SESLHD GUIDELINE COVER SHEET

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SUMMARY	This document provides clinicians with the purpose and protocol for the mental health clinical documentation (including in eMR)

SESLHD GUIDELINE COVER SHEET

Health
South Eastern Sydney
Local Health District

Clinical Documentation in Mental Health

Section 1 - Background

The original procedure SESLHDPR/521- Electronic Medical Record (eMR) Clinical Documentation – Mental Health Service (rescinded) was written to support NSW Health Guideline GL2014_002 - Clinical Documentation Guidelines and policy directive PD2010_018 - Mental Health Clinical Documentation (rescinded). This guideline replaces the previous South Eastern Sydney Local Health District Mental Health Service (SESLHD MHS) procedure and contains details on purpose, who, when and how per document type.

The purpose of clinical documentation is to support good clinical care; other goals such as administrative, policy and planning requirements are secondary. This document is a tool for the recording of essential healthcare-related information in a standard format. The recorded information should aid experienced clinicians, less experienced clinicians and managers to provide quality and optimal consumer care.

It is noteworthy that documentation alone does not lead to good team communication and clinical process, and therefore each site across the SESLHD MHS will strive to build team capacity, where required.

Section 2 - Principles

All documentation should reflect clinical processes undertaken. All clinical rationales should be written to aid the communication of information.

Clinicians must ensure timely and equitable access for all consumers, including people from Culturally and Linguistically Diverse (CALD) non–English speaking backgrounds and people of Aboriginal and/or Torres Strait Islander (ATSI) background. When indicated, the Health Care Interpreter Service (HCIS) must be used to ensure accurate assessment, that information regarding intervention has been explained and clearly understood and that the consumer has provided informed consent to treatment. All staff must comply with NSW Health PD2017_044 - Interpreters – Standard Procedures for working with Health Care Interpreters.

This document is not intended as a guide to conducting clinical assessments. References to Mental Health National Outcomes and Casemix Collection Version 2.10 2021 and existing Clinical Documentation Modules within this guideline are not a substitute for skills, training, supervision or judgement. The standards that apply to clinical documentation (mental health or otherwise) can be found in the following NSW Health Policy Directive PD2012_069 - Health Care Records - Documentation and Management.

Section 3 - Definitions

Definition: Modules

- **Modules**. There are two types of modules: Core and Additional. The modules in mental health clinical documentations are interrelated. The 'Core' modules are base documents available in eMR which provide information on which 'Additional' modules to complete. Further assessments are prompted by completing 'Additional Modules' as necessary, and this allows a coherent narrative about the episode of care to be formed. These 'Additional' modules are available as additional assessments, interventions and documentation used to reflect a particular type of care offered. **All base documents require mandatory completion by the clinical Treating Team**.

  List of Documentation per Module

  a) ***Core Modules (Base Documents/Clinical Documents in eMR)***: Triage, Assessment, Care Plan, Review and Transfer/Discharge Summary.

  b) ***Additional Modules:*** Physical Examination, Physical Appearance, Substance Use Assessment, Family Focused Assessment (COPMI), Transcultural Assessment, Clinical Functional Assessment, Cognitive Assessment (RUDAS), Cognitive Assessment (3MS/MMS), Screening for Domestic Violence, MH Consumer Wellness Plan, and Strengths Assessment.

All Clinicians must use the modules to record information in a structured format and exercise clinical judgement to guide information gathering.

Definition: Clinical Treating Team

- The **Clinical Treating Team** refers to Medical Officer, Registrar, Specialist staff, Nursing staff, Allied Health professionals, Peer Worker, and Community Health professionals. An Authorised Medical Officer is either the medical superintendent of a declared mental health facility or a doctor who has been authorised by the Medical Superintendent to fulfil responsibilities under the NSW Mental Health Act (2007). In SESLHD, all Psychiatry Trainees and CMOs are designated as authorised Medical Officers.

Definition: Australian Mental Health Care Classification (AMHCC)

- The **Australian Mental Health Care Classification** (AMHCC) is a classification commissioned by the Commonwealth to classify mental health activity. Data is used to inform further targets and budget negotiations.

Definition: National Outcomes Casemix Classifications (NOCC)

- The **National Outcomes Casemix Classifications** (NOCC) represent the agreed national minimum requirements. The set of measures are included as routine practice to provide a means to communicate with the Commonwealth to inform funding allocation. It is vital that these measures are collected accurately.

Definition: iSOFT Patient Management (iPM)

- **iSOFT Patient Management** (iPM) is the system to register a patient into the hospital system which generates or attaches to a medical record number.

Definition: Episode of care

- **Episode of care** denotes a point where a service opens a service encounter where care is delivered. Also seen as an admission and a discharge. This will include clinical modules eg an Assessment, Outcome Measures and Phase of Care (HoNOS). During an episode of care various data entry points are to occur and correspondingly there are data extraction points that go to the Commonwealth that inform funding. For instance, a type of phase of care and a high HoNOS rating attract more funding.

Section 4 - Responsibilities

Employees will:

- Follow best practice standards and comply with related NSW Health policy directives.
- Ensure their clinical documentation reflects the principles and philosophy of the guideline.
- Seek training and support where there is a gap in knowledge from subject matter experts.
- Follow SES MH Guide: Clinical Documentation Recording Rules in eMR when completing clinical documentation.

Line Managers will:

- Ensure staff are familiar with this guideline, circulated and implemented locally.
- Monitor compliance with the guideline.
- Ensure appropriate local and district education and training are provided to support relevant staff at orientation and ongoing mandatory training.

Service Directors / Clinical Directors will:

- Distribute this guideline within their relevant service.
- Ensure line managers and staff are familiar with and adhere to the mandatory process contained within this document.

Section 5 – Consumer Registration

At the commencement of a clinical encounter, registration of the client into the iPM system must occur. Once registered the encounter is attached to an existing MRN or one is generated.

In iPM the care type is chosen as mental health.

In mental health there is further categorisation into inpatient (admission) or ambulatory (community).

In general, how consumer medical record numbers are created and how consumer encounters are opened will be influenced by:

- The Service Setting that the consumer is accessing (Inpatient, Emergency or Community)
- Age Setting (CAYMHS, Adult or Older Persons)
- Service Type (Acute Care, Case Management, Consultation Liaison, etc)
- Available administrative support

Entering a person into iPM can be done by an administration officer in ED / the mental health service or by a clinician who has iPM access. Refer to local processes. Staff can use the hospital admission form for a new hospital admission and follow details on the form that utilises the iPM hotline.

A number of these processes are documented here:
SESLHDPR/490 - Patient Registration – Patient Administration System (PAS)
MH Work Process Best Practice
Mental Health Intranet

Section 6 – National Outcomes and Casemix Collection (NOCC)

The Australian Mental Health Care Classification (AMHCC) is a Commonwealth system used to classify mental health activity. The National Outcomes and Casemix Collection (NOCC) utilises specific outcome measures to gather clinical information routinely to inform budgetary allocations.

Staff will need to collect these outcome measures at specific times during the episode of care from admission, review to discharge. The data measures collected are then extracted at set times frames by the Commonwealth and funding is distributed accordingly.

	HoNOS Collection Timeframe Inpatients	HoNOS Collection Timeframe Non Acute Inpatients (Rehab Only)	HoNOS Collection Timeframe Community Consumers
Admission OM Task	Within 3 Days of Client Episode of Care Creation	Within 3 Days of Client Episode of Care Creation	Within 14 Days of Client Episode of Care Creation
Review OM Task	35 Days after Admission OM Completed or as required if Phase of Care changes	91 Days / 13 weeks after Admission OM completed or as required if Phase of Care changes	Minimum 13 weeks after Admission OM Completed or as required if Phase of Care changes
Subsequent Review OM Task	91 Days /13 weeks after initial Review or as required if Phase of Care changes	91 Days /13 weeks after initial Review or as required if Phase of Care changes	Every 1C3 weeks or as required if Phase of Care changes
Discharge OM Task	7 Days after Episode of Care Closed	Within 7 Days after Episode of Care Closed	7 Days after Episode of Care Closed

NOCC Measures / Items which are key to AMHCC classification and allocation of resources:

- Mental Health Care Type (iPM)
- Outcome Measure (OM) setting = inpatient, ambulatory
- Mental Health Phase of Care (POC)
- Age (iPM)
- Involuntary Mental Heath Legal Status (iPM)
- Indigenous Status (iPM)
- First HoNOS/HoNOSCA/HoNOS65+ Scores
- Life Skills Profile 16 (LSP-16)

Other agreed NOCC measures – national minimum standards:

- Resource Utilisation Groups – Activities of Daily Living Scale (RUG-ADL)
- Children's Global Assessment Scale (CGAS)
- Mental Health Inventory 38 (MHI 38)
- Behaviour and Symptom Identification Scale 32 (BASIS 32)
- Kessler 10+ (K-10+)
- Strengths and Difficulties Questionnaire (SDQ)
- Factors Influencing Health Status (FIHS)

Outcome measures

Clinicians and administration staff across the facility typically work together to gather the correct details on a patient at certain points in time. The information gathered includes the care type, outcome measures such as HoNOS, the Phase of Care and other items. This includes details such as their Medicare card also. This information is entered into various systems such iPM and eMR which triggers reminders that other outcome measures are required to be entered at other set points in time.

Training is required to complement the material outlined in this document.

The grid below outlines at which points across admission, review and discharge according to various age groups what outcome measure are required. The outcome measures are to be completed according to the set time frames to clinically reflect the interaction that has occurred. Not all measures are required at each point. For example the phase of care is required at admission and review across all age ranges but not at the point of discharge.

Episode Service Setting	INPATIENT			COMMUNITY RESIDENTIAL			AMBULATORY		
Collection Occasion	A	R	D	A	R	D	A	R	D[2,3]
Children and Adolescents									
HoNOSCA [4]	●	●	●	●	●	●	●	●	●
CGAS	●	●	×	●	●	×	●	●	×
FIHS	×	●	●	×	●	●	×	●	●
Parent / Consumer rated (SDQ) [5, 6]	●	●	●	●	●	●	●	●	●
Principal and Additional Diagnoses	×	●	●	×	●	●	×	●	●
Mental Health Legal Status	×	●	●	×	●	●	×	●	●
Phase of Care	●	●	×	●	●	×	●	●	×
Adults									
HoNOS [4]	●	●	●	●	●	●	●	●	●
LSP-16	×	×	×	●	●	●	×	●	●
Consumer rated (BASIS-32, K10, MHI-38[6] [7])	●	●	●	●	●	●	●	●	●
Principal and Additional Diagnoses	×	●	●	×	●	●	×	●	●
Mental Health Legal Status	×	●	●	×	●	●	×	●	●
Phase of Care	●	●	×	●	●	×	●	●	×
Older persons									
HoNOS 65+ [4]	●	●	●	●	●	●	●	●	●
LSP-16	×	×	×	●	●	●	×	●	●
RUG-ADL	●	●	×	●	●	×	×	×	×
Consumer rated (BASIS-32, K10, MHI-38[6] [7])	●	●	●	●	●	●	●	●	●
Principal and Additional Diagnoses	×	●	●	×	●	●	×	●	●
Mental Health Legal Status	×	●	●	×	●	●	×	●	●
Phase of Care	●	●	×	●	●	×	●	●	×

Abbreviations and Symbols

A Admission to Mental Health Care
R Review of Mental Health Care
D Discharge from Mental Health Care

● Reporting of data on this occasion is mandatory
× No reporting requirements apply

Summary of the Reason for Collection Codes

Across the process of admission, review and discharge there are various points that prompt a point where collection of information is required. Each of these categories are attached to a set number of outcome measures. The clinician will be required to choose one of these reasons. Each reason attracts a funding allocation.

Reason for Collection Codes	Brief explanation	Requirements or exclusions
Admission	Response to a **new referral** for mental health care	Standard measures
	For **more intensive care** following transfer from other mental health service setting or hospital, with communication of referral information	Full referral & standard measures
	Admission for **less intensive care** following transfer from other mental health service setting or hospital, with communication of referral information	Full referral & standard measures made available
	Following discharge from any mental health service setting or Hospital, without communication of referral information	Standard measures must be recorded as referrer has not submitted
	Other reason, not elsewhere classified	
Review	At standard **13 week** interval	Standard measures
	At **35 days** following admission in acute inpatient service setting	Standard measures
	Review At **change in mental health legal status** within the same mental health service setting	Standard measures are expected
	Review In response to occurrence of **critical incident**	Clinical review
	In response to **request by consumer**	Clinical review and measures determined locally
	At any other occasion determined by **clinical need**	Standard measures determined locally
	At **change of responsible service unit** within same service setting and mental health service	Standard measures determined locally
	Other reason, not elsewhere classified	
Discharge	**No further treatment** by a mental health service arranged	Standard measures
	Transferred for **more intensive care** to a different mental health service setting or hospital, with communication of referral information	Full referral & standard measures
	Transferred for **less intensive care** to another mental health service setting or hospital, with communication of referral information	Full referral & standard measures
	From non-inpatient care in response to unplanned or emergency admission to inpatient psychiatric care, **without communication of referral information**	Standard measures
	Further **contact deferred**	Standard measures
	Lost to care (including AWOL and discharged at own risk)	Attempt standard measures, if information available
	Deceased	Standard measures. Clearly no expectation to collect self report.
	Following very **brief episode of care**	Don't collect standard measures
	Other reason, not elsewhere classified	

Section 7 – Clinical Documents in eMR

The format of clinical documents on eMR varies in two ways and is available either as:

- **PowerNotes** which resemble a word document template with existing headings and subheadings

OR

- **PowerForms** which resemble a database form with fields that need to be populated.

Some clinical documents have reference text (reference points, links to policies, etc.) built into them. Refer to eMR Quick Reference Guides on how to access reference text in PowerNotes or PowerForms. For a list of which clinical documents are 'PowerNotes' or 'PowerForms', refer to the Forms Register.

CREATING CLINICAL DOCUMENTS

Clinical documents are created in a number of different ways in eMR, as per below:

Document launcher	The Document Launcher provides a quick and easy way to create clinical documentation in eMR. Details on configuration, setting and how to create clinical documents, see Role>Clinical Documentation>Document Launcher
Document tab	**Only PowerNotes unavailable via the Document Launcher should be created via the 'Documentation' tab.** This can be created via the 'Documentation' tab in the Client's record, see Role>Clinical Documentation>POWERNOTE.
Adhoc button	**Only PowerForms unavailable via the Document Launcher should be accessed via the 'Adhoc' button.** This can be created via the Adhoc button on the Menu Bar (while in the 'Client's' record).

ACCESSING EXISTING DOCUMENTS

Clinical Documentation created on a Consumer's file in eMR is accessible in several ways. The method depends on the purpose for searching a consumer's file. For example:

Document Launcher	Seeking to view when a note type was last created against a consumer's file and content detail.
Clinical Notes View	Seeking when, where, how and by whom a powernote was created
Continuous Doc View	Seeking specific detail of client information
Flowsheet tab	Seeking to view results as recorded via a number of different PowerForms (Outcome Measures, Metabolic Monitoring Forms, etc.)

For further information, refer to eMR Quick Reference Guides on how to find relevant clinical information in eMR.

UPDATING EXISTING DOCUMENTS

Updating a PowerNotes (for example a progress note):

- Utilise the modify using the strikethrough function

Additional information utilise the following:

- Commence a new note for additional information with reference to the original information by noting date, time.
- Do not add additional text or an addendum
- Copy and Paste – This tool provides advantages however the functionality can cause associated errors. In reference to SESLHDPR/605 - eMR Copy and Pasting within Electronic Documentation clinicians are responsible for:
  - As a general principle, avoiding or not copying and pasting information within clinical information systems, including ensuring the correct patient and encounter
  - As the author of a clinical document, the clinician is the person responsible for ensuring all information is accurate and appropriate
  - When a clinician feels it is necessary to copy and paste clinical information, they should do so with caution understanding potential risks, how to identify them if they occur and how to correct them.

Updating PowerNotes (for example MH Assessment, Past History)

- When completing the modules, there should be one version only. Within that version if a change is required, utilise the modify text option.
- See the eMR reference guide for specific information.

For further information, refer to eMR Reference Guides >HealthShare Guides and Training on how to update clinical information in eMR.

Types of PowerForms / PowerNotes

7.1 Triage

Purpose

The purpose of the triage system is to exercise clinical judgement and assess appropriateness for admission, determine urgency, determine the types of comprehensive assessment required and prioritise consumers at presentation to a mental health service. An integration of collaborative information available to the clinician helps to assign the consumer to a triage category. This includes a critical appraisal of the consumer's risk status in all of the categories identified in the triage model.

The process of 'Triage' requires the assessment and collection of a minimum amount of clinically relevant information around the presenting issue, using a Biopsychosocial approach, to specifically evaluate:

1. Appropriateness for further mental health intervention
2. Degree of urgency and associated response time

The determination of (1) appropriateness and (2) urgency assists the Mental Health Clinician at the receiving Service Unit to prioritise the referral within the existing caseload to maintain a clinically appropriate flow. This also includes an assessment of intellectual disability to guide care.

Who

All clinical staff within community mental health services who come into contact with new or existing consumers are to use the triage module in eMR.

When

Conduct the triage at the initial entry point to a mental health service and/or when a consumer or carer contacts with a change in mental state and/or risk status. The MH Triage document is not restricted to completion at the initial entry point to mental health services. It may be clinically appropriate to conduct a triage when a consumer's mental state is highly acute to allow a comprehensive assessment. In such a case, the clinical process would be consistent with 'triage' principles, and the aim to collect a minimum amount of clinically relevant information to assess for the appropriate triage category.

How to Use the Triage Module

a) Complete the MH Triage document in eMR whenever the clinical process of a triage occurs (as outlined above), whether that occurs as a face to face or telephone assessment. This may be appropriate for '**New**' consumers or currently '**Active**' consumers that already have an open encounter with the mental health service.

b) Consider cultural identity, migration history, cultural perception of mental illness and any communication issues when conducting a Triage, and document under '**Communication Issues**'. If the consumer has a

CALD background, complete a Transcultural Assessment document (refer to Section 8.5: Transcultural Assessment).

c) Conduct a clinical risk assessment screening at triage and document under the '**Formulation/ Overall Clinical Impression**' section of the **MH Triage** document. Clinical judgement should be documented interpreting any identified risk.

d) All Risks must be entered in the consumer file, under the '**Diagnosis, Alerts & Problems**' tab on the grey menu bar in eMR. For additional information on how to create an alert in eMR, see Patient Summary Page>ALERTS_Add, Modify or Cancel

e) The clinician should utilise the **Crisis Triage Rating Scale (CTRS)** as a guide to inform decision-making on formulating the risk mitigation plan including the urgency of response. The CTRS is a brief rating scale developed to screen emergency psychiatric consumers rapidly.

f) The scale evaluates the consumer according to three factors:
- Whether they are a danger to themselves or others
- Their support system
- Their ability to cooperate.

Risks identified in the scale must be addressed in the **Action Plan**. Overall score guides the urgency of implementing the plan, see below:

Score	Urgency	Possible Action
9 or below	Extreme	Management of risks is likely to require inpatient admission
10	Moderate	Managed from an ambulatory unit with appropriate support

As the CTRS was developed and evaluated for its reliability and validity using adult consumers, *child and adolescent clinicians may choose not to use the CTRS* as a guide for urgency of response decision. The plan following triage should be documented under '**Action Plan**', including the plan for management of each identified risk.

g) Select one of the **mandated** '**Urgency of response**' categories under the '**Action Plan**' heading. These urgency ratings may be derived after completing the CTRS and applying the clinician's judgement after balancing risk and vulnerability against protective factors. The response category should refer to the MOST URGENT item in the action plan.

h) All sections throughout the MH Triage document are **mandatory**.

i) Document all communications undertaken during triage, any contact details to aid subsequent communication and corroboration undertaken under the '**Contacts**' section. The prompts provided in the 'Contacts' table are not meant to be definitive or exhaustive. Provision is made for clinicians to specify 'other' contacts, thereby making the document more responsive and flexible to differing presentations.

Further Information

Refer to the eMR Clinical Documentation Handbook: Mental Health Services for:

- Structured text available via the MH Triage
- Information auto-populated into the MH Triage and information extraction
- Reference text is available in the MH Triage.

7.2 Assessment

Purpose

Whilst assessment is an ongoing process, the purpose of any initial comprehensive assessment is to ensure a biopsychosocial focus to obtain information essential to holistic collaborative care planning exists. The **biopsychosocial model** supports that biological, psychological (which entails thoughts, emotions, and behaviours) and social factors have a significant influence on human functioning and poor health. This focus guides the conceptualisation of symptoms and aids decisions toward the most appropriate treatment and management plan. The corroboration of information from a variety of sources, at assessment, is necessary to obtain an accurate clinical picture. It also makes provision for the documentation of both background and current factors.

Who

Any appropriate qualified mental health clinician can conduct and document the Mental Health Assessment using the standardised 'MH Assessment' documents in eMR: MH Past History and MH Current Assessment. The clinician completing the Mental Health Assessment also required to complete the HoNOS Outcome Measures as they have the most accurate information on the consumer's presentation. **If more than one clinician is involved in conducting the assessment, co-signing is not required via eMR. It is sufficient for the clinician who entered the assessment to mention, in the narrative, other clinicians who were involved in performing the assessment.**

When

During an episode of care (and within the review period), the '**Assessment**' documents can be corrected by other mental health clinicians unless the presenting issue has changed, warranting a new comprehensive assessment. To optimise the accuracy and depth of information obtained, the clinician should engage the consumer's narrative by employing appropriate communication skills including empathy, active listening, a non-judgemental attitude and respect.

How to Use the Assessment Module

a) Complete the MH Current Assessment document whenever the clinical process of a comprehensive assessment occurs. Refer to document launcher. The MH Current Assessment and MH Past History documents should aid as tools to record clinical information in a structured format, rather than as an assessment and clinical practice guide. Documentation should contextualise the presenting issue as per the practice framework of a biopsychosocial approach.

b) The MH Current Assessment document is completed to document the presenting problem during one **episode of care**.

- Where the **service setting changes**, an episode of care corresponds to encounters in eMR, and a **new** MH Current Assessment document is required when the new encounter is opened. For example, when a consumer goes from inpatient to community or from community to inpatient.
- Where the **setting does not change**, the MH Current Assessment document can be **updated** during the same episode of care and within the review period by different mental health clinicians at different times. For example, when a consumer has had a direct transfer from one inpatient team to another, or from one community team to another.

If updating an existing Assessment in eMR, use the "Modify" function.

c) If the **presenting issues change**, the MH Current Assessment document should not be updated: a new MH Current Assessment document (excluding MH Past History) should be completed as a new comprehensive assessment is required.

d) Complete the **MH Past History** document after using continuous doc tab on the grey menu bar to check that a MH Past History has not previously been completed. **It is mandatory to complete all sections in the MH Past History document**. Only one MH Past History document is required for a consumer. If there is an existing MH Past History Assessment document, the clinician should update this document with information from the previous encounter and any other corrections required using the 'correct' option in order to use the prescribed structure. Use 'Modify' when updating the MH Past History.

e) Complete the mandatory **risk questions AS INDICATED** in each section of the MH Current Assessment by selecting 'Yes' or 'No'; and document the details of each risk type in the 'Comments' section. Staff must undertake a comprehensive mental health assessment inclusive of risk and not use risk measurement tools or checklists in isolation to determine treatment decisions[1]. Where a risk is identified, this should be documented in the '**Alerts**' section in eMR by the assessing clinician, and the corresponding **Risk Management Plan** in the **MH Care Plan** must be completed.

f) Consider cultural identity, migration history, cultural perception of mental illness and any communication issues when conducting an Assessment. Where communication/ cultural issues are identified, document in '**Communication Issues**' in the **Assessment Details** section of the MH Current Assessment, and complete the MH Transcultural Assessment (refer to Section 8.5: Transcultural Assessment).

g) Complete the '**Current/ Recent Substance Use**' section. It is **mandatory** that succinct, clinically relevant core information is documented in the '**Details**' section, detailing the substance use issues. If the consumer meets the minimum criteria, complete the MH Substance Use Assessment document (refer to Section 8.3: Substance Use Assessment).

[1] NSW Health Clinical Care of People Who may be Suicidal (PD2016_007)

h) Complete the '**Current Functioning and Supports**' section in the MH Current Assessment document. The clinician is **mandated** to complete the MH Clinician Functional Assessment (Older Persons) document for **consumers over the age of 65 years**. The clinician should make particular reference to the RUG-ADL and LSP outcome measurement ratings. This document may be most relevant in an inpatient setting as it details nursing dependency requirements, and thus has implications for inpatient resource allocation. For details around the MH Clinician Functional Assessment document, refer to Section 8.6: Clinical Functional Assessment)

i) Complete the '**Current Parental/ Carer Status**' section in the MH Current Assessment document. If the clinician selects 'Yes' to the question '**Are there concerns about the safety of the child or other dependent?**' the clinician is then mandated to complete the online Mandatory Reporter Guide (MRG) to determine if there is a risk of significant harm.

If the consumer is a parent or carer for a young person(s) under 18 years (dependent children), the clinician is mandated to complete the MH Family Focused Assessment (Children of Parents with a Mental Illness - COPMI) document. (Refer to Section 8.4: Family Focused Assessment).

NB: Staff completing the assessment need to consider and add an alert for "Patient is a Primary Carer for Children" The welfare of the child should factor into the safety planning of the consumer.

The MRG decision tree will assist the clinician in determining whether or not to report their concerns to the Child Protection Helpline. For details on 'MRG', refer to the NSW Mandatory Reporter Guide. Select 'Added/edited' under '**Alert**' in eMR '**Patient is primary carer for children**' if the consumer is the primary carer for children under 18 years. This must be created during the assessment process (if not already present). Update the 'ALERT' as required during the patient encounter.

j) Complete the mandatory NSW Health '**Domestic Violence Screener**' section on the MH Current Assessment document for all females aged 16 years and over (documenting reason(s) if not completed). This section does not need to be completed in cases where domestic violence has already been identified; for example, the identification has been documented as part of the presenting issue.

The screening should be completed by a clinician who has undergone the mandatory training on 'Domestic Violence Screening'. Presenting symptomatology should be contextualised at the detection of domestic violence. A Department of community justice notification to the Child Protection Helpline must be made at the detection of domestic violence where the consumer has dependent children[2]. For further details on screening for Domestic Violence, refer to Section 8.8: Screening for Domestic Violence).

[2] NSW Ministry of Health PD2013_007 Child Wellbeing and Child Protection Policies and Procedures for NSW Health

k) Document evidence of an initial screening for cognitive impairment in the '**Mental State Examination**' section of the '**MH Current Assessment**', under the '**Cognition and Intellectual Functioning**' heading. The clinician must indicate whether a more detailed cognitive screening needs to be conducted in this section and document their clinical rationale.

Cognitive screening is **mandatory** for consumers **aged 65 years and older** as they yield the highest potential of having cognitive impairment. Screening should be conducted for consumers who mention subjective impairment of memory or cognition after considering the context, as these symptoms may be consistent with symptoms of major depression. The clinician must choose the most appropriate cognitive screening tool, either the RUDAS, or 3MS/MMS. The RUDAS may be the preferred screening tool, as cultural and educational bias has been reported with the MMS and 3MS[3]. For details around the Cognitive Assessment RUDAS and 3MS/MMS additional assessments, refer to Section 8.7: Cognitive Assessment.

l) Complete the '**Metabolic Screen**' section in **MH Current Assessment** document. The screening domain assists clinicians to identify consumers as having, or as being at risk of, Metabolic Syndrome. Where 'Yes' is selected in any of the metabolic screening questions, the clinician should ensure the completion of the Metabolic Monitoring document.

Complete the '**Rating Scales and Measures**' section. Outcome Measure results should be included in this section. Clinically significant HoNOS ratings of 2 or more should have a corresponding goal/clinical issue in the MH Care Plan. Where possible, the clinician completing the Assessment is also responsible for completing the Admission Outcome Measure (including the HoNOS). Timeframe between completion of Assessment and completion of Admission Outcome Measure should be minimal.

Outcome measures completed at admission should be **printed out** and **discussed** at the **clinical review meetings**. (The other available option is to view the Outcome Measure scores by accessing the client record in eMR and looking up relevant details via the Flowsheet). Refer to document launcher.

m) A comprehensive assessment should also include other additional risk assessments not specific to Mental Health, as required by NSW and SESLHD policy and procedures, such as the Ontario Modified STRATIFY (Sydney Scoring) Falls Risk Assessment tool. [4,5]

Further Information

Refer to the eMR Clinical Documentation Handbook: Mental Health Services for:

- Structured text available via the MH Past or Current Assessment

[3] Shulman, K. & Feinstein, A. (2003). Quick cognitive screening for clinicians. New York: Martin Dunitz.
[4] SESLHDGL/042 Falls Prevention and Management: Guideline for use of bed/chair alarm units (adult Inpatients)
[5] NSW Health GL2017_2022 NSW Older People's Mental Health SERVICE PLAN 2017-2027.

- Information auto-populated into the MH Past or Current Assessment and information extraction
- Reference text available in the MH Past or Current Assessment

Progress Notes / Alerts

Progress notes need to reflect the clinical situation and writing in a recovery oriented, non-judgmental manner. Clinical notes need to be clear and concise and cover all aspects of the period of time documented, risks identified and student involvement. Progress notes may be used and should reflect the SOAP structure[6]. Leave will be recorded as a separate PowerForm.

Subjective	Consumers view of current situation
Objective	Clinicians own observations and quantifiable information
Assessment	MSE and clinical impression, risk assessment, consumer improvement or deterioration and progress since last episode of care.
Plan	Clinicians own actions and recommendations for the next clinician which addresses current issues and any changes to the management.

All documentation requirements in progress notes are to follow the SESLHDPR/615 - Engagement and Observation in Mental Health Inpatient Unit Procedure. Alerts may be used, where a risk has been identified, as necessary during the consumer's care. Note that: All Risks must be entered in the consumer file, under the 'Diagnosis, Alerts and Problems' section on the grey menu bar in eMR. Refer to eMR Quick Reference Guides > Alert Allergy Diagnosis Problem on how to create an alert in eMR.

The progress notes and completion of document should follow the relevant patient journey chart as per site. See Appendix A.

[6] SOAP - Subjective Objective Assessment Plan

7.2.1 Assessment of Risk

Purpose

An assessment of risk must be conducted at key points of clinical care: **admission, review, discharge, and when there is a change in clinical picture**. The level of clinical risk is dynamic, changeable and may be influenced by circumstances which can alter over brief periods. Therefore, the assessment of risk should be subject to frequent review in multidisciplinary team discussions.

Among people with a mental disorder, factors such as age, gender and ethnicity are, in general, unreliable predictors of risk. Therefore, the process of risk assessment is individually specific[7]. Corroborative information should be sought, clearly documented and considered in the clinician's formulation of risk level. Sources for corroborative information should include other health care providers external to the Mental Health Service such as the General Practitioner (GP), private Psychiatrist, NGO/CMO support worker and counsellor, as well as family / carers.

Risk Assessments will be documented on different eMR forms corresponding to a consumer's treatment journey. Below are the eMR forms used to documents risk for a consumer[8]:

Mental Health Client Journey	eMR Form	Comments
Triage	MH Triage	NIL
Initial Assessment	MH Past History and MH Current Assessment	Additional MH Current Assessment to be completed if Consumer needs to be reassessed.
Handover/Day to Day Management	MH Progress Notes	"SOAP" structure should be used[9] "r" shortcut available for use "mse" shortcut available for use
Clinical Review	MH Review	NIL
Discharge	MH Transfer/Discharge Summary	NIL

Table 1: Documenting Assessment of Risk eMR Forms

Who

All mental health clinicians should manage clinical risks according to SESLHDGL/082 - Clinical Risk Assessment and Management – Mental Health guideline. The documentation of risks should be discussed and completed by the delegate within the treating team.

[7] Royal College of Psychiatrists U.K.
[8] The Risk Assessment paper form is no longer available in line with NSW Health Policy PD2016_007 Clinical Care of People Who May Be Suicidal.
[9] SOAP - Subjective Objective Assessment Plan

When

Refer to Table 1: Documenting Assessment of Risk eMR Forms, as above.

Using the Risk Assessment

a) Complete the risk assessment sections as per the document structure such as **prompts**. It is **mandatory** that the clinician supports their clinical judgement of the risks identified (any marked 'yes'), providing evidence with documentary narrative in the '**Comments**' or '**Details**' section, even if nil risk/not applicable. Where risk is 'unknown' document this in the Comment section.

b) To evaluate the presence of a risk the clinician should consider background and current factors influencing risk status. Such an approach acknowledges the changeable nature of risk affecting certainty of assessment and acknowledges the significant role situational factors can play in risk. Clinical notes in identification of **risk field** should be entered.

c) Where applicable, set the relevant alerts in the '**Alert Tool**'.

For further information on identifying people at risk of suicide, see NSW Health Policy Directive PD2016_007 - Clinical Care of People Who May Be Suicidal. The SafeSide risk assessment framework is now incorporated into our Mental Health risk assessment and safety planning for people who maybe suicide.

7.3 Care Plan

Purpose

The MH Care Plan process is consistent with the Strengths Framework[10]. All consumers **must** have an individual MH Care Plan[11]. This provides an evidence-based framework to construct short to medium term goals with interventions that enable the goal to be achieved.

If the consumer is identified as acutely unwell, the primary clinician will need to complete the person-centred care plan at the nearest available time. The MH Care Plan process should align with principles of recovery, which promotes a unique, personal journey in adjusting one's attitudes, values, feelings, goals, skills and roles[12]. Care Planning seeks to provide the consumer with the tools to acknowledge the limits presented by illness and live with a redefined purpose, so that their life is meaningful, satisfying, hopeful and fulfilling[13].

Who

The document can be completed by any qualified mental health clinician, ideally by the allocated clinician during that episode of care.

When

Commencement of the MH Care Plan follows immediately after the completion of the MH Current Assessment (and where appropriate, the Strengths Assessment).

The MH Care Plan document is mandatory within 72 hours following initial assessment in the inpatient setting, and 14 days for a consumer receiving ambulatory care.

It is **mandatory** to update the MH Care Plan document at transfer and discharge.

Information to complete the Care Plan comes from:

- The consumer. There is also information in a 'Strengths Assessment' that will identify their goals.
- The outcome measures. Identified through the HoNOS (ratings of 2 and higher).
- Carers and relevant others (eg NGO/CMO workers, cultural consultants, GP etc.) may be consulted.

How to Use the Care Plan

- Ensure the most appropriate mental health clinician develops the goals and interventions of a **MH Care Plan** collaboratively with the consumer and others involved in the consumer's care. These may be based on clinical or personal recovery oriented goals and interventions. The balance of these will be determined on the

[10] SESLHD Strengths Model Implementation Plan 2016-2018
[11] COAG Health Council (2017). National Mental Health and Suicide Prevention Plan
[12] Department of Health (2014). National framework for recovery-oriented mental health services: Guide for practitioner and providers.
[13] NSW Health (2008). Community mental health strategy 2007 –2012 (NSW): From prevent and early intervention to recovery.

individualised needs of a consumer at a given point in time. The goals and interventions should relate to the care type for inpatients. [14] Results from the **HoNOS** outcome measure (ie, those with scores of 2 or higher) should be included, and not limited to, the treatment discussion.

a) **For the community services**, assigned to the allocated clinician in community

b) Consider any identified language or cultural issues when formulating care plans (refer to Section 8.5: Transcultural Assessment)

c) In eMR, ensure that 'Personal Recovery Plan' Shortcuts are included in the 'MH Care Plan' under both the 'Goals' and 'Interventions' Sections (see, eMR Clinical Documentation Handbook: Mental Health Service>MH Care Plan> Goal/Clinical Issue and Intervention). Details on what the shortcuts are and how they should be used be used are detailed here.

Legislated Mandatory Requirements

d) Update the MH Care Plan at **Review**. New treatment targets and interventions that emerge as a result of review should be added in the 'MH Care Plan' document. Where review indicates deterioration, the strategies / interventions should be reviewed (and where applicable '**corrected**'). The goal of the review is to move beyond problem identification to build on strengths and thus enhance capacities to problem solve.

When updating an existing Care Plan in eMR, use the 'Modify' function to update the Care Plan.

e) Update the MH Care Plan document at **Transfer** and **Discharge**. The MH Care Plan document should be part of the transfer of information to the receiving clinician at transfer or discharge. The MH Care Plan document will define goals established collaboratively with the consumer for their ongoing care post discharge or transfer. The transfer period may be a time when consumers reconsider priorities which should be reflected in the care plan.

f) Complete the '**Discussed With**' section under 'MH Care Plan'. Select the 'client' category and document the date. Where the consumer is unable to participate in the development of the care due eg during acute phases of illness, this must be documented in the comments section. Select the 'carer' category and identify the complete carer name/date and where the carer was unable to participate in the development of the care plan document this in comments.

g) Complete the '**Consumer's Main Goal**' section collaboratively with the consumer. It is the responsibility of the clinician to facilitate the goal setting process, document the goals and issues identified, and monitor ongoing

[14] NSW Health PD2014_10 Care Type Policy for Acute, Sub-Acute and Non-Acute Patient Care

progress. A printed copy of the MH Care Plan must be offered to the consumer for their ongoing reference, and a final updated printed copy at transfer of care[15]. **Where available, use the medical record print over a draft print version**.

h) Ensure the MH Care Plan document is **updated before a review** is due (if clinically required). MH Care Plans should be presented at multidisciplinary team review meetings to review changes in clinical picture and associated goal setting.

i) **There should ONLY be one MH Care Plan per Client encounter**. This document should be updated using the 'Modify document' option in eMR, to allow the use of the standardised structure and multiple contributors. To access a MH Care Plan that has been created for the mentioned client encounter, access the Document Launcher in the Client's eMR Record and click the '**Blue Triangle**' next to the MH Care Plan hyperlink. (A blue triangle indicates that a MH Care Plan has already been created). This will take you to the MH Care Plan for the Client Encounter.

j) Please note that contemporaneous MH Care Plans can be present for a Consumer if the person has an open Case Management Community encounter and has recently been admitted to a MH Inpatient Service. The Consumer will have one MH Inpatient Care Plan and one MH Community Care Plan. In this circumstance, the Consumer still has **ONE MH Care Plan per Client Encounter**.

Note that in-service support should be offered to all MHS staff members on a regular basis. Contact the SESLHD MHS eHealth Support Manager or Workforce Capabilities Nurse Educator if this have not occurred within the last three months.

Further Information

Refer to the eMR Clinical Documentation Handbook: Mental Health Services for:

- Structured text available via the MH Care Plan
- Information auto-populated into the MH Care Plan and information extraction
- Reference text is available in the MH Care Plan

[15] see NSW Health Transfer of Care from Mental Health Inpatient Services PD2016_056 and *SESLHD MH Transfer of Care Checklist*

7.4 Review

Purpose

The process of review acknowledges the ever-changing clinical picture of the consumer. Review focuses on the current situation and specifically assesses whether progress, deterioration or emergence of new issues have occurred over the nominated review period. Review ensures that consumers receive the right service at the right time. Review explores the relationship between the strengths and limitations of the consumer and the effectiveness of interventions that have been implemented. Thus, the 'MH Review' and 'MH Care Plan' documents are inter-related.

Who

The MH Review document should be completed by the clinician.

When

The MH Review document is **mandatory** and is for use in both inpatient and ambulatory settings at the 'Review period'. In the inpatient setting, this is 35 days initially then every 13 weeks thereafter. In ambulatory and non-acute inpatient settings, this is at every 13 weeks.

Using the MH Review Document

a) The three processes of Care Planning, Review and Outcome Measurement aligns, inform and quantify each other and should therefore be completed in consideration of one another. The allocated primary clinician should complete the **MH Review Document and Review Outcome Collection** as they can best quantify progress in relation to the consumer's baseline.

b) Clinically significant changes in **HoNOS** (> a difference of 1 on each item) and **K10** scores between review periods should be compared and used to quantify changes in symptom, behaviour, relationships, and levels of impairment, disability and distress.

   The Outcome Measure findings are recorded in the '**Summary of progress**' section by the primary clinician. Clinical judgement/comments around changes in the clinical picture should be documented under '**Details**' in the '**Summary of Progress**' section.

c) The '**Issues Identified at assessment**' are brought forward into the MH Review Document from the MH Current Assessment and can be updated (if needed). Complete the '**Identification of Risk Section**', documenting in '**Details**' the clinical judgement of each risk type, based on the consumer's clinical presentation and information from relevant others (family/carers, service providers etc.)

d) Complete the '**Consumers view of progress**' section after reviewing progress under 'MH Care Plan' with the consumer. Any discrepancies between the clinician rated and the consumer rated measures in the Review Outcome Measure Collection should be considered, see eMR Clinical Documentation Handbook: Mental Health Services>2.5 MH Review>Outcome Measures. Where there is a difference in focus between the consumer and clinician, significant effort should be made to reach an agreement.

e) Document in the free text section of '**Clinician's involved in Review**' details of any communications undertaken during the review to identify any corroboration, also provide contact details to aid any subsequent communication.

f) Complete the **MH Review Document** at other times outside of the nominated review periods as determined by clinical need or clinical process (eg critical incident).

g) **Review Documents** and **Standard Measures** should be presented at multidisciplinary team case review meetings to assess changes in the clinical picture. **Outcome Measures** can be viewed during Clinical Review Meetings by opening the consumer's record and accessing the '**Flowsheet**'.

h) **Outcome Measures** results should be inserted into the **MH Review eMR Form** to maintain accurate electronic documentation.

Further Information

Refer to the eMR Clinical Documentation Handbook: Mental Health Services for:

- Structured text available via the MH Review
- Information auto-populated into the MH Review and information extraction
- What reference text is available in the MH Review

7.5 Discharge/Transfer Summary

Purpose

The MH Discharge/ Transfer Summary eMEDS 2.0 (Inpatients setting) or MH Discharge Transfer Summary (Ambulatory setting) document is for use at conclusion of an episode of care or in cases of transfer between services. The document aims to communicate information to the receiving service provider by providing information on the episode of care. This includes a brief account of precipitating stressors leading to admission, an assessment of presentation at admission, a synopsis of interventions conducted, summary of progress and an overall clinical risk assessment at discharge including risk vulnerabilities and protective factors.

Who

- In **Inpatient Settings**, the MH Discharge/Transfer Summary eMEDS 2.0 document should be completed and authorised by a medical officer in consultation with a Senior Medical Officer.
- In **Ambulatory Settings**, the MH Discharge/Transfer Summary document should be completed and authorised mental health Medical Officer

When

At the conclusion of an episode of care or in cases of transfer between services. Complete the MH Discharge/Transfer Summary document on or before the date of discharge.

Using the Discharge/Transfer Summary eMEDS 2.0 or MH Discharge Transfer Summary

a) Before creating a Discharge/Transfer Summary eMEDS 2.0 or MH Discharge Transfer Summary, ensure that **GP Details** are up to date via **iPM** in both inpatient and community setting. Ensure the **Community Registration** is complete in community setting. [16]

b) Ensure that information in the '**auto-populate**' box is selected.

c) Avoid using '**Free text**'. Complete all sections in the summary where possible. Ensure all patient and carer contact details are correct before discharge. This is critical for community follow up around risk follow up and not showing up for appointments.

d) A MH Diagnosis using ICD-10 codes must be recorded on the **MH Discharge/Transfer Summary** eMEDS 2.0 & MH Discharge Transfer Summary (Mandatory field).

e) Summarise current risk issues at Discharge under the 'Update Risks+' section, for additional information see eMR Clinical Documentation Handbook: Mental Health Services>2.7 MH Transfer Discharge

[16] See Import/Export Mapping (of eMR Forms)>MH GP Letter Brief

Summary>Health Status>Update Risks+ (pg. 69). [17] Assessment of risk issues/factors and clinical rationale must be documented in the free text '**Details**' sections for each risk type. Clinical judgement must reflect an overview of risk factors after balancing risks and vulnerabilities against protective factors.

f) Complete the **MH Discharge/Transfer Summary Document** eMEDS 2.0 or MH Discharge Transfer Summary in conjunction with the discharge outcome measure collection, unless an existing community mental health consumer is transferring to the inpatient unit in the same sector. Issues identified in the '**HoNOS**' ratings as clinically significant (score of 2 and greater) form the basis of information documented in '**Recommended Follow up**' section.

Outcome Measures collected throughout the episode of care must be included in the '**Outcomes Measures**' section comparing admission and discharge scores. **Clinical judgement/relevant comments should accompany this comparison**.

g) For **MH Community Clients**, as part of the final clinical review the Medical Officer must record the discharge medications using the Adhoc medication chart. This will ensure the medication list will auto populate into the MH Discharge / Transfer summary. (Do not use the eMEDS 2.0 version as this is for Inpatient use only). The Adhoc medication chart may be completed ahead of time prior to the discharge date. The MH Discharge Transfer Summary should be saved in readiness for the appropriate Medical Officer to Sign and Authorise the MH Discharge Transfer Summary.

For MH Inpatient consumers, this information will auto-populate in the Discharge/Transfer Summary eMEDs 2.0 on the premise that an eMEDS Discharge Reconciliation has been completed.

h) Document any corroboration undertaken as part of transfer or discharge planning under '**other services involved**' including contact details to aid any subsequent communication. Document any other clinicians who contributed to collaborative care with the consumer under the '**Performed by**' section. The intent of this information is to facilitate communication in ongoing care.

i) **Ensure MHS Discharge/Transfer summary is received by all parties who should be receiving it**.

1) The consumer (where appropriate **their carer**) should be provided with a copy of the Discharge/Transfer summary.
2) The consumer's **GP** should receive a copy of the Discharge/Transfer Summary at the time of discharge. If a Discharge/Transfer Summary is not available upon consumer discharge, the consumers GP should be contacted by Inpatient Staff and informed of any change to medication, etc.
3) **Acute Care Team** or the consumer's usual **Case Manager or Primary Clinician** should be aware of the consumers discharge from the MHS Inpatient Service.

[17] See eMR Clinical Documentation Handbook: Mental Health Services>2.7 MH Transfer Discharge Summary>Health Status>Update Risks+ (pg.75)

Further Information

Refer to the eMR Clinical Documentation Handbook: Mental Health Services for:

- Structured text available via the MH Transfer Discharge Summary
- Information auto-populated into the MH Transfer Discharge Summary and Information extraction
- What reference text is available in the MH Transfer Discharge Summary.

Section 8 – Additional Documents

8.1 Physical Examination

Purpose

Consistent with the biopsychosocial framework adopted in mental health assessment, the clinician must consider a consumer's physical state, noting symptoms which may result from a physical health issue. For example, a consumer with a urinary tract infection can present with symptoms consistent with psychosis.

Who

Inpatient Setting:

- The admitting nurse will commence the physical observation chart at admission. This includes the '**Initial Impression, General and Vital signs**' section in the MH Physical Examination on eMR.
- The medical officer will complete the remainder of physical examination as part of the standard assessment and recorded on PowerNotes.

Community Setting:

- When a consumer is referred to a community mental health service, strong efforts should be made, with appropriate consent, to communicate with their nominated GP. The service should liaise with the GP to complete the physical examination.
- Alternatively, the initial physical examination may be completed by a SESLHS MHS clinical staff member. When discharged from inpatient care, a copy of the '**Mental Health Clinical Documentation Physical Examination**' section with details of a completed physical examination should accompany the consumer.[18]

When

- In an **Inpatient Setting**, complete the MH Physical Exam document within 24 hours of admission.
- When a consumer is being transferred to the inpatient unit via the **Emergency Department**, the consumer must have a physical re-examination within 24 hours of admission to the inpatient unit unless the MH Physical Exam document in eMR was completed in the Emergency Department (MH document catalogue can be accessed via FirstNet).
- Complete the MH Physical Exam document within one month of admission into an **Ambulatory Setting** when a current MH Physical Examination document has not been recorded in eMR by the transferring team.
- In a **Community setting**, complete the MH Physical Exam document within 12 months of admission for all adult consumers.
- Older person **over the age of 65 years old** should have a completed MH Physical Exam document completed every six months.

[18] NSW Department of Health GL2017_019 Physical Health Care of Mental Health Consumers

Using the MH Physical Exam Document

a) The MH Physical Exam document is an additional assessment and is **mandatory** in inpatient, ambulatory, and community settings in SESLHD. Consistent with the biopsychosocial framework and holistic care planning, any clinical impression should consider physical state findings in terms of their potential effect to the presenting problem.

b) All consumers undergoing extended community care should have a MH Physical Exam document completed **every 12 months. Ambulatory consumers aged 65 years and older**, who are known to have a significant illness or disability, should have a MH Physical Exam document completed **every six months**. Document in the MH Care Plan and MH Review under '**Summary of Treatment provided since last Review**' Section, any ongoing physical issues that need to be addressed and/or monitored.

c) All consumers undergoing extended community or non-acute inpatient mental health care should have their weight and/or waist-hip ratio (WHR) measured every six months, or more frequently if the consumer is identified as over-weight.

d) The MH Physical Exam document does not need to be completed by the ambulatory team if the nominated GP conducts the physical examination. In such cases, the assigned to/primary clinician should document key findings in the '**Summary of treatment provided since last review**' heading of the '**Review**' document.

   The clinician should also document in the **MH Physical Assessment Document** that a physical was completed on **dd/mm/yyyy** and refer to the hybrid file for a copy of the physical, or any correspondence or results provided by the GP. If the consumer does not have a nominated GP, the mental health clinician should make reasonable efforts to link the consumer in with an appropriate health care provider.

e) For consumers undergoing extended inpatient mental health care and have been identified as having physical health issues, a MH Physical Exam document should be **completed every six months** at minimum.

f) Attempt to make all reasonable efforts to complete the MH Physical Exam document at admission.

g) A MH Physical Exam document may be completed on a clinical needs basis, independent of the completion of other documents. See eMR Clinical Handbook: Mental Health Service (2017) (p.27)

8.2 Physical Appearance

Purpose

MH Physical Appearance document provides a more structured format of documenting physical appearance. Information contained in the MH Physical Appearance document reflects some of the reporting requirements for consumers absconding from a mental health inpatient unit. [19]

Who

Any qualified mental health professional can complete this document.

When

- Complete the MH Physical Appearance document at admission to inpatient and ambulatory settings.
- Complete when a consumer is receiving care in an inpatient setting and assessed as a high risk for absconding. It should usually be completed at Assessment; however, it can be completed or updated when required.

Using the MH Physical Appearance document

a) Assessment of MH Physical Appearance will provide a base line identification, to assist with recognising a change or differences over time during episodes of care.

b) Physical Appearance Section on eMR is completed at assessment as part of the standard assessment under 'Physical Examination Summary'.

c) All staff should adhere to SESLHDPR/288 - Identification of patients within mental health setting where photographic identification applies or ensure an identification band is placed on the person.

[19] NSW Health – NSW Police Force Memorandum of Understanding 2018 (Including Ambulance)

8.3 Substance Use Assessment

Purpose

The MH Substance Use Assessment document provides a structured format for the documentation of alcohol and other drug use. Mental health clinicians are required to screen all consumers for current and past drug and/or alcohol consumption to formulate the overall clinical picture. If identified a referral is needed to the drug and alcohol service for specialised intervention. Alcohol and/or other drug consumption is clinically relevant and has an impact on: the presenting problem and severity of symptoms, hinder the process of rehabilitation, contribute and predict to deterioration in mental health and lead to more rapid and more severe relapse episodes.

Reported recent or current use is clinically important in an inpatient setting as it is a predictor of potential increase of aggression and violence, non-adherence with treatment, and increased clinical risk associated with drug and alcohol withdrawal.

Who

In first instance, the clinician will complete the MH Substance Use Assessment at admission. **Where clinically appropriate, the treating team may update and complete the assessment during the episode of care.** The assessment is to be completed by the treating team before discharge.

When

The MH Substance Use Assessment is **mandatory** whenever clinicians are completing the **MH Current Assessment** and **MH Review**, and responding to positive rating to the following consumption levels:

- When a consumer has had more than six standard drinks on any one occasion within the last month.
- When the consumer is an adolescent, then the '**Additional**' module should be completed if they have consumed any alcohol in the last month.
- When the consumer has used any of the following in the last month: illicit benzodiazepines, cannabis, amphetamine, cocaine, MDMA (Ecstasy), heroin, methadone, buprenorphine, solvents or hallucinogens.
- When a consumer presents during assessment as intoxicated or in withdrawal.

Clinicians should use clinical judgement regarding the completion of the module and should not exclude its completion for consumers outside the range above and <u>can be completed when deemed clinically appropriate</u>.

Using the MH Substance Use Assessment document

a) Clinical interpretation requires an assessment of related harms (eg finances, relationships, relapse factors etc.), precipitating stressor(s) that may have escalated consumption of the nominated drug(s) or alcohol, insight into the problem, potential withdrawal risk, previous withdrawal experiences – symptoms and complications, and where the consumer sits in the 'Stages of change' process.

b) The MH Substance Use Assessment document makes provision for a broad range of Substance Use domains; however, acknowledges the diversity of potential presentations so the nominated drug categories are not restrictive or exhaustive. Provision is made for identification of other drug consumption relevant to the specific presentation under 'Other (specify)'. **It is mandatory for clinicians to detail the 'Other' issue by naming it and providing a descriptor of the issue**.

c) Complete the substance use assessment by selecting '**Yes/No**' for each substance/drug type in the '**Basic Information**' section. Where '**Yes**' is selected, complete the additional generated questions. This will require checking each section with the consumer.

Under '**Usual amount**', it is acceptable to quote the consumer in the descriptor they offer eg 'two joints a day' or '$20 day'. Route of administration should be specified in the '**Route?**' section. Route of administration includes oral ingestion, chewing, nasal insufflation, smoking and parenteral (via injection) specifying intravenous (via a vein), intramuscular (via a muscle) or subcutaneous (under the skin). The mode of administration is a significant mediating factor on the effect of a drug. Various routes of administration are preferred because they can enhance or facilitate drug effects.

d) The '**Withdrawal risk**' should be described as 'low', 'moderate' or 'high' and defined according to clinical judgement (including documented clinical notes describing the observed rating). If there is **insufficient information / clinical knowledge** to specify a withdrawal risk, it is acceptable to document 'unknown'. However, in such case, is it recommended that the clinician consults with the Senior Clinicians, the local Alcohol and Other Drug Specialist Service within their service, who may provide clinical review on withdrawal risk.

'**Duration of Use**' refers to the overall duration of consumption. If the clinician documents a starting period eg 'since the age of 16', they must detail the overall time period of use eg '10 years'. It is acceptable to document comments related to the nominated drug within the grid as clinically appropriate eg under 'Methadone' 'Consumer has tooth problems but refuses to see his dentist'.

e) Complete the '**Specific Issues to be addressed in Management / Care Plan**' section by documenting, in point form and in order of priority, issues to be addressed, considering the consumer's 'Stage of Change'[20]. This information must be transferred to the consumer's **MH Care Plan**. Identifying the consumer's stage of change is essential when deciding upon **appropriate goals** and **follow up plans**. Ignoring the different stages of change often results in the adoption of inappropriate interventions.

f) A MH Substance Use Assessment may be completed independently of other documents, on a clinical needs basis.

[20] The 'Stages of Change' framework has been developed to assess consumer willingness to participate in treatment. A consumer's success with treatment is affected by how readily they accept recommendations made by the treating team or how willing they are to change their current behaviour.

8.4 Family Focused Assessment (COPMI)

Purpose

The assessment is designed to separately assess parent /carer functioning, behaviour and insight, as well as the child's current functioning in both physical and psychosocial domains (ie Strength and Difficulties Questionnaire)[21]. Outcomes from the assessment guides the clinician to balance strengths and vulnerabilities, provide a clinical impression of functioning, and identifies strategies for the **MH Care Plan**[22]. The purpose is to enhance parenting skills and ensure the ongoing care of the child.

For example:

- If the consumer is a sole carer and has an unexpected inpatient admission
- When there is a referral of the family to Early Childhood Services / Child Youth and Family Teams for access to family support
- Parenting skills or early intervention programs OR
- For referral of the child for young carer programs, mental health services or Department of Community Justice.

Who

In first instance, the Medical Officer will complete the **Family Focused Assessment** at admission. Where clinically appropriate, the treating team may update and complete the assessment during the episode of care.

When

Completed at admission as part of standard assessment on PowerNotes.

Using the Family Focused Assessment

a) Complete the **MH Family Focused Assessment** (COPMI) as per the form structured documentation, where a consumer is **identified** during assessment as a parent or a carer for children (eg grandparent caring for children during the day; living with a partner who has dependent children). Entry in eMR, see Clinical Documentation> Guide How to>Adding Clinical Information>Clinical Document Launcher>Assessment>MH Family Focused (COPMI).

The clinician is mandated to complete each question in the assessment by selecting one of the three categories: 'Y' (=Yes), 'N' (=No) and 'UK (=Unknown). If the clinician selects 'UK', reasons as to why this

[21] Strengths and Difficulties Questionnaire (SDQ)(www. http://www.copmi.net.au/professionals-organisations/what-works/evaluating-your-intervention/youth-interventions/strengths-difficulties)

[22] In Australia, approximately 23% of Australian children live in a household where at least one parent has a mental illness. Some risks associated with parenting with a mental illness include the sense of social isolation, additional stress felt by parents due to fears of losing custody and frustration / guilt arising from being unable to parent to the standard they wish. A parent with a mental illness may also experience the risk of having difficulty setting limits and boundaries with children due to their own variability in judgment given their level of wellness. This can be particularly obstructive to a child's optimal physical, emotional and social development. They may, for example, take an inordinate amount of responsibility for their age or they may feel confused, frustrated, angry, frightened or guilty with aspects of their parent's behaviours they do not understand (www.raisingchildren.net.au).

information was not available, as well as strategies to obtain this information and documented in the 'Other comments' included in each domain.

Legislated Mandatory Requirements

b) Complete '**risks**' and '**protective factors**' in the **Additional Assessment**, which assists the collation and analysis of available information for the purpose of determining urgency of response. This is done by identifying strengths/protective factors and weighing them up against vulnerabilities/risk factors. The completed **Family Focused Assessment (COPMI)** grid **must** be substantiated by clinical rationale and evidence under the '**Strengths/Protective factors**' and '**Vulnerabilities/Risk Factors**' headings from the clinician.

c) Provide an overview from the information gathered from the grid by selecting between the **mandated** categories 'Yes' and 'No' whether the '**Parent's/carer's current symptoms and behaviour interfere with undertaking parental and/or essential household duties**' and whether the '**Parent's/carer's current symptoms and behaviour is having a negative impact on the child**'.

d) The clinician must outline how any identified issues will be addressed within the care plan for the parent and/or the child in the '**Specific Issues to be Addressed in Management / Care Plan**' Section, preferably in point form and in order of priority. This information must be transferred to the consumer's MH Care Plan.

e) Be aware that the sections in the Additional Assessment should reflect information documented in the corresponding section of the MH Current Assessment document. For example, the '**Mental State Examination**' headings are intended to aid clinicians to collate information already documented in the MH Current Assessment document. The MH Family Focused Assessment (COPMI) may alert clinicians to gaps in the MH Current Assessment document which should prompt further assessment and documentation.

f) Complete the module, being aware that the MH Family Focused Assessment (COPMI) makes provision for a broad range of Family Focused Assessment domains; however, the clinician should acknowledge the diversity of potential presentations, so the category selections are not restrictive or exhaustive.

Provision is made for the identification of other relevant factors under '**Other/Comment**'. This provision reflects the complexities of Family Focused Assessment and the need for documentation to be responsive to variations in presentation. It is **mandatory** for clinicians to detail the 'Other/Comment' issue by naming it and providing a descriptor of the issue.

g) If the consumer is caring for more than one child, document where each child lives and whether there are specific issues affecting individual children.

h) Complete the MH Family Focused Assessment (COPMI) on a clinical needs basis, which may be in conjunction with a change in the clinical picture.

8.5 Transcultural Assessment

Purpose

The MH Transcultural Assessment provides an optional, structured format for the documentation of cultural information, where a consumer has been identified as being from a culturally and linguistically diverse (CALD) background. The Transcultural Assessment module will enhance the assessment process to become more culturally informed and appropriate for consumers and carers from CALD communities.

Who

The medical officer will complete the MH Transcultural Assessment as part of standard assessment at admission.

When

Complete the MH Transcultural Assessment at **Triage** and/or **Assessment** where communication issues indicate language or cultural barriers. Where screening is not possible at this stage, the clinician must indicate in the base document ('**Assessment**') why this was not possible how and when the screening will be completed. It can also be used during a **Review**.

Using the Transcultural Assessment Module

a) The Transcultural Assessment Checklist (TAC), is a resource aimed at enhancing culturally aware information gathering. The information collected should be documented in the '**Transcultural Assessment**' module and summarised findings in relevant components of the base assessment documents (Triage, Assessment, Review &/or Care Plan) to assure culturally appropriate and effective formulations and care plans.

b) Use the Transcultural Referral Guide (TRG) to consider consumer communication capacity, English proficiency, cultural issues and service preferences. The TRG helps the clinician to decide on and access the most appropriate cultural health service option(s). Once you have determined the most appropriate service option, contacts should be documented in the base module ('**Assessment**') and this can be referenced in the '**MH Transcultural Assessment**' module contacts section.

c) For **Child and Adolescent consumers**, the parents' cultural heritage and language proficiency should be considered. Consider whether the consumer has a language interpreter or cultural broker role for the family. The whole of family information may be documented on a single '**MH Transcultural Assessment**' module.

8.6 Clinical Functional Assessment

Purpose

The MH Clinician Functional Assessment provides a structured format for assessing the current functioning for consumers. For **consumers over the age of 65 years**, it is **mandatory** for the clinician to complete the MH Clinician Functional Assessment, in conjunction with MH Current Assessment, MH Review and MH Discharge/Transfer Summary documents for in **ALL** settings.

The clinician should contextualise ratings from directly relevant outcome measures (RUG-ADL or LSP-16) and compare the record of progress or deterioration across Admission, Review and Discharge. Such an assessment is beneficial in an inpatient setting where determining nursing dependency for activities of daily living has significant influences on the utilisation of resources, provision of holistic care, and completing the consumer's 'Care Plan'.

Who

The admitting nurse will complete the Clinical Functional Assessment as part of the standard measures at admission.

When

For **consumers over the age of 65 years**, clinicians **must** complete the MH Clinician Functional Assessment, in conjunction with MH Current Assessment, MH Review and MH Discharge/Transfer Summary documents. This applies to all service settings and correlates with the corresponding clinical process of assessment, review and discharge.

Using the Clinical Functional Assessment

a) Compare the functional capacity across the **assessment, review** and **discharge/transfer** processes. These comparisons will help the clinician gauge the consumer's baseline to quantify progress or deterioration and subsequently the allocation of resources.

b) It is mandated for the clinician to provide documentation of clinical rationale regarding functional ability needs by balancing strengths/skills against deficits based on the information in each section under the '**Comments**' section.

c) Consider ratings used in outcome measurement, specifically the RUG-ADL, when completing the **first section** which assesses for '**Activities of Daily Living**'. Supportive clinical documentation should include consideration of nursing resource allocation in an inpatient setting or community rehabilitation supports for ambulatory consumers.

d) Consider ratings used in outcome measurement, specifically the LSP-16, when completing the **second section** in the additional assessment document which assesses '**Instrumental Activities of Daily Living**'.

Supportive clinical documentation should indicate a need for community rehabilitation supports for ambulatory consumers or as post discharge needs for an inpatient.

e) Complete the assessment, being aware that the MH Clinician Functional Assessment makes provision for common functional issues for older adults. Given the diversity of potential presentations, the domains provided are not exhaustive or restrictive. Provision is made for the identification of other relevant factors under 'Other'. It is **mandatory** for clinicians to detail the 'Other' issue by naming it and providing supportive clinical rationale.

f) Complete the two information domains which address '**Social and Recreational Functioning**' and '**Level of Assistance Required to Engage with Health Services/Other Agencies**'. Substantiate clinical judgement with evidence. Evidence can be obtained from the consumer's narrative or as a result of corroborative information from carers, family, friends, other health professionals or other appropriate liaison points.

g) Complete the '**Issues to be addressed in Management / Care Plan**' section by documenting, in point form and order of priority, issues to be addressed, also ensuring transfer of this information to the consumer's '**Care Plan**'. Issues are identified after balancing the strengths/skills of the consumer against their deficits. The issues identified should be addressed with an associated action plan.

8.7 Cognitive Assessment (RUDAS, 3MS/MMS)

Purpose

As people age, the incidence of cognitive impairments and neurocognitive diseases will increase. It is important to screen for the presence of cognitive impairment to enable clinically appropriate interventions (type, phase, etc). A valid and appropriate cognitive screening tool will reduce the risk of misdiagnosis of symptomatology. For example, the onset of psychotic symptoms in older adults can frequently be a non-cognitive symptom of dementia[23]. A proportion of consumers may present with symptoms which are seemingly symptoms of a mental illness; however, they may actually occur in the context of cognitive impairment, including dementia. Depression is also common in dementia, with one study finding two thirds of consumers with dementia having a co-morbid psychiatric diagnosis. [24]

Performing a cognitive screening for all consumers aged 65 years and older at admission, review and discharge provides a baseline measure for subsequent interactions. There are three cognitive screening tools – the 'Mini-Mental State' (MMS), the 'Modified Mini-Mental State' (3MS) and the 'The 'Rowland Universal Dementia Assessment Scale' (RUDAS). The clinician should choose between the 3MS, MMS or RUDAS when conducting a cognitive screening.

The results of the MMS and 3MS may potentially be biased by the consumer's level of education and cultural background. The MMS is embedded in the 3MS. The 3MS (MMS plus additional four items) was developed to broaden the range and difficulty of cognitive testing, to provide superior psychometric properties[25]. **It is mandated for the clinician to have received the relevant training on the use of the cognitive screening they are conducting.**

Who

A trained or experienced clinician from the treating team will complete the Cognitive Assessment.

When

For consumers **aged 65 years and older**, the clinician is **mandated** to conduct an MH additional assessment for cognitive screening whenever the **Admission, Review** or **Transfer/Discharge** processes occurs, deciding between the 3MS/MMS or RUDAS.

[23] Mintzer, J. & Targum, S. (2003). Psychosis in Elderly Patients: Classification and Pharmacotherapy. *Journal of Geriatric Psychiatry and Neurology, 16(4), p.199-206.*
[24] Brodaty, H., Draper, B. &Low, L. (2003). Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery. *Medical Journal of Australia, 178*(5), 231-234.
[25] In Australia, a significant and a growing proportion of the older adult population are overseas born with English as a second language. This can make the MMS and 3MS difficult to use as many of their concepts do not easily translate into other languages. The RUDAS was developed in 2002 to function as a multicultural mini-mental state examination. It has been validated, showing a high degree of accuracy equivalent to the MMS, and does not appear to be influenced by language, education or gender, unlike the bias noted with the MMS. (www.alzheimers.org.au)

Using Cognitive Assessments

a) Complete the structured documentation of **Cognitive Assessment (3MS / MMS / RUDAS)** as per the form structure. Administration of the cognitive screen should occur in a quiet area with low stimulation. The clinician should ensure that the consumer can hear clearly. If the consumer has hearing aids, these should be used. Ensure the consumer is wearing their glasses and there is sufficient light. The clinician should speak slowly and clearly; do not speak loudly as this may result in distortion.

It is mandated for the clinician to have received the relevant training on the use of the cognitive screening they are conducting.

b) Conduct the 3MS or MMS or RUDAS by reading the instructions in italics verbatim to the consumer. Take note of non-italic instructions as they are directions for the clinician conducting the assessment. The Administration Guidelines for each cognitive screen recommend that the clinician sits opposite the consumer.

c) Complete the Cognitive Assessment (RUDAS) as a preferred screening tool to the Cognitive Assessment (3MS/MMSE) if the consumer needs the screening to be conducted in **a language other than English**. This practice is recommended as evidence supports superior psychometric properties for people of **culturally diverse backgrounds** or **varied education levels** with the use of the RUDAS. Refer to the scoring guidelines for each of the cognitive screens.

d) Conduct the RUDAS in the consumer's most competent and comfortable language. Ensure that a professional, health care interpreter is used as appropriate, confirming the correct dialect for the consumer. Explain to the consumer that you will be asking the questions and the interpreter will be translating. The RUDAS Administration Guidelines recommend that the interpreter sits next to the test administrator, while the consumer sits opposite.

e) The 3MS is scored out of 100 points to provide superior psychometric properties. The MMS and RUDAS are both scored out of 30, with the recommended cut off score of 23 indicating potential cognitive impairment.

f) The '**Cognitive Assessment (MMS/3MS/RUDAS)**' can be completed, on a clinical needs basis, which may be in conjunction with change in the clinical picture.

g) The original paper copy of the completed module is kept in the medical hybrid file. The clinician should transcribe the results into the chosen assessment module in eMR.

8.8 Screening for Domestic Violence

Purpose

Domestic Violence has been linked to psychological and behavioural problems. Screening is vital when contextualising symptomatology in mental health presentations. This is consistent with the assessment practice within a biopsychosocial framework.

Health outcomes resulting from being a victim of domestic violence include; alcohol and drug misuse, depression and anxiety, eating and sleep disorders, feelings of shame and guilt, phobias and panic disorder, physical inactivity, poor self-esteem, post- traumatic stress disorder, psychosomatic disorders, suicidal behaviour and self-harm behaviour and post-natal depression. [26]

Who

Completed by a clinician who has undergone training on 'Domestic Violence Screening'.

When

- For all **females aged 16 years old and over**, it is mandated to NSW Health Domestic Violence Screener at initial assessment as part of routine process. The clinician should indicate how and when the screening will be completed.
- The clinician may exercise clinical judgement (where appropriate) to complete a standalone document for male (or other specified gender) consumers. [27] (refer to Item "g" below)

The screening does not need to be completed in cases where domestic violence has already been identified; for example, as part of a presenting issue. When screening is not possible at this stage (see below), the clinician must indicate on the screening tool why this was not possible.

Using the Domestic Violence screen tool

a) Screening for Domestic Violence is not to be carried out in the presence of a partner or other family members, friends or children over the age of three years.

b) Routine screening is to be undertaken when the woman is coherent enough to participate in relation to mental state, substance intoxication and/or trauma.

c) The eMR Form to use for Domestic Violence screening where the consumer is female and 16 years or over is the MH Current Assessment eMR Form. (Completion of domestic violence screening questions is **mandatory** for this Client group via the MH Current Assessment).

[26] NSW Ministry of Health PD2006_084 Domestic Violence Identifying and Responding.
[27] AIHW (2018). Family, domestic and sexual violence in Australia 2018: Report.

d) If domestic violence is identified and the consumer is a child or has dependent children, a FACS notification to the Child Protection Helpline must be made. [28] Further assessment should be carried out to ascertain the nature of the domestic violence and any concerns for the safety of the victim, their children or others.

e) When the **safety of others is involved**, confidentiality cannot be offered unconditionally. Police should be notified when: immediate serious risk to an individual / the general public exists, the victim has serious injuries, the perpetrator has access to weapons and is threatening injury to others or health workers have been threatened by the perpetrator.

f) For consumers receiving ongoing ambulatory care, screening should take place at six monthly intervals, or at a change in circumstances eg at change of social / residential situation.

g) While not mandatory, if clinically appropriate, the DV screener can be conducted on males. While the DV screener section will not appear in the **MH Current Assessment** document for male consumers, it can be completed as a stand-alone document, found under '**Adhoc > Mental Health > Additional tools**'.

[28] NSW Health PD2013_007 Child Wellbeing and Child Protection Policies and Procedures for NSW Health

8.9 Consumer Wellness Plan

Purpose

The MH Consumer Wellness Plan is an individualised plan which promotes a journey of self-awareness, provides a relapse prevention plan and an advance crisis plan, empowering the consumer with a voice even in acute phases of their illness. It encourages the consumer to take responsibility in their care, and to actively participate and control their recovery process. **Recovery** does not refer to curing an individual's mental illness; rather, it seeks to move beyond the diagnosis. The consumer is empowered with the tools to acknowledge the limits presented by their illness and to live with purpose, independently directing their life so that it is satisfying, hopeful and fulfilling.

Who

The MH Consumer Wellness Plan is designed for completion by the consumer and, where applicable, it can be completed in partnership with the designated carer and/or the clinician.

Despite the highly personalised nature of the MH Consumer Wellness Plan, the process of recovery is not meant to occur in isolation. The process of recovery should be supported by people and resources that are able to provide support on their journey. One such support person is the allocated (or '**Assigned To**') mental health clinician. Underpinning the success to any journey of recovery is 'hope' to foster optimism.

When

- The clinician should offer the MH Consumer Wellness Plan document in conjunction with collaborative care planning, which begins as soon as appropriate after assessment for consumers receiving further care.
- It should be offered to all consumers, unless clinically inappropriate, such as during acute phases of illness or during brief episodes of care.

Using the Consumer Wellness Plan

a) The clinician should read the content contained within the MH Consumer Wellness Plan to guide their practice.

b) The MH Consumer Wellness Plan is designed for completion by the consumer. Encourage the consumer to complete the paper copy MH Consumer Wellness Plan, utilising an approach which encourages hope and supports the process of recovery.

c) With the **consumer's consent**, a copy of the MH Consumer Wellness Plan should be shared with the designated carer and others involved in the consumer's care, such as their GP. The completed **MH Consumer Wellness Plan** should also be given to any other person the consumer has nominated (eg their designated Carer under the NSW Mental Health Act (2007)). Consent to provide a copy of the MH Consumer Wellness Plan to any party described above can be withdrawn by the consumer at any time.

d) A copy should be kept in the medical hybrid file and documented as '**Completed**' under '**MH Consumer Wellness Plan**' on eMR and noted '**Refer to the hybrid file**'. While the paper document does not need to be transcribed into the electronic document in eMR, teams may choose to do this for ease of access.

e) Where required, provide guidance for the consumer to complete each domain. Remember that this is the consumer's plan and their opportunity for empowerment by directing their care. The Consumer Wellness Plan can be offered to the consumer during acute phases of illness at the discretion of the clinician, the crisis plan, and the nomination of carer can be filled out.

f) When the consumer is completing and identifying '**Stress factors**', provide psycho education around the value of managing stress, taking into account that stress can often trigger relapse episodes. When the consumer is completing and identifying early warning signs, provide psycho education around the value of early intervention to avoid potential acute episodes which may result in hospitalisation. Where there is a difference in focus between the consumer and clinician, significant effort should be made to reach an agreement.

g) Ensure the **currency** of the information contained in the MH Consumer Wellness Plan by **reviewing** it with the consumer at **minimum every six months** or when therapeutically appropriate eg the consumer requests review of their Wellness Plan.

h) When the consumer is completing the '**Things I do well / skills I have**' section, explain (when appropriate) that strengths identified can be internal or external resources eg education, insight or social supports. Aid the consumer to link their strengths to their **recovery** and reflect SESLHD Strengths Framework. [29]

i) When the consumer is completing the '**If I become unwell, I would like the following things to happen or not happen**' section, explain that this is an advance crisis plan which empowers them to direct their own treatment and care during an acute phase of illness. Acute phases of mental illness may impair insight, resulting in the loss of the consumer's voice in their treatment. This is crucial in providing some control to the consumer during a chaotic, confusing and distressing period.

j) The consumer should complete and sign each page which includes recording their name, signature and date.

[29] SESLHDGL/070 Strengths Model Mentoring Program - Mental Health Service

8.10 Strengths Assessment

Purpose

The Strengths based model is core to best practice in mental health care, which is a philosophy of practice and a set of tools and methods designed to enhance recovery. The Strengths Assessment is a tool designed to help consumers and mental health clinicians to become conscious of the resources a person possesses. It explores the experiences and knowledge accumulated in the past, at present, and what external resources they possess or have access to. The aim of the Strengths Assessment is to capture, clarify and enhance qualities, talents, skills, resources and aspirations that a person has to support their recovery journey.

Who

Completed by any mental health clinician who has successfully participated in the two day Strengths Model training. Ideally it would be completed by the allocated Primary Clinician in the Community Mental Health Service or the Primary Nurse/ Care Coordinator in an Inpatient setting.

When

A Strengths Assessment should be initiated within the first three months of allocation to the service and completed by their allocated clinician with the information used to develop a 'Personal Recovery Plan' based upon the consumer's individual goals and aspirations.

How to Use the Strengths Assessment

a) The assessment of a person's strengths is an ongoing process that begins at the first meeting. Complete the strengths assessment worksheet with the consumer to organise and record the multiple strengths the individual possesses. The assessment does not provide questions to guide the practitioner through a structured interview process, but instead encourages a conversational approach.

   The life domains in the strengths assessment correspond to those life areas that people are most concerned about. They also reflect the major niches that people occupy. The focus of the strengths assessment is on actual life activities that reflect the 'well' aspects of the person and those resources, personal and environmental, that are still being, and have been, employed.

b) Each life domain is divided into three temporal categories: **Current Strengths, Desires** and **aspirations**, and **Past Strengths**. From the desires and aspirations column a list of priorities is distilled, and work can begin on a chosen goal using the 'Personal Recovery Plan'.

c) **Critical Components** of the Strengths Assessment includes:
   - Introduced in a context that is meaningful to the person
   - Conducted in conversational manner

- Consumer paced
- On-going process/updated on regular basis
- Consumer language used
- Thorough, detailed and specific.

d) **If a person chooses not to participate in a strengths assessment template, this should be recorded in the MH progress notes and the 13 week MH Review.**

Further Information:

- My Health Learning: Mental Health- the Strengths Model in Practice- two-day training.

8.11 Home Visit Risk Assessment

Purpose

A home visit risk assessment is essential to ensure that potential risks identified and that may arise are documented and communicated. [30]

Who

Completed by a clinician who will be performing an off-site visit such as a home visit.

When

Completed prior to the home visit.

How to Use the Care Plan

a) A new Home Visit Risk Assessment PowerForm should be created for each client encounter.

b) This Home Visit Risk Assessment should be updated if new risk identified.

c) For further information see SESLHDPR/323 – Working in Isolation Risk Management.

[30] *Chapter 16: Working in the Community* in Protecting People and Property - NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies (June 2013)

Section 9 – Documentation & References

Documentation

Document as outlined within the above processes for base documents, additional documents and other documents.

References

NSW Ministry of Health

- PD2021_039 - Mental Health Clinical Documentation
- GL2014_002 - Mental Health Clinical Documentation Guidelines
- PD2017_044 - Interpreters – Standard Procedures for working with Health Care Interpreters
- PD2016_007 - Clinical Care of People Who May Be Suicidal
- IB2020_021 - Mental Health Community and Outcome Measures Collections: Reporting Requirements from 1 October 2020
- PD2006_084 - Domestic Violence – Identifying and Responding
- GL2007_024 - Client Registration Guideline
- PD2007_094 - Client Registration Policy
- PD2019_020 - Clinical Handover
- PD2012_069 - Health Care Records - Documentation and Management
- PD2013_007 - Child Wellbeing and Protection Policies and Procedure for NSW Health
- NSW Health Privacy Manual for Health Information (March 2015)
- PD2019_045 - Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services
- GL2021_006 - Physical Health Care for people living with a mental health issue
- GL2017_022 - NSW Older People's Mental Health SERVICE PLAN 2017-2027
- PD2020_032 - Nursing and Midwifery Management of Drug and Alcohol use in the Delivery of Health Care

SESLHD

- SESLHDGL/051 - Access and Patient Flow Operational Framework for Mental Health Services
- SESLHDGL/042 - Falls Prevention and Management: Guideline for use of bed/chair alarm units (adult Inpatients)
- SESLHDPR/615 - Engagement and Observation in Mental Health Inpatient Unit Procedure
- SESLHDPR/288 - Identification of patients within mental health setting
- SESLHDPR/323 - Working in Isolation Risk Management
- SESLHDGL/082 - Clinical Risk Assessment and Management – Mental Health
- SESLHDPR/605 - eMR Copy and Pasting within Electronic Documentation
- SESLHDPR/490 - Patient Registration – Patient Administration System (PAS)
- SES MH Guide: Clinical Documentation Recording Rules in eMR

- MH Work Process Best Practice
- eMR Quick Reference Guides

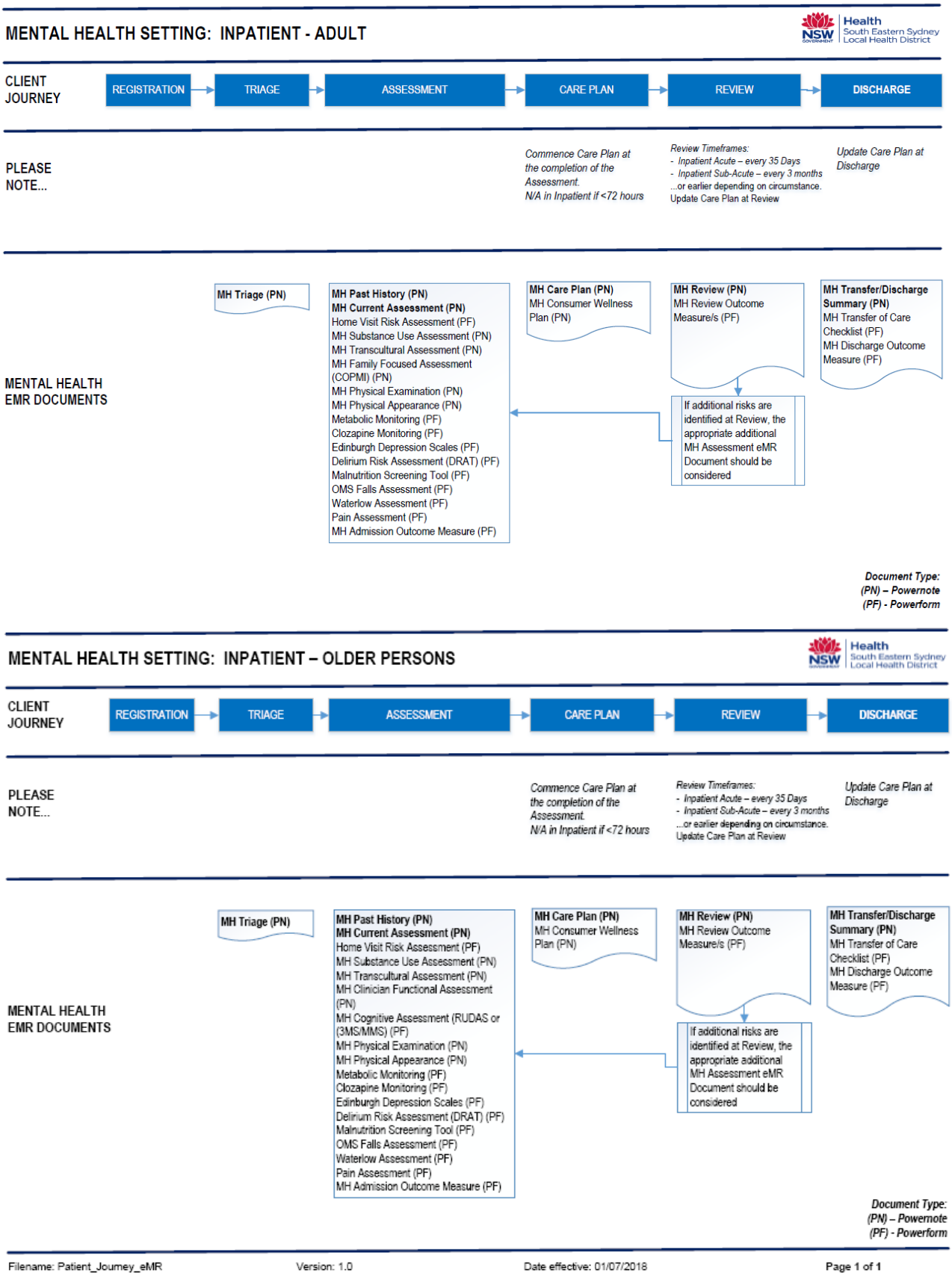
Others

- Memorandum of Understanding - Mental Health Emergency Response 2007 between NSW Health, Ambulance Service of NSW and between NSW Police Force
- National Safety and Quality Health Service Standards (Second edition) Standard 1: Healthcare records 1.16, 1.17, 1.18
- National Safety and Quality Health Service Standards (Second edition) Standard 6: Integrating clinical governance 6.1, 6.4 Organisational processes to support effective communication
- Fifth National Mental Health and Suicide Prevention Plan (August, 2017)
- Mental Health National Outcomes and Casemix Collection Version 2.1 2021
- Mental Health Information Development, Mental Health National Outcomes and Casemix Collection, Technical specification of State and Territory reporting requirements, Version 2.10

Section 10 – Revision and Approval History

Date	Revision no:	Author and approval
February 2018	0	Angela Karooz, Clinical Nurse Manager
March 2018	0	Updated document. Trinh Huynh, Policy and Document Development Officer.
May 2018	0	Disseminated for site consultation; feedback incorporated and considered.
June 2018	0	Reviewed by MHS Clinical Documentation working group. Revised by Frank Zivkovic and Trinh Huynh. Pending consultation with MHS A/Manager of Finance and Performance, Clinical Nurse Manager and Quality Manager (ESMHS).
August 2018	0	Endorsed by DDDCC. Endorsed by SESLHD MHS Clinical Council.
August/ September 2018	Draft	Major review undertaken. SESLHDPR/521 superseded by SESLHDGL/074. Draft for Comment. No further feedback received.
September 2018	Draft	Reviewed by Executive Services prior to progression to Clinical and Quality Council.
October 2018	1	Approved by CQC for publishing.
April 2021	2	Routine review commenced
October 2021	2.1	Review recommenced. Links checked and updated. Standards aligned to second edition. Circulated to DDCC for discussion.
November 2021	2.1	Circulated to DDCC only minor changes to wording identified.
January 2022	2.1	Endorsed by DDCC out-of-session for progression. Endorsed by Executive Sponsor to proceed to publication.
February 2022	2.1	Processed and published by SESLHD Policy
April 2022	3.0	Working group convened to consider more detail being included regarding the completion of specific documentation within eMR.
June 2022	3.1	Circulated to DDCC for review and feedback. Updated to ensure medical signoff occurs for CMH discharge summaries containing medication lists.
July 2022	3.2	New table for HoNOS Collection Timeframes added. No further changes identified.
August 2022	3.3	Formatted into new SELSHD GL template. All links updated. Endorsed by Executive Sponsor for progression to Draft for Comment. Final version endorsed by Executive Sponsor.

Appendix A: Patient Journey Chart



MENTAL HEALTH SETTING: COMMUNITY - ADULT

CLIENT JOURNEY: REGISTRATION → TRIAGE → ASSESSMENT → CARE PLAN → REVIEW → DISCHARGE

PLEASE NOTE...

Commence Care Plan at the completion of the Assessment. N/A in Community if <14 days

Review Timeframes:
- Community – every 3 months
...or earlier depending on circumstance.
Update Care Plan at Review

Update Care Plan at Discharge

MENTAL HEALTH EMR DOCUMENTS

MH Triage (PN)

MH Past History (PN)
MH Current Assessment (PN)
Home Visit Risk Assessment (PF)
MH Substance Use Assessment (PN)
MH Transcultural Assessment (PN)
MH Family Focused Assessment (COPMI) (PN)
MH Physical Examination (PN)
MH Physical Appearance (PN)
Metabolic Monitoring (PF)
Clozapine Monitoring (PF)
MH Admission Outcome Measure (PF)

MH Care Plan (PN)
MH Consumer Wellness Plan (PN)

MH Review (PN)
MH Review Outcome Measure/s (PF)

If additional risks are identified at Review, the appropriate additional MH Assessment eMR Document should be considered

MH Transfer/Discharge Summary (PN)
MH Transfer of Care Checklist (PF)
MH Discharge Outcome Measure (PF)

Document Type:
(PN) – Powernote
(PF) - Powerform

Filename: Patient_Journey_eMR | Version: 1.0 | Date effective: 01/07/2018 | **Page 1 of 1**

MENTAL HEALTH SETTING: COMMUNITY – OLDER PERSONS

CLIENT JOURNEY: REGISTRATION → TRIAGE → ASSESSMENT → CARE PLAN → REVIEW → DISCHARGE

PLEASE NOTE...

Commence Care Plan at the completion of the Assessment. N/A in Community if <14 days

Review Timeframes:
- Community – every 3 months
...or earlier depending on circumstance.
Update Care Plan at Review

Update Care Plan at Discharge

MENTAL HEALTH EMR DOCUMENTS

MH Triage (PN)

MH Past History (PN)
MH Current Assessment (PN)
Home Visit Risk Assessment (PF)
MH Substance Use Assessment (PN)
MH Transcultural Assessment (PN)
MH Clinician Functional Assessment (PN)
MH Cognitive Assessment (RUDAS or (3MS/MMS) (PF)
MH Physical Examination (PN)
MH Physical Appearance (PN)
Metabolic Monitoring (PF)
Clozapine Monitoring (PF)
MH Admission Outcome Measure (PF)

MH Care Plan (PN)
MH Consumer Wellness Plan (PN)

MH Review (PN)
MH Review Outcome Measure/s (PF)

If additional risks are identified at Review, the appropriate additional MH Assessment eMR Document should be considered

MH Transfer/Discharge Summary (PN)
MH Transfer of Care Checklist (PF)
MH Discharge Outcome Measure (PF)

Document Type:
(PN) – Powernote
(PF) - Powerform

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