Canberra Health Services

Dhulwa Mental Health Unit – Operational Procedure

Contents

Purpose

This document provides guidance on the operational procedures specific to the Dhulwa Mental Health Unit (Dhulwa). Adherence to this procedure is to ensure:

- Clinical practice supports the 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.

Back to Table of Contents

Scope

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

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

Back to Table of Contents

Mental Health (Secure Facilities) Act 2016

Dhulwa is a declared Secure Mental Health Facility (SMHF) in accordance with the *Mental Health (Secure Facilities) Act 2016*.

Section 60 of the *Mental Health (Secure Facilities) Act 2016* requires the CHS Chief Executive Officer (CEO) to make a SMHF Direction. The following SMHF Directions have been made:

- Use of Force – see *Use of force to conduct a search under the Mental Health (Secure Facilities) Act 2016 procedure*
- Strip Search – see *Searching (patient, personal property, bedroom, premises) under the Mental Health (Secure Facilities) Act 2016 procedure*
- Visitor Conditions – *see Visitors to Dhulwa under the Mental Health (Secure Facilities) Act 2016 procedure*
- Prohibited Items – *see Prohibited and Restricted Items under the Mental Health (Secure Facilities) Act 2016 procedure*

Back to Table of Contents

Section 1 – Introduction

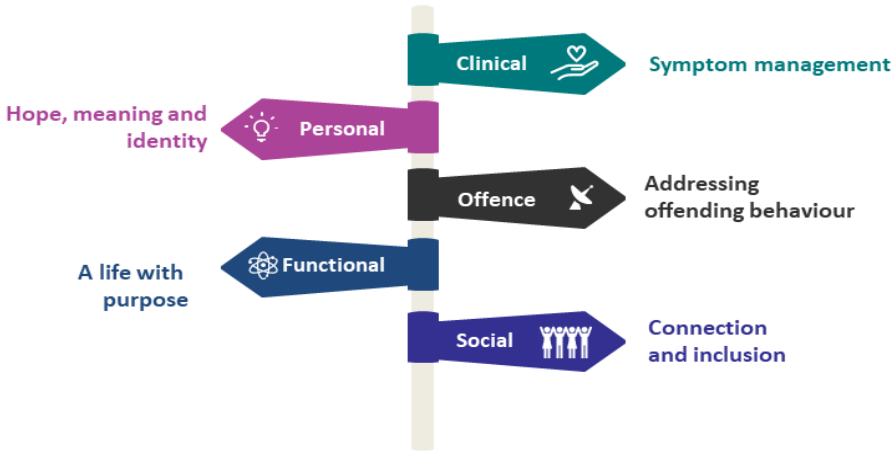
1.1 Dhulwa

Dhulwa is a forensic inpatient unit with 25 beds 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, as a forensic inpatient unit contributes to the care continuum of mental health services in the ACT provided by Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS).

Dhulwa sits at the intersection between mental health and the justice systems to deliver specialised inpatient forensic services that address mental illness and offending behaviour. Forensic mental health is a speciality area primarily focused on providing clinical services that include assessment, treatment, and management of people with a mental illness or disorder who have offended or are at risk of offending.

The forensic therapeutic support framework at Dhulwa encompasses interventions and services that promote a consumer's recovery and wellbeing across the domains of secure recovery:



The therapeutic supports are delivered across the functions of assessment and stabilisation, rehabilitation and community reintegration and are aligned with the seven pillars of the DUNDRUM to guide the delivery of services.

Risk assessment in a forensic mental health setting refers to harm individuals with a mental illness or disorder pose or have posed to others, where that risk is usually related to their mental illness or disorder. Risk assessment and management approaches are supported by clinical tools that are essential additions to clinical practice in conjunction with clinical judgement, multidisciplinary team review and other relevant factors.
Assessments of risk are to be structured using clinical instruments underpinned by clinical expertise, to support responses to escalating risks through the implementation of proactive

interventions to manage aggression risks effectively and balance safety with a consumer's recovery journey.

The risk assessments used at Dhulwa are a continuous process that form an integral part of clinical care and improves the reliability of decisions regarding the management of risk.

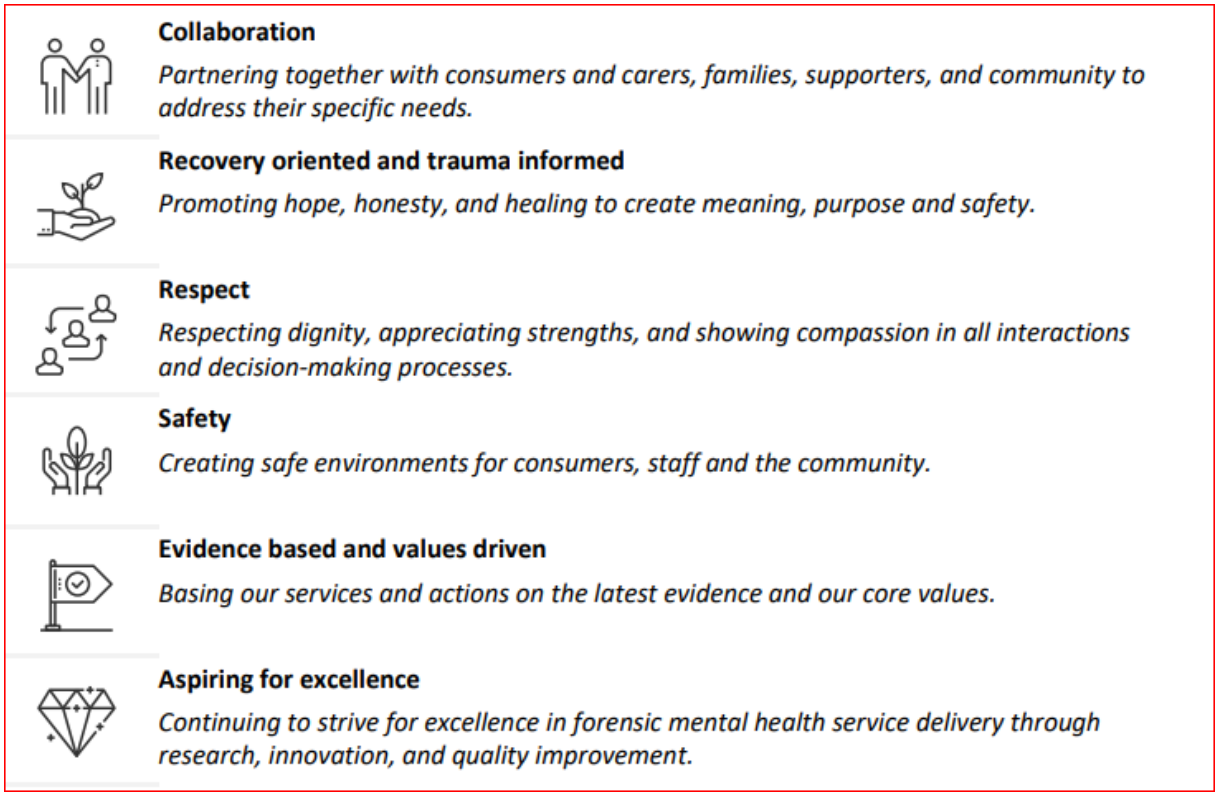
Dhulwa aligns and has implemented the Safewards model and interventions for use in mental health inpatient units. The Safewards model is designed to reduce conflict and containment or restrictive practices by identifying and addressing the causes of behaviours in staff and consumer that may result in harm (conflict) and reduce the likelihood of this occurring. Staff are trained to use a range of methods to manage consumer behaviours in a concerted effort to reduce restrictive or coercive interventions. This also requires staff to review their own behaviours and responses to conflict and the strategies used to manage challenging behaviours.

1.2 Forensic Mental Health Inpatient Service Model of Care

The Model of Care sets out an evidence-based framework for practice and guides the delivery of the right care, at the right time, by the right person/ team and in the right location across the continuum of care.

A dedicated vision for Forensic Mental Health Inpatient Services is *hope, healing and creating meaningful lives for a safer future together.*

The vision and the six principles establish a standard against which actions can be assessed, guide and direct decision making to achieve the shared vision. The six principles are:



1.3 Legislation

Dhulwa staff are required to comply with overarching legislation, which collectively aims to ensure consumers admitted with mental health needs receive appropriate and compassionate care while protecting the rights and safety of consumers and the broader community.

The legislation governs the operation of mental health services, sets standards for assessment, treatment and detention while adhering to human rights principles and best practice in the mental health field.

The legislative foundation for the approach to care provision, recovery, treatment, security and a person's requirements for privacy and dignity are considered the guiding principles of the *Human Rights Act 2004*, *Mental Health Act 2015,* and the *Mental Health (Secure Facilities) Act 2016.*

1.4 Role of security team

Security at Dhulwa is delivered in line with a therapeutic mental health care response to support the safety of consumers, carers, families, supporters, and staff. Security team at Dhulwa is responsible for the environmental security, this includes:

- Management of the entry of all persons into Dhulwa, the proof of identification requirements, registration into the security system and the condition of entry that people and their possessions be searched.
- Perimeter security consisting of the management of key and proximity card access and the storage system, the secure fence, Closed Circuit Television (CCTV), lighting and regular and random patrols.
- Providing efficient, safe, and secure supervision of consumers during escorts.

The Security team do not have a role in the provision of treatment, care or support to consumers admitted to Dhulwa and are not authorised to do the following:

- Seclude or restrain a consumer under the *Mental Health Act 2015.*
- Search a consumer under the *Mental Health (Secure Facilities) Act 2016*, (unless requested by the Person in Charge of the facility).
- Be involved in a use of force for the purposes of a search of a consumer.
- Approve prohibited or restricted items to be brought into Dhulwa.

Back to Table of Contents

Section 2 – Referral

2.1 Role and function

To ensure transparency and governance of admissions to Dhulwa, the Admission and Assessment Panel (AAP) review each referral on an individual basis to determine if the consumer is suitable for admission.

The AAP serves as a single point of access to determine if a consumer requires rehabilitative care and/or care in a secure environment.
The AAP meet weekly or as required to review referrals.

The AAP members include the following (or their delegates):

- Clinical Director, Forensic Mental Health Services (FMHS)
- Operational Director, Forensic Mental Health Services
- Assistant Director of Nursing (ADON)
- FMHS Senior Manager
- Allied Health Manager / Therapy Manager
- Dhulwa Consultant Psychiatrist(s)
- Psychiatry Registrar(s)
- Clinical Nurse Consultant(s) (CNC)
- Administration Manager (secretariat)

Additional people who may be called to attend include:

- The referring team
- Aboriginal Liaison Officer (ALO)
- Nursing team representatives
- Allied Health team representatives
- Other people as deemed relevant by the AAP Committee

2.2 Eligibility criteria

To be eligible for admission to Dhulwa, the consumer must be subject to a mental health order under the *Mental Health Act 2015*, and must meet one of the following inclusion criteria:

- Be sentenced or remanded to custody and have a mental illness or mental disorder with a need for treatment beyond what can safely be provided in a correctional setting
- Be subject to a conditional release order
- Be unable to receive treatment in a less secure non-forensic mental health services due to specialist forensic need as per *Mental Health Act 2015* (i.e., pose a danger of serious harm to others)
- Be a correctional patient as defined in the *Mental Health Act 2015*.

2.3 Exclusion criteria

The exclusion criteria are:

- Those who can be assessed and treated in non-forensic mental health services
- Those who are assessed through a validated assessment tool as requiring a level of therapeutic security commensurate with a high secure service.

2.4 How to make a referral

A referral to Dhulwa can be made by completing the Referral for Admission to Dhulwa and Gawanggal Form. This form can be obtained, by sending an email to DMHU@act.gov.au. The referring team is to email the completed referral form to DMHU@act.gov.au and save it in the consumer's clinical record.

The referral is to be completed in collaboration with the consumer and their support systems, guardian, family, carer, nominated person (if have one) and have the support of the referring Multi-Disciplinary Team's (MDT) prior to submission.

It is highly recommended the referring team consults with a member of the Dhulwa clinical team by telephone on 512 41851 prior to making a referral.

2.5 Referral assessment

Following the AAP's review of a referral, a face-to-face clinical assessment will be arranged by the Dhulwa clinical team and documented in the consumer's clinical record.

The DUNDRUM 1 and 2 assessments will be completed, and the outcome will be used by the AAP to inform the consideration of admission. The four-part validated structured tool provides a framework for the assessment and communication of:

1. Admission triage - the appropriate level of therapeutic security for a consumer.
2. Urgency - admission urgency, considering other consumers on a waiting list and consumer's assigned level of security.
3. Treatment completion - consumer's progress in relation to treatment programs.
4. Recovery assessment - levels of therapeutic security along the consumer's recovery pathway.

2.6 Admission and Assessment Panel (AAP)

The outcome of the assessment and referral information will be discussed and considered by AAP, as well the below:

- If the admission criteria are met.
- If the consumer should be admitted to Dhulwa or if a less restrictive option should be considered.
- The urgency of the admission.
- What the consumer's clinical assessment and treatment needs are.
- The mix of consumer's currently admitted to Dhulwa.
- The triaged need of consumers awaiting admission.

2.7 Urgent referrals

In exceptional circumstances a consumer may require urgent admission to Dhulwa as clinically indicated. In those circumstances the AAP may convene as required to facilitate the review and clinical assessment.

2.8 Referral outcomes

All referral outcomes and /or any recommendations for alternative treatment options for consideration will be discussed with the referring team and documented in the consumers clinical record by the CNC or delegate.

2.9 Appeals process

If the referring team does not agree with the decision of the AAP, they may choose to appeal the decision.

Firstly, the AAP will discuss the outcomes of the referral with the referring team and consider any additional relevant clinical information provided by the referring team. If admission is agreed, the AAP will advise the referring team and the admission will progress.

If disagreement regarding admission remain, AAP will formally offer the appeal process:

- A second assessment of the referral will be completed on the provision of additional information for clinical consideration.
- The second assessment will be discussed between stakeholders at a case conference and if agreement for admission to Dhulwa, the admission will progress as normal.
- If the second assessment determines the admission criteria is not met, the consumer will not be admitted to Dhulwa.
- If the referring team are still in disagreement regarding admission, they may raise their concerns with the Chief Psychiatrist for arbitration.

Back to Table of Contents

Section 3 – Admission

3.1 Role of staff during admission

3.1.1 nursing

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

- Greet and orientate the consumer to Dhulwa, provide an explanation of the unit and a copy of the Dhulwa Consumer Welcome Booklet
- Explain the admission documents to be completed, including conducting a search of the person's belongings, allocation and access to their bedroom following registration into the electronic access control system
- Within 24 hours, or as soon as practicable, in consultation with the CNC, undertaken and complete:
    - The Dhulwa Physical Appearance Form, available on the clinical forms register
    - Treatment, Placement, Restrictions, Implementation, Monitoring (TPRIM)
    - Security Classification and Leave Entitlement (SCALE)
    - Suicide Vulnerability Assessment Tool (SVAT),
    - Behaviour and Symptom Identification Scale (BASIS-32)
    - Health of the Nation Outcome Scale for Users of Secure and Forensic Services (HoNOS–secure)
    - Fagerstrom Test for Nicotine Dependence (FTND, if not completed)
    - Personal safety planning
    - Aboriginal and Torres Strait Islander Assessment (ALO if applicable)
    - Falls Assessment
    - Provide any dietary information to the kitchen
- Admit the person in the clinical record system to Dhulwa.

3.1.2 Allied health

The Allied Health staff is responsible for providing information about the therapeutic groups and individual supports aviable at Dhulwa. Some of the individual responsibly of the allied health team are outlined below:

- 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 functional assessment 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

3.1.3 The Medical team

The psychiatry registrar will:

- undertake a comprehensive assessment to identify any critical elements of care and treatment,
- 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 consumers clinical record, including any relevant observations documented. Continued attempts should be made where possible to undertake the physical health assessment and examination.

3.1.4 Administration team

The Administration team will:

- Update the consumer's clinical record indicating which room the consumer is allocated and the demographics such as guardian, nominated person, current General Practitioner, mobile telephone number and change of address to Dhulwa
- Ensure relevant admission forms are available and completed by all stakeholders
- Ensure property and valuable forms are completed and uploaded to the consumer's clinical record
- Provide the admitting nurse with an admission folder and patient identification labels

3.2 Transfer of custody

See Transfer of custody of a detainee/ young detainee admitted to Dhulwa under the *Mental Health Act 2015* procedure.

3.3 Belongings

On admission a consumer's belongings will be recorded on the consumers clothing, property, and valuables form, following a search. See Dhulwa Searching (patient, personal property, bedrooms, and premises under the *Mental Health (Secure Facilities) Act 2016* procedure.

Dhulwa has a holding room with storage for each bedroom where excessive belongings should be stored to avoid work health and safety or infection control issues in a consumer's bedroom.

The MDT will monitor and liaise with the consumer about their belongings, including information on the items that can be kept in the consumers bedroom or be held in the holding room.

Back to Table of Contents

Section 4 – Inpatient care

Inpatient care provided at Dhulwa is recovery focused, trauma informed specialist forensic mental health care. The MDT partners with the consumers, carers, families and supports to promote healing, recovery, and safety to meet the consumer's needs and support their recovery goals.

The core functions of forensic mental health inpatient care are recovery oriented clinical assessment, co-planning, individualised treatment, capacity building and risk management. The Dhulwa Therapy Framework (Attachment 2) provides guidance on the activities and interventions that may be considered across the domains of secure recovery based on a consumer's clinical progress as assessed by the DUNDRUM 3 and 4.

The Dhulwa Therapy Framework informs individual care plans and overall activity and intervention planning for the unit. Interventions aim to target individual and group clinical and rehabilitation needs within the seven pillars of health and wellbeing:

- Physical Health
- Mental Health
- Alcohol and Drugs
- Harmful Behaviours
- Activities of Daily Living
- Education and Occupation
- Social Networks

The clinical supports include behaviour change programs, other psychologist therapies and a full range of medical and psychosocial interventions.

Consumers at Dhulwa have access to a variety of activities and intervention programs such as:

- Social and recreational
- Skills based and self-help
- Pet therapy
- Mental health awareness
- Cognitive remediation
- Metacognitive and social skills training
- Problem behaviour interventions
- Community information
- Gym and actively living
- Managing physical health
- Psychoeducation relating to symptoms management, diagnosis and treatment choices and recovery
- Relapse prevention

- Alcohol and Drug programs
- Leisure activities
- Access to online and external education and training programs
- Community engagement activities.

The clinical interventions are provided in groups and individually to support consumers to understand their physical and mental health needs and make personal changes to manage their own risk of offending in the future. Dhulwa provides a minimum of 25 structured activity sessions per week. Activities and programs are scheduled in both on & off ward activity spaces.

The provision of inpatient care is supported by processes undertaken by staff.

4.1 Handover

Clinical handover is the communication of consumer care to ensure relevant, accurate and current information about the care is transferred, actions undertaken (when necessary) and continuity of care is maintained. Standardised clinical handover optimises safe, high quality consumer care.

Handover may be delivered:

- Face-to-face
- Via telephone or telehealth,
- Clinical documentation
- Discharge summaries
- Outpatient letters (e.g., by Medical Officers, Allied Health, Nurse Practitioners)
- Electronic handover tools including e-Referrals.

CHS uses a structured handover process:

- ISBAR (Introduction, Situation, Background, Assessment, Recommendation/Read back) method for verbal clinical handover
- ISOAP (Identification, Subjective information, Objective information, Analysis/Action/Advice, and Plan) for written documentation and transfer of care depending on information to be communicated.

See CHS Clinical Handover procedure for further information.

4.2 Safety huddle

The safety huddle is a communication tool to maintain a safe working environment, by identifying and mitigating or managing safety issues that arise within the clinical environments of Dhulwa. Safety issues can be occupational, environmental, operational, or clinical.

The safety huddle does not replace a clinical handover or MDT meeting and not every consumer will be discussed during a safety huddle.

The safety huddle is an open and transparent forum for staff to identify, discuss and manage or resolve immediate safety issues and support a positive culture of workplace safety. The huddles take the form of a brief, focused and structured exchange of information about potential or existing safety issues which may affect consumer/s, staff and any person accessing the healthcare environment.

The safety huddle must be systematically organised to ensure that it is effective and sustainable, and is:

- Held at the beginning of the day, immediately following the MDT huddle
- Attended by staff involved in the care of consumers on shift, including the:
  - ADON, Chair
  - Consultant Psychiatrist or Clinical Director, Deputy Chair
  - Psychiatry Registrar
  - CNC
  - NIC
  - Nursing staff who are available
  - Clinical Nurse Educator
  - Therapy Manager
  - Allied health staff that are available
  - Health and Safety Representative

4.3 Multi-Disciplinary Team (MDT)

The MDT comprises of a range of health professionals working together to deliver comprehensive consumer care. An MDT approach is first and foremost centred on the needs of the consumer and to work collaboratively in the provision of best practice health care, resulting in improved and best clinical outcomes.

MDT meetings are a structured multi-disciplinary framework by which clinical decision making is made and is the primary clinical forum for a consumer's treatment and care to be discussed. The meetings provide a structure for the varying disciplines to collaborate effectively to meet the needs of the consumer and provides a support function for clinical staff who work in Dhulwa.

MDT meetings are held weekly, and clinical discussions are to be documented in the consumer's clinical record by the chair.

The CNC will appropriately triage and manage a list of consumers to be reviewed at an MDT.

A consumer's care plan and ongoing treatment are to be discussed at MDT within the first two weeks of admission. The MDT may determine a review at a less frequent rate if the consumer's presentation does not alter.

4.4 Deterioration of mental health or physical health

4.4.1 Mental health care

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 to effectively manage the deterioration, 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 of aggression and violence of a consumer.

When staff are concerned 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 an MDT review of the treatment plan as a priority.

ISBAR principles must be used in the verbal and documented hand over of any clinical concerns. In addition, details of risk assessment observations, the use of prescribed medications and clinical interventions for the consumer should also be outlined.

See Adult Acute Mental Health Inpatient Services Operational Procedure for process of direct admission.

4.4.2 Physical Health

People accessing MHJHADS will be supported with their physical health care needs. Physical health care will be delivered in a person-centred, respectful, non-judgemental, and culturally sensitive way, with information about the illness, physical condition and treatment options provided to enable people to make informed decisions.

Under section 74 of the *Mental Health (Secure Facilities) Act 2016*, CHS is required to ensure that consumers have access to specialist health services from health practitioners, including:

- Regular health checks
- Timely treatment where necessary, particularly in urgent circumstances
- Hospital care, where necessary, and
- As far as practicable, specialist health services and necessary health care programs (including rehabilitation programs).

Staff at Dhulwa will provide consistent evidence based physical health care to consumers to ensure their acute and ongoing physical health care needs are identified, assessed, and managed in a timely and effective way.

See CHS Providing Physical Health Care across Mental Health, Justice Health and Alcohol and Drug Services Operational Procedure for more information.

4.4.3 Medical intervention

If urgent medical care is required, the consumer will be transported to an appropriate health facility in an ACT Government vehicle.

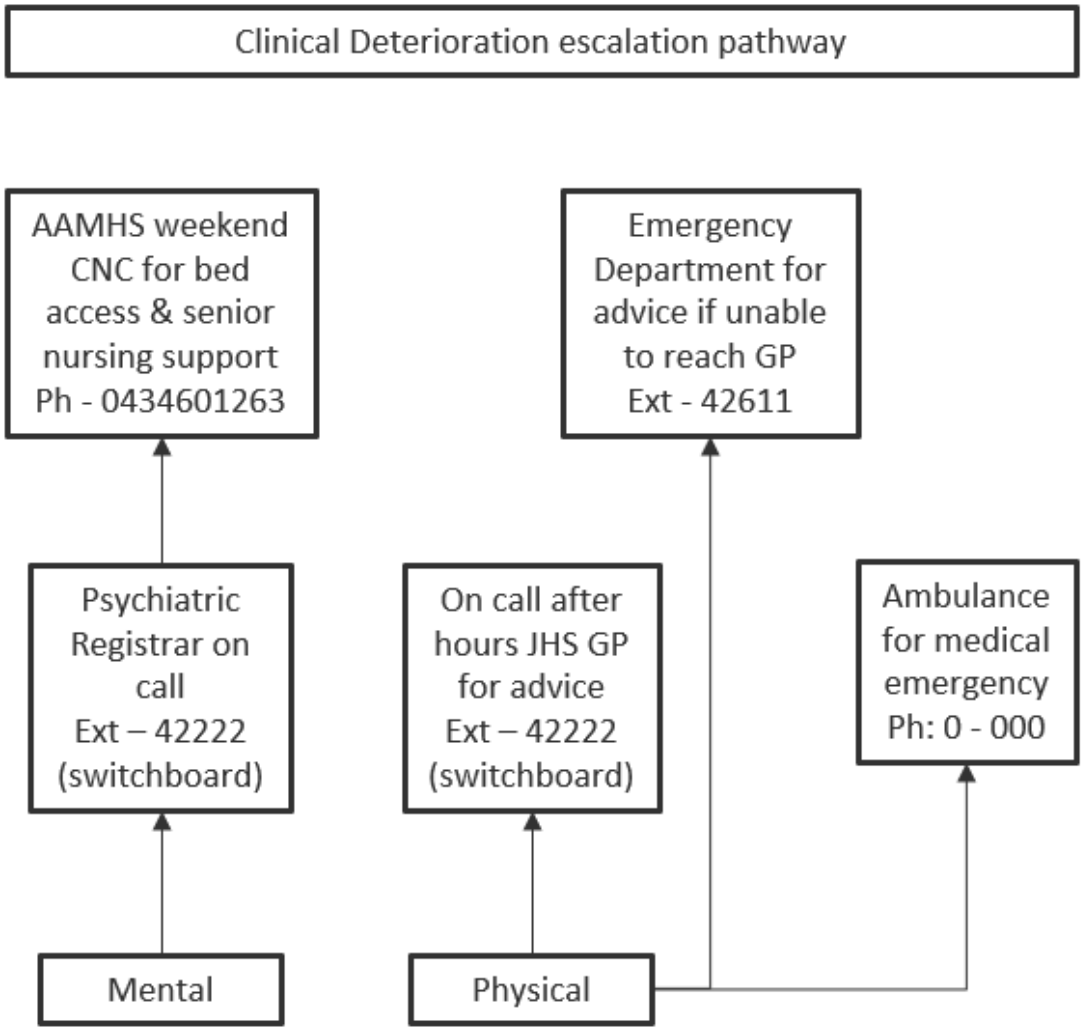
In an emergency, the consumer will be transported to an appropriate health facility via ACT Ambulance Services.

The escort level for urgent and emergency transports to another health facility is in accordance with the consumers SCALE rating. Detainees do not have a SCALE rating and the minimum escort level is 2 CHS staff + 2 security staff and handcuffed.

SCALE is the clinical tool used to determine the security and leave entitlement of a consumer admitted to Dhulwa, see Dhulwa and Gawanggal Leave Management Procedure.

All Dhulwa staff should comply with and refer to the Code Blue section contained in the Dhulwa Emergency Plan, a sub-plan of the CHS Emergency Management Plan for guidance on the escalation and management process for a medical condition that has the potential to be life threatening and / or cannot be managed at Dhulwa with the resources at hand.

Below outlined the afterhours clinical deterioration escalation pathway:



4.5 Individual Care Plan

Individual care plans (ICP) are used to actively engage the consumer in their care by the identification of their own individual recovery goals.

A comprehensive multidisciplinary assessment conducted by the clinical lead of each discipline (nursing, allied health, medical) is presented at the consumers first ICP review, and then reviewed every 3 months.

Strategies and interventions will 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.

ICP's 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.

4.6 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 consumer's clinical record and include a plan to manage the nonadherence. This must be included in the clinical hand over between shifts. Refer to CHS *Clinical Handover Procedure*.

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

4.7 Environment safety check

The purpose of Environmental Safety Checks (ESC) is for staff to observe for any items that could lead to self-harm.

ESCs at Dhulwa are different from a premises search.

The purpose of ESCs is to assess for ligatures and or ligature points and items such as torn articles of clothing, torn linen/blankets/towels, sharp objects, 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 to manage items that can be used for self-harm.

Completed ESCs are to be used at clinical handover as part of the ISBAR. They are also an appropriate source of collateral information to inform the risk assessment process and review of ARC observation levels.

Any risks identified are to be notified to the CNC or the NIC, and if related to a consumer to be documented in Riskman and the consumers clinical record, including 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 ADON during business hours and after hours to the afterhours hospital manager/executive director on call.

Door pressure sensors are fitted on all bedrooms and all toilet doors in the common area and laundry door in Dhulwa. The sensors will be triggered when a weight greater than 15 kilograms is exerted. Dhulwa staff and a Security Guard are to respond 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.

4.8 Leave

Leave from Dhulwa is an essential component of care. Leave may be for medical, emergency, legal, or therapeutic purposes, and access and type vary according to the legal status of the consumer. All consumers are allocated a leave rating (SCALE) which determines the security and leave entitlements including supervision and escort requirements.

All leave must be approved by the Dhulwa Leave Panel. Decisions about access to leave are informed by the persons legal status, therapeutic security needs as assessed on the DUNDRUM 1, recent clinical presentation, risks as assessed by the HCR-20 or other structured risk assessment, and therapeutic recovery and program completion as assessed by the DUNDRUM 3 & 4.

All Dhulwa staff are to be aware of the process for consumer leave from Dhulwa, including if a consumer takes unauthorised leave, fails to return from leave or absconds during escorted leave, see Dhulwa and Gawanggal Leave Management Procedure and CHS Missing Patient Procedure.

4.9 Visitors

Dhulwa promotes the importance of contact by consumers with family members, friends, and other people during their admission to promote successful recovery. Connection with families, friends, carers, and the community are encouraged to facilitate a supported transition back to the community. All visits are to be approved by the MDT and are to be booked.

See Dhulwa Visitors to Dhulwa under the *Mental Health (Secure Facilities) Act 2016* procedure and the Dhulwa Visitors Handbook.

Back to Table of Contents

Section 5 – Risk assessment tools

Below are the formalised risk assessments that are used for the identification and management of aggression and violence at Dhulwa. The completion of these assessments assists in the formulation of the management of risk and informs levels of observation and engagement for consumers.

Risk assessment tool	how often to be completed or reviewed
TPRIM	• admission • monthly • change in clinical presentation
DUNDRUM	• receipt of referral to Dhulwa (DUNDRUM 1&2) • 3 monthly (DUNDRUM 3&4) • change in mental state has been identified • transition and discharge (DUNDRUM 1-4)
SVAT	• admission or change in treatment setting • abrupt/significant change in clinical presentation • 3 monthly • transition and discharge
DASA - APP	• every shift
HCR-20	• within 6-8 weeks of admission • change in risk profile • 6 monthly to accompany ICP reviews • prior to transfer or discharge (“out” assessment)
5Ws	• after each incident of violence • after any seclusion or restraint
Dynamic ISBAR	• prior to interventions that have potential to illicit aggressive response
CRA	• admission • daily if change in risk / presentation • align with any DASA rating increase • if observations are unusual • showing concerning behaviour • MDT reviews • deterioration in mental state

5.1 Treatment, Placement, Restrictions, Implementation and Monitoring Plan (TPRIM)

TPRIM is the document used for the day-to-day communication of risk and risk management strategies for an individual consumer. It includes information on the bi-psychosocial and physical needs of the consumer including any behavioural risks, and the management plan for any risk. TPRIMS are developed in Dhulwa for each consumer and are working documents that are regularly updated and reviewed by the treating team.

A TPRIM reflects a consumer’s day-to-day treatment and management plan, and considers:

- 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 with enabling safe delivery of care
- Restrictions – referring to any constraints that might be required to keep the consumer safe and 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

5.2 Dangerousness, Understanding, Recovery and Urgency Manual (DUNDRUM)

DUNDRUM is a four part (Triage, Urgency, Treatment completion and Recovery assessment), validated structured professional judgment instrument to support decision making regarding care environments, admission, leave and care transitions.

The DUNDRUM ratings are used to measure therapeutic engagement and progress and to inform the planning of activities, interventions, and therapeutic programs. The DUNDRUM informs the consumer's progress towards discharge and their therapeutic security needs.

The DUNDRUM is to be completed collaboratively by the MDT. Where possible, every effort should be made to encourage the consumer to complete the self-assessment version with the support of a clinician familiar with the DUNDRUM.

5.3 Suicide Vulnerability Assessment Tool (SVAT)

SVAT is used to document the assessment of a consumer's suicide vulnerability. The SVAT is used to formulate management strategies to mitigate the risk to the consumer.

SVAT is to be completed 3 monthly or if there is a change in clinical presentation and /or risk.

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

5.4 Dynamic Appraisal of Situational Aggression (DASA) – IV

The DASA-IV is a seven-item risk assessment tool to assist clinicians in identifying a consumer's potential for risk of aggression within the next 24 hours.

The DASA-IV is in the consumer's clinical record and 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 consumer being assessed.

The DASA -IV is to be completed during each shift by the consumers primary/ allocated nurse and documented in the clinical record. The consumers' presentation and behaviour over the previous 24 hours should be considered when scoring the DASA-IV.

DASA forms part of the Aggression Prevention Protocol (APP) used at Dhulwa, to reduce aggression using appropriate nursing inventions based on the DASA rating.

The seven items of DASA are:

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

DASA -IV is to be used as a guide for assessing the short-term likelihood of inpatient aggression. It is used in conjunction with the APP to support early intervention strategies. The APP provides prompts for staff as to the types of interventions that should be considered based on an individual's DASA-IV score. It aims to ensure the intervention is proportionate to the level of risk.

The assessments are not to be prescriptive in terms of dictating interventions, nor are they isolated from clinical judgement. The interventions are determined following consideration of available interventions and knowledge of what works for the individual consumer.

5.5 Historical Clinical Risk Management (HCR) – 20

The HCR-20 is a 20-item structured professional judgement tool used to assess an individual's risk for violence in clinical and forensic settings.
HCR-20 assesses both static and dynamic risk factors associated with an increased risk of violent recidivism. The HCR-20 allow the assessors to utilise a range of 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 HCR-20 will be completed within six to eight weeks following the admission of a consumer and reviewed if there is a change in their risk profile, 6 monthly and prior to discharge. The HCR-20 informs the plan to manage the consumers risk of violence.

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

The use of the HCR-20 may be complemented by using other relevant structured professional judgment tools such as specialist assessmentsof personality, sexual offending risk, stalking risk, psychopathy, or arson risk. A decision will be made by the MDT about the use of additional assessments based on individual clinical need.

5.6 Anamnestic Assessment (5Ws)

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 to assist in prevention in future incidents.

Documentation to support anamnestic assessment follows the 5W's format and is to be completed after each incident of violence and or seclusion and restraint. A 5W's report is to be completed in the consumer's clinical record.

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

5.7 Dynamic Risk Assessment ISBAR

The short-term dynamic clinical and environmental risk assessment and management planning approach known as the 'Dynamic ISBAR' is utilised in Dhulwa to identify responses and plan interventions in a situation where it is anticipated that a consumer may respond aggressively. A situation may be, but not limited to, discussions relating to withdrawal of privileges, delivering bad news, enforcing treatment and/or episodes of restraint and seclusion.

The Dynamic ISBAR should be:

- Held before any planned intervention
- Attended by all staff involved in the care of the consumer
- Kept to a maximum of 10 minutes
- Held in a central location accessible to all team members, ensuring workflow is not obstructed and safety and confidentiality can be maintained
- Clinical and non-clinical staff are encouraged to participate, to speak up for safety and contribute to identified issues/risks and proposed management plan.

The NIC will lead the Dynamic ISBAR discussion and development of a management plan in consultation with the team present to address any identified safety issues.

The NIC or primary nurse is responsible for documenting the Dynamic ISBAR discussions and plan in the consumer's clinical record as soon as practicable after the intervention. The notes should describe how effective the intervention was and the learnings.

Dynamic ISBAR

INTRODUCTION
Consumer demographics and behaviour in past 24 hours.

SITUATION
Identify the situation that has the potential to result in aggression and the planned interventions and the potential safety issues for both staff and the consumer.

BACKGROUND
Consumer's historical and current presentation that could impact on the outcome of the planned intervention and needs to be considered in the assessment of risks involved.

ASSESSMENT
Reviewing available information and resources to identify and assess risks and develop appropriate response.

RECOMMENDATION
Development of appropriate interventions and strategies to maintain staff/consumers safety.

5.8 Clinical Risk Assessment (CRA)

A CRA is completed by the medical officer with the consumer and their support person(s) on admission to 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.

CRA's are revised regularly throughout the consumer's admission and should reflect any changes to risk according to their presentation. The risk can be revised by any member of the treating team in accordance with 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.

The CRA is reviewed and completed by the MDT:

- To inform the consumer's level of observation
- If the consumer has been managed in the de-escalation area within the last 24hours
- When observation rating of ARC 5 level (1:1 nursing)
- Following an increase in DASA rating
- When risk factors are perceived to have changed, including feedback or information from families and carers

5.9 Observation

Observation through engagement is the purposeful gathering of information from consumers to inform clinical decision making and is the formal and objective assessment of a consumer's physical, mental, and social condition.

Two nursing staff are to be on the clinical floor at all times.

Observations are not passive but requires nurses to be person centred and engage therapeutically with consumers. Observation through engagement is for safety, protection from harm and maintenance of wellbeing and provides opportunity to develop rapport and contribute to ongoing assessment and recovery.

The purpose of observation is to provide optimum care, to escalate and manage deterioration in a timely way and ensure safety of the environment where care is provided.

Observations enable engagement with consumers which actively contributes to comprehensive care. There are several principles that underlie the practice of observation:

- It is multifaceted
- Observation and assessment are interrelated
- Observation is grounded in therapeutic engagement with the consumer
- Appreciation of how Dhulwa environments influence behaviour
- Are communicated between staff
- There is a clear process of documentation that is timely and descriptive.

The consumer's allocated nurse must always know the location of the consumer. 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 the safety of consumers.

There are 5 levels of ARC observation:

ARC Level	Level of Risk	Description
Level 1	Low risk	General engagement and observations every 2 hours
Level 2	Low to Medium risk	Intermittent engagement and observation every 50-60 minutes
Level 3	Medium risk	Frequent engagement and observation every 20- 30 minutes
Level 4	Medium to High risk	Close engagement and observation every 10- 15 minutes
Level 5	High risk	Continuous engagement and observation

ARC 1 - General Observation – 2 hourly

Minimum level of observation for a consumer at Dhulwa.

ARC 2 (Intermittent engagement and observations) – 50-60 Minutes

Consumer risk requiring observation higher than ARC 1.

ARC 3 (Frequent observations) – 20-30 Minutes

Consumer risk requiring observation higher than ARC 2, as assessed as posing a significant risk of:

- Suicide /Self harm
- Overt psychotic symptoms
- Harm to others
- Falls
- Severe self-neglect
- Violence, aggression, or physical harm

ARC 4 (Close observations) – 10-15 Minutes
Consumer risk requiring observation higher than ARC3 as assessed as posing a more severe risk than for ARC 3.

ARC 5 1:1 Engagement and observations or at arm's length
Consumer risk requiring constant observation at arm's length distance, as specified by the treating team, or when a person is in seclusion, as assessed as posing a serious, significant, and immediate risk as outlined for ARC 3 and 4.

Staff must not leave the consumer unsupervised under any circumstances or for any period of time. The consumer must be managed in a highly visible area. Staff providing continuous observation during normal sleeping hours will sit outside the consumer's bedroom, with the bedroom door open. The MDT may recommend increasing the number to two staff, depending on the risk i.e., self-harm or risk of violence.

Nurses can increase an ARC level, but not decrease. All changes in ARC level are to be discussed at MDT and reflected in the consumers TRPIM.

Back to Table of Contents

Section 6 – *Mental Health Act 2015* provisions

6.1 Restraint and forcible giving of medication

All Dhulwa staff are to comply with and refer to the CHS Restraint and/or Forcible Giving of Medication to a Person Detained under the *Mental Health Act 2015* Procedure.

All incidents involving the use of restrictive practices under the *Mental Health Act 2015* are reviewed at the Dhulwa Safe Practices Committee and the MHJHADS Restraint, Seclusion, Restrictive Practices Review Committee.

6.2 Seclusion

All Dhulwa staff are to comply with and refer to *the* CHS Seclusion of Persons Detained under the *Mental Health Act 2015* Clinical Procedure.

6.3 Decision making capacity

A consumer must be assumed to have decision making capacity unless established that they do not.

Article 12 of the Convention on the Rights of Persons with Disabilities recognises that people have the right to make decisions and be supported in their decision making.

All Dhulwa staff are to comply with and refer to the CHS Assessment of decision making capacity and supported decision making for people being treated under the *Mental Health Act 2015* procedure.

6.4 Advance agreement and advance consent directions

An advance agreement is a document stating a consumer's preferences for future mental health treatment, care and support and any relevant information about practical support they may need.

An Advance Consent Direction is a document that records the consumer consent or non-consent to receiving treatment, care or support, or specific medications and procedures if they do not have decision making capacity in the future.

All Dhulwa staff are to comply with and refer to the CHS Advance Agreements, Advance Consent Directions and Nominated Persons under the *Mental Health Act 2015* procedure.

6.5 Nominated person

A Nominated Person is a someone appointed by a consumer with a mental illness or mental disorder under the *Mental Health Act 2015.* A Nominated person is to be informed and consulted about the consumer's treatment, care, and support and to ensure that the consumers interests and rights are respected.

A Nominated person does not have the power to make treatment or other decisions on behalf of the consumer with a mental illness or mental disorder.

See CHS Advance Agreement, Advance Consent Direction and Nominated Person Procedure for further information.

6.6 Transfer of Custody

All Dhulwa staff are to be aware of the transfer of custody process of a consumer admitted to Dhulwa who is a detainee or young people in court ordered detention.

See Transfer of custody of a detainee/ young detainee admitted to Dhulwa under the *Mental Health Act 2015* procedure.

Back to Table of Contents

Section 7 – Codes

7.1 Emergency codes

All Dhulwa staff should comply with and refer to the Dhulwa Emergency Plan, a sub-plan of the CHS Emergency Management Plan which provides guidance for emergency responses at Dhulwa.

7.2 Code Black

Dhulwa has Emergency Response Team (ERT) and Special Emergency Response Team (SERT) to ensure an appropriate first response of qualified personnel occurs to a code black.

7.2.1 ERT

To manage and deescalate the situation using least restrictive methods available, led by the NIC.

7.2.2 SERT

An extension of the code black emergency response where a situation has exceeded normal clinical response capabilities (i.e., extreme violence, use of non-bladed weapons or firearms, but not yet requiring intervention by police). SERT is led by the senior security officer.

7.3 Duress Alarms

All members of staff are required to wear a personal duress alarm. Duress alarms are kept in the Dhulwa key room and are to be collected by staff at the commencement of their shift. Duress alarms are registered to specific staff members for each shift.

Fixed duress alarms are located throughout Dhulwa and in the carpark. Staff are to make themselves familiar with their location.

Back to Table of Contents

Section 8 – Electronic devices for consumers

The *Mental Health (Secure Facilities) Act 2016* enables people admitted to Dhulwa to use electronic communication as a form of contact. A specific area for electronic communication is to be provided where the consumer will always be supervised, and consumers are not to use the electronic communication device to capture visual data (see definitions of terms) of the consumer of another person.

To balance those considerations of contact, restrictions or limitations may be placed on the consumers access to an electronic communication device, as a form of contact. The restrictions or limitations will be applied in accordance with the *Mental Health (Secure Facilities) Act 2016,* see Dhulwa Visitors to Dhulwa under the *Mental Health (Secure Facilities) Act 2016* Procedure for more information.

A room within the therapy space of Dhulwa has been identified as the electronic communication area. All consumers in the electronic communication area are to be always supervised by Dhulwa staff, as required by the *Mental Health (Secure Facilities) Act 2016*.

Detainees

While a detainee or young detainee transferred from a correctional centre or detention place, and their custody is transferred to CHS, their status as a detainee or young detainee remains while in Dhulwa.

Any restrictions or limitations applied to detainees or young detainee's electronic communication while admitted to Dhulwa will be in line with either the:

- *Corrections Management Act 2007* and ACT Corrective Services policies and procedures, or
- *Children and Young People Act 2008* and Bimberi policy and procedure.

Forensic History

A consumer's forensic history and offences will be considered when determining limitations and restrictions to an electronic communication profile.

Monitoring authorisation

Only a Delegated Officer may authorise a consumer's communication be monitored. The authorisation may be made if the Delegated Officer believes on reasonable grounds that the monitoring is necessary and reasonable to avoid prejudicing the effectiveness of the patient's treatment, care, or support.

Monitoring is defined in the Macquarie Dictionary as to check, observe or record the operation of (a machine) without interfering with the operation.

If a decision is made by the Delegated Officer the consumers communications are to be monitored, the parties to the communication are to be told:

- that their communication may be monitored, and
- If it is monitored, that it has been monitored.

Back to Table of Contents

Section 9 – Food services

All consumers eat their meals in the dining area and are to be supervised.

9.1 Cutlery

Each consumer is assessed by the MDT to determine if they can have cutlery at mealtimes. The assessment is informed by any risks to the consumers own safety or to others and the outcome is documented in the consumers TPRIM plan.

9.1.1 Cutlery inventory

A cutlery inventory is to be maintained for the dining rooms. The CHS food services staff are responsible for maintaining the inventory list.

Each piece of cutlery is engraved with bedrooms numbers. Consumers are allocated the cutlery matching their bedroom number for each meal.

9.2 Supervision at servery area

- Two staff members must always be present at the servery area to supervise mealtimes.
- A cutlery count is to occur at the beginning and end of each mealtime.

9.3 Supervision in dining room

- Nursing staff are required to supervise consumers in the dining room for all meals and are encouraged to interact with consumers during mealtimes (i.e., sit at each table). This provides opportunity for general engagement and opportunistic de-escalation or response to issues of safety or security that may arise in the dining room.
- If additional staff are required (e.g., one or more consumers are unsettled or have escalating behaviour).

9.4 Searches for missing cutlery

- In the event of missing cutlery, and reasonable grounds have been established for a search of the dining areas, a delegated officer may authorise a search. See Dhulwa Searching (patients, personal property, bedrooms, premises under the *Mental Health (Secure Facilities) Act 2016*.

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

- Cutlery or utensils cannot be found; or
- Near miss or an incident resulting from the misuse of cutlery or utensils.

9.5 Self-catered meals

The self-catering program at Dhulwa provides opportunities for recovery by providing occasions in a safe and supportive environment to address challenges and develop skills and resources that will promote community living and enhanced quality of life.

Consumer will be assessed by the MDT to identify the level of participation and supervision for self-catering their own meals. 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.

Back to Table of Contents

Section 10 – Discharge

All Dhulwa staff should comply with and refer to the *CHS Admission to* Discharge Procedure (Adults and Children) and the CHS Discharge Summary Completion – Inpatients.

All transfers and discharges from Dhulwa are referred to the AAP. Eligibility for discharge is considered with regard to the Dhulwa admission criteria, legal status, therapeutic security needs as assessed on the DUNDRUM 1, risks as assessed by the HCR-20 or other structured risk assessment, and therapeutic recovery and program completion as assessed by the DUNDRUM 3 & 4.

Discharge planning needs to be coordinated and comprehensive to support people on discharge in an optimal manner. As part of discharge planning, an expected discharge timeframe will be discussed with the consumer, their guardian, families and carers and any other support services or networks. It will be noted if community supports, and housing options are needed to be arranged.

The Dhulwa team are required to involve relevant stakeholders including clinical managers, families and carers, General Practitioners (GP), private psychiatrists and other treating specialists, private counsellors, and psychologists as a core element of discharge planning. For consumers subject to a Conditional Release Order being considered for discharge to a community placement, a referral must be made to the Forensic Consultation and Intervention Service (FoCIS) at least 3 months prior to discharge.

It is the responsibility of the CNC to invite the relevant people to discharge planning meetings.

Graduated leave and supported transition arrangements will be implemented to assist people to discharge safely and successfully from Dhulwa.

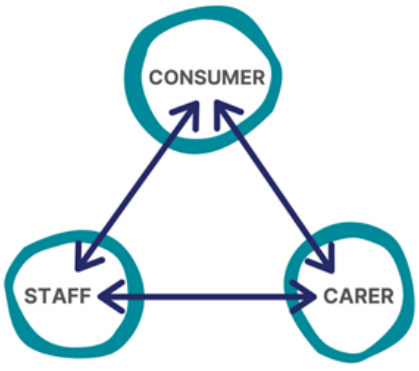
Guidance on the collection of discharge medications can be found in the CHS Medication Handling Policy.

Back to Table of Contents

Section 11 – Partnering with consumers, carers, family, and other supports

CHS and Dhulwa are committed to partnering with consumers and carers as a foundation for exceptional care. Partnering with consumers supports a person-centred approach to individual care experiences and how Dhulwa staff deliver care. Dhulwa staff work alongside consumer and carers and listens and learns from their experience which is essential to achieving the CHS vision of creating exception health care together and the dedicated Dhulwa vision of hope, healing and creating meaningful lives for a safer future together.

Dhulwa is committed to the triangle of care to encourage and improve engagement between the consumer, carer and the health professionals providing care to the consumer.



The Triangle of Care, adapted from Worthington, Rooney and Hannan, 2013

Dhulwa staff engage and partner with consumers through:

Dhulwa consumer community meetings held weekly with consumers and staff and is an opportunity to raise any issues, concerns, or questions a consumer may have, including:

- What's on for the day?
- Any housekeeping issues, or if anything fixing?
- How are we all feeling?
- What are our goals are for the day?
- Any issues or incidents to be raised?
- Suggestions from consumers**.**

Dhulwa has processes to review and monitor consumer experience. Dhulwa undertakes regular surveys using validated tools which provide information that measures:

- The roles and relationship between staff and consumers
- How consumers feel about the ward environment and co-consumers
- How consumer feel personally safe on the ward
- Consumers experience of their care.

A Carer forum provides the opportunity to identify concerns and make improvements. The forum enables open communication about the process of Dhulwa and for carers to share their experiences. This is not a forum for individual consumer clinical care discussion, as that occurs in other clinical processes.

Partnering with consumers and carers is supported by open communication between the consumer, carer and all Dhulwa staff, with consent from the consumer. Communication enables carers and families to be actively involved in the consumer journey and recovery.

Partnering with consumers are also supported by advocacy services, either individual or system support:

- ACT Disability, Aged and Carer Advocacy Service (ADACAS) an independent community organisation that provides free advocacy and information for people with disabilities, including psychiatric disability, and vulnerable older people, to assist consumers assert their rights or interests, or to have their needs met.

- Public Advocate advocates for people who may not be able to advocate for themselves, and monitors the services provided to people at Dhulwa to ensure their rights are protected, and their best interests are promoted.

- Official Visitors are independent of CHS to ensure inpatient mental health facilities in the ACT are providing the best possible care and visit Dhulwa monthly.

- ACT Mental Health Consumer Network (ACTMHCN) is an independent, consumer-lead organisation advocating for the interests of people with a mental illness in the ACT. The ACTMHCN does not provide individual advocacy, but trains and supports people to engage in systemic advocacy to improve metal health services based on the individual and collective experience of people with mental health issues.

- Carers ACT offers support, information and advice, counselling, respite, support groups, educational and social activities to family and friends caring for a loved one.

See CHS Partnering with Consumers Framework and CHS Partnering with Consumer policy for further information.

Back to Table of Contents

Section 12 – Documentation

Clinical documentation is an essential component of effective communication between the treating team and is one of the most important information sources available to a treating team.

The purpose of a clinical record is to communicate clinical information between members of the treating team. The clinical document provides accurate reflections of the assessment made, changes in clinical state, the care provided and pertinent information to support the ongoing clinical care provided to the consumer.

Clinical records are multidisciplinary and are to contain sequential entries from all health professionals on the treating team. Clinical records are to document the engagement with the consumer at the time it occurs or as soon as practicable after.

The CHS centralised clinical record system is to be used to record all interactions, assessments, and clinical tools between a consumer and CHS. The implementation of the CHS centralised clinical record system has meant paper risk assessment and templates are no longer used as they have been have built into the clinical record.

See CHS Clinical Records Procedure for further information.

For consumers who are subject to involuntary treatment and care on a mental health order under the *Mental Health Act 2015*, or other orders granted by the ACT Civil and Administrative Tribunal (ACAT) staff are to be aware of the information contained in the orders, including expiry dates and obligations regarding the provision of reports to ACAT, which are to be included into the consumers' clinical record.

Staff should make efforts to encourage consumers' engagement and attendance at ACAT hearings and in the process.

See CHS Care of Persons subject to Psychiatric Treatment Orders with or without a Restriction Order, CHS Care of Persons subject to Forensic Mental Health Orders, and CHS Care of Persons subject to a Conditional Release Order procedure.

Back to Table of Contents

Section 13 – Dhulwa governance and meeting structure

Dhulwa governance is embedded within the existing MHJHADS and CHS corporate, clinical, and operational governance systems which provide a framework that draws together initiatives, process, systems, and ways of working.

The Forensic Mental Health Services Clinical and Operational Directors provide overarching leadership to ensure service delivery is in line with the strategic direction, organisational accountability targets and corporate governance processes. The Dhulwa clinical governance structure sits within a tiered hierarchy of organisational governances regarding decision making and endorsement of service activities.

See Attachment 1 for the Dhulwa Meeting Structure.

Back to Table of Contents

Evaluation

Outcome

- Dhulwa staff orientated and aware of Dhulwa operational procedures.
- Dhulwa consumers receive safe, effective care, therapy, and treatment.

Measures

- Number of admissions by referral location reported 6 monthly to the Dhulwa Governance Meeting.
- Audit of completion of structured risk assessments reported 6 monthly to the Dhulwa Governance Committee.
- Results from annual consumer surveys reported to the Dhulwa Governance Committee.

Back to Table of Contents

Related Policies, Procedures, Guidelines and Legislation

Policies

- Informed Consent (Clinical)
- Medication Handling
- Occupational Violence
- Smoke Free Environment
- Work Health and Safety & Work Health and Safety Management System
- Partnering with Consumers

Procedures

- Incident Management
- Advance Agreements, Advance Consent Directions and Nominated Persons under the *Mental Health Act 2015*
- 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)
- Ligature Use, Response and Risk Management in MHJHADS
- Clinical Handover
- Dhulwa Mental Health Unit Searching (patients, personal property, bedrooms, premises under the *Mental Health (Secure Facilities) Act 2016*
- Dhulwa Mental Health Unit Transfer of Custody of a detainee/ young person admitted to Dhulwa under the *Mental Health Act 2015*
- Dhulwa Mental Health Unit Visitors to Dhulwa under the *Mental Health (Secure Facilities) Act 2016*
- Dhulwa Mental Health Unit Use of Force to search a consumer under *Mental Health (Secure Facilities) Act 2016*
- Dhulwa Mental Health Unit Prohibited Items under the *Mental Health (Secure Facilities) Act 2016 and restricted items.*
- Dhulwa and Gawanggal Leave 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
- Occupational Violence
- Patient Identification and Procedure Matching
- Seclusion of Persons with Mental Illness or Mental Disorder Detained under the *Mental Health Act 2015*
- Sharing Information with Carers – MHJHADS Adult Inpatient Units
- Providing Physical Health Care across MHJHADS
- Discharge Summary Completion – Inpatient
- Protective Security – Closed Circuit Television
- Care of Persons subject to Forensic Mental Health Orders
- Care of Persons subject to a Conditional Release Order
- CHS Missing Patient Procedure
- Adult Acute Mental Health Inpatient Services Operational Procedure
- Bringing Food into Canberra Health Services (Adults and Children)

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

- *Mental Health Act 2015*
- *Mental Health (Secure Facilities) Act 2016*
- *Human Rights Act 2004*
- *Health Records (Privacy and Access) Act 1997*
- *Information Privacy Act 2014*
- *Carers Recognition Act 2021*
- *Work Health and Safety Act 2011*

Other

- Australian Charter of Healthcare Rights
- ACT Charter of rights for people who experience mental health illness
- Forensic Mental Health Inpatient Services Model of Care
- Dhulwa Security Operational Framework
- Partnering with Consumers Framework

Back to Table of Contents

Definition of Terms

Capture Visual Data means a person captures visual data of another person if the person captures moving or still images of the other person by a camera or any other means, in such a way that:

- A recording is made of the images, or
- The images are capable of being transmitted in real time with or without retention or storage in a physical or electronic form, or
- The images are otherwise capable of being distributed.

Back to Table of Contents

Search Terms

Dhulwa, DMHU, secure, meals, cutlery, security, forensic, prohibited item, visitor, referral, admission, inpatient care, risk assessment, CRA, TRPIM, DUNDRUM, safety check, environment, medication, supervision, daily routine, therapy framework.

Back to Table of Contents

Attachments

Attachment 1 – Dhulwa Meeting Structure
Attachment 2 – Dhulwa Therapy Framework

Back to Table of Contents

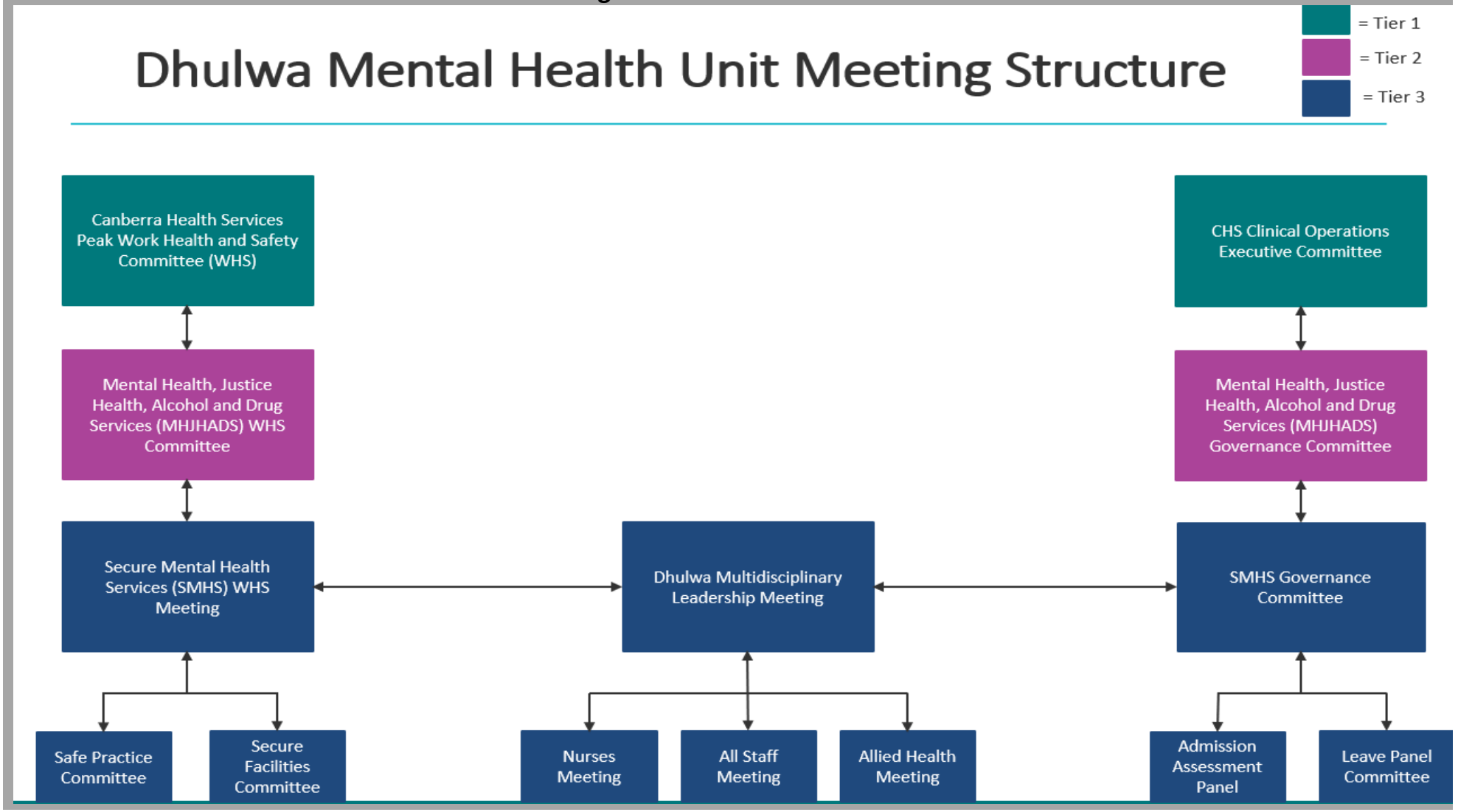
Policy Team ONLY to complete the following:

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

This document supersedes the following:

Document Number	*Document Name*

Attachment 1 – Dhulwa Mental Health Unit meeting structure



Attachment 2 – Dhulwa Mental Health Unit Therapy Framework