Canberra Health Services
Operational Procedure
Child and Adolescent Mental Health Service (CAMHS)
Adolescent Unit

Contents

Purpose

This document provides local operational procedures specific to the CAMHS Adolescent Unit (CAU), inpatient unit at Canberra Health Services (CHS). Adherence to this procedures will ensure:

- Clinical practice supports the intended Model of Care (MoC)
- Compliance with statutory responsibilities
- Adoption of evidence-based practice principles
- Practice which supports overarching CHS and Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS) policy, procedures, and frameworks.

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Scope

This document applies to all people being treated within the CAMHS Adolescent Unit (CAU).

This document applies to the following staff working within their scope of practice:

- Medical Officers
- Nurses and Midwives
- Allied Health Professionals
- Administrative Officers
- Students under direct supervision

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Section 1 – CAMHS Adolescent Unit (CAU)

The CAU inpatient unit located at Canberra Hospital is operational 24 hours a day, 365 days a year, providing assessment, evidence-based treatment and therapeutic intervention for young people aged 12 years and up to their 18th birthday who are experiencing moderate to severe mental illness or mental disorder where less restrictive options have been deemed unsuitable or unavailable.

The CAU inpatient unit, along with all of Canberra Hospital is an approved mental health facility under the *Mental Health Act 2015*, giving the unit capacity to accommodate both voluntary and involuntary persons.

The CAU is a six-bed adolescent acute mental health inpatient unit located within Building 11 of the Centenary Hospital for Women and Children. This unit is located within a paediatric medical and surgical unit which is operated by the Division of Women Youth and Children.

The CAU provides multi-disciplinary interventions for adolescents with moderate to severe mental health presentations who are medically stable.

The unit will be staffed in line with the current nursing ratio outlined in the *Nursing and Midwifery Enterprise Agreement 2023-2026.* Additional staff above ratios may be allocated to ensure staff and consumer safety and to enable care to be provided in line with the Model of Care (MoC).

In addition to the nursing staff, the multidisciplinary team within the unit consists of a mix of consultant psychiatrist, psychiatry registrar, junior medical officers, psychologist, occupational therapist, social worker, allied health assistants, art therapist, music therapist, exercise physiologist, administrative staff and other support services staff.

Recovery-oriented mental health care

CAU is a recovery-oriented and trauma informed mental health service that supports young people to recognise and take responsibility for their own recovery, define their goals, wishes and aspirations within medico-legal requirements and duty of care.

Recovery-oriented practice encapsulates mental health care that:

- recognises and embraces the possibilities for recovery and wellbeing created by the inherent strength and capacity of all people experiencing mental health issues
- maximises self-determination and self-management of mental health and wellbeing
- assists families to understand the challenges and opportunities arising from their family member's experiences
- Promotes safety

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Section 2 – Bed Management

A multi-disciplinary team (MDT) of clinical staff work collaboratively with the person, their family, and carers, and or nominated persons on active recovery/care and discharge planning and active involvement in shared decision-making. Daily liaison will occur between the CAU Clinical Nurse Consultant (CNC), the treating team and the Territory Wide Central Bed Coordinator to ensure open communication and oversight, and efficient prioritisation of patient flow across the adolescent inpatient unit.

The CNC is responsible for the escalation of bed access management issues and liaison with the Territory Wide Central Bed Coordinator. All staff must be familiar with the *CHS Capacity Escalation Procedure*.

Medical staff must feedback plans for discharge to the CNC and Nurse Team Leader (TL) of the shift as soon as practicable so the Nursing and Allied health teams can immediately progress discharge requirements.

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Section 3 – Admission Criteria and Admission Process

Admission criteria

The admission criteria for CAU is;

Adolescents aged from 12 years and up to their 18th birthday

Residing in the ACT and surrounding regions serviced by CHS

A recognised or probable acute/severe mental illness or mental disorder and a reasonable likelihood that inpatient care will result in substantial benefit

Assessed as medically stable for admission to a mental health unit. Adolescents requiring ongoing inpatient medical treatment cannot be admitted to the unit.

And at least one of the following:

- previous unsuccessful trial of intervention in a community-based settings, or circumstances that do not allow this to occur
- high risk of significant harm to self or others
- have complex needs and intervention requirements that can only safely be provided in an inpatient setting
- diagnostic complexity requiring a range of observation and assessment, most effectively performed as an inpatient.

Admissions are prioritised for adolescents experiencing severe deterioration of their mental health. This includes adolescents at immediate risk of harm, those experiencing significant functional impairment, psychological distress, medical or social consequences, that cannot reasonably be managed in the community. The decision to admit an adolescent considers their current support network and the capacity to increase this support.

CAU provides care to both voluntary and involuntary admitted adolescent patients, including those under the Mental Health Act 2015 or Section 309 of the Crimes Act.

Exclusion criteria

Exclusion from the CAU includes:

- Adolescents who do not meet the key admission criteria.
- The availability of a less restrictive means of safely caring for the adolescent

- Adolescents with a mental illness or disorder, but whose primary presentation is medical instability. These patients are best admitted to a Paediatric unit or other CHS medical units and provided with mental health services by the CAMHS Hospital Liaison Team (HLT).
- Adolescents who have been unable to be adequately assessed due to an acute medical problem such as intoxication, head injury or delirium
- Adolescents whose primary referral is for accommodation purposes due to a breakdown of primary support or problems with out-of-home care placement.

Admissions for the sole purpose of neurodevelopmental disorder diagnosis. These patients are best managed through paediatric and psychiatric outpatient services.

Adolescents who require high dependency care cannot be admitted to CAU. They will be admitted to another CHS Mental Health unit and can be transferred to CAU when suitable for a lower dependency environment.

Some older adolescents may be assessed as more appropriate for admission to an adult mental health unit based on their level of independence and psychosocial development.

At times due to the prevailing CAU ward patient mix, the overall ward acuity and risk level, and bed availability it may not be possible for an adolescent who requires admission to be admitted to the CAU. Arrangements will be made for admission to another appropriate unit.

The wishes of the adolescent and their parents and carers will be considered in any decision relating to admission.

Admissions Process

Admissions to CAU may take place 24 hours a day, 7 days a week.

Emergency department (ED)

- All adolescents presenting to the ED will be assessed as medically stable for a mental health admission by the ED team prior to the mental health assessment.
- Following this, adolescents will be assessed by either the CAMHS HLT and the Psychiatry Registrar or the Mental Health Consult Liaison (MHCL) team and/or the Psychiatry Registrar after hours. A Suicide Vulnerability Assessment Tool (SVAT) should be completed in line with CHS Procedure; Initial Management, Assessment and Intervention for People Vulnerable to Suicide CHS21/359. All adolescents must be reviewed by a Psychiatry Registrar prior to admission. The Psychiatry Registrar is responsible for accepting the admission in consultation with the CAMHS Psychiatrist or the Consultant Psychiatrist on-call outside of hours. The bed is then arranged through the Territory Wide Bed Access Coordinator.
- If the CAMHS HLT or MHCL clinician in conjunction with the Psychiatry Registrar are satisfied that the young person is not presenting with an acute medical condition, a medical review need not be completed at the time of admission and must be completed within 24 hours of admission; this must be documented in the Digital Health Record (DHR).

- An admission note is to be documented in the person's (DHR) by the CAMHS HLT Clinician, MHCL Clinician, Psychiatry Registrar, or the Consultant Psychiatrist. The admission note will include a mental health assessment, documentation of risks, the person's legal status and a management plan. DHR forms for the Clinical Risk Assessment (CRA), At Risk Category (ARC) Score and Brøset Violence Checklist (BVC) will also be completed.
- All standard hospital admissions procedures and bed management processes will apply to the admission process.
- *Mental Health Act 2015* and or *Crimes Act 1990* documentation is to be completed i.e. Voluntary/ Emergency Detention 3 (ED3)/ Emergency Detention 11 (ED11)/ Section 309 (S309). The ED3 and ED11 DHR forms can be forward to the Public Advocate and ACT Civil and Administrative Tribunal (ACAT) via the Tribunal Liaison Officer.
- If the young person is to be admitted under the *Mental Health Act 2015* information outlining their rights will be provided to them and their families and/or carers within ED.
- Access to leave is not permitted until the completion of admission, orientation to the unit and a review and risk assessment has been undertaken.
- Access to electronic devices is not permitted for young people admitted to the CAU.
- Any available clinical test results i.e. urine drug screen, or pathology will be available in DHR.
- The Psychiatry Registrar ensures that the CRA and medication charting have been completed on DHR.
- The Psychiatry Registrar, CAMHS HLT or MHCL will discuss the CAU expectations including those related to participation in the ward program and the use of electronic devices, with the young person and family, carer or guardian prior to the admission.
- A handover using Identify, Situation, Background, Assessment and Recommendation (ISBAR) principles must be provided to the CAU admitting nurse by the accompanying ED nurse if handover has not been provided verbally by telephone.

Other CHS Inpatient Unit

Adolescents may be admitted directly from another inpatient unit within CHS. The HLT will conduct an assessment to determine suitability for admission and work with the Consultant Psychiatrist for the unit to accept the admission which is then arranged through the Territory Wide Bed Access Coordinator.

Direct admissions and transfers from another hospital

- Direct admission from CAMHS Community Consultant can occur with agreement from the Consultant Psychiatrist for the ward. Assessment and clearance as medically stable for a mental health admission must be provided prior to admission.
- Referrals from GPs and Private Specialists are via ED only (GPs and Private Specialists are able to seek CAMHS advice by contacting the CHS Psychiatrist on call or by

arranging a booked phone appointment with a Child and Adolescent Psychiatrist through the CAMHS North and South Community Teams.

- Transfers from another hospital may occur with consultant-to-consultant referral.
- The management and monitoring plan for any relevant physical health conditions and medical stability must be discussed with the CAU admitting Consultant prior to admission. If it is deemed that the physical health conditions necessitate a more comprehensive evaluation prior to the CAU admission, the admitting Consultant may require that the young person attend the ED first.
- Direct admissions are only to occur in business hours in consultation with the Territory Wide Bed Access Coordinator. If a direct admission is unable to be facilitated and the person requires emergency treatment, they must present to ED for assessment. If it is a non-emergency and there is bed capacity, the Territory Wide Bed Access Coordinator will reassess the next business day.
- The accepting MDT will complete the admission procedures as outlined below.

- **Note**: CAU ability to accept direct admissions is dependent on several factors including bed availability, ward acuity, delayed discharges and clinical demand from the ED and other wards of Canberra Hospital.

Admission to other CHS units

If an adolescent requires a mental health admission and does not meet the CAU admission criteria, other options for care will be explored. This will be discussed with the referrer and may include admission to another CHS inpatient unit, an adult mental health unit and community-based options. The safety and well-being of the adolescent is a key consideration in the decision to admit to an alternative unit.

CAU Admissions processes

Nursing

- Prior to the arrival of the person to the CAU, the TL will assign the person to an admitting nurse.
- The admitting nurse and the TL are responsible for ensuring the admission process is completed by following the Admissions Checklist. Admission tasks include:
    - checking that all admission forms have been completed by the admitting Registrar and these forms are completed on DHR. This includes the CRA, medication chart, assessment note and legal documentation, and if required, a management plan for physical health conditions from the referring medical officer.
    - commence an ARC form for the person from the time of arrival to the unit.
    - initiate a BVC based on the handover prior to admission.
    - administration of the Strengths and Difficulties Questionnaire (SDQ) to the person and their parent/guardian and completion of the HoNOSCa.

- in business hours, the admitting nurse must notify the treating team of the person's arrival to the unit.
- with consent, the admitting nurse is to attend to baseline admission observations including temperature, blood pressure, respiratory rate, pulse, and sedation level. The Paediatric Early Warning Score (PEWS) will be used for all young persons admitted to CAU.
- the admitting nurse is to ensure that the person has an appropriate identification band. If the person refuses to wear an identification bracelet, this is to be documented in the DHR and a Riskman completed.
- the person's belongings will be searched with their consent and items will be documented clearly on DHR within the ADT tab under 'Belongings'. Any searching activities will follow the appropriate CHS policy and procedure. See section below on searching for further information.
- items of value are to be documented in the safe register and placed immediately in the safe located in medication room. Cash over $100 and/or any other items deemed to be of significant value, are to be placed in the hospital safe and a receipt provided to the person and documented in the person's DHR, this includes electronic devices.
- provide an orientation to the young person, and where possible their family or carers. This will include written and verbal information relating to the unit environment, visiting hours, mealtimes, use of electronic devices, unit expectations including attending the education program, the unit program and unit routine. This orientation will be documented on DHR.
- the person must be offered access to basic toiletries and donated clothing (if required/available).
- with the person's consent, their family, carer and/or nominated person will be contacted to inform them that the person has been admitted, where possible consulted, advised of the visiting hours and suitable belongings/items which can be provided to the person during their admission.
- the person is placed on the bed list by the TL.
- the medication chart is reviewed and any medication not on imprest are ordered from pharmacy through DHR.
- an ISOAP admission note will be documented within the persons DHR.
- If the admitted person has been admitted under the Mental Health Act 2015, a written and verbal explanation of their rights must be given and documented in the clinical notes. This will include a description of the role of both legal aid and the public advocate and facilitating contact if requested.
- the TL is to ensure that DHR has been updated on admission with specific diet requirements.

Psychiatry

Child and Adolescent Psychiatry have admitting rights to the unit. A comprehensive psychiatric assessment of all persons admitted to CAU is conducted to guide care and treatment whilst on the unit and facilitate appropriate treatment planning.

Medical

It's important that young people living with mental health enjoy the same rights, opportunities and good physical health as the general population. It is, therefore, essential that all young people presenting with mental health concerns also receive appropriate physical health review and care to improve physical health outcomes. This commitment builds on the Fifth National Mental Health and Suicide Prevention Plan and the National Mental Health Comimission's Equally Well Consensus Statement.

- It is also a requirement of Section 86 (2) of The Mental Health Act 2015 that all patients detained on an ED3 under the ACT receive a thorough physical examination by a doctor within 24 hours.
- It is the responsibility of the treating team to ensure that all persons admitted to CAU have been or are offered a comprehensive medical examination within 24 hours of admission, recorded and signed in the person's DHR. This is a divisional Key Performance Indicator (KPI) and is reported on monthly.
- If a physical examination is not possible within this time frame (e.g. if it would be distressing to the person to undergo a physical examination due to his or her mental state or the person refuses), then the reason will be clearly stated in the notes, any relevant observations documented (e.g. gait, posture, energy levels, levels of hydration, nutritional status), and continued attempts will be made to undertake the examination.

Care Coordinator

The Care Coordinator is a primary point of contact for parents and carers and services. They will ensure that key tasks are completed by the broader care team including standardised assessments, care and safety planning, discharge planning, referrals to other services and outcome measures are completed. The care coordinator may be a member of the allied health or nursing team and are assigned at admission by the TL.

Administrative Responsibilities

CAU administrative staff will comply with the *CHS Admission to Discharge Procedure (Adults and Children).*

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Section 4 – Inpatient Care

The team will work collaboratively within professional and legal frameworks to ensure the safe delivery of mental health in-patient care for persons admitted to CAU based on best available evidence-based practices.

Admissions within CAU will be recovery focused, therapeutic, person centred and allow informed decision making underpinned by the *Mental Health Act 2015*. The *Mental Health Act 2015* requires the inclusion of carers and family members in the provision of mental health services. The provision of treatment, care and support must facilitate the appropriate involvement of family, carers, and close friends in collaborative treatment decision-making. Acknowledgement of the contribution that carers provide in the care planning and recovery of persons is in line with the *Carer Recognition Act 2021.* Parent, carers or guardians must be notified of any significant incidents and changes to care including those leading to a Code Blue or Code Black.

While CAU staff recognise the experience and expertise of family, carers, and close friends, CAU staff adhere strictly to the *Health Records (Privacy and Access) Act 1997*, which informs the disclosure of an admitted person's health information.

Recovery focused assessment

A recovery focussed assessment and plan will be completed by the inpatient clinical staff. This assessment will assist in the recovery and discharge planning that occurs in collaboration with the person, their family and carers, or nominated person and stakeholders.

Psychosocial Needs Assessment

A need assessment is conducted for all persons to determine the allied health services that would be most beneficial while on the inpatient unit.

Family meeting

The person's family, carer, guardian and/or nominated person will be contacted and a family meeting will be organised by the social worker or medical staff.

Therapeutic Group Program

All person will be expected to attend the Therapeutic Group Program (TGP) as discussed with their treating team.

Education Program

Regular attendance at school is important for the young person's intellectual, social, emotional and physical development. All children and young people in the ACT are required to participate in fulltime education from six years of age until they complete Year 10. Young

people are then required to participate in fulltime education, training or employment until they complete Year 12 or they turn 17, whichever happens first. *The Education Participation (Enrolment and Attendance Policy)* has further details.

It is an expectation that all young people of school age will attend the CAU Education Program.

National Disability Insurance Scheme (NDIS)

(NDIS) status of the young person must be clarified by the treating team. The person's support coordinator will be notified of admission and, if possible, changes to their plan are identified. Discharge planning is commenced with the provider.

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Section 5 – Discharge

Discharge planning will commence as soon as a person is admitted to CAU. Planning will be coordinated and comprehensive in order to support persons returning home in the most timely and optimal manner. The CAU team must involve relevant stakeholders including Clinical Managers, families, carers, a nominated person and the extended care team, GP's, private Counsellors and Psychologists, Adolescent Intensive home treatment team (AIHTT), recovery-oriented services like Transition to Recovery (TRec), Step-up-step-down services, schools, Child and Youth Protection Service, NDIS Support Coordinators, as a core element of discharge planning.

The Territory Wide Bed Access Coordinator will be regularly updated with planned discharge date and bed availability.

See Attachment 5 – Discharge Checklist for nursing team tasks.

All CAU staff will comply with and refer to the CHS *Admission to Discharge Procedure (Adults and Children)* and the CHS *Discharge Summary Completion – Inpatients Procedure*.

Guidance on the collection of discharge medications can be found in the CHS *Medication Handling Policy.*

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Section 6 – Advance Agreements, Advance Consent Directions, Nominated Persons and Consent

The *Mental Health Act 2015* identifies several ways that a person can express preferences for treatment, care, or support when they have decision-making capacity in anticipation of

future loss of decision-making capacity. These include entering into an Advance Agreement and/or an Advance Consent Direction, and/or nominating a Nominated Person.

All staff must adhere to the directions as set out within the *CHS Advance Agreements, Advance Consent Directions and Nominated Persons under the Mental Health Act 2015 Operational Procedure* which provides guidance to staff to assist people in making Advance Agreements, Advance Consent Directions and explains the rights, roles and responsibilities of staff, the person, and the Nominated Person in relation to these legislated provisions under the *Mental Health Act 2015*.

CONSENT

Older children and young people may access clinicians for health advice and information without parental consent. Clinicians will encourage the child or young person to communicate with parents or guardians, unless there are concerns around their safety or wellbeing, however where the child or young person requests confidentiality, and/or if the need for examination, treatment or a procedure is identified, the clinician will consider Gillick Competence of the child or young person to seek legally valid consent. The views (if known) of the parent or guardian to the proposed examination, treatment or procedure, and any alternatives will also be considered.

Gillick Competence

In determining whether an older child or young person is capable of providing consent, clinicians need to consider whether they have sufficient understanding and intelligence to:

- Comprehend the medical advice being given, including the nature, consequences and implications of the proposed examination, treatment or procedure,
- Comprehend the potential risks to health with or without the examination, treatment or procedure and,
- Manage the emotional impact of either accepting or rejecting the advised examination, treatment or procedure.

Documentation will clearly include the clinician's determination of Gillick competence. Further guidance is contained within the CHS policy CHS20/251 *Informed Consent*.

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Section 7 – Daily Clinical Huddle

All CAU staff will comply with and refer to the *CHS Clinical Handover Procedure.*

A morning huddle will occur each morning to discuss new admission, deteriorations, discharges and the ward schedule for the day. The meeting is attended by the senior nursing, medical staff and allied health. The TL will construct the patient list for the morning and lead the discussion.

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Section 8 – Multi-disciplinary Team Meeting

An MDT will be held at least weekly which will prioritise complex case discussions including diagnostic clarification, poor treatment response and barriers to discharge. This will be documented within the patients DHR.

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Section 9 – Patient Identification

All CAU staff will comply with and refer to the overarching *CHS Patient identification and Procedure Matching Procedure.*

Alert: Under no circumstances will staff place themselves at unnecessary risk by insisting persons comply with the wearing of an identification band. Refer to *Patient identification and Procedure Matching Procedure* for other identification options.

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Section 10 – Patient and Property Search

In limited circumstances, searches may be conducted within CAU to detect and reduce the risk of items that would present a danger to anyone in the unit or could be used by the person to abscond. All visitors and persons are made aware of prohibited items through the orientation process. For guiding principles relating to consent and safeguards regarding a search of a person, please refer to the *CHS Searching of a Consumer's Person or Property Policy.* For the removal of suspected prohibited substances from the person, please refer to the *CHS Responding to Consumer Use of Alcohol and/other Drugs (AOD) Procedure*.

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Section 11 – Management of Electronic Devices

All CAU staff will comply with and refer to the CHS Patient Mobile and Recording Devices: Management and Use Operational Procedure.

Unrestricted access to personal electronic devices, including mobile phones, cameras, and video recording devices, is not permitted in CAU. To ensure participation in the ward programme and aid treatment and recovery, personal devices can only be used at certain times within the ward schedule. It may be determined by the treating team that due to the young person's mental illness or risk that they are not able to have any unsupervised access to personal devices. In this instance staff will assist young people to access messages and numbers from their phones and contact parents/ guardians/ carers as required.

On admission, young persons and their families will be:

- Informed as part of their orientation to the unit that the use of electronic devices is restricted while admitted to the unit.
- Advised that the recording and photographing of staff and other young people or visitors on the ward is not allowed.
- Encouraged to give their electronic device(s) to a nominated person, carer or family member for safekeeping at home.
- Requested to hand over their electronic device(s) to staff for safekeeping so that it may be entered in the property sheet, and stored securely.
- Encouraged to take a copy of any important phone numbers and contacts before the device(s) is stored.

If a young person needs to make contact with a carer outside the usual set times on the ward staff will support them to do this.

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Section 12 – Valuables and Property Management

Valuable items are to be put into safe keeping in patient designated lockers, and where possible, the person will be encouraged to return valuables to a family member or carer.

The admitting nurse is to ensure that the person signs the admission checklist that states that the person accepts responsibility for their items whilst an inpatient and has received all property and valuables on discharge. This form is then placed in the person's DHR.

All electrical items brought into CAU must appear to be in good working order on visual examination.

The security office is to be contacted to deposit valuables in the hospital safe between Monday to Friday 0800-1600hrs. Out of business hours the After-Hours hospital CNC and Security can be paged to request assistance with accessing and transferring items to the hospital safe. Any sum over $100 must be transferred to the hospital security safe. A patient cash receipt and transaction record form is to be completed as above.

If a person reports a missing item, staff need to investigate this fully, clarifying when the item was last seen and from where the item went missing.

Though discouraged, persons do trade and give away items. Property may deteriorate over time and may be discarded. All these avenues are important to explore when a person reports a missing item. Lost or stolen items may be recovered by way of a unit search or, where necessary, a search of an individual room or person. The dignity of all concerned must be maintained if searches are conducted (see *Search section*).

Note: Ensure the person is aware that the hospital cannot accept full responsibility for loss or damage to personal effects unless property was taken into safe keeping.

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Section 13 – Escort and Transport of People

All CAU staff will comply with and refer to the CHS *Non-urgent Escort and Transport of People with a Mental Illness (MHJHADS) Procedure*.

Where transport is required outside of the main CHS building ambulance transport must be used. Nurse escort is required.

If a person absconds, staff members need to initiate the CHS *Missing Patient Procedure* and immediately advise the DON or Executive on call after hours.

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Section 14 – Access to leave

The utilisation of the CRA framework must precede any decision to allow a person (who is voluntary or involuntary under the *Mental Health Act 2015)* periods of authorised leave. This will be discussed in collaboration with the treating team.

The determination of risk level will be consistent with the level of care the person is receiving at the time of granting leave.

It is the responsibility of the allocated nurse to discuss the leave agreement with the young person and document in the person's DHR. This includes when a person proceeds on leave, when they return and the outcome of that period of leave including contact details. This documentation will occur for every episode of leave and will include a current description of their clothes, where they are on leave to and legal status.

Family, carer or nominated persons (responsible person) will be engaged where appropriate in providing support when a person is granted authorised leave. Following a risk assessment, safeguards are required to ensure the person's wellbeing while on leave. This includes the development of a leave safety plan, encompassing the place of leave. It is important to ensure that the family, carer or nominated person are informed of issues that may affect the person and are able to agree and accept responsibility for the person while on leave. These details are to be recorded in the person's DHR and the CAU Leave Agreement form signed by the responsible person alongside the persons phone number.

If the person has been granted unescorted leave, they are to have a risk assessment prior to leaving the unit. They are also to be aware of the limits of the leave are (such as time allowed, location etc).

Leave authorisation for walks with CAU staff on the hospital grounds will follow the above guidelines. Family and carers should be advised that staff may take young people on accompanied leave within the hospital ground.

There are several leave provisions in the *Mental Health Act 2015* that are applicable to involuntary person detained in a mental health facility.

For more specific information in regard to leave for involuntary persons, please refer to the *CHS Clinical Procedure - Care of Persons Subject to Psychiatric Treatment Orders (PTOs) with or without a Restriction Order (RO)*, *CHS Management of People Subject to s.309 of the Crimes Act 1900 Transferred to the Canberra Hospital (MHJHADS) Procedure, CHS Operational Procedure - Emergency Detention in Canberra Health Services Facilities and a Person's Rights under the Mental Health Act 2015,* and *CHS Procedure - Care of Persons Subject to Forensic Mental Health Orders (FMHOs).*

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Section 15 – Visitors at CAU

The CAU team recognise the important role that families and carers have in supporting persons and for the need to have them to be actively involved in treatment and discharge planning.

Parents, guardians and carers are welcome to the unit at any time, however, contact prior to visiting is recommended. General visiting hours are 4pm to 8pm Monday to Friday and 8am to 8pm Saturday and Sunday.

Visitors to CAU will be provided with a copy of the Information for Visitors brochure and the nursing staff will communicate key information to them such as:

- All possessions and items to be given to persons admitted to CAU must be checked by staff first
- Visitors are to be reminded that persons are **not to be given** medications additional to their prescribed regime on the unit
- Under no circumstances are alcohol, drugs, knives/weapons, cigarette lighters/matches, sharp objects, or other prohibited items to be brought onto the premises, offered to, or given to persons
- Children **must not** visit unaccompanied and are to be under adult supervision at all times. Upon agreement of the treating team, meetings with younger siblings can be facilitated in the family room.
- Visitor's personal belongings will be kept in the designated lockers. Mobile phones can be taken onto the unit

Visitors are encouraged to use the open communal areas when visiting, , if there is need for privacy with parents/ guardians or carers, they are to let staff know before entering a young persons room and keep the doors open at all times.

Visitors will be made aware resources available to them within or close to the unit including

Family and carers lounge including a beverage bay
the closest vending matching and café facilities
access to toilet / bathroom/ baby change facilities
courtyard and play areas
Ronald McDonald Family Room.

The safety of admitted persons, staff and visitors is paramount. Nursing staff will conclude a visit if they feel that the safety of the person, visitors or staff may be compromised. In the event where a visitor becomes distressed by their visit, supportive counselling is to be offered by staff.

Visitors determined by staff to not have a legitimate cause to be on the unit visiting persons are to be asked to leave. If they do not comply with this request, they are to be informed that they are trespassing, and the hospital Security will be contacted.

In the event of violence or aggression by a visitor, staff are to be familiar with the *CHS Occupational Violence Operational Procedure.*

Visits by a lawyer, Official Visitor or the Public Advocate are allowed for persons admitted under the *Mental Health Act 2015 or* section 309 of the *Crimes Act 1900*. The Australian Federal Police (AFP) may limit certain people from visiting people detained under a section 309 of the *Crimes Act 1900* (see CHS Operational Procedure *Management of People Subject to Section 309 of the Crimes Act 1900 Transferred to the Canberra Hospital (Mental Health, Justice Health & Alcohol and Drug Services).*

Community Workers can attend from Government and non-Governmental organisations (NGOs) to support discharge planning and transition to the community. Community workers will identify themselves to staff and state who they wish to visit. An orientation to the unit will be provided and a portable duress device must be worn. The Nursing TL must assist the Support Worker and provide a temporary key pass if required/available. If the Community Worker wishes to take the person off the unit for leave the Consumer Leave Agreement needs to be completed.

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Section 16 – Clinical Risk Assessment (CRA)

The CRA is a tool utilised to manage, contain, and more accurately monitor issues of risk. In a mental health setting, the CRA reinforces this important concept using therapeutic engagement and observation throughout admission to hospital, based on assessed level of risk and principle risk concern(s).

Persons admitted to CAU will have an initial CRA (Attachment 1) completed using the initial CRA form. The initial CRA will be completed in the Emergency Department (ED) by the Psychiatry Registrar prior to admission, for direct admissions this is completed on initial presentation by the admitting doctor. This will determine the level of observation required for each person admitted to CAU. The CRA must be ratified by the CAU treating team as soon as practicable after admission.

Risk factors that may indicate the need for closer observation include:

- Suicidality or a history of previous suicide attempts or acts of self-harm
- Aggression / violent behaviours / harm to others, risk-rated utilising the Brøset
- Delusions, particularly paranoid ideas where the person believes other people may pose a threat
- Hallucinations, particularly voices suggesting harm to self or others
- History of absconding
- Poor adherence to medication programs
- Alcohol and Drug misuse
- History of inappropriate sexual behaviour
- Cognitive impairment
- Medical condition
- General vulnerability

Levels of Engagement including observation

The CAU believes that risk assessments are an integral part of the care provided in an acute inpatient unit and are best done collaboratively with the person, family/carer/nominated person, and the treating team. Risk assessments are recorded on the CRA form to inform a decision about the level of risk management that the person requires.

There are 5 levels of ARC observation:

Arc Level	Level of Risk	Description
Level 1	Low risk	General Engagement and Observations every 2 hours
Level 2	Low to Medium risk	Intermittent Engagement and Observation every 50-60 minutes
Level 3	Medium risk	Frequent Engagement and Observation every 20- 30 minutes
Level 4	Medium to High risk- only used for High Dependency Unit patients.	Close Engagement and Observation every 10- 15 minutes

Level 5	High risk	Continuous Engagement and Observation

ARC 1 (General Observation) – 2 hourly
General observation is the minimum acceptable level of observation for a person admitted to CAU. Prior to any person being placed on Level One / general observation a full risk assessment must be completed by the admitting staff member to assure that the individual does not pose any serious risk to either themselves or others. This initial risk assessment will also consider the potential vulnerability of the person within the unit.

Every person admitted to CAU will have a designated staff member who will have knowledge of their whereabouts, whether on or off the unit, but not all persons need to be kept within sight. Staff will check on the person's whereabouts at handover times of nursing staff and at all mealtimes.

Persons on level one observation will also be deemed to be unlikely to attempt to leave the unit on unauthorised leave. Consideration can be given to if the person can have their phone/tablet/headphones/charger while they are an inpatient. This is to be documented in their notes.

The person must be informed and actively involved in the process. The responsible nurse will engage with the person to assess mental state and record objective and subjective (i.e. the person's views) information in the DHR.

ARC 2 (Intermittent engagement and observations) – 50-60 Minutes
This level of observations is considered suitable for those persons, who following a risk assessment, are considered to be requiring a degree of supervision higher than which is provided to persons receiving ARC 1 observations.

Such persons may be deemed to be potentially, but not immediately, at risk to either themselves or others. Alternately, there may be persons who are considered to be vulnerable within the unit setting or may be identified as likely to leave the unit without informing staff. Intermittent observations will occur every hour.

More frequent checking is strongly advised in the case of persons whose risks are deemed to be higher, and it is recognised as good practice to periodically alternate the times of checking to avoid persons becoming too familiar to the routine of staff checking on them e.g. check after 50 minutes, check after 55 minutes, check again after 60 minutes and so on. Consideration can be given to if the person can have their phone/tablet/headphones/charger. This must be documented in their notes.

ARC 3 (Frequent observations) – 20-30 Minutes
This level of observations is considered suitable for those persons, who following a risk assessment, are considered to be requiring a degree of supervision higher than which is provided to persons receiving ARC 2 observations.

This level of observation will be used for persons considered to pose a significant risk of:

- Suicide /Self harm
- Overt psychotic symptoms
- Harm to others
- Falls
- Absconding
- Severe self-neglect
- Violence, aggression, or physical harm

Whilst under ARC 3 observations the whereabouts of the person must, at all times, be known by the nominated nurse and the person sighted every 20-30 minutes. It is important to review daily so there is no undue delay in re-grading the ARC to the lowest level of appropriate observation and least restrictive practices.

Consideration can **ONLY** be given to if the person can have their phone/tablet/headphones/charger after a discussion with the MDT and documented in the DHR and noted on the bed list.

ARC 4 (Close observations) – 10-15 Minutes
This level of observation will be used for persons within a High Dependency Unit only for those patients who to pose a significant risk of:

- Suicide /Self harm,
- Overt psychotic symptoms,
- Harm to others,
- Falls,
- Absconding,
- Severe self-neglect,
- Violence, aggression, or physical harm but not to the degree of needing to receive level four observations (within arm's length).

The person must be informed of ARC 4 and if possible, their cooperation will be obtained. It is acknowledged gaining the person's cooperation may be extremely difficult due to their presenting mental state; however every effort must still be taken to actively involve the person and carers throughout this process whenever possible. It is important to review daily so there is no undue delay in re-grading the ARC to the lowest level of appropriate observation and least restrictive practices.

The use of a tear-proof gown is to be considered where clinically indicated, and always for episodes of seclusion. If a tear-proof gown is considered necessary to mitigate the risk of

self-harm, the TL is to consider the person's increased vulnerability and loss of dignity of wearing the gown when in the social areas of the mental health inpatient unit.

ARC 5 1:1 Engagement and observations or at arm's length

This observation level is for persons who are required to be constantly visually observed at arm's length distance or as specified by the treating team,. Upon identification of a risk that warrants ARC 5 engagement and observation, the TL and medical staff will undertake a joint assessment of the person. Out of hours nursing staff may initiate ARC 5 and the treating team are to review the CRA as soon as practicable.

The criteria for the commencement of constant supportive observation include any person who is considered to pose a serious, significant, and immediate risk of: -

- Suicide/ Self harm
- Overt psychotic symptoms
- Harm to others
- Absconding
- Severe self-neglect
- Violence, aggression, or physical harm

Persons on ARC 5 will be reviewed by the treating team at least once every 24 hours. Issues of privacy, dignity, and consideration of the gender of allocating staff must be incorporated.

No consideration can be given to if the person can have their phone/table/headphones or charger unless an exemption is made by the treating team. This is to be documented in the DHR and bed list. Consideration must be given for the removal of belongings that may be used to self-harm such as belts, dressing gown cords, shoelaces. Thorough environmental safety checks must be conducted to assist in the environmental safety of the person.

The use of a tear-proof gown is to be considered where clinically indicated. If a tear-proof gown is considered necessary to mitigate the risk of self-harm, the TL is to consider the person's increased vulnerability and loss of dignity of wearing the gown when in the social areas of the unit.

The nurse allocated to the person receiving ARC 5 observations will make any appropriate entries in the DHR after their observation period with the person.

It is acknowledged gaining the person's cooperation may be extremely difficult due to their presenting mental state; however, every effort must still be taken to inform the person and actively involve them within this process whenever possible. It is expected that this level of observation will wherever possible be treated as an opportunity for therapeutic interaction rather than a form of custodial care.

Staff constantly observing the person will do so at a distance that enables the person's safety to be maintained. The proximity agreed by the treating team must be defined and recorded in the person's DHR. When the person is using the bathroom, the staff member is

to consider the person's dignity and may briefly extend the arm's length observation distance, however it is not permitted at any time for the staff member and the person to have a shut door between them.

The DHR will contain a detailed entry in respect to the commencement of ARC 5 observations. This entry will include:

- A full mental health risk assessment and risk management plan.
- Review of medication, this will include monitoring of side-effects and the effectiveness of any PRN medications.
- Patient reaction/ feelings to being on observations.
- An individualised multidisciplinary plan of care and treatment.
- Indication as to whether this plan has the persons agreement/ cooperation

The allocated member of nursing staff must keep the person in sight until relieved by another designated nurse. The relieved nurse must sign the Record of Observation at the time of handing over responsibility as will the oncoming member of staff about to commence the period of observation.

Alert: Nurses allocated to a person on ARC 5 observations will be relieved/rotated hourly.

Overnight observations

Levels of engagement and observation overnight must be planned and documented in the person's DHR and bed list. Persons may be assessed as different risk levels for daytime risk level and night-time risk level.

Alert: Each overnight observation must include a check of the person's regular breathing by the rise and fall of the chest.

Alert: Seclusion and or restraint is only used as a last resort in cases of immediate and imminent risk to patients, staff or visitors.

Documentation

Nursing documentation includes a CRA, which clearly records the rationale for the level of observation. Including specific care and treatment plan to be followed as well as a Record of Observation Form. All relevant information relating to the care and treatment of any person must also be recorded as above in the DHR.

Increasing the level of observation

Nursing staff have the authority to increase an ARC score however the TL must be involved in the decision-making process. Such decisions and the rationale must be recorded within the person's DHR and a CRA re-assessment form completed (Attachment 2). The person is to be reviewed by their treating team as soon as practicable.

Any circumstances that lead to increased observations level will be notified to parents, carers and guardians. In addition the change in the person's level of observation must be communicated to other clinicians during the hand over process and documented in the DHR and bed list.

Note:
Any reduction in the ARC category and level of observation can only take place after the Psychiatry Registrar or Consultant Psychiatrist have completed a CRA and downgraded the ARC score.

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Section 17 – De-escalation

The CAU services uses the Safewards model, which is a model designed to reduce conflict and restrictive practices within inpatient units by identifying and addressing the causes of behaviours in staff and patients that may result in harm (conflict) and reduce the likelihood of this occurring. Staff are trained to use a range of methods to manage patient behaviours in a concerted effort to reduce restrictive or coercive interventions. This also requires staff to review their own behaviours and responses to conflict and the strategies used to manage challenging behaviours, including trauma informed interventions.

In situations when a person shows signs of escalating, such as verbal aggression, staff will remain calm, reassure the person they are there to help and use effective communication skills to de-escalate the situation including:

- Respecting personal space
- Appropriate body language using non-confrontational manner.
- Establishing appropriate verbal contact to engage with the person.
- Communication in a clean and concise manner, avoiding repetition.
- Listening and acknowledging the person's concerns.
- Identify and validate the person's need and feelings.
- Being respectful
- Setting clear limits and boundaries
- Use of sensory room
- Expressing an intention to help the person by offering realistic choices.
- Withdrawing from the situation and providing the person time and space to settle and/or to calm down.

Where de-escalation methods are ineffective, and a safe environment can not be maintained, consideration should be given to increasing the level of care of the consumer and/or transfer of care to another area. If transport is required please refer to Section 13 Escort and Transport of People

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Section 18 – Involuntary Care

All CAU staff will comply with and refer to the:

- CHS *Restraint and/or Forcible Giving of Medication to a Person Detained under the Mental Health Act 2015 Procedure*
- *Restrictive Practices for Patients NOT detained under the Mental Health Act 2015 Procedure.*
- *CHS Restrictive Practices for Patients NOT detained under the Mental Health Act 2015 Procedure.*

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Section 19 – Non-Adherence of Medication

Medication management is an integral part of the treatment of acute symptoms of mental illness or disorder.

The medical team must be made aware at the first opportunity of any instances in which the person (involuntary or voluntary) does not adhere to their medication treatment plan, this includes refusing medications, or attempting to secrete medications. The nurse is to ensure this is documented in the DHR and discussion with the psychiatry team. Non-adherence with treatment must be acknowledged in the clinical plan and handed over from one nursing shift to the next in the inpatient setting.

Non-adherence of medication must always be explored by the treating team to determine if there is a medication preference or issue with side-effects.

When there is a known issue with medication compliance and the person is subject to the *Mental Health Act 2015* and or the *Guardianship and Management of Property Act 1991*, least restrictive interventions will always be attempted. The Psychiatry Registrar in consultation with the Consultant Psychiatrist may determine that the least restrictive options have been explored and it is in the person's best interest to receive forcible giving of medication. Each episode of forcible giving of medication must be authorised by the Psychiatry Registrar or Consultant Psychiatrist and documented in the DHR forcible giving of medication register.

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Section 20 – Management of People subject to s309

All CAU staff will comply with and refer to the CHS *Management of People Subject to s.309 of the Crimes Act 1900 Transferred to the Canberra Hospital (MHJHADS) Procedure*.

Note:
A Clinical incident report in Riskman must be completed if a person on a s309 escapes and the incident categorised as significant. The ADON, DON and Executive Director must be notified immediately within business hours and the Executive on Call must be notified immediately after hours.

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Section 21 – Procedure for Absent without leave (AWOL)

In the case where a young person is Absent without leave (AWOL) all CAU will comply and refer to the *CHS Missing Patient Procedure*. See also Attachment 4 - Step by step process to completing an Unauthorised Leave of Admitted Person from a MHJHADS Inpatient Facility.

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Section 22 – Medical Deterioration

All CAU staff will comply with and refer to the CHS *Vital Signs and Early Warning Scores Procedure* and understand Medical Emergency Team (MET) criteria. For medically unwell children and adolescents:

- All observation charts must have a copy of the current Paediatric Escalation Process.
- All patients cared for in CAU will have vital signs and the Paediatric Early Warning Score (PEWS) recorded on an age specific observation chart. However, may have vital observations recorded on the Adult Vital Signs Chart (Please refer to Section 8-12 in the Clinical Procedure*, Vital Signs & Early Warning Scores*).
- A minimum of 4/24 vital signs must be attended unless otherwise specified (Please refer to Section 8-12 in the Clinical Procedure, *Vital Signs & Early Warning Scores*).

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Section 23 – Referral pathway to other speciailties

If referral to specialty services is required, the RMO or Psychiatry Registrar will contact the Paediatric Registrar or appropriate medical specialty and request review.

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Section 24 – Code Blue

All CAU staff will comply with and refer to the CHS Emergency Management Plans – Code Blue Procedure.

Paediatric and CAMHS staff will jointly respond to Code Blue across the entire Adolescent Unit. The Paediatric Team Leader / CAU Team Leader and/or CNM's from both CAMHS and Paediatrics will provide leadership of the response.

Once the local emergency is activated, at least one (1) staff member from each paediatric ward in Building 11, and the Paediatric Team Leader will attend the area. The appropriate emergency still needs to be activated by calling "2222" to ensure the MET team and/or Security and Wardsmen attend.

The MET trolley within the CAU must be checked on each night shift or following a Code Blue, and stock updated and replaced by the Night Duty nursing staff. Paediatric and CAMHS nursing teams will jointly be responsible for MET trolley checks.

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Section 25 – Code Black

CAU adheres to Canberra Health Services Occupational Policies and Procedures for Occupational Violence. Occupational Violence is unacceptable and includes any situation where a staff member is abused, threatened, or assaulted by a patient, consumer or visitor in circumstances relating to their work.

All CAU staff will comply with and refer to the *CHS Emergency Management Plans – Code Black Procedure*.

Paediatric and CAMHS staff will jointly respond to Code Black within CAU. The CAU CNC or CAU Team Leader will lead the response.

Once the local emergency is activated, at least one (1) staff member from each paediatric ward in Building 11, and the Paediatric Team Leader will attend the area. The appropriate emergency still needs to be activated by calling "2222" to ensure the MET team and/or Security and Wardsmen attend.

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Section 26 – Ligature Management

Staff must be oriented to and be familiar with the location of the Rescue 911 ligature cutter and follow the CHS *Ligature Use, Response and Risk Management MHJHADS Procedure.* The procedure informs staff of the action to be taken and their responsibilities for the safe removal of a ligature and what to do in an emergency.

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Section 27 – Debriefing following a critical incident

The CNC, shift team leader or suitable senior mental health clinician is to facilitate a debriefing session which will be offered to staff, admitted persons and visitors who were involved or witnessed the incident, as soon as practical. The Employee Assistance Program (EAP) can also provide incident debriefing for staff. Individual staff counselling will be offered and can be accessed through EAP. Learnings from the incident will be documented and presented to the team meeting.

An incident reportable to the Executive Director of MHJHADS notification will need to be completed if the incident meets the criteria of that policy. The Operational and Clinical Directors will be notified by the senior mental health clinician. After hours, the Director on -call and the and the Psychiatrist On-Call are notified.

For further guidance refer to the CHS policy *Incident Management – Clinical,* the CHS procedure *Incident Management – Clinical* & the CHS Guidelines Psychological Support for Staff - A Manager's Guide.

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Section 28 – Use of Duress Alarms

Clinical Work Devices (CWD) are provided to help ensure safety and reduce the number and extent of injuries to staff, admitted persons and visitors, as a result of aggressive incidents or unlawful acts. All members of staff and community workers are required to wear a personal duress alarm that is registered to them.

The unit also has fixed duress alarms in the Nurses Station, interview rooms, meeting rooms and therapy rooms.

When an alarm is activated, the information will be recorded on the screens of the device.

Immediately when staff arrive on duty, they must obtain a CWD from the storage racks. Staff must then enter their name and duress number on the handset to register their details on the computer terminal.

Staff must test the duress at the commencement of each shift. Staff must then secure the device to their person following the directions contained in the Instruction Manual for their specific model.

The TL must ensure all staff and community workers have been orientated the duress system and required testing.

Note:

The location capability is only accurate within a 3-metre radius in some areas of the unit and is essential that if an alarm is deployed, staff must thoroughly search the immediate vicinity in which the alarm has been activated.

Alarms sent via the handset by:

Local and Global Alarms are sent by pushing the red pad at the top of the unit once.
Man Down is activated when the device is in a horizontal position.

When the alarm is left in the horizontal position for 7 seconds the alarm will emit a vibration and tone to indicate to the staff member that the alarm is about to sound. If the alarm is not returned to a vertical position within 7 seconds a local code will be activated.

When the personal duress alarms or the computer registers an alarm the procedure to be followed is:

read message
move to the alarm location
click to acknowledge alarm
A staff member must return to the computer and click 'concludes' to reset computer.

Malfunctions of the system or need to replace batteries must be reported to the CAU Administration Manager or TL immediately.

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Section 29 – Environmental Safety Checks

All CAU staff will comply with and refer to Section 13 of the *CHS Ligature Use, Response and Risk Management MHJHADS Procedure* which details the requirement for Environmental Safety Checks (ESC) on each nursing shift handover.

Random Environmental Checks

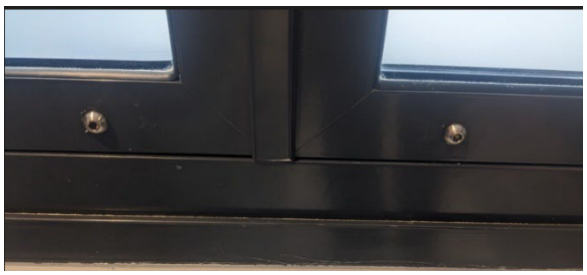
Random environmental checks will be conducted as required or at the decretion of the CNC or Team Leader

Courtyard – Roof Anchor point for ladders

There is an anchor point for ladders in the courtyard that can be potentially used to loop material to cause self-harm or escape.

CAU Nursing staff are to have line of sight of all young people accessing the courtyard and be stationed near the courtyard when this is being used by young people.

Access to blinds and ligature opportunities in bedrooms

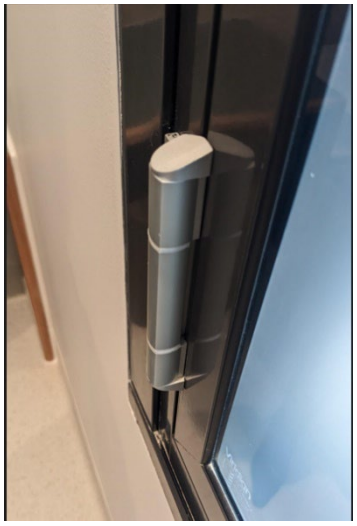


The window screws may be manipulated to gain access to the blinds which could potentially lead to self-harm or ligature event.

All nursing staff are to check screws during environmental checks and detect changes to the screws.

If screws are loose or have been manipulated, TL/CNC to ensure immediate safety of young person by removing young person and locking down the bedroom. Inform facilities management that screws have been compromised.

Potential gaps in bedroom window hinges



There are inconsistant gap between the purpose built anti-ligature hinges located in bedrooms. The gap can potentially be used to loop a cord or other materials over the hinge and could trigger a self-harm incident e.g. the cord from surgical masks looped over the hinge for self-harm.

Nursing staff to undertake regular environmental checks to identify any materials that could be used to loop around the hinges. Nursing staff to remove materials and notify CNC and treating team.

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Section 30 – Evaluation

Outcome

- Persons admitted to the CAU inpatient unit are managed as per this procedure
- CAU staff to be appropriately orientated and aware of CAU Clinical and Operational Procedures
- CAU admitted persons receive safe, effective care, therapy and treatment
- Clearly defined roles and responsibility of CAU staff for continued best practice for CAU admitted persons

Measures

- Timely review of all clinical incidents submitted for all CAU inpatient units by the CNC, risks identified are escalated to the ADON
- Monthly review of clinical incidents submitted for all CAU inpatient units through the Restraint, Seclusion and Restrictive Practices Review (RSRPR) Committee
- Timely review of consumer feedback submitted for all CAU inpatient units
- Monthly work health and safety audits of the physical environment

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Section 31 – Related Policies, Procedures, Guidelines and Legislation

Policies

- Nursing and Midwifery Continuing Competence
- Informed Consent (Clinical)
- Child Protection
- Occupational Violence
- Work Health and Safety
- Incident Management – Clinical
- ACT Language Services
- Family Violence
- CHS Medication Handling Policy

Procedures

- Admission to Discharge Procedure (Adults and Children)
- Advance Agreements, Advance Consent Directions and Nominated Persons under the Mental Health Act 2015 Operational
- Capacity Escalation
- Clinical Handover
- Care of Persons Subject to Psychiatric Treatment Orders (PTOs) with or without a Restriction Order (RO)
- Discharge Summary Completion – Inpatients
- Emergency Management Plans – Code Black
- Emergency Management Plans – Code Blue
- Health Care Workers Living with Blood Borne Viruses of Performing Exposure Prone Procedures and at Risk of Exposure to Blood Borne Viruses
- Ligature Use, Response and Risk Management MHJHADS
- Management of People Subject to s.309 of the Crimes Act 1900 Transferred to the Canberra Hospital (MHJHADS)
- Missing Patient
- Non-urgent Escort and Transport of People with a Mental Illness (MHJHADS)
- Occupational Violence
- Emergency Detention in Canberra Health Services Facilities and a Person's Rights under the Mental Health Act 2015
- Patient identification and Procedure Matching
- Patient Mobile and Recording Devices: Management and Use
- Care of Persons Subject to Forensic Mental Health Orders (FMHOs).
- Responding to Consumer Use of Alcohol and/other Drugs (AOD)
- Restraint and/or Forcible Giving of Medication to a Person Detained under the Mental Health Act 2015
- Seclusion of Persons Detained under the Mental Health Act 2015
- Vital Signs and Early Warning Scores
- Restrictive Practices for Patients NOT detained under the Mental Health Act 2015

Guidelines

- CAU Model of Care
- CHS Clinical Governance Framework

Legislation

- *Mental Health Act 2015*
- *Nursing and Midwifery Enterprise Agreement 2020-2022.*
- *Crimes Act 1900*
- *Confiscation of Criminal Assets Act 2003*
- *Carer Recognition Act 2021*
- *Health Records (Privacy and Access) Act 1997*
- *Guardianship and Management of Property Act 1991*
- *Work Health and Safety Act 2011*
- *Human Rights Act 2004*
- *Children and Young People Act 2008*
- *Information Privacy Act 2014*
- *Discrimination Act 1991*
- *Official Visitor Act 2012*
- *Workplace Privacy Act 2011*

Other

- Australian Charter of Health Care Rights

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Section 32 – Definition of Terms

ACAT – ACT Civil and Administrative Tribunal
ACTAS – ACT Ambulance Service
ADON – Assistant Director of Nursing
AFP – Australian Federal Police
ARC – At Risk Category
BVC - Brøset- Violence Checklist – MHJHADS adopted risk assessment tool for Violence and Aggression in inpatient units (except Secure Mental Health Unit)
CAMHS – Child and Adolescent Mental Health Services
CAU - CAMHS Adolescent Unit
CHS – Canberra Health Services
CNC – Clinical Nurse Consultant
CRA – Clinical Risk Assessment
DON – Director of Nursing
DHR – Digital Health Record
EAP – Employee Assistance Program
ED – Emergency Department
ED11 – Emergency Detention – 11 days

ED3 – Emergency Detention – 3 days
EDD – Estimated discharge date
Forcible Giving of Medication – medication given to a person against their will when under restraint. This is considered immediately necessary by the treating team for a person's health and safety and/or the safety of others.
GP – General Practitioner
HDU – High Dependency Unit, Adult Mental Health Unit
HLT- Hospital Liaison Team
HoNOSCA – Health of a Nation Outcome Scale Child and Adolescents
ISBAR - Acronym adopted by CHS to facilitate verbal clinical handover: Introduction. Situation. Background. Assessment. Recommendations
ISOAP – Acronym adopted by CHS to facilitate written notes: Introduction, Subjective, Objective, Plan.
KPI – Key Performance Indicator
LDU – Low Dependency Unit, Adult Mental Health Unit
MET – Medical Emergency Team
MoC – Model of Care
MDT – Multidisciplinary Team includes Medical Officers, Senior Nurse, nursing staff, Allied Health and other relevant support healthcare providers
Mental disorder – for the purposes of the *Mental Health Act 2015*, is

a) a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion; but
b) does not include a condition that is a mental illness. (s. 9 *Mental Health Act 2015)*

Mental illness – for the purposes of the *Mental Health Act 2015,* is a condition that seriously impairs (either temporarily or permanently) the mental functioning of a person in 1 or more areas of thought, mood, volition, perception, orientation or memory, and is characterised by:

a) the presence of at least 1 of the following symptoms:
    i. delusions;
    ii. hallucinations;
    iii. serious disorders of streams of thought;
    iv. serious disorders of thought form;
    v. serious disturbance of mood; or
a) sustained or repeated irrational behaviour that may be taken to indicate the presence of at least 1 of the symptoms mentioned in paragraph (a). (s. 10 *Mental Health Act 2015)*

MHCL – Mental Health Consultation Liaison
MHJHADS – Mental Health, Justice Health and Alcohol and Drug Services
NDIS – National Disability Insurance Scheme
NGO – Non-Government Organisation
TL – Nurse Team Leader
PEWS - Paediatric Early Warning Score
Prohibited Item—means items that the Director-General (or appointed delegate) has declared cannot be brought into a mental health facility. They include things that are hazardous or illegal to possess or have harmful properties or are things that may present an unacceptable safety threat in a mental health facility.

Prohibited Substance - a substance to which the medicines and poisons standard, schedule 9 applies. Schedule 9 substances are generally illegal substances that are subject to
PTO – Psychiatric Treatment Order
Recovery means gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.
Restraint – the interference with, or restriction of, an individual's freedom of movement. Restraint is defined as any device, material or equipment attached to or near a person's body and which cannot be controlled or easily removed by the person and which deliberately prevents or is deliberately intended to present a person's free body movement to a position of choice and/or a person's normal access to their body. Restraint by threat is the direct or implied threat to use restraint against a person.
RN – Registered Nurse
SDQ– Strengths and Difficulties Questionnaire
S309 – Order of the Magistrates Court for a person to be detained for a mental health assessment (Section 309, *Crimes Act 1900*)
TGP – Therapeutic Group Program
TREC – Transition to Recovery
VPS – Vulnerable Person's Suite

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Section 33 – Search Terms

Admission, Child and Adolescent Mental Health Services, Adolescent Unit, Clinical Risk Assessment, Emergency Detention, High Dependency Unit (HDU), Low Dependency Unit (LDU), Mental Dysfunction, Mental Health, Mental Health Act 2015, Mental Illness, Psychiatry, Psychiatrist, Psychiatric Treatment Order (PTO)

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Section 34 – Attachments

Attachment 1 – Clinical Risk Assessment and Management Form
Attachment 2 – Revised Clinical Risk Assessment and Management Form
Attachment 3 – Record of Observations Clinical Risk Re-Assessment
Attachment 4 – Unauthorised Leave of Admitted Person from a MHJHADS Inpatient Facility Process

Policy Team ONLY to complete the following:

Date Amended	*Section Amended*	*Divisional Approval*	*Final Approval*
24 June 2022	*Complete Review*	*Katie McKenzie, A/g ED-MHJHADS*	*CHS Policy Committee*

This document supersedes the following:

Document Number	*Document Name*
CHHS17/299	*Adult Mental Health Unit Procedure*

Attachment 1 – Clinical Risk Assessment

ACT **Health**

Acute Adult Mental Health Services (AAMHS)

CLINICAL RISK ASSESSMENT AND MANAGEMENT

Complete details or affix label

URN: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

* 3 5 2 6 2 (0918) *

DO NOT WRITE IN THIS BINDING MARGIN

Please refer to *AMHU Operational Procedure* for instruction on assessing level of risk and engagement

Name of inpatient unit: **Date:** ***Y = Yes N = No U = Unknown***

SUICIDE				*AGGRESSION*				*GENERAL VULNERABILITY*			
Suicide Static (background)	**Y**	**N**	**U**	**Aggression Static**	**Y**	**N**	**U**	**General Vulnerability Static**	**Y**	**N**	**U**
Previous attempts	☐	☐	☐	Previous incidents of violence	☐	☐	☐	Intellectual impairment	☐	☐	☐
Family history of suicide	☐	☐	☐	Previous use of weapons	☐	☐	☐	Previous diagnosis of mental illness or disorder	☐	☐	☐
Major mental health diagnosis	☐	☐	☐	Male	☐	☐	☐	History of absconding	☐	☐	☐
Serious medical condition	☐	☐	☐	Criminal history	☐	☐	☐	History of sexual vulnerability	☐	☐	☐
Separated/widowed/divorced	☐	☐	☐	Previous violent ideation	☐	☐	☐	Adolescent / Older person	☐	☐	☐
Loss of job/retired/role loss or instability	☐	☐	☐	Childhood abuse/maladjustment	☐	☐	☐	Domestic Violence	☐	☐	☐
Recorded alerts	☐	☐	☐	History of drug/alcohol misuse	☐	☐	☐	CALD / Aboriginal Torres Strait Islander / LGBTI	☐	☐	☐
Suicide Dynamic (current)	**Y**	**N**	**U**	**Aggression Dynamic**	**Y**	**N**	**U**	**General Vulnerability Dynamic**	**Y**	**N**	**U**
Expressing suicidal ideas	☐	☐	☐	Expressing intent to harm others / recent violence	☐	☐	☐	Cognitive deficit, poor orientation, memory	☐	☐	☐
Has plan / intent	☐	☐	☐	Access to available means	☐	☐	☐	Self-neglect: eating/drinking/self-care	☐	☐	☐
High levels of distress	☐	☐	☐	Paranoid ideation about others	☐	☐	☐	Non-adherence to medications	☐	☐	☐
Hopelessness / inability to cope	☐	☐	☐	Command hallucinations	☐	☐	☐	Current delusional beliefs	☐	☐	☐
Drug / alcohol misuse	☐	☐	☐	Reduced ability to control behaviour	☐	☐	☐	Intrusive behaviour	☐	☐	☐
Recent significant life events or impending anniversary	☐	☐	☐	Drug/alcohol misuse	☐	☐	☐	Disinhibition/disorganised	☐	☐	☐
Male	☐	☐	☐	Property damage	☐	☐	☐	Falls risk	☐	☐	☐
								Preoccupation with being in hospital	☐	☐	☐
Self Harm Static	**Y**	**N**	**U**	**Self Harm Dynamic**	**Y**	**N**	**U**	Absconding risk	☐	☐	☐
History of self harm	☐	☐	☐	Current thoughts of self harm	☐	☐	☐	Agitation	☐	☐	☐

Assessed level of risk and engagement *(circle)*	**Low**	**Low/Med**	**Med**	**Med/High**	**High**
	1	2	3	4	5

Authorised leave status	☐ Nil	☐ Unaccompanied CHHS/off campus	☐ Staff/family accompanied	☐ Overnight / weekend
	time:			
Access to electrical items:	☐ Electronic devices/s		☐ Headphones	☐ Charger cord/s

Psychiatry Registrar/Consultant Psychiatrist Comments:

Signature	Print name	Designation	Date	Time
		Psych Reg/ Consultant		
		Nurse		
		Nurse in Charge of Shift		

CLINICAL RISK ASSESSMENT AND MANAGEMENT

35262(0918)

35262

Acknowledgement to North Western Mental Health – Clinical Risk Assessment and Management (CRAAM)

Page 1 of 2

Mental Health Justice Health Alcohol and Drug Services (MHJHADS) believe that risk assessments are an integral part of the care provided in inpatient units and are best done collaboratively with the person, family/carer/nominated person and the treating team. The Clinical Risk Assessment (CRA) is completed by the Psychiatry Registrar or Consultant Psychiatrist and signed by the responsible Nurse. It is the responsibility of the Nurse to ensure the Nurse in Charge of the Shift has been informed also. This is to ensure effective and timely clinical handover of information, including the At Risk Category and updating the bed list.

Risk assessments are completed to evaluate an At Risk Category (ARC) and provide clinicians with the Engagement and Observation required. There are 5 levels of ARC with corresponding risk management strategies for the inpatient units to adhere to. Special instructions can be made in the comments section by the Psychiatry Registrar/Consultant Psychiatrist.

Note – a Registered Nurse can increase the ARC, however the treating team must complete a Revised CRA as soon as practicable.

ARC	Risk Level	Description of Risk	Engagement and Observation *see *AMHU Operational procedure* for overnight to minimise disruption of sleep
1	**Low**	Less distracted by psychotic symptoms, no inappropriate behaviour, not troubled by thoughts of self-harm, engaging with treatment and unit program.	**General Engagement and Observation:** Engagement with the person every 2 hours, including oversight of attending meals and the unit program. Consideration to be given for unaccompanied leave and overnight leave **AMHU/MHSSU/ED:** Consideration to be given for the person to have their electronic devices/headphones/charger. **AMHU only:** Consideration for Orange or Green corridors
2	**Low/ Medium**	Distracted by psychiatric symptoms but can manage in the LDU, potential risk to harm self or others but no immediate risk. Engaging with treatment and the unit program.	**Intermittent Engagement and Observation:** Engagement with the person every 50-60 minutes. Consideration to be for accompanied/unaccompanied/ overnight leave. **AMHU only:** Consideration for Orange and Green Corridors **AMHU/MHSSU/ED:** Consideration to be given for the person to have their electronic devices/headphones/charger.
3	**Medium**	Ambivalence to treatment, absconding risk, expressing suicidal ideation or thoughts of self-harm, some psychotic phenomena, hypomania. Some irritability.	**Frequent Engagement and Observation:** Engagement with the person every 20-30 minutes. Consideration for accompanied day leave with staff. Other day leave in consultation with community workers and family. **AMHU:** Consideration should be given to placing in Red or Yellow corridor **AMHU only:** Consideration given for Red or Yellow Corridor **AMHU/MHSSU/ED:** Consideration can be given for the person to have their electronic devices/headphones/charger ONLY after discussion with the MDT
4	**Medium/ High**	Absconding risk, expressing suicidal ideation with plan and intent or active self-harm, overt psychotic phenomena, mania. Risk of aggression and possible violence.	**Close engagement and Observation:** Person to be sighted every 10-15 minutes. Daily review of CRA No authorised leave. **ED:** Consideration given for nurse or Wards-person 1:1 special observation and transfer to the De-escalation Suite **AMHU:** Consideration should be given to HDU or Vulnerable Persons Suite No consideration to be given for the person to have their electronic devices/ headphones/charger
5	**High**	High risk of suicidal behaviours and/or imminent risk of violence. Floridly psychotic, hyper-mania, with high risk of absconding. OR **Adolescents 17 years and under must be on ARC 5, unless revised by treating team in consultation with CAMHS**	**Continuous Engagement and Observation:** Constant visual observation or within arm's length at all times, as determined by the treating team. Daily review of CRA. **ED:** Consideration given for nurse or Wards-person 1:1 special observation and transfer to the De-escalation Suite **People who are placed in seclusion must have an ARC score of 5** **No consideration to be given for the person to have their electronic devices/headphones/charger. Exceptions may include adolescents as authorised by the treating team**

DO NOT WRITE IN THIS BINDING MARGIN

3562Z(09/18)

Acknowledgement to North Western Mental Health – Clinical Risk Assessment and Management (CRAAM)

Attachment 2 – Revised Clinical Risk Assessment and Management

ACT **Health**

Acute Adult Mental Health Services (AAMHS)

REVISED CLINICAL RISK ASSESSMENT AND MANAGEMENT

Complete details or affix label

URN: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

35263

DO NOT WRITE IN THIS BINDING MARGIN

Revised Risk Assessment

Please refer to *AMHU Operational Procedure* for instruction on assessing level of risk and engagement

Name of inpatient unit:	Date:	Y = Yes N = No U = Unknown

Description *(tick)*	Y	N	U	Action plan from assessment and rational for management (include conditions for leave, any new collateral information
Suicidality	☐	☐	☐	
Self-harm	☐	☐	☐	DAY Action Plan
Substance misuse	☐	☐	☐	
Aggression	☐	☐	☐	
Cognitive Impairment	☐	☐	☐	
Inappropriate disinhibition	☐	☐	☐	
Medical Condition	☐	☐	☐	
Level of non-compliance	☐	☐	☐	NIGHT Action Plan
Disorganisation	☐	☐	☐	
Absconding	☐	☐	☐	
Falls/nutrition	☐	☐	☐	
Agitation	☐	☐	☐	
Other	☐	☐	☐	

Assessed level of risk and engagement *(circle)*	Low	Low/Med	Med	Med/High	High
	1	2	3	4	5

Authorised leave arrangements	☐ Nil	☐ Unaccompanied CHHS/off campus	☐ Staff/family accompanied	☐ Overnight / weekend
	time:			

Access to electrical items: ☐ Electronic devices/s ☐ Headphones ☐ Charger cord/s

Signature	Print name	Designation	Date	Time
		Psych Reg/ Consultant		
		Nurse		
		Nurse in Charge of Shift		

Revised Risk Assessment

Please refer to *AMHU Operational Procedure* for instruction on assessing level of risk and engagement

Name of inpatient unit:	Date:	Y = Yes N = No U = Unknown

Description *(tick)*	Y	N	U	Action plan from assessment and rational for management (include conditions for leave, any new collateral information
Suicidality	☐	☐	☐	
Self-harm	☐	☐	☐	DAY Action Plan
Substance misuse	☐	☐	☐	
Aggression	☐	☐	☐	
Cognitive Impairment	☐	☐	☐	
Inappropriate disinhibition	☐	☐	☐	
Medical Condition	☐	☐	☐	
Level of non-compliance	☐	☐	☐	NIGHT Action Plan
Disorganisation	☐	☐	☐	
Absconding	☐	☐	☐	
Falls/nutrition	☐	☐	☐	
Agitation	☐	☐	☐	
Other	☐	☐	☐	

Assessed level of risk and engagement *(circle)*	Low	Low/Med	Med	Med/High	High
	1	2	3	4	5

Authorised leave arrangements	☐ Nil	☐ Unaccompanied CHHS/off campus	☐ Staff/family accompanied	☐ Overnight / weekend
	time:			

Access to electrical items: ☐ Electronic devices/s ☐ Headphones ☐ Charger cord/s

Signature	Print name	Designation	Date	Time
		Psych Reg/ Consultant		
		Nurse		
		Nurse in Charge of Shift		

REVISED CLINICAL RISK ASSESSMENT AND MANAGEMENT 35263

35263(0818)

Acknowledgement to North Western Mental Health – Clinical Risk Assessment and Management (CRAAM)

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ACT **Health**

Acute Adult Mental Health Services (AAMHS)

REVISED CLINICAL RISK ASSESSMENT AND MANAGEMENT

Revised Risk Assessment									
Please refer to *AMHU Operational Procedure* for instruction on assessing level of risk and engagement									
Name of inpatient unit:				**Date:**				**Y = Yes N = No U = Unknown**	
Description *(tick)*	**Y**	**N**	**U**	Action plan from assessment and rational for management (include conditions for leave, any new collateral information					
Suicidality	☐	☐	☐						
Self-harm	☐	☐	☐	DAY Action Plan					
Substance misuse	☐	☐	☐						
Aggression	☐	☐	☐						
Cognitive Impairment	☐	☐	☐						
Inappropriate disinhibition	☐	☐	☐						
Medical Condition	☐	☐	☐						
Level of non-compliance	☐	☐	☐	NIGHT Action Plan					
Disorganisation	☐	☐	☐						
Absconding	☐	☐	☐						
Falls/nutrition	☐	☐	☐						
Agitation	☐	☐	☐						
Other	☐	☐	☐						
Assessed level of risk and engagement *(circle)*	**Low**		**Low/Med**		**Med**		**Med/High**		**High**
	1		2		3		4		5
Authorised leave arrangements	☐ Nil	☐ Unaccompanied CHHS/off campus			☐ Staff/family accompanied		☐ Overnight / weekend		
	time:								
Access to electrical items:	☐ Electronic devices/s		☐ Headphones		☐ Charger cord/s				
Signature	**Print name**				**Designation**		**Date**		**Time**
					Psych Reg/ Consultant				
					Nurse				
					Nurse in Charge of Shift				

Revised Risk Assessment

Please refer to *AMHU Operational Procedure* for instruction on assessing level of risk and engagement

Name of inpatient unit: **Date:** **Y = Yes N = No U = Unknown**

Description *(tick)*	**Y**	**N**	**U**	Action plan from assessment and rational for management (include conditions for leave, any new collateral information
Suicidality	☐	☐	☐	
Self-harm	☐	☐	☐	DAY Action Plan
Substance misuse	☐	☐	☐	
Aggression	☐	☐	☐	
Cognitive Impairment	☐	☐	☐	
Inappropriate disinhibition	☐	☐	☐	
Medical Condition	☐	☐	☐	
Level of non-compliance	☐	☐	☐	NIGHT Action Plan
Disorganisation	☐	☐	☐	
Absconding	☐	☐	☐	
Falls/nutrition	☐	☐	☐	
Agitation	☐	☐	☐	
Other	☐	☐	☐	

Assessed level of risk and engagement *(circle)*	**Low**	**Low/Med**	**Med**	**Med/High**	**High**
	1	2	3	4	5

Authorised leave arrangements ☐ Nil ☐ Unaccompanied CHHS/off campus ☐ Staff/family accompanied ☐ Overnight / weekend

time:

Access to electrical items: ☐ Electronic devices/s ☐ Headphones ☐ Charger cord/s

Signature	**Print name**	**Designation**	**Date**	**Time**
		Psych Reg/ Consultant		
		Nurse		
		Nurse in Charge of Shift		

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35263(0818)

Acknowledgement to North Western Mental Health – Clinical Risk Assessment and Management (CRAAM)

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Attachment 3 - Record of Observations Clinical Risk Re-Assessment

Canberra Health Services

Mental Health, Justice Health, Alcohol and Drug Services

ARC OBSERVATION CHART

Complete details or affix label

URN: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

Room No: _____

AT RISK CATEGORIES (ARC)

ARC	Risk Level	Engagement and Observation	
1	Low	General:	Engagement with the person every 2 hours, including oversight of attending meals and the unit program.
2	Low / Medium	Intermittent:	Engagement with the person every 50-60 minutes.
3	Medium	Frequent:	Engagement with the person every 20-30 minutes.
4	Medium / High	Close:	Person to be sighted every 10-15 minutes. Daily review of Clinical Risk Assessment and Management (CRAAM).
5	High	Continuous:	Constant visual observation or within arm's length at all times, as determined by the treating team. Daily review of CRAAM.

Note:
1) If a person's ARC level can be reduced overnight, an overnight plan can be documented in the comments section of the CRAAM by the Psychiatry Registrar/Consultant Psychiatrist.
2) A Registered Nurse can increase the ARC, however the treating team must complete a Revised CRAAM as soon as practicable.
3) Times of observations must be recorded at the actual time of the sighting and must be randomised within the designated time period.

Date	Time sighted	ARC Level	Location and activity	Sighted by (print name)	Signature	Designation

DO NOT WRITE IN THIS BINDING MARGIN

ARC OBSERVATION CHART

60426(0519)

60426

Page 1 of 2

Date	Time sighted	ARC	Location and activity	Sighted by (print name)	Signature	Designation
Consumers name:						

DO NOT WRITE IN THIS BINDING MARGIN

60426(0519)

Page 2 of 2

Attachment 4 – Step by step process to completing an Unauthorised Leave of Admitted Person from a MHJHADS Inpatient Facility

Step by step process to completing an Unauthorised Leave of Admitted Person from a MHJHADS Inpatient Facility- CAMHS Adolescent Unit	
Nurse to complete	1. Search the unit (all rooms and social areas) and the building surrounds (front and sides of building). If the person has failed to return from leave, continue from step 2.
Nurse to complete	2. Contact the person by phone (details on DHR or leave sign-out sheet).
Nurse to complete	3. Contact Security services by paging through switch (dial 9, request to page security services). • Ask security to review CCTV footage. • Provide a physical description of the person (may request legal status).
Nurse to complete	4. Contact the persons parent, carer or guardian.
Nurse to complete	5. Contact treating team (business hours) or on call-registrar (after hours) to discuss: • Risks (aggression, suicidal ideation, misadventure, reputation, substance misuse).
** A joint decision is made of whether the person is "at significant risk" or "not at significant risk" documented on DHR (File note)**	
Nurse to complete	6. If the person is NOT at significant risk, consider putting the person on extended leave, amending CRA and contacting community team/Access MH. The person and NOK will be informed of same (if contactable). ****AFP not required****
Nurse to complete	7. If the person is at significant risk, and contactable, the person will be requested to return, and offer assistance to return (assistance may include, allied health, community team, Access MH). **AFP or ACTAS can be notified if risks are considered too high, or above assistance fails (discuss first with above doctors). This is only a notification of emergency services, not a request of an emergency response – this will occur ASAP**
Nurse to complete	8. If the person is at significant risk, not contactable, or refusing to return and is under the *Mental Health Act 2015*, the community team and/or Access MH will be contacted to develop a return plan for the person (Community team or Emergency services response).

Nurse to complete	9. If an Emergency response is required, AFP can then be notified. AFP Ops SGT. Ph: 51270057. The RISK assessment form on DHR will be completed and sent to AFP. The AFP may require, or request, Emergency Detention paperwork or the Treatment Plan and Location Determination form. Via FAX and/or email: actcommunications@afp.gov.au **An AFP or ACTAS emergency response will only be initiated when the above assistance has failed, the person is at significant risk, and requires an emergency response to return them to the unit (discuss first with above doctors). This request of emergency services will occur ASAP**
Nurse to complete	10. Contact ADON and Clinical Director. Inform them of plan (business hours). OR Contact Afterhours Hospital Manager and Director on-call. Inform them of plan (afterhours).
** Document all steps taken and ALL notifications on DHR (File note) and in a RISKMAN**	
Nurse to complete	11. If the person returns within 48hours: • Notify same people • Medical review upon return • Consider Psychiatric review If the person DOES NOT return within 48hours: • Discussion with Treating team and Community • Teams, including admission demand in ED • *Person may be discharged after the above Discussion*
Document all steps taken on DHR (File note)	