Mental Health Clinical Documentation

Summary All NSW public mental health services are required to use available electronic medical record (eMR) systems for the documentation of clinical practice and care.

Document type Policy Directive

Document number PD2021_039

Publication date 12 October 2021

Author branch System Information and Analytics

Branch contact (02) 9461 7307

Replaces PD2010_018

Review date 12 October 2026

Policy manual Patient Matters Manual for Public Health Organisations

File number H21/148667

Status Active

Functional group Clinical/Patient Services - Governance and Service Delivery, Mental Health, Records Corporate Administration - Information and Data

Applies to Ministry of Health, Local Health Districts, Board Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Government Medical Officers, Community Health Centres, NSW Ambulance Service, Public Hospitals

Distributed to Ministry of Health, Public Health System, Divisions of General Practice, Government Medical Officers, NSW Ambulance Service, Tertiary Education Institutes

Audience All Staff of NSW Health;All Chief Executives;Area Mental Health Directors;Mental Health;Medical Records

Secretary, NSW Health

MENTAL HEALTH CLINICAL DOCUMENTATION

POLICY STATEMENT

NSW Health organisations must ensure that all mental health services use available electronic medical record (eMR) systems for the documentation of clinical practice and care. This is required in all service settings, for all service types and age groups, and enables integrated health services and clinical information systems across NSW.

Digital documentation facilitates the recording, retrieval and sharing of medical record information in an accessible, standardised and structured format. This is important at all points in the cycle of mental health care from triage through to transfer or discharge.

All NSW Public Health Organisations must ensure that local processes are in place which comply with this Policy.

SUMMARY OF POLICY REQUIREMENTS

Electronic health systems are to be supported by Local Health Districts (Districts) and Specialty Health Networks (SHNs) by implementing products and functionalities as they become available. Local systems, processes and procedures are to be maintained, including those required for downtime when needed. There must also be training and education provided for clinicians in the areas of mental health clinical documentation, and related eMR systems and processes.

eMR systems must include available electronic mental health (MH) documents, including notes, forms, measures and reports.

Clinical care and information must be documented and are to be recorded within the eMR, with paper records used only where there is no current alternative.

Documentation must occur at appropriate clinical points of care, including triage, assessment, care planning, review, transfer and discharge. It must be made as soon as practically possible in the eMR clinical document(s) relevant to the clinical point of care and needs of the person accessing the service.

Structured documentation is to be used to aid functionalities that auto-populate fields, and transfer information between documents and systems. This is critical to clinical care and support across services and systems within NSW Health. Only relevant fields need to be completed. There are no requirements that all fields or areas of a document are to be completed.

All persons registered to a mental health service must have the following recorded in their documentation: Designated Carer(s) and/or Principal Care Provider information; Diagnosis (issues that are the focus of the current admission or encounter); Legal Status; and Alerts (for care and safety of the person, carer(s) and health workers).

There must be clinical reasons to use non mental health or alternative documentation or free text. In these circumstances, the clinician must be aware that auto-population and transfer functions will not be enabled. The clinician is to ensure that documentation reflects the content of the standardised eMR document, and the format of documentation is legible and locatable by other clinicians involved in care.

For information on Mental Health resources and updates
http://ehnsw.sharepoint.nswhealth.net/apps/ClinP-eMedsHub/Pages/Mental-Health.aspx

REVISION HISTORY

Version	Approved by	Amendment notes
October-2021 (PD2021_039)	Deputy Secretary, Patient Experience and System Performance Division	Updated to reflect redesigned mental health clinical documentation, in line with current policy and transition to an electronic medical record (eMR) system
March 2010 (PD2010_018)	DDG Strategic Development	Updated to reflect redesigned mental health clinical documentation
January 2005 (PD2005_358)	DDG Strategic Development	Specified mandatory implementation of the documentation modules by all public mental health services