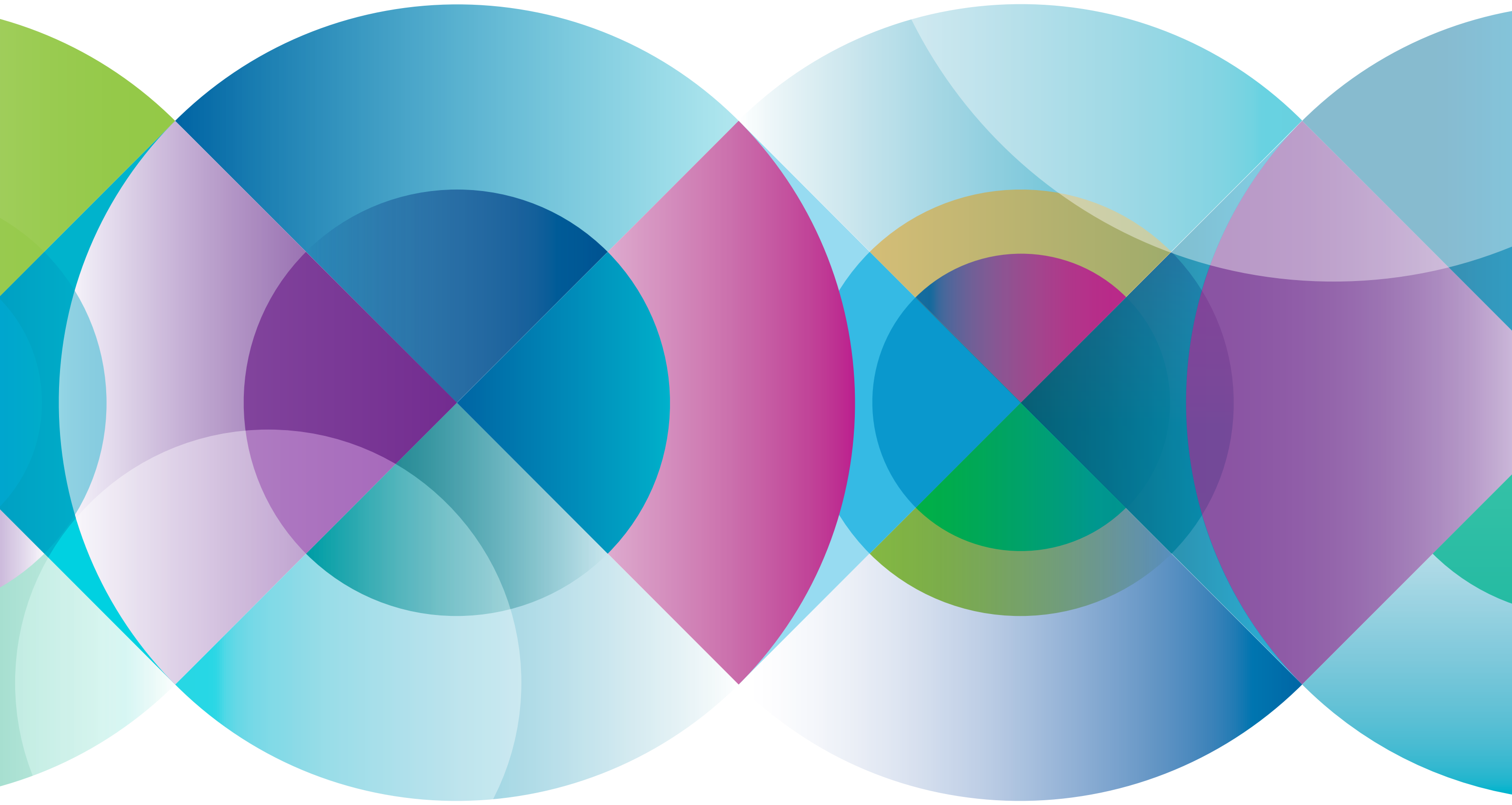
AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS
STANDARDS



National Safety and Quality Health Service Standards

User Guide for Acute and Community Mental Health Services

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Contents

Introduction

The Australian Commission on Safety and Quality in Health Care (the Commission) has developed the National Safety and Quality Health Service (NSQHS) Standards[1] in collaboration with the Australian Government, states and territories, the private sector, clinical experts, consumers, carers and families. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality-assurance mechanism, which tests whether relevant systems are in place to ensure expected standards of safety and quality are met. Importantly, these NSQHS Standards have provided a nationally consistent statement about the standard of care consumers can expect from their health service organisations.

The eight NSQHS Standards require the implementation of organisation-wide systems for clinical governance, partnering with consumers, healthcare associated infections, medication safety, comprehensive care, effective communication, blood management, and recognising and responding to acute deterioration.

The eight NSQHS Standards are:

Clinical Governance, which describes the clinical governance, and safety and quality systems that are required to maintain and improve the reliability, safety and quality of health care, and improve health outcomes for patients.

Partnering with Consumers, which describes the systems and strategies to create a person-centred health system by including patients in shared decision-making, to ensure that patients are partners in their own care, and that consumers are involved in the development and design of quality health care.

Preventing and Controlling Infections, which describes the systems and strategies to prevent infection, to manage infections effectively when they occur, and to limit the development of antimicrobial resistance through prudent use of antimicrobials, as part of effective antimicrobial stewardship.

Medication Safety, which describes the systems and strategies to ensure that clinicians safely prescribe, dispense and administer appropriate medicines to informed patients, and monitor use of the medicines.

Comprehensive Care, which describes the integrated screening, assessment and risk identification processes for developing an individualised care plan, to prevent and minimise the risks of harm in identified areas.

Communicating for Safety, which describes the systems and strategies for effective communication between patients, carers and families, multidisciplinary teams and clinicians, and across the health service organisation.

Blood Management, which describes the systems and strategies for the safe, appropriate, efficient and effective care of patients' own blood, as well as other supplies of blood and blood products.

Recognising and Responding to Acute Deterioration, which describes the systems and processes to respond effectively to patients when their physical, mental or cognitive condition deteriorates.

Scope

The Commission has developed the NSQHS Standards user guide for acute and community mental health services (the user guide) to support implementation of the NSQHS Standards. The user guide is intended to support members of the workforce when they are providing health services to people with existing or emerging mental ill health. These include:

- Community mental health services provided by Local Hospital Networks (LHNs)
- Mental health units in public and private hospitals
- Standalone mental health public and private hospitals
- Hospital in the home services.

Specialist treatment programs and services for consumers, carers and families can be provided in hospital settings, in community or outpatient settings, or in the home. The complete range of programs and services is referred to as the continuum of care. Not every person needs every type of service or program on the continuum, nor does every health service or hospital necessarily provide all the services on the continuum. Nonetheless, each element of the continuum is important to the needs of the community when responding to mental ill health.

Importantly, the NSQHS Standards are designed to facilitate the development of systems that can improve coordination and integration of care and manage the important transitions that occur as people move between services and settings.

This user guide is designed to provide strategies that can be applied in all settings where mental health care occurs. It also recognises that specialist community mental health services are as important as inpatient care for providing effective outcomes and ongoing care for consumers.

What is new in this user guide?

The user guide includes information to support mental health services to implement the NSQHS Standards. It recognises that acute and community mental health services most commonly operate in an integrated model and may be part of a larger health service. Specific information has been included for actions relevant to mental health services.

The user guide captures the intent of how actions in the NSQHS Standards are implemented in the context of delivering mental health services. Some of this information is common across health service types and the user guide avoids duplicating information already published in other NSQHS Standards resources.

The user guide draws on other national mental health policy documents. It also includes information sourced directly from stakeholders: consumers, carers and families, who told us what is important to them, and service providers who described how they have implemented the actions in their own services.

The user guide complements and builds on information contained in Commission resources and other key documents, including the:

- NSQHS Standards user guide for health services providing care for people with mental health issues[2]
- Map of the NSQHS Standards with the National Standards for Mental Health Services[3]
- National Model Clinical Governance Framework[4]
- NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health[5]
- National Safety and Quality Digital Mental Health Standards[6]
- NSQHS Standards Guide for Hospitals[7]
- National Safety and Quality Primary and Community Healthcare Standards[8]
- National Standards for Mental Health Services[9]
- National Mental Health Policy 2008.[10]

In particular, this user guide complements the NSQHS Standards user guide for health services providing care for people with mental health issues[2], which was designed for use in health services that do not specialise in mental health.

How to use the user guide

The user guide highlights specific actions in the NSQHS Standards that are key to delivering safe and high-quality mental health services (Table 1). The user guide is arranged by NSQHS Standard and each chapter contains:

- Discussion of how relevant actions apply in mental health services
- Suggestions and examples of implementation strategies.

Spotlight issues

The user guide also includes a number of spotlights on key issues. These focus on aspects of the delivery of mental health care that have been identified by stakeholders as important to them. The NSQHS Standards are designed to be implemented in an integrated way, and the spotlight boxes demonstrate the links between actions across the NSQHS Standards, and how these contribute to ensure the delivery of safe and high-quality mental health service at the point of care. The spotlight issues are:

- Aboriginal and Torres Strait Islander mental health and wellbeing
- Workforce
- Children and young people
- Responding to diversity
- Rights and responsibilities
- Working with carers and families
- Mental, physical and cognitive health care
- Trauma-informed and recovery-oriented mental health care
- Suicide prevention
- Minimising restrictive practices
- Transitions of care and integration of care.

Appendix 1 lists the linked NSQHS Standards actions from the spotlight issues.

Specific considerations for community mental health services

While implementation of the NSQHS Standards is typically managed across all settings within a mental health service, some actions have particular relevance for mental health services delivered in the community. These are highlighted in text boxes.

A note on language

The language we use is important and must be selected wisely. It has the power to offer hope and encouragement or to convey pessimism or low expectations. It can exacerbate or mitigate the significant stigma that exists towards people who experience mental ill health, alcohol and other drug use and suicide.

The terminology in common use across different domains in the health sector is not universal, particularly in referring to those who seek assistance from health services.

The NSQHS Standards, and some other published resources, use the term patient, and this is retained when these sources are quoted, for example, in the wording of the actions in the NSQHS Standards.

This user guide uses the term consumer for a person who uses, has used, or may use a mental health service.

The user guide uses the terms carers and families for the people who provide unpaid care and support to consumers.

The user guide refers to the Lived Experience workforce, which includes, but is not limited to, peer workers, consumer consultants and carer consultants.

There is a glossary at the end of the document.

More information

A range of other supporting resources to support mental health services to implement the NSQHS Standards are available on the Commission's website.

The Advice Centre provides support for health service organisations, surveyors and accrediting agencies on NSQHS Standards implementation.

Email: advicecentre@safetyandquality.gov.au

Phone: 1800 304 056

Table 1: Actions with high relevance for mental health services

Standards	Criterion	Item	Actions
Clinical Governance	Governance, leadership and culture	Governance, leadership and culture	1.01
		Organisational leadership	1.04 1.05
		Clinical leadership	1.06
	Patient safety and quality systems	Policies and procedures	1.07
		Measurement and quality improvement	1.08
		Risk management	1.10
		Incident management systems and open disclosure	1.11 1.12
		Feedback and complaints management	1.13 1.14
		Diversity and high-risk groups	1.15
		Healthcare records	1.16
	Clinical performance and effectiveness	Safety and quality training	1.20
		Performance management	1.22
		Credentialing and scope of clinical practice	1.23
		Evidence-based care	1.27
		Variation in clinical practice	1.28
	Safe environment for the delivery of care	Safe environment	1.29 1.30
Partnering with Consumers	Partnering with patients in their own care	Healthcare rights and informed consent	2.03 2.04 2.05
		Sharing decisions and planning care	2.06
	Health literacy	Communication that supports effective partnerships	2.09
	Partnering with consumers in organisational design and governance	Partnerships in healthcare governance, design, measurement and evaluation	2.11 2.12
Preventing and Controlling Infections Standard	Infection prevention and control systems	Standard and transmission-based precautions	3.08
Medication Safety	Documentation of patient information	Medication reconciliation	4.05
		Adverse drug reactions	4.07
	Continuity of medication management	Medication review	4.10

Standards	Criterion	Item	Actions
Comprehensive Care	Clinical governance and quality improvement to support comprehensive care	Designing systems to deliver comprehensive care	5.04
		Collaboration and teamwork	5.05 5.06
	Developing the comprehensive care plan	Planning for comprehensive care	5.09
		Screening of risk	5.10
		Clinical assessment	5.11
		Developing the comprehensive care plan	5.13
	Delivering comprehensive care	Using the comprehensive care plan	5.14
		Comprehensive care at the end of life	5.15
	Minimising patient harm	Preventing and managing pressure injuries	5.21
		Preventing falls and harm from falls	5.24
		Nutrition and hydration	5.28
		Preventing delirium and managing cognitive impairment	5.29
		Predicting, preventing and managing self-harm and suicide	5.31 5.32
		Predicting, preventing and managing aggression and violence	5.33 5.34
		Minimising restrictive practices: restraint	5.35
		Minimising restrictive practices: seclusion	5.36
Communicating for Safety	Correct identification and procedure matching	Correct identification and procedure matching	6.05
	Communication at clinical handover	Clinical handover	6.08
	Communication of critical information	Communicating critical information	6.09
Recognising and Responding to Acute Deterioration	Clinical governance and quality improvement to support recognition and response systems	Partnering with consumers	8.03
	Detecting and recognising acute deterioration, and escalating care	Recognising acute deterioration	8.04 8.05
		Escalating care	8.06 8.07

Clinical Governance Standard

Leaders of a mental health service have a responsibility to the community for continuous improvement of the safety and quality of their services, and ensuring that they are person-centred, safe and effective.

Intention of this standard

To implement a clinical governance framework that ensures that consumers receive safe and high-quality care.

Criteria

There are four criteria in the Clinical Governance Standard:

- Governance, leadership and culture
- Patient safety and quality systems
- Clinical performance and effectiveness
- Safe environment for the delivery of care.

Introduction

Clinical governance is the set of relationships and responsibilities established by a mental health service between its department of health (for the public sector), governing body, executive, workforce, consumers, and other stakeholders to deliver safe and high-quality health care.

It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to people who use their services, so that the community and mental health service can be confident that systems are in place to deliver safe and high-quality health care, and continuously improve services.

Clinical governance is an integrated component of corporate governance of health service organisations. Each mental health service needs to put in place strategies for clinical governance that are tailored to its local circumstances.

The Clinical Governance Standard aims to ensure that a clinical governance framework is implemented. This standard, together with the Partnering with Consumers Standard, sets the overarching requirements for the effective implementation of all other standards.

Effective governance in mental health services ensures:

- The rights of consumers, carers and families are promoted and protected
- Consumers, carers and families are given opportunities to provide feedback on their experience of care to improve the quality of care in health service organisations
- The workforce has the relevant skills, knowledge, values and experience to provide health care to consumers
- The workforce has access to, and complies with, relevant legislation, policy and clinical guidelines
- Environments in which consumers receive care are safe, welcoming and as minimally restrictive as possible.

To support health service organisations to review their systems, the Commission has developed the National Model Clinical Governance Framework.[4] The framework has five components based on criteria in the Clinical Governance Standard and Partnering with Consumers Standard. Refer to the framework for more details on clinical governance and the associated roles and responsibilities for mental health services.

Governance, leadership and culture

Action 1.01

The governing body:

a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation
b. Provides leadership to ensure partnering with patients, carers and consumers
c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community
d. Endorses the organisation's clinical governance framework
e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce
f. Monitors the action taken as a result of analyses of clinical incidents
g. Reviews reports and monitors the organisation's progress on safety and quality performance

Intent

The governing body must assure itself that a culture of safety and quality improvement operates in the mental health service.

Strategies for improvement for mental health services

The governing body sets the strategic direction for the mental health service. The governing body leads the development and maintenance of the organisation's safety and quality culture.

Where the governing body is responsible for a broad range of health services, including the mental health service, include representatives with mental health expertise in the membership of the governing body.

Provide leadership to develop safety culture

The governing body defines the vision, mission and values of the mental health service. Ensure these align with national policy with an emphasis on upholding human rights, and delivering recovery-oriented, person-centred mental health care. Foster an organisational culture that values open, just, fair and accountable behaviours, and that encourages the workforce to proactively manage risk and maximise clinical safety while delivering the care that consumers want.

Lead a culture of partnering with consumers

The governing body sets the organisation's expectations for partnering with consumers, carers and families in the planning, design and delivery of mental health services. Including consumer and carer representatives as members of the governing body models commitment to effective partnerships for the whole organisation.

Support governing body membership by ensuring that:

- Members of the governing body have a high-level understanding and current knowledge of clinical governance and the skills to perform their role, and that they understand the importance of safety and quality and partnering with consumers, carers and families
- Members of the governing body are provided with orientation to their roles, have their identified training needs addressed, and maintain their skills in assessing and evaluating safety and quality in mental health service delivery
- Members of the governing body, especially new members, are offered the opportunity to have a mentor, who will support them to develop their skills and provide space for safe reflection on how they have applied their skills and knowledge to the issues under discussion.

Set a strategic direction that promotes mental health

The governing body develops a strategic plan that supports the promotion of mental health and wellbeing and prioritises mental health service delivery in the community wherever possible. Ensure that resources are allocated to meet the mental health needs of the target population. Embed cultural practices to eliminate stigma and discrimination within the workforce.

Endorse the clinical governance framework

The governing body endorses:

- A clinical governance framework that describes the roles and responsibilities for managing safety and quality, and delegates authority to manage safety and quality in the delivery of mental health services
- The organisation's Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing strategy
- The system for mental health policy development, review and processes for monitoring compliance
- The quality improvement framework for the mental health service.

Define safety roles and responsibilities

Ensure the governance system provides a clear structure that articulates reporting lines, responsibilities and accountabilities. Clearly document, for all members of the workforce, their responsibilities and accountabilities for providing safety and quality of mental health care in their position descriptions.

Ensure the governing body embed a structured performance development system for clinicians and managers that incorporates a regular review of their engagement in safety and quality activities, including peer review and audit, supervision of the workforce, and goal setting for future activities.

Review, monitor and report safety and quality performance

The governing body is ultimately responsible for the safety and quality performance of the mental health service. Members of the governing body must ask the right questions if they are to effectively carry out their responsibilities for clinical governance. Three principles will support monitoring and oversight by governing bodies:

- See every piece of information – every measure and every indicator – in its context
- Look beyond documented evidence
- Take responsibility for learning the basics of safety and quality measurement.

Governing bodies need information that is timely, reliable, comprehensive, contextualised and suitable for their use. Key sources of information are:

- Routinely collected information (sometimes called administrative data)
- Information collected from people who use the service, their carers and families
- Information collected from the reporting activity of clinicians and managers.

Strategies for governing bodies to effectively monitor the mental health service's safety and quality performance are described in detail in the **NSQHS Standards Guide for Governing Bodies**.[11]

Specific considerations for community mental health services

Governing bodies of large organisations that include the provision of community mental health need to ensure that the sources of information they use to monitor safety and quality include information on community mental health services that is meaningful.

Organisational leadership

Action 1.04

The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people

Intent

Strategies to improve the safety and quality of care provided to Aboriginal and Torres Strait Islander people are implemented and monitored for effectiveness.

Strategies for improvement for mental health services

There are national strategies to improve mental health and wellbeing for Aboriginal and Torres Strait Islander people. It is important that mental health services are aware of these, and align organisational strategic plans with existing national, state and territory plans and frameworks.

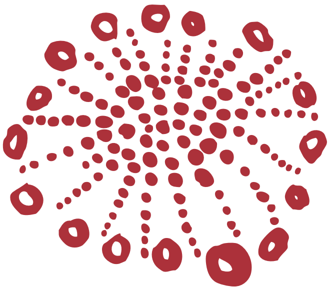
However, it is also critical that mental health services develop and maintain comprehensive understanding of the mental health safety and quality needs of their local communities. In collaboration with Aboriginal and Torres Strait Islander communities, determine the priorities for the mental health service to meet these needs. Promoting Aboriginal and Torres Strait Islander representation in governance structures will contribute to this understanding, and develop trust in local community members.

The **Gayaa Dhuwi (Proud Spirit) Declaration Implementation Guide**[12] includes strategies specifically developed for implementation by LHNs.

The guide sets out how mental health services can implement integrated planning and service delivery for Aboriginal and Torres Strait Islander peoples at the regional level through:

- Partnering with Aboriginal and Torres Strait Islander communities in the co-design of all aspects of regional planning and service delivery
- Collaborating with service providers regionally to improve referral pathways between GPs, Aboriginal Community Controlled Health Services, social and emotional wellbeing services, alcohol and other drug services and mental health services
- Developing mechanisms and agreements that enable shared healthcare information, with informed consent, as a key enabler of care coordination and service integration
- Clarifying roles and responsibilities across the health and community support service sectors
- Ensuring that there is strong presence of Aboriginal and Torres Strait Islander leadership on local mental health service governance structures
- Ensuring Aboriginal and Torres Strait Islander consumer participation in the evaluation of services and programs
- Working with Aboriginal and Torres Strait Islander communities to develop regional clinical targets where appropriate, for example, reductions in suicide in 'hot spot' areas
- Co-designing an implementation plan so that identified mental health positions are filled by suitably qualified Aboriginal and Torres Strait Islander workers.

Spotlight issue: Aboriginal and Torres Strait Islander peoples' mental health and wellbeing



Action 1.04 explicitly addresses the mental health services' responsibility to work with local communities to deliver safe and effective mental health care that meets the needs of Aboriginal and Torres Strait Islander people, both those who use the service, and those who might if existing barriers to access are mitigated.

The NSQHS Standards include 6 actions specifically related to the delivery of health care to Aboriginal and Torres Strait Islander people. These cover the governing body's responsibility (**Action 1.02**), improving cultural competency (**Action 1.21**), creating a welcoming environment (**Action 1.33**), working in partnership (**Action 2.13**) and identifying people of Aboriginal and Torres Strait Islander origin (**Action 5.8**).

These specific actions are outlined in detail in the **NSQHS Standards User guide for Aboriginal and Torres Strait Islander health**[5], which further identifies another 30 actions across the NSQHS Standards for which considering Aboriginal and Torres Strait Islander people will improve the care provided. These actions relate predominantly to Clinical Governance and Partnering with Consumers.

The NSW Centre for Aboriginal Health has developed an **Aboriginal Cultural Engagement Self-Assessment Tool**[13], which supports services to check on their implementation of these actions in the NSQHS Standards, and aligns them with actions in national and state Aboriginal Health Plans.

Action 1.05

The health service organisation considers the safety and quality of health care for patients in its business decision-making

Intent

Decisions relating to equipment, plant, building works, consumables, staffing and other resources consider the safety and quality implications for consumers, carers and families and the workforce.

Strategies for improvement for mental health services

A key factor in delivering safe and high-quality mental health care is ensuring that the organisation makes adequate resources available. For mental health services, this primarily means human resources.

Mental health services can include safety and quality goals and objectives in business and strategic plans, and risk manage any proposed changes in the delivery of mental health care.

The skill mix of the workforce is critical to the delivery of safe and effective mental health care. Consider maintaining multi-disciplinary teams, including identified roles for Lived Experience workers, throughout the opening hours in which services are provided. There is evidence that maintaining multidisciplinary teams, including allied health, on the weekends and after hours, contributes to a reduction in adverse events and the use of restrictive practices.[14]

Specific considerations for community mental health services

Mental health services that deliver both inpatient and community-based services need to distribute resources across the different settings to ensure that safe and effective care is delivered throughout the service. Community mental health services providing care in people's homes have equipment and infrastructure needs that are different to a hospital or clinic, such as access to vehicles, remote access to clinical information and mobile duress systems. Consult with community mental health staff about their needs and understand how these impact the safety and quality of care.

Ensuring that resources are also available 'upstream' to provide early recognition and response to emerging mental health issues before they become acute will improve overall outcomes for consumers, carers and families and improve efficiency. Mental health services should ensure that business processes, such as activity counting, do not prevent collaborative service delivery between inpatient and community-based members of the workforce.

Spotlight issue: Workforce

Action 1.05 explicitly addresses the mental health service's responsibility to consider safety and quality when make decisions about the allocation of resources. Adequately resourcing mental health services is key to delivery of safe and high-quality mental health care.

Having the right workforce is a critical issue for mental health services, now and in the future. The issue is most critical in regional, rural and remote mental health services, where recruiting and retaining the workforce is an ongoing challenge.

The workforce needs to be supported to deliver optimal and evidence-based care. This support includes leadership to develop a safety culture (**Action 1.01**), orientation and ongoing training (**Actions 1.19 and 1.20**), access to healthcare records (**Action 1.16**), evidence-based decision support tools (**Action 1.27)** and a safe environment (**Actions 1.29 and 1.30**).

The mental health service needs to develop a just culture, where adverse events (**Action 1.11**) and consumer complaints (**Action 1.14**) are reviewed to identify systemic problems, but also where unsatisfactory performance is effectively managed (**Action 1.22**).

Make support available for members of the workforce to better understand their mutual rights and responsibilities (**Actions 1.07, 2.03 and 2.04**) and how to engage with consumers, carers and families in shared and supported decision-making (**Actions 2.07, 5.03**).

Ensure the mental health service has an ongoing process for reviewing the role of the Lived Experience workforce. Ensure all of the supports in place for other members of the workforce are equally implemented for Lived Experience workers.

Clinical leadership

Action 1.06

Clinical leaders support clinicians to:

a. Understand and perform their delegated safety and quality roles and responsibilities
b. Operate within the clinical governance framework to improve the safety and quality of health care for patients

Intent

Clinical leaders and leaders of clinical services work with other clinicians to optimise the safety and quality of care.

Strategies for improvement for mental health services

The actions and attitudes of clinical leaders influence the perceptions, attitudes and behaviours of other members of the workforce. When clinical leaders model empathic, non-stigmatising attitudes, they support other clinicians in delivering holistic health care and upholding the human rights of consumers.

Mental health services are providing a leading role in developing and integrating the Lived Experience workforce in roles throughout their services, embedding new ways of thinking about mental health into established services.[15]

Provide leadership

Define safety and quality leadership roles and responsibilities for members of the workforce, including the Lived Experience workforce.

Ensure clinical leaders have opportunities to engage with the governing body and organisational leaders, so that:

- Mental health care is delivered consistent with the clinical governance framework
- Clinical issues inform the review of the clinical governance framework.

Involve clinical leaders in supervising, teaching and mentoring other members of the workforce and in providing support after critical incidents. Model practices of delivery of care that eliminate stigma and discrimination. Ensure that leaders of different disciplines foster a culture of multidisciplinary respect.

Develop leadership roles for Lived Experience workers.

Foster culture of reflective supervision

Reflective supervision contributes to members of the workforce being better able to perform their roles in the delivery of safe and effective mental health care. It also supports the mental health workforce to sustain their own wellbeing, addressing issues such as vicarious trauma and moral injury in a safe setting. Set aside time for senior members of the workforce to provide reflective supervision to junior colleagues and provide training to all participants in how to engage in reflective supervision. Properly done, supervision is not unidirectional; senior members of the workforce have the opportunity to reflect on and renew their own practice through considering complex issues together with junior colleagues.

Specific considerations for community mental health services

Mental health care is frequently provided in the community by individuals working on their own, without direct oversight by managers or the involvement of colleagues. This requires a culture of trust, where managers rely on members of the workforce to practice ethically and effectively. Workers need to know how and where to access support of managers and colleagues when needed.

Clinical or peer supervision provides an opportunity for safe reflective practice for members of the workforce who work autonomously.

Policies and procedures

Action 1.07

The health service organisation uses a risk management approach to:

a. Set out, review, and maintain the currency and effectiveness of policies, procedures and protocols
b. Monitor and take action to improve adherence to policies, procedures and protocols
c. Review compliance with legislation, regulation and jurisdictional requirements

Intent

The mental health service has current, comprehensive and effective policies, procedures and protocols that cover safety and quality risks.

Strategies for improvement for mental health services

The mental health service has the responsibility to ensure that all health care delivered by the workforce is consistent with current legislation and other regulatory requirements. In recent years, states and territories have made changes to mental health legislation to reflect contemporary understanding of the rights of people who experience mental ill health.

Key issues that affect consumers, carers and families include informed consent to treatment, confidentiality and minimising the use of restrictive practices. The legislative and regulatory requirements regarding these issues can be complex.

Mental health services have an obligation to ensure that the human rights of consumers are respected, upheld and not contravened. Mental health services need to support members of the workforce to practise in line with these requirements through maintaining up-to-date policies and providing the training and resources to enable the workforce to enact them.

Develop policies, procedures and protocols

Document the roles and responsibilities of individuals and committees with the authority to amend, approve and/or rescind policies and procedures.

Incorporate detailed knowledge about the risks for the mental health service, and the population to which it delivers health care into policy review.

Have clear, documented policies on accepted legislative and national policy commitments, such as:

- Upholding the rights of consumers to be treated with dignity and respect, and protected from abuse and exploitation
- The rights of carers and families, both when the consumer wishes their involvement and when they do not
- Informed consent, and capacity to consent

- Least restrictive practice
- Access to independent advocacy
- Trauma-informed care
- Recovery-oriented care
- Sexual safety
- Capacity for a mental health consumer to access a clinician or support worker of their preferred gender
- Supporting the self-determination and autonomy of consumers, carers and families.

Support effective implementation of organisational policies

Ensure the workforce has ready access to relevant policies, procedures and protocols. Communicate changes in policies to the workforce through multiple channels, including formal training, in-service presentations, online updates on the mental health service's intranet and posters in key areas. Seek feedback from members of the workforce about their understanding of policies, and changes in policy to ensure they can effectively implement these policies. Monitor compliance and act where policies are not implemented.

Develop resources that outline key legislative provisions for consumers, carers and families in a range of formats tailored to the local population.

Adopt a systematic approach to aligning policies with legislation, regulation, state and territory requirements

Each state and territory has legislation related to the care and treatment of mental health consumers. Changes in legislation are preceded by consultation periods. Following legislation being passed, there is a period before it is enacted. During this time, mental health services have the opportunity to ensure that their local policies align with the changes in legislation.

Mental health services can also initiate improvements based on review of incidents that occur in other health services. While states and territories can provide policy directives, local health services should ensure their own processes align with contemporary knowledge. Coronial investigations frequently contain detailed information about the circumstances preceding adverse events. Coroners make recommendations based on these investigations, which can be applied across mental health services.

Ensure the system for review of the mental health service's policies aligns to detailed knowledge about the specific risk profile of the mental health service, and the population to which it delivers health care.

Engage mental health consumers, carers and families and members of the workforce in review of policies and procedures

The mental health service has the responsibility to ensure local policies reflect broad legislative and regulatory factors. Engaging the people who use the mental health service and those who deliver it will ensure that local issues are effectively identified. These can be incorporated into local policies and procedures.

Measurement and quality improvement

Action 1.08

The health service organisation uses organisation-wide quality improvement systems that:

a. Identify safety and quality measures, and monitor and report performance and outcomes
b. Identify areas for improvement in safety and quality
c. Implement and monitor safety and quality improvement strategies
d. Involve consumers and the workforce in the review of safety and quality performance and system

Intent

An effective quality improvement system is operating across the mental health service.

Strategies for improvement for mental health services

Define quality and how it will be measured

Define the elements of quality to be used by the mental health service, for example, consumer experience, the outcomes they achieve, safety, effectiveness and unwarranted variation. Provide a common language for the co-design, implementation and monitoring of safety and quality performance throughout the mental health service.

Mental health services have well-established systems for measuring consumer-reported outcomes (PROMs) and experiences (PREMs), including the Your Experience of Service (YES) surveys and scales such as the Kessler 10 and Basis 32. These can be used for national benchmarking and integrated into data sources for local quality improvement processes.

Other sources of data include Hospital Acquired Complications, sentinel events and unplanned readmissions.

Implement actions to improve the quality of mental health care

Develop a structured program to identify priority areas for improvement, informed by local data, as well as national and state and territory initiatives and policy directives. Set targets to benchmark changes and increase motivation. Mobilise the range of skills available, for instance, people's capacity to critically evaluate literature. Use networks, webinars and conferences to ascertain if comparable services have implemented quality improvements not yet published in peer-reviewed literature. Compare performance with peer organisations and those known to be achieving good health outcomes.

The Clinical Excellence Commission of NSW has established the **Mental Health Patient Safety Program**,[16] which comprehensively sets out how mental health services can engage the workforce in sustainable quality improvement activities.

Engage consumers, carers and families and members of the workforce in the development of improvement strategies.

Conduct regular reviews and audits

Develop a schedule of safety and quality reviews. Conduct audits and document outcomes.

Engage key stakeholders in review of safety and quality measures.

Risk management

Action 1.10

The health service organisation:

a. Identifies and documents organisational risks
b. Uses clinical and other data collections to support risk assessments
c. Acts to reduce risks
d. Regularly reviews and acts to improve the effectiveness of the risk management system
e. Reports on risks to the workforce and consumers
f. Plans for, and manages, internal and external emergencies and disasters

Intent

The mental health service identifies and manages risk effectively.

Strategies for improvement for mental health services

This action is focused on organisational risks, not the clinical risk for individual consumers. Risks for mental health services need to be reviewed in the context of the health service organisation's overall risk appetite and risk management within the clinical governance framework.

Identify organisational risks

Ensure that the organisation's risk management system is clearly documented in policies, procedures and protocols that define a vision, principles, objectives, practices, responsibilities, resources, outcomes and how outcomes, including for mental health services, will be measured. Ensure that resources are allocated to the organisation's risk management system. Foster an organisational culture that focuses on clinical safety and continuous improvement in identifying and managing risk.

Partner with consumers, carers and families in risk mitigation strategies

Engage with consumers, carers and families to develop strategies to balance organisational risk management with recovery-oriented approaches to mental health care. Ensure these strategies enable consumers to exercise optimal choice and control in their mental health care, and support least restrictive practices. In particular, the mental health service should engage with consumers to review its appetite for supporting shared understanding of the dignity of risk, and how the service can operate safely and support consumer's human rights and choice.

Actively encourage consumers, carers and families to report potential or actual risks that they observe in interactions with the mental health service.

Embed a systems approach to risk management

Maintain risk management policies, procedures and protocols that follow best practice, and ensure that all clinical leaders, managers and other members of the mental health workforce are familiar with them. Establish a reliable and systematic process of risk identification across all areas. Ensure that the risk management system includes strategies, resources and clear accountability for remedying risks.

Ensure that the mental health service has a reliable system to scan for, identify and respond to risks reported by other organisations (for example, from the scientific literature, government agencies, insurers, coroners, or safety and quality commissions).

Provide feedback to the workforce and consumers on actions taken to mitigate risks.

Engage the workforce

The workforce has context-specific ability to identify risks in the delivery of mental health care. Foster engagement and participation of the workforce by providing information about the organisation's risk management system at orientation, and through ongoing education and training. Reinforcing information about roles, responsibilities and accountabilities for reporting and managing risk to managers, clinicians and other members of the workforce (for example, by using screensavers, the intranet, newsletters and standing items on meeting agendas).

Use routine meetings as an opportunity to identify and discuss clinical and other safety concerns.

Act to reduce risks

The mental health service undertakes actions that mitigate identified risks and prevent risks from emerging.

Examples of actions to reduce risks include:

- Ensuring adequate staffing levels and clinical skill-mix to provide appropriate care
- Providing training to members of the workforce about managing conflict
- Engaging Lived Experience workers in providing this training
- Providing an environment that minimises potential for conflict
- Providing an environment that minimises the potential for self-harm.

Plan for, and manage, emergencies and disasters

Use the risk management system to prepare for potential emergencies and disaster management. Perform a series of audits to identify potential risks and management opportunities to enable the organisation to respond efficiently and effectively in an emergency. This may involve considering:

- Appropriate infrastructure, such as emergency signage, lighting systems and backup generators
- Workforce training in evacuation systems and emergency drills
- Planning for the coordination of workforce rosters and reporting lines during an emergency
- Planning to support transfer of consumers internally or externally (to other health service organisations) during an emergency
- Business continuity planning for recovery and returning services to normal following an emergency.

Specific considerations for community mental health services

Delivery of mental health services in the community can present unique organisational risks. Mental health care is delivered in community health centres, in people's homes and in public spaces, and members of the workforce frequently work on their own, without colleagues available for immediate assistance. The context, service model, consumer population, workforce skills, experience and supports all impact on risk.

The mental health service needs to work with members of the workforce to identify risks and develop mitigation strategies that are achievable.

Incident management systems and open disclosure

Action 1.11

The health service organisation has organisation-wide incident management and investigation systems, and:

a. Supports the workforce to recognise and report incidents
b. Supports patients, carers and families to communicate concerns or incidents
c. Involves the workforce and consumers in the review of incidents
d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers
e. Uses the information from the analysis of incidents to improve safety and quality
f. Incorporates risks identified in the analysis of incidents into the risk management system
g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems

Intent

Clinical incidents are identified, managed and appropriate action taken. Analysis of incidents is used to improve safety and quality.

Strategies for improvement for mental health services

Review the incident management and investigation system

A well-designed incident management and investigation system supports the workforce to identify, report, manage and learn from incidents. Ensure the system complies with legislative requirements and with state or territory clinical incident management policies.

Develop a clear policy framework that defines the key elements of the system:

- Roles and responsibilities of individuals and committees
- Type of events to be reported
- Process for reporting, investigating, analysing, monitoring and reporting on the findings from clinical incidents
- Responsibility of and support for clinicians to report incidents.

Focus on managing each incident from a clinical perspective and ensuring the provision of safe, high-quality care to the consumer following the incident, including open disclosure, if appropriate. Outline workforce responsibilities for managing reported incidents, including grading their severity and leading further investigations.

Review and report on incidents and monitor action taken in response

Define a reporting framework that clearly identifies the data that will be available and reported at each level of the organisation.

Ensure the system facilitates timely and effective review of clinical incidents. Particular attention must be paid to incidents given high severity assessment codes, or categorised as sentinel events, to ensure that lessons about potentially preventable harm are used to inform future practice, policy and risk management. As these are relatively rare in mental health services, an incident management system should also be able to identify and respond to near misses, where severe harm has been avoided through effective interventions.

Engage members of the workforce, including Lived Experience workers, in review of incidents. Also engage consumers, carers and families in review of incidents.

Provide comprehensive information to the governing body on all serious incidents. Ensure that teams reviewing clinical incidents understand the nature of risk assessments used in mental health services.

Provide information to all stakeholders on the actions taken in response to review of incidents.

Support consumers, carers and families

Lead a culture where transparent reporting of incidents, investigations and responsive actions is demonstrated to all stakeholders. Distribute information to consumers, carers and families about what incidents are, and how to report them. Train the workforce on how to respond to consumers or carers who report incidents. Provide appropriately skilled members of the workforce, including Lived Experience workers, to support consumers, carers and families who report incidents. Ensure this support is available at the time of the incident, throughout the investigative period, at the delivery of any findings and afterwards if needed.

Support the workforce

Encourage and support the workforce to use the incident management system to report clinical incidents, near misses and adverse events. An effective incident reporting system functions best when members of the workforce understand what constitutes a clinical incident for the purpose of reporting, how to report, what happens once an incident is reported and how feedback arising from incident review is provided to the workforce and integrated into the quality improvement system.

Provide support to members of the workforce after an adverse event and, if needed, through incident investigation processes and afterwards.

Action 1.12

The health service organisation:

a. Uses an open disclosure program that is consistent with the **Australian Open Disclosure Framework**[17]

b. Monitors and acts to improve the effectiveness of open disclosure processes

Intent

An open disclosure process is used to enable the mental health service and clinicians to communicate openly with consumers, carers and families following unexpected healthcare outcomes and harm.

Strategies for improvement for mental health services

Adopt an open disclosure framework

Open disclosure is a discussion with a consumer, or carer and family, about an incident that resulted in harm to the consumer. Open disclosure is:

- A consumer right
- An essential professional requirement and institutional obligation
- A normal part of an episode of care should the unexpected occur
- An attribute of a high-quality service organisation and an important part of healthcare quality improvement.

Open disclosure sustains a just culture in a mental health service through openness and constructive learning from adverse events that resulted in harm.

Implement open disclosure

An open disclosure discussion should include:

- The elements of an apology or expression of regret (including the word ‘sorry’)
- A factual explanation of what happened
- An opportunity for the consumer to relate their experience
- An explanation of the steps being taken to manage the event and prevent a recurrence.

Support consumers, carers and families throughout the open disclosure process

Provide consumers, carers and families with access to independent advocacy. Provide information in language that the consumers, carers and families can fully understand. Provide consumers, carers and families with emotional support during and after the open disclosure process, or arrange external support if they prefer this option.

Provide training and support to members of the workforce

Reinforce through policy and training that the mental health service upholds open disclosure. Provide members of the workforce with support during and after the open disclosure process.

Develop clear process for deferring open disclosure

Only defer open disclosure in exceptional circumstances – a consumer being treated under mental health legislation has the right to participate in open disclosure.

Deferral may be requested by the consumer, their carer or family, or the clinical team may consider deferral is necessary due to concerns about the current capacity of the consumer to participate, or a potential adverse effect on their mental health.

In either case, ensure the team:

- Engages with the consumer, their carers and family to check if they agree with the decision to defer open disclosure
- Has a clear process for determining the consumer’s capacity to consent is conducted
- Documents the reasons for the deferral in the healthcare record
- Arranges for the decision to be reviewed by an independent clinician and document this
- Recommences the process at the earliest opportunity.

Feedback and complaints management

Action 1.13

The health service organisation:

a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care
b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems
c. Uses this information to improve safety and quality systems

Intent

Feedback from consumers, carers and families and members of the workforce is used to improve safety and quality.

Strategies for improvement for mental health services

Feedback about people's experience of their mental health care is an important element in determining the safety and quality of care provided. This can include positive experiences of care, or sub-optimal care that does not meet their threshold for making a formal complaint. Establishing processes for people to give their feedback in less formal ways will ensure this information is not lost.

Adopt a systematic approach to gathering feedback

The feedback system should be readily available, easy to use, and enable feedback to be incorporated into quality improvement systems. An advantage of an effective feedback process over other information sources, such as complaints or critical incident reviews, is that feedback can provide positive information about aspects of a mental health service that are working well in the view of the people who use the service. Feedback can also identify areas for improvement.

Mental health services can use validated survey instruments that incorporate the national core common consumer experience questions, such as the **Your Experience of Care** survey and the **Carer's Experience of Care** survey.

Close the loop by giving feedback to members of the workforce and people who use the service

Engage consumers, carers and families, and members of the workforce on the review of feedback.

Compare performance with similar services and any nationally available benchmarks, such as those available on the **Mental health services in Australia** webpages of the Australian Institute of Health and Welfare (AIHW).[18]

Ensure that the workforce, consumers, carers and families receive information about what has been learned from the feedback system, and how it has been used to generate improvements in the mental health service.

Action 1.14

The health service organisation has an organisation-wide complaints management system, and:

a. Encourages and supports patients, carers and families, and the workforce to report complaints
b. Involves the workforce and consumers in the review of complaints
c. Resolves complaints in a timely way
d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken
e. Uses information from the analysis of complaints to inform improvements in safety and quality systems
f. Records the risks identified from the analysis of complaints in the risk management system
g. Regularly reviews and acts to improve the effectiveness of the complaints management system

Intent

An effective complaints management system is in place and used to improve safety and quality.

Strategies for improvement for mental health services

Complaints are a rich but underutilised source of information about risk. They allow information to be gathered that is not always available through other sources. They also allow the critical voices of consumers, carers and families to be heard, augmenting the information reported by members of the healthcare workforce. There are clear benefits for consumers, carers and families, and mental health services when complaints are effectively managed at the local level.

Ensure a robust, accessible complaints reporting system

Ensure the mental health service has an effective complaints reporting system and provides clear information about how to lodge a complaint and, when needed, support to do so. Moreover, ensure the culture fosters respectful responses to complaints. If necessary, members of the workforce may need training about how to support people who have used the service to complain if they are dissatisfied. Ensure there is no discouragement, explicit or implicit, to people lodging complaints, and that people experience no concern that it a complaint may compromise future interactions with the mental health service.

As with incident review, developing a culture that supports people to make complaints depends on agreement to treat issues as systemic, and focusing on seeking improvements. That said, if an individual is considered to be at fault after internal investigation of the complaint, follow the appropriate processes.

Support consumers, carers, families, and the workforce

Nominate a support person to assist consumers, carers, families or members of the workforce who wish to make a complaint, if needed. Ensure the complainant has access to independent advocacy if they request it.

Ensure that systems are in place to encourage consumers, carers and families, and members of the workforce, to report complaints.

Provide support to members of the workforce through the complaints review process as needed.

Engage with external complaints organisations

Consumers, carers and families may lodge their complaints about a mental health service directly with an external organisation, or they may lodge a complaint if they are not satisfied with the local mental health service's response. They may speak with Official Visitors, submit a complaint to a Health Care Complaints Commissioner or Mental Health Complaints Commissioner, or voice concerns to members of the Mental Health Review Tribunal.

Ensure the mental health service has a formal process for liaising with external complaints handlers and cooperating with review of these complaints.

Report on and review complaints

Engage consumers, carers and families, and members of the workforce, including Lived Experience workers, in the review of complaints. Follow up complaints to ensure that improvements have been made. Link complaints to the organisation's policies on open disclosure, risk management, credentialing and scope of clinical practice, and quality improvement systems. Report on complaints to the governing body, the workforce, consumers and other parties (for example, state or territory complaints commissioners, and regulatory authorities) under the relevant organisational obligations.

Diversity and high-risk groups

Action 1.15

The health service organisation:

a. Identifies the diversity of the consumers using its services
b. Identifies groups of patients using its services who are at higher risk of harm
c. Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care

Intent

The diversity of consumers and their carers and families, including high-risk groups, are considered in the planning and delivery of care and services.

Strategies for improvement for mental health services

A key element of the safety culture of a mental health service is that the service effectively provides mental health care for all members of the community. Leadership is required to ensure that there are robust systems in place to identify if certain members of the community are at risk of not accessing the service, or experiencing harm when they do receive a service.

Identification of risks must be followed up with the implementation of strategies to prevent and reduce these risks. Develop these strategies in partnership with members of the identified communities.

The governing body should continue to assure itself that diversity responsiveness forms part of the organisation's safety culture as community needs change over time.

Develop and maintain comprehensive understanding of the population served

Review demographic data (such as age, gender, postcode or ethnicity) to understand the diversity of the population.

Undertake a community profiling project, which involves gathering information about the diversity within the community; its history, social and economic characteristics; the groups and networks within the community; and the social and infrastructure services that exist. Administer surveys to help identify diversity among consumers.

Use demographic data from the Australian Bureau of Statistics, or local, or state and territory government sources to understand the background of the people who use, or may use, the service.

Analyse relevant data to determine the key risks faced by different demographic groups. The Fifth National Mental Health and Suicide Prevention Plan[19] identifies the following groups as potentially at higher risk for mental health issues:

- Aboriginal and Torres Strait Islander people
- Lesbian, gay, bisexual, transgender, intersex and queer people (LGBTIQ+)
- People with intellectual and other disabilities
- People in rural and remote Australia
- People in the military and veterans
- Perinatal women
- Migrants, refugees and other people from culturally and linguistically (CALD) backgrounds.

It is also important for mental health services to effectively respond to mental health needs of the community over the lifespan. There is evidence that mental health conditions are under-treated in the older population.[20] There is also evidence that children and young people, and their families and carers, can struggle to access necessary care.[21]

Recognise diversity among carers and families of consumers, including:

- Children and young people
- Aboriginal and Torres Strait Islander people
- People from CALD backgrounds
- Families of people serving in the military and veterans
- Partners supporting perinatal women.

Conduct a risk assessment to identify issues in access or delivery of care experienced by specific groups of consumers.

Discuss the strategies to overcome these risks with the clinical governance committee, the clinical workforce, Lived Experience workers and representatives of the different risk groups.

Network with other organisations or individuals in the community to share knowledge about local community needs and preferences, including:

- CALD community groups
- Other community groups, for example LGBTIQ+ groups
- Aboriginal and Torres Strait Islander Community Controlled Health Organisations
- PHNs
- Community Managed Organisations
- Local, state and territory government organisations
- Professional associations.

Address intersectionality – that is, that people can belong to more than one marginalised group, which can potentially increase risks due to experiencing multiple types of stigma and discrimination. When engaging with representatives of a target population, ensure input from a range of voices, and do not assume the particular community holds unitary views. While this may lead to some uncomfortable conversations, avoid confrontation.

Directly engage with representatives with lived experience of more than one type of marginalisation to elicit their views on how the mental health service can best meet the full range of community needs.

Spotlight issue: Children and young people

Action 1.15 explicitly addresses the mental health service's responsibility to ensure the delivery of safe and high-quality mental health care to all of its consumers, particularly those who may be at higher risk of harm.

The mental health and wellbeing of children and young people has been identified as a national priority. In addition to delivering direct benefits to children and families, targeted mental health and wellbeing interventions can contribute to preventing the development of long-term mental ill health.

The **National Children's Mental Health and Wellbeing Strategy**[21] provides a framework for improved mental health for all children. The document identifies specific cohorts of children who may be at increased risk of experiencing mental ill health, including:

- Children who have experienced the child protection and out-of-home care system
- Aboriginal and Torres Strait Islander children
- Children of parents with mental ill health or parents with substance use problems
- Children with disability or chronic illness
- Refugees and children who have recently migrated
- Children who identify as LGBTQI+ or have a family member, parent or carer who does
- Children who are, or have been, incarcerated as part of the youth justice system.

The strategy proposes a series of linked objectives and priority actions, and mental health services form an integral part of these.

To support implementation of the strategy, the National Workforce Centre for Child Mental Health has been established, hosted on the website **Emerging Minds**.[22] This provides resources for mental health workers to improve their knowledge and skills in addressing the mental health needs of children and families.

Mental health services working with children and young people need robust informed consent processes (**Action 2.04**). While parents and guardians may formally act as substitute decision-makers, the child should be supported to understand the proposed interventions and, where possible, provide assent.

Mental health services also need to ensure that their policies and procedures meet the **National Principles for Child Safe Organisations**.[23]

Identify strategies to mitigate risks to diverse populations

Review routine processes of mental health care to determine if there are barriers to care for specific groups.

Ensure that clinical guidelines incorporate risk management strategies relevant to known risks, for instance, changes in cardiac parameters for people with eating disorders.

Adopt a health promotion approach to prevent risks of harm related to the diversity of consumers, carers and families.

Refer to existing resources for strategies, including:

- **Gayaa Dhuwi (Proud Spirit) Declaration Implementation Guide**[12]
- **Mental health in multicultural Australia framework** (Embrace)[24]
- **MindOut: Mental health and suicide prevention** (LGBTIQ+ Health Australia)[25]
- **Accessible Mental Health Services for People with an Intellectual Disability: A guide for Providers** (3DN)[26]
- **National Perinatal Mental Health Guideline** (COPE).[27]

Review current communication mechanisms

Determine whether the mental health service's current communication mechanisms meet the needs of diverse populations by reviewing mental health information developed by the organisation, such as brochures, posters and consent forms, to see whether they are:

- Culturally appropriate or available in culturally appropriate formats
- Available in a variety of community languages
- Available in a variety of accessible formats, such as audio or braille
- LGBTIQ+ aware.

Review the availability of interpreting services, and methods of access to these services for people using the service, their carers and families, and members of the workforce.

Implement communication mechanisms that meet the needs of specific populations

Provide multiple opportunities for people to gain access to information in a variety of formats. Use technology, mobile apps or social media to help communication.

Use techniques to check the consumer's understanding of information, such as a 'teach back' method.

Translate existing information into community languages. Facilitate easy access to interpreting services by:

- Identifying and promoting appropriate interpreting services that are competent at working in a mental health setting
- Developing policies and procedures, and educating the workforce on when and how to engage an interpreting service
- Educating the workforce on the appropriate use of interpreters – family or friends may not be appropriate interpreters because of health privacy issues.

Use language that recognises people's diverse gender, sexuality and relationship preferences.

Periodically review communication mechanisms with identified community groups to confirm they are meeting community needs.

Deliver care tailored to diverse populations

Embed trauma-informed care across all services delivered.

Create welcoming spaces for members of diverse communities in waiting rooms, for example, Aboriginal and Torres Strait Islander art, rainbow flags.

Enable mental health consumers to access a clinician or Lived Experience worker of their preferred gender where possible.

Provide ongoing training for members of the workforce about delivering care for people from diverse populations and engage members of community populations in the delivery of this training.

Monitor effectiveness of service delivery to diverse populations

Monitor health outcomes for at-risk groups. Analyse consumer feedback. Engage consumer and carer representatives from diverse populations in evaluation of service performance.

Spotlight issue: Responding to diversity

Action 1.15 explicitly addresses the mental health service's responsibility to ensure the delivery of safe and high-quality mental health care to all of its consumers, particularly those who may be at higher risk of harm.

Leadership plays a key role in how a service responds to the diverse needs of members of the community (**Actions 1.01, 1.03 and 1.06**); however, there are many facets that must be considered, and diverse needs are addressed through a number of actions in the NSQHS Standards.

It is part of their human rights for people to receive mental health services that reflect their individual needs (**Action 2.03**). This is enacted when people receive targeted support to fully engage in decision-making about their mental health (**Action 2.06**). A key element of such support is that information is provided in a variety of ways (**Action 2.10**) including information about how to communicate critical changes (**Action 6.09**), and how to escalate care (**Action 8.07**).

Members of the workforce may receive training in the delivery of culturally competent care (**Actions 1.20 and 1.21**) including delivery from people with lived experience (**Action 2.14**). Effective multidisciplinary teamwork (**Action 5.06**) can draw on the life experience of team members, such as the community knowledge of Aboriginal and Torres Strait Islander, and other bicultural mental health workers.

Thoughtful elements in the design of the environment contribute to a feeling of safety for members of different population groups (**Actions 1.29, 1.30 and 1.33**).

Healthcare records

Action 1.16

The health service organisation has healthcare records systems that:

a. Make the healthcare record available to clinicians at the point of care
b. Support the workforce to maintain accurate and complete healthcare records
c. Comply with security and privacy regulations
d. Support systematic audit of clinical information
e. Integrate multiple information systems, where they are used

Intent

Comprehensive, accurate, integrated and accessible healthcare records are available to clinicians at the point of care.

Strategies for improvement for mental health services

Implement and maintain the healthcare records system

An effective healthcare records system should incorporate physical or digital facilities for the reliable and secure management of healthcare records.

Structure the healthcare record to guide the workforce to record important information relevant to the safety and quality of care.

Support the workforce to use the healthcare record system effectively

The workforce needs to understand the authorisations related to their healthcare record roles and responsibilities. These include the authority to access, document, store, transmit and delete information in the healthcare record.

Provide orientation and training of the workforce in the organisation's requirements for healthcare record documentation, including the safety and quality rationale for those requirements.

Set the standards for documentation, with a focus on the information that should be recorded to enable monitoring of quality of care, contemporaneous recording of clinical information, and the availability of formal reports on investigations, including imaging and pathology tests.

Include accountability for healthcare record documentation in performance development processes for the clinical workforce.

Review privacy and confidentiality

Information about an individual's physical or mental health and wellbeing is both personal and sensitive, and there are many ethical, professional and legal restrictions on the way this information can be used.

People assume all communications with their mental health workers are private, and the law reflects this expectation. The confidentiality or privacy of most health information is protected by statutory or common law requirements of confidentiality and privacy. However, the precise legislative requirements vary between states and territories.

Explicitly recognise the sensitivity of clinical information, and the need to protect confidentiality and privacy. Explain to consumers, carers and families how healthcare information is collected, used and disclosed, and the safeguards that apply.

Recognise the conflicting responsibilities that can occur between upholding the consumer's right to confidentiality and the carer's right to information.

Understand the issues that face mental health services when working with other services, such as accommodation providers. Identify or develop specific guidelines to support the workforce to navigate their responsibilities around confidentiality and information-sharing in these situations and provide training and supervision on these guidelines.

Recognise the role of informed consent in the use or disclosure of information for purposes other than direct provision of care.

Develop and implement specific policies and procedures addressing the use of clinical information for clinical, educational, quality assurance and research purposes, including robust authorising procedures for any uses or disclosures outside the usual provision of care.

Provide the appropriate physical infrastructure (for example, private interview rooms, consumer status boards that are screened from public view) to ensure privacy and confidentiality.

Audit the system

The healthcare records system is an important source of information about how the mental health service is performing. Periodically audit the design and performance of the healthcare records system to ensure its completeness and effectiveness.

Specific considerations for community mental health services

Ensuring that up-to-date mental health information is available at the point of care requires specific considerations in community mental health services. Members of the workforce who work off-site may not be able to take a consumer's complete health care record with them on community visits. Robust processes must be in place to support safe delivery of care and documentation as close as possible to care delivered. At a minimum, information that enables matching of the consumer with their planned care, including administration of medication, must be available to the clinician at the point of care.

Mental health services also require systems that allow clinicians in inpatient services, including emergency departments and acute mental health units, to have timely access to information in community healthcare records. Access to electronic medical records supports point-of-care availability of information.

Safety and quality training

Action 1.20

The health service organisation uses its training systems to:

a. Assess the competency and training needs of its workforce
b. Implement a mandatory training program to meet its requirements arising from these standards
c. Provide access to training to meet its safety and quality training needs
d. Monitor the workforce's participation in training

Intent

The workforce is appropriately trained to meet the need of the mental health service to provide safe and high-quality care.

Strategies for improvement for mental health services

Establish an education and training program that integrates organisational values

Define mandatory education and training requirements in relevant aspects of safety, quality, leadership and clinical risk for all members of the workforce, including Lived Experience workers.

Incorporate organisational values, including the commitment to trauma-informed, recovery-oriented practice, into training and orientation to support the reduction of stigma and discrimination in the workforce.

Provide each member of the workforce with the opportunity (through performance review and development programs) to define their education and training goals, and agree with their manager on opportunities to achieve these goals.

Orientation is the opportunity for new members of the workforce to learn about the values of the mental health service. This includes expectations about workers' understanding of key safety and quality issues in mental health services. Orientation also provides an opportunity to describe the processes the mental health service has in place to support the delivery of safe and high-quality care.

Provide orientation that covers the essential elements of clinical governance and quality improvement systems. Ensure that orientation covers all workforce members' roles and responsibilities to:

- Uphold the rights of people accessing mental health care
- Protect consumers, carers and families from abuse and exploitation
- Deliver care that is person-centred and trauma-informed
- Always practise strategies that minimise the use of coercion or restrictive practices.

Periodically evaluate the content of the orientation and induction training program for its effectiveness and currency of content.

Consider potential roles for consumers, carers, families and Lived Experience workers in orientation.

Specific considerations for community mental health services

There are aspects of the delivery of mental health care in the community that differ from inpatient services, including:

- Legislative requirements
- Safe administration of medication
- Risk assessment and risk mitigation strategies
- Integration of care with community partners.

Ensure that workers who move to community settings from inpatient settings are oriented to these differences and provided training where required.

Performance management

Action 1.22

The health service organisation has valid and reliable performance review processes that:

a. Require members of the workforce to regularly take part in a review of their performance
b. Identify needs for training and development in safety and quality
c. Incorporate information on training requirements into the organisation's training system

Intent

The mental health service routinely reviews and discusses individuals' performance and systematically collects information on individuals' safety and quality training needs.

Strategies for improvement for mental health services

Mental health care is delivered by individuals working in teams. It is not enough to have good policies and procedures at an organisational level, there should be processes to review and improve workers performance. The mental health service must be able to ensure members of the workforce are delivering safe and high-quality care in every encounter.

Develop an effective performance review system

Ensure continuous, constructive interaction between members of the workforce and their managers. Set and clarify expectations for employees. Monitor employee performance and implement structured performance review.

Recognise employee achievements. Resolve unsatisfactory employee performance through developing employee capability.

Outline organisational and individual responsibilities

The mental health service is responsible for establishing a culture in which safe, high-quality care can be delivered and assisting members of the workforce, including Lived Experience workers, to develop their competence and performance by supporting them to achieve agreed goals.

Members of the workforce are responsible for understanding organisational objectives, setting professional goals that are consistent with the organisation's objectives and working collaboratively with the mental health service to achieve professional and organisational goals.

Mental health consumers, carers and families still report experiencing stigma and discrimination from members of the workforce. Managers need to know how workers are performing, identify where there may be problems, and work with individuals to support them to provide care consistent with the values of the mental health service.

Specific considerations for community mental health services

Mental health care is frequently provided in the community by individuals working on their own, without direct oversight by managers or support from peers.

Multidisciplinary team meetings offer an opportunity for colleagues to review their practice and the quality of care being provided.

Other sources of information to monitor performance include consumer and carer rated experience surveys.

Credentialing and scope of clinical practice

Action 1.23

The health service organisation has processes to:

a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan
b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice
c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered

Intent

Members of the workforce are appropriately skilled and experienced to perform their roles safely, and to provide services within agreed scope of clinical practice.

Strategies for improvement for mental health services

This action explicitly addresses clinical practice. Where a mental health service employs non-clinical members of the workforce who deliver mental health care, their scope of practice should reflect and describe this.

As part of ongoing review of service delivery, the mental health service should consider how the Lived Experience workforce is integrated into the model of care, with clear descriptions of their scope of practice.

Define scope of practice for members of the workforce

Develop structures and processes that ensure:

- Clear definition of scope of practice in the context of the mental health service's needs and legislative accountabilities
- Regular review of workers' scope of clinical practice
- Appropriate supervision of mental health workers, when necessary
- Effective processes for reviewing workers' competence and performance
- Procedures are followed if a concern arises about the capability of a mental health worker.

Define the scope of clinical practice for junior members of the workforce of varying levels of expertise and describe the requirements for supervision and support at each level.

Provide resources to support implementation

Ensure members of the workforce, including Lived Experience workers, deliver mental health care within their defined scope, and are not placed in positions where they are required to work beyond their defined scope.

Specific considerations for community mental health services

Mental health workers in the community work relatively autonomously. At times, access to other multidisciplinary team members is limited, for instance, medical colleagues to update treatment charts.

Ensure workers operate within their own scope of practice.

Develop processes to mitigate risks related to lack of access, including regular multidisciplinary reviews and partnerships with local GPs and nurse practitioners.

Evidence-based care

Action 1.27

The health service organisation has processes that:

a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways and decision support tools relevant to their clinical practice
b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care

Intent

The mental health workforce is supported to use the best available evidence.

Strategies for improvement for mental health services

Evidence-based practice integrates research evidence, the expertise of the workers involved, and the knowledge and values held by the consumer, their carers and families.

Support the workforce to access contemporary evidence

Provide the workforce with access to clinical guidelines, clinical care standards and decision-support tools at the point of care.

Deliver in-service training to collectively review new evidence and its potential applicability in the local setting.

Foster a culture of multidisciplinary engagement

Mental health care is provided by workers from multiple disciplines, each of which have specific bodies of evidence. Create opportunities for the workforce to share examples of evidence from their respective disciplines when considering practices used in the local context. Encourage members of the workforce to participate in interdisciplinary journal clubs as part of continuing professional development.

Integrate the consumer’s knowledge and values into local practice

Support the workforce to acknowledge the central roles played by the consumer’s knowledge and experience, and that of their carers and families, in delivering evidence-based practice for the individual. Engaging Lived Experience workers in various roles, including the provision of training and delivery of direct mental health care, will reinforce the contribution of experiential knowledge to practice-based evidence.

Variation in clinical practice and health outcomes

Action 1.28

The health service organisation has systems to:

a. Monitor variation in practice against expected health outcomes
b. Provide feedback to clinicians on variation in practice and health outcomes
c. Review performance against external measures
d. Support clinicians to take part in clinical review of their practice
e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems
f. Record the risks identified from unwarranted clinical variation in the risk management system

Intent

Clinical practice levels of activity, processes of care and outcomes are reviewed regularly and compared with data on performance from external sources and other similar mental health services.

Strategies for improvement for mental health services

Effective mental health care relies on therapeutic engagement between consumers and mental health workers. This requires workers to balance providing care that draws on their individual skills and the evidence-base (see also **Action 1.27**).

Review the data

Identify internal and external data sources. Benchmark local consumer outcomes with national data published on the AIHW website.[18] Review the data to see if the mental health service's performance varies from known best practice or the performance of similar organisations. Investigate outlying data to identify if variation is warranted.

In addition to consumer outcomes, review data on performance indicators, to determine how the service compares to similar mental health services, and if there is room for improvement.

Analyse information on unwarranted clinical variation

Ensure the clinical and management teams work in partnership with consumers, carers and families to analyse these data, and:

- Identify issues, and solutions to deal with them
- Disseminate information about any unwarranted variation, and how it will be addressed
- Act to make changes to care if required
- Report actions taken to reduce unwarranted variation and ongoing performance to the governing body, through the clinical governance framework, and to other relevant organisations.

Safe environment

Action 1.29

The health service organisation maximises safety and quality of care:

a. Through the design of the environment
b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose

Intent

The physical environment supports safe and high-quality care and reflects the consumer's clinical needs.

Strategies for improvement for mental health services

There is evidence that well-designed physical environments reduce harms in mental health services, including the use of restrictive practices.

Use evidence-based design principles to promote safe practice

Engage consumers in co-design of the environment.

Ensure adequate space to prevent crowding and enable freedom of movement. Provide access to natural light. Use soft furnishings and warm colours to reduce the impact of background noise on consumers and create a home-like environment. Add designated low-stimulus therapeutic areas promoting safety, symptom management and emotional regulation.

Design rooms for scalability, adaptability and flexibility, including capacity to provide gender-appropriate areas.

Reduce the risk of harm through removing potential ligature points, using collapsible rails for curtains and shower screens and reducing access to unsecured heights.

Action 1.30

The health service organisation maximises safety and quality of care:

a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce
b. Provides access to a calm and quiet environment when it is clinically required

Intent

Aspects of the environment that can increase risks of harm are identified and managed.

Strategies for improvement for mental health services

A structured approach, such as **Safewards**[28], can support implementation of this action. **Actions 1.29 and 1.30** provide the literal building blocks for later actions in the NSQHS Standards that are designed to reduce the harm related to the use of restrictive practices in mental health services, including restraint and seclusion.

Identify potential flashpoints

Review incident logs to determine if the frequency and severity of incidents are correlated to specific locations or times. Minimise routines that lead to crowding in the environment.

Minimise environmental restriction – provide leave from unit if safe.

Provide environments that can be adapted to meet different needs

Assess how the environment can be modified to meet consumers' needs, for example:

- A calm and quiet environment may be clinically appropriate for a consumer experiencing agitation and aggressive feelings
- Conversely, a consumer with thoughts of self-harm may consider being moved to a space on their own as isolating, and may require one-to-one nursing until their safety is assured.

Provide access to sensory modulation strategies and equipment.

Partnering with Consumers Standard

Leaders of a health service organisation develop, implement and maintain systems to partner with consumers. These partnerships relate to the planning, co-design, delivery, measurement and evaluation of care. The workforce uses these systems to partner with consumers.

Intention of this standard

To create an organisation in which there are mutually valuable outcomes for consumers and for the mental health service, by having:

- Consumers, carers and families who are partners in planning, co-design, delivery, measurement and evaluation of systems and services
- Consumers, carers and families as partners in care, to the extent that they choose.

Criteria

There are four criteria in the Partnering with Consumers Standard:

- Clinical governance and quality improvement systems to support partnering with consumers
- Partnering with consumers in their own care
- Health literacy
- Partnering with consumers in organisational co-design and governance.

Introduction

Actions within the Partnering with Consumers Standard closely align with the principles of recovery-oriented mental health practice. Many people who experience mental ill health have years of experience of symptoms and treatment. They have extensive knowledge of what can exacerbate their symptoms, and what helps to mitigate risks. This knowledge is individual, but is frequently shared, formally or informally, with carers, families and mental health workers. Acknowledging the expertise that people hold in their own treatment and integrating this into treatment plans that also address other health conditions creates the best opportunity to achieve optimal mental and physical health outcomes. Acknowledging that carers and families also have extensive knowledge of treatment effectiveness and the operation of mental health systems, developed from lived experience of another's ill health, can benefit the mental health service and the consumer.

Although there are times when a consumer's mental health issues may impair their capacity to participate in shared decision-making, mental health services can implement practices for partnering with these consumers, and their carers and families, that are consistent with legislation and recovery-oriented practice.

Many consumers, carers and families are motivated to contribute the knowledge and expertise they have developed in their own recovery to support initiatives to improve mental health services, in their own local contexts, and for the mental health system in general. Mental health services can use co-design principles to partner with consumers, carers and families on improving the safety and quality of the service.

Healthcare rights and informed consent

Action 2.03

The health service organisation has a charter of rights that is:

a. Consistent with the Australian Charter of Healthcare Rights
b. Easily accessible for patients, carers, families and consumers

Intent

Consumers, carers and families are provided with information about their healthcare rights.

Strategies for improvement for mental health services

The Australian Charter of Healthcare Rights (the Charter)[29] describes what a consumer, or someone they care for, can expect when receiving health care. These rights apply to all people in all places where health care is provided in Australia. This includes mental health services, public and private hospitals, day procedure services, general practice and other community health services.

It is critical that mental health services partner with consumers to develop mutual recognition of rights and responsibilities and embody these throughout the delivery of care, and not just provide people with copies of their rights or have posters on the walls.

The Mental Health Statement of Rights and Responsibilities[30], used by many mental health services, is an example of a charter of rights, and meets the requirements for implementing this action.

My healthcare rights

This is the second edition of the **Australian Charter of Healthcare Rights.**

These rights apply to all people in all places where health care is provided in Australia.

The Charter describes what you, or someone you care for, can expect when receiving health care.

I have a right to:

Access
- Healthcare services and treatment that meets my needs

Safety
- Receive safe and high quality health care that meets national standards
- Be cared for in an environment that is safe and makes me feel safe

Respect
- Be treated as an individual, and with dignity and respect
- Have my culture, identity, beliefs and choices recognised and respected

Partnership
- Ask questions and be involved in open and honest communication
- Make decisions with my healthcare provider, to the extent that I choose and am able to
- Include the people that I want in planning and decision-making

Information
- Clear information about my condition, the possible benefits and risks of different tests and treatments, so I can give my informed consent
- Receive information about services, waiting times and costs
- Be given assistance, when I need it, to help me to understand and use health information
- Access my health information
- Be told if something has gone wrong during my health care, how it happened, how it may affect me and what is being done to make care safe

Privacy
- Have my personal privacy respected
- Have information about me and my health kept secure and confidential

Give feedback
- Provide feedback or make a complaint without it affecting the way that I am treated
- Have my concerns addressed in a transparent and timely way
- Share my experience and participate to improve the quality of care and health services

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AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

For more information ask a member of staff or visit safetyandquality.gov.au/your-rights

Adopt a charter of rights

Include information about the rights of consumers, carers and families, and the workforce during orientation for new members of the workforce. Run regular education and training sessions for the workforce on their responsibilities for upholding the rights of consumers, carers and families; this includes clinical and non-clinical members of the workforce, and, if relevant, volunteers.

Build a charter of rights into organisational processes, policies and codes of conduct.

Inform consumers, carers and families about their rights

Discuss rights and responsibilities with consumers, carers and families at the earliest opportunity. Display brochures or posters advertising rights and responsibilities at reception desks, and in waiting areas, wards, corridors, consulting rooms and other strategic locations. Ensure that information about rights and responsibilities is available in community languages and provide copies of the charter to any nominated interpreters. Provide information in a format that is suitable for consumers who are visually impaired, such as audio, in braille or on fully accessible websites. Provide easy-to-read summaries.

Review the effectiveness of processes to uphold rights and responsibilities

Conduct surveys of consumers, carers and families to check whether they have received information about their rights and responsibilities, and whether their rights have been upheld.

Conduct surveys of the workforce about their understanding of the mutual rights and responsibilities for consumers, carers, families and the workforce.

Spotlight issue: Rights and responsibilities

Action 2.03 explicitly addresses the rights of all healthcare consumers, using the Australian Charter of Healthcare Rights. For mental health services, the Mental Health Statement of Rights and Responsibilities[30] is a good example of a document that aligns with the Charter, and meets the requirements of the action.

An overarching theme is that mental health consumers have the right to be treated with respect and dignity.

Each state and territory has mental health legislation that sets out consumers' rights. The rights of carers and families are set out in the national Carer Recognition Act 2010.[31]

Action 1.07 requires mental health services to have processes to ensure that their policies are up-to-date and that members of the workforce practice in accordance with legislation. The NSQHS Standards do not duplicate rights that are already set out in legislation, as there are existing mechanisms that require mental health services to practice within legislation.

Many other actions in the NSQHS Standards apply to specific rights for consumers. These include the right to:

- Participate in shared and supported decision-making about their care (**Actions 2.06 and 5.13**)
- Have their needs understood in a way that is meaningful to them (**Action 2.10**)
- Receive care only after providing informed consent (**Action 2.04**)
- Provide feedback (**Action 1.13**)
- Make complaints without concern that this will affect their care (**Action 1.14**)
- Engage with workforce who are appropriately credentialed (**Action 1.23**), orientated to the values of the mental health service (**Action 1.19**) and participate in regular and updated training (**Action 1.20**)
- Be treated in a safe and welcoming environment (**Actions 1.29, 1.30 and 1.33**)
- Choose who they wish to have involved in their care (**Action 2.06**)
- Receive care that safely and competently responds to the diversity of their lived experience (**Actions 1.15 and 1.21**)
- Have their healthcare information handled to maintain their privacy and confidentiality (**Action 1.16**).

The rights referred to in these actions also apply to carers and families.

Action 2.04

The health service organisation ensures that its informed consent processes comply with legislation and best practice

Intent

Consumers are involved in appropriate informed consent processes.

Strategies for improvement for mental health services

Informed consent is a consumer's voluntary decision about their health care that is made with knowledge and understanding of the benefits and risks involved.

Ensure that the mental health service has effective processes in place to:

- Inform consumers (and, if applicable, their carers, families and substitute decision-makers) about the risks, benefits and alternatives of a treatment, including any fees and charges associated with treatment and referrals
- Determine consumer preferences for treatment, including those documented in advance care directives and other planning documents
- Document consumer consent to treatment.

Review current informed consent processes

Ensure that informed consent processes comply with legislation and best practice. The following are best practice principles for informed consent systems:

- Provide information to consumers in a way that they can understand before asking for their consent
- Obtain informed consent or other valid authority before undertaking any examination or investigation, or providing treatment (except in an emergency)
- Document consent appropriately and provide guidance on what to do if there are concerns about a consumer's capacity to provide consent.

Meet the common law and legal requirements of the relevant state or territory relating to:

- Providing information about treatment
- Obtaining consent to treatment, including the requirement to disclose all risks.

Support informed consent through safety and quality systems across all areas of the mental health service that ensure that:

- No treatment is provided without the consumer's informed consent (or, if applicable, that of their substitute decision-maker)
- Specific consent requirements established by state or territory legislation – such as mental health Acts, guardianship and administration Acts – are complied with.

Support informed consent through education and training for all members of the workforce in:

- Effective communication to underpin good clinical practice
- The legal, ethical and practical foundations of requirements for informed consent and engagement in clinical decision-making
- The process for determining a consumer's capacity to consent
- The organisation's consent policy and procedures
- Understanding how individual health literacy levels and the health literacy environment can act as barriers to understanding during the consent process.

The Commission has developed a fact sheet for clinicians on **Informed Consent in Health Care**.

Monitor performance of informed consent processes

Periodically review the performance of informed consent processes to evaluate whether they comply with best practice principles and legislation. Ensure that the mental health service can demonstrate that the workforce seek the consumer's informed consent prior to any interventions, whether the consumer is receiving treatment on a voluntary or involuntary basis. The workforce must also be competent at engaging with consumers to determine their capacity to give informed consent.

Action 2.05

The health service organisation has processes to identify:

a. The capacity of a patient to make decisions about their own care
b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves

Intent

Consumers who do not have the capacity to make decisions about their care are identified, and systems are put in place so that they, or agreed substitute decision-makers, are involved in decision-making, including informed consent.

Strategies for improvement for mental health services

Under Australian legislation, all adults are presumed to have the capacity to decide whether they wish to receive health care, except when it can be shown that they lack the capacity to do so.

A consumer has the capacity to make a decision about their care if they can:

- Understand and retain the information needed to make a decision
- Use the information to make a judgement about the decision
- Communicate the decision in some way, including by speech, gestures or other means.

Decision-making capacity can be decision- and situation-specific. This means that a consumer's capacity can vary at different times, in different circumstances and between different types of decisions.

Review processes for determining a consumer's capacity to make decisions

Ensure that effective processes are in place to identify:

- Consumers who do not have the capacity to make decisions about their own health care
- Appropriate substitute decision-makers who can make decisions on behalf of the consumer
- Consumer's wishes documented in advance care plans or directives.

If these systems are not in place, use the strategies below to develop them:

- Review the local legislation regarding the criteria for a consumer to be considered capable of making decisions about their own care, and incorporate these criteria into any policies and procedures that the mental health service develops; note that state and territory legislation may differ in its definition of consumers who have the capacity to make healthcare decisions
- Develop an organisational policy that outlines the requirements of clinicians to assess consumers for their capacity to make health decisions.

Work with clinicians and consumers to develop procedures to support the organisational policy, including guidance on:

- Assessing fluctuations in a consumer's decision-making capacity
- Considerations for special populations, such as children
- Requirements for recording and documenting decisions.

Educate the workforce about assessing a consumer's capacity to make decisions about their care. Develop or provide resources and tools to reinforce training and assist the workforce to assess a consumer's capacity to make decisions.

Review processes for identifying substitute decision-makers

Develop clear processes for identifying a substitute decision-maker if a consumer does not have capacity to make decisions about their own care. Ensure these processes are consistent with state and territory legislation. Develop resources that outline the process for identifying a substitute decision-maker. Include information about these processes in communications with consumers about informed consent. Educate the workforce about the processes.

For some consumers, the substitute decision-maker may be an appointed guardian. Ensure that there are processes to clearly identify the extent or limits of the guardianship order and provide training for members of the workforce on effective engagement with both the consumer and their appointed guardian. Collect feedback from consumers, carers and families about their experiences when substitute decision-makers are engaged.

Periodically review the design and performance of these processes.

Sharing decisions and planning care

Action 2.06

The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals and make decisions about their current and future care

Intent

Consumers receive safe and high-quality care by being involved in decisions and planning about current and future care.

Strategies for improvement for mental health services

Create a supportive organisational culture

Develop policies that outline the mental health service's commitment to shared and supported decision-making, tailored to consumers' wishes. Engage leadership and the governing body in championing this commitment. Provide adequate resources to support members of the workforce to partner with consumers in their care.

Enable communication and knowledge exchange between clinicians and consumers

Identify communication barriers during admissions processes and implement mitigation strategies for communication throughout the consumer's episode of care. Incorporate consumers' advance care plans in care planning. Support active engagement of consumers, carers and families in care planning meetings, including discharge planning. Provide consumers with access to information about their health care in formats that meet their needs. Provide consumers with timely access to information in their healthcare record. Use technology to share information with consumers, carers and families.

Develop meaningful measures to monitor success

Collect information about consumers', carers' and families' experiences of care through formal surveys and other feedback mechanisms. Use this information to monitor the organisation's performance. Engage consumers, and their carers and families in these reviews.

Review the workforce's current competencies for partnering with consumers, carers and families

Assess the workforce understanding of, and skills in:

- Communication and interpersonal interactions
- Shared decision-making
- Supported decision-making, and the difference between these approaches
- Delivering trauma-informed, recovery-oriented care
- Health literacy.

Provide resources, education and training to support the workforce

Based on the review of the workforce's current skills, provide support to augment identified gaps. Engage consumers, carers, families and Lived Experience workers in the development and delivery of education and training.

Spotlight issue: Working with carers and families

Carers and families play key roles in the lives of consumers. They frequently carry great responsibility for the wellbeing and recovery of consumers. A number of key principles underpin how mental health services can work effectively with carers and families:

- Support consumers to choose who is involved in their care, and how much involvement those people should have
- With the consumer's consent, involve carers and families in all stages of planning and evaluation of a consumer's mental health care
- Consumers, carers and families may have different views on a consumer's needs for mental health care
- If a consumer chooses that carers or family members not be involved in decision-making, their privacy and confidentiality must be respected, in line with legislation governing risk
- Mental health services can support consumers to review their decisions about carer and family involvement
- Mental health services can provide carers and families with publicly available information on mental health care without revealing details about a consumer's individual care
- Mental health services can receive information from carers and families
- Carers and families may have their own needs, and mental health services should ensure they are linked with supports.

More information can be found in **A practical guide for working with carers of people with a mental illness**.[32]

(cont'd)

Spotlight issue: Working with carers and families

Action 2.06 explicitly addresses the mental health service's responsibility for working with carers and families, which has been identified as a key element of effective partnerships by both mental health consumers and carers.

The workforce needs skills in engaging with carers and families when the consumer wishes the carers' involvement. This includes:

- Creating a safe environment includes allowing flexible visiting arrangements to meet consumers', carers' and families' needs (**Action 1.32**)
- Recognising the diversity of carers and families, including children (**Action 1.15**)
- Identifying carers and family members early in the episode of care and involving them in development of the comprehensive care plan (**Action 5.13**)
- Working in partnership with carers and families to monitor the effectiveness of the comprehensive care plan (**Action 5.14**)
- Having processes in place for carers and families to directly escalate care when they are concerned about deterioration in a person's mental state (**Action 8.07**).

The workforce also needs skills in engaging with carers and families when the consumer does not want the carer involved. This includes:

- Upholding the consumer's right to confidentiality and privacy
- Working with the consumer to understand their perspective on information-sharing. Ensure clarity about whether they want certain information shared but other information kept confidential, or whether they want complete privacy
- Communicating with the consumer about the role of carers and families and the potential impact of withholding information
- Checking back with consumers, as their wishes may change over time
- Providing general information about mental health and care and treatment options (**Action 2.10**)
- Notifying the carer and family if specific risks have been identified (**Action 6.09**).

Note: The NSQHS Standards users the terms 'carer', and 'substitute decision-maker' when these are specifically relevant, but also includes carers in the definition of consumers of healthcare services for many actions. Mental health carers have reported concerns that this usage can make carers invisible. Mental health services should adopt their own context-specific language in policies.

Communication that supports effective partnerships

Action 2.09

Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review

Intent

Consumers are involved in the development of information about the mental health service, so it is easy to understand and act on.

Strategies for improvement for mental health services

Consumers, carers and families who have used the mental health service hold knowledge about what information they would like to have, and the format and language(s) in which they prefer to access resources. Engage them in the co-design of information about the mental health service.

Review existing processes for involving consumers in the development of consumer information

Establish a Lived Experience worker-led consumer information working group to co-design consumer and carer information about the mental health service. Hold focus groups or workshops to plan and develop information for consumers, carers and families. Attend community meetings to discuss the information needs of local communities, and the barriers and facilitators to understanding health information in the community.

Engage consumers to review and provide feedback on existing information and incorporate this into improvements

Conduct surveys and focus groups with consumers, carers and families who have used the mental health service's publications to review and provide feedback on current information resources. Incorporate this feedback into the development of new publications and the revision of existing publications.

Partnerships in healthcare governance planning, co-design, measurement and evaluation

Action 2.11

The health service organisation:

a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care
b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community

Intent

Consumers help to shape the way the mental health service operates to achieve mutually beneficial outcomes, and these consumers are reflective of the diversity of the people in the local community.

Strategies for improvement for mental health services

Mental health services partner with consumers, carers and families to co-design new initiatives or substantive reviews of existing processes, and engage consumers, carers, and families in substantive roles in governance and evaluation of their services.

Co-design

Mental health services have a long history of partnering with consumers, and meaningfully engaging through service co-production and co-design processes. 'Co-design engages consumers in the design of services so they will better serve their intended purpose. Planning, designing and producing services with people that have experience of the problem or service… means the final solution is more likely to meet users' needs'.[33]

The Agency for Clinical Innovation has developed a **Co-design toolkit**,[34] which contains resources to guide health services, consumers, carers and families to practice co-design. The toolkit also contains links to a wide range of practice examples that demonstrate co-design in action.

Mental health services can review these resources at whatever level of maturity their co-design practice is.

Review the current level of consumer partnerships

Assess the current opportunities for consumers, carers and families to be involved in the mental health service's:

- Governance
- Strategic and operational planning
- Mental health service design, redesign and evaluation
- Review of safety and quality performance.

Collate information on current stakeholder participation on organisational committees.

Support consumer partnerships in governance and strategic leadership

Create meaningful positions for consumers, carers and families on formal governance committees. Create a consumer and carer advisory group with direct input to leadership and management. Develop a formal, consistent and transparent process for recruiting consumers and carers for participation opportunities. Review the diversity of people who use the mental health service and make up the local community. Integrate information developed to meet Action 1.15 into processes for these partnerships.

Consumers, carers, families and Lived Experience workers have both shared and distinct input across a range of issues. Create opportunities for all voices to be heard. Provide multiple opportunities for consumers to provide feedback on the safety and quality of service and engage them in analysing the service's safety and quality performance.

Provide remuneration to consumers and carers who participate in committees.

Involve consumers, carers and families in the delivery of training to the workforce

Create paid roles for consumers, carers and families in training the workforce on the experience of care. Topics can include, but are not limited to:

- Person-centred care
- Trauma-informed care
- Recovery-oriented care
- Working with carers and families
- Open disclosure.

Provide support for consumer, carer and family involvement in training, including managing their information with sensitivity and maintaining privacy and confidentiality.

Action 2.12

The health service organisation provides orientation, support and education to consumers who are partnering in the governance, co-design, measurement and evaluation of the organisation

Intent

Consumers partnering in organisational co-design and governance are supported to exercise the skills they need to be able to contribute effectively.

Strategies for improvement for mental health services

Develop and facilitate access to orientation, training and resources

In partnership with consumers, carers and families, identify their needs for training and support when they are involved in the mental health service's governance, co-design, measurement or evaluation processes. Training can include:

- Orientation to the mental health service
- Orientation to health service decision-making processes for consumers
- Meeting procedures
- Communication skills.

Implement a structured support program for consumers involved in governance and strategic leadership roles. This could include a mentoring service between experienced and new consumer partners.

Consider the needs of consumers involved in informal partnerships and ensure that they:

- Are aware that the information they provide is separate to the process of providing or receiving care, and will not affect their treatment
- Understand the process in which they are participating and how the information they provide will be used
- Have an opportunity to provide further comment later if they wish
- Have an opportunity to raise concerns about the process if they wish.

Preventing and Controlling Infections Standard

Leaders of a mental health service develop, implement and monitor systems to prevent, manage and control infections and antimicrobial resistance; reduce harm for patients, consumers and members of the workforce; and achieve good health outcomes for patients. The workforce uses these systems to minimise and manage risks to patients and consumers.

Note: This action is from the **updated edition of the NSQHS Standards**, released in May 2021.

Intention of this standard

To reduce the risk to patients, consumers and members of the workforce of acquiring preventable infections; effectively manage infections, if they occur; prevent and contain antimicrobial resistance; promote appropriate prescribing and use of antimicrobials as part of antimicrobial stewardship; and promote appropriate and sustainable use of infection prevention and control resources.

Criteria

There are four criteria in the Preventing and Controlling Infections Standard:

- Clinical governance and quality improvement systems are in place to prevent and control infections, and support antimicrobial stewardship and sustainable use of infection prevention and control resources
- Infection prevention and control systems
- Processing of reusable equipment devices
- Antimicrobial stewardship.

This user guide focuses on one action from the Preventing and Controlling Infections Standard, addressing standard and transmission-based precautions, as this is of the greatest relevance for mental health services.

Introduction

Evidence-based systems are used to mitigate the risk of infection. These systems account for individual risk factors for infection, as well as the risks associated with the clinical intervention and the clinical setting in which care is provided. A precautionary approach is warranted when evidence is emerging or rapidly evolving.

Patients, consumers and members of the workforce with suspected or confirmed infection are identified promptly, and appropriate action is taken. This includes persons with risk factors for transmitting or acquiring infection, or colonisation with an organism of local, national or global significance.

The mental health service is clean and hygienic, and has well-maintained and configured engineering systems for the delivery of effective models of care.

Action 3.08

Members of the workforce apply standard precautions and transmission-based precautions whenever required, and consider:

a. Patient's risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated during care
b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance
c. Accommodation needs and patient placement to prevent and manage infection risks
d. The risks to the wellbeing of patients in isolation
e. Environmental control measures to reduce risk, including but not limited to heating, ventilation and water systems; workflow design; facility design; surface finishes
f. Precautions required when a patient is moved within the facility or between external services
g. The need for additional environmental cleaning or disinfection processes and resources
h. The type of procedure being performed
i. Equipment required for routine care

Intent

The exposure of consumers and the workforce to infectious agents that cannot be contained by standard precautions alone is minimised. Risk is assessed at all access opportunities to the mental health service, and necessary precautions are implemented and maintained for as long as necessary.

Strategies for improvement for mental health services

Review and assess the mental health service's processes that will inform risk management strategies to minimise exposure of consumers, the workforce and the organisation to infectious agents.

These include:

- How the risk of infection or communicable disease is assessed on admission, on referral or on presentation for care in the organisation
- What processes are in place to reassess the risks when clinically indicated during care
- How infection risks are acted on, if identified
- What processes are in place to inform the workforce or external services of a risk of an infectious agent or communicable disease
- How contracts and service performance of any external providers of goods and services are reviewed.

Information sources to help with this assessment may include:

- Data on waiting times for admission, movement through the emergency department and delays in consumer admission because of a lack of appropriate accommodation, resources and equipment
- Pathology reports on infectious agents of local, national or international significance that require transmission-based precautions
- Surveillance data and reports from the organisation and other sources (for example, national, or state or territory surveillance reports) that have been gathered using national systems and definitions (if available)
- Incident reports relating to possible transmission of infectious agents
- Consumer feedback reports
- Maintenance or service history and pathology reports to identify appropriate monitoring of air-handling systems, water supply systems and other relevant equipment
- Data on cleaning and disinfection regimes.

Develop strategies to respond to any risks identified as part of the review, or any risks identified as part of a public health response or pandemic planning.

Include identified risks in the organisation's quality improvement program so that actions and outcomes are monitored, measured, assessed and reported to leadership, the workforce and consumers. If appropriate, report recommendations to external departments, facilities or services that may be involved in the care of the consumer.

If the mental health service is part of a larger organisation or corporate group, refer to their policies, procedures and protocols for managing and communicating risk of infectious agents of local, national and international significance.

The **Australian Guidelines for the Prevention and Control of Infection**[35] provide detailed information about risk assessment processes for infection prevention and control.

Consider the risks to the wellbeing of the person in isolation

This is a new sub-action in the 2021 version of this standard.

If a consumer needs to stay in isolation due to the presence of a transmissible infection, ensure the mental health service implements a range of strategies to support their wellbeing. These can include:

- Regular verbal engagement with the consumer, not restricted to clinical interventions; for instance, conversing with them at mealtimes (while maintaining social distance)
- Access to television, smartphones, electronic tablets, or other communications device to keep them engaged with their preferred information.

Medication Safety Standard

Leaders of a mental health service describe, implement and monitor systems to reduce the occurrence of medication incidents, and improve the safety and quality of medicine use. The workforce uses these systems.

Intention of this standard

To ensure clinicians are competent to safely prescribe, dispense and administer appropriate medicines and to monitor medicine use. To ensure consumers are informed about medicines and understand their individual medicine needs and risks.

Criteria

There are four criteria in the Medication Safety Standard:

- Clinical governance and quality improvement to support medication management
- Documentation of consumer information
- Continuity of medication management
- Medication management processes.

Introduction

The Medication Safety Standard aims to ensure that clinicians safely prescribe, dispense and administer appropriate medicines, and monitor medicine use. It also aims to ensure that consumers, and where appropriate, carers and families, are informed about medicines, and understand their own medicine needs and risks.

Medication in mental health services

Medicines are a common treatment used in mental health care. Although appropriate use of medicines contributes to substantial improvements in health, medicines can also be associated with harm. Because they are so commonly used, medicines are associated with a higher incidence of errors and adverse events than other healthcare interventions. Some of these events are costly, in terms of morbidity, mortality and resources.

Some medication use can create its own potential for increased morbidity. Medication use in mental health care should be part of a comprehensive treatment plan incorporating non-pharmacological therapies and that plan should include active components to address the possible side effects of that medication use.

Medication reconciliation

Action 4.05

Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care

Intent

Consumers, carers and families are actively involved in taking a best possible medication history (BPMH) as the first step in the process of medication reconciliation.

Strategies for improvement for mental health services

Complete a BPMH as early as possible on admission – this is the key first step of a formal process of medication reconciliation. At least two sources of information are needed to obtain and then confirm the consumer's BPMH – for example, the consumer and their nominated GP, their community pharmacist or My Health Record.

If the consumer is unwell and declines or is unable to participate in the BPMH, check with the family and carer, the community mental health service or private psychiatrist, and confirm details with the consumer when they are ready.

A BPMH should be completed, or the process supervised, by a clinician with the required skills and expertise. Policies, procedures and guidelines for obtaining a BPMH should include:

- A structured interview process
- The key steps of the process
- Documentation requirements (where and what should be documented, such as use of the National Medication Management Plan or equivalent; paper or electronic)
- Roles and responsibilities of clinicians
- Training requirements for clinicians
- Involvement of consumers, carers and families.

Use a standard form for recording the BPMH. This creates 'one source of truth', and acts as an aid to reconciliation on admission, clinical handover, transfer and discharge. If the consumer has an advance care plan, refer to this when undertaking medication reconciliation, and ensure changes to medication are subsequently reflected in the advance care plan.

Consider training requirements to ensure that clinicians with responsibility for obtaining a BPMH are sufficiently competent. Learning modules and instructional videos are available from various state, national and international organisations.

Ensure the BPMH and associated information is easily accessible to all clinicians involved in managing the consumer's medicines, and used to reconcile against medication orders on admission, at transfers of care and on discharge. At the end of an episode of care, transfer and communicate verified information effectively to the next health service organisation to ensure continuity of medication management (see also **Action 4.6**, using the BPMH, **Action 4.11**, providing consumers with information about their medicines and **Action 4.12**, providing a medicines list at transitions of care).

Adverse drug reactions

Action 4.07

The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation

Intent

Medicine-related risks for consumers are minimised by documenting and referring to the consumer's history of medicine allergies and adverse drug reactions (ADRs).

Strategies for improvement for mental health services

As part of a BPMH, clinicians must elicit and document known medicine allergies and ADRs experienced by a consumer before their current admission.

Review organisational policies, procedures and guidelines on recording known medicine allergies and ADRs in the consumer's healthcare record. These should:

- Identify the clinician responsible for recording information on known medicine allergies and ADRs
- Outline what information to include (for example, type of reaction experienced, its severity, how it was managed)
- Describe what action should be taken if the nature of the documented reaction needs to be challenged or verified, including instances of allergy mismatch
- Describe where and when it is appropriate to record a known allergy or adverse reaction to substances other than medicines, such as food, in the consumer's medicine allergy and ADR history.

Ensure that known medicine allergies and ADRs are recorded.

Provide orientation, training and education to clinicians, and review clinician work practices for:

- Determining and documenting known medicine allergies and ADRs in the consumer's medicine allergy/ADR history
- Referring to a consumer's medicine allergy/ADR history before, or at the point of, decision-making when prescribing, dispensing or administering medicines.

Conduct audits of documentation on medicine allergies and ADRs. These may focus on consumers who have experienced previous medicine allergies or ADRs, the information that has been documented and where it has been documented (for example, in the medication chart, MMP or equivalent, discharge summary, medicines list, electronic medication management system).

Collate and review audit trends, and provide information to clinicians through medication safety bulletins, in-service orientation sessions, case reports or grand rounds.

Medication review

Action 4.10

The health service organisation has processes:

a. To perform medication reviews for patients, in line with evidence and best practice
b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems
c. That specify the requirements for documentation of medication reviews, including actions taken as a result

Intent

Medicines use is optimised, and medicine-related problems are minimised by conducting medication reviews and documenting the outcomes, in partnership with consumers and their carers and families.

Strategies for improvement for mental health services

Medication review is an essential process in mental health services. It provides an opportunity to understand the current role of medicine in the consumer's overall treatment plan, in the context of their previous experiences, both positive and negative. It also contributes to supporting the consumer's physical health, through setting up effective processes for monitoring side-effects and planning interventions to reduce preventable long-term problems.

Conduct evidence-based medication reviews

Ensure that medication reviews are conducted or supervised by a clinician with the appropriate skills and expertise, acting as part of a multidisciplinary team. In large health service organisations, pharmacists may be the main provider of medication review services for mental health services.

For each medicine being reviewed, consider the clarity, validity and appropriateness of the medicine order, as well as the expected treatment outcomes. A consumer's experience of using medicines and their needs may change over time, especially during an admission to an acute mental health service. This means that medicines may be reviewed more than once during an episode of care.

If a consumer has an advance care plan, ensure that medication review refers to the consumers' will and preference regarding medications.

Use medication reviews to understand the consumer's experience with their current medicines and any newly prescribed medicines and ensure that their medicine use is as safe as possible. Make reference to any advance care plan that is in effect. The medication review might include discussion of:

- When, how and whether the consumer has been taking their prescribed medicines before admission to the mental health service
- The consumer's satisfaction with the outcomes from their medicines (including those newly prescribed), as well as a positive care experience – for example, no avoidable medicine-related problems
- The consumer's quality of life and expected duration of medication (for consumers with long-term conditions).

Medication review should include assessment of current (existing and newly prescribed) medicines; the history of all medicine-related orders and administration records, including oral and parenteral, and multiple- and single-dose medicines; anaesthetic and operative records; and ceased medicine orders.

When conducting a medication review, consider the following:

- Is there a documented reason or evidence base for use of a medicine?
- Does the consumer still need the medicine?
- Is the medicine still working?
- What risks are associated with use of the medicine, and what monitoring is required?
- Are there any consumer-specific issues that will affect use of the medicine for the individual?
- What are the consumer's will and preference regarding the medicine?

Assess individual consumer risk

Review the mental health service's risk assessment criteria for consumers who might be at risk of a medicine-related adverse event. Include consideration of the consumer's capacity to understand the risks of medicine use and make decisions about their medicines, and the need to involve carers, families or interpreters.

Set up processes to conduct and document medication reviews

For medication review to be effective, mental health services need to have a formal, structured process in place for medication review that is conducted in partnership with the consumer, their carer or family member, and in collaboration with relevant providers involved in the consumer's care. Processes will depend on the infrastructure and resources available.

Use quality improvement methodology to monitor and implement change. This can be achieved by auditing and evaluating medication review processes using national, state or territory, or local indicators.

The NSW Clinical Excellence Commission produces a **Guide to Medication Reviews**[36] that can assist to embed these in the organisational processes of mental health services.

Comprehensive Care Standard

Leaders of a mental health service set up and maintain systems and processes to support clinicians to deliver comprehensive care. They also set up and maintain systems to prevent and manage specific risks of harm to consumers during the delivery of health care. The workforce uses the systems to deliver comprehensive care and manage risk.

Intention of this standard

To ensure that consumers receive comprehensive care – that is, coordinated delivery of the total health care required or requested by a consumer. This care is aligned with the consumer's expressed goals of care and healthcare needs, considers the effect of the consumer's health issues on their life and wellbeing, and is clinically appropriate.

To ensure that risks of harm for consumers during health care are prevented and managed. Clinicians identify consumers at risk of specific harm during health care by applying the screening and assessment processes required in this standard.

Criteria

There are four criteria in the Comprehensive Care Standard:

- Clinical governance and quality improvement to support comprehensive care
- Developing the comprehensive care plan
- Delivering comprehensive care
- Minimising harm.

Introduction

In mental health services comprehensive care extends beyond the concept of dealing with the immediate symptoms of mental ill health. It incorporates the need for a recovery-oriented focus to care planning and an understanding of the diversity of consumer needs when practising trauma-informed care. It also requires an appreciation of the disproportionate physical healthcare needs often experienced by mental health consumers and ensuring that these are not ignored.

Designing systems to delivery comprehensive care

Action 5.04

The health service organisation has systems for comprehensive care that:

a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment
b. Provide care to patients in the setting that best meets their clinical needs
c. Ensure timely referral of patients with specialist healthcare needs to relevant services
d. Identify, at all times, the clinician with overall accountability for a patient's care

Intent

The mental health service provides systems to enable and support the delivery of comprehensive care to consumers.

Strategies for improvement for mental health services

Co-design processes to develop, document and communicate comprehensive care plans

Work with consumers, carers, families and clinicians on implementation of comprehensive care planning.

Determine:

- Minimum expectations for comprehensive care plans, including recovery orientation
- Processes for shared and supported decision-making
- Process for integrating advance care directives into comprehensive care plans
- Agreed signs for review of comprehensive care plans
- Templates for documenting comprehensive care plans
- Processes for communicating the content of the plan
- Processes for integrating care when people receive care from more than one service.

Build templates into electronic and paper systems to ensure consistency.

Refer to evidence-based clinical pathways, where available, to minimise unwarranted variation.

Develop processes to ensure that consumers receive care in the setting that best meets their needs

Work with consumers, and their carers and family to identify their preferred place to receive care, for example, their home, a community health centre, a hospital, or their GP.

Conduct risk assessments to determine the least restrictive option that is safe. Develop processes to divert people from emergency departments where possible.

Develop clear structures for escalation of care in response to change in a consumer's mental state.

Establish referral processes

Provide accessible guidance about referral processes that outline the:

- Clinical or other criteria for referral
- Process for making the referral
- Process for expediting urgent referrals
- Expected response times
- Follow-up and escalation processes for delayed response.

Work with external services to identify referral processes to support ongoing comprehensive care. Ensure referral for medical care for medical comorbidities. Involve carers and families in the planning process.

Provide the consumer with a copy of the completed discharge instructions that include recovery goals, possible relapse signs, ways to deal with them, and the details of whom to contact in case of emergency, customised for the particular consumer.

Set up processes for identifying the clinician with overall accountability

Work with clinicians to develop consistent processes for identifying the clinician with overall responsibility. Use a range of communicating mechanisms to advise the consumer, carers and family who this clinician is. Ensure new, agency and locum clinicians have ready access to this information. Develop processes to identify which clinician has accountability for a consumer's care in the absence of their identified primary clinician.

Further information can be found in **Implementing the Comprehensive Care Standard – A conceptual model for supporting comprehensive care delivery**.[37]

Collaboration and teamwork

Action 5.05

The health service organisation has processes to:

a. Support multidisciplinary collaboration and teamwork
b. Define the roles and responsibilities of each clinician working in a team

Intent

Members of the workforce are supported to work in collaborative multidisciplinary teams, and they understand their own roles and responsibilities, and those of other team members.

Strategies for improvement for mental health services

Effective mental health care integrates multiple skill sets, including formulation and diagnosis, psychoeducation, psychological support, pharmacology, support navigating a diverse range of social needs, rehabilitation, functional support with daily living skills and physical health care. Delivering this care requires a workforce with different disciplinary skills. Mental health workforce planning is focused on workers providing care specific to their disciplinary expertise in a coordinated and integrated manner.

Ensure the mental health service develops a plan for recruiting Lived Experience workers in a range of roles across the service.

If a mental health service employs a workforce with a broad range of disciplinary expertise, ensure their processes support internal integration of care. If a mental health service is focused on a defined area of expertise, develop partnerships with other organisations to ensure that integrated interdisciplinary care is available to consumers.

Review current teamwork processes

Define roles and responsibilities for members of the workforce in relation to multidisciplinary teamwork. Review the structures for teamwork, including handover, case conferences and communicating critical information. Determine how the Lived Experience workforce is integrated with the clinical workforce.

Strengthen teamwork processes

Design or adapt relevant tools, for example, structured handover formats. Provide training to members of the workforce to increase individual competence.

Address professional and disciplinary barriers to multidisciplinary collaboration through identifying accountabilities and engaging clinical and executive leaders.

Action 5.06

Clinicians work collaboratively to plan and deliver comprehensive care

Intent

Clinicians work together to plan and deliver comprehensive care in partnership with consumers, carers and families.

Strategies for improvement for mental health services

In partnering with consumers, carers and families to deliver comprehensive care, mental health services may work in partnership with other organisations, including the National Disability Insurance Agency and Community Managed Organisations. Members of the workforce can support consumers, carers and families to navigate these partnerships, so that all care that is necessary is provided, but services are not duplicated.

Collaborate with consumers, carers and families

Use the Partnering with Consumers Standard to guide the development of processes for comprehensive care.

Engage consumers, and their carers and families in all decision-making discussions. Avoid relegating carers and families to sources of information for clinicians.

Implement shared or supported decision-making

Engage with the consumer, their carers and families to determine if they prefer shared decision-making (with the decision shared by the clinician and consumer) or supported decision-making (where the clinician provides information about options, but the consumer makes the decisions).

Review clinicians' competencies in delivering care in these modalities and practising consistent with legislative requirements regarding supported decision-making. Provide training if needed to enhance clinicians' competencies.

Use decision support tools

Provide consumers, and their carers and families with decision support tools to facilitate their participation in decision-making discussions.

Provide information in formats that are accessible to a diverse range of stakeholders.

Planning for comprehensive care

Action 5.09

Patients are supported to document clear advance care plans

Intent

Consumers are supported to document clear advance care plans and the mental health service integrates these plans into comprehensive care planning.

Strategies for improvement for mental health services

In mental health services, advance care planning typically refers to processes for understanding and documenting a consumer's treatment preferences for times when their mental state deteriorates and alters their decision-making capacity. More broadly in health services, advance care plans are often used for understanding a person's wishes at the end of life.

There will be times when people with mental ill health make plans for their end-of-life care – see **Action 5.15** for more detail.

Understand your service's responsibilities and build effective procedures

Review the legislation related to advance care plans that applies in your state or territory. Align policies and procedures to this legislation.

Have clear policies and procedures that describe the roles of substitute decision-makers, witnesses, carers, families and clinicians in treatment decision-making and how each of these roles relates to the wills and preferences of the consumer. Ensure the consumer understands their right to appoint a substitute decision-maker, consistent with local legislation, in an advance care plan.

Provide support for consumers, carers and families to document and update advance care plans. Provide training and education for the workforce in integrating advance care planning.

Develop resources to support advance care planning

When undertaking advance care planning, consumers need to consider many issues, including:

- How their previous experiences of health care influence their preferences for future care
- Their previous experience of the effects of different medications
- Who they would want to speak for them if they lack the capacity to take part in decision-making
- How they will maintain the relevance and currency of their advance care plan.

Use templates co-designed by consumers.

Ensure supports are in place, including Lived Experience workers or interpreter support where necessary, to assist in negotiating and documenting and advance care plan.

Specific considerations for community mental health services

Community mental health services are ideally placed to support consumers to develop, document and update advance care plans. They provide opportunities for consumers to engage with the workforce when their capacity to make decisions is strongest. They provide time to review past experiences that have supported or challenged their recovery and include information about this within plans for future care.

Screening of risk

Action 5.10

Clinicians use relevant screening processes:

a. On presentation, during clinical examination and history taking, and when required during care
b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm
c. To identify social and other circumstances that may compound these risks

Intent

Consumers receive initial and, if necessary, repeated screening for cognitive, behavioural, mental and physical conditions, issues or risks of harm.

Strategies for improvement for mental health services

Provide clinicians with training in person-centred approaches to screening

Training should include:

- Effective communication strategies, with a focus on developing collaborative relationships
- Empathic questioning to avoid 'tick and flick' approach
- Use of interpreters.

Provide clinicians with validated screening tools for physical, mental and cognitive conditions

Validated screening tools support the workforce to undertake comprehensive screening.
Tools should cover, at a minimum:

- Mental state examination
- Physical health checklist

- Cognitive screen
- Substance use
- Social and economic circumstances
- Cultural determinants.

General screening should be augmented in specific contexts, for example, use of the postnatal depression screening tool.

Provide clinicians with clear pathways to follow when screening, to identify need for further assessment and planning of risk mitigation strategies. In screening for risks, avoid:

- Locally developed tools, unless they align strongly with validated tools
- Using a numerical score
- Trying to predict the likelihood of behaviour such as suicide or aggression.

Risk assessment cannot predict behaviour; only identify risks and circumstances that may compound them.

Spotlight issue: Mental, physical and cognitive health care

Action 5.10 explicitly addresses screening for mental, physical and healthcare needs and making plans to deliver care to meet those needs. The following actions in the Comprehensive Care Standard outline processes for conducting further assessments to address identified needs and partnering with consumers to develop plans to deliver the care to achieve their healthcare goals (**Actions 5.11, 5.12, 5.13 and 5.14**).

These actions build on actions in the Partnering with Consumers Standard, such as **Actions 2.06 and 2.07**.

Multidisciplinary teamwork (**Actions 5.06 and 5.07**) is essential to meeting consumer's healthcare needs, and the mental health service needs to provide this within the service or through partnerships with other providers, for example, through the local PHN. Mental health consumers are at higher risk of a range of physical health problems, including metabolic syndrome. Mental health services do not necessarily need to provide all of a consumer's physical health needs, but they do have a duty to ensure that consumers are effectively linked with services that can support them in monitoring their long-term physical health needs.

Mental health services need to have processes in place for members of the workforce to recognise when a person experiences acute deterioration in their mental or physical health (**Actions 8.04 and 8.05**) and escalate care to the appropriate healthcare providers (**Action 8.06**).

The Equally Well[38] website contains resources and links to support mental health and other services in improving the physical health of people who experience mental ill health.

Clinical assessment

Action 5.11

Clinicians comprehensively assess the conditions and risks identified through the screening process

Intent

Consumers receive comprehensive assessment to determine their healthcare needs and appropriate treatment options.

Strategies for improvement for mental health services

Provide access to timely comprehensive mental health assessment by suitably skilled clinicians

Ensure assessment is conducted by clinicians with mental health expertise. Engage members of the multidisciplinary team to develop comprehensive understanding of the consumer's needs. Use standardised assessment documentation to support clinical judgement. Ensure all information contained in a consumer's healthcare record is available at the point of care (refer **Action 1.16**).

Use a person-centred approach in conducting a comprehensive mental health assessment

Partner with consumers, carers and families throughout the assessment process. Integrate advance care plans in assessment. Link assessment directly to shared or supported decision-making processes.

Developing the comprehensive care plan

Action 5.13

Clinicians use processes for shared decision-making to develop and document a comprehensive and individualised plan that:

a. Addresses the significance and complexity of the patient's health issues and risks of harm
b. Identifies agreed goals and actions for the patient's treatment and care
c. Identifies the support people a patient wants involved in communications and decision-making about their care
d. Commences discharge planning at the beginning of the episode of care
e. Includes a plan for referral to follow-up services, if appropriate and available
f. Is consistent with best practice and evidence

Intent

Clinicians use shared and supported decision-making processes to develop person-centred and goal-directed comprehensive care plans that meet the consumer's identified needs.

Strategies for improvement for mental health services

Identify goals of care

Adopt a recovery-oriented approach to agreeing on goals of care. Provide clinical input to inform goals of care and identify the range of options and how interventions, such as medication, can fit into overall goals. Provide support to address functional goals, including referral to external services. Integrate consumers' values and personal goals into the comprehensive care plan.

Identify support people

Ask the consumer during initial conversations to identify the carers or family members they wish to be involved in communications and decision-making about their care. Allow the consumer to update their nominated support people during the episode of care. Document the contact details of the consumer's carers and family in the healthcare record. Engage the consumer's nominated carers and family in decision-making and document this in the healthcare record.

Provide consumers with access to Lived Experience workers, cultural and spiritual liaison workers, and independent advocates.

Plan for discharge

Ensure current episode of care is integrated into the consumer’s overall recovery plan.

Engage key participants in discharge planning, including:

- Consumer
- Carers and families
- Lived Experience workers or other support people
- Community mental health service
- Primary care provider
- GP (if not primary care provider)
- Community managed service
- Rehabilitation provider
- Private psychiatrist
- Private psychologist or counsellor.

Document the discharge plan and provide copies to relevant stakeholders. Include relapse prevention strategies in the discharge plan, and what to do if the person’s mental state deteriorates, including information about how to re-enter the service if needed.

Spotlight issue: Trauma-informed, recovery-oriented mental health care

The principles of trauma-informed and recovery-oriented practice underpin the delivery of mental health services.

Trauma-informed care involves recognising the significance and complexity of the consumer's health issues and risks of harm which, for mental health consumers, frequently includes a history of trauma both prior to and within previous healthcare episodes.[39]

Recovery-oriented care focuses on the agreed goals of care, recognising that the consumer's own recovery goals will not be restricted to clinical goals.[40]

They are strengths-based approaches, that require mental health services to ensure that their processes are effectively tailored to the individual consumer and reflect both their previous experiences, and their will and preferences for future care.

Action 5.13 sets out key issues to address when members of the workforce partner with consumers, carers and families to plan care.

Mental health practice that is recovery-oriented upholds the rights of consumers (**Action 2.03**), including the right to providing informed consent prior to any intervention (**Action 2.04**). Consumers, carers and families are engaged in shared and supported decision-making (**Actions 2.06 and 5.03**) and their advance care plans are integrated into current care (**Action 5.09**). Practice must align with mental health legislation (**Action 1.07**) and uphold the consumer's rights at all times.

The principles of trauma-informed and recovery-oriented practice are also critically important when a consumer experiences deterioration in their mental state. While services must ensure safety for the consumer and others, it is essential that members of the workforce sustain partnerships with consumers, carers and families to manage identified risks and maximise opportunity for the consumer to exercise choice and control (**Action 8.03**).

Using the comprehensive care plan

Action 5.14

The workforce, patients, carers and families work in partnership to:

a. Use the comprehensive care plan to deliver care
b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care
c. Review and update the comprehensive care plan if it is not effective
d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur

Intent

The comprehensive care plan is used to direct the delivery of safe and effective care that aligns with the consumer's needs and preferences.

Strategies for improvement for mental health services

Provide education and training

Education for the workforce can include:

- When and how to use the comprehensive care plan
- Roles, responsibilities and accountabilities of different team members in delivering comprehensive care
- Assessing, documenting and communicating the consumer's progress in line with the goals of care
- Partnering with consumers
- Partnering with carers and families
- How to access additional expertise to support the delivery of comprehensive care
- Working collaboratively with other service providers.

Education for consumers, carers and families can include:

- How to identify the roles of different members of the workforce, including Lived Experience workers
- The available means for communication with members of the workforce, such as daily handover or case conferences
- How to escalate concerns about the consumer's wellbeing
- How to request and participate in review of the comprehensive care plan
- How to provide feedback on the delivery of comprehensive care.

Involve consumers, carers and families in recovery-oriented practice

Recovery oriented practice supports a consumer to exercise optimal autonomy at all stages of an episode of care. Members of the workforce can do this by:

- Communicating with the consumer prior to any intervention to confirm they understand the purpose and agree to it happening now
- Engaging with the consumer's carers and family for all key decisions (with the consumer's consent)
- Recognising the diversity of consumers, carers and families and tailoring interventions to reflect their individual needs
- Providing opportunities for consumers, carers and families to give feedback on the care that is delivered, and make changes as needed.

Review the comprehensive care plan

Develop processes for review of comprehensive care plan:

- At routine time intervals
- In response to a change in the consumer's condition
- If a consumer is not making the progress they wished for
- If a change in the plan is being considered.

Action 5.15

The health service organisation has processes to identify patients who are at the end of life that are consistent with the **National Consensus Statement: Essential elements for safe and high-quality end-of-life care**[41]

Intent

People at the end of life are identified as soon as possible to maximise opportunities for appropriate decision-making and care.

Strategies for improvement for mental health services

Clinicians in mental health services may only rarely be called upon to participate in identifying when a consumer is nearing the end of life. The process should be undertaken with expertise from other disciplines as well as mental health.

The **National Consensus Statement: Essential elements for safe and high-quality end-of-life care**[41] sets out suggested practice for health service organisations delivering end-of-life care in settings that provide acute health care. A series of online education modules based on the consensus statement and targeted at clinicians working in hospitals is available from the **End-of-Life Essentials website**.[42]

Conversations about end-of-life care

Mental health clinicians involved in long-term therapeutic engagements with mental health consumers may be key participants in end-of-life discussions with consumers, their carers and families and other treating clinicians. Having conversations about death, dying and the end of life requires compassion, knowledge, experience, sensitivity and skill on the part of the clinicians involved.

The principles and practice of supported decision-making used in ongoing care of mental health apply in end-of-life discussions. Provide orientation, education and training for clinicians to understand their individual roles, responsibilities and accountabilities in working with the consumer, their carers and families to make shared decisions about end-of-life care. This may include developing peer support and mentoring programs to help clinicians practise and improve their skills over time. Training, education and mentoring programs should be consistent with the actions described in the consensus statement.

Additional information is available in the NSW Health document **Dignity, Respect and Choice: Advance care planning for end of life for people with mental illness**.[43]

Preventing and managing pressure injuries

Action 5.21

The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines

Intent

Evidence-based guidelines are used for prevention and care for consumers at risk of or with a pressure injury.

Strategies for improvement for mental health services

Pressure injuries are relatively rare occurrences in mental health services. Risks that must be considered include:

- A proportion of consumers at higher risk of pressure injuries due to poor nutrition and weight gain
- Sedative effects of psychotropic medications which prolong immobility
- Clinical staff with less experience in preventing, detecting and managing pressure injuries.

Prevention and Treatment of Pressure Ulcers: Clinical practice guideline[44] is the relevant best-practice guideline. These guidelines outline the components of, and techniques for, comprehensive skin and tissue inspections.

Screening for risk of pressure injuries should be integrated into the physical health assessment that mental health services conduct when a consumer is admitted for care.

Mental health clinicians should have access to expert advice in the management of a pressure injury if one occurs.

Preventing falls and harm from falls

Action 5.24

The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for:

a. Falls prevention
b. Minimising harm from falls
c. Post-fall management

Intent

Clinical practice for preventing and managing falls is evidence-based, and consumer risks and harm are minimised.

Strategies for improvement for mental health services

Falls remain a major safety and quality risk in health service organisations. In mental health services, there are additional risks related to the side-effects of psychotropic medication, including sedation and postural hypotension.

Falls prevention and harm minimisation plans based on best practice and evidence can improve consumer outcomes. These can include strategies such as initiating monitoring of a consumer's lying and standing blood pressures and providing education about sitting up between lying and standing.

Best-practice guidelines and guides for preventing falls and harm from falls in older people are available on the **Falls Prevention** section of the Commission's website. These resources were developed for hospital, community and aged care home settings. The resources comprise detailed guidelines, shorter guidebooks and fact sheets, and include strategies for falls prevention, managing falls risks and responding to falls.

Delirium should be considered a risk factor for falls. Refer to **Action 5.29** and the **Delirium Clinical Care Standard**[45] for strategies to manage risks of harm related to delirium.

Nutrition and hydration

Action 5.28

The workforce uses the systems for preparation and distribution of food and fluids to:

a. Meet patients' nutritional needs and requirements
b. Monitor the nutritional care of patients at risk
c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone
d. Support patients who require assistance with eating and drinking

Intent

The workforce ensures that the consumer's nutrition and hydration needs are met.

Strategies for improvement for mental health services

Conduct a nutrition risk assessment

Assess risk of malnutrition and dehydration prior to admission due to:

- Loss of functional skills
- Hyperactivity
- Ability to swallow safely
- Economic hardship.

Assess risk of metabolic syndrome or other weight gain issues due to:

- Side-effects of psychotropic medication
- Lack of nutritional knowledge
- Economic hardship
- Hypoactivity.

Monitor the nutritional care of consumers at risk

Ensure that nutritional care is planned and documented for each consumer. Monitor intake and changes in weight. Modify the nutritional care plan in response to identified changes. Support consumers who require assistance with eating and drinking.

The Royal Australian and New Zealand College of Psychiatrists has developed **Clinical Practice Guidelines for the treatment of eating disorders**.[46] These are endorsed by the **Butterfly Foundation,** the national charity for all Australians impacted by eating disorders and body image issues, and for the families, friends and communities who support them.[47]

Identify and provide access to individual nutritional supports

Ensure culturally appropriate food is available. Provide access to food and drink outside set mealtimes for consumers who have not attended meals. Provide education to consumers around healthy nutritional choices.

Preventing delirium and managing cognitive impairment

Action 5.29

The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to:

a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the **Delirium Clinical Care Standard**, where relevant
b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation

Intent

A system for caring for cognitive impairment is implemented that minimises the risk of harm for people with cognitive impairment or at risk of developing delirium. The use of antipsychotics and other psychoactive medicines is in line with best practice and legislation.

Strategies for improvement for mental health services

Implement a system for screening

Routinely screen for cognitive impairment in consumers aged 65 years or over, and 55 years and over for Aboriginal and Torres Strait Islander people, using a validated tool. Screen consumers of any age at risk of delirium when the consumer, carer, family or other key informants raise concerns about cognitive impairment. Note that a positive score on a screening tool is not a diagnosis but a prompt for further assessment, early intervention and family involvement.

Document and communicate the result of screening. Include information about forms of cognitive impairment other than dementia and delirium.

Assessment and understanding underlying causes

Assess for delirium and reassess with any changes in behaviour or thinking using validated delirium assessment tools applicable to the setting.

If delirium is detected, investigate and treat the causes of delirium; comprehensive history taking and physical examination can enable targeted investigations.

Investigate (or refer for investigation) other causes of cognitive impairment – for example, a consumer may have developed cognitive impairment as a result of a recent acquired brain injury or an undiagnosed dementia, requiring further assessment, treatment and follow-up.

Partner with consumers, carers and family members

Partner with consumers, carers and family members who have a central role in the prevention, early recognition, assessment and management of cognitive impairment; develop systems for their early consultation and involvement. Recognise that delirium may be a frightening experience for consumers and families, and can be associated with feelings of remorse and shame. Provide relevant information to consumers, carers and families in an easy-to-understand format.

Delivering comprehensive care

Respond to other care needs, including assistance with nutrition and hydration, reorientation, safe mobilising, maintaining or restoring functioning, and providing meaningful activities.

Set goals of care based on the needs and preferences of the consumer with cognitive impairment; use processes for informed consent, shared and substitute decision-making, and advance care planning to set goals of care.

Manage medication issues, including:

- Treating pain and reducing sedation
- Undertaking medication reconciliation, and reviewing to identify, reduce or stop medicines that can cause or exacerbate cognitive impairment
- Providing accurate medicines lists
- Consulting, informing and educating consumers, carers, families and substitute decision-makers about these processes.

Provide a supportive environment, for example, implement evidence-based design principles in scheduled major capital works or refurbishments, as well as through simple, small-scale changes at the ward and room level.

Manage transitions effectively, including:

- Information exchange and transfer of responsibilities among all relevant health service organisations and care providers, including seeking early primary care input
- Access to hospital substitution, outreach, fast-track or transition programs
- Referral for appropriate follow-up for undiagnosed cognitive impairment and after a delirium episode, for example, many consumers who are identified with cognitive impairment or experience delirium may have undiagnosed dementia.

If a comprehensive diagnostic process is not appropriate during admission, arrangements must be put in place for post-discharge assessment.

Note that these steps are not linear. For example, keeping a consumer safe through responding to other care needs should happen at the same time as investigating the possible cause of delirium, if detected.

Delirium prevention strategies

Delirium prevention strategies are also useful delirium management strategies, for example, early treatment of:

- Dehydration
- Sepsis
- Metabolic imbalance
- Immobilisation
- Sensory impairment
- Sleep disturbance.

Introduce protocols to:

- Prevent and treat pain
- Reduce sedation.

Be alert to, and assess for, delirium

Members of the mental health workforce may mistakenly assume that changes in a person's mental state are exclusively related to the person's diagnosed mental illness. To prevent this unconscious bias from occurring:

- Provide training to members of the workforce in recognising the signs of delirium
- Conduct delirium screening when changes in a person's mental state are noted
- Initiate proactive preventive treatment interventions
- Provide access to resources and expertise to assist in differential diagnosis.

Further strategies to assist with the implementation of **Action 5.29** can be found in the **NSQHS Standards user guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium**.[48]

Predicting, preventing and managing self-harm and suicide

Action 5.31

The health service organisation has systems to support collaboration with patients, carers and families to:

a. Identify when a patient is at risk of self-harm
b. Identify when a patient is at risk of suicide
c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed

Intent

The workforce has the skills and knowledge to engage collaboratively to identify and respond to consumers at risk of self-harm or suicide.

Strategies for improvement for mental health services

Develop therapeutic engagement with the consumer at risk of self-harm or suicide

The focus is on collaboration between the workforce, consumers, carers and families to identify risk, rather than the workforce simply conducting risk assessments and implementing risk management plans.

Consumers can experience thoughts of self-harm or suicide for a long time and possess clear knowledge about strategies to manage these feelings, including what clinical support they need. For other consumers, thoughts of self-harm can occur suddenly, often in the context of loss. They may be very frightened by these thoughts and have little idea of how to manage them.

Engage therapeutically with the consumer to understand what the act or thought of self-harm means for the consumer. Self-harm can be related to suicidal thoughts, or can be independent of these. The consumer may or may not be clear about their intent. Some self-harm may be enacted without suicidal ideation, but still present a risk to the consumer's life. Engage with the consumer's carers, family and other support people.

Always consider self-harm seriously:

- Avoid use of stigmatising language
- Avoid use of language that minimises the severity of the harm or makes presumptions about a consumer's intent
- Maintain an empathic, non-judgemental approach while implementing clinical actions.

Comprehensively assess the consumer's risk of self-harm or suicide

Adopt multidisciplinary approach to comprehensive assessment of suicide risk, including:

- Lived Experience workers
- Psychiatrists
- Psychologists
- Mental health nurses
- Social workers
- Physical health clinicians
- Drug and alcohol specialists
- First responders
- Transport services.

Assess range of immediate and longer-term causes of psychological distress, including:

- Mental illness
- Pain
- Physical illness
- Sense of being a burden
- Relationship difficulties or breakdown
- Domestic violence
- Workplace difficulties
- Financial hardship
- Social isolation
- Trauma, including childhood and inter-generational trauma.

Consumers who have been treated after a suicide attempt report that the attitudes of members of the healthcare workforce were an important factor determining whether they would disclose suicidal thoughts in the future.

Implement effective strategies to keep people safe

Strategies to keep consumers safe when they are experiencing thoughts of self-harm or suicide include:

- Therapeutically engaging the consumer
- Maintaining level of clinical observation appropriate to acuity of risk
- Minimising access to ligature points, sharp objects, medications or other means of self-harm
- Providing treatment for symptoms of mental or physical illness identified as contributing to acute distress for the consumer
- Offering engagement with Lived Experience workers, where available.

Many consumers who have experienced suicidal ideation report that being in clinical settings, especially emergency departments, increases their stress. Aim to provide services in the least restrictive setting possible, including:

- The consumer's home
- Purpose-built safe spaces.

Adopt a recovery-oriented approach, focused on restoring hope, throughout clinical engagement with a consumer after a suicide attempt. The specific treatment immediately after a suicide attempt is likely to be a brief episode in the consumer's experience. They and their families will be dealing with the long-term effects, and interventions need to:

- Align with the consumer's and family's existing skills, values and preferences
- Identify the supports that may be needed to achieve these
- Link to these services.

Spotlight issue: Suicide prevention

Suicide prevention is a national priority.

Actions 5.31 and 5.32 specifically address suicide prevention strategies.

As with other actions focused on in spotlight issues, these build on actions throughout the NSQHS Standards.

The National Suicide Prevention Adviser's Final Advice[49] identifies key enablers and priority shifts that are needed to address suicidal distress and its causes. While these apply broadly to government and communities, they provide a useful framework for mental health services to review their approach.

The key enablers and priority shifts are listed below, along with actions in the NSQHS Standards that support their implementation.

Key enablers

- Leadership and governance to drive a whole of government approach (**Action 1.01** – leadership to develop culture of safety and quality improvement)
- Lived experience knowledge and insight (**Actions 2.11, 2.12, 2.13 and 2.14** – partnerships in healthcare governance, planning, co-design, measurement and evaluation)
- Data and evidence to drive outcomes (**Action 1.08** – measurement and quality improvement; **Action 1.10** – risk management; **Action 1.11** – incident management systems; **Action 1.27** – evidence-based care)
- Workforce and community capability (**Action 1.23** – scope of practice; **Action 1.20** – safety and quality training).

Key shifts

- Responding earlier to distress (**Action 8.03** – partnering with consumers when recognising and responding to deterioration; **Action 8.07** – processes for consumers, carers and families to escalate care)
- Connecting people to compassionate services and supports (**Action 5.14** – working in partnership to deliver care to meet the consumer's needs)
- Targeting groups that are disproportionately affected by suicide (**Action 1.15** – diversity and high-risk groups; **Action 1.4** – Aboriginal and Torres Strait Islander safety priorities)
- Delivering policy responses that improve security and safety (**Actions 1.29 and 1.30** – safe environment).*

* Adapted from The National Suicide Prevention Adviser's Final Advice: Executive Summary, (2020) Australian Government: Canberra

Action 5.32

The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts

Intent

Adequate follow-up support is arranged and agreed by the nominated participants for when consumers who have self-harmed or reported suicidal thoughts leave the mental health service.

Strategies for improvement for mental health services

Consumers who have recently attempted suicide are at increased risk of a subsequent attempt in the days and weeks following discharge from healthcare settings. This risk can be exacerbated for consumers who have recently started antidepressant medicines.

Develop follow-up arrangements

Ensure that development of the discharge plan is collaborative and recovery-oriented, using the principles of supported decision-making. Suicide safety planning can be the foundation for the consumer's long-term recovery. Engage the consumer, their carers and family, and any other person involved in implementing the plan, and give them the opportunity to advise whether actions within the plan are feasible.

Post-discharge care may require cooperation across a number of different health and other service organisations in the community. Ensure information about these organisations, their roles and contact details are available to all key participants. If there is a person coordinating services, or if care is shared between different clinicians and services, include this information in the plan.

Ensure that the consumer is being discharged to a safe environment. In particular, ensure that no consumer who has presented with thoughts of self-harm or suicide is discharged into homelessness.

Communicate follow-up arrangements

Ensure that communication of the discharge plan is multimodal, using verbal, written and electronic means (where available). Confirm receipt of communication about the plan from key participants before discharge. Conduct all communications in respectful, non-judgemental language. Ensure the consumer, their carers and family have ready access to copies of the discharge plan, including steps to take in a crisis.

Implement follow-up arrangements

Establish and maintain partnerships with local organisations that have a role in supporting people after a suicide attempt, including:

- Within health, for example, GP, community nurses, private psychiatrist and psychologist
- Beyond health, including housing, social, employment, domestic violence, justice and educational services. These arrangements must be negotiated so that they do not breach privacy legislation, but also so that privacy cannot be invoked and leave key participants uninformed of critical information.

The consumer, their carers and family have a role in engaging in follow up with relevant services. Ensure they are provided with support to make the appropriate links, and not left alone to navigate disparate services. Use quality improvement methodology to monitor implementation of follow-up arrangements.

Predicting, preventing and managing aggression and violence

Action 5.33

The health service organisation has processes to identify and mitigate situations that may precipitate aggression

Intent

The risk of aggression and violence is minimised by reducing environmental or procedural triggers for aggression.

Strategies for improvement for mental health services

The experience of distress is predictable in mental health settings, and for some people, this can lead to feelings of aggression or violent behaviours. Mental health services need to implement strategies to reduce the risk of aggression occurring and reduce the risk of harm when it does occur.

This action relates to steps that a mental health service can take to modify environmental or procedural factors that can contribute to the risk of aggression.

It links to **Action 1.29**, which addresses designing healthcare environments to maximise safety. It also links to **Action 5.34**, which addresses strategies to reduce the risk of aggression in individual consumers.

A structured approach, such as **Safewards**[28], can support implementation of this action.

Embed a culture of safety in unit processes

Support safety culture through clinical and organisational leadership. Use the given environment in ways that reduce the risk of aggression, such as:

- Allowing people to move around, preferably with access to outside areas
- Reducing stimulus such as bright lights or loud noises
- Providing privacy using curtains or side lounges.

Review incidents to identify contributing factors

Use the incident management system to identify factors that may precipitate aggression related to routine processes of care. Review incidents with members of the workforce, Lived Experience workers and people who have used the service to better understand the influence of routine processes on people's experience of care, and repeated sources of frustration, distress and conflict. Consider which processes are amenable to modification, to ameliorate identified risks.

Action 5.34

The health service organisation has processes to support collaboration with patients, carers and families to:

a. Identify patients at risk of becoming aggressive or violent
b. Implement de-escalation strategies
c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce

Intent

Collaborative processes are used to minimise the risk of aggression and violence, and incidents are managed safely when they occur.

Strategies for improvement for mental health services

Screen for risk of aggression or violence

Screening for risk of aggression and violence is an important and complex undertaking for members of the healthcare workforce.

Predictive factors for risk of aggression include:

- Previous history of aggression or violence
- Intoxication or withdrawal from licit or illicit substances
- Acute brain injury
- Cognitive impairment.

It is important that the use of screening tools and risk management processes does not lead to stigmatising practices, which have been associated with poor experiences of mental health care. Risk assessment needs to take historical and dynamic factors into account. Risk management must be flexible and responsive to clinical or social changes. There will also be times when a consumer who has not been screened as presenting a risk of violence becomes aggressive.

Partner with consumers, carers and families to reduce risk of aggression

The key to successful implementation of this action is using collaborative processes. People accessing mental health care, and their carers and families must be engaged in strategies to reduce the risk of aggression or violence.

Train members of the workforce in de-escalation strategies

De-escalation strategies are an effective way of managing the risk of aggression. Skilfully done, they support the consumer themselves to participate in reducing their level of distress and agitation. The basic principles and techniques are included in policies and procedures in most states and territories, and training in these is frequently mandatory.

Safewards Victoria[28] have published videos role-playing a range of de-escalation techniques.

Develop strategies to safely manage incidents of aggression

Ensure the mental health service has strategies in place to minimise harm, either through resources within the organisation, or through established partnerships with other agencies, such as local police, if violence occurs. Offer the appropriate support to all people involved, including witnesses.

Specific considerations for community mental health services

Community mental health services providing care in small community clinics or in people's homes are isolated from assistance should aggression occur. Develop procedures specifically for use when help is not readily available.

Minimising restrictive practices: Restraint

Action 5.35

Where restraint is clinically necessary to prevent harm, the health service organisation has systems that:

a. Minimise and, where possible, eliminate the use of restraint
b. Govern the use of restraint in accordance with legislation
c. Report use of restraint to the governing body

Intent

Harm relating to the use of restraint is minimised.

Strategies for improvement for mental health services

Mental health services nationally have committed to the goal of eliminating the use of restraint. Ensure local policies reflect this goal.

Develop and review local policy on use of restraint

Align local policy with the relevant state or territory legislation. Consistent with **Action 1.07**, ensure that policies are updated to reflect any changes in legislation. Provide education and training to members of the workforce on practicing within legislation and update this training to reflect any changes in legislation.

Engage consumers, carers and families in reviews of local policies on restrictive practices.

Benchmark local use of restraint

A key strategy is to benchmark, report and review the use of restraint. This attention can then lead to consideration of alternative strategies to the use of restraint, which can in turn be evaluated.

Using principles from the Partnering with Consumers Standard, people who have experienced restraint in different settings, and their carers and families, can be involved in evaluation of its use and the development of strategies to reduce it.

Train members of the workforce in de-escalation strategies

De-escalation strategies have been discussed in **Action 5.34** with regard to aggression, but they also form a critical part of strategies to minimise the use of restraint. Skilfully used, they can engage the consumer in the process of resolving conflict, and prevent situations escalating to the point where clinicians believe restraint is the only option to maintain safety of the consumer or others.

The key to minimising use of restrictive practices is to be alert to changes in a consumer's behaviour or demeanour that may suggest a deterioration in their mental state. Ensure the workforce is receptive to information from the consumer themselves, and from their carers and families. Consumers, carers and families frequently have detailed knowledge about what can lead to a deterioration in their mental state, and what strategies are most effective for restoring their capacity to manage their mental state without the use of restrictive practices.

Train members of the workforce in safe restraint techniques

Restraint is almost universally reported as a traumatic experience. Mental health services must be able to demonstrate strategies to reduce the use of restraint, in acknowledgement of its potential for creating immediate, and frequently enduring psychological trauma.

In addition, the potential for physical trauma must be addressed. Only authorise members of the workforce who have been trained in safe restraint techniques to practise restraint. Training needs to cover specific risks related to techniques, in particular the need to avoid prone restraint, which is prohibited in some states and territories. It also needs to cover the risks related to specific groups, for example, people with history of respiratory or cardiac conditions and people who are overweight.

Offer support to the consumer who has experienced restraint, their carers and family, witnesses and staff who were involved. Ensure members of the Lived Experience workforce are not placed in the position of implementing restrictive practices.

Minimising restrictive practices: Seclusion

Action 5.36

Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that:

a. Minimise and, where possible, eliminate the use of seclusion
b. Govern the use of seclusion in accordance with legislation
c. Report use of seclusion to the governing body

Intent

Harm relating to the use of seclusion is minimised.

Strategies for improvement for mental health services

The strategies to minimise the use of restraint (see **Action 5.35**) also apply to seclusion, as both are restrictive practices.

Ensure that the workforce is trained in de-escalation skills, implement routine observations of the consumer in seclusion, and provide for the consumer’s physical needs and dignity.

The use of seclusion in mental health services is governed by state and territory legislation and mandatory policy. This typically includes designated processes for reporting and review of the use of seclusion, at local unit, hospital, LHN, state or territory, and national levels.

Spotlight issue: Minimising restrictive practices

The use of restrictive practices in mental health care is a human rights issue. The Commission supports the goal of working towards eliminating the use of restrictive practices.

The use of restrictive practices is also a safety and quality issue. People who have experienced restrictive practices report psychological trauma and additional challenges in their recovery. Use of restrictive practices has also been associated with serious physical harm and death.

Minimising restrictive practice provides the strongest example of how actions across the NSQHS Standards, together, build the systems to implement actions directly affecting practice. The actions to reduce the use of restraint (**Action 5.35**) and seclusion (**Action 5.36**) depend on mental health services adopting a holistic approach to implementing the NSQHS Standards.

Actions in the Clinical Governance Standard provide the structures that support the minimisation of restrictive practices in clinical settings. Mental health services have demonstrated that minimising the use of restrictive practices, and working towards their elimination, is achievable through quality improvement processes (**Action 1.08**). These involve benchmarking the rate of restrictive practices and understanding the antecedents to its use and implementing evidence-informed reduction strategies (**Action 1.27**). Providing a safe environment can contribute significantly to safety, both in terms of the physical environment (**Action 1.29**), and the ways in which the environment is used (**Action 1.30**). Ensuring that all of these processes are in place requires leadership at the highest level of the organisation (**Action 1.01**). This includes ensuring that care is delivered consistent with legislation (**Action 1.07**).

Actions in the Partnering with Consumers Standard address partnerships both in the direct delivery of care (**Actions 2.06 and 2.07**), and in planning and evaluating the effectiveness of the services delivered (**Action 2.11**). These are underpinned by the mental health service upholding the rights of mental health consumers (**Action 2.03**).

Care must be taken to ensure that other coercive practices are not substituted for those practices which are now monitored. The Medication Safety Standard includes use of medication to treat a consumer's symptoms and avoiding the use of medication solely to control a consumer's behaviour.

The Comprehensive Care Standard includes actions on screening (**Action 5.10**) and assessment (**Action 5.11**) of a consumer's mental, physical and cognitive healthcare needs and any risks of harm. These are followed by **Action 5.13**, which requires clinicians to partner with consumers, carers and families to develop comprehensive care plans to meet these needs, and **Action 5.14**, which extends these partnerships to the delivery, monitoring and review of the comprehensive care plan, to reflect changes in a consumer's health status or needs. **Actions 5.29 and 5.30** address preventing delirium and managing cognitive impairment, conditions which, if mismanaged, can result in restrictive practices being used.

(cont'd)

Spotlight issue: Minimising restrictive practices

Two critical actions for minimising restrictive practices address predicting, preventing and managing aggression and violence. **Action 5.33** requires mental health services to identify and mitigate situations that may precipitate aggression. Importantly, this action calls for services to consider processes beyond risk factors in the individual being cared for – what elements of routine practices, for instance, mealtimes, medication rounds or group work, could interact with an individual's risk factors and result in the potential for aggression. **Action 5.34** then considers individual risk factors, but in a collaborative sense, not simply members of the workforce using their observational skills to identify risks, but working with consumers and their carers and families to consider the potential for risks, and mobilise their own skills to avoid progressing to aggression. De-escalation strategies are core skills for mental health workers, and ongoing training should be provided to support these skills being enacted.

The Communicating for Safety Standard includes **Action 6.9**, where team members effectively communicate critical information, and **Action 6.10**, processes for consumers, carers and families to directly communicate critical information and risks about care.

Early recognition and effective response to deterioration in a consumer's mental state can reduce the use of restrictive practices in health care (**Actions 8.05 and 8.06**), through engaging the consumer when they are best able to mobilise their own resources to manage their mental health. Adopting the lens of recognition and response offers a broader range of options than risk identification and risk management, which can take away from a consumer exercising choice and control and hamper their recovery journey.

Communicating for Safety Standard

Leaders of a mental health service set up and maintain systems and processes to support effective communication with consumers, carers and families; between multidisciplinary teams and clinicians; and across health service organisations. The workforce uses these systems to effectively communicate to ensure safety.

Intention of this standard

To ensure timely, purpose-driven and effective communication and documentation that support continuous, coordinated and safe care for consumers.

Criteria

There are five criteria in the Communicating for Safety Standard:

- Clinical governance and quality improvement to support effective communication
- Correct identification and procedure matching
- Communication at clinical handover
- Communication of critical information
- Documentation of information.

Introduction

This standard recognises that effective communication is needed throughout consumers' care and identifies high-risk times when effective communication is critical. It describes the systems and processes to support effective communication at all transitions of care: when critical information emerges or changes; to ensure correct consumer identification and procedure matching; and to ensure essential information is documented in the consumer's healthcare record.

Correct identification and procedure matching

Action 6.05

The health service organisation:

a. Defines approved identifiers for patients according to best-practice guidelines
b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated

Intent

A comprehensive, organisation-wide system is in place for the reliable and correct identification of patients when care, medicine, therapy and other services are provided or transferred.

Strategies for improvement for mental health services

Mental health services differ from other parts of the health sector in several key ways that relate directly to identification processes:

- Consumers have longer lengths of stay, so the workforce develops greater familiarity with each consumer
- Consumers do not stay in bed or in one space
- Consumers do not routinely wear identification bracelets while admitted
- Interventions primarily comprise talking and administration of medications – while these still carry risks, the risks are different to those related to, for instance, surgery.

Mental health services need to develop systems for consumer identification that are rigorous, protect consumers from harm and maintain confidentiality, while not creating artificial or redundant processes.

Develop a consumer identification system

Approved consumer identifiers can include:

- Consumer’s name (given name and surname)
- Date of birth
- Healthcare record number
- Gender
- Address
- Photo identification.

Specify when identifiers will be used, for example:

- On admission
- When matching a consumer to care, medicine, therapy or other service
- Whenever clinical handover or transfer occurs
- When discharge documentation is generated.

Clinical handover

Action 6.08

Clinicians use structured clinical handover processes that include:

a. Preparing and scheduling clinical handover
b. Having the relevant information at clinical handover
c. Organising relevant clinicians and others to participate in clinical handover
d. Being aware of the patient's goals and preferences
e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient
f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care

Intent

Clinicians use structured clinical handover processes that are consistent with the key principles of clinical handover, to effectively communicate relevant, accurate and up-to-date information about a consumer's care to ensure safety.

Strategies for improvement for mental health services

Prepare for and schedule clinical handover

Consider the environment and determine the best time to conduct clinical handover. Ensure enough members of the workforce are available to maintain safety on the unit during handover. Engage members of the multidisciplinary team in clinical handover. Provide structured communication tools, and training in their use, to participants in clinical handover. Set priorities for inclusion in handover.

Involve consumers, carers and families in clinical handover where possible.

Have relevant information at clinical handover

Provide participants with access to relevant, up-to-date information from key sources, including:

- Healthcare records
- Advance care plans
- Progress notes
- Results of investigations and multidisciplinary assessments.

Ensure that handover includes a structured update on a person's mental state. Too often, this is reduced to a behavioural summary, such as 'settled'.

Handover is the opportunity to share observations, and collaborate on tracking trends, whether that be deterioration or improvement. Different members of the workforce may be able to contribute information that has not been available to others, which provides a comprehensive collective understanding of the person's mental state. Information from the person themselves, and their carers and families is key to this understanding.

Organise relevant clinicians and others to participate

Provide participants with structured time away from other duties to participate in clinical handover. Clarify roles and responsibilities for participants. Ensure that handover is multidisciplinary. Allocate responsibility to a senior clinician to maintain clinical handover on track.

Support consumer, carer and family involvement

If consumers, carers and family members are able, and want to be involved, give them plenty of notice of when to attend. Provide clear opportunities for the consumer, carer or family to speak in the meeting – a prompt in the structured communication tool can support this. Signpost the mental health service's processes for transfer so the consumer, and their carer and family can fully participate in discharge planning. If the consumer or carer cannot participate, ensure that the consumer's goals and preferences have been discussed with them, and these are represented in clinical handover.

Ensure transfer of responsibility and accountability for care

Use structured communication processes for the transfer of responsibility for care. Use structured communication processes to coordinate concurrent care by more than one treating team. Involve consumers, carers and families in these processes.

Provide copies of discharge summaries to all participants who have an ongoing role in the consumer's care, including:

- The consumer
- The family
- The carer
- The consumer's primary care provider
- Private psychiatrist and psychologist
- Community mental health services
- Other support services.

Spotlight issue: Transitions of care and integration of care

There are significant risks for people at transitions of their care between healthcare locations or settings, providers, levels of care within the same location, or as their conditions and care needs change. This is evidenced by health system data, the literature and recent findings from Royal Commission inquiries. This is particularly true for people with conditions or backgrounds that put them at increased risk of harm in healthcare settings.

These risks are compounded by the complexity of the Australian healthcare system and its intersections with the social support sector where existing power imbalances can influence decisions.

The Commission defines transitions of care as situations when all or part of a consumer's care is transferred between healthcare locations or settings, providers, or levels of care within the same location, as the consumer's conditions and care needs change. Transitions of care also occur between care delivery types or when a consumer's preferences or access to services change.

The common principle is that the consumer remains central as they transition through the healthcare system. Collaborate with the consumer and, with their consent, their carers and family, and the receiving services to plan the transfer of care before it occurs. Agree on what will be provided, by whom, and what action will be taken if there is a need to deviate from the agreed plan. Any issues regarding clinical responsibility or the appropriateness of transition arrangements must be resolved in a timely manner so that it does not impact on safety or access to care. The referring service retains clinical responsibility until the receiving service communicates that they have commenced care, or the consumer decides on an alternative process.

Key domains for safe transitions of care are listed below, with the related actions from the NSQHS Standards:

- Discharge planning (**Action 5.13**)
- Complete communication of information (**Actions 6.04 and 6.07**)
- Availability, timeliness, clarity and organisation of information (**Action 6.08**)
- Medication safety (**Actions 4.06 and 4.12**)
- Education for consumers (**Actions 2.06 and 4.11**)
- Enlisting help from carers, families and social and community supports (**Action 5.13**)
- Advance care planning (**Action 5.09**)
- Coordinating care among team members (**Actions 5.04 and 5.05**)
- Monitoring and managing symptoms after discharge (**Action 2.10**)
- Follow-up (**Actions 2.10 and 5.32**)

Communicating critical information

Action 6.09

Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to:

a. Clinicians who can make decisions about care
b. Patients, carers and families, in accordance with the wishes of the patient

Intent

Emerging or new critical information, alerts and risks are communicated in a timely manner to clinicians who can make decisions about care, and to the consumer, their carers and family, to ensure safe mental health care.

Strategies for improvement for mental health services

Identify critical information

Types of critical information could include:

- Change in a person's mental state
- Change in a person's self-report, including thoughts of self-harm or suicide
- Change in a person's physical health
- Changes to medicines
- New critical results of diagnostic tests or other assessments
- Change in consumer goals
- Allergies or adverse drug reactions
- Change in contact details
- Information that requires follow-up with another clinician or the consumer (or family or carer, if appropriate).

Action taken in response to critical communication should be documented in review of the consumer's comprehensive care plan (see **Action 5.14**).

Review policies for communicating critical information

Ensure that policies and processes clearly define:

- The types of critical information that need to be communicated
- The method for communicating critical information to the responsible clinician or multidisciplinary team
- The method for communicating critical information to the consumer (or family or carer, if appropriate)
- The expected time frames for this communication
- How the information is documented.

Ensure the policies for communicating critical information to consumers, carers and families also consider whether open disclosure is relevant (see **Action 5.12**).

Use specific strategies and frameworks

Strategies to enable clinicians to communicate critical information could include implementing daily or triggered 'safety huddles' or team rounds as a mechanism for everyone to discuss potential risks and identify safety issues.

Develop 'critical language' – an agreed set of terms or common language that indicates to all members of the team that there is a problem or concern – for example, phrases such as 'I need some clarity' or 'I am worried about'; teams that respond to critical language know that, when this type of phrase is spoken, they need to stop, take a moment, pay attention and ensure that everyone on the team is on the same page.

Establish agreed communication processes and pathways between clinicians across multidisciplinary teams to ensure that members of the workforce are clear about who to communicate new critical results to, and who is responsible for the action or follow-up. These will support actions in the **Recognising and responding to acute deterioration standard**.

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Recognising and Responding to Acute Deterioration Standard

Leaders of a mental health service set up and maintain systems for recognising and responding to acute deterioration. The workforce uses the recognition and response systems.

Intention of this standard

To ensure that processes are in place for the workforce to recognise and effectively respond to acute changes in a consumer's physical, cognitive and mental health.

Criteria

There are three criteria in the Recognising and Responding to Acute Deterioration Standard:

- Clinical governance and quality improvement to support recognition and response systems
- Detecting and recognising acute deterioration, and escalating care
- Responding to acute deterioration.

Introduction

The Recognising and Responding to Acute Deterioration Standard aims to ensure that a person's acute deterioration is recognised promptly, and appropriate action is taken. Acute deterioration includes physiological changes, as well as acute changes in cognition and mental state.

Partnering with consumers

Action 8.03

Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to:

a. Actively involve patients in their own care
b. Meet the patient's information needs
c. Share decision-making

Intent

Clinicians understand the systems for partnering with consumers and use them when recognising and responding to acute deterioration.

Strategies for improvement for mental health services

Seek consent for treatment, in line with policies that reflect relevant legislation. Engage the consumer, carer and, if needed, the substitute decision-maker in shared or supported decision-making, consistent with the consumer's wishes. If the clinician is not certain about the consumer's capacity to participate in decision-making, use systematic process for assessing capacity. If available, integrate information from a consumer's advance care plan into decision-making discussions.

Provide information to consumers, carers and families about recognition and response systems in a format that is easily understood and ensure that consumers are given the opportunity to ask questions. Ensure that the information for consumers is current and that clinicians have ready access to it.

When a consumer is an involuntary patient under mental health legislation, ensure members of the workforce still seek to involve the consumer in decision-making about their care as much as possible, consistent with maintaining safety.

Recognising acute deterioration

Action 8.04

The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to:

a. Document individualised vital sign monitoring plans
b. Monitor patients as required by their individualised monitoring plan
c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient

Intent

Consumers experiencing acute physiological deterioration are identified early.

Strategies for improvement for mental health services

Mental health consumers experience physical ill health at higher rates than the general population. While it is not the primary focus for mental health services, these services are still accountable for monitoring a consumer's physical health at the same time as they are delivering mental health care.

Develop monitoring plans

Develop individualised vital sign monitoring plans to manage the clinical risks and needs of each consumer.

Describe the minimum expectations for vital sign monitoring in policy. **The National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration**[50] identifies a core set of six vital signs:

- Respiratory rate
- Oxygen saturation
- Heart rate
- Blood pressure
- Level of consciousness
- Temperature.

Determine the frequency for monitoring and documentation of vital signs for each consumer. In a mental health unit, vital signs are typically monitored on admission, and at least daily for three days, with frequency reduced if no concerning signs are detected.

If a consumer is unwilling to consent to vital sign monitoring on admission, monitoring should be re-initiated as soon as they do provide consent.

Implement standardised vital sign monitoring plans for consumers in specific circumstances, including:

- Commencement of clozapine
- Commencement of other medications with significant side-effects, such as postural hypotension, cardiac disorders or metabolic effects.

Ensure appropriate skills and equipment

Develop processes to ensure that clinicians are trained to use monitoring equipment correctly and are competent in measuring and interpreting vital signs accurately. Educate the mental health workforce about the clinical significance of normal and abnormal vital sign observations in the context of acute physiological deterioration.

Use an audit of vital sign observation charts to evaluate whether vital sign monitoring practices align with policy and provide feedback to clinicians about their practice.

Ensure that equipment for measuring and monitoring vital signs and other physiological parameters is readily available and in good working order.

Document and track vital signs

Regardless of the type of system used to document vital signs, ensure it includes:

- The capacity to display documented vital signs graphically
- The capacity to track changes in vital signs over time
- Thresholds for each vital sign parameter or combination of parameters that indicate abnormality
- Information about the response or action needed when thresholds are reached, or physiological deterioration is identified
- The potential to document the normal range for the consumer.

Many state and territory health departments and private hospital groups have developed and implemented track-and-trigger observation charts. Specialist vital sign observation charts have been developed for use in a range of populations, including children of different age groups, obstetric consumers and adults. Use these as required by the state, territory or private hospital group.

Action 8.05

The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to:

a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium
b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan
c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported
d. Determine the required level of observation
e. Document and communicate observed or reported changes in mental state

Intent

Adverse outcomes relating to acute deterioration in a consumer's mental state are prevented through early recognition and effective response.

Strategies for improvement for mental health services

The Commission has developed the **Escalation Mapping Template** to support services to assess the efficacy of their systems for recognising and responding to deterioration in a person's mental state.

Be alert for signs of deterioration in a person's mental state

A core capacity for mental health workers is the capacity to engage empathically with people experiencing mental distress and build rapport so that people can trust members of the workforce enough to disclose their experiences, thoughts and feelings.

However, there is room for improvement in many mental health services in how clinicians document their assessments of consumer's mental state over time, and how effectively they communicate observed or reported changes to colleagues.

Use comprehensive care plans to manage consumers at risk

Ensure that all members of the workforce involved in a consumer's care are aware of the contents of the comprehensive care plan and are alert to changes that have been identified as individual markers indicating a deterioration in the person's mental state.

For all consumers at risk of delirium, include tailored delirium prevention interventions, regular monitoring and reassessment for delirium with any changes in the plan.

Monitor consumers at risk

Ensure members of the workforce prioritise engagement with the consumer, their carers and family when monitoring the consumer's mental state. Use documenting and reporting processes that highlight the consumer's self-report and information from carers and families.

Develop systems to routinely monitor consumers at risk of deterioration in mental state, including:

- Prompts for assessment
- Identification of the clinician responsible for assessment, documentation and communication processes
- Actions to be taken, including level of nursing observation
- Regular review and feedback processes.

If delirium is identified as a cause of deterioration in the person's mental state, use indicators from the **Delirium Clinical Care Standard**[45] for local review and feedback mechanisms.

Use tools and resources

Use context-specific tools to support clinical judgement.

The **Escalation Mapping Template** (Module B: Recognising deterioration) includes examples of multiple tools that have been developed for use in specific settings, or with particular populations, including the:

- Mental state examination
- Mental health triage tool
- Australasian triage scale
- 4AT delirium assessment tool
- Edinburgh postnatal depression scale.

Ensure that members of the workforce are trained in using, documenting and reporting on any tool that is used in the specific setting. The Escalation Mapping Template is available as on online tool.

Specific considerations for community mental health services

Community mental health services are ideally placed to pick up early changes in a person's mental state and take actions that will prevent further deterioration. For consumers, carers and families, avoiding hospitals and emergency departments can support their ongoing recovery.

Community mental health services can broaden a person's support network by developing close links and effective communication practices with other service providers, including GPs, Community managed service providers, NDIS providers, and local housing and employment services.

These can be formal arrangements, as between LHNs and PHNs, or they can be more informal.

Escalating care

Action 8.06

The health service organisation has protocols that specify criteria for escalating care, including:

a. Agreed vital sign parameters and other indicators of physiological deterioration
b. Agreed indicators of deterioration in mental state
c. Agreed parameters and other indicators for calling emergency assistance
d. Patient pain or distress that is not able to be managed using available treatment
e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration

Intent

The mental health service has an effective system for escalation of care to minimise risks for consumers whose health is acutely deteriorating.

Strategies for improvement for mental health services

Develop context-specific processes for escalating care. A key element is evaluation of the availability of additional expertise to manage deterioration. A mental health inpatient unit co-located in a tertiary hospital, with direct access to a Medical Emergency Team will set different parameters for escalation of a consumer's physical health to a community mental health setting where escalation entails calling an ambulance and transferring the consumer to an emergency department.

Providing safe and effective response to deterioration in a person's mental state is core business for mental health services. Ensure there is a clear protocol for escalation of care in place, particularly for the benefit of junior or agency colleagues.

Existing protocols should be periodically reviewed, to ensure they are performing as intended. Many consumers who have previously engaged with mental health services will have individual advance care plans, and escalation protocols should integrate these into practice.

Identify parameters for escalation

Use a graded response system within the escalation protocol. This means that the escalation protocol includes at least two levels of response to acute deterioration:

- An emergency response (for example, from a rapid response team) to criteria that indicate severe acute deterioration
- At least one other level of response (for example, from the treating or on-call team) for criteria that indicate less severe deterioration.

The two levels are recommended because early treatment of acute deterioration is better.

Work with clinical groups to agree on the criteria that indicate acute deterioration in a consumer's physiological, cognitive and mental state. Use context-specific tools to support clinical judgement.

Include concern or worry expressed by clinicians, consumers, carers or family members in the escalation protocol.

Develop policies and guidance

Use standardised state-wide escalation protocols where available, including:

- **Between the flags** (NSW)[51]
- **Compass** (ACT)[52]
- **Recognising and responding to the deteriorating patient: Clinical engagement in recognition and response systems** (VIC).[53]

Provide training to the workforce on the escalation protocol used in the setting. Ensure information on the local escalation protocol is readily available to clinicians.

Action 8.07

The health service organisation has processes for patients, carers or families to directly escalate care

Intent

Consumers, carers and family members can directly escalate care.

Strategies for improvement for mental health services

Review existing local process for direct escalation of care by consumers, carers and families.

Check alignment with standardised state-wide system, for example:

- CARE (ACT)
- REACH (NSW)
- REACT (NT)
- Ryan's Rule (Queensland)
- You're worried, we're listening (SA)
- HEAR Me (Victoria)
- CARE (WA).

Ensure that the system can be activated easily and independently. Provide written, verbal and visual information about the system for consumers, carers and families. Provide these resources in language and format to support consumers, carers and families with diverse communication and health literacy needs.

Train non-clinical members of the workforce, including Lived Experience workers, in how to escalate care to appropriate responders. Provide training to members of the workforce in communicating, negotiating and clarifying accountability when more than one team involved in response to deterioration.

Endpapers

Appendix 1: Spotlight issues with linked actions in NSQHS Standards

Core actions highlighted in blue

Spotlight issue	Linked NSQHS Standards actions	
Aboriginal and Torres Strait Islander peoples' mental health and wellbeing	1.02	governing body's responsibility
	1.04	**working with local communities**
	1.21	improving cultural competency
	1.33	creating a welcoming environment
	2.13	working in partnership with Aboriginal and Torres Strait Islander communities
	5.08	identifying people of Aboriginal and Torres Strait Islander origin
Workforce	1.01	leadership to develop a safety culture
	1.05	**adequate resources**
	1.07	practice within legislation
	1.11	incident reporting
	1.14	complaints management
	1.16	access to healthcare records
	1.19	orientation
	1.20	training
	1.22	performance management
	1.27	evidence based decision support tools
	1.29	safe environment
	1.30	safe environment
	2.03	healthcare rights
	2.04	informed consent
	2.07	partnering with consumers on delivery of care
	5.03	shared decision-making

Spotlight issue	Linked NSQHS Standards actions	
Responding to diversity	1.01	leadership to develop a safety culture
	1.15	**diversity responsiveness**
	1.20	training
	1.21	cultural competency training
	1.29	safe environment
	1.30	safe environment
	1.33	welcoming environment
	2.03	healthcare rights
	2.06	partnering with consumers, carers and families on decision-making
	2.10	communication that supports partnerships
	2.13	working in partnership with Aboriginal and Torres Strait Islander communities
	2.14	consumer partnership in workforce training
	5.06	multidisciplinary teamwork
	6.09	communicating critical information
	8.07	processes for consumers, carers and families to escalate care
Rights and responsibilities	1.07	practice within legislation
	1.13	feedback processes
	1.14	complaints management
	1.15	diversity responsiveness
	1.16	access to healthcare records
	1.19	orientation
	1.20	training
	1.21	cultural competency training
	1.23	credentialing and scope of clinical practice
	1.29	safe environment
	1.30	safe environment
	1.33	welcoming environment
	2.03	**healthcare rights**
	2.04	informed consent
	2.06	partnering with consumers, carers and families on decision-making
	2.10	communication that supports partnerships
	5.09	advance care planning
	5.13	partnering with consumers to develop comprehensive care plan
Working with carers and families	1.15	diversity responsiveness
	1.32	flexible visiting arrangements
	2.06	**partnering with consumers, carers and families on decision-making**
	2.10	communication that meets the needs of consumers and carers
	5.13	partnering with consumers to develop comprehensive care plan
	5.14	working in partnership to deliver comprehensive care
	6.09	communicating critical information
	8.07	processes for consumers, carers and families to escalate care

Spotlight issue	Linked NSQHS Standards actions	
Mental, physical and cognitive health care	2.06	partnering with consumers, carers and families on decision-making
	2.07	partnering with consumers on delivery of care
	5.06	multidisciplinary teamwork
	5.07	planning for comprehensive care
	5.10	**screening for mental, physical and cognitive healthcare needs**
	5.11	comprehensive assessment
	5.12	document findings of assessment, including alerts
	5.13	partnering with consumers to develop comprehensive care plan
	5.14	working in partnership to deliver comprehensive care
	8.04	recognising and responding to physiological deterioration
	8.05	recognising and responding to deterioration in a person's mental state
	8.06	escalating care
Trauma-informed, recovery-oriented mental health care	1.07	practice within legislation
	2.03	healthcare rights
	2.04	informed consent
	2.06	partnering with consumers, carers and families on decision-making
	5.03	shared decision-making
	5.09	advance care plans
	5.13	**partnering with consumers to develop comprehensive care plan**
	8.03	partnering with consumers to share decision-making when experiencing acute deterioration
Suicide prevention	1.01	leadership to develop a safety culture
	1.08	measurement and quality improvement
	1.10	risk management
	1.11	incident reporting
	1.20	training
	1.23	credentialing and scope of clinical practice
	1.27	evidence-based care
	1.29	safe environment
	1.30	safe environment
	2.11	partnering with consumers in healthcare governance, planning, co-design and evaluation
	2.12	support for consumers in these partnerships
	2.13	working in partnership with Aboriginal and Torres Strait Islander communities
	2.14	consumer partnership in workforce training
	5.31	**collaboration to identify people at risk of self harm or suicide**
	5.32	**follow-up after suicidal thoughts identified**
	8.03	partnering with consumers to recognise and respond to deterioration
	8.07	processes for consumers, carers and families to escalate care

Spotlight issue	Linked NSQHS Standards actions	
Minimising restrictive practices	1.01	leadership to develop a safety culture
	1.07	practice within legislation
	1.08	measurement and quality improvement
	1.10	risk management
	1.27	evidence based decision support tools
	1.29	safe environment
	1.30	safe environment
	2.03	healthcare rights
	2.06	partnering with consumers, carers and families on decision-making
	2.07	partnering with consumers on delivery of care
	2.11	partnering with consumers in healthcare governance, planning, co-design and evaluation
	5.10	screening for mental, physical and cognitive healthcare needs
	5.11	comprehensive assessment
	5.13	partnering with consumers to develop comprehensive care plan
	5.14	working in partnership to deliver comprehensive care
	5.29	preventing delirium
	5.30	managing cognitive impairment
	5.33	identifying and mitigating situations with potential for aggression
	5.34	predicting, preventing and managing aggression
	5.35	**minimising restraint**
	5.36	**minimising seclusion**
	6.09	communicating critical information
	6.10	processes for consumers, carers and families to communicate critical information
	8.05	recognising and responding to deterioration in a person's mental state
	8.06	escalating care
Transitions of care	2.06	partnering with consumers, carers and families on decision-making
	2.10	communication that supports partnerships
	4.06	medication reconciliation
	4.11	information for consumers
	4.12	provision of a medicines list
	5.04	systems to deliver comprehensive care
	5.05	collaboration and teamwork
	5.09	advance care planning
	5.13	comprehensive care planning
	5.32	follow-up after suicidal thoughts identified
	6.04	processes to support effective communication
	6.07	**handover**

Glossary

advance care directive: a voluntary, person-led document completed and signed by a competent person that focuses on an individual's values and preferences for future care decisions, including their preferred outcomes and care.[54]

carer: a person who provides personal care, support and assistance to another individual who needs it because they have mental health issues, suicidal thinking or behaviour, or alcohol and other drug use. A carer may be a family member, friend, someone bound by kinship, a supporter or significant other whose life, because of their active caring and supporting role, has been affected by their association with an individual who has, or has had, mental illness, suicidal thinking or behaviour, or alcohol and other drug use.[55] An individual is not a carer merely because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care. A person is not considered a carer if they are employed and paid to provide care to a consumer, a volunteer for an organisation, or caring as part of a training or education program, but a person who receive a carer's benefit is regarded as a carer.[31] The role and rights of a carer can be defined in state and territory mental health legislation.

dignity of risk: consumers receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk.

diversity: the varying social, economic and geographic circumstances of consumers who use, or may use, the services of a mental health service, as well as their cultural backgrounds, age, disability status, religions, beliefs and practices, languages spoken, sexual orientation, gender identity and gender expression, and sex characteristics.

evidence-based practice: is practice driven by the integration of relevant research that has been conducted using sound methodology, the practitioner's cumulated education, experience and skills and the unique preferences, concerns and expectations each patient brings to a therapeutic encounter.[56]

health literacy: the Australian Commission on Safety and Quality in Health Care separates health literacy into two components – individual health literacy and the health literacy environment. Individual health literacy is the skills, knowledge, motivation and capacity of a consumer to access, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action. The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the healthcare system, which affect the ways in which consumers access, understand, appraise and apply health-related information and services.[57]

informed consent: a process of communication between a consumer and service provider about options for treatment, care processes, data management or potential outcomes.[58] This communication results in the consumer's authorisation or agreement to participate in planned care or data management. The communication should ensure that the consumer has an understanding of the care they will receive or the data to be managed, all the available options and the expected outcomes.[59]

Lived Experience Workforce: is made up of people who are employed in paid positions that require Lived Experience as an essential employment criterion, regardless of position type or setting. This is a professional approach in which diverse personal experience-based knowledge is applied within a consistent framework of values and principles. The Lived Experience workforce includes but is not limited to: Consumer Consultants; Carer Consultants; Peer support workers; family/carer peer support workers; specialist peer workers; and various designated Lived Experience roles in executive governance; paid board and committee representation; education; training; research; consultancy; policy design; and systemic advocacy across various service settings.[15]

Local Hospital Networks: Entities established by state and territory governments to manage single or small groups of public hospital services, including managing budgets and being directly responsible for performance. LHNs may also manage other health services such as community-based health services. LHNs have different names in different jurisdictions, for example, Local Health Districts (NSW), Health and Hospital Services (QLD) and Health Service Providers (WA).[19]

open disclosure: an open discussion with a consumer, their family and or carer about an incident that resulted in harm to the consumer while receiving care. The criteria of open disclosure are an expression of regret, including use of the phrase ‘I am sorry’ or ‘we are sorry’, and a factual explanation of what happened, the potential consequences, and the steps taken to manage the event and prevent recurrence.[17]

recovery oriented practice: the application of a set of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.[40]

Safewards: the objective of the Safewards model is to reduce conflict and containment within mental health services. The model attempts to identify and address the causes of behaviours in staff and patients that may result in harm, such as violence, self-harm or absconding and reduce the likelihood of this occurring.[28]

shared decision-making: a consultation process in which a healthcare provider and a patient jointly participate in making a health decision, having discussed the options, and their benefits and harms, and having considered the patient’s values, preferences and circumstances.[60]

substitute decision-maker: a person appointed or identified by law to make health, medical, residential and other personal (but not financial or legal) decisions on behalf of a consumer whose decision-making capacity is impaired. A substitute decision-maker may be appointed by the consumer, appointed for (on behalf of) the person, or identified as the default decision-maker by legislation, which varies by state and territory.[61]

supported decision-making: the process whereby a person with a disability is enabled to make and communicate decisions with respect to personal, healthcare or legal matters.[62] Supported decision-making means that people are provided with the support they need to be able to make their own decisions. In the context of mental health services, this usually means making medical treatment decisions, but it may include other types of decisions too.[33]

trauma-informed care and practice: an organisational and practice approach to delivering health and human services directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and its prevalence in society. It is a strengths-based framework that emphasises physical, psychological and emotional safety for people who have experienced trauma, their families and carers, and service providers.[63]

workforce: all people working for a service provider, including Lived Experience workers, mental health support workers, advocates, counsellors, clinicians, technicians and any other employed or contracted locum, agency, student or volunteer workers.

References

1. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. 2nd ed. Sydney: ACSQHC; 2021.
2. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards user guide for health services providing care for people with mental health issues. Sydney: ACSQHC; 2018.
3. Australian Commission on Safety and Quality in Health Care. Map of the National Safety and Quality Health Service Standards (second edition) with the National Standards for Mental Health Services. Sydney: ACSQHC; 2018.
4. Australian Commission on Safety and Quality in Health Care. National Model Clinical Governance Framework. Sydney: ACSQHC; 2017.
5. The Wardliparingga Aboriginal Research Unit of the South Australian Health and Medical Research Institute. National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander health. Sydney: ACSQHC; 2017.
6. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Digital Mental Health Standards. Sydney: ACSQHC; 2020.
7. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards guide for hospitals. Sydney: ACSQHC; 2017.
8. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Primary and Community Healthcare Standards. Sydney: ACSQHC; 2021.
9. Commonwealth of Australia. National Standards for Mental Health Services 2010. Canberra: Commonwealth of Australia; 2010.
10. Commonwealth of Australia. National Mental Health Policy 2008. Canberra: Commonwealth of Australia; 2009.
11. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards user guide for governing bodies. Sydney: ACSQHC; 2019.
12. National Aboriginal and Torres Strait Islander Leadership in Mental Health. Gayaa Dhuwi (Proud Spirit) Declaration Implementation Guide. Sydney: NATSILMH; 2018.
13. Centre for Aboriginal Health. NSW Health Services Aboriginal Cultural Engagement Self-Assessment Tool. St Leonards: NSW Ministry of Health; 2020.
14. Rauchberger I, Whitecross F. Reflection of a 2-year journey since the introduction of psychiatric behaviour of concern (Psy-BOC) call, a medical emergency team (MET) call equivalent for the deteriorating mental health of patients. Australasian Psychiatry. 2020;28(4):407-409.
15. Byrne L, Wang L, Roennfeldt H, Chapman M, Darwin L, Castles C, et al. National Lived Experience Workforce Guidelines. Sydney: National Mental Health Commission; 2021.
16. Clinical Excellence Commission. Mental Health Patient Safety Program. [Internet] Sydney: CEC; 2018 [cited October 2021] Available from: **https://www.cec.health.nsw.gov.au/keep-patients-safe/mental-health-patient-safety-program**.

17. Australian Commission on Safety and Quality in Health Care. Australian Open Disclosure Framework. Sydney: ACSQHC; 2013.
18. Australian Institute of Health and Welfare. Mental health services in Australia. [Internet] Canberra: AIHW; 2022 [cited 14 Feb] Available from: **https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia**.
19. Department of Health Commonwealth of Australia. The Fifth National Mental Health and Suicide Prevention Plan. Canberra: Commonwealth of Australia; 2017.
20. Royal Commission into Aged Care Quality and Safety. Final Report: Care, Dignity and Respect. Canberra: Commonwealth of Australia; 2021.
21. National Mental Health Commission. National Children’s Mental Health and Wellbeing Strategy. Sydney: NMHC; 2021.
22. Emerging Minds. Emerging Minds. [Internet] 2022 [cited 22 Feb] Available from: **https://emergingminds.com.au/**.
23. Australian Human Rights Commission. National Principles for Child Safe Organisations. [Internet] Sydney: AHRC; 2019 [cited February 2022] Available from: **https://childsafe.humanrights.gov.au/national-principles/about-national-principles**.
24. Embrace Multicultural Mental Health. The Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery. [Internet] Canberra: Embrace; 2017 [cited February 2022] Available from: **https://embracementalhealth.org.au/service-providers/framework-landing**.
25. LGBTIQ+ Health Australia. MindOut: Mental Health and Suicide Prevention. [Internet] Sydney: LGBTIQ+ Health Australia; 2022 [cited February 2022] Available from: **https://www.lgbtiqhealth.org.au/mindout**.
26. Department of Developmental Disability Neuropsychiatry (3DN). Accessible Mental Health Services for People with an Intellectual Disability: A Guide for Providers. [Internet] Sydney: 3DN; 2014 [cited October 2021] Available from: **https://www.3dn.unsw.edu.au/the-guide**.
27. Centre of Perinatal Excellence. National Perinatal Mental Health Guideline. [Internet] Melbourne: COPE; 2017 [cited February 2022] Available from: **https://www.cope.org.au/health-professionals/health-professionals-3/review-of-new-perinatal-mental-health-guidelines/**.
28. Department of Health Victoria. Safewards Victoria. [Internet] Melbourne: DOH; 2021 [cited February 2022] Available from: **https://www.health.vic.gov.au/practice-and-service-quality/safewards-victoria**.
29. Australian Commission on Safety and Quality in Health Care. Australian Charter of Healthcare Rights. [Internet] Sydney: ACSQHC; 2019 Available from: **https://www.safetyandquality.gov.au/consumers/working-your-healthcare-provider/australian-charter-healthcare-rights**.
30. Commonwealth of Australia. Mental Health Statement of Rights and Responsibilities 2012. Canberra: Commonwealth of Australia; 2012.
31. Australian Government. Carer Recognition Act 2010 (No. 123). Canberra: Australian Government; 2010.
32. Mind Australia, Helping Minds, Private Mental Health Consumer Carer Network, Mental Health Carers Arafmi, Mental Health Australia. A Practical Guide for Working with Carers of People with a Mental Illness. 2016.
33. Roper C, Grey F, Cadogan E. Co-production: Putting principles into practice in mental health contexts. Melbourne: University of Melbourne, 2018.

34. Agency for Clinical Innovation. Co-design toolkit. [Internet] St Leonards: Agency for Clinical Innovation; 2022 [cited 5 March] Available from: **https://aci.health.nsw.gov.au/projects/co-design**.

35. National Health and Medical Research Council. Australian Guidelines for the Prevention and Control of Infection in Healthcare. Canberra: NHMRC; 2019.

36. Clinical Excellence Commission. A Guide to Medication Reviews for NSW Health Services. Sydney: CEC; 2019.

37. Australian Commission on Safety and Quality in Health Care. Implementing the Comprehensive Care Standard: A conceptual model for supporting comprehensive care delivery. Sydney: ACSQHC; 2018.

38. Equally Well Australia. Equally Well: Quality of Life – Equality in Life. [Internet] 2020 [cited February 2022] Available from: **https://www.equallywell.org.au/**.

39. Benjamin R, Haliburn J, King S, editors. Humanising mental health care in Australia: a guide to trauma-informed approaches. Oxford: Routledge; 2019.

40. Commonwealth of Australia. A national framework for recovery-oriented mental health services: Guide for practitioners and providers. Canberra: Commonwealth of Australia; 2013.

41. Australian Commission on Safety and Quality in Health Care. National Consensus Statement: Essential elements for safe and high-quality end-of-life care. Sydney: ACSQHC; 2015.

42. Australian Government Department of Health. End-of-life Essentials. [Internet] Canberra: Australian Government; 2021 [cited March 2022] Available from: **https://www.endoflifeessentials.com.au/**.

43. NSW Ministry of Health. Dignity, Respect and Choice: Advance Care Planning for End of Life for People with Mental Illness – A Comprehensive Guide. Sydney: NSW Ministry of Health; 2015.

44. European Pressure Ulcer Advisory Panel (EPUAP), National Pressure Injury Advisory Panel (NPIAP), Pan Pacific Pressure Injury Alliance (PPPIA). Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. [Internet] 2019 [cited November 2021] Available from: **https://www.internationalguideline.com/guideline**.

45. Australian Commission on Safety and Quality in Health Care. Delirium Clinical Care Standard. Sydney: ACSQHC; 2021.

46. Hay P, Chinn D, Forbes D, Madden S, Newton R, Sugenor L, et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. Australian and New Zealand Journal of Psychiatry. 2014;48(11):1-62.

47. Butterfly Foundation. Butterfly. [Internet]: Butterfly Foundation; 2022 [cited February 2022] Available from: **https://butterfly.org.au/**.

48. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards user guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium. Sydney: ACSQHC; 2019.

49. National Mental Health Commission. National Suicide Prevention Adviser Final Advice. [Internet] Sydney: NMHC; 2021 [cited 15 February] Available from: **https://www.mentalhealthcommission.gov.au/Mental-health-Reform/National-Suicide-Prevention-Adviser-Final-Advice**.

50. Australian Commission on Safety and Quality in Health Care. National consensus statement: Essential elements for recognising and responding to acute physiological deterioration (3rd ed.). Sydney: ACSQHC; 2021.

51. Clinical Excellence Commission. Between the Flags. [Internet] Sydney: CEC; 2010 [cited November 2021] Available from: **https://www.cec.health.nsw.gov.au/keep-patients-safe/deteriorating-patient-program/between-the-flags**.

52. ACT Health. Compass. [Internet] Canberra: ACT Health; 2021 [cited December 2021] Available from: **https://www.health.act.gov.au/health-professionals/compass**.

53. Safercare Victoria. Recognising and responding to the deteriorating patient: Clinical engagement in recognition and response systems. Melbourne: Safercare Victoria; 2020.

54. Australian Government Department of Health. National framework for advance care planning documents. Canberra: Australian Government; 2021.

55. Royal Australian and New Zealand College of Psychiatrists. Position Statement 76: Partnering with carers in mental health care. Melbourne: RANZCP; 2021.

56. Gibbs L. Evidence-based practice for the helping professions: A practical guide with integrated multimedia. Pacific Grove, CA: Brooks/Cole-Thomson Learning; 2003.

57. Australian Commission on Safety and Quality in Health Care. Health literacy: Taking action to improve safety and quality. Sydney: ACSQHC; 2014.

58. American Medical Association. Informed consent. [Internet]: AMA; [cited March 2022] Available from: **https://www.ama-assn.org/delivering-care/ethics/informed-consent**.

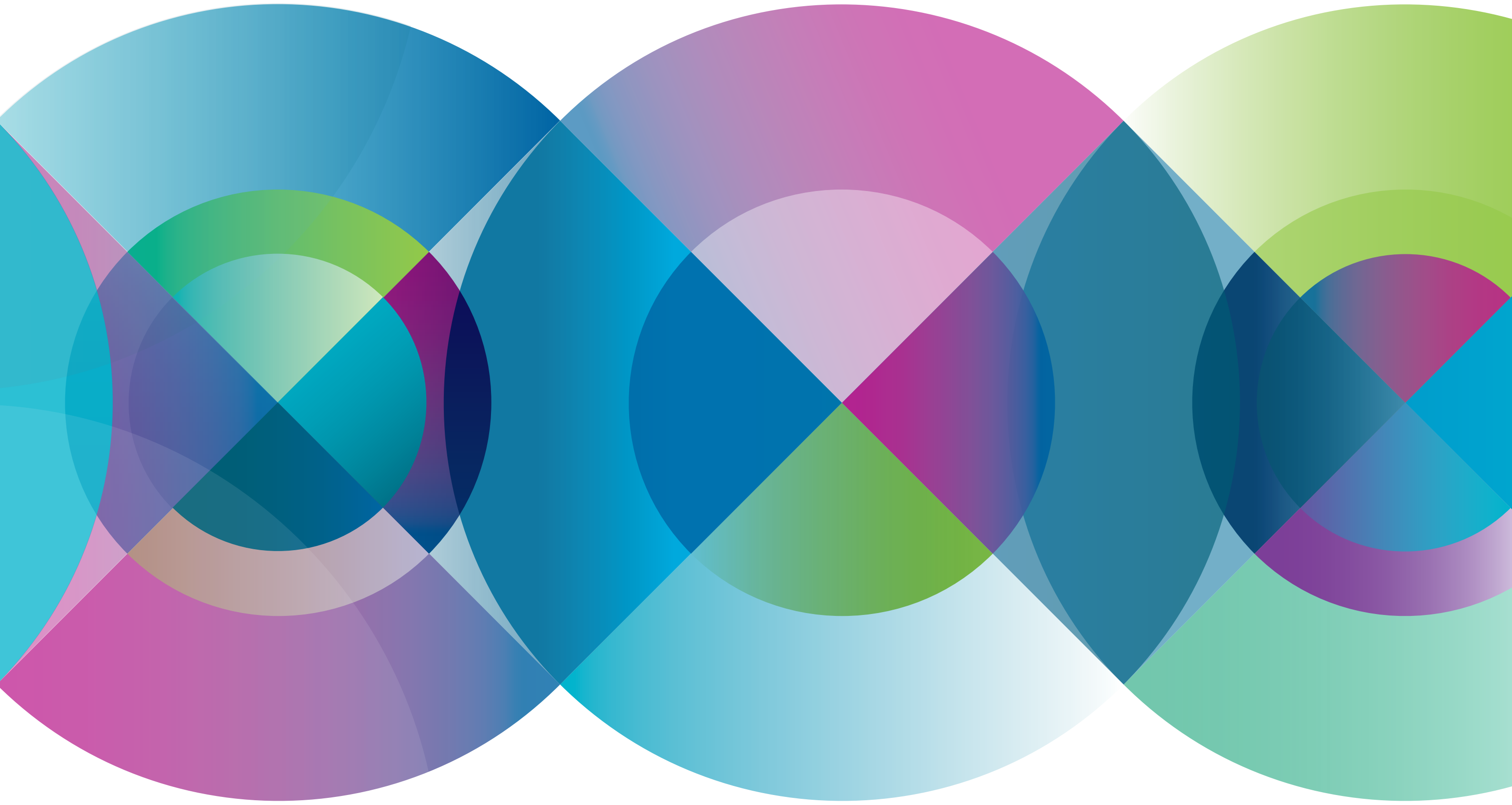
59. Carey-Hazell K. Improving patient information and decision-making. Australian Health Consumer. 2005;1.

60. Hoffman T, Legare F, Simmons M, McNamara K, McCaffery K, Trevena L. Shared decision-making: What do clinicians need to know and why should they bother? Medical Journal of Australia. 2014;201(1):35-39.

61. Australian Commission on Safety and Quality in Health Care. A better way to care: safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital. Sydney: ACSQHC; 2014.

62. United Nations. Office of the High Commissioner for Human Rights. Thematic Study by the Office of the United Nations High Commissioner for Human Rights on Enhancing Awareness and Understanding of the Convention on the Rights of Persons with Disabilities. United Nations, General Assembly Human Rights Council; 26 January 2009; Geneva: UN; 2009.

63. Bateman J, Henderson C, Kezelman C. Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction. Sydney: Mental Health Coordinating Council; 2013.



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