PURPOSE

To ensure all patients admitted to Healthscope Mental Health facilities are assessed and monitored for risk factors that may impact upon their own safety and / or the safety of others. The suite of Healthscope Mental Health Clinical Risk Assessment Forms are used to determine clinical risk and appropriate level of observation required for each patient and recording of all observations and engagements. Management strategies, including the outcomes of patient observation and engagements are tailored to meet the patient's individual requirements.

SCOPE

This policy applies to all Healthscope Mental Health hospitals, facilities and wards within Australia.

POLICY

The Healthscope policy on Patient Risk Assessment and Observation Levels is:

- **Risk Assessment: A Risk Assessment is initiated at the point of first contact with a Healthscope Mental Health facility and is continued by clinical staff thereafter:**
  - **The Mental Health Preadmission Form with Risk Assessment is completed at preadmission by the Intake Clinician to ascertain suitability for admission.**
  - **The Initial Mental Health Clinical Risk Assessment Form HMR 6.24 is completed on admission to unit / facility / program.**
  - **A risk assessment is undertaken at least once per shift by the delegated Mental Health Clinician.**

INPATIENT RISK ASSESSMENT:

- **CONSULTANT / MEDICAL PRACTITIONER INITIAL RISK ASSESSMENT. The admitting Psychiatrist / Doctor complete an initial risk assessment, as part of the admission process of the patient. Risk Assessment and actions/management plan must be documented on the *Consultant / Medical Practitioner Initial Risk Assessment Form* (HMR 6.24).**
  - **If Risk Assessment has changed: Document on the *Revised Mental Health Clinical Risk Assessment Form (HMR 6.24A)* AND in the patient's progress notes, including rationale for the change by the delegated Mental Health Clinician.**
  - **If Risk Assessment has NOT changed: Document in the patient's progress notes, including current mental state.**
  - **Once per 24 hours, after a review and assessment of patients mental state and clinical risk, the current risk assessment should be documented on the *Daily Mental Health Clinical Risk Assessment Form (HMR 6.24B),* in addition to any documentation in the progress notes.**
- **A *Revised Mental Health Clinical Risk Assessment Form* is completed whenever there is a change of risk level or observation, including in the circumstances below:**
  - **Prior to patient going on leave and again on return from leave**
  - **After significant changes in clinical condition, i.e. any time risk factors are perceived to have changed**
  - **Following major treatment reviews, i.e. patient review meeting care plan review**
  - **On transfer OR discharge from one program to another**

- **As part of the management of any clinical incident**
- **Whenever any member of the multidisciplinary team feels that a formal review of risk is required**
- **Following collection of information from the patient or carer which impacts on the patient's mental or emotional state**

- **In addition to completion of the *Revised Mental Health Clinical Risk Assessment Form*, changes to Risk Assessment should be recorded in the patient's progress notes.**
- **When a patient declines or displays resistance to attend 1;1 therapy, group program and/or treatment a clinical risk assessment and MSE should be completed, documented in the medical record and communicated to the treatment team.**
- **AUTHORISATION OF LEAVE BY TREATING DOCTOR: Prior to the authorisation of leave a risk assessment is to be undertaken and documented on the *Mental Health Initial Clinical Risk Assessment Form OR Revised Mental Health Clinical Risk Assessment Form* and documented in the progress notes by the treating doctor. Patients must not be granted leave prior to VMO Risk Assessment.**

OUTPATIENT SERVICES:

- **Risk assessment is to be completed and documented on the Mental Health Clinical Risk Assessment Form at initial assessment with outpatient services.**
- **Patient's behaviour and presentation are observed during every patient contact. If patient's presentation indicates a change in level of risk, an individual risk assessment is conducted and documented on *Revised Mental Health Clinical Risk Assessment Form,* progress notes and care plan. This is completed in partnership with the consumer and, if appropriate, carer. Management plan is to be initiated as described in the 'RISK MANAGEMENT AND OBSERVATION LEVELS FOR OUTPATIENT SERVICE' table (Page 6).**
- **If a patient does not attend without advising of reason for non-attendance, the clinician is to attempt to contact the patient to establish reason for non-attendance and review risk where indicated.**
- **Risk assessment is to be reviewed where an unexpected break in contact of greater than three weeks occurs.**
  - **If no change in Risk Rating: review and outcome to be documented in Progress Notes**
  - **If Risk Rating changes: document on *Revised Mental Health Risk Assessment Form* and in Progress Notes.**
- **If a patient enters a new program, and the break in Day Program attendance is three weeks or less, a risk assessment is not required unless a change in presentation or behaviour (with reference to previous risk assessment) is observed**.

INPATIENT & OUTPATIENT SERVICES

- **Clinical risk management measures are tailored to meet each patient's individual observation requirements.**
- **Staff training is completed as per the Healthscope Policy 4.10 Mandatory Training.**

DEFINITIONS

Visual Observation- sighting, checking the location and activity of a patient, assessing for any changes in their presentation, condition or behaviour through engagement and checking environment for safety. [1]

Engagement and Interaction

- Engagement and interaction with patients is a therapeutic tool used to monitor issues of risk. It involves the purposeful gathering of information from patients to inform the risk rating and management.
- Mental Health Clinicians engage with patients by developing a relationship via hearing, listening, understanding and collaborating. The Mental Health Clinician can use the following techniques:
    - Asking open ended questions
    - Observing body language
    - Reflecting on the conversation with the patient
    - Closing an engagement with a summary
- Observation through therapeutic engagement with the patient is documented in the Progress Notes and will inform the Risk Assessment rating
- Engagement with a patient can be difficult when a patient declines or displays resistance to attend 1:1 therapy, group program and/or treatment. In this situation a clinical risk assessment and MSE should be completed, documented in the medical record and communicated to the treatment team or escalated to the most Senior Mental Health Clinician on duty.

Healthscope Observation Practice Standard- Visual Observations

- The visual observation of a patient should include the full faced unequivocal identification and screening of the patient each and every time, and the appropriate recording of.
- The visual observation rounds at night, or when the patient is sleeping is to meet the following standard
    - The patient is to be seen (not checked through a closed door)
    - The patient is observed to ensure that they are alive (evidence of breathing) and safe and any action that is required to be taken is promptly taken.
- Visual observations should be recorded on the Visual Observations Chart, HMR 7.8.
- No Visual Observation Round Chart is to be pre-completed or completed without actually having sighted and observed the patient for current status. The actual time of the sighting is to be documented.[2]

PROCEDURE

Patient Risk Assessment

A risk assessment using outcome of observations and engagements is to be undertaken to confirm the current risk rating, and is to be documented as set out below:

When	Person Responsible	Where
Prior to a decision to admit to any HSP facility /program	Clinician performing intake role	*Preadmission Form*
Upon assessment to Day Programs or Outreach	Clinician performing Day Program or Outreach assessment	*Mental Health Clinical Risk Assessment Form*
Upon admission to inpatient facility	Mental Health Clinician performing inpatient admission	*Initial Mental Health Clinical Risk Assessment Form*

Upon admission by Admitting Psychiatrist/Medical Practitioner On referral to Day Program or Outreach Service	Admitting Psychiatrist/Medical Practitioner Referring Psychiatrist/Medical Practitioner	*Consultant / Medical Practitioner Initial Risk Assessment Form / Referral Form*
At regular intervals (for Inpatients at least once per shift)	Delegated Mental Health Clinician	Progress notes (each shift) **AND** *Daily Mental Health Risk Assessment Form* (every 24 hours)

When	Person Responsible	Where
Prior to the granting of leave	By the treating doctor and delegated Mental Health Clinician	*Mental Health Clinical Risk Assessment Form or Revised Mental Health Clinical Risk Assessment Form* and Progress Notes
Prior to going on leave and on return from leave	Delegated Mental Health Clinician	*Imatis Leave Register* and Progress Notes
After significant change in clinical condition	Delegated Mental Health Clinician and confirmed by treating doctor	*Revised Mental Health Clinical Risk Assessment Form* and Progress Notes
Following major treatment reviews	Delegated Mental Health Clinician and confirmed by treating doctor	*Revised Mental Health Clinical Risk Assessment Form* and Progress Notes
On transfer/discharge to another program	Delegated Mental Health Clinician discharge/receiving clinician on transfer	*Revised Mental Health Clinical Risk Assessment Form* and Progress Notes
Whenever a member of the multidisciplinary team feels that a formal review of risk is required	Delegated Mental Health Clinician and confirmed by treating doctor	*Revised Mental Health Clinical Risk Assessment Form* and Progress Notes
Following collection of information from the patient or carer which impacts on the patient's mental or emotional state	Delegated Mental Health Clinician and confirmed by treating doctor	*Revised Mental Health Clinical Risk Assessment Form* and Progress Notes
When a patient declines or displays resistance to attend 1:1 therapy, group program and/or treatment	Delegated Mental Health Clinician and confirmed by treating doctor	*Revised Mental Health Clinical Risk Assessment Form and Progress Notes*

1. All HSP Mental Health Facilities will use the standardised Mental Health *Clinical Risk Assessment Forms.*
2. The risk assessment of patients takes into account all sources of information i.e. previous clinical records, patient interview, referral sources, significant others, etc.

3. The risk assessment of patients must be communicated to all members of the care team including nursing, medical and allied health staff.
4. The Revised e Mental Health Clinical Risk Assessment Form is completed when there is a risk rating change and actions / management plan clearly documented, including a revision of observation level. Reasons for the change in risk are to be noted in the patient file.
5. The Patient (Family / Carer, as appropriate) is informed of the outcome of the risk assessment process.
6. Inpatient Revised Risk Assessment Form is to be co-signed by the Mental Health Clinician undertaking the assessment/review and the treating psychiatrist/medical officer.
7. Home visiting services (i.e. Outreach) have additional risk assessment requirements with reference to environmental factors, as per environmental risk assessment.
8. It is the responsibility of the treating doctor / Mental Health Clinician/clinician undertaking a risk assessment / risk review to ensure the outcome of this assessment is conveyed to other clinicians who will be providing services to the patient through documentation in the clinical notes and handover.
9. Inpatient: Any disputes regarding categorisation of risk are referred to the most senior Mental Health Clinician or clinician, After Hours Supervisor / Director of Nursing.
10. Outpatient Services: Any disputes regarding categorisation of risk are to be referred to the Team Leader, Outreach Manager (Outreach), or Program Coordinator / Program Manager (Day Program).

RISK MANAGEMENT AND OBSERVATION LEVELS FOR INPATIENT UNITS

Observation	Descriptor	Conditions
Low	**Low Risk** – there is no apparent immediate or significant threat or danger to patient or the public.	• The general location of the patient is known to staff at all times. • Routine visual observations – shift handovers, medication times, meals & 1-hourly overnight To be documented on the Visual Observations Chart, HMR 7.8. • Leave limitations (see Healthscope Policy 9.01 –Leave from Mental Health Facilities-Patient).
Moderate	**Moderate Risk** – the risk posed is likely to place the patient in danger or they are a threat to themselves or others.	• The general location of the patient is known to staff at all times. • Visual observations every 3 hours at a minimum, medication times and 1 hourly overnight. To be documented on the Visual Observations Chart, HMR 7.8. • Leave only in extenuating circumstances, or as per VMO, as per Healthscope Policy 9.01 – Leave from Mental Health Facilities – Patient.

High	**High Risk** – The risk posed is immediate and significant and there are substantial grounds for believing that the patient is in danger because of their own vulnerability or mental state OR the risk posed is immediate and significant and there are substantial grounds for believing that the public is in danger through the subject's mental state.	• Constant observation may fall into the following categories: a. Intensive Psychiatric Care Program at The Melbourne Clinic - Continuous Visual observations. **NO LEAVE.** **OR** b. If in an **OPEN WARD –** Patient assessed as **HIGH RISK** must be 'specialled' (at arm's length) not left unattended by a Mental Health Clinician whilst awaiting transfer to a public Mental Health facility. **NO LEAVE.**

RISK MANAGEMENT AND OBSERVATION LEVELS FOR OUTPATIENT SERVICES

Observation	Descriptor	Conditions
Low	**Low Risk** – There is minimal apparent immediate or significant threat or danger to patient or the public.	• Continue treatment as per Care Plan. • Observe patient behavior at each contact to determine if Low Risk remains. Document in Progress Notes at each contact. • Where presentation indicates a change, assess, revise and document accordingly.
Moderate	**Moderate Risk**: • The patient is likely to engage in risky behaviour posing a moderate risk to their safety (i.e. continues to engage in self-harming behaviours that are unlikely to be life-threatening), or • The patient reports current suicidal ideation which may be acute or of a chronic experience, denies immediate plan or intent but has a history of impulsivity. Patient is agreeable to engaging in a crisis management plan, or • The patient reports urge to harm others, however denies plan or intent and is agreeable to engaging in a crisis management plan should urge escalate, or	• Continue treatment as per Care Plan. • Identify and agree a Crisis Management Plan. • Notify Psychiatrist of Risk Assessment and agreed Crisis Management Plan either at initial assessment or if change occurred requiring the development of Crisis Management Plan. • Observe patient behavior at each contact to determine if Moderate Risk remains evident. • Where presentation indicates a change, assess, revise and document accordingly.

	• The patient reports other vulnerability factors which pose a moderate risk to their safety or well-being.	
High	**High Risk** – The risk posed is <u>immediate and significant</u> and there are substantial grounds for believing that the patient is in danger because of their own vulnerability or mental state, or - the risk posed is <u>immediate and significant</u> and there are substantial grounds for believing that the public is in danger through the patient's mental state. - Risk to self or others cannot be managed in the community.	• Alert Program Manager for support and guidance. • If unavailable, alert DON, ADON or GM. • Contact Psychiatrist, advise of risk & discuss. • Determine appropriate admission process. • Patient to be 'specialled' (at arm's length) not left unattended by a clinician whilst awaiting admission or transfer to a public Mental Health facility. • Contact Next of Kin as required. • At next contact, review risk and complete Revised Risk Assessment Form if any change. • Continue to observe patient behavior at each contact to determine appropriate risk rating. • Where presentation indicates a change, assess, revise and document accordingly.

Risk Management and Observation Levels

- Ideally decisions regarding the implementation of an observation level are made jointly by the treating doctor and clinical staff.

NOTE: Initiating *Moderate* and *High* ratings requires the authorisation of <u>one</u> clinician.

- **For INPATIENTS:**
  - Initiation of and changes to observation levels are co-signed by the treating doctor and responsible clinician.
  - A downgrading of observation level must be authorised jointly by the treating doctor and appropriate clinician (e.g. Mental Health Clinician caring for the patient).
- **For OUTPATIENTS:**
  - Where risk is assessed to be Moderate or High, the psychiatrist is to be notified as specified in Conditions described above. Risk rating is to be documented in Progress Notes and/or Revised Risk Assessment Form as required.
  - A downgrading of risk may be authorised by the RN or Allied Health Clinician assessing the patient. The RN or Allied Health Clinician is to note in the progress notes reasoning for reduction. Revised Risk assessment form to be completed.

- The least intrusive level of observation that is appropriate to the situation is always adopted so that due sensitivity is given to the patient's dignity and privacy whilst maintaining safety for the individual and those around them.
- Each staff member responsible for observation takes an active role in familiarising and engaging themselves with the patient by knowing their history, risk factors and early warning signs. They should be familiar with the environment, and with emergency procedures and potential risks in the environment.

- Clinicians are to explain to patients and nominated carers about why they are under observation. Where 'specialling' has been agreed, a review must be carried out within 4 hours. Initiation and review outcome must be discussed with the General Manager with the view of transferring.

KEY PERFORMANCE INDICATORS

- Evidence of training in risk assessment, engagement and observation incorporated into induction and mandatory education programs.
- Completion of audits on completion rates of risk assessment/review Forms & documentation in the clinical file.

REFERENCES

Author: Mental Health Committee Coordinator

- American Psychiatric Mental Health Clinician Association- Psychiatric Nursing Observation
- Healthscope Policy 2.19 Chain of Command (Nursing)
- Healthscope Shared learnings reports
- Alfred Psychiatry Clinical Risk Screen
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- North Western Health – Mental Health Program, IWAMHS, Risk Management Policy, October 1998
- Mental Health Observation, including Constant Observation: Good Practice Guidelines for healthcare staff working in prisons, August 2006
- CAMHS – Patients who go missing, December 2005
- Joint Protocol for service user missing from hospital or other healthcare setting, November 2005
- Coroners findings report - July 2016
- QLD Health guidelines: Therapeutic Visual Observation for Mental Health Alcohol and Other Drugs Services ID: QH-GDL-479:2020
- Melbourne Health: Adult and Youth Acute Inpatient Clinical Ris Assessment and Management (CRAAM) Policy Number NWMH19.01.03G Version 4.1
- Department of Health Victoria Guideline: Nursing Observation through Engagement in Psychiatric Inpatient Care September 2013
- NSW Health Policy Directive: Engagement and Observation in Mental Health Inpatient Units PD 2017_025 July 2017
- NSW South Eastern Sydney Local Health District Policy SESLHDPR/615, May 2021 Engagement and Observation in Mental Health Inpatient Units Procedure

REVIEW / CONSULTATION

All General Managers | All Directors of Nursing | All Quality Managers

Mental Health Cluster