MHAIDS Mental Health & Addiction Triage Scale	
Type: Protocol	
Issued by: MHAIDS	**Version:** 2
Applicable to: Te Whatu Ora - Capital, Coast, Hutt Valley and Wairarapa MHAIDS	**Contact person:** MHAIDS Operations Centre Manager
Document Owner: MHAIDS Operations Centre Manager	**Senior Document Owner:** Group Manager Mental Health and Addiction Directorate
Lead District: Capital and Coast	

Purpose:

This protocol sets out how clinicians use the triage scale to determine the timeframe within which MHAIDS will respond to, or see, a person referred to the service, irrespective of the channel through which the person was referred.

The protocol ensures inter-rater accuracy and consistency which optimises the potential for an equitable service response that is determined by the presenting level of clinical acuity and risk.

Scope:

Mental Health, Addiction and Intellectual Disability Service (MHAIDS) clinicians responsible for triaging referrals to the service in the Capital, Coast, Hutt Valley and Wairarapa District. This includes those who work at point of entry services or as intake and assessment clinicians.

Forensic services are out of scope, triage time scales are detailed in the *Operating Guidelines Ara Poutama and Regional Forensic Services (in development)*.

Definitions:

CMHT	Community Mental Health Team
CRS	Crisis Resolution Service
MHAIDS	Mental Health, Addiction and Intellectual Disability Service
MHS	Mental Health Service
Triage/Intake Assessment	Brief assessment completed either on the phone or face to face, used to screen for MH related signs, symptoms, and risks that inform decisions about the service response
Initial Assessment Choice Appointment	A planned, more detailed assessment that is conducted face to face, for the purposes of assessing the need for case management or ongoing MHS involvement.

Crisis Assessment	A face to face assessment undertaken to support someone who presents in crisis, with a high degree of mental health related distress and risk, for the purpose of crisis-management.

Background

Triage is a clinical function that aims to provide an initial mental health and addiction screening assessment to determine:

- whether the person has a mental health or addiction related issue
- the urgency with which services should respond to the presentation
- the most appropriate service response
- what is needed to ensure the person gets an equitable health outcome.

In cases where an assessment determines that a person does not require specialist mental health services, triage will include:

- assisting them by linking to more appropriate services and/or providing advice
- supporting and advising carers and whānau, and linking them with appropriate services to meet their needs, including cultural support services

Clinicians may also perform triage to assess current or former users of mental health or addiction services who make unplanned contact with services.

Protocol

The MHAIDS Mental Health and Addictions Triage Scale (see appendix for the full scale) provides for seven codes from A to G. These codes reflect a person's assessed need, risk, and thus the urgency of response required.

The first and second column in the scale provides the triage code and optimal response timeframe.

The third column summarises typical presentations used to assign each triage code, and the fourth column identifies the response type required.

The last column lists the actions the triage clinician undertakes for each triage code. The triage clinician selects a triage code consistent with the level of urgency and presentation.

Codes A-E are used when a person requires a face-to-face contact with a MHAIDS clinician. Codes F-G, do not require a face-to-face contact with a MHAIDS clinician.

Assignment of a triage code is always based on the person's clinical presentation, not the service's capacity to respond. Clinicians must always exercise their professional judgement drawing on their clinical experience and knowledge when deciding the triage code. In some cases, the clinician may want to seek advice from a senior colleague or service management. If unsure, clinicians must err on the side of caution and assign the higher of the codes they are considering.

In deciding a triage code, clinicians are guided by:

- the person's identified need for specialist mental health services
- the presence of any specific risk factors and the context in which they may occur
- the urgency of the response required from mental health and addiction services to ensure an optimal outcome
- the cultural needs of the person
- prioritised populations (Māori, Pacific people, Tāngata whaikaha | Disabled people, rural communities, those on low incomes, rainbow community, refugee and migrant communities: *Te Whatu Ora & Te Aka Whai Ora (2022) Te Pae Tata Interim New Zealand Health Plan).*

While there is some overlap in these dimensions, it is important that each dimension is individually assessed.

Identifying the Need for Secondary Mental Health and Addiction Services

The presence, severity and complexity of mental illness symptoms and addiction issues, and impact on functioning, are key determinants of a person's need for MHAID services.

Other factors to consider are whether the person has increased vulnerability due to:

- Alcohol and other drug problems
- Other co-morbidities (e.g. intellectual or physical disabilities, medical condition etc.)
- Social / environmental issues (e.g. absence of appropriate social supports, poverty, homelessness, unstable housing, domestic violence, problem gambling, involvement with criminal or youth justice systems etc.)

Particular consideration should be given to the impact of mental illness or addiction and other vulnerability factors on the person's functional status, such as their ability to maintain activities of daily living (including work, school, and self-care) and fulfilling family responsibilities.

Where it is felt that MHAIDS is not the appropriate service for a highly vulnerable person, a plan must be made to connect them to the most appropriate other service capable of meeting their needs.

Assessing the level of risk

The triage clinician always adopts an individualised approach to risk assessment. The clinician must complete an initial screening for risk. Where risks are identified, a more in depth assessment should be undertaken. The assessment includes the following:

- current risk of harm to self (suicidal ideation and intent, acts of self-harm, significant self-neglect, impaired judgement or impulse control, or high risk behaviours etc.)
- current risk of harm to others (e.g. homicidal, aggressive or destructive ideation or acts, impulsivity or behaviour endangering others, neglect of dependents, psychological harm etc. The assessment should identify any specific persons at risk)
- current risk of harm from others (e.g. neglect, violence, exploitation, sexual abuse etc).

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The assessment collects information from all available sources as circumstances permit and should include:

- static and dynamic risk factors, patterns of risk behaviour, severity, frequency and dates of past harm
- situational factors; for example, the person's access to means of harm (potential weapons, medications etc.)
- mental state factors; for example, the person's thought, affect and intent. For example, if the person is experiencing command hallucinations it is important to ascertain whether he / she feels compelled to act on them.
- the person's experience (e.g. trauma history, side effects of medication, previous experiences with mental health or addiction services, stigma etc.)
- the person's strengths and protective factors
- the person's social context (including people who may be able to help stabilise a situation, and / or people who may be subject to harm).
- the person's level of engagement. People with mental health and / or addiction issues vary greatly in the extent to which they recognise their difficulties and their desire and ability to engage with potential sources of help. Poorer engagement can increase the risk to the person and / or others and thus require a higher-level triage disposition. In lower acuity situations, the person's ambivalence and /or reluctance to seek help may make it more appropriate to provide advice and / or information.
- consideration of risks to dependents (for example, children, and elderly parents) are part of the triage risk assessment and must be taken into account when determining the person's need for MHAIDS or other services, and the urgency with which intervention is required. The clinician's knowledge of research evidence (for example, risk factors for suicide / violence etc.) informs the risk assessment.

Some people may present with chronic risk factors e.g. a history of self-harm and / or are frequent presenters to mental health services. The triage clinician must be alert to factors which indicate current increased risk. A critical question to consider in the triage process is; "**why is this person presenting now?"** It may also be useful to ask whether the situation has worsened since the last contact and whether any planned appointment needs to be brought forward.

While risk can never be completely eliminated, effective decision-making can support risk management while supporting the person's ongoing recovery. The triage clinician must work with the person and significant others (including whānau), where appropriate, to identify what is likely to be helpful. Particular attention must be paid to the views of the person, their whānau and significant others when deciding a plan of action.

Determining the urgency of response

Decisions about urgency of response overlap to a large degree with the person's need for services. The assessment of urgency focuses on short-term risk of harm rather than longer-term risks. However, longer-term risks may be very important in determining the person's need for MHAIDS.

Short term risks that would indicate the need for a face to face assessment may include:

- Suicidal ideation / self-harm / intent
- Bizarre or unusual thinking or behaviour
- Significant changes of mood or activity, including significant deterioration in basic functioning. Check for depression / low mood
- Irrational or overwhelming fear or anxiety
- Aggression
- Restless, agitated and disorganised behaviour
- Confusion and disorientation

The most urgent clinical feature should determine the triage code selected. For example, if the clinician is able to provide a brief intervention on the phone to ease the crisis (Code G) but there is a need for further assessment / review with the community mental health team within the next 3 weeks (Code E); Code E should be assigned.

Critical questions for clinicians to consider to help determine an appropriate timeframe for response include:

- What is the nature of the risk?
- Is the situation reasonably stable or are there indications of rapidly changing risks?
- Will the opportunity to engage the person be lost if action is not taken in a particular timeframe?
- Are capable supports available? If so, how long can they reasonably be expected to maintain the situation?
- Are there dependents which rely on the person to function and is risk involved if the intervention is not timely?

Assigning a triage code

The triage code is assigned after the triage clinician has collected sufficient information to make a decision about what response is required to manage the referral appropriately.

The triage code is used at initial screening of the referral to allocate a priority response to all new referrals and is documented on the MHAIDS Intake form and in the Digital Client Record progress notes.

The response time for intervention is measured from the time the triage code is assigned to the time of the face-to-face contact for assessment.

The triage code and response time for intervention may be updated following completion of triage assessment, as the situation may change after the initial priority response is allocated.

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When assigning a triage code, consider the maximum amount of time the person can safely wait for assessment or intervention; and the time any capable support person can reasonably be expected to maintain the situation.
All triage assessments must be closed to an outcome and the appropriate actions including referrals, reporting and handovers to other services are complete.

The triage code may change during triage as further information is gathered. It is important to note the allocation of a triage code does not prevent the person from being seen earlier if this is possible, particularly if the person's mental state has deteriorated and/or there is increased risk to self and others and the need for an equitable health outcome.

A – Emergency, immediate referral

The triage assessment is completed immediately. This code is assigned when the situation presents an immediate threat to the safety of the person of concern, the referrer or to others. For example, serious overdose, suicide attempt, violent aggression or possession of a weapon. Immediate action is taken to contact emergency services. Direct contact with person is maintained until emergency services arrive. A plan is then made for a mental health crisis assessment at an appropriate location. It may be necessary to inform other relevant services, such as Oranga Tamariki if there are dependents at risk or the person is under the age of 16 and a parent/guardian is not available.

B – Very Urgent, face-to-face contact within 4 hours

The triage assessment is completed immediately. This code is assigned when triage and/or referral information indicates that the person of concern is likely to deteriorate to the extent of presenting a significant threat to the safety of themselves or others unless there is an urgent service intervention from MHAIDS. For example a person presenting with acute suicidal ideation or risk of harm to others with clear plan or means, very high risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control. This indicates that they may require urgent assessment under the Mental Health Act, inpatient acute admission, crisis respite, home-based care or intensive community follow-up.

Consider historical risk factors, willingness and capacity to wait or travel, and the likelihood of absconding. Determine what support is available for the person while awaiting face to face crisis response. An emergency triage response may be more appropriate if concerns in these areas are present.

If contact was not directly with or from the person of concern, and the clinician is unable to contact the person to follow up, whanau / support person are to be contacted and escalation to emergency services may be required.

Where a very urgent (within 4 hours) mental health service response is required:

- Confirm the plan for crisis response/assessment including the location for assessment, and the clinician/s to undertake this.
- May advise person to attend Emergency Department for assessment if there are medical concerns, for example injury or overdose. Follow protocol for advising relevant services where this action is advised.
- Advise caller to ring back if the situation changes
- Clarify parental / carer supervision for dependents where appropriate.

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C – Urgent, face-to-face contact within 24 hours

The triage assessment is completed immediately. This code is assigned when triage and/or referral information indicates that the person of concern requires urgent assessment of their mental health. For example, presenting with suicidal ideation with no plan or ongoing history of suicidal ideas with possible intent, rapidly increasing symptoms of psychosis or severe mood disorder, significant vulnerability due to mental illness, high risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control (such as wandering at night).

Consider the support available for the person while awaiting a face to face crisis response; as well as their willingness and ability to make or have input into making appointments with MHAIDS and to contact services should they feel the situation deteriorates before face-to-face contact is made. A more urgent triage response may be more appropriate if concerns in these areas are present.

If contact was not directly with or from the person of concern, and the clinician is unable to contact the person to follow up, whanau / support person are to be contacted and escalation to emergency services may be required.

Where an urgent (within 24 hours) mental health service response is required:

- Confirm the plan for crisis response/assessment including the location for assessment, and the clinician/s to undertake this
- Clarify parental / carer supervision for dependents where appropriate
- Obtain / verify additional information from significant others as appropriate.
- Ensure the person of concern or their support persons have the means to make contact with services should they feel the situation deteriorates before face-to-face contact is made with clinicians.

D – Semi-Urgent, face-to-face contact within 72 hours

The triage assessment is completed immediately. This code is assigned when triage and/or referral information suggests that an assessment with MHAIDS is indicated **and** there is risk that the person would deteriorate significantly if not seen within the next few days. The person of concern or their support persons are considered to have the means to make contact with services in the next few days should they feel the situation deteriorates before face-to-face contact is made with clinicians. Presentations may include significant person/carer distress associated with severe mental illness, the person lacks insight, early symptoms of psychosis, high risk behaviour associated with delirium or dementia (e.g. daytime wandering, resistive aggression in hospital), the person is isolated or lacks support.

Where a semi-urgent (within 72 hours) mental health service response is required:

- Confirm the plan for acute response/assessment including the location, date and time for assessment, and the clinician/s to undertake this
- Determine support available for the person while awaiting a face to face acute response.
- Clarify parental / carer supervision for dependents where appropriate
- Obtain / verify additional information from significant others as appropriate.
- Advise caller to ring back if the situation changes.

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E – Non-urgent, face-to-face contact within 3 weeks

The triage assessment is to be started within 24 business hours of receipt of referral. This code is assigned when triage and/or referral information indicates that an assessment with MHAIDS is needed, and person of concern is stable and at low risk of harm during the waiting period. Where risk and severity of symptoms are higher, the person has support people and/or stabilising factors allowing them to safely wait for assessment. They may have other services involved that are able to manage until MHAIDS assessment. The person of concern or their support people are considered to have the means to make contact with services should they feel the situation deteriorates before face-to-face contact is made with clinicians. The presenting difficulties would indicate symptoms of moderate to severe mental health difficulties. They may be a known service user requiring non-urgent review, a referral for diagnosis, or requests for capacity assessment.

Where a non-urgent (within 3 weeks) mental health service response is required:

- Determine support available for person while awaiting a face to face initial assessment / choice appointment
- Advise the caller to ring back if situation changes. Consider a more urgent response if the person cannot wait within a non-urgent timeframe due to their risk/mental state.
- Clarify parental / carer supervision for dependents where appropriate.
- Contact whanau / support person if unable to contact client
- Obtain / verify additional information from significant others as appropriate.

In situations where the person is not able to be reached, a minimum of 3 attempted contacts must be made using at least two different methods (phone call, text, email). If the clinician is unable to reach the person, contact must be made with the identified whanau/ support person. If no support person has been identified by the referrer, the clinician will contact the referrer to request this information. Attempted contacts are made with at least 7 days between the first and last contact. Referral may be escalated if required. See triage code H - Inconclusive Contact below for actions when not able to make contact.

F and G – Referral or advice to contact alternative provider / Advice, consultation and information

Triage to be completed within 24 business hours of receipt of referral. Code F is assigned when triage and/or referral information indicates that other services are more appropriate for the current situation or need. Triage code G is assigned where contact was for consultation or advice, or initial notification pending further information or detail, for example the person, parent or carer requiring information or advice, GP/NGO or other service provider requesting consult / specialist advice.

Where referral to an alternative provider or advice / consultation are required:

- Provide information on appropriate alternative service provider and advise contact details OR assist/facilitate referral where indicated (e.g. person or carer unable to complete this themselves)
- Provide support and advice
- Provide consultation, advice and / or brief intervention.

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If further discussion or advice on the allocation of the triage response code is required, this should be documented on the person's progress notes in the digital client record, and the assessing clinician can discuss the allocation of the response number with a senior colleague or service manager.

Revising a triage code

Once triage actions have been completed, for example the referral is closed with advice, any subsequent contacts should be treated as a new triage episode requiring reassessment of the person's current situation including any problems, issues, stressors or events that have occurred since the last contact with MHAIDS.

Where new information becomes available soon after the original decision has been made and before the service has responded (e.g. the person is waiting for a face-to-face appointment) the triage code may be revised, if required, to reflect the new information obtained in the subsequent contact. The reasons for revising the triage code should be documented clearly in the clinical record.

Triage codes must never be revised due to lack of available mental health resource.

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Summary of key points

1. When conducting the triage, consider:
   - the person's need for MHAIDS
   - the presence of any risk factors and the context in which they may occur
   - the urgency of response required.
2. An individualised approach to risk assessment and decision-making must be adopted, drawing on the strengths of the person and facilitating their active participation in the triage process. The views of the person and significant others (for example family, GP, NGO etc.) where appropriate must be considered.
3. Assignment of a triage code must always be based on the person's clinical presentation not the service's capacity to respond.
4. A higher-level triage code should be considered when a person has mental illness or addiction issues and:
   - has increased vulnerability due to other factors
   - shows signs of poor engagement.
5. The most urgent clinical feature should determine the triage code selected.
6. For people with a background of chronic risk, the clinician needs to determine whether the current risk is increased: "Why is this person presenting now?"
7. When assigning a triage code, consider the maximum amount of time:
   - the person can safely wait for assessment or intervention
   - any support person can reasonably be expected to maintain the situation.
8. If unsure about the optimal response time, always err on the side of caution. Seek advice if unsure.
9. Where MHAIDS is not considered appropriate, the clinician should direct the person to the most appropriate service (where applicable). This is particularly important for those with increased vulnerability.
10. Assign the triage code after the triage assessment has been completed; and ensure a plan is documented for the response intervention. All triage assessments must be closed to an outcome.

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Monitoring

- Compliance and effective assigning of triage codes is measured in routine annual service audits for the intake and assessment roles.

References:

- Sands, N. Elsom, S. & Colgate, R. *UK Mental Health Triage Scale Guidelines,* UK Mental Health Triage Scale Project, Wales, 2015.
- Victorian Government Department of Health. Statewide Mental Health Triage Scale: Guidelines. Melbourne, 2010.
- Department of Human Service. Mental Health Triage: Programme Management Circular. Mental Health Branch, Metropolitan Health and Aged Care Services Division, Victorian Government, Department of Human Services. 2005.
- Sands, N. & Gerdtz, M. Victorian (draft) Area Mental Health Triage Scale Pilot Project Evaluation. Final Report, Department of Human Services Victoria, 2008.

Related Documents:

Te Ara Oranga Policy
MHAIDS Intake and Assessment Procedure

Appendix

MHAIDS, Mental Health and Addictions Triage Scale

Keywords for searching:

- Triage, triage code, urgency of response, assessing risk

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Appendix: MHAIDS Mental Health & Addiction Triage Scale

MHAIDS Triage Scale				
Triage Code / Description	Response type / time to contact	Typical presentation	Service action / response	Additional actions to consider
A Emergency	**IMMEDIATE REFERRAL Emergency service response**	Current actions endangering self or others Overdose / suicide attempt / violent aggression Possession of a weapon	**Immediately notify 111 Emergency services (ambulance, police, fire service)**	Keep caller on the line until emergency services arrive Notify Emergency Department once plan agreed with emergency services. Confirm plan for crisis response (assessment) Notify other relevant services where appropriate e.g. Oranga Tamariki if there are dependents at risk or person is under the age of 16 without a parent/guardian
B Very high risk of imminent harm to self or others	**WITHIN 4 HOURS Very urgent mental health response**	Acute suicidal ideation or risk of harm to others with clear plan or means Ongoing history of self-harm or aggression with intent Very high risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Urgent assessment under Mental Health Act	**Face-to-face assessment by Crisis Team AND/OR Triage clinician**	Confirm plan for crisis response (assessment) Determine support available for person while awaiting face to face crisis response. May advise person to attend Emergency Department for assessment and follow protocol for advising relevant services Advise caller to ring back if situation changes Clarify parental / carer supervision for dependents where appropriate. Contact whanau/support person if unable to contact client
C High risk of harm to self or others and/or high distress, especially in absence of capable supports	**WITHIN 24 HOURS Urgent mental health response**	Suicidal ideation with no plan Ongoing history of suicidal ideas with possible intent Rapidly increasing symptoms of psychosis and / or severe mood disorder High risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Overt / unprovoked aggression in care home or hospital ward setting Wandering at night (community) Vulnerable isolation or abuse	**Face-to-face assessment by Crisis Team / Liaison / Community Mental Health Team (CMHT)**	Determine support available for person while awaiting face to face crisis response. Confirm plan for crisis response (assessment) Advise caller who to contact if situation changes. Clarify parental / carer supervision for dependents where appropriate. Obtain / verify additional information from significant others as appropriate. Contact whanau/support person if unable to contact client
D Moderate risk of harm and/or significant distress	**WITHIN 72 HOURS Semi-urgent mental health response**	Significant patient / carer distress associated with severe mental illness (but not suicidal) Absent insight /early symptoms of psychosis Resistive aggression / obstructed care delivery Wandering (hospital) or during the day (community) Isolation / failing carer or known situation requiring priority intervention or assessment	**Liaison / Face-to-face assessment by CMHT**	Confirm plan via telephone for acute response (assessment) Determine support available for person while awaiting face to face acute response. Advise caller to ring back if situation changes. Clarify parental / carer supervision for dependents where appropriate. Obtain / verify additional information from significant others as appropriate. Contact whanau/support person if unable to contact client

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E **Low risk of harm in short term or moderate risk with good support/ stabilising factors**	**WITHIN 4 WEEKS** **Non-urgent mental health response**	Requires specialist mental health assessment but is stable and at low risk of harm during waiting period Other services able to manage the person until mental health service assessment (+/- telephone advice) Known service user requiring non-urgent review adjustment of treatment or follow-up Referral for diagnosis (see below) Requests for capacity assessment, service access for dementia or service review / carer support	**Face-to-face initial assessment / choice appointment with CMHT**	Provide an appointment date/time for face to face assessment Determine support available for person while awaiting face to face initial assessment / choice Advise caller to ring back if situation changes. Consider more urgent response if person cannot wait within non-urgent timeframe due to their risk/mental state. Clarify parental / carer supervision for dependents where appropriate. Contact whanau/support person if unable to contact client Obtain / verify additional information from significant others as appropriate.
F **Referral not requiring face-to-face response from mental health**	**Referral or advice to contact alternative provider**	Other services (outside mental health) more appropriate to current situation or need	**Triage clinician to provide advice for and/or referral to alternative service provider**	Provide information on appropriate alternative service provider and advise contact details OR Assist/facilitate referral where indicated (e.g. person or carer unable to complete this themselves)
G **Advice, consultation, information**	**Advice or information only** **OR** **More information needed**	Patient or carer requiring advice or information Service provider providing information (collateral) Initial notification pending further information or detail	**Provide advice, support and/or collect further information**	Provide consultation, advice and / or brief intervention Consider courtesy follow up telephone contact

Adapted from: Sands, N. Elsom, E, Colgate, R & Haylor, H. (2016) Development and inter-rater reliability of the UK Mental Health Triage Scale (In Press). *International Journal of Mental Health Nursing.*

***Response time is measured from time triage code assigned to time of face-to-face contact.**

MHAIDS Internal request for service	
Type: Procedure	
Issued by: Te Ara Oranga Committee	**Version:** 1.2
Applicable to: Health NZ - Capital, Coast and Hutt Valley MHAIDS	**Contact person:** MHAIDS Quality Coordinator
Document Owner: MHAIDS Quality Coordinator	**Senior Document Owner:** MHAIDS Quality and Risk Manager

Purpose:

To provide a consistent and clear process for Mental Health, Addictions and Intellectual Disability Service (MHAIDS) staff when a primary team requests additional services or consultation from another MHAIDS team.

Scope:

Includes

- all MHAIDS staff.
- any request from one MHAIDS team to another for specialist consultation, assessment or service provision on behalf of a current service user.

Excludes

- admissions to inpatient units.
- transfer of care from one MHAIDS team to another.
- transfer of care to or from another DHB.
- new referrals from Te Haika, Intake and other DHBs.
- requests for consultation outside of MHAIDS.

Definitions:

Person/Service user/Patient	The term 'person' will be used to describe an individual using mental health, addictions or intellectual disability services. Where appropriate 'service user' may be used. Inpatient teams may use the word 'patient' to describe a person using those services whom is under the Mental Health Act.
Request for service	A request from one team to another team within MHAIDS, for a current service user for specialist consultation, assessment or service provision
Primary team	The main treating team the 'primary' episode of care is open to.
Requesting team	Team requesting additional services on behalf of the service user.
Receiving team	Team receiving the service user.

Roles and Responsibilities

Team leaders/Clinical nurse managers
- ensure all team members are aware of this procedure and adhere to its requirements.

MHAIDS clinical and administration staff
- be familiar with the content of this procedure and adhere to the requirements.

Content

Rationale
An internal request for service (IRFS) from one team to another within MHAIDS, for a current service user may be initiated if the primary team

- believes that the person would benefit from a specialist MHAIDS team assessment
- requires advice or support with treatment
- requires a second opinion from another health practitioner eg. a second opinion for the purposes of the Mental Health Act
- is seeking additional co-work input from another team.

Procedure

Requesting team
- Discuss proposed request with the person/ their whānau and document in MHAIDS digital notes.
- MDT to discuss and document the rationale and agree to initiate the process.
- Update Comprehensive Plan to reflect the request and rationale.
- Contact the receiving team to discuss the request for service – they will advise of documentation that may be required (referral information/ screening information etc).
- Complete appropriate additional information required for the specific request.
- Open and complete the requesting section of the *MHAIDS Internal Request for Service template* based on the *Quick Guide: Internal Request for Service Process.*

Receiving team:
- On receipt of the IRFS, the team leader or coordinator ensure the correct documentation is available and update the status of the MHAIDS Request for Service Template to 'received'.
- The team leader/coordinator follow their own internal team process for allocation of request, and update the IRFS template.

Related Documents
- MHAIDS Te Ara Oranga Policy
- Transfer of Care Procedure
- Quick Guide: Internal Request for Service

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MHAIDS Intake and Assessment Procedure	
Type: Procedure	
Issued by: MHAIDS	**Version:** 2.0
Applicable to: Health NZ - Capital, Coast, Hutt Valley and Wairarapa MHAIDS	**Contact person:** MHAIDS – Project Manager
Document Owner: MHAIDS – Project Manager	**Senior Document Owner:** MHAIDS – Group Manager
Lead District: Capital, Coast	

Procedure purpose

To provide consistent, person and whānau centred processes for Mental Health, Addiction, and Intellectual Disability Service (MHAIDS) staff completing intake and assessment. Equity considerations are included throughout this procedure to demonstrate MHAIDS commitment to Te Tiriti ō Waitangi principles.

More detailed processes on day-to-day administration and management of referrals can be found in the Intake and Assessment desktop manual. The MHAIDS Te Ara Oranga Client Pathway Policy and Triage Protocols are the overarching documents and should be read alongside this procedure and the MHAIDS Intake and Assessment policy.

Scope

Includes:

- All MHAIDS clinicians who undertake intake and assessment work, including other members of the teams who provide cover in cases of planned and unplanned leave.
- All leaders/managers (i.e. Local Service/Team Leaders/Coordinators, Operations Managers/Clinical Leaders) responsible for recruiting and managing staff and processes in this area.
- MHAIDS administration staff who are involved with the intake/referral process.

The scope also includes the below services in the Mental Health and Addiction Sector:

- All services within the scope and functions of the Local Adult Specialist Mental Health and Addiction Service.
- Cultural Services (Te Whare Mārie, Specialist Māori Mental Health Service; and Health Pasifika).
- Tūhonohono Addiction Service.
- Younger Persons Community Mental Health and Addictions Service.
- Older Persons Community Mental Health.
- Specialty teams – Maternal Mental Health, Early Intervention in Psychosis Service (EIS).

This procedure excludes management of referrals/service requests for the below areas:

- Subspecialty teams that require:
  - Specific medical information collected to proceed with a referral e.g. Central Region Eating Disorder Service.
  - Service requests from general hospital services e.g. Consultation Liaison.
  - Referrals/service requests from other MHAIDS teams e.g. Team for Assertive Community Treatment (TACT), Ngā Tai Oranga.
- Admissions to all inpatient hospital units under Mental Health, Addiction & Intellectual Disability Services.
- Referrals to the Regional Rehabilitation Service are managed via Mental Health Needs Assessment and Service Coordination (MHNASC).
- Regional Forensic Service (including Forensic Coordination Service (Intellectual Disability [FCS(ID)], and other Regional Forensic Services). Referrals for these services are usually received via the court system or Ara Poutama Department of Corrections.
- Referrals for Intellectual Disability Services inpatient units.
- Referrals for Wellington Co-Response Team (CRT) (refer to the CRT Memorandum of Understanding) - these are received via NZ Police Communications 111. Service requests can be made internally via MHAIDS teams.
- Internal transfers of care within MHAIDS (follow MHAIDS Internal Transfer of Care Procedure).
- Internal requests for service within MHAIDS (follow MHAIDS Internal Request for Service).

Definitions:

Person/tangata whaiora; and people/tāngata whaiora

The term person (or people for plural) is used to describe an individual seeking care from MHAIDS. Tangata whaiora (singular) or tāngata whaiora (plural, with a macron) is the preferred term within MHAIDS, this translates in Te Reo Māori to ‘a person seeking wellness’.

Whānau

Who is considered to be whānau is determined by the tangata whaiora and may include significant support people who may or may not be biologically or legally related whānau members. For Māori, this includes Hapū, Iwi and Hāpori.

Equity

Equity is the action of treating people fairly and being prepared to work differently in a way that support positive outcomes as defined by the tangata whaiora/whānau receiving our services.

Request for service (or service request/referral)

Contact by or on behalf of an identifiable person seeking assistance with mental health or addiction related concerns. This may be a request for information or advice; assessment and/or treatment.

Screening

A brief screen is conducted by any clinician receiving a referral/request for service. The purpose of screening is to read the referral or respond to the initial query, check that it is appropriate for specialist mental health and addiction services, the urgency of response required, and evidence of consent.

Triage

Triage is the process of prioritising the initial contact that occurs at the point of entry to specialist mental health and addiction services. It is a clinical function in which a brief telephone or in-person based mental health screening is undertaken to determine:

- whether the tāngata whaiora/person has a mental health related issue,
- the urgency of the problem,
- and the most appropriate service response.

Initial Assessment

Also known as an Intake Assessment or Choice appointment.

An Initial Assessment is a more detailed assessment that is conducted face-to-face for the purposes of assessing and formulating presenting issues and identifying if specialist mental health and addiction intervention best meets the person's needs.

If appropriate, inclusion of Māori kaimahi or kaumātua to support and guide the process, utilising tikanga if tāngata whaiora request it.

Roles and Responsibilities:

Team Leaders/Local Service Leads and Coordinators

- Ensure all team members are aware of this policy, associated procedures and adhere to its requirements.
- Ensures that intake and assessment clinician(s) have appropriate support, protected time and supervision to be effective in their role.
- Ensure intake and assessment clinicians are well trained, competent and have completed all appropriate competencies such as Implicit/Unconsious Bias and Te Rau Ora.
- Monitor and report on, wait times, risks and complaints and ensure that any service risks are escalated to the Operations Manager and Clinical Leader.
- Alongside the clinical team, ensures that the intake and assessment clinician role is covered daily in cases of planned and unplanned leave and absences and dedicated time for this role is protected.
- Develop effective partnership relationships with community providers and other key

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services, to ensure an appropriate, localised response and address any equity challenges such as reducing barriers to accessing specialist mental health and addiction care. This also includes linking primary care providers with the Primary Care and Community Transitions function within the Local Adult Specialist Mental Health and Addiction Service or similar role in other specialist services.

Referral Coordinator:

- Provides advice and support for MHAIDS intake and assessment clinicians.
- Participates in any changes/quality improvement.
- Support and training for Intake and Assessment Clinicians.
- Oversight of the intake whiteboards across the service.
- Liaison with MHAIDS team leaders and Whakarongorau.
- Provides guidance in identifying any potential equity issues, particularly during the screening process.

Intake and Assessment Clinicians:

- Provide a welcoming, respectful approach to the service, acknowledging that approaching a service is the first step to getting help for mental health and addiction issues.
- If appropriate and available, includes cultural experts in the process to ensure tikanga can be followed so tāngata whenua feel welcome and safe. Cultural assessment can be useful at ascertaining all required information.
- Are dedicated FTE roles whose focus is the management of service requests/referrals.
- Able to manage distress, and give a person-directed, empathetic and trauma-informed response – particularly if the tāngata whaiora and whānau are presenting in crisis.
- Are familiar with this procedure/associated policy and adhere to its requirements.
- Respond to all referrals as per the Mental Health and Addiction Prioritisation (Triage) Scale Protocol.
- Work in accordance with the Te Ara Oranga (Client Pathway) Policy principles and process maps.
- Document referrals and clinical work as per the policy requirements.

Intake and assessment procedure principles:

- We make sure we capture the tangata whaiora/person's story, in their own words. We acknowledge that asking tāngata whaiora and whānau to tell their stories to multiple clinicians and providers can cause distress and trauma. We lower the risk of this by communicating effectively with each other's services and external providers in an integrated way, and whenever possible include a culturally appropriate provider in the assessment process
- Decisions are made based on the tangata whaiora/person's individual needs, not the service resourcing.

- Screening/triage is an ongoing process, and the person's risk/mental state is constantly checked and documented at all points of contact.
- However, in some cases, there is no clinical indication to triage the tangata whaiora/person. If a referral is of high quality, with sufficient information, telephone triage is not required, and the person can be booked in for an appointment. This can also apply to tāngata whaiora who are known to the service and are returning for treatment.
- Tāngata whaiora/people are kept updated on the referral process particularly if their referral has not been accepted. Options (e.g. e-therapies, other community service options) and a plan should be provided to the tangata whaiora/person and the referrer if the decision is made not to accept the referral for follow-up. The decision (s) are documented providing rationale for declining of the referral and the options given directly to the tāngata and their whānau.
- While tāngata whaiora /people are waiting to be seen, we offer options to prepare for treatment. For example, this may consist of recommendations to the GP or referrer - or the Intake and Assessment Clinician providing focussed intervention in the short term.
- Decisions are made from the point of screening by the Intake and Assessment Clinician, and they are trusted to make their decisions with support from the team.

Procedure content

At all points of contact in the intake and assessment process:

- All Intake and Assessment Clinicians will use the Mental Health and Addictions Prioritisation (Triage) Protocol for direction in providing a response appropriate to the level of clinical acuity, timeframes for response, and risk for each tāngata whaiora /person referred. The Intake and Assessment Clinician will use triage scales contained within the protocol to determine the priority and urgency of response.
- Note that this process is not just a 'one-off' on entry to the service – all contacts are screened and prioritised, particularly if there are escalating concerns that the person's mental health is deteriorating and/or the risk is increasing. Any changes are documented in the Clinical Portal.
- The MHAIDS Te Ara Oranga Client Pathway policy also provides guidance on this process.

Service requests/referrals

The process of opening referrals is outlined in the MHAIDS Te Ara Oranga Client Pathway policy (under Entry).

Service requests can be received:

- By phone, or the tangata whaiora/person coming into the service base.
- Via the Clinical Portal e-referral system from GPs.
- By general hospital and health services.

- By a support person, whānau member or by a concerned member of the public.
- From an NGO provider e.g. Emerge Aotearoa, Pathways.
- From other NZ Government agencies such as NZ Police, Kāinga Ora, Plunket etc.
- On occasion – international referrals (see desktop manual for management of these referrals).

Screening referrals

All referrals are opened and prioritised/screened for risk within 8 working hours of receipt.

- Referrals require regular screening and Local Service Leads and/or Coordinators are responsible for checking this twice a day at a minimum. It is expected that the Local Service Lead or Local Service Coordinator will be available to the Intake and Assessment Clinician for any queries or clinical concerns.
- Screening is brief and completed by the Intake and Assessment clinician (or whoever receives the referral). Screening involves reading the content of the referral, prioritising the urgency of response and planning for follow up. The initial triage response code on receipt of the referral and screening must always be documented in the Clinical Portal.
- The screening and a brief follow-up plan are documented on the MHAIDS Intake form or in the Notes section on the Clinical Portal. In some cases, the Intake and Assessment Clinician may request the historical paper file to gain more background information relevant to the current presentation.
- The Intake and Assessment Clinician will check the tangata whaiora/person's consent for referral is included before it is triaged, and the referrer must be contacted if there is no consent recorded to discuss next actions. The referral is not opened if there is no evidence of consent.
- If, on screening, the referral is lacking the necessary clinical content to allow the Intake and Assessment clinician to plan the response, the Intake and Assessment Clinician will write to the referrer to request more information. For GP's, this is usually via the MHAIDS Note to GP function on the Clinical Portal (same process applies if the referral lacks consent).
- In the case of application for compulsory assessment and treatment, this should be forwarded to the Crisis Resolution Service for follow up.
- If any referral contains additional information about a tangata whaiora already open to a MHAIDS team, this is communicated to the relevant team. This should be documented in the Notes section in the Clinical Portal.

All referrals should have:

- Up to date demographics:
  - Name,
  - Address,
  - Date of Birth (ideally NHI but not essential),

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  - Iwi affiliations,
  - Next of kin or support contacts. Referrals for rangatahi/ younger people under the age of 18 years old should have details of any custodial issues – e.g. Oranga Tamariki guardianship/custody, main caregiver if parents are separated/divorced.

- A description if the person has a disability, and any support is needed to facilitate communication.
- If English is a second language – detail if an interpreter is required. In this case, the person should be booked into an initial assessment following a brief screen for risk/mental state.
- Explanation of the rationale for referral.
- The degree of risk that has been identified by the referrer (although noting that some referrers may not be able to articulate the risk from a mental health perspective, so this will need further exploration by the Intake and Assessment Clinician).
- Evidence of consent:
  - If the tangata whaiora cannot consent - e.g. Gillick principles/requirements for rangatahi/younger people, or if the tangata whaiora does not have capacity, Enduring Power of Attorney or other alternative decision-making processes should be referenced.
- For GP and private practitioner referrals, there is clear evidence that the GP/practitioner has tried interventions and treatments without success and that the person's need is beyond their scope or expertise.
- Eligibility for publicly funded services/refugee status as per the Health New Zealand | Te Whatu Ora – Capital, Coast and Hutt Valley (note this also covers MHAIDS) Eligibility for publicly funded healthcare policy and related procedure.

Following the screen, an initial triage scale code is documented in the notes on the Clinical Portal using the MHAIDS Mental Health & Addiction Triage Scale Protocol.

The referral is then either:

- Opened for a telephone triage or straight to an initial assessment in some cases.
- Redirected to another team or the correct team if the person is open for treatment to another team or sent to the service in error.
- Closed following feedback to the referrer/other appropriate parties.

All the actions and outcomes from above must be documented in the Clinical Portal.

Self-referrals (by phone or in person)

- Tāngata whaiora/people can self-refer to our mental health and addiction service. Every attempt should be made to see the tangata whaiora/person if they walk into the service.
- The Intake and Assessment Clinician will speak with the tangata whaiora/person

within the same day to determine their current concerns, risk, and any current or previous treatments, to assess if they are likely to require further assessment with MHAIDS.

- If the Intake and Assessment Clinician is unavailable, the Duty Clinician, Local Service Coordinator or Team Leader will see the person and follow the same process as detailed above.
- If the self-referral is assessed as urgent (Triage A-D), as per the MHAIDS Prioritisation (Triage) Scale, refer to Emergency Services or CRS. See below for management of crisis referrals.
- If the referral is assessed as non-urgent, and the Intake and Assessment Clinician cannot see the person at that time, an Initial Assessment appointment is booked and the person is encouraged to contact the service directly if their circumstances change. After-hours crisis phone numbers and what to do in an emergency information should also be provided.
- This is documented in the MHAIDS Intake document and Notes.

Management of crisis referrals:

- Referrals screened by the Intake and Assessment Clinician as a Scale/Code A-D are prioritised and given more urgency over other referrals. Note that triage level A is usually immediately referred to Emergency Services (Police, Fire, NZ Ambulance for follow up) by the receiving clinician.
- On receipt of a referral coded B-D, the Intake and Assessment Clinician will ring the person as soon as possible and complete a brief triage, prioritising mental state, risk assessment and urgency. A plan for follow-up is agreed with the person and after-hours crisis contact details given. The referrer should also be kept informed of the situation.
- It is acceptable however, that following a triage telephone call, a referral that is screened as urgent (Scales B-D) is reduced in urgency, and the Triage Scale changes to non-urgent/advice given/refer elsewhere (Scales E – G).
- If following the call, the code remains at B-D, the Intake and Assessment Clinician will call the local crisis/Rapid Response function and provide a verbal handover.
- The Intake form is completed using the relevant triage scale and ensuring it is re-directed to appear on the CRS whiteboard.
- For those referrals rated semi-urgent (Scale D) following triage; it is recommended that the Intake and Assessment Clinician liaise with the co-ordinator or Team Leader/Local Service Lead ascertain if it is possible, within available resources, to assess the person within a 72-hour period. If this is not possible then the referral will be handed over to the crisis/Rapid Response function.
- While referrers are advised not to send an urgent referral through the non-urgent pathway, referrals that are urgent will be received and are managed and dealt with as per usual processes.
- Should an urgent referral be sent via the non-urgent pathway, it is recommended that feedback/education is given to the referrer about the correct pathway for future referrals once the intake process is complete.

Initial assessments:

- Initial assessments are booked following a telephone triage if the person is new to the service, and there are questions about whether specialist mental health and addiction intervention can best meet the person's needs.
- It is a face-to-face process and lengthier than the initial screening (UK Triage Scale Guidelines, 2015) and can also provide diagnostic clarity and form part of a plan for treatment.
- The initial assessment should occur within the time limits for Category E – i.e. within four weeks. If this cannot occur within 4 weeks, the referral goes back to the MDT meeting who are responsible for making a follow-up plan.
- In all cases a plan should be completed at the initial assessment so the tangata whaiora/person and their supports have a clear pathway and actions for follow up and what to do if the situation deteriorates. This includes other services that may better meet the needs of the tangata whaiora/person for example, partner violence support, Care NZ etc.
- Māori and Pacific whānau are prioritised for an initial assessment, and cultural modalities offered in this case.
- Following a quick phone screen by the Intake and Assessment Clinician for mental state and imminent risk, a person can be directly booked for an initial assessment if:
    - There is enough clinical evidence in the referral that specialist mental health and addiction services are indicated.
    - There is a second referral received within 8 weeks, and/or there is evidence that the person's risk/acuity is escalating.
    - The person has a disability, or another issue that means communication via telephone is restricted – e.g. interpreter services are required.
    - Māori and Pacific whānau should be booked directly for a face-to-face assessment.

Management of information received from another district:

- The Intake and Assessment Clinician may receive clinical information from other districts that is not intended to be an active referral or external Transfer of Care. This is also known as 'For Your Information' or FYI.
- The purpose of this is usually to provide information about the tangata whaiora /person who may be temporarily within the MHAIDS district, and who may present to the service.
- If there are any queries about the intent of the information, or whether it is an External Transfer of Care, the Intake and Assessment Clinician should contact the sending district for clarification.
- All discussions on this and outcomes are recorded on the Clinical Portal as a 'Non MHAIDS client eNote'.

External Transfers of Care

- External Transfers of Care (TOC) are received for people already under the care of a

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secondary or tertiary mental health and addiction service in another district. External Transfers of Care are automatically accepted into MHAIDS.

- In all cases, External Transfers of Care must adhere to the National agreement: Transfer of patient care across DHB boundaries.
- For tāngata whaiora subject to compulsory treatment, referrals are managed in accordance with legislative requirements.
- Intake and Assessment Clinicians will contact the transferring service to confirm demographics and triage risk on receipt of the TOC.
- If the person has been discharged from another district inpatient unit, then they must be seen in person within 7 days of the discharge date.
- External transfers of care for Special/Restricted Patients in forensic mental health services are outside the scope of this procedure and are immediately referred to Forensic Services, as these types of referrals require Ministry of Health direction.

Non-contact and closure of referral

- At least three attempts to contact the tangata whaiora/person are made at all steps (i.e. screening, triage, initial assessment contact) during the intake process.
- Contact is attempted using at least two different methods, including phone calls, text messages and email.
- If whānau/support person details are available, the Intake and Assessment Clinician should also attempt contact with whānau if the person is not responding to contact.
- There should be at least 10 days between first and last contact attempts to ensure sufficient time for the tangata whaiora/person to respond to any messages left.
- During the attempts to contact, the referrer will be kept updated on the situation. If the person is unable to be contacted, the referrer is contacted and a request made for alternative contact methods, including whānau contact details if not already provided. If the referral is coded B-D, the Intake and Assessment Clinician should speak with the referrer if the person has not responded to the first contact attempt.
- Any urgent risk concerns are discussed with the referrer and assertive action taken if required, including increasing attempts to contact.
- If all contact attempts are unsuccessful, the referral is closed due to non-contact. This is documented on the Clinical Portal, and a letter/MHAIDS Note to GP sent to the person and referrer. This is documented in activity data as ‘attempted contact - unplanned’ code.
- Administration staff should not contact tāngata whaiora/people referred to the service and book appointments – this is the Intake and Assessment clinician's responsibility following the screening process.
- Booking tāngata whaiora/people in to triage their referrals over the phone is actively discouraged, as this can cause delays in processing referrals, along with potential distress for tāngata whaiora if they need immediate help.
- If the Intake and Assessment Clinician calls the person, and they are unable to speak at the current time (e.g. they are in a public space), then it is acceptable for the

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Intake and Assessment Clinician to arrange an agreed time with the person to call back. However, if for whatever reason the Intake and Assessment Clinical is unable to talk at this time, they should let the person know alternative arrangements.

Actions following completion of the intake/initial process:

- The Intake and Assessment Clinician will collaborate with the MDT, General Practitioners, and any other person involved to provide the best possible outcome for the tangata whaiora/person referred or redirect the referrer to an alternative service when appropriate.
- Not all referrals or outcomes of initial assessments will be presented to the full service multi-disciplinary team meeting. For example, if it is clear following an initial assessment that the tangata whaiora/person needs specialist mental health and addiction services, or the person is known to the service and returning.
- Any complex referrals that need further discussion will be an agreed process with the Intake and Assessment Clinician and Local Service Lead and should only occur if there is lack of agreement on an outcome or a wider discussion would be helpful. A small, multi-disciplinary meeting between the Intake and Assessment Clinician, Local Service Coordinator/Lead, and other relevant professionals should take place (no longer than an hour) and an outcome from this meeting will be decided. If there is no outcome from this meeting, then this is escalated to a Clinical Leader for direction.
- Following an initial assessment, if a decision has been made to allocate the person to treatment, the Local Service Lead/Team Leader or Local Service Coordinator is responsible for allocating a case manager. This will be updated as soon as possible on the Clinical Portal.
- The case manager (or duty worker/Team Leader/Local Service Lead if the case manager is absent) is the point of contact for the tāngata whaiora and the whānau once the initial assessment is completed.

Related Documents

- MHAIDS Intake and Assessment policy
- Te Ara Oranga (Client Pathway) policy
- 3DHB Mental Health and Addictions Prioritisation (Triage) Scale ProtocolNational agreement Transfer of patient care across DHB boundaries
- MHAIDS Administrative Letter guidelines
- Te Ara Oranga (Client Pathway) SharePoint page
- E-whiteboards allow community services to see real-time caseload details for their team and provide visibility on the caseload across the service. Please refer to the **Quick Guide: E-Whiteboards**

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Type: Procedure	
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Applicable to: Health NZ - Capital, Coast, Hutt Valley and Wairarapa MHAIDS Inpatient Services	**Contact person:** MHAIDS Director of Nursing
Document Owner: MHAIDS Director of Nursing	**Senior Document Owner:** MHAIDS Executive Clinical Director
Lead District: Capital, Coast, Hutt Valley and Wairarapa MHAIDS	

Policy Statement

It is Capital, Coast, Hutt Valley and Wairarapa MHAIDS policy to engage with tāngata whai ora in mana enhancing ways utilising a structured framework to guide observation and engagement practice, including supportive and therapeutic engagement; assigning and reviewing observation levels; conducting observations; and documenting outcomes in tāngata whai ora's digital clinical records.

Scope

Includes:

- Capital, Coast, Hutt Valley and Wairarapa Mental Health, Addiction and Intellectual Disability Service (MHAIDS) healthcare workers in inpatient units and Wairarapa crisis respite services

Excludes:

- observation and engagement of mental health patients in general wards (staff should refer to relevant local hospital policies and procedures)
- observation and engagement of mental health patients in NGO respite facilities (staff should refer to relevant NGO policies and procedures)

Definitions

Allocated Nurse	Registered nurse assigned to work with the tangata whai ora for the duration of the shift.
Engagement	Establishing relationships with tāngata whai ora which are meaningful, grounded in trust, and therapeutic. The relationship aims to empower tāngata whai ora to actively participate in their care. This may include use of a range of non-pharmacological interventions such as, but not limited to, sensory modulation, distraction or diversional activities.
Enhanced Observations	Refers to level 1 and 2 observations.
Multidisciplinary Team (MDT)	A group of professionals from different disciplines with complementary skills and perspectives who are committed to a common purpose, performance goals, and approach, for which they hold themselves mutually accountable (Mental Health Commission, 2006).
Observing Staff member	Staff member responsible for observing and engaging with the tangata whai ora. This may be a mental health support worker (MHSW) or a student under the direction of a registered nurse (RN).
Observation	Observation is a formal and objective assessment of a tangata whai ora's health, well-being, and behaviour. It includes the purposeful gathering of information about a tangata whai ora to inform clinical decision-making.
Tāngata whai ora / tangata whai ora	Literal translation of tāngata whai ora – people seeking health. Literal translation of tangata whai ora – person seeking health. Refers to individual(s) using mental health services. Other terms used include patient, service user, client, person
Vulnerable	Used in the same manner as in the Crimes Act 1961- a vulnerable person is someone who, for the purposes of sections 151, 195, and 195A, is unable to, by reason of detention, age, sickness, mental impairment, or any other cause, withdraw himself or herself from the care or charge of another person

Roles and Responsibilities

Director of nursing is responsible for keeping the procedure up to date; ensuring that regular audits of observation practices are undertaken; and that corrective actions are developed and implemented to improve the quality of practice.

Group Manager/Operations manager is responsible for ensuring that clinical staff in their respective areas are aware of and understand the requirements of the procedure and support its implementation with relevant staff.

Team leader/ clinical nurse manager is responsible for ensuring that:

- observation and engagement is included in the local induction of clinical staff
- staff adhere to the observation and engagement procedure
- staff are up to date with Safe Practice, Effective Communication (SPEC) and other relevant training and that a record of completed training is maintained on ConnectMe.

Nurse in charge is responsible for:

- allocating observation and engagement duties, and is accountable for the decision to delegate or direct the role of observation and engagement to others
- the overall implementation, recording and documentation of the observation and engagement process, ensuring that any worker who undertakes observation and engagement duties is sufficiently knowledgeable (including being fully aware of risk factors), competent, alert and free from other duties which could potentially impede their ability to implement the required level of observation and engagement
- reviewing decisions made to increase observations to ensure their appropriateness
- reducing observations in collaboration with the allocated nurse, tangata whai ora, their whānau and members of the MDT (where appropriate).

Nurses, mental health support workers and student nurses are responsible for:

- carrying out observation and engagement duties in accordance with this policy,
- ensuring that their observation and engagement practice is consistent with recovery principles. The principles of a recovery oriented approach include understanding that each person is different and should be supported to make their own choices, listened to and treated with dignity and respect. Each person is the expert of their own life and support should assist them to achieve their hopes, goals and aspirations. Recovery will mean different things to different people. (New South Wales government. 2022).

All staff must be assessed as competent before undertaking observation and engagement practice. It is the responsibility of the registered nurse working with a student nurse or new entrant to ensure that the requirements of the procedure are fully understood by the student or staff member and that a competency assessment has been completed satisfactorily before allocating observation and engagement duties.

Medical and allied health staff have a responsibility to safely manage any issues that arise and that have a bearing on the level of observation and engagement for a tangata whai ora, and advise the allocated nurse of these issues or actions.

Clinical nurse specialist, associate charge nurse manager or clinical coordinators are responsible for undertaking routine audits of observation and engagement practice to ensure adequate standards of practice are maintained.

Procedure Content

Introduction

All staff are responsible for working in ways that support a tangata whai ora's recovery, and ensure that all tāngata whai ora are safe from harm. Observation and engagement is one of many interventions which can help achieve this outcome. By engaging therapeutically with tāngata whai ora, meaningful information relating to their wellness and safety can be elicited and used to inform clinical decision-making and enhance care planning, which will contribute to better outcomes of care.

General Principles

- The purpose of therapeutic engagement and observation is to promote positive therapeutic relationships and ensure the safety and well-being of tāngata whai ora receiving inpatient care, and to enable a rapid, mana enhancing, response to any change. (National health service 2021)
- Observation and engagement practice is in compliance with the Code of Health and Disability Services Consumers' Rights and uses a recovery framework (DH, 2013; see appendix 1).
- Tāngata whai ora have a right to expect that MHAIDS will take every reasonable step to ensure their safety.
- Observation should be set at the least restrictive level, for the least amount of time within the least restrictive setting (Black Country Healthcare NHS 2019)
- The appropriate level of observation for any tangata whai ora should be based on a thorough clinical risk assessment.
- Observation and engagement and risk assessment are interrelated: observation both informs risk assessment and is an outcome of the assessment process.
- Risk assessment and decisions on level of observation are carried out in collaboration with tāngata whai ora, their whānau and MDT, where appropriate. Tāngata whai ora and their whānau should be fully informed and enabled to contribute fully to the process.
- Any enhanced level of observation for a tangata whai ora should have a clearly stated rationale, purpose and goal (HSCB, 2011).
- Enhanced observation can be used with tāngata whai ora who are admitted informally or formally under any legislation that applies within the clinical setting (MHA, IDCCR, CPMIP).
- Timely review, and discontinuation of enhanced observations which are no longer required, is essential to the process of engagement and its therapeutic value.
- Tāngata whai ora's rights to privacy and dignity are protected and any observations are conducted as unobtrusively as possible.
- Therapeutic observations cover the 24 hour period. The frequency of observations during the night shift should be consistent with daytime observations unless otherwise agreed and documented. Night time observations, regardless of the level of observation, must be made as unobtrusively as possible so as not to disturb sleep.

Engagement

Engaging with tāngata whai ora whilst carrying out observations can have a positive effect on levels of distress.

Observation must extend beyond visually sighting a tangata whai ora and should be used as a therapeutic intervention to engage with a tangata whai ora through conversation and/or meaningful activity and to facilitate the building of a therapeutic relationship.

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All staff must be aware that tāngata whai ora respond differently to the use of observation and engagement. Some tangata whai ora may welcome being observed because it helps them feel safe; for others, observation can feel distressing and provocative, and may increase their level of anxiety, agitation and aggression.

Staff must work to develop an understanding of the tangata whai ora's history and past experiences and how these may impact on their experience of being observed. Being empathic towards the tangata whai ora, providing gender- and culturally-sensitive care, and adopting a recovery-orientated approach can contribute to the experience being perceived as positive and therapeutic (Jørgensen, Hansen,and Karlsson 2022).

To ensure that the care provided is consistent with the tangata whai ora's needs and preferences, the allocated nurse must take time to understand what matters to the tangata whai ora. To facilitate this, the allocated nurse will spend time with the tangata whai ora in ways that are meaningful to the tangata whai ora, using their therapeutic skills and thoughtful enquiry.

At least once per shift (morning and afternoon) the allocated nurse will purposefully talk with the tangata whai ora to assess their mental and physical state. This assessment is documented in the progress notes. For completeness; engagement is not required during night time while tāngata whai ora remain asleep. Staff are expected to exercise clinical judgement about engaging with tāngata whai ora who wake during the night.

The allocated nurse will:

- work to establish a therapeutic relationship with the tangata whai ora
- convey acceptance of different views and beliefs
- collaborate with tangata whai ora and their whānau (where appropriate) during periods of assessment and review; identifying what support and level of observation is required, the extent to which the tangata whai ora is able to manage the identified risks themselves and how their capacity for self-management can be supported or increased
- discuss with the tangata whai ora why observations have been assigned, the level prescribed, how best to provide them and the agreed plan of how observations are to occur
- seek feedback from the tangata whai ora about the observation methods employed, and use this to inform future observations
- conduct observations in a way that is respectful, seek to maintain the tangata whai ora's dignity, and foster a meaningful relationship with the tangata whai ora
- have an awareness of the tangata whai ora's mental and physical wellbeing and their whereabouts throughout the shift

Trauma-informed care

Observation practice must be consistent with the principles of trauma-informed care. In particular, staff should:

- be aware of a tangata whai ora's trauma history and how re-traumatisation during observation can be prevented
- help the tangata whai ora understand the purpose of the observation and why it has been prescribed
- talk to the tangata whai ora about how observations are undertaken and whether any modifications need to be made for their comfort e.g. how to maintain observations safely when they are attending to self-care, or at night when the tangata whai ora is sleeping.

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Assigning observation levels

Tāngata whai ora are observed at a level appropriate to their care and safety needs.

The observation level must be consistent with specific identified clinical risks e.g. potential harm to self (including vulnerability) and/or others, or due to a physical health condition.

Enhanced observations may represent a more restrictive environment. If a tangata whai ora with capacity to give informed consent at any stage refuses to consent to engage, and if this refusal heightens the tangata whai ora's risk to themselves, the use of the MHA may be considered.

Assigning an observation level follows an assessment of mental state, risk and physical health status. The allocated nurse must consult with the clinical team and significant others involved in the care and treatment of the tangata whai ora.

Medical and allied health staff have a responsibility to advise the allocated nurse if they become aware of issues that may have a bearing on the level of observation. Observation level must be recorded in the progress notes if there are changes from level 3 observations (or in the comprehensive plan if the observation level is part of a longer term plan).

Decisions on the level of observation occur in collaboration with the tangata whai ora and their whānau where appropriate. Any change to observation status must be discussed with the nurse in charge (see Reviewing Observation Levels section).

On admission to the unit, and in de-escalation areas, each tangata whai ora's observation level is at a minimum of level 2 (frequent) observations.

Any child or young person admitted to an adult MHAIDS unit, or any vulnerable tangata whai ora is on level 1 (continuous) observation throughout their admission to the unit.

The level of observation is always determined by assessment of risk, not adjusted according to time of day or resource issues. If the observation status is reduced overnight, the requirements of this procedure must still be followed and the change documented accordingly.

Levels of observation

MHAIDS prescribes five levels of observation:

- Level 1 Continuous observations
- Level 2 Frequent observations
- Level 3 General observations.
- Level 3 Overnight observations long term inpatient (applies to rehabilitation, forensic and intellectual disability)
- Level 4 Follow-up call (applies on an intensive recovery services unit for a tangata whai ora, who is on leave)

Regardless of level of observation assigned, where a tangata whai ora is assessed to be at risk of committing acts of violence, the staff member carrying out the observation must seek assistance from a colleague before entering that tangata whai ora's room to check on their well-being.

Higher levels of care

It may be necessary to consider more intensive levels of care than those specified in this procedure. In situations where risk to the tangata whai ora or to others cannot be safely managed, higher ratios of care may need to be considered (e.g. 2:1, 3:1).

Level 1 Continuous Observation

Continuous observation is the highest observation level and requires 1:1 nursing.

The allocated nurse

- is responsible for the tangata whai ora and available for assistance at all times
- checks in with the tangata whai ora and staff member observing them hourly
- completes the Level 1 Continuous Observation Care Plan and Recording Form (see appendix 2 for exemplar). When a tangata whai ora is in seclusion the Continuous observation and engagement record for use of seclusion (Ministry of Health) is completed.

Level 1 observation should only be used for a tangata whai ora:

- considered to be at significant risk of harm to self or others
- with significant physical health concerns
- is a child or young person admitted to an adult unit
- who is in seclusion (unless a different level of observation is specified by RC)

Continuous observation must be considered for a tangata whai ora who is expressing or experiencing:

- suicidal thinking with active intent and plan
- a psychotic or mood state with impulsive behaviour
- a physical condition which is likely to compromise the safety of themselves or others
- sexual disinhibition which may compromise the tangata whai ora's dignity and sexual safety.

Continuous observation can have significant implications for the dignity and privacy of the tangata whai ora, and should only be used when there is a clear rationale, and for the minimum length of time possible. Research (Lambert et al 2018) shows that the frequency of adverse events increases when continuous observation is used. For this reason staff must endeavour to establish a positive and therapeutic engagement with the tangata whai ora to minimise the intrusiveness of observations and maximise the benefit of using continuous observation.

To minimise the distress and discomfort that may be experienced during periods of continuous observation a careful balance of activity, rest and privacy must be obtained.

Respect for privacy is important, but this needs to be balanced with maintaining continuous observation and safety at all times, including:

- escorting to the toilet or bathroom
- when visitors are present
- when the tangata whai ora is attending therapy and other activities.

Any agreed exemptions need to be clearly documented in the Level 1 Continuous Observation Care Plan and Recording Form.

The observing staff member must remain vigilant at all times. Any items that could be used to harm self or others are removed, wherever possible. If the staff member has a reasonable belief that the tangata whai ora may have a potentially harmful item in their possession, a search may be conducted in accordance with the *Conducting Searches within Mental Health Addiction and Intellectual Disability Service Policy*.

Level 2 Frequent Observations

Frequent observation is a therapeutic intervention involving frequent, documented observations and assessment of a tangata whai ora. These observations include supportive interaction.

Frequent observations should be considered for a tangata whai ora expressing or experiencing:

- suicidal thinking and/or thoughts of harming others with no immediate intent
- ideas or intent to self-harm
- a psychotic or mood state with impulsive behaviour
- a serious medical condition

Frequent observation involves the assigned staff member:

- Sighting the tangata whai ora at **least five times** during an hour and at intervals of **no more than 15 minutes**. The observations should be staggered or irregular and **not** at constant 12 minute intervals. Meaningful engagement with the tangata whai ora must occur at least once per hour.
- Monitoring each tangata whai ora in terms of the identified requirements.
- Identifying and responding to the immediate needs of the tangata whai ora or referring issues that cannot be immediately addressed to the allocated nurse.
- Documenting observations on the Frequent Observation form (see appendix 3 for completed exemplar).

Level 3 General observation

General observation requires a partnership between the tangata whai ora and staff to maintain safety, and an assessment that there are no significant risks to the tangata whai ora or to others.

General observation should be considered for a tangata whai ora when:

- there are no known significant risks
- the parameters for risk are well known
- the tangata whai ora is able to maintain their own safety and be safe with others.

General observation involves the assigned staff member:

- visually confirming the presence of the tangata whai ora, and monitoring for signs of life (airway, breathing, circulation) at least once an hour
- documenting observations on the General Observation form (see exemplar in appendix 4)
- engaging actively and meaningfully with the tangata whai ora at least twice per shift.

Level 3 Night time observations

Those on level 3 observations in forensic, rehabilitation and intellectual disability units whose overnight physical health risk and mental health risk are assessed as low by the MDT may be

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observed in a non-intrusive manner overnight (staff not entering room) This is to be reviewed fortnightly, or earlier if clinically indicated, to ensure it is still the safest option for the tangata whai ora. Staff remain responsible for ensuring that tāngata whai ora are safe, are not in emotional distress, and to check that they are not experiencing, or have not experienced, any physical distress, loss of vital signs (ABC) or collapse.

Level 4 Follow-up call

Level 4 follow-up calls are recorded in digital notes. This level of observation only applies to intensive recovery service inpatient units for:

- a tangata whai ora who is on leave to respite or at home
- follow up with tangata whai ora leave progress or if they or their whanau have any concerns
- the allocated nurse to record their notes from the once daily call to the tangata whai ora to check on their progress. Call frequency can increase to twice per day if there are concerns for the tangata whai ora's mental state or if staff are unable to get in touch with the tangata whai ora. If concerns mount the tangata whai ora is recalled back to the inpatient unit.

Night-time Observations

Night-time can be a high risk period for some people, but it is also important to enable tāngata whai ora to get a good night's sleep. Nursing staff must work with individual tangata whai ora to identify ways to carry out observation effectively and with the least disruption and discomfort to the tangata whai ora. At night, staff must continue the agreed levels of observation, unless otherwise planned and documented. Where a difference is to be made in observation levels during the day and night, this must be agreed with the nurse in charge and documented in the progress notes (or the comprehensive plan if the changing observation level is part of a longer term plan), including the rationale for the difference. Night-time observation requires entering the tangata whai ora's bedroom to ensure they are safe, are not in emotional distress, and to check that they are not experiencing, or have not experienced, any physical distress, loss of vital signs (ABC) or collapse.

Nursing staff assess each tangata whai ora's need for observation during the night and record this clearly in the digital notes. Observation levels must be discussed in the evening handover between afternoon and night staff.

When a tangata whai ora appears to be asleep, the staff member carrying out the observations must monitor their physical health, noting changes in body position, breathing etc. Safety must take priority over privacy. Staff must not assume that a tangata whai ora is sleeping. If the staff member has not observed the tangata whai ora moving or cannot observe the tangata whai ora breathing, they must ensure the tangata whai ora is responsive by:

- increasing lighting
- getting close enough to observe breathing
- checking for a pulse
- rousing them.

Observations in de-escalation and seclusion areas

Any tangata whai ora requiring care in a de-escalation area is nursed on a minimum of level 2 (frequent) observations.

Any tangata whai ora in seclusion is nursed on level 1 (continuous) observation, as per the Guidelines for Reducing and Elimination Seclusion and Restraint under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Ministry of Health 2023).

There is a compulsory requirement to continuously observe a tangata whai ora during seclusion. Seclusion ends after 2 hours, unless a decision is made for it to continue after the mandatory review at 2 hours to determine if seclusion is still required.

All staff carrying out continuous observation and engagement must be familiar with all service policies and procedures relating to this seclusion and have completed the required training.

Continuous observation means that there must be an identified person who is continuously available and is immediately outside the seclusion room.

This person must watch for both safety and appropriate opportunities to engage the tangata whai ora in therapeutic interactions and use de-escalation techniques to reduce the level of distress in the tangata whai ora.

If continuous visual observation is contributing to distress in a tangata whai ora or is intruding on privacy and dignity, non-registered staff must seek direction from the RN, who may need to discuss the level of observation further with the responsible clinician.

All non-registered staff must work under the direction and delegation of a RN and observe the following guidance;

> They are accountable to the RN who has responsibility for the tangata whai ora, and they work under the RN's direction at all times.
>
> They must receive a handover from this RN at the start of the period of observation and engagement for this seclusion episode – NOT just from the previous allocated observing staff member for this tangata whai ora.
>
> They must notify the RN immediately of any change in condition or concerns.
>
> They must not leave the tangata whai ora without the RN's permission and a relieving person being available to take over.

Allocation of observation duties

The nurse in charge/shift coordinator allocates observation duties for hourly periods for the duration of each shift. When observation duties cannot be safely managed within existing resources, additional staff may be requested via the Duty Nurse Manager. In Wairarapa respite facility, additional resources are requested through local processes.

When allocating staff to undertake enhanced observation, the nurse in charge takes account of:

- the importance of continuity of care and assigning staff members the tangata whai ora has a trusting relationship with
- the complexity of the tangata whai ora's needs and the skills required to safely undertake observation and engagement duties
- cultural and gender needs
- history of trauma
- the competence of the staff member to conduct observations and engage with the tangata whai ora (see delegation of observations section below)
- the staff member's familiarity with the unit, including emergency procedures and potential risks in the environment

- the staff member's orientation to the MHAIDS Observation & Engagement Procedure and satisfactory completion of competence assessment
- SPEC training currency

If observation and engagement is allocated to a staff member other than the allocated nurse, the tangata whai ora's allocated nurse remains responsible for daily assessment of mental state and implementation of the nursing care plan. The observing staff member provides information to the allocated nurse, as required, to inform their ongoing assessment.

It is the responsibility of registered nursing staff to oversee the assigned level of observation on the unit.

The observing staff member must not be asked to perform other duties during the period they are required to observe and engage.

No period of level 1 continuous observations undertaken by a staff member should exceed two hours. At the end of each observation period the staff member should have a break from observation for at least half an hour.

Delegation of observations

Mental health support workers can be delegated to undertake and document observations under the direction and delegation of the allocated registered nurse. The delegating nurse is accountable for ensuring the support worker is competent to undertake this task. Delegation of tasks must occur in accordance with the *3DHB Clinical Direction and Delegation Policy*.

Student nurses can undertake level 3 observations, but it is the responsibility of the registered nurse working with them to ensure they understand the requirements for doing observations, and to monitor their practice.

Ensuring continuity of care

Observation may involve a number of staff, thus effective communication is essential to maintain continuity of care. The District Wide Clinical Handover Policy provides the framework for effective handover and maintaining continuity of care.

Observation duties must not cease until another staff member is available to take over.

Before taking over observation, observing staff must read recent clinical notes and receive a handover from the preceding observer and allocated nurse. The observing staff member must receive information on:

- the tangata whai ora's condition
- reason for the observation
- behaviours to monitor
- specific observation requirements/arrangements e.g. night-time observations, use of bathroom etc.
- interventions to reduce or manage behaviours
- how to contact the allocated nurse
- break times

At shift handover the exiting and incoming staff members undertaking frequent and general observations do a joint observation round.

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Use of leave while on enhanced levels of observation

A tangata whai ora being nursed on level 1 or level 2 observations should primarily remain on the unit due to the risk to self or others.

It is acknowledged that restricting leave may be counterproductive and lead to a deterioration in behaviour. Any decisions regarding leave must be made in conjunction with the MDT after weighing up the risks and benefits associated with each option and documenting the same.

Increasing the numbers of staff allocated may enable time away from the ward.

Missing persons

If a tangata whai ora is not located on the unit within the specified timeframe of the current observation level the nurse-in-charge must be informed and the missing person of concern process is activated as per policy.

If the tangata whai ora is on leave the escalation indicated in the leave plan should be followed.

Documentation

To help ensure that observations are carried out as planned, accurate, clear, contemporaneous record-keeping is essential. Records must be documented in the digital notes, relevant observation and engagement recording forms and in the comprehensive plan.

Digital notes

The observation status, rationale for the observation level and date/time of review, a summary of observations over the course of a shift, and the tangata whai ora's experience of being observed are recorded in the digital notes.

Changes to observation levels, ongoing risk assessment and the tangata whai ora's response to observation are also documented in digital notes, using 'Observation' as the heading.

Comprehensive Plan

The clinical rationale for observation and care requirements is documented in the Comprehensive Plan. The Comprehensive Plan is updated whenever there are changes in the care plan, observation level or clinical circumstances and always reflects the current situation.

Observation Records

Observation records must be maintained as a current record without any omissions. Observations should document the physical sighting of the tangata whai ora and relevant information gleaned from interacting with them. **Observations must not be entered retrospectively.** Any alterations or amendments are made in accordance with local documentation policies.

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The observation forms must provide adequate instructions for those staff providing the observation (see appendices for completed examples).

Level 1 continuous observations - a contemporaneous record is kept on the Level 1 Continuous Observation Care Plan and Recording Form. A summary of continuous observations is recorded in the digital notes at the end of the assigned observation period.

Level 2 observations are documented on the frequent observation recording form at each check.

Level 3 general observations are recorded on the *MHAIDS General Observations Recording Form* (see appendices for exemplars).

All completed observation forms are placed in the paper file.

Implementation and monitoring compliance with/effectiveness of document

Observation requires highly developed skills in a variety of areas including building therapeutic relationships and attending to psychosocial, physical health and safety needs.

Staff undertaking observation are:

- orientated to the unit including its layout, emergency procedures and potential risks in the environment

Monitoring

The monitoring arrangements for this policy are set out in the table below.

Aspect being monitored	Monitoring method	Individual responsible for monitoring	Frequency of the monitoring activity	Committee /person to receive monitoring report	Person responsible for ensuring actions are completed
Process of conducting observations	Audit	CNS	Annual	Sector CGG OM & DoN	DoN
Completion of Observation & Engagement Competence Assessment	Review orientation records	Team leader	On completion of orientation programme		Team leader
SPEC training attendance (including maintaining currency)	Review of SPEC currency report	Team Leader	Monthly		Team leader

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References

Clinical Resource and Audit Group (2002) Engaging People Observation of People with Acute Mental Health Problems: A Good Practice Statement. Scotland: NHS Scotland.

Department of Health (2013) Nursing Observation Through Engagement in Psychiatric Inpatient Care Department of Health Guideline. Victoria: Department of Health.

Health & Social Care Board & Public Health Agency (2011) Regional Guideline on the Use of Observation and therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland.

Mental Health Commission. (2006). Multidisciplinary Team Working: From Theory to Practice. Dublin: Mental Health Commission.

New South Wales government. (2022). Principles for effective support - what is a recovery oriented approach?. What is a recovery oriented approach? - Principles for effective support. https://www.health.nsw.gov.au/mentalhealth/psychosocial/principles/Pages/recovery.aspx

New Zealand Director of Mental Health Nurses Group (undated) Position Paper: Enhanced Engagement and Observation: A Paper to inform the development of engagement and observation policies and procedures within inpatient units.

National health service (2021) Therapeutic Engagement and Observation Policy. https://www.dpt.nhs.uk/download/ASzNbWmaRU

Standing Nursing and Midwifery Advisory Committee (1999) Safe and Supportive Observation of Patients at Risk. Mental Health Nursing “Addressing Acute Concerns”

Veale, D. (2019). Against the stream: intermittent nurse observations of in-patients at night servce no purpose and cause sleep deprivation. BJPsych Bulletin,43. 174-176. https://www.cambridge.org/core/services/aop-cambridge-core/content/view/BF2CD76D8F8970581ED48C7594E9A3C4/S205646941800116Xa.pdf/against-the-stream-intermittent-nurse-observations-of-in-patients-at-night-serve-no-purpose-and-cause-sleep-deprivation.pdf

Appendices:

Appendix 1 Recovery Framework for Observations

Appendix 2 Exemplar Level 1 Continuous Observation Care Plan and Recording Form (MHAIDS Level 1 Continuous Observation Care Plan and Recording Form, DistrictDocs ID 1.11375)

Appendix 3 Exemplar Level 2 Frequent Observations Recording Form (Frequent Observation Form MHAIDS, DistrictDocs ID 1.101857)

Appendix 4 Exemplar Level 3 MHAIDS General Observations Recording Form (General Observation Form MHAIDS, DistrictDocs ID 1.101856)

Appendix 1: Recovery Framework for Observations

Domain	Examples of good observation practices
Promoting a culture of hope	Note behaviours and events that indicate positive signs of recovery and remind people receiving care and others of these occurrences.
Promoting autonomy and self-determination	Engage people in ongoing dialogue and enquiry about their needs, wishes and experiences. Discuss with people about the need for observation and how it will occur. Invite feedback on how these practices could be modified to enhance care. Avoid practices that people may experience as traumatic.
Collaborative partnerships and meaningful engagement	Demonstrate empathy and respect in all interactions with people and their significant others. Use person-centred humanistic language, rather than identifying people as their diagnosis. Elicit people's preferences and give them maximum choice in big and small decisions, and be accommodating and flexible in responding to their preferences. Work to understand what is important to people. Support people to make sense of their experiences and to find positive meaning. Acknowledge and respond to people's views, understandings and experiences. Work with people in a way that supports their cultural identity and values. Work to understand people's triggers for episodes of 'unwellness' and what they find works well for them in their recovery efforts. Use inquisitive and active listening and personalised, supportive, positive and hopeful language. When people do not express their points of view, actively seek their viewpoint through gentle enquiry. Use aspects and examples from one's own life and experiences to create a friendly, professional relationship. Use professional skills and expertise to provide people with optimal choice and tailored support.
Focus on strengths	Ask people about their strengths, what they have done well and what they have found easy. Use enquiry that emphasises solutions to situations rather than just the problems. Assist people to tap into existing strengths and resilience by considering what has worked well for them in the past. Encourage self-sufficiency in accordance with people's wishes and goals. Assist people and their significant others to assess their own needs and to choose how those needs are met.

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Domain	Examples of good observation practices
	In history taking and reflections with the Tāngata Whaiora, include recognition of areas of functioning where there are no problems and times in their lives when they did cope well. Emphasise successes and achievements prominently at first contact. Encourage people to take personality strengths that are causing problems in one area and use them to improve functioning in another (for example, a young client can find drugs at any time in any part of town – can that tenacity and resourcefulness be focused on obtaining housing?) Support people to approach new challenges or to revisit old challenges.
Holistic and personalised care	Routinely enquire about people's wishes, support needs, goals, values and interests and use this information to personalise care. Support people to enjoy full physical health and to address health concerns when they present.
Family, carers, support people and significant others	Talk with families and significant others about how things are for them, how they understand the needs of the Tāngata Whaiora and how they can support with what is needed.
Community participation and citizenship	Be aware of the cultural, social and historical factors that limit people's access to resources and opportunities.
Responsiveness to diversity	Understand how cultural differences affect people and their experiences. Understand different cultural communication styles and use respectful ways of communicating. Use non-technical language and use the services of an interpreter when necessary. Recognise that different people have different understandings and experiences of community and that community has different significance for different people. Respectfully enquire about the backgrounds and cultural needs of people. Use innovative practices to meet the different needs of people. Understand and demonstrate respect in relation to different understandings and meanings attributed to mental health across different cultures. Recognise the diverse family and kinship structures across different cultures and the need for family work to accommodate these. Be aware of personal values that may unintentionally affect practice.
Reflection and learning	Reflect on whether one's professional practice is aligned with a recovery approach. Reflect on one's own values, development needs and limitations.

Source: Department of Health (2013) Nursing Observation through Engagement in Psychiatric Inpatient Care Department of Health Guideline. Victoria: Department of Health (adapted).

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APPENDIX 2: Exemplar Level One Continuous Observation Care Plan and Recording Form

Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addiction and Intellectual Disability Service

Surname: ..... NHI: .....
First Names: .....
Date of Birth: ...../...../..... Sex: .....
Place patient ID here

Level 1: Continuous Observation Care plan and recording form

Criteria for Observation/Special	
☐ Risk of Self Harm ☑ Risk to others/environment ☐ Suicide Risk ☐ Risk of falls or confused / agitated / dementia / delirium / disorientated / medical condition ☑ Sexual Safety	☑ Psychotic or mental state with impulsive behaviour ☐ harm from others ☑ Trying to leave ward/hospital ☐ Vulnerable person e.g. minor ☐ Other Please describe .....
Observation/Special required – Must be renewed at least once per shift and as care needs change	
☑ Number of staff required (1) 2 3 ☐ Registered Nurse [male/female/either]	☐ Security Orderly [male/female/either] ☑ Support worker [male/female/either]
Observation level Discussed	
☑ With Person ☑ With Whanau	☑ With MDT
Specific behaviour to be observed, recorded and addressed. Must be reflected in digital notes	
1. Disorganised and Vulnerable	
2. Unpredictable and Impulsive behaviour	
3. Risk to self	
4. Sexual disinhibition	

Observer Instructions and Handover Sheet			
Observation	☑ Yes	☐ No	In sight at all times [observer must be in the room]
	☑ Yes	☐ No	May use bathroom/toilet in private
	☑ Yes	☐ No	May be left with family/whanau/friends
	☑ Yes	☐ No	May be in sight when asleep [observer at door of room]
Activity (Use Wellness plan to guide awareness of triggers, EWS and strategies for de-escalation)	☐ Yes	☑ No	Leave within the building with observer [inform RN first]
	☐ Yes	☑ No	Leave on hospital grounds with observer [inform RN first]
	☐ Yes	☑ No	May leave ward with family/whanau/friends [inform RN first]
	☑ Yes	☐ No	Involve in ward activities
	☑ Yes	☐ No	Help the patient remain orientated to person place and time
	☑ Yes	☐ No	Take the patient for a short walk around the ward every ..... hours
	☑ Yes	☐ No	Do not over stimulate
	☑ Yes	☐ No	Diversional activity
Activities of Daily Living	☑ Yes	☐ No	Support with personal cares
	☑ Yes	☐ No	Assistance required: FULL / SOME
Nutrition	☑ Yes	☐ No	Support with nutrition
	☑ Yes	☐ No	Assistance required: FULL / SOME
Documentation	Level, Rationale, Date and Time of next review recorded in notes ☐		

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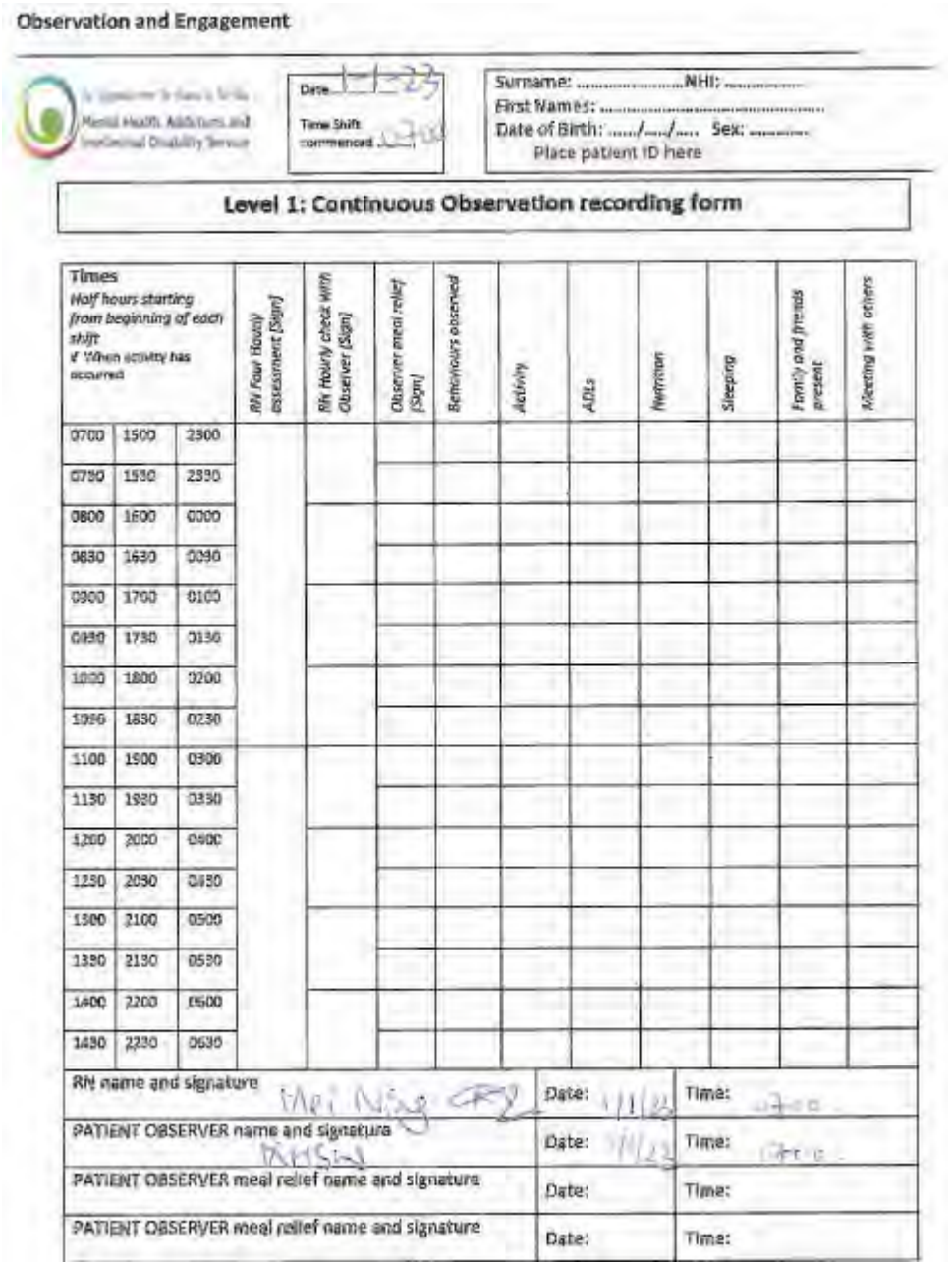

Observation and Engagement

Te Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

Date: 1-1-23
Time Shift commenced: 2200

Surname: ..... NHI: .....
First Names: .....
Date of Birth: ...../...../..... Sex: .....
Place patient ID here

Level 1: Continuous Observation recording form

Times *Half hours starting from beginning of each shift* *√ When activity has occurred*			RN Four Hourly assessment (Sign)	RN Hourly check with Observer (Sign)	Observer meal relief (Sign)	Behaviours observed	Activity	ADLs	Nutrition	Sleeping	Family and friends present	Meeting with others
0700	1500	2300										
0730	1530	2330										
0800	1600	0000										
0830	1630	0030										
0900	1700	0100										
0930	1730	0130										
1000	1800	0200										
1030	1830	0230										
1100	1900	0300										
1130	1930	0330										
1200	2000	0400										
1230	2030	0430										
1300	2100	0500										
1330	2130	0530										
1400	2200	0600										
1430	2230	0630										

RN name and signature Mei Ning	Date: 1/1/23	Time: 2200
PATIENT OBSERVER name and signature RMSim	Date: 1/1/23	Time: 0700
PATIENT OBSERVER meal relief name and signature	Date:	Time:
PATIENT OBSERVER meal relief name and signature	Date:	Time:

Appendix 3 Exemplar MHAIDS Frequent Observations

Shift: B **Unit: Purehurehu** **Date: 15.05.15**

Name	Date of birth	NHI	Legal Status
	Gender	Ethnicity	

Monitoring Requirements
1. Observe EWS as identified in partnership plan
2. Secretion of objects at any opportunity
3. Their whereabouts
4. Signs of life
5.

Risk assessment SELF-HARM

- LIGATURES
- SHARP OBJECTS
- RISK OF INSERTING OBJECTS

Full Name: Karen Clark Signature *Karen Clarke*

THE PERSON MUST BE SIGHTED AT LEAST 5 TIMES PER HOUR AND AT INTERVALS OF NO MORE THAN 15 MINUTES.

HOUR	CHECK TIME		LOCATION AND OBSERVED ACTIVITY	Full Name	Signature
07:00 hrs	1st	07:00	In bed. L) side and snoring	Karen Clarke	Karen Clarke
	2nd	07:10	In bed, on back, snoring loudly	Karen Clarke	Karen Clarke
	3rd	07:25	In bed awake and yawning	Karen Clarke	Karen Clarke
	4th	07:40	At toilet, seen through observation window	Karen Clarke	Karen Clarke
	5th	07:55	Back in bedroom attending to ADLs and requested a towel.	Karen Clarke	Karen Clarke
	1st				
	2nd				
	3rd				
	4th				
	5th				

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THE PERSON MUST BE SIGHTED AT LEAST 5 TIMES PER HOUR AND AT INTERVALS OF NO MORE THAN 15 MINUTES.					
	TIME		LOCATION AND OBSERVED ACTIVITY		Full Name
Signature					
	1st				
	2nd				
	3rd				
	4th				
	5th				
	1st				
	2nd				
	3rd				
	4th				
	5th				
	1st				
	2nd				
	3rd				
	4th				
	5th				
	1st				
	2nd				
	3rd				
	4th				
	5th				

Appendix 4 Exemplar MHAIDS General Observations Recording Form

Unit: Purehurehu

Name	Date of birth	NHI	Legal Status
	Gender	Ethnicity	

Person's Details (or patient label)

DATE	CHECK TIME	LOCATION AND OBSERVED ACTIVITY	FULL NAME	SIGNATURE
15.5.15	15.00	In rec' room playing pool with peer	Tanya Higgott	Tanya Higgott
	16.00	Requesting phone call to family	Tanya Higgott	Tanya Higgott
	17.00	Sitting in dining room eating dinner	Tanya Higgott	Tanya Higgott
	18.00	In lounge with writer discussing current events	Tanya Higgott	Tanya Higgott
	19.00	In bathroom taking a shower, verbal response given	Tanya Higgott	Tanya Higgott
	20.00	Receiving prescribed medication, chatting in usual manner	Tanya Higgott	Tanya Higgott
	21.00	Watching TV in bed	Tanya Higgott	Tanya Higgott
	21.30	Asleep breathing audibly.	Tanya Higgott	Tanya Higgott

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