Mental Health Services

Ballarat Health Services

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Ballarat Health Services
Putting your health first

14 Apr 2020

Statement for the Coroner

Re: [redacted] coroner inquest
Ref: COR 2017 002215

I, Anoop Raveendran Nair, of the Ballarat Health Services- Mental Health Services at Sturt Street, Ballarat, in the State of Victoria, state as follows:
Qualifications and experience

1. I am the Director of Clinical Services for the Ballarat Health Services- Mental Health Service. I joined Ballarat Health Services- Mental Health Service in June 2015 as a Staff Specialist and have been in my role as Director of Clinical Services since May 2018.
2. My qualifications are MBBS, DPM (Psychiatry), MD (Psychiatry) and Fellow of Royal Australian and New Zealand College of Psychiatrists (FRANZCP) and I am registered as a Specialist Psychiatrist with the Medical Board of Australia.

Access and triage services provided in Ballarat Health Services- Mental Health Service I enclose the following:

1. Ballarat Health Services- Mental Health Service have made changes in the triage and access services and major changes have been made in the last 12 months.

2. Ballarat Health Services- Mental Health Service has developed a specialist Access and Triage (A&T) service with highly trained clinicians undertaking all triage into the service 24/7. At this stage the centralised A&T service is taking triage calls for the Ballarat and Golden Plains areas for people aged 16 - 64. As staff recruitment progresses it is the intention to bring in Ararat, Horsham, Infant and Child Mental Health Services and Aged Mental Health Services into the centralised triage service. The functioning of the team is being continuously reviewed and managed accordingly.

3. All contacts made during the work hours with the A& T team are documented in a screening register by the A&T team and handed over to the community teams during the same day. The contacts made after hours with A&T team and ECATT tem are also documented in a screening register and handed over to the community teams on the following morning.

4. All staff working in community settings within mental health have attended a compulsory one day of training which included the following topics:
    a. Statewide mental health triage scale (SMHTC)
    b. Risk assessment and planning
    c. The Mental Health Act 2014
    d. Documentation
    e. Role of the Duty Worker

5. This training will be compulsory for all new staff entering community roles and is scheduled to be repeated every four months.

6. Some of the topics will be offered annually as stand-alone sessions including Risk assessment, SMHTC and the Mental Health Act 2014

7. More rigorous structures and processes around clinicians receiving clinical supervision.

I am enclosing:

i. Access and Triage Service Guidelines
ii. Clinical handover protocol
iii. Clinical documentation – mental Health services protocol
iv. Clinical supervision policy

Yours sincerely,

Dr Anoop Raveendran Nair Lalitha MBBS DPM,, MD, FRANZCP
Director of Clinical Services
Ballarat Health Services Mental Health Services

BALLARAT HEALTH SERVICES
MENTAL HEALTH SERVICES

ACCESS AND TRIAGE PROCESS GUIDE

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SERVICE SUMMARY

Access and Triage is a clinical division of Ballarat Health Services Mental Health Services (BHS MHS).

Access and Triage is the first point of contact with BHS MHS for all potential consumers in the Grampians region with a known mental illness or possible mental concern, or people seeking assistance on behalf of someone with a known mental illness or possible mental concern. It provides a consistent, systematic mental health response and means of entry to Public Adult Mental Health, Aged Persons Mental Health, Youth Mental Health, Mother and Family Unit, Perinatal Mental Health and Infant and Child Mental Health Services. Access and Triage provides a number of functions:

- Telephone Triage
- BHS ED response and assessment of acute mental health presentations
- Acute/urgent mental health response and assessment of members of the community
- Assessment of consumers who self-present to the service in the Queen Victoria Building (QVB) (walk in)
- PACER (Police and Clinician Emergency Response in Ballart LGA)

Access and Triage provides telephone and face to face assessment and support 24 hours, 7 days a week. The aim is to ensure that consumers who require mental health services receive the most appropriate service for their needs at that time.

Referrals to Access and Triage may result in a number of outcomes or recommendations including referral to an appropriate Community Team within the public mental health service, referral to emergency services and/or direction to attend an Emergency Department, or recommendations to engage with other health and welfare services within the community sector in the Grampians Region.

This document has been developed in accordance with the State-wide mental health triage scale Guidelines (Department of Health Victoria, 2010). The triage scale is applied after the triage clinician has collected sufficient information to determine whether there is a need for further assessment or intervention by BHS MHS in response to the request for advice or assistance, or whether referral to another service should be considered.

1. Managing Triage Telephone Calls

- Answer the telephone call introducing the service Ballarat Mental Health Service Triage) and introduce yourself by first name.
- Be polite, calm, professional and helpful. Remember that callers contacting Access and Triage may be calling in crisis seeking support and advice, and that you are their first point of contact with the service.
- Check consumer demographics and determine whether the person resides within the GRAMPIANS catchment area. An exception to this is MAFU which accepts referrals from South West and Barwon regions.
- If the consumer resides out of area provide details for the correct Area Mental Health Service (AMHS) and conduct a 'warm' transfer of the call. *Note: If the caller is distressed you may need to allow them some time to describe their concerns before transferring their call.*
- If the consumer is homeless and currently in the Grampians region, they should be triaged as though resident in the Grampians region.
- Once it is established that the consumer meets the GRAMPIANS demographic criteria, a client enquiry will be conducted on CMI to check whether the consumer is a current consumer, past registered consumer or known to another AMHS state-wide (Function→client→enquiry – please ensure the ODS box is ticked to be able to view state wide registrations). This search allows the Clinician to see whether the consumer is currently receiving treatment (under activity), diagnosis, alerts, alias, past episodes of care, admissions and current/past involuntary treatment.
- A screening register search will also be completed to ascertain whether there has been recent contact or a recent referral made to the community team (Function→screening register→ search→ search by: client).
- A 'wild card' search can also be completed by entering the first few letters of the consumer's name followed by * (For example; Emily Smi*). This is often helpful in case the consumer's name has previously been entered with different spelling.
- If the consumer is a current consumer of the service and they are calling during business hours a 'warm' transfer of the call will be conducted to the respective Community Team.

2. Referrals Received by Fax

If a referral is received by fax and all of the required information has not been provided the Triage clinician will contact the referrer to obtain further information and confirm that the consumer is aware of the referral. The referral will then be triaged as usual.

3. Referrals Received From Private Psychiatrists

- If a referral is received from a private psychiatrist the Triage clinician will prioritise the referral.
- Information will be obtained regarding the reason for referral (alert, transfer of care, request for shared care) urgency, how long the Private Psychiatrist has known the consumer, date of last appointment, any future appointments organised, current medication regime, current mental state and risks, and whether the consumer is aware of the referral.
- A referral letter from the Private Psychiatrist is helpful but not compulsory.
- The referral will be triaged as usual and referred as appropriate depending on the urgency of the presenting issues.
- If there are any clinical concerns regarding the referral (e.g. it does not appear to be appropriate for an AMHS) this will be discussed with the Consultant Psychiatrist and/or Team Leader.

4. Completing Screening Registers

- All areas of the screening register need to be completed.
- The Triage clinician will always make all possible attempts to speak directly with the consumer to complete a comprehensive mental health assessment and to discuss the referral and recommendations with them.
- Exceptions to this include where the consumer refuses to speak with the Triage clinician, the consumer does not have a telephone, where speaking to the consumer is likely to result in increased risk to the consumer (including flight risk), risk to others, or risk of damage to the relationship between the consumer and referrer, the consumer has cognitive deficits which impair his/her ability to communicate by phone (e.g. dementia or profound intellectual disability), the consumer has other communication deficits which prevent their communicating by phone (e.g. hearing impairment), or the consumer is young and asking them to speak by phone may unnecessarily exacerbate their distress. Rationale for not contacting the consumer directly must be clearly articulated and documented.
- If the consumer is a child under the age of 18 years and in the care of their parents or a legal guardian, it is best practice to obtain parental/guardian consent to the referral before the triage proceeds. However information can be obtained from a referring agent, and then the parents or legal guardian contacted to obtain consent. An exception to this is where there is imminent or significant risk of harm, distress and/or deterioration which requires a very urgent mental health response and a parent or legal guardian is not able to be contacted within the required time frame.
- If the consumer is unwilling to engage with BHS MHS this will be discussed with a Consultant Psychiatrist regarding the best course of action to take i.e. does there need to be a more assertive response due to risk or do we engage the referrer to assist in facilitating the assessment?

- Where possible collateral information will be obtained from the referrer, family/carer and any current treating professionals, and documented in a clear and concise manner (see appendix #4 for template).
- If the consumer is not known to BHS MHS but has had contact with another AMHS then collateral information will be sought from that service about the consumer's usual presentation.
- If the consumer has been registered with BHS MHS in the past, then a ***registered*** screening register will be completed regarding the contact and information from past episodes reviewed to inform the clinical decision making process.
- If the consumer is not known to BHS MHS then an **unregistered** screening register will be completed for the contact.
- If the consumers' address or contact details have changed this will be updated through the client registration (as above or Options→Client Maintenance).
- Record the referrer's name, relationship and contact number in the "referred from" section of the screening register.
- Complete screening description, outcome comments box, referral from, perception of problem and carer details.
- Select the appropriate triage scale in accordance with the State-wide mental health triage scale, service response and outcome boxes.
- If the triage requires a MHS response the plan discuss this with the consumer and/or referrer and document the discussion in the **outcome comments box**.
- The triage is then opened (allocated) to the correct campus and follow up subcentre for the respective Community Team to follow up.
- If a triage is rated category B or C the respective Community Team will be advised of this as a courtesy as soon as practicable, and preferably within 2 hours (see #6).
- Each Community Team is responsible for checking CMI each morning prior to their morning meeting to identify all triages that have come in overnight and require allocation within that team.
- The Access and Triage Team hold clinical governance over the screening assessment and subsequent disposition of the triage scale and the BHS MHS Community Teams must accept this clinical determination. If there is disagreement regarding the triage scale the care to the consumer must be actioned as directed and any disagreements must be discussed Team Leader to Team Leader the next business day.
- The rating of the triage against the statewide mental health triage scale cannot be downgraded without approval of the Consultant Psychiatrist, this should only occur under exceptional circumstances.
- If the respective Community Team is not able to respond within the required time frame this will be discussed with the Consultant Psychiatrist or Team Leader of the respective Community Team or, if after hours, the On-call Manager.
- If a plan changes in the process of triaging then this will be updated in the outcome comments box accordingly.
- A placeholder document will be opened in BOSSNET for each screening register.

Note: There is only one screening register per consumer per day (ie. from 00.00 hours to 24.00 hours). All clinical information obtained from or about the same consumer, on the same day, is documented in the same screening register that is already open for the day. Additional contact data entry may be added via the "Additional Contacts" tab in the screening register or the Contact Forms Data Entry Function on CMI.

Note: Perinatal triages rated category D and E are handed over to the Perinatal Team. Perinatal triages requiring a more urgent service response will receive a response from the Access and Triage Team or respective Community Team (#6).

Note: Referrals of consumers registered with the clozapine program will be triaged as per any other community member.

If there is further follow up or contact regarding a consumer the next day (from 00:00 hours) then a new screening register should be commenced.

5. Category A Triages (Emergency Services Response)

Category A Triages are those in which there is an imminent risk to life and the most pressing need is to provide physical safety for the person and/or others. In this instance it is the Triage clinician's responsibility to mobilise an emergency services response (police, ambulance and/or fire brigade) as soon as possible.

All referrals to emergency services are allocated a category A in accordance with the State-wide mental health triage scale.

If the person has taken an overdose or otherwise inflicted serious self harm, an ambulance must be called and if possible a 'warm' transfer of the caller/referrer to emergency services should occur.

If injury to others has occurred or there is an imminent threat of this based on the Triage clinician's judgement, police should be called. The views of family/carers and other referrers are taken into consideration when deciding whether to allocate this category. However the Triage clinician should take action based on their clinical judgement rather than rely solely on family, carers or consumers to contact Emergency Services. If there is any doubt about the most appropriate course of action then this can be discussed with the Consultant Psychiatrist and/or Team Leader.

5.1 Calling an Ambulance

- All requests for ambulance attendance are allocated a category A in accordance with the State-wide mental health triage scale.
- If the Triage clinician determines that an ambulance is required following triage of the referral then the clinician will offer to facilitate a warm transfer to 000, introducing themselves as an employee of BHS MHS and providing a brief summary of the reason for the call before transferring the call.

- If the caller is agreeable then the Triage clinician may conference call the caller through to 000. This allows the Triage clinician to participate in the call and ensure that the caller completes the request for an ambulance.
- If the Triage clinician assesses that the consumer requires an ambulance but the consumer or referrer declines this then the clinician will proceed with contacting 000 and request an ambulance.
- The Triage clinician will advise the ED Triage Nurse or Urgent Care Centre of the respective hospital that the consumer will be presenting by ambulance and record this contact in the outcome comments box of the Screening Register.
- The Triage clinician must ensure the consumer's arrival to the ED.
    - If the consumer does not present to ED, the Triage clinician will contact the Duty Manager for Ambulance Victoria through 000 to determine the outcome of the ambulance attendance.
    - If the consumer has been taken to an alternative Emergency Department then the Triage clinician will contact the appropriate AMHS Triage service to provide a verbal handover and fax through available documentation.
    - If the consumer has **NOT** been transported to an Emergency Department then the Triage clinician will follow up and re-contact the consumer/referrer or alternatively refer to the police for a welfare check if required.

5.2 Requesting Police Attendance and Welfare Checks

- All requests for police attendance will be allocated a category A in accordance with the State-wide mental health triage scale.
- If the Triage clinician determines that police attendance or welfare check is required then the clinician will either warm transfer the call through to 000, introducing themselves as an employee of BHS MHS and providing a brief summary of the reason for the call, facilitate a conference call to 000, or alternatively end the call and contact 000.
- A Triage clinician will only use the option of a police Welfare Check in circumstances when there is clear evidence of risk to the consumer or others and no one has been able to make contact with the consumer to
    - Determine their safety and
    - Conduct a more comprehensive risk assessment.
- A Welfare Check is not an alternative to a mental health assessment and other options to facilitate a mental health assessment should always be considered first e.g. are the consumers' needs better met via a referral to the respective Community Team when there are no imminent risks indicated but Access and Triage cannot speak with the consumer? Is there someone else (e.g. family or service provider) who can assist with facilitating an assessment?
- When a Welfare Check is requested, the Triage clinician will request that the police contact Access and Triage on the VIP line to provide feedback regarding the outcome.

- The Triage clinician will recontact police to determine the outcome of the Welfare Check if police do not contact Access and Triage within a reasonable timeframe. If necessary this task may need to be handed over to the next shift to follow up.
- Once feedback is obtained from police about the outcome of the welfare check the Access and Triage clinician will make a clinical determination about how best to follow up the referral to ensure that the person's mental health needs are addressed. This may require further assessment of the consumer and/or a referral to the respective Community Team.
- The Triage clinician will liaise with the consumer's other mental health service providers (including GP) about the contact with the consumer and the outcome.

6. Category B-C Triages Requiring Urgent Face to Face Assessment

Urgent Triages occur when there is a significant risk of harm, distress and/or deterioration which requires a very urgent mental health response within 2 hours (Category B) or an urgent response within 8 hours (Category C). They also occur when a person self-presents to the service requesting to see someone (walk-in).

- Access and Triage Ballarat will respond to all Category B & C triages of new consumers residing within the Ballarat Local Government Area (LGA).
    - Where possible collateral information will be sought from the consumer's carer and/or treating mental health professionals (e.g. GP, private psychiatrist, private psychologist) to aid decision-making about the consumer's care.
    - If safety risks are identified for Access and Triage clinicians to attend situations in the community, police will be contacted and requested to attend with the Triage clinician(s) within the required time frame.
    - A face-to-face mental health assessment conducted in response to category B and C triages will be documented on an Intake Assessment form in BOSSNET (MR 901.00).
    - PR 1 and PR1A will be completed (cf CPP0276 Mental Health Intake Assessment).
    - The assessment must be discussed with a Consultant Psychiatrist for endorsement of the plan.
    - If the outcome of the assessment by the Access and Triage clinician is for the consumer to receive treatment from BMHS, the rationale for this will be clearly documented and handed over to the Duty clinician of the respective Community Team with a timeframe for follow up as determined by the risk assessment and risk mitigation strategies put in place. *e.g The consumer needs to be reviewed within the next 24 hours.*
    - If it is determined that the consumer requires admission to hospital, this will be discussed with the on-call psychiatrist and Shift Leader, and the respective

Clinical Practice Protocol followed to facilitate the admission (cf CPP 0405, CPP 0482).

- If the outcome of the assessment by the Access and Triage clinician is that the consumer does not require treatment from BMHS, feedback will be provided to the referrer and referrals made to other providers as necessary.
- PR1 will be updated for closure and the assessment diarized for discussion at the Access and Triage clinical meeting.
- Clinical meeting discussion of the assessment will be documented on an MDT Intake Assessment Review form in BOSSNET (MR901.07).
- Access and Triage ASO will be advised of the need to close the episode in BOSSNET.

- The Community Teams will respond to all Category B or C Triages of consumers residing outside Ballarat LGA.
- On weekends 0900-1700, the Duty clinician of the Adult Community Mental Health Team will also provide the service response to consumers who are open to ICMHS, YMHS, AGED or Adult MHS in Ballarat and require an urgent review (although the follow up sub centre will be selected as ICMHS, YMHS, AGED or Adult).
- In Ararat and Horsham the Duty worker of the respective Community Team will provide the service response whether the consumer is open or new to the service.
- As a courtesy, the Access and Triage clinician will advise the Duty clinician of the respective Community Team of the need for an urgent response as soon as practicable (preferably within 2 hours).
- If the respective Community Team is not able to respond within the required time frame this should be discussed with the Team Leader, Consultant Psychiatrist or, after hours, the On-call Manager.

6.1 Consumers referred to Access and Triage from an Emergency Department

- Consumers may present directly to an ED with mental health difficulties rather than utilise the telephone triage service. Access and Triage will generally be advised of these referrals via an ED Triage nurse. These referrals will be rated as a category B in accordance with the State-wide mental health triage scale.
- Consumers may present with acute onset or relapse of mental illness, behavioural disturbance (including that associated with alcohol or other substance use), complex social problems and personal psychosocial crisis.
- BHS MHS may be asked to provide psychiatric assessment, treatment planning and implementation, suicide risk assessment and management (including of the intoxicated person and of persons who repeatedly self-harm), assistance with the management of BHS MHS consumers admitted to SSU, and risk assessment of persons who require medical admission (and provide ISBAR handover to Psychiatric CL).
- In Ballarat the Shift Coordinator will determine which clinicians respond to requests for mental health assessment in BHS ED.

- In Horsham and Ararat the on-call worker will be activated as required to respond to requests for mental health assessment in WHCG ED, or Stawell or Ararat Urgent Care.
- BHS MHS will provide assessment and secondary consultation for consumers in ED or Urgent Care as needed.
- If on attending ED it is not possible to complete a mental health assessment due to the consumer's physical health status, this will be discussed with ED staff to determine the most appropriate course of action. But, as a minimum, a risk assessment will be conducted with a management plan developed outlining the timeframe when a mental health clinician will attempt to complete the mental health assessment.
- The assessment and plan must be discussed with a Consultant Psychiatrist.
- If it is determined that the consumer requires further assessment and/or treatment from a Community Team the rationale for this will be clearly documented and verbally handed over to the Duty clinician of the respective Community Team with a timeframe for follow up as determined by the risk assessment and risk mitigation strategies put in place. *e.g The consumer needs to be reviewed within the next 24 hours.*
- If it is determined that the consumer requires admission to hospital, this will be discussed with the on-call psychiatrist and Shift Leader, and the respective Clinical Practice Protocol followed to facilitate the admission (cf CPP 0405, CPP 0482).
- If a consumer is placed on an AO under the MHA 2014 and transferred from another medical facility in the Grampians region the on-call psychiatrist will be advised and a review arranged. A clinician will attend ED to complete the receipt paperwork.
- If a consumer or patient is subject to a compulsory order under the MHA 2014 the Triage clinician will ensure that the relevant MHA 2014 paperwork has been completed correctly and assist ED staff in ensuring correct paperwork is in use and forms have been filled out correctly (see appendix 5).

Note: The on-call psychiatrist must be notified when a consumer in an ED is placed on an Assessment Order and/or subject to restrictive interventions under the MHA 2014.

Note: Access and Triage are responsible for completing admission paperwork and coordinating the transfer of the consumer from BHS ED to the inpatient unit (see CPP0405).

- If a consumer who is currently open to BHS MHS presents to an ED or Urgent Care and requires a mental health response, it is best practice for the consumer's Treating clinician to attend ED and conduct a face to face review.
- If this is not possible the request for service will be directed to the Duty clinician of the respective Community Team (see # 9).
- If neither the Treating clinician nor the Duty clinician of the respective Community Team are able to respond to ED within a reasonable time frame (2 hours) this will be discussed with the Team Leader of the respective Community Team or, if after hours, the On-call Manager.
- Liaison with the Team Leader of the Access and Triage Team will then occur to facilitate a service response.
- An ED may request secondary consultation regarding a consumer. Secondary consults will be documented on a screening register and outline the presenting problem,

rationale for the consult, risk issues and advice provided. These triages will be rated as category G on the State-wide mental health triage scale.

6.2 Consumers referred to Ballarat Health Services ED by Access and Triage

- All referrals to the Emergency Department where emergency services are not involved will be rated as category B in accordance with the State-wide mental health triage scale.
  - If a consumer contacts Access and Triage and describes medical problems, he/she should be encouraged to seek medical attention as soon as possible. If the consumer also describes concurrent mental health difficulties these should also be considered in determining the most appropriate service response.
  - If the consumer states that that they intend to make their own way to ED, the ED Triage Nurse of the respective health service will be contacted to advise of the pending presentation. The screening register will be opened to the relevant campus and sub campus.
  - The Triage clinician will allow reasonable time for the consumer to attend ED and confirm whether the consumer has presented. On occasions this may be needed to be handed over to the next shift to follow up.
  - If the consumer does not present to ED or leaves ED without being seen and there are ongoing concerns about the consumer's mental health, the Triage clinician will attempt to make contact with the consumer, referrer and/or carer to further assess the situation and ensure that the consumer receives appropriate medical and psychiatric care. Emergency Services will be contacted if necessary to assist in locating the person so that they can receive medical and psychiatric assessment as clinically indicated.

6.3 Consumers placed under Section 351 of the Mental Health Act 2014

- All referrals of consumers placed under Section 351 or the in the company of police will be rated as category B in accordance with the State-wide mental health triage scale.
- Priority will be given to attendance at ED to review consumers who have been place under section 351.
- If police contact Access and Triage about someone they have placed under section 351 the Triage clinician will obtain the name, demographic details and a brief summary of why the consumer has been placed under Section 351.
- The Triage clinician will also ascertain if there is a risk of aggression and whether the consumer requires security presence at ED.
- The Triage clinician will confirm with police which health service they will be taking the consumer to. Triage will then either provide the service response (Ballarat) or notify the respective Community Team (Ararat or Horsham) of the pending presentation.

Note: If the person has been placed on an Inpatient Assessment Order under MHA 2014 which has subsequently expired, the police may transport the person to hospital under section 351 of MHA 2014 if they are satisfied that the person has a mental illness and needs to be apprehended to prevent serious and imminent harm to themselves or to another person.

6.4 PACER (Police and Clinician Emergency Response Ballarat)

- All requests for PACER will be rated as category B in accordance with the State-wide mental health triage scale.
- PACER is a model of service delivery aimed at providing a more timely mental health response to consumers within the Ballarat LGA.
- The Shift Coordinator will determine which clinician provides the service response for PACER each Friday, Saturday, Sunday and Monday evenings.
- The PACER clinician will provide the service response when Police phone the PACER Mobile and request assistance.
- When PACER is required the clinician will complete a search of the consumer on the CMI and Bossnet data bases to inform their service response.
- Police will collect the PACER clinician from QVB to attend the location of the referral.
- If Police are unable to staff PACER with an officer then PACER will not operate. Police will advise Triage of this as soon as they are able.

Note: The need for PACER and the outcome of the assessment should be discussed with the On-call psychiatrist.

7. Category D Triages Requiring Semi-Urgent Face to Face Assessment

Category D triages occur when there is a moderate risk of harm and/or significant distress which requires a service response within 72 hours (although even with this rating the Triage clinician can recommend that the service response occurs within a shorter time frame than this).

- If a category D triage requires a service response within 24 hours this will be verbally handed over to the Duty worker of the respective Community Team as a courtesy as soon as practicable, and the time of the call and the name of the clinician documented in the "Outcome Comments" box of the screening register.
- If the respective Community Team is not able to respond within the required time frame this will be discussed with the Consultant Psychiatrist, Team Leader or, if after hours, the On-call Manager.
- Each Community Team is responsible for checking CMI each morning prior to their morning meeting to identify all category D triages that have come in overnight and require allocation within that team.

8. Category E Non-urgent Triages Requiring Face to Face Assessment

Category E triages occur when there is a low risk of harm in the short-term or a moderate risk with high support and stabilising factors. They may be of new and existing consumers entering the service, a transfer of care from other AMHS or existing consumers who contact Access and Triage after hours (cf #section 9).

- The time frame which BHS MHS has set to respond to category E is one week.
- Each Community Team is responsible for checking CMI each morning prior to their morning meeting to identify all category E triages that have come in overnight and require allocation within that team.

8.1 Transfers of Care from other AMHS

Transfers of care will be rated in line with the assessed urgency of the presenting issues but in most cases this will likely be as a category E in accordance with the State-wide mental health triage scale.

- Transfers of care between mental health services will be managed between services directly. This applies to all consumers and patients, including forensic patients, regardless of their mental health status.
- Access and Triage will obtain demographic details, ensure that the consumer is resident in the region, complete a screening registration with the category E, and warm transfer the call to the respective Duty clinician.
- An exception to this is where there acute symptoms and/or risks identified which require a more urgent service response to be facilitated by Access and Triage, or where the call is made between the hours of 2200-0830.
- If the consumer is being treated compulsorily under MHA 2014 the psychiatrist of the referring service must speak with the receiving psychiatrist of the respective Community Team (cf policy CPP 0406).
- A screening register will be completed to record the contact and ensure the request for transfer of care proceeds.
- If a patient has been transferred from another AMHS (including Forensicare) under the MHA 2014, a clinician will provide assistance as required to ED to complete the receipt paperwork.
- Overnight, Access and Triage will facilitate a service response.

Note: If a referring AMHS is handing over a call it has triaged and provided a response category for, the response is determined irrespective of which AMHS responds. The call does not need to be re-triaged, but responded to in accordance with the rating on the State wide mental health triage scale.

9. Calls From/Regarding Current Consumers

9.1 Business Hours

- If a current consumer of BHS MHS (or someone regarding a current consumer) calls Access and Triage during business hours then they will be provided with the telephone number or the respective Community Team, advised to call the team directly during business hours and a warm transfer of the call facilitated.
- If the caller has been experiencing difficulties with getting through to the Community Team or speaking to a clinician, the Triage clinician will ask the caller to briefly describe the reason for their call and facilitate a service response as clinically indicated if no one from the respective Community Team is available.
- In these instances a screening register will be completed and rated according to the State-wide mental health triage scale,

9.2 After Hours and Weekends

Access and Triage may receive calls about or from current consumers of the Community Teams after hours. This may occur for consumers receiving acute intervention and after hours follow up from the Duty clinicians, or for consumers who are contacting the service for other reasons.

- The Triage clinician will access recent file notes via CMI and BOSSNET to determine if the consumer is currently open to the service and warm transfer the call to a Duty clinician.
- It is an expectation that the Duty clinicians accept calls from current consumers.
- If the Duty clinicians do not answer their phone then the Triage clinician will ask the caller to briefly describe the reason for their call and facilitate a service response as clinically indicated.
- In these instances a screening register will be completed and rated according to the State-wide mental health triage scale
- If Emergency Services are required and the Duty clinician is not available, the Triage clinician will facilitate this.
- If the consumer can wait for follow up by their Treating clinician the plan for this will be clearly documented in the screening register with outcome ‘refer to case manager’ selected and open to the appropriate campus and sub-campus.
- If the caller has been experiencing difficulties with getting through to the Community Team or speaking to a clinician, the Triage clinician will ask the caller to briefly describe the reason for their call and facilitate a service response as clinically indicated if no one from the respective Community Team is available.
- In these instances a screening register will be completed and rated according to the State-wide mental health triage scale.

Note: Triage are not to leave a voicemail message to request the Community Team follow up a current consumer who has contacted the service.

Note: Consumers who are being overseen by the Clozapine Coordinator may or not be open to BHS MHS. This should be ascertained by conducting a search on CMI and BOSSNET and reviewing the clinical file.

9.3 Calls from Consumers who have been exited from the service in the past three months

- Consumers who have been discharged from an open episode of care within the last three months and present with symptoms suggestive of relapse and/or escalating risk will be able to return directly to their previous treating team with an automatic re-acceptance for entry to the service.
- The rationale for this rule is that the relevant Community Team knows the consumer and is best placed to determine their needs to prevent an acute relapse of their mental illness and/ or de-escalate a crisis.
- A screening register will be completed and rated according to the State-wide mental health triage scale, with consideration given to the person's recent closure plan and relapse signature.
- If there are imminent risk issues identified at the time of contact with Access and Triage then the Triage clinician will facilitate a service response and/or contact Emergency Services as clinically indicated.

Note: If an ex- consumer contacts the Community Team directly within Business Hours, and does not wish to speak with the Access and Triage Team, the Community Team will accept the call and facilitate a service response as clinically indicated.

10. Category F-G Triages (Do Not Require AMHS Follow Up)

10.1 Referral or Advice to Contact Alternative Services (Category F)

- Many people who contact triage do not require further assessment and/or treatment from a public mental health service and their needs are better met by other services. These triages are rated category F under the State-wide mental health triage scale.
- If it is determined that a consumer does not require AMHS service follow up, the rationale for this decision will be discussed with the consumer and/or referrer and clearly documented in the 'outcome comments' box of the screening register.
- Where possible, and when clinically indicated, Triage clinicians will facilitate referrals to other organizations rather than merely provide information about other services. Consent to do this will be obtained from the consumer. However in certain situations the requirement for consent does not apply (see MHA 2014 section 346).

- The clinician will speak with the consumer about providing information about their contact with Access and Triage to their GP, Private Psychiatrist or other relevant health professional and document this.
- If it is recommended that the consumer's GP completes a MHCP or Private Psychiatrist referral then the GP will be advised of this. If the GP is unavailable by telephone then a letter can be faxed to the GP with the relevant information (and ccd to other private providers as indicated).
- When advice is given to refer to a Private Psychiatrist under Medicare Item 291 then the clinician will consider GAP/out of pocket costs to the consumer, particularly if it is known that the consumer is experiencing significant financial hardship.
- If the consumer is already engaged with a Private Psychiatrist, the Triage clinician will contact the Psychiatrist the same or next business day to advise them of the consumer's contact with BMHS. If the Private Psychiatrist is unavailable by telephone then a letter can be faxed to the Psychiatrist's Consulting Suites regarding the contact (and ccd to the consumer's usual GP).
- The consumer, carer and/or referrer will be engaged in contingency planning for the period while they are waiting for another service and advised to recontact BMHS if their situation changes

10.2 Advice or Information Only (Category G)

Triages are rated as category G when no further action is required of the mental health service and referral to another service is not required, or more information is required. This includes:

- where existing and former consumers call for support and advice;
- where the caller has requested advice or assistance in relation to a particular individual (secondary consultation);
- the request is for consultation and liaison with a consultant psychiatrist and this has been handed over to the relevant community team psychiatrist
- the consumer declines any further service (and there are no grounds to proceed with the referral);
- there is no further action required of the mental health service and referral to another service is not required;
- more information needs to be collected before deciding whether a face to face assessment is required;
- other AMHS or private psychiatrist contacts to provide alert information (see # 10.3 Alerts).
- All triages requiring further follow up will have a clear and concise plan documented in the outcome comments box of the screening register.
- If the contact is completed this will be clearly documented – with rationale - in the 'outcome' drop down box.

- If the consumer has a GP or private health practitioner then a letter providing feedback about the contact will be provided. The consumer's consent should be obtained prior to sending the letter.

Note: If the Access and Triage Team have been unable to contact the consumer and/or referrer for a period of 24 hours, this should be escalated and discussed with the Consultant Psychiatrist.

Note: All category F and G triages will be reviewed by the Consultant Psychiatrist the following business day and closed if they are satisfied that the clinician's disposition is appropriate. Where the F or G triage does not have enough information or the plan or outcome is unclear to the Psychiatrist, the Psychiatrist will document this and liaise with the Shift Leader for follow-up.

10.3 Alerts

Access and Triage will only accept alerts from other AMHS and Private Psychiatrist**s.** Access and Triage will not accept alerts from private mental health providers or non-clinical services such as CPU or Uniting.

- If an AMHS or Private Psychiatrist wishes to provide alert information about a consumer the Triage clinician will clarify the time period for the alert and what needs to occur if Access and Triage receives contact about or from the consumer within that time frame. A screening register will be completed and any faxed information received sent for scanning and uploading to BOSSNET. The triage is rated category G.
- If there are any concerns about the alert received, this should be escalated to the Access and Triage Team Leader, Consultant Psychiatrist and/or Program Manager.
- If information is obtained which indicates the consumer requires an active service response the triage is to be rated according to the statewide mental health triage scale.
- If there is no contact from or about the consumer within the specified time period, this should be fed back to the referrer.

11. Forensic Referrals

11.1 Referrals from Clinical Forensic Services

Forensicare provides clinical forensic mental health programs located within prisons. These include:

- Melbourne Assessment Prison – Adult Assessment Unit (AAU)
- Thomas Embling Hospital (TEH)
- Port Phillip Prison – St Paul's Unit
- Dame Phyllis Frost – Marmak Unit

    - Mobile Forensic Mental Health
    - Forensicare Clinicians located within a prison (may be treating and referring a prisoner from general population).
    - Ravenhall

- Referrals from Forensicare clinical programs are considered to be a direct transfer of care from another Area Mental Health Service (see #8.1).
- If the referrer initially consults with BHS MHS Forensic Clinical Specialist (FCS) prior to referring, the FCS should direct the referring clinical service to contact the Duty clinician of the respective Community Team to complete the transfer of care.
- Consumers released from Court or prison and placed on an inpatient Assessment Order because they are acutely unwell should receive a service response as per sections 6.1 and 8.1.

11.2 Referrals from Non-Clinical Forensic Services

Non-Clinical Forensic services are those which work with consumers in prison or in the Community Corrections System. These include the following:

- Melbourne Juvenile Justice
- General prison staff or Registered Nurses from Port Phillip Prison, Dame Phyllis Frost, Malmsbury (Youth) Prison, Metropolitan Remand Centre.
- Community Corrections
- Department of Health and Human Services
- Mental Health Advice and Response Service

Referrals from non-clinical services will be triaged by Access and Triage as per referrals from any non-clinical service (see #2). If the consumer is incarcerated at the time of the referral the Triage clinician may not be able to speak with the consumer and will need to make an assessment based on the available information

Additional information to be collected for forensic referrals is as follows:

- Location of client
- Court Hearing dates and contact information for legal representative
- Bail conditions or orders
- Status while in prison
- Behaviours or incidences whilst in prison
- Current mental state
- Risk profile (e.g. HCR 20, PCL) and information regarding primary offences
- Compliance with treatment
- Release date
- Legal status on release (parole, bail, straight release)

- Services involved on release (including GP details)
- Discharge summary and medication chart
- Legal paperwork and other indicated documentation
- Whether the consumer will be released on a Community Assessment Order?
- Establish what the referring service is seeking, e.g. brief, medium or long term intervention
- Encourage management of the consumer prior to release where possible.

Note: Clinicians do not complete fitness to charge assessments. This is the role of the Forensic Medical Officer

11.3 Patients of Thomas Embling Hospital on Temporary Leave

- Some consumers of Thomas Embling Hospital will reside in the GRAMPIANS catchment area while on leave (extended or limited off-ground) from Thomas Embling Hospital on a Custodial Supervision Order.
- These consumers may come into contact with AMHS during acute relapse or crisis whilst residing in the community.
- If these consumers require an admission they have a guaranteed bed at Thomas Embling Hospital.
- All consumers on leave from Thomas Embling Hospital will have a detailed Crisis Risk Management Plan.
- Forensicare will notify the relevant AMHS and provide the Crisis Risk Management Plan to the relevant AMHS.
- Clinicians should check the "legal status" of consumers on CMI.
- ACCESS AND TRIAGE should alert Forensicare regarding any contact that is received about consumers on a Custodial Supervision Order.
- Legally these consumers remain the responsibility of Forensicare.
- Forensicare contact numbers:
    - Business Hours Ph: 9947 2500
    - After Hours Ph: 9495 9156 Clinical Administration - to access on call Psychiatrist and co-ordinate service response.

12. Reception Calls

- Reception calls from individuals who have contacted the wrong service or are out of area are considered 'reception calls'.
- These calls are documented in a screening register named RECEPTION (Surname), CALLS (First Name).
- A new screening register for RECEPTION CALLS will be opened every day. This is for the purpose of searching for the screening register on the day.

- All contacts that are not related to specific consumers, are providing advice or re-direction will be recorded in this screening register.
- Clinicians will record their name before the contact, their designation and complete an additional contact.
  e.g.*1240 hrs A. Smith RPN 4- PC from a consumer seeking D & A service, nil acute MH problems identified, call transferred to directline*

13. Shift Coordinator

- A Shift Coordinator will be allocated for every shift. The AM Shift Coordinator will write this down in the Triage diary for the day.
- The Shift Coordinator is a Senior Clinician on shift who is responsible for allocating work, coordinating the triage diary and convening the handover meeting to ensure that any outstanding triages that require follow up from the shift before are handed over to the next shift.
- Shift Coordinators must ensure that the workload is distributed equitably. This includes assigning clinicians to respond to consumers who require assessment in ED, allocating clinicians to respond to category B & C triages in Ballarat LGA, allocating new faxed referrals to be followed up and allocating incomplete triages to be completed.

14. Triage Diary

- The Triage diary is used to communicate work for follow up that shift.
- The Shift Coordinator is responsible for ensuring that tasks are noted in the diary, allocated for follow up, and completed
- Priority is to be given to triages already in the diary as they are referrals that Access and Triage has already received and need to be followed up. However, clinicians need to balance workload demand. If there are any concerns regarding prioritising workload then clinicians are to discuss this with the Shift Coordinator or Team Leader for further direction
- The workload will be distributed equitably and consideration will be given to the number of assessments and triages allocated to each clinician.
- Each clinician is responsible for following up on work allocated to them.
- Completed tasks will be ticked off in the diary or handed over to the next shift if incomplete.
- Throughout the shift and prior to handover the shift leader will confirm what tasks have been completed, what completed tasks need to be ticked off in the diary and what needs to be handed over in preparation for the afternoon clinical handover.
- Triage Clinicians will place triages requiring follow up in the diary. Details will be clearly written in UPPER CASE lettering in the diary to ensure that the next Clinician is able to read it.

- Referrals received by fax will be entered in the Triage diary and allocated for follow up (#2).The faxed documents should be forwarded to HIS for scanning to the BOSSNET EMR.

15. Clinical and Handover Meetings

- Handover between the change of shifts will occur at 0730, 1330 and 2200 hours using a standardized process and the ISBAR format.
- These handovers will be used to discuss triages that are incomplete and require further follow up by another clinician on the next shift.
- A clinical review meeting with the consultant psychiatrist will occur at 0900 each morning to allow time to plan interventions required for complex cases, address any difficulties there might be with regards to a triage taken the day before, or any other issues where input from the team would be helpful. All triages should be reviewed in this meeting so that none remain without an outcome for more than 24 hours. On weekends and public holidays the on call consultant will attend this meeting.
- Any other issues that arise during a shift should be discussed during the shift with the Team Leader or Consultant Psychiatrist or escalated to the relevant Manager.
- Triages that are handed over to the next shift will be documented in the diary along with the name of the clinician handing over and the name of the clinician allocated to follow up.

16. Night Shift Duties

- The triaging and processing of incoming calls remains the priority for clinicians working nightshift. However, during periods of low call volume/workload, night shift clinicians may assist with correspondence.

17. Screening Register Reviews (Category A-E)

- The previous day's category A-E screening registers will be reviewed at the 0900 Clinical Review meeting with the Consultant Psychiatrist present and acknowledged. This prevents information being entered retrospectively or altering of the document post script.
- When reviewing these screening registers it is expected that the following is in place before acknowledging :
    - All relevant clinical information is documented and the screening register has been completed appropriately.
    - The outcome of the triage is clear.
    - There is clear documentation that the triage have been handed over where required.

    - The screening register has been opened to the correct campus and sub-campus to ensure that the respective teams can access the screening register.
    - All Category A triages have been followed up to determine the outcome and/or that the consumer has presented to ED.
    - Additional contacts have been completed.
- If there are any identified issues with a screening register then that particular screening register should not be acknowledged but escalated to the Team Leader to discuss with the respective clinician.
- If the screening register is incomplete and the Team Leader is not available, then that screening register will be diarised for follow-up that shift.
- If a category A or B triage has not been followed up, the clinician will contact 000 operation or BHS ED to confirm the outcome of the triage.
- If the consumer has not presented to BHS ED the clinician will attempt to either follow up with emergency services regarding the outcome of their attendance or attempt to contact the consumer and/or family (if appropriate) – depending on the risk issues.
- If there is no conclusive outcome from following up category A and B triages then the triage will be placed in the diary for follow up.
- Clinicians are not to acknowledge their own screening registers.

Appendix 1

About CMI

What is the CMI?

- CMI stands for Client Management Interface. It is a database holding client related information for anyone who comes into contact with mental health services across Victoria.
- The CMI also collects service activity and other relevant information and generates reports to assist with the development and provision of services.
- Some information entered into the CMI is transmitted to a State-wide data repository called the Operational Data Store (ODS). This information is available from the Client Enquiry function and is used by the Department of Health, the Chief Psychiatrist and the Mental Health Tribunal for reporting, monitoring patient activity and MHT scheduling.

Who can access the CMI?

- Authorised clinical staff and administrative staff only.
- Access to the CMI is protected by a 2-stage password login process to ensure security of the information held on the database. Information held on CMI is subject to the same data protection and confidentiality as required by all medical records held by services.
- Access and use of information in the CMI is governed by the Health Records Act 2001. It permits information in the CMI to be used to provide treatment to clients. Access and use of information in the ODS (i.e. Client enquiry screen) is governed by the Mental Health Act 2014. You may only use the client enquiry function to collect information from the ODS to enable the treatment of Clients.

Appendix 2

Managing Triage Telephone Calls

Answer the call

"Ballarat Mental Health Triage *name* speaking"

Confirm the identity of the person being referred

Check spelling of Christian name and surname, confirm DOB, confirm current address and phone number

Complete client enquiry on CMI

Function → screening register → enquiry - make sure ODS box is ticked so you can see statewide registrations

Look to see if the person is a current client (under activity), diagnosis, alerts, alias, past episodes of care, admissions, current/past involuntary treatment

Complete Screening Register Search

Function→ Screening Register →Search by "client"

This will allow you to see if there has been recent contact and/or referral made to the community team

A current consumer calling during business hours

Provide with the correct CMHS phone number and ask them to contact the clinic directly

Appendix 3

One screening register per person per day

Always check to see if a screening register for that person has been completed for that day

If so, then use that screening register to add further contact information

Search screening registers by Campus, Client or the clinician who completed the screening register. This will generate a list.

Double click on the name of the person to open up the screening register.

Add information to the “outcomes” box. Double click on >> to open the box.

Unregistered Screening Register Consumer

(for consumers not known to Grampians MHS)

In CMI select: Functions > Screening Register > Add new > Unregistered.

Complete all fields in “Unregistered client” tab.

Complete all fields in “Referred from” tab.

Complete all fields in “Screening detail”. NAME in CAPITALS. Note “screening” time (the time you took the first call/contact) and “referred from”.

For “follow-up subcentre” select the community team associated with the age group and location regardless of the triage rating category. This allows the relevant team and CP to see their referrals, and for CPs to close off ‘F’ and ‘G’ triages for their area.

Once all the above fields are completed; press save.

Add triage information under the “presenting problem” section. Add the plan under the “Outcome comments” section.

Complete all fields in “Screening detail”. Please note, screening time is the time you took the first call/contact.

Complete all fields in “referred from” tab.

Once all the above fields are completed, press save.

Registered Screening Register

The person will need to be registered with Access and Triage if there are no previous contacts with Access and Triage (even if past contact with the service)

In CMI select: Functions > Screening Register > Add new

Confirm the identity of the person (check spelling of Christian name and surname).

Put in the person’s first name, surname and/or local UR and select ‘find now’.

Confirm DOB, confirm current address and phone number.

If these have changed, update them whilst in the screening register via client registration → options → client maintenance, save and exit “client maintenance”

For registered consumers you do not have to complete the “unregistered client” tab.

For both registered and unregistered consumers; you are only required to complete the whole Triage Assessment template if you have contact with he person. If you only have contact with a referrer, you only complete the “Reason for referral” and “Plan”.

Category D and E triages in Ballarat LGA are handed over to the respective community teams. Category B-E triages are handed over to the respective community team outside the LGA of Ballarat. Category F-G do not need to be verbally handed over to the community for follow-up.

Create placeholder for Screening Register in Bossnet

Open up the consumer’s clinical record

Click on star symbol

Click on ‘BHS900.1 Triage Referral Screening Register

Once e-form opens, click on ‘submit’. DO NOT DOUBLE CLICK

Appendix 4 Access And Triage Assessment Guide (cf CPP0276 Mental Health Intake Assessment & CPG 0042 Clinical Risk Assessment and Management in Mental Health)

Reason For Referral

Presenting difficulties, onset, context, impact of problems on relationships, daily functioning (e.g. ADLs, self, care, attendance at work or study, living situation, supports, details of dependents (including any legal or protective orders in place).

Psychiatric History

- Admissions, case management, diagnosis
- Family history of mental illness

Medical History

Other history as relevant

AOD, Forensic, Developmental, Trauma, Education and Employment, LGBTQI, Cultural issues

Medication

Other Services Involved

Name, contact details, when last seen, when next appointment will be.

Mental State Examination

- Appearance
- Behaviour
- Speech
- Mood and Affect
- Biological (sleep, appetite, concentration and motivation)
- Thought Form
- Thought Content
- Perception
- Cognition (orientation time, place and person, memory)
- Insight & judgement

Risk Assessment

- Accidental self harm: *intellectual impairment, physical impairment, cognitive deficits, impulsivity, other behavioural problems, substance use, age, delusions, hallucinations, environment (including risk of harm from others due to exploitation, family violence)*

- Deliberate self-harm: *current plans, intent and access to means, past history of attempts and precipitants, family history of suicide, significant life events, recent loss including that associated with physical illness or injury, knowledge of suicide, substance use, command hallucinations to suicide, delusions of persecution poverty or guilt, profound hopelessness and worthlessness, emotional distress such as frustration or anxiety, limited coping strategies, environment and poor engagement.*

- Risk to others*: past history (including forensic history), preoccupation with violence, current thoughts, plans and intent to harm others and access to means, delusions of paranoia, erotomania, infidelity, guilt, nihilism, command hallucinations, altered mood, delirium and dementia, substance abuse, significant life events, loss, emotional distress such as frustration or agitation, limited coping strategies, environment. Note: include risk to dependents and animals and* risks in the home environment for staff *(e.g. aggressive animals, gun ownership)*.

- Vulnerability: *history of exploitation, sexual disinhibition, history of abuse, cognitive deficits or impairment, poor insight, altered mood or sensorium, perceptual disturbance, delusions, disorganization, limited communication skills, substance use, estrangement from family, lack of supports, unstable housing, employment and relationships, environment, demographic factors(e.g. males under 30 and over 70 are considered at increased risk of suicide).*

- Treatment Engagement*: insight, judgement, entrenched psychiatric symptoms impacting on judgement, insight and compliance, expectations of treatment, history of engagement, itinerant lifestyle, financial and geographical limitations to engaging in treatment, side effects to medication*

- Protective Factors*: Intact insight and judgement, sound cognitive functioning, good problem solving skills, functional social networks, seeking treatment and positive experience of same, future focused, adaptive coping strategies, good communication, stable housing, employment and relationship, engagement in meaningful activities such as work or study, attitudes towards suicide, religious beliefs.*

Note: Considerations of risk should always inform your clinical determination, particularly if the consumer declines mental health services (cf # CPG 0042)

Formulation

A succinct and clear summary of the presentation is captured which outlines your concerns regarding risk and your rationale as to why you have made the decision you have.

For example-

"26 year old male, single and unemployed residing with his parents in Ballarat. Referred to Psychiatric Triage following concerns raised by family that he was suicidal with plan and intent to end his life by hanging in the setting of a relationship breakdown and mounting financial pressures. Referral made to triage following police welfare check after he made statements of suicide by hanging via text to his ex-partner. I managed to speak with the patient who is presenting with a full range of depressive symptoms and suicidal ideas with plan to end his life by hanging. He has a background history of suicide attempt 12 months ago whereby he was referred to the Adult MHS for treatment. Significant concerns regarding his risk profile, current suicidal ideas, thoughts of hanging, has disengaged from treatment, he is drinking excessively and has had a previous attempt on his life 12 months ago. He is unemployed and has recently broken up his partner of 2 years which seems to be the catalyst or setting for this current presentation. The pt. is agreeable to the referral. His family are very concerned about his level of risk and are seeking treatment from the AMHS. He will require a CAT C referral to be seen within 8 hours by the Adult Community Mental Health team".

Plan

Immediate clinical intervention, including response to risk

Then document that the referral has been made to the appropriate team and note the time and name of the clinician you have handed over to.

e.g."0932 J. Smith RPN4 - PC made to the Adult AMHS, CAT C referral made to Sarah".

For Eating Disorder Assessment

Current weight, highest and lowest weight, amenorrhoea. Water intake, attitude towards food and body. Presence of restrictive behaviours (e.g. not eating particular food groups), preoccupation with food, calorie counting, bingeing and compensatory behaviours (e.g. purging, exercise, laxatives).

For APATT Assessment

Physical health status, delirium screen, behavioural charts, Geriatrician or ACAS information. Detailed medical summary and letter of referral from GP (clinical judgement where urgent referrals occur).

For Young People Under the Age of 18 Years:

Is the parent/legal guardian aware of the referral? Does the parent/legal guardian consent to the referral? If there are concerns about disruptive behaviour identify when, how often, how long does it last, when does it last, context and known triggers, Consider risks associated with change in mood, impulsive behaviour, truancy, and oppositional behaviour

Obtain information about the young person's school (name, grade, teachers, attendance, intellectual impairment/developmental delay) and other agencies – nature of involvement, length of involvement, helpful, still involved? Expectations of ICMHS, are the parents willing to engage in treatment?

Appendix 5 Assessment Template Screening Register

Reason for referral/presenting problem

Psychiatric History

- Admissions, case management, diagnosis
- Family history

Medical History

Other history as relevant

Eg. AOD, Forensic, Trauma, Education, Employment, LGBTQI, Cultural issues

Medication

Other Services Involved

Mental State Examination

- Appearance
- Behaviour
- Speech
- Affect & mood
- Biological (sleep, appetite, concentration and motivation)
- Thought Form
- Thought Content
- Disorders of perception
- Cognition (orientation time, place and person, memory)
- Insight & judgement

Risk Assessment

- Accidental self harm
- Deliberate self harm
- Harm to others
- Vulnerability
- Treatment compliance
- Protective Factors

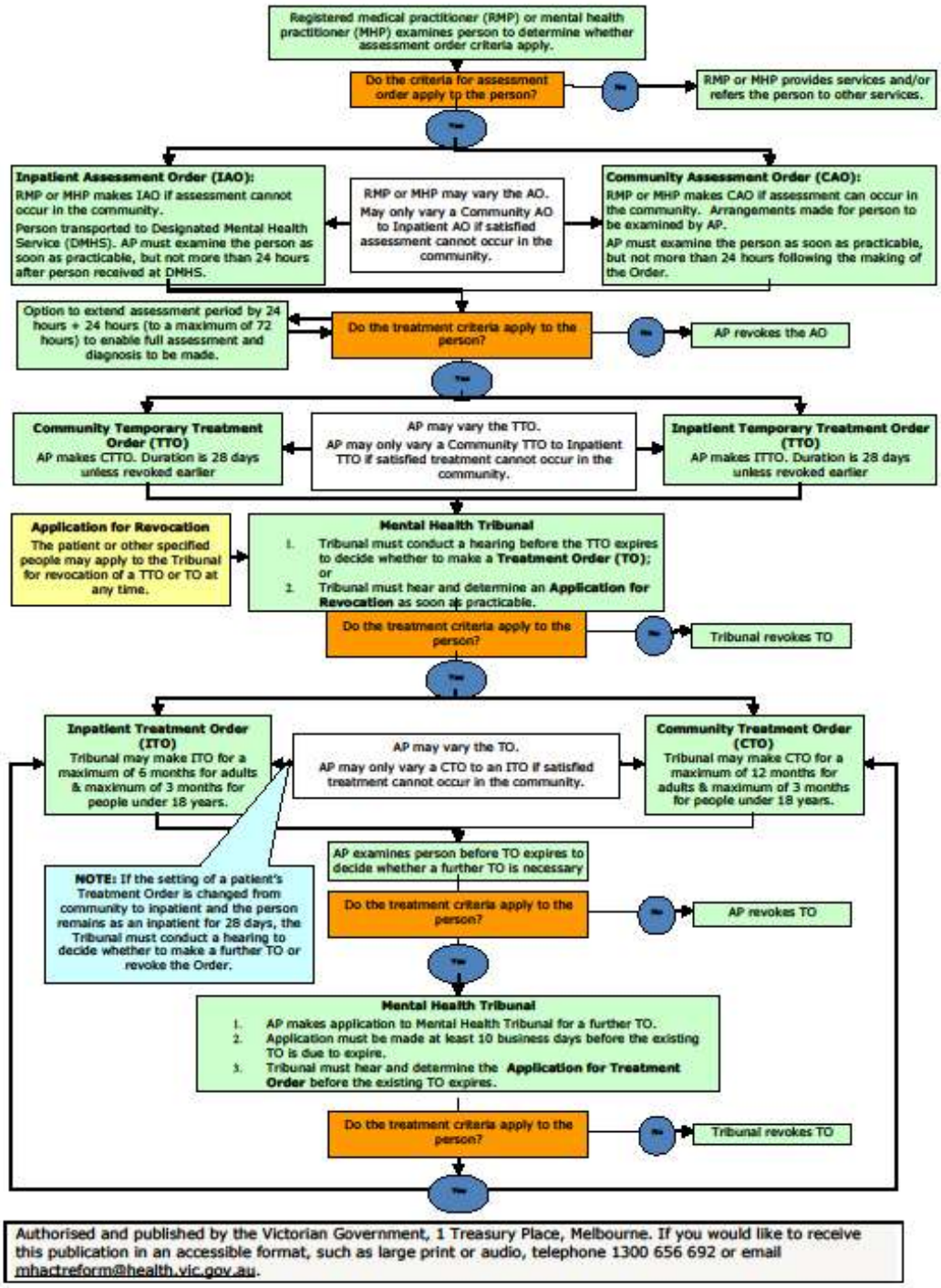
Formulation

Including clinical Interpretation of Risk and rationale

Plan/Immediate Clinical Intervention including response to risk

Appendix 6

Mental Health Act 2014 – Treatment Orders flowchart



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Appendix 7 Resources and Links:

Policies are available on Gov docs

Below are examples of some policies (not all) to familiarize yourself with:

CPP0596 Patient Statement of Rights – Mental Health

CPP0276 Mental Health Intake Assessment

CPG0042Clinical Risk Assessment and Management in Mental Health.

CPP0405 Admission to the Adult Acute Unit - Mental Health Services

CPP0482 Admission to the Steele Haughton Aged Acute Unit - Mental Health Services

CPP0386 Clinical Documentation – Mental Health Services

CPP0406 Patient Transfer – Mental Health Services

POL 0002 Record Management Incorporating Information Privacy

POL 0003 Privacy Confidentiality of Information

NCP0063 Use and Disclosure Personal Information

NCP0092 Child Protection Reporting and Child First Referral

NCP0192 Referral Triage and Assessment process for the Mother and Family Unit

Clinical Practice Guideline for Working with the Suicidal Person in ED (DoH 2010)

https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014

https://www.myhospitals.gov.au/our-reports/time-in-emergency-departments/december-2012/report/introducition/the-national-emergency-access-target

https://www.blackdoginstitute.org.au

https://www.beyondblue.org.au/health-professionals/clinical-practice-guidelines

https://oyh.org.au

https://www.neura.edu.au

https://www.spectrumbpd.com.au

https://projectairstrategy.org

https://bpdfoundation.org.au

https://www.dementia.com.au/services

http://ceed.org.au/resources-and-links

https://raisingchildren.net.au

Ballarat Health Services

CLINICAL PRACTICE PROTOCOL

Clinical Handover Protocol
SCOPE (Area): All Areas
SCOPE (Staff): Clinical Staff

Printed versions of this document SHOULD NOT be considered up to date / current

Rationale

Clinical handover is valued as a priority in clinical work in order to maintain patient safety. Clinical staff are required to perform appropriate, safe, timely and effective clinical handover using a standard set of key principles and a minimum data set using the ISBAR framework.

Expected Objectives / Outcome

- To ensure staff understand their accountability to deliver effective clinical handover appropriate to the clinical setting.
- To ensure staff give and receive safe, timely and structured clinical handover.
- To involve patient and/or carers wherever possible in handover processes.

Definitions

Patient: patient, client, resident or consumer.

Clinical Handover: The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis, internally or externally (NSQHS Standards September 2012). It includes verbal, written and electronic handovers and handovers occurring within Ballarat Health Services and to external agencies and clinicians. Documented evidence of handover needs to occur.

ISBAR: ISBAR is the endorsed communication tool across Ballarat Health Services
An acronym to guide the structure and content of handover

- **I - Identify** Yourself and the patient (using 3 patient identifiers). If the patient is present introduce staff to the patient.
- **S - Situation** State the immediate issue/current situation. Is the patient

stable/unstable?
- **B - Background** Relevant past history. Alerts/Allergies. Overview of current story.
- **A - Assessment** Provide your assessment of the patient's current status. Include recent vital signs/relevant results.
- **R - Request** Be clear about what you are requesting. Responsibility for actions and clear timeframes.

Minimum Data Set for Clinical Handover: The minimum set of information and content that must be contained and transferred in a particular type of clinical handover. There are many possible minimum data sets which will vary depending on the context and reason for handover.

- 3 patient Identifiers
  - *Inpatient*: Patient name, DOB & UR number
  - *Ambulatory Services:* Patient name, DOB & Address
- Admission Date
- Location/Ward/Program
- Treating Doctor/GP
- Diagnosis/Problem
- Goals of Care
- Advanced care directives
- Criteria for escalation to a senior clinician
- Clinical risks relevant- e.g. Falls Risk, Skin Integrity, Infectious status, High Risk Medications, Allergies, Alerts, Behavioral, Bariatric
- Procedures/therapies/interventions/relevant results
- Change or cessation in medications
- Management Plan
- Expected Discharge Date/Destination

Flexible Standardisation of Clinical Handover: Standardisation of the handover process and minimum data set to fit the particular needs of the patients and clinical workforce staff tailored to a local context.

Handover Preparation: Review and include relevant clinical information (procedure/s, test results) as derived from medical, allied health, nursing progress notes, care plans and medication chart.

Dedicated Time: Specific time set aside to undertake clinical handover. No other activities to be performed during this time (unless an emergency situation occurs). Depending on the area, dedicated time may occur at the same time each day (i.e. Nursing at the commencement of each shift).

Indications

Clinical Handover must occur when a responsibility for a patients care (or an aspect of treatment) is transferred from one clinican to another.

Inter-professional handovers include and not limited to:

- Escalation of deteriorating patient

- Safety brief at shift change
- Bedside handover
- Patient transfers to another ward/department/team or referrals
- Patient transfers to a test or appointment
- Multi-disciplinary team handover/discussions e.g. case conferences
- Patient transfers to/from another facility
- Patient transfers to/from the community

Refer to Appendix 1 Clinical Handover Solutions Matrix

Refer to Appendix 2 Example of Disciplines of Handover

Issues To Consider

- Potential patient movements will be highlighted so that incoming teams can develop plans to manage their workload (e.g. admissions, discharges, transfers).
- Staffing numbers and arrangements may also need to be defined, mentioned and discussed.

Detailed Steps, Procedures and Actions

To ensure safe, effective clinical handover is applied in all clinical situations, a standardised and structured approach using the principles of safe clinical handover will apply.

The principles of safe clinical handover must be standard to all scenario's of clinical handover and include:

1. Preparation

- Key participants must be identified.
- Staff are allocated to deliver clinical handover (where relevant).
- Where handover occurs in a specific location, ensure staff are aware of the venue, duration and dedicated time for handover.
- Relevant documentation will be prepared prior to handover including handover sheets, progress notes, test results etc.
- If receiving handover, staff must have the relevant paperwork or resources to collect and record any tasks, actions or other relevant handover information.
- Bedside handover will include documents to assist in handover such as observation charts, medication charts and patient management plans where appropriate.

2. Leadership

- Clinical Managers and Program Managers must lead and support clinical teams to perform best practice clinical handovers.
- Provide orientation of clinical handover processes to all new staff.
- A clinician must be designated to lead the handover. This would be a senior clinician involved in the patient's care.

- Staff must be punctual and ensure all participants in the handover have arrived.
- Multidisciplinary participation in clinical handover is encouraged wherever feasible.
- No interruptions are to occur during clinical handover except in the event of an emergency.
- Handover must be respectful to the patient and the whole team.
- Have a process for following up and providing feedback to staff who do not participate in handover effectively.

3. Process

- Handover will deliver essential information, utilising the ISBAR framework (*refer to Appendix 3 ISBAR Communication Example*).
- Specific information about patients who require significant levels of care will be highlighted, e.g. deteriorating patient, Goals of Care, falls risk, skin integrity risk, high risk medications, infectious status, behavioral issues, allergies and alerts and other identified risks.
- Adverse Drug Reactions (ADRs), high risk medications and change or cessation in medications will be discussed/ documented at clinical handover.
- Current patient medication charts (including ancillary charts) are considered the most accurate comprehensive list of medicines in clinical handover procedures.
- Handover will occur in the most appropriate context-ideally face to face and at the bedside unless contraindicated (*refer to Appendix 4 Bedside Handover Flowchart (Nursing) & Appendix 5 ISBAR Bedside Handover (Nursing)*).
- Wherever possible and unless specifically contraindicated, clinical handover should include patient and carer participation with the patient/carer present.

4. Transfer of accountability and responsibility for patient care

- Handover will be understood by staff as an explicit transfer, not just information, but of clinical accountability and responsibility.
- Staff have an opportunity to clarify information.
- Ongoing actions/tasks will be discussed at the time of transfer of responsibility of care.
- Where relevant handover will be supported by clearly documented notes in the medical record.
- In the event that staff are not in agreement of the above issues, details will be escalated to a more senior member of the team.
- Any incident involving clinical handover or if adequate handover does not occur, a VHIMS report must be completed to ensure appropriate follow up and action (*refer to Appendix 6 A Guide for Reporting Clinical Handover Incidents*).

5. Discharge

- A discharge summary will be completed for every in-patient who is discharged including the minimum data set of information (BOSSnet is the preferred discharge tool).
- Transfer guidelines and/or forms must be used for patients transferred to other facilities for ongoing care or investigation.
- Ongoing care requirements at discharge must be clearly defined and understood by the patient and ongoing care providers.
- Post hospitalisation follow up care will be clearly documented in a referral document to ongoing health providers and to the General Practitioner (GP) in a

completed discharge summary.

For Ambulatory Services:

For patients requiring transfer to Ambulatory Services (e.g. Radiology, Dialysis, Radiotherapy and Chemotherapy) the following steps must be undertaken:

- The 'ISBAR Ambulatory Patient Handover Checklist' must be completed and sent with all patients.
- All relevant documents must accompany the patient (e.g. Patient History, Observation Response Chart, Goals of Care Summary)
- A clinician escort (Nurse/ Midwife and/or Medical Officer) is required for any patient requiring clinical assessment, monitoring, intervention or supervision during transport.
- On transferring the patient back to the original department a documented handover in the patients history must occur where relevant (e.g. post intervention management).
- If adequate handover does not occur a VHIMS report must be completed to ensure appropriate follow up and action.

Key Performance Indicators

- Clinical handover education occurs with all new clinical staff.
- Scheduled observation audits of clinical handover between staff will take place, e.g. at bedside handover.
- Scheduled documentation audits will take place, e.g. clinical handover documents, completion of discharge summaries and referral documentation.
- Number of serious adverse events related to handover/communication.
- Consistent use of standard clinical handover tools.
- Percentage of multi-day patients whose discharge summaries are sent to the patient's GP/ongoing provider within 48 hours.

Related Documents

- POL0003 - Privacy, Confidentiality Of Information
- CPP0231 - Escalation Of Patient Safety Concerns
- CPP0245 - Discharge Planning - Mental Health Services
- CPP0401 - Discharge - Community Programs
- POL0249 - Information Management Security
- POL0260 - Admission, Transfer And Discharge: Agreement And Regulations
- CPP0206 - Medical Inpatient Discharge Summary
- CPP0559 - Clinical Handover - Shift To Shift (residential Aged Care Services)
- CPG0065 - Discharge Of Day Surgery Patients

- POL0070 - Clinical Handover
- POL0036 - Patient Identification And Procedure Matching
- POL0209 - Recognising And Responding To Clinical Deterioration
- POL0072 - Person Centred Care
- CPP0549 - High Risk Medications
- CPP0573 - Adverse Drug Reactions (including Allergies) - Recording And Reporting
- CPP0604 - Bhs Dental Clinical Handover
- CPP0607 - Allied Health Clinical Handover Documentation Within Ballarat Health Service
- CPP0608 - Community Programs Clinical Handover Protocol
- SOP0001 - Principles Of Clinical Care

References

- Australian Commission on Safety and Quality in Health Care. (2010). The OSSIE guide to clinical handover improvement. Sydney: ACSQHC. Retrieved from
- Australian Commission on Safety and Quality in Health Care. (2011). National Safety and Quality Health Service Standards. Sydney: ACSQHC. Retrieved from
- Australian Commission on Safety and Quality in Health Care. (2012). Safety and quality improvement guide standard 6: clinical handover. Retrieved from
- NSW Department of Health. (2009). Implementation toolkit: Standard key principles for clinical handover. Retrieved from

Appendix

- Appendix 1 Clinical Handover Solutions Matrix
- Appendix 2 Examples of Disciplines of Handover
- Appendix 3 ISBAR Communication Example
- Appendix 4 Bedside Handover Flow Chart (Nursing)
- Appendix 5 Nursing ISBAR Bedside Handover Guide (Nursing)
- Appendix 6 A Guide for Reporting Clinical Handover Incidents

Reg Authority: Clinical Governance Documentation Online Review Group	**Date Effective:** 28-09-2017
Review Responsibility: Quality Improvement Coordinator	**Date for Review:** 28-09-2020

Ballarat Health Services

CLINICAL PRACTICE PROTOCOL

Clinical Documentation - Mental Health Services
SCOPE (Area): Mental Health
SCOPE (Staff): Clinical Staff, Mental Health Staff

Rationale

This protocol provides all clinical staff with clear expectations of the requirements for documentation in the health care record.

Expected Objectives / Outcome

That documentation in the clinical record is at all times completed in an accurate and timely manner. Documentation should provide a comprehensive, factual and sequential record of the patient's condition, assessment, treatment and the services provided.

Detailed Steps, Procedures and Actions

Entries in the Clinical Record
All entries in the clinical record are required to be relevant, objective, accurate, concise and sequential. This protocol must be read in conjunction with BHS - Clinical Documentation Policy POL0206.

Community (all ages)

- Documentation of each clinical appointment, telephone conversation and written correspondence (including email and fax) with a patient, family or with key stakeholders about a patient must occur.
- Documentation should be completed as soon as practical following conclusion of the contact, by the conclusion of same business day.

Triage
Triage must be completed for all new referrals. All triage must be completed on the appropriate triage form (MR900.00 Adult/Aged, MR900.06 Infant and Child, MR900.05 PEHP and MR900.02 Youth). All fields on the Triage form must be completed.

Documentation must be completed in accordance with the Triage & Service Access

CPG0021.

Intake Assessments
Intake Assessments must be documented on the appropriate Intake Assessment form (MR901.00). All fields on the Intake Assessment form must be completed.

Documentation must be completed in accordance with the Intake Assessment CPG0011.

Clinical Appointments
Introduction - a brief statement indicating who is present and where the intervention is taking place and when the appointment occurred.

Purpose of Visit - outline the reason and aims for the appointment.

Review of Progress - evaluation of the clinical interventions is required to be recorded. This may include review of patient and family rating scales and outcome measures. Review of the following should routinely occur:

- Symptom profile
- Bio-psychosocial interventions including engagement to all prescribed treatments.
- Progress of goals achievement – both patient and family
- Difficulties, problems or issues currently experienced by the patient or family
- Include role of relevant services e.g. GP, accommodation services, emergency services, NDIS etc.

Mental State Examination (MSE) and Risk Assessment - salient features of MSE and risk assessment are documented as clinically indicated. Where clinically indicated, a clinical risk management plan Type 1, 2 or 3 is completed and documented.

Clinical Treatment

- Documentation should be consistent with psychosocial treatments listed in the Clinical Treatment Plan (CTP).
- Explicitly outline the specific types of clinical treatments that are to be implemented followed by a clear plan regarding the implementation process, the review plans and evaluative techniques to be employed.
- Problems and/or barriers to treatment should be identified and documented along with their proposed management.

Next appointment - document date, time and venue for the next appointment.

Telephone Contact (incoming and outgoing)

- Outline the reason for the telephone contact.
- Immediate clinical interventions - succinct outline of the issues addressed and the clinical response.
- Plan - detail the plan for future clinical treatment or the next actions to be taken.

Multidisciplinary Team (MDT) Meetings
Document the content and issues raised including relevant comments such as nature of

treatments to be implemented, family involvement, liaison activity, treatment adherence and management and appraisal of risk and current management of same.

Plan must include a response to the above and be congruent with the CTP.

Case Closure - at the conclusion of community based clinical treatment, a Case Closure must be completed for all patients of BHS MHS. All case closures must be completed on the Case Closure template (MR 935.00). All fields on the Case Closure template must be completed.

INPATIENTS UNITS

Shift Entries

- Acute inpatient and SECU nursing staff are required to complete documentation at least once each shift for each patient.
- Aged Residential Unit documentation is completed at least monthly or as clinically indicated.
- As clinical need dictates, additional entries must be made detailing the clinical interventions undertaken.

Mental State Examination (MSE)
Refer Mental State Examination – CPG0014.
Note comparative improvements/changes to the mental state.

Risk Assessment - as per risk assessment process.
Risk management interventions must relate to the assessment, the context of the risk, the MSE, stage and progress of treatment.

All Risk Management Plan changes and reviews are to be documented in the progress notes.
Refer Clinical Risk Assessment and Management CPG0042

Randomised Nursing Observation Categories (RNOC)
Document the current and any changes to RNOC relevant to MSE and Risk Assessment. Include clinical rationale for the level of observation.
Refer Protocol - Randomised Nursing Observation Categories (NOC) Inpatient Units - Mental Health Services CPP0460.

Clinical Treatment - Interventions
Note the specific types of clinical treatments that are to be implemented followed by a clear *plan* regarding the implementation process, the review plans and evaluative mechanisms to be employed.

Problems and/or barriers to treatment should be identified and documented along with their proposed management.

Include role of applicable persons where relevant, for example: family/significant others, clinical staff, GP, accommodation services, emergency services, sexual assault services etc.

Note difficulties in engagement with families and/or any other relevant resources and confirm future intentions to resolve.

Utilising the Nursing Assessment and Treatment Plan - note the specific psychosocial clinical treatments that have been implemented over the shift. Ensure that the effectiveness of each intervention is documented.

Physical health requirements and/or interventions must be documented.

PRN Medication administration is documented in accordance with BHS Policy POL0048. Progress note documentation must also include clinical rationale for use and effectiveness.

Family Involvement - documentation should include involvement of families in the treatment and planning.

Discharge Planning - as per Discharge Policy CPP0245.

COMMUNITY CARE UNIT

Shift Entries

- Clinical staff are required to complete documentation at least once each shift for each patient.
- As clinical need dictates, additional entries must be made detailing the clinical interventions undertaken.

Clinical Treatment - Interventions

A weekly summary of progress against CTP goals and interventions must be documented. Ensure that the effectiveness of each intervention is recorded.

Problems and/or barriers to treatment should be identified and documented along with their proposed management.

Include role of relevant persons where relevant, for example: family/significant others, clinical staff, GP, accommodation services, emergency services, sexual assault services etc.

Physical health requirements and/or interventions must be documented.

PRN Medication administration is documented in accordance with BHS Policy POL0048. Progress note documentation must also include clinical rationale for use and effectiveness.

Mental State Examination (MSE)
Refer Mental State Examination – CPG0014. Note comparative improvements/changes to the mental state.

Risk Assessment - as per risk assessment process. Risk management interventions must relate to the assessment, the context of the risk, the MSE, stage and progress of

treatment.

All Risk Management Plan changes and reviews are to be documented in the progress notes. Refer Clinical Risk Assessment and Management CPG0042

Related Documents

- CPP0460 - Randomised Nursing Observation Categories (noc) Inpatient Units - Mental Health Services
- POL0206 - Clinical Documentation
- CPG0011 - Intake Assessment - Mental Health Services
- CPG0014 - Mental State Examination - Mental Health Services
- CPG0021 - Triage And Service Access - Mental Health Services
- CPG0042 - Clinical Risk Assessment And Management In Mental Health
- SOP0001 - Principles Of Clinical Care

References

- Australian Commission on Safety and Quality in Health Care (2012). National Safety and Quality Health Service Standards (Standard 1.9.1).
- Australian Commission on Safety and Quality in Health Care. (2017). National Safety and Quality Health Service Standards (2nd ed.).
- Australian Government (2010). National standards for mental health services 2010 (Standard 1.14 & 9.3).

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Ballarat Health Services

POLICY

Clinical Supervision - Mental Health Services
SCOPE (Area): Mental Health
SCOPE (Staff): Clinical Staff

Rationale

To identify processes through which clinical supervision will be provided to the organisation for the delivery of safe and effective care.

To support the development of skills and knowledge to enhance clinician growth and to ensure quality patient focused practice.

Expected Objectives / Outcome

To provide staff with a safe and supportive environment for the development of professional practice through reflection.

Support learning and effective clinical decision making.

Delivery of high patient care and treatment through accountable clinical practice.

Facilitation of learning and professional development.

Promotion of staff wellbeing by provision of support.

It is acknowledged that performance management, line management and counselling are not considered to be the same as clinical supervision.

Definitions

Clinical Supervision:

Clinical Supervision is a formal working alliance between two or more practitioners which is facilitated by a clinician trained in clinical supervision (Supervisor). The supervisee's clinical work is reviewed and reflected upon with the aim of improving the supervisee's work; ensuring quality consumer care; supporting the supervisee in relation to their work;

and enhancing professional learning and development.

Supervisor:

An experienced and /or qualified staff member who is deemed by the respective manager of the organisation to be appropriately experienced and qualified to provide clinical supervision.

Supervisee:

The staff member seeking supervision who is involved in providing direct/indirect clinical care to consumers.

Principles

Management/Guidelines: - Nursing/Occupational Therapists/Social Workers:

As per the Victorian Public Mental Health Services Agreement 2016-2020, up to a maximum of 2 hours per month of clinical supervision pro rata is to be offered to employees in each discipline. The supervision will be provided by a supervisor of the clinician's choice, either from within the service or from an external source as determined by agreement between the clinician, the proposed supervisor and employer.

- Respective managers are to be consulted prior to staff arranging supervision sessions to ensure they are facilitated to participate in same.
- Staff will be released to attend the supervision time only.
- Supervision can be in person or via tele or video conference.
- If external supervision is preferred, staff will be time released for the session but the cost incurred will be the responsibility of the employee.
- Supervision contract to be completed prior to commencing sessions.
- Supervisor to have no more than 3-4 clinicians to supervise at any one time.
- Supervision arrangements to be reviewed every 6 months.
- Documentary evidence of each formal supervision session (as per appendix 1) will be kept securely by the supervisor. The Supervisee will retain a copy also. The depth of documentation for each session is to be negotiated between the supervisor and supervisee.
- Discussions that occur as part of the supervision process between the supervisor and the supervisee will be confidential. However, if there are concerns raised about the wellbeing of the supervisee or there is a risk to patient care, then the concern will be escalated. If this is to occur the supervisee will be informed of the escalation.
- A contract is to be completed between the supervisor and supervisee (as per appendix 2; 3; 4 and 5).

Management/Guidelines: - Psychologists:

As per the Victorian Public Health Sector Medical Scientists, Pharmacists & Psychologists Enterprise Agreement 2017 – 2021:

- Grade 2 Psychologists will be provided with individual fortnightly clinical

supervision.

- Grade 3, Grade 4, Grade 5 Psychologists will be provided with a minimum of 10 hours of individual clinical supervision per annum, plus an additional 12 hours peer supervision, as defined by the PBA.
- A Psychologist who is employed part – time will be provided with pro – rata supervision, as per their EFT fraction.
- Individual clinical supervision will be provided in person by a psychologist employed in the same clinical service. Where there are difficulties in providing face to face supervision to Psychologists Grades 4 and 5, alternative options for supervision will be offered and agreed with the Psychologist, the employer and the proposed supervisor, consistent with Psychology Board of Australia (PBA) guidelines.
- Supervision will be provided by a PBA approved supervisor who has a skill set appropriate to the needs of the supervisee and their role, provided that a supervisor who is located outside Australia shall not be required to be a PBA approved supervisor. Provided further, a Psychologist Grade 3 or above who is providing clinical supervision to other Psychologists as at the date of operation of this Agreement, and who is not a PBA approved supervisor, will have eighteen months to achieve approved supervisor status, and may continue to provide supervision to existing supervisors until PBA approved supervisor status is obtained.
- It is preferred, where possible, that the supervisor is not the line manager of the Psychologist. In smaller services where there is limited capacity to provide supervision by senior psychologists employed by the employer, apart from the line manager, alternatives for supervision will be explored and negotiated with the Psychologist, the employer and the proposed supervisor, consistent with PBA guidelines. The Psychologist may agree for the clinical supervision to be provided by the line manager. Where there is not agreement and the Psychologist believes that there may be difficulties if they are supervised by their manager, sub-clause 87.9 of this clause will apply.
- Where the PBA minimum requirements for individual clinical supervision exceed the hours set out above, for example supervision of Psychologists Grade 1 who are employed outside University placements with PBA approval, grade 1 Interns or Grade 2 Registrars, the employer will provide sufficient supervision to meet the PBA requirements.
- Where the individual supervision of a Psychologist Grade 3 and above cannot be provided by a supervisor with the appropriate skill set at the same work-site, or employed in the same clinical service, the employer shall provide and pay for external supervision. External supervision arrangements will be agreed between the Psychologist, the employer and the proposed supervisor.
- It is recognised that there may be difficulties between a Psychologist and their proposed clinical supervisor which may impair the supervisory relationship, or that such difficulties may develop. In such instances the Psychologist may request a change of supervisor, which will be agreed between the Psychologist, the employer and the proposed supervisor.
- Other dot points included in the Nursing/Occupational Therapists/Social Workers Management/Guidelines will also be adhered to.

Related Documents

SOP0001 - Principles Of Clinical Care

References

- Australian Commission on Safety and Quality in Health Care. (2012). Safety and quality improvement guide standard 1: governance for safety and quality in health service organisations (section 1.10.5.
- Australian Government. (2010). National standards for mental health services 2010 (Standard 8.7).

Appendix

- Appendix 1: Clinical Supervision Notes
- Appendix 2: Nursing Clinical Supervision Contract
- Appendix 3: Occupational Therapist Clinical Supervision Contract
- Appendix 4: Psychologist Clinical Supervision Contract
- Appendix 5: Social Worker Clinical Supervision Contract

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