Consultation instructions: *National Safety and Quality Health Service Standards user guide for health services providing care for people with mental health issues*

**Target audience and purpose**

This resource is for health service organisations that provide health care to people who have mental health issues as well as other healthcare needs. The user guide includes actions for governing bodies, managers, and clinicians. This user guide is not intended as a guide for specialist mental health services.

People who use healthcare services, and their families and carers, are invited to contribute to the consultation.

**Consultation dates**

Consultation on this resource will be open until **14 July 2018**

**Consultation questions**

- Will the actions identified in this guide support health services to deliver health care to people with mental health issues?
- Is the information provided in the guide useful to implementing the NSQHS Standards (second edition) in your setting?
- Are there any gaps or duplication in the content?
- Are there examples of current practice that could be included as practice resources?

You are invited to provide feedback on the whole resource, or alternatively, specific components of the resource that are important to you. Included below are questions to guide your feedback, though you are not restricted to answering these questions and should feel free to offer additional suggestions. There is no word limit for your responses.

**Submitting your feedback**

Our preferred method for receiving your feedback is by:

**Email:** mentalhealth@safetyandquality.gov.au

You may also **mail** your responses to:

Mental Health User Guide Consultation

GPO Box 5480


**Our contact details**

If you have any questions in relation to this consultation, please contact Andrew Moors on (02) 9126 3590, or mentalhealth@safetyandquality.gov.au
June 2018

National Safety and Quality Health Service Standards

User Guide for Health Services Providing Care for People with Mental Health Issues

CONSULTATION DRAFT
Introduction

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in collaboration with the Australian Government, states and territories, the private sector, clinical experts, and people who use health services and their carers. 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 that tests whether relevant systems are in place to ensure that 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 second edition of the NSQHS Standards embeds person-centred care and addresses the needs of people who may be a greater risk of harm. This includes people with mental health issues. Forty-five percent of Australians experience a mental disorder within their lifetime, with 20% reporting experience of mental disorder in the previous 12 months.\(^1\) The rate of mental disorder for people in hospital is higher than for the general population.\(^2\) Yet, despite the clear evidence of the high prevalence of comorbidity, people report sub-optimal experiences when they access health care. In particular, they report that their mental health is not treated with the same thoroughness as their physical health.\(^5\)

Health outcomes are particularly bad for people with serious mental illness, who live between 10 and 32 years less than the general population.\(^6\) This is significantly due to preventable physical illness. Due to stigma and other psychosocial factors, people with serious mental illness access physical health services less, and receive less care when they do access services.\(^7\) There is room for improvement in how health services are delivered to people with mental health issues. The physical health of people with serious mental illness has been identified as a priority in the Fifth National Mental Health and Suicide Prevention Plan.\(^8\)

In order to address these safety and quality issues, the Commission has incorporated significant changes in the second edition of the NSQHS Standards. There are eight NSQHS Standards, including a new standard, Comprehensive Care. There are two overarching standards, Clinical Governance and Partnering with Consumers, and the actions in the NSQHS Standards are designed to be implemented as a whole. Embedded across the standards are a number of actions that will particularly support improvements in the delivery of health care to people with mental health issues. These have been identified in Table 1, and form the basis for this user guide.

The fundamental principle underpinning the new actions is that caring for a person’s mental and physical health are integrated processes. While different members of the workforce have different roles, it is everyone’s responsibility to collaborate to deliver person-centred care that meets all of the person’s health needs.
How to use this guide

The *NSQHS Standards User Guide for Health Services Providing Care for People with Mental Health Issues* (the user guide) highlights the actions that will support health service organisations when they are delivering health care to people with mental health issues (Table 1). The user guide is arranged by NSQHS Standard and each chapter contains:

- Brief contextual information about the standard
- Detailed discussion of how relevant actions apply to providing services to people with mental health issues
- Suggestions and examples of implementation strategies.

The user guide also provides practical examples from across Australia that demonstrate how health services are addressing the mental health needs of people they care for.

The user guide is designed as a supplement to existing resources to assist health service organisations to implement the NSQHS Standards. These include:

- Guide for Hospitals
- Guide for Multi-Purpose Services and Small Hospitals
- Guide for Day Procedure Services
- User Guide for Aboriginal and Torres Strait Islander Health
- User Guide for Acute and Community Health Service Organisations that Provide Care for Children
- National Model Clinical Governance Framework
- Guide for Governing Bodies (out for consultation).

Links to these resources are available on the Commission's website at:

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Appendix A summarises linked actions in the NSQHS Standards that have been highlighted throughout the text as critical for supporting implementation of the suggested strategies.
Language

This user guide uses the term ‘person with mental health issues’. In contemporary, recovery-oriented mental health services the term ‘patient’ is no longer used. The term also reflects the fact that people accessing health care services may experience mental health issues in the absence of a diagnosed mental illness. Where the terms ‘consumer’ and ‘mental illness’ are used in quoted resources, these terms are retained.

Other terms have specific meanings in mental health discourses. These are defined below.

Recovery

Recovery is understood to be more than reduction in clinical symptoms, and as ‘being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues’.  

Recovery-oriented practice

Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.

Trauma-informed care

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 consumers, their families and carers, and service providers.
1. Clinical Governance Standard

The intention of the Clinical Governance Standard is to implement a clinical governance framework that ensures that people receive safe and high-quality care.

The four criteria are:

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

Effective governance in health services organisations providing care to people with mental health issues ensures:

- The rights of people with mental health issues are promoted and protected
- People with mental health issues and their 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 and experience to provide health care to people with mental health issues
- The workforce has access to, and complies with, relevant legislation, policy and clinical guidelines
- Environments in which people with mental health issues receive care are safe, welcoming and as minimally restrictive as possible.

A critical element of providing health care to people with mental health issues is acknowledgement that the person’s mental health issues are part of core business.
Governance, leadership and culture

Action 1.1
The governing body:

- Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation
- Provides leadership to ensure partnering with patients, carers and consumers
- 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
- Endorses the organisation’s clinical governance framework
- Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce
- Monitors the action taken as a result of analyses of clinical incidents
- Reviews reports and monitors the organisation’s progress on safety and quality performance

How does this action apply to people with mental health issues?
For people with mental health issues to receive optimal health care, mental health must be recognised as a core part of health care. The governing body has overall responsibility for the culture of the health service organisation. Fostering a culture in which health care is not compartmentalised supports members of the workforce to provide holistic health care, which may include supporting a person’s mental health while they are also receiving care for physical health problems. The governing body will provide optimal leadership by ensuring that the health service organisation partners with people who use its services, including people with lived experience of mental health issues.

Suggested strategies

Set strategic direction that mental health is an integral part of health
The governing body sets the strategic direction for the health service organisation. The governing body leads the development and maintenance of the organisation’s safety and quality culture. When the governing body incorporates recognition of the health service organisation’s responsibility for the mental health of people accessing health care, and the mental health of members of the workforce, it establishes the conditions under which interventions that support people’s mental health are enacted throughout the organisation.

Include a mental health representative on the governing body
One way to ensure mental health is considered by the governing body is to include a mental health representative within the body itself. This strategy has recently been highlighted after a review sparked by serious adverse outcomes for people with mental health issues in New South Wales. In 2018, NSW Health released Mental...
While many actions will focus on acute mental health facilities and emergency departments, significant change needs to occur at a system level. Accountability at the highest levels of the health system, a focus on culture and leadership, new forms of data and reporting, workforce development, and more open engagement of consumers, carers and families will support system-level change for mental health care in NSW.

Under Action 3.1 in the plan, NSW Health has directed all local health districts and speciality health networks to, ‘Review senior executive structures and include Directors of Mental Health as members of the senior executive and report to Chief Executive.’

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.15c The health service organisation incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care

**Lead a culture of partnering with consumers**

People with mental health issues and, in particular, their carers, have reported a sense of disconnection between their experiences of engaging with the governing bodies of health service organisations, and their experiences of clinical care. Thus, while they are listened to with respect in committee meetings, and their participation welcomed and acknowledged, they continue to feel disempowered when they are actually receiving health care, or supporting a person receiving health care.

It is the responsibility of the governing body to understand if this is happening in its health service organisation, and develop strategies so that people are treated with the same respect at whatever point of the organisation they are interacting with. One way of doing this is for the governing body to engage with members of the workforce who provide direct clinical care. Clinicians will be able to identify those aspects of the organisation that support them to provide optimal care, and what can be changed to improve their capacity. This may be additional resources, redeployment of existing resources, training or clinical supervision.

Successful implementation of this strategy will be supported by, or rely on, the following action:

2.7 The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care
Monitor the organisation’s safety and quality performance

The governing body has ultimate responsibility for the performance of the organisation. 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:

1. See every piece of information – every measure and every indicator – in its context
2. Look beyond written intelligence
3. Take responsibility for learning the basics of safety and quality measurement.

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

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

Strategies for governing bodies to effectively monitor the organisation’s safety and quality performance are described in detail in the NSQHS Standards (second edition) Guide for Governing Bodies (out for consultation).

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.9 The health service organisation ensures that timely reports on safety and quality systems and performance are provided to:

   a. The governing body
   b. The workforce
   c. Consumers and the local community
   d. Other relevant health service organisations

Examples of supporting evidence

- Strategic plans that include mental health as an organisational priority
- Committee and meeting records that document participation by people with experience of mental health issues
Organisational leadership

Action 1.3

The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality

How does this action apply to people with mental health issues?

It is through organisational leadership that the strategic directions of the health service organisation, set by the governing body, are implemented. Robust clinical governance is needed to ensure that mental health stays in the organisation’s focus. A key element is that each person in the system understands that they have a role in contributing to the mental health of others. The clinical governance framework should be tailored to the specific function of the health service organisation.

Strategies for improvement

Establish and maintain a clinical governance framework

The Commission has developed the National Model Clinical Governance Framework (the Framework) to support services to implement the NSQHS Standards. The Framework describes clinical governance:

Clinical governance is the set of relationships and responsibilities established by a health service organisation between its state or territory department of health, governing body, executive, workforce, patients, consumers and other stakeholders to ensure good clinical outcomes. It ensures that the community and health service organisations 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. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of health services that are safe, effective, integrated, high quality and continuously improving.

A key part of Action 1.3 is that the service ‘uses the processes within the framework to drive improvements in safety and quality’. Organisational leaders and managers have the responsibility to ensure that all stakeholders who have a role described in the organisation’s clinical governance framework are aware of it, and have the resources to fulfil their role.

Involve people with experience of mental health issues in developing strategies to support safety culture

One way of establishing and maintaining a robust safety culture is to involve people who have experienced mental health issues in developing responsive strategies. They can provide input, based on their experience of using the health service organisation, that complements suggestions from members of the workforce. They
may also come up with ideas, drawn from their experience outside this particular health service, that can contribute to an enriched safety culture.

Successful implementation of this strategy will be supported by, or rely on, the following 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 consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community

Clinical leadership

Action 1.6
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

How does this action apply to people with mental health issues?
Clinical leaders can drive safety and quality improvements, and make them a priority. 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 to people experiencing mental health issues, they support other clinicians in delivering holistic health care. This also applies to clinical leaders in different specialties demonstrating respectful attitudes to members of the workforce with different expertise.

Strategies for improvement

Foster multidisciplinary links
Clinical liaison psychiatry and clinical liaison mental health nursing offer visible specialist mental health practice across many health settings. One of the advantages of the role is the capacity of mental health experts to model approaches with people with mental health issues to colleagues in other health disciplines.

One effective strategy for building multidisciplinary links is creating opportunities for members of the workforce to spend time ‘embedded’ in a different setting to their usual place. Observing others’ clinical practice, for instance, over the duration of a full shift, often enables clinicians to develop insights that they can then use in their own practice.
A more formal process to foster multidisciplinary links is to arrange meetings between different teams. These can be focused around particular case studies that involve joint participation in delivering clinical care.

Successful implementation of this strategy will be supported by, or rely on, the following action:

5.5 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

**Foster culture of clinical supervision**

Clinical supervision is a process for professional development. Members of the workforce participate in regular discussion of practice issues with a senior colleague. The process creates the opportunity for participants to reflect on real experiences of clinical practice. Clinical supervision has demonstrated benefits for both clinical practice, and the mental wellbeing of participants.13

**Examples of supporting evidence**

- Committee and meeting records for multidisciplinary teams
- Clinical supervision register
Patient safety and quality systems
Policies and procedures

Action 1.7
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

How does this action apply to people with mental health issues?
The health service organisation has 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 with mental illness.

Key issues that affect people with mental health issues, and other people accessing health services, include informed consent to treatment, and the use of restraint. The legislative and regulatory requirements regarding these issues can be complex. It is important that members of the workforce understand that practices that make sense from a strictly clinical point of view can involve restrictions on people’s rights. Health service organisations have an obligation to ensure that the human rights of people accessing health care are not contravened. Organisations 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.

Suggested strategies

Adopt systematic approach to aligning policies to key information sources, including changes in legislation and coronial recommendations

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

Health service organisations 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 that can be applied across health services.

The system for review of the health service organisation’s policies should be aligned to detailed knowledge about the specific risk profile of the organisation, and the population to which it delivers health care.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

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

5.35b Where restraint is clinically necessary to prevent harm, the health service organisation has systems that govern the use of restraint in accordance with legislation

**Ensure ready access to current policies for members of the workforce**

Policies and procedures need to be understood by members of the workforce for them to enact them. In particular, people working in emergency departments need access to up-to-date local policies that accurately reflect relevant legislation.

Changes in policy have to be communicated effectively to members of the workforce. Formal training can be augmented by in-service presentations, online updates on the health service organisation’s intranet and posters in key areas.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.20c The health service organisation uses its training systems to provide access to training to meet its safety and quality training needs

**Examples of supporting evidence**

- Schedule for routine review of policies, incorporating triggers for review linked to legislative and other jurisdictional processes
- Training documents for members of the workforce
Measurement and quality improvement

Action 1.9

The health service organisation ensures that timely reports on safety and quality systems and performance are provided to:

a. The governing body  
b. The workforce  
c. Consumers and the local community  
d. Other relevant health service organisations

How does this action apply to people with mental health issues?

Transparent reporting of a health service organisation’s safety and quality performance enables all stakeholders to participate effectively in the evaluation and improvement of the system. Mental health needs to be one of the focus areas for safety and quality reporting. Information on mental health safety performance can come from multiple sources, including experience of service surveys, health outcome measures, sentinel events and other critical incidents, and external reviewers’ reports. If this information remains dispersed, and is not collated and critically reviewed, the health service organisation and its community may not be able to form a clear picture of the service’s performance.

Suggested strategies

Governing body needs to know

For the governing body to perform its role effectively, it must work with comprehensive information about the organisation’s performance. This is a key action within the establishment of a clinical governance framework.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.3 The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality

1.8 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 review of safety and quality performance and systems
The workforce needs to know

Members of the workforce need to be aware of results of evaluation of their safety and quality performance in order to be able to improve it. This action relates to how clinical areas are functioning, rather than assessment of individual performance. If a particular unit has rates of critical incidents that are outside the norm, the workforce may be aware of it, and working to implement strategies to reduce the rate of incidents; or they may not be aware, and need additional support to address the problems.

Consumers need to know

Public reporting of a health service organisation’s safety performance has become a driver for quality improvement. Reports should be available to the people who use the service, and the broader community. The service must also ensure that reports are available in language and formats that are accessible to the range of people who use the service. Reports should contain de-identified information to protect the privacy of the people involved. This can be challenging for smaller services in communities where the majority of people know each other.

Successful implementation of this strategy will be supported by, or rely on, the following action:

2.11a The health service organisation involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care

Other health service organisations need to know

People with mental health issues typically receive health care from more than one organisation. Performance in one organisation can have an impact on a person’s health outcomes, and determine the level of need placed upon other services. Transparent reporting with service partners, for instance, review of the effectiveness of communications, can address these issues, and lead to improved outcomes for people using the services.

Examples of supporting evidence

- Committee and meeting records in which information on safety and quality indicators, data or recommendations by the governing body are discussed
- Records of safety and quality performance information published in annual reports, newsletters or other local media
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

How does this action apply to people with mental health issues?

People with mental health issues may be at higher risk of harm when they access health services. Harms can include missed or incomplete diagnoses, adverse medication events, or the traumatic use of restrictive practices. People’s own actions can lead to harm, including self-harm or harm to others. The health service organisation has to address all of these risks systemically. Actions in the Comprehensive Care Standard describe how risks related to an individual’s care are addressed.

Suggested strategies

Identify risks
An organisation needs to use a range of data sources to properly understand risks. For example, the use of restrictive practices outside specialist mental health services may not be systematically documented in clinical data sets. However, review of the log of calls for assistance from security services may provide a summary of incidents where restrictive practices have been used.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.15c The health service organisation incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care

Act to reduce risks
Actions to reduce risks related to the unpredictable behaviours of people accessing health care include:

- Ensuring adequate staffing levels and clinical skill-mix to provide appropriate care
- Providing training to members of the workforce about managing conflict
- Providing an environment that minimises potential for conflict
- Providing an environment that minimises the potential for self-harm.
These actions will support people with mental health issues, as well as other people in crisis.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

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

1.20c The health service organisation uses its training systems to provide access to training to meet its safety and quality training needs

1.29a The health service organisation maximises safety and quality of care through the design of the environment

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

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

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

Examples of supporting evidence

- Risk register documenting specific organisational risks related to health care delivery to population with mental health issues
Incident management

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

How does this action apply to people with mental health issues?

The identification and management of incidents provides valuable lessons to contribute to safety and quality improvement. Internal sources of information include incidents where harm has occurred, and near misses, where serious harm has been averted.

The governing body has a responsibility and opportunity to lead an organisational culture that is demonstrably just and open, and that learns constructively from mistakes and encourages workforce involvement. (NSQHS Standards (second edition) guide for governing bodies (out for consultation).)

Working within the incident reporting system that is in place within their state or territory, health service organisations can also use local definitions of what constitutes an incident. For example, mental health stakeholders would define any form of restraint as an incident, and expect that it is reported and integrated into a system designed to reduce the incidence of restraint. This is reflected in mental health legislation, and rates of restraint in mental health settings are now reported nationally. However, in some healthcare settings, restraint is regarded simply as an intervention to support delivery of safe care, and not counted as an incident. The health service organisation should develop clear guidelines so that members of the workforce can use the clinical incident reporting system effectively to improve care for people with mental health issues.

Support workforce to recognise and report incidents

An effective incident reporting system functions best when the workforce understand what constitutes a clinical incident for the purpose of reporting, how to report, and what happens once an incident is reported. Leadership is needed to ensure the incident reporting system is not misconstrued as being about apportioning blame to...
 Successful implementation of this strategy will be supported by, or rely on, the following action:

1.20c The health service organisation uses its training systems to provide access to training to meet its safety and quality training needs

**Support people accessing health care to communicate concerns or incidents**

This action links to other actions about communicating for safety. The action also relates to culture; encouragement for a transparent reporting culture from organisational leadership should mean that clinicians support people using the service to openly communicate their concerns. To be effective, the process needs to include follow-up to respond to the concern, and communication back to the reporter about that follow-up.

 Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.12 The health service organisation:

   a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework 
   b. Monitors and acts to improve the effectiveness of open disclosure processes 

6.10 The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians

8.7 The health service organisation has processes for patients, carers or families to directly escalate care

**Monitor action taken as a result of clinical incidents**

The governing body needs to ensure that it is kept informed of incidents through regular reporting from the executive. The executive has responsibility for responding to incidents reported through the clinical incident monitoring system and implementing actions to improve service delivery. Effective use of the clinical incident monitoring systems should be supported through cultural means; building awareness in the workforce that speaking up about critical issues is welcome, and that individuals will not be blamed for errors arising from the system (unless investigation demonstrates this is warranted).

 Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.9a The health service organisation ensures that timely reports on safety and quality systems and performance are provided to the governing body

5.35c Where restraint is clinically necessary to prevent harm, the health service
organisation has systems that report use of restraint to the governing body

5.36c Where seclusion is clinically necessary to prevent harm, the health service organisation has systems that report use of seclusion to the governing body

Examples of supporting evidence

- An accessible incident reporting system
- Safety and quality performance data that demonstrates incorporation of actions taken following review of clinical incidents
- Results of completed clinical incident investigations demonstrating involvement of members of the workforce and people who use services in the review of incidents

Feedback

Action 1.13

The health service organisation:

a. Has processes to seek regular feedback from patients, carers and families about their experience 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

How does this action apply to people with mental health issues?

Feedback about people’s experience of health care is an important element in determining the quality of care provided. It may not be apparent from existing data collection methods that a person accessing health care may have comorbid mental health issues, yet they may have important information for the health service organisation, or a local unit, about how this influenced their experience of care. This can include experiences of sub-optimal care that do not meet the threshold for them to make a formal complaint. Establishing processes for people to give their feedback in less formal ways will ensure this information is not lost.

Suggested strategies

**Adopt a systematic approach to gathering feedback**

The feedback system should be readily available, easy to use, and enable incorporation of feedback 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 health service organisation that are working well in the view of the people who use the service. Feedback can also identify areas for improvement.
The health service organisation may need to work with individuals, and the community who use the service, to develop tools to elicit the information being sought, as standard data collection methods may not work.

**Practice resource: Australian Hospitals Patient Experience Question Set**

Measuring patients’ experiences of their treatment and care is an increasingly important focus of safety and quality efforts. To track patient experiences effectively, a validated and nationally consistent measurement tool is needed.

For this reason, the Commission has developed a set of 12 questions, known as the Australian Hospital Patient Experience Question Set (AHPEQS), which hospitals and day procedure services can use when asking patients what they observed and felt about their care. The question set will allow facilities to ask the same questions as facilities elsewhere, promoting comparability and more effective tracking of improvements over time.

You can download the questions and find out more about the current terms of use here.

Mental health services can also use the longer *Your Experience of Service* survey:


**Ensure service users are aware of how to provide feedback**

Include reference to the feedback system in information provided to people entering the service. Other avenues of advertising the feedback process include prominent links on health service organisation webpages, and posters in physical facilities.

Successful implementation of this strategy will be supported by, or rely on, the following action:

2.9 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

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

Information can be published in newsletters, on noticeboards or on the organisation’s webpage. Feedback can be incorporated as a standing item in regular meetings of members of the workforce. More informal methods, such as providing direct feedback to members of the workforce in clinical ‘huddles’ can also be used.

Successful implementation of this strategy will be supported by, or rely on, the
following action:

1.9 The health service organisation ensures that timely reports on safety and quality systems and performance are provided to:
   a. The workforce
   b. Consumers and the local community

Examples of supporting evidence

- Data collection tools for collecting feedback from the workforce and people who use the service
- Committee or meeting records that demonstrate to the workforce and people who use the service the incorporation of feedback into improvements

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

How does this action apply to people with mental health issues?

Many processes in the delivery of health care are developed to facilitate the effective delivery of health care to the majority of people. They do not necessarily reflect individual needs or preferences. Once these processes are routinely implemented, they can seem to be immutable, and the logic that led to their development can impede flexible implementation.

Health service organisations have recognised that diversity can influence how people experience health care. This has frequently involved identifying specific groups that people belong to, for example, Aboriginal and Torres Strait Islander, or lesbian, gay, bisexual, transgender and intersex (LGBTI) communities, and working with representatives from these groups to deliver health services that reflect diverse needs.

People can belong to multiple groups, and there are intersections and tensions that must be taken into account. For instance, people who identify as Aboriginal and LGBTI report experiencing homophobia from some Aboriginal community members, and racism from some members of LGBTI communities. This exposes them to increased risk of harm. Similarly, many groups within broader society hold particular stigmatising views about people with mental health issues. There are national
resources available that address mental health for Aboriginal and Torres Strait Islanders, LGBTI community members, and people from culturally and linguistically diverse backgrounds.

People with mental health issues have frequently reported experiencing sub-optimal care in health services. This includes people who experience stigma from members of the workforce. Incorporating understanding of how mental health can influence a person’s experience in general health care into a service’s diversity profile can reduce the risks of these negative experiences and other adverse outcomes occurring.

Many people who have experienced mental health issues have also experienced trauma. At times this may have occurred within health settings such as emergency departments. Receiving care again in such an environment can trigger negative feelings and unpredictable responses.

Suggested strategies

Include mental health as a focal issue when identifying the population accessing care

Information about the population that accesses a health service organisation can be gathered from multiple sources; screening for experience of mental health issues on admission supports both the direct delivery of care, and service-level understanding of prevalence. Linkages with partner organisations, such as Primary Health Networks, will also provide information about local needs.

Surveys of people who have used the health service can also be a source of information. Use the Australian Hospital Patient Experience Question Set, outlined in Action 1.13 in this guide.

Successful implementation of this strategy will be supported by, or rely on, the following 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

Support the workforce to deliver person-centred, recovery-focused care

The ‘National framework for recovery-oriented mental health services: guide for practitioners and providers’ states that recovery-oriented practice:

Maximises self-determination and self-management of mental health and wellbeing and involves person-first, person-centred, strengths-based and evidence-informed treatment, rehabilitation and support.
These principles can be incorporated into the approach to care delivery in general health settings as well as specialist mental health services. The health service organisation needs to determine the level of skills and confidence that clinicians have when working with people with mental health issues.

Successful implementation of this strategy will be supported by, or rely on, the following action:

2.7 The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care

**Provide training to the workforce on delivering trauma informed care**

‘Trauma informed care’, as it is understood in contemporary mental health discourse, may be a new term for general health clinicians, who may be more used to understanding trauma in terms of physical damage. The prevalence and effects of trauma are increasingly recognised in national and international policy. For example, the delivery of trauma informed care and practice is recommended in the Fifth National Mental Health and Suicide Prevention Plan.\(^8\)

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.20c The health service organisation uses its training systems to provide access to training to meet its safety and quality training needs
Practice example: Trauma informed care
The Scottish National Health Service has developed ‘Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce’,\(^2\) which includes guidance about trauma informed practice for all members of the workforce. The framework gives examples of what workers can do to achieve outcomes:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>What workers know (knowledge)</th>
<th>What workers can do (Capacity/skill/ability)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The widespread occurrence and nature of trauma is realised</td>
<td>All workers understand: • that a person affected by trauma might understandably want to avoid people, places or situations that remind them and bring back distressing memories of the trauma and associated feelings</td>
<td>All workers can: • identify the kinds of experiences that are traumatic • identify the types of situations that can bring back memories of the trauma and associated feelings</td>
</tr>
<tr>
<td>The different ways in which trauma can affect people are recognised</td>
<td>All workers understand: • that trauma can affect people in different ways • that the consequences of trauma can affect people’s ability to successfully access the care, support and treatment they require in a range of settings (for examples physical health, mental health, education, justice, employment, housing)</td>
<td>All workers can: • listen when a person speaks about his or her experiences of trauma and/or abuse • respond to the person with empathy and without criticism or blame • respond to the person by asking what help (if any) he or she needs • hold in mind that a person’s behaviour or reactions might be trauma-related • make sense of a person’s current difficulties by considering ‘What happened to you?’, instead of ‘What’s wrong with you?’, in responding to a person affected by trauma</td>
</tr>
</tbody>
</table>

(Table adapted from Transforming Psychological Trauma).

The Framework is available to download at:

[http://www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf](http://www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf)
Examples of supporting evidence

- Clinical audit of screening for mental health issues
- Membership of committees with consumer representation that includes people with experience of mental health issues
- Information from patient experience of care surveys
Safe environment for the delivery of care

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 is fit for purpose

How does this action apply to people with mental health issues?

Health service environments are stressful – they are brightly lit, noisy and constrained. In emergency department waiting rooms, people with a range of presenting problems are crowded together, uncertain about what is about to happen, and frequently frustrated by actual or perceived delays in accessing treatment. This can exacerbate stress for people who are already experiencing stress.

Suggested strategies

Ensure the healthcare environment minimises risks related to unpredictable behaviour

Effective design of the environment in which care is delivered can directly support safe care. When a person has thoughts of self-harm, an environment which reduces the potential for them to act on these thoughts is essential. Removal of potential ligature points, and the use of collapsible rails for curtains and shower screens has the highest level of evidence as a means of reducing suicide. Similarly, reducing access to unsecured heights reduces risk.

Design healthcare environments with the flexibility to support safe delivery of care

Good design of the environment can support quality care. Natural light and fresh air are therapeutic. Use of colour and furnishings creates a welcoming environment.

Engage people with experience of mental health issues in co-design of the environment. This is one of the key recommendations in the ‘Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities’.

Successful implementation of this strategy will be supported by, or rely on, the following action:

2.11a The health service organisation involves consumers in the governance of, and to design, measure and evaluate, health care

Examples of supporting evidence

- Observation of design of the environment to reduce risks relating to self-harm
- Minutes of planning meetings that document consumer involvement
- Maintenance schedule
Action 1.30
The health service organisation:

a. Identifies service areas where there is 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

How does this action apply to people with mental health issues?
Within any health setting, there are physical spaces where there is a higher potential for stress and conflict. These include high-traffic areas, and the entrances to nursing stations or staff offices.

This can also apply to specific times in which ward routines are conducted. When a significant proportion of clinical staff are involved in handover or ward rounds, people can get frustrated at a perceived lack of responsiveness to clinical or other needs. Waiting for transport for tests, or discharge medications, while understood by staff as ordinary, may be experienced as unusual delays by people and their families.

There is evidence that emergency departments are particularly stressful environments for people with mental health issues.5,19

Suggested strategies

Identify potential flashpoints
Review incident logs to determine if the frequency and severity of incidents are correlated to specific locations or times. Determine if these routines can be modified, to reduce the likelihood of causing stress.

If processes cannot be modified, determine if people and their families are given adequate information about expected timeframes involved in hospital processes.

Successful implementation of this strategy will be supported by, or rely on, the following action:

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

Provide environments that can be adapted to meet different needs
People respond to stress in different ways, and have different needs in terms of environmental response. A calm and quiet environment is clinically appropriate for a person experiencing agitation and aggressive feelings. Conversely, a person 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 they have been assessed and treatment has been initiated.

Contemporary research has shown promising results for the use of basic sensory modulation strategies in emergency departments.22 These include the use of simple equipment such as fidget-spinners to assist people to manage their anxiety or frustration while awaiting treatment.
Successful implementation of this strategy will be supported by, or rely on, the following 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 is fit for purpose

Examples of supporting evidence
- Observation of flexible use of the environment to meet clinical need
- Review of incidents
- Access to sensory modulation equipment
2. Partnering with Consumers Standard

The intention of the Partnering with Consumers Standard is to create an organisation in which there are mutually valuable outcomes by having:

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

The four criteria are:

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

A major development in the second edition of the NSQHS Standards is the inclusion of actions related to partnering with consumers in the direct delivery of care.

There are two ways in which this standard has specific applicability for delivering services to people with mental health issues. First, many people who experience mental health issues 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 family members, carers and 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.

The second factor that influences partnering with consumers is that there are times when a person’s symptoms of mental health issues can impair their capacity to participate in shared decision making. Health service organisations can implement practices in these cases that are consistent with legislation and recovery-oriented practice.
Partnering with patients in their own care
Healthcare rights and informed consent

Action 2.4

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

How does this action apply to people with mental health issues?

The usual processes for informed consent in health care apply to people with mental health issues. However, there are some additional considerations related to determining a person’s capacity to consent to treatment when they are intoxicated or acutely unwell. These are particularly relevant in emergency departments.

Mental health, guardianship and disability service standards each allow health services to be delivered to people without their informed consent in specific circumstances. It is critical that members of the workforce are aware of when they can use legislation, and the limits of their powers under legislation. This applies to treatment provided for mental health issues, such as rapid tranquilisation, as well as to treatment for physical problems.

Suggested strategies

Review current informed consent processes
Support informed consent through safety and quality systems across all areas of the organisation that ensure that specific consent requirements established by state or territory legislation, such as mental health acts, are complied with.

Support informed consent through education and training for all members of the clinical workforce in the legal, ethical and practical foundations of requirements for patient consent.

Mental health legislation is subject to periodic review. Ensure that the health service organisation provides support to workforce to understand changes in legislation, and how these may have an impact on informed consent processes in their local contexts.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.7c The health service organisation uses a risk management approach to review compliance with legislation, regulation and jurisdictional requirements

Develop local policies and procedures that support workforce to deliver health care
The service needs to have a policy that covers the rights and responsibilities of members of the workforce when they determine the need to invoke mental health, or other legislation to provide treatment to a person who does not consent to be treated.
The policy needs to extend to non-clinical members of the workforce. In particular, security personnel in emergency departments need clear knowledge about their role, and the limits of ‘duty of care’ in situations where a person deemed at risk is refusing health care and leaving the facility.

See, for example, NSW Ministry of Health Policy Directive PD2018_010: Emergency Department Patients Awaiting Care, which states:

People brought to the ED under the Mental Health Act by Police are not to be handed over to NSW Health security staff only. Security staff should act under the direction of the lead clinician and undertake actions consistent with the scope of their role.23

Examples of supporting evidence
- Policy documents for informed consent that are consistent with legislation and best practice
- Review process to ensure local policy remains consistent with current legislation
- Training documents on informed consent processes
- Written information for consumers, their carers and families about informed consent to treatment

Action 2.5
The health service organisation has processes to identify:
- The capacity of a patient to make decisions about their own care
- A substitute decision maker if a patient does not have the capacity to make decisions for themselves

How does this action apply to people with mental health issues?
Mental health legislation in some states and territories describes how to determine capacity to make decisions.

Suggested strategies
Mental health legislation in several states and territories includes specific provisions detailing health service responsibilities in determining a person’s capacity to make decisions about their own care. These provisions apply for people who are on involuntary treatment orders as well as voluntary admissions.

Clinicians need to practise within the law. Informed clinicians maintain current knowledge of changes in legislation, and how these govern what steps they must take to ensure they ascertain a person’s capacity to participate in decision making about their care. The health service organisation will support all clinicians by ensuring policies and procedures are consistent with current legislation and providing ongoing training to clinicians.

Documentation of steps to determine capacity to participate in decision making should be entered in the clinical record. Documentation templates should prompt clinicians to record if a substitute decision maker is involved in a person’s care.

NSQHS Standards User Guide for Health Services Providing Care to People with Mental Health Issues. Not for citation
Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.7c The health service organisation uses a risk management approach to review compliance with legislation, regulation and jurisdictional requirements

Examples of supporting evidence

- Policy documents about identifying a person’s capacity for making decisions about their care, which are consistent with legislation
- Training for workforce about determining capacity for shared decision making
- Written information for consumers, their carers and families about healthcare decision making capacity
- Audit of healthcare records that demonstrate documentation of process for determining a person’s capacity to make decisions about their health care

Sharing decisions and planning care

Action 2.6

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

How does this action apply to people with mental health issues?

Shared decision making incorporates all aspects of a person's health care.

One effective strategy used by people with experience of mental health issues is to develop advance care plans, or consumer wellness plans. An example of a consumer wellness plan is at Appendix B. Consumer wellness plans contain information about a person’s choices and preferences for the ongoing care of their mental health.

Note that, while these plans share terminology with advance care directives for end-of-life care, the two processes should not be confused. For situations where people with mental health issues are faced with end of life decisions, the NSW Ministry of Health has produced a comprehensive guide to support people with mental illness who are making end of life decisions:


Suggested strategies

Integrate consumer wellness plans into shared decision making

One of the first steps in integrating a person’s consumer wellness plan into shared decision making processes is asking if the person has such a plan. As consumer wellness plans are typically developed when the person is well, they can often
include useful details that they may not recall when stressed, such as when being admitted to hospital for treatment of a physical problem. Consumer wellness plans also include information about the person’s individual signs that may indicate deterioration in their mental state. This gives clinicians a form of baseline against which they can compare their current observations. Consumer wellness plans also contain information about particular strategies that help the person manage their mental health.

Discussing the consumer wellness plan can make the conversation about mental health issues easier for the person and clinicians. Health service organisations can support this process by routinely integrating existing wellness plans into care planning processes.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.15c The health service organisation incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care

5.13 Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan

Incorporate carers in the planning, delivery and evaluation of health care

Carers play a significant role in supporting people with mental health issues to maintain their physical and mental health. Yet they frequently report the experience of feeling sidelined when a person enters an acute treatment facility. It is important that members of the workforce do not simply treat carers as sources of information, but as genuine partners throughout the processes of shared decision making.

There are occasions when people receiving health care do not wish to have carers or family members involved in decisions about their health care. Members of the workforce have to respect these wishes, unless they determine there is imminent risk to the safety of the person or others. The rights of people and receiving care and carers are contained in national, state and territory legislation.
Practice resource: A practical guide to working with carers of people with a mental illness

A consortium of organisations representing mental health consumers and carers has developed *A practical guide to working with carers of people with a mental illness*. The guide describes key actions a health service organisation can do when partnering with carers.

We can work together to:

- Recognise who carers are and acknowledge the importance of their role
- Always welcome carers and enquire about their reason for visiting or contacting the service
- Request information from carers to assist with the care and support of the consumer
- Provide information about our service, including its purpose and how it can be contacted
- Provide information about carer rights and responsibilities
- Ask if carers have any questions and do our best to answer them
- Explain what can, and cannot, be discussed
- Refer carers to separate carer information and support services
- Ensure carers are fully engaged in all stages of care

The guide is available at:

https://mhaustralia.org/media-releases/practical-guide-working-carers-of-people-mental-illness

Examples of supporting evidence

- File audit indicating integration of consumer wellness plans into shared decision making processes

Action 2.7

The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care

How does this action apply to people with mental health issues?

Clinicians working outside the speciality of mental health have reported uncertainty and lack of confidence in their capacity to manage people presenting with mental health problems. For some clinicians, it is uncomfortable to practise outside the specialty in which they feel confident.

Consumers and carers have reported being subject to stigma and discrimination from healthcare workers. One reported manifestation of this is being treated with the
attitude of ‘we treat everyone the same’ which, while superficially equitable, in fact erases the specific health needs people with mental health issues have.

The previous experiences of both clinicians and consumers and carers can inhibit the formation of successful partnerships.

When a health service organisation supports the workforce to develop knowledge and skills in their roles in managing mental health issues, this reduces clinicians’ lack of confidence, and can contribute to a reduction in discriminatory practices.

Suggested strategies

**Identify specific training needs for clinicians about partnering with consumers around mental health issues and deliver targeted training to address these needs**

The landmark study on the experience of people with mental health issues in general hospitals in the United Kingdom, ‘Treat as One: Bridging the gap between mental and physical healthcare in general hospitals’\(^{26}\) includes the recommendation:

> All hospital staff who have interaction with patients, including clinical, clerical and security staff, should receive training in mental health conditions in general hospitals. Training should be developed and offered across the entire career pathway from undergraduate to workplace based continued professional development.

Training is resource intensive, and opportunities for members of the workforce are frequently limited. Therefore, training and education should be targeted to identified need. Clinicians who have recently completed undergraduate or post-graduate courses are likely to have some contemporary theoretical knowledge about approaches to mental health care. Frontline clinicians in small regional hospitals may have extensive practical experience of managing a range of problems that people present with, including intoxication. The health service organisation will achieve more with its education resources by delivering training congruent to the workforce’s needs.

**Practice example: Consultation Liaison Nurses Top Tips**

The Australian College of Mental Health Nurses’ Consultation Liaison Special Interest Group publishes a list of issues that typically face consultation liaison nurses:


These comprehensively cover the types of requests consultation liaison nurses may receive, and highlight the critical importance of effective response to delirium, which is frequently associated with acute deterioration in a person’s mental state.

In addition to capturing the types of issues related to mental health that clinicians may need support with, the Top Tips also emphasise that each referral is an opportunity to provide targeted education to colleagues.
Successful implementation of this strategy will be supported by, or rely on, the following action:

1.20 The health service organisation uses its training systems to:
   a. Assess the competency of its training needs
   c. Provide access to training to meet its safety and quality training needs

Provide adequate time for clinicians to genuinely partner with consumers

Providing person-centred care entails members of the workforce addressing the individual’s health and wellbeing goals, in collaboration with their existing support networks. When a person’s mental health is recognised as a key component of their health, integrating mental health care into the comprehensive care plan is core business for the health service organisation. Clinicians may have the skills and desire to be able to deliver person-centred care, but they also require organisational support. Historically, this has best been achieved by shifting care away from a task-oriented approach to a person-centred one.

Practice example: Releasing time to care/the productive ward

The productive ward is an initiative developed in the UK to address the issue of the disproportionate amount of time clinical staff are required to complete administrative tasks, and the pressure this put on them in also providing direct delivery of care. The program has been implemented in both general and mental health inpatient units. There is evidence that the program improves outcomes in the quality and efficiency of health care. More information is available at:


Successful implementation of this strategy will be supported by, or rely on, the following actions:

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

1.15c The health service organisation incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care

Provide opportunities for clinical supervision to allow clinicians to address their uncertainties in a safe way

Clinical supervision enables clinicians to reflect on their practice. This supports the development of enhanced skills and clinical judgement, which in turn contributes to safety for people accessing health care. The content of clinical supervision can include clinical skills outside a person’s primary field of expertise, such as caring for people with mental health issues. When delivered in an environment of trust, clinical supervision allows clinicians to honestly explore issues that concern them about their

Draft NSQHS Standards User Guide for Health Services Providing Care to People with Mental Health Issues. Not for citation
own practice and encourages them to identify ways to improve that they can implement.

**Successful implementation of this strategy will be supported by, or rely on, the following actions:**

1.26 The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate

**Examples of supporting evidence**

- Training programs for clinicians about strategies for managing mental health issues
- Results from patient experience surveys reporting all healthcare needs were met
4. Medication Safety Standard

The purpose of the Medication Safety Standard is to ensure clinicians are competent to safely prescribe, dispense and administer appropriate medicines and to monitor medicine use. In addition to this, the Medication Safety Standard aims to ensure consumers are informed about medicines and understand their individual medicine needs and risks.

The four criteria are:

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

Medication forms a key part of treatment for many people with mental health issues. However, use of medicines is frequently associated with adverse events, many of which are avoidable. Using medication safety systems and partnering with consumers, members of the workforce can effectively reduce the risks of preventable adverse medication events.
Documentation of patient information

Medication reconciliation

Action 4.5

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.

How does this action apply to people with mental health issues?

Interruption in routine medication can lead to recurrence of symptoms for people with mental health issues. This can have an impact on their capacity to participate in shared decision making, and lead to poor outcomes in both mental and physical health.

In the landmark study ‘Treat as One: Bridging the gap between mental and physical healthcare in general hospitals’, the researchers identified marked variance between medication reconciliation of medications for physical and mental health conditions. This variance occurred both on admission and in subsequent clinical reviews. This resulted in people not receiving their appropriate medication, and experiencing sub-optimal health outcomes. The data confirmed experiences reported by consumers with mental health histories in Australia.

Many mental health consumers have consumer wellness plans (see Action 2.6). These typically include information on what treatments, including medications, have been effective in the past, and which have caused problems. The consumer wellness plan can be referred to as part of taking a best possible medication history (BPMH).

Suggested strategies

Ensure equity of medication reconciliation

It has been noted that specific techniques for taking a BPMH can influence its accuracy. The first part of the process is for clinicians to ensure their history-taking is comprehensive, and not focused exclusively on the particular presenting problem in the current episode of care, but also includes prior history of treatment for other conditions. More broadly, clinicians will have to ensure they are not practising in a way that stigmatises mental health issues, and inadvertently discouraging a person from disclosing their existing treatment.

The Commission provides a template for a medication management plan on its website at:

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.15c The health service organisation incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care

4.3a Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to actively involve patients in their own care

Examples of supporting evidence

- Training documents about taking and documenting a BPMH
- Audit results of healthcare records for documentation of a BPMH

Action 4.6

Clinicians review a patient’s current medicine orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care

How does this action apply to people with mental health issues?

It is not unusual when a person is treated for physical health care that all routine medications are temporarily ceased by the treating team. This can occur for diagnostic purposes, that is, to rule out an adverse drug reaction as potential cause for a presenting problem. It can also occur as part of protocols, for example, prior to surgery. If a person’s regular medications are not reinstated, they can experience recurrence of symptoms and withdrawal syndromes that can manifest as exacerbations of mental illness. These risks can be mitigated if accurate medication reconciliation occurs at all transitions of care.

Another problem that is frequently experienced by people with mental health issues is that medication that has been initiated for specific purposes during hospital admissions is not formally ceased prior to discharge. Even when it is intended that medication be continued post-discharge for a brief period (for example, a short-term anxiolytic), if this is not clear, they can continue to be prescribed, and take medication long-term, with negative consequences. Ensuring that clear information about medications is included in discharge planning and documentation will reduce this risk.

Suggested strategies

Ensure medication reconciliation at all transitions of care

Medication reconciliation can occur:

- On admission
- During the episode of care
- On discharge.
Medication reconciliation forms an integral part of the information about a person’s health care that needs to be communicated whenever care is transferred. The system to document medication reconciliation should align seamlessly with other clinical handover processes.

**Successful implementation of this strategy will be supported by, or rely on, the following actions:**

6.8f Clinicians use structured clinical handover processes that include ensuring that clinical handover results in the transfer of responsibility and accountability for care

**Engage the person, their carers, and clinicians involved in their ongoing care in medication reconciliation processes**

People who live with longstanding health conditions, including mental health issues, have substantial experience with medication. They assume responsibility for maintaining their health by incorporating medication routines into their everyday lives, sometimes with the support of carers or family members. This knowledge and experience is a useful resource during brief episodes of care, often provided by clinicians who will have a transient relationship with the person.

Strategies can be as simple as checking with the person or their carers that the medication they are currently prescribed is consistent with their usual regime, unless agreed changes have been initiated.

**Successful implementation of this strategy will be supported by, or rely on, the following actions:**

4.3 Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to:

- Actively involve patients in their own care
- Meet the patient’s information needs
- Share decision-making

6.8f Clinicians use structured clinical handover processes that include ensuring that clinical handover results in the transfer of responsibility and accountability for care

**Examples of supporting evidence**

- Standardised tools that align medication reconciliation with clinical handover
- Healthcare record audit results documenting engagement of person and their families in medication reconciliation
Adverse drug reactions

Action 4.7
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.

How does this action apply to people with mental health issues?
Many people with mental health issues take medication for years. They may have significant past experience with a medication, including adverse drug reactions, that is not part of their recent treatment.

Suggested strategies
Use the medication management plan to document historical adverse drug reactions as well as currently noted adverse drug reactions.

Information about earlier adverse drug reactions is frequently recorded in a person’s consumer wellness plan (see Action 2.6). Integrating information from consumer wellness plans into current medication management plans will ensure they provide a comprehensive summary of all of a person’s medication history.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

2.6 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.

Examples of supporting evidence
• Standardised tools for recording documentation of adverse drug reactions
• Audits of healthcare records to confirm consistency of adverse drug reaction documentation across relevant documents, including medication charts
5. Comprehensive Care Standard

The intention of the Comprehensive Care Standard is to ensure that people receive comprehensive care – that is, coordinated delivery of the total health care required or requested by a person. This care is aligned with the person’s expressed goals of care and healthcare needs, considers the impact of the person’s health issues on their life and wellbeing, and is clinically appropriate.

In addition, the purpose of this standard is to ensure that risks of harm for people during health care are prevented and managed. Clinicians identify people at risk of specific harm during health care by applying the screening and assessment processes required in this standard.

The four criteria are:

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

In recognition of the fact that people with mental illness frequently experience sub-optimal physical health, the National Mental Health Commission developed the Equally Well Consensus Statement, elements of which align directly with actions in the Comprehensive Care Standard.

**Practice example: Equally Well Consensus Statement**

The National Mental Health Commission led the development of a consensus statement, ‘Equally Well: Improving the physical health and wellbeing of people living with mental illness in Australia’ (Equally Well). Equally Well aims to build on work that had already begun to address the mortality gap experienced by people with mental health issues. The Consensus Statement is available at:


Equally Well calls on health service organisations to commit to the following actions:

‘We will improve the physical health of people living with mental illness by acting to deliver:

1. a holistic, person centred approach to physical and mental health and wellbeing
2. effective promotion, prevention and early intervention
3. equity of access to all services
4. improved quality of health care
5. care coordination and regional integration across health, mental health and other services and sectors which enable a contributing life
6. the monitoring of progress towards improved physical health and wellbeing.’
Developing the comprehensive care plan

Screening of risk

Action 5.10

Clinicians use relevant screening processes:

a. At 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

How does this action apply to people with mental health issues?

This is a new action in the second edition of the NSQHS Standards. The intent is that, regardless of the setting in which health care is delivered, people are screened for risks to their physical, mental or cognitive health. The purpose of screening is to identify risks, and develop strategies to mitigate those risks before problems occur.

People with experience of mental health issues have reported problems with general health services that adopt a ‘one-size-fits-all’ approach, typically articulated as ‘we treat everyone the same’. The problem with this approach is that it too easily misses the particular health needs an individual may have. While it may be true that some interventions for a general health problem will be similar for most members of the population, the way in which health care is delivered should be modified to meet the individual’s needs, values and preferences.

Another problem experienced by people with mental health issues when they present for physical health care is termed ‘diagnostic overshadowing’. This describes the situation where clinicians focus on the person’s mental health issues, and do not comprehensively screen the person’s physical needs. This is associated with significant harms occurring to people.

Suggested approaches

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

The Mental Health Triage Tool is an example of a validated screening tool, specifically designed to screen for mental health. Another tool used for screening is the Mini Mental State Examination. This was designed for the purpose of screening for cognitive impairment, but does provide cues that signal the need for further assessment of a person’s mental state. There are also screening tools designed for use in particular health settings, such as the Edinburgh Postnatal Depression Scale.

Provide clinicians with training in person-centred approaches to screening

A problem identified with screening for risks is that they are treated as ‘tick and flick’ exercises. The way that questions are asked can act as a deterrent to people disclosing mental health issues, particularly given many people’s experience of
stigma when accessing health services. The provision of a screening tool is not enough to guarantee an individual’s healthcare needs are wholly met. The workforce needs to act to address all of a person’s identified healthcare needs with empathy and respect.

<table>
<thead>
<tr>
<th>Successful implementation of this strategy will be supported by, or rely on, the following actions:</th>
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<tbody>
<tr>
<td>1.15b The health service organisation identifies groups of patients using its services who are at higher risk of harm</td>
</tr>
<tr>
<td>1.20c The health service organisation uses its training systems to provide access to training to meet its safety and quality training needs</td>
</tr>
<tr>
<td>5.3 Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:</td>
</tr>
<tr>
<td>a. Actively involve patients in their own care</td>
</tr>
<tr>
<td>b. Meet the patient’s information needs</td>
</tr>
<tr>
<td>c. Share decision-making</td>
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**Provide clinicians with clear pathways to follow when screening, to identify need for further assessment and planning of risk mitigation strategies**

In many instances, a person with a history of mental health issues will have no need for specialist mental health intervention during an episode of care for a general health condition. In these cases, it is enough that their potential health needs are identified, and contingency plans developed should they be required.

If a previously untreated mental health issue is identified during screening, or if screening indicates the potential for a deterioration in the person’s mental state, frontline clinicians need to have clear pathways to follow. These may include further assessment within the current treating team, or access to mental health specialists. In either case, the relevant processes should be established and clinicians provided with information about how to use them.

Note that existing processes for recognising and responding to deterioration in a person’s mental state do not necessarily use the language of ‘recognise and respond’ for mental health issues.
Practice resource: Clinical pathway for screening, assessment and management of anxiety and depression in adult cancer patients
The Psycho-oncology Co-operative Research Group has developed a Clinical Pathway for the Screening, Assessment and Management of Anxiety and Depression in Adult Cancer Patients:


This addresses mental health needs that have been identified for people in a non-mental health setting. Importantly, this is a population whose mental health needs have at times been inadequately responded to, as they have been treated as ‘normal’ responses to life-threatening events.

Successful implementation of this strategy will be supported by, or rely on, the following action:

8.6b The health service organisation has protocols that specify criteria for escalating care, including agreed indicators of deterioration in mental state

Examples of supporting evidence

- Validated screening tools available in paper or electronic form in clinical areas
- Training programs for workforce in person-centred approaches to screening for risks
- Documented clinical pathways for responding to risks identified through screening
Clinical assessment

Action 5.11
Clinicians comprehensively assess the conditions and risks identified through the screening process

How does this action apply to people with mental health issues?
There is no point screening for risk if no action is taken in response to the findings. The health service organisation needs to have a process for comprehensive mental health assessment if a risk related to mental health issues has been identified during screening.

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

A clinician, trained in screening processes, and using a validated screening tool, should be able to effectively determine a suitable time frame within which a comprehensive mental health assessment should be undertaken. A clinician who is not trained in mental health should not be expected to undertake a comprehensive mental health assessment. For health settings that do not have mental health workers available on-site, there should be a clear process for referring to specialist mental health services, with established partnerships between organisations.

Successful implementation of this strategy will be supported by, or rely on, the following action:

8.12 The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated

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

It is not just the questions that are asked, but how questions are asked that will determine how effective an assessment process is. There is clear evidence that the way in which people are engaged has an influence on the information they provide. This can include priming effects, related to the order in which questions are asked, or the particular words used to ask questions. More importantly, it relates to the strength of the rapport, and the sense of trust necessary to elicit sensitive information.

People with history of mental health issues frequently have clear knowledge about their conditions, the sorts of things that can lead to an exacerbation of their symptoms, and which strategies are effective in ameliorating these risks. A person-centred approach which acknowledges the person’s expertise will contribute to the comprehensiveness of the assessment. Integration of information from a person’s
advance care directive, or consumer wellness plan (see Action 2.6), will also contribute to the comprehensive care plan.

Successful implementation of this strategy will be supported by, or rely on, the following action:

2.6 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

<table>
<thead>
<tr>
<th>Conduct comprehensive mental health assessment using standardised documentation to support clinical judgement</th>
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<tbody>
<tr>
<td>Comprehensive assessment should be conducted using a systematic approach, including assessment of historic and dynamic risks. All information that is held in healthcare records by the health service organisation about a person should be available to the assessing clinician.</td>
</tr>
</tbody>
</table>

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.16a The health service organisation has healthcare record systems that make the healthcare record available to clinicians at the point of care

<table>
<thead>
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<th>Examples of supporting evidence</th>
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<td>• Documented clinical pathways for responding to risks identified through screening</td>
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<tr>
<td>• Training programs for workforce in person-centred approaches to comprehensive assessment</td>
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</tbody>
</table>
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 any 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 where available
- f. Is consistent with best practice and evidence

How does this action apply to people with mental health issues?

People maintain their mental health in a range of ways. This can include minimising exposure to stress, ensuring regular sleep and exercise, and taking medication. All of these strategies are disrupted by admission to hospital for treatment for physical health, potentially leading to deterioration in the person's mental state. The stress of physical illness alone can precipitate changes in a person's mental health. Using shared decision making to collaborate on the development of a comprehensive care plan can mitigate the risk of poor mental or physical health outcomes for people.

Ensure that the plan is truly comprehensive

Health care has been characterised as operating in siloes; if a person is admitted for cardiac symptoms, care can be focused simply on treating those symptoms, with other aspects of the person's health ignored, or presumed to be someone else's responsibility. At times, this responsibility is left with the person themselves, or their family or carers, without their capacity to take this responsibility being determined.

There is increasing evidence of the links between physical and mental illness, including correlations between depression and cardiac problems, and anxiety and chronic pain. For example, for people with eating disorders, physical and mental health are inseparable, and treatment must reflect this.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

5.3 Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:

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

5.6 Clinicians work collaboratively to plan and deliver comprehensive care
Practice resource: National Eating Disorders Framework

People who have eating disorders have high rates of morbidity and mortality. Eating disorders present a complex picture of physical, behavioural and psychological factors. Each has to be treated with expertise, which typically requires the involvement of separate clinical teams. The National Eating Disorders Collaboration developed the *National Eating Disorders Framework: An integrated response to complexity.*

For many people with long-term eating disorders, physiological changes mean that their physical observations do not fall within normative parameters indicating deterioration. Comprehensive assessment should take into account both their physical and mental health at the same time.
Delivering comprehensive care
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

How does this action apply to people with mental health issues?
This is a key action in the NSQHS Standards, bringing together multiple concepts:

- Clinicians working in partnership with the person, their families and carers
- Delivery of safe, effective care
- Collaborative review of the effectiveness of that care
- Response to changes in a person’s condition.

These concepts apply to all people receiving health care, including people who have comorbid mental health issues.

Strategies for improvement
Ensure systems are in place to enable collaborative delivery of care

For members of the workforce to effectively deliver health care consistent with a comprehensive care plan, they have to be aware of the plan and able to access it. They also need access to current information about the person’s health status.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.16a The health service organisation has healthcare record systems that make the healthcare record available to clinicians at the point of care

Deliver care collaboratively

Delivery of care consistent with the comprehensive care plan will be most effective if team members with appropriate expertise work together. If the team delivering care need support to critically evaluate the information they should be able to liaise with clinicians with the relevant expertise.

Clinical leadership supports a safety culture where members of the workforce respect each other’s skills and expertise, and demonstrate this respect through communication practices, including in front of the person receiving care and their family and carers.
Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.6 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

5.5 The health service organisation has processes to:
   a. Support multidisciplinary collaboration and teamwork
   b. Define the roles and responsibilities of each clinician working in the team

5.6 Clinicians work collaboratively to plan and deliver comprehensive care

Work in partnership with the person, their family and carers

Maintain clarity about the roles and responsibilities of different members of the workforce, and the person and their support network. The comprehensive care plan documents these in general, but who is actually doing what in a particular context may require further verbal explanation at the time.

The service should also have clear protocols for escalating care when the person, their family or carers report changes that indicate to them that the person’s mental state is deteriorating.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

5.3 Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:
   a. Actively involve patients in their own care
   b. Meet the patient’s information needs
   c. Share decision-making

6.10 The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians

Develop and communicate the processes for review of effectiveness of care delivered

Clinical handover is a formal process which includes reviewing the effectiveness of care and communicating about it. This is covered in more detail in Action 6.8. As noted there, engagement of the person and their carers in clinical handover contributes to the comprehensive care plan accurately reflecting their preferences and goals.

Draft NSQHS Standards User Guide for Health Services Providing Care to People with Mental Health Issues. Not for citation
There should also be clear processes for reviewing the comprehensive care plan and escalating care if critical information indicates deterioration in the person’s health status.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

6.9 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

8.6b The health service organisation has protocols that specify criteria for escalating care, including agreed indicators of deterioration in mental state

Examples of supporting evidence

- Experience of care surveys
- Audit of healthcare records to confirm regular updates to comprehensive care plan
- Reduction in rates of critical incidents
- Improvements in health outcomes
Minimising patient harm
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

How does this action apply to people with mental health issues?
In 2016, suicide was the leading cause of death among all people 15-44 years of age.32 A significant number of people access health services every year with thoughts of self-harm or suicide. The experience during and immediately after a healthcare episode can have a major influence on a person’s willingness to engage further with health services. This can mean they do not get the help they need, and increases the risk of future self-harm or suicide.

Suggested strategies
Develop therapeutic engagement with the person at risk of self-harm or suicide

The focus is on collaboration. People 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 people, 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.

In either case, therapeutic engagement is critical, as the main way for clinicians to know about the risk of suicide or self-harm is to elicit the information from the person themselves. Another important source of information is the person’s carer of family member, who may recognise uncharacteristic behaviour or speech that does not necessarily indicate high risk to the clinician.

Maintain an empathic, non-judgemental approach while implementing clinical actions. Engage therapeutically with the person to understand what the act or thought of self-harm means for the person. Self-harm can be related to suicidal thoughts, or can be independent of these. The person 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 person’s life. Always consider self-harm seriously.

Processes of respectful and effective therapeutic engagement create safety for people who have thoughts of self-harm or suicide. Avoid making presumptions about the person’s intent, including whether the person’s self-harm does or does not indicate suicidal thoughts or is ‘attention-seeking’. Communicate with the person, their carers and family, and other clinicians in non-judgemental language.
People 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.

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

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

**Practice resource: National Institute for Health and Care Excellence (NICE) Self-harm Quality standard**

The Royal Australian and New Zealand College of Psychiatrists endorses the national guidelines developed in the United Kingdom by the National Institute for Health and Care Excellence on the clinical management of self-harm. These are available at:

[https://www.nice.org.uk/guidance/qs34](https://www.nice.org.uk/guidance/qs34)

Successful implementation of this strategy will be supported by, or rely on, the following actions:

5.3 Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:

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

5.13a Clinicians use processes for shared decision making to develop a comprehensive and individualised plan that addresses the significance and complexity of the patient’s health issues and risks of harm

**Understand the multifaceted components of suicide risk**

Assessment of risk for suicide is complex. While there are a number of indicators that suggest higher risk, many people who exhibit all of these indicators will not go on to suicide. Conversely, people who complete suicide have sometimes not demonstrated any of the typical signs of suicidal thoughts. The evidence is that it is not effective to assess suicide risk in isolation from a comprehensive assessment of a person’s mental state and life circumstances.

For some people, treatment after a suicide attempt may be the first time that the clinical or social stressors leading to the attempt have come to light. Comprehensive
psychosocial assessment may reveal mental health issues or substance use conditions that can respond to clinical treatment, or social factors such as domestic violence that increase the risk of suicide. A thorough assessment should include the person’s mental and physical health, and their current social circumstances.

Some Aboriginal and Torres Strait Islander communities experience higher rates of self-harm and suicide than the general population. Reflecting the specific issues facing Aboriginal and Torres Strait Islander Australians, there is a National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. Ensure that members of the workforce are familiar with this strategy, and review processes to ensure that they cover the issues for the local Aboriginal and Torres Strait Islander communities. Support this approach with workforce training in culturally competent care, and the employment of, or partnerships with, experts in Aboriginal and Torres Strait Islander mental health, and social and emotional wellbeing.

Rates of mental health issues, self-harm and suicide are also higher in the LGBTI communities, as a result of stigma and discrimination. The ‘National Lesbian, Gay, Bisexual, Transgender and Intersex Mental Health and Suicide Prevention Strategy: A new strategy for inclusion and action’, contains actions that health service organisations can implement to support people effectively.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

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

1.21 The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients

2.13 The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs

Implement effective strategies to keep people safe

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

- Therapeutically engaging the person
- Maintaining level of nursing observation appropriate to acuity of risk
- Minimising access to 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 person.
The Black Dog Institute has initiated the LifeSpan program, an ‘innovative, evidence-based, world-class approach to suicide prevention currently being trialled in select sites in NSW’. The program involves implementation of nine strategies, the first of which is ‘Improving emergency and follow-up care for suicidal crisis’.

Practice resource: Black Dog Institute Guidelines
As part of its LifeSpan program, the Black Dog Institute has published Guidelines for integrated suicide-related crisis and follow-up care in Emergency Departments and other acute settings, available at:


Examples of supporting evidence
- Audit of healthcare records demonstrating comprehensive assessment of mental state and psychosocial circumstances for people who present with self-harm or suicidal thoughts
- Patient and carer experience surveys indicating collaborative practice

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

How does this action apply to people with mental health issues?
People who have recently attempted suicide are at increased risk of a subsequent attempt in the days and weeks following discharge from healthcare settings. This makes sense, as people frequently return to the health and psychosocial contexts in which they initially experienced these feelings. People who have recently started antidepressant medicines are at increased risk of suicide. However, there is considerable variation in follow-up arrangements when people leave a health service organisation after a suicide attempt, with up to 30% of people leaving without any formal arrangements in place. It is therefore essential that health service organisations ensure adequate follow-up for people who have harmed themselves or reported suicidal ideation. The ‘Living is for Everyone’ framework underlines that ‘it is critical that the chain not be broken, as levels of risk can change rapidly’.  

Effective discharge planning has long been recognised as an integral part of health episodes. Issues of shared decision making, forming partnerships with other organisations, and having clear processes for transfer of accountability have been identified as important for an extensive range of health conditions.

In the Scoping Study on the Implementation of National Standards in Mental Health Services, clinicians identified problems in the existing processes for transferring accountability of care, particularly when care is being transferred to a team or individual in a different health service organisation. For specialist mental health
services, rate of post-discharge community care within seven days is a nationally agreed performance indicator, and follow-up can be confirmed internally within the organisation. This 'built-in' process may not be available or appropriate for all health service organisations. Nonetheless, due to the identified risk of harm in this period, some arrangements must be in place.

**Suggested strategies**

**Develop follow-up arrangements**

Ensure that development of the discharge plan is collaborative and recovery-oriented, using the principles of shared decision making outlined in the Partnering with Consumers Standard. Engage the person, 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 that the 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.

Successful implementation of this strategy will be supported by, or rely on, the following action:

5.3 Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:

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

5.13e Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that includes a plan for referral to follow-up services, if appropriate and available

**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.

Successful implementation of this strategy will be supported by, or rely on, the following action:

6.8f Clinicians use structured clinical handover processes that include ensuring that clinical handover results in the transfer of responsibility and accountability for care...
Implement follow-up arrangements

The first two parts of this action, developing and communicating follow-up arrangements, are familiar to health service organisations, and should already be routine practice. They draw on the Partnering with Consumers and Communicating for Safety Standards, and incorporate principles of shared decision making, and clear, multi-modal communication, tailored to the specific needs and skill-sets of participants. It is the third part of the action that some health service organisations may find challenging.

In situations where clinical accountability is being transferred between services, this process is supported by establishing partnerships. 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.

Challenges in implementing follow-up arrangements are ameliorated by doing the first two parts of the action well. Development of the discharge plan using a genuinely collaborative approach will ensure that all participants will understand their planned role, and agree to it. Similarly, effective communication of the discharge plan, using different modes and confirming information has been received and accepted, will support all participants fulfilling their roles.

Practice resource: Way Back Support Service

Beyond Blue developed the Way Back Support Service specifically to support people returning home from hospital following a suicide attempt. The service provides one-on-one, non-clinical care and practical support for the three months after a person has attempted suicide. The service has demonstrated reduced rates of suicide attempts in the areas where it has been trialled, and there are plans to offer the service more broadly. Information about the Way Back Support Service and related resources are available at:


Examples of supporting evidence

- Audits of clinical files demonstrating:
  - evidence of collaborative discharge planning
  - discharge communications
  - notes documenting follow-up communication to confirm receipt and acceptance of communications
- System evaluation processes demonstrating involvement of people with lived experience of self-harm
- Where follow-up involves other agencies, there should be evidence of established partnership agreements
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

How does this action apply to people with mental health issues?
Aggression and violence are often predictable in healthcare settings, and health service organisations need to implement strategies to reduce the risk of aggression occurring, and reduce the risk of harm when it does occur. In order to do this, health service organisations need to adopt a range of complementary strategies. These strategies need to address risks related to:

- The environment
- The clinical context
- The person, their family and carers.

Actions 1.29 and 1.30 in the Clinical Governance Standard addressed environmental risk factors. Action 5.34 addresses collaborative processes for working with the person, their family and carers to reduce the risk of violence. This action relates to risks related to the clinical context.

Healthcare environments can be stressful places. People are dealing with uncomfortable experiences, including pain and uncertainty, in environments that are both unfamiliar and high stimulus. People also experience frustration with processes that may be routine for members of the healthcare workforce, but are new and not always comprehensible from the perspective of the patient or carer. For some people, these contextual factors can lead to feelings of aggression.

Suggested strategies
Embed a culture of safety in unit processes

Entering different healthcare settings can engender feelings of calm or unease, unrelated to the specific populations or diagnostic groupings treated in the setting. Rather, these feelings are generated by the sense of engagement and safety, and related to the processes the health service organisation adopts that can trigger distress in people, and potentially lead to aggression.

Safety culture needs to be supported by clinical and organisational leadership. The governing body has a role in establishing safety culture. But it is through the actions of clinicians and other members of the workforce who people encounter directly that safety culture is enacted and experienced. There needs to be congruence between messages contained in resources such as the ‘Australian Charter of Healthcare Rights’, and people’s experience of care.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.1a The governing body provides leadership to develop a culture of safety and...
quality improvement, and satisfies itself that this culture exists within the organisation

1.6 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

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 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.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.11f The health service organisation has organisation-wide incident management and investigation systems, and incorporates risks identified in the analysis of incidents into the risk management system
Practice example: Safewards

Safewards is a model of delivering mental health services that comprehensively addresses the range of factors that can lead to conflict. These are arranged in domains:

- Patient characteristics
- Patient community
- Staff team
- Physical environment
- Regulatory framework
- Outside hospital.

The model is explicit about the fact that elements from each of these domains can lead to conflict, that is, aggression and violence are not simply acts perpetrated by individuals not taking responsibility for their actions.

The model gives examples of strategies that staff can adopt in the long and short term to mitigate conflict. These range from creating a welcoming environment, and fostering a culture which reduces the divisions between staff and patients, through to specific techniques for de-escalating conflict.

The model acknowledges that staff cannot necessarily modify all of these factors. For instance, if a person receives a phone call from home with bad news, they may experience distress and frustration that members of the workforce cannot mitigate. Nonetheless, if members of the workforce maintain awareness of the interaction of each of the domains, they will have greater opportunities to reduce the potential for issues to escalate to aggression.

The model, developed in the UK, has been successfully rolled out across mental health services in Victoria. Trials have begun on adapting the model to general health wards.

Review the Victorian Department of Health and Human Services Safewards website:

https://www2.health.vic.gov.au/safewards
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 and families, and the workforce

How does this action apply to people with mental health issues?
Distress, frustration, fear and anger can all lead to people experiencing aggressive impulses. Intoxication or withdrawal from substances, delirium and pain, can lead to aggressive feelings. For some people with mental health issues, their symptoms can generate these feelings. Interactions with perceived figures of authority, such as health workers, can exacerbate these feelings.

Health service organisations need to be prepared to address aggression and violence, and manage situations so that all the people involved are safe. They need to do this without adopting approaches that can lead to stigmatising practices.

Suggested strategies
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 sub-optimal healthcare delivery. In particular, people with mental health issues should not be automatically assessed as presenting high risk for aggression. 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 person who has not been screened as presenting a risk of violence becomes aggressive.
Practice example: Managing challenging behaviour

South Australia has developed a *Challenging behaviour policy framework* to ‘support health services to focus action on prevention and response to challenging behaviour in a systematic way’. The home page is at:


An information sheet summarises how health service organisations can navigate the resources across the strategy for preventing and responding to challenging behaviour:


The framework is applicable across all health settings in the state.

Partner with consumers and carers to reduce risk of aggression

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

Successful implementation of this strategy will be supported by, or rely on, the following action:

5.3 Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:

- Actively involve patients in their own care
- Meet the patient’s information needs
- Share decision-making

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 person themselves to participate in reducing their level of distress and agitation. The basic principles and techniques are set out in the following practice example, and these can be successfully implemented by clinical staff who don’t have mental health expertise.
Practice example: De-escalation techniques

The NSW guidelines for the management of Acute Severe Behavioural Disturbance in Emergency Departments provides a clear description of de-escalation techniques.

The guideline is available at:


A summary of the key points is as follows:

- Approach in a calm, confident and non-threatening manner, with a non-aggressive stance with arms relaxed
- Be empathic, non-judgemental and respectful. Listen to the patient’s concerns
- Introduce yourself, your role and the purpose of the discussion, lead the discussion and engage the patient (whilst other staff remain in the vicinity to offer support, it is imperative that only one staff member verbally engage the patient)
- Emphasise your desire to help. Ask what they want and what are they worried about
- Focus on the here and now, identify what is achievable, rather than declining all requests, small concessions can build trust and rapport
- Try to identify the patient’s unmet needs and help them explore their fears
- Use short clear statements which do not include medical jargon. The patient may not have the capacity to process information
- Use a slow, clear and steady voice and don’t raise your voice. If the patient raises their voice, pause and wait for an opening and allow the patient to vent some of their frustrations
- Courtesies such as a cup of (lukewarm) tea, sandwiches, access to a telephone (or a staff member making a phone call on their behalf) and attending to physical needs can be very helpful
- Offer a choice of Nicot ine Replacement Therapy (NRT) e.g. gum / lozenges, patches or a nicotine inhaler if they request a cigarette. Avoid entering into discussions about leaving ED to have a cigarette and focus these conversations on keeping the patient within the safety of the ED
- Getting trusted relatives or staff to talk to the patient may help. If the patient persists in directing their anger or suspicion directly at the clinician, it may be appropriate for you to ask another staff member to attempt de-escalation
- Avoid potentially provocative statements such as “calm down” or “if you don’t settle down ….x will happen” “you better stop that right now…or else” as this is likely to escalate their behaviour to another level in response to the perceived threat.

Successful implementation of this strategy will be supported by, or rely on, the
following actions:

1.20c The health service organisation uses its training systems to provide access to training to meet its safety and quality training needs.

5.1 Clinicians use the safety and quality systems from the Clinical Governance Standard when:

   b. Managing risks associated with comprehensive care
   c. Identifying training requirements to deliver comprehensive care

**Develop strategies to safely manage incidents of aggression**

Should violence occur, the health service organisation should have in place strategies to minimise harm, either through resources within the organisation, or through established partnerships with other agencies, such as local police. If violence has occurred, all people involved, including witnesses, should be offered appropriate support.

**Examples of supporting evidence**

- Training documents about de-escalation strategies
- Documentation of integration of incident review processes into quality improvement activities
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

Restraint: key definitions

**Restraint** is the restriction of an individual's freedom of movement. It includes mechanical restraint, physical restraint, and chemical or pharmacological restraint.

**Physical restraint** is the application by members of the healthcare workforce of hands-on immobilisation or the physical restriction of a person to prevent them from harming themselves or endangering others, or to ensure that essential medical treatment can be provided.

**Mechanical restraint** is the application of devices (including belts, harnesses, manacles, sheets and straps) to a person’s body to restrict their movement.

There is a lack of consensus on the definition of **chemical/pharmacological restraint**, because of difficulties in determining whether a clinician’s intent is primarily to treat a person’s symptoms or to control their behaviour. For this reason, the Commission does not currently require health service organisations to report on the use of chemical restraint (except where this is directed under state or territory legislation). Nonetheless, organisations should seek to understand if there is inappropriate use of medicines, and note if rates of rapid tranquilisation increase.

How does this action apply to people with mental health issues?

Mental health services have been working for decades to reduce the use of restraint. Minimising its use was identified as a key safety priority in 2005, and in 2017, the Towards Eliminating Restrictive Practices Forum hosted by Western Australia was the 11th National meeting dedicated to the topic.

Restraint is used in other healthcare settings, but it has not been subject to the same scrutiny as it is in mental health settings. This is despite the fact that people who have experienced it, and their families and carers, have frequently reported trauma related to its use, and use of restraint has also been associated with severe adverse outcomes, including injury and death from falls.

Restraint is frequently used to facilitate the delivery of aspects of care, such as placing wrist cuffs on a person to prevent them pulling out tubes. Clinicians and health service organisations have stated that this is part of duty of care. Many services, particularly intensive care units, have developed local protocols which include:
• The need for medical officer ‘prescription’ of restraint
• Hourly monitoring of skin integrity
• Reporting the use of restraint to the person’s family or carer.

This action calls for additional strategies that will support the reduction of the use of restraint.

Suggested strategies

Benchmark local use of restraint

Action 5.35 builds on work undertaken in mental health services to reduce the 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 families and carers, can be involved in evaluation of its use, and development of strategies to reduce it.

Health settings outside mental health services will be able to adapt work that has been developed in mental health services to benchmark, report and review its use. Incident reporting systems can also be used to contribute to building useful data.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.1f The governing body monitors the action taken as a result of analysis of clinical incidents

1.11f The health service organisation has organisation-wide incident management and investigation systems, and incorporates risks identified in the analysis of incidents into the risk management system

2.11a The health service organisation involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care

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 person in the process of resolving conflict, and prevent situations escalating to the point that clinicians believe restraint is the only option to maintain safety of the person or others.

The key to minimising use of restrictive practices is to be alert to changes in a person’s behaviour or demeanour that may suggest a deterioration in their mental state. The workforce should be receptive to information from the person themselves, and from their carers and families. People who have experienced mental health issues, or cared for someone who does, 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. These principles are outlined in the *National consensus statement: Essential elements for recognising and responding to deterioration in a person's mental state*[^1] (see Recognising and Responding to Acute Deterioration Standard).

Successful implementation of this strategy will be supported by, or rely on, the following actions:

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

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

Train members of the workforce in safe restraint techniques

Restraint is almost universally reported as a traumatic experience. Health service organisations 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 members of the workforce who have been trained in safe restraint techniques should be authorised to practise restraint. Training needs to cover specific risks related to techniques, in particular the need to avoid prone restraint. 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.

Support should be offered to the person who has experienced restraint, their family and carers, witnesses and staff who were involved.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.20c The health service organisation uses its training systems to provide access to training to meet its safety and quality training needs.

Monitor compliance with legislation

The health service organisation must ensure that any use of restraint is only done in compliance with legislation.

Successful implementation of this strategy will be supported by, or rely on, the following action:

1.7c The health service organisation uses a risk management approach to review

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[^1]: Draft NSQHS Standards User Guide for Health Services Providing Care to People with Mental Health Issues. *Not for citation*
Examples of supporting evidence

- Policy documents that outline:
  - processes to treat people without using restraint
  - use of restraint in line with legislation
  - reporting requirements when restraint is used
- Training documents about strategies to minimise the use of restraint
- Evidence of design and use of the environment to minimise the use of restraint
- Evidence of a systematic approach to minimising coercive practices
- Audit results of healthcare records that show the use of individualised plans to minimise the use of restraint
- Reports provided to the governing body that document the use of restraint
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

How does this action apply to people with mental health issues?

Seclusion is the confinement of a patient, at any time of the day or night, alone in a room or area from which free exit is prevented.

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, local health network, state or territory, and national levels. The use of seclusion outside designated mental health services is unlawful, and health service organisations should ensure that it does not occur.

Jurisdictions have clear protocols about how seclusion can be implemented. These typically include details about:

- When a person can be secluded
- How long a person can be secluded
- How frequently observations of the person in seclusion should be made
- What provisions in terms of hygiene and other needs are made
- What support they are offered after the seclusion episode.

It is important that clinicians are aware of the relevant legislation and policy, and act in accordance with it. The health service organisation should have processes that alert the governing body to any deviation from protocols.

Suggested strategies

Review emergency department processes and design

Processes to minimise the use of seclusion are closely related to minimising the use of restraint (Action 5.35).

The Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities \(^{19}\) makes a number of recommendations relevant to emergency departments:

14 The NSW seclusion and restraint data collection and reporting should include declared emergency departments.

15 All emergency departments should have clinical pathways for people presenting with mental health issues that are reflective of their needs. There
needs to be a pathway that does not include the use of safe assessment rooms.

16 There should be an immediate review of the design and use of safe assessment rooms, using a co-design methodology.

18 All acute mental health units and declared emergency departments should conduct a review of their facilities and implement minor capital works and equipment purchases to improve the therapeutic potential.

Information developed in evaluating implementation of these recommendations can inform strategies to reduce and eliminate the use of restrictive practices in all health services.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.29a The health service organisation maximises safety and quality of care through the design of the environment

2.11a The health service organisation involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care

Examples of supporting evidence

- Policy documents that outline:
  - criteria for use of seclusion
  - use of seclusion in line with legislation
  - reporting requirements when seclusion is used
- Training documents about strategies to minimise the use of seclusion
- Evidence of design and use of the environment to minimise the use of seclusion
- Evidence of a systematic approach to minimising coercive practices
- Audit results of healthcare records that show the use of individualised plans to minimise the use of seclusion
- Seclusion register
- Reports to the governing body on the use of seclusion
6. Communicating for Safety

The intention of the Communicating for Safety Standard is to ensure timely, purpose-driven and effective communication and documentation that support continuous, coordinated and safe care for patients.

The five criteria are:

- **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**

When people with mental health issues are accessing care for their physical health, there needs to be communication between clinical teams and the person and their families and carers. When communications are done well, they can ensure that preventable adverse events do not occur.

Partnering with consumers enables members of the workforce who are not specialist mental health workers to effectively incorporate the person’s own knowledge about their health into comprehensive care planning.
Communication at clinical handover

Action 6.8

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
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

How does this action apply to people with mental health issues?

Structured handover is important when care is being transferred, or resumed by clinical teams. If a person who is being treated for a physical health problem is also treated for mental health issues, it is more than likely that more than one clinical team will be involved in their care. Implementation of structured processes will support clarity for the person, their family and carers about which clinical team is responsible for what. This is particularly important if a person is receiving concurrent care from more than one team, as it is essential that any proposed changes to treatment are communicated and agreed to by relevant people and communicated to the person.

Recovery-oriented mental health services balance clinical recovery with the person’s own wishes. While the person and their carer should not be given sole responsibility as custodians of clinical information, they should be involved in transfer processes, and it should be clarified that they understand the information that is being transferred.

Suggested strategies

Use structured communication processes for the transfer of responsibility for care

Clinical handover should be consistent with the comprehensive care plan, developed collaboratively with the person, their family and carers. At points where there is a change in this plan, or a transfer of care as forecast in the plan, using structured communication processes that align with the documented plan will minimise the risk of important information being missed, or misunderstood.

Successful implementation of this strategy will be supported by, or rely on, the following action:

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

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
Use structured communication processes to coordinate concurrent care by more than one treating team

If more than one treating team is involved in a person’s care, clear protocols must be in place for communications. These should cover verbal communications and documentation. Team members should check that the way they communicate is understood by others – it may be possible that clinical terms are shared, but some terms may be differently interpreted, and lead to risk for adverse outcomes.

Key issues requiring structured communications include timeframes for review by different clinical teams, and prescription of medication.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

1.16a The health service organisation has healthcare record systems that make the healthcare record available to clinicians at the point of care

5.5a The health service organisation has processes to support multidisciplinary collaboration and teamwork

Involve consumers and carers in these processes

For people who are unfamiliar with clinical settings, transitions in their health care may be unfamiliar. Even if a process has been discussed with the person and their family during comprehensive care planning, they should be involved in discussion when the planned care is being evaluated or changed, or when an episode of care is being formally transferred.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

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

6.3 Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to:

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

Examples of supporting evidence

- Policy documents that describe a structured clinical handover process
- Observation of clinician’s practice that shows use of structured clinical handover processes and tools
- Information provided to consumers, carers and families that outlines their role in clinical handover processes
Communication of critical information

Action 6.9
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

How does this action apply to people with mental health issues?
Health care is dynamic, and subject to change when a person’s condition changes. The person and their carers cannot be assumed to take responsibility for alerting clinicians to changes, but should be supported to inform clinicians when they observe changes that they view as important.

Suggested strategies
Identify critical information
The comprehensive care plan developed in Action 5.13 includes identified risks. This can form the basis for identifying specific areas of focus for clinicians to be aware of. As part of the development and delivery of this plan, the changes or emerging issues of critical importance can be described.

Identify key people who should be notified of changes in critical information
There needs to be clear definition of the roles of members of the workforce. In particular, there needs to be explicit agreement about what information and interventions can be implemented by the local treating team, and which ones require contact with specialist mental health clinicians. Communications between different teams can frequently function as informal opportunities for education.

Successful implementation of this strategy will be supported by, or rely on, the following actions:
5.5 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

8.6b The health service organisation has protocols that specify criteria for escalating care, including agreed indicators of deterioration in mental state
Examples of supporting evidence

- Policy documents that outline the:
  - types of critical information that are likely to be received and actions to be taken in response
  - method for communicating critical information to the responsible clinician and the multidisciplinary team
  - method for communicating critical information to the patient, carer and family
  - time frames for communicating critical information
- Policy documents for identifying the clinicians responsible for a person’s care
- Standardised templates to support communication of critical information
- Systems for alerting clinicians who can make decisions about care when there is a change in the person’s condition, or new critical information is received.

Action 6.10

The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians

How does this action apply to people with mental health issues?

A consistent theme reported by families and carers is that they are the first to notice changes in a person’s mental state, but when they report this information to clinicians, their information does not always seem to be acted on. There may be many reasons for this. Clinicians may in fact incorporate the information into care planning, but not communicate this back to families and carers. Clinicians in general health services may feel they do not have the skills to respond effectively. They may also make presumptions that some other clinician or team is responsible for caring for a person’s mental health, and that they do not have to do anything. In some cases, consumers and carers have reported experiencing their information about a person’s deteriorating mental state not seeming to be taken seriously by clinicians.

Open communication about critical health issues between clinicians and the people they are caring for needs to occur across the whole episode of care. This starts at screening and assessment, continues through planning and delivery of care and, when necessary, when care needs to be escalated. Throughout, there needs to be a clear message that information about mental health issues will be taken seriously and treated respectfully.

Suggested strategies

Inform people receiving care, and their families and carers, what constitutes critical information

The issues regarded as ‘critical’ for clinicians, identified in Action 6.9, can form the basis of information for people receiving health care, their families and carers about what they should convey to clinicians. This can be integrated into information that
people receive when they are initially orientated to the unit. Any list should not be presented as complete, and people should be encouraged to communicate anything they regard as critical.

**Successful implementation of this strategy will be supported by, or rely on, the following actions:**

2.6 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

2.9 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

**Incorporate processes for consumer and carer communication of critical information throughout the care episode**

Partner with consumers and carers to create shared understanding about what constitutes critical information, and how to communicate it to clinicians in a way that will achieve jointly shared outcomes. Establishing effective communications from the beginning of the care episode will support effective communication processes when a person's condition changes, or new issues emerge.

Formal strategies for escalation of care are covered in more detail in Action 8.6.

**Successful implementation of this strategy will be supported by, or rely on, the following actions:**

6.3 Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to:

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

8.6d The health service organisation has protocols that specify criteria for escalating care, including worry or concern in members of the workforce, patients, carers and families about acute deterioration

**Examples of supporting evidence**

- Policy documents that outline how patients, carers and families are informed about the processes for communicating concerns to clinicians
- Examples of information provided to patients, carers and families about processes for communicating concerns to the clinicians responsible for care
- Resources or tools for patients, carers or families to use to communicate with clinicians
8. Recognising and Responding to Acute Deterioration

The intention of the Recognising and Responding to Acute Deterioration Standard is 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.

The three criteria are:

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

Services that provide physical health care will be familiar with the recognition and response model, but may not feel skilled in applying it to deterioration in a person’s mental state. The Commission has developed the National Consensus Statement: Essential elements for recognising and responding to deterioration in a person’s mental state (the Consensus Statement: see box) to support implementation of new actions in this standard.

Key factors underpinning implementation of the Consensus Statement are:

- Effectively recognising and responding to deterioration in a person’s mental state is everyone’s responsibility, it is not ‘in addition’ to their health care
- The development of an escalation protocol based on a clear assessment of the resources and skills that are available in the specific health context
- Collaboration with the person experiencing and carers, integrating their skills and knowledge into recognition and response processes.

Health service organisations may be at different phases of implementation of the Consensus Statement, but must be able to demonstrate understanding of the essential elements.

There is growing evidence of the impact of not recognising and responding to deterioration in a person’s mental state. Each year, 30 suicides on inpatient units are reported in Australian hospitals. The rates of use of restrictive practices (seclusion and restraint), while declining, remain high. These are the extreme adverse events associated with deterioration in a person’s mental state. There is also evidence that people experience poorer health outcomes, for both their mental and their physical health, when their mental health is not adequately treated.
Practice resource: National Consensus Statement

The Commission developed the *National consensus statement: Essential elements for recognising and responding to deterioration in a person’s mental state* (the Consensus Statement) which describes ten elements that are essential for a prompt and reliable response to deterioration in a person’s mental state. The elements are arranged in three parts:

**Processes of care**

1. Recognising deterioration in a person’s mental state  
2. Escalating care  
3. Responding to deterioration in a person’s mental state

**Therapeutic approach**

4. Creating safety and minimising restrictive practices  
5. Teamwork and shared decision making  
6. Communicating for safety

**Organisational supports**

7. Leadership and governance  
8. Workforce development  
9. Standardised processes to support high-quality care  
10. Evaluation and feedback.

The Consensus Statement is available on the Commission’s website at:

Detecting and recognising acute deterioration, and escalating care

Recognising acute deterioration

Action 8.5

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 for 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

How does this action apply to people with mental health issues?

This action specifically relates to people experiencing mental health issues.

Suggested strategies

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

Initial screening can identify people who are at risk of acute deterioration in their mental state. However, people who have not been identified as being at high risk can also experience deterioration in their mental state. Be alert for changes in mental state in all people receiving health care, including people at risk of developing delirium. Delirium can occur at any age and can be prevented.

When a person is experiencing deterioration in their mental state, they may be able to self-report this to members of the workforce. Similarly, carers or family members may recognise the specific signs that they know indicate the person’s mental state is deteriorating.

Successful implementation of this strategy will be supported by, or rely on, the following action:

5.10 Clinicians use relevant screening processes:

a. At 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
Practice resource: Recognising signs of deterioration in a person’s mental state

During national consultation for the Consensus Statement, stakeholders reported there is no tool in current clinical use for the comprehensive identification and monitoring of signs of deterioration in a person’s mental state. The Commission engaged Gaskin Research to undertake a project to identify these signs. They conducted a literature review, interviews and sequential surveys with people with experience of mental health issues, their families and carers, clinicians from multiple disciplines, health service managers and researchers. They propose five overarching indicators, to provide logical structure to the process of recognising when a person’s mental state is deteriorating. The five indicators are:

1. Reported change
2. Distress
3. Loss of touch with reality or the consequences of behaviours
4. Loss of function
5. Elevated risk to self, others or property

The report is available on the Commission’s website:


Partner with consumers and carers to monitor risks

Develop collaborative systems to routinely monitor and support people 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, the Delirium Clinical Care Standard\(^42\) includes indicators for local review and feedback.

Engagement with carers and families can help maintain safety for the person experiencing deterioration in their mental state and others, while arrangements for specialist intervention are under way.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

2.6 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

5.14d The workforce, patients, carers and families work in partnership to reassess
the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur

Examples of supporting evidence

- Policy documents about recognising, documenting and observing acute deterioration in a person's mental state
- Screening and assessment policies and procedures for mental health in line with the Comprehensive Care Standard
- Training documents about recognising acute deterioration in mental state and how to deal with reports of deterioration from the patient, carer or family
- Documentation of integration of information from consumer wellness plans in comprehensive care plan.

Escalating care

Action 8.6

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

How does this action apply to people with mental health issues?

Acute deterioration in a person's mental state in a healthcare setting requires urgent response. The workforce in every setting need to have an understanding of what they can do when they recognise this occurring. Effective response may require specialist mental health intervention.

Suggested strategies

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 deterioration in a person's mental state:

- An emergency response (for example, from specialist mental health clinicians) 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.
There should be a clear system in place for the person themselves, or their family or carer to directly call for escalation of care when they are concerned about deterioration in the person’s mental state. Examples of these include:


Successful implementation of this strategy will be supported by, or rely on, the following action:

6.10 The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians.

**Develop local escalation protocol**

If the person’s mental state is deteriorating in a non-mental health specialist setting, the local protocol should be clear about how access to specialist mental health care is achieved. In a large tertiary hospital, this may be an internal referral to a consultation liaison service. Many of these services have referral forms that prompt non-specialist clinicians about what to look for and communicate when they have concerns about a person’s mental state.

For other services, where specialist mental health services may not be located on-site, it will be necessary to have an escalation protocol that links to another agency. These protocols should be supported by established partnerships, and clear processes for communication for both the referring clinician and the service receiving the referral. These should cover:

- Designation about which service or clinician holds clinical responsibility for the person’s care
- Expected timeframes for response.

Tailor the escalation protocol to the specific health setting, taking into account:

- The size, location and role of the setting
- The available resources, including the clinical workforce skill mix
- The capacity to engage specialist help.

The Commission developed an escalation mapping tool to support services to implement processes for recognising and responding to physiological deterioration. It provides a template that local units can use to set out what changes in observations...
will indicate need for escalation in the local context. The tool can be adapted to reflect what needs to be done when signs of deterioration in a person’s mental state are reported or observed. The tool is available on the Commission’s website at:


Successful implementation of this strategy will be supported by, or rely on, the following action:

8.12 The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated

Examples of supporting evidence

- Policy documents that identify agreed criteria that indicate acute deterioration in a person’s mental state that trigger escalation of care, and the expected responses
- Policy documents that include consideration of the organisation’s size, role, location and services provided
- Documented localised escalation protocols
- Resources or tools that help clinicians to use the escalation protocols
- Audit results of compliance with the escalation protocols

Responding to acute deterioration

Action 8.12

The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated

How does this action apply to people with mental health issues?

This action specifically relates to people experiencing mental health issues.

Suggested strategies

Develop internal and external partnerships to support escalation of care to specialist mental health services

Large tertiary hospitals typically have consultation liaison psychiatry services available internally. Ensure that all members of the workforce are aware of how to contact the service when they recognise deterioration in a patient’s mental state. Many consultation liaison services provide templates for referral that support effective communication and enable reviews to be prioritised across the hospital. Support
consultation liaison processes with education for the workforce. Consultations can provide opportunities for further education and upskilling of the workforce.

For organisations that do not have consultation liaison services on site, develop and maintain local partnerships to enable rapid referral. This may involve linking with the local community mental health service, a general practitioner or on-call psychiatrists.

Successful implementation of this strategy will be supported by, or rely on, the following actions:

5.5 The health service organisation has processes to:

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

8.6b The health service organisation has protocols that specify criteria for escalating care, including agreed indicators of deterioration in mental state

Examples of supporting evidence

- Policy documents about rapid referral to mental health services
- Audit results of episodes of acute deterioration in a person’s mental state, to determine whether rapid referrals were made to mental health services
References


25. Mind Australia, Helping Minds, Private Mental Health Consumer Carer Network, Mental Health Carers Arafmi Australia, Mental Health Australia. A practical
guide for working with carers of people with a mental illness. Mind Australia and Helping Minds; 2016.


Appendix A: Linked actions

The following table summarises linked actions in the NSQHS Standards (2nd ed.) that have been highlighted throughout the text as critical for supporting implementation of the suggested strategies.

<table>
<thead>
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<th>Standard</th>
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<th>Item</th>
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<td>Healthcare rights and informed consent</td>
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<td>Minimising restrictive practices: restraint</td>
<td>Predicting, preventing and managing aggression and violence</td>
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<td><strong>Recognising and Responding to Acute Deterioration</strong></td>
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<td>Recognising acute deterioration</td>
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### Appendix B: Consumer wellness plan

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**CONSUMER WELLNESS PLAN**

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This module has been designed by consumers. All consumers are encouraged to complete it in partnership with their clinician and/or nominated carer. The intent of the module is to facilitate consumer involvement in their own care, particularly in terms of symptom management, relapse prevention and crisis planning. It serves as a recovery aid and as a prompt and reminder about what to do to support recovery.

**Things I do well / skills I have**

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**Things I can do to keep myself well / what helps me stay well**

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*Draft NSQHS Standards User Guide for Health Services Providing Care to People with Mental Health Issues. Not for citation*
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**Support / Treatment / Medications that I have been helpful / or I have liked**

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**Support / Treatment / Medications that have been unhelpful and / or I have disliked**

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**CONSUMER WELLNESS PLAN**

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<th>Things that stress me</th>
<th>Things I can do to reduce stress</th>
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<th>Things that help with early warning signs</th>
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If I become unwell I would like the following to happen or not to happen

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<th>RELATIONSHIP</th>
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<th>COPY OF PLAN?</th>
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Review Date:

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<tr>
<td>I have been fully informed about my rights and responsibilities (includes receipt of consumer package)</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I have been informed of peer support options</td>
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People who have helped me complete the Plan:

Consumer Name:  
Signature:  
Date: