have a Mental Health Advance Directive?

There are advantages to having a mental health advance directive:

- You have more control over what happens during periods of crisis.
- Providers and others will know what you want even if you cannot express it on your own.
- Your directive can help your case manager and others who are involved in your mental health treatment.
- The law requires providers to respect what you write in a mental health advance directive to the fullest extent possible.

What is included in a Mental Health Advance Directive?

Anything that might be involved in your treatment can be a part of a mental health advance directive. For example:

- Consent for, or refusal of, particular medications or inpatient admission.
- Who can visit if you are in the hospital.
- Who is appointed to make decisions and take actions for you (your agent).
- Anything else you want or do not want in your future care.

Should I have an Agent?

You have the option of naming an agent:

- Who is at least 18 years old.
- Who knows you and knows what you want when you are doing well.
- Who can inform treatment providers about your preferences and can advocate for you.

By law, your agent cannot be your doctor, your case manager or your residential provider unless that person is also your spouse, adult child, or sibling.

Who should get a copy of my Mental Health Advance Directive?

If you name an agent, that person must be given a copy. After that, it is up to you to provide copies. Think about giving one to your current mental health provider, your lawyer (if you have one) and trusted family members. Bring a copy if you are being admitted into the hospital. Any treatment provider who gets a copy is required to make it a part of your medical record.

Will everything in my Mental Health Advance Directive be followed?

Here is the instances in which your mental health advance directive may not be followed:

- Your instructions are against medical advance directive may not followed.
- Following your directive would violate state or federal law.
- You are hospitalized under the Involuntary Treatment Active, or are in jail.

What can I do if I feel my Mental Health or Medical Health Advance Directive is not followed?

If you feel your mental health or medical health advance directive was not followed, you can receive information or file a complaint with the Washington State Department of Health (DOH):

- You may call DOH at 360.236.2620
- You may email DOH at HSQAComplaintIntake@doh.wa.gov
- You may go online to DOH at www.doh.wa.gov

All complaints are reviewed by DOH to decide if there is a violation of the law or if DOH has authority to take legal action. If there is a violation of the law and authority to take legal action, DOH conducts an investigation.

Can I change or revoke my Mental Health Advance Directive?

As long as you have capacity, you can change or revoke your mental health advance directive at any time. If you can incapacitated, you can only change or revoke your directive if it is already written in. Changes need to be made in writing. Be sure to tell everyone who has a copy if you revoke or change your directive.

What if I already have a Living Will or other Durable Power of Attorney?

If there is a conflict between a mental health advance directive and other directive, like a living will, the newer document will have legal priority. To reduce confusion, it is probably best to have one person act as both, the mental health advance directive (agent) and durable power of attorney.

Where can I get more information about Mental Health Advance Directive?

- To create a mental health advance directive, visit www.dshs.wa.gov/dbhr/advdirectives.html.
- Read the law, Revised Code of Washington (RCW) 71.32, on-line at http://www.leg.wa.gov.
- Call your local mental health provider or ombudsman service.
- Call the Division of Behavioral Health and Recovery's (DBHR) office of Consumer Partnerships at 800.446.0259 x7.
  -OR-
- Ask your Program Therapist to provide you with a form to complete.