Health
Western Sydney
Local Health District

WESTERN SYDNEY LOCAL HEALTH DISTRICT (WSLHD)

BORONIA NON ACUTE MENTAL HEALTH INPATIENT UNIT, CUMBERLAND HOSPITAL

MODEL OF CARE (MOC)

Version 4.0, 15th September 2020

DOCUMENT ADMINISTRATION

Version	Date	Issued To	Remarks
1.0	August 2018 February 2019	EDMH MOC workshop attendees	Issued as 18/103076 for WSLHD-wide Subacute and Non-acute MH IPUs MOC
2.0	13 July 2020	Members of the Cumberland West Operational Change and Delivery Committee (OCDC)	Issued as a draft MOC specific to the new 20-bed subacute MH IPU at Cumberland West, prior to further consultation.
3.0	7/8/20	Feedback form OCDC	Sub-acute changed to non-acute to reflect – like for like build and transition of current consumers
4.0	15/9/20	Feedback from OCDC	Multiple changes throughout document

TABLE OF CONTENTS

1. Introduction

Western Sydney LHD Mental Health Services

OUR PRIORITIES

The three key priorities of the WSLHD Mental Health Service are:

1. Delivering world-class holistic and person centred mental health care;
2. Fostering a culture of innovation;
3. Developing research and evidence based practice.

OUR PURPOSE

We are committed to providing the highest quality of mental health care to the people we serve in a compassionate and respectful manner.

OUR GOALS

- Quality & Safety
- Patient & Staff Satisfaction
- Teamwork, Partnerships & Collaboration
- Skills, Competence, Research and Innovation
- Promoting Healthy Communities

OUR VALUES

- Professionalism
- Teamwork
- Evidenced based practice
- High standards of compassionate mental health care
- Continuous learning and development
- Collaboration

The Boronia unit is built next to the current site to enable Parramatta Light Rail as a like for like build in current Australasian Facility Guidelines (AusHFGs). This has provided an opportunity for enhancing safe therapeutic environment. The unit will continue to provide non-acute clinical rehabilitation and holistic care to current cohort of consumers.

Boronia is a 20 bed non- acute Mental Health Unit providing recovery –oriented rehabilitation care for adults and who no longer require acute in-patient care but whose mental health problems requires further stabilisation in the least restrictive in-patient environment, prior to transition back into the community. Care provision is focused on the recovery paradigms of hope, self-determination, self-management, empowerment and advocacy in order to optimise independent functioning. Along with self-responsibility and the restoration of family and community relationships.

The strategic framework for mental health

Significant guidance is provided by an array of key strategies and policies at state and national level, including:

The NSW Mental Health Reform (*Living Well*) calls for mental health care that is:

- Person-centred and tailored
- Family and community focussed
- Recovery-oriented
- Trauma-informed
- Provided in the least restrictive way
- Delivered in partnership with people with lived experience and their families and carers and other organisations.

The *Fifth National Mental Health and Suicide Prevention Plan* (2017) focuses on eight priority areas:

- Achieving integrated regional planning and service delivery
- Suicide prevention
- Coordinating treatment and supports for people with severe and complex mental health problems
- Improving Aboriginal and Torres Strait Islander mental health and suicide prevention
- Improving the physical health of people living with mental health problems and reducing early mortality
- Reducing stigma and discrimination
- Making safety and quality central to mental health service delivery
- Ensuring that the enablers of effective system performance and system improvement are in place.

The national framework for recovery orientated mental health services: Policy and theory
Principles of recovery oriented mental health practice

Australia's *National Standards for Mental Health Services 2010* underpin the national recovery framework. Of particular importance are the 'Principles of recovery oriented mental health practice' and the 'Supporting recovery' standard (Standard 10.1).

They are reproduced here in full:

1. Uniqueness of the individual

Recognises that recovery is not necessarily about cure but about having opportunity for choices and living a meaningful, satisfying and purposeful life and being valued member of the community
Accepts that recovery outcomes are personal and unique for each individual and go beyond an exclusive health focus to include an emphasis on social inclusion and quality of life

Empowers individuals so that they recognise that they are at the centre of the care they receive

2. Real Choices

Supports and empowers individuals to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored

Supports individuals to build on their strengths and take as much responsibility for their lives as they can at any given time

Ensure that there is a balance between duty of care and support for individuals to take positive risks and make the most of the new opportunities.

3. Attitudes and rights

Involves listening to, learning from and acting upon communications from the individual and the carers about what is important to each individual

Promotes and protects individuals' legal, citizenship and human rights

Supports individuals to maintain and develop social, recreational, occupational and vocational activities which are meaningful to the individual

Instils hope in an individual's future and ability to live a meaningful life

4. Dignity and Respect

Consists of being courteous, respectful and honest in all interactions

Involves sensitivity and respect for each individual, particularly for their values, beliefs and culture

Challenges discrimination and stigma wherever it exists within our own service or the broader community

5. Partnership and communication

Acknowledges each individual is an expert on their own life and that recovery involves working in partnership with individuals and their carers to provide support in a way that makes sense to them

Values the importance of sharing relevant information and the need to communicate clearly to enable effective engagement

Involves working in positive and realistic ways with individuals and their carers to help them realise their own hopes, goals and aspirations

6. Evaluation recovery

Ensures and enables continual evaluation of recovery-based practice at several levels

Individuals and their carers can track their own progress

Uses the individual's experiences of care to inform quality improvement activities

The mental health system reports on key outcomes that indicate recovery including (but not limited to) housing, employment, education and social and family relationships.

2. Definitions

The following are definitions of terms, abbreviations and acronyms used in this document.

Term	Definition
AusHFGs	Australasian Health Facility Guidelines
CMHT	Community Mental Health Team
DBT	Dialectical Behaviour Therapy
ECT	Electroconvulsive Therapy
ED	Emergency Department
MHICU	Mental Health Intensive Care Unit
IPU	Inpatient Psychiatric Unit
MHAU	Mental Health Assessment Unit
MHRT	Mental Health Review Tribunal
NGO	Non-Government Organisation
NDIS	National Disability Insurance Scheme
PCLI	Pathways to Community Living Initiative
PDA	Personal Duress Alarm
PHN	Primary Health Network
WSLHD	Western Sydney Local Health District

3. Service Model

3.1. Aim

The non-acute health inpatient care service provides treatment and rehabilitation in a safe, structured environment for people with severe symptoms of mental illness and significant associated disturbance in behaviour which precludes their receiving treatment in a less restrictive environment.

It will provide continuity of care for consumers who need to transition from acute care services into non-acute services. The service will provide rehabilitation and recovery oriented trauma informed care that meets the needs and the expectation of the consumers to ensure the culture of the unit remains focused on collaborative partnerships. Integrated care is provided with consumer-led transitional care to community living.

Services include:

- specialist behavioural and symptom management programs;
- Individualised and group rehabilitation programs aimed at maximising individual functioning and minimising the effects of long term care
- Rehabilitation is currently provided primarily by medical and nursing staff with limited allied health involvement. The level of involvement of allied health is currently under review.
- community placement planning to support safe transition to more independent living.

Three core elements of the service will include;

1- structured interactions to support recovery, including symptom reduction/stabilisation and optimisation of functioning

2 - specialised multidisciplinary care including intensive individualised rehabilitation and highly specialised structured multidisciplinary

3 - specialist clinical care for consumers with ongoing clinical needs and clinical risk profiles such that a less restrictive form of care is not currently appropriate.

3.2. Key Features

The unit is designed to provide a secure and safe environment, to enable consumers to transition when appropriate from an acute MH IPU. Programs have a strong focus on providing individualised clinical rehabilitation to meet the needs of each consumer in a therapeutically safe environment.

Principles of Care

The *Mental Health Act 2007* establishes principles for care and treatment (s68) as follows:

- people with a mental illness or mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given,

- people with a mental illness or mental disorder should be provided with timely and high quality treatment and care in accordance with professionally accepted standards,
- the provision of care and treatment should be designed to assist people with a mental illness or mental disorder, wherever possible, to live, work and participate in the community,
- the prescription of medicine to a person with a mental illness or mental disorder should meet the health needs of the person and should be given only for therapeutic or diagnostic needs and not as a punishment or for the convenience of others,
- people with a mental illness or mental disorder should be provided with appropriate information about treatment, treatment alternatives and the effects of treatment and be supported to pursue their own recovery,
- any restriction on the liberty of consumers and other people with a mental illness or mental disorder and any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances,
- any special needs of people with a mental illness or mental disorder should be recognised, including needs related to age, gender, religion, culture, language, disability or sexuality,
- people under the age of 18 years with a mental illness or mental disorder should receive developmentally appropriate services,
- the cultural and spiritual beliefs and practices of people with a mental illness or mental disorder who are Aboriginal persons or Torres Strait Islanders should be recognised,
- every reasonable practicable effort should be made to involve persons with a mental illness or mental disorder in the development of treatment plans and recovery plans and to consider their views and expressed wishes in that development,
- every reasonable practicable effort should be made to obtain the consent of people with a mental illness or mental disorder when developing treatment plans and recovery plans for their care, to monitor their capacity to consent and to support people who lack that capacity to understand treatment plans and recovery plans,
- people with a mental illness or mental disorder should be informed of their legal rights and other entitlements under this Act and all reasonable efforts should be made to ensure the information is given in the language, mode of communication or terms that they are most likely to understand,
- the role of carers for people with a mental illness or mental disorder and their rights under this Act to be kept informed, to be involved and to have information provided by them considered, should be given effect.

Opportunities will exist for holistic general health assessment to be undertaken and consumers provided with treatment as required.

MH Outcomes measures will be incorporated into consumers care plans in collaboration with consumers to support each consumer's clinical rehabilitation plan whilst receiving care within non-acute care settings.

3.3. Diagnostic Profile

Primary diagnoses will include schizophrenia, psychosis or severe mood disturbances. There will also be consumers who have complex presentations including issues with personality disorders or exacerbations of underlying personality traits, drug and alcohol illnesses, complex trauma, cognitive deficits and clinically significant deficits in psychosocial functioning. Associated issues of behaviour and risk which indicate a need for rehabilitation include severely disorganised behaviour leading to difficulty in managing activities of daily living, impaired impulse control, vulnerability, ongoing risk of aggression, and other risk factors.

3.4. Description of the Service Model

This adult non-acute mental health inpatient unit:

- is declared under the NSW Mental Health Act (2007);
- typically, has consumers transitioning from acute mental health inpatient units, subacute or other non-acute units
- has a length of stay up to 12 months (365 days)
- Consumers who have a length of stay over 365 days are considered eligible for PCLI (pathways to community living) and are provided with access to additional supports to assist with meeting community based transitional needs
- facilitates transitions of consumers based on clinical needs to appropriate care settings (other cottage units or community or acute units)

The following features characterise a non- acute model of care:

- individual recovery plans aligned to the ultimate goal of developing the capacity and capability for the consumer to return home and/or to the community, and this is in alignment with the Pathways to Community Living Initiative (PCLI);
- a multidisciplinary and team bio-psycho-social approach to care;
- treatment and therapeutic programs tailored to individual consumer needs with a focus on promoting independence and skills that enable transition to the community;
- an integrated service designed to support effective transition from the inpatient setting to services provided in the community by the Community Mental Health Teams (CMHTs), community organisations and Primary Health Network (PHN) services
- increased engagement with CMHTs, community organisations and PHN commissioned NGO service providers with capacity to provide both in-reach programs to the MH IPU and a community-based programs and continuity of support following discharge
- Involvement of the family/carer where appropriate in the rehabilitation and recovery process.

This approach to non-acute care is not prescriptive, it recognises that consumers at different phases of recovery may benefit from accessing different services at different levels matched to current and changing need. It does not require the consumer to progress from lower to higher levels but emphasises the importance of longer term care provisions as determined by consumers individual mental health needs.

3.5. Intended Role

The non-acute inpatient unit provides multidisciplinary, family focused, culturally sensitive assessment and treatment for consumers affected by mental health problems.

4. Consumer Profile

4.1. Consumer Eligibility Criteria

The unit will admit both voluntary and involuntary consumers under the provisions of the NSW Mental Health Act 2007. During an admission, a consumer's status can change between voluntary and involuntary depending on risk factors, treatment plans and the consumer's response to treatment.

Indications for admission include:

- Severe mental illness.
- Consumers admitted to an acute inpatient unit but with a relatively stable pattern of clinical symptoms;
- including high levels of severe unremitting symptoms of mental illness; and
- requirements for very high levels of need for additional support.

The age of admission to the non-acute MH IPU is defined as an adult age 18 – 64 years. Consumers younger or older than the specified age group will need to be assessed based on care needs. Any other outlining referrals will be assessed on a case by case basis.

4.2. Consumer Exclusion Criteria

Consumers under 18 years of age or over 65 years old - note exception outlined above.

Consumers requiring acute inpatient care.

Primary diagnosis of Intellectual disability or delay / acquired brain injury

Primary diagnosis of substance use

5. The Consumer Journey

5.1. Referral & Screening

Ideally the consumers proposed treatment plan outlining the need for admission, their required care level and the required setting to begin the admission will be determined prior to the admission.

Referral form with all the required accompanying paperwork is to be sent by the current treating team to Rehabilitation Services for consideration.

Email address for all referral forms - WSLHD-RecoveryReferrals <WSLHD-RecoveryReferrals@health.nsw.gov.au> . Referral form is in Appendices 1

Referral scanned and sent to NUMs and medical staff

Screening assessment via an interview with consumer and staff form referring team completed according to screening roster. There is a set KPI of having the screening process of all referrals completed with 48 Hrs.

Referral forwarded and discussed with unit most appropriate for pt. referred

Full Assessment will be completed by at least 2 Unit based staff. This can include staff from any of the following disciplines - Nursing/Allied Health / Medical. There is a set KPI of having the full assessment completed for all referrals within 1 week from the receipted date of the screening assessment decision.

Referral Outcome will be communicated to referring unit and consumer and family/ carer

Transition plans organised with timeframes based on available negotiated between Boronia Unit NUM and the NUM of the referring Unit.

5.2. Access

The non-acute MH IPU will provide access to appropriate screened and assessed consumers to transition from acute, subacute and other non-acute settings.

The unit is gazetted and will be contained, with controlled access and egress. Consumers are regularly monitored based on the level of observations. All leave provisions are determined as part of the provisions of the *NSW Mental Health Act (2007)*.

5.3. Treatment / Intervention

Upon admission to the non-acute unit, the consumer and their family/carers will be involved in developing a care plan with the treating team

The unit is to provide structured programs to provide rehabilitation and recovery focused interventions including symptom reduction and stabilisation and optimisation of functioning.

Multi-disciplinary care is provided including well planned, goal oriented and time limited intensive individualised rehabilitation interventions. The range of clinical interventions include:

- provision of a tailored therapeutic milieu
- psychological interventions
- pharmacotherapy
- family and partner psycho-education
- Electroconvulsive Therapy (ECT).
- Occupational therapy
- Social Work
- Diversional therapy
- Exercise program
- Diet interventions
- Art Therapy
- Peer support services
- Chaplaincy

Bio-sociocultural differences should be considered when tailoring clinical interventions for culturally diverse families, including Aboriginal families.

Consumers and carers will be made aware of the Mental Health Review Tribunal process and actively included in the process. Rights and responsibilities information will be provided to all consumers in the appropriate language. Appeal processes and legal representation entitlement should be included with the information where appropriate

5.4. Discharge Planning

Assessment, care planning, clinical review and discharge planning processes will ensure early engagement with the consumer's social network and the role of services in the community.

Early in the admission, an estimated date of discharge may be determined by the treatment team and in consultation with the consumer, their family / carers. The estimated date of discharge is used as a guide for treatment goals and for discharge planning to allow for the treating team to support the consumer to plan for what support they will need when they are discharged. This may involve a range of community based supports including CMHTs.

Close partnership with a range of government and non-government agencies and services. The NSW Health, and Housing NSW, Housing and Accommodation Support Initiative (HASI) program is a key partner

Non-Government Organisations (NGOs) offer additional care options and care, particularly under the NDIS. Links should also be provided back to a consumer's General Practitioner

INSERT Diagram Non acute consumer journey once completed

6. Key Service Relationships

6.1. External to WSLHD

An extensive range of external partners includes: Family and Community Services (FACS); regional Public and Community Housing Offices; Other government services; non-government organisations; Aboriginal Community-Controlled Health Organisations; local Health Care Interpreter Services; specialist multicultural agencies and local government services; GPs, Primary Healthcare Networks, primary care Mental Health Nurses and other specialist health practitioners.

Mental Health reform across both state and national levels have a key focus on networking and integrating care with key partners to achieve optimal care of our community. Strong relationships with partners in primary health and non-government organisations (NGOs) will be strengthened to enable step-up and step-down services, along with in-reach into inpatient mental health units. Expanding psycho-social supports provided by the NGO sector for adults with severe mental health problems living in the community is evidenced by the Community Living Support (CLS) initiative, which aims to reduce hospitalisations and length of stay in hospitals and improve mental and physical health.

Consumers will continue to be strongly encouraged and supported to access the packages and services available under the National Disability Insurance Scheme (NDIS) as applicable to their individual needs.

6.2. Internal to WSLHD

Key functional relationships will include yet not be limited to: acute MH IPUs at Cumberland,, Westmead and Blacktown hospitals; Other Non-acute services within MHS , Cumberland Admissions Unit; Aboriginal Liaison Officer; Transcultural Mental Health Centre; Healthcare Interpreter Service, Chaplains, Patient Trust Office, Centre for Addiction Medicine and other relevant programs, such as Westmead Ambulatory Clinics and the Emergency Department.

7. Operational Arrangements

7.1. Hours of Operation

The non- acute MH IPU will operate 24 hours per day, 7 days per week.

Visitors will be able to access the unit between 0800 and 2000 hours or as negotiated with the treating team. There is a visitor log book that will be placed in the reception area for all visitors to use.

Family members and carers of consumers are to be encouraged to have visits, meetings and where relevant supervised or unsupervised access on the unit and in the community.

8. Staffing Model

Non-acute staff work as a multidisciplinary team in a permanent and visiting capacity. Staffing levels and skill mix will vary. The treating team is a multidisciplinary team that consists of a Consultant Psychiatrist, a Registrar or CMO, Nurse Unit Manager / other nursing staff and allied health staff (including Psychologist, Occupational therapist, Exercise physiologist , Art Therapy , Diversional Therapist, Dietician and Social workers) in addition to Peer Workers , Pharmacy, Aboriginal Liaison Officer and Family and Carer Supports.

9. Facility features of the new subacute MH IPU

[needs to be checked against final floor plans to ensure all spaces are included]

The new subacute MH IPU has been built to the standards required in the AusHFGs. It has several features that support the model of care and offer choice to consumers, visitors and staff:

- Each consumer will have a single bedroom with an ensuite
    - One bedroom of the twenty is slightly larger and has an accessible ensuite
    - *Four* bedrooms have a nurse call installed.
- There is a dining area with a mix of tables and chairs so consumers can choose different seating arrangements. It contains a small kitchenette bench area so consumers can access food and beverage items for themselves as required.
- A main lounge area, with two other small lounge areas.
- A multifunction room (and store) for group activities, an art room and a music room.
- A quiet room for sensory modulation
  A low stimulus environment is utilised to promote recovery and rehabilitation with different age groups and populations, where consumers have opportunities to manage distress and agitation using sensory modulation equipment, such as music or different textures.

- An interaction desk adjacent to the clinical workroom. This space can be utilised by both staff and consumer to access computers as required.
- A lounge / consumer family room adjacent to the main lounge area for the family to meet consumers who need to remain close to staff and without coming into the main part of the unit. There is also a second Family / Interview room close to the entrance to the unit. The location of these family rooms is in response to feedback from family and visitors about some of the difficulties associated with coming into the wards to see their loved one.
- Two interview rooms for consultations and therapeutic sessions with staff.
- There is an internal courtyard and an external courtyard with a BBQ and other therapeutic aspects, such as a water feature and landscaping.
- A consumer laundry with washing machines and dryers and a small courtyard for drying clothes.
- A store – for consumer property.

A new space called the Pavilion will open in September 20202 and will provide a range of recreation / leisure and group spaces for consumers to use in addition to an indoor exercise gym for consumers with trained staff. There is also an outside BBQ area that offers an alternate space for consumers and their friends / families to enjoy. All these spaces will be bookable.

In addition to the therapeutic environment assisting staff, the following features are for staff to utilise:

- A staff room. This is where a portable duress charging station will be located.
- A property bay with lockers
- Two staff toilets and a staff shower.
- A clinical workroom with an Electronic Patient Journey Board for handover and a number of workstations for writing up notes etc.
- A Clean Utility and a Treatment Room.
- A kitchen and pantry for the service of meals, with the opportunity to use the kitchen as an ADL kitchen outside meal times.
- A cleaner's room.
- A general property store.
- Linen store.
- Disposal room.
- A NUM's office within the ward.
- Three offices for Director Rehabilitation, Staff Specialist and a shared office for two Registrars, along with a Reception area.

Staff can also utilise the following areas for alternate uses:

- The multifunction room may be used for large meetings e.g. multidisciplinary team (MDT) and will have a large screen in the rooms so could be used for training purposes – for consumers or staff.
- The art room, which is relatively close to the entrance, could be used for meetings with external providers or large family case conference groups so that visitors do not have to go into the ward.

For visitors there will be:

- Within the entrance area, a waiting area with
    - lockers for visitor valuables
    - two toilets
    - a small play area for children who are waiting to visit
- two family rooms that can be used casually or booked for visits – one near the entrance to the unit and one closer in to the unit. Families may want to arrange a small gathering for a special occasion and can be supported to do this.

10. Support Systems

10.1. Information and Communications Technology

Information and communication systems are essential for the effective running of the unit and to provide a basis for performance evaluation. The enablers of the digital health capabilities in WSLHD require ongoing investment in ICT infrastructure, eMR and Clinical Support Systems and Digital Platform Services.

The commonly used IT platforms include but not limited to;

- Electronic medical record (CERNER)
- Patient administration system (PIMS)
- Incident management system (IIMS)
- Library / journal access system (CIAP)
- Rostering systems
- eMEDS
- Google
- Wifi for consumers
- MS teams
- Skpe and zoom
- Outlook and other web based applications used within the service

10.2. Maintenance / Electronics

Close relationships with the maintenance and electronics trades is required in order to assist with the increased capital assets within the department, including but not limited to;

- Duress system
- Zip boils within beverage bays
- Management of electronic remote releases for departments
- CCTV cameras – there will be CCTV in the waiting area and along the length of the three bedroom corridors.

All maintenance jobs are to be booked by staff via the AFM system

10.3. General Services

General services should consult with staff, consumers and carers regularly to ensure the environment is maintained at an appropriate level. General services will provide support for the department in the following items;

- General waste management
- Linen supply
- Department cleaning
- Consumer transfers (in/out)

10.4. Pharmacy

All medications required for the non-acute unit will be sourced from the Mental Health central pharmacy.

10.5. Pathology

All required pathology needs will be accessed for the consumer via the treating team.
The pathology services will continue with the hospital protocols/processes within Cumberland hospital and Westmead ICPMR.

10.6. Infection Control

Infection control procedures and measures will be in accordance with NSW Health policies and Hospital Infection Control Committee. Hand hygiene and infection control measures will be promoted and audited.

10.7. Safety and Security

Personal and fixed duress alarms will be used and security response systems will be incorporated into those already in use in the Cumberland Hospital Security Department. Personal duress alarms are to be worn by all staff whilst in the unit. Security services and considerations for the unit will be provided as follows:

- Mental Health security staff will provided security services on a needs basis.

- Critical incident responses may require the rapid movement of medical emergency and mental health staff from within the facility/campus.
- All consulting rooms will have dual egress points to allow safe escape in the event of a personal threat.
- Fixed alarms will be located in designated rooms. However all staff should wear a personal duress unit while on the unit
- Fire safety measures will comply with all relevant legislative standards. Procedures for safe egress and assembly points will be developed at the appropriate stage of the development.

10.8. Education

All Educational needs will be provided to all staff via HETI, Education Centre, CNEs and CNC as per mandatory requirements and as per the needs of the staff defined by changing consumer cohort. This may include Drug and Alcohol training, training for managing special groups e.g. - : younger cohort or elderly apart from the WSLHD nominated training protocols in collaboration with the Education department and relevant internal and external agencies.

11. Monitoring systems

11.1. Quality & Safety Systems

Consideration of safety and security risks have been addressed in the design while minimising the institutional feel of the new facility.

A CCTV camera and intercom system from the staff work station to the unit entrance will allow staff to control access to the unit. Staff access to the unit will be controlled by proximity access card at all times. CCTV will also be provided in the three bedroom corridors, and linked to a screen in the clinical workroom. CCTV footage can only be viewed in real time on the ward. Any CCTV recorded footage is stored off the ward, as per usual practice.

The non-acute unit has controlled entry and exit points so that movements in and out by consumers, visitors and visiting staff can be monitored.

An airlock is provided. The unit has automatic lock-up and lock-down capability, and electronic systems require key override in the event of a power failure.

In addition to fixed duress alarms, staff will use Personal Duress Alarms (PDAs) with location finders when in areas on the unit accessed by consumers, including outdoor areas. PDA charging panels will be required within the staffroom / clinical workroom. Security personnel will respond to critical incidents within the unit automatically on activation of duress alarms (mobile and fixed) and as required on request from clinical staff.

12. Operational Policies & Procedures

WSLHD Infection Control Manual
WSLHD Sexual Safety Policy
WSLHD Human Resources Manual
WSLHD WH&S Risk Management Guidelines
NSW Health Protecting People and Property
WSLHD Security Policy and Procedure Manual
WSLHD Voice communications Policy and Procedure Manual
WSLHD Quality Framework
WSLHD Health Care Interpreter Service Circular 94/10 Policy and Procedures
WSLHD Aggression Minimisation Policy
And other Policy documents as recommended by your Service Director / Manager
Insert others

13. Legislation and Policy Directives [incomplete]

Acts

1. *NSW Mental Health Act 2007*
2. *Children and Young Persons (Care and Protection) Act 1998 (revised 2010)*
3. *Guardianship Act 1987*
4. *Disability Services Act 1993*
5. *Health Records and Information Privacy Act 2002*
6. *Poisons and Therapeutic Goods Legislation*
7. *Poisons and Therapeutic Goods Regulation 2008*
8. *Work Health Safety Act 2011*

NSW Health Policy Directives

PD2017_033 Physical Health Care within Mental Health Services

14. References and Related Policies

NICE guidleines – Rehabilitation for adults with complex psychosis (NG 181)
AusHFG- Non acute Inpatient Mental health Unit facility guidleines
Fifth National Mental Health and Suicide Prevention Plan (2017
NSW Mental Health Reform (*Living Well*)
Australia's *National Standards for Mental Health Services 2010*

Appednices 1

Insert referral form