

Introduction

STRENGTHS RECOVERY MODEL OF CARE

The primary purpose of the Strengths Model of Care is to “assist another human being, not treat a patient” (Rapp & Goscha 2012, p. 514). Within this model it is perceived that resources are external and internal and a consumer can be assisted through their recovery whilst achieving their own goals. The Recovery Partnership Model is now the Model of care in the setting of the Acute Inpatient Service. Engagement with the consumer is imperative and reliant on ‘the trusting and reciprocal relationship as a basis for working together’ (Rapp and Goscha 2012, p.70). This role is supported by the Associate Recovery Partner. The model is inclusive of Allied Health in the Recovery Partnership role and is further supported by the continuity of care obtained by working alongside a nominated treating team. The role of the community case manager remains unchanged. Psychologists employed by the Acute Inpatient Service will not be a Recovery Partner under this model of care. This manual should be used in conjunction with the Recovery Partnership policy; Acute Inpatient Service (AIS).



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Definitions:

ACAS – Aged Care Assessment Service

AIS – Acute Inpatient Service

ANUM – Associate Nurse Unit Manager

ARP – Associate Recovery Partner

AWOL – Absence Without Leave

ASSIST – Alcohol, Smoking, Substance Involvement Screening Test

AWS – Alcohol Withdrawal Scale

BSL – Blood Sugar Level

BP – Blood Pressure

CALD – Cultural And Linguistic Diversity

Clinician – A nurse or Allied health staff not allocated as a RP or ARP

ECG – Electrocardiograph

ECT – Electro-Convulsive Therapy

ECU – Extra Care Unit

FBC – Fluid Balance Chart

FRAP – Family Recovery Action Plan

HADS – Hamilton Anxiety Depression Scale

HONOS – Health of the Nation Outcome Scales

IMI – Intramuscular Injection

MDT – Multidisciplinary Team – all health professionals working with the consumer in the
Acute setting

MMSE – Mini Mental State Examination

MRO- Medical Records On-line

NUM – Nurse Unit Manager

OOA- Out Of Area

OT – Occupational Therapist

PAS – Patient Administration System

PRN – As required medication

RP – Recovery Partner

TPR – Temperature, Pulse and Respirations

VCAT – Victorian Civil and Administrative Tribunal

VHIMS – Victorian Health Incident Management System

WRAP® – Wellness Recovery Action Plan

Strengths Recovery Model of Care

In order to incorporate the principles of recovery into a model of Care there will now be a Recovery Partner (RP). Within this model, Allied Health staff will also be RPs for consumers admitted to the AIS and there will no longer be Primary or Associate Nurses.



Role and Responsibilities of the Recover Partner

- All full-time, 0.6 EFT and above Division 1, Division 2/ Enrolled Nurses, Division 3 nursing staff and Allied Health Staff can be allocated as a RP or Associate Recovery Partners (ARP) for consumers admitted into the AIS.
- Part-time clinicians that work less than 0.6 EFT will not be RPs but will take on the role as ARPs.
- Graduate Nurses will initially take on the role of ARP and when deemed appropriate by their preceptor in consultation with their ANUM, NUM and/or Graduate Co-Ordinator may take on the role of RP.

Overview of functions of the RP

- To ensure that the consumer has co-ordinated, comprehensive and individualised care from admission to discharge.
- Introduce self, explain role and orientate consumer and family/carers to the service and the mental health system of care.
- Is responsible for assessing, planning and evaluating all care with the consumer and it's documentation in medical records/MRO, PAS and CMI.
- To ensure that all risks are assessed on a shift by shift basis in collaboration with the consumer and the treating team. Any changes made are clearly documented on the WRAP®, risk assessment and in progress notes and the ANUM /Shift leader and medical staff are informed of these changes.
- In discussion with and consent from the consumer, attempt to contact the family and/ or significant others as soon as possible following admission. It is important to

obtain consent from the consumer to contact family/significant others. If the consumer chooses not to consent then consideration of the relevant policy (St Vincent's, 2008), the Chief Psychiatrist guidelines (Chief Psychiatrist, 2005) - Appendix 14 and Section 120A of the Mental Health Act (1986) – Appendix 15 is essential. If the treating team's decision is to contact family and or significant others without consent from an involuntary consumer then reasons to involve family and or significant others require explanation to the consumer and documentation of rationale is essential. Voluntary consumers can choose not to have their family involved however please talk with senior clinicians to provide guidance when you feel more information is needed.

- Obtain relevant documentation: previous discharge summaries, previous assessments, treatment plans, other involved agencies and associated documentation.
- All appropriate MHA paperwork is completed or updated as required, particularly MHA21.
- Provide continuity of care:
 - Where applicable contact consumers' case manager including those OOA consumers with case managers as soon as possible following admission to discuss the consumer's WRAP®, Strength's assessment and Goal Plan or care planning from OOA Services.
 - Keep communications open with the Case Manager throughout admission - re: progress, changes to treatment and any issues that arise i.e. accommodation issues.
 - Keep communication open with families or significant others throughout admission – re: progress, changes to treatment and interventions: i.e. increase or decrease of any restrictive interventions.
 - Review strength's documentation on admission and throughout the admission with the consumer and the Case manager if applicable.
 - Liaise and ensure there is a case manager referral with appropriate community MH services if required.
- Work in collaboration with the consumer based on an assessment of their needs from the WRAP®, Strength's Assessment and Goal Plan or care planning from OOA service.
- Identify elements of the group program in collaboration with the consumer that they would like to attend.
- Facilitate the consumer and/or their family/carers to work on their WRAP®, FRAP, Strength's assessment and Goal Plan either with individuals or as part of a group.
- Work with the consumer prior to the MDT clinical review to prepare what they would like to be discussed and considered in the review; what goals they are working towards.
- Attend MDT clinical review and be an advocate for the consumer and represent what the consumer wants to be discussed including medication preferences. (Nursing staff are required to actively request shifts that coincide with their teams clinical review day).

- If the RP or the ARP is unable to attend the MDT Meeting, they are responsible to have prepared key points that have been discussed with the consumer to be documented for discussion at clinical review on the appropriate MDT form (Treatment Plan – Appendix 17)
- Liaise with appropriate medical staff when there are physical concerns about the consumer. (Appendix 1: Flowchart of the deteriorating patient).
- In discussion with treating team, organise family meetings and invite family/carers and Case Manager if applicable.
- Ensure that interpreters (if required) are booked/confirmed or cancelled for any medical reviews, family meetings or when needed.
- Attend family meetings and support the consumer in these meetings. If unable to attend communicate with ARP to check if they are available.
- Work with the consumer, treating team and case manager (if applicable) on discharge plans.
- Provide a comprehensive handover to Case Manager or GP/PP/ or other agencies upon discharge, either by e-mail or telephone or in person if appropriate.
- Provide verbal and written information, psycho education and support to the consumer, family or significant others in an appropriate language if possible.
- Attend 0700hrs, 1300hrs, or 2100hrs handover (depending on hours of work). Allied health to seek morning handover from ANUM/shift leader at 0830hrs and handover to PM staff at 1300hrs. If there is any significant information to be handed over following afternoon handover at 1300hrs, the Allied Health RP is to handover this information to the ANUM/Shift Leader prior to leaving for the day at 1700hrs.
- Provide support and be present when consumer is being administered PRN medication. This is an opportunity to discuss any problems that the consumer may be experiencing with medication, their preferences and an opportunity to share information about medication to the consumer.
- Set aside individual times to work with the consumer on the WRAP® and/or with families/carers on the FRAP.
- Liaise and work collaboratively with medical staff, nursing staff, social workers, occupational therapists and psychologists to discuss allocation/delegation of tasks to the relevant discipline/professional with the right skill set as needed.
- Any identified needs from the admission assessment that required referral to other disciplines other than the AIS MDT will be followed up by the RP/ARP. This involves ensuring that the referral was made and appropriate action has been taken. It is up to the RP/ARP to document and hand over the outcome and status of referral in the medical record and PAS to ensure appropriate action and follow-up continues.
- The RP is responsible to ensure that any changes to treatment, referrals or follow up is followed through and reviewed regularly.
- It is vital that the RP checks their e-mail every day to ensure that they receive communication from either the ARP and/or from specific disciplines re: the consumer's progress updates and/or changes to treatment in their absence.



Responsibilities of the RP/ARP/Clinician regarding Early Psychosis Program

The St Vincent's Mental Health – Early Psychosis Program (EPP) has been developed to meet the principles outlined in the Australian Clinical Guidelines for Early Psychosis. The Early Psychosis Care pathway reflects these principles and is a fundamental tool for monitoring that care is provided.

- For all new Admissions, it is the responsibility of the Admitting Clinician to identify whether consumers meet the Intake Criteria for the EPP. (Appendix 10: Early Psychosis Care Pathway). If it is identified that this is their first admission for a psychotic episode, the Early Psychosis Care Pathway or within three months of them commencing treatment must be commenced.
- The Admitting Clinician needs to ensure that baseline metabolic data is collected at time of admission and recorded on the St Vincent's Metabolic Monitoring Form. (Appendix 11).
- It is the responsibility of the RP to follow-up and monitor care as identified in the Early Psychosis Pathway, the metabolic monitoring form and liaises with the ARP to ensure it is maintained.
- It is the responsibility of the RP to ensure that referral for Case Management is completed/or private follow-up where applicable.

Responsibilities of the RP/ARP/Clinician with ECT

- If a RP has a consumer who is having ECT, the RP has responsibilities prior to the ECT session.
- This involves completing:
 - a Hamilton's scale for depression (completed prior to ECT) and a
 - Mini Mental State Exam (MMSE)
- The MMSE needs to be completed prior to the first treatment and again on a non ECT day each week during the course of ECT.
- If the treating team recommends ECT for a consumer it is the RP/ARP/Clinician's responsibility to ensure that the ECT co-ordinator is informed either by e-mail or face to face when possible. It is understood that

Allied Health RP's may not be on duty when this decision is made therefore these responsibilities lie with the clinician allocated to the consumer that shift.

- It is the responsibility of the RP/ARP/Clinician to ensure that the consumer is given a consumer information booklet on ECT.
- The RP/ARP/clinician are responsible to ensure the consumer is given the opportunity to talk to nursing or medical staff about any concerns they, the consumer and/or family may have regarding the procedure.
- It is the responsibility of the RP/ARP/Clinician to inform the medication nurse on that shift that the consumer is having ECT and what day.
- It is the responsibility of the RP/ARP/Clinician to follow-up with the treating team that all medications that need to be ceased prior to ECT are ceased e.g. benzodiazepines and mood stabilisers and that this is documented on the medication chart and in the progress notes prior to procedure.
- It is the responsibility of the RP/ARP/Clinician to check that the consumer is booked in for ECT on PAS.
- The RP/ARP/Clinician needs to ensure that the consent form is signed and valid prior to ECT.
- On the day prior to ECT, the RP/ARP/Clinician needs to ensure that the consumer's progress notes and PAS reflects they are having ECT the following day to ensure that the consumer is fasted.
- The RP/ARP/Clinician is responsible for ensuring that if the consumer requires one to one nursing for escort to ECT that the ANUM on duty is informed and that this is reflected on the handover sheet through PAS.
- It is a nurse specific duty to ensure that all ECT physical work-up tasks have been completed.

Responsibility of RP/ARP/ANUM/Shift Leader when consumer is nursed 1: 1.

The AIS will support the additional resource of a nurse special for a consumer when it is assessed by a Consultant Psychiatrist that it is the least restrictive manner by which to provide a safe environment for the consumer, other consumers and staff. Historically the AIS rely largely on casual bank and agency staff to fulfil this role. A RP and Associate RP will be allocated to a consumer nursed on a special and will continue to oversee that all tasks relating to their consumer are completed. The RP/ARP/ANUM/Shift Leader has a responsibility to ensure that:

- The consumer is actively engaged in the commencement of and then frequently revisits the WRAP® with their RP/ARP.
- Any identified carers / family are provided with timely communication of changes to care and current treatment and that this is documented.

- The consumer may be identified as an ideal individual to be presented at Brainstorming.
- Continuity of care is maintained.
- Any requests for investigations including pathology and ECG's are performed.
- Referrals to specialist areas and discipline specific tasks are followed up and completed with an understanding of any outcomes of assessment.
- The consumer has appropriate representation and advocacy at Clinical Review Meetings. RP/ARP's are to ensure the treatment plan (Appendix 17) is completed with the consumer's wishes prior to clinical review.
- All appropriate MHA paperwork is reviewed and completed daily, particularly MHA21.
- Advocacy for the consumer to be nursed in the least restrictive environment is addressed daily with the treating team.
- Co-ordination of care from admission through to discharge, including post discharge liaison with services occurs.

Roles and Responsibilities of the Associate RP (ARP)

- Each RP will also act as an ARP except for Allied Health, for approximately 3 consumers and will support the RP in all of the functions outlined previously.
- It is vital that the ARP checks their e-mail every shift to ensure that they receive communication from the RP, treating team, or others involved in the provision of care.

In the absence of the RP, the ARP will lead the care for that consumer during the RPs period of absence.

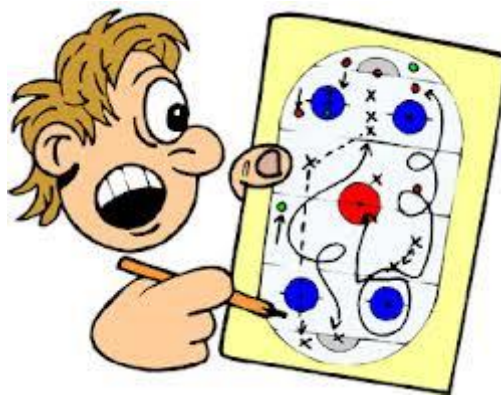
- It is vital that the ARP communicates any updates and issues to the RP either in person or via e-mail so that the RP is fully informed of progress when they haven't been on duty.

Allocation Process

- RPs will be allocated at the seniors/ANUM/Shift Leaders meeting - Monday to Friday by the senior nursing group and day shift ANUM/Shift Leaders following allocation of the consumer to a consultant. Following this meeting the ANUM/Shift Leaders are responsible for updating PAS, the allocation list in the IPS folder and the journey board.
- No consumer will be allocated to a RP during the weekend however nursing staff allocated by the ANUM/Shift Leader to that consumer on a shift by shift basis over the weekend will undertake the tasks required of a RP where appropriate (i.e. admission processes and day to day needs of the consumer). When the RP has been

allocated it is the RPs responsibility to follow-up on documentation, planning and treatment that has already taken place.

- When allocating RPs the senior team and ANUM/Shift Leaders must be mindful of the consumer needs and risks and allocate appropriately (i.e. if it has been identified that consumer is in need of a functional OT assessment and an OT is available for allocation then that consumer may benefit from being allocated an OT as their RP or if a consumer is homeless and a social worker is available for allocation then the consumer may benefit from being allocated a social worker as a RP).
- If the consumer is readmitted to the unit they should wherever possible be allocated to the same RP and/or ARP as on the previous admission to enhance continuity of care.
- When allocating RPs and Associate RPs, the senior team and ANUM/Shift Leaders need to be mindful of skill mix and when allocating to junior staff.



THE TEAM STRUCTURE

There will be three teams, each one represented by a Consultant Psychiatrist allocated to PSG and PS1. This system minimises any perceived disruption caused by re-deployment of nursing staff between the floors to meet the operational needs of the unit. The concept allows for nursing staff to belong to a team on an ongoing basis, providing continuity of care, optimising consumer care and allowing for the RPs to maintain a consistent professional relationship with their team Consultants. The notion of Allied Health representation over three teams takes into account that the Graduate Social Work position is ongoing in the AIS and like a Graduate nurse they should only become a RP when deemed competent by the senior Social Worker who provides them with supervision. Allied Health currently work with allocated Consultants who belong to either PSG or PS1, in this team structure, an Allied Health RP may be attached to any team.

TEAM 1

CONSULTANTS: SUSAN ONG & ANISH UNADKAT

ANUMS: Two from PSG and Two from PS1

NURSES: RPN2 / Post Graduate / Graduate / Division II (non/meds endorsed) / Casual bank

ALLIED HEALTH: One Occupational therapist or one Social Worker and Graduate S/W

TEAM 2

CONSULTANTS: PREM CHOPRA & TESSA REIMERS

ANUMS: Two from PSG & two from PS1

NURSES: RPN2 / Post Graduate / Graduate / Division II (non/meds endorsed) / Casual bank

ALLIED HEALTH: One Occupational therapist or one Social Worker and Graduate S/W

TEAM 3

CONSULTANTS: SUZANNE KOH & ERIN REDMOND (Koori)

ANUMS: One from PSG & two from PS1

NURSES: RPN2 / Post Graduate / Graduate / Division II (non/meds endorsed) / Casual bank

ALLIED HEALTH: One Occupational therapist or one Social Worker and Graduate S/W

Each RP will be allocated to a team which will be identified by two consultant Psychiatrists, one from each unit, i.e. PSG/PS1. Each team will be led by ANUMs and within the team there will be nursing staff of all grades and an Allied Health clinician.

RPs and/or Associate RPs who are rostered on night duty must retain the function of the consumers RP and communicate via e-mail, handovers and PAS what they require from the Associate RP or allocated clinician to be implemented or followed up.



Generic Tasks

The listed generic tasks are duties that can be undertaken by the RP. These tasks were once discipline specific but are now shared under the new Recovery Partnership Model of consumer care while the consumer is on the AIS. There are tasks that continue to be discipline specific and are outlined later in this manual under headings Social Work, Occupational Therapy and Nursing. The Generic Tasks are:

- Ensuring ADL's are monitored
- Individual Clinical Risk Assessment
- VHIMS – Incident reporting
- Admission Process
- Discharge Process
- AWOL Procedures
- ASSIST Screening Tools including AWS
- Breath Alcohol Levels (BAL) and document
- Updating PAS
- Escorts – (Taking consumers to appointments, local shops, groups)
- Metabolic Monitoring – (height, weight, measurement of abdo circumference) – Appendix 11
- Early Psychosis Care Pathway – Appendix 12
- Individual and Group work (as part of or outside Group Programme)
- Clinical Handover
- Provide interventions in sensory modulation – Individual and group
- Mandatory Reporting – Child Protection notifications – Appendix 12
- Centrelink liaison and referral – Appendix 16
- Referrals to North Yarra Community Services (i.e. Meals on wheels, Home help)
- Family/Carer Consent
- Family/Carer orientation Letter – Appendices 2 and 3
- Apply for the Carer support Fund – Appendix 4

- Mini Mental Examinations (Post ECT) – Appendix 13
- Hamilton’s Depression scale
- Provide support to consumers to access group space for individual work (i.e. -Art work)
- Documentation – All RPs, ARPs and clinicians are responsible for writing progress notes for the consumer they have been working with during their hours of work. This includes progress notes and PAS.



Social Work (Discipline Specific Tasks)

While the social work team will work as RPs and share the generic tasks as outlined above, they will still maintain discipline specific tasks that require referral from other RPs. A request from any AIS discipline to Social Work relating to a discipline specific task may be made using verbal and written mediums. A verbal request may be made directly to Social Work whilst in an informal setting or whilst in the forum of the MDT Handover or weekly Clinical Review. A written request may be conveyed in the ward diary, the consumer’s progress notes, by using PAS or via email.

These include:

- Direct Service
 - Psychosocial Assessments
 - Counselling
 - Accommodation referral
 - Financial counselling liaison and referral
 - Guardianship application (VCAT)
 - Administration order application (VCAT)
 - Public Advocate Office referral and liaison
 - ACAS Aged Care Referral/Assessment
- Family Strategy Program (SW2)
 - Carer Counselling Sessions

➤ Community and Client Liaison

- Co-ordinate Mental Health Pathways Program Homeground (SW2)



Occupational Therapy (Discipline Specific Tasks)

While the Occupational Therapy team will work as RPs and share the generic tasks as outlined previously, they will still maintain discipline specific tasks that require referral from other RPs. A request from any AIS discipline to Occupational Therapy relating to a discipline specific task may be made using verbal and written mediums. A verbal request may be made directly to an Occupational Therapist whilst in an informal setting or whilst in the forum of the MDT Handover or weekly Clinical Review. A written request may be conveyed in the ward diary, the consumer's progress notes, by using PAS or via email. These include:

- Individual OT Assessments
- Co-ordination of Group Program
- Sensory Modulation Program
 - Individual Sensory Profile assessment



Nursing (Discipline Specific Tasks)

While the nursing team will work as RPs/ ARPs and share the generic tasks as outlined previously, they will still maintain discipline specific tasks which need to be communicated from other RPs. A request from any AIS discipline to nursing relating to a discipline specific task may be made using verbal and written mediums. A verbal request may be made directly to a Nurse whilst in an informal setting or whilst in the forum of the MDT Handover

or weekly Clinical Review. A written request may be conveyed in the ward diary, the consumer's progress notes, by using PAS or via email. These include:

- Shift Leadership and co-ordination
- Administration of all medications (IM, oral, topical, subcutaneous, sublingual, PRN and regular)
- Venepuncture
- Physical Observations – BP, TPR, Neurological
- Supportive observations – (including level one: Seclusion)
- Extra Care Unit (ECU)
- Seclusion reviews and procedures
- Section 12 Escorts
- ECT – Preparation , during procedure and post recovery the RP/ARP is responsible that all ECT work up tasks have been completed - this includes:
 - Chest X-ray
 - Bloods
 - Height
 - Weight

And where indicated:

- Food and Fluid Chart
 - Fluid Balance Chart
 - Blood Glucose levels
-
- BAL – Breath Alcohol Levels
 - ECG's
 - Urinalysis



Psychologists

The Psychologists will not take on the role of a RP or ARP but will work in collaboration with all RPs, RPs, clinicians, allied health and medical teams across all teams within the Acute Inpatient Service. A request from any AIS discipline to Psychology relating to a discipline specific task may be made using verbal and written mediums. A verbal request may be made directly to a psychologist whilst in an informal setting or whilst in the forum of the

MDT Handover or weekly Clinical Review. A written request may be conveyed in the ward diary, the consumer's progress notes, by using PAS or via email.



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Role and Responsibilities of the Nurse Unit Manager (NUM)

- The NUM is responsible for the ongoing facilitation of the Recovery Partnership Model within the Acute Inpatient Setting. The NUM will oversee the allocation of portfolios to ANUM's who will in turn undertake the following activities:
 - Establish a working party
 - Ensure high standards of care are met
 - Will continuously monitor of the workings of the Recovery Partnership Model
- The NUM in conjunction with the ANUM group and Senior Nursing Group will ensure that periodic audits are conducted in regard to documentation, MDT Meeting processes, medication administration, admission procedures and other procedural activities to ensure that RPs are practicing to a high standard in keeping with the philosophy of recovery, legislative and policy guidelines.
- The NUM in consultation with the Clinical Nurse Educator will ensure that training is planned for existing staff and new staff.
- The NUM will ensure that all staff receives supervision within their respective team from the ANUM leading each team.
- The NUM will be mindful when rostering that the RP and/or the ARP will be rostered on their respective teams MDT meeting day so the RP and ARP can fulfil their role in these meetings.

Roles and responsibilities of the ANUM/Shift Leader

The role of the ANUM/shift leader is to provide leadership, support, and to guide best practice for all RPs and ARPs.

- Each ANUM will hold a portfolio allocated by the NUM. The ANUM will undertake the following activities within their portfolio
 - Establish a working Party
 - Ensure standards of care are met
 - Will continuously monitor the workings of the Recovery Partnership Model

- The ANUMs will lead a team of RPs and ARPs allocated to particular consultant groups.
- ANUM/Shift Leaders will attend morning handover at 0900hrs on weekdays for MDT Meeting in Eric Seal Room and have prepared for handover prior to the meeting.
- ANUMs and Shift leaders have a responsibility to ensure that all admissions have been commenced appropriately, including legal paperwork and that the WRAP® has been started. The ANUM/shift leader also needs to ensure that PAS is updated and that the admitting nurse has addressed all relevant consumer needs.
- The ANUM/Shift Leader is responsible for allocation of staff to a consumer. On the morning shift the ANUM/Shift Leader needs to ensure that they allocate either the RP or an ARP to their allocated consumer to ensure continuity of care. The exception to this would be if the RP is a nurse and is in ECU for the day. If this occurs it is ideal then that the ARP is allocated if possible.
- ANUM/Shift Leaders must be mindful to allocate clinicians to consumers who are not their RP or ARP to their respective teams if skill mix allows.
- When allocation of a room is required for a female consumer, the ANUM/shift leader must take into account the persons vulnerability and whether a room in the women's only area is needed. When allocating rooms for male consumers the ANUM/Shift Leader needs to be mindful not to allocate a room on the same corridor to the entrance of the women's only area wherever possible. Transgender consumers must always be allocated a single room.
- During the hours of 0730hrs and 0830hrs the ANUM/Shift Leader will assist all consumers in an Allied Health partnership until Allied Health commence their day at 0830hrs.
- On the afternoon shift and night duty only RPs that are Nurses can be allocate within their partnerships, all Allied Health Recovery Partnerships need to be allocated to the ANUM/shift leader. ANUM/shift leader will commence care of the consumer for Allied Health Recovery Partnerships following the Allied Health leaving for the day at 1700hrs.
- If the RP or ARP is not on duty for that shift then the consumer can be allocated to other nursing clinicians for that shift, taking into consideration their respective teams and skill mix.
- The ANUM/Shift Leader is responsible for allocating a Medication nurse for each shift as well as a Medication Nurse buddy, ECU Nurse and ECU Nurse Buddy. Allied Health cannot be allocated to work in ECU but can enter ECU to see a consumer, if completed TRAM Training and if allocated as a RP to the consumer in ECU, or facilitating a group.
- Wherever a Division 2 or Graduate Nurse is allocated as a RP then the ARP must be either a Division 1 or 3.
- It is the responsibility of the ANUM/Shift Leader to allocate an admission clinician for each shift. The admission clinician can be a Div. 1, Div. 3, and EN, OT or social

worker. Allied Health cannot be allocated to undertake an admission after 1600hrs due to their finishing time of 1700hrs.

- The ANUM/Shift Leader is responsible for allocation of category observations to be carried out by nursing staff during each shift. Allied Health will not be allocated to perform category observations.
- The ANUM/Shift Leader is responsible to ensure that risk assessments, WRAP®'s, physical/Neuro observations, FBC, BSL, AWS, weight charts and all other nursing tasks are completed and maintained throughout the shift.
- The ANUM will be a RP for two consumers and will undertake the role of RP on behalf of Allied Health staff between the hours of 0730hrs and 0830hrs and 1700hrs – 2130hrs. Allied Health is required to communicate to the ANUM/Shift Leader when they will not be available during the day due to other discipline specific duties to address any needs or concerns from the consumer. During these times it is the responsibility of the ANUM/Shift Leader to assist the consumer if required.
- ANUM/Shift Leaders will co-ordinate any OOA consumers to facilitate their transfer back to the consumer's area mental service.
- Ensure the safety of consumers money



Admission Process

Pre-Admission

The ANUM on duty is responsible for allocating a clinician including Allied Health to complete an admission. This occurs at the commencement of each shift. During business hours but no later than 1600hrs, all Nursing and Allied Health clinicians can be allocated to complete an admission; following 1600hrs only nursing clinicians can be allocated to complete admissions due to the finishing time of the Allied Health at 1700hrs.

- When the admitting clinician is informed of an admission they are required to prepare as much as possible prior to the consumer coming onto the unit (where possible) by collating any available documents (i.e. MRO, PAS, CMI or temporary G drive) and where applicable liaise with Case Managers for information. This information should be used to begin to formulate a risk management assessment

and plan to assist with bed allocation i.e. the need for a single room or ECU or gender safety area.

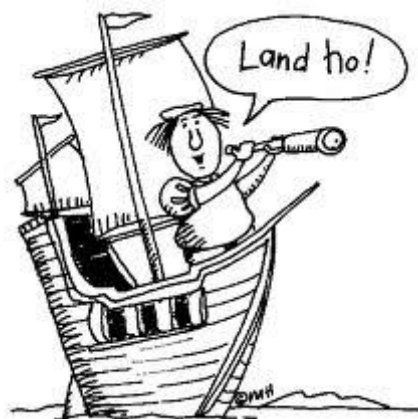
- Allocating an admission to agency clinicians is not encouraged and should only be utilized when there is no alternative. If no other option, the ANUM is responsible to ensure that all initial admission requirements are met.
- The admitting clinician will not necessarily be the RP for that consumer.
- The admitting clinician needs to liaise with the ANUM to ensure that the consumer's bed is ready before arrival.
- The admitting clinician needs to obtain an admission pack which has all of the appropriate paperwork required for an admission – this includes
 - Admission PR2 Form
 - After hours admission request
 - Admission and Discharge check list
 - Admission assessment form
 - Clinical Risk assessment (pink)
 - Medication Chart
 - Wellness Recovery Action Plan (WRAP®)
 - The WRAP® Guide (for consumers)
 - HONOS – Outcome measures worksheet
 - GP Notification
 - Progress Notes –
 - Functional Observation Chart
 - ASSIST (blue)
 - Early Psychosis Care Pathway
 - Metabolic Monitoring
 - Patient Rights and responsibilities booklet
 - Information for consumers and carers booklet
 - Application Form for the Mental Health Carer Support Fund
- The ANUM ensures that the admitting Medical Officer is aware of the pending admission and notifies the admitting Medical Officer when the consumer arrives to the unit.
- If it is established that the consumer being admitted is from a non-English speaking/CALD background, a telephone interpreter should be organised if appropriate otherwise an interpreter must be organised as soon as possible following admission.

Consumer arrival

- Upon arrival of the consumer onto the unit, the admitting clinician must introduce self and show the consumer their room and orientate the consumer to the unit/ECU.

This activity needs to be documented in the clinical notes because if not documented then it is assumed it has not been done.

- The admitting clinician must ensure that the consumer receives a copy of consumer rights and responsibilities (DHS) and have these rights and responsibilities explained verbally. If the consumer is from a non-English speaking background it is important to arrange an interpreter to explain these rights as soon as possible following admission. When giving and explaining a consumer's rights and responsibilities this must be documented in the progress notes. If it is not recorded then it is assumed that it was not done.
- Consumer and carer booklets are to be given to consumers and family/significant others as soon as possible following admission and documented that this has been done. If it is not documented then it is assumed that this was not done. CALD consumers need to have booklets provided in the appropriate language where possible.
- The admitting clinician must conduct a search of the consumer's belongings as per AIS policy and if indicated a personal search of the consumer needs to be facilitated as per AIS policy. These activities must be documented in the progress notes. If it is not documented then it is assumed that this was not done. Any valuables which are kept by the consumer or placed in the unit safe or property room or sent home with family or carers/significant others, these must be documented in the progress notes and an indemnity invoice to be completed and a copy of this to the consumer. Consumers need to be made aware of hospital policy re: their responsibilities when having valuable goods on their person while admitted to AIS.
- The admitting clinician is to commence a WRAP®; the information gathered from the WRAP® will provide the basis of consumer directed care in conjunction with a risk assessment and the treatment plan (Appendix 17) developed in conjunction with the medical staff and any legal requirements.



Admitting officer arrival

- The admitting clinician must ensure that the consumer receives a thorough physical examination at time of admission by the admitting officer or as soon as practical following admission and that weight, height, physical observations and measurement of abdo circumference is completed on admission by the admitting clinician. It is important that this activity is documented in the medical records as if not it is assumed it this task has not completed.
- The admitting clinician should assess the consumer with the admitting medical officer and start to develop a WRAP®. If the consumer is case managed and already has a WRAP®, Strength's assessment and goal plan, these should be used to inform the conversation with the consumer and family/carer/significant others to add to the current WRAP®, keeping in mind risk and legal requirements.
- It is the admitting clinician's responsibility to ensure that the consumer is fully informed of the admission process at all times.
- Any identified needs from the admission assessment that require referrals to other disciplines will be initiated by the admitting clinician where appropriate. It is extremely important to document and handover these referrals in handover, medical record and PAS to ensure appropriate action and follow-up.

Post Assessment

- Ensure that the consumer is aware of surroundings and if still required further orientation to the unit.
- Ensure that the consumer is aware how to order their meals and times of meals and whether any special dietary requirements need to be recorded on PAS.
- Offer the WRAP® to the consumer to continue working on while an inpatient and discuss with the consumer what was added to the WRAP® during assessment.
- Ensure that the risk assessment is completed and commence any category observations that may have been ordered. Gender sensitivity needs to be taken into account for consumers who are vulnerable, this entails considering whether the risks indicate that a bed in the women's only area is needed.

ECU

- If a consumer is admitted into ECU, the consumer must be provided with an ECU consumer booklet along with the rights and responsibilities booklet (DHS).
- The ECU nurse is responsible to ensure that the information in the booklet is verbally explained to consumers while in ECU.
- The consumer must be orientated to the ECU area.
- The consumer must be searched as per AIS policy upon arrival to ECU and informed of regular searches by staff of the environment throughout the day as per AIS policy.
- The consumer needs to be informed of activities that are planned for the day in ECU

THE WRAP® – Wellness Recovery Action Plan

- The Wellness Recovery Action Plan (WRAP®) is based on the principles of recovery and has superseded the nursing care plan in the AIS. It is based on the philosophy that the consumer is the best source of information on their mental health and what they find useful or beneficial in their treatment. Essentially the consumer is the driver of the bus in terms of what they find helpful or unhelpful in their treatment and recovery.
- Principles of recovery include:
 - The person is taking control of major decisions in life
 - The person is forming an understanding and acceptance of his/her life
 - The person takes a forward-thinking approach to life
 - The person is taking active steps to own wellness
 - The person has hope
 - The person is able to enjoy life
- It has been adapted for the inpatient service from the WRAP® developed by Mary Ellen Copeland and a group of people in the USA who experience mental health challenges.
- It assists the consumers to identify what makes them well and use their own identified wellness tools to relieve difficult feelings and maintain wellness.
- Key components of the WRAP® include:
 - Wellness Toolbox
 - Wellness Daily Maintenance Plan
 - Relapse Prevention Plan
 - Crisis and Post Crisis plan
 - Supports

Admitting Clinicians responsibility for the WRAP®

- It is the responsibility of the admitting clinician to introduce and commence the WRAP® with the consumer. It is important to explain to the consumer that it is a way for them to express what is important for them during recovery and what they would like to happen during their recovery.

RPs responsibilities for the WRAP®

- Once the RP has been allocated, it is the RPs responsibility to revisit the WRAP® every time they are working with the consumer or review the WRAP® where the consumer can or doesn't want to do it.

- RPs play the major role in working with the consumer to explore and determine their own wellness daily maintenance plan, relapse prevention strategies and crisis/post crisis management within warm respectful conversations.
- Wellness Recovery Action Plans take time and can be introduced over a period of time and each section can be developed when most useful to the consumer. For example: many people complete a wellness maintenance plan in early recovery and develop a relapse prevention plan when they explore their experience of illness and gain some insight into the impact of their mental health on their lives.
- There are no rules about the order that these sections of the WRAP® are addressed; we match the development of the WRAP® to the consumer's interests and needs
- The consumer may wish to work with the whole WRAP® or divide it into sections and work with one or two of them at a time. For example: it may be very confronting for a person to develop a relapse prevention plan when they are still grappling with the idea they have any kind of mental illness and/or when they are very unwell.
- The consumers use their own language in the WRAP® and determine their own priorities; they may work on it by themselves, work with their RP or Associate RP, in therapeutic groups or ask for help from their family members.
- RPs encourage the consumer to write a description of what they are like when they are feeling well and what others notice about them when they are well. If this is difficult for them they can write down a few words, for example: bright, cheerful, reliable or curious.
- Consumers may not be able to describe themselves and may find it easier to describe themselves from someone else's point of view. For example: my mother says I'm less irritable when I am well. This discussion includes a clear message that they have been well before and the suggestion that they will be well again, maintain their current level of wellness. It also provides clinicians with a vision of the person at their best.
- RPs or clinicians ask them what they do or might do for fun when the consumer is feeling down and what helps lift their spirits. This also includes the things that people use to stay well and help relieve symptoms. A daily maintenance plan helps people recognise those things they need to do to remain well and plan their days accordingly.
- The consumer can also identify feelings when things are not quite right and it can often be traced back to not doing something from the daily maintenance plan or wellness tool box. RPs or clinicians work with consumers, encouraging the consumer to take an active role in preventing their possible relapse into a more acute period of illness.

- The RP continuously engages the consumer in their WRAP®
- The RP in collaboration with the consumer will explore the questions within the consumers WRAP® and support the consumer in their understanding of the WRAP®.
- It is important that if the RP is writing the WRAP® for the consumer that the consumer's own language is used.
- If the consumer has expressed that they don't want to be involved in their WRAP®, the admitting clinician or RP/ARP will commence and write on the WRAP® what the consumer is expressing verbally and/or the behaviours they may be exhibiting during interactions. It is important to use the consumer's own language, avoid jargon and absolutely vital that the RP/ARP or clinician working with the consumer revisits the WRAP® with the consumer to clarify the content written by others other than the consumer themselves.
- To ensure that the consumer is constantly aware and agrees with what has been written in their WRAP® if the consumer is not writing it themselves.
- On discharge the consumer is to be given their WRAP® and the RP/ARP or discharge clinician is to ensure that a copy is taken of the WRAP® for MRO.



Daily and nightly functions of a RP/Associate RP/Clinician

AM Shift:

- The RP/ARP/clinician must ensure that they allocate themselves a DECT phone for the shift. This requires testing before use, writing name next to number on whiteboard and ensuring the DECT phone is replaced on the charger at the end of each shift.
- The RP/ARP/clinician must make themselves available for phone calls or visits from family, and or significant other at all times. If the RP/ARP/clinician is going to be unavailable for a particular amount of time they need to inform the ANUM of this.
- RP/ARP/clinician will read the appropriate file, check e-mails and PAS to ascertain what needs to be completed that shift, and including discharge (refer to discharge section of manual).

- It is important that the RP/ARP/clinician look in the unit diary at the beginning of each shift to see if anything is planned for the consumer. (i.e. family meetings, tests etc.)
- The RP/ARP/clinician will be responsible for encouraging the consumer to attend to their personal hygiene, dietary and physical needs to promote independence.
- It is important for each RP/ ARP/clinician to look in the diary for any in-services that are planned for that day and plan their day to attend if possible or appropriate.
- If the RP/ARP/clinician is a nurse it is important that the nurse take note of when they are responsible for sight observations and ensure they make themselves available for these allocated times. If they are unable to fulfil that responsibility at the time allocated then it is important that they inform the ANUM.
- It is the responsibility of nursing clinicians to ensure that those consumers that are booked for ECT have had their pre ECT observations completed, that relevant information regarding the safety of ECT is handed over to the ECT co-ordinator, that the consumer is prompted to void prior to procedure and that the file and medication chart is taken over with the consumer to day procedures.
- The RP/ARP/clinician is to ensure that all specimens/investigations that are requested be collected and sent to pathology for the consumer. Any discipline specific tasks, the RP/ARP/clinician needs to ask the appropriate discipline to carry out the task.
- It's important that the RP/ARP/clinician make contact with allocated consumers; follow up any baseline scoring weight, height, HADS, MMSE, MSE, and FBC. If the RP/ARP/clinician requires task specific baseline scoring (AWS, BSL, physical obs, etc...) to be completed then the RP/ARP/clinician needs to delegate this to a nursing clinician.
- The RP/ARP/clinician is to liaise with case managers, GP's, family members to get collateral history and to clarify medications etc. if appropriate.
- The RP/ARP/clinician is to review the WRAP® with the consumer. It is important that during the shift, time is blocked out to spend with each consumer allocated to work on the WRAP®.
- The RP/ARP/clinician will check that all paperwork is in order, accounted for and up to date; especially legal paperwork and MHA21.
- The RP/ARP/clinician will advocate for their consumers at all times, considering their wishes, desires and needs and liaise effectively with the treating team, especially during ward rounds and reviews. This requires communicating, actively listening with and understanding the consumer.
- Following clinical reviews the RP/ARP/clinician that attends clinical review needs to communicate to the medication nurse any changes to medication charts or new additions to medication charts that have been made. It is the responsibility of the medication nurse to ensure that the changes and/or additions are completed correctly, if not then gets the order changed immediately by medical staff. It is also the responsibility of the medication nurse to ensure that if medications are changed

or started, that this medication is in stock or has been ordered with pharmacy if needed. It is the responsibility of the RP/ARP/clinician following clinical review to handover any changes to medications to the next shift.

- RP/ARP/clinician needs to review and if clinically indicated request the change of sight observations for their consumer. The RP/ARP/clinician needs to liaise with the appropriate treating team to implement these changes. The RP/ARP/clinician is responsible to communicate these changes to the ANUM/Shift Leader and ensure that the risk assessment and PAS is updated and handover these changes to the next shift.
- The RP/ARP/clinician will ensure that all correspondence/information/instruction/referrals and contact regarding the consumer is documented and is clear and concise.
- The RP/ARP/clinician are required to transcribe relevant information to PAS in a clear, concise manner. This needs to be updated every shift, avoiding abbreviations.
- The RP/ARP/clinician in discussion with the consumer will facilitate any PRN (as required) medication and delegate administration of this to the medication nurse for that shift.
- The RP/ARP/clinician will review with the consumer their voluntary/involuntary status on a daily basis, if the consumer is involuntary this needs to be reviewed on a regular basis along with leave of absence (MHA21)
- All RP/ARP/clinicians whose involuntary consumers have been granted escorted leave will attempt to facilitate this as requested and where possible.
- RP/ARP's will ensure that the consumer has a discharge plan and that this is communicated in the documentation and PAS.

PM Shift:

Following handover at 1300hrs all consumers will be allocated a nursing clinician for the PM shift. Those consumers that have an Allied Health clinician as their RP will be allocated to them the ANUM/Shift Leader and following 1700hrs when the Allied Health clinician has finished work for the day the ANUM/Shift Leader takes over the care of that consumer until the end of their shift at 2130hrs; the responsibility of consumer care remains with the Allied Health RP until 1700hrs.

- The RP/ARP/clinician must make themselves available for phone calls from family, and or significant other at all times. If the RP/ARP/clinician is going to be unavailable for a particular amount of time they need to inform the ANUM of this time.
- The RP/ARP/clinician must ensure that they allocate themselves a DECT phone for the shift. This requires testing before use, writing name next to number on journey board and ensure the DECT phone is replaced on the charger at the end of each shift.
- The RP/ARP/clinician will be responsible for encouraging the consumer to attend to their personal hygiene, dietary and physical needs to promote independence.

- The RP/ARP/clinician will read the appropriate file and ascertain what needs to be completed that shift, including discharge (refer to discharge section of manual).
- It is important that the RP/ARP/clinician looks in the unit diary at the beginning of each shift to see if anything is planned for the consumer (i.e. family meetings, x-rays etc.).
- RP/ARP/clinicians must take note of when they are responsible for sight observations and ensure they make themselves available for these allocated times. If they are unable to fulfil that responsibility then it is important that they inform the ANUM.
- The RP/ARP/clinician is to ensure that all specimens/investigations that are requested be collected and sent to pathology for the consumer.
- Important that the RP/ARP/clinician makes contact with allocated consumers; follow up any baseline scoring weight, height, HADS, MMSE, MSE, FBC, AWS, BSL, physical obs, etc. if appropriate.
- The RP/ARP/clinician is to liaise with case managers, GP's, family members to get collateral history and to clarify medications etc. if appropriate.
- The RP/ARP/clinician is to review the WRAP® with the consumer. It is important that during the shift, time is blocked out to spend with each consumer allocated to work on the WRAP®.
- The RP/ARP will check that all paperwork is in order, accounted for and up to date, especially legal paperwork and MHA21.
- The RP/ARP/clinician will advocate for consumers at all times, considering their wishes, desires and needs and liaise effectively with their treating team. This requires communicating, actively listening with and understanding the consumer.
- Following clinical reviews the RP/ARP/clinician that attends clinical review needs to communicate to the medication nurse any changes to medication charts or new additions to medication charts that have been made. It is the responsibility of the medication nurse to ensure that the changes and/or additions are completed correctly and if not gets the order changed immediately by medical staff. It is also the responsibility of the medication nurse to ensure that if medications are changed or started, that this medication is in stock or has been ordered with pharmacy if needed. It is the responsibility of the RP/ARP/clinician that attends clinical review to handover any medication changes to the next shift.
- RP/ARP/clinician needs to review and if clinically indicated request the change of sight observations for their consumer. The RP/ARP/clinician needs to liaise with the appropriate treating team or on call medical staff to implement these changes. The RP/ARP/clinician is responsible to communicate these changes to the ANUM/Shift Leader and ensure that the risk assessment and PAS is updated and handover these changes to the next shift.
- The RP/ARP/clinician will ensure that all correspondence/information/instruction and contact regarding the consumer is documented and is clear and concise.

- The RP/ARP/clinician is required to transcribe relevant information to PAS in a clear, concise manner. This needs to be updated every shift, avoiding abbreviations.
- The RP/ARP/clinician in discussion with the consumer will facilitate any PRN (as required) medication and delegate administration of this to the medication nurse for that shift.
- All RPs/ARP/clinicians whose involuntary consumers have been granted escorted leave will attempt to facilitate this as requested and where possible.

Night Shift:

All consumers will be allocated a nursing clinician for this shift due to Allied Health staff members are not required to do night shift. However if a RP or ARP for a consumer is on night duty it is important that the RP or ARP is allocated to the consumer for that shift.

- The RP/ARP/clinician must ensure that they allocate themselves a DECT phone for the shift. This requires testing before use, writing name next to number on whiteboard and ensuring the DECT phone is replaced on the charger at the end of each shift.
- The RP/ARP/clinician will read the appropriate file and check e-mails to ascertain what needs to be completed that shift.
- The RP/ARP/clinician will be responsible for encouraging the consumer to attend to their personal hygiene, dietary and physical needs to promote independence.
- The RP/ARP/clinician is to ensure that all fasting bloods that are requested and able to be collected are completed and ready to be sent to pathology by placing them in the pathology fridge.
- It is important that the RP/ARP/clinician make contact with allocated consumers; follow up any baseline scoring weight, height, MSE, FBC , AWS, BSL, physical obs, etc.
- The WRAP® document is to be reviewed and continued as appropriate.
- It is the responsibility of the RP/ARP/clinician to ensure that consumers booked for ECT have been prepped for the procedure, this includes:
 - Ensuring that the consumer is fasted from midnight and this fasting is maintained
 - Identification bracelet insitu
 - Allergies (if any) bracelet insitu
 - Pre op observations are completed
 - Theatre pack to be completed
 - that relevant information regarding the safety of ECT is handed over to the ECT co-ordinator and nursing clinicians
- The RP/ARP will check that all paperwork is in order, accounted for and up to date, especially legal paperwork and MHA21.

- The RP/ARP/clinician will advocate for their consumers at all times, considering their wishes, desires and needs and liaise effectively with overnight medical staff.
- The RP/ARP/clinician will ensure that all correspondence/information/instruction and contact regarding the consumer is documented and is clear and concise.
- The RP/ARP/clinician is required to transcribe relevant information to PAS in a clear, concise manner. This needs to be updated every shift, avoiding abbreviations.

Additional night shift duties

The RP and ARP rostered to night shift have a responsibility to prepare the environment for colleagues rostered to day and evening shifts. There are particular tasks which are required to be completed on a nightly basis, whilst others are to be considered when the shift permits.

- Preparation of admission packs (nightly)
- Blood Glucose Meter recalibration (nightly).
- Restock cases with lancets, test strips and cotton wool (nightly).
- Restock and tidy medication trolley (nightly).
- Emergency trolley checks to be performed by night shift on weekends including oxygen, suction and recording of fridges temperature.
- Cut and paste s11 list of medication into the register.
- Change the linen on the examination table in the treatment room (nightly).
- Restocking of the treatment room.
- Restock of coffee, tea bags, milk etc. into ECU.
- Restock of ECU linen.
- Restock linen cupboards on LDU.
- Ensuring the dishwasher is turned on after supper.
- Rewriting of the journey board.
- Daily returns (nightly at midnight).
- Checking of DECT phones for morning shift.
- Counting of consumer's money (nightly).
- Printing and assortment of Bradma labels (nightly).

K shift responsibilities

- Receive a handover of consumers from the ANUM and ECU nursing staff at the commencement of the shift.
- In liaison with ECU nurse and ANUM agree on a shift plan
- In discussion with the ECU nurse, decide which consumers require more support. Additional support would be considered in situations of increased acuity, treatment escort to IPS, group attendance and supervised visits etc.
- Ensure that safety checks of ECU have been completed.

- Ensure that documentation regarding all consumers in ECU is up to date and complete. Ensure that each consumer has a current risk assessment and Wellness and Recovery Plan (WRAP®).
- Cover staff breaks on both floors.
- Provide 1:1 observation to consumers that may have trial leave on the open ward.
- Ensure that there is a member of staff in ECU at all times.
- Provide therapeutic and social activities with consumers.
- Ensure that ECU cupboards are fully stocked with appropriate linen. This includes seclusion blankets and gowns, sheets and pillow cases, towels and face washers. ECU stock also consists of urinals and pans, disposable hand wipes, toilet paper, gloves, disposable cups and plates.
- Ensure that ECU cupboards are fully stocked with appropriate linen. This includes seclusion blankets and gowns, sheets and pillow cases, towels and face washers.
- ECU stock also consists of urinals and pans, disposable hand wipes, toilet paper, gloves, disposable cups and plates.
- K shift should ensure that consumer's belongings are labelled (not with a bradma) correctly and are stored in the ECU cupboard according to the allocated bedroom. There should be no contraband stored in the ECU cupboard. Examples of contraband include any sharps, medications, smoking paraphernalia, cords or any form of ligature and plastic bags
- Participate in the observations of any Consumer in seclusion as directed by the ANUM/shift leader.
- Any other ECU related task as directed by the ANUM/shift leader
- In liaison with the ECU nurse review and update all WRAP®'s on a shift by shift basis where appropriate.
- All staff that is rostered onto the 'K' shift will ensure that they have made an entry into the consumer case notes for all care that they have provided during their shift as per policy on documentation.



Discharge

Pre discharge

The RP/ARP will allocate time with the consumer to review, update and make changes to the WRAP® before discharge into the community. Following this the RP/ARP/clinician will

photocopy the WRAP® and give the original to the consumer while the copy is placed in the medical record for scanning.

Consumer about to leave

Discharge on the day may not necessarily be completed by the RP or ARP; therefore these tasks may be completed by a discharge clinician.

- Ensure consumer has all their belongings, checking the safe and property room.
- Ensure the consumer has all their medication and understands their medication regime.
- Contact the case manager if applicable, family or significant others of consumers discharge.
- Provide the consumer with any appointment information that has been arranged in the community
- Liaise with the consumer re: plans to get safely to destination

Post discharge

- It is the responsibility of the RP/ARP or discharge clinician to
 - document in/on the medical record a MSE,
 - time of departure from the unit,
 - what was given to the consumer upon discharge, i.e. medication, WRAP®, any property given, and
 - any booked appointments that have been arranged in the community post discharge.
- The RP/ARP or discharge clinician is to complete a discharge HoNoS.



Clinical Review

The Clinical review is a process that enables review of current treatment and support. The review should be conducted in line with the St Vincent's Clinical Review Policy. The RP/ARP should represent the consumer in this forum, offering clinical knowledge as well as sharing insight into the consumer's needs explored through the Recovery Partnership whilst using

the tools that are the WRAP®, Strengths Assessment and Goal Plan. The role of the RP/ARP is fundamental in advocating on behalf of the consumer.

- RP's are responsible for attending the consumer's MDT Clinical review each week. This would comprise of rostering oneself to work on the corresponding shift, alternatively discussing with the ARP to attend if this is not feasible.
- The RP must prepare by discussing with the consumer what they would like to be discussed at the Clinical Review and complete the appropriate clinical documentation, the treatment plan (Appendix 17).
- Content shared at the Clinical Review should reflect any relevant information previously identified as important by both the consumer and their carers if they are involved in care. The RP/ARP is to be an advocate for the consumer and represent what the consumer wants to be discussed and provide relevant information from the consumers WRAP®.
- If the RP or ARP are not available to attend the relevant Clinical Review, they should ensure that they have prepared key points previously discussed with consumer so that appropriate information is shared by another clinician.
- Following Clinical Review, it is the RP's (or nominated clinician on that day) responsibility to communicate to the medication nurse of any changes to the consumer's medication regime and handover to the next shift.
- The RP/ARP should play an active role in identifying the need for further assessment and treatment. Within this role, the RP/ARP will be responsible for overseeing that any existing and new referrals are directed to the appropriate specialty area and are then attended to within a timely manner. The RP/ARP is also responsible for any collaboration regarding any discipline specific tasks within the team. Follow up regarding referrals and discipline specific tasks should be communicated effectively in clinical progress notes and PAS.
- The RP/ARP should play an active role in any discussion regarding transfer of care and discharge planning, including referrals to community mental health services.



Clinical Handover

- RPs must attend clinical handover to hand over the consumer to the next shift.
- Allied health must attend the 1300hrs clinical handover to ensure that the clinician allocated to the consumer for the next shift are aware of any changes to the WRAP®, risks or mental state, medication changes, improvements, referrals to other disciplines and investigations completed or outstanding. Medical records and PAS must also reflect this.

Group Brainstorming - A Team Approach

Group Brainstorming is a concept that promotes team involvement within a closed and supported environment. It provides a framework in which clinicians can achieve further professional development whilst enhancing their understanding of the tools which are used by the AIS and the wider service (WRAP®, Strengths Assessment and Goal Plan). The Brainstorming process involves a clinician presenting a consumer and identifying an issue or goal, previously identified by the consumer that may require assistance or strategies to achieve a desired outcome. The function of the Brainstorming process is for the team to generate creative strategies in order for the clinician to identify resources or ways in which to overcome any current challenges.

The Group Brainstorming process:

- Provides clinicians with support and development of their skills and working knowledge of the WRAP®, Strengths Assessment and Goal Plan.
- Generates new ideas for working with consumers whilst providing a sharing environment and opportunity to learn about community resources, interventions and other relevant services.
- Allows clinicians to practice within the six principles of the Strength's Model.
- Is conducted every fortnight on a Friday in the AIS and will be attended by nursing staff and Allied Health. Clinical handover is postponed for one hour with the expectation that all rostered afternoon staff attend with their morning shift peers who have been nominated. Casual bank staff will be required to represent the nursing discipline. Undergraduate students however should not attend Brainstorming.
- The Brainstorming process commences at 1300 hours and becomes a closed group at 1305 hours. Attendance after this time is not allowed as the concept of a closed group is necessary to maintain the integrity of Brainstorming.
- There is an expectation that all permanent staff will rotate through the roles of presenter and facilitator. All staff may volunteer a preferred date, alternatively the NUM will roster these tasks accordingly.

- Support and guidance is offered by a senior nurse from the AIS team during preparation for the role of presenter and facilitator.
- The Brainstorming process encourages open and free discussion where all ideas are welcomed and none are dismissed prematurely
- Each staff member builds on their knowledge of community resources which ideally would be naturally acquired resources and apply their new found knowledge to aspects of their own work with consumers.



Professional development and service training

A fundamental aspect of the Recovery Partnership Model is the underpinning principle of sharing knowledge between disciplines. With this established, clinicians can enhance on already learnt skills in an environment and under a model of care which is consumer focused as well as being professionally rewarding to the clinician. The principles relating to the Recovery Partnership promotes detailed and holistic care driven by the consumer and facilitated by the clinician. Job satisfaction and professional development are the identified benefits for the clinician. The model encourages discharge planning to commence from admission with the notion that one RP with the assistance of an ARP will enable the consumer to direct all aspects pertaining to their care. In order to facilitate this sharing environment, the AIS will encourage and ensure effective and timely education in areas which have previously been identified as belonging to a specific discipline.

All disciplines will have a responsibility to provide a sharing forum, to take place within structured in-services, external training or informally provide assistance and education to RP peers. Education sessions will be provided by Social Work, Occupational Therapy and Nursing on the following identified areas:

SOCIAL WORK

- Child Protection Program in the North and West Metropolitan Region - In service.
- Mental Health Carer Support Fund – In service.
- Initial Contact with Carers and Families – In service. (Appendix 3)

- Referral procedure to Social Work – In service.
- Centrelink Liaison Team

OCCUPATIONAL THERAPY

- Sensory Modulation – In service/Informal education
- Referrals for services offered by North Yarra Health and Inner East Community Health – In service.
- Referral procedure to Occupational Therapy – In Service

NURSING

- Overview and function of the Risk Assessment form – In service / informal education.
- Admission Process and Metabolic Monitoring – In service / informal education.
- Discharge Process – In service / informal education.
- Documentation – In-service/informal education.
- AWOL procedure – In service / informal education. (Appendix 4)
- ASSIST screening tools including Alcohol Withdrawal Scale and breathalyser use – In service / informal education.
- Hamilton’s depression scale and Mini Mental State examination – In service and Informal education.
- Early Episode Pathway and metabolic monitoring– In service education.
- Medication – Administration remains task specific to nursing however Allied Health RPs should be involved and consulted in decisions to administer PRN medication. Education provided throughout the year will relate to classifications and properties, doses, possible EPSE’s and other relevant information – In service / informal education.
- PAS – In service/ informal education



