MonashHealth

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22 September 2017

Deputy State Coroner Iain West
Coroners Court of Victoria
65 Kavanagh Street
Southbank VIC 3006

Dear Deputy State Coroner West,

Court Reference: COR 2015 003498

I refer to the recommendations arising from your Finding into Death with Inquest of the late Mr Samer Damouni.

Thank you for your recommendations in relation to Monash Health. I have considered the matters that you have raised and Monash Health responds as follows:

Recommendations:

1. ***That Monash Health implement a Behavioural Assessment Room at Casey Hospital, and if appropriate, across the network of Monash Health.***

   Monash Health Response:

   A Behavioural Assessment Room (BAR) exists at Dandenong Hospital Emergency Department (ED), and one has recently been built at Monash Medical Centre ED. Department of Health & Human Services (DHHS) has provided funding in 2017 for a BAR at Casey Hospital with design planning underway and a targeted completion date of late 2017, early 2018.

2. ***That Monash Health, in conjunction with Better Care Victoria, implement a Behavioural Assessment Precinct at Casey Hospital and, if appropriate, across the network of Monash Health Hospitals.***

   Monash Health response:

   Behavioural Health Precincts within ED's are a new and developing concept. Designed to provide a range of areas (including low security, high security and long stay areas) in close proximity to each other, in order to create a safer and low stimulus environment more suitable for the assessment and care of behaviourally disturbed persons. It is Monash Health's intention to work with DHHS and incorporate such design concepts into any major redesign of Monash Health EDs; the first being at Monash Medical Centre. At Casey Hospital, where there are no immediate plans to rebuild the ED, consideration is presently being given to the temporary repurposing of an area within the existing ED footprint to allow some of the attributes of a Behavioural Health Precinct to be implemented.

3. ***That Monash Health, in conjunction with Better Care Victoria, increase the acute mental health inpatient bed capacity at Casey Hospital and, if appropriate, across the network of Monash Health Hospitals.***

Monash Health response:

Monash Health in partnership with DHHS are working on both short and longer term solutions to increase Mental Health inpatient bed capacity. We are looking at options to increase bed capacity at Casey Hospital, looking to enter into an arrangement with a private provider of Mental Health service for Inpatient Mental Health Care along with an opportunity for additional capacity at the clayton campus in 2018 when the Early in Life Mental Health Service relocates into its new facility in Monash Children's Hospital.

4. ***That Monash Health review the manner in which clinical histories are obtained by staff when performing mental health assessments for patients presenting at the emergency department.***

Monash Health response:

Monash Health has been reviewing its model of care operating in ED, including how it manages the care and treatment of mental health patients. This review has considered and developed improvements in the function of the multi-disciplinary team, collaboration and communication between ED staff and mental health staff, the conduct of the assessments, the environment in which assessments occur (see discussion above about the Behavioural Health Precinct) and the escalation process when there is clinical concern. The implementation of this review, which includes increasing mental health staff in the ED, will occur over the next 12 months.

5. ***That Monash Health review its policies and procedures (if any), for incorporating information received from third parties about patients who present to the emergency department, particularly with psychiatric conditions.***

Monash Health response:

Monash Health has reviewed and updated relevant procedures. The attached three procedures explicitly state our attitudes and practices in regard to incorporating third party (particularly family) information into care planning of patients who present to ED with psychiatric conditions:

Mental Health Assessment: Para 1.4 states *"Where possible, obtain consumer consent specific for the gathering of information from family, other health and welfare professionals and agencies".*

Mental Health Assessment, Treatment, Transfer & Discharge in the Emergency Department: Para 1.5 states *"ECATT assess the patient and where necessary consult with the… [list includes] … Next of kin and/or any third parties who may be able to give insight into the patient's mental state and risks".*

Mental Health Risk Assessment: Para 2.2 states *"Conduct a risk assessment from information provided by….[list includes]….Other informants (e.g. Family, friends, work colleagues)".*

Monash Health also emphasises the need for consultation with, and inclusion of views of any carers, family members, and Nominated Persons in the following procedures:

i. Mental Health Community Care & Case Management
ii. Mental Health Treatment & Recovery Plan
iii. Mental Health Multidisciplinary Clinical Review

These procedures help guide our clinicians in providing care in the community.

Yours sincerely

Anjali Dhulia
Acting Chief Medical Officer
22/9/2017.

Who must comply with this procedure?

All Mental Health and Aged Persons Mental Health Program clinical staff

This procedure applies in the following settings where:

All Mental Health and Aged Persons Mental Health sites and any Southern Health site where mental health program staff conduct assessments.

Precautions and Contraindications

Only suitably qualified and experienced mental health professionals conduct clinical assessments.

Where undergraduate students are conducting assessments as part of their clinical placement, the assessment will occur in the presence of a qualified mental health professional and any file entry co-signed and designated by the supervising health professional.

When a patient re-presents to hospital within 48 hours with a similar condition, the Consultant Psychiatrist will be contacted by ECATT staff to discuss the outcome of the assessment prior to discharging the patient.

Equipment

Mental Health MH-DOC.COM suite of guidelines and assessment tools

Computer with access to Scanned Medical Records (SMR) and Client Management interface (CMI)

Access to Symphony for clinicians working in the Emergency Department

Procedure:

1. Prior to commencing assessment, the mental health clinician will:

    1.1. Gather all referral information from the referral source

    1.2. Check Scanned Medical Record and Clinical Information Management for previous medical and psychiatric history.

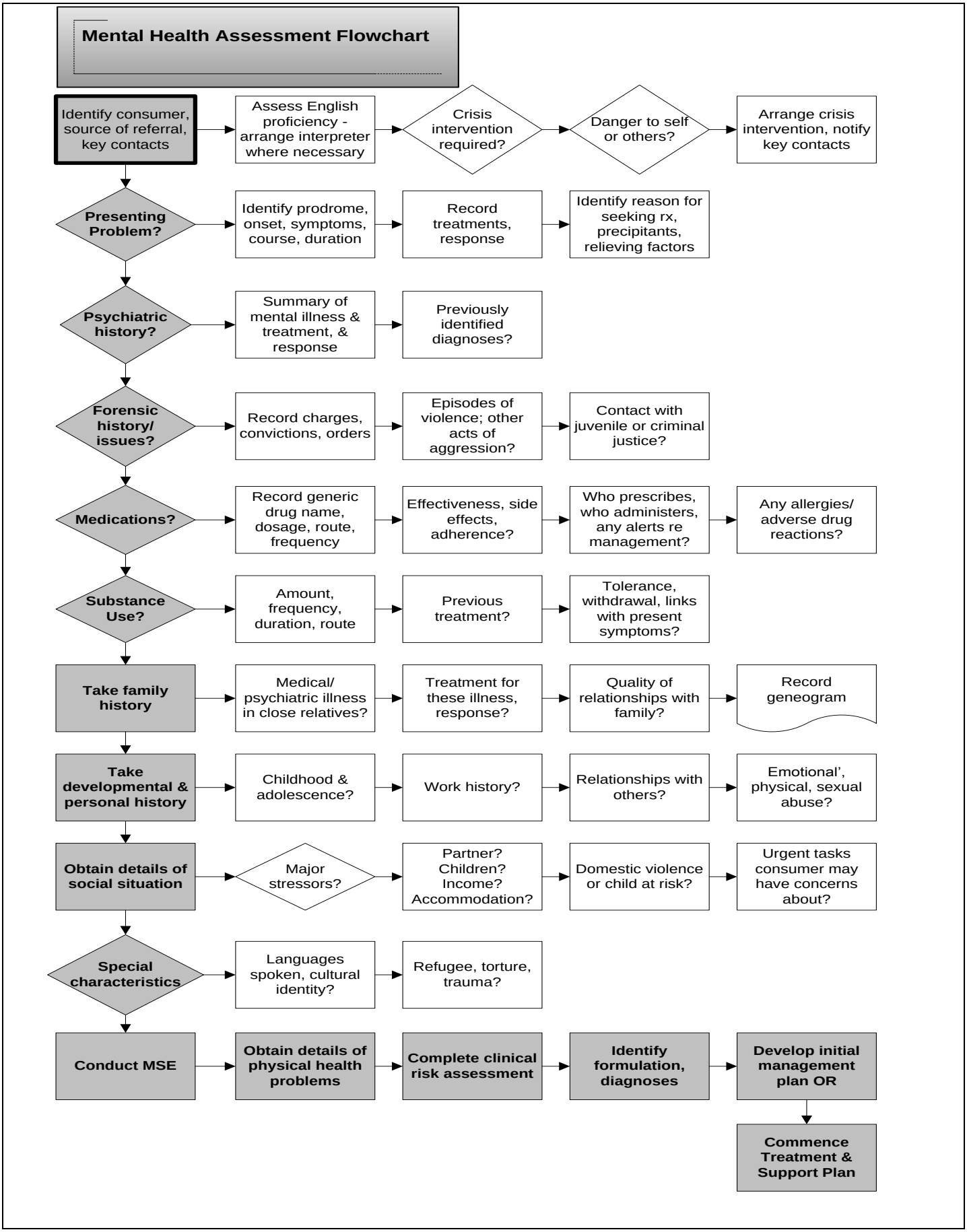
    1.3. ECATT and CATT clinicians will additionally check current and previous presentation information on Symphony if the patient is presenting to the Emergency department.

    1.4. Where possible, obtain consumer consent specific for the gathering of information from family, other health and welfare professionals and agencies.

    1.5. Ensure an appropriate environment in which to undertake assessment

    1.6. Utilise interpreters where required, to allow assessment to be conducted in the preferred language of the consumer/patient and their carers.

2. The Mental Health Clinician/s is to conduct an initial comprehensive mental health assessment as per flowchart below:


Mental Health Assessment Flowchart
Identify consumer, source of referral, key contacts
Assess English proficiency - arrange interpreter where necessary
Crisis intervention required?
Danger to self or others?
Arrange crisis intervention, notify key contacts
Presenting Problem?
Identify prodrome, onset, symptoms, course, duration
Record treatments, response
Identify reason for seeking rx, precipitants, relieving factors
Psychiatric history?
Summary of mental illness & treatment, & response
Previously identified diagnoses?
Forensic history/ issues?
Record charges, convictions, orders
Episodes of violence; other acts of aggression?
Contact with juvenile or criminal justice?
Medications?
Record generic drug name, dosage, route, frequency
Effectiveness, side effects, adherence?
Who prescribes, who administers, any alerts re management?
Any allergies/ adverse drug reactions?
Substance Use?
Amount, frequency, duration, route
Previous treatment?
Tolerance, withdrawal, links with present symptoms?
Take family history
Medical/ psychiatric illness in close relatives?
Treatment for these illness, response?
Quality of relationships with family?
Record geneogram
Take developmental & personal history
Childhood & adolescence?
Work history?
Relationships with others?
Emotional', physical, sexual abuse?
Obtain details of social situation
Major stressors?
Partner? Children? Income? Accommodation?
Domestic violence or child at risk?
Urgent tasks consumer may have concerns about?
Special characteristics
Languages spoken, cultural identity?
Refugee, torture, trauma?
Conduct MSE
Obtain details of physical health problems
Complete clinical risk assessment
Identify formulation, diagnoses
Develop initial management plan OR
Commence Treatment & Support Plan

3. Where sections are completed by different assessors, ensure these are clearly indicated by name, position and signature
4. If additional information is referenced in progress notes or on an alternative sheet, appropriately cross reference with date and attach as applicable
5. Where consumer/patient is to be provided service, present assessment at next clinical review meeting for discussion with relevant actions by multidisciplinary team (MDT) and any planned discharge timeframes.
6. When the patient has presented to the hospital Emergency Department with a similar problem in the last 48 hours, the ECATT clinician will contact the Consultant Psychiatrist to discuss the results of the assessment prior to discharging the patient.
7. Where a person is assessed as not eligible for ongoing intervention, discuss with consumer/patient and/or significant others, provide information regarding alternative services, assist with any referral arrangements and as applicable provide a copy of the assessment to the consumer/patient and/or alternative service provider. Discuss at the next scheduled clinical review meeting (refer to Treatment and Review procedure.
8. Annually complete a comprehensive mental health assessment for any consumer/patient remaining in the same service area for over 12 months

Useful resources

National Standards for Mental Health Services

Document Management
Policy supported: Safe and Effective Care
Executive sponsor: Executive Director Mental Health Program
Person responsible: Program Medical Director, Mental Health Program

Who must comply with this procedure

All Mental Health program staff (including ELMHS, Adult, and Aged Persons)

This policy applies in the following setting:

All Community Teams providing case management

Precautions and Contraindications

- The Mental Health Clinical documentation procedure outlines the documentation requirements for all Monash Health staff involved in planning and/or delivering clinical case management within a community mental health service.
- All clinical contacts, assessments, significant phone calls, contacts with carers, family members, or nominated persons, and any other case management activities, must be recorded in both the clinical file and on CMI.
- Allocation of case managers will prioritise continuity of care.

A note about language:
Although the terms 'consumer', 'client', 'patient' and 'service user' are variously used to describe persons seeking help from health services, the word *patient* is preferentially used here to connote the clinical nature of the setting and the service.

1. General Principles

1.1. Case management provides a flexible service based on the individual needs of the patient and relevant family members or carers. The intensity, frequency and duration of service will vary according to the identified needs and focus of care (acute functional gain, intensive-extended or maintenance).

1.2. Case management services are provided within a recovery-based model of care by an integrated multi-disciplinary team, and are delivered to the patient across the mental health service in a timely and effective manner.

1.3. Within the multidisciplinary team (MDT), a clinician will be assigned the role of case manager (or primary clinician or care coordinator). The case manager takes the lead in the coordination of treatment of the patients, remaining involved during episodes of care within acute or sub-acute services, (including ECATT, CATT, inpatient and PARC services), and working in collaboration with Mental Health Community Support Services (MHCSS) as appropriate.

2. Referral, Allocation & Assessment

2.1. Referrals for new cases may come via Psychiatric Triage Service (PTS), inpatient units, or other parts of the mental health service.

2.2. Community teams will have appropriate processes for the timely allocation of new referrals to case managers and may hold regular intake meetings according to need (e.g. daily for CCT; twice weekly for MST). Responsibility for allocation rests with the team manager and treating psychiatrist.

2.3. Case managers will complete the Registration form (MH3) on allocation of new referrals.

2.4. Case managers will arrange to see new cases within one week of allocation, and complete assessment within two weeks (with the exception of cases triaged as non-urgent (code E), where the patient will be seen in a timeframe consistent with clinical need). In all instances, the completion of a Mental Health Clinical Assessment form (MRAF01), a Risk Assessment, relevant Outcome Measures (HONOS / HONOSCA / HONOS 65+ / BASIS-32 / SDQ), and where appropriate an Off-site Risk Screening tool (MRA83) will also be completed.

2.5. Junior medical officers (HMO or registrar), where allocated*, will see all new cases within this two weeks (*a junior medical officer may not be allocated for all ELMHS clients).

2.6. New cases will be presented at the formal multidisciplinary Clinical Review meeting, including psychiatrist input, within 4 weeks of registration. The Clinical Review Form (MRAF04) and the Treatment and Recovery Plan (MRAG02, where ongoing treatment within the same team is agreed to) will be completed for the Clinical Review meeting.

3. Continuing Care

Thereafter:

3.1. Case managers will generally provide a face-to-face review of patients on a fortnightly basis for patients aged over 12 years. If seen less frequently than fortnightly, the rationale must be documented in the clinical file including consultant psychiatrist endorsement/signature

3.1 Junior medical officers (HMO or registrar), where allocated*, will review continuing cases at a minimum of monthly intervals (*a junior medical officer may not be allocated for all ELMHS clients).

3.2 Consultant psychiatrists will review patients at a minimum of every 3 months, ideally immediately prior to presentation at the 91-day Clinical Review. Treatment & Recovery Plans will be reviewed at each clinical review.

3.3 All staff are responsible for documenting clinical contacts on the appropriate SMR eNote (or progress note if eNote is unavailable), including a brief mental state and risk assessment.

3.4 The Mental Health Assessment form will be reviewed every 12 months. The Risk Assessment form will be reviewed every 3 months prior to the 91-day Clinical Review, or sooner if clinically indicated.

3.5 Outcome measures will be completed at the start of each episode of care, at each Clinical Review, and at each separation (transfer or discharge), in accordance with the Outcome Measures procedure.

3.6 The Registration form (MH3) will be completed at the start of each subsequent episode of care, on the same day of discharge from the respective treating team (e.g. CATT, inpatient unit, PARC). This is to ensure there are no gaps between episodes of care on CMI.

3.7 Caseload review will take place on a regular basis (e.g. every 6 weeks) and involve the case manager, Team Leader (or equivalent), and consultant psychiatrist.

3.8 See related Mental Health procedures: Conduct of Multidisciplinary Clinical Review, Preparing a Treatment Plan, and Frequency of Medical Review.

3.9 **Mental Health Community Care & Case Management Quick Guide** in **APPENDIX** for clinical appointment and documentation requirements.

4 Discharge

4.1 Discharge planning will be an integral part of case management, and will involve the patient and relevant family/carer and nominated persons.

4.2 Patients must be supported to make decisions about their discharge and ongoing treatment

arrangements to support their continuing recovery.

4.3 The discharge process will focus on the smooth transition of care to a GP, carers / family members, and any other healthcare providers or MHCSS services.

4.4 Where available, the GP Liaison Officer will assist with GP shared-care arrangements.

4.5 Discharge planning will be discussed at caseload review and Clinical Review.

4.6 Patients will be reviewed by the treating psychiatrist prior to discharge, with relevant carer/family and nominated person involvement, to ensure that a plan is in place and appropriate handover has occurred or is in the process of occurring. In ELMHS, this may occur via the clinical review meeting, where clinically appropriate.

4.7 The Community MH Discharge Summary (SMR eNOTE where available) will be completed for all patients prior to discharge, for approval by the consultant psychiatrist.

4.8 Copies of the discharge summary will be provided to the patient, the GP, and any other healthcare providers or MHSCC services within one week of discharge. Copies are also provided to any carers/family members or nominated person at the patient's request.

4.9 Patients will not be discharged from the care of the team until:
- the Discharge Summary has been completed,
- the external service providers expected to provide the ongoing care have been consulted with and are in agreement with the ongoing management plan.
- The patient and any carers/family members and nominated person involved in their care are in agreement with the plan.

4.10 See, also, the mental health section in the Clinical Handover & Patient Discharge procedure.

4.11 Where a patient fails to attend appointments or unilaterally disengages with the service, they will be followed up by the treating team according to the Mental Health Appointments procedure.

5 Inter-service transfer

5.1 Transfer of a patient from another mental health service on a Treatment Order requires the receiving psychiatrist to agree with the referring service when to formally transfer the Treatment Order on CMI.

5.2 This will usually be done after the patient has been registered and assessed by the receiving treating team.

6 Intra-Service Referral

6.1 Discuss transfers from case management to another Monash Health mental Health Service (e.g. inpatient service, CATT, MST, PARC, CCU), with the patient and, wherever appropriate, their carer / family.

6.2 Patient consent must be sought wherever possible (although it is acknowledged that this may not be possible in the event of a compulsory admission to an inpatient unit, or a referral to a CATT team for more assertive follow-up where a patient is difficult to engage).

6.3 For patients under the age of 16 years this consent can be sought from the legal guardian.

6.4 Provide a verbal handover to the receiving team, and complete the Intra-Service Referral form (MRAD02) for the purpose of transferring care. Complete relevant Outcome Measures forms, indicating the closure of the episode of care.

7 Case Management in the inpatient service

7.1 Wherever a patient receiving a case management service is admitted to a psychiatric inpatient unit, the ward will contact the case manager within one working day of admission, by email or telephone, to facilitate ongoing contact.

7.2 The case manager will then visit the patient in the inpatient unit at their earliest opportunity (face-to-face contact is preferable, but teleconference may be considered).

7.3 Whilst in inpatient care, the case management role is to provide continuity of care, providing information about the overall management goals and plan, and maintaining contact with the patient and their carers/family members and nominated person, and offered a peer support worker (where appropriate) to facilitate a seamless discharge and integration into the community and reduce risk of readmission.

7.4 Case managers must maintain their contact with the patient and their carers/family members and nominated person, throughout the inpatient admission.

7.5 This must include at least weekly contact with the inpatient unit, and discuss discharge plans with them (face to face contacts are preferable, but teleconference can be considered, where practicable).

7.6 Arrange an appointment for the patient to see the case manager in the community prior to discharge, to take place within 3-7 days of discharge, according to clinical need.

7.7 Where high risk of readmission is identified, the Post Discharge Peer support worker will conduct 3 follow up appointments with consenting patient and/or carer/family members and nominated person, during 28 days post discharge.

7.8 This support must be offered prior to discharge with time for face to face meeting for consumer prior to discharge. Carers/family members and nominated persons must have a connection prior to discharge by phone of face to face.

8 Special situations

8.1 Crisis Assessment Treating Teams (CATT)

8.1.1 For new referrals for case management from CATT, a joint assessment (either at home or the clinic) must occur between the CATT clinician and case manager prior to discharge from CATT. This will take place within 3 business days / 72 hours from the day of referral from CATT to case manager.

8.1.2 For case managed patients referred to CATT, a comprehensive verbal handover must be provided by the case manager in addition to the provision of an Intra-Service Referral form (MRAD02).

8.1.3 Regular communication (telephone or email) will be maintained between CATT and case manager during the acute episode of care and prior to transfer back to case manager.

8.2 Emergency Department

8.2.1 When a case managed patient is admitted to the Emergency Department, the ECATT

clinician will make contact with the case manager to inform them of the presentation.

8.2.2 During business hours, the case manager is expected, if practicable, to join the ECATT clinician in the Emergency Department to assess the patient, unless otherwise indicated in the Treatment Plan.

8.2.3 This provides the client with continuity of care, and enables the Emergency Department and ECATT to benefit from the case manager's longitudinal knowledge of the patient.

8.2.4 If the case manager is not available to attend, they will be available for telephone consultation.

8.2.5 If the case manager is not available, the duty worker will be available for consultation during business hours.

8.3 **Mental Health Consultation-Liaison (CL) Psychiatry Service**

8.3.1 If a patient receiving case management is to be admitted, or has been admitted, to a non-psychiatric ward for medical/surgical care, communication will occur between the case manager and the CL service as soon as it is known.

8.3.2 Where appropriate, the case manager will visit the patient and record an entry in the health record (current admission progress notes).

8.3.3 Discharge planning remains the responsibility of the medical/surgical treating team but will be facilitated by the CL team, with the case manager contributing to the planning process.

9 Keeping of Clinical records

9.1 Once a patient is allocated to case management, a single episode of care will be created on Scanned Medical record (SMR).

9.2 This episode of care will remain open until the patient is discharged from case management (i.e. from the treating Monash Health mental health service).

9.3 It will not to be closed each time a patient is referred to another part of the service for a brief episode of care (e.g. CATT, inpatient unit, PARC) and expected to return to the care of the community case management team.

9.4 All clinicians are responsible for completing clinical documentation through:

- Increasingly, using e-notes in SMR, or
- On paper, submitted for scanning into SMR.

9.5 Clinicians are also responsible for recording all contacts and clinical encounters on CMI.

Useful resources

Carer Recognition Act 2012

Clinical handover patient discharge procedure - see mental health section

Compulsory Orders Assessment Order or Court Assessment Order procedure

Compulsory Orders Treatment Order and Court Secure Treatment Order procedure

Compulsory Treatment Orders - Temporary Treatment Order procedure

Mental Health Act 2014 Mental Health Advance Statements procedure Mental Health Appointments procedure Mental Health Multidisciplinary Clinical Review procedure Mental Health Medical Review procedure Mental Health Nominated Persons procedure Mental Health Outcome Measures procedure Mental Health Treatment and Recovery Plan procedure Mental Health risk assessment procedure Mental Health Tribunal procedure Prescribing and administering Olanzapine Pamoate Depo Injection (Zyprexa Relprevv®)
Keywords or tags Community care, case management, Referral, Assessment, Treatment Planning & Multidisciplinary Clinical Review

Document Management
Policy supported: Clinical Communication (Operational)
Executive sponsor: Chief Operating Officer, South East Sector
Person responsible: Operational Manager, Community Care and Recovery

APPENDIX – Mental Health Community Care & Case Management Quick Guide

New referrals for case management (from PTS, CATT or inpatient unit):

- **Registration form** completed on allocation or discharge from inpatient unit / CATT
- **Case Manager** to assess patient on inpatient unit prior to discharge, where possible, or undertake a joint assessment with CATT
- **Case Manager** will see patient for formal assessment within one week
- **HMO/registrar** will see patient for assessment within 2 weeks
- **Mental Health Clinical Assessment** will be jointly completed within 2 weeks
    - Includes **Initial Risk Assessment**, **Outcome Measures**, **Off-site Risk Screening** and provisional **Treatment & Recovery Plan.**
- **Psychiatrist** review, and formal **MDT Clinical Review**, occur within 4 weeks
    - **Treatment & Recovery Plan** will be finalised at this time.

New episodes of care (case managed patients transferred back from CATT or inpatient units):

- **Case Manager** will have seen the patient whilst on the ward
- **Patient re-registered with community team** on same day of discharge from CATT or inpatient unit
- **Case Manager** will see patient for follow-up within 1 week
- **Outcome Measures** will be completed at first appointment
- **HMO/registrar** will review patient within 2 weeks
- **Mental Health Clinical Assessment, Risk Assessment and Treatment & Recovery Plan** will be reviewed, but not necessarily re-written, within 2 weeks, and discussed with MDT
- **Psychiatrist** review, and formal **Clinical Review**, will occur within 91-days, or earlier if clinically indicated

Ongoing case management

- **Case manager** face-to-face minimum every 2 weeks, except with rationale and discussion
- **HMO/registrar** review at minimum monthly
- **Psychiatrist** review at minimum 3-monthly, in association with Clinical Review
- Each direct contact to be documented on SMR eNote form, and include a brief mental state assessment and risk assessment

Outcome Measures completed at:

- At initial assessment on commencement of new case
- Clinical Reviews – every 3 months
- At the end of any episode of care (e.g. transfer to CATT, inpatient unit), and the start of each new episode of care (e.g. discharge back from CATT or inpatient unit)
- On final discharge from case management

Treatment & Recovery Plan will be:

- Completed within 4 weeks of initial case commencement and revised at every 3 months at each Clinical Review, or earlier at any time if required.

Risk Assessment:

- **Initial Risk Assessment** completed at case commencement, and **Subsequent Risk Assessment** completed every 3-months, at the time of the Clinical review, or more frequently if situation changes.

Mental Health Clinical Assessment:

- Completed within 4 weeks of initial case commencement and revised every 12 months at a minimum

	New cases				Ongoing cases						
Task / documentation requirements	On allocation	Within 1 week	Within 2 weeks	Within 4 weeks	Every 2 weeks	Every 4 weeks	Every 3 months	Each new registration	Each new separation	Annually	On final discharge
Case manager appointments		✓			✓						✓
Junior doctor appointments			✓			✓					✓
Treating psychiatrist appointments				✓			✓				✓
Adult/ELMHS/Aged Registration & Admission MH3	✓							✓			
Outcome Measures MRAF05		✓		✓			✓	✓	✓		✓
BASIS 32 MRAF06		✓		✓			✓	✓	✓		✓
Consumer Consent MRD38		✓									
Mental Health Assessment MRAF01			✓							✓	
Nicotine Dependence Management Form MRJ209		✓									
Offsite visiting risk screening tool (Part 1) MRA83			✓								
Offsite Risk Management tool (Part 2) MRA86			✓								
Clinical Review MRAF04				✓			✓				
Treatment and Recovery Plan MRAG02				✓			✓				✓
Clinical Risk Assessment MRAR01			✓				✓				
Community MH Discharge Summary eNote											✓
Services to use relevant eNotes to document all direct and indirect contacts. All clinical significant contacts (direct and indirect) must include a brief risk assessment											
Medication Chart (Community Mental Health) MRL50	As required										
Advanced Statement MH1 / Revocation of an Advanced Statement MH2	Review at each registration then as required										
Nominated Person MH8 / Revocation of a Nominated Person MH9	Review at each registration then as required										
Compulsory Notification Person MHT32	For compulsory patients only. Complete at each registration then each time MHA form is submitted to the Mental Health Tribunal										

Mental Health patient assessment, treatment, transfer and discharge in the Emergency Department

Procedure

MonashHealth

Who must comply with this procedure?

Emergency Department (ED) and Mental Health Medical and Nursing staff.

This procedure applies in the following setting:

Mental Health patients assessment, treatment, transfer and discharge in the ED

Precautions and Contraindications

Referral to Emergency Crises and Treatment Team (ECATT) is only official when completed via Symphony. **Request will not be considered** as an official request for ECATT input via telephone calls, corridor dialogue and other means.

Where a patient presents to ED with an acute psychiatric presentation requiring evaluation, such as with deliberate self-harm, but has a co-occurring acute medical condition, the treatment of which is taking precedence, the ECATT clinician will undertake a mental health assessment of the patient as appropriate to the circumstance prior to the patient leaving ED.

Psychiatric wards cannot take severely medically compromised patients or, in general, patients having continuous IV therapy.

A patient who has taken alcohol can be admitted to an inpatient psychiatric bed as long as they have been assessed as being medically stable, with a Glasgow coma scale (GCS) of 15, they can walk, and have been cleared as safe by toxicology in regard to overdose of any drugs which may interact with the alcohol.

During admissions where ECATT is not available and there is a patient who is a safety risk and/or a flight risk and/or agitated the ED nurse in charge and clinician initiate the necessary safety measures required to keep the patient safe including help from Security, a constant patient observer (CPO) and ensuring the patient is adequately medicated.

All bed requests including direct admissions will go via bed access unit (BAU).

Where direct admission is arranged ECATT is not required

Equipment

- Symphony
- Clinical handover patient transfer form (MRD13) for inter site and external transfers
- The clinical handover ED Symphony inter/intra hospital transfer form
- Mental Health assessment form (MRAFO1(I)
- Mental Health intra-service referral form MRAD02(i)

This procedure outlines the following

1. Assessment and treatment ED Triage will:

1.1 Perform and record a set of vital signs.

1.2 Assign an acute care group to the patient if they meet the following criteria:

- Is aged >65.
- Vital signs are abnormal.
- Has ingested significant amounts of a drug or alcohol.
- First presentation with an apparent serious mental illness e.g. psychosis.
- Has multiple medical co-morbidities.
- Initiate a mental health referral on Symphony and allocate the referral the appropriate triage category.

1.3 ECATT:

- Receive the Symphony mental health referral, will prioritise according to the triage category and acknowledge receipt of this referral at a minimum via Symphony Medical e-notes.
- Will verbally notify the ED nurse in charge if they anticipate delays in commencing an assessment.
- Cannot commence their assessment due to a patient being medically unstable, ECATT record this in Symphony Medical e-notes and await approval from the ED clinician.

1.4 The ED clinician will verbally advise ECATT as soon as it is possible to undertake a mental health assessment and record this handover in Symphony Medical e-notes.

1.5 ECATT assess the patient and where necessary consult with the:

- ECATT Registrar or Consultant (business ours)
- After hours the on call Registrar or Consultant Psychiatrist, including specialist psychiatrist (Adolescent or Aged Mental Health) where secondary consult is indicated.
- ED consultant/treating doctor
- Community team case manager (where applicable)
- Next of kin and/or any third parties who may be able to give insight into the patient's mental state and risks.
- All appropriate data bases for recorded mental states and historical risks.

1.6 ECATT record the outcome of their initial assessment in the relevant Symphony fields and record a summary outcome and plan in the Symphony Medical e-notes

1.7 If the ECATT recognise any:

- medical concerns, the patient will be referred for medical assessment to the ED Medical Team Leader.
- mental health concerns escalate to the ECATT Registrar or Consultant (business hours) or the afterhours the on call Registrar or Consultant Psychiatrist.

1.8 If ECATT assess security or CPO supports are required highlight this in the relevant Symphony fields in the mental health assessment section and verbally handover requirement to ED nurse in charge and/or ED clinician.

Record handover in Symphony Medical e-notes, including the name of ED nurse in charge who will make these arrangements.

1.9 If after both medical and mental health assessments and it is determined that a patient has both medical and psychiatric needs, the acute care group doctor will liaise with the Mental Health Registrar/Consultant to determine the most appropriate clinical setting to which the patient ought to be transferred.

2. Booking a bed for transfers from ED to a Psychiatric inpatient bed:

2.1 ECATT request a bed from bed access unit via Symphony bed request

2.2 Urgent bed request ECATT will call bed access unit to give the reasons for the urgency.

2.3 ECATT must record in the Symphony e-notes all bed booking actions they undertake.

2.4 When bed access unit have sourced a bed they will notify:

- ECATT via an SMS and a lanpage.
- ED nurse in charge via Symphony.
- The Receiving ward via a lanpage.

3. Transfer and transport a patient to an inpatient bed:

3.1 ECATT will confirm with ED nurse in charge the details of where a bed has been sourced and determine the safest least restrictive means to transport the patient.

3.2 ED nurse in charge will liaise with ED ward clerk to book the agreed transport if a bed is at another site or external.

3.3 If the bed is at the same site, ECATT will arrange the transfer from ED to the ward.

3.4 If a patient had been assigned to an ED acute care group, the ED clinician will liaise with ED nurse in charge for when the patient is medically cleared and make a note of this handover in Symphony.

4. Clinical handover to the receiving ward

4.1 ECATT will call the receiving ward to give verbal clinical handover before the patient leaves the ED.

4.2 Both the ECATT and ED nurse in charge ensure all the clinical handover forms are attached to the documents going to the receiving ward i.e.

- Mental Health Assessment form (MRAFO1(I) prepared by ECATT
- ED Clinical Handover Symphony Inter/Intra Hospital Transfer form (MRD13) prepared by ED staff

4.3 Where the original plan to transfer a patient changes (extraordinary delay or change of wards) ECATT notify the receiving ward.

5. Patient being discharged to community care

5.1 When a patient is being discharged home to the care of their GP and/or other service providers and they had been assigned to an acute care group while in ED the ED clinician will give the patient a discharge letter detailing the outcome of their medical and mental health assessment to take to their GP and/or other service provider.

5.2 If the patient is case managed, then ECATT will fax clinical handover documents to the

respective Community Treatment Team
- The Mental Health Assessment form MRAF01(I) and
- Discharge summary prepared by the ED clinician if the patient had been assigned an acute care group while in ED.

5.3 Where a patient is being discharged with CATT follow up, ECATT will fax clinical handover documents i.e.
- Mental Health Intra-service referral form MRAD01(i) and follow up this referral with a telephone handover if during business hours.
- Discharge summary prepared by the ED clinician if the patient had been assigned an acute care group while in ED.

5.4 Before closing each Symphony episode of a mental health patient ECATT and ED nurse in charge will ensure their respective Symphony e-notes are updated with all current information before the patient's Symphony episode is closed and that respective clinical handover documents are sent to scanned medical record no later than the end of that shift.

6. Transfers from the ED to a medical inpatient bed:

6.1 ED Nurse in charge will:
- Request a bed from bed access unit via Symphony bed request and give details pertinent to each request.
- Record all bed booking actions undertaken in the Symphony e-notes

When bed access unit have sourced a bed they will notify:
- ED Nurse in charge via Symphony.
- The receiving ward via a lanpage.
- ensure the nurse unit manager/team leader of the receiving ward receives a telephone handover regarding the planned patient transfer.

6.1 Where the nurse unit manager/team leader indicates any requests to delay the transfer the ED nurse in charge will agree on a timeline for the transfer to occur and this will be recorded on Symphony.

6.2 Either the clinical handover patient transfer form (MRD13) or the clinical handover ED Symphony Inter/Intra hospital transfer form is completed and sent with the documents going to the receiving ward.

6.3 All handovers to the ward/unit nurse in charge and to the ward/unit doctor have occurred are recorded in the Symphony e-notes.

6.4 Notify the receiving ward changes (extraordinary delay or change of wards) to the original plan to transfer a patient.

6.5 Determine the safest least restrictive means to transport the patient with the assistance of the ECATT team.

6.6 ECATT will attach the mental health assessment form MRAFO1(I) to the documents going to the receiving ward.

6.7 The ED clinician will ensure the doctor of the receiving ward/unit is given an up-to-date telephone handover and is aware of the outcome of the ECATT assessment and the referral pathway for Psychiatric consultation liaison.

7 Triaged patient's waiting in the ED

The following actions are required for patients that have been

- waiting for a long time,
- are assessed and not discharged
- are required to wait in the ED for any reason (including an inpatient bed):

7.1 ECATT staff must remain available for extra support if needed by ED staff.

7.2 The Psychiatric Registrar will review the patient as required and if requested by the Emergency staff or ECATT.

7.3 The ED clinicians will continue to monitor and treat the patient:

- as set out in the relevant ED local patient management procedures.
- providing emergency management and prescription of vital medications (similar to SATC medications) as required.

7.4 The ED clinician and/or a Psychiatric Registrar will initiate a pharmacological management plan as soon as practicable and prescribe medications adequate and appropriate to manage the patient's symptoms or behavioural disturbance for the duration of the stay. Refer to the acute behavioural disturbance clinical guideline.

7.5 The ED nurse in charge will ensure that all compulsory patients who are at risk of absconding have the security they need for the entire duration of their stay in ED i.e. CPO and/or security and/or mechanical restraint.

7.6 If a compulsory patient absconds or if a voluntary patient leaves, the ED nurse in charge will notify ECATT immediately who will mobilise the Mental Health Patients in ED unplanned departure procedure.

7.7 If an adverse incident occurs log an incident on Riskman

Useful resources

Acute Behavioural Disturbance clinical guideline

Document Management
Policy supported: Assessment, Care Planning and Discharge (Operational)
Executive sponsor: Chief Operating Officer
Person responsible: Mental Health Bed Access Unit Manager

Who must comply with this procedure?

All Mental Health program staff (including ELMHS, Adult, and Aged Persons)

This procedure applies in the following setting:

Mental Health Inpatient Units, Rehabilitation Units (SECU, CCU), Crisis Assessment & Treatment Teams, PARCS, Community Residential Withdrawal Unit, Eating Disorders community clinics, AGILE clinics, and Community Teams providing case management involved in multidisciplinary clinical review

Precautions and Contraindications

- Each patient must have a Multidisciplinary Clinical Review completed at the frequency prescribed by this procedure, and have this approved by the treating psychiatrist.
- Clinical Review activities must adhere to the recovery principles and practices set out in the National Standard Mental Health Services and the Mental Health Act 2014.
- The multidisciplinary team must include a consultant psychiatrist, and may also include the following; HMO/Registrar, Mental Health Nurse, Occupational Therapist, Peer Support Worker, Social Worker, Psychologist.

A note about language*:*
Although the terms 'consumer', 'client', 'patient' and 'service user' are variously used to describe persons seeking help from health services, the word *patient* is preferentially used here to connote the clinical nature of the setting and the service.

Equipment

Clinical Review form(MRAF0)

Outcome Measures forms

Complex Needs Plan (MRAG03)

1. The Clinical Review (multidisciplinary team) will meet to develop, review and confirm a Treatment and Recovery Plan, or review progress according to the Plan, and/or undertake discharge planning.
2. Patients are discussed at Clinical Review (or 'Ward Round' for inpatient units) at the following frequencies:
   - 2.1. Inpatient wards, sub-acute community beds and crisis teams – weekly.
   - 2.2. Eating disorders clinics and AGILE clinics – weekly.
   - 2.3. Rehabilitation Units - six weekly.
   - 2.4. Community case management teams - within four weeks of initial registration / case commencement, and every three months or 91 days thereafter.
   - 2.5. PARCS – weekly; EPARCS – fortnightly.
   - 2.6. Following initial admission / registration to service area.
   - 2.7. Prior to discharge from service or planned transfer of care to another treating team within the Mental Health Program.
   - 2.8. Where a significant change has occurred in mental state and/or personal events or physical health.
   - 2.9. Whenever a patient declines treatment or disengages from treatment in the community.

2.10. Whenever there is a significant change in risk following significant harm to self or others.

3. At all Clinical Review meetings, the patient must be presented in ISBAR format by a medical or mental health practitioner with relevant knowledge of the patient, and include the following information:

3.1. A brief psychosocial formulation including demographics, living situation, financial situation, occupation, significant relationships, history of mental illness, history of intellectual disability, history of other cognitive disabilities, cultural background, family psychiatric and medical history, and diagnosis;

3.2. The patient's views and preferences regarding their current treatment, including any documented in an Advance Statement, and the views of any carers/family members and nominated person.

3.3. A past psychiatric history including contact with services, admissions, and efficacy of previous treatment.

3.4. A summary of any past and current risk factors, including harm to self and others, and forensic history.

3.5. A summary of others involved in the patient's care, including general practitioner, carers and family members, nominated person, and other agencies including Mental Health Community Support Sector Services (MHCSS), and include their views on the patient's treatment and recovery.

3.6. A summary of any physical health problems, including past and current management.

3.7. The outcomes of any specialist assessments undertaken and any recommendations made.

3.8. A summary of the current Treatment and Recovery Plan, including goals, actions, and persons responsible.

3.9. Current medication, its efficacy and any reported side effects.

3.10 Current Mental Health Act legal status.

3.10. Any enablers / barriers to discharge and strategies to address these.

4. The relevant Outcome Measures forms must be completed in accordance with the Outcome Measures in Mental Health procedure.

5. The Treatment and Recovery Plan (MRAG02) must be updated with any changes resulting from the Clinical Review meeting.

6. A Clinical Review form (MRAF04) must be completed for each clinical review meeting including participants, discussions and outcomes. The treating psychiatrist must sign the completed Clinical Review form.

7. The completed Clinical Review form, revised Treatment and Recovery Plan, and Outcome Measures must be entered into the patient's scanned medical record and entered onto CMI in accordance with the Outcome Measures in Mental Health procedure.

8. The case manager will ensure the outcomes of clinical review are discussed with patient and other relevant parties, including carers/family members, nominated persons, and other service providers.

9. If the clinical review identifies that the patient has complex needs and requires a co-ordinated multi-

service/agency response, a Complex Needs Plan (MRAG03) will be developed. The case manager/clinician and treating psychiatrist will:

9.1. Convene a clinical case conference to discuss and agree on diagnosis, indicators for accessing services and specific service responses/actions to these indicators.

9.2. Develop and document the Complex Needs Plan, providing a copy to all services involved. This may involve consultation from specialist services such as SPECTRUM (State-wide Personality Disorder Service) and Victorian Dual Disability Service (VDDS).

9.3. Forward a copy of completed and signed plan to Psychiatric Triage Service (PTS).

9.4. In collaboration with patient and any carers/family members and nominated person, discuss complex needs interventions.

9.5. Provide a copy to patient and any carers/family members and nominated personas appropriate, and ensure it is also included in the patient's scanned medical record.

Useful resources

Mental Health Act 2014

Document Management

Policy supported: Assessment, Care Planning and Discharge (Operational)

Background Assessment, Care Planning and Discharge

Executive sponsor: Program Director, Mental Health

Person responsible: Program Director, Mental Health

Who must comply with this procedure?

Mental Health clinical staff

This procedure applies in the following setting:

All hospital sites, community clinics, residential settings and any other community setting where a patient is receiving assessment or care from mental health staff

Precautions and Contraindications

Risk assessment is an ongoing and dynamic therapeutic engagement process of estimating and attempting to limit the likelihood that an adverse event will occur to a person. It is a process of identifying, analysing and summarising the person's potential risk factors that inform intervention and management strategies that mediate potential risks and amplify the person's strength and protective factors.

- Any risks rated medium to high, require immediate action to be taken.
- For inpatient admissions- until a risk assessment is completed by the Consultant within 24 hours of admission to the ward, consumer/patients are classified as an unknown risk and therefore treated as high risk.
- The results of the risk assessment inform level of nursing care.

Equipment

Computer with access to Scanned Medical Records and Client Management Interface (CMI)

Clinical Risk Assessment form MRAR01

Inpatient Clinical Risk Assessment form MRAR02(i)

Acute clinical risk assessment (continuation) MRAR02 (ii)

MRAK 20 Observation level 1, 2, and 3.

MRAK 21 Observation level 4

MRAK 22 Observation level 5

MRAK 23 Special Observation

MRAK 28 Special Intervention & Assessment

For inpatient admissions:

Procedure

1. Frequency for conducting and documenting clinical risk assessment

   1.1 A clinical risk assessment must be conducted and documented on all of the following occasions:

   - On the admission mental health assessment form (MRAF01)
   - As part of the Psychiatrist review within 24 hours of all new patients admitted to acute inpatient services.
   - At change in legal (MHA) status.
   - Change in life events e.g. loss.
   - Significant change in mental state.
   - Where the person harms themselves or others.
   - Prior to each Clinical Review.
   - Prior to discharge or transfer of care.

- Where variation in management or treatment is planned.
- At the frequency identified by the treating psychiatrist.
- Where the person declines treatment.

1.2 In addition, for Acute Inpatient Units

- Within 3 hours of commencement of shift
- Each shift unless the frequency is revised by the treating psychiatrist
- Prior to leave with permission
- Upon return from leave (including leave without permission)
- When a person is undergoing a transfer of care environment (i.e. Seclusion/ AMA/ HDU/ FCA)

1.3 In addition, for Community Mental Health Services

- Each visit/direct (face-to-face) contact

2 Conducting and documenting Mental Health Clinical Risk Assessment

2.1 Involve the patient/consumer in the risk assessment, formulation, care planning and explain the clinical process.

2.2 Conduct a risk assessment from information provided by:

- The patient/consumer
- Other informants (e.g. Family, friends, work colleagues)
- Previous health records including SMR and CMI
- Other health sources (e.g. Referrer, GP, ambulance)
- Police and court records

2.3 Gather information on protective factors which may include:

- An optimistic outlook
- Good current mental health care
- Strong social supports (as seen by the individual)
- Feeling supported by carers/parents.
- Problem solving and coping skills.
- Help seeking behaviour

2.4 Formulate, and document the overall assessment of risk to self and to others by indicating the level of concern (low, medium, high) in the context of qualitative formulation of risk factors.

2.5 In bed-based services this needs to be communicated to the Shift Leader.

2.6 If risk rated medium to high, discuss with senior mental health staff.

2.7 Develop a risk management plan for any identified risk of suicide, self-harm, seclusion, sexual safety, vulnerability to abuse/ neglect, falls, compromised physical state/ medical condition, absconding and/or harm to others. Involve the consumer in the development of the risk management plan

2.8 Document the clinical risk assessment by completing the appropriate Clinical Risk Assessment form /Care Plan and include:
- Description of risk
- Risk estimation (rating)
- Rationale for risk estimation. The rationale for risk estimation will consider protective factors which are to be documented.
- Management of all identified risks
- Interventions to directly address all risks.

2.9 Document the identified appropriate interventions and actions and include:
- Immediate risks
- Ongoing management and review.
- Future preventative actions, taking into account the context, opportunity, means and motivation.
- Consumer strengths and protective factors.
- Consumer preferences/ Advance statements and discussions with the patient's, carers and other stakeholders.
- Contingency plans to deal with likely risks must be communicated to the Nominated person, family or carers.

2.10 Risk assessments and management plans must accompany patients transferred within mental health services

2.11 Where the patient/consumer is assessed as a high risk of harm to others and this risk is to staff (occupational violence), this risk must be communicated to all team members and appropriate actions recorded in the progress notes of the health record.

2.12 A Staff Alert form must be completed and filed at the very front of the patient/consumer health record.

3 All staff involved in the treatment and care of the patient/consumer must act in accordance with the plan to manage risk/s.

3.1 Evaluate outcomes and review the plan to manage risks.
- Effectiveness of the plan will be evaluated at each Clinical Review.
- The plan to manage the risks will be reviewed by clinical staff regularly (after each Clinical Risk Assessment) and gaps identified, information rechecked with the patient/consumer and/or their carer and all new information considered.

4 For patients / consumers presenting to the Emergency Department with serious self-harm attempts, the ECATT Clinician will:

4.1 Discuss with consultant on call a planned discharge of patients/consumers presenting at Emergency Departments with serious self-harm attempts.

4.2 Communicate to the most senior ECATT clinician prior to discharge.

Useful resources

Assessment treatment and discharge of Mental Health patients in ED

Falls prevention

Nursing levels of care Mental Health implementation tool

Nursing levels of care Mental Health procedure

Document Management
Policy supported: Assessment, Care Planning and Discharge (Operational)
Executive sponsor: Chief Operating Officer
Person responsible: Medical Director Mental Health Program

Who must comply with this procedure?

All Mental Health program staff (including ELMHS, Adult, and Aged Persons)

This procedure applies in the following setting:

Mental Health Inpatient Units, Rehabilitation Units (SECU, CCU), Crisis Assessment & Treatment Teams, PARCS, and Community Teams providing case management preparing and reviewing treatment recovery plan.

Precautions and Contraindications

- Each patient must have a current Treatment and Recovery Plan developed by the treating team in collaboration with the patient and relevant carers/family members and nominated person, and approved by the treating psychiatrist.
- Activities associated with preparing a Treatment and Recovery Plan must comply with recovery principles and practices as set out in the National Standard Mental Health Services and the Mental Health Act 2014.

A note about language:
Although the terms 'consumer', 'client', 'patient' and 'service user' are variously used to describe persons seeking help from health services, the word *patients* is preferentially used here to connote the clinical nature of the setting and the service.

Equipment

Treatment and Recovery Plan (MRAG02)

Mental Health Inpatient Care Plan (MRAG02 (III)

Mental Health Safety Plan (MRCG02)

Outcome Measures forms

1. Definitions and Principles

1.1. All patients in the care of community mental health services will have a **Treatment and Recovery Plan** (MRAG02) which gives the patient and the treating team a long term view of the goals of treatment and the actions required for a pathway to recovery.

1.2. The Treatment and Recovery Plan is developed by the treating team in collaboration with the patient and their family, also taking into consideration other stakeholders and healthcare providers. It is finally signed off by the treating team and, if well enough, the patient.

1.3. Following completion of a Treatment and Recovery Plan, patients will also be supported to develop a **Mental Health Safety Plan** (MRCG02).

1.4. The Treatment and Recovery Plan will be completed as soon as practicable after admission / registration to the community mental health service. This will generally be expected within 72 hours of admission to a PARCS and CATT services, and within 4 weeks for a community case management service or a community residential services (CCU and SECU). The Treatment and Recovery Plan will be formally reviewed every 3 months as part of the Clinical Review process.

1.5. Patients admitted to an acute inpatient unit will have a **Mental Health Inpatient Care Plan** (MRAG02) (III) which describes the plan of management for the acute episode. The Mental Health Inpatient Care Plan does not rescind the longer term Treatment and Recovery Plan but, rather, nest within it, being consistent with the long term plans for recovery.

1.6. The Mental Health Inpatient Care Plan will be completed within 24 hours of admission or registration.

2. Procedure

2.1. On commencing preparation of a Treatment and Recovery Plan or a Mental Health Inpatient Care Plan, the clinician will:

2.1.1. Explain process and purpose of treatment planning with the patient and, where relevant, any carers/family members or nominated person.

2.1.2. Seek to understand the patient's treatment preferences, including any documented in an Advance Statement, and the views of any carers/family members and nominated person involved in their care.

2.1.3. Review any existing Treatment / Recovery / Care Plan, and health information regarding previous treatments and their outcomes.

2.1.4. Complete relevant Outcome Measures forms (in accordance with the Outcome Measures in Mental Health procedure) utilise information from these to formulate the Treatment and Recovery Plan. Where a HoNOS / HoNOS65+ / HoNOSCA area is rated at 3 (moderately severe) or 4 (severe to very severe), incorporate this into the Treatment and Recovery Plan or Mental Health Inpatient Care Plan as a priority need.

2.2. The Treatment and Recovery Plan or Mental Health Inpatient Care Plan must also include:

2.2.1. The names and roles of all members of the treating team (including the psychiatrist, treating doctor, mental health practitioners, peer support worker, and alcohol and other drug / AOD specialists, as appropriate);

2.2.2. Contact details of any legal guardians, carers/family members and nominated person involved in the patient's care;

2.2.3. Contact details of other health professionals (e.g. general practitioner), any Mental Health Community Support Sector Services, and any other relevant service providers (e.g. housing, financial, AOD services) involved in the patient's care;

2.2.4. Any specific gender/cultural needs.

2.3. Following completion of the Treatment and Recovery Plan, the treating team will also support the consumer/patient to develop a Mental Health Safety Plan (MRCG02), to include:

2.3.1 Things the patient can do to stay well;

2.3.2 Warning signs of distress;

2.3.3 Things the patient can do to help cope and stay safe;

2.3.4 Family and friends the patient can ask for help;

2.3.5 Professionals or agencies the patient can contact for help;

2.3.6 Removal of access to lethal means.

2.4. On completion, the patient or parent/guardian (for children) are provided with the opportunity to sign their Treatment and Recovery Plan, and their Mental Health Safety Plan, and be provided with their own copy.

2.5. The carer/family member or nominated person are provided with a copy where the patient gives consent to do so.

2.6. The completed Treatment and Recovery Plan must also be signed by the author (usually the case manager) and the treating psychiatrist, and included in the patient's scanned medical record.

2.7. The Treatment and Recovery Plan will be reviewed every 3 months at the multidisciplinary Clinical Review meeting, with any changes being made in collaboration with the patient and documented.

The revised plan must be signed and included in the patient's health record as per point 2.5 above.

Useful resources

Mental Health Act 2014

Document Management
Policy supported: Assessment, Care Planning and Discharge (Operational)
Background Assessment, Care Planning and Discharge
Executive sponsor: Chief Operating Officer
Person responsible: Director Mental Health Program