### Document control

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<tr>
<th>Document owner</th>
<th>Gayle Goodman</th>
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<tr>
<td>Title</td>
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<td>Gayle Goodman, Danny Tapscott, Alex Edwards-Brown, Dr Rohan Dhillon, Alison Pickering, Michael Baldock, Roman Onilov, Darryl Watson Kathryn Zeitz</td>
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### Document history

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<td>2</td>
<td>30/12/2015</td>
<td>30/12/2015</td>
<td>Revised post Union Consultative Forum 22 December. CALHN MH Short Stay MoC appended Localised for implementation at RAH</td>
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<td>2A</td>
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### Document list (for consultation)

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### Endorsement / sign off

This table is completed when a section of the document, or the document in its entirety, is endorsed or signed off by the service and/or the Mental Health Directorate.

Endorsement and sign off of the final draft version by the Director Strategic Operations should include completion of the signature and date section underneath the table.

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In July 2015 the Models of Care (MoC) for Unplanned Emergency Access Pathways and Mental Health Short Stay (MHSS), was released and supports Central Adelaide Local Health Network’s (CALHN) Commitment to Care and Single Service, Multiple Site approach across the Royal Adelaide Hospital (RAH) and The Queen Elizabeth Hospital (TQEH), along with the SA Model of Care for Major Hospitals.

Introduction
The purpose of the MoC is to convert unplanned presentations to mental health services on to planned pathways, supporting our workforce to safely and effectively transfer consumers’ care into the most appropriate setting as soon possible.

The July 2015 CALHN Mental Health Short Stay MoC was to be considered with respect to the whole of CALHN but with plans for immediate implementation within RAH. The announcement of 8 Short Stay beds at TQEH in late October 2015 provides the opportunity for the CALHN Mental Health Short Stay MoC to be implemented at TQEH.

The MHSS Operational Guidelines aim to provide the detail to support the operationalisation of the MHSS MoC proposed to be implemented at the RAH and describe the local day to day ways of working for the new bed footprint at RAH.

The MHSS is intended as an integral element of the CALHN Mental Health Service targeting consumers requiring brief, acute mental health care, for a period not expected to exceed 72 hours.

The MHSS will care for consumers between the ages of 18 and 65 years old, whose assessed presentation requires a short period of stabilisation and may include further assessment, observation, diagnosis and/or therapeutic intervention. It provides a more appropriate and therapeutic environment for people in times of distress than the Emergency Department and provides an alternative for people for whom an acute inpatient environment may not be appropriate.

As described in the MoC, MHSS caters for consumers who have presented on the Unplanned Pathway to the Emergency Department or from the Integrated Community Mental Health Team and is generally aimed at consumers whose expected Transfer of Care (ToC) will be home, either to the care of their GP or the Community MH Team. On occasion, following further assessment and observation, consumers may require transfer from the MHSS to an acute inpatient care or intermediate care service. However, the primary function of the SS is not a waiting area for these services. Admission to the MHSS in lieu of an acute care admission will be via Executive override processes.

The focus of the service is multi-disciplinary assessment and treatment, using community psychiatry principles, addressing symptoms, behaviours and psychosocial needs of consumers, working with families and other support systems in the community.

The goal is to stabilise consumers quickly, facilitate a return home, whilst engaging people with ICMHT or other community based supports and services.

The service is characterised by frequent review (twice daily on weekdays), multi-disciplinary planning and transparent tracking of required and completed actions.

Unplanned presentations assessed as requiring Psychiatric Intensive Care (PIC) or presenting behaviours of concern and will receive care and treatment on the Medical, including Toxicology Pathway, within the Emergency Department rather than the Mental Health SS pathway.

Location
The MHSS in the East Wing consist of 10 individual bedrooms supported by a number of assessment and shared spaces.

Operating hours
24 hours throughout the year.
Staffing

BACKGROUND TO THE PROPOSED STAFFING PROFILES

The proposed 7.00 NHPPD for the RAH MHSS (based within East Wing), is being used to guide development of staffing profiles.

Compliant with the current EA, we are proposing the implementation of the current long shift configuration already in place at Cramond TQE

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<th>Finish</th>
<th>Worked Shift length</th>
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<td>0700</td>
<td>1906</td>
<td>10.86 hrs</td>
<td>15 minutes night to day shifts</td>
</tr>
<tr>
<td>1840</td>
<td>0721*</td>
<td>11.69 hrs</td>
<td>26 minutes day to night shifts</td>
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*The 1840 – 0721 shift has a 1 hour unpaid meal break factored into the start and finish times.

While acknowledging the staffing profile for the RAH MHSS still being negotiated and therefore yet to be finalised, the following is proposed:

PROPOSED NURSING STAFF PROFILES

The staffing profiles are based on 10.86 hours day shift lengths and 11.69 hours night shift lengths and are over a 7 day period.

3 on days; 2 on nights (7 NHPPD) –
- Rostered - total 10.31 FTE (RNs 8.31 FTE / EN/Grad dip 2.00 FTE)
- Budget FTE 12.88 FTE

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<tr>
<th>DAY DUTY</th>
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<td>GRAD</td>
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RAH MENTAL HEALTH CONSULTATION LIASON into ED

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Work from and support MHSS when ED demand low.

OTHER WORKFORCE PROFILES

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<th>Notes</th>
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<td>Between 6-7.5 hours 5 days a week additional administration capacity (post closure EICC)</td>
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<td>AHP205*</td>
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<td>Social Worker 4 hours a day 7 days a week</td>
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<tr>
<td>OPS203*</td>
<td>1.5</td>
<td>Clinical Support – 7 days a week</td>
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<td>MD029G*</td>
<td>0.6</td>
<td>In addition to existing</td>
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<tr>
<td>MDP27G*</td>
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<td>In addition to existing</td>
</tr>
<tr>
<td>Lived Experience Worker</td>
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<td>Existing</td>
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* includes backfill
Leadership

The Clinical Director retains overall clinical responsibility for the MHSS

Mental Health Medical staff will report professionally to the Clinical Director.

Nursing and Allied Health will report professionally through their discipline specific structure: Clinical Practice Consultant and Nursing Director, Principle Social Worker CALHN, or Principle Occupational Therapist CAHLN.

All MHSS staff are responsible operationally to the Service Manager via the CSC of RAH ED/MHSS and CL

Responsibilities

Medical

> During weekdays, admitted consumers will be reviewed twice per day by the medical team.
> Medical staff facilitate assessment, initiate treatment and follow up reviews, engage with the multi-disciplinary team and are proactive in discharge planning.
> Medical officer will be responsible for the timely completion of discharge summary within 48 hours of discharge from SSU.
> Designated consultant and junior medical officer will work Monday to Friday, usual working hours.
> During weekdays, after hour medical cover will be provided by the junior medical officer based in RAH & TQEH emergency department till 11pm and remote call thereafter. A remote call consultant psychiatrist will support SS after 5pm and can be contacted through the switchboard.
> The onsite on call roster consultant and junior medical officer will cover weekend and public holidays. Consultant psychiatrist along with the junior medical officer will review the admitted consumers in SS and provide clinical input.

Nursing

> The nurse will participate in the multidisciplinary assessment, care plan review and discharge planning.
> The nurse will report operationally to the CSC and the allocated shift Team Leader and clinically to the CPC at RAH and TQEH.
> The nurse will participate in the staff shift changes clinical handovers.
> The Nurse liaises closely with a network of key stakeholders, including families and carers, other mental health teams, primary care providers and other government and non-government organisations which support consumers with mental disorders.
> The allocated Team Leader or Shift Coordinator will be responsible for representing SS on the morning conference call.
> Will complete risk assessments and reviews as needed.
> Maintain a proactive role in coordinating consumer ToC.
> The nurse will provide 7 day follow up of consumers discharged from the SSU. This may include supporting the consumer to access agreed community based referrals.
> The Nurse will provide short term therapeutic interventions where appropriate, during an admission or as part of the 7 day follow-up plan.
Social Worker

> The Social Worker will participate in the multidisciplinary assessment, care, review and discharge planning.
> The Social Worker contributes to the assessment process through psychosocial screenings and assessments of consumer, family and/or carer needs.
> The Social Worker liaises closely with a network of key stakeholders, including families and carers, other mental health teams, primary care providers and other government and non-government organisations which support consumers with mental disorders.
> The Social Worker facilitates consumers’ access, linkage and referral to appropriate service systems aligned with their needs, aspirations and goals upon discharge from the SSU.
> The Social Worker will provide short term therapeutic interventions to consumers, families and carers, where appropriate, during an admission or as part of the 7 day follow-up plan.
> The Social Worker may coordinate support post discharge for people waiting to be allocated a care coordinator by the Integrated Community Mental Health Team.
> The Social Worker may undertake the 7 day follow up of consumers discharged from the SSU. This may include supporting the consumer to access agreed community based referrals.
> Maintain a proactive role in coordinating consumer ToC.
> Will complete risk assessments and reviews as needed.

Lived Experience Worker

> The Lived Experience worker will participate in the multidisciplinary assessment, care, review and discharge planning.
> The Lived Experience worker uses what they have learnt from their lived experience of living with a mental illness or caring for someone with a mental illness to support and educate consumer and carers.
> The Lived Experience worker supports consumers and carers in an individual and group context.
> The Lived Experience workers is also a resource for the clinical team modelling recovery and living well with a mental illness as well as being a resource by providing information of services that are useful for consumers or family recovery

Occupational Therapist

> The Occupational Therapist (OT) will participate in multi-disciplinary assessments, care, reviews and discharge planning.
> The OT contributes to the assessment process by providing:
  > functional
  > psycho-social and/or
  > functional cognitive assessments as required and subsequent input into planning.
> The OT promotes a safe ward environment and contributes to the reduction of seclusion and restraint through facilitation of ward based therapy and group programs, promoting self-management and addressing issues associated with challenging behaviours.
> The OT provides sensory modulation intervention either directly with consumers or modelling and supporting other staff to apply these principles to enhance the consumer’s capacity to self-regulate.
> The OT will identify functional support needs and appropriate follow-on services for consumers upon discharge of the SSU.
> Maintain a proactive role in coordinating consumer ToC.
> The OT may provide short term therapeutic interventions where appropriate, during an admission or as part of the 7 day follow-up plan.
> Will complete risk assessments and reviews as needed.

Criteria for Admission

Consumers with established or suspected mental disorder or crises affecting mental state and function, who do not have an acute medical illness/condition and will include:

1. Consumers with predicted short length of stay of not more than 72 hours and discharge either to primary care or an Integrated Community Mental Health team
2. Consumers admitted to a psychiatric bed and waiting in the ED for further assessment and disposition planning.
3. Consumers in the ED, on a MH pathway, requiring further on-going mental health assessment.
4. Consumers assessed in the community by the ICMHTs requiring inpatient assessment and who have no major physical or medical disorder/illness.

Consumers who may not be suitable for admission

1. Consumers requiring Psychiatric Intensive Care Unit admission.
2. Consumers with a primary presenting problem of substance abuse.
3. Consumers requiring a forensic mental health bed or under a forensic legal order.
4. Consumers who have developed a mental disorder over age 65; or are aged under 18.
5. Consumers who require “stepping down” from an acute unit.

If resolution is unclear, the decision should be escalated to CD or DSO for Executive support.

Pathways

See attachment

1. **Via ED**
   > People presenting to the ED on an unplanned pathway can be admitted to SS where it is agreed the person requires further assessment, observation or short term intervention and there is no outstanding medical issue to preclude this.
   > "Within the RAH, use of the Collaborative Triage Tool will determine whether medical clearance is required to ascertain this. See attached “New Process” and CTT documents.
   > MHSS beds are included in the Bed Allocation System (BAS) but distinguished from other acute beds, and usual admission protocols apply.
   > Consumers determined to require closed bed care will remain in the ED.
   > Consumers determined to require open acute beds (previous history, nature of presentation) may wait in the SS for transfer if deemed appropriate.

2. **Transfer of Consumers from the Community Services**
   > Admission to SS for consumers from an ICMHT will be via Direct Admission **OWI Direct Admission**
   > Consumers awaiting acute inpatient beds in the community need to be recorded on BAS (Bed Allocation System) for an Acute Bed. The same process applies for MHSS but the reason for the admission will align with the purpose of the SS. Once approval is granted to fill a SS bed, the community team member will
contact the SSU to advise of expected arrival time and provide a comprehensive handover. The community team will arrange transfer of the consumer to the SS and will attend SS to facilitate the admission.

> The consumer will have had a comprehensive assessment and HoNos completed which will be integral to the clinical handover. Written assessment must be available at time of admission

3. **Clinical Processes** (These may occur after the consumer is accommodated in the Unit depending on events leading to admission i.e. unplanned admission via community team review).

> All consumers admitted will have a multidisciplinary assessment within the first 24 hours of admission.

> Consumers will be assessed/reviewed at least twice during the course of the day on weekdays and at least once daily on weekends by the medical staff which may include other members of the multidisciplinary team.

> A multidisciplinary clinical handover and review of all consumers will occur every morning (preferably 9.00 am) to affirm actions required to achieve discharge at the appointed time. All consumers will have NOCC completed on discharge.

> Discharge planning will incorporate a multidisciplinary assessment of family, carer and community supports required to underpin a sustainable discharge of consumers being discharged home.

> Discharge planning will incorporate a Sensory Modulation Plan where appropriate.

> Risk assessments will be reviewed during the morning clinical handover or as clinically indicated.

> The SS nurse will review the risk assessments of consumers throughout the admission and will be updated post morning clinical review. Night duty SSU staff will review risk assessments overnight and a new risk assessment will be completed if the consumer’s behaviour has improved or deteriorated.

**SS Clinical Operational Guidelines**

Application of Organisation Wide Instructions will ensure consistent practice across all services. Relevant OWIs include:

- OWI 03230 Restraint and Seclusion – Minimisation of – mental health
- OWI00495 Code Black – Personal threat
- OWI 03703 Emergency Dept MH Flow Escalation
- OWI 03704 Mental health Flow Executive
- OWI 03722 Sensory Modulation
- OWI00199 Medical emergency response activation RAH
- OWI Bedded units- observation – mental health
- SSI03225 Code blue mental health
- SSI03224 Code black - mental health
- OWI03251 Discharge/Transfer Bedded Services.
- OWI03250 Discharge from Inpatient Services Follow Up: Seven (7) Day After (including ICCs and CRCs) - Mental Health

**Escalation of Dispute and Unresolved Issues**

Any unresolved issues related to the operation/function of the SS are to be escalated to the Clinical Director.
Complaints and Compliments

All complaints and compliments will be forwarded to the CSC who will log them through SLS. The CSC remains responsible for the completion of the SLS but may request appropriate staff to assist with the response.

Division Reporting Pathways / Governance

> A monthly management meeting will take place in regards to the SS utilising the standard meeting agenda format
> The minutes of this meeting and action plans will be reported monthly to the CALHN Mental Health Directorate Quality and Governance Committee.

Quality and Safety

> Information will be monitored from current information systems (Homer, HASS, CBIS, SLS)
> An agreed suite of Key Performance Outcomes and Indicators will be used to monitor the performance of the SS (As per ED and Inpatient Management Reports KPI Suite)

Contingency Plan for Nursing

> The contingency plan will be activated when the absence of the rostered nurse cannot be replaced through the current process of hiring additional nurse, ie, casual, additional hours by part time staff, agency, overtime and transferring staff from other services.
> The Clinical Services Coordinator and in his/her absence the Shift Coordinator can implement contingency planning in consultation with the Service Manager.
> Out of hours the Shift Coordinator, the Duty Coordinator in consultation with the Executive on call can implement this contingency plan
> The following actions should be considered:
  > cancel external and internal escorts where not critical
  > cancel unit meetings
  > cancel clinical rounds or limit number of nurses who attend
  > request assistance from allied health and medical staff within unit
  > request medical review of consumers who could be discharged to reduce consumer numbers
  > cancel professional development activities
  > stagger meal breaks to better balance staffing levels
  > use security guards for any specials if security rather than clinical needs are pre-eminent
  > request medical review of any ‘specials’ to determine if clinically still required
  > use non-mental health nursing staff where appropriate
  > divert all phones to clerical staff
  > suspend activity and therapy programs and reallocate staff
  > prioritize essential individual consumer care
  > request staff on part-time/special rosters adjust hours to meet clinical needs
  > Clinical Practice Coordinator utilise their non-clinical time to provide direct care to consumers.
Information to Consumers and Carers

Managing consumers within an SS compresses the amount of time available for educating consumers, their families and/or carers about their mental illness, treatment and follow-up arrangements and what to do in the event that the consumer’s mental state subsequently deteriorates. This model limits the opportunity to reinforce key messages. Therefore, the processes to convey information to consumers, families and/or carers will require careful attention.

The SS will develop information leaflets that address consumer information both verbally and in writing. Where possible key information will be provided to the consumer and their family and/or carer, and written consumer information should be used to describe:

- Diagnosis.
- On-going care instructions.
- Medication instructions.
- Follow-up arrangements.
- Expected course of the illness.
- What to do in the event that the consumer’s mental state deteriorates.

Review of Operational Guideline

This operational guideline is a working draft and will be reviewed during its operation at the monthly management meeting to consider changes to better meet consumer and service needs.