Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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13 June 2022

9(2)(a) [redacted]

RE Official Information Act request CDHB 10857

I refer to your email dated 19 April 2022 requesting the following information under the Official Information Act from Canterbury DHB, on how the DHB undertakes suicide risk assessment to inform decisions on access to services. Specifically:

1. **Full descriptions and/or a copy of the *measurement tool(s), procedure(s) or method(s)* used to assess the *risk* of *suicide or self-harm*, informing decisions on providing access to the *DHB's services*.**
   - **By "measurement tool(s), procedure(s) or method(s)", I mean how risk is determined, which may also involve any of the following (but not limited to these): surveys; protocols; checklists; questionnaires; scales; instruments; screening tools; inventories; evaluation tools; scores; an index or indices; psychometric tools; psychological tests; psychiatric tests; ratings; interviews; items; forms; status forms; decision trees; pathways; safety plans; template; risk stratification; formulation or risk formulation; action plan; risk banding; risk categorisation. These may feed into a "traffic light system" that categorises individuals according to varying degrees of risk.**
   - **By "risk", I mean the probability (of suicide or self-harm occurring). The measurement tool(s)/procedure(s)/method(s) in question may refer to any of the following terms (but not limited to these): likelihood; possibility; potential; prediction; danger; hazard.**
   - **By "suicide" I mean an individual taking their own life. By "self-harm" I mean an individual intentionally damaging their body, with or without suicidal intent. The measurement tool(s)/procedure(s)/method(s) in question may use other terms, including the following (but not limited to these): attempted suicide/suicide attempt; suicidality; self-injury; self-injurious behaviour; parasuicide.**
   - **By "the DHB's services", I mean those services related to all ages, all teams, all specialities, including but not limited to mental health, inpatient and outpatient, Emergency Department, EIS/Early Intervention, maternal mental health, cultural teams, youth forensic services, older adult, dual disability, liaison psychiatry, emergency psychiatric service, crisis team. Hence, I request information regarding *any* DHB service where suicide risk is assessed during decisions on service access.**

The following list provides copies of measurement tool(s), procedure(s) or method(s) used to assess the risk of suicide or self-harm, informing decisions on providing access to the Canterbury DHB's services.

Please refer to Appendix 1 (attached) for the following:

1. Clinical risk assessment management Policy Ref: 23371
2. Clinical Risk Assessment and Management Protocol Ref: 2405255
3. CASPI Risk Algorithm and Management Protocol Ref: 2403671
4. CASPI Guidelines Ref: 2403674
5. Mental Health Telephone Triage Scale Ref: 2404208
6. CAF Mental Health Telephone Triage Scale Ref: 2405055
7. CAF Emergency Safety Plan
8. CAF Emergency Safety Plan Option 2
9. Emergency Department (ED) Clinical Pathway: ED Mental Health patients rapid screening and monitoring form
10. ED – Mental Health Patients Triage and Observation Process
11. Emergency Department (ED) Security Observation information

I trust that this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely

Ralph La Salle
Senior Manager, OIAs
Canterbury DHB & West Coast DHB

Clinical risk assessment and management

Purpose

To outline the philosophy, principles and practice of risk assessment and management which guide clinical care.

Policy

All Specialist Mental Health Service (SMHS) clinicians will seek to minimise the likelihood of adverse events by:

- Conducting a clinical risk assessment, based on the structured clinical risk assessment framework, during all clinical interactions.
- Additional specific risk assessment should be completed, following training, where relevant e.g Family Safety Assessment, CASPI, DASA or HCR 20.

Implementing effective clinical risk management strategies.

Documenting the assessment, risk scenarios and management strategies.

Communicating results of the assessment and management plans with consumers and family/whanau/caregivers (unless clinically indicated not to).

SMHS will ensure that clinicians are competent to carry out risk assessment and know when to seek a more specialised assessment.

Scope

All SMHS clinicians involved in the care and treatment of consumers are responsible for assessing and monitoring clinical risk, in line with their scope of practice

The process of clinical risk assessment and management applies to all SMHS consumers regardless of their legal status and is an integral part of their clinical care.

Definitions

Risk: The likelihood of particular adverse events occurring with a particular consumer under particular circumstances within a specified period of time. Risk refers to all forms of risk to self and to others.

Risk assessment: A process of clinical evaluation to determine risk, including the likelihood, imminence and severity of risk. Risk management: The development of an intervention plan which aims to reduce risk based on the assessment and at risk scenarios.

Roles and responsibilities

Risk assessment, intervention and documentation must be coordinated by the person primarily involved in the consumer's care at the relevant point in time.

This would usually be the case manager or key nurse but may be Duly Authorised Officer (DAO) or other clinician in an urgent situation.

Associated documents

New Zealand standards and legislation

Health Information Privacy Code 1994

Mental Health (Compulsory Assessment & Treatment) Act 1992 and Amendment 1999

NZS 8134: 2008 Health and Disability Services (General) standards

Privacy Act 1993

Canterbury District Health Board policies and procedures

Child Abuse and Neglect: Management (2017)

Child Protection Alerts Management (2014)

Elder Abuse (2010)

Intimate partner violence policy (2018)

Specialist Mental Health Service policies

SMHS Bed management: sleepovers

SMHS Family-whanau involvement in consumer's treatment

SMHS Search for and removal of banned items

SMHS Weapons removal protocol

Guidelines

Ministry of Health (2016) Preventing suicide: Guidance for emergency departments

Ministry of Health (2013) New Zealand suicide prevention action plan, 2013-2016

Ministry of Health (2006) Assessment and management of risk to others: Guidelines and development of training toolkit.

Ministry of Health (2005) Suicide prevention: A review of risk and protective factors, and points of effective intervention

Ministry of Health (2000), Involving families' guidance notes: Guidelines for involving families and whanau of mental health consumers/tangata whai ora in care, assessment and treatment planning.

Associated forms

Core Information portal (Case Manager work station) in Healthlinks

Discharge Letter

Service clinical processes (hospital health pathways or service provision framework)

Treatment Plan

Policy statement

Risk assessment and management is an ongoing process

Assessing clinicians must have an understanding of

(i) static risk factors that may affect a consumer's risk

(ii) the individual consumer's current dynamic internal and dynamic situational risk factors

(iii) the consumer's current protective factors

(iv) family or whanau perspectives on current risk and management strategies

(v) cultural issues that may affect an individual consumer's risk or risk management

Risk assessment is based on clinical reasoning that includes

1 explicit recognition of patterns of risk behaviour based on previous risk events

2 explicit consideration of other factors, including the consumer's static, dynamic internal and dynamic situational risk factors, the individual consumer's current protective factors, and the viewpoints of the consumer's family/whanau

Risk assessment must lead to an identification of at risk scenarios that are likely to result in significant risk behaviours. An individual might have more than one scenario that might lead to significant risk.

Risk management plans should attempt to identify and build on the individual consumer's strengths

The assessment, at risk scenarios and management must be documented in the core information portal in Healthlinks and be reflected in the Treatment Plan.

The consumer's risk assessment must be included in all referral letters, and transfer or discharge summaries. The assessment should be written as a statement on contextual risk (rather than whether or not the person is at risk at that particular point in time).

Appropriate intervals for documenting risk changes include:

- A consumer's first contact with SMHS.
- A consumer's admission to hospital.
- Nursing notes once every shift (if the consumer is an inpatient)
- Formal clinical review.
- Discharge from the Mental Health Act.
- Referral or transfer to a new service or unit including sleepover
- Discharge from a service or unit.
- Significant changes in leave status.
- Any change in risk for any reason.

Any significant increase in risk must be documented before the clinician finishes work for the day.

Policy Owner	Director of Nursing, SMHS
Policy Authoriser	Chief of Psychiatry SMHS
Date of Authorisation	6 March 2019

Clinical risk assessment and management protocol

Contents

Purpose

The purpose of this protocol is to assist clinicians applying a clinical risk assessment framework, formulating the assessment, implementing effective intervention strategies and documenting these.

This protocol is to be used in conjunction with the Clinical risk assessment and management policy.

Scope/Audience

All Specialist Mental Health Service (SMHS) clinicians involved in the care and treatment of consumers, in line with their scope of practice

Associated documents

CDHB documents or other references directly applicable to this protocol:

Clinical risk assessment and management policy

Associated forms:

Core Information portal (Case Manager work station) in Healthlinks

Treatment Plan

Discharge Letter

Service clinical processes (hospital health pathways or service provision framework)

Crisis Resolution Wellness Plan / Child Adolescent Family Emergency Safety Plan

Definitions

Risk: The likelihood of particular adverse events occurring with a particular consumer under particular circumstances within a specified period of time. Risk refers to all forms of risk to self and to others.

Risk assessment: A process of clinical evaluation to determine risk, including the likelihood, imminence and severity of risk.

At risk scenario identification is a clinical judgement made by an adequately trained mental health professional.

Risk management: The development of an intervention plan which aims to reduce risk based on the assessment and at risk scenarios.

Equipment

Accessibility to the core information portal on Healthlinks.

Relevant training

SMHS training in the use of a Structured Clinical risk assessment framework.

Training for CASPI, DASA and HCR20 is offered to staff working in units where this is part of the clinical process.

1 Assessment

Risk assessment is ongoing and part of all clinical interactions It should include the:

- Identification of an individual's *static risk* factors - situations that are historical (that is, they have already occurred) or are enduring – (factors that lead to risk relative to others in a stated population). This could include information from previous contacts with mental health services.

  Information from risk incidents, should include a factual description of:

  - when they occurred
  - what happened
  - the context (including if possible, an understanding of the dynamic internal and dynamic situational risk factors at the time)
  - the outcome of the risk event
  - the consumer's and the family/whanau's view on what the intent of the risk behaviour was.

- Identification of *dynamic internal* factors - consumer's current mental state (this include mental illness, but also includes other states, such as fear, anger, helplessness etc.) and the consumer's current physical state which could impact on their risk (for example dehydration, delirium, hypoglycaemia, intoxication)
- Identification of the *dynamic situational* factors are factors that are external to the consumer. These can, for example, include factors such as access to means for suicide or harm to others for example weapons, loss of relationships, housing or income, or the actions of other people that affect the consumer's risk.
- Consumer's strengths and protective factors, for risk reduction, from the perspective of the consumer.
- The viewpoints of family/ whanau/ caregivers about the current risk and possible risk management strategies
- In some units additional assessment by using the HCR20 and DASA (for violence risk assessment) is also required.
- Consider long term risk vs more acute changes in presentation. Longitudinal information from family, whanau or significant others can highlight important fluctuations in presentation that are not apparent at the time of assessment.

Assessment of family and child safety issues should follow the relevant CDHB policies.

2 At risk scenarios

Risk assessment must lead to the identification and description of scenarios that are likely to result in risk behaviours.

Risk scenarios are a structured description of the risk information that has been recorded in the history and dynamic internal/situational sections. Scenarios can also be informed by clinical reasoning. A consumer might require more than one scenario as different pathways to violence and suicide may have been identified from the risk assessment.

Scenarios should describe the nature and context in which the risk behaviour is most likely to occur, including internal and situational factors that increase the risk. Scenarios should also incorporate statements regarding seriousness, imminence, who the likely victim/s might be, and the availability of the means and opportunity to carry out the harm.

3 Management

Risk management plans should be discussed with the individual consumer and their family or whanau, unless clinically contraindicated, before being enacted.

The management plan should identify interventions for the individual that will reduce or contain risk behaviours, including:

- Interventions to address dynamic internal risk factors contributing to risk (for example, use of medication; use of 'talking' treatments).

- Interventions to address situational factors contributing to risk (for example, interventions to address social stressors including relationships; accommodation and financial situation; access to alcohol and illicit substances; access to weapons; access to potential victims)
- Strategies for building on existing strengths and protective factors to reduce risk.
- Resources which are immediately accessible to the consumer, family/ whanau and clinical team to support risk reduction.
- "Guarantees of safety" or "no-suicide" contracts are contra-indicated and are not to be asked of consumers by clinicians.
- CASPI risk allocation protocol must be applied in services where this is established.
- In certain situations, (continued) admission to hospital will be appropriate, including potential use of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

The management plan must reflect the changes to risk over time, given the dynamic nature of risk.

Risk management strategies should show why strategies were chosen for an individual. In some circumstances it is useful to briefly describe why other strategies were not used (for example, these may have proved unhelpful for the consumer at previous times, the consumer or family considered they would increase risk, or the resource may not have been available)

Risk management strategies should reflect each risk that has been identified

Management of family and child safety issues should follow the relevant CDHB policies.

4 Documentation

4.1 Location

The core information portal on Healthlinks – case manager work station- is the primary place for risk to be documented.

A clinician who does not know a consumer should be able to find key information in the Core Information portal. It should be of a practical nature to assist the clinician to understand high risk situations and the suggested management/ intervention strategies for these.

The template reflects a structured clinical risk assessment framework and is completed for each consumer assessed in SMHS.

4.2 Relationship to other documents

Assessment and Discharge Summaries: A statement about risk should be included in all assessment and discharge summaries. This should be a statement about contextual risk, not whether or not that person is considered a low, medium or high risk at that point in time. This should reflect threat risk scenarios and management sections from the Core Information portal. Other significant risks such as child and family protection issues should be part of this.

Treatment Plan: Overall risk management strategies should be documented in Core Information but the treatment plan may include more detailed strategies. The Treatment Plan and Crisis Plans are the documents shared with the consumer and family, whanau so they must contain relevant aspects of the risk management strategy.

Progress Notes: Day to day assessments of risk should be noted in progress notes with any significant changes transcribed to the Core Information.

4.3 Responsibility for documentation

Responsibility for documentation generally lies with the clinician most involved in the consumer's care, usually the case manager, but in an emergency situation this may be a DAO or anyone else responsible at that point in time.

Updating core risk information should be completed by the person undertaking the risk assessment at any point in time. Other clinicians who are given new risk information are responsible for both informing the consumer's usual coordinating clinician and for documenting this information themselves

The case manager or key clinician is responsible for ensuring that the treatment plan is current and incorporates risk management strategies.

Any significant increase in risk must be documented before the clinician finishes work for the day.

5 Review of Risk

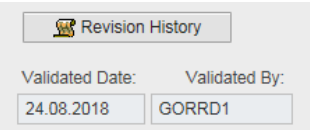
5.1 When to review

Appropriate intervals for reviewing and documenting risk changes include:

- A consumer's first contact with SMHS.
- A consumer's admission to hospital.
- Nursing notes once every shift (if the consumer is an inpatient)
- Formal clinical review.
- Discharge from the Mental Health Act.
- Referral or transfer to a new service or unit including sleepover
- Discharge from a service or unit.
- Significant changes in leave status.
- Any change in risk for any reason, including following a risk event

5.2 Use of the validation field

The validation fields – date and by - are to be used to show when and who reviewed the risk information.



Validation fields are also able to be used in the situation where the information has been reviewed but there is no change required. This reduces the need for clinicians to enter 'place holder' or date lists in the documentation fields.

Fields that have been amended or items deleted are automatically archived and are able to viewed as an historical record – revision history

These fields auto populate the user ID and date when save is clicked.

5.3 Risk warning button

The warning buttons (flag) (low/medium/high) are a VISUAL RISK WARNING tool. They offer a visual flag or identification to other clinicians to help identify that there is history or events of note.

This records the **highest ever risk** e.g. psychotic depression with past CO poisoning would rate a "high" (red), or a consumer with no significant risk history would rate a "low" (green).

All consumers that have been assessed or where risk information has been entered must have the risk warning button completed.

Once a warning flag has been determined it should not be lowered, but can be increased if the risk has increased.

Procedure Owner	Director of Nursing
Procedure Authoriser	Chief of Psychiatry
Date of Authorisation	6 March 2019

SUICIDE RISK ALLOCATION and INITIAL MANAGEMENT TOOL

RISK ALLOCATION	FEATURES	INITIAL MANAGEMENT PLAN
EXTREME	1 OF THE FOLLOWING: - Recent serious suicide attempt - Severe psychosis (new or command hallucinations) - Unrelenting agitation	Do not leave patient unattended until psychiatric review Contact with family / whanau Likely hospital admission
HIGH	1 OF THE FOLLOWING: - Suicide attempt (not fitting features of extreme risk) - Crisis presentation with past serious suicide attempt - Preparations, with lethal method or intent - Severe mood disorder - Psychosis - Agitation - Escalating AoD use - Significant AoD withdrawal - Unrelieved hopelessness	Discuss management with Registrar or Psychiatrist at time of review. Review in next CR MDT Contact with family / whanau Completion of Safety plan / provision of information pack Discussion re: removal of means Home visit during first 24hrs and integrate family supports
INTERMEDIATE	Individuals who do not fit in the other 3 categories - Suicidal ideation planned, not fleeting - Significant symptomatology or distress - Problematic AoD use - Not future focused	Discuss with on-call CNS or senior CR staff. Review next CR MDT Contact with family / whanau Completion of Safety plan / provision of information pack Discussion re: removal of means Face to face visit within 72hrs and integrate family supports
LOW	ALL OF THE FOLLOWING: - Fleeting or no suicidal ideation - No major symptomatology or distress - Non-problematic AoD use - Future focused	As indicated

*Concerns about the risk categorisation can be reviewed in discussion with Psychiatrist (including MO's)

CaSPI Project

How to use the Suicide Risk Allocation Table (Initial Management tool)

- The tool is designed to provide guidance on the clinical management of adult consumers who are presenting with suicidality for the first time. These may be people who are presenting to mental health services for the first time, people that are re-presenting or people currently under care.
- This tool is to be used after the person has been seen for an initial assessment and suicidality is identified as a presenting problem.
- For people currently under care, if a management plan or crisis plan exists to support suicidality and the clinician is comfortable it is current and applicable, the existing plan would take priority over the CaSPI management plan.
- The tool is aimed at assisting staff to determine a level of risk which is consistent and useful
- The criteria are for clinically significant presentations (e.g. agitation)
- Risks are allocated as low, intermediate, high and extremely high.
- Elevated risks are determined by the most significant feature(s) the patient presents i.e. one serious feature can determine the risk (e.g. recent suicide attempt)
- It is anticipated that high risk will apply to about half the cases presenting to CR
- Extremely high risk is for people thought to be at immediate risk of suicide who should not be left alone
- Low risk is also determined by specific features (see table)
- Intermediate risk is the residual category when no specific other risk category can be determined
- If staff feel that the risk allocation is too low they can increase the risk allocation (and initial management requirements) themselves
- If staff assessing the person feel the risk allocation is too high it can be reduced after a further psychiatric assessment or in an MDT discussion
- The mandatory management plan centres around the provision of a Safety Plan and guided self-help documentation to the patient family and whanau and time framed medical review.
- Use any **current** management plans that the patient has for presentations that fit this description but if no management plans exist, use the CASPI tool.

CaSPI Project

Guided self-help tools

The information kit is for consumers and their family-whanau and contains pamphlets for both.

- Feel free to add pamphlets off the SMHS website in addition to those in the regular pack. This could be to cover additional topics or to assist with language issues.
- When sharing the pack with consumers handle the pack, pull out the contents, highlight pamphlets and pages relevant to the consumer and their support people.
- Use highlighter, underline or mark relevant sections to assist in making points clear
- Suggest staged use of tools "first do this then after a few days try this"
- Feel free to split the pack up to distribute its contents or give out additional packs or pamphlets
- Refer to the pack on review to see if they understand the advice and have tried some of the techniques or tools
- Feel free to recommend relevant internet resources (from reputable agencies) as well as the pack, heathinfo.org.nz is a good place to start.

Wellness and Safety Plan

This plan is designed as an initial safety plan to be used in community settings (that's why it's on paper) and can be developed and expanded within the Crisis Plan structure in SAP

- The plan should be self-explanatory and consumer focused, as much as possible in their own words in the first 3 sections
- The fourth section on page 1 is for staff to write the treatment plan,as expressed in appointments but could include other planned activities
- Page 2 is self-explanatory
- You can consider asking the consumer to take a picture of their completed wellness plan to put on their phone.
- 2 copies are provided – a copy to be left with the consumer and a copy to be retained by the clinician.
- The clinician copy should be placed in the clinical file. If a consumer stays under care then the wellness and safety plan should be used to develop the SAP crisis plan.

Mental Health Telephone Triage Scale

Code/description	Response type/time to face-to-face contact	Typical presentations	Mental health service action/response	Additional actions to be considered
A Extreme Risk- current actions endangering self or others	EMERGENCY Emergency services response IMMEDIATE REFERRAL	• Overdose • Other medical emergency • Siege • Suicide attempt or serious self-harm in progress • Violence or threats of violence and possession of weapon	Triage clinician to notify ambulance, police or fire brigade OR advise caller to notify ambulance, police or fire brigade	Keeping caller on line until emergency services arrive, if necessary. CR attendance Notification of other relevant services (e.g. child protection)
B Extreme risk of imminent harm to self or others	ACUTE Very urgent mental health response WITHIN 2 HOURS	• Suicidal ideation or risk of harm to others with clear plan and means and /or history of significant self-harm or aggression • Very high risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control • Unrelenting agitation • Urgent assessment requested by Police under Section 109 of Mental Health Act	CR or equivalent face-to-face assessment – may require DAO AND/OR Triage clinical advise to attend a hospital emergency department (where CR cannot attend in timeframe or when the person requires ED assessment) Likely to require Police assistance.	Providing or arranging support of consumer and carer while awaiting face-to-face MHS response (e.g. telephone support; alternative provider response) Telephone other relevant health providers while awaiting face-to-face MHS response (e.g. telephone support; alternative provider response) Telephone secondary consultation to other service provider while awaiting face-to-face SMHS response Advise referrer to ring back if the situation changes. Advise referrer to contact police if there are immediate risks should the potential consumer leave. Arrange parental or carer supervision for a child or adolescent, where appropriate.
C High risk of either harm to self or others or high distress, especially in absence of capable supports	ACUTE Urgent mental health response WITHIN 8 HOURS	• Intense suicidal ideation with no plan and/or a history of serious suicidal behaviour • Rapidly increasing symptoms of psychosis and/or severe mood disorder • High risk behaviour associated with perceptual or thought disturbance, delirium, dementias, or impaired impulse control, including alcohol or substance use • Unable to care for self or dependants or perform activities of daily living • Known consumer requiring urgent intervention to prevent or contain relapse	CR, face to face assessment within 8 hrs OR refer to equivalent service (e.g. CAFEm) for urgent response. CR, continue monitoring of situation, telephone follow-up within the shift period – evaluate situation, review triage category, provide info to referrer re progress towards face to face response. Consider physical needs Consider use of PRN if prescribed	Provide harm minimisation info when required & self-care advice. Obtain corroborating and additional information from relevant others including past treating team members. Consider carer and family needs for support / referral to support services (e.g. SF, Kina). Consider need to provide phone support whilst awaiting CR response. Always advise caller to re-contact if situation deteriorates.

(Adapted from Statewide Mental Health Triage Scale Guidelines, Victorian Govt. 2010 & UK Mental Health Triage Scale Guidelines, 2015)
Authoriser: DoN **2 Nov 2017**
Ref: 239445

D Intermediate risk of either harm or significant distress	URGENT Urgent mental health response WITHIN 72 HOURS	• Significant consumer and carer distress associated with serious mental illness (including mood or anxiety disorder). May have suicidal ideation but no plan or intent • Early symptoms of psychosis, absent insight • Escalating alcohol or drug use + risks and/or mental illness. • Requires priority face-to-face assessment due to risks and in order to clarify diagnostic status • Isolation or failing carer or known consumer requiring priority intervention or review	CR assessment unless discharged within last 3x months then Clinical Manager or CNS to be informed to decide appropriate response. Motivational interviewing techniques if appropriate. Consider use of PRN if prescribed	Continued telephone support and advice. Consider family and carer needs as above. Provide reassurance and advice as necessary. Phone again as necessary until consumer seen. Always advise caller to re-contact if situation deteriorates
E Low risk in short term, or moderate risk but has support or stabilising factors	Non-Acute Non-urgent	• May require specialist mental health assessment but is stable and at low risk of harm • Other service providers able to manage the person until assessment appointment • Known consumer requiring non-urgent review, treatment or follow-up	Provide feedback re importance of seeing GP for review asap. Options could include GP reviewing current treatment or commencing treatment as relevant; providing physical review ensuring medical problems not causing deterioration in MH state. Provide advice re options to access a GP if there is no current GP.	Advice to GP of person's contact. Making follow-up telephone contact as a courtesy Always advise caller to re-contact if situation deteriorates
F Low Risk: – Referral On: not requiring face-to-face response from SMHS in this instance	Referral or advice to contact alternative service provider	• Other services (e.g. GPs, private counsellors, NGO providers) more appropriate to person's current needs • Symptoms of mild to moderate depression, anxiety, adjustment, behavioural or developmental disorder • Homelessness • Early cognitive changes in an older person	Triage clinician to provide formal or informal referral to an alternative service provider or advice to attend a particular type of service provider	Facilitating appointment with alternative provider (subject to disclosure requirements), especially if alternative intervention is time-critical
G Low Risk: - advice or information only, service provider consultation or SMHS requires more information	Advice or information only OR More information needed	• Consumer and carer requiring advice or opportunity to talk • Service provider requiring telephone consultation or advice • Issue not requiring mental health or other services • Mental health service awaiting possible further contact • More information (including. discussion with an MHS team) is needed to determine whether MHS intervention is required	Triage clinician to provide consultation, advice or brief counselling if required AND/OR Mental health service to collect further information over telephone	Making follow-up telephone contact as a courtesy Provide support & advice to existing and former consumers Provide support & consultation to other service providers

NB Consult with CNS out-of-hours whenever there is doubt or if consumer or if referrer unhappy with plan.
Document any information relevant to the triage decision, including where applicable: – advice given to consumer, carer or referrer
- Specific additional actions provided or required - Specific timeframe required - Information necessitating revision of triage code.

(Adapted from Statewide Mental Health Triage Scale Guidelines, Victorian Govt. 2010 & UK Mental Health Triage Scale Guidelines, 2015)
Authoriser: DoN **2 Nov 2017**
Ref: 239445

CAF Mental Health Triage Scale

Code/description	Response type/time to face-to-face contact	Typical presentations	Mental health service action/response	Additional actions to be considered
A Extreme Risk- current actions endangering self or others	EMERGENCY Emergency services response IMMEDIATE REFERRAL	• Overdose • Other medical emergency • Siege • Suicide attempt or serious self-harm in progress • Violence or threats of violence and possession of weapon	Triage clinician to notify ambulance, police or fire brigade OR advise caller to notify ambulance, police or fire brigade	Keeping caller on line until emergency services arrive, if necessary. CAFEm/CR attendance Notification of other relevant services (e.g. child protection)
B Extreme risk of imminent harm to self or others	ACUTE Very urgent mental health response WITHIN 2 HOURS	• Very urgent ideation or risk to self and/or of harm to others with clear plan and means and /or history of self-harm or aggression • Very high-risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control • Unrelenting agitation • Urgent assessment requested by Police under Section 109 of Mental Health Act	CAFEm/CR or equivalent face-to-face assessment – may require DAO AND/OR Triage clinical advice to attend a hospital emergency department (where CAFEm/CR cannot attend in timeframe or when the person requires ED assessment) Contact Police if necessary	Providing or arranging support of consumer and carer while awaiting face-to-face MHS response (e.g. telephone support; alternative provider response) Telephone other relevant health providers, including GP, while awaiting face-to-face MHS response (e.g. telephone support; alternative provider response) Telephone secondary consultation to other service provider while awaiting face-to-face SMHS response Advise referrer to ring back if the situation changes to keep CAFEm/CR up to date. Advise referrer should the potential consumer leave to contact police if appropriate. Arrange parental or carer supervision for a child or adolescent, where appropriate.
C High risk of either harm to self or others or high distress, especially in absence of capable supports	ACUTE Urgent mental health response WITHIN 8 HOURS	• Intense suicidal ideation with no plan and/or history of suicidal ideation • Rapidly increasing symptoms of psychosis and/or severe mood disorder • High risk behaviour associated with perceptual or thought disturbance, delirium, dementias, or impaired impulse control, including alcohol or substance use • Unable to care for self or perform activities of daily living • Known consumer requiring urgent intervention to prevent or contain relapse • If seen briefly afterhours by PCL/CR – review assessment and safety planning documentation	If mental health assessment and risk is NOT clear CAFEm face-to-face assessment to take place within 8 hours of presentation following discussion with MDT. If mental health assessment and risk is documented with a clear safety plan in place CAFEm face-to-face assessment can take place with 16 hours. CAFEm/CR (as required)continue monitoring of situation, telephone follow-up within each shift period leading up to face to face appointment and while waiting for CAF community urgent appointment. This reviewed weekly by MDT or more often if risks change. Face to Face assessment must be conducted by CAFEm prior to any urgent referral to CAF community teams and is a requirement within the 16-hour timeframe. If seen by CR & on call Reg, then Reg discussed with CAF Consultant Psychiatrist, full assessment not required but face-to-face risk assessment to occur within the 16-hour timeframe. Ongoing monitoring/review as required must include safety planning – evaluate situation prn, review triage category, provide info to referrer re: follow up being provided. Always consider physical needs and ability for assessment e.g. physical capacity of consumer and family, whanau. Consider PRN Medication	Obtaining corroborating any additional information from relevant others including past treating team members. Consider carer and family needs for support – referral to support services (e.g. Yellow Brick Road, Tough Love, Manu Ka Rere) if required. Consider need to provide Ph. Support/Brief work intervention while waiting for CAF North or South urgent response. CAFEm/CR response. Provide CAF Em Safety Planning document : provide harm minimisation info and & self-care advice. Always advise caller to re-contact if situation deteriorates.
D Intermediate risk of either harm or significant distress	URGENT Urgent mental health response Within 72 HOURS	• Significant consumer and carer distress associated with serious mental illness (including mood or anxiety disorder) but not suicidal or minimal suicidal ideation. • Early symptoms of psychosis, absent insight • Escalating alcohol or drug use • Requires priority face to face assessment to clarify clinical picture. • Isolation or failing carer or known consumer requiring priority intervention or review • If seen briefly afterhours by PCL/CR – review assessment information	If clinical picture and risk is fully understood a face-to- face by CAFEm needs to occur within 72 hours and prior to any urgent referral to CAF community teams. MDT discussion to occur. Motivational interviewing techniques if appropriate. Safety plan in place Consider PRN Medication	Continued telephone support and advice. Consider family and carer needs as above. Provide reassurance and advice as necessary. Phone again as necessary until consumer seen. Always advise caller to re-contact if situation deteriorates Consider Brief intervention work post CAFEm assessment.
E Low risk in short term, or moderate risk but has support or stabilising factors	Non-Acute Non-urgent mental health response	• May Require specialist mental health assessment but is stable and at low risk of harm • Other service providers able to manage the person until assessment appointment • Known consumer requiring non-urgent review, treatment or follow-up	Provide feedback re importance of seeing GP for review and possible referral to SMHS asap.GP may e.g. review current treatment or commence treatment as relevant, provide physical review ensuring medical problems not causing deterioration in MH state. Provide advice re options to access a GP if there is no GP.	Advise to GP re contact. Always advise caller to re-contact if situation deteriorates Making follow-up telephone contact as a courtesy
F Low Risk: – Referral On: not requiring face-to-face response from SMHS in this instance	Referral or advice to contact alternative service provider	• Other services (e.g. GPs, private counsellors, NGO providers) more appropriate to person's current needs • Symptoms of mild to moderate depression, anxiety, adjustment, behavioural or developmental disorder • Homelessness	Triage clinician to provide formal or informal referral to an alternative service provider or advise to attend a particular type of service provider	Facilitating appointment with alternative provider (subject to disclosure requirements), especially if alternative intervention is time-critical

G Low Risk: - advice or information only, service provider consultation or SMHS requires more information	Advice or information only OR More information needed	• Consumer and carer requiring advice or opportunity to talk • Service provider requiring telephone consultation or advice • Issue not requiring mental health or other services • Mental health service awaiting possible further contact • More information (inc discussion with an MHS team) is needed to determine whether MHS intervention is required	Triage clinician to provide consultation, advice or brief counselling if required Mental health service to collect further information over telephone If under care of a service/community team and in hours refer through to that service.	Making follow-up telephone contact as a courtesy Provide support & advice to existing and former consumers/parents/caregivers. Provide support & consultation to other service providers

NB Consult with Clinical Manager or CR CNS out-of-hours whenever there is doubt or if consumer or if referrer unhappy with plan.
Document any information relevant to the triage decision, including where applicable: advice given to consumer, carer or referrer, specific additional actions provided or required, specific timeframe required, information necessitating revision of triage code.
CAF Access Team operates Monday to Friday standard business hours. After Hours & Public Holidays covered by Crisis Resolution Team.

(Adapted from Statewide Mental Health Triage Scale Guidelines, Victorian Govt. 2010 & UK Mental Health Triage Scale Guidelines, 2015)

CAF
EMERGENCY SAFETY PLAN

7

_____ was seen by _____

of the Child, Adolescent and Family, Emergency Team (CAFEm) on the _____/_____/_____

Together we identified that when _____ is feeling unsafe / distressed they experience the following:

_____

_____

What needs removing / securing / monitoring? By who?

_____ _____

_____ _____

_____ _____

How people can assist?	Who?	How will this happen?
Increased supervision & Monitoring	_____	_____
Someone to talk to	_____	_____
Someone that makes me feel good	_____	_____

List at least three things to try if feeling distressed/unsafe:

_____

_____

_____

List at least two things you can do to improve your wellbeing:
e.g. Taking prescribed medications, sleep and eating routine, treating physical illness, decrease or stop alcohol and drug use, keep attending school / course, connect with friends

_____

_____

_____

Your follow up plan: e.g. Referral to Service / NGO / GP follow up / useful resources & websites:

_____

_____

This safety plan was created and agreed to by: _____

Signed by Service User: _____ **Signed by Clinician:** _____

CAFEm: Monday to Friday 8:30am-5pm on **0800 218 219 (then press option 2)**

Crisis Resolution: After hours, weekends and public holidays on **0800 92 00 92**

Please place these numbers into your phone(s) before you leave CAFEm

SELF HELP RESOURCES

Smilingmind.com.au – Discover the benefits of being 'in the moment' verses being swept away with your thoughts. Smiling Mind is a unique tool developed by psychologists and educators to help bring balance to your life. Practice your daily meditation and mindfulness exercises via pc or app.

Healthinfo.org.nz – Access a range of physical and mental health resources, specifically for the people of Canterbury

Netsafe.org.nz – Netsafe is New Zealand's independent, non-profit online safety organisation. They provide online safety help, support, expertise and education to people in New Zealand.

Virtual Hope Box App – The Virtual Hope Box (VHB) is a smartphone application designed for use by patients and their behavioral health providers as an accessory to treatment. The VHB contains simple tools to help patients with coping, relaxation, distraction, and positive thinking.

Allright.org.nz/sparklers/kids – A range of child-friendly activities that promote well-being

Youth.anxietycanada.com – Better understand what anxiety is and how to gradually adapt your thinking and behaviour to feel empowered

Bullyingfree.nz – Information for people being bullied

Calm Harm App – Assists people to manage self-harming urges

Thelowdown.co.nz – The Lowdown is a website to help young New Zealanders recognise and understand depression or anxiety.

MHERC. The Mental Health Education and Resource Centre (MHERC) provides information, a free public library, as well as professional development and community education about mental health, wellbeing, mental illness, and addiction.

Search: Sensory Self Soothing Kit – Discover your unique way to self-sooth via your senses. Create a container of sensory items that assist you to relax and regain your composure.

Search: Reading in Mind. Reading in Mind Book Scheme for mental health and wellbeing supports people across Canterbury to better manage their mental health through promoting the reading of recommended books on a range of mental health and wellbeing topics. Reading in Mind is for people of all ages and backgrounds, and those looking to support family/whānau or friends who may be experiencing poor mental health.

CAF
EMERGENCY SAFETY PLAN

8

_____ was seen by _____

of the Child, Adolescent and Family, Emergency Team (CAFEm) on the _____/_____/_____

Together we identified that when _____ is feeling unsafe / distressed they experience the following:

_____

_____

What needs removing / securing / monitoring? By who?

_____ _____

_____ _____

_____ _____

How people can assist?	Who?	How will this happen?
Increased supervision & Monitoring	_____	_____
Someone to talk to	_____	_____
Someone that makes me feel good	_____	_____

List at least three things to try if feeling distressed/unsafe:

_____

_____

_____

List at least two things you can do to improve your wellbeing:
e.g. Taking prescribed medications, sleep and eating routine, treating physical illness, decrease or stop alcohol and drug use, keep attending school / course, connect with friends

_____

_____

_____

Your follow up plan: e.g. Referral to Service / NGO / GP follow up / useful resources & websites:

_____

_____

This safety plan was created and agreed to by: _____

Signed by Service User: _____ Signed by Clinician: _____

CAFEm: Monday to Friday 8:30am-5pm on **0800 218 219 (then press option 2)**

Crisis Resolution: After hours, weekends and public holidays on **0800 92 00 92**

Please place these numbers into your phone(s) before you leave CAFEm

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Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Christchurch Hospital Campus

(Attach Label here or Complete Details)

NAME:_____ NHI:_____

GENDER: ____ DOB:_____ AGE:_____ WARD:_____

Date / Time	Observations & Reviews: including demeanour, activities, interactions	Asleep / Sedated	Calm	Using Phone / Reading / Other	Restless / Pacing	Tearful	Shouting	Aggressive / Threatening / Abusive	Violent	Family Present	Nursing Intervention	Medical Review	Mental Health Review	Attempted self-harm	Security Intervention	Signature
15-06-14, 1200	***Example:*** *In Interview Room* ***or:*** *Sitting by bed*				✓		✓						✓			*A. Smith*

Use Observation Record Continuation – Mental Health (C280117) if observation continues

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Christchurch Hospital
Emergency Department

(Attach Label here or Complete Details)

NAME: _____ NHI: _____

GENDER: ____ DOB: _____ AGE: _____ WARD: _____

ED Clinical Pathway: ED mental health patients rapid screening and monitoring

Date: .....

NOTES: These questions are to assist in the assessment of people with potential mental health problems in the ED, to consider urgency of need for mental health referral and supervision

Abbreviations used: *SMHS = Specialist Mental Health Service, PCLT = Psychiatric Consult Liaison Team, CR = Crisis Resolution*

As a minimum, complete page 1 and 2 of this document

PRE-TRIAGE REFERRAL

Time of referral ..... Referring person ☐ GP Other: .....

Triage code given by caller ..... Ethnicity .....

Reason to attend AND Any known medical concerns

PRE-TRIAGE REFERRAL TAKEN BY:

Print name ..... *Signature* ..... *Designation* ..... *Time* .....

TRIAGE NURSE

POLICE QUESTIONS: *"Why are you bringing the patient to ED?"*

☐ Patient under MHA Section 109 – *Police to stay with patient*
☐ Under arrest – *to stay with patient*
☐ Transporting only – *may leave*

Police job number .....

Police Officer name .....

Patient searched for weapons / medications or other substances held? ☐ Yes ☐ No

PATIENT QUESTIONS:

"CR (or other) has told me that... [Repeat reason above]. Is there anything else I need to know?"
Or
"What has brought you in today?" ± other comments

			Specify
"Have you tried to hurt yourself today or someone else?"	☐ Yes	☐ No	
"Have you been feeling physically (un)well recently?"	☐ Yes	☐ No	
"Are you (still) having suicidal thoughts?"	☐ Yes	☐ No	
"Are you under the care of a mental health team?"	☐ Yes	☐ No	
"Have you contacted them today?"	☐ Yes	☐ No	

If not already searched for weapons / medications or other substances: *"Everybody's safety is important to us, including yours, so do you have any weapons / medications or other substances?"* ☐ Yes ☐ No

Specify Actions

What level is this patient risk? *– use clinical judgement and document variances from the triage code*

Triage 1 – Immediate
- ☐ Violent
- ☐ Possesses weapon
- ☐ Self-destruction in ED
- ☐ Poses danger to life
- ☐ Hearing voices to harm self or others
- ☐ Under Mental Health Act

Triage 2 – Emergency
- ☐ Extreme agitation
- ☐ Physically / verbally aggressive
- ☐ Confused, unable to cooperate
- ☐ Hallucinations / delusions / paranoia
- ☐ Attempt / threat of self-harm

Triage 3 – Urgent
- ☐ Agitation, restlessness
- ☐ Intrusive or bizarre
- ☐ Confused, psychotic symptoms
- ☐ Suicidal ideation
- ☐ Ambivalent about treatment

Triage 4 – Semi-urgent
- ☐ No agitation or restlessness
- ☐ Irritable without aggression
- ☐ Cooperative coherent history
- ☐ Pre-existing mental health disorder
- ☐ Reports anxiety or depression

Triage 5 – Non-urgent
- ☐ Cooperative, communicative, and compliant
- ☐ Known patient with chronic unexplained somatic symptoms or non-acute mental health disorder
- ☐ Request for medication

Medical Triage 2
- ☐ Sudden change in mental state with no known mental health history

Medical Triage 2 or 3
- ☐ Medical condition requiring treatment e.g., overdose / significant injury

151523

Variance reason: .....

MENTAL HEALTH SCREENING PATHWAY C240093

Canterbury
District Health Board
Te Poari Hauora ō Waitaha
Christchurch Hospital
Emergency Department

(Attach Label here or Complete Details)

NAME: _____ NHI: _____

GENDER: ____ DOB: _____ AGE: _____ WARD: _____

Does this patient require observation? *– use of clinical judgement allowed*

☐ Not required	
☐ Triage 1 = Level 1 = Continuous surveillance (specialling 1:1)	Direct visual observation within arm's reach at all times, patient's hands and neck in full view, includes bathroom / toilet use
☐ Triage 2 = Level 2 = Continuous observation (consider 1:1)	Direct visual observation at all times, within line of sight / room, includes bathroom / toilet use
☐ Triage 3 = Level 3 = Close observation	Random observation and contact (max. 10 minute intervals)
☐ Triage 4 = Level 4 = Intermittent waiting room observation	Random observation and contact (max. 30 minute intervals)
☐ Triage 5 = Level 5 = General waiting room observation	Random observation and contact (max. 60 minute intervals)

Ensure adequate personnel to provide supervision / restraint / detention

- ☐ Family
- ☐ Hospital Aide
- ☐ Registered Nurse
- ☐ Registered Nurse, Mental Health
- ☐ Security < 4h: request "*Patient Precaution*"
- ☐ Security ≥ 4h: request "*Patient Watch*"
- ☐ Police
- ☐ Advise observer (e.g. family) that if they need to leave to inform staff

ACTIONS

- ☐ T1 and T2 patients: Move to suitable treatment area and then register in treatment area
- ☐ T3 to T5 patients: Register at reception, then move to suitable treatment area, including the waiting room
- ☐ T3 to T5 patients: Place notes in the queue for FAST or Primary Nurse Assessment, pathway page to stay with triage nurse
- ☐ Text page PCLT (7060) state: Patient name, Date of birth, Triage code, Location, +/- any medical condition

TRIAGE NURSE CARE PROVIDER:

Print name *Signature* *Designation* *Time*

FAST / PRIMARY NURSE Screen for medical assessment and / or potential violence to patient, visitors, or staff

Collect the pathway from triage, review observation page if held separately by an observer – file completed pathway with notes and return the observation page to the observer

Is the patient interviewable? ☐ Yes ☐ No *Specify*

Consider substance withdrawal risk *"Have you ever experienced alcohol or drug withdrawal symptoms?"*

Ethnicity *PRN: assist to obtain advocate, support person ± interpreter e.g., Pukenga Atawhai or ED Māori Health Worker*

Current and past medical concerns

Plans

Is there an existing ED Management Plan? ☐ No ☐ Yes – review plan

Is there an existing Mental Health Crisis Plan? ☐ No ☐ Yes – review plan with PCLT or on HCS

ACTIONS

- ☐ Call the Behaviour Emergency Team (BET) on 777 and Tannoy for aggressive patients – *as clinically indicated*
- ☐ Complete the Assessing competence in non-consenting patients (C240358) form – *as clinically indicated*

SMHS assessment only – *no medical input required*

- ☐ Move to a suitable location
- ☐ Observe – *as clinically indicated, document on pages 3 & 4*

ED assessment – *medical input required*

- ☐ Move to a suitable location
- ☐ Observe – *as clinically indicated, document on pages 3 & 4*
- ☐ Initiate / provide treatment – *as clinically indicated*
- ☐ Discharge / admit ± refer to / contact PCLT – *as clinically indicated*

FAST / PRIMARY NURSE CARE PROVIDER:

Print name *Signature* *Designation* *Time*

Use Observation Record – Mental Health (C280116) to record observation
Use Observation Record Continuation – Mental Health (C280117) if observation continues

Canterbury
District Health Board
Te Poari Hauora ō Waitaha
Christchurch Hospital Campus

(Attach Label here or Complete Details)

NAME:_____ NHI:_____

GENDER: ____ DOB:_____ AGE:_____ WARD:_____

Observation Record – Mental Health

Indicate level of observation

☐ **Level 1**	☐ **Level 2**	☐ **Level 3**	☐ **Level 4**	☐ **Level 5**
Continuous Surveillance (Specialling 1:1) Direct visual observation within arm's reach at all times, patient's hands and neck in full view, includes bathroom / toilet use	**Continuous Observation (Consider 1:1)** Direct visual observation at all times, within line of sight / room, includes bathroom / toilet use	**Intermittent Observation** Random observation and contact (max. 10 minute intervals)	**Intermittent Waiting Room Observation** Random observation and contact (max. 30 minute intervals)	**General Waiting Room Observation** Random observation and contact (max. 60 minute intervals)

Responsibilities

Observer
- Observation required continuously to half hourly according to Level
- Observed activity to be documented at a maximum of 60 minute intervals
  - *Nurse to document activity if the family is undertaking the observation*
- Observer is responsible to the RN caring for this person

Nurse reviews
- Level 1: RN observation is continuous
- Levels 2-5: RN review is required hourly

Reassessment
- Required – Level 1: 1 hourly, levels 2- 5: 4 hourly
- Undertaken by PCLT / CR or RN / RMO
- To be documented as they occur on this form

Reducing level or ending observation
- Undertaken by PCLT / CR in liaison with the RN / RMO and Observer or undertaken by RN / RMO in liaison with the PCLT / CR and Observer
- Document decision and rationale on this form

Behaviours of concern

- ☐ Self-harm (intentional)
- ☐ Harm to others
- ☐ Unpredictable behaviour
- ☐ Risk of absconding
- ☐ Impaired judgement or insight
- ☐ Threatening / damaging property
- ☐ Agitation, arousal or unknown risk e.g. unknown consumer
- ☐ At risk from someone else
- ☐ Other: _____

Observer's role / actions

- ☐ Patient to stay in bed
- ☐ Patient to stay in cubicle / room
- ☐ Observer to remain in the room / with patient
- ☐ Patient to avoid self-harm
- ☐ Patient to avoid a fall
- ☐ Observer to contact RN if patient wants to leave

Prevent the patient from leaving – using:
- ☐ Distraction and delay techniques
- ☐ Crimes Act, Section 41: Prevention of suicide
- ☐ Crimes Act, Section 48: Self-defence and defence of another or property
- ☐ Mental Health Act – Section 111: RN power to detain – *requires mandatory 6-hour mental health assessment*
- ☐ Other: _____

Observation to be undertaken by

- ☐ Security ☐ HA ☐ Psychiatric HA ☐ Other: _____
- ☐ Anyone e.g. family ☐ RN ☐ Psychiatric RN

Observation Details

Authorised by: *Print name* *Signature* *Designation* *Date/Time*

Responsible RN 1: *Print name* *Signature* *Date/Time*

Observation commenced: *Date* *Time*

Observer 1: *Print name* *Signature* *Designation* *Date/Time*

Observer 2: *e.g., meal relief* *Print name* *Signature* *Designation* *Date/Time*

If applicable

Responsible RN 2: *e.g., after shift change* *Print name* *Signature* *Date/Time*

Discontinuation authorised by: *Print name* *Signature* *Designation* *Date/Time*

151523

OBSERVATION RECORD - MENTAL HEALTH C280116

Mental Health Patients Triage and Observation process

Triage patient – Decide observation level then location

Triage 1 Level 1 – Continuous Surveillance (Specialling)

Observation by: 1:1 RN / Skilled EN
Direct visual observation within arm's reach at all times, patient's hands and neck in full view, includes bathroom / toilet use
Document at least every 30 min on observation page – pathway and observation page with observer
Decide location: Resus, Monitored, Work Up, or SMHS room / cubicle – *Inform ACNM of room use*
Notify PCLT: Text 7060# State: Patient name, Date of birth, Triage code, Location, +/- any medical condition
Register patient: At bedside / treatment area – file notes in box allocated to location
Nurse assessment: Primary nurse or PCLT / CR – complete pathway, review observation page – observation page with observer
Medical / SMHS assessment: Review pathway and observation page with observer – file pathway with notes, observation page with observer
Reassess observation level: 1 hourly, document in notes
Transfer of care / observation: Must occur in the presence of the client, document in notes

Triage 2 Level 2 – Constant observation

Observation by: RN / PCLT / CR / Observer (consider specialling)
Direct visual observation at all times, includes bathroom / toilet use
Document at least every 30 min on observation page – pathway with triage / primary nurse, observation page with observer
Decide location: Resus, Monitored, Work Up, or SMHS room / cubicle – *Inform ACNM of room use*
Notify PCLT: Text 7060# State: Patient name, Date of birth, Triage code, Location, +/- any medical condition
Register patient: At bedside / treatment area – file notes in box allocated to location, collect pathway and add to notes
Nurse assessment: Primary nurse or PCLT / CR – complete pathway, review observation page – observation page with observer
Medical / SMHS assessment: Review pathway and observation page with observer – observation page with observer until observation ceased
Nurse reassessment: 1 hourly, receive a verbal update from observer
Reassess observation level: 4 hourly, document in notes
Transfer of care / observation: Must occur in the presence of the client, document in notes

Triage 3 Level 3 – Close observation

Observation by: RN / PCLT / CR / Observer at least every 10 min
Document at least every 30 min on observation page – pathway into FAST box, observation page with observer, name onto whiteboard
Decide location: Monitored, Work Up, or Ambulatory cubicle, Waiting Room, or SMHS room / cubicle – *Inform ACNM of room use*
Notify PCLT: Text 7060# State: Patient name, Date of birth, Triage code, Location, +/- any medical condition
Register patient: At reception – file notes in FAST box
Nurse assessment: Primary or FAST nurse – complete pathway, review observation page – file pathway with notes, observation page with observer
Medical / SMHS assessment: Review pathway and observation page with observer – observation page with observer until observation ceased
Nurse reassessment: 1 hourly, receive a verbal update from observer
Reassess observation level: 4 hourly, document in notes
Transfer of care / observation: Must occur in the presence of the client, document in notes

Triage 4 Level 4 – Intermittent observation

Observation by: RN / PCLT / CR / Observer at least every 30-60 min
Document at least every 30 min on observation page – pathway with triage / primary nurse, observation page with observer
Decide location: Monitored, Work Up, Ambulatory cubicle, Waiting Room, or SMHS room / cubicle – *Inform ACNM of room use*
Notify PCLT: Text 7060# State: Patient name, Date of birth, Triage code, Location, +/- any medical condition
Register patient: At reception – file notes in FAST box
Nurse assessment: FAST nurse – complete pathway, review observation page – file pathway with notes, observation page with observer
Medical / SMHS assessment: Review pathway and observation page with observer – observation page with observer until observation ceased
Nurse reassessment: 1 hourly, receive a verbal update from observer
Reassess observation level: 4 hourly, document in notes
Transfer of care / observation: Must occur in the presence of the client, document in notes

Triage 5 Level 5 – General observation

Observation by: RN / PCLT / CR / Observer at least every 60 min
Document at least every 60 min on observation page – pathway with triage / primary nurse, observation page with observer
Decide location: Ambulatory cubicle, Waiting Room, or SMHS room
Notify PCLT: Text 7060# State: Patient name, Date of birth, Triage code, Location, +/- any medical condition
Register patient: At reception – file notes in FAST box
Nurse assessment: FAST nurse – complete pathway, review observation page – file pathway with notes, observation page with observer
Medical / SMHS assessment: Review pathway and observation page with observer – observation page with observer until observation ceased
Nurse reassessment: 1 hourly, receive a verbal update from observer
Reassess observation level: 4 hourly, document in notes
Transfer of care / observation: Must occur in the presence of the client, document in notes

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Emergency Department (ED) Security Observation information

Welcome. You have been requested to perform a patient or multiple patients' observation, this observation has been determined as a fundamental part of the patient's management.

As the person undertaking the observation you are responsible to:

- *The registered nurse (RN) in charge of this patient's care and*
- *The Associate Clinical Nurse Manager (ACNM) who is in charge of the department*

It is important you identify and have the RN document:

- *The observation level and*
- *The reason for the observation being started and*
- *Any risks identified i.e. potential to self-harm in the department / to abscond / aggression towards staff or members of the public*

Once the observation has been commenced under no circumstances are you able to leave, including for meal / toilet breaks, unless you have been relieved by another security officer.

Responsibilities

Presentation Report to the security office in ED in a clean, well presented uniform for a briefing. A security officer will take you to the RN / ACNM responsible for the patient and will inform you of the observation level.

Paperwork The Observation Record requires completing by you at time intervals indicated on the record sheet. You are expected to maintain the set level of observation until such time as a review has been performed by the mental health team, the RN, or the medical staff.

Emergency preparedness Spend time considering delaying and distraction techniques that may be useful if the patient wishes to leave against advice. Remain awake and vigilant at all times. No personal cell phones are permitted for use whilst observing a patient.

Fatigue Remember the patient, the ED staff, the general public and your own wellbeing and safety are paramount. If you feel sleepy take steps to prevent this according to your security training. You will be relieved for a break approximately every 2 hours (dependant on operational requirements).

If a patient wishes to leave ED to smoke a cigarette or to get fresh air, seek authorisation from the RN:

I. If permission given – the patient must be escorted at all times.
II. On returning please inform the RN of any behaviour of note.

Security emergency

I. **If you feel in danger or you are concerned you cannot control the situation please call 777 on any internal phone and give the operator brief details.**
II. **Hospital security will respond immediately, or the clinical / clerical staff may call the police if the situation is deemed to be dangerous to other patients or staff.**
III. In all other circumstances call the **security office ext. 89020** or page as often the office is not manned.
IV. In the event of a fire alarm – *remain with the patient* and take directions from the ACNM.

Any concerns or queries can be addressed by contacting the Security Supervisor who is available 24hrs.

The observation level must be determined and documented before the observation commences.
The observation chart must be completed at the set time intervals indicated by the observation level.
At any RN handover or security handover the ongoing observation level must be documented.