Canberra Health Services
Operational Guideline
Management of Mental Health beds in the general hospital

Contents

Guideline Statement

The use of general hospital beds for the short-term management of patients admitted under mental health is a practice that has been used over time.

Mental Health Justice Health, Alcohol and Drugs Service (MHJHADS) supports the treatment of mental health consumers for their mental health condition on a general hospital ward in instances when it is safe to do so, ensuring that the person receives an appropriate level of care and treatment as they would if they were in the Emergency Department (ED) or in a Mental Health Unit. The person will remain under the care of the MHJHADS team.

There may be occasions when it may be suitable to place a person who is detained under the Mental Health Act 2015, within a general hospital ward. The risk of harm to self or others should be considered, including the completion of a Clinical Risk Assessment (CRA). Only consumers with a Low or Low/Medium risk will be admitted to a general hospital ward. Under no circumstances should a person with a CRA indicating Medium/High or High risk be admitted to a general hospital ward.

Key Objective
The key objectives of the document are to provide guidelines for staff caring for mental health consumers cared for on a general hospital ward when inpatient mental health beds are not available.

Alerts

- People who are admitted to general hospital wards for mental health care and treatment, care and support must not pose any significant or serious risk to themselves, other patients within the same environment or to staff working within the general hospital wards.
- The option to use mental health beds in a general hospital environment is a last resort when all other avenues for securing an appropriate mental health bed have been exhausted. Conditions in relation to the appropriate and safe clinical care of the patient must be ensured.

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Scope

These guidelines apply to all staff in the following areas:

- The Canberra Hospital Emergency Department
- Adult Mental Health Unit
- Ward 12B
- Mental Health Short Stay Unit

- Mental health Consultation Liaison
- Canberra Hospital Patient Flow Unit
- All staff accepting co-located admitted people under the responsibility of the Mental Health team.

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Section 1 – Accepting people into a mental health bed within a general hospital environment

Operational Responsibility:
The responsibility to open mental health beds located in general hospital wards is the sole responsibility of the Executive Director of MHJHADS (in hours), or Executive on Call (out of hours). Once the decision is made to admit a mental health patient to a general hospital ward, the clinical and operational governance of these spaces is the responsibility of the Adult Inpatient Mental Health Services (AIMHS).

It is the preference of the AIMHS that the admission of mental health patients to a general hospital ward occurs within business hours on weekdays, or morning shifts on weekends. These are the times when additional supports are available. These include the expertise of the Territory Wide Mental Health Access Coordinator or the Weekend Adult Acute Mental Health Units Clinical Nurse Consultant (CNC).

Ultimately, however, the Chief Operation Office or delegate (in hours) and the Executive on Call (after hours) have the delegation to enable the admission of a mental health consumer to a general hospital ward, in alignment with CHHS16/235 Capacity Escalation Procedure.

When there is high peak demand, the Canberra Hospital Patient Flow Unit (Business Hours) or After-Hours Hospital Manager (AHHM) (After-Hours) facilitate the transfer to a general hospital bed. To do this, the

- CHS Patient Flow Unit will contact the Territory Wide Mental Health Access Coordinator (business hours) who in turn will escalate as per the CHS Capacity Escalation Procedure.
- The AHHM will contact the CHS Executive On-Call (After Hours), to discuss and seek approval.

Patient identification:

Suitability for admission to a general hospital ward is to be determined following specialist psychiatrist review (e.g. patients who are known to AMHU/MHSSU/12b teams and deemed suitable or patients who have been reviewed by the Mental Health Consultation Liaison (MHCL) Psychiatrist or the Consultant Psychiatrist on call and have been found suitable for admission). Patients cannot be admitted to general hospital wards after an initial assessment by the psychiatry registrar only.

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Section 2 – Care and responsibility

2.1 Nursing

The identified Mental Health beds in the general hospital ward at the Canberra Hospital come under the responsibility of the Mental Health Short Stay Unit (MHSSU) and Ward 12B with regards to nursing and administrative support.

Nursing staffing for the Mental Health beds in the general hospital ward will be provided Adult Acute Mental Health Service (AAMHS). Allocation of staff will be undertaken by the CNC Rostering and Recruitment, in consultation with the Ward 12B CNC and AAMHS Assistant Director of Nursing (ADON).

Staffing the clinical area allocated for mental health beds in the general hospital environment is based on a 1:4 ratio and includes at a minimum a full-time equivalent (FTE) Registered Nurse from the Adult Acute Mental Health Service per shift and one Assistant in Nursing per shift over a twenty-four-hour, seven day per week period.

The Ward 12B CNC has clinical and management responsibility of mental health staff working in the general hospital ward. Responsibilities of the CNC includes ensuring that staff are supported and have a direct reporting line to the CNC for any concerns or clinical issues and compliance with Canberra Health Service (CHS) Policies and Procedures that apply to the general hospital environment as well as any MHJHADS Policies, Procedures and Guidelines.

The Ward 12B CNC reports directly to the AAMHS ADON

2.2 Administration Support

The Ward 12B Administrative Support Officer (ASO) is responsible for providing administrative support for people admitted to mental health beds in the general hospital wards, exactly as is current practice within Ward 12B and MHSSU. The nursing staff will be able to contact the Ward 12B ASO as required to complete administrative requirements. It will be expected that the ASO attends the location where the people are receiving care and treatment at a minimum of once per day to collect any paperwork, files, or Mental Health Act 2015 documents.

2.3 Psychiatry Support

The person is formally admitted under the care of a designated Consultant Psychiatrist who is responsible for the ongoing psychiatric care of the person.

Clinical responsibility for patients admitted to general hospital wards lies with the Consultant Psychiatrist who has agreed to continue the care of the person and has transferred the

patient to this bed (from AMHU, Ward 12B or MHSSU). If a direct admission from the ED or another general hospital ward occurs, the Consultant Psychiatrist allocated to the MHSSU is the default Consultant Psychiatrist responsible for care.

The medical care (medical/surgical or otherwise) is provided by the Junior Medical Officer (JMO)/ Registered Medical Officer (RMO) of the admitting team (MHSSU, Ward 12B, AMHU). Psychiatric reviews on business days will be daily by the treating team. On weekends, reviews will occur as required. Out of hours medical cover is provided by the JMO assigned to mental health inpatient units.

In hours doctor to patient ratios will be maintained as per RANZCP requirements.

2.4 Allied Health

People admitted to the general hospital wards are able to access the therapeutic program in Ward 12B. Most patients are expected to have unaccompanied leave and be able to make their way to Ward 12B independently, or otherwise accompanied by the Registered Nurse (RN) and Assistant in Nursing (AIN) allocated to the general hospital environment.

The Allied Health Assistant in Ward 12B will facilitate the transfer of people to and return from Ward 12B.

Lunch for people attending Ward 12B from the general hospital will be provided in Ward 12B.
If it is considered unsuitable for people to attend the therapeutic group program or a person refuses to attend, then the transfer of all people will not occur, and lunch will be provided in the area where the people are in the general hospital.

In addition, the Allied Health Professionals allocated to AMHU and Ward 12B will also be responsible for coordinating and facilitating any allied health supports for those people in general hospital wards.

2.5 Medication and Medical interventions

Medication and other medical supplies will be provided by the ward where the people were originally admitted and stored in a Computer on Wheels on the general hospital ward. The administration of medication or medical interventions will be carried out by the AIMHS assigned Registered Nurse allocated to provide care to the people admitted to the area allocated.

When required, any interventions outside of the scope of the RN will be provided in discussion with the Ward 12B CNC and the JMO/RMO on-call. The on-call JMO/RMO may consult with the on-call Psychiatry Registrar or the on-call Consultant Psychiatrist to seek advice if further escalation of care is needed.

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Section 3 – Risk Assessment and Review

A thorough Mental Health and Clinical Risk Assessment is mandatory to establish the suitability of people being admitted to a mental health bed in the general hospital. Patients can only be admitted to general hospital wards if their risk profile allows treatment in such an environment. This is a clinical decision that includes discussion with medical, nursing, and allied health staff as required. Typically, patients will be a maximum ARC level 2 (see below). Some patients on ARC 3 may still be suitable for these beds, although this decision must be weighed up carefully.

People who have been admitted to a mental health bed in the general hospital ward must receive a Clinical Risk Assessment Review during each nursing shift. The At-Risk Category (ARC) will be reviewed each shift and discussed with the treating team or on-call Registrar if required.

Risk assessments are an integral part of the care provided to people admitted to a mental health bed in a general hospital environment and are best done collaboratively with the person, family/carer/nominated person, and the treating team. Risk assessments are recorded on the Clinical Risk Assessment (CRA) form on the Digital Health Record (DHR) to inform a decision about the level of risk management that the person requires (See *Adult Acute Mental Health Services (AAMHS) Operational Procedure*).

Engagement and interaction with the person is a clinically valid, therapeutic tool used to manage, contain and more accurately monitor issues of risk. In a mental health setting, the CRA reinforces this important concept through the use of therapeutic engagement and observation throughout admission to Hospital, based on assessed level of risk and principle risk concern(s).

3.1 Risk Assessment

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	Close Engagement and Observation every 10- 15 minutes
Level 5	High risk	There are 2 levels of Continuous Engagement and Observation: • Constant visual observation • Constant proximity observation (arm length)

3.2 Leave under the Mental Health Act 2015

There are several leave provisions in the Mental Health Act 2015 that are applicable to involuntary person detained in a mental health facility. Providing a person with leave is recognised as an important and integral part of the care and rehabilitation process.

No provision for leave for any reason will be permissible until reviewed by the Psychiatrist responsible for the consumers care and treatment. The On-call Psychiatrist is not authorised to approve leave for consumers admitted to a mental health bed in the general hospital environment unless they have sighted and reviewed the consumer and documented in the DHR.

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).

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

3.3 Increasing the Level of Observation

The Registered Nurse responsible for the area identified for caring for people admitted to mental health beds in the general hospital environment has the authority to increase an ARC score. Such decisions and the rationale must be recorded within the person's clinical file notes and a CRA re-assessment form completed. The person is to be reviewed by their treating team as soon as practicable.

If the consumer's CRA increases to medium risk, a decision on whether the patient is still suitable for hospital general hospital ward must be made by the MDT. If the consumer's CRA increases to Medium High or High Risk, the RN must immediately contact the Territory Wide Mental Health Access Coordinator (Business Hours), Weekend CNC or the Patient Flow Unit (After Hours) to arrange an urgent transfer to a suitable inpatient mental health unit. If an immediate bed is unable to be located the Ward 12B CNC must be contacted to request appropriate staffing support (e.g. a Security person, Wards person or nurse special) in the area and the person placed on either ARC 4 or 5 as discussed with the treating team. Afterhours, the consumer may require review by the on-call psychiatry registrar. Transfer to another mental health inpatient unit should be coordinated through the team leader of the

receiving unit and the nurse caring for the consumer. The bed management unit should also be informed.

The Patient Flow Unit/After Hours Hospital Manager and the Territory Wide Mental Health Access Coordinator will continue to identify the first available inpatient mental health bed. Changes within the level of observation must be communicated to the person and efforts made to engage their cooperation within their treatment, care, and support. In addition, the change in the person's level of observation has to be communicated to other clinicians during the hand over process and documented in the DHR and bed list.

3.4 Decreasing the Level of Observation

Evidence to support a decrease in level of observation must be based upon documentation, verbal reports and observed behaviour to suggest that the level of risk has reduced.

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

Once the decision to reduce the level of observation has been agreed in consultation with the treating Psychiatrist, the rationale for this decision must be fully documented within the person's DHR on the Clinical risk re-assessment form.

All changes within the level of observation must be communicated to the person and efforts made to engage their cooperation within their prescribed care. In addition, the change in the person's level of observation must be communicated to other clinicians during the hand over process.

The results of the review are to be communicated to the clinicians during the hand over process and to the person who it affects.

3.5 Clinical Risk Assessment (CRA) Review

A review of the CRA is to take place during the Multi-Disciplinary Team (MDT) meeting when the person's care is being discussed. The result of the review and rationale for the decision is to be documented in the person's clinical notes.

Additionally, CRA reviews are to be completed by medical staff in consultation with nursing staff on the following occasions:

- If a person's risk factors are perceived to have changed due to changes in their mental state or behaviour, and
- Prior to a person's discharge.

3.6 Observation Forms

An ARC Observation form must be completed for each person by the Registered Nurse or the medical team.

All observations are to be recorded at the actual time stating the date, the actual time sighted, (not an approximation), location/activity and the name of the staff member sighting the person.

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Section 4 – Management of challenging behaviour or at-risk situations

During the course of the persons admission to a mental health bed in a general hospital environment there may be occasions when a person may pose a significant risk to themselves or others.

AAMHS nursing staff will be available within the area to identify any escalation in at risk situations or notable deterioration in mental state.

It is important to recognise potential for violence and aggression that may be due to treatment, social factors, illness/health issues, and put strategies in place to manage risk. Rapid assessment and early intervention can prevent or reduce the risk of harm in a violent or aggressive incident.

If the person is becoming a risk to themselves or others the nurse must attempt de-escalation techniques to defuse any further deterioration or increase in risk. The registered nurse should request that AIN seek assistance from the ward staff in the immediate location and contact the Ward 12B CNC to attend the area where the Nurse and person is located (see *Occupational Violence Policy or Procedure* and Adult Acute Mental Health Services (AAMHS) Operational Procedure).

On occasions where the person becomes aggressive and threatening the nurse should leave the immediate area but be able to maintain visual contact with the person and request a Code Black is called by either the ward staff in the area or by the AIN.

The Wards 12B CNC or Weekend CNC must attend all Code Black situations within the area, unless a similar or higher risk code is called in Ward 12B or the MHSSU.
If the CNC is unable to attend the Code Black, they should come to the area following de-activation of the code to support and review the incident.
Afterhours, the Ward 12B team leader must attend all Code Black situations within the area, unless a similar or higher risk code is called in Ward 12B or the MHSSU.
If the 12B team leader is unable to attend the Code Black, they should come to the area following de-activation of the code to support and review the incident.

4.1 Immediate Response to Actual or Potential Patient, Consumer or Visitor Violence or Aggression

Staff safety and the safety of patients, consumers and the public are paramount. The response to violence and aggression should be proportionate to the level of violence and aggression being displayed (see O*ccupational Violence Policy or Procedure* and Adult Acute Mental Health Services (AAMHS) Operational Procedure).
Options for action include:

- Attempting to de-escalate the situation where possible using defusing techniques learnt in training such the Canberra Health Services Occupational Violence training).
- Involving a carer or support person in de-escalation if available and as appropriate
- Consideration of review of the patient or consumer by a clinician e.g. violence due to pain, impairment
- Advise the violent person that assistance has been requested and seek support from other staff, and
- If the person is a visitor, or not an inpatient, request that the person leave the immediate area.

If unable to de-escalate the situation follow the Code Black procedures for your location. Emergency Plans for all CHS and ACT Health Directorate locations are available on the ACT Health intranet by going to HealthHub Home - Emergency & Safety - Emergency Plans

To call a Code Black staff should:

- Dial 2222 and call a Code Black
- Provide details of the incident (location, code)

In addition, staff should

- Attempt to de-escalate the situation where possible using defusing or de-escalation techniques
- Involve a carer or support person in de-escalation if available and as appropriate
- Consider of review of the patient or consumer by a clinician e.g. violence due to pain, impairment.
- Advise the violent person that assistance has been requested and seek support from other staff, and
- If the person is a visitor, or not an inpatient, request that the person leave the immediate area.

4.2 Absent Without Leave or unauthorised leave

When a person cannot be located or has not returned from approved leave, refer to the *Canberra Health Services Missing Patient Procedure.*

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Section 5 – Clinical Handover

Handover takes place according to the CHS *Clinical Handover Procedure* available on the Policy and Guidance Documents Register.

Clinical Handovers will occur at the consumer's bedside where possible. This should occur on every shift as a minimum. Opportunity should be provided at each handover for consumers/carers to be involved. The involvement of carers or visitors in handover can only occur following consent from the consumer.

Whilst it is preferable that handover occur at the persons bedside, it is recognised that some private or sensitive information may need to be discussed that may cause distress or deterioration in the person's mental state. Matters related to confidentiality should also be recognised.

At times when privacy and confidentiality are a concern and need to be recognised the handover may take place elsewhere, such as a common private area on the ward or office space.

When on occasions the handover needs to take place in an area away from the person's clinical area there should be one (1) member of the clinical team or AIN present at all times.

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Section 6 – Discharge/Transfer

It is the intent of this guideline that, when required, general hospital wards are utilised for patients who are currently admitted to a mental health unit and present with the lowest possible acuity. Transfers to general hospital wards should be facilitated during the working hours of the Territory Wide Mental Health Access Coordinator and AMHU/Ward 12B or weekend CNC as a preference. Noting after hour protocols are also in place (see section 1).

As per section 1 of this document, there is provision for a person to be directly transferred from the ED post review from a Consultant Psychiatrist or by the On-call Consultant Psychiatrist.

All patients admitted under Psychiatry receiving care in a general hospital ward must be transferred to a mental health inpatient bed as soon as is practicably possible depending on acuity, risk, and bed availability.

The Territory Wide Mental Health Access Coordinator (business hours) or weekend CNC is responsible for identifying a suitable bed within a timely manner. The Acuity and Clinical Risk

of the person including staff and the environment are considerations when determining bed availability and transfer.

There may be occasions that the person transferred to a mental health bed in a general hospital environment only requires a short period of care and treatment. On these occasions the person may be discharged home directly from the area without requiring a transfer to a mental health inpatient unit.

All people admitted to a mental health bed in a general hospital environment are required to have an Estimated Discharge Date (EDD) recorded in their clinical file. The EDD may be moveable, in that the EDD is dependent on mental state improvements or deteriorations, which may change from the initial EDD.

When a decision is made to discharge a person, the RN must immediately inform the Territory Wide Mental Health Access Coordinator, Ward 12B CNC and Ward clerk in hours, or the Weekend CNC/CHS Patient Flow and Ward 12B Team after hours.

Pre-transfer observations, for arranging the transfer, and for ensuring adequate communication of clinical and risk information that would include all relevant documentation of the persons management plan, should accompany the patient.

The bed area should immediately be made ready for the next admission by following usual CHS procedures.

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Evaluation

Outcome
Patients admitted under MHJHADS teams placed in a general hospital ward are managed as per this procedure.

Measure
- Annual review of clinical incidents related to MHJHADS patient in general hospital ward
- Annual review of consumer feedback related to MHJHADS patient in general hospital ward

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Related Policies, Procedures, Guidelines and Legislation

Policies
- Occupational Violence Policy
- Work Health and Safety

Procedures

- Adult Acute Mental Health Services (AAMHS) Operational Procedure
- Emergency Department and Mental Health Interface
- Admission to Discharge Procedure- (adults and children)
- Occupational Violence Procedure
- Dynamic Risk Assessment
- Clinical Handover Procedure
- Missing patient
- Assessment of Decision making Capacity and Supported Decision making for people being treated under the Mental Health Act 2015
- Missing Patient Procedure
- Alert Management

Guidelines

- Challenging Behaviour Guideline

Legislation

- *Health Records (Privacy and Access) Act 1997*
- *Human Rights Act 2004*
- *Work Health and Safety Act 2011*
- *ACT Mental Health Act 2015*

Other

- Australian Charter of Healthcare Rights
- ACT Public Sector Nursing and Midwifery Safe Care Staffing Framework
- ACT Public Sector Nursing and Midwifery Enterprise Agreement, 2020-2022

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Search Terms

Bed Management, MHJHADS, Adult Acute Mental Health Services, AAMHS, Mental Health Short Stay Unit, MHSSU, Adult Mental Health Unit, AMHU, Mental Health beds, Mental Health Consultation Liaison, MHCL, Mental Health Pod, Territory Wide Mental Health Access Coordinator

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Policy Team ONLY to complete the following:

Date Amended	*Section Amended*	*Divisional Approval*	*Final Approval*
30 September 2021	*New Document*	*Karen Grace, ED-MHJHADS*	*CHS Policy Committee*
21 March 2022	*Ratio information updated*	*Karen Grace ED NMPSS*	*CHS Policy Committee Chair*
16 November 2023	*Related Policies, Procedures, Guidelines and Legislation*	*Policy Team*	*Policy Team*

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