TARGET AUDIENCE and SETTING

This procedure applies to all mental health staff and is applicable across all sites (inpatient units, residential settings, community clinics, mobile assessments, and Emergency Department) where a patient is receiving assessment or care from mental health staff.

PURPOSE

The purpose of this procedure is to guide clinicians on when the Clinical Risk Assessment Screen document is to be completed. Please note that this procedure does not outline the process for escalation of care other than the general principles listed in precautions/contraindications below.

PRECAUTIONS/CONTRAINDICATIONS

- While safety is the primary concern in the assessment and management of risk, human rights such as respect, privacy, dignity and confidentiality must be taken into account.
- Risk assessment screening is just one part of the clinical assessment and therapeutic engagement process. It is a structured process to facilitate the assessment of the likelihood of an adverse event occurring and it guides the development of management strategies that mediate risks and amplify the person's strength and protective factors.
- Clinical Risk is reviewed:
    - When a person is undergoing transfer of care (e.g., assessment, admission, discharge)
    - Or any other time that there is some clinical change.
- Until an initial risk assessment screen is completed, a patient is considered to be an unknown risk and potentially a high risk. A risk assessment screen should be prioritized at all times
- Risks rated medium or high are an immediate risk and require an immediate risk management plan, which is recorded on the Clinical Risk Assessment Screen form, and also incorporated into the relevant ongoing management plan – depending on setting: Emergency Department, inpatient setting or community. Please refer below for the specific forms to be completed.
- Where the patient is assessed as being of a high risk of harm to self or others, this risk must be communicated to all other team members and appropriate actions recorded in the progress notes of the health record.
- If a risk increases, consult with senior clinical staff to develop or review the plan for management of risk. For inpatients, any change in assessment of risk is to be escalated to the shift will also be brought to the attention of treating medical staff (registrar and/or psychiatrist).
- For patients who display harmful behaviours (including suicide attempts, assault and self-harm) staff must be vigilant to identify and remove and /or restrict access to any items that may be used to inflict harm to the patient or another person. NOTE: Consideration must be given to any additional physical or environmental hazards.

- The most recent Clinical Risk Assessment Screens and management plans would accompany patients being transferred within and between mental health services.
- Where a patient/consumer requires direct admission to an inpatient unit from the community accompanied by the referring clinician, and documentation in SMR is unable to be completed prior to arrival on the unit, documentation will occur:
    - immediately following verbal handover of the patient /consumer and
    - prior to the clinician leaving the unit.
- For patients / consumers presenting with serious self-harm or suicide attempts who are to be discharged, the Clinician will:
    - Encourage participation and communication with family in the development of a Safety Plan (MRACG02)
    - Discuss with the consultant their assessment of risk and the intended management plan including appropriate information.

EQUIPMENT

- Computer with access to Scanned & Electronic Medical Records and Client Management Interface (CMI)
- Clinical Risk Assessment Screen MRAR01
- Mental Health Inpatient Care Plan MRJ03
- Mental Health Inpatient Care Plan Continuation MRJ03(i)
- Treatment and Recovery Plan MRAG02(i)
- Levels of Nursing Observations MRAK05

STANDARD REQUIREMENTS

When undertaking any clinical interaction with a patient, staff are expected to:

- Perform routine hand hygiene. Refer to the Hand Hygiene Procedure.
- Introduce themselves to the Patient and Carer/ Family if in attendance
- Check patient identification. Refer to the Patient Identification Procedure.
- Obtain consent as per the Consent to Medical Treatment Procedure.
- Keep the patient/carer informed and involve them in decision making.
- Document interaction in the electronic medical record or health record using black pen; including date, time, signature and designation.

PROCEDURE

1. Frequency of risk assessment screen:

Inpatient Units

A detailed clinical risk assessment screen will be conducted and documented on MRAR01 on the following occasions:

- At the beginning of each episode of care; more specifically on admission to an inpatient unit
- On discharge/transfer from inpatient unit

Please note that there are other occasions whereby the clinical risk is reviewed and these risk reviews are recorded on documentation other than the detailed clinical risk assessment screen. These occasions include:

- Within 4 hours of commencement of morning shift, and at commencement of afternoon and evening shift (recorded on the Inpatient Nursing Plan (MRJ03) or continuation form (MRJ03(i) – see Mental Health Levels of Nursing Observations procedure)
- When a person is undergoing change of care environment e.g. seclusion / intensive care area (recorded on the Inpatient Nursing Plan (MRJ03) or continuation form (MRJ03(i) – see Mental Health Levels of Nursing Observations procedure)
- Pre and Post Leave (recorded on MRAK05 – see Mental Health leave inpatient units procedure)

Community Mental Health Services

A detailed clinical risk assessment screen will be completed on the following occasions:

- Upon admission
- At 91 day review

An abbreviated clinical risk assessment in the Mental Health Community Progress e-note will be completed on the following occasions:

- On each subsequent clinical encounter following the admission
- When there is a change in clinical risk profile or presentation, Clinical team to determine the appropriate risk assessment screen to be completed – either the detailed version or the abbreviated version

Emergency Psychiatric Services (EPS)

The Clinical Risk Assessment Screen is completed during the initial assessment (MRAR01), and reviewed after that as often as necessary, such as when the clinical situation changes. At a minimum, clinical risk is reviewed every shift for clients waiting in the emergency department for a bed or psychiatric review, though the complete Clinical Risk Assessment Screen does not need to be repeated.

Crisis Assessment and Treatment Teams (CATT)

The Clinical Risk Assessment Screen is completed during the initial assessment, and reviewed after that as often as necessary, such as when the clinical situation changes. At a minimum, clinical risk is reviewed at every contact for clients in the community, though the complete 'clinical risk assessment screen' does not need to be repeated until discharge / transfer of care.

Community Care Units (CCU), Transition Support Unit (TSU) and Prevention and Recovery Care

Service (PARCS)
A Clinical Risk Assessment Screen is completed upon admission. Thereafter, a review of clinical risk is done daily, and pre- and post-leave, though the complete Clinical Risk Assessment Screen does not need to be repeated.

2. Documentation

Risk assessment screens require documentation of:

- Risk estimation rating (low, medium, high)
- Details about the risk, and rationale for the risk rating, taking into consideration long term and short term risk.
- The patient, family or nominated person view of the risks.
- A risk and strengths formulation based on your assessment of:
    - Factors or circumstances likely to increase the risk
    - Strengths and protective factors likely to decrease the risk
- An immediate risk management plan for any immediate risks (risks rated as medium or high)
    - Interventions to directly address any immediate risks
    - Consideration of patient preferences / Advance Statements and discussions with the patient's, carers and other stakeholders
    - Contingency plans to deal with likely risks must be communicated to the Nominated Person, family or carers
- This clinical risk assessment screen guides the development of a mental health safety plan, the Inpatient Care Plan or the Treatment and Recovery Plan. N.B Please ensure risks rated as low on the risk assessment screen are considered

For inpatient units, following the admission Clinical Risk Assessment Screen, all other reviews of clinical risk will be documented on the Inpatient Care Plan (MRJ03) and the Inpatient Care Plan Continuation (MRJ03(i))

For community mental health services, following the initial Clinical Risk Assessment Screen, all other reviews of clinical risk will be documented on the Mental Health Community Progress e-note.

RELATED DOCUMENTATION

Assessment treatment and discharge of Mental Health patients in ED
Falls prevention
Levels of Nursing Engagement Implementation Tool
Levels of Nursing Observation
Safety Plan MRACG02

Document Governance	
Supporting Policy	Assessment, Care Planning and Discharge (Operational)
Executive Sponsor	Chief Operating Officer
Program, Service, Unit, Department or Committee Responsible	Mental Health Program
Document Author	Mental Health Program
Consumer Review Yes or No	If Yes, [Insert date reviewed by Consumer] (Not required for non-clinical documents)
This Procedure has been endorsed by an EMR Subject Matter Expert (SME)	There are no Order Set or Quick Reference Guides linked