Mental Health

care domains and domain outcomes
Mental Health Nursing is a specialist field of nursing which focuses on meeting the mental health needs of the consumer, in partnership with family, significant others and the community in any setting. It is a specialised interpersonal process embodying a concept of caring, which is designed to be therapeutic by:

- Supporting consumers to optimise their health status within the reality of their life situation
- Encouraging consumers to take an active role in decisions about their health care and
- Involving family/significant others and communities in the care and support of consumers

_Australian College of Mental Health Nurses 1995_

Mental health care focuses on consumer recovery as a principle for care delivery that embodies the concepts of consumer self-determination, resilience and self-management in determining nursing interventions.

There are nine broad domains of nursing care on which the Mental Health Essentials of Care are focussed. These domains represent the major elements of care delivery that impact on consumer outcomes in any setting. All nine domains are interrelated and are cross-referenced throughout the document.

Many elements of care have been categorised into domains as depicted in Diagram 1: Mental Health Essentials of Care Domains on the next page. The elements listed under each domain are a guide to the components of each domain, though these lists are not designed to exhaustive.

The Care Domains identified are:

1. Personal care
2. Documentation and communication
3. Promoting self-care and wellbeing
4. Medications and iv products
5. Privacy and dignity
6. Therapeutic interventions
7. Clinical monitoring and management
8. Preventing risk and promoting safety
9. Learning and development culture

Care outcomes have been developed to set internal benchmarks for acceptable standards of practice within specific care domains. The care outcomes in this resource have been developed through consultation with mental health nurses working across multiple care settings, using the original resource document created by the staff from Prince of Wales Hospital. While these will be similar in a range of ways, there are a number of differences specific to mental health care.

The benchmarks are broad indices, which can be rated in terms of attainment, ranging from ‘optimal’ or highest attainable through to not attained. It is expected that nurses will strive to achieve optimal attainment; however care can often fall somewhere in between. Some indices are mandated by various governing bodies and legislation, such as medication administration, where the highest attainable standard is required.
NSW Health • Essentials of care: Mental Health

Essentials of Care — Framework

Personal care
- Hygiene
- Elimination
- Nutrition/hydration
- Oral care
- Grooming/appearance
- Eye care

Documentation and communication
- MH-OAT
- Handover
- Multidisciplinary team meetings/nursing handover
- Interaction/negotiation with consumers/patients/carers/GP
- Risk management
- Collaborative care plan
- Legislation used in healthcare (MHA, Guardianship etc)

Promoting self-care and wellbeing
- Consumer/patient
- Education
- Mobility/access
- Healthy lifestyle
- Collaborative care planning
- Relapse planning
- Promoting activity and function

Medications and IV products
- Engagement and adherence
- Administration
- Transport and storage
- Assessment of efficacy and side effects
- Education

Privacy and dignity
- Confidentiality
- Ethics and boundaries
- Respectful care
- Consumer/patient rights
- Spiritual/emotional care

Clinical monitoring and management
- Physical health parameters
- Mental State Assessment
- Clinical review
- Observation levels
- Management of leave

Learning and development culture
- Orientation
- Clinical skills development
- Clinical supervision/mentoring/preceptorship
- Journal clubs/in-services/conferences
- Mandatory training
- Research
- Professional development
- Reflective practice

Therapeutic interventions
- Therapeutic relationship
- Clinical formulation
- Management planning and review
- Clinical guidelines/pathways
- Recovery focus
- Psychological interventions
- Biological interventions

Preventing risk and promoting safety
- Risk Assessment (suicide, aggression, absconding, vulnerability etc)
- Adverse event identification and management
- PMVA
- Physical, cultural and sexual safety
- Manual handling
- Infection control

Personal care
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- Elimination
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- Oral care
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Promoting self-care and wellbeing
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- Adverse event identification and management
- PMVA
- Physical, cultural and sexual safety
- Manual handling
- Infection control
Domain 1: Personal Care

Purpose
1. To provide safe, comfortable and appropriate personal care ensuring that consumer/patient dignity and wellbeing is maintained during the provision of this care.
2. To maintain an optimum level within all facets of personal care.

Includes but not limited to:
- Personal hygiene
- Elimination
- Nutrition
- Hydration
- Grooming and appearance
- Eye care

Cross-references
- Documentation and communication
- Promoting self-care and wellbeing
- Clinical monitoring and management
- Therapeutic interventions
- Privacy and dignity

Care outcomes
Personal care will:
1. Include an individualised assessment, action plan and outcome for consumers/patients to achieve all facets incorporated within the personal care domain.
2. Meet all necessary requirements as outlined by the professional code of conduct and ethical standards in the provision of personal care.
3. Ensure that episodes of personal care are documented in the consumer’s/patient’s medical records.
4. Ensure the provision of personal care is carried out in a coordinated and timely manner.
5. Be provided in accordance with hospital policy where applicable.

Related policies and guidelines

Please refer to your local and area policies and guidelines.
<table>
<thead>
<tr>
<th>Care Outcomes</th>
<th>Optimal / Highest Attainable</th>
<th>Not Attained</th>
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<tr>
<td>1. Include an individualised assessment, action plan and outcome for consumers/patients to achieve all facets incorporated within the personal care domain.</td>
<td>Prior to the provision of personal care an individual consumer/patient assessment is conducted. An individualised care plan is developed with the consumer/patient, based on the assessment findings that incorporates all aspects of personal care. The outcomes from the care plan are continuously evaluated.</td>
<td>There is no evidence that the consumer’s/patient’s personal care requirements have been assessed. There is no evidence that an individualised care plan has been developed or that the consumer/patient has been involved in its development. There is no evidence of continuous evaluation of the consumer’s/patient’s personal care needs.</td>
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<tr>
<td>2. Meet all necessary requirements as outlined by the professional code of conduct and ethical standards in the provision of personal care.</td>
<td>The professional code of conduct is maintained at all times during the provision of consumer/patient care. Nursing staff act in an ethical manner during episodes of personal consumer/patient care.</td>
<td>Personal care is carried out in a manner that is not in line with the Professional code of conduct. Nursing staff act in a manner which is not in line with ethical standards.</td>
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<tr>
<td>3. Episodes of personal care are documented in the consumer’s/patient’s medical records.</td>
<td>All documentation is legible and contains correct consumer/patient identification and date and time. The time recorded is an accurate reflection of the time that personal care was attended. All aspects of the provision of personal care are documented in the consumer’s/patient’s medical records.</td>
<td>Documentation is unreadable and lacking consumer/patient identification information, date or time. The time recorded does not accurately reflect the time the consumer/patient interventions occurred. Episodes of personal care are not documented in the consumer’s/patient’s medical records.</td>
</tr>
<tr>
<td>4. The provision of personal care is carried out in a coordinated and timely manner.</td>
<td>The time of delivery of personal care is negotiated with the consumer/patient or carer. Preparation for and completion of personal care needs is coordinated and performed in a timely manner.</td>
<td>There is no negotiation between the nurse and the consumer/patient as to the timing of the provision of personal care. There is no preparation and the intervention is conducted in a haphazard manner taking an inordinate amount of time to complete the intervention.</td>
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<tr>
<td>5. The provision of personal care is delivered in accordance with hospital policy where applicable.</td>
<td>Nursing staff are familiar with which aspects of personal care are governed by hospital policy and follow that policy accordingly. Nursing staff access the clinical procedures manual to obtain the relevant information when required.</td>
<td>Nursing staff are unaware of which aspects of personal care are covered by hospital policy, or do not follow the policy. Nursing staff do not access the clinical procedures manual or refer to other clinicians appropriately.</td>
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Domain 2: Documentation and Communication

Purpose
1. Communication is required to ensure continuity in care and prevent system breakdown in consumer’s/patient’s care.
2. Documentation provides an accurate detailed account of the consumer’s/patient’s care, problems and outcomes throughout their hospital journey.

Includes but is not limited to:
- MH-OAT assessments, risk management plan
- Collaborative care planning, review
- Outcome measures
- Provision of care
- Observation and ongoing assessment
- Interaction/negotiation with consumers/patients/family/carers/GP
- Discharge planning
- Handover
- Referral
- Clinical Incident
- Professional advice/education
- Legislation used in health care (MHA, Guardianship etc)

Cross-references
- Personal care
- Promoting self-care and wellbeing
- Medications and IV products
- Privacy and dignity
- Therapeutic intervention
- Clinical monitoring and management
- Minimising risk and promoting safety
- Learning and development culture

Care outcomes

Communication will:
1. Be effective and include all members of the health care team, consumers/patients and carers, with a comprehensive plan, that is regularly updated and evaluated.
3. Be accessible, accurate and up-to-date and consistently meet the needs of individuals.

Documentation will:
4. Be clear, concise, contemporaneous, progressive and accurate.
5. Include assessment, action and outcome and complications.
6. Meet all necessary medico-legal requirements for documentation.

Related policies and guidelines

NSW Health
- PD 2005-015 Medical records
- PD 2005–04 Medical records in Hospitals and Community Care Centres
- PD 2007-092 Discharge Planning: Responsive Standards

Documentation and Communication


Please refer to your local and area policies and guidelines.
### Essentials of Care: Mental Health

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| 1. Communication is effective and inclusive, with a comprehensive plan which is regularly updated and evaluated. | - Communication between health professionals, and with consumer/patient or carers is recorded.  
- Care planning is accessible, evaluated and current.  
- Continuity of care is achieved through effective and accurate handover between health care workers. | - Communication is not recorded or documented.  
- Care planning is not easily distinguishable, accessible or current.  
- Handover between healthcare workers is ineffective and does not accurately reflect consumer/patient needs. |
| 2. Consumer/patient confidentiality is maintained during communication.       | - Information and care planning relating to consumer/patient is shared with health care professional, consumer/patient and carers in a professional manner while maintaining consumer/patient rights to confidentiality. | - Information sharing and care planning is unprofessional and breaches consumer/patient confidentiality. |
| 3. Documentation is clear, concise, contemporaneous, progressive and accurate. | - Documentation is to the point, enabling an independent clinician to fully understand the consumer/patient events that have occurred.  
- Documentation accurately reflects the care that has been provided.  
- Provision of care is documented at the time it occurs in a sequential manner. | - The care that has taken place is not easily recognisable to the reader.  
- The information recorded is not an accurate representation of the care provided.  
- Written documentation occurs at the end of a shift. |
| 4. Documentation includes assessment actions and outcomes.                    | - Incorporates observation, assessment, medical and nursing diagnosis, management and treatment, and response to clinical interventions reflecting consumer/patient outcomes.  
- Observation and assessment information is recorded in the appropriate chart / record at the time of collection. | - Documentation of assessment and interventions is incomplete and does not reflect consumer/patient outcomes.  
- Observation and assessment information is incomplete, documented incorrectly, in an inappropriate place or delayed. |
| 5. Documentation meets all necessary medico-legal requirements.               | - All documentation is legible and contains correct consumer/patient identification and date and time.  
- The time recorded is an accurate reflection of the time observations were collected or the consumer/patient intervention being documented took place.  
- Only accepted abbreviations are used.  
- All documentation includes identification of the person, their signature and designation. | - Documentation is unreadable and lacking consumer/patient identification information, date or time.  
- The time recorded does not accurately reflect the time the consumer/patient interventions or observations occurred.  
- Documentation contains abbreviations that are non-standard or not accepted for use.  
- Documentation does not include identification of the person, their signature or designation. |
Domain 3: Promoting Self-Care and Wellbeing

Purpose
1. Promoting self-care and wellbeing is an integral part of optimising a consumer’s/patient’s overall functioning and level of independence. This process is underpinned by the recovery model approach which creates a collaborative partnership to involve the consumer/patient in all decisions regarding treatment and overall care planning.
2. The recovery model approach seeks to integrate the principles of health promotion, prevention, and early intervention. The focus of care aims to equip the consumer/patient with the resources to be able to lead a meaningful and satisfying life.

Includes but is not limited to:
- Individual assessment, to maintain, optimise or return the consumer/patient to a maximum level of self-care and independence incorporating:
  - Activities of daily living
  - Financial and budgeting skills
  - Problem-solving skills
  - Accommodation needs
  - Healthy lifestyles
  - Relationships and supports including family and primary carer
- Education
- Discharge planning and relapse prevention
- The consumer/patient will be treated with dignity and given necessary information to achieve their healthcare goals.
- Teaching of fundamental skills in managing one’s own mental health.

Cross-references
- Personal care
- Documentation and communication
- Medications and IV products
- Privacy and dignity
- Preventing risk and promoting safety
- Clinical monitoring and management
- Therapeutic interventions

Care outcomes
1. Each consumer/patient has an individualised continuous assessment and appropriate interventions related to level of functioning, support networks, discharge needs and education.
2. Recovery and self-management activities occur safely and in the most appropriate environment without incident to consumer/patient or staff.
3. Consumer/patient is involved in self-management activities and strategies to optimise level of functioning.
4. Consumer/patient is discharged safely consistent with clinical status with all necessary resources and follow-up treatment planned.
5. The consumer/patient will be given the opportunity to develop skills and strategies that will assist in the recovery process and towards independent self-care and to achieve the highest level of functioning.
6. The consumer/patient will have set goals towards achieving a sense of wellbeing.
7. Relapse prevention activities are carried out including identifying early warning signs of relapse and development of a wellness plan.
8. Information about a healthy lifestyle is given including diet and nutrition, sleep, exercise and social activities.

Related policies and guidelines
- NSW Health
  - NSW Community Mental Health Strategy 2007–2012 From prevention and early intervention to Recovery
  - PD 2007–092 Discharge Planning: Responsive Standards

Please refer to your local and area policies and guidelines.
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| 1. Each consumer/patient has an individualised continuous assessment and appropriate interventions related to level of functioning, support networks, discharge needs and education. | • Mobility aides and other resources and equipment is provided as required.  
• All consumers/patients are assessed for level of functioning and self-management needs including mobility and education.  
• Level of functioning and support networks are assessed and interventions are based on this assessment. | • Mobility aides, resources and equipment are not available or provided when required.  
• Consumer/patient self-management needs are not assessed.  
• Level of functioning and support networks are not assessed and interventions are not based on this assessment. |
| 2. Recovery and self-management activities occur safely and in the most appropriate environment. | • Risk assessment tools are utilised, i.e. Falls, red dot system.  
• Identify and remove contributing factors to unsafe mobilisation.  
• Staff are educated re manual handling and falls minimisation.  
• Consumer’s Patient’s are adequately supervised during self-management activities.  
• Staff are provided with adequate training and support to provide consumer/patient supervision, teaching and promote consumer/patient independence. | • Falls and other risks are not assessed.  
• Consumer/patient mobilised without appropriate equipment or environment.  
• Staff needs not identified or addressed.  
• Consumers/patients are not adequately supervised during self-management activities.  
• Staff needs not identified or addressed. |
| 3. Consumers/Patients are involved in self-management activities and strategies to optimise level of functioning. | • Consumers/patients are involved in the process of addressing self-management needs and deficits.  
• The consumer’s/patient’s right to choose, dignity and independence are maintained.  
• Consumer/patient concerns are listened to respected and acted upon.  
• Consumers/patients and/or carers are provided with education to manage optimal mental health. | • Consumer/patient is not involved in the process of self-management needs and deficits.  
• Consumer/patient dignity, independence or right to choose is not maintained.  
• Consumer/patient concerns not identified, listened to or addressed.  
• Consumers/patients and/or carers are not provided with education towards managing mental health. |
| 4. Consumers/Patients are discharged safely as consistent with clinical status with all necessary resources and follow-up treatment planned | • Health care workers and consumers/patients collaborate to meet pre-admission or revised self-care management.  
• Self-management assessment discharge needs commence at admission and are re-evaluated whenever the patient’s condition changes.  
• Resources (i.e. community services and agencies) are available at the time the patient is ready for discharge.  
• Any costs regarding the delivery of follow-up care are discussed with consumers/patients and their family.  
• Home assessment and/or community follow-up is arranged and provided in an appropriate timeframe for the patient’s needs.  
• Consumer/patients are discharged safely with appropriate resources or services in place. | • Health care workers and patients do not collaborate and patient does not meet their identified goals.  
• Self-management and discharge needs are not identified at admission and referrals are inappropriate or not made as required.  
• Resources have not been identified, arranged or are not available.  
• Any costs regarding the delivery of follow-up care is not discussed with patient/consumer and their family.  
• Community follow-up or assessment is not arranged or provided at the time required by the patient.  
• Patients are discharged without appropriate resources or services in place. |
### Mental Health

#### Care domains and care outcomes

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<td>5. The consumer/patient will be given the opportunity to develop skills and strategies that will assist in the recovery process and towards independent self-care and the highest level of functioning.</td>
<td>• The consumers/patients are exposed to individual and group programs that provide information regarding self-management skills including problem solving skills and goal setting. &lt;br&gt; • Assistance and support is given in applying these skills to the individuals situation. &lt;br&gt; • These skills will be trialled in a range of situations such as community setting or in the consumer’s/patient’s home.</td>
<td>• The consumer/patient is not exposed to individual and group programs that provide information regarding self-management skills. &lt;br&gt; • Assistance and support is not given in applying these skills to the individuals situation. &lt;br&gt; • These skills are not trialled in a range of situations such as community settings or in the consumer’s/patient’s home.</td>
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<td>6. Relapse prevention activities are carried out including identifying early warning signs of relapse and development of a wellness plan.</td>
<td>• The rationale for relapse prevention activities is clearly given. &lt;br&gt; • Early warning signs are clearly identified and documented. &lt;br&gt; • A response plan is developed with the consumer/patient and is documented on the wellness plan.</td>
<td>• The importance of relapse prevention is not discussed with the consumer/patient or their family. &lt;br&gt; • Early warning signs are not identified or documented. &lt;br&gt; • There is no response plan developed and the wellness plan is not completed.</td>
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<td>7. Information about a healthy lifestyle is given including diet and nutrition, sleep, exercise and social activities.</td>
<td>• The relationship between physical healthcare and mental health is clearly given. &lt;br&gt; • Consumers/patients are given the opportunity to access healthy lifestyle programs that identify how to manage diet, exercise, sleep patterns and social connectedness.</td>
<td>• The relationship between physical healthcare and mental health is not clearly identified. &lt;br&gt; • The opportunity to access healthy lifestyle programs that identify how to manage diet, exercise, sleep patterns and social connectedness is not given.</td>
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Domain 4: Medications and IV Products

Purpose
1. Medication refers to a drug that is used to treat an illness or disease according to established medical guidelines. This domain refers to the prescribing, storage, handling and administration of medications via any route.
2. Blood and blood components are not medications, however, as they are prescribed, handled, stored and administered using similar principles to the administration of medications, they are also covered by this domain.

Includes but is not limited to:
- Medications via any route
- Intravenous fluids
- Blood and blood components

Cross-references
- Documentation and communication
- Promoting self-care and wellbeing
- Preventing risk and promoting safety
- Therapeutic interventions
- Clinical monitoring and management
- Learning and development culture

Care outcomes
Medications and blood components will be:
1. Prescribed, stored, handled and administered in a manner that is safe, legal and appropriate according to NSW legislation and other appropriate governing bodies (i.e. Australian Red Cross Blood Service ARCBS) and local policies.
2. Medications and blood components are administered in accordance with hospital policy.
3. Adverse events and errors are identified, managed and reported appropriately.
4. Prescription of medications and blood components follows local and national guidelines and is appropriate for the consumer’s/patient’s clinical condition.

5. Adherence, clinical effectiveness and tolerability of medications are continually assessed, monitored and documented.
6. All consumers/patients and their families are offered education about their medication including rationale, expected outcomes, its use and how to take the medication.

Related policies and guidelines
NSW Health
- PD 2007–077 Medication Handling in Public Hospitals

Other links
- Clinical Excellence Commission Blood Watch Program

Please refer to your local and area policies and guidelines.
## Mental Health Care domains and care outcomes

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| **1. Medications and blood components are prescribed, stored, handled and administered in a manner that is safe, legal and appropriate according to NSW Health Department, other appropriate governing bodies (i.e. ARCBS) and local policies.** | • Medications and blood components are administered according to hospital clinical standards based on evidence of best practice and national guidelines.  
• Medications are prescribed according to national guidelines in a legal and legible manner.  
• Appropriate action is taken to address prescriptions that do not meet national prescribing standards.  
• Medications and blood components are stored, handled and transported according to clinical and national standards. | • Medication and blood component administration is not performed according to national guidelines or hospital clinical standards.  
• Medication orders are not legible, are incomplete or not in accordance with national guidelines.  
• Action is not taken in response to identification of prescription that don’t meet required standards.  
• Medications and blood components are stored and transported inappropriately or not in compliance with to local and national standards. |
| **2. Medications and blood components are administered in accordance with hospital standards.** | • Consumers/patients are identified via arm bands according to hospital consumer/patient identification standard.  
• Medications are administered to the correct consumer/patient, in the correct form and dose of the correct drug at the correct time via the correct route for the correct reasons.  
• Medications and blood components are checked with appropriate person/s according to hospital standards and legislative requirements.  
• Medications are administered using medication trolleys, or locked cabinets at the consumer’s/patient’s bedside according hospital policy. | • Consumers/patients are not identified correctly using full name, unique identifier and date of birth.  
• The five rights of medication administration are not followed.  
• Medications or blood components are not checked with a staff member accredited in medication administration. Hospital policy legislative requirements are breached.  
• Medications are not administered at the consumer’s/patient’s bedside.  
• Oral medications are not administered from a medication trolley or locked cabinet and the consumer/patient is not observed taking the medication. |
<p>| <strong>3. Adverse events and errors are identified, managed and reported appropriately.</strong> | • Adverse events and errors are detected through clinical monitoring, acted upon and reported accordingly in a timely manner. | • Adverse events are not detected, managed or reported in an appropriate or timely manner. |
| <strong>4. Prescription of medications and blood components follows local and national guidelines and is appropriate for the consumer’s/patient’s clinical condition.</strong> | • Medications and blood components are prescribed according to accepted local and national indications for administration. | • Medications and blood components are prescribed outside of the local and national accepted indications for administration. |</p>
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| 5. Adherence, clinical effectiveness and tolerability of medications are continually assessed, monitored and documented. | • Adherence, clinical effectiveness and tolerability of medications is established and documented through discussion with consumer/patient and their family.  
• Adherence strategies are implemented in consultation with the consumer/patient.  
• Side effects are detected, discussed with the prescribing medical officer, and consumer/patient and are addressed accordingly.                                                                 | • Adherence, clinical effectiveness and tolerability of medications is not established nor documented as no discussion with the consumer/patient or their family has taken place. |
| 6. All consumers/patients and their families are offered education about their medication including rationale, potential side effects, expected outcomes, and how to take the medication. | • Current knowledge and understanding of medication is established for all consumers/patients and their families.  
• All consumers/patients and their families are given the opportunity to understand the rationale, potential side effects, expected outcomes of their medication and how to take the medication appropriately. | • The consumer/patient or family’s current knowledge and understanding of the medication has not been established nor documented.  
• There is no documentation of the consumer/patient and their family having been offered education about their medication including the rationale, potential side effects, expected outcomes, and how to take the medication appropriately. |
Domain 5: Privacy and Dignity

Purpose
1. Promote and preserve the trust that is inherent in the privileged relationship between a nurse and an individual and respect both the person and property of that individual.
2. Provide beneficial care that is respectful towards the individual and is free from inappropriate and unnecessary intrusion.
3. Respect the dignity, culture, values and beliefs of an individual and any significant other person.
4. Maintain an environment and relationships that are appropriately private and dignified thereby enabling protection of the individuals civil rights, dignity and self-respect.
5. Any interference and or restrictions with their civil rights is to be kept to a minimum necessary in the circumstances.

Includes but is not limited to:
- Physical and mental health care
- Attitudes, behaviours and beliefs
- Personal identity
- Personal boundaries and spaces
- Communicating with consumers/patients and carers
- Privacy and confidentiality of consumer/patient information
- Respect for diverse backgrounds such as domestic violence in family, refugee status, culture and religious beliefs
- Involuntary admissions, community treatment orders
- Restraint use
- End of life care
- Confidentiality and consent

Care outcomes
Privacy and dignity will: Meet all necessary requirements as outlined by the Code of Professional Conduct for Nurses in Australia
1. Promote a feeling amongst consumers/patients that they matter all of the time.
2. Actively encompass individual values, beliefs and personal relationships.
3. Provide personal space that is identified, communicated, supported and respected by all health care workers.
4. Ensure communication between staff and consumers/patients is respectful of consumer’s/patient’s individuality.
5. Allow individuals information to be shared, with their consent, to enable care.
6. Ensure delivery of care that is negotiated with the consumer/patient and protects consumer/patient privacy, dignity and modesty.
7. Provide a safe environment for consumers/patients and carers to have privacy.

Related policies and guidelines
NSW Health
- GL 2005-057 End-of-Life Care and Decision-making guidelines
- PD2005_554 NSW Health Privacy Management Plan
- PD 2005_593 NSW Health Privacy Manual
- GL2006 NSW Health Internal Review Guidelines

New South Wales Government Privacy Facts Sheets
- Fact Sheet 1: Privacy and Confidentiality
- Fact Sheet 2: Personal Information and the Media

Legislation
- Privacy and Personal Information Protection Act 1998
- Health Records and Information Privacy Act 2002
- NSW Mental Health Act 2007
### Care Outcomes

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<tr>
<td>- No physical or psychological harm and care for the possessions and property of that individual.</td>
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<tr>
<td>- Maintenance of a professional boundary between that nurse and an individual, and between that nurse and any significant other person.</td>
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<tr>
<td>- Roles outside of the professional role, including family member, friend and community member are fulfilled. Avoidance of dual relationships that compromise care outcomes and conduction of professional relationships with the primary intent of benefit to the individual.</td>
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<tr>
<td>- No sexual relationship, consensual or otherwise, between a nurse and an individual for whom they provide care.</td>
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<tr>
<td><strong>Not Attained</strong></td>
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<tr>
<td>- Physical or psychological harm occurs and minimal care for the possessions and property of that individual.</td>
</tr>
<tr>
<td>- Professional boundary between that nurse and an individual, and between that nurse and any significant other person broken.</td>
</tr>
<tr>
<td>- Roles outside of the professional role, including family member, friend and community member are not fulfilled. Dual relationships that compromise care outcomes and conduction of professional relationships with the primary intent of benefit to the individual are formed.</td>
</tr>
<tr>
<td>- Sexual relationship, consensual or otherwise, between a nurse and an individual for whom they provide care occurs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Meet all necessary requirements as outlined by the Code of Professional Conduct for Nurses in Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Optimal / Highest Attainable</strong></td>
</tr>
<tr>
<td>- Promotes and protects the interests of an individual, irrespective of gender, age, race, sexuality, lifestyle, or religious or cultural beliefs.</td>
</tr>
<tr>
<td>- In making professional judgements in relation to the individual’s interests and rights, ensure no contravening of any law or breach to individual human rights occurs.</td>
</tr>
<tr>
<td>- Supports the health, well being and informed decision-making of an individual.</td>
</tr>
<tr>
<td>- Informs the individual and any significant other person regarding the nature and purpose of that individual’s care, and assist that individual to make an informed decision.</td>
</tr>
<tr>
<td>- In situations where individuals are unable to decide or speak independently endeavours to ensure that the perspective of that individual is represented by an appropriate advocate.</td>
</tr>
<tr>
<td><strong>Not Attained</strong></td>
</tr>
<tr>
<td>- Interests of individual are not promoted and protected.</td>
</tr>
<tr>
<td>- Contravening or breaching of individuals interests and rights has occurred.</td>
</tr>
<tr>
<td>- No/ Minimal support regarding health well being and decision-making given.</td>
</tr>
<tr>
<td>- No/Minimal information given to assist informed decision or choice.</td>
</tr>
<tr>
<td>- No advocate supplied for representation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Promote a feeling amongst consumers/patients that they matter all of the time.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Optimal / Highest Attainable</strong></td>
</tr>
<tr>
<td>- Appropriate attitudes and behaviour are promoted and assured, including consideration of non verbal behaviour, body language and inappropriate attitudes and behaviours are challenged.</td>
</tr>
<tr>
<td>- Fears and anxieties relating to their hospital admission and physical condition are explored and addressed in a compassionate and empathetic manner.</td>
</tr>
<tr>
<td><strong>Not Attained</strong></td>
</tr>
<tr>
<td>- Inappropriate attitudes and behaviours are not addressed with individuals.</td>
</tr>
<tr>
<td>- Fears and anxieties are not addressed or ignored.</td>
</tr>
<tr>
<td>- Experience deliberate negative and offensive attitude and behaviours.</td>
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</tbody>
</table>
### Mental Health

**Care domains and care outcomes**

<table>
<thead>
<tr>
<th>Care Outcomes</th>
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</thead>
<tbody>
<tr>
<td><strong>4. Actively encompass individual values, beliefs and personal relationships.</strong></td>
<td>• Individual needs and choices are ascertained and continuously reviewed.</td>
<td>• Individual values, beliefs and personal relationships are never explored.</td>
</tr>
<tr>
<td></td>
<td>• Valuing diversity is demonstrated.</td>
<td>• Diversity is not tolerated.</td>
</tr>
<tr>
<td></td>
<td>• Stereotypical, racial and patronising views are challenged.</td>
<td>• Stereotypical, racial and patronising views exist and are never challenged.</td>
</tr>
<tr>
<td><strong>5. Provide, communicate and respect personal space.</strong></td>
<td>• Preferred name is agreed and used.</td>
<td>• Addressed by a name decided by staff or are referred to by bed number, diagnosis or procedure.</td>
</tr>
<tr>
<td></td>
<td>• Personal boundaries, including touch, are identified and communicated.</td>
<td>• Personal space and boundaries are disregarded or invaded.</td>
</tr>
<tr>
<td></td>
<td>• Not disturbed or interrupted unnecessarily or without warning e.g. knocking on door before entering.</td>
<td>• Privacy is not maintained and staff enter closed area without warning.</td>
</tr>
<tr>
<td></td>
<td>• Mixed gender accommodation and facilities are discussed and whenever possible same gender accommodation and facilities are provided.</td>
<td>• Placed in mixed gender accommodation and share facilities without any warning or discussion.</td>
</tr>
<tr>
<td><strong>6. Ensure communication between staff and patients is respectful of patients’ individuality.</strong></td>
<td>• Access to appropriate translation and interpreter services are utilised and clear communication with the consumer/patient and carer is maintained.</td>
<td>• Translation and interpreter services are not utilised, and information is not available in different formats, media or languages.</td>
</tr>
<tr>
<td></td>
<td>• Information is provided in a manner that is understandable and considers individual needs</td>
<td>• Information is not provided in a manner that meets the needs or is delivered at a level inappropriate for the ability to understand.</td>
</tr>
</tbody>
</table>
Domain 6: Therapeutic Interventions

Purpose
1. To provide safe, evidence-based and appropriate therapeutic interventions that are planned and designed with the consumer/patient.
2. Therapeutic interventions should be recovery focused, consumer/patient focused and have clear measurable goals and work in partnership with other care providers.
3. Therapeutic interventions should be structured and be consistent with the type of activities expected from a mental health service.

Includes but not limited to:
- Care coordination
- Relapse prevention
- Psychoeducation
- Therapeutic group programs
- Cognitive Behavioural Therapy (CBT)
- Interpersonal Therapy (IPT)
- Motivational interviewing
- Acceptance and Commitment Therapy (ACT)

Cross-references
- Documentation and communication
- Clinical monitoring and management
- Privacy and dignity

Care outcomes

Therapeutic Interventions will:
1. Include an individualised assessment, action plan and outcome for consumers/patients to achieve all facets incorporated within the therapeutic care domain.
2. Meet all necessary requirements as outlined by the professional code of conduct and Boundaries of Practice and ethical standards in the provision of therapeutic care.
3. Episodes of therapeutic care are documented in the consumer/patient medical records.
4. The provision of therapeutic interventions is carried out in a coordinated and timely manner in partnership with other care providers.
5. Be provided in accordance with NSW Health policy where applicable and maintain confidentiality and consent.
6. Nurse are expected to engage in clinical supervision.

Related policies and guidelines
- NSW Nurses & Midwives Board Boundaries of Professional Practice 1999

Please refer to your local and Area policies and guidelines.
<table>
<thead>
<tr>
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</thead>
</table>
| 1. Therapeutic interventions should include an individualised assessment, action plan and outcome for consumers/patients to achieve all facets incorporated within the therapeutic care domain | • Prior to the provision of therapeutic interventions an individual consumer/patient Biopsychosocial assessment is conducted.  
• An individualised care plan is developed with the consumer/patient based on the assessment findings which incorporates all aspects of therapeutic care.  
• The outcomes from the care plan are continuously evaluated. | • There is no evidence that the consumer’s/patient’s personal Biopsychosocial assessment being performed.  
• There is no evidence that an individualised care plan has been developed or that the consumer/patient has been involved in its development.  
• There is no evidence of continuous evaluation of the consumer/patient in relationship to the therapeutic care needs. |
| 2. Meet all necessary requirements as outlined by the professional code of conduct and Boundaries of Practice and ethical standards in the provision of therapeutic care | • The professional code of conduct is maintained at all times during the provision of consumer/patient care.  
• Nursing staff act in an ethical manner in the delivery of therapeutic interventions to consumer/patient care. | • Therapeutic care is carried out in a manner that is not in line with the Professional code of conduct or Boundaries of Practice.  
• Nursing staff act in a manner which is not in line with ethical standards. |
| 3. Episodes of therapeutic care are be documented in the consumer’s/patient’s medical records | • All documentation is legible and contains correct consumer/patient identification and date and time.  
• The time recorded is an accurate reflection of the time that the therapeutic interventions occurred.  
• All aspects of the provision of therapeutic care are documented in the consumer’s/patient’s medical records. | • Documentation is unreadable and lacking consumer/patient identification information, date or time.  
• The time recorded does not accurately reflect the time the consumer/patient interventions occurred.  
• Episodes of therapeutic care are not documented in the consumer’s/patient’s medical records. |
| 4. The provision of therapeutic interventions is carried out in a coordinated and timely manner in partnership with other care providers. | • Therapeutic care is planned and coordinated with other health care providers including GPs.  
• Preparation for and completion of therapeutic care is coordinated and performed in a timely manner. | • There is no evidence of collaboration with other services.  
• There is no preparation and the intervention is not conducted in a planned manner. |
| 5. Be provided in accordance with NSW Health policy where applicable and maintain confidentiality and consent. | • Nursing staff are familiar with which aspects of therapeutic care are governed by NSW Health policy and follow that policy accordingly.  
• Nursing staff access the clinical procedures manual to obtain the relevant information when required. | • Nursing staff are unaware of which aspects of therapeutic care are covered by NSW Health policy, or do not follow the policy.  
• Nursing staff do not access the clinical procedures manual or refer to other clinicians appropriately. |
| 6. Nurses are expected to engage in clinical supervision. | • Nurses are engaged in regular contracted clinical supervision | • No evidence of engagement in clinical supervision |
Domain 7: Clinical Monitoring and Management

Purpose
1. Clinical monitoring involves the measurement of subjective and objective physiological and psychological parameters in order that the clinician can detect changes in consumer/patient condition, intervene promptly when necessary and develop an individualised action plan.
2. Clinical monitoring promotes best and safe practice.

Includes but not limited to:
- Performing, recording, documenting and interpreting vital signs
- Mental State Assessment and interpretation
- Early identification and management of changes in mental state
- Clinical review
- Managing, reviewing and documenting observation levels and leave status

Cross-references
- Documentation and communication
- Medications and IV products
- Privacy and dignity
- Therapeutic interventions
- Preventing risk and promoting safety
- Learning and development culture

Care outcomes
Clinical monitoring and clinical review will:
1. Ensure the frequency of physical and mental health assessment is individualised to the consumer’s/patient’s needs and clinical condition
2. Be performed in a safe manner and environment that prevents an increased risk or harm to the consumer/patient.
3. Will inform the management of observation levels and leave status.
5. Abnormal findings are acted upon within an appropriate time frame according to the consumer’s/patient’s clinical condition.

Related policies and guidelines
NSW Health
- Patient Matters Manual for Health Service Areas
- PD2009_027 Physical Health Care within Mental Health Services
- PD2009_007 Physical Health Care of Mental Health Consumers
- PD2008_005 Discharge Planning for Adult Mental Health
- GL2008_016 Mental Health Clinical Documentation – redesigned

Please refer to your local and Area policies and guidelines.

Other links
- Clinical Excellence Commission ‘Between the Flags’ Project
# Mental Health
## Care domains and care outcomes

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| 1. The frequency of Physical and Mental State Assessment is individualised to the consumer’s/patient’s needs and clinical condition. | • Assessment occurs at least as frequently as required by hospital clinical standards and evidence of best practice.  
• Assessment occurs at least as frequently as required by the consumer’s/patient’s clinical condition.  
• Frequency is reassessed continually and adjusted if a deterioration or change in the consumer’s/patient’s clinical condition is detected. | • Assessment is not performed as required by hospital clinical procedure guidelines and standards.  
• Assessment is ritualistic rather than based on consumer’s/patient’s clinical condition.  
• Changes in the consumer/patient clinical condition are not considered in decision-making in relation to frequency of assessment. |
| 2. Be performed in a safe manner and environment that prevents an increased risk or harm to the consumer/ patient. | • All clinical monitoring maintains consumer/patient dignity.  
• Assessment is performed appropriately with regard to safety and the environment.  
• Assessment is performed in the most appropriate clinical area for the consumer/patient clinical condition. | • Assessment is performed in an open environment without considering consumer/patient dignity.  
• Clinical standards, or best practice are not met.  
• The environment is not the most appropriate area for the consumer’s/patient’s clinical condition. |
| 3. Will inform the management of observation levels and leave status       | • Clinical findings inform changes in the consumer’s/patient’s level of observation.  
• Clinical findings inform changes in the consumer’s/patient’s leave status. | • Observation levels are not changed in relation to the consumer’s/patient’s clinical condition.  
• Leave status is not changed according to the consumer’s/patient’s clinical condition. |
| 4. Follow hospital policies, procedures and guidelines using evidence of best practice. | • Clinical findings are documented in the appropriate location of the consumer/patient medical records at the time of collection. | • Clinical findings are not documented in the correct place of the consumer’s/patient’s medical records in a timely manner. |
| 5. Abnormal findings are acted upon within an appropriate timeframe according to the consumer’s/ patient’s clinical condition. | • Clinical judgment is used in conjunction with best practice guidelines and hospital policies to interpret findings.  
• Changes in physical and mental state are detected promptly, reported and acted upon appropriately. | • Clinical judgment is not used to interpret findings and/or hospital procedures are not followed.  
• Abnormal parameters and changes in the consumer’s/patient’s condition are not detected, or not acted upon appropriately or in a timely manner. |
Domain 8: Preventing Risk and Promoting Safety

Purpose
To maintain an environment to minimise risk and promote consumer/patient safety during their hospital admission.

Includes but not limited to:
- Orientation to the health environment
- Assessment of risk of self-harm
- Assessment of risk of harm to others
- Balancing observation and privacy in a safe environment
- Meeting consumer/patient safety needs
- Positive culture to learn from complaints and adverse incidents related to harm and abuse

Cross-references
- Documentation and communication
- Promoting self-care and wellbeing
- Clinical monitoring and management
- Personal care
- Therapeutic interventions
- Medication and IV products
- Privacy and dignity
- Learning and development culture.

Outcomes
Preventing Risk and Promoting Safety will ensure:
1. Mental health care is delivered in an environment that is sensitive to the needs of vulnerable people and encourages consumers/patients to voice safety concerns.
2. All consumers/patients have a risk assessment on entry to the service, repeated at agreed time periods and on discharge from the services, that identifies risk to self or others.
3. All staff who carry out risk assessments do so using the appropriate tools.
4. Outcomes of risk assessments are documented in a clear concise and accurate way and appropriate actions are taken to eliminate or minimise risk.
5. Protective and supportive systems are in place to allow consumers/patients to make complaints relating to their care and treatment.
6. Systems are in place to capture incident reporting, where necessary investigated incidents and monitor the implementation of agreed action.

Related policies and guidelines
- Framework for Suicide Risk Assessment and Management for NSW Health
- NSW Health Suicide Risk Assessment and Management Protocols: Mental Health In-Patient Units
- NSW Health GL2005_049 Guidelines for the promotion of Sexual Safety in NSW Health Services (Second Edition)
- NSW Health GL2008_016 Mental Health Clinical Documentation – Redesigned
- NSW Health PD2008_005 Discharge Planning for Adult Mental Health Inpatient Facilities
- NSW Health PD2007_036 Infection Control Policy
- NSW Health PD2005_224 Manual Handling Incidents – NSW Health Services, Policy/best Practice Guidelines Prevention
Please refer to your local and Area policies and guidelines.
### Risk assessment for harm to self and others

<table>
<thead>
<tr>
<th>Care Outcomes</th>
<th>Optimal / Highest Attainable</th>
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</table>
| 1. The risk assessment tools used by staff have the capacity to effectively identify any potential and/or actual risks (e.g. MH-OAT documentation). |  - All clinical staff that carry out risk assessments, use the appropriate tools consistently.  
  - Risks are clearly documented consistently.  
  - Appropriate actions are implemented based on any risks identified. |  - Clinical staff that carry out risk assessments do not use the appropriate tools consistently.  
  - Risks are not consistently documented.  
  - There is a failure to act consistently to any identified risks. |
| 2. A comprehensive history is obtained using consumer/patient input and any relevant historical data, and such history is shared with any appropriate people involved in consumer/patient care. |  - MHOAT documentation is used consistently to obtain a consumer/patient history, with the aid of the consumer/patient and previous history.  
  - Relevant information is shared with the nominated Primary carer. |  - History of the consumer/patient is gathered and recorded inadequately, or does not involve the consumer/patient.  
  - The Primary carer is inconsistently informed of relevant information. |
| 3. Staff attitudes to self-harm and harm to others is ascertained, measured and supported with education where necessary. |  - All staff have up-to-date information about deliberate self-harm and harm to others, and understand the causes of such behaviour  
  - Staff can maintain therapeutic relationships with consumers/patients who perform deliberate self-harm, or harm to others. |  - Staff are unaware of the causes of deliberate self-harm and harm to others, they do not appreciate the background behind such behaviours  
  - Staff are not able to consistently maintain effective therapeutic relationships with consumers/patients who deliberately self-harm or harm others. |
| 4. Risk assessments need to be carried out by both inpatient and community teams prior to discharge. |  - As part of the discharge process risk assessments are carried out on consumers/patients in both the inpatient and community settings. |  - Risk assessments are not consistently carried out on consumers/patients being discharged from both community and inpatient settings. |
| 5. Relevant Non Government Organisations (NGOs) and User Groups are effectively engaged and offer useful support to consumers/patients and staff. |  - All staff coupled with the consumer/patient, consultant, are aware of local/national Non Government Organisations (NGOs) & support groups operating in their area and can access consumers/patients if requested to provide support and assistance. |  - Support groups and Non Government Organisations (NGOs) in the area are not linked in with the MHS, and cannot access consumers/patients, easily requesting the support. |
| 6. Effective measures are in place to detect and identify the use of alcohol and drugs. |  - Effective ‘gatekeeper’ policies are in place to monitor consumers/patients on admission and during inpatient leave periods to ensure alcohol and other drug usage is minimised. |  - Consumer/patients are not monitored on admission, or after returning from leave to ensure alcohol and other drug usage is identified and minimised. |
| 7. Effective measures are in place to detect and identify the use of alcohol and drugs. |  - Effective ‘gatekeeper’ policies are in place to monitor consumers/patients on admission and during inpatient leave periods to ensure alcohol and other drug usage is minimised. |  - Consumer/patients are not monitored on admission, or after returning from leave to ensure alcohol and other drug usage is identified and minimised. |
### Consumer/patient safety needs

<table>
<thead>
<tr>
<th>Care Outcomes</th>
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<tbody>
<tr>
<td>1. Safety issues are addressed in the care plan and are regularly reviewed and how they are best achieved.</td>
<td>All staff maintain a sensitivity to the safety needs of vulnerable people in the inpatient environment, identified issues are documented in the Care Plan. Processes used to provide a safe environment are regularly discussed and identified issues are subject to the quality improvement process to be effectively resolved.</td>
<td>Some staff do not fully appreciate the safety needs of vulnerable consumers in the inpatient setting. This results in issues not being identified and documented in the Care Plan consistently, potentially leading to reportable incidents.</td>
</tr>
<tr>
<td>2. Consumers/patients feel happy to voice any safety or security concerns.</td>
<td>Consumers/patients are encouraged to voice any safety concerns. Staff take any issues raised as an opportunity to improve the safety environment on the ward.</td>
<td>Consumers/patients are not encouraged to raise safety concerns. Staff react to any concerns defensively, and do not seek to validate and/or address safety issues consistently.</td>
</tr>
<tr>
<td>3. Consumers/patients have a say in negotiating choice of primary carer e.g. gender.</td>
<td>Consumer/patient preferences are considered and where possible the primary carer is allocated to meet those preferences.</td>
<td>Consumer/patient preferences are not considered when allocating the primary carer.</td>
</tr>
<tr>
<td>4. Consumers/patients have a copy of their care plan, in a format they understand.</td>
<td>Consumers/patients are collaboratively involved in their care planning. Consumers/patients also receive a copy of the care plan on the relevant MHOAT documentation, staff ensure the consumer/patient understands the care plan, and if necessary explain, and/or provide the care plan in a format the consumer/patient understands.</td>
<td>Consumers/patients are not consistently included in the care planning process. Consumers/patients are not provided with a copy of the care plan or an explanation of any problematic issues.</td>
</tr>
<tr>
<td>5. Staff are aware of potential communication barriers, and can demonstrate how these are overcome.</td>
<td>Staff are aware of any cultural, gender, language, age-related barriers to communication and can show how to overcome these, or access resources to aid in overcoming barriers.</td>
<td>Staff are not consistently aware of potential communication barriers and/or do not know where to access resources to aid in overcoming barriers to communication.</td>
</tr>
<tr>
<td>6. Known consumers/patients of the service are helped to record a detailed personal crisis plan and preferences when well. How these are used and considered when the consumer/patient is in acute crisis is documented and policies made.</td>
<td>In collaboration between the treating clinical team and a known consumer/patient, preferences and a crisis plan is encouraged to be made using the MHOAT documentation. There are clear instructions in the consumer/patient record showing when these are to be used. This is supported by policy.</td>
<td>Consumers/patients are inconsistently offered and opportunity to develop preferences and a crisis plan is well. There is inconsistent documentation of the crisis plan in the consumer/patient records. Policies have not been developed to support the process.</td>
</tr>
<tr>
<td>7. Where a safety issue is identified that cannot be adequately met by the Service, appropriate external agencies are engaged to offer support: e.g. Domestic Violence services, Sexual Assault.</td>
<td>Clear contacts and regular meetings are held between mental health services and support agencies to ensure effective use of resources. Staff are fully aware of services available and appropriate referral criteria and processes.</td>
<td>Inconsistent contacts and/or irregular meetings between mental health services and support agencies occur. Staff are unsure of appropriate referral criteria and the range of services available.</td>
</tr>
<tr>
<td>8. The privacy of women and other vulnerable groups is secured.</td>
<td>Vulnerable groups are identified early on admission and the facility provides support to manage them safely and with as much privacy as the facility can allow. Identified risks associated with vulnerable groups are resolved in a timely manner.</td>
<td>Vulnerable groups do not receive consistent support to provide increased safety and privacy in the facility. Identified risks with vulnerable groups are not consistently resolved.</td>
</tr>
</tbody>
</table>
A positive culture to learn from complaints and adverse incidents related to harm and abuse

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<th>Care Outcomes</th>
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</thead>
<tbody>
<tr>
<td>1. The complaint procedure is made user-friendly, accessible, and usable, particularly for vulnerable groups and barriers to communication are identified and overcome.</td>
<td>Consumers/patients of the service are made aware of the complaints procedure upon entering the service.</td>
<td>Consumers/patients are unaware of the complaints procedure.</td>
</tr>
<tr>
<td></td>
<td>Any identified barriers to the complaints procedure are overcome, particularly for vulnerable consumers/patients.</td>
<td>Barriers are inconsistently identified, vulnerable consumers/patients experience particular problems accessing the complaints process.</td>
</tr>
<tr>
<td>2. Systems are in place for staff, practitioners, or carers to report practitioners who are abusive or harmful.</td>
<td>Reports of abusive or harmful behaviour by practitioners is always investigated and taken seriously, no matter who makes the complaint, in accordance with NSW Health complaints procedures.</td>
<td>Reports of abusive or harmful behaviour is not consistently investigated, regardless of the source of the complaint.</td>
</tr>
<tr>
<td></td>
<td>IIMS reports of critical incidents are documented/recorded, investigated and where necessary action taken to prevent/minimise further incidents of a similar nature.</td>
<td>Critical incidents are not consistently recorded using the aims procedure, as a result similar critical incidents are not prevented or minimised.</td>
</tr>
<tr>
<td>3. Critical incidents such as acts of violence, aggression, seclusion and procedures and policies are audited, including ensuring that action is taken if required.</td>
<td>Data from IIMS incidents and other identified risks are used to inform allocated resources, to monitor performance, and identify training needs</td>
<td>Data from IIMS, and other identified risks is not consistently used to inform resource allocation, performance is not monitored effectively, and training needs are not met adequately.</td>
</tr>
<tr>
<td>4. Risk-related information is collected and used in determining resources and monitoring performance and to inform training.</td>
<td>Appropriate external agencies and/or user groups are involved in the audit of complaints and critical incidents, and provide feedback on service evaluation</td>
<td>External agencies and/or user groups are not effectively involved in the audit of complaints and critical incidents, and are unable to provide meaningful feedback on the quality of service provision.</td>
</tr>
<tr>
<td>5. External agencies or advocates or user groups are involved in audit of complaints and critical incidents and evaluation of services.</td>
<td>Staff and consumers/patients have opportunities to debrief if wanted from critical incidents, and these are offered consistently.</td>
<td>Staff and consumers/patients are inconsistently offered the opportunity to debrief from a critical incident, it is not considered usual practice.</td>
</tr>
<tr>
<td></td>
<td>Results from critical incident debriefing inform practice.</td>
<td>Critical incident debriefing results does not inform practice, and allows for similar incidents to occur.</td>
</tr>
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Balancing observation and privacy in a safe environment

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<tbody>
<tr>
<td>1. The mental health service has a documented policy on observation of consumers/patients which gives clear direction to staff</td>
<td>● There is evidence of a clearly documented policy governing the prescribing and monitoring of consumers/patients on higher levels of observations</td>
<td>● There is no evidence of a documented policy on higher levels of observation.</td>
</tr>
<tr>
<td>2. Observation levels are assigned to individual patients based on a documented risk assessment.</td>
<td>● A risk assessment has been completed and agreed level of observation is clearly documented in the clinical file.</td>
<td>● There is no documented evidence of a risk assessment or level of observation.</td>
</tr>
<tr>
<td>3. Allocation of staff to provide higher levels of observation for consumers/patients must take into consideration the needs of the patient.</td>
<td>● Rosters are arranged to allow for a variety of skill mix, gender and roles, to allow for the needs of safe and appropriate observation of consumers/patients. ● Allocation of staff to provide observation takes into account the needs of the consumer/patient.</td>
<td>● Rostering does not consistently take into account the need for an appropriate skill mix and to provide safe and appropriate observation. ● Allocation of staff takes into account the needs and preferences of the consumer/patient.</td>
</tr>
<tr>
<td>4. Opportunities are taken for maintaining privacy and dignity during observations.</td>
<td>● Clinicians are able to identify privacy and dignity issues and where possible allow consumers/patients the least intrusive level of observation. ● Observations are performed in a supportive and therapeutic manner.</td>
<td>● Clinicians do not take opportunities to reduce potential privacy and dignity discomfort for consumers/patients in a consistent manner.</td>
</tr>
<tr>
<td>5. Consumers/patients are informed or educated regarding the observational process and how their satisfaction with these processes is ascertained.</td>
<td>● Staff inform all consumers/patients who are subject to observation of the process and aims behind the observation levels. ● Consumer/patient opinion on observation is sought and evaluated.</td>
<td>● Staff inconsistently provide information on observation and the aims behind any observation levels. ● Consumer/patient opinion of observation is not consistently sought and evaluated.</td>
</tr>
<tr>
<td>6. Carers’ satisfaction with observation and privacy policy is ascertained.</td>
<td>● Feedback is sought from Carers on the Observation and Privacy policies.</td>
<td>● Staff do not consistently provide Carers with an opportunity to understand and comment on the Observation and Privacy policies.</td>
</tr>
<tr>
<td>7. Environmental safety checks are carried out at regular intervals to ensure the maintenance of a safe environment.</td>
<td>● Regular Health and Safety meetings provide for the identification of systemic, and environmental dangers that could lead to increased risk. ● Workplace dangers are quickly identified and action is taken to reduce/eliminate the risks as soon as practical.</td>
<td>● Health and Safety meetings are not held regularly, systemic and environmental dangers are not readily identified. ● Workplace dangers are not addressed in a timely manner.</td>
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## Infection control

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</table>
| 1. Infection prevention and control measures are identified and implemented. | • Standard precautions, including hand hygiene and the appropriate use of PPE, are used for all episodes of direct consumer/patient care according to local hospital and department of health policy directives.  
• Additional precautions (airborne, droplet and/or contact precautions) for microorganisms are implemented where there is a known or suspected infection.  
• Sharps are handled and disposed of responsibly using safe practice according to local hospital policy and department of health policy directives. | • Standard precautions are not used for all episodes of direct consumer/patient care, hand hygiene does not occur at the appropriate times and policy guidelines are not followed.  
• Requirements for the implementation of additional precautions for preventing the transmission of infection are not identified or are not implemented appropriately.  
• Sharps are not disposed of in an appropriate sharps container by the user, or are not handled in a safe manner and policy guidelines are not adhered to. |

## Manual handling

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<tr>
<th>Care Outcomes</th>
<th>Optimal / Highest Attainable</th>
<th>Not Attained</th>
</tr>
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</table>
| 1. Risks associated with manual handling of consumers/patients and equipment are identified and measures taken to prevent injury. | • All staff are trained in approved manual handling techniques for their work area.  
• The provision of appropriate equipment to prevent and minimise risk of injury.  
• The workplace environment is designed and adapted to comply with NSW Health and local policies and procedures. | • Staff are not trained in approved manual handling techniques.  
• Appropriate equipment is not supplied for staff to be able to complete manual handling tasks safely.  
• The workplace is not designed or adapted to minimise/prevent manual handling injury in accordance with NSW Health and local policies and procedures. |

## Prevention and management of violence and aggression

<table>
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<tr>
<th>Care Outcomes</th>
<th>Optimal / Highest Attainable</th>
<th>Not Attained</th>
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</table>
| 1. All facilities have identified and taken measures to ensure consumers/patients and staff have a minimal risk of injury due to violence and aggression. | • There are documented policies and procedures relating to the prevention and management of violence and aggression in the workplace.  
• All staff are trained in appropriate approved violence and aggression prevention and management techniques.  
• Consumers/patients are treated with dignity and respect even if behaving in violent and aggressive ways when unwell.  
• The risk of injury to staff and consumer/patients is minimized through the implementation of effective education and training around the prevention and management of violence and aggression. | • There are no documented policies or procedures relating to the prevention and management of violence and aggression.  
• Staff are not trained in approved manual handling techniques.  
• Consumers/patients do not always have their dignity and respect maintained when behaving in violent and aggressive ways.  
• The risk of injury to staff and consumer/patients is not minimized. No effective education and training around the prevention and management of violence and aggression is implemented. |
Domain 9: Learning and Development Culture

Purpose
To promote learning and development opportunities that will enhance person-centred care.

Includes but not limited to:
- Orientation and induction
- Clinical skills development and competence
- Clinical supervision/mentoring/preceptorship
- Journal clubs/inservices/conferences
- Mandatory education
- Research
- Professional development
- Reflective practice
- Clinical teaching
- Access to learning resources

Cross-references
- Documentation and communication
- Medications and IV products
- Therapeutic interventions
- Clinical monitoring and management
- Preventing risk and promoting safety.

Learning outcomes
Learning and development of staff is promoted through the following mechanisms:
1. Every staff member has orientation and induction to the hospital and the ward
2. Formal Performance development review is undertaken
3. Experienced and senior staff act as role models, mentors and preceptors and facilitate learning with new, junior and inexperienced staff
4. Educational and information resources are readily available
5. Opportunities for learning are utilised and reflective practice is used to learn from experiences
6. Skills acquisition occurs in a timely manner relevant to clinical needs

Related policies and guidelines
Please refer to your local and area policies and guidelines.
## Mental Health

### Care domains and care outcomes

<table>
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<tr>
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<th>Optimal / Highest Attainable</th>
<th>Not Attained</th>
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</table>
| 1. Every staff member has orientation and induction to the hospital and the ward. | - An orientation information package is provided for all new staff.  
- Orientation and mandatory training is attended by every new nurse at the commencement of their employment and annually as required  
- A supernumerary period is negotiated according to learning needs for all new staff. | - There is no orientation information available for new staff.  
- Orientation not attended, or attended well after commencing employment.  
- Mandatory training not updated annually.  
- There is no supernumerary period or the period provided is inadequate for staff requirements. |
| 2. Performance development review is undertaken.                             | - All staff have an annual performance development review.  
- An individual professional development plan is devised and reviewed during the appraisal process.  
- Opportunities exist for formal learning and development; available access to study leave.  
- Learning and development needs analysis is undertaken at least annually | - Performance development reviews are not completed annually.  
- Areas for professional development are not identified or reviewed.  
- Opportunities formal learning and development are not provided or study leave is not available.  
- There is no analysis of learning and development needs undertaken. |
| 3. Experienced and senior staff act as role models, mentors and preceptors and facilitate learning with new, junior and inexperienced staff. | - Every new staff member has an identified resource person to facilitate their learning for the first 3 months of employment.  
- Staff at all levels challenge and critique practices, assumed knowledge and competence.  
- Senior nurses and clinical resource people are identifiable, available and utilised as required | - There is no evidence of role modelling, mentorship or preceptorship for junior staff.  
- Practices, knowledge and competence are never challenged.  
- Senior nurses are not available or utilised appropriately. |
| 4. Educational and information resources are readily available.              | - There is a professional library of relevant textbooks and journals that is accessed and utilised by staff  
- Staff have access to, and utilise the online clinical policy and procedure manual as required to check local policy and procedures.  
- Up-to-date hospital-wide and unit specific orientation manuals are available and accessible on the ward.  
- All staff have input into the critique, review and development of clinical policy and procedures and ward information material. | - Relevant books or other resources are not available, or utilised by staff appropriately or consistently.  
- Staff do not have computer access when required, or utilise the clinical policy and procedure manual appropriately.  
- Orientation manuals are not available, or are out-of-date.  
- Staff do not contribute to the development, review or appraisal of ward information or clinical policies and procedures. |
| 5. Opportunities for learning are utilised and reflective practice is used to learn from experiences. | - Ward nurses regularly participate in and contribute to ward rounds, case conferences, case study review and/or clinical rounds  
- An education and training program exists in every ward.  
- Incidents and errors are used as opportunities for learning from mistakes and to improve practice and consumer/patient safety  
- Opportunities for reflection are provided regularly for individuals and/or groups. | - Nurses do not participate or contribute in ward rounds, case conferences, clinical rounds or case study reviews.  
- There is no education and training program for the ward.  
- Incidents and errors are not discussed, reviewed and learnt from.  
- No evidence of reflective practice opportunities being provided. |
| 6. Skills acquisition occurs in a timely manner relevant to clinical needs.  | - All nurses are competent in core nursing skills within 3 months.  
- An agreed timeframe exists for acquisition of unit specific advanced skills development. | - Core skill competencies not meet at 3 months.  
- There is no plan for the development of unit-specific skills. |