

National Safety and Quality
Health Service Standards

**User Guide for Health Services
Providing Care for People with
Mental Health Issues**



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ISBN: 978-1-925665-67-3

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Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards User Guide for Health Services Providing Care for People with Mental Health Issues. Sydney: ACSQHC; 2018

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Introduction

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in collaboration with the Australian Government, states and territories, the private sector, clinical experts, and people who use health services and their families and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met. Importantly, these NSQHS Standards have provided a nationally consistent statement about the standard of care that people can expect from their health service organisations.

The second edition of the NSQHS Standards embeds person-centred care and addresses the needs of people who may be at greater risk of harm. This includes people with mental health issues. Forty-five percent of Australians experience a mental disorder within their lifetime, with 20% reporting experience of mental health issues in the previous 12 months.¹ The rate of mental health issues for people in hospital is higher than for the general population.²⁻⁴

National and international evidence suggests that meeting the psychological and mental health needs of people with concurrent physical health conditions improves both physical and mental health. Despite this, mental and physical multimorbidities are often undetected, and even when detected, care and support for both physical and mental health is often uncoordinated and ineffective.⁵

This is consistent with an earlier report by the Commission, in which people with mental health issues reported sub-optimal experiences when they accessed health care. In particular, they reported that their mental health was not treated with the same thoroughness as their physical health.⁶

Health outcomes are particularly bad for people with serious mental illness, who live between 10 and 32 years less than the general population.⁷ This is significantly due to preventable physical illness. Due to stigma and other psychosocial factors, people with serious mental illness access physical health services less, and receive less care when they do access services.⁸ The physical health of people with serious mental illness has been identified as a priority in *The Fifth National Mental Health and Suicide Prevention Plan*.⁹ There is room for improvement in how health services are delivered to people with mental health issues.

In order to address these safety and quality issues, the Commission has incorporated significant changes in the second edition of the NSQHS Standards. There are eight NSQHS Standards, including a new standard, Comprehensive Care. There are two overarching standards, Clinical Governance and Partnering with Consumers, and the actions in the NSQHS Standards are designed to be implemented as a whole.

Embedded across the standards are a number of actions that will particularly support improvements in the delivery of health care to people with mental health issues. These have been identified in Table 1, and form the basis for this *NSQHS Standards User Guide for Health Services Providing Care for People with Mental Health Issues* (the User Guide). Links between actions within the NSQHS Standards are identified within the text and summarised in Appendix A.

The fundamental principle underpinning the new actions is that caring for a person's mental and physical health are integrated processes. While different members of the workforce have different roles, it is everyone's responsibility to collaborate to deliver person-centred care that meets all of the person's health needs.

Scope

This user guide is intended to support implementation of the NSQHS Standards in all healthcare settings where the standards apply. In particular, the User Guide is designed to support services which are not specialist mental health services. The User Guide is intended to support members of the workforce when they are providing health services to people with existing or emerging mental health issues.

The guide contains information that may be useful in specialist mental health services. The Commission recognises that there are specific challenges to implementing the NSQHS Standards in specialist mental health services. The Commission has developed a document that maps the second edition of the NSQHS Standards with the *National Standards for Mental Health Services*.¹⁰ This is available on the Commission's website at:

<https://www.safetyandquality.gov.au/our-work/mental-health/>

The Commission is partnering with key stakeholders to implement actions in *The Fifth National Mental Health and Suicide Prevention Plan*⁹ related to national standards in mental health services, and will update stakeholders and the website as new resources are developed.

How to use this guide

The User Guide highlights the actions that will support health service organisations when they are delivering health care for people with mental health issues (Table 1). The User Guide is arranged by NSQHS Standard and each chapter contains:

- Brief contextual information about the standard
- Detailed discussion of how relevant actions apply to providing services to people with mental health issues
- Suggestions and examples of implementation strategies
- Links between actions in the NSQHS Standards.

The User Guide also provides practice resources from across Australia that demonstrate how health services are addressing the mental health needs of people they care for. These are summarised in Appendix B.

The User Guide is designed as a supplement to existing resources to assist health service organisations to implement the NSQHS Standards. These include:

- *Guide for Hospitals*
- *Guide for Multi-Purpose Services and Small Hospitals*
- *Guide for Day Procedure Services*
- *User Guide for Aboriginal and Torres Strait Islander Health*
- *User Guide for Acute and Community Health Service Organisations that Provide Care for Children*
- *National Model Clinical Governance Framework*
- *Guide for Governing Bodies.*

Links to these resources are available on the Commission's website at:

<https://www.nationalstandards.safetyandquality.gov.au/>

Acknowledgements

The Commission acknowledges the contribution of members of the Mental Health Advisory Group in the development of the User Guide. The Commission acknowledges respondents to the national consultation, many of whom contributed information that has improved the guide.

The Commission also acknowledges the many organisations and individuals who are implementing innovative approaches to delivering safer and more effective health care for people who experience mental health issues, and whose examples of practice informed this guide.

Table 1: Actions with high relevance to mental health in the NSQHS Standards

Standard	Criterion	Item	Actions	
Clinical Governance	Governance, leadership and culture	Governance, leadership and culture	1.1	
		Organisational leadership	1.3	
		Clinical leadership	1.6	
	Patient safety and quality systems	Policies and procedures	Policies and procedures	1.7
			Measurement and quality improvement	1.9
			Risk management	1.10
			Incident management systems and open disclosure	1.11
			Feedback and complaints management	1.13, 1.14
			Diversity and high-risk groups	1.15
Safe environment for the delivery of care	Safe environment	1.29, 1.30		
Partnering with Consumers	Partnering with patients in their own care	Healthcare rights and informed consent	2.4, 2.5	
		Sharing decisions and planning care	2.6, 2.7	
Medication Safety	Documentation of patient information	Medication reconciliation	4.5, 4.6	
		Adverse drug reactions	4.7	
Comprehensive Care	Developing the comprehensive care plan	Screening of risk	5.10	
		Clinical assessment	5.11	
		Developing the comprehensive care plan	5.13	
	Delivering comprehensive care	Using the comprehensive care plan	5.14	
	Minimising patient harm	Predicting, preventing and managing self-harm and suicide	5.31, 5.32	
		Predicting, preventing and managing aggression and violence	5.33, 5.34	
		Minimising restrictive practices: restraint	5.35	
		Minimising restrictive practices: seclusion	5.36	
Communicating for Safety	Communication at clinical handover	Clinical handover	6.8	
	Communication of critical information	Communicating critical information	6.9, 6.10	
Recognising and Responding to Acute Deterioration	Detecting and recognising acute deterioration, and escalating care	Recognising acute deterioration	8.5	
		Escalating care	8.6	
	Responding to acute deterioration	Responding to deterioration	8.12	

Appendix A summarises linked actions in the NSQHS Standards that have been highlighted throughout the text as critical for supporting implementation of the suggested strategies.

Language

Person/patient/consumer

This user guide uses the term ‘person with mental health issues’. In contemporary, recovery-oriented mental health services the term ‘patient’ is no longer used. The term also reflects the fact that people accessing health care services may experience mental health issues in the absence of a diagnosed mental illness.

Where the terms ‘patient’, ‘consumer’ and ‘mental illness’ are used in quoted resources, including actions in the NSQHS Standards, these terms are retained.

Recovery

Recovery is understood to be more than reduction in clinical symptoms, and as ‘being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues’.¹¹

Recovery-oriented practice

Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.¹²

Trauma-informed care

Trauma-informed care is an organisational and practice approach to delivering health and human services directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and its prevalence in society. It is a strengths-based framework that emphasises physical, psychological and emotional safety for people who have experienced trauma, their families and carers, and service providers.⁹

1

Clinical Governance Standard



Clinical Governance Standard



The intention of the Clinical Governance Standard is to implement a clinical governance framework that ensures that people receive safe and high-quality care.

The four criteria are:

Governance, leadership and culture

Patient safety and quality systems

Clinical performance and effectiveness

Safe environment for the delivery of care

Effective governance in health service organisations providing care to people with mental health issues ensures:

- The rights of people with mental health issues are promoted and protected
- People with mental health issues and their families are given opportunities to provide feedback on their experience of care to improve the quality of care in health service organisations
- The workforce has the relevant skills, knowledge and experience to provide health care to people with mental health issues
- The workforce has access to, and complies with, relevant legislation, policy and clinical guidelines
- Environments in which people with mental health issues receive care are safe, welcoming and as minimally restrictive as possible.

A critical element of providing health care to people with mental health issues is acknowledgement that the person's mental health issues are part of core business.

Governance, leadership and culture

Governance, leadership and culture

Action 1.1

The governing body:

- a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation
- b. Provides leadership to ensure partnering with patients, carers and consumers
- c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community
- d. Endorses the organisation's clinical governance framework
- e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce
- f. Monitors the action taken as a result of analyses of clinical incidents
- g. Reviews reports and monitors the organisation's progress on safety and quality performance

How does this action apply to people with mental health issues?

For people with mental health issues to receive optimal health care, mental health must be recognised as a core part of health care. The governing body has overall responsibility for the culture of the health service organisation. Fostering a culture in which health care is not compartmentalised supports members of the workforce to provide holistic health care, which may include supporting a person's mental health while they are also receiving care for physical health problems. The governing body will provide optimal leadership by ensuring that the health service organisation partners with people who use its services, including people with lived experience of mental health issues.

Suggested strategies

Set strategic direction that mental health is an integral part of health

The governing body sets the strategic direction for the health service organisation. The governing body leads the development and maintenance of the organisation's safety and quality culture. When the governing body incorporates recognition of the health service organisation's responsibility for the mental health of people accessing health care, and the mental health of members of the workforce, it establishes the conditions under which interventions that support people's mental health are enacted throughout the organisation.

Include a mental health representative on the governing body

One way to ensure mental health is considered by the governing body is to include a mental health representative within the body itself. This strategy has recently been highlighted after a review sparked

by serious adverse outcomes for people with mental health issues in New South Wales. In 2018, NSW Health released *Mental Health Safety and Quality in NSW: A plan to implement recommendations of the Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities*.¹³ The plan has a broad scope:

While many actions will focus on acute mental health facilities and emergency departments, significant change needs to occur at a system level. Accountability at the highest levels of the health system, a focus on culture and leadership, new forms of data and reporting, workforce development, and more open engagement of consumers, carers and families will support system-level change for mental health care in NSW.

NSW Health has directed all local health districts and speciality health networks to: 'Review senior executive structures and include Directors of Mental Health as members of the senior executive and report to Chief Executive.'¹³

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.15c The health service organisation incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care

Lead a culture of partnering with consumers

People with mental health issues and, in particular, their carers, have reported a sense of disconnection between their experiences of engaging with the governing bodies of health service organisations, and their experiences of clinical care.⁶ Thus, while they are listened to with respect in committee meetings, and their participation welcomed and acknowledged, they continue to feel disempowered when they are actually receiving health care, or supporting a person receiving health care.

It is the responsibility of the governing body to understand if this is happening in its health service organisation, and develop strategies so that people are treated with the same respect wherever they are interacting with the organisation. One way of doing this is for the governing body to engage with members of the workforce who provide direct clinical care. Clinicians will be able to identify those aspects of the organisation that support them to provide optimal care, and what can be changed to improve their capacity. This may be additional resources, redeployment of existing resources, training or clinical supervision.

Successful implementation of this strategy will be supported by, or rely on, the following action:

2.7 The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care

Monitor the organisation's safety and quality performance

The governing body has ultimate responsibility for the performance of the organisation. Members of the governing body must ask the right questions if they are to effectively carry out their responsibilities for clinical governance. Three principles will support monitoring and oversight by governing bodies:

- See every piece of information – every measure and every indicator – in its context
- Look beyond written intelligence
- Take responsibility for learning the basics of safety and quality measurement.

Governing bodies need information that is timely, reliable, comprehensive and suitable for their use. Key sources of information are:

- Routinely collected information (sometimes called administrative data)
- Information collected from people who use the service, carers and families
- Information collected from the reporting activity of clinicians and managers.

Strategies for governing bodies to effectively monitor the organisation's safety and quality performance are described in detail in the *NSQHS Standards (second edition) Guide for Governing Bodies*.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.9 The health service organisation ensures that timely reports on safety and quality systems and performance are provided to:

- a. The governing body
 - b. The workforce
 - c. Consumers and the local community
 - d. Other relevant health service organisations
-

Examples of supporting evidence

- Strategic plans that include mental health as an organisational priority
- Committee and meeting records that document participation by people with experience of mental health issues

Organisational leadership

Action 1.3

The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality

How does this action apply to people with mental health issues?

It is through organisational leadership that the strategic directions of the health service organisation, set by the governing body, are implemented. Robust clinical governance is needed to ensure that mental health stays in the organisation's focus. A key element is that each person in the system understands that they have a role in contributing to the mental health of others. The clinical governance framework should be tailored to the specific function of the health service organisation.

Strategies for improvement

Establish and maintain a clinical governance framework

The Commission has developed the *National Model Clinical Governance Framework*¹⁴ (the Framework) to support services to implement the NSQHS Standards. The Framework describes clinical governance:

Clinical governance is the set of relationships and responsibilities established by a health service organisation between its state or territory department of health, governing body, executive, workforce, patients, consumers and other stakeholders to ensure good clinical outcomes. It ensures that the community and health service organisations can be confident that systems are in place to deliver safe and high-quality health care, and continuously improve services.

Clinical governance is an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of health services that are safe, effective, integrated, high quality and continuously improving.

A key part of Action 1.3 is that the service 'uses the processes within the framework to drive improvements in safety and quality'. Organisational leaders and managers have the responsibility to ensure that all stakeholders who have a role described in the organisation's clinical governance framework are aware of it, and have the resources to fulfil their role.

Involve people with experience of mental health issues in developing strategies to support safety culture

One way of establishing and maintaining a robust safety culture is to involve people who have experienced mental health issues in developing responsive strategies. They can provide input, based on their experience of using the health service organisation, that complements suggestions from

members of the workforce. They may also come up with ideas, drawn from their experience outside this particular health service, that can contribute to an enriched safety culture.

Successful implementation of this strategy will be supported by, or rely on, the following action:

2.11 The health service organisation:

- a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care
 - b. Has processes so that consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community
-

Clinical leadership

Action 1.6

Clinical leaders support clinicians to:

- a. Understand and perform their delegated safety and quality roles and responsibilities
- b. Operate within the clinical governance framework to improve the safety and quality of health care for patients

How does this action apply to people with mental health issues?

Clinical leaders can drive safety and quality improvements, and make them a priority. The actions and attitudes of clinical leaders influence the perceptions, attitudes and behaviours of other members of the workforce.

When clinical leaders model empathic, non-stigmatising attitudes to people experiencing mental health issues, they support other clinicians in delivering holistic health care. This also applies to clinical leaders in different specialties demonstrating respectful attitudes to members of the workforce with different expertise.

Strategies for improvement

Foster multidisciplinary links

One effective strategy for building multidisciplinary links is creating opportunities for members of the workforce to spend time 'embedded' in a different setting to their usual workplace. Observing others' clinical practice, for instance, over the duration of a full shift, often enables clinicians to develop insights that they can then use in their own practice.

A more formal process to foster multidisciplinary links is to arrange meetings between different teams. These can be focused around particular case studies that involve joint participation in delivering clinical care. Multidisciplinary teamwork involves identifying the full range of disciplinary

specialists that can contribute to a person's care. This means looking beyond the medical and nursing expertise in different teams, to other potential participants, including pharmacists, psychologists and nutrition experts.

Successful implementation of this strategy will be supported by, or rely on, the following action:

5.5 The health service organisation has processes to:

- a. Support multidisciplinary collaboration and teamwork
 - b. Define the roles and responsibilities of each clinician working in a team
-

Foster culture of clinical supervision

Clinical supervision is a process for professional development. Members of the workforce participate in regular discussion of practice issues with a senior colleague. The process creates the opportunity for participants to reflect on real experiences of clinical practice. When delivered in an environment of trust, clinical supervision allows clinicians to honestly explore issues that concern them about their own practice and encourages them to identify ways to improve that they can implement. Clinical supervision has demonstrated benefits for both clinical practice, and the mental wellbeing of participants.¹⁵ The Australian College of Nursing has identified clinical supervision as a core component of contemporary clinical practice, and calls for health service organisations to support it through policy and workplace culture.¹⁶

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.5 The health service organisation considers the safety and quality of health care for patients in its business decision-making

1.26 The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate

2.7 The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care

Examples of supporting evidence

- Committee and meeting records for multidisciplinary teams which include mental health representation
- Workforce satisfaction surveys
- Clinical supervision register

Patient safety and quality systems

Policies and procedures

Action 1.7

The health service organisation uses a risk management approach to:

- a. Set out, review, and maintain the currency and effectiveness of policies, procedures and protocols
- b. Monitor and take action to improve adherence to policies, procedures and protocols
- c. Review compliance with legislation, regulation and jurisdictional requirements

How does this action apply to people with mental health issues?

The health service organisation has responsibility to ensure that all health care delivered by the workforce is consistent with current legislation and other regulatory requirements. In recent years, states and territories have made changes to mental health legislation to reflect contemporary understanding of the rights of people with mental illness.

Key issues that affect people with mental health issues, and other people accessing health services, include informed consent to treatment, and the use of restraint. The legislative and regulatory requirements regarding these issues can be complex. It is important that members of the workforce understand that practices that make sense from a strictly clinical point of view can involve restrictions on people's rights. Health service organisations have an obligation to ensure that the human rights of people accessing health care are not contravened. Organisations need to support members of the workforce to practise in line with these requirements through maintaining up-to-date policies and providing the training and resources to enable the workforce to enact them.

Suggested strategies

Adopt a systematic approach to aligning policies to key information sources, including changes in legislation and coronial recommendations

Each state and territory has legislation related to the care and treatment of people with mental health issues. Changes in legislation are preceded by consultation periods. Following legislation being passed, there is a period before it is enacted. During this time, health service organisations have the opportunity to ensure that their local policies align with the changes in legislation.

Health service organisations can also initiate improvements based on review of incidents that occur in other health services. While states and territories can provide policy directives, local health services should ensure their own processes align with contemporary knowledge. Coronial investigations frequently contain detailed information about the circumstances preceding adverse events. Coroners make recommendations based on these investigations that can be applied across health services.

The system for review of the health service organisation's policies should be aligned to detailed knowledge about the specific risk profile of the organisation, and the population to which it delivers health care.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

2.4 The health service organisation ensures that its informed consent processes comply with legislation and best practice

5.35b Where restraint is clinically necessary to prevent harm, the health service organisation has systems that govern the use of restraint in accordance with legislation

Ensure ready access to current policies for members of the workforce

Members of the workforce need to know and understand the health service organisation's policies and procedures to be able to enact them. In particular, people working in emergency departments need access to up-to-date local policies that accurately reflect relevant legislation.

Changes in policy have to be communicated effectively to members of the workforce. Formal training can be augmented by in-service presentations, online updates on the health service organisation's intranet and posters in key areas.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.20c The health service organisation uses its training systems to provide access to training to meet its safety and quality training needs

Engage people with mental health issues, their families and carers, and members of the workforce in review of policies and procedures

The health service organisation has responsibility to ensure local policies reflect broad legislative and regulatory factors. Engaging the people who use the health services and those who deliver it will ensure that local issues are effectively identified. These can be incorporated into local policies and procedures.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

2.9 Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review

2.11a The health service organisation involves consumers in partnership in the governance of, and to design, measure and evaluate, health care

Examples of supporting evidence

- Schedule for routine review of policies, incorporating triggers for review linked to legislative and other jurisdictional processes
- Training documents for members of the workforce
- Policy review meeting minutes documenting the involvement of people with experience of mental health issues

Measurement and quality improvement

Action 1.9

The health service organisation ensures that timely reports on safety and quality systems and performance are provided to:

- a. The governing body
- b. The workforce
- c. Consumers and the local community
- d. Other relevant health service organisations

How does this action apply to people with mental health issues?

Transparent reporting of a health service organisation's safety and quality performance enables all stakeholders to participate effectively in the evaluation and improvement of the system. Mental health needs to be one of the focus areas for safety and quality reporting. Information on mental health safety performance can come from multiple sources, including experience of service surveys, health outcome measures, sentinel events and other critical incidents, and external reviewers' reports. If this information remains dispersed, and is not collated and critically reviewed, the health service organisation and its community may not be able to form a clear picture of the service's performance.

Suggested strategies

Governing body needs to know

For the governing body to perform its role effectively, it must work with comprehensive information about the organisation's performance. This is a key action within the establishment of a clinical governance framework.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.3 The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality

1.8 The health service organisation uses organisation-wide quality improvement systems that:

- a. Identify safety and quality measures, and monitor and report performance and outcomes
 - b. Identify areas for improvement in safety and quality
 - c. Implement and monitor safety and quality improvement strategies
 - d. Involve consumers and the workforce in review of safety and quality performance and systems
-

The workforce needs to know

Members of the workforce need to be aware of results of evaluation of their safety and quality performance in order to be able to improve it. This action relates to how clinical areas are functioning, rather than assessment of individual performance. If a particular unit has rates of critical incidents that are outside the norm, the workforce may be aware of it and working to implement strategies to reduce the rate of incidents; or they may not be aware and need additional support to address the problems.

People who use the service need to know

Public reporting of a health service organisation's safety performance has become a driver for quality improvement. Reports should be available to the people who use the service, and the broader community. The service must also ensure that reports are available in language and formats that are accessible to the range of people who use the service. Reports should contain de-identified information to protect the privacy of the people involved. This can be challenging for smaller services in communities where the majority of people know each other.

Successful implementation of this strategy will be supported by, or rely on, the following action:

2.11a The health service organisation involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care

Other health service organisations need to know

People with mental health issues typically receive health care from more than one organisation. Performance in one organisation can have an impact on a person's health outcomes, and determine the level of need placed upon other services. Transparent reporting with service partners, through processes such as reviewing the effectiveness of communications, can address these issues, and lead to improved outcomes for people using the services.

Examples of supporting evidence

- Committee and meeting records in which information on safety and quality indicators, data or recommendations by the governing body are discussed
- Records of safety and quality performance information published in annual reports, newsletters or other local media

Risk management

Action 1.10

The health service organisation:

- a. Identifies and documents organisational risks
- b. Uses clinical and other data collections to support risk assessments
- c. Acts to reduce risks
- d. Regularly reviews and acts to improve the effectiveness of the risk management system
- e. Reports on risks to the workforce and consumers
- f. Plans for, and manages, internal and external emergencies and disasters

How does this action apply to people with mental health issues?

People with mental health issues may be at higher risk of harm when they access health services. Harms can arise from missed or incomplete diagnoses, adverse medication events, or the traumatic use of restrictive practices. People's own actions can lead to harm, including self-harm or harm to others. The health service organisation has to address all of these risks systemically. Actions in the Comprehensive Care Standard describe how risks related to an individual's care are addressed.

Suggested strategies

Identify risks

An organisation needs to use a range of data sources to properly understand risks. For example, the use of restrictive practices outside specialist mental health services may not be systematically documented in clinical data sets. However, review of the log of calls for assistance from security services may provide a summary of incidents where restrictive practices have been used.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.15c The health service organisation incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care

Act to reduce risks

Actions to reduce risks related to the unpredictable behaviours of people accessing health care include:

- Ensuring adequate staffing levels and clinical skill-mix to provide appropriate care
- Providing training to members of the workforce about managing conflict
- Providing an environment that minimises potential for conflict
- Providing an environment that minimises the potential for self-harm.

These actions will support people with mental health issues, as well as other people in crisis.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.5 The health service organisation considers the safety and quality of health care for patients in its business decision-making

1.20c The health service organisation uses its training systems to provide access to training to meet its safety and quality training needs

1.29a The health service organisation maximises safety and quality of care through the design of the environment

5.31 The health service organisation has systems to support collaboration with patients, carers and families to:

- a. Identify when a patient is at risk of self-harm
- b. Identify when a patient is at risk of suicide
- c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed

5.33 The health service organisation has processes to identify and mitigate situations that may precipitate aggression

5.34 The health service organisation has processes to support collaboration with patients, carers and families to:

- a. Identify patients at risk of becoming aggressive or violent
 - b. Implement de-escalation strategies
 - c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce
-

Examples of supporting evidence

- Risk register documenting specific organisational risks related to health care delivery to population with mental health issues

Incident management systems and open disclosure

Action 1.11

The health service organisation has organisation-wide incident management and investigation systems, and:

- a. Supports the workforce to recognise and report incidents
- b. Supports patients, carers and families to communicate concerns or incidents
- c. Involves the workforce and consumers in the review of incidents
- d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers
- e. Uses the information from the analysis of incidents to improve safety and quality
- f. Incorporates risks identified in the analysis of incidents into the risk management system
- g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems

How does this action apply to people with mental health issues?

The identification and management of incidents provides valuable lessons to contribute to safety and quality improvement. Internal sources of information include incidents where harm has occurred, and near misses where serious harm has been averted.

Working within the incident reporting system that is in place within their state or territory, health service organisations can also use local definitions of what constitutes an incident. For example, mental health stakeholders would define any form of restraint as an incident, and expect that it is reported and integrated into a system designed to reduce the incidence of restraint. This is reflected in mental health legislation, and rates of restraint in mental health settings are now reported nationally.¹⁷ However, in some healthcare settings, restraint is regarded simply as an intervention to support delivery of safe care, and not counted as an incident. The health service organisation should develop clear guidelines so that members of the workforce can use the clinical incident reporting system effectively to improve care for people with mental health issues.

Support workforce to recognise and report incidents

An effective incident reporting system functions best when the workforce understand what constitutes a clinical incident for the purpose of reporting, how to report, and what happens once an incident is reported. Leadership is needed to ensure the incident reporting system is not misconstrued as being about apportioning blame to individuals, nor misused to harass others, or circumvent established reporting pathways to the governing body.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.20c The health service organisation uses its training systems to provide access to training to meet its safety and quality training needs

Support people accessing health care to communicate concerns or incidents

This action links to other actions about communicating for safety. The action also relates to culture; encouragement for a transparent reporting culture from organisational leadership should mean that clinicians support people using the service to openly communicate their concerns. To be effective, the process needs to include follow-up to respond to the concern, and communication back to the reporter about that follow-up.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.12 The health service organisation:

- a. Uses an open disclosure program that is consistent with the *Australian Open Disclosure Framework*
- b. Monitors and acts to improve the effectiveness of open disclosure processes

6.10 The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians

8.7 The health service organisation has processes for patients, carers or families to directly escalate care

Monitor action taken as a result of clinical incidents

The governing body needs to ensure that it is kept informed of incidents through regular reporting from the executive. The executive has responsibility for responding to incidents reported through the clinical incident monitoring system and implementing actions to improve service delivery. Effective use of the clinical incident monitoring systems should be supported through cultural means; building awareness in the workforce that speaking up about critical issues is welcome, and that individuals will not be blamed for errors arising from the system (unless investigation demonstrates this is warranted).

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.9a The health service organisation ensures that timely reports on safety and quality systems and performance are provided to the governing body

5.35c Where restraint is clinically necessary to prevent harm, the health service organisation has systems that report use of restraint to the governing body

5.36c Where seclusion is clinically necessary to prevent harm, the health service organisation has systems that report use of seclusion to the governing body

Examples of supporting evidence

- An accessible incident reporting system
- Safety and quality performance data that demonstrates incorporation of actions taken following review of clinical incidents
- Results of completed clinical incident investigations demonstrating involvement of members of the workforce and people who use services in the review of incidents

Feedback and complaints management

Action 1.13

The health service organisation:

- a. Has processes to seek regular feedback from patients, carers and families about their experience and outcomes of care
- b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems
- c. Uses this information to improve safety and quality systems

How does this action apply to people with mental health issues?

Feedback about people's experience of health care is an important element in determining the quality of care provided. It may not be apparent from existing data collection methods that a person accessing health care may have comorbid mental health issues, yet they may have important information for the health service organisation, or a local unit, about how this influenced their experience of care. This can include experiences of sub-optimal care that do not meet the threshold for them to make a formal complaint. Establishing processes for people to give their feedback in less formal ways will ensure this information is not lost.

Suggested strategies

Adopt a systematic approach to gathering feedback

The feedback system should be readily available, easy to use, and enable incorporation of feedback into quality improvement systems. An advantage of an effective feedback process over other information sources, such as complaints or critical incident reviews, is that feedback can provide positive information about aspects of a health service organisation that are working well in the view of the people who use the service. Feedback can also identify areas for improvement.

The health service organisation may need to work with individuals, and the community who use the service, to develop tools to elicit the information being sought, as standard data collection methods may not work.

Practice resource: Australian Hospital Patient Experience Question Set

Measuring patients' experiences of their treatment and care is an increasingly important focus of safety and quality efforts. To track patient experiences effectively, a validated and nationally consistent measurement tool is needed.

For this reason, the Commission has developed a set of 12 questions, known as the Australian Hospital Patient Experience Question Set (AHPEQS), which hospitals and day procedure services can use when asking patients what they observed and felt about their care. The question set will allow facilities to ask the same questions as facilities elsewhere, promoting comparability and more effective tracking of improvements over time. Access to the questions is available through the Commission's website at:

<https://www.safetyandquality.gov.au/our-work/indicators/hospital-patient-experience/>

Mental health services can also use the longer *Your Experience of Service* survey:

<https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/national-mental-health-committees/mental-health-information-strategy-standing-commit/your-experience-of-service-survey-instrument>

Ensure service users are aware of how to provide feedback

Include reference to the feedback system in information provided to people entering the service. Other avenues of advertising the feedback process include prominent links on health service organisation webpages, and posters in physical facilities.

Successful implementation of this strategy will be supported by, or rely on, the following action:

2.9 Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review

Close the loop by giving feedback to members of the workforce and people who use the service

Information can be published in newsletters, on noticeboards or on the organisation's webpage. Feedback can be incorporated as a standing item in regular meetings of members of the workforce. More informal methods, such as providing direct feedback to members of the workforce in clinical 'huddles' can also be used.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.9 The health service organisation ensures that timely reports on safety and quality systems and performance are provided to:

- b. The workforce
- c. Consumers and the local community

Examples of supporting evidence

- Data collection tools for collecting feedback from the workforce and people who use the service
- Committee or meeting records that demonstrate to the workforce and people who use the service that feedback has been used to inform quality improvement initiatives

Action 1.14

The health service organisation has an organisation-wide complaints management system, and:

- a. Encourages and supports patients, carers and families, and the workforce to report complaints
- b. Involves the workforce and consumers in the review of complaints
- c. Resolves complaints in a timely way
- d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken
- e. Uses information from the analysis of complaints to inform improvements in safety and quality systems
- f. Records the risks identified from the analysis of complaints in the risk management system
- g. Regularly reviews and acts to improve the effectiveness of the complaints management system

How does this action apply to people with mental health issues?

Complaints are a rich but underutilised source of information about patient risk.¹⁸ They allow for information to be gathered that is not always available through other sources. They also allow the critical voices of people who have used services and their families and carers to be heard, augmenting the information reported by members of the healthcare workforce.

The Mental Health Complaints Commissioner of Victoria reports complaints in key areas, including the use of restraint in health care settings outside mental health services, and sexual safety.¹⁹

Suggested strategies

Ensure a robust, accessible complaints reporting system

The health service organisation should create an effective complaints reporting system. This includes clear information about how to lodge a complaint and, when needed, support in doing this. Moreover, it should also include a culture that fosters respectful responses to complaints. If necessary, members of the workforce may need training about how to encourage people who have used the service to complain if they are dissatisfied. There should be no discouragement, explicit or implicit, to people lodging complaints, and people should experience no concern that it will compromise future interactions with the health service.

As with incident review, developing a culture that supports people to make complaints depends on agreement to treat issues as systemic, and focusing on seeking improvements. That said, where an individual may be at fault, appropriate processes should be followed, including referral to the Australian Health Practitioner Regulation Agency.

Involve people with experience of mental health issues, their families and carers, in review of complaints

The process for review of complaints should include participation by representatives of all the people who use the health service. Where a complaint relates to how the service responds to people with mental health issues, it is essential that the views of people with lived experience of mental health issues are included in the review of the complaint, and the development of a response.

Successful implementation of this strategy will be supported by, or rely on, the following action:

2.11a The health service organisation involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care

Use information from the analysis of complaints to inform improvements in safety and quality systems

Information from the analysis of complaints can be used to make improvements within the health service organisation. Through health care complaints commissions, they can also be used to inform improvements more broadly in the health system.

Examples of supporting evidence

- Visible information about process for making a complaint
- Minutes of complaint-review meetings indicating participation of people with experience of mental health issues
- Reports back to the workforce and community about improvements arising from review of complaints

Diversity and high-risk groups

Action 1.15

The health service organisation:

- a. Identifies the diversity of the consumers using its services
- b. Identifies groups of patients using its services who are at higher risk of harm
- c. Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care

How does this action apply to people with mental health issues?

The purpose of this user guide is to improve health care for people with mental health issues. The first step in doing this is to recognise the diversity of experience that people accessing health care have. Health service organisations need to acknowledge that:

- Many people who are receiving health care for physical health also have mental health issues
- People receiving health care have a range of diverse experience that can influence how they experience health care service delivery
- People can experience more than one type of diversity, and these intersections can further influence their experience within the health service organisation.

Many processes in the delivery of health care are developed to facilitate the effective delivery of health care to the majority of people. They do not necessarily reflect individual needs or preferences. Once these processes are routinely implemented, they can seem to be immutable, and the logic that led to their development can impede flexible implementation.

People with mental health issues have frequently reported experiencing sub-optimal care in health services.^{6,20} This includes people who experience stigma from members of the workforce. Incorporating understanding of how mental health can influence a person's experience in general health care into a service's diversity profile can reduce the risks of these negative experiences and other adverse outcomes occurring.

Many people who have experienced mental health issues have also experienced trauma.²¹ At times this may have occurred within health settings such as emergency departments. Receiving care again in such an environment can trigger negative feelings and unpredictable responses.

*The Fifth National Mental Health and Suicide Prevention Plan*⁹ identifies a number of populations with specific mental health needs, including Aboriginal and Torres Strait Islander people, lesbian, gay, bisexual, transgender, intersex and queer people (LGBTIQ), people with intellectual disability, people in rural and remote Australia, people in the military and veterans, perinatal women, migrants, refugees and other people from culturally and linguistically (CALD) backgrounds.⁹ Resources to implement actions in the NSQHS Standards for some of these groups are described below. Mental health needs are also different for people across the lifespan, with children and adolescents, and older Australians experiencing mental health issues that are not always effectively addressed by adult services.

People can belong to multiple groups, and there are intersections and tensions that must be taken into account. For instance, people who identify as Aboriginal and LGBTIQ report experiencing homophobia from some Aboriginal community members, and racism from some members of LGBTIQ communities. This exposes them to increased risk of harm.²²

Suggested strategies

Include mental health as a focal issue when identifying the population accessing care

Information about the population that accesses a health service organisation can be gathered from multiple sources. Screening for experience of mental health issues on admission supports both the direct delivery of care, and service-level understanding of prevalence. Linkages with partner organisations, such as Primary Health Networks, will also provide information about local needs.

Surveys of people who have used the health service can also be a source of information. Use the Australian Hospital Patients Experience Question Set, outlined in Action 1.13 in this guide.

Successful implementation of this strategy will be supported by, or rely on, the following action:

5.10 Clinicians use relevant screening processes:

- a. On presentation, during clinical examination and history taking, and when required during care
- b. To identify cognitive, behavioural, mental and physical conditions, issues and risks of harm
- c. To identify social and other circumstances that may compound these risks

Provide training to the workforce on delivering trauma-informed care

Trauma-informed care, as it is understood in contemporary mental health discourse, may be a new term for general health clinicians, who may be more used to understanding trauma in terms of physical damage. However, the prevalence and effects of trauma are increasingly recognised in national and international policy. For example, the delivery of trauma-informed care and practice is recommended in *The Fifth National Mental Health and Suicide Prevention Plan*.⁹

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.20c The health service organisation uses its training systems to provide access to training to meet its safety and quality training needs

Practice resource: Trauma-informed care

The Scottish National Health Service has developed *Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce*,²³ which includes guidance about trauma informed practice for all members of the workforce. The Framework gives examples of what workers can do to achieve outcomes.

Outcome	What workers know (knowledge)	What workers can do (capability/skill/ability)
The widespread occurrence and nature of trauma is realised	<p>All workers understand:</p> <ul style="list-style-type: none"> • That a person affected by trauma might understandably want to avoid people, places or situations that remind them and bring back distressing memories of the trauma and associated feelings 	<p>All workers can:</p> <ul style="list-style-type: none"> • Identify the kinds of experiences that are traumatic • Identify the types of situations that can bring back memories of the trauma and associated feelings
The different ways in which trauma can affect people are recognised	<p>All workers understand:</p> <ul style="list-style-type: none"> • That trauma can affect people in different ways • That the consequences of trauma can affect people's ability to successfully access the care, support and treatment they require in a range of settings (for examples physical health, mental health, education, justice, employment, housing) 	<p>All workers can:</p> <ul style="list-style-type: none"> • Listen when a person speaks about his or her experiences of trauma and/or abuse • Respond to the person with empathy and without criticism or blame • Respond to the person by asking what help (if any) he or she needs • Hold in mind that a person's behaviour or reactions might be trauma-related • Make sense of a person's current difficulties by considering 'What happened to you?', instead of 'What's wrong with you?', in responding to a person affected by trauma

(Table adapted from *Transforming Psychological Trauma*).

The Framework is available to download at:

<http://www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf>

Understand approaches to meet mental and physical healthcare needs of diverse populations

There are many resources available to support health service organisations to provide effective responses to people with diverse needs. A selection is included in the guide, and summarised in Appendix B. The Commission is keen to hear of further examples that could be captured in a website. Suggestions can be emailed to:

mentalhealth@safetyandquality.gov.au

Aboriginal and Torres Strait Islander people

The NSQHS Standards contain six actions specifically designed to support health service delivery to Aboriginal and Torres Strait Islander people. The Commission has developed a user guide to support implementation of these actions. The *NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health* is available on the Commission's website at:

<https://www.safetyandquality.gov.au/wp-content/uploads/2017/12/National-Safety-and-Quality-Health-Service-Standards-User-Guide-for-Aboriginal-and-Torres-Strait-Islander-Health.pdf>

Practice resource: Health in Culture – Policy Concordance

There are many useful resources to support Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing.

National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) has developed a policy concordance to map the interconnectedness of Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health and suicide prevention policy. The document is available at:

<http://natsilmh.org.au/sites/default/files/NATSILMH%20Health%20in%20Culture%20Policy%20Concordance%20%282%29.pdf>

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.4 The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people

People with intellectual disability

People with intellectual disability who also have mental health issues frequently experience problems when accessing health services. These problems are often related to communication problems, and a lack of capacity among clinicians to identify and effectively respond to the full range of people's needs.

Practice resource: Intellectual disability mental health e-learning

3DN provides free elearning about intellectual disability to professionals, carers and consumers. The course is made up of 17 modules which provide a comprehensive guide to working effectively with people who experience both intellectual disability and mental health disorders.

About Intellectual Disability

- Module 1: Introduction to Intellectual Disability
 - Module 2: Living with an Intellectual Disability
 - Module 3: Intellectual Disability – Changing Perspectives
-

Fundamental Skills in IDMH

- Module 4: Communication: The Basics
 - Module 5: Improving your Communication
 - Module 6: Equality in Mental Health Care – A Guide for Clinicians
 - Module 7: Consent, Decision-making & Privacy – A Guide for Clinicians
-

Clinical Skills in IDMH

- Module 8: Mental Disorders in Intellectual Disability
 - Module 9: Assessment of Mental Disorders in Intellectual Disability
 - Module 10: Management of Mental Disorders in Intellectual Disability
-

Specialist Topics in IDMH

- Module 11: Challenging Behaviour I – Introduction
 - Module 12: Challenging Behaviour II – Assessment
 - Module 13: Challenging Behaviour III – Management
 - Module 14: Emergency Mental Health Care 1: Understanding Intellectual Disability in the Emergency Department
 - Module 15: Emergency Mental Health Care 2: Journey Through the Emergency Department
-

Cardiometabolic Health

- Cardiometabolic Health in People with Intellectual Disability – Understanding Risk
 - Cardiometabolic Health in People with Intellectual Disability – Screening and Intervention Strategies
-

Registration is free, and more information is available at:

<http://www.idhealtheducation.edu.au/>

Veterans

People who have served in Australia's and other defence forces can experience a range of physical and mental health conditions, including post-traumatic stress disorder (PTSD) and misuse of substances. They may, or may not have good understanding of these conditions, their own triggers, and strategies for ameliorating risks.

Practice resource: Department of Veterans' Affairs 'At Ease' website

'At Ease' is a website providing the serving and ex-serving community with tailored mental health tools and resources. As well as tools to help people recognise the signs of mental distress, take action and maintain higher levels of wellness, this website includes resources for health care professionals engaging with veterans. The health care professionals' page is at:

<https://at-ease.dva.gov.au/professionals>

LGBTIQ people

LGBTIQ Australians have higher rates of mental health issues than the general population, frequently as a result of experience of stigma and discrimination, including from family members and members of the healthcare workforce.

Practice resource: LGBTI Health Alliance Cultural Competency Implementation Framework

The LGBTI Health Alliance developed the *Cultural Competency Implementation Framework* to support health service organisations to achieve inclusive practice with LGBTI communities. The Framework includes a set of principles, suggested strategies, and scenarios designed to increase knowledge and understanding of LGBTI people. It is available at:

<https://www.lgbtihealth.org.au/sites/default/files/Cultural%20Competency%20Implementation%20Framework.pdf>

Women in the perinatal period

One in ten women who are pregnant experience some form of mental illness, including depression and anxiety. The rate is slightly higher for women who have given birth. The needs of these women, their children and other family members require specific responses.⁹

Practice resource: Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline²⁴

The Centre of Perinatal Excellence (COPE) released guidelines in 2017 to support health professionals in providing evidence-based care. The guidelines were approved by the National Health and Medical Research Council for five years, and are available at:

http://cope.org.au/wp-content/uploads/2018/05/COPE-Perinatal-MH-Guideline_Final-2018.pdf

The COPE website also contains information on working through the emotional challenges of becoming and being a parent. The website is at:

<http://cope.org.au/>

People from culturally and linguistically diverse (CALD) backgrounds

People from CALD backgrounds experience barriers to health service utilisation, including language barriers, cultural misunderstanding, stigma and discrimination.

Practice resource: Mental Health in Multicultural Australia (MHiMA) Framework: Towards culturally inclusive service delivery

This Framework was initially released in 2014. It was developed to help health service organisations to evaluate their cultural responsiveness and develop action plans to enhance their delivery of services to CALD communities. The Framework and supporting resources are available at:

<http://framework.mhima.org.au/framework/index.htm>

Mental Health Australia is undertaking a project building on the MHiMA framework to provide a national focus on mental health and suicide prevention for people from CALD backgrounds. Further information is available at:

<https://mhaustralia.org/national-multicultural-mental-health-project>

Examples of supporting evidence

- Clinical audit of screening for mental health issues
- Membership of committees with representation that includes people with experience of mental health issues
- Information from patient experience of care surveys

Safe environment for the delivery of care

Safe environment

Action 1.29

The health service organisation maximises safety and quality of care:

- a. Through the design of the environment
- b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that is fit for purpose

How does this action apply to people with mental health issues?

Health service environments are stressful – they are brightly lit, noisy and constrained. This can exacerbate stress for people who are already experiencing distress. There can also be elements within hospitals that can present potential risks for people with thoughts of self-harm.

Suggested strategies

Design healthcare environments with the flexibility to support safe delivery of care

Good design of the environment can support quality care. Natural light and fresh air are therapeutic. Use of colour and furnishings creates a welcoming environment.

Engage people with experience of mental health issues in co-design of the environment. This is one of the key recommendations in the *Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities*.²⁰

Successful implementation of this strategy will be supported by, or rely on, the following action:

2.11a The health service organisation involves consumers in the governance of, and to design, measure and evaluate, health care

Ensure the healthcare environment minimises risks related to unpredictable behaviour

Effective design of the environment in which care is delivered can directly support safe care. When a person has thoughts of self-harm, an environment which reduces the potential for them to act on these thoughts is essential. Removal of potential ligature points, and the use of collapsible rails for curtains and shower screens has the highest level of evidence as a means of reducing suicide. Similarly, reducing access to unsecured heights reduces risk.

Examples of supporting evidence

- Observation of design of the environment to reduce risks relating to self-harm
- Minutes of planning meetings that document consumer involvement
- Maintenance schedule

Action 1.30

The health service organisation:

- a. Identifies service areas where there is a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce
- b. Provides access to a calm and quiet environment when it is clinically required

How does this action apply to people with mental health issues?

Within any health setting, there are physical spaces where there is a higher potential for stress and conflict. These include high-traffic areas, and the entrances to nursing stations or staff offices.

This can also apply to specific times in which ward routines are conducted. When a significant proportion of clinical staff are involved in handover or ward rounds, people can get frustrated at a perceived lack of responsiveness to clinical or other needs. Waiting for transport for tests, or discharge medications, while understood by staff as ordinary, may be experienced as unusual delays by people and their families.

There is evidence that emergency departments are particularly stressful environments for people with mental health issues.^{6,20} In emergency department waiting rooms, people with a range of presenting problems are crowded together, uncertain about what is about to happen, and frequently frustrated by actual or perceived delays in accessing treatment.

Suggested strategies

Identify potential flashpoints

Review incident logs to determine if the frequency and severity of incidents are correlated to specific locations or times. Determine if these routines can be modified, to reduce the likelihood of causing stress.

If processes cannot be modified, determine if people and their families are given adequate information about expected timeframes involved in hospital processes.

Successful implementation of this strategy will be supported by, or rely on, the following action:

5.33 The health service organisation has processes to identify and mitigate situations that may precipitate aggression

Provide environments that can be adapted to meet different needs

People respond to stress in different ways, and have different needs in terms of environmental response. A calm and quiet environment is clinically appropriate for a person experiencing agitation and aggressive feelings. Conversely, a person with thoughts of self-harm may consider being moved to a space on their own as isolating, and may require one-to-one nursing until they have been assessed and treatment has been initiated.

Contemporary research has shown promising results for the use of basic sensory modulation strategies in emergency departments.²⁵ These include the use of simple equipment such as fidget-spinners to assist people to manage their anxiety or frustration while awaiting treatment.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.29 The health service organisation maximises safety and quality of care:

- a. Through the design of the environment
 - b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that is fit for purpose
-

Examples of supporting evidence

- Observation of flexible use of the environment to meet clinical need
- Review of incidents
- Access to sensory modulation equipment

2

Partnering with Consumers Standard



Partnering with Consumers Standard



The intention of the Partnering with Consumers Standard is to create an organisation in which there are mutually valuable outcomes by having:

- Consumers who are partners in planning, design, delivery, measurement and evaluation of systems and services
- Patients as partners in their own care, to the extent that they choose.

The four criteria are:

Clinical governance and quality improvement systems to support partnering with consumers

Partnering with patients in their own care

Health literacy

Partnering with consumers in organisational design and governance

A major development in the second edition of the NSQHS Standards is the inclusion of actions related to partnering with consumers in the direct delivery of care. Actions within the Partnering with Consumers Standard closely align with the principles of recovery-oriented mental health practice.

There are two ways in which this standard has specific applicability for delivering services to people with mental health issues. First, many people who experience mental health issues have years of experience of symptoms and treatment. They have extensive knowledge of what can exacerbate their symptoms, and what helps to mitigate risks. This knowledge is individual, but is frequently shared, formally or informally, with family members, carers and health workers. Acknowledging the expertise that people hold in their own treatment, and integrating this into treatment plans that also address other health conditions creates the best opportunity to achieve optimal mental and physical health outcomes.

The second factor that influences partnering with consumers is that there are times when a person's symptoms of mental health issues can impair their capacity to participate in shared decision making. Health service organisations can implement practices in these cases that are consistent with legislation and recovery-oriented practice.

Partnering with patients in their own care

Healthcare rights and informed consent

Action 2.4

The health service organisation ensures that its informed consent processes comply with legislation and best practice

How does this action apply to people with mental health issues?

The usual processes for informed consent in health care apply to people with mental health issues. However, there are some additional considerations related to determining a person's capacity to consent to treatment when they are intoxicated or acutely unwell. These are particularly relevant in emergency departments.

Mental health, guardianship and disability service legislation includes provisions for health services to be delivered to people without their informed consent in specific circumstances. It is critical that members of the workforce are aware of when they can use legislation, and the limits of their powers under legislation. This applies to treatment provided for mental health issues, such as rapid tranquilisation, as well as to treatment for physical problems.

Suggested strategies

Review current informed consent processes

Support informed consent through safety and quality systems across all areas of the organisation that ensure that specific consent requirements established by state or territory legislation, such as mental health acts, are complied with.

Support informed consent through education and training for all members of the clinical workforce in the legal, ethical and practical foundations of requirements for consent.

Mental health legislation is subject to periodic review. Ensure that the health service organisation provides support to the workforce to understand changes in legislation, and how these may have an impact on informed consent processes in their local contexts.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.7c The health service organisation uses a risk management approach to review compliance with legislation, regulation and jurisdictional requirements

Develop local policies and procedures that support the workforce to deliver health care

The service needs to have a policy that covers the rights and responsibilities of members of the workforce when they determine the need to invoke mental health, or other legislation to provide treatment to a person who does not consent to be treated. The policy needs to extend to non-clinical members of the workforce. In particular, security personnel in emergency departments need clear knowledge about their role, and the limits of 'duty of care' in situations where a person deemed at risk is refusing health care and leaving the facility.

See, for example, *NSW Ministry of Health Policy Directive PD2018_010: Emergency Department Patients Awaiting Care*, which states:

People brought to the ED under the *Mental Health Act* by Police are not to be handed over to NSW Health security staff only. Security staff should act under the direction of the lead clinician and undertake actions consistent with the scope of their role.²⁶

Successful implementation of this strategy will be supported by, or rely on, the following action:

- 1.20** The health service organisation uses its training systems to:
- a. Assess the competency of its training needs
 - c. Provide access to training to meet its safety and quality training needs

Examples of supporting evidence

- Policy documents for informed consent that are consistent with legislation and best practice
- Review process to ensure local policy remains consistent with current legislation
- Training documents on informed consent processes
- Written information for consumers, their carers and families about informed consent to treatment

Action 2.5

The health service organisation has processes to identify:

- a. The capacity of a patient to make decisions about their own care
- b. A substitute decision maker if a patient does not have the capacity to make decisions for themselves

How does this action apply to people with mental health issues?

Mental health legislation in some states and territories describes how to determine capacity to make decisions.

Suggested strategies

Mental health legislation in several states and territories includes specific provisions detailing health service responsibilities in determining a person's capacity to make decisions about their own care. These provisions apply for people who are on involuntary treatment orders as well as voluntary admissions.

Clinicians need to practise within the law. Informed clinicians maintain current knowledge of changes in legislation, and how these govern what steps they must take to ensure they ascertain a person's capacity to participate in decision making about their care. The health service organisation will support all clinicians by ensuring policies and procedures are consistent with current legislation and providing ongoing training to clinicians.

Documentation of steps to determine capacity to participate in decision making should be entered in the clinical record. Documentation templates should prompt clinicians to record if a substitute decision maker is involved in a person's care.

Practice resource: SA Health Impaired Decision-Making Capacity Factsheet

SA Health has developed a fact sheet that guides clinicians on the steps they need to take to properly determine if a person genuinely has the capacity to give informed consent to treatment. The Factsheet refers to legislation specific to South Australia, but the questions that guide the process are applicable in all states and territories. The Factsheet is available at:

<http://www.sahealth.sa.gov.au/wps/wcm/connect/8a241b804459db088a0daa76d172935c/Assessing+Capacity+Fact+Sheet+PC+20140613.pdf?MOD=AJPERES&CACHEID=8a241b804459db088a0daa76d172935c>

It is important to emphasise that to do these actions effectively, the person's communication strengths and weaknesses must be properly understood. Where necessary, alternative means of communicating information to the person, and alternative means for the person to express their preferences and choices, should be considered. Use of interpreters is one important strategy. In some cases, engaging speech pathologists in the assessment of people's communication needs will also ensure that capacity to participate in shared decision making is adequately supported.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.7c The health service organisation uses a risk management approach to review compliance with legislation, regulation and jurisdictional requirements

Examples of supporting evidence

- Policy documents about identifying a person's capacity for making decisions about their care, which are consistent with legislation
- Training for the workforce about determining capacity for shared decision making
- Written information for consumers, their carers and families about healthcare decision making capacity
- Audit of healthcare records that demonstrate documentation of process for determining a person's capacity to make decisions about their health care

Sharing decisions and planning care

Action 2.6

The health service organisation has processes for clinicians to partner with patients and/or their substitute decision maker to plan, communicate, set goals and make decisions about their current and future care

How does this action apply to people with mental health issues?

Shared decision making incorporates all aspects of a person's health care.

One effective strategy used by people with experience of mental health issues is to develop advance care plans, or consumer wellness plans. An example of a consumer wellness plan is at Appendix C. Consumer wellness plans contain information about a person's choices and preferences for the ongoing care of their mental health.

Note that, while these plans share terminology with advance care directives for end-of-life care, the two processes should not be confused. For situations where people with mental health issues are faced with end-of-life decisions, the NSW Ministry of Health has produced a comprehensive guide²⁷ to support people with mental illness who are making end-of-life decisions, which is available at:

<http://www.health.nsw.gov.au/patients/acp/Publications/comprehensive-guide.pdf>

Suggested strategies

Integrate consumer wellness plans into shared decision making

One of the first steps in integrating a person's consumer wellness plan into shared decision making processes is asking if the person has such a plan. As consumer wellness plans are typically developed when the person is well, they can often include useful details that the person may not recall when stressed, such as when being admitted to hospital for treatment of a physical problem. Consumer wellness plans also include information about the person's individual signs that may indicate deterioration in their mental state. This gives clinicians a form of baseline against which they can compare their current observations. Consumer wellness plans also contain information about particular strategies that help the person manage their mental health.

Discussing the consumer wellness plan can make the conversation about mental health issues easier for the person and clinicians. Use of the plan also saves the person from having to explain details about their health history multiple times to different members of the workforce. Health service organisations can support this process by routinely integrating existing wellness plans into care planning processes.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.15c The health service organisation incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care

5.13 Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan

Incorporate carers in the planning, delivery and evaluation of health care

Carers play a significant role in supporting people with mental health issues to maintain their physical and mental health. Yet carers frequently report feeling sidelined when a person enters an acute treatment facility. It is important that members of the workforce do not simply treat carers as sources of information, but as genuine partners throughout the processes of shared decision making.

There are occasions when people receiving health care do not wish to have carers or family members involved in decisions about their health care. Members of the workforce have to respect these wishes, unless they determine there is imminent risk to the safety of the person or others. The rights of people and receiving care and carers are contained in national, state and territory legislation.

Practice resource: A practical guide for working with carers of people with a mental illness

A consortium of organisations representing mental health consumers and carers has developed *A practical guide for working with carers of people with a mental illness*.²⁸ The guide describes key actions a health service organisation can do when partnering with carers.

These include:

- Recognising who carers are and acknowledging the importance of their role
- Always welcoming carers and enquiring about their reason for visiting or contacting the service
- Requesting information from carers to assist with the care and support of the consumer
- Providing information about our service, including its purpose and how it can be contacted
- Providing information about carer rights and responsibilities
- Asking if carers have any questions and do our best to answer them
- Explaining what can, and cannot, be discussed
- Referring carers to separate carer information and support services
- Ensuring carers are fully engaged in all stages of care

The guide is available at:

<https://mhaustralia.org/media-releases/practical-guide-working-carers-of-people-mental-illness>

Examples of supporting evidence

- File audit indicating integration of consumer wellness plans into shared decision making processes
- File audit indicating inclusion of carers in decision making

Action 2.7

The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care

How does this action apply to people with mental health issues?

Clinicians working outside the speciality of mental health have reported uncertainty and lack of confidence in their capacity to manage people presenting with mental health problems. For some clinicians, it is uncomfortable to practise outside the specialty in which they feel confident.

People with mental health issues and their carers have reported being subject to stigma and discrimination from healthcare workers. One reported manifestation of this is being treated with the attitude of 'we treat everyone the same' which, while superficially equitable, in fact erases the specific health needs that people with mental health issues have.

The previous experiences of clinicians, people with mental health issues and their carers and families can inhibit the formation of successful partnerships, especially if these experiences have involved trauma.

When a health service organisation supports the workforce to develop knowledge and skills in their roles in managing mental health issues, this reduces clinicians' lack of confidence, and can contribute to a reduction in discriminatory practices.

Suggested strategies

Support the workforce to deliver person-centred, recovery-focused care

The *National framework for recovery-oriented mental health services: guide for practitioners and providers*¹² states that recovery-oriented practice:

Maximises self-determination and self-management of mental health and wellbeing and involves person-first, person-centred, strengths-based and evidence-informed treatment, rehabilitation and support.

These principles can be incorporated into the approach to care delivery in general health settings as well as specialist mental health services.

Identify specific training needs for clinicians about partnering with consumers around mental health issues and deliver targeted training to address these needs

The landmark study on the experience of people with mental health issues in general hospitals in the United Kingdom, *Treat as One: Bridging the gap between mental and physical healthcare in general hospitals*²⁹ includes the recommendation:

All hospital staff who have interaction with patients, including clinical, clerical and security staff, should receive training in mental health conditions in general hospitals. Training should be developed and offered across the entire career pathway from undergraduate to workplace-based continued professional development.

Training is resource intensive, and opportunities for members of the workforce are frequently limited. Therefore, training and education should be targeted to identified need. Clinicians who have recently completed undergraduate or post-graduate courses are likely to have some contemporary theoretical knowledge about approaches to mental health care. Frontline clinicians in small regional hospitals may have extensive practical experience of managing a range of problems that people present with, including intoxication. The health service organisation will achieve more with its education resources by delivering training that meets the workforce's needs.

Practice resource: Consultation liaison nurses' top tips

The Australian College of Mental Health Nurses' Consultation Liaison Special Interest Group publishes a list of issues that typically face consultation liaison nurses:

<http://www.acmhn.org/images/stories/CLSI/ToptipsforCLnurses.pdf>

These comprehensively cover the types of requests consultation liaison nurses receive, and highlight the critical importance of effective response to delirium, which is frequently associated with acute deterioration in a person's mental state.

In addition to capturing the types of issues related to mental health that members of the workforce may need support with, the Top Tips also emphasise that each referral is an opportunity to provide targeted education to colleagues with different specialist expertise.

Successful implementation of this strategy will be supported by, or rely on, the following action:

- 1.20** The health service organisation uses its training systems to:
 - b. Assess the competency of its training needs
 - d. Provide access to training to meet its safety and quality training needs

Provide adequate time for clinicians to genuinely partner with consumers

Providing person-centred care entails members of the workforce addressing the individual's health and wellbeing goals, in collaboration with their existing support networks. When a person's mental health is recognised as a key component of their health, integrating mental health care into the comprehensive care plan is core business for the health service organisation.

Clinicians may have the skills and desire to be able to deliver person-centred care, but they also require organisational support. Historically, this has best been achieved by shifting care away from a task-oriented approach to a person-centred one.

Practice resource: Releasing Time To Care/ The Productive Ward

The productive ward is an initiative developed in the United Kingdom to address the issue of the disproportionate amount of time clinical staff are required to complete administrative tasks, and the pressure this puts on them in also providing direct delivery of care. The program has been implemented in both general and mental health inpatient units. There is evidence that the program improves outcomes in the quality and efficiency of health care. More information is available at:

<http://www.health.nsw.gov.au/nursing/Pages/releasing-time-to-care.aspx>

Successful implementation of this strategy will be supported by, or rely on, the following action:

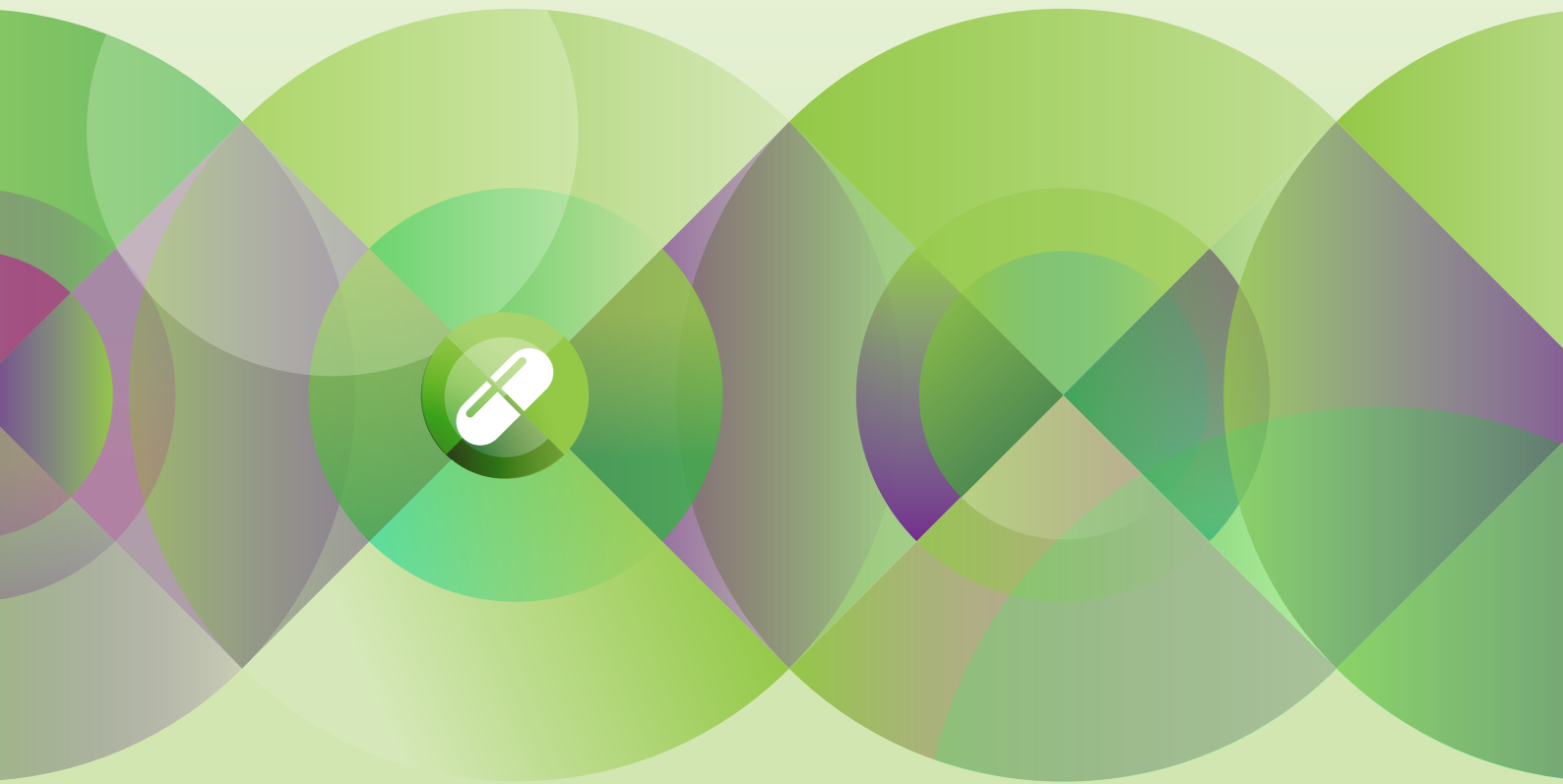
1.5 The health service organisation considers the safety and quality of health care for patients in its business decision-making

Examples of supporting evidence

- Training programs for clinicians about strategies for managing mental health issues
- Results from patient experience surveys reporting all healthcare needs were met

4

Medication Safety Standard



Medication Safety Standard



The purpose of the Medication Safety Standard is to ensure clinicians are competent to safely prescribe, dispense and administer appropriate medicines and to monitor medicine use. In addition to this, the Medication Safety Standard aims to ensure consumers are informed about medicines and understand their individual medicine needs and risks.

The four criteria are:

Clinical governance and quality improvement to support medication management

Documentation of patient information

Continuity of medication management

Medication management processes

Medication forms a key part of treatment for many people with mental health issues. However, use of medicines is frequently associated with adverse events, many of which are avoidable.³⁰ By using medication safety systems and partnering with consumers, members of the workforce can effectively reduce the risks of preventable adverse medication events.

Documentation of patient information

Medication reconciliation

Action 4.5

Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care

How does this action apply to people with mental health issues?

Interruption in routine medication can lead to recurrence of symptoms for people with mental health issues. This can have an impact on their capacity to participate in shared decision making, and lead to poor outcomes in both mental and physical health.

In the study *Treat as One: Bridging the gap between mental and physical healthcare in general hospitals*,²⁹ the researchers identified marked variance between medication reconciliation of medications for physical and mental health conditions. This variance occurred both on admission and in subsequent clinical reviews. This resulted in people not receiving their appropriate medication, and experiencing sub-optimal health outcomes. The data confirmed experiences reported by people with mental health histories in Australia.³⁰

Many people with previous experience of mental health issues have consumer wellness plans (see Action 2.6). These typically include information on what treatments, including medications, have been effective in the past, and which have caused problems. The consumer wellness plan can be referred to as part of taking a best possible medication history (BPMH).

Suggested strategies

Ensure equity of medication reconciliation

It has been noted that specific techniques for taking a BPMH can influence its accuracy. The first part of the process is for clinicians to ensure their history-taking is comprehensive, and not focused exclusively on the particular presenting problem in the current episode of care, but also includes prior history of treatment for other conditions. More broadly, clinicians will have to ensure they are not practising in a way that stigmatises mental health issues, and inadvertently discourages a person from disclosing their existing treatment.

The Commission provides a template for a medication management plan on its website at:

<https://www.safetyandquality.gov.au/wp-content/uploads/2010/01/Medication-Management-Plan.pdf>

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.15c The health service organisation incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care

4.3a Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to actively involve patients in their own care

Examples of supporting evidence

- Training documents about taking and documenting a BPMH
- Audit results of healthcare records for documentation of a BPMH

Action 4.6

Clinicians review a patient's current medicine orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care

How does this action apply to people with mental health issues?

It is not unusual when a person is treated for physical health care that all routine medications are temporarily ceased by the treating team. This can occur for diagnostic purposes, that is, to rule out an adverse drug reaction as potential cause for a presenting problem. It can also occur as part of protocols, for example, prior to surgery. If a person's regular medications are not reinstated, they can experience recurrence of symptoms and withdrawal syndromes that can manifest as exacerbations of mental illness. These risks can be mitigated if accurate medication reconciliation occurs at all transitions of care.

Another problem that is frequently experienced by people with mental health issues is that medication that has been initiated for specific purposes during hospital admissions is not formally ceased prior to discharge. Even when it is intended that medication be continued post-discharge for a brief period (for example, a short-term anxiolytic), if this is not clear, people can continue to be prescribed, and take medication long-term, with negative consequences. Ensuring that clear information about medications is included in discharge planning and documentation will reduce this risk.

Suggested strategies

Ensure medication reconciliation at all transitions of care

Medication reconciliation can occur:

- On admission
- During the episode of care
- On discharge.

Medication reconciliation forms an integral part of the information about a person's health care that needs to be communicated whenever care is transferred. The system to document medication reconciliation should align seamlessly with other clinical handover processes.

Successful implementation of this strategy will be supported by, or rely on, the following action:

6.8f Clinicians use structured clinical handover processes that include ensuring that clinical handover results in the transfer of responsibility and accountability for care

Practice resource: National Quality Use of Medicines Indicators for Australian Hospitals

In 2014, the Commission funded the NSW Therapeutic Advisory Group to revise the Quality Use of Medicines (QUM) indicators to align with contemporary evidence. The *National QUM Indicators 2014* include a set of indicators for use in acute mental health care. These are:

- 7.1 Percentage of as required (PRN) psychotropic medication orders with documented indication, dose (or dose range), frequency and maximum daily dose specified
- 7.2 Percentage of patients taking lithium who receive appropriate monitoring during their inpatient episode
- 7.3 Percentage of patients who receive written and verbal information on regular psychotropic medicines initiated during their admission
- 7.4 Percentage of patients taking antipsychotic medicines who receive appropriate monitoring for the development of metabolic side effects
- 7.5 Percentage of patients prescribed two or more regular antipsychotic medicines at hospital discharge

These indicators are applicable in all hospital settings where people are prescribed medication for mental health issues. The mental health specific set is available at:

<http://www.nswtag.org.au/qum-indicators-set-7/>

The complete set of indicators is at:

https://www.safetyandquality.gov.au/wp-content/uploads/2014/11/SAQ127_National_QUM_Indicators_V14-FINAL-D14-39602.pdf

Engage the person, their carers, and clinicians involved in their ongoing care in medication reconciliation processes

People who live with longstanding health conditions, including mental health issues, have substantial experience with medication. They assume responsibility for maintaining their health by incorporating medication routines into their everyday lives, sometimes with the support of carers or family members. This knowledge and experience is a useful resource during brief episodes of care, often provided by clinicians who will have a transient relationship with the person.

Strategies can be as simple as checking with the person or their carers that the medication they are currently prescribed is consistent with their usual regime, unless agreed changes have been initiated.

Successful implementation of this strategy will be supported by, or rely on, the following action:

4.3 Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to:

- a. Actively involve patients in their own care
- b. Meet the patient's information needs
- c. Share decision-making

Examples of supporting evidence

- Standardised tools that align medication reconciliation with clinical handover
- Healthcare record audit results documenting engagement of the person and their families in medication reconciliation

Adverse drug reactions

Action 4.7

The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation

How does this action apply to people with mental health issues?

Many people with mental health issues take medication for years. They may have significant past experience with a medication, including adverse drug reactions, that is not part of their recent treatment.

Suggested strategies

Use the medication management plan to document historical adverse drug reactions as well as currently noted adverse drug reactions

Information about earlier adverse drug reactions is frequently recorded in a person's consumer wellness plan (see Action 2.6). Integrating information from consumer wellness plans into current medication management plans will ensure they provide a comprehensive summary of all of a person's medication history.

Successful implementation of this strategy will be supported by, or rely on, the following action:

2.6 The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care

Examples of supporting evidence

- Standardised tools for recording documentation of adverse drug reactions
- Audits of healthcare records to confirm consistency of adverse drug reaction documentation across relevant documents, including medication charts

5

Comprehensive Care Standard



Comprehensive Care Standard



The intention of the Comprehensive Care Standard is to ensure that people receive comprehensive care – that is, coordinated delivery of the total health care required or requested by a person. This care is aligned with the person’s expressed goals of care and healthcare needs, considers the impact of the person’s health issues on their life and wellbeing, and is clinically appropriate.

In addition to outlining comprehensive care, this standard is intended to ensure that risks of harm for people during health care are prevented and managed. Clinicians identify people at risk of specific harm during health care by applying the screening and assessment processes required in this standard.

The four criteria are:

Clinical governance and quality improvement to support comprehensive care

Developing the comprehensive care plan

Delivering comprehensive care

Minimising patient harm

The Commission is working with key stakeholders to develop additional resources to support implementation of the Comprehensive Care Standard. The first of these are available on the Commission’s website at:

<https://www.safetyandquality.gov.au/our-work/comprehensive-care/>

In recognition of the fact that people with mental illness frequently experience sub-optimal physical health, the National Mental Health Commission developed the Equally Well Consensus Statement, elements of which align directly with actions in the Comprehensive Care Standard.

Practice resource: Equally Well consensus statement

The National Mental Health Commission led the development of a consensus statement, *Equally Well: Improving the physical health and wellbeing of people living with mental illness in Australia* (Equally Well).³¹ Equally Well aims to build on work that had already begun to address the mortality gap experienced by people with mental health issues. The consensus statement is available at:

<https://equallywell.org.au/getinvolved/>

Equally Well calls on health service organisations to commit to the following actions:

‘We will improve the physical health of people living with mental illness by acting to deliver:

1. a holistic, person centred approach to physical and mental health and wellbeing
2. effective promotion, prevention and early intervention
3. equity of access to all services
4. improved quality of health care
5. care coordination and regional integration across health, mental health and other services and sectors which enable a contributing life
6. the monitoring of progress towards improved physical health and wellbeing.’

Developing the comprehensive care plan

Screening of risk

Action 5.10

Clinicians use relevant screening processes:

- a. At presentation, during clinical examination and history taking, and when required during care
- b. To identify cognitive, behavioural, mental and physical conditions, issues and risks of harm
- c. To identify social and other circumstances that may compound these risks

How does this action apply to people with mental health issues?

This is a new action in the second edition of the NSQHS Standards. The intent is that, regardless of the setting in which health care is delivered, people are screened for risks to their physical, mental or cognitive health. The purpose of screening is to identify risks, and develop strategies to mitigate those risks before problems occur.

People with experience of mental health issues have reported problems with general health services that adopt a 'one-size-fits-all' approach, typically articulated as 'we treat everyone the same'. The problem with this approach is that it too easily misses the particular health needs an individual may have. While it may be true that some interventions for a general health problem will be similar for most members of the population, the way in which health care is delivered should be modified to meet the individual's needs, values and preferences.

Another problem experienced by people with mental health issues when they present for physical health care is termed 'diagnostic overshadowing'.³² This describes the situation where clinicians focus on the person's mental health issues, and do not comprehensively screen the person's physical needs. This is associated with significant harms occurring to people.

Suggested approaches

Provide clinicians with training in person-centred approaches to screening

A problem identified with screening for risks is that they are treated as 'tick and flick' exercises. The way that questions are asked can act as a deterrent to people disclosing mental health issues, particularly given many people's experience of stigma when accessing health services. The provision of a screening tool is not enough to guarantee an individual's healthcare needs are wholly met. The workforce needs to act to address all of a person's identified healthcare needs with empathy and respect.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.15b The health service organisation identifies groups of patients using its services who are at higher risk of harm

1.20c The health service organisation uses its training systems to provide access to training to meet its safety and quality training needs

5.3 Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:

- a. Actively involve patients in their own care
 - b. Meet the patient's information needs
 - c. Share decision-making
-

Provide clinicians with validated screening tools for physical, mental and cognitive conditions

The Mental Health Triage Tool³³ is an example of a validated screening tool, specifically designed to screen for mental health. Another tool used for screening is the Mini Mental State Examination. This was designed for the purpose of screening for cognitive impairment, but does provide cues that signal the need for further assessment of a person's mental state. There are also screening tools designed for use in particular health settings, such as the Edinburgh Postnatal Depression Scale.

Screening for substance use should also form part of initial screening. Queensland Health provides a summary of tools in current use:

<https://www.health.qld.gov.au/public-health/topics/atod/screening>

Provide clinicians with clear pathways to follow when screening, to identify need for further assessment and planning of risk mitigation strategies

In many instances, a person with a history of mental health issues will have no need for specialist mental health intervention during an episode of care for a physical health condition. In these cases, it is enough that their potential health needs are identified, and incorporated into comprehensive care plans.

If a previously untreated mental health issue is identified during screening, or if screening indicates the potential for a deterioration in the person's mental state, frontline clinicians need to have clear pathways to follow. These may include further assessment within the current treating team, or access to mental health specialists. In either case, the relevant processes should be established and clinicians provided with information about how to use them.

Practice resource: Clinical Pathway for the Screening, Assessment and Management of Anxiety and Depression in Adult Cancer Patients

The Psycho-oncology Co-operative Research Group has developed a *Clinical Pathway for the Screening, Assessment and Management of Anxiety and Depression in Adult Cancer Patients*:

http://www.pocog.org.au/doc/ClinicalPathways_Sept%202017.pdf

This addresses mental health needs that have been identified for people in a non-mental health setting. Importantly, this is a population whose mental health needs have at times been inadequately responded to, as they have been treated as 'normal' responses to life-threatening events.

Successful implementation of this strategy will be supported by, or rely on, the following action:

8.6b The health service organisation has protocols that specify criteria for escalating care, including agreed indicators of deterioration in mental state

Examples of supporting evidence

- Validated screening tools available in paper or electronic form in clinical areas
- Training programs for the workforce in person-centred approaches to screening for risks
- Documented clinical pathways for responding to risks identified through screening

Clinical assessment

Action 5.11

Clinicians comprehensively assess the conditions and risks identified through the screening process

How does this action apply to people with mental health issues?

There is no point screening for risk if no action is taken in response to the findings. The health service organisation needs to have a process for comprehensive mental health assessment if a risk related to mental health issues has been identified during screening.

Suggested approaches

Provide access to timely comprehensive mental health assessment by suitably skilled clinicians

A clinician, trained in screening processes, and using a validated screening tool, should be able to effectively determine a suitable timeframe within which a comprehensive mental health assessment should be undertaken. A clinician who is not trained in mental health should not be expected to undertake a comprehensive mental health assessment. For health settings that do not have mental health workers available onsite, there should be a clear process for referring to specialist mental health services, with established partnerships between organisations.

Successful implementation of this strategy will be supported by, or rely on, the following action:

8.12 The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated

Use a person-centred approach in conducting a comprehensive mental health assessment

It is not just the questions that are asked, but how questions are asked that will determine how effective an assessment process is. There is clear evidence that the way in which people are engaged has an influence on the information they provide. This can include priming effects, related to the order in which questions are asked, or the particular words used to ask questions. More importantly, it relates to the strength of the rapport, and the sense of trust necessary to elicit sensitive information.

People with history of mental health issues frequently have clear knowledge about their conditions, the sorts of things that can lead to an exacerbation of their symptoms, and which strategies are effective in ameliorating these risks. A person-centred approach which acknowledges the person's expertise will contribute to the comprehensiveness of the assessment. Integration of information from a person's advance care directive, or consumer wellness plan (see Action 2.6), will also contribute to the comprehensive care plan. With the person's permission, involving their family and carers will support assessment.

Successful implementation of this strategy will be supported by, or rely on, the following action:

2.6 The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care

Conduct comprehensive mental health assessment using standardised documentation to support clinical judgement

Comprehensive assessment should be conducted using a systematic approach, including assessment of historic and dynamic risks. All information that is held in healthcare records by the health service organisation about a person should be available to the assessing clinician.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.16a The health service organisation has healthcare record systems that make the healthcare record available to clinicians at the point of care

Examples of supporting evidence

- Documented clinical pathways for responding to risks identified through screening
- Training programs for workforce in person-centred approaches to comprehensive assessment, including mental health issues
- Availability of standardised assessment tools to support comprehensive mental health assessment

Developing the comprehensive care plan

Action 5.13

Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that:

- a. Addresses the significance and complexity of the patient's health issues and risks of harm
- b. Identifies agreed goals and actions for the patient's treatment and care
- c. Identifies any support people a patient wants involved in communications and decision making about their care
- d. Commences discharge planning at the beginning of the episode of care
- e. Includes a plan for referral to follow-up services, if appropriate and where available
- f. Is consistent with best practice and evidence

How does this action apply to people with mental health issues?

People maintain their mental health in a range of ways. This can include minimising exposure to stress, ensuring regular sleep and exercise, and taking medication. All of these strategies are disrupted by admission to hospital for treatment for physical health, potentially leading to deterioration in the person's mental state. The stress of physical illness alone can precipitate changes in a person's mental health. Using shared decision making to collaborate on the development of a comprehensive care plan can mitigate the risk of poor mental or physical health outcomes for people.

Ensure that the plan is truly comprehensive

Health care has been characterised as operating in siloes; if a person is admitted for cardiac symptoms, care can be focused simply on treating those symptoms, with other aspects of the person's health ignored, or presumed to be someone else's responsibility. At times, this responsibility is left with the person themselves, or their family or carers, without their capacity to take this responsibility being determined.

There is increasing evidence of the links between physical and mental illness, including correlations between depression and cardiac problems, and anxiety and chronic pain. The authors of Australia's *Mental and Physical Health Tracker* state, 'A care provision approach based on single conditions does not reflect the reality of patients' health needs in the 21st century.'⁵

Successful implementation of this strategy will be supported by, or rely on, the following actions:

5.3 Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:

- a. Actively involve patients in their own care
- b. Meet the patient's information needs
- c. Share decision-making

5.6 Clinicians work collaboratively to plan and deliver comprehensive care

Practice resource: National Eating Disorders Collaboration website

People who have eating disorders have high rates of morbidity and mortality. Eating disorders present a complex picture of physical, behavioural and psychological factors. Each has to be treated with expertise, which typically requires the involvement of separate clinical teams. For many people with long-term eating disorders, physiological changes mean that their physical observations do not fall within normative parameters indicating deterioration. Comprehensive assessment should take into account both their physical and mental health at the same time.

The National Eating Disorders Collaboration (NEDC) was established to develop a nationally consistent, evidence-based approach to the prevention and management of eating disorders. Their website contains information and resources for a range of stakeholders, including the *National Eating Disorders Framework: An integrated response to complexity*.³⁴ Information about the collaborative is available at:

<https://www.nedc.com.au/>

Delivering comprehensive care

Using the comprehensive care plan

Action 5.14

The workforce, patients, carers and families work in partnership to:

- a. Use the comprehensive care plan to deliver care
- b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care
- c. Review and update the comprehensive care plan if it is not effective
- d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur

How does this action apply to people with mental health issues?

This is a key action in the NSQHS Standards, bringing together multiple concepts:

- Clinicians working in partnership with the person, their families and carers
- Delivery of safe, effective care
- Collaborative review of the effectiveness of that care
- Response to changes in a person's condition.

These concepts apply to all people receiving health care, including people who have comorbid mental health issues.

Strategies for improvement

Ensure systems are in place to enable collaborative delivery of care

For members of the workforce to effectively deliver health care consistent with a comprehensive care plan, they have to be aware of the plan and able to access it. They also need access to current information about the person's health status.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.16a The health service organisation has healthcare record systems that make the healthcare record available to clinicians at the point of care

Deliver care collaboratively

Delivery of care consistent with the comprehensive care plan will be most effective if team members with appropriate expertise work together. If the team delivering care need support to critically evaluate the information they should be able to liaise with clinicians with the relevant expertise.

Clinical leadership supports a safety culture where members of the workforce respect each other's skills and expertise, and demonstrate this respect through communication practices, including in front of the person receiving care and their family and carers.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.6 Clinical leaders support clinicians to:

- a. Understand and perform their delegated safety and quality roles and responsibilities
- b. Operate within the clinical governance framework to improve the safety and quality of health care for patients

5.5 The health service organisation has processes to:

- a. Support multidisciplinary collaboration and teamwork
- b. Define the roles and responsibilities of each clinician working in the team

5.6 Clinicians work collaboratively to plan and deliver comprehensive care

Work in partnership with the person, their family and carers

Maintain clarity about the roles and responsibilities of different members of the workforce, and the person and their support network. The comprehensive care plan documents these in general, but who is actually doing what in a particular context may require further verbal explanation at the time.

The service should also have clear protocols for escalating care when the person, their family or carers report changes that indicate to them that the person's mental state is deteriorating.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

5.3 Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:

- a. Actively involve patients in their own care
- b. Meet the patient's information needs
- c. Share decision-making

6.10 The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians

Develop and communicate the processes for review of effectiveness of care delivered

Clinical handover is a formal process which includes reviewing the effectiveness of care and communicating about it. This is covered in more detail in Action 6.8. As noted there, engagement of the person and their carers in clinical handover contributes to the comprehensive care plan accurately reflecting their preferences and goals.

There should also be clear processes for reviewing the comprehensive care plan and escalating care if critical information indicates deterioration in the person's health status.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

6.9 Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to:

- a. Clinicians who can make decisions about care
- b. Patients, carers and families, in accordance with the wishes of the patient

8.6b The health service organisation has protocols that specify criteria for escalating care, including agreed indicators of deterioration in mental state

Examples of supporting evidence

- Experience of care surveys
- Audit of healthcare records to confirm regular updates to comprehensive care plan
- Reduction in rates of critical incidents
- Improvements in health outcomes

Minimising patient harm

Predicting, preventing and managing self-harm and suicide

Action 5.31

The health service organisation has systems to support collaboration with patients, carers and families to:

- a. Identify when a patient is at risk of self-harm
- b. Identify when a patient is at risk of suicide
- c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed

How does this action apply to people with mental health issues?

In 2016, suicide was the leading cause of death among all people 15-44 years of age.³⁵ A significant number of people access health services every year with thoughts of self-harm or suicide. The experience during and immediately after a healthcare episode can have a major influence on a person's willingness to engage further with health services. This can mean they do not get the help they need, and increases the risk of future self-harm or suicide.

Suggested strategies

Develop therapeutic engagement with the person at risk of self-harm or suicide

The focus is on collaboration. People can experience thoughts of self-harm or suicide for a long time, and possess clear knowledge about strategies to manage these feelings, including what clinical support they need. For other people, thoughts of self-harm can occur suddenly, often in the context of loss. They may be very frightened by these thoughts, and have little idea of how to manage them.

In either case, therapeutic engagement is critical, as the main way for clinicians to know about the risk of suicide or self-harm is to elicit the information from the person themselves, and it is essential to create a sense of trust for this to be possible. Another important source of information is the person's carer or family member, who may recognise uncharacteristic behaviour or speech that does not necessarily indicate high risk to the clinician.

Maintain an empathic, non-judgemental approach while implementing clinical actions. Engage therapeutically with the person to understand what the act or thought of self-harm means for the person. Self-harm can be related to suicidal thoughts, or can be independent of these. The person may or may not be clear about their intent. Some self-harm may be enacted without suicidal ideation, but still present a risk to the person's life. Always consider self-harm seriously.

Processes of respectful and effective therapeutic engagement create safety for people who have thoughts of self-harm or suicide. Avoid making presumptions about the person's intent, including whether the person's self-harm does or does not indicate suicidal thoughts. Communicate with the

person, their carers and family, and other clinicians in non-judgemental language. In particular, avoid use of stigmatising language, such as suggesting an act of self-harm is 'attention-seeking'.

People who have been treated after a suicide attempt report that the attitudes of members of the healthcare workforce were an important factor determining whether they would disclose suicidal thoughts in the future.

Adopt a recovery-oriented approach, focused on restoring hope, throughout clinical engagement with a person after a suicide attempt. The specific treatment immediately after a suicide attempt is likely to be a brief episode in the person's experience. They and their families will be dealing with the long-term effects, and interventions need to:

- Align with the person's and family's existing skills, values and preferences
- Identify the supports that may be needed to achieve these
- Link to these services.

Practice resource: National Institute for Health and Care Excellence (NICE) self-harm quality standard

The Royal Australian and New Zealand College of Psychiatrists endorses the national guidelines developed in the United Kingdom by the National Institute for Health and Care Excellence on the clinical management of self-harm. These are available at:

<https://www.nice.org.uk/guidance/qs34>

Successful implementation of this strategy will be supported by, or rely on, the following actions:

5.3 Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:

- a. Actively involve patients in their own care
- b. Meet the patient's information needs
- c. Share decision-making

5.13a Clinicians use processes for shared decision making to develop a comprehensive and individualised plan that addresses the significance and complexity of the patient's health issues and risks of harm

Understand the multifaceted components of suicide risk

Assessment of risk for suicide is complex. While there are a number of indicators that suggest higher risk, many people who exhibit all of these indicators will not go on to suicide. Conversely, people who die by suicide have sometimes not demonstrated any of the typical signs of suicidal thoughts. The evidence is that it is not effective to assess suicide risk in isolation from a comprehensive assessment of a person's mental state and life circumstances.

For some people, treatment after a suicide attempt may be the first time that the clinical or social stressors leading to the attempt have come to light. Comprehensive psychosocial assessment may reveal mental health issues or substance use conditions that can respond to clinical treatment, or social factors such as domestic violence that increase the risk of suicide. A thorough assessment should include the person's mental and physical health, and their current social circumstances. These will not come to light if assessment is focused solely on the presence of suicidal thoughts, or symptoms of mental illness.

Some Aboriginal and Torres Strait Islander communities experience higher rates of self-harm and suicide than the general population. Reflecting the specific issues facing Aboriginal and Torres Strait Islander Australians, there is a *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*.³⁶ Ensure that members of the workforce are familiar with this strategy, and review processes to ensure that they cover the issues for the local Aboriginal and Torres Strait Islander communities. Support this approach with workforce training in culturally competent care, and the employment of, or partnerships with, experts in Aboriginal and Torres Strait Islander mental health, and social and emotional wellbeing.

Rates of mental health issues, self-harm and suicide are also higher in the LGBTIQ communities, as a result of stigma and discrimination. The *National Lesbian, Gay, Bisexual, Transgender and Intersex Mental Health and Suicide Prevention Strategy: A new strategy for inclusion and action*,³⁷ contains actions that health service organisations can implement to support people effectively.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.15 The health service organisation:

- a. Identifies the diversity of the consumers using its services
- b. Identifies groups of patients using its services who are at higher risk of harm
- c. Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care

1.21 The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients

2.13 The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs

Implement effective strategies to keep people safe

Strategies to keep people safe when they are experiencing thoughts of self-harm or suicide include:

- Therapeutically engaging the person
- Maintaining level of nursing observation appropriate to acuity of risk
- Minimising access to sharp objects, medications or other means of self-harm
- Providing treatment for symptoms of mental or physical illness identified as contributing to acute distress for the person.

The Black Dog Institute has initiated the LifeSpan program, an evidence-based, approach to suicide prevention currently being trialled in select sites in NSW. The program involves implementation of nine strategies, the first of which is 'Improving emergency and follow-up care for suicidal crisis'.

Practice resource: Black Dog Institute guidelines

As part of its LifeSpan program, the Black Dog Institute has published *Guidelines for integrated suicide-related crisis and follow-up care in Emergency Departments and other acute settings*,³⁸ available at:

https://blackdoginstitute.org.au/docs/default-source/lifespan/delphi-guidelines-clinical-summary_web.pdf?sfvrsn=0

Examples of supporting evidence

- Audit of healthcare records demonstrating comprehensive assessment of mental state and psychosocial circumstances for people who present with self-harm or suicidal thoughts
- Patient and carer experience surveys indicating collaborative practice

Action 5.32

The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts

How does this action apply to people with mental health issues?

People who have recently attempted suicide are at increased risk of a subsequent attempt in the days and weeks following discharge from healthcare settings. This makes sense, as people frequently return to the health and psychosocial contexts in which they initially experienced these feelings. People who have recently started antidepressant medicines are at increased risk of suicide. However, there is considerable variation in follow-up arrangements when people leave a health service organisation after a suicide attempt, with up to 30% of people leaving without any formal arrangements in place. It is therefore essential that health service organisations ensure adequate follow-up for people who have harmed themselves or reported suicidal ideation. The *Living is for Everyone* framework underlines that 'it is critical that the chain not be broken, as levels of risk can change rapidly'.³⁹

Effective discharge planning has long been recognised as an integral part of health episodes. Issues of shared decision making, forming partnerships with other organisations, and having clear processes for transfer of accountability have been identified as important for an extensive range of health conditions.

In the *Scoping Study on the Implementation of National Standards in Mental Health Services*,⁴⁰ clinicians identified problems in the existing processes for transferring accountability of care, particularly when care is being transferred to a team or individual in a different health service organisation. For specialist mental health services, rate of post-discharge community care within seven days is a nationally agreed performance indicator,⁴¹ and follow-up can be confirmed internally within the organisation. This 'built-in' process may not be available or appropriate for all health service organisations. Nonetheless, due to the identified risk of harm in this period, some arrangements must be in place.

Suggested strategies

Develop follow-up arrangements

Ensure that development of the discharge plan is collaborative and recovery-oriented, using the principles of shared decision making outlined in the Partnering with Consumers Standard. Engage the person, their carers and family, and any other person involved in implementing the plan, and give them the opportunity to advise whether actions within the plan are feasible.

Post-discharge care may require cooperation across a number of different health and other service organisations in the community. Ensure that the roles and contact details are available to all key participants. If there is a person coordinating services, or if care is shared between different clinicians and services, include this information in the plan.

Successful implementation of this strategy will be supported by, or rely on, the following action:

5.3 Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:

- a. Actively involve patients in their own care
- b. Meet the patient's information needs
- c. Share decision-making

5.13e Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that includes a plan for referral to follow-up services, if appropriate and available

Communicate follow-up arrangements

Ensure that communication of the discharge plan is multimodal, using verbal, written and electronic means (where available). Confirm receipt of communication about the plan from key participants before discharge. Conduct all communications in respectful, non-judgemental language. Ensure the person and their family and carers have ready access to copies of the discharge plan, including steps to take in a crisis.

Successful implementation of this strategy will be supported by, or rely on, the following action:

6.8f Clinicians use structured clinical handover processes that include ensuring that clinical handover results in the transfer of responsibility and accountability for care

Implement follow-up arrangements

The first two parts of this action, developing and communicating follow-up arrangements, are familiar to health service organisations and should already be routine practice. They draw on the Partnering with Consumers and Communicating for Safety Standards, and incorporate principles of shared decision making, and clear, multi-modal communication, tailored to the specific needs

and skill-sets of participants. It is the third part of the action that some health service organisations may find challenging.

In situations where clinical accountability is being transferred between services, this process is supported by establishing partnerships. These arrangements must be negotiated so that they do not breach privacy legislation, but also so that privacy cannot be invoked and leave key participants uninformed of critical information.

Challenges in implementing follow-up arrangements are ameliorated by doing the first two parts of the action well. Development of the discharge plan using a genuinely collaborative approach will ensure that all participants will understand their planned role, and agree to it. Similarly, effective communication of the discharge plan, using different modes and confirming that information has been received and accepted, will support all participants to fulfil their roles.

Practice resource: Way Back Support Service

Beyond Blue developed the Way Back Support Service specifically to support people returning home from hospital following a suicide attempt. The service provides one-on-one, non-clinical care and practical support for the three months after a person has attempted suicide. The service has demonstrated reduced rates of suicide attempts in the areas where it has been trialled, and there are plans to offer the service more broadly. Information about the Way Back Support Service and related resources is available at:

<https://www.beyondblue.org.au/about-us/about-our-work/suicide-prevention/the-way-back-support-service>

Examples of supporting evidence

- Audits of clinical files demonstrating:
 - evidence of collaborative discharge planning
 - discharge communications
 - notes documenting follow-up communication to confirm receipt and acceptance of communications
- System evaluation processes demonstrating involvement of people with lived experience of self-harm
- Where follow-up involves other agencies, there should be evidence of established partnership agreements

Predicting, preventing and managing aggression and violence

Action 5.33

The health service organisation has processes to identify and mitigate situations that may precipitate aggression

How does this action apply to people with mental health issues?

Aggression and violence are often predictable in healthcare settings, and health service organisations need to implement strategies to reduce the risk of aggression occurring, and reduce the risk of harm when it does occur. To do this, health service organisations need to adopt a range of complementary strategies. These strategies need to address risks related to:

- The environment
- The clinical context
- The person, their family and carers.

Actions 1.29 and 1.30 in the Clinical Governance Standard addressed environmental risk factors. Action 5.34 addresses collaborative processes for working with the person, their family and carers to reduce the risk of violence. This action relates to risks related to the clinical context.

Healthcare environments can be stressful places. People are dealing with uncomfortable experiences, including pain and uncertainty, in environments that are both unfamiliar and high stimulus. People also experience frustration with processes that may be routine for members of the healthcare workforce, but are new and not always comprehensible from the perspective of the person or carer. For some people, distress arising from these contextual factors can lead to feelings of aggression.

Suggested strategies

Embed a culture of safety in unit processes

Entering different healthcare settings can engender feelings of calm or unease, unrelated to the specific populations or diagnostic groupings treated in the setting. Rather, these feelings are generated by the sense of engagement and safety, and related to the processes the health service organisation adopts that can trigger distress in people, and potentially lead to aggression.

Safety culture needs to be supported by clinical and organisational leadership. The governing body has a role in establishing safety culture. But it is through the actions of clinicians and other members of the workforce who people encounter directly that safety culture is enacted and experienced. There needs to be congruence between messages contained in resources such as the *Australian Charter of Healthcare Rights*,⁴² and people's experience of care.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.1a The governing body provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation

1.6a Clinical leaders support clinicians to understand and perform their delegated safety and quality roles and responsibilities

Review incidents to identify contributing factors

Use the incident management system to identify factors that may precipitate aggression related to routine processes of care. Review incidents with members of the workforce and people who have used the service to better understand the influence of routine processes on people's experience of care, and repeated sources of frustration, distress and conflict. Consider which processes are amenable to modification, to ameliorate identified risks.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.11f The health service organisation has organisation-wide incident management and investigation systems, and incorporates risks identified in the analysis of incidents into the risk management system

Practice resource: Safewards

Safewards is a model of delivering mental health services that comprehensively addresses the range of factors that can lead to conflict. These are arranged in domains:

- Patient characteristics
- Patient community
- Staff team
- Physical environment
- Regulatory framework
- Outside hospital.

The model is explicit about the fact that elements from each of these domains can lead to conflict, that is, aggression and violence are not simply acts perpetrated by individuals not taking responsibility for their actions.

The model gives examples of strategies that staff can adopt in the long and short term to mitigate conflict. These range from creating a welcoming environment, and fostering a culture which reduces the divisions between staff and patients, through to specific techniques for de-escalating conflict.

The model acknowledges that staff cannot necessarily modify all of these factors. For instance, if a person receives a phone call from home with bad news, they may experience distress and frustration that members of the workforce cannot mitigate. Nonetheless, if members of the workforce maintain awareness of the interaction of each of the domains, they will have greater opportunities to reduce the potential for issues to escalate to aggression.

The model, developed in the United Kingdom, has been successfully rolled out across mental health services in Victoria. Trials have begun on adapting the model to general health wards.

The Victorian Department of Health and Human Services Safewards website is at:

<https://www2.health.vic.gov.au/safewards>

Action 5.34

The health service organisation has processes to support collaboration with patients, carers and families to:

- a. Identify patients at risk of becoming aggressive or violent
- b. Implement de-escalation strategies
- c. Safely manage aggression, and minimise harm to patients, carers and families, and the workforce

How does this action apply to people with mental health issues?

Distress, frustration, fear and anger can all lead to people experiencing aggressive impulses. Intoxication or withdrawal from substances, delirium and pain, can also lead to aggressive feelings. For some people with mental health issues, their symptoms can generate these feelings. Interactions with perceived figures of authority, such as health workers, can exacerbate these feelings.

Health service organisations need to be prepared to address aggression and violence, and manage situations so that all the people involved are safe. This includes keeping the people who are receiving care safe from violence perpetrated by other people receiving care and members of the workforce. It includes keeping members of the workforce safe, consistent with workplace health and safety legislation. It also includes maintaining safety for the person who may perpetrate violence inadvertently due to alteration in their mental state. These strategies need to address aggression without adopting approaches that can lead to stigmatising practices.

Suggested strategies

Screen for risk of aggression or violence

Screening for risk of aggression and violence is an important and complex undertaking for members of the healthcare workforce.

Predictive factors for risk of aggression include:

- Previous history of aggression or violence
- Intoxication or withdrawal from licit or illicit substances
- Acute brain injury
- Cognitive impairment.

It is important that the use of screening tools and risk management processes does not lead to stigmatising practices, which have been associated with sub-optimal healthcare delivery. In particular, people with mental health issues should not be automatically assessed as presenting high risk for aggression. Risk assessment needs to take historical and dynamic factors into account. Risk management must be flexible and responsive to clinical or social changes.

There will also be times when a person who has not been screened as presenting a risk of violence becomes aggressive.

Practice resource: Managing challenging behaviour

South Australia has developed a *Challenging behaviour policy framework* to 'support health services to focus action on prevention and response to challenging behaviour in a systematic way'. The home page is at:

<http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/challenging+behaviour+strategy/challenging+behaviour+policy+framework>

An information sheet summarises how health service organisations can navigate the resources across the strategy for preventing and responding to challenging behaviour:

<http://www.sahealth.sa.gov.au/wps/wcm/connect/d14db480487714fdaa68fb021cf34788/15019.14+Preventing+Responding+Fact+Sheet-FINAL.pdf?MOD=AJPERES&CACHEID=d14db480487714fdaa68fb021cf34788>

The Framework is applicable across all health settings in the state.

Partner with consumers and carers to reduce risk of aggression

The key to successful implementation of this action is that processes should be collaborative. People accessing health care, and their families and carers must be engaged in strategies to reduce the risk of aggression or violence.

Successful implementation of this strategy will be supported by, or rely on, the following action:

5.3 Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:

- a. Actively involve patients in their own care
- b. Meet the patient's information needs
- c. Share decision-making

Train members of the workforce in de-escalation strategies

De-escalation strategies are an effective way of managing the risk of aggression. Skilfully done, they support the person themselves to participate in reducing their level of distress and agitation. The basic principles and techniques are set out in the following practice resource, and these can be successfully implemented by clinical staff who don't have mental health expertise.

Practice resource: De-escalation techniques

The NSW Health guideline for the *Management of patients with Acute Severe Behavioural Disturbance in Emergency Departments* provides a clear description of de-escalation techniques.

The guideline is available at:

http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2015_007.pdf

A summary of the key points is as follows:

- Approach in a calm, confident and non-threatening manner, with a non-aggressive stance with arms relaxed
- Be empathic, non-judgemental and respectful; listen to the patient's concerns
- Introduce yourself, your role and the purpose of the discussion, lead the discussion and engage the patient (whilst other staff remain in the vicinity to offer support, it is imperative that only one staff member verbally engage the patient)
- Emphasise your desire to help; ask what they want and what are they worried about
- Focus on the here and now, identify what is achievable, rather than declining all requests; small concessions can build trust and rapport
- Try to identify the patient's unmet needs and help them explore their fears
- Use short clear statements which do not include medical jargon; the patient may not have the capacity to process information
- Use a slow, clear and steady voice and don't raise your voice; if the patient raises their voice, pause and wait for an opening and allow the patient to vent some of their frustrations
- Courtesies such as a cup of (lukewarm) tea, sandwiches, access to a telephone (or a staff member making a phone call on their behalf) and attending to physical needs can be very helpful
- Offer a choice of nicotine replacement therapy, for example, gum / lozenges, patches or a nicotine inhaler if they request a cigarette; avoid entering into discussions about leaving the emergency department to have a cigarette and focus these conversations on keeping the patient within the safety of the emergency department
- Getting trusted relatives or staff to talk to the patient may help. If the patient persists in directing their anger or suspicion directly at the clinician, it may be appropriate for you to ask another staff member to attempt de-escalation
- Avoid potentially provocative statements such as "calm down" or "if you don't settle downx will happen" or "you better stop that right now...or else" as this is likely to escalate their behaviour to another level in response to the perceived threat.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.20c The health service organisation uses its training systems to provide access to training to meet its safety and quality training needs.

5.1 Clinicians use the safety and quality systems from the Clinical Governance Standard when:

- b. Managing risks associated with comprehensive care
 - c. Identifying training requirements to deliver comprehensive care
-

Develop strategies to safely manage incidents of aggression

Should violence occur, the health service organisation should have in place strategies to minimise harm, either through resources within the organisation, or through established partnerships with other agencies, such as local police. If violence has occurred, all people involved, including witnesses, should be offered appropriate support.

Examples of supporting evidence

- Training documents about de-escalation strategies
- Documentation of integration of incident review processes into quality improvement activities

Minimising restrictive practices: restraint

Action 5.35

Where restraint is clinically necessary to prevent harm, the health service organisation has systems that:

- a. Minimise and, where possible, eliminate the use of restraint
- b. Govern the use of restraint in accordance with legislation
- c. Report use of restraint to the governing body

Restraint: key definitions¹⁷

Restraint is the restriction of an individual's freedom of movement. It includes mechanical restraint, physical restraint, and chemical or pharmacological restraint.

Physical restraint is the application by members of the healthcare workforce of hands-on immobilisation or the physical restriction of a person to prevent them from harming themselves or endangering others, or to ensure that essential medical treatment can be provided.

Mechanical restraint is the application of devices (including belts, harnesses, manacles, sheets and straps) to a person's body to restrict their movement.

There is a lack of consensus on the definition of **chemical/pharmacological restraint**, because of difficulties in determining whether a clinician's intent is primarily to treat a person's symptoms or to control their behaviour. For this reason, the Commission does not currently require health service organisations to report on the use of chemical restraint (except where this is directed under state or territory legislation). Nonetheless, organisations should seek to understand if there is inappropriate use of medicines, and note if rates of rapid tranquilisation increase.

How does this action apply to people with mental health issues?

Mental health services have been working for decades to reduce the use of restraint. Minimising its use was identified as a key safety priority in 2005,⁴³ and in 2017, the Towards Eliminating Restrictive Practices Forum hosted by Western Australia was the 11th national meeting dedicated to the topic.

Restraint is used in other healthcare settings, but it has not been subject to the same scrutiny as it is in mental health settings. This is despite people who have experienced it, and their families and carers, frequently reporting trauma related to its use. The use of restraint has also been associated with severe adverse outcomes, including injury and death from falls.

Restraint is frequently used to facilitate the delivery of aspects of care, such as placing wrist cuffs on a person to prevent them pulling out tubes. Clinicians and health service organisations have stated that this is part of duty of care.

This action calls for additional strategies that will support the reduction of the use of restraint. It is critical that approaches to reducing the use of restrictive practices, including restraint and seclusion, maintain focus on improving care, not simply reducing reportable incidents of these interventions. There is an imminent risk that focusing on the numbers can lead to the development of 'workarounds' that perpetuate coercive practices.

Suggested strategies

Develop a local policy on use of restraint

Many services, particularly intensive care units, have developed local protocols which include:

- The need for medical officer 'prescription' of restraint
- Hourly monitoring of skin integrity
- Reporting the use of restraint to the person's family or carer.

Practice resource: Liverpool Hospital Intensive Care Unit: Clinical Guideline Physical Restraints

The Liverpool Hospital aims for a restraint-free service, but recognises that at times restraints may be required. The clinical guideline supports members of the workforce to minimise harm in the use of restraint. It includes guidance on decision making prior to the use of restraint, monitoring and documentation.

The Clinical Guideline is available at:

https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0019/306451/liverpoolPhysical_Restraints.pdf

Benchmark local use of restraint

Action 5.35 builds on work undertaken in mental health services to reduce the use of restraint. A key strategy is to benchmark, report and review the use of restraint. This attention can then lead to consideration of alternative strategies to the use of restraint, which can in turn be evaluated. Using principles from the Partnering with Consumers Standard, people who have experienced restraint in different settings, and their families and carers, can be involved in evaluation of its use, and development of strategies to reduce it.

Health settings outside mental health services will be able to adapt work that has been developed in mental health services to benchmark, report and review its use. Incident reporting systems can also be used to contribute to building useful data.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.1f The governing body monitors the action taken as a result of analysis of clinical incidents

1.11f The health service organisation has organisation-wide incident management and investigation systems, and incorporates risks identified in the analysis of incidents into the risk management system

2.11a The health service organisation involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care

Train members of the workforce in de-escalation strategies

De-escalation strategies have been discussed in Action 5.34 with regard to aggression, but they also form a critical part of strategies to minimise the use of restraint. Skilfully used, they can engage the person in the process of resolving conflict, and prevent situations escalating to the point where clinicians believe restraint is the only option to maintain safety of the person or others.

The key to minimising use of restrictive practices is to be alert to changes in a person's behaviour or demeanour that may suggest a deterioration in their mental state. The workforce should be receptive to information from the person themselves, and from their carers and families. People who have experienced mental health issues, or cared for someone who does, frequently have detailed knowledge about what can lead to a deterioration in their mental state, and what strategies are most effective for restoring their capacity to manage their mental state without the use of restrictive practices. These principles are outlined in the *National consensus statement: Essential elements for recognising and responding to deterioration in a person's mental state*⁴⁴ (see Recognising and Responding to Acute Deterioration Standard).

Successful implementation of this strategy will be supported by, or rely on, the following actions:

5.33 The health service organisation has processes to identify and mitigate situations that may precipitate aggression

5.34 The health service organisation has processes to support collaboration with patients, carers and families to:

- a. Identify patients at risk of becoming aggressive or violent
 - b. Implement de-escalation strategies
 - c. Safely manage aggression and minimise harm to patients, carers, families and the workforce
-

Train members of the workforce in safe restraint techniques

Restraint is almost universally reported as a traumatic experience. Health service organisations must be able to demonstrate strategies to reduce the use of restraint, in acknowledgement of its potential for creating immediate, and frequently enduring psychological trauma.

In addition, the potential for physical trauma must be addressed. Only members of the workforce who have been trained in safe restraint techniques should be authorised to practise restraint. Training needs to cover specific risks related to techniques, in particular the need to avoid prone restraint. It also needs to cover the risks related to specific groups, for example, people with history of respiratory or cardiac conditions and people who are overweight.

Support should be offered to the person who has experienced restraint, their family and carers, witnesses and staff who were involved.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.20c The health service organisation uses its training systems to provide access to training to meet its safety and quality training needs.

Monitor compliance with legislation

The health service organisation must ensure that any use of restraint is only done in compliance with legislation.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.7c The health service organisation uses a risk management approach to review compliance with legislation, regulation and jurisdictional requirements

Examples of supporting evidence

- Policy documents that outline:
 - processes to treat people without using restraint
 - use of restraint in line with legislation
 - reporting requirements when restraint is used
- Training documents for clinical and security staff that outline:
 - strategies to minimise the use of restraint
 - the application of safe restraint techniques
 - the legislative and policy requirements for using restraint
- Evidence of design and use of the environment to minimise the use of restraint
- Evidence of a systematic approach to minimising coercive practices
- Audit results of healthcare records that show the use of individualised plans to minimise the use of restraint
- Regular audits of compliance with legislative and policy requirements
- Routine review of complaints about the use of restraint
- Reports provided to the governing body that document the use of restraint

Minimising restrictive practices: seclusion

Action 5.36

Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that:

- a. Minimise and, where possible, eliminate the use of seclusion
- b. Govern the use of seclusion in accordance with legislation
- c. Report use of seclusion to the governing body

How does this action apply to people with mental health issues?

Seclusion is the confinement of a person, at any time of the day or night, alone in a room or area from which free exit is prevented.

The use of seclusion in mental health services is governed by state and territory legislation and mandatory policy. This typically includes designated processes for reporting and review of the use of seclusion at local unit, hospital, local health network, state or territory, and national levels. The use of seclusion outside designated mental health services is unlawful, and health service organisations should ensure that it does not occur.

Jurisdictions have clear protocols about how seclusion can be implemented. These typically include details about:

- When a person can be secluded
- How long a person can be secluded
- How frequently observations of the person in seclusion should be made
- What provisions in terms of hygiene and other needs are made
- What support they are offered after the seclusion episode.

It is important that clinicians are aware of the relevant legislation and policy, and act in accordance with it. The health service organisation should have processes that alert the governing body to any deviation from protocols.

Suggested strategies

Review emergency department processes and design

Processes to minimise the use of seclusion are closely related to minimising the use of restraint (Action 5.35).

The *Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities*²⁰ makes a number of recommendations relevant to emergency departments:

- 14 The NSW seclusion and restraint data collection and reporting should include declared emergency departments.
- 15 All emergency departments should have clinical pathways for people presenting with mental health issues that are reflective of their needs. There needs to be a pathway that does not include the use of safe assessment rooms.
- 16 There should be an immediate review of the design and use of safe assessment rooms, using a co-design methodology.
- 18 All acute mental health units and declared emergency departments should conduct a review of their facilities and implement minor capital works and equipment purchases to improve the therapeutic potential.

Information developed in evaluating implementation of these recommendations can inform strategies to reduce and eliminate the use of restrictive practices in all health services.

Note that leaving a person alone in a safe assessment room in an emergency department may constitute seclusion, and may breach state or territory legislation.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

- 1.29a The health service organisation maximises safety and quality of care through the design of the environment
- 2.11a The health service organisation involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care

Examples of supporting evidence

- Policy documents that outline:
 - criteria for use of seclusion
 - use of seclusion in line with legislation
 - reporting requirements when seclusion is used
- Training documents about strategies to minimise the use of seclusion
- Evidence of design and use of the environment to minimise the use of seclusion
- Evidence of a systematic approach to minimising coercive practices
- Audit results of healthcare records that show the use of individualised plans to minimise the use of seclusion
- Seclusion register
- Reports to the governing body on the use of seclusion

6

Communicating for Safety Standard



Communicating for Safety Standard



The intention of the Communicating for Safety Standard is to ensure timely, purpose-driven and effective communication and documentation that support continuous, coordinated and safe care for patients.

The five criteria are:

Clinical governance and quality improvement to support effective communication

Correct identification and procedure matching

Communication at clinical handover

Communication of critical information

Documentation of information

When people with mental health issues are accessing care for their physical health, there needs to be communication between clinical teams and the person and their families and carers. When communications are done well, they can ensure that preventable adverse events do not occur.

Communication at clinical handover

Clinical handover

Action 6.8

Clinicians use structured clinical handover processes that include:

- a. Preparing and scheduling clinical handover
- b. Having the relevant information at clinical handover
- c. Organising relevant clinicians and others to participate
- d. Being aware of the patient's goals and preferences
- e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient
- f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care

How does this action apply to people with mental health issues?

Structured handover is important when care is being transferred, or resumed by clinical teams. If a person who is being treated for a physical health problem is also treated for mental health issues, it is likely that more than one clinical team will be involved in their care. Implementation of structured processes will help to:

- Support clarity for the person, their family and carers about which clinicians are responsible for care
- Improve communications between teams, especially if care is concurrently provided by more than one team, so that proposed treatment changes can be agreed
- Facilitate shared decision making
- Improve communication to the person, their family and carers about treatment and changes to treatment.

Recovery-oriented mental health services balance clinical recovery with the person's own wishes. While the person and their carer should not be given sole responsibility as custodians of clinical information, they should be involved in transfer processes, and it should be clarified that they understand the information that is being transferred.

Suggested strategies

Use structured communication processes for the transfer of responsibility for care

Clinical handover should be consistent with the comprehensive care plan, developed collaboratively with the person, their family and carers. At points where there is a change in this plan, or a transfer of care as forecast in the plan, using structured communication processes that align with the documented plan will minimise the risk of important information being missed, or misunderstood.

Successful implementation of this strategy will be supported by, or rely on, the following action:

5.13 Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that:

- d. Commences discharge planning at the beginning of the episode of care
 - e. Includes a plan for referral to follow-up services, if appropriate and available
-

Use structured communication processes to coordinate concurrent care by more than one treating team

If more than one treating team is involved in a person's care, clear protocols must be in place for communications. These should cover verbal communications and documentation. Team members should check that the way they communicate is understood by others – it may be possible that clinical terms are shared, but some terms may be differently interpreted, and lead to risk for adverse outcomes.

Key issues requiring structured communications include timeframes for review by different clinical teams, and prescription of medication.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.16a The health service organisation has healthcare record systems that make the healthcare record available to clinicians at the point of care

5.5a The health service organisation has processes to support multidisciplinary collaboration and teamwork

Involve consumers and carers in these processes

For people who are unfamiliar with clinical settings, transitions in their health care may be unfamiliar. Even if a process has been discussed with the person and their family during comprehensive care planning, they should be involved in discussion when the planned care is being evaluated or changed, or when an episode of care is being formally transferred.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

5.32 The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts

6.3 Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to:

- a. Actively involve patients in their own care
 - b. Meet the patient's information needs
 - c. Share decision-making
-

Examples of supporting evidence

- Policy documents that describe a structured clinical handover process
- Observation of clinician's practice that shows use of structured clinical handover processes and tools
- Information provided in different formats (such as brochures, web pages and posters) to people with mental health issues, carers and families that outlines their role in clinical handover processes

Communication of critical information

Communicating critical information

Action 6.9

Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to:

- a. Clinicians who can make decisions about care
- b. Patients, carers and families, in accordance with the wishes of the patient

How does this action apply to people with mental health issues?

Health care is dynamic, and subject to change when a person's condition changes. The person and their carers and families cannot be assumed to take responsibility for alerting clinicians to changes, but should be supported to inform clinicians when they observe changes that they view as important.

Suggested strategies

Identify critical information

The comprehensive care plan developed in Action 5.13 includes identified risks. This can form the basis for identifying specific areas of focus for clinicians to be aware of. As part of the development and delivery of this plan, the changes or emerging issues of critical importance can be described.

Identify key people who should be notified of changes in critical information

There needs to be clear definition of the roles of members of the workforce. In particular, there needs to be explicit agreement about what information and interventions can be implemented by the local treating team, and which ones require contact with specialist mental health clinicians. More detailed information about existing escalation processes (such as Ryan's rule) to use when critical information emerges is provided at Action 8.6 Escalating care.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

5.5 The health service organisation has processes to:

- a. Support multidisciplinary collaboration and teamwork
- b. Define the roles and responsibilities of each clinician working in a team

8.6b The health service organisation has protocols that specify criteria for escalating care, including agreed indicators of deterioration in mental state

Examples of supporting evidence

- Policy documents that outline the:
 - types of critical information that are likely to be received and actions to be taken in response
 - method for communicating critical information to the responsible clinician and the multidisciplinary team
 - method for communicating critical information to the person, carer and family
 - timeframes for communicating critical information
- Policy documents for identifying the clinicians responsible for a person's care
- Standardised templates to support communication of critical information
- Systems for alerting clinicians who can make decisions about care when there are changes in the person's condition, or new critical information is received

Action 6.10

The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians

How does this action apply to people with mental health issues?

A consistent theme reported by families and carers is that they are the first to notice changes in a person's mental state, but when they report this information to clinicians, their information does not always seem to be acted on. There may be many reasons for this. Clinicians may in fact incorporate the information into care planning, but not communicate this back to families and carers. Clinicians in general health services may feel they do not have the skills to respond effectively. They may also make presumptions that some other clinician or team is responsible for caring for a person's mental health, and that they do not have to do anything. In some cases, people experiencing deterioration in their mental state and their carers have reported that the information they provided did not seem to be taken seriously by clinicians.

Open communication about critical health issues between clinicians and the people they are caring for needs to occur across the whole episode of care. This starts at screening and assessment, continues through planning and delivery of care and, when necessary, when care needs to be escalated. Throughout, there needs to be a clear message that information about mental health issues will be taken seriously and treated respectfully.

Suggested strategies

Inform people receiving care, and their families and carers, what constitutes critical information

The issues regarded as 'critical' for clinicians, identified in Action 6.9, can form the basis of information for people receiving health care, their families and carers about what they should convey to clinicians. This can be integrated into information that people receive when they are initially orientated to the unit. Any list should not be presented as complete, and people should be encouraged to communicate anything they regard as critical.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

2.6 The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care

2.9 Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review

Incorporate processes for consumer and carer communication of critical information throughout the care episode

Partner with consumers and carers to create shared understanding about what constitutes critical information, and how to communicate it to clinicians in a way that will achieve jointly shared outcomes. Establishing effective communications from the beginning of the care episode will support effective communication processes when a person's condition changes, or new issues emerge.

Formal strategies for escalation of care are covered in more detail in Action 8.6.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

6.3 Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to:

- a. Actively involve patients in their own care
- b. Meet the patient's information needs
- c. Share decision making

8.6d The health service organisation has protocols that specify criteria for escalating care, including worry or concern in members of the workforce, patients, carers and families about acute deterioration

Examples of supporting evidence

- Policy documents that outline how people accessing care, carers and families are informed about the processes for communicating concerns to clinicians
- Examples of information provided to people, carers and families about processes for communicating concerns to the clinicians responsible for care
- Resources or tools for people, carers or families to use to communicate with clinicians

8

Recognising and Responding to Acute Deterioration Standard



Recognising and Responding to Acute Deterioration Standard



The intention of the Recognising and Responding to Acute Deterioration Standard is to ensure that a person's acute deterioration is recognised promptly and appropriate action is taken. Acute deterioration includes physiological changes, as well as acute changes in cognition and mental state.

The three criteria are:

Clinical governance and quality improvement to support recognition and response systems

Detecting and recognising acute deterioration, and escalating care

Responding to acute deterioration

Services that provide physical health care will be familiar with the recognition and response model, but may not feel skilled in applying it to deterioration in a person's mental state. The Commission has developed the *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state* (the Consensus Statement) to support implementation of new actions in this standard.

Key factors underpinning implementation of the Consensus Statement are:

- Effective recognition and response to deterioration in a person's mental state is everyone's responsibility, it is not 'in addition' to their health care
- The development of an escalation protocol based on a clear assessment of the resources and skills that are available in the specific health context
- Collaboration with the person experiencing deterioration in their mental state, and their carers, integrating their skills and knowledge into recognition and response processes.

Health service organisations may be at different phases of implementation of the Consensus Statement, but must be able to demonstrate understanding of the essential elements.

Practice resource: National Consensus Statement

The Commission developed the *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state* (the Consensus Statement) which describes ten elements that are essential for a prompt and reliable response to deterioration in a person's mental state. The elements are arranged in three parts:

Processes of care

1. Recognising deterioration in a person's mental state
 2. Escalating care
 3. Responding to deterioration in a person's mental state
-

Therapeutic approach

4. Creating safety and minimising restrictive practices
 5. Teamwork and shared decision making
 6. Communicating for safety
-

Organisational supports

7. Leadership and governance
 8. Workforce development
 9. Standardised processes to support high-quality care
 10. Evaluation and feedback.
-

The Consensus Statement is available on the Commission's website at:

<https://www.safetyandquality.gov.au/wp-content/uploads/2017/08/National-Consensus-Statement-Essential-elements-for-recognising-and-responding-to-deterioration-in-a-person%E2%80%99s-mental-state-July-2017.pdf>

Detecting and recognising acute deterioration, and escalating care

Recognising acute deterioration

Action 8.5

The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to:

- a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium
- b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan
- c. Assess possible causes for acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported
- d. Determine the required level of observation
- e. Document and communicate observed or reported changes in mental state

How does this action apply to people with mental health issues?

There is growing evidence of the impact of not recognising and responding to deterioration in a person's mental state. Each year, 30 suicides on inpatient units are reported in Australian hospitals. The rates of use of restrictive practices (seclusion and restraint), while declining, remain high. These are the extreme adverse events associated with deterioration in a person's mental state. There is also evidence that people experience poorer health outcomes, for both their mental and their physical health, when their mental health is not adequately treated.⁵

Suggested strategies

Be alert for signs of deterioration in a person's mental state

Initial screening can identify people who are at risk of acute deterioration in their mental state. However, people who have not been identified as being at high risk can also experience deterioration in their mental state. Be alert for changes in mental state in all people receiving health care, including people at risk of developing delirium. Delirium can occur at any age and can be prevented.

When a person is experiencing deterioration in their mental state, they may be able to self-report this to members of the workforce. Similarly, carers or family members may recognise the specific signs that they know indicate the person's mental state is deteriorating.

Successful implementation of this strategy will be supported by, or rely on, the following action:

5.10 Clinicians use relevant screening processes:

- a. At presentation, during clinical examination and history taking, and when required during care
 - b. To identify cognitive, behavioural, mental and physical conditions, issues and risks of harm
 - c. To identify social and other circumstances that may compound these risks
-

Practice resource: Recognising Signs of Deterioration in a Person's Mental State

During national consultation for the Consensus Statement, stakeholders reported that there is no tool in current clinical use for the comprehensive identification and monitoring of signs of deterioration in a person's mental state. The Commission engaged Gaskin Research to undertake a project to identify these signs. They conducted a literature review, interviews and sequential surveys with people with experience of mental health issues, their families and carers, clinicians from multiple disciplines, health service managers and researchers. They propose five overarching indicators, to provide logical structure to the process of recognising when a person's mental state is deteriorating. The five indicators are:

1. Reported change
2. Distress
3. Loss of touch with reality or the consequences of behaviours
4. Loss of function
5. Elevated risk to self, others or property

The report is available at:

<https://www.safetyandquality.gov.au/publications/recognising-signs-of-deterioration-in-a-persons-mental-state/>

Partner with consumers and carers to monitor risks

Develop collaborative systems to routinely monitor and support people at risk of deterioration in mental state, including:

- Prompts for assessment, including reports from the person or their family or carers
- Identification of the clinician responsible for assessment, documentation and communication processes
- Actions to be taken, including level of nursing observation
- Regular review and feedback processes
- Documentation of all of the above.

If delirium is identified as a cause of deterioration in the person's mental state, the Delirium Clinical Care Standard⁴⁵ includes indicators for local review and feedback.

Engagement with carers and families can help maintain safety for the person experiencing deterioration in their mental state and others, while arrangements for specialist intervention are underway.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

2.6 The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care

5.14d The workforce, patients, carers and families work in partnership to reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur

Examples of supporting evidence

- Policy documents about recognising, documenting and observing acute deterioration in a person's mental state
- Screening and assessment policies and procedures for mental health in line with the Comprehensive Care Standard
- Training documents about recognising acute deterioration in a person's mental state and how to deal with reports of deterioration from people with lived experience, their carers or family
- Documentation of integration of information from consumer wellness plans in comprehensive care plan.

Escalating care

Action 8.6

The health service organisation has protocols that specify criteria for escalating care, including:

- a. Agreed vital sign parameters and other indicators of physiological deterioration
- b. Agreed indicators of deterioration in mental state
- c. Agreed parameters and other indicators for calling emergency assistance
- d. Patient pain or distress that is not able to be managed using available treatment
- e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration

How does this action apply to people with mental health issues?

Acute deterioration in a person's mental state in a healthcare setting requires urgent response. The workforce in every setting need to have an understanding of what they can do when they recognise this occurring. Effective response may require specialist mental health intervention.

Suggested strategies

Identify parameters for escalation

Use a graded response system within the escalation protocol. This means that the escalation protocol includes at least two levels of response to deterioration in a person's mental state:

- An emergency response (for example, from specialist mental health clinicians) to criteria that indicate severe acute deterioration
- At least one other level of response (for example, from the treating or on-call team) for criteria that indicate less severe deterioration.

There should be a clear system in place for the person themselves, or their family or carer to directly call for escalation of care when they are concerned about deterioration in the person's mental state. Examples of these include:

- Ryan's Rule: patient, family and carer escalation process (QLD):
<https://clinicalexcellence.qld.gov.au/priority-areas/safety-and-quality/ryans-rule>
- Call and Respond Early (CARE) (WA & ACT):
<http://www.fhhs.health.wa.gov.au/For-patients-and-visitors/Your-hospital-stay/Call-and-Respond-Early-CARE>
- REACH (Recognise, Engage, Act, Call, Help is on its way) (NSW):
http://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0007/362608/REACH-Toolkit-Updated-version-May-2017.pdf

Successful implementation of this strategy will be supported by, or rely on, the following action:

6.10 The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians

Develop a local escalation protocol

If the person's mental state is deteriorating in a non-mental health specialist setting, the local protocol should be clear about how access to specialist mental health care is achieved. In a large tertiary hospital, this may be an internal referral to a consultation liaison service. Many of these services have referral forms that prompt non-specialist clinicians about what to look for and communicate when they have concerns about a person's mental state.

For other services, where specialist mental health services may not be located onsite, it will be necessary to have an escalation protocol that links to another agency. These protocols should be supported by established partnerships, and clear processes for communication for both the referring clinician and the service receiving the referral. These should cover:

- Designation about which service or clinician holds clinical responsibility for the person's care
- Expected timeframes for response.

Tailor the escalation protocol to the specific health setting, taking into account:

- The size, location and role of the setting
- The available resources, including the clinical workforce skill mix
- The capacity to engage specialist help.

The Commission developed an escalation mapping tool to support services to implement processes for recognising and responding to physiological deterioration. It provides a template that local units can use to set out what changes in observations will indicate need for escalation in the local context. The tool can be adapted to reflect what needs to be done when signs of deterioration in a person's mental state are reported or observed. The tool is available on the Commission's website at:

<https://www.safetyandquality.gov.au/wp-content/uploads/2012/02/Escalation-mapping-template-editable-PDF.pdf>

Successful implementation of this strategy will be supported by, or rely on, the following action:

8.12 The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated

Examples of supporting evidence

- Policy documents that identify agreed criteria that indicate acute deterioration in a person's mental state that trigger escalation of care, and the expected responses
- Policy documents that include consideration of the organisation's size, role, location and services provided
- Documented localised escalation protocols
- Resources or tools that help clinicians to use the escalation protocols
- Audit results of compliance with the escalation protocols

Responding to acute deterioration

Responding to deterioration

Action 8.12

The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated

How does this action apply to people with mental health issues?

When a person experiences acute deterioration in their mental state, their health care needs to incorporate mental health expertise. If the health service organisation does not employ mental health clinicians onsite, there should be established processes to ensure prompt access to a specialist mental health service. Members of the workforce need to be aware of, and utilise these processes.

Suggested strategies

Develop internal and external partnerships to support escalation of care to specialist mental health services

Large tertiary hospitals typically have consultation liaison psychiatry services available internally. Ensure that all members of the workforce are aware of how to contact the service when they recognise deterioration in a person's mental state. Many consultation liaison services provide templates for referral that support effective communication and enable reviews to be prioritised across the hospital. Support consultation liaison processes with education for the workforce. Consultations can provide opportunities for further education and upskilling of the workforce.

For organisations that do not have consultation liaison services onsite, develop and maintain local partnerships to enable rapid referral. This may involve linking with the local community mental health service, a general practitioner or on-call psychiatrists.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

5.5 The health service organisation has processes to:

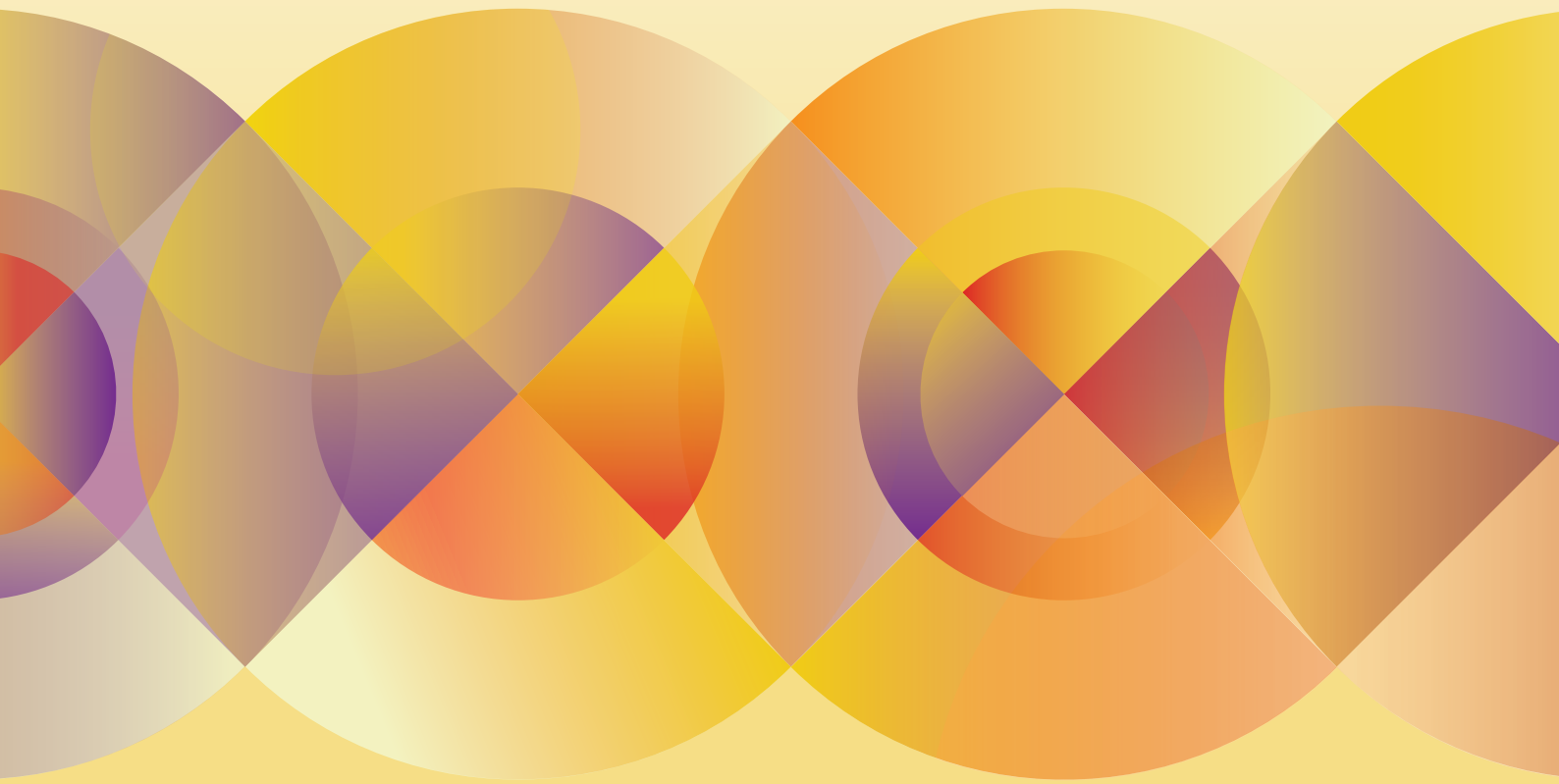
- c. Support multidisciplinary collaboration and teamwork
- d. Define the roles and responsibilities of each clinician working in a team

8.6b The health service organisation has protocols that specify criteria for escalating care, including agreed indicators of deterioration in mental state

Examples of supporting evidence

- Policy documents about rapid referral to mental health services
- Audit results of episodes of acute deterioration in a person's mental state, to determine whether rapid referrals were made to mental health services

Appendices



Appendix A: Linked actions

The following table summarises linked actions in the NSQHS Standards that have been highlighted throughout the text as critical for supporting implementation of the suggested strategies

Table 2: Summary of linked actions in the NSQHS Standards

Standard	Criterion	Item	Action	Links	
Clinical Governance	Governance, leadership and culture	Governance, leadership and culture	1.1	1.9, 1.15, 2.7	
		Organisational leadership	1.3	2.11	
		Clinical leadership	1.6	1.5, 1.26, 2.7, 5.5	
	Patient safety and quality systems	Patient safety and quality systems	Policies and procedures	1.7	1.20, 2.4, 2.9, 2.11, 5.35
			Measurement and quality improvement	1.9	1.3, 1.8, 2.11
			Risk management	1.10	1.5, 1.15, 1.20, 1.29, 5.31, 5.33, 5.34
			Incident management	1.11	1.9, 1.12, 1.20, 5.35, 5.36, 6.10, 8.7
			Feedback and complaints management	1.13	1.9, 2.9
				1.14	2.11
			Diversity and high-risk groups	1.15	1.4, 1.20, 5.10
	Safe environment for the delivery of care	Safe environment	1.29	2.11	
			1.30	1.29, 5.33	
Partnering with Consumers	Partnering with patients in their own care	Healthcare rights and informed consent	2.4	1.7, 1.20	
			2.5	1.7	
		Sharing decisions and planning care	2.6	1.15, 5.13	
			2.7	1.5, 1.20	
Medication Safety	Documentation of patient information	Medication reconciliation	4.5	1.15, 4.3	
			4.6	4.3, 6.8	
		Adverse drug reactions	4.7	2.6	

Table 2: Continued

Standard	Criterion	Item	Action	Links
Comprehensive Care	Developing the comprehensive care plan	Screening of risk	5.10	1.15, 1.20, 5.3, 8.6
		Clinical assessment	5.11	1.16, 2.6, 8.12
		Developing the comprehensive care plan	5.13	5.3, 5.6
	Delivering comprehensive care	Using the comprehensive care plan	5.14	1.6, 1.16, 5.3, 5.5, 5.6, 6.9, 6.10, 8.6
	Minimising patient harm	Predicting, preventing and managing self-harm and suicide	5.31	1.15, 1.21, 2.13, 5.3, 5.13
			5.32	5.3, 5.13, 6.8
		Predicting, preventing and managing aggression and violence	5.33	1.1, 1.6, 1.11, 1.29, 1.30, 5.34
			5.34	1.20, 5.1, 5.3
		Minimising restrictive practices: restraint	5.35	1.1, 1.7, 1.11, 1.20, 2.11, 5.33, 5.34
	Minimising restrictive practices: seclusion	5.36	1.29, 2.11	
Communicating for Safety	Communication at clinical handover	Clinical handover	6.8	1.16, 5.5, 5.13, 5.32, 6.3
	Communication of critical information	Communicating critical information	6.9	5.5, 8.6
			6.10	2.6, 2.9, 6.3, 8.6
Recognising and Responding to Acute Deterioration	Detecting and recognising acute deterioration, and escalating care	Recognising acute deterioration	8.5	2.6, 5.10, 5.14
		Escalating care	8.6	6.10, 8.12
	Responding to acute deterioration	Responding to deterioration	8.12	5.5, 8.6

Appendix B:

List of practice resources

These are listed under the NSQHS Standards actions they are described under within the text.

1.13 Feedback

Australian Hospital Patients Experience Question Set

<https://www.safetyandquality.gov.au/our-work/indicators/hospital-patient-experience/>

Your Experience of Service (YES) survey

<https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/national-mental-health-committees/mental-health-information-strategy-standing-commit/your-experience-of-service-survey-instrument>

1.15 Recognising diversity

Trauma-informed care: Scottish NHS Training Framework

<http://www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf>

Aboriginal and Torres Strait Islander Health in Culture – Policy Concordance

<http://natsilmh.org.au/sites/default/files/NATSILMH%20Health%20in%20Culture%20Policy%20Concordance%20%282%29.pdf>

Intellectual disability mental health e-learning

<http://www.idhealtheducation.edu.au/>

Department of Veterans' Affairs 'At Ease' website

<https://at-ease.dva.gov.au/professionals>

LGBTI Health Alliance Cultural Competency Framework

<https://www.lgbtihealth.org.au/sites/default/files/Cultural%20Competency%20Implementation%20Framework.pdf>

Mental Health Care in the Perinatal Period

http://cope.org.au/wp-content/uploads/2018/05/COPE-Perinatal-MH-Guideline_Final-2018.pdf

Mental Health in Multicultural Australia Framework

<http://framework.mhima.org.au/framework/index.htm>

2.5 Informed consent

SA Health Impaired Decision-Making Factsheet

<http://www.sahealth.sa.gov.au/wps/wcm/connect/8a241b804459db088a0daa76d172935c/Assessing+Capacity+Fact+Sheet+PC+20140613.pdf?MOD=AJPERES&CACHEID=8a241b804459db088a0daa76d172935c>

2.6 Shared decision making

A practical guide for working with carers of people with mental illness

<https://mhaustralia.org/media-releases/practical-guide-working-carers-of-people-mental-illness>

2.7 Supporting workforce for partnering with consumers

Consultation liaison nurses' top tips

<http://www.acmhn.org/images/stories/CLSI/ToptipsforCLnurses.pdf>

Releasing Time to Care/The Productive Ward

<http://www.health.nsw.gov.au/nursing/Pages/releasing-time-to-care.aspx>

4.6 Medication safety

National Quality Use of Medicines Indicators for Australian Hospitals: Acute Mental Health Care Set

<http://www.nswtag.org.au/qum-indicators-set-7/>

5 Comprehensive Care Standard

Equally Well consensus statement

<https://equallywell.org.au/getinvolved/>

5.10 Screening of risk

Clinical pathway for the screening, assessment and management of anxiety and depression in adult cancer patients

http://www.pocog.org.au/doc/ClinicalPathways_Sept%202017.pdf

5.13 Developing the Comprehensive Care Plan

National Eating Disorders Collaboration

<https://www.nedc.com.au/>

5.31 Predicting, preventing and managing self-harm and suicide

National Institute for Health and Care Excellence (NICE) self-harm quality standard

<https://www.nice.org.uk/guidance/qs34>

Black Dog Institute Guidelines for integrated suicide-related crisis and follow-up care in Emergency Departments and other acute settings

https://blackdoginstitute.org.au/docs/default-source/lifespan/delphi-guidelines-clinical-summary_web.pdf?sfvrsn=0

5.32 Follow-up after a suicide attempt

Beyond Blue Way Back Support Service

<https://www.beyondblue.org.au/about-us/about-our-work/suicide-prevention/the-way-back-support-service>

5.33 Creating safety and mitigating risk of aggression

Safewards

<https://www2.health.vic.gov.au/safewards>

5.34 Managing aggression

Challenging behaviour policy framework

<http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/challenging+behaviour+strategy/challenging+behaviour+policy+framework>

De-escalation techniques

http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2015_007.pdf

5.35 Minimising restraint

Liverpool Hospital ICU Clinical Guideline Physical Restraints

https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0019/306451/liverpoolPhysical_Restraints.pdf

8 Recognising and Responding to Acute Deterioration

National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state

<https://www.safetyandquality.gov.au/wp-content/uploads/2017/08/National-Consensus-Statement-Essential-elements-for-recognising-and-responding-to-deterioration-in-a-person%E2%80%99s-mental-state-July-2017.pdf>

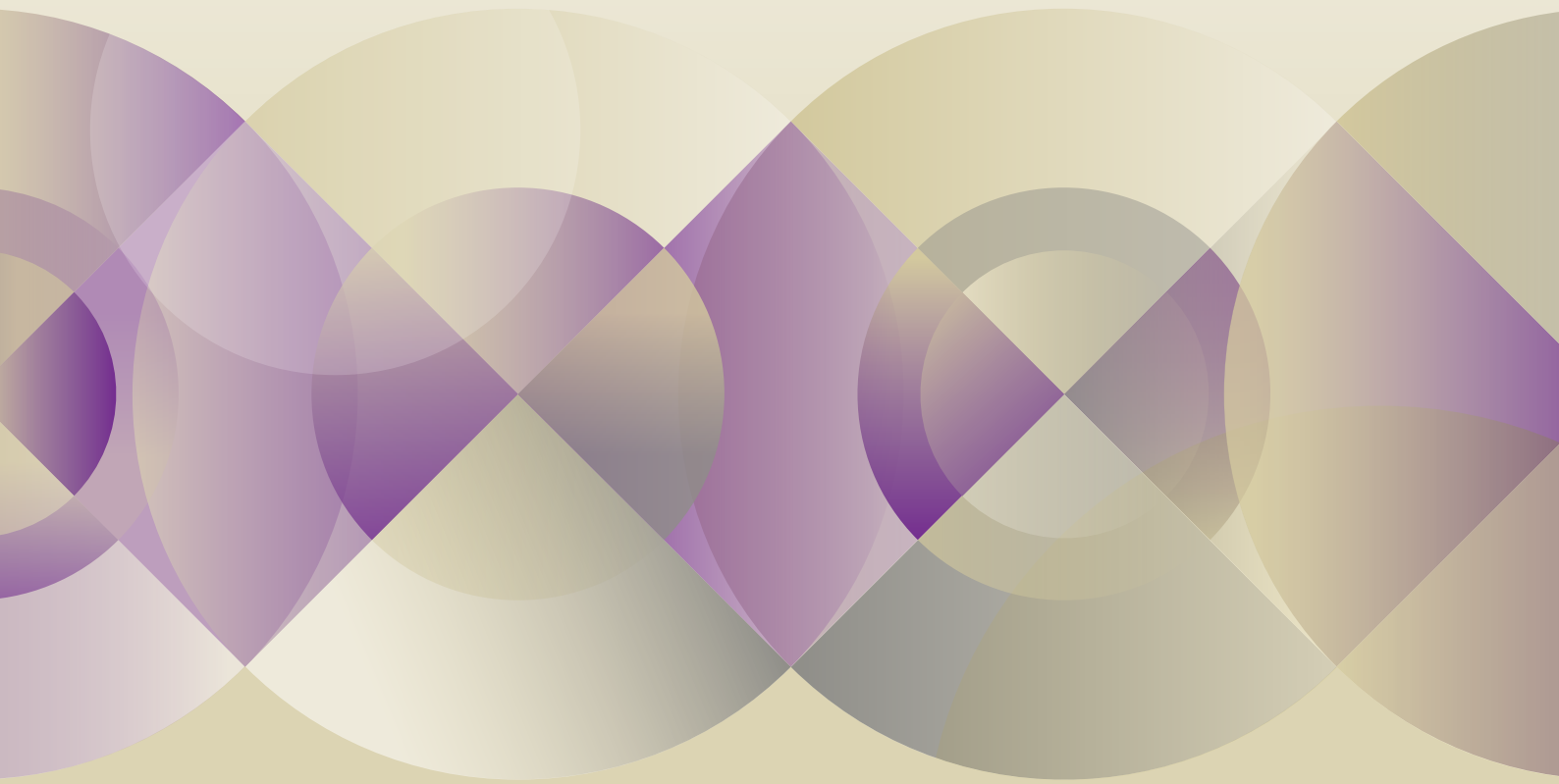
Appendix C: Example of a consumer wellness plan

	FAMILY NAME		MRN
	GIVEN NAMES		<input type="checkbox"/> MALE
	D.O.B	M.O.	<input type="checkbox"/> FEMALE
	ADDRESS		
FACILITY	LOCATION		
Mental Health CONSUMER WELLNESS PLAN	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		
<p>This module has been designed by consumers. All consumers are encouraged to complete it in partnership with their clinician and/or nominated carer. The intent of the module is to facilitate consumer involvement in their own care, particularly in terms of symptom management, relapse prevention and crisis planning. It serves as a recovery aid and as a prompt and reminder about what to do to support recovery.</p>			
<p>Things I do well/skills I have</p>			
<p> </p>			
<p>Things I can do to keep myself well/what helps me stay well</p>			
<p> </p>			
<p> </p>			

Support/treatment/medications that have been helpful/I have liked		
Support/treatment/medications that have been unhelpful/I have disliked		
Things that stress me	Things I can do to reduce stress	
My early warning signs are	Things that help with early warning signs	
When I am unwell, I and/or others may notice that I...		
If I become unwell I would like the following to happen or not to happen		

CONTACT DETAILS OF MY NOMINATED SUPPORT PEOPLE						
NAME	RELATIONSHIP	CONTACT DETAILS	INPUT INTO PLAN?		COPY OF PLAN?	
			YES	NO	YES	NO
	Family/primary carer		YES	NO	YES	NO
	GP		YES	NO	YES	NO
			YES	NO	YES	NO
			YES	NO	YES	NO
REVIEW DATE						
Copy provided to consumer					YES	NO
I have been fully informed about my rights and responsibilities (includes receipt of consumer package)					YES	NO
I have been informed of peer support options					YES	NO
People who have helped me complete the Plan						
Consumer name			Signature			
Date						

References

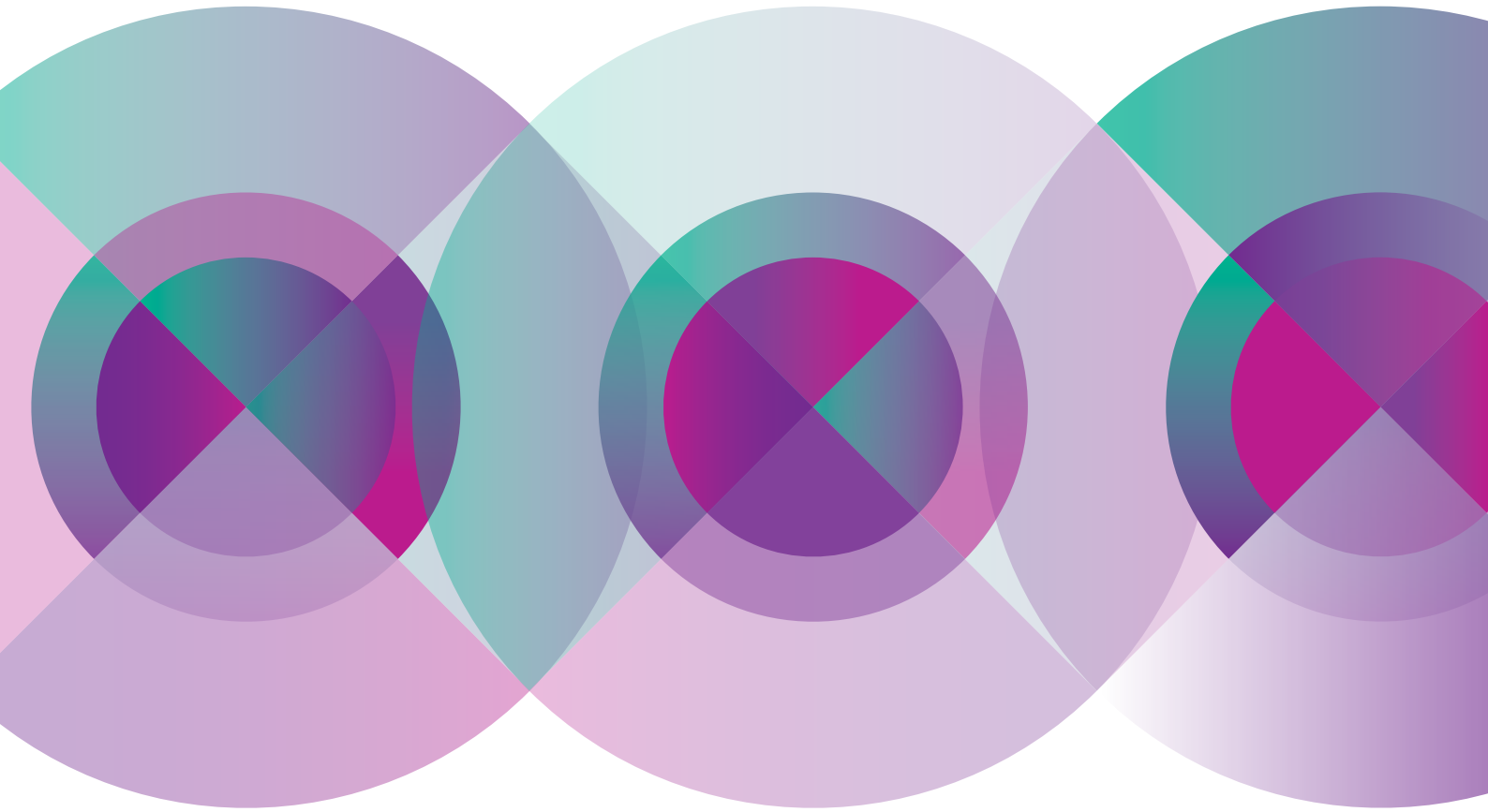


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