Procedure | Canberra Health Services

Observation through Therapeutic Engagement in MHJHADS Mental Health Inpatient Settings

Contents

Purpose

The purpose of this procedure is to identify the minimum requirements for Mental Health, Justice Health, Alcohol and Drugs (MHJHADS) inpatient mental health services relating to observation through therapeutic engagement. This procedure outlines clinicians' responsibilities in ensuring therapeutic engagement and observation levels align to interventions and care planning to assess and address risk of harm to consumers and staff. This procedure outlines the minimum period between each interaction, however there may be situations that require more frequent interactions.

The primary aim of observation through therapeutic engagement is the purposeful gathering of information to inform clinical decision making within the inpatient setting, and to support safety of the consumer and others, protection from harm and maintenance of wellbeing. This practice supports optimum care and timely escalation of care during psychological or physical deterioration. Determination of the level or risk and completion of observation requires clinicians to be person centred and to engage therapeutically with those receiving care.

This procedure supports the implementation of the National Safety and Quality Health Service Standards:

- Clinical Governance Standard
- Partnering with Consumers Standard
- Comprehensive Care Standard
- Communicating for Safety Standard
- Recognising and Responding to Acute Deterioration Standard

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Scope

This procedure applies to all people being treated within MHJHADS inpatient mental health services:

- Adult Mental Health Unit (AMHU)
- Ward 12B
- Mental Health Short Stay Unit (MHSSU)
- Adult Mental Health Rehabilitation Unit (AMHRU)
- Dhulwa Forensic Mental Health Unit (DMHU)
- Gawanggal Forensic Mental Health Unit (GMHU)
- Child and Adolescent Unit (CAU)
- Eating Disorders Residential Treatment Centre (EDRTC)

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

- Medical staff
- Nurse Practitioners
- Nurses

- Student nurses under direct supervision by a Registered Nurse

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Section 1 – Promoting Recovery and Trauma Informed Care

The role of staff working within an inpatient mental health setting is to provide treatment and care in a manner that promotes recovery and safety. A requirement of staff working within these settings is to engage in person-centred, recovery orientated practices, that place the consumer at the centre of care to support their individual recovery towards a meaningful life. Many people accessing mental health services have experienced trauma and may find some forms of observation to be re-traumatising. For consumers under some levels of observation there may be feelings of a loss of privacy, autonomy, and emotional distress. Staff have a responsibility to provide care in an environment that prioritises safety, trustworthiness, and transparency. Through practicing in a way that is trauma informed, staff have the opportunity to enhance the care consumers receive by:

- Understanding that all people may have experiences of trauma
- Being mindful of past experiences and using this information to help form holistic and integrated treatment plans
- Having awareness of how re-traumatisation during observation may occur and could be prevented
- Help people understand why certain forms of observation are in place

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Section 2 – Roles and Responsibilities

Consumers and Carers

Inclusion of consumers and carers in meaningful communication and treatment planning is essential for developing a person-centred, collaborative approach to care planning and identification and mitigation of risks. Every effort should be made to include the consumer in their care planning to support their recovery journey.

Medical Staff and Nurse Practitioners

The CRA must be completed by a Medical Officer/Nurse Practitioner (in the Eating Disorder Residential Treatment Centre) to determine the level of observation required for each consumer. When determining a CRA/ARC the Medical staff/Nurse Practitioner should discuss and collaborate with the multidisciplinary team (MDT), the consumer and their carer when possible. The rationale and goals of the CRA/ARC must be clearly defined and documented in the DHR and verbally handed over to the CNC/Nurse in Charge (NiC), with specific areas of focus identified to assist nursing staff carrying out the engagement and observation and ongoing targeting of nursing care. The application of an ARC should not be applied at a default level for certain clinical areas (except seclusion) and must ensure that therapeutic goals are maintained. CRAs must be assessed regularly in line with Table 1

(Section 5) to ensure the assessment of risk and ARC are appropriate to the care needs of the consumer. Medical Officers/Nurse Practitioner are required to provide feedback to the consumer, family and carers regarding the observation levels and assessment to ensure ongoing collective engagement of all parties within treatment and care planning.

Clinical Nurse Consultant

The Clinical Nurse Consultant (CNC) is responsible for setting the clinical standards in their unit and supporting nursing staff to deliver safe, high-quality care. The CNC is responsible for ensuring that all nursing staff are aware and can fulfill their responsibilities in relation to observation through therapeutic engagement. The CNC must ensure that all consumers have a current CRA/ARC. The CNC or delegate (e.g. Nurse In Charge (NIC)) should ensure that any staff on continuous observations are rotated regularly to manage fatigue and that each consumer has an allocated nurse on each shift. The CNC or delegate is to escalate to the responsible Medical Officer or Nurse Practitioner a review of nurse-initiated increase in ARC.

Nurses

While all health professionals are involved in the delivery of care to consumers in mental health inpatient facilities, the practice of observation through therapeutic engagement lies with the nursing team to complete.

Nurses may at any time increase the level of care based on clinical assessment or clinical judgement, though only a medical office/nurse practitioner may decrease the level of care. Documentation of observations are to be recorded on the At Risk Category (ARC) Observations form located in the consumer's digital health record (DHR). Progress notes in the consumer's DHR will reflect the engagement with the consumer throughout the shift as outlined in Table 1. The documentation of engagement should include the consumer's mental state, subjective and objective risks and relevant interactions with staff and other persons, using recovery orientated language. Observations are to be conducted regularly according to the assessed level of risk or concern. Where observations have been missed, the reason why must be documented on the consumer's observation form by the responsible nurse. The ARC level, engagement and resulting assessments must form part of each clinical handover. Staff allocating and maintain observations should explain to the consumer their level of observation and the requirements relating to this level of observation to ensure engagement and participation of the consumer in their health care.

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Section 3 – Observation through Engagement

Observation alone has often been implemented by assigning a nurse to monitor a consumer within a designated period of time, aiming to ensure their safety and care needs are being met. However, relying solely on observation can be viewed as non-therapeutic and, at times, even harmful. This practice can be perceived as custodial or passive, where nursing staff simply track the consumer's physical location on the ward and complete documentation without meaningful interaction. Research and best practice evidence emphasise the

necessity of regular therapeutic engagement with consumers throughout their care. Effective mental health care requires observation that extends beyond merely noting a consumer's location, position, and activity; it requires actively engaging with the consumer to address their emotional and psychological needs.

Therapeutic engagement provides a foundation for recovery orientated care. When staff actively engage with a consumer, they work within an integrated triad of listening, understanding, and responding. These are all vital in planning care with consumer involvement and for creating an environment that facilitates emotional and personal growth. The consumer's feelings and priorities are acknowledged, validated, and they are actively engaged with in a constructive way. Therapeutic engagement in mental health inpatient settings is strongly associated with reductions in aggression, violence, self-harm, absconding and an increase in positive consumer experiences and perceptions of the service. The need for clinical staff working in mental health inpatient settings to therapeutically engage with consumers has been identified as a priority in research and policy.

When staff are therapeutically engaging with a consumer they should:

- Work in partnership with consumers and carers
- Determine the whereabouts and activity of the consumer
- Interact and speak with the consumer about their wellbeing
- Listen to the consumer without judgment, showing kindness and compassion
- Objectively assess and review a consumer's mental state and general behaviour to identify potential triggers, strengths, and progress towards recovery
- Determine current risks and identify if any other interventions are required
- Ensure the consumer has their personal needs met
- Establish whether the overall environment looks and feels safe
- Encourage the consumer to participate in activities available
- Be honest about what can and can't be done within the limitations of the environment/service
- Be visible
- Be hopeful, show people they matter

Some simple ways to engage with someone in the moment include:

- Asking the person what they are interested in e.g. hobbies, pets
- Do a mindfulness exercise
- Ask the consumer to engage in an activity with you, such as a game, crossword or art
- Read a paper together
- Listen to and discuss music
- Play basketball, or go for a walk around the courtyard

Understanding and applying a strengths-based approach is integral to identifying and managing risks, and empowers consumers to develop resilience, coping mechanisms and critical thinking skills. Encouraging consumers to believe in their capacity for growth and achievement of personal goals can assist to build protective factors against potential risks.

The determination of observation levels should be a collaborative process, including the multidisciplinary team (MDT), the consumer and their carer/family, and align with the consumers care requirements.

In determining observation levels, the least restrictive observation level, consistent with the consumers risks and need for engagement should be used. Further consideration must be given to the following:

- The consumer's clinical presentation
- Clinical risk assessment
- Care plans, Advanced Agreements and/or Advanced Care Directives
- Consumer demographics such as age, developmental stage, gender, and cultural background
- History of trauma
- Providing care in the least restrictive environment possible, in the least intrusive way possible
- Collaboration and communication with the MDT, the consumer, and their carer

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Section 4 – Clinical Risk Assessment and Management (CRAAM)

Guiding Principles

Regular awareness and formal assessment of clinical risks are required to be performed throughout a consumer's inpatient episode of care and require regular review. The risk assessment process aims to keep consumers and staff safe through identifying and responding by anticipating outcomes and making collaborative decisions to adjust care and treatment strategies to prevent adverse outcomes. The risk assessment process is multifaceted, requires clinical judgment, and should be completed with both static and dynamic risk factors informing decisions.

Static, or enduring risk factors, are not subject to change, and can include factors such as age, ethnicity, and history. While static risk factors alone are incomplete predictors of risk, it is important to consider them during a risk assessment. Dynamic, or changeable risk factors, can change or alter over time and can include factors such as presenting symptoms (e.g. confusion), recent substance use or psychological stressors.

Risk Factors

Risk factors that may indicate the need for closer observation can include, but are not limited to:

- Suicidality or a history of previous suicide attempts or acts of self-harm
- Aggression or violent behaviours/harm to others, risk-rated utilising the Brøset or DASA
- 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 use
- History of inappropriate sexual behaviour
- Cognitive impairment
- Medical condition
- General vulnerability

Risk Assessment

The requirements for the completion of CRAs for MHJHADS mental health inpatient units are outlined in Table 1. An ARC will be established at the completion of the initial CRA. This will determine the level of observation required for each person admitted to MHJHADS mental health inpatient services (see section 5).

Risk assessment should always aim to provide care in the least restrictive means possible. The initial risk assessment is comprehensive and includes static and dynamic risk factors, history of risk, and is informed by relevant collateral and corroborative information. Collateral and corroborative information should be sought from the person's General Practitioner and Nominated Person and, where consent is given, their carer, family and/or guardian, and relevant others who may have useful information. Where this type of information is not available, the level of assessment confidence needs to be considered. Low assessment confidence flags the need for a more conservative approach to managing risks when developing a risk management plan with the person.

Increasing the level of observation

Nursing staff have the authority to increase an ARC score however the NiC 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. The person is to be reviewed by their treating team as soon as practicable.

Changes within the level of observation must be communicated to the person and efforts made to engage their cooperation within their care/ treatment. 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 the person's DHR.

Decreasing the level of observation

Only a Psychiatrist/Medical Officer or Nurse Practitioner can decrease a level of observation. Evidence to support a decrease in level of observation must be based upon documentation and verbal reports and observed behaviour to suggest that the level of risk has reduced.

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

Note:

Any reduction in the ARC category and level of engagement and observation can only take place after the NIC/Care nurse **and** the Psychiatry Registrar or Consultant Psychiatrist have completed a CRA and downgraded the ARC score.

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.

Observation Forms

An ARC Observation flowsheet **must** be completed for each person by the clinician.

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.

Documentation of Therapeutic Engagement

The NSQHS Standards Communicating for Safety Action 6.11 outlines that:

"Undocumented or poorly documented information relies on memory and is less likely to be communicated and retained. This can lead to a loss of information, which can result in misdiagnosis and harm…For documentation to support the delivery of safe, high-quality care, it should:

- *Be clear, legible, concise, contemporaneous, progressive and accurate*
- *Include information about assessment, action taken, outcomes, reassessment processes (if applicable), risks, complications and changes"*

Contemporaneous documentation of active engagement with consumers must be completed at the minimum frequency outlined in Table 1. Documentation of engagement may include:

- Any care, treatment or safety planning completed with the consumer, including identification of any risks
- The nature of the engagement and any notable specific details or changes for the consumer such as changed behaviour or changes to their mental state
- Consumer strengths, preferences, priorities, concerns and perspectives
- Any Pro Re Nata (PRN) medication given and its associated effects

Canberra Health Services Clinical Handover Procedure.docx outlines key principles designed to guide and direct staff to implement a minimum standard for written and verbal communication about a consumers health care.

All clinical interventions and plans for treatment must be documented and include any relevant information that is likely to impact on the clinical care of the consumer.

Written handover of clinical information can be completed using either:

- ISBAR (introduction/identification, situation, background, assessment and recommendation)
- ISOAP (Introduction/Identification, subjective information, objective information, analysis/ action/ advice and plan).

Further information in relation to ISBAR and ISOAP can be found in the Procedure link above. CHS staff can choose the handover tool that best suits their clinical area, who the information is being communicated to and the information to be communicated.

Example of documentation of engagement:

Smart form Headings	Note contents
Engagement undertaken (e.g. location, what was the interaction or intervention)	Author sat with Jane in the lounge area today to identify strategies to manage distress and regulate emotions. Jane mentioned when at home she likes to dim the lights and listen to music. Discussed the options available to Jane on the unit and introduced her to the sensory modulation room.
Current mental state (e.g. response to the engagement, general activity, symptoms	Jane had showered and was wearing a new outfit today. She attended breakfast and was observed to have good oral intake. Jane described her mood as “getting better”. Jane was smiling and engaging throughout the conversation and denied any current thoughts of self-harm.
General comments (e.g. concerns from the consumer or staff, current impressions, consumer priorities, recommendations or actions taken/to be taken	Jane requested to speak with the Dr as she would like to take some leave with her Mum for lunch tomorrow.

CRA Review

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

- As indicated by the person’s ARC (see Table 1, Section 7).
- The CRA review frequency is to be reviewed during business hours and on weekends when clinically indicated by the NiC.
- If a person’s risk factors are perceived to have changed due to changes in their mental state or concerning behaviours
- When a person returns from being on unauthorised leave
- Prior to a person’s discharge
- Following an increase in DASA/Brøset
- Following a nurse-initiated increase in ARC

Access To Electronic Devices

During completion of the CRA, the Treating Team may consider whether the consumer can have access to electronic devices, such as a phone or tablet. All staff should familiarise themselves with CHS Procedure Consumer Mobile and Recording Devices Management.docx (sharepoint.com). Staff should consult their relevant unit Operational Procedure for further information around access to these devices.

Assistance Animals

During completion of the CRA, the Treating Team may consider whether the consumer is able to care for an assistance animal while on the unit. All staff should familiarise themselves with CHS Procedure Animal Visits Guideline.docx (sharepoint.com). Staff should consult their relevant unit Operational Procedure for further information.

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Section 5 – At Risk Category (ARC)

The ARC outlines the minimum level of observation for each consumer, based on the outcome of the CRA.

There are 5 levels of ARC observation:

Table 1

ARC Level	Level of Risk	Minimum required clinical observation and engagement frequency	Minimum documentation of engagement and assessment per shift		CRA Review Frequency
Level 1	Lower risk	General Observations – minimum 120-minute intervals This level of observation should include random and regular checks of the location and activity of the consumer every two hours.	This level of ARC requires a minimum of one (1) assessment of therapeutic engagement and observation by the consumers allocated	The documentation of each engagement must include: • The consumer's mental state • The current risks and concerns (both subjective and objective) • The interactions with staff and other persons,	Every 72hrs in acute services. Weekly in subacute and/or rehabilitation services.

			nurse in the DHR. This entry must be made following an observation round or as soon as practicable.	and be reflective of the targeted rationale for observation.	
Level 2	Lower to Medium risk	Intermittent Observations – *minimum* 60-minute intervals This level of observation should include random and regular checks of a consumer's location and activity within the unit at least every 60 minutes.	This level of ARC requires a minimum of two (2) assessment of therapeutic engagement and observation by the consumers allocated nurse in the DHR. This entry must be made following an observation round or as soon as practicable.		Every 48hrs
Level 3	Medium risk	Frequent Observations – *minimum* 30-minute intervals This level of observation should include random and regular checks of a	This level of ARC requires a minimum of three (3) assessment of therapeutic		Every 24-48 hrs

		consumer's location and activity within the unit at least every 30 minutes.	engagement and observation by the consumers allocated nurse in the DHR. This entry must be made following an observation round or as soon as practicable.		
Level 4	Medium to Higher risk	Close Observations – *minimum* 15-minute intervals This level of observation is significantly restrictive to mitigate risks for consumer who are assessed as being at a high level of concern. Nurses must regularly engage, and randomly observe consumers on this level at least every 15 minutes.	This level of ARC requires a minimum of four (4) assessment of therapeutic engagement and observation by the consumers allocated nurse in the DHR. This entry must be made following an observation round or as soon as practicable.		Every 24hrs
Level 5	Higher risk	Continuous supportive observation and engagement	This level of ARC requires a minimum of		Every 24hrs

		(specialling) – visual and/or at arms length Recording of the observations can reflect the time (eg write 13:15 to 14:00 with the consumer). Clinicians must not exceed an hour without documenting their observations.	four (4) assessment of therapeutic engagement and observation by the consumers allocated nurse in the DHR. This entry must be made following an observation round or as soon as practicable.		

ARC 1 (General Observation) – Minimum 120-minute intervals

Prior to any person being placed on Level One / general observation a full risk assessment must be completed by the admitting medical officer to assure that the individual does not pose any serious risk to either themselves or others. This initial risk assessment should also consider the potential vulnerability of the person within the unit.

Every person admitted 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.

Persons on ARC 1 observations should also be deemed to be unlikely to attempt to leave the unit on unauthorised leave.

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 person's DHR.

ARC 2 (Intermittent engagement and observations) – Minimum 60-minute intervals

This level of observations is considered suitable for those persons, who following a risk assessment, require 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 should 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.

ARC 3 (Frequent observations) – Minimum 30-minute intervals

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 should 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, 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.

ARC 4 (Close observations) – minimum 15-minute intervals

This level of observation should be used for persons who 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 5 observations (within arm's length).

The person must be informed of ARC 4 and if possible, their cooperation should be obtained. It is acknowledged gaining the person's cooperation may be difficult due to their presenting mental state; however, every effort must still be taken to actively involve the person, nominated person and, with consent, their carer and/or family 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 to mitigate the risk of self-harm, the NIC 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

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, or when a person is in seclusion. Upon identification of a risk that warrants an ARC 5 continuous engagement and observation, the NIC and medical staff should 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. When 1:1 specialling is required for an acutely unwell consumer, experienced staff (such as a senior RN/EN) should be allocated to the care of this consumer.

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
- Other vulnerabilities such as age, sexual disinhibition

Consumers may also be placed on an ARC 5 for other identified risks, such as a risk of falls. In this case, Assistants in Nursing (AINs) can be allocated to this role, based on the consumers clinical presentation and requirements of the unit.

Persons on ARC 5 should be reviewed by the treating team at least once every 24 hours. The following considerations should be made by staff:

- Cultural – another person of the same culture to be present
- Gender- preferences
- Language – interpreters to be present
- Disability – plain and appropriate language
- Aboriginal and Torres Strait Islander – officers to be present.

Consideration must be given for the removal of belongings that may be used to self-harm such as belts, dressing gown cords, shoelaces etc. 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 to mitigate the risk of self-harm, the NIC 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 is required to document all relevant interactions/interventions in the person's DHR following their observation period with

the person. It is acknowledged gaining the person's cooperation may be difficult due to their presenting mental state; however, every effort must still be taken to inform the person and actively involve them in this process whenever possible. It is expected that this level of observation should, 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.
- A treatment plan that outlines treatment goals and opportunities to target nursing care and activities
- Review of medication, this will include monitoring of side-effects and the effectiveness of any PRN medications.
- Consumer 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 ARC Observation Form at the time of handing over responsibility as should the oncoming member of staff about to commence the period of observation.

Alert: The NiC must establish a schedule at the commencement of shift to ensure ongoing observation and the management of fatigue whilst engaging in ARC 5. Requirements for this are to be identified in unit/service Operational Procedures.

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 nighttime risk level.

If risk management is dependent on the time of the day or the activities of persons (for example, awake or asleep), such details should be adequately recorded on the CRA (which includes both day and night action plan). Regardless, the risk management requirements for overnight are informed by the CRA and handed over to night staff at each night handover.

Overnight risk status must be recorded in the the person's DHR for each shift. If risk status has been changed overnight, clear rationale must be documented. For persons categorized as medium and high risk the minimum standard is hourly checks/observation. If the person is awake and exhibiting any signs of distress or agitation, the daytime observations should apply until the person is settled again.

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

Seclusion

If a person is secluded, the ARC category must be increased to an ARC 5 to reflect the increased observations required.

Prior to seclusion being ceased, the NIC and another registered nurse (RN) are to complete a clinical risk re-assessment form to determine the person's level of risk to either return to previous ARC, or to increase.

For further information relating to seclusion please see Seclusion of Persons Detained under the Mental Health Act 2015.docx

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Evaluation

Key Performance Indicators and Service Measures

- Incident management reports via Riskman:
  - Episodes of self-harm during a given period
  - Episodes of suicide attempts during a given period
  - Rates of Occupational Violence towards staff
  - Absconding rates
- Safewards Fidelity Checklist
- Relevant clinical indicators
- YES Survey feedback
- CRA/ARC Clinical Audit

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Related Policies, Procedures, Guidelines and Legislation

Policies

- *Nursing and Midwifery Board of Australia (NMBA) Requirements for Practice*

Procedures

- Seclusion of Persons Detained under the Mental Health Act 2015 Procedure CHS22/193
- Restraint and/or Forcible Giving of Medication to a Person Detained under the Mental Health Act 2015 CHS22/203
- Occupational Violence (OV) Procedure CHS22/026
- Initial Management, Assessment and Intervention for People Vulnerable to Suicide Procedure CHS21/359
- ? Ligature Procedure
- Clinical Handover Procedure CHS22/138

Legislation

- Mental Health Act 2015
- Forensic legislation
- *Health Records (Privacy and Access) Act* 1997
- *Human Rights Act* 2004
- *Work Health and Safety Act* 2011
- *Carers Recognition Act 2021*

Other

- Adult Acute Mental Health Services (AAMHS) - Operational Procedure CHS22/270
- Dhulwa Mental Health Unit – Operational Procedure CHS24/239
- Eating Disorders Residential Treatment Program Operational Guide
- Your Experience of Service (YES)

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Search Terms

Engagement, therapeutic engagement, observation, observation and engagement, clinical risk assessment, at risk category

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For Policy Team to complete:

Date amended	Section amended	Divisional approval	Final approval

This document supersedes the following:

Document number	Document name

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Acknowledgement of Country

Canberra Health Services acknowledges the Ngunnawal people as traditional custodians of the ACT and recognises any other people or families with connection to the lands of the ACT and region. We acknowledge and respect their continuing culture and contribution to the life of this region.

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