MENTAL HEALTH SERVICE PROCEDURE COVER SHEET

Health
South Eastern Sydney Local Health District

NAME OF DOCUMENT	Clinical Review in Mental Health
TYPE OF DOCUMENT	Procedure
DOCUMENT NUMBER	SESLHDPR/642
DATE OF PUBLICATION	August 2025
RISK RATING	High
LEVEL OF EVIDENCE	National Safety and Quality Health Service Standards (second edition) 1.6, 2.6, 2.7, 5.7,10, 13, 6.7, 8 PD2021_039 Mental Health Clinical Documentation
REVIEW DATE	August 2027
FORMER REFERENCE(S)	N/A
EXECUTIVE SPONSOR	Dr Nicholas Babidge Clinical Director, Mental Health Service
AUTHOR	Clinical Review Procedure Working Group, Mental Health Service
POSITION RESPONSIBLE FOR THE DOCUMENT	Policy and Document Development Officer, Mental Health Service SESLHD-MentalHealth-PoliciesandDocuments@health.nsw.gov.au
FUNCTIONAL GROUP	Mental Health
KEY TERMS	Care planning, care plan, management plan, review, collaborative
SUMMARY	This procedure describes the minimum requirements during Clinical Review to ensure comprehensive and consistent clinical review, planning and implementation processes. The evaluation of clinical review aims to promote safe, high quality and collaborative mental health care.

1. POLICY STATEMENT

The purpose of this procedure is to ensure patient (or consumer) safety, quality improvements and collaboration in mental health care. This will be facilitated by comprehensive and consistent planning and implementation of clinical review within all Mental Health Services (MHS) in South Eastern Sydney Local Health District (SESLHD). The procedure is consistent with NSW Health PD2021_039 Mental Health Clinical Documentation, Improving Consumer Outcomes In Mental Health: Clinical Documentation and Outcomes Measures and NSW Health PD2024_010 Clinical Governance in NSW.

1.1. The expected outcomes of this clinical review procedure are to ensure that:

- Care is planned and delivered in the form of specified interventions that are based on best evidence.
- A platform is available for dialogue to ensure consumer driven outcomes are included in the review. This should occur **systematically**, **in partnership** with the consumer and their family or carers when consent is given, and **regularly**.
- Clinical Review and Planning are clearly documented in eMR as required in PD2021_039 Mental Health Clinical Documentation: *NSW Health organisations must ensure that all mental health services use available electronic medical record (eMR) systems for the documentation of clinical practice and care. This is required in all service settings, for all service types and age groups, and enables integrated health services and clinical information systems across NSW.*

2. BACKGROUND

The Clinical Review process is the pivotal point of care to ensure that every consumer continually benefits from the treatment and care they receive. The coordination of a consumer's care is a collaborative process, in which the consumer, family and carers and the clinical care team together foster a therapeutic alliance and facilitate recovery goals.

A Clinical Review will occur at prescribed intervals of the consumer's journey, and additionally at critical points including:

- transitions of care; or
- significant changes of condition.

As per PD2021_039 Mental Health Clinical Documentation, a documented Clinical Review "MH Review" and corresponding "MH Care Plan" for each consumer is **mandatory**. These are to be reviewed and updated regularly to ensure accurate documentation of *diagnosis, needs, goals, treatment plan, interventions, progress* and *outcomes*.

2.1 Definitions

- **Attending Medical Officer (AMO)** is the Consultant Psychiatrist to whom the consumer is assigned in electronic medical record (eMR).
- **Care Coordinator** refers to the assigned clinician, allocated nurse, primary clinician, or the equivalent, as defined by the team.

- **Clinical plan** is a phrase used in this procedure to define a plan developed by the treating team, in consultation with the consumer and carers, for the care of that consumer within the Mental Health Service.
- **Clinical planning** refers to process of effective and consistent planning for the care and/or management of an individual consumer within the Mental Health Service.
- **Clinical Review** is the term used to describe the formal meeting of the Multi-Disciplinary Team (MDT) to review and discuss the consumer's clinical plan. This process may also be referred to as **MDT meeting**, **ward round**, **CRM meeting**, **Care Review** or **Care Conference**. For the purpose of this document the term **Clinical Review** is used for consistency and in alignment with NSW Health reference document.
- **Community Managed Organisation (CMO)** previously referred to as a Non-Government Organisation or NGO.
- **MH Care Plan** refers to the formal documentation of the consumer's short to medium term goals with interventions that enable the goal to be achieved, which is then documented in the consumer's eMR PowerNote "MH Care Plan" document. **The MH Care Plan document is mandatory within 72 hours following initial assessment in the inpatient setting, and 14 days for a consumer receiving community care**. The MH Care Plan **must be updated in accordance with the Clinical Review process outlined in section 4.1**.
- **MH Review** refers to the formal documentation of the Clinical Review in the eMR PowerNote "MH Review" document.
- **Multidisciplinary Team (MDT)** refers to a group of clinicians from different healthcare disciplines. The interdisciplinary group may include but are not limited to: Nurse, Occupational Therapist, Psychiatrist, Psychiatry Trainee, Psychologist, Social Worker, Diversional Therapist and Peer Worker.
- **PowerForm** refers to a suite of electronic documents that are available through the AdHoc section of the eMR.
- **PowerNote** refers to a catalogue of electronic documents that are available in the PowerNotes section of the eMR.

3. RESPONSIBILITIES

3.1. Employees will:
Follow the procedure.

3.2. Line Managers will:
Ensure clinical staff members are familiar with the procedure, circulate the procedure document and enable local implementation. Ensure non-clinical staff members are aware of the procedure.

3.3. Service Managers:
Will distribute the procedure within their relevant service. Ensure that line managers are familiar with the procedure and ensure staff adhere to the procedure.

3.4. Service Directors will:
Monitor the compliance and review of the procedure at the local Clinical Governance Committee, and report to the District Clinical Governance Committee.

4. PROCEDURE

The Clinical Review should be undertaken during the episode of care. The following activities are conducted as minimum requirements:

4.1 Scheduling and Location of the Clinical Review

Inpatient

- Inpatient services will conduct regular Clinical Reviews to discuss the clinical plan for consumers in the Unit.
- In the SESLHD MHS Clinical Review occurs at least weekly in acute units, and at least once per fortnight in subacute and non-acute units. Clinical Review may occur more frequently as clinically required.
- Clinical Review should occur at a fixed time and at the same venue each week to enable staff to participate regularly.
- Minimum requirements for Clinical Review venue:
  - Large enough to comfortably accommodate all members.
  - Private and safe environment.
  - Accessibility to eMR and connected to a data projector or large LCD screen, plus videoconferencing facilities.
- Consumers and carers must be informed of the time and location of Clinical Review meetings and are invited to participate in person (preferred), or by attending virtually via NSW Government endorsed video or teleconferencing platforms. If attendance in person or virtually is unable to occur, consumer and carer participation must be facilitated by conducting a pre-review meeting with the allocated nurse so that information can be tabled at the review. The allocated nurse should ensure that feedback from the meeting is provided to the consumer.
- Clinical Review Meetings **must be documented within "MH Review" in the eMR PowerNote** refer to *Appendix A: Correctly documenting the MH Review*.

Community Mental Health

- Clinical Review must occur in community teams at least once every 13 weeks. Clinical Review may occur more frequently as clinically required.
- Clinical Review conference should occur at a fixed time and at the same venue each week to enable staff to participate regularly.
- Minimum requirements for Clinical Review venue:
  - Large enough to comfortably accommodate all members.
  - Private and safe environment.
  - Accessibility to eMR and connected to a data projector or large LCD screen, plus videoconferencing facilities.
- Consumers and carers must be informed of the time and location of Clinical Review meetings and are invited to participate in person (preferred) or by attending virtually via NSW Government endorsed video or teleconferencing platforms. If attendance in person or virtually is unable to occur, consumer and carer participation must be facilitated by conducting a pre-review meeting with Care Coordinators so that information can be tabled at the review. The Care Coordinator should ensure that feedback from the meeting is provided to the consumer.
- Clinical Review Meetings must be **documented within "MH Review" in the eMR PowerNote**.

4.2 Preparing for the Clinical Review meeting

- Ensure room is set up and equipment is operational.
- Prepare Unit Round list (inpatient) and Team's Care Review list (Community) in eMR.
- The assigned clinician/allocated nurse/care coordinator reviews current care plan and updates the Clinical Managers for completeness and accuracy (Inpatient: Medical Officer, Community: Care Coordinator).
- Where possible, HoNOS should be drafted/pre-populated in advance for the 13 week review meeting and updated/finalised during the Clinical Review.

4.3 Roles and Responsibilities in Clinical Review meeting

Ensure the core participants in the Clinical Review meeting are the relevant clinical team, involved with the care of the consumer. All attending members should contribute to the discussion as required, and undertake the activities assigned within their responsibilities.

Inpatient

Attending Medical Officer (or delegated NUM)	- Has primary responsibility for chairing the meeting, including conduct of the Clinical Review and allocation of tasks. - Task allocation to specific team members may vary from this procedure by direction of the meeting chair. - Ensure the "MH Review" and "MH Care Plan" PowerNotes are signed in eMR at the conclusion of each Clinical Review.
Consultant Psychiatrist	- Final formulation of the Clinical plan. - Ensuring all elements of the Clinical plan are completed and documented as per this procedure. - Endorsement of the completed "MH Review" and "MH Care Plan" PowerNotes - Consideration of leave and endorsement of "MH Observation Level and Leave Approval" PowerNote
Inpatient – Psychiatry Trainee	- Pre-prepares "MH Review" PowerNote populating it appropriately. - Gives brief summary of consumer's clinical presentation and progress. - Contributes to discussion giving input as required. - Navigates the eMR displaying information to the team, as appropriate. - Completes the "MH Review" PowerNote and other documentation, as required. - Completes allocated tasks as delegated. - Complete/update the observation and leave prescription - Updates Phase of Care in eMR. - Development of "MH Observation Level and Leave Approval" PowerNote
Consumers and Carers	- Are able to participate in the review by actual or virtual attendance, or they are consulted prior to the meeting regarding their views, and are encouraged to be directly involved as part of the "MH Review" meeting in order to: o Report their progress, goals, concerns and plans. o Discuss outstanding issues with the treating team. o Co-formulate care plans and consumer wellness plans. - In some instances, it may be more appropriate to, discuss the consumer's and carer's views separately.

	- In all cases, the consumer should be engaged prior to the meeting, documented consent obtained for carers to participate. - If consumers and carers are not in attendance they must be informed of the outcome of the meeting and advised of any changes to their care plan within 24 hours of the review occurring.
Allocated Nurse (Inpatient Units)	- Gives a brief summary of current presentation and progress from a nursing perspective, highlighting relevant issues and concerns. - Contributes to discussion and comprehensive care planning. - Updates “MH Care Plan” PowerNote.
Social Worker	- Gives a brief summary of current presentation and progress from a social work perspective, highlighting relevant issues and concerns including (where relevant) income and housing support, etc. - Contributes to discussion and comprehensive care planning. - Updates “MH Care Plan” PowerNote.
Psychologist	- Gives a brief summary of current presentation and progress from a psychology perspective, highlighting relevant issues and concerns, including relevant results of psychometric testing and behavioural plans. - Contributes to discussion and comprehensive care planning. - Updates “MH Care Plan” PowerNote.
Occupational Therapist	- Gives brief summary of current presentation and progress from an occupational therapy perspective, highlighting relevant issues and concerns including results of functional assessments, identified needs and required supports. Contributes to discussion and care planning, and ensures a Life Skills Profile (LSP) has been completed. Note that the LSP is not OT specific and can be completed by any member of the MDT. - Contributes to discussion and comprehensive care planning. - Updates “MH Care Plan” PowerNote.
Community Team Clinicians (Inpatient Units)	- Where a Community Care Coordinator is assigned, they should attend the inpatient Clinical Review meeting. If they are unable to attend, then the Community Team Clinical Manager must nominate a delegate. - Where there is no Community Care Coordinator assigned, a community team representative will attend each inpatient Clinical Review conference meeting in person or via tele/videoconference.

	- Gives a brief summary of current presentation and progress from a community team perspective, highlighting relevant issues and concerns. - Contributes to discussion and comprehensive care planning. - Updates “MH Care Plan” PowerNote.
CMO or Private Clinicians	- GPs, CMO providers and other private sector clinicians involved in the care of the consumer should be invited to attend the meeting either in person or via tele/videoconference, where possible. - Contributes to discussion and comprehensive care planning

Community

Community – Clinical Team Manager	- Has primary responsibility for chairing the meeting, including conduct of the Clinical Review and allocation of tasks. - Task allocation to specific team members may vary from this procedure by direction of the meeting chair. - Ensure the “MH Review” and “MH Care Plan” PowerNotes are signed in eMR at the conclusion of each Clinical Review.
Consultant Psychiatrist	- Final formulation of the Clinical plan. - Ensuring all elements of the Clinical plan are completed and documented as per this procedure. - Endorsement of the completed “MH Review” and “MH Care Plan” PowerNotes
Community –Care Coordinator	- Pre-preparesfor Clinical Review meeting by populating MH Review PowerNote appropriately. - Gives brief summary of consumer’s clinical presentation and progress inclusive of their Strengths Assessment and Personal Recovery Plan. - Contributes to discussion, giving input as required. - Navigates the eMR, displaying information to the team as appropriate. - Completes the “MH Review” PowerNote and other documentation, as required. - Completes allocated tasks, as delegated. - Updates Phase of Care in eMR.
Consumers and Carers	- Are able to participate in the review by actual or virtual attendance, or they are consulted prior to the meeting regarding their views and are encouraged to be directly involved as part of the Clinical Review meeting in order to: o Report their progress, goals, concerns and plans. o Discuss outstanding issues with the treating team. o Co-formulate care plans and consumer wellness plans.

	- In some instances, it may be more appropriate to, discuss the consumer's and carer's views separately. - In all cases, the consumer should be engaged prior to the meeting, documented consent obtained for carers to participate. - If consumers and carers are not in attendance they must be informed of the outcome of the meeting, and advised of any changes to their care plan, within 24 hours of the review occurring.
Nurse	- Where relevant, gives a brief summary of current presentation and progress from a nursing perspective, highlighting relevant issues and concerns including (where relevant) income and housing support, etc. - Contributes to discussion and comprehensive care planning. - Updates "MH Care Plan" PowerNote.
Social Worker	- Where relevant, gives a brief summary of current presentation and progress from a social work perspective, highlighting relevant issues and concerns including (where relevant) income and housing support, etc. - Contributes to discussion and comprehensive care planning. - Updates "MH Care Plan" PowerNote.
Psychologist	- Where relevant, gives a brief summary of current presentation and progress from a psychology perspective, highlighting relevant issues and concerns, including relevant results of psychometric testing and behavioural plans. - Contributes to discussion and comprehensive care planning. - Updates "MH Care Plan" PowerNote.
Occupational Therapist	- Where relevant, gives brief summary of current presentation and progress from an occupational therapy perspective, highlighting relevant issues and concerns including results of functional assessments, identified needs and required supports. Contributes to discussion and care planning and ensures a Life Skills Profile (LSP) has been completed. Note that the LSP is not OT specific and can be completed by any member of the MDT. - Contributes to discussion and comprehensive care planning. - Updates "MH Care Plan" PowerNote.
CMO or Private Clinicians	- GPs, CMO providers, NDIS support worker and other private sector clinicians involved in the care of the consumer should be invited to attend the meeting, either in person or via tele/videoconference, where possible.

	- Contributes to discussion and comprehensive care planning

4.4 Clinical Review Meeting Process

Inpatient

a. Team assemble in allocated area at appropriate time.
b. Psychiatry Trainee (Inpatient Unit), opens eMR to display on large screen.
c. List of consumers for review displayed.
d. Psychiatry Trainee gives brief overview of each consumer, including current presentation, progress and issues for discussion.
e. Allocated Nurse provides update and nursing observations
f. Allied Health staff provide update and raise relevant issues.
g. Consumer and carers are invited to participate
h. Chair mediates clinical discussion including:
    i. Accuracy of standard measures
    ii. Leave status
    iii. Discharge date and planning
    iv. Observation level and risk management
    v. Suicide and self-harm prevention plan
    vi. Medications; Ensures Best Possible Medication History and Admission Reconciliation complete and ongoing reconciliation and review of medications
    vii. ECT and other physical treatments
    viii. Psychological and other non-pharmacological therapies
    ix. Any adverse incidents involving the consumer
    x. Use of restrictive measures
    xi. Strengths assessment and goals
    xii. Physical health review and update, including e-ECG, metabolic monitoring, physical observations etc
    xiii. Additional Relevant Comprehensive Care Areas; Falls, Malnutrition, Wound / Pressure Injury Care and Cognitive Impairment
i. Meeting Chair identifies and allocates tasks to be completed, specifying required timeframes.
j. Psychiatry Trainee completes “MH Review” PowerNote and documents discussion including task allocation.
k. Allocated team member amends previous standard measures and enters current Standardised Measures results.
l. MDT members and external clinicians involved in the clinical plan must be documented in the “Clinicians involved in the Review” section of the “MH Review” PowerNote.
m. All relevant team members complete/update Standard Measures and “MH Care Plan” PowerNote. Include consumer goals and updates from the Clinical Review. Provide a hard copy to the consumer and carer.
n. Allocated Nurse, or other designated staff member, reviews the MH Wellness Plan with the consumer. This should include a plan for managing thoughts of suicide or self-harm, both while on the Unit and on leave. A hard copy is provided to the consumer and carer, and updated in accordance with the current “MH Care Plan” PowerNote.

o. The “MH Review” and “MH Care Plan” PowerNotes are signed off by the relevant clinicians and then sent for endorsement by the treating Attending Medical Officer.
p. Attending Medical Officer checks content of “MH Review” and “MH Care Plan” PowerNotes, makes any required modifications and endorses the final version.

Community

a. Team assemble in allocated area at appropriate time.
b. Care Coordinator opens eMR to display on large screen.
c. List of consumers for review displayed.
d. Care Coordinator gives brief overview of each consumer including current presentation, progress and issues for discussion.
e. Care Coordinator provides update and observations
f. Allied Health staff provide update and raise relevant issues.
g. Consumer and carers are invited to participate
h. Chair mediates clinical discussion including:
    i. Accuracy of standard measures
    ii. Discharge date and planning
    iii. Risk management
    iv. Suicide and self-harm prevention plan
    v. Medications
    vi. ECT and other physical treatments
    vii. Psychological and other non-pharmacological therapies
    viii. Any adverse incidents involving the consumer
    ix. Strengths assessment and goals
    x. Physical health review and update
    xi. Additional Relevant Comprehensive Care Harm Areas; Falls, Malnutrition, Wound / Pressure Injury Care and Cognitive Impairment
i. Meeting Chair identifies and allocates tasks to be completed, specifying required timeframes.
j. Care Coordinator completes “MH Review” including medications and documents discussion including task allocation.
k. Allocated team member finalises pre-populated standard measures and enters current Standardised Measures results (due to time constraints, Standardised Measures may be pre-populated, but must be discussed and finalised during the Clinical Review).
l. MDT members and external clinicians involved in the clinical plan must be documented in the “Clinicians involved in the Review” section of the “MH Review” PowerNote.
m. Care Coordinator completes/updates Standard Measures and “MH Care Plan” PowerNote.
n. Care Coordinator or other designated staff member reviews the MH Wellness Plan with the consumer, updating in accordance with the current “MH Care Plan” PowerNote.
o. Care Coordinator or other designated staff member reviews and updates the suicide and self-harm prevention plan (also known as a “Safety Plan”) with the consumer. This plan should be documented in a MH Progress Note and a hard copy provided to the consumer. The “MH Care Plan” is updated to contain the date and time of the MH Progress Note containing the suicide and self-harm prevention plan, so that it can be easily located.

p. The “MH Review” and “MH Care Plan” PowerNotes are signed off by the relevant clinicians and then sent for endorsement by the treating Attending Medical Officer.
q. Attending Medical Officer checks content of “MH Review” and “MH Care Plan” PowerNotes, makes any required modifications and endorses the final version.

Please Note:
Process to follow to ensure that all care coordinated consumers of the Community Service are formally presented at a Clinical Review meeting at minimum every 13 weeks as per NSW Health GL2014_002 Mental Health Clinical Documentation Guidelines.

Community Care Coordinators should:
- Maintain, by regularly extracting a report from eMR, a list of consumers that includes due dates for 13-week review
- Schedule reviews in keeping with the list of consumers
- Present consumers at Clinical Review meetings as scheduled
- Update the consumer list following presentation
- Escalate any concerns e.g. consumers overdue for presentation; workload; resource issues to the Team Leader in a timely manner

Community Team Leaders should:
- Ensure each Care Coordinator is maintaining a consumer list that includes due dates for 13-week review
- Respond to any escalation of concern received from Care Coordinators to ensure that all consumers are presented, as required.
- Monitor compliance with requirements in monthly audits and escalate if any concerns or issues are identified.

Community Service Manager / Service Director:
- Oversee compliance by review of monitoring activities in place

Additional Documentation
Additional eMR PowerNotes and PowerForms may be used to assist and support Clinical Review meetings.

Additional eMR PowerNotes and PowerForms should be **used as appropriate to the clinical situation.** These include, but are not limited to:

Comprehensive Care Screening and Assessment Tools:
- MH Care Plan
- MH Wellness Plan PowerNote
- MH Family Focused Assessment (COPMI) Power Note
- MH Safety Plan

Self-Harm:
- MH Substance Use Assessment PowerNote
- K10 LM PowerForm, LSP 16 PowerForm
- Domestic Violence Screen PowerForm

Physical Health:
- MH Physical Exam
- Metabolic Monitoring PowerForm
- Fagerstrom test for nicotine dependence

Skin Integrity / Pressure Injuries:
- Waterlow Assessment PowerForm

Falls
- OMS Falls Risk Screening Assessment PowerForm
- MH Clinician Functional Assessment PowerNote (Older People)

Cognitive Impairment / Delirium:
- 4AT – Rapid Assessment Test for Delirium

Hydration and Nutrition:
- Malnutrition Screening Tool

From Inpatient Assessment – Adults
- Clinical Opiate Withdrawal scale

From Heredity Cancer Care
- Hospital Anxiety and Depression Scale

From Community Health Adult Services – Assessment – Aboriginal Aged and Chronic Care
- DASS 21
- Frontal Assessment Battery
- Modified Barthel Index
- PHQ-9
- Parkinsons Assessment

From Community Health Adult Services – Assessment – Allied Health Nutrition
- Eating Disorder
- Mini Nutritional Assessment

From Community Health Adult Services – Assessment – Allied Health Occupational Therapy
- Folstein MMSE
- Goal Attainment Scale
- RUDAS Form

4.5 Performance Measures

Review of Clinical Planning processes within each service should occur regularly to determine the extent to which they meet quality standards defined in this procedure.

- Percentage of medical records with MH Current Assessment PowerNotes with all required sections completed including evidence of risk assessment and an action plan.
- Percentage of medical records with evidence of a completed “MH Review” PowerNote within the prescribed period for the setting. Completed document requires all sections completed including risk assessment and action plan.
- Percentage of medical records with evidence of a completed “MH Care Plan” PowerNote within the prescribed period for the setting. Completed document requires all sections completed including risk assessment and action plan.
- Percentage of “MH Review” PowerNotes with documented consumer involvement.
- Percentage of “MH Review” PowerNotes with evidence of carer involvement.
- Percentage of “MH Care Plan” PowerNotes with evidence of consumer involvement.
- Percentage of “MH Care Plan” PowerNotes with evidence of carer involvement

4.6 Links and tools

QRG - Mental Health Review PowerNote
Mental Health- NSW eHealth Share Point; Mental Health
SESLHDGL/074 Clinical Documentation in Mental Health
PD2021_039 Mental Health Clinical Documentation

5. DOCUMENTATION

- MH Review
- MH Care Plan
- MH Observation Level and Leave Approval
- MH Wellness Plan
- MH Safety Plan

See also *4.4 Clinical Review Meeting Process -> Additional Documentation* and *4.5 Performance Measures*.

6. AUDIT

Monthly Performance data for “MH Review” and “MH Care Plan” completion submitted to local Clinical Governance Committee. This data is also tabled at the MHS Comprehensive Care Committee.

Quarterly QARS Audit Performance data on “MH Review” and “MH Care Plan” quality submitted local Site Clinical Governance Committees.

Report any compliance issues at local Clinical Governance meeting and documented in minutes for record purposes. Where necessary, identified issues are to be escalated to SESLHD MHS Clinical Governance meeting.

7. REFERENCES

NSW Health

- PD2021_039 Mental Health Clinical Documentation

- GL2014_002 Mental Health Clinical Documentation Guidelines
- PD2020_004 Seclusion and Restraint in NSW Health Settings
- PD2019_045 Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services
- PD2024_010 Clinical Governance in NSW

Others

NSW Health (2011) Improving Consumer Outcomes in Mental Health: Clinical Documentation and Outcome Measures. NSW Department of Health

8. VERSION AND APPROVAL HISTORY

Date	Version	Author and Approval
June 2018	1.0	Drafted by Dr. Peter Young, SESLHD MHS A/Clinical Director. Reformatted by Trinh Huynh, SESLHD MHS Policy and Document Development Officer.
August 2018	1.0	Established working party to include: Gareth Marr, Clinical Operations Manager ESMHS; Mathew Large, Chief Psychiatrist ESMHS; Candice Fogarty, NUM2 TSH; Robin Ellis Community Service Manager ESMHS; and Mike Gatsi Service Director ESMHS.
September 2018	1.1	Revised by Trinh Huynh: policy statement, background, definition, responsibilities, overview of procedure, format, revision history. Working Group revised: responsibilities, documentation and clarified content.
October 2018	1.2	Feedback from wider consultation across sites and multidisciplinary team considered and incorporated by Peter Young, A/Clinical Director, SESLHD MHS and Trinh Huynh, Policy and Document Development Officer, SESLHD MHS. Pending DDDCC endorsement.
November 2018	1.3	Final review by Service Directors, Clinical Operations Managers, and Clinical Directors. Updated Service Director responsibility and local clinical governance committee confirmed invitation of consumers and their carers and community managers.
December 2018	1.3	Endorsed by SESLHD MHS DDCC
January 2019	1.3	Endorsed by SESLHD MHS Clinical Council
April 2019	1.3	Listed on Draft for Comment. No comments/feedback received. Approved by Executive Sponsor.
May 2019	1.4	Processed by Executive Services and progressed to Clinical and Quality Council for approval prior to publication. Approved to publish at Clinical and Quality Council May 2019 meeting.
September 2020	1.5	Reference table updated to current NSW Ministry of Health documents – no change to content noting that full review due May 2021

November 2020	1.5	Endorsed by SESLHD MHS Document Development and Control Committee Endorsed by SESLHD MHS Clinical Council
May 2021	1.6	Routine review commenced. Feedback held over due to COVID-19 operational requirements
October 2021	1.7	Review recommenced. Feedback received minor. Document separated into Inpatient Review and CMH review to clearly detail the requirements for the review and additional documentation now has subheadings and has been grouped accordingly.
December 2021	1.7	Further review by DDCC – no further changes identified. Progressed to Executive Sponsor for Endorsement
January 2022	1.8	Executive Sponsor requested review and inclusion for SafeSide Safety Planning by the Project Manager, Zero Suicides In Care. Document reviewed and updated in line with Executive Sponsor feedback. Endorsed by Executive Sponsor for publication.
September 2022	2.0	Updated at DDCC request to include section for formal MDT review of CMH consumers at least once every 13 weeks
September 2022	2.1	MDT review accepted into document without change. Additional changes identified – “Primary Clinician” changed to “Care Coordinator”. References to PD2021_039 included throughout document. Performance Measures updated to reflect current practice
December 2022	2.2	Feedback from SGMHS ACMH Manager incorporated. Returned to SGMHS ACMH Manager for further review/feedback.
January 2023	2.3	Feedback received from SGMHS ACMH Manager. Circulated to DDCC for review/feedback.
February 2023	2.3	Endorsed for publication by Executive Sponsor
March 2023	3.0	Published by SESLHD Policy Team
March 2025	4.0	Sent to DDCC for routine review and feedback
July 2025	4.1	Minor feedback incorporated. Resent to DDCC for review and out-of-session endorsement.
July 2025	4.2	Updated definitions to standardise language “Clinical Review” definition updated to include the interchangeable terms MDT meeting, ward round, CRM meeting, Care Review, Care Conference to be represented by the term “Clinical Review”. Document updated to only refer to Clinical Review. Addition of Appendix A: Correctly documenting the MH Review.
1 August 2025	4.3	Addition of MH Observation Level and Leave Approval, MH Physical Exam. Endorsed by Executive Sponsor for publication.

Appendix A: Correctly documenting the MH Review

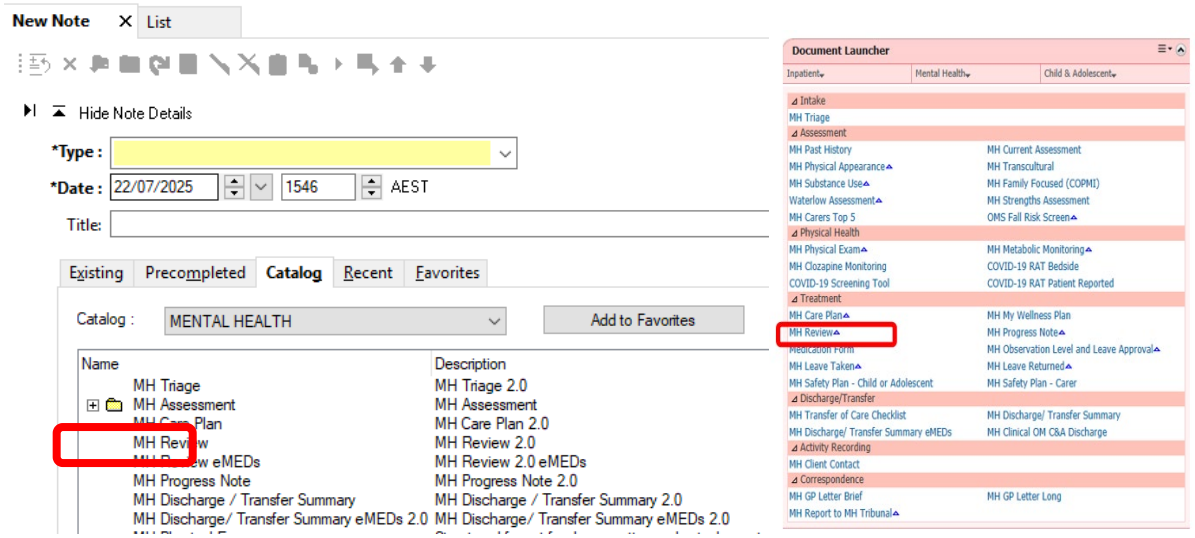
Who: This applies to **all staff** who document Clinical Review meetings
What: Clinical Review must be documented in the eMR PowerNote **"MH Review"**
When: Clinical Review meetings are mandatory, occurrence will vary depending on the area but must occur at minimum:

- **Weekly in Acute settings**
- **Fortnightly in Non-acute settings**
- **Every 13 weeks in Community settings**

For more information, refer to:

- SESLHDGL 074 Clinical Documentation in Mental Health
- SESLHDPR/642 Clinical Review in Mental Health

Where: In the **Consumers eMR PowerNote "MH Review"**



Why:

- MH Review is mandatory, compliance is audited monthly.
- Should staff retitle a MH Progress note, this will not be captured in the monthly audit report.
- By using the structure, information will pre-populate to other documents e.g. By completing structure within the MH Review → this will pre-populate in the MH Review.

For more information, speak with the Nurse Unit Manager or Clinical Manager.