The NeuroDiagnostic Institute of Indiana is a state-operated acute psychiatric hospital with the goal of providing excellence in mental health treatment. Our hospital serves as a specialty consult treatment facility for high-acuity behavioral health disorders. NDI’s organizational charter and mission foster training and research programs to establish the best acute patient care by quality providers. In order to accomplish this mission, the hospital staff combines a range of clinical services: Psychiatry, Psychology, Medical, Psychiatric Nursing, Pharmacy, Nutrition and Dietetics, Rehabilitation Therapy, Social Work, Transitional Care, Academic Education, and Spiritual Care.

Patient Intake

Patients are referred by a Community Mental Health Center (CMHC). Referral packets should contain current mental status including most recent psychiatric assessment; risk factors such as self-harm, aggression, elopement, and falls; physical exam within 30 days of referral; commitment papers; legal papers including guardianship, wardship, advance directives, Do Not Resuscitate (DNR) orders, and probation details; current treatment plan; current psychological testing; all financial information; a current tuberculosis test results, and ANSA/CANS assessments indicating the need for hospitalization. Youth packets must also include immunization records, school history and IEP, and birth certificate. Anyone with an IQ below 70 will generally be better served by Bureau of Developmental Disabilities Services (BDDS) than in a state psychiatric hospital (SPH). The initial referral form also includes a specific measurable recovery goal as well as primary and secondary treatment needs, anticipated length of stay, CMHC discharge plan, and post hospitalization needs that can be incorporated into the patient’s treatment and used to evaluate discharge readiness through the patient’s stay.

Those referred are typically individuals who have a serious and persistent mental illness and have not responded to a full course of treatment in a less restrictive setting or require transfer from another facility for continued intensive treatment. Clinical descriptors include history of repeated acts of endangering self or others, documented failure to respond to a variety of conventional treatment protocols and management efforts in a less restrictive setting, severe incapacitating emotional symptoms inhibiting appropriate social and familial interactions, and further skilled observation and evaluation as provided by a 24-hour structured therapeutic environment available only in a psychiatric hospital setting.

Once accepted for treatment, youth patients are admitted to the hospital on a voluntary commitment, meaning they are signed in for treatment by their parent or guardian. Adult patients are involuntarily placed through a civil commitment proceeding or a criminal placement for those incompetent to stand trial or who have forcible felony charges pending. Patients are admitted from 7:30 a.m. to 3:30 p.m. Monday through Friday. A family member or friend is always welcome to help support a patient during admission.
After arriving at NDI, a patient’s belongings are inspected for safety reasons. Security personnel use a metal-detecting wand to scan a patient in the admission interview room. Security staff will “wand” all belongings in the belongings room and note if the wand detects any items that need further search. Hospital staff discourage expensive items and encourage clients to label all their belongings prior to arrival. If the wand sounds, a more in-depth search will occur with direct-care and security staff in tandem. All cash, credit cards, debit cards and/or prepaid cards will be given to the assigned social worker for safe keeping. Admission staff members collect demographic information missing from the referral packet received by the CMHC, attempt to have all Conditions of Admission signed by the patient, and attempt to take a photo of the patient. This information is then entered into the Electronic Medical Record (EMR) and shared with appropriate members of the treatment team for review. Once the Face Sheet is generated from the EMR, the unit staff/Transitional Care Specialist (TCS) will escort the patient to a unit for introduction to his/her team and unit orientation.

Staff members from clinical disciplines, including psychiatry, psychology, social work, recreational therapy, dietetics, and chaplaincy, provide initial assessments to determine comprehensive areas of need to be addressed by the multi-disciplinary treatment team as well as patient strengths that can be used to empower the patient for success. These assessments are then used to create a treatment plan to monitor progress toward goals and assess for discharge readiness.

Clinical Programming

Program Goals

- To provide patient-centered care that allows patients to participate in their recovery process;
- To ensure all hospital disciplines are operating collectively for the betterment of the patients;
- To maintain a Center of Excellence by utilizing best practices, empirically-validated treatments and accreditation standards.

Objectives

Clinical Program staff will:

Apply the Recovery Model in every aspect of the patient’s care.

Assess, develop, and implement a measurable and individualized treatment plan that is tailored to the patient’s mental health and medical care necessary for recovery.

Updated 4/19
Collaborate with intra-hospital disciplines, gatekeepers, families and outside resources regarding the patient’s care before, during and after his/her return to the community.

Establish a positive therapeutic working relationship with the patient through the practice of empirically-validated psychotherapies emphasizing trauma-informed principles and educational groups/programs that enable the patient to reclaim a sense of self, engage in treatment, and be an active participant in life.

**Recovery Model**

From SAMHSA’s *Working Definition of Recovery: 10 Guiding Principles of Recovery*

1. **Hope**
   Recovery is grounded on the certainty that improvement is possible. People can and do overcome internal as well as external challenges and obstacles with the assistance of peers, families, and providers.

2. **Independence**
   Along the way to recovery, individuals increase their autonomy by collaborating with their families and care-givers in treatment decisions. Patients are part of their Treatment Team being equipped with the skills and resources to aid in their recovery.

3. **Personal**
   Since individuals are unique, there are many pathways to recovery. These may include professional clinical treatment, medications, support from family and friends, faith-based approaches, peer support, and others. Setbacks are also a part of the recovery process, therefore it is important to foster resilience in individuals and families. The creation of a safe, supportive environment, free from the use of alcohol, illicit drugs, tobacco and non-prescribed medications, will enable these recovery pathways.

4. **Holistic**
   Recovery must reach and affect a person’s entire life: mind, body, spirit, and community. As a result, treatment must address issues such as self-care, family, housing, employment, transportation, education, clinical treatment, healthcare, dental care, faith and spirituality, creativity, social networks and community participation.

5. **Peer and Ally Support**
   The sharing of skills and knowledge among peers can be a powerful support to one’s chosen recovery path. Generally, we help ourselves by helping others. Peer-operated groups and services provide important
resources for one’s journey to recovery. Peer supports for families are especially important for children with behavioral health problems and play a supportive role for youth in recovery.

6. Relationships and Social Networks
An essential part of the recovery process is the involvement of people who believe in a person’s ability to recover. Through relationships with peers, family, providers, faith groups, and community members, people are able to leave behind unhealthy life roles and take on more positive ones.

7. Culturally-based
Another key factor in recovery is taking into account the diverse cultural backgrounds of individuals. Any path to recovery must be sensitive and congruent with a person’s values, traditions, and beliefs.

8. Trauma-informed
All treatment and services must be aimed at the trauma that is at the center of mental health and addiction issues. Services and supports should ensure safety and build trust.

9. Strength-based
Individuals, families, and communities have strengths and resources which must be drawn upon to support recovery. Individuals have a responsibility for their own self-care and should be encouraged to advocate for themselves. Families have a responsibility to be informed and actively support the recovery of their loved one, especially in the case of children. Communities have a responsibility to provide resources and opportunities to address discrimination and encourage social inclusion.

10. Respect
All must recognize that the path to recovery takes great courage. Crucial to this process is regaining belief in one’s self along with a positive sense of identity. This must be unhindered by discrimination while protecting patient’s rights.

Treatment Teams
The Treatment Team is responsible for directing patient treatment to ensure that every aspect of care facilitates patient progress toward wellness and discharge. The team assures that the clinical and material needs of the patient are met. The Treatment Team meets weekly to review patient treatment plans and progress toward goals. The team also determines when the patient is ready for discharge. Members of the team may meet daily for “rounds” to discuss current levels of functioning, concerning behaviors, and other urgent needs that cannot wait for weekly treatment team review.
A patient’s Treatment Team is led by the service line manager and must also include a physician and unit director or nurse and social worker. Additionally, psychologist, rehabilitation therapist, transitional care specialist, pharmacist, dietician, and chaplain may attend Treatment Team meetings and be consulted on patient care. A teacher of record is consulted for youth patients and adult patients who attend school. Patients and, where applicable, their families/guardians are invited to participate in Treatment Team meetings to discuss ongoing treatment and discharge plans.

**Goals**

- To create an individualized patient-centered treatment plan;
- To review patient progress toward goals;
- To determine when patients are ready for discharge;
- To increase patient (and family) contact with the Treatment Team;
- To allow for patient treatment needs to be assessed by all relevant parties on an ongoing basis.

**Treatment Plans**

Treatment Plans set goals and objectives for a patient’s treatment with the ultimate goal of release into a less-restrictive environment. Treatment Plans are formulated and maintained by a patient’s Treatment Team and updated every 28 days. Gatekeepers and family members may attend team meetings because it is important for patients to maintain ties with their community and families. These are sources of support once a patient leaves the hospital.

Individual Behavior Plans may be implemented by Treatment Teams to help motivate or specifically address individual needs and issues. Behavior Plans are designed to enhance Treatment Plans to help each patient meet goals.

**Patient Safety Assurance: Individual and Facility-Based Commitments**

Safety is a primary component of the hospital’s mission. This concept is introduced the first day of an employee’s orientation, the first day a patient is admitted to our hospital, and as part of any visitation to the hospital by patient families or care coordinators.

Our multidisciplinary team approach trains, tracks, and addresses safety from numerous angles. Our Staff Development team provides extensive training for our employees in CPR, de-escalation techniques and safety maneuvers to help prevent people from being a danger to themselves or others. NDI recognizes that patient safety assurance is part of our daily duty, licensure maintenance, and general mental health
education protocols. This commitment is monitored by our Quality Assurance Department, which is responsible for keeping a watchful eye on how we maintain our patient environment.

We also approach safety at the individual patient level. Our patients have a wide array of psychological issues. This drives the need to promote individualized safety plans at the time of admission based upon the patient’s condition and ongoing plan adjustment while he/she is in our care. Situations such as seclusion, restraint, injury, or threats to others trigger a patient’s safety plan review at that time. These plans are shared with the patient’s family and any other clinical organization that may extend care to the patient off-grounds.

When a patient stabilizes and is under consideration for discharge, case history and current safety plan are shared in discharge planning and determination of best environment after leaving NDI.

Patient Access and Programming

Adult Patient Access to Hospital Areas
The Access Program is designed to ensure patients are safe in the hospital and able to participate in treatment appropriate to their level of functioning as they prepare for discharge. Patients are assigned access to different areas of the hospital based upon staff evaluation of safety. Specific behaviors may be deemed unsafe and require additional monitoring as determined by the treatment team. There are two types of access.

Unit Restricted/On Precautions:
Patients are on unit restriction when there is a specific risk to their safety or the safety of others if they go off the unit. This is typically tied to being on “precautions.”

Reasons for unit restriction: New admission*, any unsafe behavior, including physical assault, AWOL or attempted escape, SIB or suicidal ideation, stealing, destruction of property, possession or use of drugs or alcohol, sexual involvement, verbal or written threats (including profanity directed at others with the intent to verbally abuse or provoke others), significantly disruptive behavior in groups/activities on or off the unit.

*New admissions are admitted as unit restricted and placed on specific precautions based on history at admission for a minimum of 72 hours. At 72 hours, the precautions will discontinue if there have been no further incidents or concerns. Patient will remain unit restricted until treatment team determines the patient is appropriate to go off the unit.
UR Rules:

- Patient does not leave the unit unless for medical purposes with staff. Adult clients may resume regular group/treatment schedule including both on and off unit groups once they have shown they can be safe and are no longer an imminent risk to self or others. Precautions that necessitated unit restriction may continue even if the patient is able to resume attending groups off the unit. Patient should attend on unit groups during this time.

- Getting off unit restriction is on an individual basis. Patient must follow unit rules and be off precautions to be eligible to go off the unit.

- Although precautions will discontinue 72 hours after last incident, the treatment team will decide when patient is appropriate for escort access. Patient will remain unit restricted until the team meets to discuss at morning report.

Escort

All patients must be escorted the first time they move off unit restriction to learn what areas of the hospital are accessible to patients. Treatment team members will determine when the patient is appropriate to be unescorted in the building. May attend off ground outings and or/visits as approved by the treatment team.

Patients are escorted anytime they move off unit restriction if treatment team members feel it is warranted due to safety.

Escort Privileges/Rules

- Participate in all on-unit or in-building groups and activities with staff escort.

- Patients can be escorted to the canteen on evening shift if they followed unit rules for the day.

- Patients can be escorted to the outside terrace when available for patient use.

Groups

Adult group sessions are scheduled at 8:30 a.m., 9 a.m., 10 a.m., 1 p.m. and 2 p.m. (See appendix.) In addition, all adult units have a morning meeting at 8:30 a.m. and a social break at 9:45 a.m. Attendance at these group sessions is an essential part of the patient’s recovery. Participation in groups is required in order to attend more leisurely activities. For youth patients group leaders score participation at the end of each group session.
**Meals**

Adult and Youth meals are served on unit in the dining specified area. Meals times are from 7:15 - 8:15 AM for breakfast, 11:30 AM - 12:30 PM for lunch, and 5:00 - 6:00 PM for dinner. Patients will also receive snacks at 7:30 PM. Youth receives additional snack at 3:15 PM in order to comply with the National School Snack Program. All food must be consumed in designated areas. Patients on Escort may go to the Snack Bar, but all snacks must be consumed before returning to the unit.

**Visitation and Home Visits**

In-hospital visits are permitted as arranged by a patient’s social worker and with a doctor’s order. Patients may go on home visits if they are not on precautions and maintain the appropriate level with no significant behavioral issues within 24 hours of the visit. All home visits must be approved by the Service Line Manager.

**School**

Adult patients up to age 21 may attend Indianapolis Public Schools classes at the hospital. They may work toward a high school diploma or certificate of completion.

**Youth Patient Programming**

Youth patients follow a behavioral level program that is structured to provide patients feedback regarding their progress. The purpose of the program is to provide structure for learning life skills that will enable the patient to function more successfully. Patients earn points from staff to determine a level of least restriction. Severe misconduct may be referred to the Unit Director, Associate Director of Nursing, or Service Line Manager to judge if the behavior is so inappropriate that it is outside the scope of the level program, resulting in more immediate action in order to maintain a safe environment.

**Program Goals**

1. To help gain greater self-awareness;
2. To help accept responsibility for behavior;
3. To help gain a more positive outlook;
4. To provide a measuring tool for evaluating progress and strengths;
5. To help the patient understand how his/her behavior directly affects ability to safely participate in other activities safely.
The Scoring System (points)
Points are awarded every 30 minutes during waking hours. The accompanying staff during each rating period awards points. Points are totaled each night and a list of levels and points earned is posted at 7 a.m. daily. Four bonus points may be earned each day for observed acts of kindness toward others, a very clean bedroom, promptness for all programs, and anger control or other helpful behaviors. A bonus point may also be earned for taking personal time to regroup during stressful situations.

2 = Excellent behavior: Actively participating in treatment program as scheduled, without constant reminders or staff assistance.

1 = Average behavior: Participating in programming with some redirection or assistance from staff. A 1 is the highest score received if not participating in assigned activities.

0 = Unacceptable behavior: Being disruptive, lying, refusing to participate in activities, badgering or provoking others, threatening, stealing, expressing foul or insulting remarks, refusing to attend school and other programs, or sleeping during non-bedtime hours.

Pass Privilege Cards
Youth on adolescent units are eligible to receive a Pass Vote Sheet. This sheet is issued by the social worker responsible for the living unit. The sheet must be signed by all members of a patient’s Treatment Team. A patient must maintain a Level 4 for one week in order to receive a Pass Vote Sheet. If a patient earns a Level 3 or below, the one-week period starts over. If the patient has earned his or her Pass Vote Sheet and is in the process of getting signatures, he/she may keep the Signature Sheet but cannot earn the Pass Status until one full week of Level 4 has been achieved. Any member of the team may request the Signature Sheet to withdraw a signature.

It is the patient’s responsibility to meet with each team member to receive his/her signature. The team member should take this opportunity to explain why he/she feels the patient has earned this opportunity. The team member can share what he/she is expecting from someone who has earned a Pass Privilege Card.

Some specifics about the Pass Privilege Card include:

- Dropping below a Level 4 for one day makes the patient ineligible to use pass status that day.

- Dropping below a Level 4 for three consecutive days will result in revocation of the card and the need to start over.
- Dropping below a Level 3 will result in a patient’s card being immediately placed on hold.

- Privileges may be revoked due to a single act of poor behavior if the behavior is determined to be a danger to oneself or others.

- Any staff member may temporarily place privileges on hold until the team has an opportunity to meet and determine if pass status should continue.

- A weekly Pass Outing is scheduled only for adolescents who have earned a Pass Privilege Card.

- Card holders may be escorted to the canteen at the discretion of staff to spend their own money. All items must be consumed before returning to the unit.

- After completion of a signature sheet, it should be turned into a social worker who will then issue the Pass Privilege Card.

**Precautions/Behavior Plans**

Patients who exhibit behavior deemed a danger to themselves or others will be assessed for Precautions by the RN and/or physician. Patients will remain on precautions for 72 hours. Items from the patient’s room will be removed for safety reasons. All newly admitted patients will be on Precautions for at least the first 72 hours so that they can be assessed. Patients 12 and younger may have shorter precautionary times based on the treatment team’s recommendations. Precautions issued due to behavioral problems will be observed for 72 hours unless an exception is approved by the Treatment Team and Service Line Manager. The type of Precaution will reflect the specific behavior displayed.

While on Precautions, a patient is restricted to Level 1 programming. The patient is unit-restricted, which allows for school attendance. The physician may then make modifications. Precautions for patients 12 and younger may be discontinued or modified earlier, according to their abilities.

Off-grounds activities and visits are not allowed while on Precautions except visits adjacent to the unit. A physician order is required to discontinue a Precaution. Points will continue to be assessed on Precautions.

**Behavior Plans**

Individual Behavior Plans may be implemented by Treatment Teams to help motivate or specifically address individual needs and issues. Behavior Plans are designed to enhance the Treatment Plan to help each patient meet individual goals. Any Behavior Plans that contradict the Behavioral Program should be brought to the attention of the Service Line Manager and respective Assistant Director of Nursing (ADON).

If property destruction is involved, community service may be required to assist in making restitution. A list of required community service or reparations will be written in the care plan.

Updated 4/19
While cursing alone may not place a patient on Assault Precautions, cursing with threats of violence toward others is not acceptable. Actual contact with another individual is not necessary for staff to place a patient on Assault Precautions as a preventive measure.

**Meals**

Youth meals are served on the living units on the third floor. Meals are served from 7:30 a.m. for breakfast, 11 a.m.-12:45 p.m. for lunch, and 5-6 p.m. for dinner. Patients will also receive snacks at 3:15 p.m. and 7 p.m. All food must be consumed in designated areas. Level appropriate patients may be escorted to the Canteen, but all snacks must be consumed before returning to the unit.

**Visitation and Home Visits**

Patients are permitted to have visitors as arranged by their social worker and with the doctor’s order. Patients not on Precautions and able to maintain the appropriate level may leave on home visits at the discretion of the Treatment Team. A patient will not be allowed to go on a visit if he/she had a significant behavioral problem within 24 hours of the visit. The Service Line Manager must approve all home visits.

**School**

School records are requested before admission so a patient’s education may continue. Indianapolis Public Schools teachers instruct elementary through high school classes at the hospital. Every effort is made to help patients with their education so they do not lose ground.

**Discharge**

Social workers are responsible for a large portion of the discharge process. Ongoing contact occurs with the gatekeeper, Department of Child Services (DCS), and the family/guardian beginning at the time of admission. Social workers submit pre-discharge to gatekeeper via Viewpoint. This will include the most recent treatment plan, psychiatric assessment, psychosocial assessment, and any other specifically requested information for the gatekeeper including a summary of care provided during hospitalization. Once approved by the gatekeeper, the patient may then be added to the 90-day discharge list. The Social Worker will additionally complete a pre-discharge plan/aftercare referral form within the electronic medical record. Upon receiving post-discharge intake appointment, Social Work then completes the internal 590 form, ten days prior to discharge. Social Workers also complete the discharge summary in Viewpoint, or the discharge/transfer form for patients with legal status, and submit requested documents to the gatekeeper, accepting agency, and DCS personnel, if applicable. The Social Worker will complete an inpatient discharge within the electronic medical record. Adult social workers and, to some degree, youth
social workers assist with choosing a placement for post-discharge in cooperation with the gatekeeper and/or DCS. NDI staff also obtain information to determine the need for prescriptions, in addition to a seven-day medication supply, for patient transfer to another facility. Social workers provide education on the process of obtaining IEP/school assistance and acquiring school records. Social workers complete referral packets for placements, make requests for expedited Bureau of Developmental Disability Services targeting, and coordinate appointments for assessments/interviews. They contact Medicaid for the youth and have benefits transferred to the new placement or changed to non-residential if youth are transitioning to home or foster/group homes. For adults, social workers help patients apply for Medicaid one week prior to discharge, and notify Medicaid liaison of application date and request that patient be removed from 590 coverage. If necessary, a guardian will sign the Medicaid application. For youth and adults, social workers contact Social Security Administration to indicate that NDI will no longer be the payee, and indicate new addresses and payees. Once patients are discharged, social workers submit signed discharge forms to Health Information Services (HIS) and to the gatekeeper.

For adults with Office of General Counsel (OGC) status, two additional forms are required: Forensic report summary and the Treatment Team’s recommendation for Leave of Absence (LOA) for criminally involved persons.

Upon admission, the social worker, treatment team, client, family/guardian, and gatekeeper begin discussing options for discharge and placement back into the community so a plan can be immediately drafted. Special concern is given for those clients who have chronic health issues or are on medications that are difficult to manage in the community. All clients are informed that they have the right to change gatekeepers, upon discharge, if they wish.

Regular contact between the team and the gatekeeper, via the social worker, will occur, and when the necessary requirements for discharge have been met, the gatekeeper and the social worker will begin working toward placement in the agreed upon less-restrictive environment.

The social worker will meet with family and potential caregivers to provide the Viewpoint discharge summary and all necessary education, support, and referrals (especially for those patients who will reside with family) to assist in continuity of care. On the day of discharge, the social worker will meet with family and potential caregivers to provide the Viewpoint discharge summary and all necessary education, support, and referrals (especially for those patients who will reside with family) to assist in continuity of care and nursing staff will provide and explain the medication list to the client and caregiver.
Psychiatry: Overview

Program Description
The psychiatry section of the NDI is comprised of adult, adolescent, and child services. Since this is a referral hospital, background history and information are received and reviewed prior to admission. Patients may arrive from anywhere in the state, including transfers from other state hospitals. These patients typically have already had considerable exposure to mental health care and have not responded to treatment. They arrive under a regular commitment and, in certain cases, a voluntary commitment under legal guardian signature. Others may be sent to the hospital under the status of Incompetent to Stand Trial (ICST).

Program Goals
- A patient’s mental health history and symptoms are reviewed, as well as current/historic medications and their effects.
- Patient assessments are conducted upon admission to help determine objectives and desired outcomes.
- Patients are also assessed for other diseases and, if present, they are referred to NDI’s internist for physical examination and recommended treatment.
- Following assessment, psychotropic medication is administered when appropriate. This may involve continuation and adjustment of current dosing, addition of another appropriate psychotropic, or start of a new medication.
- For patients on ICST status, their goals are to become competent to return to court and stand trial with the help of legal education classes, while their psychotropic medications are monitored.
Psychiatry: Children and Adolescents

Program Description
The child and adolescent psychiatrists prescribe and manage psychotropic medications in order to improve patient symptoms. Psychiatrists perform routine assessments of patient psychiatric symptoms and monitor for medication effects and side effects.

Program Goals
- To assess patient mental status and psychiatric symptoms.
- To prescribe and manage psychotropic medications in order to maximize benefits and minimize harm to the patient.
Psychology

Program Description
The Psychology Department is composed of licensed psychologists and master’s level clinicians with diverse areas of expertise including severe mental illness, addictions, trauma, neuropsychology, forensics, and pediatric psychology. Based on the Scientist-Practitioner Model, the Psychology Department adheres to the American Psychological Association's (APA) ethical principles and code of conduct and is dedicated to following a biopsychosocial perspective of health and illness and providing cutting-edge best practice in inpatient treatment.

Members of the Psychology Department employ empirically-validated assessment measures, clinical observation, and a thorough review of medical records and collateral information in order to ascertain each patient’s neurocognitive/behavioral/emotional/psychological difficulties, functional limitations, and strengths. After establishing diagnostic clarity, psychologists identify targeted and individualized interventions. Approaches to treatment include, but are not limited to, cognitive-behavioral therapy (CBT), dialectical behavior therapy (DBT), motivational Interviewing, interpersonal psychotherapy, psychoeducation, biofeedback, and mindfulness-based interventions. Members of the Psychology Department actively engage in direct patient care via individual/group/family psychotherapy and function as consultants to other members of the multidisciplinary team, providing specific insights and recommendations regarding therapeutic approaches, behavior management, and discharge planning. Recognizing the high prevalence of complex trauma among our patients, the Psychology Department also provides ongoing staff education in order to create a therapeutic institutional milieu that promotes trauma-informed care and a chronic calm. Finally, consistent with the hospital’s mission, psychologists conduct research to better understand the impact of treatment and improve the quality of care.

Program Goals

- Collaborate with psychiatrists to ascertain diagnostic clarity.
- Improve patients’ overall well-being via individualized, evidence-based treatment.
- Create an institutional milieu based on a chronic calm and trauma-informed care.
- Evaluate treatment outcomes.
Program Objectives

- Complete initial/referred psychological assessments and competency evaluations in a timely manner.

- Facilitate case conceptualization conferences and individualized treatment planning.

- Provide individual/group/family psychotherapy and document patient progress in a timely manner.

- Attend multidisciplinary meetings to provide guidance on therapeutic approaches, behavior management, and discharge planning.

- Attend hospital management and committee meetings in order to bring about positive changes to the institutional milieu and patient care.

- Provide staff education and training.

- Supervise practicum students.

- Develop and conduct treatment outcome research.
Patient General Medical Services / Co-Morbidity (Disease) Treatment

Medical services will be provided to NDI patients by an internal medicine physician. This includes close consultation plus management of and implementation of standard-of-care practices to address co-existing medical problems. Common areas of focus include, but are not limited to, asthma, Chronic Obstructive Pulmonary Disease (COPD), diabetes management, hypertension, sleep apnea, and hyperlipidemia (high cholesterol).

In the event a medical problem requires more specialized assessments, the internist will initiate appropriate and timely consultation with specialty physicians. Furthermore, consultations by the internist will be performed on patient units as a convenience to patients.

Included in such medical services will be repair and treatment of minor lacerations, abrasions, musculoskeletal injuries or other common immediate care concerns.

General medical services are provided both on unit and at the on-site Larue Carter clinic. Emergent and complex medical conditions are treated at medical-surgical hospitals or specialty clinics. Any such off-premises treatments require a NDI attendant to accompany a patient during transportation and, in some circumstances, while a patient is admitted elsewhere.
Psychiatric Nursing

Program Description

Nursing staff members are on the front line of assessment and treatment of our patients, providing 24-hour direct care by Registered Nurses, Licensed Practical Nurses, Qualified Medication Attendants, Certified Nursing Aides, and Behavioral Health Recovery Attendants. Direct care describes a wide variety of duties including medication administration, assistance with or provision of personal care and activities of daily living, assessment and care of physical illnesses and disabilities, education, and monitoring of patient risk factors and safety considerations.

The Nursing Department collaborates with a variety of professionals from various disciplines to determine and provide the best possible care for patients through nursing care plans and participation in ongoing interdisciplinary treatment planning activities according to individualized patient need.

Program Goals

- To maintain a safe environment for patients while providing for their physical and emotional needs.
- To establish a therapeutic rapport with each assigned patient through consistency, trust, respect and non-judgmental attitude.
- To assist patients with identifying and managing psychiatric symptoms in order to achieve the least restrictive environment.
- To accurately administer medications and assess for effects and side effects.
Pharmacy

Program Description

The Clinical Pharmacist provides pharmaceutical care and cost reduction strategies as an active participant in the health care and treatment team. The pharmacist monitors all drug therapy for efficacy and adverse effects and maintains all data in the Clozapine Registry. The pharmacist completes medication reconciliation at admission and readmission and provides recommendations and guidance to prescribers. The pharmacy is one of the founding participants in the Pharmacy and Therapeutics Committee, which maintains and updates the hospital formulary and oversees all medication-related issues in the hospital.

Program Goals

- To facilitate evidence-based medication treatment implementation in both psychiatric and medical conditions.
- To monitor drug efficacy and prevent adverse events through laboratory result monitoring.
- To maintain and enter all data into the National Clozapine Registry in accordance with FDA requirements.
- To participate in the treatment team through medication recommendations.
- To perform patient discharge counseling to facilitate outpatient compliance with medication regimens when requested.
- To perform medication reconciliation and formulary compliance suggestions.

Program Objectives

The clinical pharmacist will:

1. Attend treatment teams and provide advice and guidance on drug selection.
2. The clinical pharmacist will monitor drug therapy for duplications and drug interactions and will intervene with the prescriber when necessary.
3. The clinical pharmacist will review all laboratory results and provide feedback when needed to the prescriber.
4. The clinical pharmacist will monitor lab values required by the Clozapine Registry and will initiate compliance with the Clozapine Risk Evaluation and Mitigation Strategy (REMS) program guidelines when values require it.
5. The clinical pharmacist will provide medication regimen counseling to discharging patients at the request of the prescriber.
6. The clinical pharmacist will provide usage and compliance data on medication as required by the Pharmacy and Therapeutics Committee for continuous quality improvement.
Nutrition and Dietetics

Program Description
The Registered Dietitian Nutritionist (RDN) is the nutrition expert on a patient’s treatment team. The RDN completes nutritional assessments and provides guidance and education to patients in individual and group settings. The RDN also provides education to a patient’s family, significant others and staff.

The RDN collaborates with professionals from other disciplines to determine and provide optimal nutrition to each patient.

Program Goals
- To assess patients’ nutritional needs and make recommendations for treatment based on the identified needs.
- To review and revise plans, as needed, to improve nutritional care for patients while taking their safety and emotional needs into consideration.
- To establish a therapeutic rapport with each assigned patient through consistency, trust, respect and a non-judgmental attitude.
- To assist patients with identifying and achieving their nutritional goals.
- To provide drug-nutrient interaction education to patients.
- To monitor meals to ensure compliance with patients’ diet prescriptions.

Program Objectives
The RDN will:
- Complete Initial Nutritional Assessment within 5 business days of patient’s admission and Annual Nutritional Assessment during the month of the anniversary of the patient’s admission.
- Write diet and nutrition supplement orders for pending physician’s signature prior to implementation.
- Identify nutritional diagnosis and collaborate with the patient and treatment team to address these concerns.
- Lead nutrition educational groups based on the needs identified in the assessments.
- Complete additional documentation for each patient. This includes progress notes, consults, and diet orders on an as-needed basis.
- Observe meals to ensure compliance with patient’s diet order.
- Evaluate quality of meals and provide input to the food service department.
Rehabilitation Therapy

Program Description
The Rehabilitation Department offers recreational and leisure education group activities to patients. Therapists are key members of the Treatment Team. They develop and implement educational groups and recreational activities based on patient needs as identified through assessment.

Our treatment service is designed to restore, remediate and rehabilitate a person’s level of functioning and independence in life activities, to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition.

Rehabilitation Therapists utilize a wide range of activity and community-based interventions and techniques to improve the physical, cognitive, emotional, social, and leisure needs of their patients.

Program Goals
- To provide assessment of patient needs to create an individualized treatment program.
- To provide active treatment based on the specific, individual needs of each patient, as noted in his/her treatment plan.
- To provide leisure education and community reintegration in structured social settings to promote improvement in overall well-being to be successful in a least restrictive environment.

Program Objectives
The Rehabilitation Therapist will:

1. Complete additional documentation for each patient. This includes progress notes on a weekly basis for the first 8 weeks following admission and monthly thereafter and daily therapeutic notes for groups attended.

2. Identify individual RT goals and work with the Treatment Team to place patients in active treatment groups based on the needs identified in the initial assessment. This program plan will be incorporated into the treatment plan.

3. Complete additional documentation for each patient. This includes progress notes on a weekly basis for the first 8 weeks following admission and monthly thereafter and weekly group treatment encounter notes.

4. Provide each patient with opportunities for leisure education, recreational activities, and community reintegration outings.

5. Work with patients to incorporate specific interests and community resources into therapy to achieve optimal outcomes that transfer to their real life situations.
Social Work

Program description
They assess patient treatment needs and oversee the creation of an individualized treatment plan for each patient. They formulate, develop, and implement specific treatment strategies for each patient in individual, family, and group settings. Social workers assess patient progress toward goals and analyze data related to patient outcomes to determine discharge readiness. They facilitate placement and post-discharge services for patients who are discharge-ready and provide feedback to the gatekeepers on patient post-discharge needs. Social workers are the liaisons between the Treatment Team and those outside the hospital, including patient families, gatekeepers, Division of Mental Health and Addiction/Office of General Counsel, Department of Child Services, Indianapolis Public Schools, Bureau of Developmental Disability Services, Court Appointed Special Advocates, Guardians ad Litem (court appointed), attorneys, schools, probation officers, and other residential facilities. They provide education to families and coordinate patient visits. Social workers also help patients with their material needs by providing assistance with money management; benefit applications, such as Medicare D, Medicaid, Social Security, BDDS, Section 8 housing, CICOA, PASSR, and prescriptions; and acquiring identification and documentation, such as ID cards, Social Security cards, birth certificates, marriage licenses and Green Cards.

Program Goals
- To provide an assessment of patient needs in order to establish a basis for the creation of an individualized treatment plan.
- To provide active treatment based on the specific, individual needs of each patient, as noted in a treatment plan.
- To provide fluid communication between all who are involved in patient care internally and externally.
- To facilitate patient discharge planning and coordination of post-discharge services.
Program Objectives

The social worker will:

1. Complete biopsychosocial assessments 24 hours of patient admission and annually during the month of the anniversary of the patient’s admission.

2. Create an individualized treatment plan for each patient within 5 business days of admission. The plan will be reviewed every 30 days for all patients.

3. Complete the following additional documentation for each patient: Progress Notes on a weekly basis for the first 8 weeks following admission and monthly thereafter; Group Treatment Notes (GTNS) weekly, and Treatment Encounter Notes as noted on patient treatment plans. Additionally, social workers will complete a Progress Note within 24 hours of admission and discharge.

4. Complete patient discharge in Viewpoint, complete aftercare and inpatient discharge within the electronic medical record, providing information on patient progress, post-discharge needs and follow up appointments within 24 hours of patient discharge.
Transitional Care

Program Description

Transitional Care Program
Discharge planning begins immediately after admission and continues throughout the patients hospital stay. The transition care program is designed to ensure the coordination and continuity of care as patients transfer between different locations or different levels of care within the hospital. Examples of transfers include: Transferring to a different level of hospital care, transferring from the hospital to a group home or supported living housing, or from the hospital back home.

- Transition care will focus on skills building and discharge preparation.
- Transition groups will focus on the following areas: Life and social skills, budgeting and finances, living on your own, treatment and recovery, primary care and specialist follow-up, knowledge of red flags, jobs and employment, computer skills, and positive support.

Program Goals

- Reduce readmission rates and adverse events.
- Improve patients’ transition from the hospital into the next level of care or setting.
- Increase patient engagement and active participation in life.
- Assist with developing patients’ independence by teaching useful life skills.
- Increase patients’ awareness of community resources.

Program Objectives

- Create a positive environment that will foster learning, exploration, and open discussions through the integration of life skills resources, group work, and question and answer sessions.
- Enhance personal development by promoting confidence, supporting well-being, and focusing on personal strengths.
- Encourage patients to explore their strengths by engaging in creative activities that promote healthy living.
- Enhance patients’ ability to identify, access, and utilize community resources.
**Academic Educational Services**

Youth will be assessed for academic needs. The school liaison will review the record and look for any indication of an Individualized Education Plan (IEP) from the last school attended, test results indicating the patient’s ability level and the last grade attended. When applicable, credits will be reviewed to determine appropriate class placement. The hospital provides educational opportunities for all students from first grade through graduation.

NDI works with Indianapolis Public Schools to help students fulfill their educational requirements. IPS teachers staff three middle school/high school classes and an elementary classroom. Each student is assigned a teacher of record who assists with specific needs. Teachers instruct special education classes as well as English, mathematics, science, social studies, and elementary education. The school year follows the IPS calendar.

Teachers provide the treatment team with monthly notes and review each plan with team members.

Each classroom has a Behavioral Health Recovery Attendant (BHRA) assigned to it to assist with any behavioral issues. They use the Behavioral Level Program and assign points as indicated. If unique or severe problems arise, the Educational Liaison or Service Line Manager is consulted.

Consistent communication among educators, unit staffers and remaining treatment team members is very important. Treatment team members review educational notes each morning and discuss concerns.

Educational services are offered to all students with an IEP. IPS will continue to offer services to all students up to 22 years old. General Education students may participate through the school year in which they turn 18 or until they graduate, whichever occurs sooner. Students who are eligible for special education services may receive services through the school year in which they turn 22 or until they graduate or receive a Certificate of Completion.

A certificate of completion, a high school diploma, a recommendation to continue with adult educational programming or vocational opportunities are all possibilities.
Program Goals

- Minimize loss of knowledge and skills while a person is hospitalized.
- Build on knowledge and skills students already have acquired.
- Provide opportunity for high school students to recover credits they may have missed.
- Help students learn the value and necessity of lifelong learning.
- Help students develop positive learning skills such as achieving self-direction, asking for help, and learning how to access available resources.

Program Objectives

Educators will:

1. Develop a picture of each student’s current achievement by
   (a) Reviewing prior academic records and available assessment reports
   (b) Conducting formal and/or informal content-specific assessments
   (c) Talking with the student and her/his parent(s)/guardian(s)

2. Provide appropriately challenging instruction, based on the initial assessment, periodic formative assessment, and Indiana State Academic Standards.

3. Convene Case Conference Committee meetings for students eligible for special education services within 10 school days of a student entering school in order to develop an appropriate Individualized Education Program (IEP)

4. Report each student’s progress to the Treatment Team monthly

5. Report each student’s progress to her/his parent(s)/guardian(s) at least quarterly

6. Provide information about the student’s progress, current achievement, and challenges to the receiving school when he/she is discharged
Spiritual Care / Chaplaincy

Program Description
The program offers spiritual care services to the hospital’s multi-faith population and integrates these services throughout the hospital.

Program Goals
- Offer a consistent spiritual presence across the hospital to provide support to patients, staff, and families.
- Facilitate better communication among patients and staff members to improve quality of patient care, as well as staff morale and retention.
- Participate in and support interdisciplinary efforts throughout the hospital.
- Provide educational opportunities to enhance awareness and inclusion of spiritual issues as part of quality health care.

Program Objectives
Chaplain Educator/ The Institute for Clinical Pastoral Training Certified Supervisor will:
1. Provide a model of love through presence, word and deed.
2. Recognize and respond to spiritual needs.
3. Provide daily ministry of presence and support for patients and staff.
4. Offer weekly interfaith worship services.
5. Facilitate spirituality groups on patient care units to expand active treatment offerings.
6. Consult with interdisciplinary staff and faith representatives as required.
7. Complete initial spiritual assessments.
8. Provide spiritual resources as requested and appropriate.
9. Offer Accredited Clinical Pastoral Education Programs through ACCET as recognized by the U.S. Department of Education for graduate level seminarians and community faith representatives desiring continuing education.