Health
Justice Health &
Forensic Mental Health Network

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# Care Coordination, Risk Assessment, Planning and Review Forensic Hospital

**Policy Number** 1.078

**Policy Function** Continuum of Care

**Issue Date** 8 March 2017

**Summary** Clinical risk assessment, management and recovery care coordination, assessment, planning and review are pivotal aspects of forensic mental health service delivery that reflect, support and nurture the principles of person-centredness and carer participation. The process involves identifying the range of an individual patient's needs and strengths, providing interventions to address needs and build upon strengths in consultation with the patient, his/her carer(s) and with others if nominated by the patient. Care coordination, risk assessment, care planning and review are intimately linked.

**Responsible Officer** Executive Director Clinical Operations

**Applicable Sites**

- ☐ Administration Centres
- ☐ Community Sites (e.g. Court Liaison Service, Community Integration Team, etc.)
- ☐ Health Centres (Adult Correctional Centres or Police Cells)
- ☐ Health Centres (Juvenile Justice Centres)
- ☐ Long Bay Hospital
- ☒ Forensic Hospital

**Previous Issue(s)** Policy 1.069 *Care Coordination, Planning and Review – Forensic Hospital* (Mar 2011, Nov 2008)

Policy 1.078 *Clinical Risk Assessment and Management – Forensic Hospital* (Jun 2011, Feb 2009)

Policy 1.069 and 1.078 are amalgamated into Policy 1.078 *Care Coordination, Risk Assessment, Planning and Review Forensic Hospital* in March 2017

**Change Summary**

- Amalgamation of policies 1.069 and 1.078
- Deletion of repeated information
- Information added regarding updated risk assessment tools
- Updated in line with the revised *Clinical Risk Assessment & Management:*

*A Practical Guide for Mental Health Clinicians* 2015

**TRIM Reference** POLJH/1078

**Authorised by** Chief Executive, Justice Health & Forensic Mental Health Network

# 1. Preface

This policy applies to the Forensic Hospital (FH) only and outlines the clinical review and risk assessment process. It is not meant to prescribe the full complement of assessment tools and processes utilised by FH clinicians. This policy does not aim to 'teach' clinicians how to complete risk assessment and care planning processes, but rather sets out fundamental principles on which the processes are based and specifies the times and events at which these processes must be completed and stipulates which clinicians are responsible.

Care coordination, risk assessment, planning and review are pivotal aspects of mental health delivery that reflect, support and nurture the principle of person centredness and carer participation. The process involves identification of an individual patient's needs, implementing and monitoring progress towards meeting those needs in consultation with the patient, their carers and others as nominated by the patient.

The high secure physical environment and clinical context must be taken into consideration when planning, assessing and reviewing care provision. The Justice Health & Forensic Mental Health Network (JH&FMHN) has a duty to ensure the safety of the patients, FH staff, visitors and the community of which the FH is part. The FH is a high secure hospital which uses clinical security measures together with specialised technology to provide a secure environment that enables the safe delivery of care. The core philosophy of the FH is that persons with mental illness, who have been involved with the criminal justice system, should have access to care and treatment of a very high standard equal to that provided in the wider community, in the least restrictive environment enabling the care to be effectively and safely provided.

Assessment, planning and review processes should routinely include arrangements for delineating, measuring and evaluating rehabilitative outcomes. Care coordination, assessment, planning and review are a continual process from admission through to transfer and discharge. This will allow the greatest opportunity for the patient to progress along their recovery pathway. These processes must address, but may not be limited to, biological, psychological, social, occupational, risk, financial and legal issues, and care pathways. All information in relation to the care planning process must be comprehensively documented in the patient's health record.

Risk assessment forms an integral part of care coordination, assessment, planning and review processes within the FH. A structured approach to risk assessment improves the validity of decisions regarding risk management. There are a number of approaches to risk assessment and JH&FMHN has adopted the structured Professional Judgement approach endorsed in the Clinical Risk Assessment & Management (CRAM) framework. There are a number of risk assessment tools which guide clinicians. These include the *Historical Clinical Risk Management-20 Version 3* (HCR-20 V3), the *Psychopathy Checklist Revised* (PCL-R), the *Dynamic Appraisal of Situational Aggression (DASA)*, *DASA: Youth Version* (DASA:YV), the *Dangerousness, Understanding, Recovery and Urgency Manual* (DUNDRUM) Quartet of tools, and the *Structured Assessment of Violence Risk in Youth* (SAVRY).

The objectives of this policy are to:

- Ensure all patients have a comprehensive Treatment & Management Plan (TPRIM), risk assessment and care pathway clearly documented in the patients' health record;
- Ensure patients are reviewed and assessed at minimum specified intervals, or more frequently as clinically indicated;

- Provide direction in relation to roles and responsibilities of the multidisciplinary team (MDT) when planning and reviewing care;
- Provide guidelines to clinical staff about the expected processes and pathways of care for patients;
- Guide FH clinicians in relation to completion of risk assessment tools and collection of data in relation to risk, and allow for central collation of risk assessment data;
- Ensure that the assessment and planning process is person-centred and meets the needs of the individual patient and his/her carers; and
- Provide a minimum standard framework for planning and review of care and treatment.

# 2. Policy Content

## 2.1 Mandatory Requirements

A patient admitted to the FH must be assessed and reviewed at intervals set out in this policy or more frequently if clinically indicated. All members of the MDT have a role to play in the coordination, assessment, planning and review of patients' care and treatment. Care planning should commence prior to admission and continue throughout the patient's stay, with a focus on recovery and achieving transfer of care to a less secure environment. The pathway through the different units of the FH will vary for each patient, but the principles and guidelines for coordination, assessment, planning and review must be followed to ensure a standardised continuum of care for each patient, ensuring that biological, psychological and social needs are identified and addressed.

There are multiple risks in forensic mental health populations including, but not limited to, the risk of victimisation, non-adherence, self-harm, violence and recurring problematic behaviour. This policy applies to all risks applicable to individual patients and these must be considered by FH clinicians as part of a comprehensive clinical assessment process. All patients in the FH must have a TPRIM, care pathway and risk assessment to manage their identified risks comprehensively documented in the patient's health record in accordance with the FH Procedure *Clinical Review and Clinical Risk Assessment and Management*. Clinicians within the FH must be formally trained in the CRAM framework and processes.

## 2.2 Implementation - Roles & Responsibilities

### 2.2.1 Multidisciplinary Team (MDT)

An MDT involves a range of health professionals, working together to deliver comprehensive patient care to improve health outcomes. By working collaboratively with the patient and their carers and/or legal guardian, the MDT also aims to enhance satisfaction for patients, carers and/or their legal guardian (if relevant). This requires:

- Respect and trust between team members,
- The best use of the skill mix within the team,
- Agreed clinical governance structures,
- Agreed systems and protocols for communication and interaction between team members.

The responsibilities of the MDT are to:

- Plan, coordinate and deliver individualised clinical interventions and programs in consultation with the patient and where possible, his/her family and/or designated carers;
- Work with patients, their designated carers and families to maximise their participation in the care planning and delivery process and to enhance patients' empowerment within their care pathway;
- Act as a consistent point of contact for all parties involved in the care of the patient;
- Ensure the comprehensive and ongoing assessment of the patient's mental state, physical and emotional health and social and occupational needs;
- Coordinate the timely preparation of the comprehensive multidisciplinary Mental Health Review Tribunal report;
- Ensure up to date TPRIMs and care plans are in place;
- Ensure that the patient and his/her carer receive a patient specific care plan;
- Ensure the MH-OAT minimum data set information, Patient Administration System (PAS), FH Patient Information Reporting Centre (FHPIRC) and any other electronic databases are completed and updated as necessary;
- Ensure all appropriate necessary services are engaged, accessed and collaborate regarding assessment, treatment and support from other JH&FMHN and external health specialists where necessary; and
- Initiate and coordinate the discharge planning process.

The MDT should liaise with relevant agencies as clinically indicated. Identified patient needs that cannot be managed by the MDT must be referred to the appropriate health care professional to meet those needs.

The patient must be central and actively involved in the assessment, planning and review processes to ensure that the patient and their carers' preferences are respected. Information should be provided via verbal and written communication to inform patients and carers of the care and treatments being provided.

The FH unit MDT consists of:

- Consultant Psychiatrist
- Psychiatry Registrar and/or Resident Medical Officer
- Care Coordinator (CC) or delegate
- Psychologist
- Social Worker/Welfare Officer
- Occupational Therapist
- Nursing Unit Manager (NUM)

There a number of other professionals who may be involved in the patients care and these are outlined below in point 2.2.9.

### 2.2.2 Consultant Psychiatrist

The Consultant Psychiatrist is responsible for integrating biopsychosocial models in understanding and managing the patient's mental illness or mental condition, including any associated emotional disturbance, problem behaviours or criminogenic factors. The Consultant Psychiatrist has overall responsibility for clinical care provided to patients. All significant clinical decisions in relation to patient care and treatment must be made in collaboration with the Consultant Psychiatrist. The Consultant Psychiatrist functions as the leader of the MDT, coordinating the work of the other team members in order to provide the highest quality care for individual patients.

### 2.2.3 Psychiatry Registrar

The Psychiatry Registrar is responsible for day to day management of patients within the FH, and for assisting the MDT with assessment, management, planning and reviews. The Registrar is responsible for informing the Consultant Psychiatrist of significant changes in patient presentation and in patient care, and is able to act as a delegate of the Consultant in relation to agreed clinical decision making responsibilities.

After business hours, the on-call Psychiatry Registrar may make decisions regarding patient care and treatment in consultation, where appropriate, with the on-call Consultant Psychiatrist and the clinical team present on the unit. Any changes to a patient's care or treatment must be clearly documented in the patient's health record and handed over to the patient's Psychiatry Registrar as soon as possible.

### 2.2.4 Care Coordinator (CC)

The role of the CC is to ensure that planned care is implemented. The role of the CC may be undertaken by any suitably qualified health professional; however, the majority of CCs are from the nursing discipline. The CC must take an active role in developing and monitoring a patient's TPRIM and care plan and in ensuring that planned interventions are implemented in a timely manner. The CC will not assume responsibility for other professionals involved in the assessment or the services provided to support the agreed care plan. The CC has a central coordinating role to ensure MDT tasks are completed by allocated workers and that the outcomes of those interventions are communicated back to the MDT.

The CC approach is complemented by an allocated nurse to each patient on a shift-by-shift basis. The allocated nurse for each patient has a responsibility to ensure that all clinical documentation after assessment or review has been completed on a shift-by-shift basis. Allocated nurses must familiarise themselves with their allocated patients' TPRIM and care plan. This is to ensure the implementation of the MDT agreed management strategies on a shift by shift basis. Where possible, the nurse who is a CC or Associate CC for a patient should be the patient's allocated nurse when they are on duty. This allocation will be determined by the individual patient needs, unit based staff skill mix and workloads.

### 2.2.5 Associate Care Coordinator

The role of the Associate CC is to act for the CC when they are unavailable and to take on duties delegated to them. The Associate CC has the same authority as the CC, or, in the case of an Enrolled Nurse, the Associate operates under the supervision of the CC.

### 2.2.6 Allied Health Professionals

Allied Health Professionals include Psychologists, Occupational Therapists, Social Workers, Diversional Therapists, Art Therapists, Social workers, Welfare Officers and others. Each discipline has a unique perspective to provide to patient assessment, planning and review processes.

The **Psychologist** is responsible for providing comprehensive psychological assessment, case formulation and interventions. This includes undertaking psychological, psychometric, personality and neuropsychological assessments, functional behaviour analysis and risk assessments. Psychological therapy could address mental health, problem behaviour and/or interpersonal problems.

The **Occupational Therapist** is responsible for providing practical support to enable people to facilitate recovery and overcome barriers that prevent them from doing the activities (occupations) that matter to them. This helps to increase people's independence, their degree of participation, and satisfaction in aspects of their life.

The **Social Worker** provides intervention and support to patients and their families using a range of clinical interventions. These interventions might include psychosocial assessment, crisis intervention, trauma counselling, group and family work, grief and bereavement counselling and discharge planning.

The **Welfare Officer** is responsible for the provision of welfare assessments, counselling, referral and support services.

### 2.2.7 Nursing Unit Manager (NUM)

The NUM is responsible for leading, directing and co-ordinating practice and management, and establishing processes that enable participation of all members of the MDT at a unit level.

### 2.2.8 Other professionals who may be consulted in a patient's care coordination, risk assessment, planning and review processes

#### 2.2.8.1 Medical Superintendent

The Medical Superintendent has a key statutory role in accordance with the *Mental Health Act 2007,* hereafter the *MH Act*, and the *Mental Health (Forensic Provisions) Act 1990,* hereafter the *MHFP Act.* This includes reviewing patients who make requests to the Medical Superintendent related to their care, treatment or ongoing detention. It also includes providing second opinions about specific patients at the request of any MDT, as well as reviewing particular aspects of patient care (e.g. protracted episodes of seclusion, serious episodes of aggression).

#### 2.2.8.2 Designated Carer/Principle Care Provider/Guardian

Under section 68 of the *MH Act*, the role of designated carer is defined as follows: "(j) the role of carers for people with a mental illness or mental disorder and their rights under this Act to be kept informed, to be involved and to have information provided by them considered, should be given effect". When the patient has a legal guardian, the Guardian is responsible for protecting the well-being and rights of the patient, including his/her lifestyle, health, medical and/or financial decisions. Consequently the Designated Carer/Principle Care Provider or Guardian should be consulted in MDT decision making and care planning processes.

#### 2.2.8.3 Diversional Therapist

The Diversional Therapist is responsible for the development, delivery and evaluation of leisure and recreation-based interventions to enhance the patient's health and well-being.

#### 2.2.8.4 Art Therapist

The Art Therapist provides opportunities for creative expression and interaction, whilst exploring the patient's psychological perspective to assist the patient to develop self-awareness.

#### 2.2.8.5 General Practitioner (GP)

The GP is responsible for the provision of general medical services when a patient is referred to them by a Psychiatry Registrar as delegated by the MDT

#### 2.2.8.6 Mental Health Care Worker (MHCW)

The MHCW is responsible for general service delivery under the supervision of the MDT; this includes diversional activities, escort duties and other non-clinical duties.

#### 2.2.8.7 Allied Health Assistant (AHA)

The AHA is responsible for the initiation of patient related activities under the supervision of an Allied Health clinician; this includes diversional and therapeutic activities.

#### 2.2.8.8 Chaplain

The Chaplain is responsible for assisting patients and carers and families with their spiritual needs, in conjunction with the MDT.

# 3. Procedure Content

## 3.1 Clinical Review Process

### 3.1.1 Referral

The MDT must commence all referral processes as described in JH&FMHN policy 1.325 *Referral, Admission & Transfer of Care (Adults) Forensic Hospital*, policy 1.327 *Referral, Admission & Transfer of Care (Adolescents) Forensic Hospital*, and the associated manuals 1.325M *Referral, Admission & Transfer of Care (Adults) Forensic Hospital Procedure Manual* and 1.327M *Referral, Admission & Transfer of Care (Adolescents) Forensic Hospital Procedure Manual*.

A TPRIM must be commenced by the MDT on referral, identifying the initial relevant biopsychosocial needs of the individual. The TPRIM is completed using the Clinical Risk Assessment and Management (CRAM) Framework – Treatment, Placement, Restrictions, Implementation and Monitoring. TPRIMs provide a contemporaneous record of the patient's current health needs and management strategies which assist with the continuity of patient care.

### 3.1.2 Initial Assessment –Admission

The patient must be formally admitted immediately on arrival to the FH by the MDT or on-call Psychiatry Registrar. Admitting staff must commence all admission processes as described in JH&FMHN policy 1.325 *Referral, Admission & Transfer of Care (Adults) Forensic Hospital*, policy 1.327 *Referral, Admission & Transfer of Care (Adolescents) Forensic Hospital* and associated manuals.

The patient's initial TPRIM developed on referral must be updated post-admission assessment. The assessment and care planning process should address a person's aspirations and strengths, as well as his/her mental health issues and identified risks. A care plan should also be commenced by the MDT following admission. This should identify the targets and the choice of interventions in collaboration with the patient.

### 3.1.3 Regular Clinical Reviews

#### 3.1.3.1 Patient Review

The Patient Review is a forum for the Consultant Psychiatrist and/or Psychiatry Registrar to engage with the patient, review his/her progress, discuss any changes in the TPRIM, to determine the plan for care until the next review and to document these changes in the patient health record and electronic TPRIM document. The patient should be reviewed at least weekly in the acute units and at least fortnightly in the non-acute units and/or as often as indicated by the Psychiatrist or Psychiatry Registrar. In the Austinmer Women's and Adolescent units where there will be a mix of acute and non-acute patients, the MDT must specify the patient's clinical review requirements in the patient's TPRIM.

#### 3.1.3.2 Multidisciplinary Team (MDT) Meeting

The MDT Meeting must occur on a regular basis and all clinical staff involved in patient care should make their best efforts to attend. Patients in the acute units must be discussed at least fortnightly and those in the non-acute units at least monthly or as often as clinically indicated. The MDT Meeting should occur at a time when maximal clinical staff can attend the meeting, whilst maintaining safe staff numbers on the unit. Each unit must determine the most appropriate day and time for this meeting. Where there are practical impediments that prevent the attendance of specific members of the team (i.e. part-time staff who do not work on the day of the MDT meeting) then these staff will need to provide input to the meeting via other means. The MDT Meeting can be held with or without the patient being present but the CC or delegate must ensure that the views of the patient and/or carers regarding their care and treatment are represented at the meeting and that any changes are relayed to the patient and/or carer. The patient's involvement must be encouraged to the greatest degree possible, remaining mindful of all safety considerations.

The MDT Meeting should be chaired by the Consultant Psychiatrist for that team. The purpose of this meeting is for each multidisciplinary member of the treating team to present, discuss and make decisions about patient care. Any new admissions must be formally presented at the first MDT Meeting after admission, with a full overview of the patient's history, current mental state, current risks, issues, current strengths or protective factors and proposed management strategies. Each patient managed by that treating team should be discussed on a regular basis. At the MDT Meeting, a delegated MDT member must comprehensively document the MDT discussions and agreed care planning and management strategies in the patient's health record and another must update the patient's TPRIM and care plan. Where necessary, care plan objectives should be updated in collaboration with the patient. The patient should be provided with a copy of their own care plan.

#### 3.1.3.3 In-depth Case Review

A full in-depth case review must be conducted on each patient every six months while the person remains in the FH. Ideally, this should occur at least 6 weeks prior to the patient's MHRT review but must occur no later than 4 weeks prior, to facilitate preparation of the report. The MDT must complete a risk review using the CRAM framework as outlined in the FH Procedure *Clinical Review and Clinical Risk Assessment and Management*. Risk assessment should inform those aspects of the care plan which can reduce risk. The in-depth case review must include discussion of the patient's progress, current presentation and future/discharge planning. The in-depth case review must be completed by the MDT at a dedicated meeting organised by the Consultant Psychiatrist or delegate. The care plan objectives should be updated. Attendees should include other members of the clinical team, the patient's family and/or carers (if appropriate) and any other services involved in the patient's care.

## 3.2 Clinical Risk Assessment & Management Process

A risk assessment incorporates information obtained from a review of the patient's health record, collateral sources and a clinical interview. The structured assessment process reviews a patient's episodes of violence and aggression, the historical factors, the dynamic (internal, situational and case specific factors) as well as assessing protective factors. It must be completed using the CRAM Framework and following the FH Procedure *Clinical Review and Clinical Risk Assessment and Management*. It is the responsibility of the MDT to complete and document these reviews, whereas it is the role of the CC to coordinate the reviews and ensure that they are completed. All risk assessment processes must be accompanied by an updated TPRIM. A risk assessment must be completed at the following times:

- **Admission** – all clinical risk assessment and management processes as outlined in FH Procedure *Clinical Review and Clinical Risk Assessment and Management* must be completed as soon as possible or prior to the patient's first In-depth Case Review post admission. The Consultant Psychiatrist and NUM are responsible to ensure this occurs within the timeframe outlined.
- **Review** – all clinical risk assessment and management processes as outlined in FH Procedure *Clinical Review and Clinical Risk Assessment and Management* must be completed prior to or at the In-depth Clinical Review Meeting. The patient's TPRIM must be reviewed and updated at the MDT Meeting and In-depth Case Review Meeting and/or as clinically indicated. The Consultant Psychiatrist and NUM are responsible to ensure this occurs within the timeframe outlined.
- **Transfer Planning** – if an MDT is considering the transfer of a patient to another unit within the FH, the MDT must provide a risk assessment as outlined in FH Procedure *Clinical Review and Clinical Risk Assessment and Management* prior to transfer. The Consultant Psychiatrist and NUM are responsible to ensure this occurs within the timeframe outlined.
- **Discharge Planning** – when recommending the discharge of a patient to a lower security setting, the MDT must provide a risk assessment as outlined in FH Procedure *Clinical Review and Clinical Risk Assessment and Management*. The Consultant Psychiatrist and NUM are responsible to ensure this occurs within the timeframe outlined.

The risk assessment process within the FH is outlined fully in the *Clinical Risk Assessment & Management: A Practical Guide for Mental Health Clinicians.*

# 4. Definitions

**Must**

Indicates a mandatory action that must be complied with.

**Should**

Indicates a recommended action that should be followed unless there are sound reasons for taking a different course of action.

# 5. Legislation and Related Documents

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| Legislation | *Mental Health Act 2007*<br>*Mental Health (Forensic Provisions) Act 1990* |
| JH&FMHN Policies and Procedures | 1.075 *Clinical Handover Implementation Guide – Ministry of Health PD2009_060*<br>1.319 *Patient Observation – Forensic Hospital and Long Bay Hospital Mental Health Unit*<br>1.322 *Recognition and Management of Patients who are Clinically Deteriorating – Implementation Guide Ministry of Health PD2013_049*<br>1.325 *Referral, Admission & Transfer of Care (Adults) Forensic Hospital*<br>1.325M *Referral, Admission and Transfer of Care (Adults) Forensic Hospital Procedure Manual* |

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| | 1.327 *Referral, Admission and Transfer of Care (Adolescents) Forensic Hospital*<br>1.327M *Referral, Admission and Transfer of Care (Adolescents) Forensic Hospital Procedure Manual*<br>FH Procedure – *Clinical Review and Clinical Risk Assessment and Management* |
| JH&FMHN Forms | FH001 *Forensic Hospital Admission Checklist*<br>FH002 *Forensic Hospital Discharge Checklist* |
| NSW MoH Policy Directives and Guidelines | PD2009_060 *Clinical Handover – Standard Key Principles*<br>PD2012_050 *Forensic Mental Health Services*<br>PD2013_049 *Recognition and Management of Patients who are Clinically Deteriorating*<br>GL2014_002 *Mental Health Clinical Documentation Guidelines* |
| Other | Allnutt, S., O'Driscoll, C., Nanayakkara, V., Adams, J., Ogloff, J.R.P., & Daffern, M. (2015) *Clinical Risk Assessment & Management: A Practical Guide for Mental Health Clinicians*. Sydney, NSW; Justice Health & Forensic Mental Health Network. |