Health
South Eastern Sydney
Local Health District

MENTAL HEALTH SERVICE BUSINESS RULE SESLHDBR/012

Name	Community Mental Health Acute Care Teams – Key Practices		
What it is	A business rule to clearly explain key practices required of Community Mental Health (CMH) Acute Care Teams.		
Risk Rating	Medium	**Review date**	January 2025
What it is not	It is not an exhaustive summary of team-based requirements related to the assessment, treatment and referral of people who require urgent mental health assessment and support.		
Who it applies to	This business rule applies to CMH Acute Care Teams, CMH Acute Care Consultant Psychiatrists and Psychiatric Registrars, other appropriate Medical Officers and SESLHD Mental Health Service (MHS) referring teams. **This also applies to Clinical Nurse Consultants assessing clients in the Emergency Department.**		
Transitions of care	Transitions are times of significant risk for mental health consumers and their families/carers. Collaborative and comprehensive planning for discharge or transfer of care improves safety for the consumer, their family/carer and the wider community as per NSW Health PD2019_045 Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services		
What to do	**The Role of Acute Care Teams** CMH Acute Care Teams provide safe time-limited mental health interventions and support to people in the community who are experiencing an acute episode of mental illness or distress. Acute Care Teams facilitate transfers of care and referrals to other CMH teams, or community-based agencies, for ongoing treatment, care and support. The acute phase of mental illness or distress is a vulnerable and distressing time for individuals and their carers. CMH Acute Care Teams are critical in supporting people through a mental health crisis and facilitating recovery. A recovery-oriented approach to crisis aims to: • Assist individuals to develop strategies that might prevent a future crisis • Ensure collaborative and person centred care planning • Support people to maintain their sense of identity during and beyond the crisis. • Ensure least restrictive care is prioritised throughout the episode of care • Support consumers strengths and their ability to remain connected with their community		

Acute Care Teams will ensure that an individual's decision-making capacity is regularly considered and where decision-making capacity is impaired previous treatment preferences should be used where possible.

These principles are embedded in the National Standards for Mental Health Services (2010): "The MHS encourages and supports the self-determination and autonomy of consumers and carers." (Standard 10: 'Delivery of care' [10.1.4])

Care Coordinators and other clinicians should work with consumers to develop and maintain the MH Care Plan document in the consumer's electronic medical record (eMR) so that a record of the consumers' preferences can guide service provision in times of crisis.

The key functions and processes for CMH Acute Care Teams are as follows:

1. Receiving referrals
2. Triage
3. Assessments
4. Risk assessment
5. Service provision – including counselling, psycho-education, advocacy and practical assistance
6. Medication administration and monitoring
7. Physical health care – assessment, monitoring and education
8. Supporting consumers on leave from public mental health inpatient units
9. Collaboration with other services and partners
10. Clinical handover
11. Transfer of care

1. Receiving Referrals

a) Referrals from SESLHD State-wide Mental Health Telephone Access Line (SMHTAL)

- Transfer of Care from SMHTAL to the local Acute Care Team is to occur as per section *4.2 Transfer of care to another mental health service* within SESLHDPR/500 State Mental Health Telephone Access Line (SMHTAL)

b) Referrals from SESLHD Intake Team

- Verbal handover to the CMH Acute Care Team must occur
- Facilities are responsible for implementing processes to ensure that the service encounter is open to accurately record the transition of care for patients.
- Intake/triage must document the referral on the triage form and the clinical handover is to be documented in the medical record, including an immediate risk assessment based on the information available.
- The 'Mental Health Assessment' section of the electronic

	Medical Record (eMR) software must be completed, following the initial face-to-face assessment. *c) Referrals from SESLHD Community Teams (non-acute)* • A verbal handover of the current presentation must be provided according to the ISBAR (Introduction, Situation, Background, Assessment, Recommendation) framework detailed within SESLHDBR/040 Clinical Handover for Mental Health Services (ISBAR) • The hybrid medical record must be made available to the CMH Acute Care Team as soon as possible • The referring clinician should engage consumers and/or their nominated carer(s) to develop and document a plan. and clearly documented in the medical record. This should ideally reflect strategies identified by the consumer in their MH Care Plan document prior to the crisis period. The plan must be verbally communicated to the Acute Care Team. • CMH Acute Care Team clinicians must document acceptance of the referral and the identified plan. The CMH Acute Care Team and the Care Coordinator must liaise at least every second day to discuss the consumer's progress. • Care Coordinators are to continue to have contact with consumers while being supported by the CMH Acute Care Team. • CMH Acute Care Teams are to liaise with consumers, the Care Coordinator must liaise with the consumer and their identified next of kin/carer, prior to a transfer of care occurring to the Care Coordinator. • All discussions regarding transfer of case to the Care Coordinator must be verbal and documented by both parties in the consumer's eMR. • The current care plan must be outlined in a clinical handover to the Care Coordinator and documented in the consumer's eMR. *d) Referrals from Inpatient Units (Mental Health and General)* • CMH Acute Care Teams are pivotal in facilitating the safe and successful transition of people with a mental illness from hospital to the community. For referrals from Inpatient Mental Health and General Units, Consultation Liaison or Mental Health Rehabilitation, the following is required: - A copy of the most recent Mental Health Assessment from eMR - The last seven days of clinical notes or – for admissions of shorter duration – all of the clinical notes, including test results (for sites without eMR) and a copy of the current medication chart - A copy of the Discharge Plan and details of any follow-up appointment dates/times (for sites without eMR). **NB. Follow up within seven days of transfer of care**

from an inpatient setting is a mandatory requirement.

- A comprehensive written handover (for sites without eMR) and verbal handover (for sites with eMR) from the inpatient unit team to the CMH Acute Care Team is required. This should include a copy of the MH Care Plan document outlining the consumers' wishes for service provision during the time of crisis.

2. Triage

- A preliminary telephone call is generally made to triage the referral, using eMR triage forms and including information about the need for CMH Acute Care Team assessment and any risk issues, including concerns for consumer or staff safety. In addition to referrals from within the MHS, there are many other sources of potential referral for urgent mental health assessment and support, including GPs, courts, airports, NSW Police/Ambulance Service of NSW, community-based services (e.g. housing, Centrelink), consumer self-referral or carer referral, community members and mental health services external to SESLHD.
- All initial phone contacts with consumers and referrers must be documented using the eMR triage forms. If referral is made by a third party, attempts must be made to have direct contact with consumers in order to complete the triage.
- In all cases, the verbal and written communication regarding requests for urgent mental health assessment and support should be comprehensively recorded and responded to accordingly.
- The triage form does not need to be completed for an internal transfer of care. However, the current mental state of the consumer (including the reason for referral to the CMH Acute Care Team) must be documented by the referrer in the progress notes.

3. Assessments

- MH assessment is to be completed face-to-face, unless contact cannot be arranged and carried out in a safe manner. In this case, evidence of discussion with a Clinical Manager /Consultant Psychiatrist and the rationale is to be documented within the progress notes.
- Wherever possible, when consumers are agreeable and safety permits, the initial assessment should take place in consumers' homes.
- Home visit risk assessments should be completed prior to home visiting.
- If assessments occur in a venue other than consumers' homes, notation of the reason for an alternative venue should be identified, the risk assessed and documented in the clinical notes in line with the SESLHDPR/230 Work

Health and Safety - Working Off Site - Risk Management Procedure and the SESLHDHB/016 Safety When Working Offsite Handbook

- Corroborative information must be sought from families/ carers/support networks/other clinicians whenever this is available.

4. Risk Assessments

- **A comprehensive assessment that considers all potential risks to the consumer must be completed at the time of the initial contact and each subsequent contact** (by phone or face-to-face) by the CMH Acute Care Team and documented. The clinician is to refer to the **Formulation and Diagnosis** section of the **Assessment Reference Free Text** in the "Mental Health Current Assessment" powernote in eMR (which includes guidance/considerations), when formulating a risk profile.
- A corroborative history should be obtained from carers/ support networks.
- Completed Risk Assessments with 'low confidence' or 'high changeability' require further corroboration. Clinicians must seek urgent advice from a more senior clinician and/or Clinical Manager in developing a comprehensive management plan. Clinicians must organise re-assessment within 24 hours.
- All consumers presenting with individual factors that might increase their risk of self-harm, suicide or harm to others **(Which include all first presentations with Psychosis)** must receive an assessment/review by two separate clinicians (one being a Medical Officer) within 24hrs if the client is to be managed by the community. All relevant collaborative history needs to be obtained and discussed with a Consultant Psychiatrist.
- **Each consumer must receive a comprehensive and collaborative assessment that considers individual risk and protective factors to formulate a supportive plan to mitigate risks where possible** as per SESLHDGL/082 Clinical Risk Assessment and Management – Mental Health. Categories of "Low", "Medium " and "High" should not be used to stratify risk due to the potential for inaccuracy.
- Young people under 17 years of age should be discussed with the CAMHS On-call Consultant.
- First presentation clients with Psychosis must have a face-to-face Consultant Psychiatrist review within 48-72 hrs.
- If clients refuse the review then the Consultant Psychiatrist must contact the client by telephone and personally offer a review.
- CMH Acute Care Teams must adhere to the guiding principles outlined in NSW Ministry of Health Policy PD2016_007 Clinical Care of People Who May Be Suicidal.

5. Service Provision

To ensure comprehensive service provision to all consumers supported by the CMH Acute Care Team, regular reviews are to be undertaken in line with the following process:

- Consumers must be assessed face-to-face by a CMH Acute Care Clinician or Medical Officer **at least once every seven days**. Less frequent contact with consumers may only take place as part of a predetermined care plan endorsed by a Consultant Psychiatrist.
- Consumers **must be contacted daily or every second day** by CMH Acute Care staff. Less frequent contact may only take place as part of a predetermined and endorsed care plan.
- Following each contact with consumers or other service providers, an assessment of risks is to be clearly documented in the clinical notes with a **plan for response** and intervention.
- Medical review of the risk status should be undertaken by either the CMH Acute Care Consultant Psychiatrist/ Psychiatric Registrar or other appropriate Medical Officer, according to the predetermined care plan. This review should be documented in the medical record. **A further assessment of risk should be completed when there is an increase in the risk status.** This should be communicated through discussion with the team, including consumers and their carers and/or advocates.
- Consumers who have a significant change in their clinical presentation or increase in their risk are to be discussed with the CMH Acute Care Consultant Psychiatrist or other appropriate Medical Officer during that shift.
- The duration and type of intervention provided by the CMH Acute Care Team is dependent on: risk assessments; consumers' stage of recovery; the level of support provided by carers; and whether other health professionals are to be involved in follow-up care (e.g. Care Coordinator, private Psychiatrist).
- The plan for intervention and response to suicide risk is guided by protocols of the NSW Ministry of Health Framework for Suicide Risk Assessment and Management for NSW Health Staff.
- If there are safety concerns for a consumer, a request for a NSW Police Welfare Check can be made to "sight the consumer". The Clinician who contacts NSW Police should request to speak with the Duty Officer (where available). When requesting the Welfare Check, the Clinician must clearly mention the possible use of force to gain entry to residential premises in the event of serious safety concerns.
    - NSW Police rely on the information provided by the requestor to inform the actions they take during a Welfare Check, and forced entry is not a routine

element of this procedure.

NOTE: Skill mix deficits may be identified within the Acute Care Team due to sick leave or other unpredictable circumstances. This would likely impact on the capacity of the team to provide comprehensive and timely assessments. If this occurs, the Acute Care In-Charge must escalate the matter to their Line Manager or the after hours on-call Executive as appropriate.

6. Medication Administration and Monitoring

CMH Acute Care Teams should:

- Administer, chart and document medication as per NSW Ministry of Health Policy PD2013_043 Medication Handling in NSW Public Health Facilities.
- Small amounts of imprest stock for ACT can only be provided in repackaged clearly labelled child resistant containers
- Provide education to consumers and their families regarding the desired effects of medication on symptoms, possible side effects and expected outcome of treatment.
- Manage physical health issues arising from the use of psychotropic medication and other mental health interventions. This includes coordination of blood tests, medical imaging and other tests, as required.
- Respond comprehensively to consumer concerns about any medications or treatments prescribed, and (as far as possible) negotiate the most acceptable forms of treatment.
- Document and communicate consumers' concerns to the entire CMH Acute Care Team, including the team's treating Medical Officer.
- Provide information to consumers and carers about how to prevent and manage common medication side effects, and how to identify side effects that may be rare but high risk.
- Monitor medication adherence, effectiveness and emergence of side effects.

7. Physical Health Care

- Where a CMH Acute Care Team clinician believes consumers are at significant risk of physical health complications, reasonable steps must be taken to ensure that a prompt physical assessment is completed. Where appropriate this may be undertaken by the consumer's GP. CMH Acute Care Teams are to comply with NSW Ministry of Health Policy PD2017_033 Physical Health Care Within Mental Health Services.
- CMH Acute Care Team clinicians play an important role in educating consumers and their carers about physical health issues related to mental health symptoms, their treatment, potential unwanted effects of medication, promotion of self-care and the use of available community resources.

8. Supporting Consumers on leave from public mental health Inpatient Units

- The provision of overnight or weekend leave from an inpatient unit is an important treatment strategy which is consistent with least restrictive care and supports planning for transfer of care. For many consumers on leave, support and input from CMH Acute Care Teams is pivotal to successful transition back to community living. Occasionally, consumers may be placed on extended leave (72 hours or more) from the inpatient unit.
- The CMH Acute Care Team must be informed of any planned leave prior to the commencement of leave if the CMH Acute Care Team is required to provide follow up during the period of leave.
- The CMH Acute Care Team must be provided with details of: the current risk status, duration of leave, details of carers or others who are to provide support during the leave process and a response plan in the event of consumers having a poor response to leave.
- When consumers go on leave for 72 hours or more, they must be provided with a follow up appointment with a specified SESLHD Mental Health Team or clinician (e.g. the CMH Acute Care Team).
- The appointment must be planned and confirmed prior to the commencement of the leave period.
    - Should the consumer not attend an appointment as scheduled, clinicians are to follow the process as per SESLHDBR/41 Management of Missed Appointments, noting in particular the escalation of a Welfare Check to NSW Police.
- A comprehensive clinical handover from the inpatient unit to the CMH Acute Care Team is required whenever consumers go on overnight or extended leave and the CMH Acute Care Team is required to provide follow up.
- The type, and intensity, of follow up provided by the CMH Acute Care Team may be influenced by: the duration of leave, the purpose of leave, the stage of recovery, and the risk status.
- Follow up most often involves planned and face-to-face contact with consumers.
- During periods of brief overnight leave a telephone call may be sufficient to monitor consumers' progress and provide support.
- A plan for targeted and purposeful follow up must be negotiated and agreed by consumers, their carers, the Inpatient Team and the CMH Acute Care Team prior to the approval of leave.
- Carers must be provided with clear instructions regarding their role during consumers' leave, as well as MHS contact

details should they have any concerns.

- The leave plan must be documented in the medical record and communicated to all relevant stakeholders.
- SESLHDPR/484 - Patient Leave from Acute Inpatient Units - Mental Health Service provides clear guidelines for consistent and safe practice in the planning, management and review of inpatient leave across the MHS.
- Information previously provided via the 'Risk Assessment and Patient Leave' sticker is central to this process and should now be entered in the free text area within the 'Risk Assessment Module' in eMR.

9. Collaboration with other Services and Partners

- CMH Acute Care Team clinicians work in partnership with other providers to promote coordinated responses to the broader needs of consumers. Providers include GPs, private Psychiatrists and other community-based mental health and non-mental health services such as accommodation, education, recreation and employment.
- SESLHDPR/418 - Relationships with External Clinical Care Providers - Mental Health Service provides a framework for developing collaborative partnerships with a range of external providers of services to people with mental health disorders.
- CMH Acute Care Teams must actively engage consumers, carers and family members in the development, implementation and evaluation of care plans. Consumer MH Care Plan should be central to the planning of service provision during times of crisis.
- Provision of clinical information to relevant service partners must be consistent with consumers' consent and privacy legislation, and must be documented in the clinical notes.

10. Clinical Handovers

- CMH Acute Care Team handovers are to occur at the beginning of each afternoon shift, with members of the multidisciplinary team present.
- Updates of consumers' clinical presentation, risk level, care plan and transfer of care planning should be provided at the clinical handovers.
- A Psychiatry Registrar and/or Consultant Psychiatrist are to be present at handovers at least once daily Mondays to Fridays.
- Acute Care handovers are to be consistent with the ISBAR communication framework as per SESLHDBR/040 Clinical Handover for Mental Health Services (ISBAR).
- Clinical handovers involve the transfer of care, responsibility and accountability and the sharing of current clinical information from shift to shift and from team to team.
- Handovers of any change or progress are to be

	documented in the medical record (NB. If there is no change in consumers' status, identifying details about the person handing over the determination of 'no change' should be made in the medical record). **11. Transfer of Care** • NSW Ministry of Health Policy PD2019_045 Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services presents a structured, standardised process for effective transition into the community. CMH Acute Care Team staff and referrers should familiarise themselves with this policy as local procedures must be consistent with the principles outlined. • Transfer of care from the CMH Acute Care Team requires authorisation by the CMH Acute Care Consultant Psychiatrist. This should be done in consultation with relevant service providers, consumers, their carers and/or referrers as appropriate. • Transfer of care should not proceed in circumstances where a consumer has not been reviewed as planned prior to the transfer of care. ○ The care must not be transferred until a full discussion with the CMH Acute Care Consultant Psychiatrist has occurred. Consideration must be given to a home visit and/or contacting carers, if the consumer is unable to be contacted as originally planned. • At the point of transfer from the CMH Acute Care Team, a comprehensive verbal and written handover must be given to all relevant stakeholders in line with the ISBAR communication framework. This should include a copy of Consumer Wellness Plans or Advance Directives outlining consumers' wishes for service provision during times of crisis. All communication should be recorded in the medical record using the MH Transfer of Care Checklist (which is accessible via the Document Launcher in eMR). • A written discharge summary must be provided to the service or clinician to whom care will be transferred, e.g. GP, Private Psychiatrist/Psychologist, or other service within SESLHD. • Where consumers are being transferred to longer-term CMH care, the CMH Acute Care Team is required to work closely with the relevant CMH Team to ensure a seamless and safe transfer of care.
When to use it	This business rule is to be used in the provision of CMH Acute Care services and when referring consumers to CMH Acute Care Teams.
How to use it	This business rule is to be used as a reference for key roles, functions and processes related to the provision of CMH Acute Care services and referral.
Why the rule is	This business rule is necessary to ensure the roles, functions

necessary	and key processes of SESLHD CMH Acute Care services are reflected in practice.
Who is responsible	Responsible staff include all SESLHD MHS clinicians and referring teams.
Ministry of Health / SESLHD reference	**NSW Ministry of Health** • PD2016_007 Clinical Care of People Who May Be Suicidal • NSW Ministry of Health Framework for Suicide Risk Assessment and Management for NSW Health Staff • PD2013_043 Medication Handling in NSW Public Health Facilities • PD2017_033 Physical Health Care Within Mental Health Services • Suicide Risk Assessment and Management Protocols: Community Mental Health Service • PD2019_020 Clinical Handover • GL2014_002 Mental Health Clinical Documentation Guideline • PD2019_045 Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services **SESLHD** • SESLHDPR/230 Work Health and Safety - Working Off Site - Risk Management Procedure • SESLHDHB/016 Safety When Working Offsite Handbook • SESLHDPR/484 - Patient Leave from Acute Inpatient Units - Mental Health Service • SESLHDPR/418 - Relationships with External Clinical Care Providers - Mental Health Service • SESLHDBR/040 Clinical Handover for Mental Health Services (ISBAR) • SESLHDGL/082 Clinical Risk Assessment and Management – Mental Health • SESLHDGL/074 Clinical Documentation in Mental Health **Other** • National Standards for Mental Health Services 2010: Standard 10: Delivery of care (10.1.4) • 100 ways to support recovery: A guide for mental health professionals. Rethink Recovery: Vol 1. Mike Slade, 2009 • Australian Clinical Guidelines for Early Psychosis
Executive Sponsor	Dr Nick Babidge, Clinical Director, MHS
Author	Community Mental Health Services Managers
Functional Group	Mental Health

Revision and Approval History

Date	Revision Number	Author and Approval
Oct 2012	0	Ratified by MHS Clinical Council.
September 2014	1	Endorsed by MHS Clinical Council.
November 2015	2v1	Initial review led by Robin Ellis, ESMHS Community Services Manager, with input from Peter Griffiths, TSH MHS A/Community Services Manager and Rebecca O'Brien, ESMHS Acute Care Team Leader.
December 2015	2v2	Minor additions by MHS District Document Development and Control Committee, including a paragraph regarding skill mix deficits to address a NSW Coroner's recommendation.
January 2016	2v2	Submitted to SESLHD MHS Clinical Council, which requested clarity regarding the definition of 'risk assessment' and alignment with definitions in the electronic Medical Record.
May 2017	2v3	Minor additions by SESLHD MHS District Document and Control Committee, included Clinical Nurse Consultant under 'Who it applies to'. Feedback updated under 'Risk assessment'. Endorsed by SESLHD MHS Clinical Council.
July 2017	2v4	Revised by Author with minor updates to Health Information records.
May 2018	2	Risk Rating changed from High Risk to Medium Risk – approved by Executive Sponsor.
December 2021	3	Process for SMHTAL referral added to document. Process for referral from SESLHD non-acute community teams reworded. Addition of specific requirement to sight consumer when requesting a NSW Police welfare check, imprest stock and Transfer of Care when a consumer has not been reviewed as planned. Need for model of care review identified – to be actioned in 2022. Endorsed SESLHD MHS Document Development and Control Committee and Clinical Council.
January 2022	3	Processed and published by SESLHD Policy.