Canberra Health Services Procedure

Dhulwa Mental Health Unit

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Purpose

This document provides local operational procedures specific to the Dhulwa Mental Health Unit (Dhulwa). Adherence to these procedures will ensure:

- Clinical practice supports the intended model of care
- Compliance with statutory responsibilities
- Adoption of evidence-based practice principles
- Practice which supports overarching, Canberra Health Services (CHS) and Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS) policy, procedures and frameworks.

Dhulwa is a 25 bed (17 commissioned beds) secure mental health facility for people with complex mental illness or people with mental illness who have or are likely to come into contact with the criminal justice system and are unable to be cared for in a less restrictive environment.

Dhulwa is an enhancement of existing mental health services provided in the ACT and is operational 24 hours a day, 365 days a year. Dhulwa is regulated and subject to the provisions of the *Mental Health (Secure Facilities) Act 2016* and governed by MHJHADS Division.

Dhulwa provides contemporary inpatient mental health services including acute care, rehabilitation programs and forensic services led by a specialist multidisciplinary team in accordance with *CHS Clinical Governance Framework 2020-2023.*

The Dhulwa team work in close collaboration with consumers, their families and carers, General Practitioners, MHJHADS, CHS, ACT Corrections, community agencies, and service providers in the private sector to deliver the highest quality, timely and appropriate care for consumer who require secure mental health rehabilitation, treatment, and care. These include intensive psychiatric treatment and biopsychosocial interventions to facilitate continued recovery and to improve their capacity to live a fulfilling and contributing life within the community.

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Scope

This document applies to all staff providing care to consumers at Dhulwa.

This document applies to the following staff working within their scope of practice:

- Medical Officers
- Nurses
- Allied Health Professionals

- Administration staff
- Security officer
- Support staff
- Students under direct supervision.

This document is to be followed in conjunction with all relevant, CHS and MHJHADS policies, procedures, and frameworks.

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Section 1 – Dhulwa as a Secure Mental Health Facility

Dhulwa is an approved mental health facility in accordance with the *Mental Health Act 2015* and has also been declared a Secure Mental Health Facility (SMHF) in accordance with the *Mental Health (Secure Facilities) Act 2016*.

All staff working in Dhulwa must be familiar with the legislated requirements as set out in the *Mental Health (Secure Facilities) Act 2016* and how they apply to daily practice within this facility.

1.1 Prohibited Items

To ensure the safety and security of consumers, staff and visitors, certain items are regulated within Dhulwa under the *Mental Health (Secure Facilities) Act 2016*.

All staff are to be familiar with or refer to the *Dhulwa Mental Health Unit: Prohibited and Restricted Items and Items Requiring Approval Procedure* which identifies prohibited and restricted items and outlines the requirements for managing these items in Dhulwa.

The *Dhulwa Mental Health Unit: Prohibited and Restricted Items and Items Requiring Approval Procedure* has been issued by the CEO as a SMHF Direction which requires all workers at Dhulwa to adhere to the mandatory procedure.

1.2 Directions to Workers

Section 10 of the *Mental Health (Secure Facilities) Act 2016* determines that in order to ensure the security and good order of Dhulwa as a SMHF, the person in charge of a SMHF may direct a worker at the facility to give the assistance that the person in charge believes on reasonable grounds is necessary. The Person in Charge of the facility is the Assistant Director of Nursing or after hours the most senior nurse on the unit.

The worker must comply with this direction.

If the person in charge of a SMHF directs a worker who is an authorised person (security officer) to assist an authorised health practitioner in a clinical area of the facility,the person in charge must:

(a) make a written record of the direction; and
(b) make the record available for inspection by the CEO

1.3 Visitors

All staff must be familiar with and refer to the *Dhulwa Mental Health Unit: Visitors Procedure* which provides staff with information regarding the processes in place to support safe and therapeutic visits to consumers at Dhulwa. The Procedure includes the visiting conditions, requirements for entry and the process of a visitor attending Dhulwa to visit a consumer.

1.4 Search

All staff are to be familiar with and refer to the Dhulwa Mental Health Unit *(Dhulwa): Searching Policy and Procedure.*

The Dhulwa Mental Health Unit: Searching Policy has been issued by the CEO as a SMHF Direction which requires all workers at Dhulwa to adhere to the mandatory policy.

1.5 Use of Force

All staff are to be familiar with and refer to the *Dhulwa Mental Health Unit (Dhulwa): Use of Force Procedure.*

The *Dhulwa Mental Health Unit: Use of Force Procedure* has also been issued by the CEO as a SMHF Direction which requires all workers at Dhulwa to adhere to the mandatory procedure.

1.6 Security

As Dhulwa has been declared a SMHF there are several policy and procedural documents that are confidential in nature and are not available to staff on the CHS Policy and Guidance Documents Register.

The restricted documents listed below apply to all staff working within Dhulwa:

- Dhulwa – Perimeter Security Policy and Procedure
- Dhulwa – Escape and Abscond Procedure
- Dhulwa – Escort – Role of Security Procedure

Further information about the documents listed above please contact the following:
Assistant Director of Nursing – Secure Mental Health Services
Phone: 5124 1851

All staff working in Dhulwa must be familiar with the

- Dhulwa Operational Model of Care,
- Dhulwa Security Procedural Framework,
- Relevant CHS and MHJHADS policies and procedures.

The safety and security framework operating principles adopted within Dhulwa relate to environmental, procedural and relational security.

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Section 2 – Referral and Admission to Dhulwa

All staff are to be familiar with and refer to the *Dhulwa Mental Health Unit (Dhulwa) Referral, Admission and Transfer of Care Operational Procedure, Dhulwa Operational Model of Care* and the *Dhulwa Consumer Handbook.*

A consumer can be referred to Dhulwa using the *Referral for Admission to Secure Mental Health Inpatients* available from the electronic clinical database. All referrals prior to admission are considered though the Assessment and Admissions Panel (AAP) which occurs weekly or as required.

Note: It is highly recommended that the referrer consults with a member of Dhulwa Management Team (UMT), by telephone on 512 41851, prior to making a referral.

The referral must have the support of the consumer's Multi-Disciplinary Team (MDT) prior to submission.

2.1 Patient Identification

For any health care activity to be undertaken, the patient must be identified by a staff member who can confirm the patient's identity **using 3** of the following **patient identifiers**:

- Full Name
- Date of birth
- Address
- Medical Record Number (MRN) allocated by the ACT Patient Administration System (ACTPAS)
- Photographic Identification

Dhulwa utilises Photo Identification as the primary form of identification. Prior to taking a person's photo, staff are required to seek consent from a consumer and explain the following:

- They are being asked to confirm their identity as a measure for their safety so they do not receive the incorrect care, therapy or service
- How photos will be used, stored, and disposed of

Consumers have the right to decline providing photo identification. In this event staff should:

- Document in the Electronic Clinical Record (ECR) the person declined the request and the reason they gave

All procedure matching identification must be in accordance with the: *CHS Patient Identification and Matching Procedure* and *CHS Photo, Video and Audio Capture Storage Disposal and Use Procedure*.

2.2 Role of Staff During Admission

The admitting nurse is responsible for ensuring the admission process is complete, and will:

- Greet and orientate the person to Dhulwa, provide an explanation of the unit and provide a copy of the Dhulwa Consumer Booklet
- Explain the admission documents to be completed, including the searching of the person's belongings, complete physical observations, and the introduction of other staff
- Update the persons ECR and ACTPAS

The Allied Health staff will:

- Provide information about the therapeutic groups and individual support at Dhulwa
- Social Worker - contact guardian, family, carer, nominated person or any other significant support person to introduce themselves and organise a family meeting
- Occupational Therapist - identify a suitable time to undertake a functionalassessment to inform functional needs of the therapy program
- Psychologist - identify a suitable time to conduct appropriate psychological and cognitive assessments to inform psychological and cognitive needs of therapy program
- Provide any dietary information to the kitchen

The Medical team will:

- Psychiatry Registrar undertake a comprehensive assessment to identify any critical elements of care and treatment. The assessment must be documented in recorded in the consumers ECR
- Complete Clinical Risk Assessment - Initial (CRA) form and medication charts including prescribing adequate PRN medication
- Complete physical health assessment and relevant medical examination of a consumer within 48 hours of their admission. If a medical examination is not possible at the time of admission (e.g. if it would be distressing to the person to undergo a physical examination due to his or her mental state, or if a person refuses), the reason should be clearly stated in the person's clinical notes and ECR, including any relevant observations documented. Continued attempts should be made where possible to undertake the physical health assessment and examination

The Administration team will:

- Update ACTPAS indicating which room the person is allocated to and the demographics such as Guardian, nominated person, current General Practitioner, mobile telephone number and change of address to Dhulwa Mental Health Unit
- Ensure relevant admission forms are available and completed by all stakeholders
- Ensure property and valuable forms are completed and uploaded to a consumers ECR
- Provide the admitting nurse with and admission folder and patient identification labels

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Section 3 – Inpatient Care

3.1 Person Centred Care (PCC)

Dhulwa recognises the importance of the consumers, their families, carers and nominated others, working together with clinicians and acknowledge these relationships are imperative to support optimum clinical outcomes and recovery.

Dhulwa staff will adopt a PCC approach through the demonstration of compassionate care, considering care that is respectful and recognises the individual needs of consumers. This will be demonstrated through:

- Acknowledging that the lived experience of a consumer is central to their recovery and provide an environment that enables consumers to direct their lives and meet their needs as they have identified
- Shared decision making with consumer and the multidisplinary team
- Considering and responding to the consumer's expressed needs, values, family situations, social circumstances, and lifestyle
- Providing care that is tailored to the consumer's preferences, life circumstances and aspirations, and to their family and or personal supports
- Acknowledging, respecting, and addressing the elements that affect a person's wellbeing including personal beliefs, cultural background, values, social and family contexts, physical health, housing, education and employment

3.2 Culturally Responsive Care

Culturally responsive care is an extension of person-centred care that focuses on the social and cultural factors that enables therapeutic interactions with people from different cultural backgrounds. Culturally responsive care requires all clinical and non-clinical staff to engage in regular self-reflection and be proactive in responding to the social, emotional and cultural needs of consumers, family and their community.

Culturally responsive care at Dhulwa for consumers from culturally and linguistic diverse communities will be taken into account during assessment, when planning recovery goals and throughout their treatment and care at Dhulwa. This will include but is not limited to their cultural, religious, dietary, social, sexual identity and communication needs. To promote best practice and collaborative care, referrals to culturally appropriate services will be initiated by the MDT.

Consumer's who identify as being of Aboriginal and Torres Strait Islander background will be offered a referral to an Aboriginal and Torres Strait Islander Liaison Officer (ALO) by the treating team. If a consumer consents to the referral, the ALO will work collaboratively with the treating team to support the consumer and their family. This support may include but is not limited to:

- providing well-being services
- helping the consumer connect with their culture and their community
- facilitating cultural security and safety and providing education to staff on this

- supporting Women's/Men's Business (gender dependent)
- providing cultural understanding for staff working with Aboriginal and Torres Strait Islander peoples in the unit
- providing and facilitating access to early intervention services to aid disease prevention and health promotion
- providing an understanding of local community
- supporting education activities
- supporting ward or community day program groups and activities
- providing a holistic and team approach to health care

Dhulwa staff can contact the MHJHADS ALO Team to make a referral or consult with the ALO staff regarding cultural matters through email to: CHS.ALO-MHJHADS@act.gov.au.
or via telephone: ALO for Justice Health Services 0435 967 353

3.3 Gender Sensitive Practice

Gender is a key marker of identity and a strong predictive factor connected to health and wellbeing outcomes. The expression and experience of mental health issues can thus be understood in the context of gender. This 'gendered' understanding relates to risk factors, prevalence, manifestations of symptoms, experiences of symptoms and effects of treatment.

Gender-sensitive practice is informed by knowledge and understanding of differences, inequalities and varying needs of consumers and the interrelationship of gender identity with:

- childhood and adult life experiences such as trauma and/or abuse histories and experiences of discrimination
- day-to-day social, family and economic realities such as poverty, housing situation and primary care of children
- expression and experience of mental health and/or alcohol and drug issues
- pathways to services, treatment needs and responses such as help-seeking behaviour and the type of service sought
- cultural and community background, and
- physical health issues such as risk factors and responses to medication

Lesbian, Gay, Bisexual, Transgender or Intersex Individuals (LGBTI)

LGBTI individuals have been subject to increased social exclusion, bullying and violence, which may contribute to poorer mental health for some people.

The National LGBTI Mental Health and Suicide Prevention Strategy (2017) states that:

- LGBTI people and communities experience stigma, prejudice, discrimination, abuse, violence, isolation and exclusion associated with their genders and bodies
- This is coupled with the expectation that these experiences may happen at any time, creating a hostile and stressful social environment that impacts on mental wellbeing
- These experiences form a compounding factor in the strong links between mental illness and suicidal behaviour; social and economic circumstances; and key risk areas

- Key risk areas include stressful life events, unemployment, insecure housing, chronic illness, alcohol and substance use, and experiences of trauma or abuse
- Such experiences, in conjunction with existing predisposing risk factors, result in lesbian, gay, bisexual, transgender and intersex people having a heightened vulnerability to various mental health issues, in particular depression and anxiety, as well as an elevated risk for suicidal ideation

Dhulwa Mental Health Service recognises the challenges associated with providing treatment, care and support that is sensitive to consumer's gender identity and sexual orientation within a mixed gender ward. Dhulwa staff will provide, treatment, care and support for all consumers residing at Dhulwa, inclusive of their gender identity and sexual orientation.

To promote treatment, care and support that is responsive to all consumer's gender identities and sexual orientations, all Dhulwa clinical staff will:

- undertake professional development activities to ensure current knowledge of best practice gender sensitive care is incorporated into routine practice. This training may include:
  - working with families and carers
  - delivering trauma informed care
  - violence risk assessment guidelines
  - working with lesbian, gay, bisexual, transgender and intersex consumers
- reflect on how practice can accommodate consumer's needs and preferences in relation to their gender identity and sexual orientation in order to support consumers to feel safe and to optimise their wellbeing
- seek professional supervision that encourages reflective practice in relation to gender sensitivity and safety, and sexual orientation
- participate in team meetings that consider how to best meet a consumer's individual needs including culturally-appropriate practice in engaging with people from specific cultures, and interpretation of cultural identity with respect to gender, gender identity and sexual orientation.

Staff gender mix will be considered in rostering and all efforts will be made to ensure that the gender of staff working with consumers is appropriate for the individual needs of consumers and the mix of consumers at Dhulwa at the time

3.4 Recovery Focused Care

Recovery focused care provides support to consumer's to optimise wellbeing and live meaningful and valued lives in the community. All members of the MDT will use the person's recovery goal in allaspects of treatment, care and discharge planning.

Dhulwa promotes consumer recovery by:

- Recognising of and complying with human rights legislation
- Creating a culture of optimism, healing, empowerment, and inclusion

- Valuing and being responsive to the uniqueness of the consumer, their circumstances and their hopes and challenges
- Investing in positive engagement and the therapeutic relationship
- Instilling hope and being sensitive to the consumer's priorities
- Building on the consumer's strengths and encouraging participation and choice in treatment, care, and support
- Promoting personal responsibility, effectiveness, and self-determination, by encouraging the consumer to take the lead in their recovery
- Providing effective treatment, care, and support, informed by evidence and being responsive to the consumer's needs, goals and preferences
- Listening to the expertise gained from lived experience and working in partnership with the consumer and their carers
- Promoting and protecting the rights of consumers on an individual level as well as working with communities to reduce the stigma and discrimination associated with mental illness
- Acknowledging the role that families and carers play and involving them appropriately in the care and treatment process
- Responding to and anticipating physical health care needs of the consumer

3.5 Protected Engagement Time (PET)

Protected Engagement Time (PET) provides opportunity for nursing staff within the acute mental health setting to develop therapeutic and purposeful relationships with admitted consumers. PET provides a fixed period each day where nursing staff are able to focus on individual contact and a genuine working partnership with a consumer admitted to the unit.

Dhulwa has two protected engagement times per day, 7 days per week.

- 1100 hrs - 1145 hrs (45 mins)
- 1530 - 1615 hrs (45 mins)

3.6 Individual Care Planning

Individual care plans are used to actively engage the consumer in their care by the identification of their own, individual recovery goals. Care planning will commence on transfer into Dhulwa and will be reviewed and discussed at each case review. Strategies and interventionswill be clear, specify a target date for completion and identify a member of the MDT or service responsible for actioning clinically and therapy led items. Individual care plans will be guided by the MDT but will be led, developed, and maintained in collaboration with the consumer, nominated persons, carers and or family members.

The Treatment Placement Restrictions Implementation Monitoring (TPRIM) is the primary care planning document used in Dhulwa that informs the bio-psychosocial and physical needs of the consumer and is used when reviewing consumer management. It's a component of the Clinical Risk Assessment and Management (CRAM) framework and used as a risk management plan.

Person Specific TPRIMS are developed in Dhulwa and are individual, working documents which are regularly updated by the treating team. A TPRIM reflects a consumer's progress and treatment plan, and considers the following:

- **Treatment** – the biological, psychological and social treatment interventions
- **Placement** – determining the location of treatment provision and decision making to ensure the least restrictive alternative is used and this is balanced withenabling safe delivery of care for a person
- **Restrictions** – referring to any constraints that might be required to keep the consumer safeand reduce opportunity for harm to others. Restrictions may include or be influenced by:
  - Legislation or legal orders
  - Environmental factors
  - Personal factors
- **Implementation** – identifying who is responsible for implementing the elements of the plan
- **Monitoring** – determining what needs to be monitored, by whom and when.
- **Review** – identify when, how and who will be involved in reviewing the plan

3.7 Mental Health Deterioration

- All staff must be familiar with Canberra Health Services Occupational Violence Strategy 2020 - 2022
- Identification, Mitigation and Management of Aggression and Violence for MHJHADS Procedure.
- CHS Seclusion of Persons with Mental Illness or MentalDisorder Detained under the Mental Health Act Procedure

All Dhulwa staff will be trained in the CHS endorsed Occupational Voilence prevention training (OV). OV training will be delivered by either Dhulwa Clinical Development Nurses or in collaboration with CHS accredited trainers and registered in Capabiliti once training is complete.

Mental health deterioration of the consumer may become evident through an increase in Dynamic Appraisal of Situational Aggression (DASA) scores or an acute episode of agitation and distress which requires immediate clinical intervention. In the instance a consumer exhibits an acute deterioration of their mental health or behaviour a management plan will be developed in order to effectively manage the deterioration and ensure consumer and staff safety.

All staff are responsible to ensure the appropriate management and or an escalation of resources and clinical support to prevent potential episodes of consumer aggression or violence. The expertise of allied health, nursing and medical staff should be utilised through the MDT when seeking to address the complex issues relating to the prevention and management ofaggression and violence of a consumer.

When staff have concerns of a consumer's behaviour is becoming increasingly disturbed or there are issues of clinical concern, it is an expectation that they be supported by their colleagues in escalating these concerns to other more senior members of the treating team. Their concerns must be proactively followed up in a timely manner by the implementation of a multidisciplinary review of the treatment plan as a priority.

Identify, Situation, Background, Assessment and Recommendation (ISBAR) principles must be used in the verbal and documented hand over of any clinicalconcerns, refer to *CHS Clinical Handover Procedure*. In addition, details of risk assessment observations, the use of prescribed medications and clinical interventions for the consumer should also be outlined.

Consumer's presenting with deteriorating mental state and complex behaviours will require a MDT review. Where concerns cannot be resolved at the team level, this process can be escalated through a Complex Treatment and Recovery Forum facilitated by the Clinical Director, Assistant Director of Nursing, Team Leader, Clinical Nurse Consultants, Allied Health Team and the relevant Community Recovery Service clincians. This forum will provide peak clinical decision making and oversight of the revision of the treatment and recovery plan for consumers presenting with complex and challenging dimensions to their clinical care and recovery.

Additional nursing support can also be requested through the Assistant Director of Nursing /After Hours Hospital Manager. *Refer to Increased Nursing Patient Care and or Supervision Procedure.*

3.8 Physical Health Deterioration

Staff at Dhulwa will provide consistent evidence based physical health care to consumers of Dhulwa Mental Health Unit and will ensure:

- A consumer's acute physical health care needs are identified, assessed and managed in a timely and effective way, and
- A consumer's have their ongoing physical health needs identified, assessed and managed in accordance with the *Dhulwa Mental Health Unit (Dhulwa) – Provision of Physical Health Care Procedure*

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Section 4 – Clinical Risk Assessment and Observation and Management

In a mental health setting, there are many risks that can be identified, mitigated, and managed with comprehensive clinical risk assessment and management procedures. The risks include self-harm, suicide, victimisation, reputation, non-adherence to treatment and violence and aggression.

Clinical risk assessment is a continuous process which forms an integral part of clinical care and risk management at Dhulwa. It is a task that is completed on an ongoing basis and not at

a singlepoint in time. A structured approach to risk assessment improves the reliability of decisions regarding risk management based on those risk assessments. The risk assessment is used to determine factors that may indicate risk level and assist with the development of the realistic risk management plan that can be implemented.

Clinical Risk Assessment and Management (CRAAM) – A Practical Manual for Mental Health Clinicians is an online resource for mental health clinicians working in a secure setting and provides practical guidance for the risk assessment process and the development of a risk management plan.The manual can accessed via
http://www.justicehealth.nsw.gov.au/publications/handbook-february-2011.pdf
This procedure is adapted from these guidelines.

Additionally, all Dhulwa staff must be familiar with the MHJHADS Procedure *Identification, Mitigation and Management of Aggression and Violence for MHJHADS* .

Risk assessment should maximise the involvement of consumers, carers, and nominated persons.It should emphasise strengths, protective factors, positive risk-taking and recovery. A recovery oriented mental health service balances, and supports, opportunities for positive risk taking by consumers whilst considering duty of care and risk of harm to self and others. Decisions are made with the aim of improving the consumer's quality of life and the recovery journey. Dhulwa clinical staff must remain aware of the safety needs of the consumer, their carer, family and friends, and the public.

As part of the CRAAM process, positive risk taking:

- is part of a carefully constructed plan that is developed through a collaborative approach.
- involves making decisions based on knowledge of research evidence, knowledge of the consumer's own experiences, clinical risk assessment and clinical judgment.
- involves using available resources and support to achieve the desired outcomes, and to minimise the potential harmful outcomes.
- includes decisions that carry some risks. This should be explicit in the decision-making process and will involve working with the consumer and /or their carer/nominated person

All agreed plans for positive risk taking are to be documented in the consumer's ECR and TPRIM.

4.1 Risk Assessment Tools

Clinical Risk Assessment (CRA) forms are available on the CHS Clinical Forms Register.

The admitting Medical Officer will complete the initial CRA with the consumer and their support person(s) on arrival to the Dhulwa. If the medical officer is not available to participate in the initial assessment, the CNC or the NiC will review all relevant pre-admission information including the risk assessments completed by referring agency and

complete the CRA. The medical officer will review the consumer and complete a CRA as soon as possible.

The CRA completion process will be explained during the admission procedure and throughout the consumer's stay in Dhulwa. Where the engagement and involvement of the consumer is not possible the issue of assessment confidence needs to be considered. Low assessment confidence requires a reassessment of risks within 24 hours.

Revised CRA forms are available on the CHS Clinical Forms Register. Revised CRAs are completed regularly throughout the consumer's admission and should reflect any changes to risk according to their presentation. Risk assessment can be revised by any member of the treating team in accordance to process outlined in section (e) Change of Risk Category on the form. These assessments should involve the consumer and when possible,family/ carer/ nominated person / advocate, and be completed at the following times:

- At MDT reviews
- Daily for consumers who have been managed in the de-escalation area within the last 24 hours or for anyone requiring one-on-one nursing care
- With any increase in DASA scores
- At any time risk factors are perceived to have changed, including feedback orinformation from families and carers
- Where the clinician believes there is a lowlevel of assessment confidence in the last assessment – low levels of assessment confidence need to be documented in the clinical file
- Whenever a consumer who absconded returns to the unit
- When a consumer is transferred between Cassia to Lomandra due to deterioration in mental state
- Observation of unusual or concerning consumer behaviours by staff
- Pre-Discharge

There are several approaches to formalised risk assessment which have been adopted by Dhulwa for the assessment of potential consumer aggression and violence. These include but are not limited to:

- Dynamic Appraisal of Situational Aggression: Inpatient Version (DASA-IV)
- HCR-20 (Historical, Clinical, Risk 20 item checklist) and
- Anamnestic Assessment are used as tools to assess for risk of violence

The completion of these assessments assists in the formulation of a CRAAM Plan and inform the required level of clinical observation and engagement which need to be prioritized by inpatient staff.

For further information on these risk assessment tools please refer to Clinical Risk Assessment and Management – A Practical Manual for Mental Health Clinicians see link above.
Current risk assessment tools for the identification and management of aggression and violence as adopted within Dhulwa includes:

4.2 Dynamic Appraisal of Situational Aggression: Inpatient Version (DASA-IV)

The DASA-IV is a seven-item risk assessment tool to assist identifying consumers at risk of aggression within the next 24 hours. The seven items are as follows:

- Irritability
- Impulsivity
- Unwillingness to follow instructions
- Sensitive to perceived provocation
- Easily angered when requests are denied
- Negative attitudes
- Verbal threats

The DASA-IV is located in the Q: Drive must be completed by a clinician who has been trained in the use of the tool and who is familiar with the current presentation of the person being assessed.

Refer to Attachment 1 for a sample DASA-IV Form and the Clinical Risk Assessment and Management –Voilence and Aggression for further information about DASA-IV

4.3 The Historical-Clinical-Risk Management-20 (HCR-20 ^{V3})

The HCR-20 ^{V3} is a 20-item checklist located in the Q: Drive that is used to assess an individual's risk for violence and other problem behaviours in forensic settings. HCR-20 ^{V3} assesses both static and dynamic risk factors associated with an increased risk of violent recidivism. The HCR-20 ^{V3} allow the assessors to utilise a range clinical information sources to determine the presence of past, recent, or potential future problems with identified risk factors which may be a feature of their history, clinical presentation, or context/situation. The The HCR-20 ^{V3} will be completed within six to eight weeks following the admission of a forensic consumer and reviewed if there is a change in their risk profile and prior to discharge.

The HCR-20 ^{V3} must only be completed by a clinician who has been trained in the use of the HCR-20 ^{V3} tool or under the supervision of a clinician who has been trained in its use.

A decision will be made by the MDT about the use of additional assessments based on individual clinical need. The use of the HCR-20 ^{V3} may be complemented using other relevant assessments including the SAPROF (Structured Assessment of Protective Factors for violence risk) and PCL-R (Psychopathy Checklist - Revised). In addition, specialist assessments of personality, sexual offending risk, stalking risk, or arson risk may be utilised. A decision will be made by the MDT about the use of additional assessments based on individual clinical need.

4.4 Anamnestic Assessment

Anamnestic assessment involves a detailed review of previous incidents of violence and aims to identify common factors and patterns. The analysis will assist in ensuring the risk

management plan for each consumer addresses the person's individual needs and vulnerabilities.

The Anamnestic assessment will utilise the 5W's format and be completed after each incident of violence and or seclustion and restraint. A 5W's report is to be completed in the consumer clinical record as a file note with 5Ws at the beginning of the file title.

For each episode of aggression consider:
- When the episode occurred
- Where it occurred
- Who the victim(s) were (role, age, sex, and relationship)
- What behaviour they engaged in and what the consequences were
- Why they engaged in the behaviour

This information could also be included in the Riskman Clinical Incident report form. Refer to Clinical Risk Assessment and Management – A Practical Manual for Mental Health Clinicians for more information.

4.5 Suicide Vulnerability

All Dhulwa staff must be familiar with the MHJHADS *Initial Management, Assessment, and Intervention for People Vulnerable to Suicide* Procedure which can be found on the CHS Policy Register and the Suicide Vulnerability Assessment Tool (SVAT) to assess a consumer's suicide vulnerability.

Dhulwa staff are expected to have fully familiarised themselves with the appropriate suicide prevention tool and attended the divisions suicide intervention training (or equivalent) prior to working with potentially vulnerable persons. Until such time that the Connecting with People system has been incorporated into MHJHADS procedures, all clinical staff of MHJHADS must use the SVAT to document their assessment of a person's suicide vulnerability.

The SVAT can be found in the ECR and on the Clinical Forms Register.

A comprehensive risk assessment must be conducted at the following times:

- Admission
  - Interim risk assessment of the consumer must be completed on the Dhulwa Admission Assessment form and TPRIM. Both forms are available on the Clinical Forms Register
  - DASA-IV must be completed daily for a consumer by a clinician who has been trained in the use ofthe tool and who is familiar with the current presentation of the consumer being assessed
  - The HCR-20 V3 will be completed for forensic consumers within six to eight weeks of admission

- Review
  - At each MDT ward round the consumers TPRIM must be reviewed and updated
  - The HCR-20 ^{V3}, SAPROF and TPRIM for a consumer will be reviewed and updated at each Individual Case Review meeting, held every 3 months, with full risk HCR-20 ^{V3} and SAPROF risk assessments formally conducted every 6 months. All risk assessment tools and documents can be reviewed at any time if clinically indicated

- **Application for Leave** – if MDT is considering a consumers application for community leave, a risk assessment must be completed and the TPRIM must be updated identifying how the plan (incorporating the management of identified risk factors) can be safely implemented and included as part of the leave application

- **Reports** – prior to the preparation of reports for the ACT Civil and Administrative Tribunal (ACAT) or other body, a risk assessment must be completed and the TPRIM updated

- **Discharge Planning or Transfer of Care** – when recommending the discharge or transfer of care of a consumer to another setting, a risk assessment must be completed and the TPRIM updated identifying how the Treatment & Management Plan (incorporating the management of identified risk factors) can be safely implemented in the proposed environment

4.6 Observation

Engagement and interaction are a clinically valid, therapeutic tool utilised to manage, contain, and more accurately monitor issues of risk. In a mental health setting, CRAAM guidelines are adopted to reinforce this important concept using therapeutic engagement and observation throughout admission to hospital, based on assessed level of risk and principal risk concern(s).

General principles of Consumer Observation and engagement in Dhulwa are as follows:

- All consumers within Dhulwa must have a document level of observation in their Treatment, Placement, Restrictions, Monitoring Plan (TPRIM), at all times, consistent with their current mental state and level of assessed risk
- Observation is a process that ensures monitoring of and engagement with consumers and should be purposeful and therapeutic
- There may be times when a consumer requires more intensive observation to ensure their safe management e.g. when there is an increased risk of harm to self or harm to others,or during times of increased distress
- If a consumer's observation level is increased, the reasons for the observation level, a clear instructions of the actions required by AIN/EN/RN staff during observation and reviews of the observation level must be documented in the consumer's ECR
- Observation times should always be staggered, i.e. five minutes before or after the hour, to prevent consumers predicting them

- Consumer observation can be intrusive and impinge on the rights and dignity of the person.Observation should be set at the least restrictive level, for the least amount of time within the least restrictive setting
- The consumer's privacy, rights, dignity and autonomy should be fully maintained where possible and consistent with safe and effective care with an understanding of the actions required when there is an escalation of risk. This should include:
    - ensuring gender and cultural sensitivity is maintained, along with sensitivity to previous traumatic experiences, and
    - making provisions for any special needs the consumer may have, wherever possible, e.g.any physical limitations or disability
- The consumer and their Primary Carer/Nominated Person should be provided with a clear explanation of the rationale for the level of observation assigned to them and indications of what would reduce their level of observation, e.g. reduction in distress, reduced risk ofharm to self or others, increased safety
- A MDT approach should be taken when developing TPRIM plans, including the level of observation and engagement of the consumer
- Risk management plans should be thoughtful and considerate of the consumer as an individual and will be determined by the consumer's mental state. The risk should be welldocumented in the consumer's ECR
- Whenever possible the consumer should be included in the decision to alter their level of observations. Risk assessment will inform development of the TPRIM and must be conducted in line with the *Identification, Mitigation and Management of Aggression and Voilence for MHJHADS* and the Clinical Risk Assessment and Management (CRAM)
- Observation of consumers in seclusion must be in accordance with the MHJHADS Seclusion of Persons with Mental Illness or Mental Disorder Detained under the Mental Health Act Procedure

All consumers in Dhulwa require general observation (see definition of terms) unless a different observation level as been assigned by the MDT. Hourly observations are the minimum acceptable level of observation for a person admitted to Dhulwa. Refer to CHS *Vital Signs and Early Warning Score Procedure*.

The consumer's allocated nurse must always know the location of the consumer. General observation should be established as part of unit routine and performed regularly by the consumer's allocated nurse as part of their everyday practice to maintain thesafety of consumers.

Continual observation (see definition of terms) should be used for consumers considered to pose a significant and imminent risk to self and/or others. Continual observations require a minimum 1:1 AIN/EN/RN staff as determined by the MDT.

The AIN/EN/RN must visually observe the consumer all times. Respect for privacy should be an important consideration but safety is priority in all matters such as escorting the consumer to the toilet orbathroom, for example.

The AIN/EN/RN must not leave the consumer unsupervised under any circumstances or for any period, no matter how short. If the staff member needs to complete another task or go on a break the observation role needs to be handed over to another staff member.

The consumer must be managed in a highly visible area of the unit. Staff providing continuous observation during normal sleeping hours will sit outside the consumers bedroom, with the bedroom door open. The allocated staff should be relieved at regular intervals or have another staff with them to prevent isolation. The MDT may recommend increasing the number to two AIN/EN/RN, depending on the risk i.e. self-harm or risk of violence.

4.7 Special Observations One:One or at arm's length

Special Observations (see definition of terms) are implemented when the consumer is at very high immediate risk and cannot be safely managed on Continuous Observations. The consumer should always be within arm's reach of a member of staff under all circumstances. Special Observations require a minimum 1:1 AIN/EN/RN allocation as determined by the MDT.

The allocated AIN/EN/RN must not leave the consumer under any circumstances or for any period, no matter how short. If they need to complete another task or have a break they must hand over the observation role to another staff member.

Special Observation is intrusive and should only be used when considered necessary by the MDT.

The consumer must be clinically assessed as requiring intensive and skilled intervention due to significantly elevated level of risk.
Respect for privacy of the consumer should be an important consideration but safety is priority in all matters such as escorting the consumer to the toilet or bathroom, for example.

Where a consumer requires nursing care in their bedroom, e.g. overnight or if they are sedated due to medication, careful consideration should be given concerning gender, culture, and associated risks.

The consumer assigned special observation will not have access to leave, unless during an emergency. In such situations a minimum of two staff must be in attendance with the consumer to facilitate escort. Leave is restricted to external medical leave.

4.8 Review of Observation Levels

The MDT, in consultation with the Consultant Psychiatrist or on-call Psychiatry Registrar (after hours) must review and document the review of the consumer's level of observation for consumers on increased, continual, or special observation at least every 24 hours. This review must include documenting the continued need for this level of observation or alternative management strategies.

Any change to the consumer's observation level must be implemented immediately.

4.9 Documentation

- A consumer's observation level must be documented in their electronic clinical record and TPRIM
- DMHU Daily Visual Observations form, located on clinical forms register, must be used to document consumer's observations throughout the day
- Both the relieved AIN/EN/RN and the AIN/EN/RN commencing observations must sign the Daily Visual Observation form at the time of handing over responsibility for observation of the consumer
- The following need to be documented in the consumer's clinical record:
    - For consumerss on general observations, observations must be documented once per shift at a minimum and more frequently if there are significant changes in the consumer's presentation
    - Alterations to the consumer's mental state, activities and any interactions.
    - For consumers on increased, continual or special observations, observations must be documented every two hours
    - Significant aspects of the consumer's mental state, activities and any interactions.
    - An increase in a consumer's observation level, including the reason for and duration of increased levels of observation
    - A decision to reduce a consumer's level of observation, including the rationale for this decision, must be fully documented by the Consultant Psychiatrist or the on-call Psychiatry Registrar or on-call Dhulwa Consultant Psychiatrist (after hours)

4.10 Environmental Safety Checks

The purpose of Environmental Safety Checks (ESC) is for staff to observe for any items that could lead to self-harm. As well as prohibited items these checks also assess for ligatures and or ligature points and items such as torn articles of clothing, torn linen/blankets/towels, sharp objects, non-prescription and illicit drugs, drug paraphernalia, cigarettes, tobacco, alcohol, cigarette lighters, knives, plastic bags, glass objects, razor blades and any damage, tampering to fittings and changes in the immediate environment that may increase potential for self-harm and suicide attempt.

While ESCs are completed on each shift, there will arise occasions where opportunistic actions are taken by staff in order to manage items that can be used for self-harm. All additional checks need to be well integrated within the overall patient safety, clinical risk and Risk Management Systems.

Completed ESCs are to be used at clinical handover as part of the ISBAR staff communication system. They are also an appropriate source of collateral information to inform the Clinical Risk Assessment process and the review of ARC observation levels.

Any risks identified are to be notified to the CNC or the Nurse-In-Charge Shift (NICS), documented in Riskman and in the medical record, and include documentation of action(s) taken to reduce the risk of harm. Information in ESCs is collated by the CNC and used as part

of the unit's clinical governance and risk reporting systems and staff line management system.

Significant findings such weapons and suspected illicit substances etc must be reported to the Assistant Director of Nursing during business hours and after hours to the afterhours hospital manager/executive director on call.

Door pressure sensors are fitted on all ward bedrooms and toilets in the Dhulwa. The sensors will be triggered when a weight greater than 15 kilograms is exerted. All Dhulwa staff and a Security Guard will respond immediately to the activation of a door pressure sensor alarm.

All Dhulwa staff must ensure they are familiar with the *CHS Clinical Procedure Ligature Risk Management for MHJHADS Inpatient Mental Health Units* and *CHS Clinical Procedure, Ligature use in Inpatient Mental Health Units: Response and Management Procedure.*

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Section 5 – Medication

Medications prescribed by the medical team are done so with the expectation that they will be taken by the consumer.

Note: When a consumer does not follow the agreed medication treatment plan (including refusing medication or attempting to hide medication) the treating team must be informed as soon as possible .

Non adherence with medication treatment by a consumer must be documented in electronic clinical record and include a plan to manage the nonadherence. This must be included in the clinical hand over from one nursing shift to the next. Refer to CHS *Clinical Handover Procedure*.

See *CHS Medication Handling Policy* for more information about prescribing, administering or managing consumer medications.

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Section 6 – Therapy Space

Information about the use of equipment, tools and materials in each therapy space is available from the respective therapy space manual, located in the therapy space.
In some circumstances posters on display in the room may also be used as an easy reference for example, hand washing in the Activities of Daily Living (ADL) Kitchen.

Dhulwa therapy spaces include:

- ADL Kitchen
- Barbeque Area
- Dining rooms
- Group Activity rooms
- Gymnasium
- Multipurpose Room
- Sensory Modulation Room
- Electronic Communication area

Dynamic clinical factors may govern the decision to approve a consumer's participation on a given occasion (i.e. leave, mental state, DASA score, TPRIM updates and group mix).
The dynamic factors will be assessed by the staff member facilitating the activity on each occasion prior to providing access to the therapy space. The decision on accessing the therapy space will be determined by the NiC

Prior to commencing an activity, staff responsible for supervising the activity should:

- Be aware of the consumer's TPRIM Plan and current mental state of each consumer considered for an activity
- Check the space for any hazards, e.g., restricted items and items requiring approval

6.1 Booking Therapy Spaces

6.1.1 On-ward Therapy Group Rooms

Activities and programs scheduled in the on-ward group activity rooms will be documented on the Dhulwa timetables, located on the staff station noticeboard and community noticeboards. If there is no activity scheduled in the space the rooms can be accessed and used as required with the prior approval of the NiC.

6.1.2 Off-ward Therapy Spaces

Activities and programs scheduled in each therapy space will be documented on the relevant therapy space timetable, located on the door of the space and on the community noticeboard.

If there is no activity scheduled in the space, a member of staff may use the space with a consumer after first seeking approval from the staff member responsible for the space or Dhulwa Allied Health Manager.

6.1.3 Electronic Communication Area

The *Mental Health (Secure Facilities) Act 2016* enables consumers admitted to Dhulwa to use electronic communication as a form of contact. A specific electronic communication area has been identified where consumers are to be supervised at all time in the dedicated area.

As electronic communication is a form of contact with family, friends and other people, contact limitations may be applied to the individual consumer's computer profile.

Usage of the electronic communication area is to be booked in advance.

6.1.4 Games Table

The therapeutic games table is in Cassia Unit provides consumers with the opportunity to engage in a sporting activity with their peers, enjoy a variation in their structured activities and to promote cognitive, motor, perceptual and socialisation skills.

A range of equipment is to be stored in the nurse's station or in locked cupboard or equipment bench. There may also be a range of miscellaneous equipment available in games room that these guidelines may or may not be applicable to. Resources currently available include:

- Pool table
- Cue stick
- Balls
- Chalk
- Triangle cover
- Kelly Pool numbers
- Table Tennis cover
- Table tennis bats, nets and balls.

6.2 Time frames

The therapeutic spaces can be accessed outside of core activity times between 1.30pm and 6.30pm. Access during core activity times is approvedby the NiC.

6.3 Documentation/Record keeping

- Completed audit checklists must be maintained by the supervising staff using the therapeutic games table and stored in the Q:Drive
- Any consumer who is eligible to access the therapeutic games table must be always supervised during the session
- Individual outcomes/comments/ participation must be documented in consumers ERC .
- Increased staffing requirements should be decided based on the group mix andindividual needs of consumers attending the group
- Consideration should be given to forensic risk assessments available, consumer past behaviour, current mental state of consumers and environmental factor at all times during the session

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Section 7 – Safety and Security During Mealtimes

All consumers will eat their meal in the dining area, unless otherwise stipulated in their TPRIM Plan - see *Dhulwa Referral, Admission and Transfer of Care Procedure.* Consumers will be supervised in the dining rooms at all times.

For consumers who are granted cutlery via Dhulwa MDT Meeting the following applies:

- Food Services is responsible for maintenance of the cutlery inventory, located in the Lomandra or Cassia dining rooms
- The Property Manager will arrange identification/engrave prior to cutlery and utensils being made available for use
- Any modifications, additions, replacements or removal to the cutlery inventory must be approved by CNC or ADON

Consumers who are restricted to finger food (as indicated in the consumer's TPRIM Plan) must not be provided cutlery.

7.1 Meal Supervisors at Servery Area

- Two staff members will act as meal supervisors and must be present at the servery area at all times during meals. These roles will be allocated to Registered Nurses (RN), Enrolled Nurses (EN) and or Assistants in Nursing (AIN) by the NiC at the beginning of each shift. A minimum of one RN will be allocated as a meal supervisor
- The second meal supervisor can be a RN, EN or AIN and is responsible for managing the safety of staff and concumer at the servery area
- The NiC will assign two staff members RN, EN or AIN to count and audit cutlery before and during mealtimes

7.2 Food Services Staff

- Food Services staff will prepare cutlery to be handed out to each consumer and place it on their meal tray prior to the meal being served. In the absence of Food Services staff the NiC may nominate a member of Dhulwa staff to prepare cutlery

7.3 Supervision in Dining Room

- Nursing staff are required to supervise consumers in the dining room for all meals
- Nursing staff are encouraged to interact with consumers during mealtimes (i.e. sit at each table). This will ensure that staff are aware of each consumer's mental state and any issues that may be arising and are able to respond accordingly to maintain safety and security in the dining room
- If additional staff are required for supervision (e.g. one or more consumers are unsettled or have escalating behaviour), security staff may be requested to assist with supervision.
- All consumers are required to remain in the dining room for the duration of the meal and until all cutlery is counted back in

7.4 Staff to Consumer Ratio in Therapy Spaces

- Lomandra (Acute) –minimum staff to consumer ratio of 1:3 will be maintained
- Cassia (Rehabilitation) –minimum staff to consumer ratio of 1:4 will be maintained

7.5 Searches for Missing Cutlery

- The NiC will instigate a rigorous search as per the *Dhulwa Searching Procedure*. A search may include a physical search of a consumer which will be conducted while maintaining respect and dignity of the consumer

The NIC is responsible for ensuring that a clinical incident report on Riskman is completed when:

- cutlery or utensils cannot be found; or
- there is a near miss or an incident resulting from the misuse of cutlery of utensils

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Section 8 – Self Catering of Meals

The rehabilitation program is designed to provide consumers opportunities for recovery by providing a safe and supportive environment to address challenges and develop skills and resources that will promote successful community living and enhanced quality of life.

All practices are in line with safe food handling and storage requirements as outlined in the *CHS Bringing Food into Canberra Health Services (Adults and Children) Procedure*.

8.1 Food Safety

To reduce the risk of an adverse incident occurring because of handling/working with food in a therapeutic setting, it is recommended that all staff adhere to and comply with the:

- CHS Occupational Therapy Food Safety Procedure which is based on the Australia New Zealand Food Authority, August 2015 Safe Food Australia, A Guide to the Food Safety Standards

8.2 Personal Hygiene and Health

It is the responsibility of all those who come in contact with food to maintain a high standard of personal hygiene and cleanliness to minimise the risk of food contamination. All staff need to adhere to the principles outlined in the *CHS Bringing Food into Canberra Health Services (Adults and Children) Procedure.*

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Section 9 – Daily Routine

9.1 Routine and Timetable

A structured ward routine and timetable has been developed to maximise consumer engagement in Dhulwa. Consumers will be actively encouraged to participate in ADLs, core programs, physical activity, and approved leave from the facility.

Consumers suitable to access leave to participate in training and vocational programs or activities in the community are supported to do so. For consumers that remain in Dhulwa the following routine will support them in active participation in the program.

8:00-8:30	Consumers will be required to prepare their own breakfast with the assistance of Dhulwa staff and facilitated by Allied Health Assistants.
8.30	Bush Walk
9:00	Community Meeting - this meeting will be led by the NiC.
9:00-10:30	Activities of Daily Living (ADLs). This is the opportunity for consumers to have access to their rooms to perform their ADLs. This includes showering, grooming, cleaning rooms, laundry, and other essential daily routines. Physical Activity. Consumers will have access to the "Hub" to make use of the gym and physical activity area.
11:00-12:00	Core Programs. This period is designated for consumer participation in formal group programs including psychological or other therapy related groups as determined by the program schedule.
12.30 -15:00	Lunch and Community Based Activities
	This period will be allocated for consumers to access their approved leave. At times, leave may be dependent on the scheduling of external activities. This is also an opportunity for consumers to have lunch with their visitors.
16.00 1700	Sports and physical activity – Core Programs. This period is designated for consumer participation in formal group programs as determined by the program schedule.
17:00-1900	Social time and meal preparation in the hub. This period is designated for self- catering. Consumers will have access to the kitchen to prepare their meals for dinner with the assistance of Dhulwa staff and facilitated by the Allied Health Assistants and AINs.
1900	Relaxation on the unit – No leave after 1700 unless pre - approved by MDT

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Section 10 – Consumer Money

Consumers bank cards, credit cards and any cash the consumer brings with them on admission to Dhulwa will be held in the consumer's assigned valuables container secured within the Dhulwa safe. If the consumer has a financial guardian all matters concerning their money will be managed by their guardian.

Consumer's Money
The consumer's money (cash/card) may be used so that the consumer can purchase items such as foods, personal items, and for approved therapeutic leave.
For a consumer that does not have access to therapeutic leave, online shopping will enable a consumer access to purchase various items using their money from their personal bank account using their card stored at Dhulwa.

When a consumer would like to access their money for planned spending and or for theraputic leave the Dhulwa Property Officer or Administration Team in conjuction with Allied Health Assistants will issue the consumer's money (cash/card)

Clinical staff managing the consumer's leave during the week, (i.e. Monday to Friday) will obtain the consumer's money from the Property Officer and or Administration Team prior to the consumer leaving the unit to going on leave. There are circumstances where a consumer property will be held in the safe within the security office.

On returning from leave, clinical staff responsible for the consumer's leave will return the consumer's remaining money to the Property Officer or Administration team on Level 2, with the exception of circumstances in which the consumer property should be signed back into the safe within the security office.

Financial Management
If a consumer is unable to manage their financial affairs due to accident, illness, age or disability, and do not have a financial Guardian or Enduring Power of Attorney (EPOA), the Public Trustee and Guardian can provide assistance with the administration of financial affairs. The relevant Dhulwa staff will assist the consumer in contacting the Public Trustee and Guardian to seek support.

If consumers are being supported by the Public Trustee and Guardian they may have limited living allowances. If a consumer requires assistance in adjusting their living allowances the Dhulwa staff will assist the consumer to contact the Public Trustee to increase their living allowance. For the remainder of the non- public trustee consumers their full income is received into their individual bank accounts.

Consumers Money Upon Discharge

It is the responsibility of a consumer's clinical team to notify the Administration team of the discharge of a consumer. This should occur at least 24 hours prior to discharge or the earliest possible convenience.

The Property Officer and or Administration Officer will release money (and valuables) from the safe at the time of discharge.

Once the consumer and staff are satisfied that all money and valuables is accounted for, two members of staff will sign the discharge section of the *Consumers Clothing, Property and Valuables Form* located on the Clinical Forms Register.

If the consumer is transferred to another mental health care facility, property will be packaged and given to the relevant staff at the point of transfer and will include the transfer documentation.

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Section 11 – Other Facilities in Dhulwa

11.1 Laundry

There are two internal laundry within Dhulwa that consumers can use for the laundering of clothing and personal linen. A clothes iron and board are available for use under nursing supervision in each laundry. Consumers should be encouraged to launder their clothing and change their linen regularly.

- Consumers will be instructed on the use of laundry equipment on admission to the unit, or when their mental/physical state allows
- On units without free access to the facilities, consumers will need to request access to the laundry room from a staff member
- Only one consumer is permitted to use the laundry area at any given time.
- A consumer's mental state and current risks must be assessed prior to accessing this area
- Consumers must be always supervised as per their approved observation level while using this area
- Consumers must only launder their own personal clothing and linen.
- Hospital linen must not be laundered
- Use of clothes iron and ironing board will be accessed and supervised by nursing staff on an individual request basis only. The consumers risk, and mental state should be assessed prior to a patient gaining access to the iron and board.
- Laundry and machines must be kept in a clean, dry and tidy condition, free of debris and slip hazards
- Excess laundry powder must be kept in the locked cupboard in the laundry room.
- Nursing staff must assist/complete laundry needs for those consumers who require help.

- Any maintenance issues with the washing/drying machines must be brought to the immediate attention of the NiC for escalation to the Property Manager

11.2 Hairdressing Services

Dhulwa will ensure consumers have access to hairdressing services (relating to cutting, styling, colouring or otherwise significantly altering a consumer's hair) through an external community provider.

All consumers will be advised when the hairdresser will be visiting at the regular community meetings.

Procedure for consumer to access hairdressing service:

1. The consumer is to complete the *DMHU Hairdressing Request Form* (located on the Clinical Forms Register) to indicate the type of hairdressing service the consumer is requesting and must be completed at least 24 hours prior to the hairdresser visiting.

2. The completed *Hairdressing Request Form* must be placed on the consumer's ECR. The consumer's allocated nurse can approve the hairdressing service request. Staff will email *DHMU Hairdressing Request* Form to DMHU@act.gov.au. The Administration team will collate requests and book hairdressing services as required, in consultation with the CNC.

3. The hairdresser's attendance will be booked into the Dhulwa Security outlook calendar, ideally with at least 24 hours notice by the Dhulwa Administration staff.

4. The hairdresser will enter Dhulwa through security and will undergo the visitor search process refer to *Dhulwa Searching Procedure* for further information

5. A count of tools and equipment will be made by the hairdresser and a member of staff assigned to supervise the provision of hairdressing services and recorded on the Tool and Material Checklist, as provided by security staff on entry.

6. The hairdresser must be escorted by the member of staff assigned by the CNC at all times while in Dhulwa (see *Dhulwa Visitor Procedure* for more information).

7. A tool count must be conducted between and before a consumer leaves the room. If any item remains missing, the NiC should be advised. The NiC will initiate appropriate searches to locate the item(s) (see *Dhulwa Searching Procedure* for more information).

8. At the conclusion of hairdressing services, the hairdresser will be escorted back to the security desk. All tools and equipment will be counted by Security.

11.3 Razor Blades

The allocation of razor blade to a consumer will be determined by their current mental state, and risk of harm to self and others. The following outline the steps involved in assessing and managing the risk of consumers to have access to razor blades:

1. Mental State Examination: the consumers mental state, risk factors and recent DASA scores must be assessed prior to allocation of a razor, or whether the use of the razor should be supervised or unsupervised

2. The MDT and clinical team will discuss any concerns they may have regarding the consumer's or others safety when allocating razors

3. Risks associated with razor allocation will be discussed at clinical handover

4. Where the risk of a consumer being allocated a disposable razor is too high, the consumer may be offered the choice of either purchasing an electric razor (to be stored in their personal locker) or using hair removal cream

5. Any risks identified should be documented in the consumer's TPRIM

6. In exceptional circumstances such as clinical deterioration or acute behavioural disturbance, the use of electric and/or disposable razors may be suspended until the consumer's mental state improves so that it is safe for them to have access to these items

Storage and Counts

As a restricted item, razors must be stored in a suitable designated lockable storage facility on Cassia and Lomandra Units. Both electric razors and disposable razors may be reused. They will be labelled and individually stored securely the non consumer area (see Section 3 for integrity checks). A consumers razor is signed in and out each time for use. Checks of the razor register, stored in the nurse's station of each unit, will be completed daily by nursing staff to ensure items have been returned intact.

Disposeable Razor Provision

The nurse must check the integrity of the blade before providing the razor to the consumer and advise them of any restrictions surrounding the use and return of the razor. Upon return the nurse must check the integrity of the whole razor including the blades and ensure the razor is intact, documenting same in the razor register.

All disposable razors must be disposed off in a yellow sharps container by the nurse. If a consumer fails to return, tamper with-or loses the razor, the NiC must be informed immediately. The NiC will determine if a search is required (see DMHU Search Procedure).

Electric Razors

The allocation of electric razors to a consumer require prior assessment of their mental state and current risk factors, as measured by DASA. This will determine whether the consumer can have access at that time and whether the use of the electric razor will be supervised or unsupervised.

If a consumer wishes to use a personal electric razor this may be purchased with their own funds and must meet electrical safety guidelines, including testing and tagging.
After use, the electric razor must be returned to the NiC for storage, clearly labelled with the consumer's name.

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Evaluation

Outcome

- Improved operational and clinical outcomes
- Dhulwa staff to be appropriately orientated and aware of Dhulwa clinical and operational procedures
- Clearly defined roles and responsibility of Dhulwa staff for continued best practice for Dhulwa consumers
- Dhulwa consumers receive safe, effective care, therapy and treatment

Measures

- Review of clinical incident data relating to Dhulwa Mental Health Unit
- Continued review of consumer feedback relating to patient care at Dhulwa
- Regular audits occur of therapy spaces
- Evaulation of staff training

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Related Policies, Procedures, Guidelines and Legislation

Policies

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- Dhulwa Mental Health Unit Searching
- Dhulwa Mental Health Unit Use of Force
- Dhulwa Mental Health UnitSecurity
- Incident Management
- Informed Consent (Clinical)
- Medication Handling
- Occupational Violence
- Smoke Free Environment

- Work Health and Safety
- Work Health and Safety Management System

Procedures

- Advance Agreements, Advance Consent Directions and Nominated Persons
- Assessment of Decision-making Capacity and Supported Decision-makingfor people being treated under the Mental Health Act 2015
- Care of Persons Subject to Psychiatric Treatment Orders (PTOs) with or without a Restriction Order (RO)
- CHS Ligature Risk Management for MHJAHDS Inpatient Mental Health Units
- CHS Ligature use in Inpatient Mental Health Unit Response Management
- Clinical Handover
- Dhulwa and Gawanggal Mental Health Units – Leave Management for People Admitted
- Dhulwa Mental Health Unit – Provision of Physical Health Care
- Dhulwa Mental Health Unit – Referral, Admission and Transfer of Care
- Dhulwa Mental Health Unit - Searching
- Dhulwa Mental Health Unit - Transfer of Custody
- Dhulwa Mental Health Unit - Visitors
- Dhulwa Mental Health Unit (DMHU) Use of Force
- Dhulwa Mental Health Unit Prohibited and Restricted Items
- Dhulwa Security Placeholder
- Incident Management
- Infection Prevention and Control - Healthcare Associated Infections
- Information and Communication Technology Resources: Acceptable Use
- Initial Management, Assessment and Intervention for People Vulnerable to Suicide
- Managing Nicotine Dependence
- Occupational Violence
- Patient Identification and Procedure Matching
- Searching of a Consumer, Person or Property
- Seclusion of Persons with Mental Illness or Mental Disorder Detained under the Mental Health Act 2015
- Sharing Information with Carers – MHJAHDS Adult Inpatient Units
- Unauthorised Leave of Admitted People from MHJHADS Inpatient Units
- Vital Signs and Early Warning Scores

Guidelines

- Dhulwa Security Operational Framework
- Dhulwa Operational Model of Care
- Dhulwa Mental Health Unit Practice Sensitive to Gender Identity and Sexual Orientation
- Providing Physical Health Care across MHJHADS

Standards

- National Standards for Mental Health Services 2010
- National Safety and Quality in Health Service Standards 2017

- Standards of Practice for ACT Health Allied Health Professionals 2016

Legislation

- *Carers Recognition Act 2010*
- *Food Standards Australia New Zealand (FSANZ).*
- *Health Records (Privacy and Access) Act 1997*
- *Human Rights Act 2004*
- *Information Privacy Act 2014*
- *Medicines, Poisons and Therapeutic Goods Act 2008*
- *Medicines, Poisons and Therapeutic Goods Regulation 2008*
- *Mental Health (Secure Facilities) Act 2016*
- *Mental Health Act 2015*
- *Work Health and Safety Act 2011*

Other

- Australian Charter of Healthcare Rights

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References

National Lesbian, Gay, Bisexual, Transgender and Intersex Prevention Strategy 2017
LGBTI-Report-Mental-Health-and-Suicide-Prevention-Strategy.pdf (ntmhc.org.au)

Definition of Terms

MHJHADS	Mental Health, Justice Health, Alcohol and Drug Services. A division within Canberra Health Services
Physical Health	Includes life expectancy, physical health conditions, smoking and drug and alcohol abuse.
General Observation	The consumer's allocated nurse has knowledge of the consumer's general whereabouts at all times, whether in or out of the unit. General observations should be an established part of unit routine and followed rigorously and regularly by nurses as part of their everyday practice to maintain the safety of consumers. Hourly observations are the minimum acceptable level of observation for a consumer admitted to Dhulwa.
Continual Observation	One on one observation, i.e. with the nurse visually observing a consumer at all times.
Special Obervation	One on one observation, 1:1 i.e. with a nurse being within arm's reach of the consumer at all times and in all circumstances.

	Allocated nurse must not leave the consumer under any circumstances.
HCR-20 V3	Comprehensive set of professional guidelines for violence risk assessment and management.

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Search Terms

Dhulwa, DMHU, Secure Mental Health Unit, SMHU, SMHI, SMHS, Secure

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Attachments

Attachment 1 – Sample DASA-IV

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Policy Team ONLY to complete the following:

Date Amended	*Section Amended*	*Divisional Approval*	*Final Approval*

This document supersedes the following:

Document Number	*Document Name*

Attachment 1 – DASA -IV

Forensicare

DYNAMIC APPRAISAL OF SITUATIONAL AGGRESSION

Centre for Forensic Behavioural Science
MONASH University

Name:_____

Week beginning:_____/_____/_____

The following ratings are based on your knowledge and observations of the patient during the PREVIOUS 24 HOURS. Well-known patients are scored a 1 for an increase in the behaviour described, the patient's usual behaviour while being non-violent is scored as 0.	Monday (Circle One)	Tuesday (Circle One)	Wednesday (Circle One)	Thursday (Circle One)	Friday (Circle One)	Saturday (Circle One)	Sunday (Circle One)
Irritability The patient is easily annoyed or angered. The patient is unable to tolerate the presence of others.	0 1	0 1	0 1	0 1	0 1	0 1	0 1
Impulsivity The patient displays behavioural and affective instability (i.e., dramatic fluctuations in mood, or general demeanour; inability to remain composed and directed).	0 1	0 1	0 1	0 1	0 1	0 1	0 1
Unwillingness to Follow Directions The patient tends to become angry or aggressive when they are asked to adhere to treatment or to the ward's routine.	0 1	0 1	0 1	0 1	0 1	0 1	0 1
Sensitivity to Perceived Provocation The patient tends to see other people's actions as deliberate and harmful; they may misinterpret other people's behaviour or respond with anger in a disproportionate manner to the extent of provocation.	0 1	0 1	0 1	0 1	0 1	0 1	0 1
Easily Angered When Requests are Denied The patient tends to be intolerant, or is easily angered when they make a request that is denied or when they are asked to wait.	0 1	0 1	0 1	0 1	0 1	0 1	0 1
Negative Attitudes The patient displays antisocial and negative attitudes and beliefs which may relate to violence and aggression.	0 1	0 1	0 1	0 1	0 1	0 1	0 1
Verbal Threats The patient displayed a verbal outburst, which is more than just a raised voice, and where there is a definite intent to intimidate or threaten another person.	0 1	0 1	0 1	0 1	0 1	0 1	0 1
Total	/7	/7	/7	/7	/7	/7	/7
Final risk rating *Based on the DASA score and clinical assessment rate (H) high, (M) medium or (L) low risk for the next 24 hours*							
Record of aggression ***During the previous 24 hours has the patient behaved aggressively in any of the following ways? (Please mark with a cross in the appropriate box)***							
Physical Aggression against OBJECTS Slams door, throws objects down, kicks furniture, breaks objects, smashes windows, sets fires, throws objects.							
Verbal Aggression against OTHER PEOPLE Shouts angrily, insults, curses viciously, uses foul language in anger, or makes clear threats of violence to others.							
Physical Aggression against OTHER PEOPLE Makes threatening gesture, swings at people, grabs at clothes, strikes, kicks, pushes, pulls hair, or attacks others.							