Guideline

Mental Health Clinical Documentation Guidelines

Summary This guideline supports the Policy Directive Mental Health Clinical Documentation (PD2010_018) by outlining the suite of Mental Health Clinical Documentation to be used by NSW Mental Health Services. The primary aim of this guideline is to provide broad guidance for the use of the modules to document the episode of care from triage through to transfer/discharge. It is not intended as a script or text for conducting a clinical assessment, deciding upon interventions to be undertaken or the application of care.

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Audience Mental Health Directors and staff;Community Health staff;Medical Records staff

Secretary, NSW Health

GUIDELINE SUMMARY

MENTAL HEALTH CLINICAL DOCUMENTATION GUIDELINES

PURPOSE

This Guideline supports the Policy Directive Mental Health Clinical Documentation (PD2010_018) by outlining the suite of Mental Health Clinical Documentation to be used by NSW Mental Health Services. The primary aim of this Guideline is to provide broad guidance for the use of the modules to document the episode of care from triage through to transfer/discharge. It is not intended as a script or text for conducting a clinical assessment, deciding upon interventions to be undertaken or the application of care.

KEY PRINCIPLES

Mental Health Clinical Documentation is separated into Core (required in all circumstances and clinical settings) and Additional modules (to be undertaken when clinically indicated) to be applied across the episode of care. The modules interrelate such that completion of the Core modules informs what Additional modules to document further assessments are required and such that the clinical record as documented through the clinical documentation forms a coherent narrative about the episode of care.

The suite of Clinical Documentation Modules are to be viewed as a tool for recording assessments and care provided and are not a script for undertaking these procedures. The modules are a place to document clinical information and are not a substitute for clinical skills, training, supervision or judgement.

USE OF THE GUIDELINE

This Guideline should inform the use of the suite by clinicians in mental health and other settings and provides advice on the intent and process of the development of the documents. The Guideline provides advice on when to complete individual Clinical Documents and where the results of a thorough clinical assessment should be recorded to allow consistency across episodes of care and between clinical records.

REVISION HISTORY

Version	Approved by	Amendment notes
January 2014 GL2014_002	DDG System Purchasing and Performance	Amended GL2008_016 to include Metabolic Monitoring Module
GL2008_016	DDG Strategic Development	

ATTACHMENTS

1. Mental Health Clinical Documentation: Guidelines.

Mental Health Clinical Documentation Guidelines

NSW GOVERNMENT Health

GUIDELINE

Issue date: January-2014

GL2014_002

CONTENTS

1 BACKGROUND

1.1 About this document

These Guidelines have been developed to facilitate the implementation of the redesigned Mental Health Clinical Documentation by public mental health services.

The primary aim of the current document is to provide broad guidelines for the use of the modules to document an episode of care from triage through to transfer/discharge. It is not intended as a guideline or text on conducting a clinical assessment. The modules are a place to document clinical information; they are not a substitute for skills, training, supervision or judgement.

The Guidelines provide the following information on each module:

Heading	Description
Purpose	Outlines the clinical situation for which the module is intended.
Target services	Outlines the services and settings expected to use the module.
Completion requirements	Outlines any prerequisite skills or knowledge required for the completion of the module.
Associated resources	Outlines educational and/or other resources that have been, or are being, developed to support the completion of the module.
Issues for CAMHS and SMHSOP services	Highlights any issues related to the use of the modules by these services
Completion tips	Provides information to guide clinicians in the completion of particular information domains.

The Guidelines replace those contained in the *Your Guide To MH-OAT* (2004) regarding the use of standardised mental health clinical documentation. The Guidelines reflect the recommendations of the participants in the redesign process, along with the feedback received from participants in the field testing of the draft redesigned modules. Further input into the Guidelines was received from the following sources:

- Informal consultations undertaken state-wide via email with clinicians, managers and other key stakeholders during May 9 -June 9 2008;
- Forum undertaken with MH-OAT and MHIDP personnel on May 26 and 27 2008;
- Feedback from over 140 clinicians, managers and other key stakeholders during state-wide Information Sessions on the redesigned modules undertaken from May 28 to June 4 2008;
- Feedback from relevant NSW Health personnel.

It is anticipated that Local Health District (LHD) protocols would further define the completion of the modules, reflecting consideration of the nature of the clinical process being undertaken by the service, and LHD business processes. The completion of the modules should also always be guided by the clinician's informed judgement regarding the consumer's clinical status and needs at the time. Progress notes can be used to supplement information documented in the modules as appropriate.

1.2 Key definitions

Mental Health Clinical Documentation is separated into Core (required in all circumstances and clinical settings) and Additional modules (to be undertaken when clinically indicated) to be applied

across the episode of care. The modules interrelate such that Core modules inform what Additional modules to document further assessments are required and such that the clinical record as documented through the clinical documentation forms a coherent narrative about the episode of care.

- **Core Modules**: *Triage*, *Assessment*, *Care Plan*, *Review* and *Transfer/Discharge Summary.*

  These are to be used for all settings and age groups.

- **Additional Modules**: *Physical Examination*, *Metabolic Monitoring, Physical Appearance*, *Risk Assessment*, *Substance Use Assessment*, *Family Focused Assessment (COPMI), Functional Assessment (Older People), Screening for Domestic Violence, Cognitive Assessment (RUDAS), Cognitive Assessment (3MS/MMS) and the Consumer Wellness Plan.*

  These are to be used as appropriate to the clinical situation.

The logic of the 'core' and 'additional' module relationship is that the core module is the primary location for clinical documentation; the 'additional' modules are available for additional assessment and documentation support for specific information domains. This approach gives clinicians and services greater flexibility in terms of choosing the degree of support and structure that they require for particular information domains. It also affords clinicians and services greater flexibility in terms of the documentation of information gathered over the course of the assessment process. The 'additional' modules are also available for use at points of care other than assessment, such as review and transfer/discharge, affording clinicians and services greater flexibility in the documentation of the episode of care.
Clinicians should use the modules as tools to record the information in a structured format, rather than as assessment and clinical practice guides, with **clinical judgement paramount in guiding information gathering**.

1.3 Overview of Clinical Documentation modules

MENTAL HEALTH CLINICAL DOCUMENTATION: "MODULE LOGIC"

CORE MODULES	ADDITIONAL MODULES	SUPPORT MATERIAL
Modules to be used for all settings and age groups	Modules which are to be used as appropriate to the clinical situation	Educational and other resources to support module completion and/or use
TRIAGE TRIAGE		CRISIS TRIAGE RATING SCALE
ASSESSMENT ASSESSMENT	PHYSICAL EXAMINATION PHYSICAL APPEARANCE METABOLIC MONITORING RISK ASSESSMENT SUBSTANCE USE ASSESSMENT SCREENING FOR DOMESTIC VIOLENCE FAMILY FOCUSED ASSESSMENT (COPMI) FUNCTIONAL ASSESSMENT TRANSCULTURAL ASSESSMENT COGNITIVE ASSESSMENT (RUDAS) COGNITIVE ASSESSMENT (3MS/MMS)	TRANSCULTURAL REFERRAL GUIDE TRANSCULTURAL ASSESSMENT CHECKLIST RISK ASSESSMENT: completed fictional example SUBSTANCE USE ASSESSMENT: completed fictional example FAMILY FOCUSED ASSESSMENT (COPMI): Completed fictional example RUDAS Administration & scoring guide 3MS/MMS rescource materials
CARE PLANNING AND REVIEW CARE PLAN Summary of issues and updated rating of progress REVIEW	CONSUMER WELLNESS PLAN	CARE PLAN: completed fictional example. Resources to facilitate use of outcome measures Inpatient Care Plan (possible future development)
TRANSFER & DISCHARGE TRANSFER/ DISCHARGE SUMMARY		Cumulative treatment history (possible future electronic medical record [EMR] development)

1.4 Policy framework

The use of standardised Mental Health Clinical Documentation is mandated under Policy Directive Mental Health Clinical Documentation (PD2010_018).

Components of the Assessment, Physical Examination and Metabolic Monitoring modules support Policy Directive Provision of Physical Health Care within Mental Health Services (PD2009_027) and Guideline Physical Health Care of Mental Health Consumers Guidelines (GL2009_007)

2 CORE MODULES

TRIAGE

Purpose

The *Triage* module has been developed for use in both face-to-face and telephone triage.

Target services

All mental health services conducting telephone or face-to-face triage.

Completion requirements

The *Triage* module can be completed by any appropriately qualified and experienced mental health professional.

Associated resources

The Crisis Triage Rating Scale (CTRS) (Bengelsdorf et al., 1984) is provided as a laminated resource and can be used as a guide in informing decision making about the urgency of response. The Scale assesses the consumer on three factors: (A) whether they are a danger to themselves or others, (B) their support system, and (C) their ability to cooperate. The clinician selects the score under each factor that best describes the consumer's presentation. Scores range from 1 to 5 for each factor, resulting in a maximum total score of 15 (A+B+C). Lower scores indicate more significant crisis. The Scale was originally based on a telephone triage scale and has been demonstrated to be a useful tool in determinations of the need for hospitalisation, with this indicated by scores below 9. It has since been modified and expanded to cover a range of 'urgency of response' options in inpatient and community settings. This Scale should be used by a clinician in conjunction with the available triage information to make an informed decision about the urgency of response.

Issues for CAMHS and SMHSOP services
Nil.

Completion tips

- Any 'Alerts/Risks' identified during triage should be summarised in the text box on page 1 after the triage is completed. Some examples: 'High risk for suicide', 'Fire risk – smokes in bed', 'Fall risk due to hypotension'.
- 'Communication issues' includes issues such as language or cultural barriers and any sensory impairment. If an interpreter is required, then the preferred language should be noted, for example, 'Arabic interpreter is required'. Where cultural issues are present, a brief summary should be noted, for example: 'Cultural issues may be present, Aboriginal Liaison Officer may be required'.

- The CTRS is available to assist clinicians in determining the 'Urgency of response', particularly whether inpatient or community based care is required. The intent of the CTRS is to support, not replace, clinical judgement. Where used, clinicians should note the scores (A+B+C) for the CTRS under 'Details of Action Plan'. If in the clinician's judgement the required 'Urgency of response' is different to that indicated by the CTRS they should document their view and the issues underlying it under 'Details of Action Plan'.
- Clinicians should document their overall clinical impression, including any possible risks under 'Summary'. The information should reflect their clinical overview given their synthesis of the information gathered during the triage.
- The clinician should document the details of any communications undertaken during the triage under 'Contacts' to identify any corroboration undertaken, as well as provide contact details to aid any subsequent communication. The prompts provided in the 'Contacts' table are not meant to be definitive or exhaustive. Provision is made for clinicians to specify 'Other' contacts, thereby making the module more flexible and responsive to differing presentations.

ASSESSMENT

Purpose

The *Assessment* module provides a framework for documenting a mental health assessment on first contact or at other times when a comprehensive mental health assessment is indicated.

Target services

All mental health services conducting assessment.

Completion requirements

The module can be completed by any appropriately qualified and experienced mental health professional.

Issues for CAMHS and SMHSOP services
Nil.

Completion tips

- The *Assessment* module has been designed to reflect standard assessment processes to aid its completion during the assessment. Nevertheless, clinicians should use the *Assessment* module to record assessment information in a structured format, not as an assessment guide. The process of information gathering should be determined by clinical judgement and discretion.
- The module has been designed to be completed by one mental health professional, at one point in time. Where the module is completed by more than one person, then each subsequent professional should identify the section they have completed by writing the heading 'Addendum' next to it and undertaking sign off below the information provided (name (PRINT), signature, designation (PRINT) and date).
- Where a clinician completes the module over a number of assessment sessions, then s/he should identify the additional information by writing the heading 'Addendum' prior to it and undertaking sign off below the information provided. Given consideration of the number of sessions required for the assessment process, clinical judgement should determine whether this information is recorded entirely in the *Assessment* module, or a combination of the module and progress notes.
- The module makes provision for a broad range of information domains. If a section is unable to be completed, the clinician should document why the information has not been collected.

For example, the clinician can document that 'the information was unavailable at the time of assessment' or 'the information is not relevant to the current presentation'. If the information was not available at the time of assessment, clinicians should document any follow up actions planned to obtain that information.

- The *Assessment* module makes provision for the documentation of both background and current, situational factors as this underpins the requirements of a comprehensive mental health assessment. In completing the module for consumers well known to the service, clinicians may balance the level of detail recorded for issues such as 'Past Psychiatric/Mental Health History' given access to previously documented information in the file and the understanding that background factors are not necessarily static.
- When documenting 'Current Medications' clinicians should note any complementary, alternative medicines reported including multivitamins and minerals and herbal preparations.
- 'Parental Status and/or Other Carer Responsibilities' section prompts documentation of dependents such as children aged 18 or less and disabled adults or aged. It also prompts documentation of consumers who may have access to children through access visits or shared residence. The major aim is to facilitate the incorporation of parental/carer responsibilities and dependents into management/care planning, particularly any safety concerns.
- The 'Mental State Examination' is where clinicians document their observations of the consumer during the assessment process. Issues such as 'anhedonia', 'sleep' and 'appetite' reflect reported information and are typically expected to be recorded under 'History of Presenting Problem' rather than under 'Mental State Examination'.
- Clinicians should document their overall clinical impression, including any possible current and longer term risks under 'Formulation/Overall Clinical Impression'. The information should reflect their clinical overview given their synthesis of the information gathered during the assessment process.

Links to additional modules

- The *Assessment* module can be supplemented with the 'additional' assessment modules and clinicians should document any 'additional' modules they have completed on the *Assessment* module. The intent of the 'additional' modules is to provide more structure for specific information domains contained in the *Assessment* module.
- For example, the *Assessment* module contains screening questions regarding 'Parental Status and/or Other Carer Responsibilities' on page 5. Where parental/carer status for a child/young person 18 years or under has been determined on the *Assessment* module, clinicians can complete the *Family Focused Assessment (COPMI)* module to facilitate the collation of information gathered regarding this issue and determinations of the urgency of response. The completion of this module needs to then be documented on page 5 to highlight the links between the two modules.
- Likewise, the *Assessment* module contains screening questions regarding suicide and violence risk. Where these screening questions suggest significant risk, clinicians should complete the *Risk Assessment.* The completion of this module needs to then be documented on page 7 to highlight the links between the two modules.

Relationship to routine outcome measures

During the assessment process, clinicians should offer the consumer the relevant consumer-completed outcome measure to enhance and support dialogue and engagement with the consumer. In the case of Adult and Aged Care services this would be the *K10*, with Child and Adolescent services this would be the *Strengths and Difficulties Questionnaire (SDQ).* In the case of Child and Adolescent services, the parent/carer should also be offered the *SDQ (Parent)* for their completion.

Based on the information gathered during the assessment, clinicians should complete the relevant outcome measures such as the HoNOSCA, HoNOS and HoNOS65+ and record the results in the *Assessment* module under 'Measures'.

CARE PLAN

Purpose

The *Care Plan* module provides a framework for **summarising** the goals and clinical issues that are the targets for the episode of care with the intent of aiding the monitoring of clinical status.

Target services

All mental health services providing treatment and intervention.

Completion requirements

The module can be completed by any appropriately qualified and experienced mental health professional, for example, the Case Manager/Care Coordinator.

Issues for CAMHS and SMHSOP services
Nil.

Completion tips

- The allocated Case Manager/Care Coordinator should ideally identify the targets and the choice of interventions in collaboration with the consumer and/or carers, and where appropriate with other health professionals and service providers. The Coordinator should also take responsibility for coordinating appropriate interventions and the review and monitoring of clinical status and their documentation in the *Care Plan*.
- While clinical judgement should determine the goals and clinical issues that are addressed, this process should be aided by the consumer and clinician completed outcome measures. In addition to facilitating the determination of goals and clinical issues to be targeted, the outcome measures information can inform the monitoring and review of progress.
- In settings where multiple professionals are involved in care planning and its implementation, it is practical for the documentation of this to be undertaken by the allocated Case Manager/Care Coordinator. Where other service delivery approaches are utilised and the involved clinicians wish to make their own entries, the contributors should document their details in 'Person/service responsible' and date and initial their review ratings. Their details should also be documented in 'Persons/services involved in the care planning process'.
- If using standard outcome measures reports to review care planning and rate progress, these should be attached to the relevant *Review* module.
- Where it has been determined that an inpatient stay will be 72 hours or less, or that ambulatory care will be for a period of less than 14 days, the clinician may elect not to use the Care Plan, if they deem that the 'Initial Management Plan' documented in the *Assessment* module adequately covers the period of care. The 'Initial Management Plan' can be supplemented and supported by the use of the *Review* module.

Relationship to Review module

The *Care Plan* is intended to summarise the issues and interventions undertaken during the episode of care. As a result, it should be used in tandem with the *Review* module, with the information contained in the *Review* module forming the basis for review ratings. New treatment targets and interventions that emerge as a result of a review can be summarised in the *Care Plan* to aid monitoring. The *Review* module can also be used to document the short term components of the medium or longer goals outlined in the *Care Plan.* For example, it can be used to document actions such as phone calls that need to be undertaken with other health professional or services involved in the consumer's care.

Relationship to Transfer/Discharge Summary module

A copy of the current *Care Plan* should be attached to the *Transfer/Discharge Summary* module on discharge to facilitate a transfer of care and ongoing management.

REVIEW

Purpose

The *Review* module provides a framework for documenting clinical reviews undertaken during the episode of care.

Target services

All mental health services providing treatment and intervention.

Completion requirements

The module can be completed by any appropriately qualified and experienced mental health professional.

Issues for CAMHS and SMHSOP services
Nil.

Completion tips

- The protocols in place for outcome measurement (see *Your Guide to MH-OAT, 2004)* provide a rough guide to expected points of clinical review; however, these may vary depending on the clinical situation and service context.
- During inpatient mental health care, the first routine review should take place at 35 days following the date of admission. The second routine review should take place at 13 weeks following the date of admission. Subsequent routine reviews should take place at intervals of 13 weeks from the preceding review.
- During community based care, the first routine review should take place 13 weeks following the date of 'admission', with subsequent routine reviews occurring at intervals of 13 weeks from the preceding review.
- The module can also be completed at other times as determined by clinical judgement and discretion and the wishes of the consumer and/or primary carer.

Relationship to outcome measures

Where the *Review* module is being completed in response to routine outcome measures protocols, the outcome measures should be completed on the basis of information gathered during the clinical review of progress. The findings of the outcome measures should then be documented in the *Review* module under 'Measures'. If using standard outcome measures reports to aid the review of progress, these should be attached to the *Review* module.

During the review process, clinicians should offer the consumer the relevant consumer-completed outcome measure to enhance and support ongoing dialogue and engagement with the consumer.

Relationship to the Care Plan module

The *Care Plan* and *Review* can be used as inter-related modules. The information documented in the *Review* module should form the basis of the *Care Plan's* review ratings. The *Review's* 'Action Plan' can be used to record care planning issues that are short term components of the longer term goals outlined in the *Care Plan*. New treatment targets and interventions that emerge as a result of a review can be summarised in the *Care Plan* to aid monitoring.

Relationship to additional modules

Where additional modules have been used to support review, their completion and key findings should be documented under 'Summary of Progress and Current Status'.

TRANSFER/DISCHARGE SUMMARY

Purpose

The *Transfer/Discharge Summary* module documents the current episode of care and its outcomes. It allows provision for documentation of issues requiring ongoing management, where care is being transferred to another mental health service unit or other service provider, such as a general practitioner. The module is intended for use in both inpatient and ambulatory settings and should be completed on or before the day of discharge (see PD2012_069, PD 2012_060). Ideally, discharge planning should be commenced at admission/opening of a service request.

Target services

All mental health services providing treatment and intervention.

Completion requirements

In inpatient settings, the *Transfer/Discharge Summary* should be completed and signed by a medical officer. In ambulatory settings, the *Summary* should be completed and signed by a community medical officer or any appropriately qualified and experienced mental health professional in accordance with local Local Health District policy.

Issues for CAMHS and SMHSOP services
Nil.

Completion tips

- 'Communication issues' includes issues such as language or cultural barriers and any sensory impairment. If an interpreter is required, then the preferred language should be noted, for example: 'Arabic interpreter required'. Where cultural issues are present, a brief summary should be noted.
- The module makes provision for the documentation of 'Current medications'. If these details are comprehensively outlined in other sources (e.g. inpatient pharmacy printout, referral letter), the clinician can attach this to the *Transfer/Discharge Summary* and document this under 'Current medications'. The brief documentation should indicate attachment details, for example, 'see attached referral letter for details on current medications'.
- The module makes provision for the documentation of 'Contacts' to identify any corroboration undertaken as part of transfer or discharge planning, as well as provide contact details to aid any subsequent communication. The prompts provided in the 'Contacts' table regarding 'Role/service' (e.g. Care Coordinator) are not meant to be definitive or exhaustive. Provision is made for clinicians to specify 'Other' contacts, thereby making the module more flexible and

responsive to differing presentations. In the case of 'Clinicians who provided care during the current episode', the intent of this information is to facilitate communication.

Relationship to other modules

Where care is being transferred, particularly to another mental health service, a copy of the current *Care Plan* should be attached to the *Transfer/Discharge Summary* module on discharge, to facilitate transfer of care and ongoing management. With the consumer's consent, a copy of their completed *Consumer Wellness Plan* should be attached to the *Transfer/Discharge Summary* at the time of discharge and transfer of care. A copy of a completed *Physical Examination* module should also accompany the *Summary* at discharge from an inpatient setting.

3 ADDITIONAL MODULES

PHYSICAL EXAMINATION

Purpose

The *Physical Examination* module provides a structured format for the completion of a physical examination undertaken by a medical officer.

Target services

All mental health services. Where possible, Emergency Departments and general practitioners.

Development background

The module reflects the Policy Directive *Physical Health Care within Mental Health Services* (PD2009_027), with the information domains reflecting the standards outlined in the *Physical Health Care for Mental Health Consumers Guidelines* (GL2009_007).

Completion requirements

The module can be completed by a medical officer or general practitioner. The initial component of the first page can be completed by an appropriately qualified and experienced nurse.

Issues for CAMHS and SMHSOP services
Nil.

General completion tip

- The first component of the module can be completed by a nurse. If the nurse has provided 'general appearance and observations' information elsewhere, s/he would not be required to duplicate. Rather, the medical officer would then complete this information as appropriate.

Completion tips at assessment

- The Policy Directive *Physical Health Care within Mental Health Services* (PD2009_027) stipulates that all admissions to inpatient settings should have a physical examination at the time of admission, or at least within 24 hours of admission, unless an examination has already been conducted by the mental health service from which the consumer is being transferred and documentation of this is available within the consumer's clinical record.
- For consumers admitted to community mental health care, all attempts must be made to have a physical examination and consideration of investigation as soon as feasible. The examination must be conducted within 1 month of a new admission to community mental health care and can be undertaken by the consumer's general practitioner. Where a *Physical*

Examination module has been completed this should be noted in the *Assessment* module under 'Physical Examination Summary'.

- For consumers admitted to a mental health inpatient unit via the Emergency Department, a more comprehensive physical assessment than it is reasonable to routinely expect of Emergency Department staff is often required. Unless an appropriately comprehensive physical assessment has been documented in the Emergency Department, patients must be re-examined within 24 hours upon admission to a mental health unit.
- If at the time of community admission, an adequate physical examination is available within the previous month from an Emergency Department medical officer, a general practitioner or transferring mental health service unit, then a repeat examination is not required unless clinically indicated. The examination should be attached to the *Assessment* module, with the key findings documented in the module under 'Physical Examination Summary'.
- If a consumer refuses a physical examination this should be documented in the *Assessment* module under 'Physical Examination Summary', with the 'Initial Management Plan' to reflect monitoring of the consumer's status and strategies to facilitate a physical examination. Where a consumer is receiving community mental health care, they can be referred to their nominated general practitioner, with this noted in the *Assessment* module under 'Physical Examination Summary'.
- Two staff members should be present for physical examination that requires removal of clothing or palpation of more than limbs (such as initial examinations), unless a need for urgent care prevents this, or the consumer specifically requests this does not occur. In such situations, the reason for not using a chaperone should be documented, for example in the *Assessment* module under 'Physical Examination Summary', or under 'General Appearance and Observations' in the *Physical Examination* module. The second staff member may be a qualified healthcare interpreter if they are agreeable to this role. Staff availability requires consideration, but usually one staff member should be of the same gender as the consumer. It may sometimes be appropriate for a family member, friend or carer to be present during the examination. Details of the chaperone should be documented in the under 'People present'.

Completion tips for long term consumers at review

- All consumers who are undergoing extended community or non-acute inpatient mental health care should have their weight and/or waist-hip ratio (WHR) measured every 6 months, or more frequently if the consumer is identified as over-weight, and a physical examination no less frequently than every 12 months. For consumers who are 65 years or older, or whom are known to have significant physical illness or disability, this should be no less frequently than every 6 months. In these instances where the *Physical Examination* has been completed post-assessment, this needs to be documented in the *Review* module under the heading 'Summary of Care/Treatment Provided'.
- In community settings these ongoing examinations can be undertaken by the consumer's general practitioner, with the key findings to be noted in the *Review* module under the heading 'Summary of Care/Treatment Provided'. Where a consumer does not have a nominated general practitioner, the mental health service should make reasonable efforts to link the consumer with an appropriate health care provider.

Relationship to Transfer/Discharge Summary module

When discharged from inpatient care, a copy of the completed *Physical Examination* module should accompany the *Transfer/Discharge Summary*.

METABOLIC MONITORING

Purpose

The *Metabolic Monitoring* module provides a structured format to support the monitoring of consumers identified as having, or as being at risk of, metabolic syndrome.

Target services

All public mental health services providing treatment and intervention.

Development background

NSW Health's Mental Health Clinical Advisory Council recommended the development of the *Metabolic Monitoring Clinical Documentation Module* in order to consolidate work being undertaken by several LHDs and to standardise metabolic monitoring across NSW. The module was developed by an Advisory Group comprising experts, representatives from services using metabolic monitoring forms and clinicians from a range of public mental health services. PD2009_027 Provision of Physical Health Care within Mental Health Services and GL2009_007 Physical Health Care of Mental Health Consumers Guidelines.

Completion requirements

Completion of the *Metabolic Monitoring Module* is not mandatory as part of PD2010_018 Mental Health Clinical Documentation Policy. However it is the responsibility of NSW Mental health services to monitor physical health status for people under their care (PD2009_027 Provision of Physical Health Care within Mental Health Services and GL2009_007 Physical Health Care of Mental Health Consumers Guidelines) This module, in combination with the *Physical Examination* module, assists services to meet those requirements.

Information for completion of these modules may be obtained directly by the service or from other professionals such as GPs. LHDs should develop local policies regarding which staff record this monitoring or how information is shared with GPs.

Associated resources

Positive Cardiometabolic Health: An early intervention framework for patients on psychotropic medication (Curtis, Newall & Samaras, 2011)[1] is a resource aimed at supporting the management of risk factors associated with metabolic syndrome.

The heart of the matter: Cardiometabolic care in youth with psychosis (Curtis, Newall & Samaras, 2012)[2] is a discussion paper about the model of care for metabolic screening and management in an early episode psychosis team.

Screening for the metabolic syndrome in patients receiving antipsychotic treatment: a proposed algorithm (Waterreus & Laugharne, 2009)[3] is a discussion paper about screening of mental health consumers for metabolic syndrome. It can be accessed via https://www.mja.com.au/journal/2009/190/4/screening-metabolic-syndrome-patients-receiving-antipsychotic-treatment-proposed.

[1] Curtis, J., Newall, H. D. & Samaras, K. (2011). Positive Cardiometabolic Health: An early intervention framework for patients on psychotropic medication. Retrieved from http://www.heti.nsw.gov.au/resources-library/positive-cardio-metabolic-algorithm-2011/

[2] Curtis, J., Newall, H. D. & Samaras, K. (2012). The heart of the matter: Cardiometabolic care in youth with psychosis. *Early Intervention in Psychiatry*, 6, 347–353.

[3] Waterreus, A.J. & Laugharne, J.D.E. (2009). Screening for the metabolic syndrome in patients receiving antipsychotic treatment: a proposed algorithm. *The Medical Journal of Australia, 190*(4), 185 – 189.

Concord Centre for Cardiometabolic Health in Psychosis (ccCHiP) has a website (http://ccchip.com.au/) designed for mental health clinicians which provides information on how to deliver cardiometabolic and lifestyle services to improve the global health outcomes for those with mental illness.

An on-line learning package on the metabolic syndrome (Skills Training in Metabolic Management of Patients with Severe Mental Illness) is available on the NSW Health Education and Training Institute (HETI) site (http://www.heti.nsw.gov.au).

A range of resources have been developed as part of NSW Health's 'Linking physical and mental health...it makes sense' (LPMH) initiative. These resources are available on the LPMH website (http://www.cadre.com.au/nsw_health) and include information sheets and pamphlets for consumers, carers and clinicians on the responsibilities of public mental health services to consider the physical as well as mental health of consumers. On-line training is also available that is based on the GL2009_007 Physical Health Care of Mental Health Consumers Guidelines. Participants will receive certification after completion of the training.

Issues for CAMHS

The diagnostic criteria outlined in the module covers consumers 16 years and over, as well as children and adolescents 10 to ≤16 years and 6 to ≤10 years.

Issues for SMHSOP services

Nil.

Completion tips

- The module targets consumers identified as having, or as being at risk of, metabolic syndrome, including those:
  - on antipsychotic medication
  - with familial physical risk factors (e.g. diabetes, obesity, cardiovascular disease)
  - with personal physical risk factors (e.g. diabetes, obesity, cardiovascular disease)
- The identification of these consumers is supported by the inclusion of screening questions within the *Assessment* and *Physical Examination* modules.
- The module includes diagnostic criteria and guidelines for intervention to assist the provision of appropriate care. In the case of waist circumference, there is a separate at risk range identified for European men (≥94cm) compared to South Asian, Japanese, South & Central American men (≥90cm). Where a male consumer belongs to a non-European group that is not specified above (e.g. African, Aboriginal), clinicians are advised to be conservative and use the later criteria.
- While the module targets key metabolic syndrome information domains, it makes provision for the inclusion of other health issues via the use of 'Other (*specify)'.* This approach aims to facilitate the use of the one document by all services, versus the development of multiple versions.
- To assist care planning and monitoring, the module is intended to be used at baseline (drug naïve if possible), at three monthly reviews and more frequently when abnormalities are identified, or medication or dose is changed. As a result, it is expected that the module will be used in conjunction with the *Care Plan* and *Review* modules.
- Where possible, the module should be completed in collaboration with the consumer's general practitioner. Where a consumer does not have a nominated general practitioner, the mental health service should make reasonable efforts to link the consumer with an appropriate health care provider.

Relationship to the Assessment and Physical Examination modules

- The *Assessment* and *Physical Examination* modules contain screening questions to aid the identification of consumers at risk of metabolic syndrome.
- The *Assessment* module has supports for the recording of information on the following metabolic syndrome risk factors:
  - Under 'Family Medical/Mental Health History' (pg.2), screening questions address familial physical risk factors (e.g. family history of diabetes, obesity, cardiovascular disease).
  - Under 'Medical History' (pg.3), personal physical risk factors are addressed (e.g. history of diabetes, obesity, cardiovascular disease)
  - Under 'Current Treatments' (pg.3), the documentation of 'Current medications' is supported.
  - A 'yes' to any of the above may indicate that a more detailed assessment of metabolic syndrome is required.
- The *Physical Examination* module contains documentation supports for a range of metabolic syndrome risk factors including blood pressure and waist circumference. Diagnostic criteria are also provided to aid interpretation of available information and screening. Supports for the ordering and recording of blood results relevant to the screening of metabolic syndrome are also provided under 'Immediate Actions' (pg.2). Where blood results are available in hard copy, these can be attached to the module rather than transcribed. In the event of positive findings, blood results should be recorded in the *Metabolic Monitoring* module to minimise duplication and facilitate monitoring.

Relationship to the Care Plan and Review modules

- The module is to be used in conjunction with the *Care Plan* and *Review* modules to aid the management and monitoring of any identified metabolic syndrome risk factors. Reviews are to be undertaken three monthly and more frequently when abnormalities are identified, or medication or dose is changed. Further information on monitoring requirements is provided in PD2009_027 Provision of Physical Health Care within Mental Health Services and GL2009_007 Physical Health Care of Mental Health Consumers Guidelines.

PHYSICAL APPEARANCE

Purpose

The *Physical Appearance* module provides a structured way of documenting physical appearance. It partly reflects the Memorandum of Understanding (2007) between NSW Health, NSW Police and NSW Ambulance regarding the reporting requirements for patients absconding from a mental health inpatient unit (http://www.health.nsw.gov.au/pubs/2007/pdf/mou_mentalhealth.pdf).

Target services

All mental health services providing assessment.

Development background

The development of this module was in response to a request by non-medical clinicians for an optional, more structured approach to the documentation of appearance.

Completion requirements

Can be completed by any appropriately qualified and experienced mental health professional.

Issues for CAMHS and SMHSOP services

Nil.

Completion tips

- While the module has more applicability to the inpatient setting, it also applies to ambulatory settings, where clinicians or services may elect to provide more detail regarding appearance.
- If the *Physical Appearance* module is completed at assessment, clinicians can note its completion under the *Assessment* module's 'Physical Examination Summary'.

RISK ASSESSMENT

Purpose

The *Risk Assessment* module provides a structured format for the documentation of risk.

Target services

All mental health services.

Development background

The module was developed as a recommendation of the MH-OAT Modules Redesign Risk Assessment Advisory Group. The Group's membership included recognised experts in the field of suicide prevention and violence risk management.

Completion requirements

The module can be completed by any appropriately qualified and experienced mental health professional. It is important to note that training in suicide risk assessment and management is a mandated NSW Health requirement, with a NSW Health endorsed course available to all public mental health services clinicians (see PD2005_121).

Issues for CAMHS and SMHSOP services
Nil.

Completion tips

- The module makes provision for the documentation of 'General Risk Factors'. These reflect factors that can apply to suicide, violence and other types of risks.
- The module outlines factors associated with different types of risks. Given the diversity in potential presentations, provision is made for the identification of other factors relevant to the particular presentation under 'Other (specify)'. This provision reflects the complexities of risk and the need for documentation to be responsive to variations in presentation.

Overview of risk assessment approach adopted in modules

- The *Assessment* and *Review* modules contain a 'Risk Assessment' suicide and violence screening component which is based on the *Clinical Assessment of Risk Decision Support (CARDS)* approach developed by the Maudsley's Institute of Psychiatry (Watts et al., 2002). A positive answer to any of the screening questions for suicide and violence risk indicates that the *Risk Assessment* module should be completed.
- Where information gathered during the course of an assessment, and responses to the suicide and violence screening questions, indicate that the consumer is at low risk, the clinician and/or service may elect to complete the *Risk Assessment* module.
- Where during the course of the assessment or review, risks other than suicide and violence are identified, the *Risk Assessment* module can be used to provide more structured detail and/or a means for facilitating collation of gathered information.

- The module reflects the 'structured clinical judgment' approach to risk assessment[4]. Within this approach prompts are provided regarding potential risk factors, with the clinician required to provide clinical comment on the risks s/he has identified. The clinician is then required to provide their 'Overview/Impression' and to summarise their perceptions of the level of risk. The final requirement of the 'structured clinical judgement' approach is for the clinician to outline 'Specific risks will be addressed in (the) management/care plan'. The 'structured clinical judgement' approach is promoted by the literature, rather than the use of a numerical rating scale, given the complexities of risk assessment, the interplay of background and current situation factors and the importance of clinical judgement.

Relationship to Assessment module

The *Assessment* module is where the overall mental health assessment is documented, with the module containing a 'Risk Assessment' suicide and violence screening component. A positive answer to any of the screening questions for suicide and violence risk indicates that the *Risk Assessment* module should be completed.

The *Risk Assessment* module provides a structure for collating available assessment information and assisting the formulation of current risk. The relationship between the two modules reflects the understanding that risk assessment is a component of a comprehensive mental health assessment. Where the *Risk Assessment* module has been completed at assessment, this should be documented in the *Assessment* module under 'Risk Assessment'.

Relationship to Review module

Where the *Risk Assessment* module has been completed at review, this should be documented in the *Review* module under 'Summary of Progress and Current Status'.

SUBSTANCE USE ASSESSMENT

Purpose

The *Substance Use Assessment* module provides a structured format for the documentation of alcohol and other drug use on first contact or at other times when a comprehensive assessment is indicated.

Target services

The module applies to both inpatient and community settings.

Development background

The module was developed in consultation with the NSW Health Alcohol and Other Drugs Quality In Treatment Advisory Group.

Completion requirements

The module can be completed by any appropriately qualified and experienced mental health professional.

Issues for CAMHS and SMHSOP services
Nil.

[4] For example: Maden, A. (2003) Standardised risk assessment: why all the fuss? *Psychiatric Bulletin, 27,* 201-204.

Completion tips

The module makes provision for structured documentation of substance use assessment, in addition to the provision made for 'Drug and Alcohol History' in the *Assessment* module. In terms of presentations where the *Substance Use Assessment* should be completed, the following has been proposed:

- A consumer who has had more than 6 standard drinks on any one occasion within the last month. If the consumer is an adolescent, then the module should be completed if s/he has consumed any alcohol in the last month.
- A consumer who has used any of the following in the last month: alcohol, tobacco, benzodiazepines, cannabis, amphetamine, cocaine, MDMA (Ecstacy), heroin, prescription analgesics, methadone, buprenorphine, solvents, hallucinogens.
- A consumer who is currently intoxicated or in withdrawal.

Clinicians should use their clinical judgement regarding the completion of the module and should not exclude its completion for consumers outside this proposed range.

Relationship to Assessment module

The *Assessment* module makes provision for the documentation of 'Drug and Alcohol History' with clinicians prompted to document past and current substance use, amounts and frequency, features of dependence and abuse, prior treatments and their outcomes. Where the *Substance Use Assessment* module has been completed, this should be noted in the Assessment module under 'Drug and Alcohol History'.

Relationship to Review module

The module can also be completed after the initial assessment or as part of a review, when substance use may be disclosed or become apparent. If completed as part of a review, its completion should be noted in the *Review* module under 'Summary of Progress and Current Status'.

FAMILY FOCUSED ASSESSMENT (COPMI)

Purpose

Where at assessment parental/carer status has been determined and the child is aged 18 years or less, then the *Family Focused Assessment (COPMI)* module provides a structured format for documenting parent/carer and child functioning. The module addresses the impacts of the parent's/carer's mental illness or disorder on the child, with this inclusive of child protection concerns.

Target services

All adult mental health services.

Development background

The module was developed in response to the recommendations of NSW Health MH-Kids. The module reflects the *'Crossing Bridges'* NSW Health mandated COPMI training initiative targeting adult mental health workers and due to commence in 2008.

Completion requirements

The module can be completed by any appropriately qualified and experienced mental health professional.

Issues for CAMHS and SMHSOP services

While intended principally for adult mental health services, the module can be used by other services where appropriate. For instance, if a client of a CAMHS or SMHSOP team has been identified as having parental/carer responsibilities for a child aged 18 or less, then the module can be completed.

Completion tips

- The module's first page assists clinicians to summarise assessment information available on the parent/carer and child. Ideally, the available information should reflect that gathered from a face-to-face assessment, with corroborative information also obtained. The summarised information may reflect information gathered as a result of liaison between Child and Adolescent and Adult mental health services.
- Page 2 assists the collation and analysis of available information for the purpose of determining urgency of response, with this assisted by the identification of strengths/protective factors and vulnerabilities/risk factors. Clinicians are also prompted to provide an 'Overview' indicating whether the 'parent's/carer's symptoms and behaviour interfere with undertaking parental and/or essential household duties' and whether the 'parent's/carer's symptoms and behaviour are having a negative impact on the child'. The final requirement is for the clinician to outline 'specific issues to be addressed in (the) management/care plan' for the parent and child.
- The information domain headings used in the module reflect, where possible, the information domains of the *Assessment* module. For example, page 1 uses 'Mental State Examination' headings. This is intended to aid clinicians to collate information already documented in the *Assessment* module. Where the use of the *Family Focused Assessment (COPMI)* module alerts clinicians to gaps in their assessment information and the need to gather more information, similarities in the headings between the module and the *Assessment* may aid this process.
- If the parent/carer has more than one child, then a separate *Family Focused Assessment (COPMI)* module may need to be completed for each child.

Relationship to the Assessment module

Where the *Family Focused Assessment (COPMI)* module has been completed as part of assessment, this should be noted in the *Assessment* module under 'Parental Status and/or Other Carer Responsibilities' on page 5.

Relationship to the Review module

The module can also be completed after the initial assessment as part of a review. If completed at review, its completion should be documented in the *Review* module under 'Summary of Progress and Current Status'.

FUNCTIONAL ASSESSMENT (OLDER PEOPLE)

Purpose

The *Functional Assessment (Older People)* module provides a structured format for the documentation of current functioning for consumers presenting to Aged Care services.

Target services

SMHSOP services.

Development background

The module was developed as a recommendation by the MH-OAT Modules Redesign Steering Committee's Aged Care representatives and the SMHSOP Advisory Council.

Completion requirements

The module can be completed by any appropriately qualified and experienced mental health professional.

Issues for CAMHS and Adult services
While intended for SMHSOP services, the module can be used by other services addressing rehabilitation issues, for instance non-acute adult mental health rehabilitation services.

Completion tips

- The information domains in the *Functional Assessment (Older People)* facilitate the completion of the RUG-ADL, the LSP and relevant items on the HoNOS65+.

Relationship to the Assessment module

Where the *Functional Assessment (Older People)* module has been completed at assessment, this should be documented in the *Assessment* module under 'Current Functioning and Supports'.

Relationship to the Review module

The module can also be completed after the initial assessment and as part of a review. If completed as part of a review, its completion should be documented in the *Review* module under 'Summary of Progress and Current Status'.

SCREENING FOR DOMESTIC VIOLENCE

Purpose

The completion of the *Screening for Domestic Violence* module is mandatory for females aged 16 and over who present to mental health services. The module is a key identification strategy that reflects NSW Health's *Policy and Procedures for Identifying and Responding to Domestic Violence* (2003, revised 2006 [PD2006_084]).

Target services

All mental health services seeing females aged 16 and over.

Development background

The *Screening for Domestic Violence* is a major strategy for health services to identify female consumers whose health and wellbeing may be affected by a current domestic violence situation. The module reflects the information domains regarding screening required by NSW Health's *Policy and Procedures for Identifying and Responding to Domestic Violence* (2003).

Completion requirements

Mental health professionals should undertake the routine screening for domestic violence training program prior to commencing screening.

Associated resources

NSW Health has made available to all services the domestic violence screening protocols and 'Z' cards. The 'Z' cards outline issues in relation to domestic violence and appropriate service providers and should be handed to all women who are screened for domestic violence.

Completion tips

- If domestic violence has already been identified at assessment, for example, on presentation or in a referral'[5], the clinician can still elect to complete the *Screening for Domestic Violence* module.
- If domestic violence is determined by the *Screening*, or as a result of routine assessment, clinicians should document it as a risk under the *Assessment* module's 'Risk Assessment' under 'Other (specify)'. It should also be documented in 'Alerts/Risks' on page 1 of the *Assessment* module. Any actions resulting from the *Screening* should also be documented under the *Assessment* module's 'Initial Management Plan' to facilitate continuity of related information.
- *Screening* question 1 asks: 'Within the last year have you been hit, slapped or hurt in other ways by your partner or ex-partner'. Hence, for long term consumers, it would be advisable to consider completing the *Screening* as part of ongoing clinical review. If completed after the initial assessment as part of a review, this should be documented in the *Review* module under 'Summary of Progress and Current Status'.

COGNITIVE ASSESSMENT (RUDAS)

Purpose

The *Cognitive Assessment (RUDAS)* module provides a structured format for the documentation of cognitive functioning through the availability of the Rowland Universal Dementia Assessment Scale (RUDAS). This Scale was developed by Storey and colleagues (Storey, Rowland, Basic, Conforti & Dickson, 2002) to function as a 'multicultural minimental state examination'.

Target services

SMHSOP services.

Development background

The module was developed as a recommendation by the MH-OAT Modules Redesign Steering Committee's Aged Care representatives and the SMHSOP Advisory Council. The developers have given permission for the use of the RUDAS.

Completion requirements

The RUDAS can be completed by an appropriately qualified and experienced mental health professional who has undertaken training on the use of the RUDAS and/or has experience with its use. This reflects the developers' instructions for use.

Associated resources

RUDAS Administration and Scoring Guide.

Issues for CAMHS and Adult services
While intended for SMHSOP services, the module can be used by adult services.

[5] *NSW Health Routine Screening for Domestic Violence: Snapshot Report 1* (NSW Health, 2004) (page 6)

Completion tips

- A score below 23 out of 30 indicates likely cognitive impairment.
- Please note that any score derived from the RUDAS requires clinical interpretation.
- While the RUDAS and 3MS/MMS are available to clinicians, it is not expected that both would be completed. Clinicians can choose the one which best meets their needs.
- While the RUDAS has been made available in response to the needs of Aged Care services, clinicians from other settings may elect to use it as a cognitive impairment screening tool.
- In addition to the RUDAS, the module makes provision for the documentation of any other cognitive tests undertaken. As a final prompt, it requires clinicians to provide a 'Clinical Overview/Issues to be Addressed in (the) Management/Care Plan'.

Relationship to Assessment module

Where the *Cognitive Assessment (RUDAS)* module has been completed at assessment, this should be noted in the *Assessment* module under the 'Mental State Examination' heading 'Cognitive and Intellectual Functioning'.

Relationship to Review module

The module can also be completed after the initial assessment and as part of a review. If completed as part of a review, its completion should be documented in the *Review* module under 'Summary of Progress and Current Status'.

COGNITIVE ASSESSMENT (3MS/MMS)

Purpose

The *Cognitive Assessment (3MS/MMS)* module provides a structured format for the documentation of cognitive functioning through the availability of the Modified Mini Mental State (3MS) (Teng & Chui, 1987). The module reflects the 3MS, with the shaded areas reflecting the minimental state (MMS) approximation contained with the 3MS.

Target services

SMHSOP services.

Development background

The module was developed as a recommendation by the MH-OAT Modules Redesign Steering Committee's Aged Care representatives and the SMHSOP Advisory Council. The developers have given permission for the use of the 3MS/MMS.

Completion requirements

The 3MS/MMS can be completed by an appropriately qualified and experienced mental health professional who has undertaken training on its use and/or has experience with its use. This reflects the developers' instructions for use.

Associated resources

3MS/MMS training materials.

Issues for CAMHS and Adult services
While intended for SMHSOP services, the module can be used by adult services.

Completion tips

- With the MMS approximation the total score is 30, the following ratings have been recommended:
    - ‘Normal’ is greater than or equal to 27
    - ‘Cognitive impairment: ‘Mild’ = 20-26; ‘Moderate’ = 10-19; ‘Severe’ <10.
- With the 3MS the total score is 100 and a score under 76 indicates likely cognitive impairment.
- Please note that any score derived from the 3MS/MMS requires clinical interpretation.
- While the RUDAS and 3MS/MMS are available to clinicians, it is not expected that both would be completed. Clinicians can choose the one that best meets their needs.
- While the 3MS/MMS has been made available in response to the needs of Aged Care services, clinicians from other settings may elect to use it as a cognitive impairment screening tool.
- In addition to the 3MS/MMS, the module makes provision for the documentation of any other cognitive tests undertaken. As a final prompt, it requires clinicians to provide a ‘Clinical Overview/Issues to be Addressed in Management/Care Plan’.

Relationship to Assessment module

Where the *Cognitive Assessment (3MS/MMS)* module has been completed at assessment, this should be noted in the *Assessment* module under the ‘Mental State Examination’ heading ‘Cognitive and intellectual functioning’.

Relationship to Review module

The module can also be completed after the initial assessment and as part of a review. If completed as part of a review, its completion should be documented in the *Review* module under ‘Summary of Progress and Current Status’.

CONSUMER WELLNESS PLAN

Purpose

The *Consumer Wellness Plan* module has been designed by consumers. All consumers are encouraged to complete it. It can be completed 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.

Target services

All mental health services.

Development background

The module was developed as a recommendation by the MH-OAT Consumer Consultative Committee.

Completion requirements

The module is intended to be completed by the consumer. It can be completed in partnership with their clinician and/or nominated carer. The module has provision for the documentation of people who have helped complete the module.

Issues for CAMHS and SMHSOP services
Nil.

Completion tips

- While all consumers should be offered the opportunity to complete the module, clinical judgement is paramount in determining when the module is offered. It should be offered as part of the discharge planning process when the consumer is settled and not undergoing acute crisis.
- Where the consumer is unable to complete the module, there may be circumstances where it is appropriate for a parent or carer to complete the module. For instance, with an aged care consumer who is unable to complete the module as a result of dementia, the carer may be given the opportunity to complete the module. This will enable the documentation of information useful to the care of the consumer that may not otherwise be available. Clinical judgement and the wishes of the consumer are paramount in this determination.
- A copy of the completed module is to be given to the consumer, with the original kept in the file. The consumer is able to document on the *Plan* who else they would like to receive a copy of the module.
- In order to ensure the currency of the information contained in the module, it should ideally be reviewed every 6 months for consumers engaged in ongoing care. The module can be reviewed at other times based on the discretion of the clinician and the wishes of the consumer.

Relationship to Transfer/Discharge Summary module

With the consumer's consent a copy of their completed *Consumer Wellness Plan* should be attached to the *Transfer/Discharge Summary* at the time of discharge and transfer of care.

4 GENERAL PRINCIPLES FOR COMPLETION OF THE MODULES

- The use of the modules should always be guided by the clinician's informed judgement regarding the consumer's clinical status and needs at the time.
- Local Health District protocols regarding the use of the modules should be informed by consideration of LHD business processes. Local protocols should also reflect consideration of the nature of the clinical process being undertaken by the service and the module best suited to its documentation.
- The bottom of every page of every module must be signed off by the clinician completing the module including the name (PRINT), signature, designation (PRINT) and date.
- A module has been designed to be completed by one mental health professional, at one point in time. Where the module is completed by more than one person, then each subsequent professional should identify the section they have completed by writing the heading 'Addendum' next to it and undertaking sign off below the information provided (name (PRINT), signature, designation (PRINT) and date).

- If a section is unable to be completed, the clinician should document why the information has not been collected. For example, the clinician can document that 'the information was unavailable at the time of assessment' or 'the information is not relevant to the current presentation'. If the information was not available at the time of assessment, clinicians should document any follow up actions planned to obtain that information.
- If a completed module is photocopied for the purposes of information transfer, then the original and photocopied module should not be altered by the addition of information.
- The modules reflect the recent state-wide standardised form template requirements mandated by NSW Health's State Forms Management Committee. This includes issues such as the formatting and spacing of the facility and patient identification at the top of each page, along with the forms' colours and patterns. In terms of identifying the facility, the Committee have defined the following categories[6]: (a) Site: Physical facility or Service e.g. Hospital, Community Health Centre, Renal Service, Justice Health site, (b) Location: Ward, Clinic, Unit e.g. ICU, ED.

  An example of an inpatient mental health facility is: Site: Macquarie Hospital, Location: Parkview Unit.

  Examples of an ambulatory mental health facility are: (1) Site: Castle Hill Community Health Centre, Location: Adult Mental Health; (2) Site: Lower Hunter Mental Health Service, Location: Parry St Marrickville.

  Advice on local facility identification should be sought from the LHD MHIDP Manager. This issue will have most impact on clinicians who are handwriting the details, with other clinicians and services having access to local patient labels.
- Clinicians need to meet other requirements of record keeping as outlined by:
  - Australian Standard AS2828-1999 Paper-based health care records
  - PD2005_127 Records – Principles for Creation, Management, Storage and Disposal of Health Care Records (Issued 10 July 1998)
  - PD2005_015 Medical Records (Issued 27 July 1981)
  - PD2005_004 Medical Records in Hospitals and Community Care Centres (Issued 24 August 1976)

5 FUTURE DEVELOPMENTS

A governance process auspiced by the Mental Health Clinical Advisory Council will be established to oversee any future developments of the modules. To increase the responsiveness of the modules to any change/s, the NSW Health endorsed printer has an inventory management system that aims to warehouse a maximum 3 month supply of the modules.

The development of the state based build of the Mental Health electronic medical record will require modification to the layout and functioning of some clinical documentation modules to accommodate the computer based system the documents will be display in. Wherever possible this will be reflected in the paper based documents to support seamlessness of the paper and electronic records.

[6] Draft Policy Directive as at August 4 2008.