

# Clinical Risk Assessment and Management (CRAM) in Western Australian Mental Health Services

Policy and Standards



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Mental Health Division, WA Department of Health (2008). *Clinical Risk Assessment and Management (CRAM) in Western Australian Mental Health Services: Policy and Standards*. Perth, Western Australia: Department of Health.

## Executive Director's Foreword



The Clinical Risk Assessment and Management Project was implemented under Key Initiative 5 (Workforce and Safety Initiatives) of the *Mental Health Strategy 2004-2007* from a long-standing need to develop a consistent approach to clinical risks in mental health settings. A Project Reference Group of consumer and carer representatives, clinicians and service managers was formed to provide specialist input into the project.

The Project Reference Group spent many hours considering the current literature and evidence base, including guidelines and frameworks from other services, internationally, from other states, and from our own services. It also spent many hours deliberating about what happens in the 'real world' of mental health practice and what could be realistically done to manage clinical risks.

From the outset, the Project Reference Group acknowledged that mental health services in Western Australia are committed to the best outcomes for consumers, carers and staff. It became clear though that services had different procedures for assessing risk and that they offered different types of training related to clinical risk management, for example aggression management courses.

One of the original aims of the project was to develop a clinical framework for risk assessment and management and to develop a training package. Whilst undoubtedly important, it became apparent that a clinical framework or risk assessment tool is not enough to ensure consistent evidence-based risk management practice across the state. The Project Reference Group defined a standardised approach for services to assess and manage clinical risks that could then be tailored to the specific service requirements of each service.

The result is a policy that details five steps to identify, assess and manage clinical risks in mental health settings. The policy outlines a standardised approach to clinical risk assessment and management throughout the Western Australian public mental health service. The aim is that through clinical governance processes, services can use the policy to develop new, or audit existing, procedures.

Finally, I would like to thank the Project Reference Group for their hard work and commitment in producing the policy and standards.

A handwritten signature in black ink, appearing to read 'Steve Patchett', written in a cursive style.

Dr Steve Patchett  
Executive Director, Mental Health



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# 1. Policy

## Policy Statement

One of the outcomes of the *National Mental Health Plan 2003-2008* has been the increased safety of consumers, carers and families, staff and the community. Western Australian mental health services are committed to the safety and well-being of consumers, carers and staff and will work to minimise the likelihood and impact of adverse clinical risks.

Mental health staff have the right to work in a safe environment, and consumers and their carers have a right to receive mental health care in an environment that actively works to protect their safety. However, mental health services are never risk-free and clinical risks like suicide and violence cannot be predicted with 100% accuracy. Instead, good clinical risk management is based on effective treatment that is focused on an individual's history and current circumstances.

In order to minimise the possibility of harm to consumers, their carers and staff, services require:

- A common, evidence-based understanding of the principles of clinical risk assessment and management to support a consistent approach and process.
- The capacity to manage clinical risks that includes the appropriate allocation of staffing, access to training and the ability to manage and rectify the physical work environment.

This policy outlines the **minimum requirements** for safe practice in this area. At the outset, it should be acknowledged that services and staff often already demonstrate evidence-based, safe practice in this area. This policy therefore aims to highlight and support existing safe practice and provide a structure for accountability.

## Scope

This policy applies to all clinicians and managers in the Western Australian public mental health services. It is a system-wide policy that supersedes all policies and guidelines related to clinical risk assessment and management previously produced by the Mental Health Division.

All staff are required to take reasonable steps toward their own and their colleagues' health and safety. This means that individual clinicians and managers will need to be familiar with the policy to ensure the safety and well-being of the workforce, as well as to ensure safe standards of practice. This policy should serve as the foundation for service-level procedures and protocols concerning clinical risk. It should also be used in the development of other policies pertaining to staff safety and security within the mental health services.

## Objectives

The objectives of this policy are to:

1. Promote a safe environment for mental health consumers, carers and staff.
2. Establish the minimum standards for clinical risk assessment and management in the Western Australian public mental health services.
3. Assist both services and individual staff to understand and apply the principles of clinical risk assessment and management.

## Relevant Documents

This policy should be considered within the following legislation, standards, policies, guidelines and operational circulars.

### Legislation and Codes

*Occupational Safety and Health Act 1984 (WA).*

Occupational Safety and Health Regulations 1996 (WA).

*Mental Health Act 1996 (WA).*

Professional Codes of Conduct for mental health professions, including psychiatry, nursing, psychology, social work and occupational therapy.

### Standards

Australian/New Zealand Standard - Risk Management (AS/NZS 4360:2004). Standards Australia International Ltd and Standards New Zealand.

*Department of Health and Ageing (1996). National Standards for Mental Health Services.* Canberra: Government of Australia.

Department of Health and Ageing (2002). *National Practice Standards for the Mental Health Workforce.* Canberra: Government of Australia.

### Policy and Guidelines

WA Department of Health, (2004). *Guidelines for Responding to Child Abuse, Neglect and the Impact of Family and Domestic Violence.* Perth, Western Australia: Department of Health.

WA Department of Health, (2004). *Prevention of Workplace Aggression and Violence: Policy and Guidelines.* Perth, Western Australia: Department of Health.

Office of Safety and Quality, WA Department of Health (2005). *Clinical Risk Management Guidelines for the Western Australian Health System.* (Information Series No. 8). Perth, Western Australia: Department of Health.

Mental Health Division, WA Department of Health (2006). *Guidelines: The management of disturbed/violent behaviour in inpatient psychiatric settings.* Perth, Western Australia: Department of Health.

### Operational Circulars

WA Department of Health (February 2005). OP 1914/05 Access to the Mental Health Clinical Information System (PSOLIS).

<http://www.mhidp.health.wa.gov.au/one/uploads/resource/94/OP191505.pdf>

WA Department of Health (April 2006). OP 2050/06 Patient Confidentiality and Divulging Patient Information to Third Parties.

[http://www.health.wa.gov.au/circulars/circular.cfm?Circ\\_ID=12052](http://www.health.wa.gov.au/circulars/circular.cfm?Circ_ID=12052)

WA Department of Health (September 2006). OP 2102/06 Child Protection - *Children and Community Services Act 2004*.

<http://www.health.wa.gov.au/circulars/pdfs/12105.pdf>

WA Department of Health (April 2006). OP 2055/06 *Emergency Psychiatric Treatment and Issues of Consent: Mental Health Act 1996* (SS113-115 and Part 5, Div 2).

[http://www.chiefpsychiatrist.health.wa.gov.au/publications/docs/\\_Emergency\\_Psychiatr.pdf](http://www.chiefpsychiatrist.health.wa.gov.au/publications/docs/_Emergency_Psychiatr.pdf)

WA Department of Health (April 2006). OP 2058/06 Seclusion, *Restraint and Time Out: Mental Health Act 1996*.

[http://www.chiefpsychiatrist.health.wa.gov.au/publications/docs/Seclusion,\\_restraint.pdf](http://www.chiefpsychiatrist.health.wa.gov.au/publications/docs/Seclusion,_restraint.pdf)

WA Department of Health (April 2006). OP 2061/06 Matters To Be Reported To The Chief Psychiatrist.

<http://www.health.wa.gov.au/circulars/pdfs/12063.pdf>

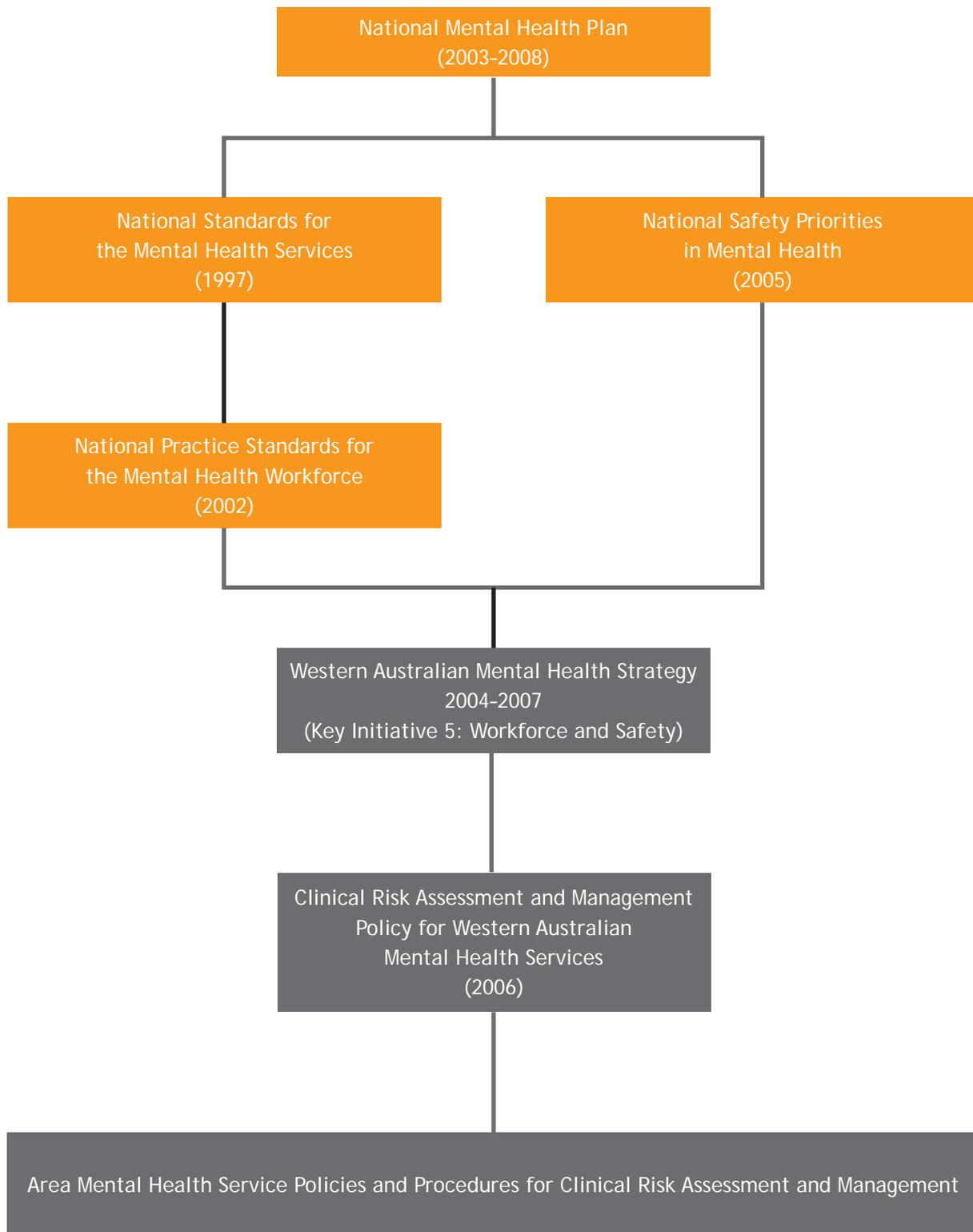
### Source Documents

A number of national and state documents provide the context for the development of this policy, namely:

- The *National Safety Priorities for Mental Health (2005)*
- The *National Practice Standards for the Mental Health Workforce (2002)*.

The policy is underpinned by the *Clinical Risk Management Guidelines for the Western Australian Health System (Guidelines)* (Office of Safety and Quality, 2005). The Office of Safety and Quality produced the *Guidelines* to assist Department of Health staff in meeting their risk management responsibilities through consistent and systematic identification and management of clinical risk. As such, mental health clinicians are also subject to these guidelines. Services therefore should review this policy in light of the *Guidelines*.

Figure 1: Context of the Clinical Risk Assessment and Management Policy and Framework



## Policy Background

### The Clinical Risk Assessment and Management Project

In 2002, the Metropolitan Mental Health Service (MMHS) Interim Clinical Advisory Group (ICAG) endorsed the *Framework for Clinical Risk Assessment and Management of Harm*. This document was an adaptation of a framework developed at the Institute of Psychiatry (IOP) and Maudsley in London (2001). Over the following years, some services in WA made use of and adapted this framework, including implementing screening tools. However, the overall approach to clinical risk management within the state was not consistent.

Following the release of the *National Practice Standards for the Mental Health Workforce (Standards)* in September 2002, a statewide reference group was formed by the Western Australian Office of Mental Health (as the Mental Health Division was then known) to review how the *Standards* could best be implemented and evaluated. The membership included academic and clinical staff, and the work of the group was informed by emerging trends from the Office of the Chief Psychiatrist Clinical Governance reviews.

As a result of these developments, the Clinical Risk Assessment and Management Project was one of several projects under Key Initiative 5 (Workforce and Safety Initiatives) of the *Mental Health Strategy 2004-2007* aimed at supporting implementation of the *Standards*. Other initiatives on workforce safety include the development of the *Guidelines: The management of disturbed/violent behaviour in inpatient psychiatric settings (2006)*.

### Remit of the Reference Group

The Clinical Risk Assessment and Management Project Reference Group was established to provide consumer, carer and specialist clinical input. In developing the policy, the Project Reference Group confined its deliberations to the risk of harm to self or others.

The Project Reference Group's priority was for consumers, carers and staff to feel secure and to work within safe surroundings. As such, the Project Reference Group acknowledged the conflicting and competing tensions between maintaining a consumer's confidentiality and privacy and the importance of informing relevant others to ensure a reasonable standard of care. Added to this was the consideration of the public interest when there is an identified risk.

The Project Reference Group also carefully considered the complex issue of risk assessment, particularly the role of standardised instruments, forms and checklists. The Project Reference Group determined that while such tools are useful for supporting consistency in assessment, they do not, in themselves, constitute comprehensive risk assessment or the infallible prediction of risk. The Project Reference Group was mindful of the need to rate and communicate levels of risk against the need for a flexible, individualised approach. That is, there is a need to balance the use of checklists and standardised instruments against the clinician's judgement. Clinicians are encouraged to consider all elements of assessment and methods to understand clinical risk.

### Policy Development

The development of this policy was informed by:

- The Project Reference Group, consisting of consumer and carer representatives, clinicians and managers
- The evidence and a review of the literature
- The source documents outlined above

- Broader discussions and consultation with the clinical field and other key stakeholders, including:
  - Leaders in clinical governance and staff development
  - Office of the Chief Psychiatrist
  - Office of Safety and Quality
- The results of a survey of clinicians' training needs and competency in this area
- A review of a number of state, national and international policies and guidelines on clinical risk, suicide and violence, namely:
  - American Psychiatric Association (2003). *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors*. Arlington, USA: American Psychiatric Association.
  - Auditor General of Western Australia (2001). *Life Matters: Management of Deliberate Self-Harm in Young People*.
  - Auditor General of Western Australia (2005). *Follow-up Performance Examination*.
  - Barwon Health (2003). *ACE Guidelines: Assessment Care & Evaluation (Version 3)*. Geelong, Victoria: Barwon Mental Health Service.
  - Clinical Risk Assessment & Management Training Project (2005). *A Guide to Clinical Risk Assessment and Management for Violence, Suicide and Absence without Permission*. Queensland: Queensland Government.
  - East London and the City Mental Health Trust (2002). *Clinical Risk Assessment & Management Policy*. London: NHS.
  - Glenside Campus Mental Health Service, Royal Adelaide Hospital (2002). *Clinical Practice Manual - Risk Assessment Policy and Procedure (MHCLPR-0900)*. Adelaide: Government of South Australia.
  - Greater Glasgow Primary Care Trust Mental Health Division (2005). *Aggression Management Policy and Guidance*. Greater Glasgow: National Health Service.
  - Health Services Research Department (2002). *Clinical Assessment of Risk Decision Support (CARDS)*. London: Institute of Psychiatry.
  - Kingsley, B. (2001). *Elder Abuse: Protocol and policy guidelines to prevent the abuse of older people in community and residential care*. Perth, Western Australia: The Centre for Research into Aged Care Services, Curtin University of Technology.
  - Mental Health Reference Group (2000). *Risk Management*. Scotland: Scottish Executive.
  - Ministry of Health and Health Funding Authority (1998). *Guidelines for Clinical Risk Assessment and Management in Mental Health Services*. Wellington, New Zealand: Ministry of Health.
  - National Institute for Clinical Excellence (2004). *Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*. Clinical Guideline 16. London: NICE.
  - National Institute for Mental Health (2003). *Preventing Suicide - A Toolkit for Mental Health Services*. Leeds, United Kingdom: NIMH.

New South Wales Department of Health (2004). *Suicide Risk Assessment & Management Protocols*. North Sydney: NSW Department of Health.

New South Wales Department of Health (2005). *Policy Directive: (Policy Guidelines for) Management of Patients with Possible Suicidal Behaviour (PD2005\_121)*. Sydney: NSW Health.

Royal Australian and New Zealand College of Psychiatrists (2000). *Guidelines for the Management of Deliberate Self Harm in Young People*. Australasian College for Emergency Medicine.

Service Development Unit (2003). *Guidelines for Clinical Risk Assessment and Management*. Warrnambool, Victoria: Service Development Unit, South West Healthcare Psychiatric Services Division (Unpublished).

## 2. Standards for Clinical Risk Assessment and Management

### Risks: An Outline

Risk in mental health has been defined as the likelihood of an event happening with potentially harmful or beneficial outcomes for self and others (Morgan, 2000).

Mental health services are particularly concerned about risks that are highly likely in terms of probability and that have severe consequences, such as imminent suicide attempts or violence. Examples of clinical risks in mental health include:

<b>Risks to Self:</b>	Self-harm and suicide, including repetitive self-injury Self-neglect Absconding and wandering (which may also be a risk to others) Health including: <ul style="list-style-type: none"> <li>■ Drug and alcohol abuse</li> <li>■ Medical conditions, e.g. alcohol withdrawal, unstable diabetes mellitus, delirium, organic brain injury, epilepsy</li> </ul> Quality of life, including dignity, reputation, social and financial status.
<b>Risks to Others:</b>	Harassment Stalking or predatory intent Violence and aggression, including sexual assault or abuse Property damage, including arson Public nuisance Reckless behaviour that endangers others e.g. drink driving.
<b>Risks by Others:</b>	Physical, sexual or emotional harm or abuse by others Social or financial abuse or neglect by others.

(Adapted from Ministry of Health, 1998; Top End Mental Health, 2004).

Risks may also be posed to consumers by systems and treatment, such as the side-effects of medication, ineffective care, institutionalisation and social stigma. Whilst these types of clinical risks are often not immediately obvious, they should be carefully considered in management planning (Ministry of Health, 1998).

The frequency and prevalence of certain clinical risks that clinicians encounter will also depend on the setting and age group seen. For instance, the risk of abuse or neglect by others may be higher in children, and the risk of self-neglect higher in older adults. However, age alone does not preclude the presence of certain clinical risks. Adolescents may still be at risk of self-neglect, and adults living independently can still be at risk of exploitation.

## The Clinical Risk Management Process

In line with both the Australian/New Zealand Standard AS/NZS 4360:2004 *Risk Management and the Clinical Risk Management Guidelines for the Western Australian Health System*, this policy follows a five-step process and contextualises this processes for mental health settings.

Step 1: Establish the context.	Identify and understand the service's operating environment and strategic context.
Step 2: Identify the risks.	Identify internal and external clinical risks that may pose a threat to the health system, organisation, business unit, and team and/or patient.
Step 3: Analyse the risks.	Undertake a systematic analysis to understand the nature of risk and to identify tasks for further action.
Step 4: Evaluate and prioritise the risks.	Evaluate the risks and compare against acceptability criteria to develop a prioritised list of risks for further action.
Step 5: Treat the risks.	Identify the range of options to treat risks, assess the options, prepare risk treatment plans and implement them using available resources.

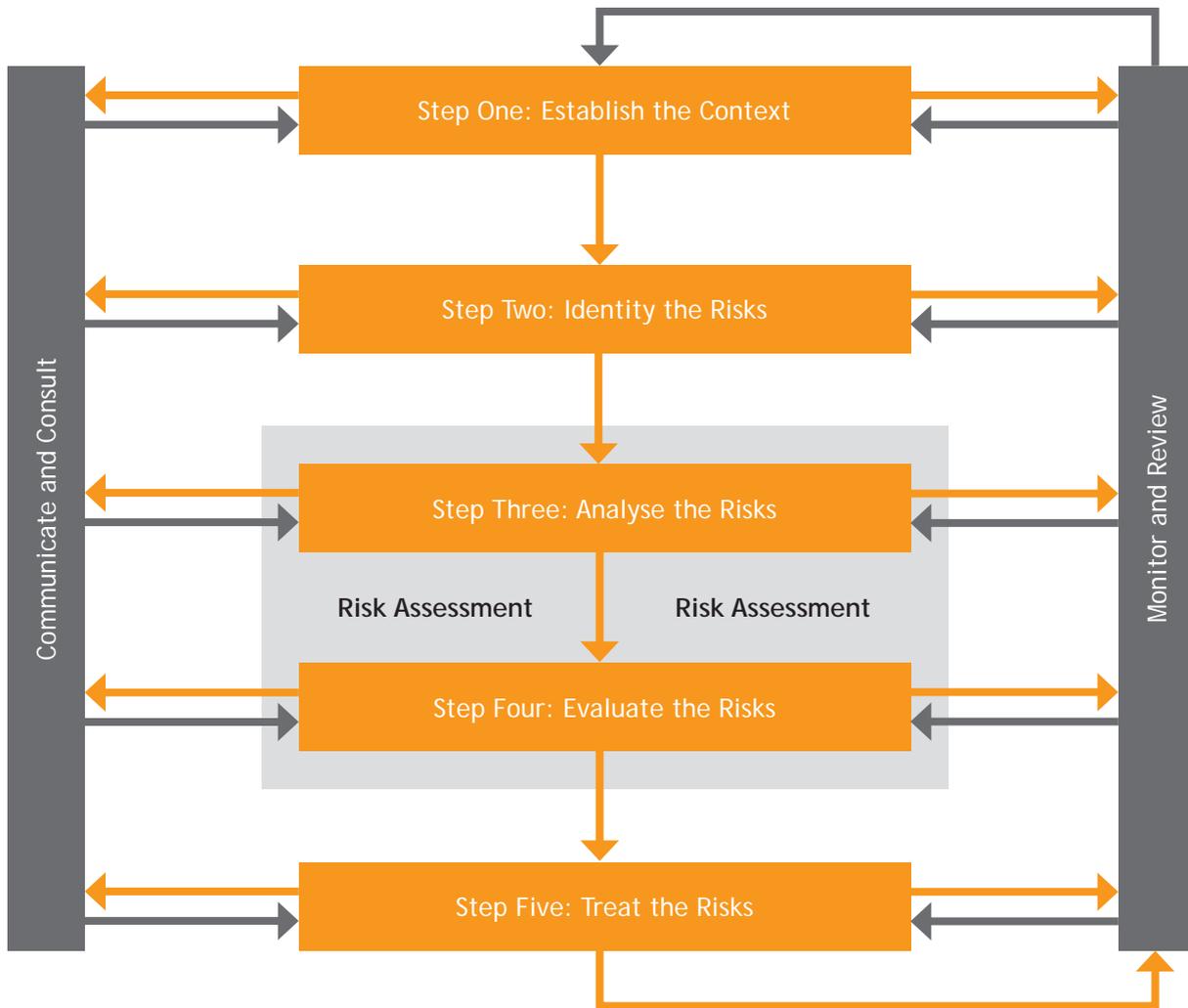
Two factors underpin these five steps, namely:

- Communication and Consultation
- Monitoring and Review.

Both are vital to effective clinical risk management and need to be implemented simultaneously at each level of the clinical risk management process.

Services seeking further information about this process should refer to both the Australian Standard and the Department of Health's *Guidelines*.

Figure 2: Overview of the Clinical Risk Management Process (Office of Safety and Quality, 2005).



## Standards

Within each of the above steps of the clinical risk management process are core principles and standards for assessing and managing clinical risk within mental health settings. These standards are aligned to the National Mental Health Standards (NMHS), and are:

	NMHS	Clinical Risk Assessment and Management Standard
<b>1. Establish the Context</b>	11.3.1 11.3.15 11.3.16 11.4.E.1 11.4.E.3 11.4.E.6 11.4.E.14	1.1 Clinical risk assessment and management in mental health services must be legal, ethical and evidence-based. 1.2 The practice of clinical risk assessment and management is person-centred and promotes the dignity of risk. 1.3 Clinical risk assessment and management is a shared, systemic responsibility, underpinned by a 'no-blame' culture. 1.4 Clinical risk assessment and management is regarded as a core competency for practice.
<b>2. Identify the Risks</b>		2.1 Clinical risks are identified and their nature documented.
<b>3. Analyse the Risks (Assessment)</b>	11.2.12 11.3.1 11.3.2 11.3.3 11.3.5 11.3.6 11.4.E.4	3.1 Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate harm to self or others. The assessment is timely, biopsychosocial and according to clinical best practice that is based on structured clinical judgement.
<b>4. Evaluate the Risks</b>		4.1 On the basis of the information gathered during the assessment, clinical risk is evaluated.
<b>5. Treat the Risks (Management)</b>	11.4.3 11.4.10 11.4.11 11.4.A.12 11.4.D.6 11.4.E.2 11.4.E.5 11.5.4 11.5.6 11.6.5	5.1 In managing risk, the immediate safety of consumers, carers and staff is prioritised. 5.2 A Clinical Assessment and Management (CRAM) plan is generated and incorporated within the overall management plan. 5.3 Consumers actively participate in CRAM Planning at the first appropriate opportunity. 5.4 Families and carers actively participate in CRAM Planning within the limits of confidentiality. 5.5 The clinical risk is managed in the least restrictive manner possible, appropriate to the type and level of risk. 5.6 Risk management utilises appropriate pathways and specialised models of care for the consumer as far as possible.
<b>6. Communicate and Consult</b>	11.3.8	6.1 The CRAM Plan is communicated to those parties involved in managing the risk. 6.2 Recording and documentation of the CRAM Plan is standardised and clearly identifiable in the clinical notes and on Psychiatric Services On-line Information System (PSOLIS).
<b>7. Monitor and Review</b>	11.3.14 11.3.17 11.3.18 11.6.4	7.1 The clinical risk is re-assessed and the CRAM Plan is monitored, evaluated and reviewed. 7.2 Services utilise existing systems (e.g. Advanced Incident Management System (AIMS), Occupation Safety and Health (OSH)) that record incidents and near misses to inform the CRAM process. 7.3 Sentinel incidents and adverse events are considered a system responsibility, not an individual failure, and should be viewed as opportunities for improvement. 7.4 Following an adverse event, sentinel or critical incident involving serious assault or abuse, injury or death, the restoration and maximisation of the well-being and mental health of all involved is a service priority.

The following table outlines each of these standards against the Clinical Risk Management Process, along with:

- The criteria for meeting each standard
- The conditions and circumstances required to meet the criteria (including additional or pre-requisite processes and resources)
- Particular factors that may challenge, or prevent, the criteria from being met
- Recommended evaluation or audit methods.

	NMHS	Standard	Criteria	Conditions to Fulfilling the Criteria	Challenges to Fulfilling the Criteria	Evaluation or Audit Method
1. Establish the Context	11.3.1, 11.3.15, 11.3.16, 11.4.E.1, 11.4.E.3, 11.4.E.6, 11.4.E.14	1.1 Clinical risk assessment and management in mental health services must be legal, ethical and evidence-based.	<p>Assessment and management is undertaken within the parameters of OSH, the Mental Health Act, the National Mental Health Standards, this policy, professional codes of conduct and ethics and other relevant laws.</p>	<p>Staff have access to OSH training and policies, Mental Health Act training and copies of their professional codes of conduct.</p> <p>The physical environment is safe and in accordance with relevant legislation, guidelines and policies.</p>	Nil.	<p>Identification of mandatory training requirements.</p> <p>Percentage of staff trained in these areas.</p> <p>OSH audit.</p>
		1.2 The practice of clinical risk assessment and management is person-centred and promotes the dignity of risk.	<p>Assessment and management of clinical risk occurs within a holistic understanding of the person that:</p> <ul style="list-style-type: none"> <li>• Is culturally appropriate to the local area and to the consumer and carers</li> <li>• Is sensitive to issues of gender and sexuality</li> <li>• Is based on an understanding of the consumer's individual history and circumstances</li> <li>• Takes into account their views and needs, even where their mental states or age precludes consent to treatment.</li> </ul>	<p>Staff can access training in areas related to clinical risk assessment and management, particularly when working with factors known to elevate risk such as cultural factors, sexuality concerns and abuse or trauma.</p> <p>Services are structured along population demographics to ensure adequate service provision in relation to matters of equity and diversity.</p>	<p>Availability of interpreter services.</p> <p>Factors and resources that prevent services being established or having the necessary capacity, such as geographic location, staffing and infrastructure.</p>	<p>Identification of mandatory training requirements.</p> <p>Percentage of staff trained in these areas.</p> <p>Population demographics.</p>

1. Establish the Context	NMHS	Standard	Criteria	Conditions to Fulfilling the Criteria	Challenges to Fulfilling the Criteria	Evaluation or Audit Method
		<p>1.3 Clinical risk assessment and management is a shared, systemic responsibility, underpinned by a just culture.</p>	<p>Consumers and carers are assisted to understand the service's expectations of treatment and behaviour, including the process of containing risk in the event of harm to self or others.</p>	<p>Information about the service's expectations and policies are clearly visible, e.g. anti-violence statements. Consumers and carers are provided with information about the setting (including rights and responsibilities of consumers, carers and staff) and are assisted to understand this information.</p> <p>Treatment planning includes Advance Statements - Mental Health.</p>	<p>Level of acuity of illness and understanding of verbal and written information provided.</p>	<p>Information is visible. Consumer and carer surveys and audits. File audit.</p>
		<p>1.3 Clinical risk assessment and management is a shared, systemic responsibility, underpinned by a just culture.</p>	<p>Mental health services promote a multi-disciplinary team-based approach to decision-making about clinical risk and staff are encouraged to learn from situations.</p>	<p>Teams use and foster peer and supervisor consultation in decision-making about clinical risk management, such as discussion of risk management formulations and plans at intake and review.</p> <p>Managers, team leaders and/or clinical supervisors have an 'open door' policy, and are directly and/or indirectly accessible to staff at short notice.</p> <p>Staff have access to clinical supervision, peer discussion and/or mentoring around clinical risk management decisions as alternative sources of support.</p>	<p>Various professions are not available or accessible within the team.</p> <p>Resources, training or policies are not reasonably available or geographically accessible.</p>	<p>Percentage of staff accessing supervision. File audit. Consumer participation. Snapshot of staff participating in clinical intake and review. Service policy. Clinical duty/on-call systems. Services provide supervision in accordance with local policy and/or the Clinical Supervision Framework.</p>

1. Establish the Context	NMHS	Standard	Criteria	Conditions to Fulfilling the Criteria	Challenges to Fulfilling the Criteria	Evaluation or Audit Method
		<p>1.4 Clinical risk assessment and management is regarded as a core competency for practice.</p>	<p>Services provide standardised training and annual updates in clinical risk assessment and management.</p>	<p>Training materials are standardised and learning objectives set in accordance with the above standards for care.</p> <p>Services actively support staff to access the training; funding is quarantined and resources are available to train and backfill staff.</p> <p>Annual updates may be provided in a variety of formats such as in-situ discussion, short refresher courses or online vignettes.</p> <p>Services support staff to access training related to clinical risk factors, particularly cultural competency, sexuality and gender diversity, broad suicide prevention training and aggression management training that focuses on de-escalation.</p> <p>Information about staff roles and responsibilities is communicated through Job Description Forms (JDFs) and induction processes.</p>	<p>Resources, training or policies are not reasonably available or geographically accessible.</p> <p>Efficiency of staff planning and review processes.</p>	<p>Training materials.</p> <p>Training evaluation.</p> <p>Percentage staff trained.</p> <p>Performance development documentation.</p> <p>Staff development databases.</p> <p>Identification of mandatory training requirements.</p> <p>Review of Job Description Forms.</p> <p>Service policy, especially regarding orientation.</p>

	NMHS	Standard	Criteria	Conditions to Fulfilling the Criteria	Challenges to Fulfilling the Criteria	Evaluation or Audit Method
2. Identify the Risks		2.1 Clinical risks are identified and their nature documented.	<p>Clinical risk types, concepts and definitions are understood by staff.</p> <p>Clinical risk is identified and responded to through behavioural, verbal or physical presentation, collaborative information and other indicators of clinical risk with sensitive enquiry and questioning.</p>	<p>Staff have access to training in clinical risk identification appropriate to their setting.</p> <p>Staff can access resources and tools that support the policy and/or training, such as related guidelines.</p> <p>Clinical risk factors and protective factors are understood by staff, appropriate to the setting.</p>	Nil.	Percentage staff trained.
3. Analyse the Risks (Assessment)	11.2, 12, 11.3.1, 11.3.2, 11.3.3, 11.3.5, 11.3.6, 11.4.E.4	<p>3.1 Consumers assessed by mental health services undergo a clinical risk assessment to evaluate harm to self or others.</p> <p>The assessment is timely, biopsychosocial and according to clinical best-practice, based on structured clinical judgement.</p>	<p>Clinicians undertaking risk assessments seek and respond to information from:</p> <ul style="list-style-type: none"> <li>• The consumer</li> <li>• Carers and/or parents</li> <li>• other records (past mental health records from other hospitals, districts, or social services departments and a history of criminal offences [where applicable], referral letters, including PSOLIS)</li> <li>• Other professionals.</li> </ul>	<p>Sources are available and reasonably accessible, e.g. from another health service or hospital in Australia.</p>	<p>Where information is missing or sources inaccessible, this is noted in the assessment.</p> <p>Information cannot be reasonably accessed, e.g. records from another country.</p> <p>Clinical risk assessments are often not easily locatable in files.</p> <p>Consumers may be unable or unwilling to participate.</p>	<p>File audit.</p> <p>Consumer and carer feedback and involvement.</p>

	NMHS	Standard	Criteria	Conditions to Fulfilling the Criteria	Challenges to Fulfilling the Criteria	Evaluation or Audit Method
3. Analyse the Risks (Assessment)			<p>Assessments include assessing the safety of others, e.g. vulnerable family and staff.</p>	<p>Adequate information is available to make the assessment with regard to vulnerable family members and staff. Family can be contacted and are willing to be interviewed with appropriate consent.</p>	<p>Factors evident during initial information make it unsafe for the assessment to proceed, e.g. presence of weapons, unsafe interviewing environment.</p>	<p>File audit. Feedback from all stakeholders.</p>
				<p>Assessments of suspected child abuse or neglect follow Department of Health policy.</p>	<p>Nil.</p>	<p>File audit.</p>
			<p>Initial assessments of urgent referrals should occur within best-practice standards and/or commence within one hour of initial contact and non-urgent initial assessments are commenced within 24 hours of initial contact.</p>	<p>Best-practice is defined for settings, e.g. Emergency Departments.</p>	<p>Resources, training or policies are not reasonably available or geographically accessible.</p>	<p>Australasian College of Emergency Medicine (ACEM) Triage Benchmarks. Service policy and referral pathways.</p>
		<p>Assessments are undertaken:</p> <ul style="list-style-type: none"> <li>• When a consumer is admitted or assessed for the first time</li> <li>• When a consumer is discharged or transferred</li> <li>• At clinical team reviews (every 3 months) in WA mental health services</li> <li>• When there has been a significant change in the person's status, e.g. serious incident, concern about current injuries, change in circumstance or significant life events such as loss.</li> </ul>		<p>Staff understand how to assess clinical risk.</p>	<p>Nil.</p>	<p>File audit.</p>

NMHS	Standard	Criteria	Conditions to Fulfilling the Criteria	Challenges to Fulfilling the Criteria	Evaluation or Audit Method
3. Analyse the Risks (Assessment)		<p>Where there are concerns about clinical risk in the presenting history or referring information, and the consumer and/or carers refuse a service's involvement, alternative steps to manage the risk are taken, e.g. referral back to referrer and/or GP, letter to consumer and/or carer with support information and contact numbers, ongoing support to carers.</p>			
4. Evaluate the Risks	4.1 On the basis of the information gathered during the assessment, clinical risk is evaluated.	<p>Risk is rated against accepted criteria.</p>	<p>The criteria refer to the likelihood and consequences of the risk, and may include estimates of immediacy or imminence.</p> <p>Staff understand the criteria and can use the criteria consistently.</p>	Nil.	Service policy and explanations of criteria.
		<p>Risk is formulated as the basis for the management plan.</p>	<p>Risk formulation summarises and documents the types of risks and to whom, what escalates or decreases the risk, how imminent, serious and volatile the risk is, what strategies can reduce the risk and how effective the management plan will be.</p>	Nil.	File audit. Consumer carer involvement is obvious and evident.
			<p>Risk formulation and/or management plan connected to the assessment is in the file notes. In particular, the use of a 'tick-box' checklist or identification form is accompanied by prompts or a proforma for risk formulation and management plan.</p>	Nil.	File audit.

	NMHS	Standard	Criteria	Conditions to Fulfilling the Criteria	Challenges to Fulfilling the Criteria	Evaluation or Audit Method
5. Treat the Risks (Management)	11.4.3, 11.4.10, 11.4.11, 11.4.A.12, 11.4.D.6, 11.4.E.2, 11.4.E.5, 11.5.4, 11.5.6, 11.6.5	5.1 In managing risk, the immediate safety of consumers, carers and staff is prioritised.	<p>In the instance of imminent harm, all services ensure that emergency procedures and response codes are followed.</p> <p>Risk escalation:</p> <p>a) Extreme and high clinical risk is subject to team input, review and consultation.</p> <p>b) Moderate risk is managed according to assessment/ formulation of risk and availability of clinical risk management controls.</p> <p>c) Low risk is subject to regular review ad-hoc, as per the Monitoring and Review Standard (7.1).</p>	<p>Flowcharts and guidelines exist for accessing emergency services.</p> <p>First aid kits are available.</p> <p>Staff understand how to access emergency services.</p> <p>Staff are trained according to service requirements in basic life support.</p> <p>Consultation with senior clinicians/ medical staff about instances of extreme or high clinical risk occurs immediately.</p> <p>Instances of extreme or high clinical risk are prioritised for team review.</p> <p>Controls are available to the clinician and service, such as beds, carer support and removal of means or opportunity to harm or be harmed.</p> <p>Where controls may not be available, or where clinicians cannot manage a component of the CRAM Plan, clinicians to consult with, and may escalate management to, senior staff.</p> <p>Staff understand the dynamic nature of clinical risk and are able to monitor accordingly.</p>	<p>Nil.</p> <p>Resources, training or policies are not reasonably available or geographically accessible.</p> <p>Adequate controls such as beds or carer support are not available.</p> <p>The unavailability of controls should be considered and noted in the assessment and formulation of risk.</p> <p>Consumer is untraceable or new information about them is unavailable.</p>	<p>Service policy.</p> <p>Percentage staff trained.</p> <p>File audit.</p> <p>File audit.</p>

NMHS	Standard	Criteria	Conditions to Fulfilling the Criteria	Challenges to Fulfilling the Criteria	Evaluation or Audit Method
5. Treat the Risks (Management)		<p>Consumers are provided with a safe, supervised environment.</p>	<p>Care environments and staffing levels reflect the degree of management required to contain the risk.</p> <p>Carers/family and other social supports are willing and able to provide a supervised environment where appropriate.</p>	<p>Beds and staff are not available; increased family supervision and support is required.</p>	<p>File audit.</p>
		<p>Staff are able to de-escalate or contain violent incidents.</p>	<p>Staff attend de-escalation training that includes recognition of early warning signs of anger/aggression, antecedents and risk factors.</p>	<p>Factors make the situation unsafe for clinicians to proceed with managing the risk, e.g. presence of weapons, unsafe physical environment, lack of back-up staff.</p>	<p>Percentage staff trained.</p>
		<p>Advance Statements - Mental Health are taken into account when managing immediate or imminent risk.</p>	<p>Staff and consumers are able and have the opportunity to develop Advance Statements - Mental Health.</p>	<p>Nil.</p>	<p>File audit.</p>
		<p>The use of restraint and seclusion are reduced, and where possible, eliminated.</p>	<p>Seclusion is only used for the protection and well-being of the consumer and/or others and for the least amount of time possible.</p> <p>Physical intervention/restraint is only considered once all de-escalation techniques have failed.</p>	<p>Nil.</p>	<p>Office of the Chief Psychiatrist, Council of Official Visitors and Mental Health Review Board reporting.</p>

NMHS	Standard	Criteria	Conditions to Fulfilling the Criteria	Challenges to Fulfilling the Criteria	Evaluation or Audit Method
5. Treat the Risks (Management)			<p>The circumstances and management of instances of restraint and seclusion are reviewed by the service and, where possible, the team. Restraint and seclusion are in accordance with Guidelines: The management of disturbed/violent behaviour in inpatient psychiatric settings (2006).</p> <p>Consumers and carers understand that seclusion and restraint may be used to protect their well-being and that of others.</p> <p>Following an instance of restraint or seclusion, consumers and involved others are debriefed and have an opportunity for feedback; their Advance Statements - Mental Health are reviewed.</p>		
	5.2 A CRAM Plan is generated and incorporated within the overall management plan.	<p>The CRAM Plan is formulated from the risk information obtained in the assessment.</p> <p>The CRAM Plan is clearly identifiable within the management plan.</p>	<p>Consumers assessed by mental health services undergo a clinical risk assessment to evaluate harm to self or others.</p> <p>The CRAM Plan must demonstrate a biopsychosocial assessment that details those static (historical) and dynamic (clinical) factors affecting clinical risk, including</p> <ul style="list-style-type: none"> <li>• Risk and protective factors, triggers and early warning signs</li> <li>• Mental state.</li> </ul>	Nil.	File audit.

NMHS	Standard	Criteria	Conditions to Fulfilling the Criteria	Challenges to Fulfilling the Criteria	Evaluation or Audit Method
5. Treat the Risks (Management)	5.3 Consumers actively participate in CRAM Planning at the first appropriate opportunity.	<p>Advance Statements - Mental Health are determined with the consumer to ascertain the most appropriate steps for safety.</p> <p>Consumers are made aware of possible interventions the service may undertake to protect their own safety and that of others.</p>	<p>Advance Statements - Mental Health are developed during periods when the clinical risk is moderate to low; physical safety is not an immediate priority and the consumer is well enough to participate.</p> <p>Consumers are able to consent to treatment and participate in developing their Advance Statements - Mental Health.</p> <p>Consumers are able to understand treatment options.</p> <p>Information is to be provided in many formats - verbal and written.</p>	<p>The initial assessment occurs in crisis; safety and supervision is prioritised for a new consumer coming into the service.</p> <p>Safety issues may preclude some parts of the management plans being issued or discussed with consumers.</p> <p>Consumers are unable to understand treatment options or processes and require a proxy or guardian.</p> <p>Lack of awareness of advocacy services.</p>	<p>Documented evidence of consumer participation - signed file copy of overall management plan and Advance Statements - Mental Health.</p> <p>Consumer satisfaction survey.</p> <p>File audit.</p> <p>Service policy.</p> <p>Carer/consumer survey or interview.</p>

	NMHS	Standard	Criteria	Conditions to Fulfilling the Criteria	Challenges to Fulfilling the Criteria	Evaluation or Audit Method
5. Treat the Risks (Management)		5.4 Families and carers actively participate in GRAM Planning, within the limits of confidentiality.	<p>Carers, parents or primary caregivers are:</p> <ul style="list-style-type: none"> <li>Made aware of clinical risks and the imminence/severity of that risk and possible interventions the service may undertake</li> <li>Educated and instructed about removing means or methods of harm</li> <li>Provided with information about securing safety for themselves and their family member.</li> </ul>	<p>Carers, parents or primary caregivers are accessible, able and willing to be engaged in, and implement, the management plan with the service and case manager.</p> <p>Carers, parents or primary caregivers have support, given the stress associated with their responsibilities.</p> <p>Identified or nominated carers, parents or primary caregivers have knowledge of and are provided with a copy of the safety plan or Advance Statements – Mental Health. (See Communicating with Carers and Families (Office of the Chief Psychiatrist, 2007)).</p> <p>The involvement of carers, parents or primary caregivers is determined by considering the consumer’s right to confidentiality, the right to receive a reasonable standard of care, and child protection issues.</p>	<p>The behaviour of the parent or primary caregiver or family circumstances places the consumer at risk.</p> <p>After negotiation and with due consideration to their mental state, adult consumers refuse to allow their family to be contacted. (See Consent to Treatment Policy for the Western Australian Health System (Office of Safety &amp; Quality, 2006)).</p> <p>The behaviour of the parent or primary caregiver or family circumstances places the consumer at risk.</p>	
			<p>Carers, parents or primary caregivers are able to provide feedback to the case manager about changes in risk.</p> <p>Where the consumer refuses treatment or is not able to be engaged, the management and containment of risk occurs through supporting the family or carers as far as possible.</p>	<p>Carers, parents or primary caregivers understand how to access the service to discuss clinical risk issues.</p> <p>Carers are willing to manage the risk with the support of the service.</p>	<p>Carers, parents or primary caregivers are disengaged or not able to be contacted.</p> <p>Carers, parents or primary caregivers are disengaged or not able to be contacted.</p>	<p>File audit. Carer survey or interview.</p> <p>File audit. Carer survey or interview.</p>

NMHS	Standard	Criteria	Conditions to Fulfilling the Criteria	Challenges to Fulfilling the Criteria	Evaluation or Audit Method
5. Treat the Risks (Management)	<p>5.5 The clinical risk is managed in the least restrictive manner possible, appropriate to the type and level of risk.</p>	<p>The CRAM Plan shows consideration of least restrictive strategies, and may include a range of care settings and strategies such as:</p> <ul style="list-style-type: none"> <li>• Using Advance Statements - Mental Health</li> <li>• Increasing supervision and reducing opportunities for harm</li> <li>• Voluntary hospitalisation.</li> </ul> <p>Hospitalisation may provide the most appropriate environment for the individual with consideration to risk from others, absconding, self-harm and harm to others. This may include:</p> <ul style="list-style-type: none"> <li>• The use of observation and proximity to the nursing station</li> <li>• Management in low stimulus or high dependency area</li> <li>• Use of Community Treatment Orders under the Mental Health Act 1996 (WA).</li> </ul>	<p>There is a safe, least restrictive care setting available.</p> <p>Carers, parents or primary caregivers have the capacity and willingness to manage the risk in the short-term.</p> <p>Consumers are able to consent to treatment and participate in developing their Advance Statements - Mental Health</p> <p>It is safe for the clinician to immediately intervene.</p> <p>Staff have training in appropriate management strategies, including de-escalation and conflict resolution.</p> <p>Appropriate staffing numbers are provided conducive to the level of nursing observation required.</p> <p>Physical environment is secure, including collapsible ligature points in room or showers, restricted access to nursing station, line of sight, removal of potentially harmful objects on admission.</p> <p>Consumers requiring 1:1 specialising are not left in the care of relatives, friends or untrained staff.</p> <p>Any restraint, seclusion and sedation practices are undertaken in accordance with the Mental Health Act 1996 (WA). Incorporate the Guidelines: for the management of disturbed/violent behaviour in inpatient psychiatric settings (2006).</p>	<p>The risk is extreme and requires involuntary hospitalisation, including deteriorating mental state, under the Mental Health Act 1996 (WA).</p> <p>Other factors make it unsafe for the clinician to continue treating the risk, e.g. physical environment, lack of back-up staff, presence of weapons.</p> <p>The clinical risk is illegal or involves illegal activity that may put others at risk and requires reporting to the appropriate authority.</p>	<p>File audit.</p> <p>OSH audit.</p> <p>Service-level policy.</p> <p>AIMS reporting.</p> <p>Office of Chief Psychiatrists (OCP), Council of Official Visitors (COV) and Mental Health Review Board (MNRB) reporting.</p> <p>Service audits.</p> <p>Consumer satisfaction survey.</p>

	NMHS	Standard	Criteria	Conditions to Fulfilling the Criteria	Challenges to Fulfilling the Criteria	Evaluation or Audit Method
		5.6 Clinical risk management utilises appropriate pathways and specialised models of care for the consumer as far as possible.	Attempts are made to refer and maintain within the consumer's area and appropriate to their age.	Appropriate and specialised resources and services are available.	No appropriate services available at that time.	Exception reporting. File audit.
6. Communicate and Consult	11.3.8	6.1 The CRAM Plan is communicated to those parties involved in managing the risk.	<p>The consumer's right to confidentiality is protected.</p> <p>Therefore information can be released where consent to release information is obtained.</p> <p>Failing this, information cannot be released unless:</p> <ul style="list-style-type: none"> <li>The clinician is legally directed to disclose information, e.g. by subpoena or warrant to produce medical records</li> <li>There is an imminent threat of harm to self or others and information is released in accordance with local policies.</li> </ul>	<p>Staff understand how to communicate about risk, taking into account:</p> <ul style="list-style-type: none"> <li>The limitations of confidentiality and taking into account Communicating with Carers and Families, (Office of the Chief Psychiatrist, 2007);</li> <li>Their duty to provide a reasonable standard of care</li> <li>Informed consent</li> <li>The Mental Health Act 1996 (WA).</li> </ul>	<p>Safety issues may preclude some parts of the management plan being issued or discussed with consumers.</p> <p>Protection of third parties.</p>	Evidence of consent on file.

NMHS	Standard	Criteria	Conditions to Fulfilling the Criteria	Challenges to Fulfilling the Criteria	Evaluation or Audit Method
		<p>Communication of relevant clinical information, including the CRAM Plan should occur within best-practice standards and timeframes.</p>	<p>Best-practice is defined according to urgency and clinical need. Degrees of urgency can range from immediate (within the hour) to urgent (overnight) to routine (two to three days).</p> <p>Discharge information is sent to relevant treating parties prior to discharge.</p>	<p>Resources, training or policies are not reasonably available or geographically accessible.</p>	<p>ACEM Triage Benchmarks. Service policy and referral pathways.</p>
		<p>Risk is communicated and explained (as far as possible in the presence of the consumer), including:</p> <ul style="list-style-type: none"> <li>Information on the current mental state of the consumer, medication, precipitants of the clinical risk and the degree of risk</li> <li>Noting a contact person or organisation for further urgent support on a 24 hour basis</li> <li>Advising about the level of supervision that the consumer requires.</li> </ul>	<p>The carer is able to respond to changes in the state of the consumer.</p> <p>The carer has knowledge of, and is provided with a copy of, the safety plan and/or Advance Statements - Mental Health, should further deterioration occur.</p> <p>The carer is aware of the possibility of increased/additional restrictive treatment and involuntary treatment and that the police may be called in emergencies.</p>	<p>Carers, parents or primary caregivers are disengaged or not able to be contacted.</p> <p>Carer does not have the capacity or ability to respond.</p> <p>Involvement may compromise the carer's welfare.</p> <p>Consumer's mental state precludes active participation and/or may compromise the process of communication with carers.</p> <p><b>There is a significant and rapid change in circumstances.</b></p>	<p>File audit.</p> <p>Consumer and carer survey.</p>

6. Communicate and Consult

6. Communicate and Consult	NMHS	Standard	Criteria	Conditions to Fulfilling the Criteria	Challenges to Fulfilling the Criteria	Evaluation or Audit Method
			Risk is communicated to other treating parties and referrers, including General Practitioners (GPs), who are actively involved in management.	Copies of the CRAM Plan are provided to other treating parties and referrers, meeting the requirements of the consumer's right to confidentiality, the duty to provide a reasonable standard of care and child protection issues.	Information systems are unable to communicate with one another, e.g. PSOLIS, Emergency Department Information System (EDIS).  Information processes are not consistent or data is not updated or maintained.  Active treating parties and referrers are unable or unwilling to participate in the CRAM Plan.	File audit.
		6.2 Recording and documentation of the CRAM Plan is standardised and clearly identifiable in the clinical notes and on PSOLIS.	Documentation is accurate and objective and according to WA Health record-keeping standards.	Staff have training on, or are able to access, WA Health record-keeping standards.	Nil.	File audit.
			Recording for the CRAM Plan is standardised across the state.	The standardised recording format is not used for assessing and predicting risk. It reflects where risk is recorded and can be found.  A Mental Health Network recommendation and a State Health Executive Forum directive is given to implement the standardised recording of the CRAM Plan.	Resistance by stakeholders to standardised recording of the CRAM Plan.	File audit.
			Review timeframes for the CRAM Plan are documented.	Staff understand when to undertake a review of the CRAM Plan.	Nil.	File audit.

	NMHS	Standard	Criteria	Conditions to Fulfilling the Criteria	Challenges to Fulfilling the Criteria	Evaluation or Audit Method
			<p>Reassessment is documented with any changes to the risk (increase or decrease) and why the reassessment was done is documented.</p>	<p>Staff understand when to reassess risk.</p>	<p>Nil.</p>	<p>File audit.</p>
7. Monitor and Review	11.3.14, 11.3.17, 11.3.18, 11.6.4	7.1 The clinical risk is re-assessed and CRAM Plan is monitored, evaluated and reviewed.	<p>The clinical risk is reviewed within best-practice standards and timeframes, based on the level of risk.</p> <p>A review of risk therefore occurs:</p> <ul style="list-style-type: none"> <li>When there has been a significant change in the person's mental state or circumstances, e.g. following a serious incident (violence, self-injury) or a significant life event such as loss</li> <li>When a consumer is discharged or transferred</li> <li>At clinical team reviews (at a minimum, every three months)</li> <li>In the event that the consumer fails to attend the service (Did Not Attend (DNA) outpatient appointment) or openly refuses, in advance of the appointment, to attend.</li> </ul> <p>Risk escalation protocols under Standard 5.1 apply.</p>	<p>The service is able to support and resource staff to manage the risk.</p> <p>Specific appointments are made available to review risk. Outpatient follow-up for consumers indicating chronic suicidality is a priority.</p> <p>Reassessment of risk is triggered by disengagement, non-compliance or non-attendance.</p>	<p>Consumer is untraceable or information about them is unavailable.</p>	<p>File audit. Consumer survey.</p>

	NMHS	Standard	Criteria	Conditions to Fulfilling the Criteria	Challenges to Fulfilling the Criteria	Evaluation or Audit Method
7. Monitor and Review		7.2 Services utilise existing systems that report, record and review clinical incidents and near misses (e.g. AIMS, PSOLIS and OSH).	<p>Services have clear guidelines for the types of incidents that should be reported, such as:</p> <ul style="list-style-type: none"> <li>• Verbal as well as physical aggression from whatever source</li> <li>• Incidents that were potentially dangerous or harmful but were resolved ('near misses').</li> </ul> <p>Sentinel events and adverse incidents are reported in a timely manner and in accordance with statutory reporting requirements.</p> <p>The review of sentinel events and adverse incidents are considered a system responsibility, underpinned by a just culture.</p>	<p>Staff understand the importance of reporting even apparently minor incidents, because of:</p> <ul style="list-style-type: none"> <li>• The adverse effects of repeated exposure to 'low level' incidents</li> <li>• The possibility that minor problems can lead to development of systems to respond to more serious incidents.</li> </ul> <p>Reporting and recording systems are accessible and staff are familiar with their use.</p> <p>Services ensure that local protocols exist for reporting.</p> <p>Appropriate authorities are notified (OSH, OCP, Director General (DG)), in accordance with standing operational directives.</p> <p>Root Cause Analysis (RCA) is used; RCA processes are in place and documented.</p>	<p>Nil.</p> <p>Nil.</p> <p>Nil.</p> <p>Identified staff/Managers have training in RCA.</p>	<p>Service policy.</p> <p>Service-level policy Service audits</p> <p>OSH audit. Service-level policy. OCP, COV and MHRB reporting. Service audits.</p> <p>Service-level policy. OCP reporting. Service audits.</p>

	NMHS	Standard	Criteria	Conditions to Fulfilling the Criteria	Challenges to Fulfilling the Criteria	Evaluation or Audit Method
7. Monitor and Review		<p>7.3 Following an adverse event, sentinel or critical incident involving serious assault or abuse, injury or death, the restoration and maximisation of the well-being and mental health of all involved is a service priority.</p>	<p>Proper support and treatment is provided for injuries, physical or psychological, for staff, carers and consumers.</p>	<p>Line managers and clinicians are trained in:</p> <ul style="list-style-type: none"> <li>• Effective post-incident reviewing and have a system of referral for critical stress support</li> <li>• The types of post-trauma and critical incident reactions to expect.</li> </ul> <p>Proper support and treatment for staff may include:</p> <ul style="list-style-type: none"> <li>• Post-incident review (operational)</li> <li>• Defusing (immediate support)</li> <li>• Professional critical incident (acute trauma) support.</li> </ul> <p>Care of self and others is promoted following an incident and staff are alert to signs of distress in others and ways of giving effective help.</p>	<p>Access to external resources and availability of trained staff.</p>	<p>OSH audit. Service-level policy. OCP, COV and MHRB reporting. Service audits.</p>
	<p>A post-incident review takes place within 72 hours. It aims to support staff and consumers, seeks to learn lessons and re-establish the therapeutic relationship with affected consumers.</p>	<p>Services have systems and skilled staff in place for post-incident support and review mechanisms.</p> <p>Those involved have the opportunity to defuse/debrief and receive feedback about the incident.</p> <p>Managers inform and/or refer staff on for specialist debriefing, counselling and support if necessary.</p> <p>The treatment of consumers exhibiting violent behaviour is not compromised and their dignity is preserved.</p>	<p>Remoteness of service. Lack of availability of trained staff. Unable to access those involved in the incident within the timeframe. Staff are trained and supported in the process of 'Open Disclosure'.</p>	<p>Service-level policy. OCP reporting. Service audits. Consumer feedback surveys.</p>		

## 3. Implementation

### Staged Implementation

Achieving the standards outlined in this policy should be regarded as a long-term investment in safe practice. It will take time and, as such, there will be a gap between the release of the policy and full compliance at a local service level. Therefore, whatever processes and procedures services currently have in place should continue on the proviso that services demonstrate they are moving toward compliance. Services are therefore encouraged to take a staged approach to implementation. These stages might include:

1. Services reviewing policy and standards.
2. Developing service-level audit tools in line with the standards.
3. Auditing services against the policy, identifying compliance with the standards and any gaps, and identifying current practice, such as checklists/tools used in services.
4. Developing an implementation plan to address compliance gaps, including roll-out of training, identification of resources, and budgeting.
5. Using the implementation plan to undertake activities toward compliance with the policy.
6. Identifying full compliance.

Given that Area Health Services (AHSs) operate with different structures and capacities, the duration of each phase will differ and consequently, some AHSs may take longer to become compliant than others.

### Auditing

As outlined above, an audit of existing policy, procedures and/or training against the policy will assist services to identify current good practice and any gaps. There are two parts to the audit process:

1. Operationalising the policy by assessing compliance with the policy through examining existing practice and identifying any gaps in comparison to the standards.
2. Defining strategies and activities in order to achieve compliance, including training.

The first step can be achieved through the development of an audit tool, against the standards. This tool should pay particular attention to the five-step CRAM process outlined in the standards, enabling assessment against the criteria for each standard. The tool should form part of the clinical audit tool, under clinical governance. An example of an audit tool is included in the Policy Pack.

The series of strategies and activities arising from the audit will form the implementation plan. Area Health Services will need to allocate adequate resources for auditing and implementation drive, and coordinate this implementation plan at a local level. That is, each health service will need to allocate sufficient human and other resources to embed the policy.

### Training and Development

Safe practice in mental health requires a combination of mental health skills, a collaborative attitude, willingness to work with consumers, carers and colleagues and knowledge about clinical risks. As such, training and skill development activities will assist in achieving and sustaining the standards of safe practice outlined in the policy.

Skill development occurs where there are opportunities for clinicians to learn, practice and reflect. Therefore, it may take many forms, including face-to-face workshops, in-situ exposure, team discussion of cases, clinical supervision and peer mentoring.

The clinical experience of clinicians can vary greatly and different clinicians will have different needs for skill development. In addition, effective clinical risk assessment and management is part of, and synonymous with, effective treatment. As such, some skills and knowledge are pre-requisites for, or should be developed alongside, those required for clinical risk assessment and management. At a minimum, these are:

- Interview, communication and therapeutic engagement skills
- Mental State Examination
- De-escalation of aggressive incidents
- Understanding the *Mental Health Act 1996 (WA)*
- Consumer perspectives training.

As part of the implementation of the CRAM Policy, Area Mental Health Services and the Mental Health Division will collaborate to develop and roll out a standardised Clinical Risk Assessment and Management Training package for WA.

## Policy Review

Following the completion of the project, the state-wide CRAM Project Reference Group intends to review its Terms of Reference and continue to meet four times per year to review the implementation of the policy. The Project Reference Group will report to the Mental Health Network regarding its deliberations.

The CRAM policy is a living document and, particularly within the first twelve months of release, will require regular reviews against implementation progress in Area Health Services to troubleshoot any difficulties in interpretation of the standards. Following this, the policy will be reviewed by the Mental Health Network and the Mental Health Division every three years or earlier, as required.

## 4. Acknowledgements

The Mental Health Division wishes to thank the members of *Clinical Risk Assessment and Management Project Reference Group* for their time, expert input and commitment to developing and drafting the policy:

Dr Steve Patchett	(Chair) Executive Director, Mental Health Division
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Mr Keith Wilson	Carer Representative

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## 5. Glossary

Advance Statements - Mental Health:	A document that contains the instructions of a person with mental health problems setting out their requests in the event of a relapse, an incident of disturbed/violent behaviour, etc. It sets out the treatment that they do not want to receive and any treatment preferences that they may have in the event that they become violent. It also contains people they wish to be contacted and any other personal arrangement that they wish to be made. (See the National Institute for Health and Clinical Excellence (NICE) Guideline 25, 2005)
Adverse events:	An incident in which harm results to a person. Harm includes death, disease, injury, suffering and/or disability (Australian Council for Safety and Quality in Health Care, cited in Office of Safety and Quality (OSQ), 2006).
Biopsychosocial:	In the health field, the biopsychosocial model is a general model or approach that posits that biological (including medical, physical and genetic), psychological (including thoughts, emotions, and behaviors) and social factors all play a significant role in human functioning in the context of disease or illness.
Clinical risk:	The risk of clinical errors and adverse incidents which may affect the quality of healthcare that patients receive.  Clinical risk can never be completely eradicated - some degree of risk is inherent in the patient's lifestyle and initial condition, in the nature of medicine and of human performance in stressful conditions - but some risks are avoidable and the process of identifying, assessing and managing them will contribute to improving professional practice and the quality of healthcare provision (British Medical Association (BMA), 2002).
Dignity of risk:	(Sometimes known as the 'Balance of Risk'). The concept of the 'dignity of risk' states that the complete removal of risk may also remove personal dignity and that taking risks is part of life.

Formulation (of risk):	Risk formulation is a process of identifying the risk factors, analysing and summarising these factors to make a clinical decision about the potential risk of an adverse event and therefore, potential strategies to mitigate the risk. It provides the information base for, and is an important component in communicating about, risk management and treatment.
Person-centred:	'Person-centered' usually denotes a way of engaging with the patient that is non-directive and supportive of the patient's wishes and thoughts about their own treatment and/or illness.
Risk:	The chance of an event occurring that will have an impact upon values, goals or intentions. It is assessed in terms of repercussions and likelihood.
Risk assessment:	A gathering of information and analysis of the potential outcomes of identified behaviours. Identifying specific risk factors of relevance to an individual, and the context in which they may occur. This process requires linking historical information to current circumstances, to anticipate possible future change. (Morgan, 2000, p.2).
Risk factors:	The responses to the symptomatology of the disorder, pre-morbid patterns of behaviour and circumstances that alone or in combination lead to an increased risk.
Reasonable standard of care and Duty of care:	The special nature of the relationship between a health worker and their client has been recognised at law as giving rise to a duty of care. A health worker may be liable for negligence where they fail to take steps that a reasonable person would have taken to prevent a reasonably foreseeable risk of harm to a client or other person to whom they owe a duty of care.
Risk management:	(Clinical) risk management aims to minimise the likelihood of adverse events within the context of the overall management of an individual. It provides the opportunity for targeted interventions to minimise the causative factors to achieve the best possible outcome and deliver safe, appropriate, effective care. Risk management can occur with the individual clinician and at a systemic level, such as the development of relapse prevention, training, environmental design.

Sentinel events:

Rare events that lead to catastrophic patient outcomes.

Sentinel events required to be reported to the Chief Medical Officer at the WA Department of Health are:

- Procedures involving the wrong patient or body part
- Suicide of a patient in an inpatient unit (under the *Mental Health Act 1996 (WA)*, Mental Health Services are required to report to the Chief Psychiatrist episodes of unexpected death. See Operational Circular OP 2061/06)
- Retained instruments or other material after surgery requiring re-operation or further surgical procedure
- Intravascular gas embolism resulting in death or neurological damage
- Haemolytic blood transfusion reaction resulting from ABO incompatibility
- Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs
- Maternal death or serious morbidity associated with labour or delivery
- Infant discharged to wrong family or infant abduction
- Other catastrophic event resulting in serious patient harm or patient death.

Structured clinical judgement:

The process of using assessment methods constructed on evidence about both historical (static) and clinical (dynamic) risk factors using assessment tools in combination with a clinician's judgement.

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## Acronyms

ACEM	Australasian College of Emergency Medicine
AHS	Area Health Service
AIMS	Advanced Incident Management System
BMA	British Medical Association
COV	Council of Official Visitors
CRAM	Clinical Assessment and Management System
DG	Director General
DNA	Did Not Attend
EDIS	Emergency Department Information System
GP	General Practitioner
ICAG	Interim Clinical Advisory Group
IOP	Institute Of Psychiatry
JDF	Job Description Form
MHRB	Mental Health Review Board
MMHS	Metropolitan Mental Health Service
NICE	National Institute for Health and Clinical Excellence
NMHS	National Mental Health Standards
OCP	Office of Chief Psychiatrists
OSH	Occupational Safety and Health
OSQ	Office of Safety and Quality
PSOLIS	Psychiatric Services On-line Information System
RCA	Root Cause Analysis







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