LOCAL OPERATING PROCEDURE

Approved by Quality & Patient Care Committee
21 June 2018

MENTAL HEALTH ESCALATION – MATERNITY INPATIENT

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM

- Appropriate assessment, diagnosis and treatment to ensure the safe care of a pregnant or postpartum woman with **acute mental health symptoms**

2. PATIENT

- Pregnant or postpartum woman who is an inpatient and may be displaying **any of the following symptoms**:
  - Disorganised behaviour
  - Incoherence
  - Suicidal and/or infanticidal ideation or intention
  - Paranoia
  - Mania
  - Confusion
  - Severe depression
  - Psychosis
  - Severe panic attack

3. STAFF

- Medical, midwifery and nursing staff
- Allied health
- Access and Demand Manager (ADM)
- After Hours Nurse Manager (AHNM)

4. **EQUIPMENT**

- Nil

5. CLINICAL PRACTICE

- Identify the unwell woman according to the criteria above
- Assess risk of suicide/infanticide as per Appendix 1
- Assess the immediate safety of the woman and neonate and provide safe care of the neonate, if postpartum
- Inform ward manager and ADM/AHNM
- **NOTIFY SECURITY IF WOMAN'S BEHAVIOUR IS THREATENING TO SELF OR OTHERS (ext. 22847) OR INITIATE CODE BLACK (777)**
- Organise mental health review as per Appendix 2

6. DOCUMENTATION

- Medical records
- Obstetric database
- Schedule 1 Mental Health Act (2007)
- Schedule 3 Statement of Rights (Involuntary patient)
- Schedule 3A Statement of Rights (Voluntary patient)

7. EDUCATIONAL NOTES

- Prenatal experiences can influence later psychological and developmental outcomes for the unborn baby. This evidence underpins the practice of early identification and intervention with women in mental health distress during the perinatal period.

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MENTAL HEALTH ESCALATION – MATERNITY INPATIENT cont'd

8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP

- Mental Health Escalation Policy – Maternity Outpatient
- Care Coordination; Planning from Admission to Transfer of Care in NSW Public Hospitals Procedures. PO2011_015
- Inter-facility Transfer Process for Adults Requiring Specialist Care. PD2011_031
- RHW Business Rule. Admissions.
- RHW Business Rule. Inter-hospital Transfer

9. RISK RATING

- High

10. NATIONAL STANDARD

- CC – Comprehensive Care

11. REFERENCES

1. Mental Health Act (2007) Guide Book 5th addition incorporating the 2015 Mental Health Act Amendments http://www.mha.nswiop.nsw.edu.au/images/Mental-Health-Act_Guide-Book_2016.pdf
2. Mental Health Act (2007) http://www.legislation.nsw.gov.au/viewtop/inforce/act+8+2007+FIRST+0+N/
3. NSW Department of Health, 2009, NSW Health/Families NSW Supporting Families Early Package – SAFE START Guidelines: Improving mental health outcomes for parents and infants, NSW Department of Health

REVISION & APPROVAL HISTORY
Reviewed and endorsed Maternity Services LOPs 19/6/18
Approved Quality & Patient Safety Committee 18/12/14
Endorsed Maternity Services LOPs 2/12/14

FOR REVIEW : JUNE 2023

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Appendix 1

ASSESSMENT OF SUICIDE/INFANTICIDE RISK

Developed from the recommendations in SESLHD PD 2006/5 Clinical Risk Assessment and Management Policy

TO BE USED IN CONJUNCTION WITH THE EDINGBURGH DEPRESSION SCALE (EDS)

If risk is suspected, please explore the woman's current situation and if possible complete the EDS. If QUESTION 10 SCORE IS 1, 2 OR 3, PLEASE DO THE FOLLOWING:

1) PRELIMINARY EXPLORATION

a) LANGUAGE AND COMPREHENSION

i) Did she read and correctly understand the question?
ii) Culturally and Linguistically Diverse (CALD) women may misunderstand "self-harm"
iii) Fear of an accident during pregnancy may be thought of as self-harm e.g. hurting yourself if you have a fall
iv) Distinguish between thoughts present now and within the past week versus some time ago

b) SELF HARM OR SUICIDAL

i) Some women are recurrent self-harmers without suicidal intent e.g. those who inflict superficial lacerations but are not likely to come to serious harm

c) AREAS TO DISCUSS AND DOCUMENT

i) What exactly is the thought?
ii) How often is it present and how severe?
iii) Has she made any attempt to harm herself? When? How?
iv) Has she got a plan? How likely is it to be effective?
v) What would stop her from acting on her thoughts (e.g. child, husband)?
vi) How hopeless is she feeling?
vii) What supports does she have (e.g. family, General Practitioner or family doctor, friends)?
viii) If she has a partner, has she told him/her and how did he/she react?
ix) Does she have thoughts of harming the baby?
x) How does she interact with the baby at interview?
xi) Your confidence in the assessment?

SPECTRUM OF RISK

Use the tables below to identify the score associated with the level of risk

SUICIDE RISK SPECTRUM		
RISK LEVEL	**EXPRESSED THOUGHTS**	**SCORE**
LOW	Wants to escape situation e.g. "run away" no thoughts of harm to self or baby	**1**
LOW	Would rather not wake up. Wants to go to sleep to shut things out of mind. No other thoughts	**2**
LOW	Passive suicidal thoughts. Wouldn't mind if had serious accident or illness (e.g. got run over or told she had cancer) but no active thoughts	**3**

MODERATE	Suicidal thoughts - “I wish I was dead” etc. But NO plan	**4**
MODERATE	Fleeting suicidal plans BUT wouldn’t do it because of baby /husband/religion etc	**5**
HIGH	Repeated thoughts of suicidal plan AND “no reason to live” or hopelessness is prominent	**6**
EXTREME	Current specific plans with past attempts	**7**
EXTREME	Previous diagnosis of a mental health disorder such as schizophrenia, bipolar etc.	**8**

2) TIMING OF MENTAL HEALTH CLINIC REVIEW

Use the table below to clarify the urgency of the mental health review in relation to the risk spectrum score

Timing of mental health review		
SCORE	**Situation**	**Review**
1-3	Situation contained at home	Next available Clinic appointment and Multidisciplinary Case Discussion (MCD)
	Situation not contained at home	Clinic appointment within 1-2 weeks and MCD
4-5	Situation contained at home	Clinic appointment within 1-2 weeks and MCD
	Situation not contained at home	Same day (RHW psychiatrist/POWH Emergency Department (ED))
6-8	Urgent	Immediate (RHW psychiatrist/POWH ED)

APPENDIX 2

FLOW CHART – Mental health escalation – INPATIENT