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Health Assessments in Male and Female Adult Correctional Centres and Police Cells

Policy Number	1.225
Policy Function	Continuum of Care
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Summary	This policy outlines the standardised clinical screening and assessment processes across Justice Health and Forensic Mental Health Network (the Network) which aim to ensure that appropriate health assessments are completed in order to identify patients with acute and/or chronic conditions.
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 1.225 (Jul 2017; May 2015; Mar 2011)
Change Summary	• Updates on roles and responsibilities • Updates on the RSA across settings • Updates to Chronic Disease Screening • Updated links to new policies and documents
TRIM Reference	POLJH/1225
Authorised by	Chief Executive, Justice Health and Forensic Mental Health Network

1. Preface

Justice Health and Forensic Mental Health Network (the Network) is committed to providing appropriate patient centred care within Adult Correctional Centres, Community Sites and identified Police Cell locations. This is facilitated through a staged health assessment process that commences with a reception screening assessment. This usually occurs when the patient arrives at a reception centre. Further assessments are undertaken in a planned and co-ordinated manner with follow up appointments arranged for those patients identified as being at risk of developing or currently having a diagnosed acute and/or chronic condition.

2. Policy Content

Staged health care provision is provided for all patients with the aim of identifying, managing and reviewing patients based on clinical need and best practice guidelines.

The following processes illustrate the approach by the Network as an organisation to a patient's health care journey. These processes must not be altered at a local level. Any changes deemed necessary will be made by the Network following consultation with front line clinicians/staff, managers and/or patients.

2.1 Mandatory Requirements

Health care provision is facilitated via the following processes:

2.1.1 Police Cells Triage (PCT)

The focus of this assessment is to identify and manage clinical risk and stabilisation of a patient's immediate health needs. This assessment is paper-based and is used for *Police Bail Refused (PBR)* patients in police custody.

Registered Nurses (RNs) working in Police Cells should complete a Police Cell Complex – Reception Triage Process form or a reception screening assessment (RSA) e-form for patients under custodial care.

Where possible the PCT should be completed within 24 hours of reception to the Police Cells.

2.1.2 Reception Screening Assessment (RSA)

The purpose of the RSA is to assess patients for any Primary Health, Mental Health, Drug and Alcohol and/or Population Health issues that require immediate or ongoing treatment. When further management of any identified conditions is required a waitlist entry must be made via Patient Administration System (PAS) for the appropriate health specialist.

2.1.3 Gross Observation of Patients

Sometimes a clinician may not be able to perform a RSA, for example, if the patient is uncooperative, confused, violent, or sedated. In this situation gross observation must be conducted and will provide important information. Clinicians should document key observation points *(for reference, NSW Health: Mental Health for Emergency Departments. A Reference Guide 2015)* in the patient's electronic progress notes in Justice Health electronic Health System (JHeHS) – with the SOAP Methodology as the preferred option.

2.1.4 Chronic Disease Screen

The assessment and management of chronic disease takes place with the use of the following clinical assessment and management processes:

- Chronic Disease Screen
- Multidisciplinary Care Plan
- Clinical Pathways as identified in the Chronic Conditions Guidelines

2.1.5 Chronic Care Clinical Pathways

The Network *Procedure for Managing Patients with a Chronic Condition in Custody* and *Chronic Conditions Clinical Pathways* are designed to aid in the assessment and management of chronic conditions within the environment in which the Network clinicians deliver health care. They provide a pathway of care from reception, while in custody and to release. The Chronic Conditions Guidelines assist clinicians to manage patients with chronic conditions.

3. Procedure Content

3.1 Police Cells

For the health assessment in Police Cells please refer to the Network policy 1.111 *Court and Police Cell Complexes (Adults) Healthcare Responsibilities*.

3.2 Reception Screening Assessment (RSA)

3.2.1. Reception from Police Cells to Health Centre

- An RN or Enrolled Nurse (EN) must complete an RSA in JHeHS for all patients entering NSW Correctional Centres. When started in Police Cells, the RSA will be completed by another nurse in the reception health centre.
- The RN or EN must check, review, update and/or cease all active and inactive PAS alerts, JHeHS health conditions, allergies and adverse drug reactions to inform the current RSA. The completion of this review including documentation of any health conditions, allergies or adverse drug reactions must be documented in the patient's eprogress notes in JHeHS. . A review of the patient's medications must also occur and be documented appropriately within the Medication Chart.
- Where possible, an RSA should be completed within 24 hours of reception to the health centre. If this is not possible due to the patient's psychological or physical impairment, an RSA must be commenced with documentation outlining the reason for delay. A primary health nurse appointment must be made on PAS for review as soon as possible.
- When a health condition is identified during the reception assessment of the patient:
    - Health conditions, Allergies or Adverse Drug Reactions must be placed on JHeHS and documented in the patient's eprogress notes in JHeHS.
    - Non clinical alerts must be placed in PAS
    - Health Problem Notification Form (HPNF) must be completed on PAS and a copy given to CSNSW.

- A Release of Information (ROI) request must be sought from the patient's regular health service provider through the Network's Health Information and Records Service (HIRS) within 72 hours of a completed RSA. Once the ROI is received, HIRS scan the ROI into JHeHS, which must be reviewed/signed through the JHeHS Scanned Document Dashboard. The clinician must review the ROI and document the ROI review through an eprogress note and link the ROI. JHeHS must be updated accordingly in regards to health condition information.
- PAS waitlists must be made via PAS for the appropriate health practitioner.
- A plan of care must be developed and documented in the patient's eprogress notes in JHeHS

3.2.2. Long Bay Hospital

When a patient is admitted directly to Long Bay Hospital (LBH) the RSA must be completed as soon as is practical by the RN or EN. LBH contains the specialty units: Medical Subacute Unit (MSU), Aged Care Rehabilitation Unit (ACRU) and Mental Health Unit (MHU). The RSA must be completed in addition to the LBH admission protocol.

3.2.3. After Hours Admissions to Health Centres:

- If a new patient arrives at a health centre after hours, CSNSW will notify the After Hours Nurse Manager (AHNM) of their arrival.
- The RSA is to be completed as soon as possible, i.e. next time nursing staff attend the health centre.

3.2.4. Training requirements for Nursing Staff undertaking Reception Screening

RNs and ENs are required to gain experience and/or education in mental health, primary health, population health and drug and alcohol assessment and management before completion of the RSA Education program as part of "*JHeHS – Assessment Completing an eForm*" on My Health Learning. This is linked to the practical requirements undertaken at a reception health centre. RNs and ENs working at Reception Centres or Police Cells may apply for the Reception Screening Education course via My Health Learning online.

3.3 Chronic Disease Screen (CDS)

A patient's ongoing assessment and management takes place using the following clinical assessment and management processes:

- Chronic Disease Screen (CDS)
- Multidisciplinary Care Plan (MCP)
- Clinical pathways as identified in the Network *Procedure for Managing Patients with a Chronic Condition in Custody* and *Chronic Conditions Clinical Pathways*

The patient must have a Chronic Condition recorded as a Health Condition within JHeHS and a CDS must be completed by an RN or EN in JHeHS. There are three criteria that determine if a patient requires a CDS:

1. Patients with a confirmed chronic condition (following ROI from a community practitioner confirming the condition).
2. All Aboriginal and/or Torres Strait Islander patients who are 45 years old and over.

3. All non-Aboriginal and/or Torres Strait Islander patients who are 55 years old and over.

The aim of the CDS is to assess, identify and manage chronic diseases for patients in custody. All patients who have a CDS completed must also have a MCP completed, to ensure continuity of care.

If during the chronic disease assessment there are symptoms identified that indicate the need for further investigation, the patient will be referred via PAS to the appropriate clinical stream for expert management of the chronic illness e.g. Primary Care, Drug and Alcohol, Mental Health, Population Health. Patients identified with a chronic condition must be referred to the Integrated Care Service as appropriate.

Patients with identified acute or chronic conditions must be treated according to clinical guidelines or defined clinical pathways and placed on appropriate waiting lists in PAS for clinicians in the respective clinical streams.

An eprogress note can be documented to assist the clinician to communicate in regards to CDS.

3.3.1. Initial CDS

- If a patient meets the CDS criteria at the time the RSA is completed the patient must be placed on the 'Initial Chronic Disease Screen' waiting list on PAS including a 'see by' date. The patient must have a CDS completed in JHeHS within 30 days of their RSA.
- If a patient meets the criteria at another point during their incarceration (e.g. is diagnosed with a chronic disease or reaches the age of 55 years), a CDS must be completed in JHeHS within 30 days of the patients' presentation to health staff. The patient should be placed on the 'Initial Chronic Disease Screen' waiting list on PAS including a 'see by' date.
- The CDS can be completed on any patient at any time deemed appropriate by the health practitioner. Clinicians are encouraged to exercise clinical autonomy as appropriate.

3.3.2. Follow up CDS

- Once a patient has had an initial CDS they must be placed on the 'CDS Follow up' waiting list on PAS including a 'see by' date if they require a follow up.
- Patients being treated for chronic illness must have a CDS included in the MCP every 6 months if on medication, or every 12 months if not on medication.
- The patient must be placed on the 'CDS Follow Up' waiting list on PAS including a 'see by' date.
- Aboriginal or Torres Strait Islander patients over 45 years must have a CDS every 12 months. Non Aboriginal patients over 55 years must have a CDS every 2 years. The patient must be placed on the 'CDS Follow Up' waiting list on PAS including a 'see by' date.

3.4 Multidisciplinary Care Plan (MCP)

All patients who have a CDS completed must have a MCP completed on JHeHS by the Health Centre Nurse with input from the Medical Officer (MO), Nurse Practitioner (NP) and Allied Health Clinicians as appropriate. This will be completed with reference to the clinical pathways defined in the Procedure for Managing Patients with a Chronic Condition in Custody, the *Chronic Conditions Clinical Pathways* and PAS processes. Included in the MCP will be the timeframe for the patient's next CDS as decided by the clinician and the appropriate pathway.

Any health conditions identified during the CDS will appear on the MCP for treatment by all clinical streams. The MCP will outline treatment of any health conditions, clinical findings and the interventions initiated to manage them.

The MCP must be completed and updated on JHeHS and must not be printed or replicated anywhere else. All disciplines and specialties as appropriate are expected to contribute to the MCP and be instrumental in the timely review of the MCP. Every effort should be made for the MCP to be written in collaboration with the patient. Once initiated, patients will have one MCP in JHeHS which will be updated continuously over time.

A waiting list entry for any patient follow-up documented in the MCP must be booked via PAS.

A MCP can be completed on any patient at any time deemed appropriate by health staff. Clinicians are encouraged to exercise clinical autonomy as appropriate.

An eprogress note can be documented to assist the clinician to communicate in regards to the MCP

3.5 Procedure for Managing Patients with a Chronic Condition in Custody and the Chronic Conditions Clinical Pathways

3.5.1. Chronic Conditions Clinical Pathways

The Network *Procedure for Managing Patients with a Chronic Condition in Custody* and the *Chronic Conditions Clinical Pathways* are designed to assist clinicians in the assessment, timely diagnosis and management of chronic conditions. These documents are available on the Network Intranet.

3.5.2 Transfer of Relevant Clinical Information to CSNSW/the Private Operators

Information in relation to the health of the patient is transferred to CSNSW/the private operators under the Network's Guidelines on use and disclosure of health information (HPNF) amongst other relevant forms. Confidential clinical details must not be disseminated to CSNSW/the private operators but instructions on how to care/manage the patient must be provided and clearly communicated via the HPNF and PAS Alerts. Designated PAS alerts are also shared automatically with CSNSW Offender Integrated Management System (OIMS) as identified in PAS and also in the Chronic Conditions Toolkit. This will assist CSNSW/the private operators to provide appropriate care, accommodation and access to health services that are in keeping with the patient's clinical needs.

4. Definitions

Must

Indicates a mandatory action to be complied with.

Should

Indicates a recommended action to be complied with unless there are sound reasons for taking a different course of action.

Medication Chart

Refers to a paper-based (Long Stay Medication Chart, National Inpatient Medication Chart) or electronic medication order.

Patient Health Record

A hybrid record of paper-based and electronic information pertaining to the health of the patient.

5. Legislation and Related Documents

Network Policies, Procedures & Guidelines	1.111 *Court and Police Cell Complexes (Adults) Healthcare Responsibilities* 1.130 *Oral Health Services* 1.135 *Therapeutic Diets – Clinically Recommended* 1.230 *Health Care Interpreter Services – Culturally and Linguistically Diverse and d/Deaf Patients* 1.231 *Health Problem Notification Form (Adults)* 1.262 *Medical and Nursing Certificates (Adults)* 1.395 *Transfer and Transport of Patients* 1.430 *Management of Pregnant Women in Custody* 4.030 *Requesting and Disclosing Health Information* 5.155 *Management of Nicotine Dependence and Smoking Cessation* 4.014 *Clinical Application Systems – Alerts, Health Conditions, Allergies or Adverse Drug Reactions* 1.040 *Drug and Alcohol Services* *Procedure for Managing Patients with a Chronic Condition in Custody* *Chronic Conditions Clinical Pathways* *PAS Quick Step Guide*
NSW Health Policy Documents	*Consent to Medical and Healthcare Treatment Manual* *Mental Health for Emergency Departments – A Reference Guide* *Mortality and Hospitalisation Due to Injury in the Aboriginal Population of NSW*
Commonwealth of Australia Department of Health	*National Strategic Framework for Chronic Conditions*