1. Purpose

This Procedure outlines the process to be followed by West Coast District Health Board (WCDHB) Mental Health Service (MHS) staff to ensure that the client's clinical record is completed and maintained to a standard that meets professional and statutory requirements.
NOTE: This Procedure must be read in conjunction with the WCDHB Clinical Documentation Procedure

2. Application

This Procedure is to be followed by all staff of the WCDHB MHS.

3. Definitions

For the purpose of this Procedure:

Clinical documentation is the process of recording the client's clinical pathway and recovery progress from admission to discharge, and is required to be a full and accurate representation of the care delivery process. This forms the clinical record.

Clinical record is taken to mean the 'one clinical file', paper and/or electronic versions. The paper record is divided into discrete episodes of care with each episode containing full information related to the client's treatment, and progress towards discharge.

4. Responsibilities

For the purposes of this Procedure:

Every individual clinician is responsible for

- Documenting interventions and clinical care in a timely manner;
- Maintaining and updating required key documents for individual clients
- Ensuring any concerns are both documented and discussed verbally with appropriate members of the clinical team

Ensuring any concerns about the standard of clinical documentation are brought to the Line Manager's attention.

5. Resources Required

This Procedure requires the following resources:

- WCDHB MHS Referral / Triage Form
- Manaakitanga Triage Log
- Details of Client of Concern Notification (if completed) ie updated risk assessment, risk management, crisis and relapse prevention plan.

The Case Manager is responsible for the overall maintenance of the file *(see One Clinical File Procedure*) in CMH settings, and to co-ordinate the treatment planning and ongoing care (see *Clinical Case Management Model document in the WCDHB Service Provision Framework).*

The Whole Clinical Team is responsible for the overall maintenance of the file in the inpatient setting.

6. Process

1.00 Structure Of The Clinical Record

1.01 The paper based clinical record is organised into discrete episodes of care.

1.02 The record is multidisciplinary in nature, with all clinicians contributing to the complete record.

1.03 Forms/templates used will be the standard MHS format, located on the shared drive. Note: Where specialist teams have had specialist documentation approved through the document control process, these may be used instead of the general MHS documentation.

2.00 Electronic Record

2.01 All key clinical documents (see 6.2.2) will be typed, checked and uploaded to the clinical electronic system, Healthviews This enables access off-site and after-hours to staff providing care, and allows for efficient and timely review and update of records. (see Healthviews user guide).

2.02 Key clinical documents for electronic completion:

- Referral and Triage Form
- Comprehensive Assessment
- Risk Assessment, Risk Management, Relapse Prevention and Crisis Management Plan
- Individual Treatment & Recovery Plan
- Discharge and Transfer Summary of care

2.03 Once completed these documents will also be printed, signed, and filed in the paper based record.

2.04 No documents can be scanned into Healthviews, as this does not allow for later updating of documents.

2.05 Clerical staff can assist in transcribing handwritten documents or recorded assessments.

3.00 Comprehensive Assessments

3.01 Comprehensive assessments

- will be completed on entry to the service and reviewed/updated at times of significant change.
- will be coordinated, where more than one service is involved
- will include information from involved wider sources including family/whanau, carers, Police, schools, GPs (as appropriate)
- will use the MHS approved format/headings
- will be current (note, while not specifically detailed in standards of care, accepted practice is that assessments are updated at least two-yearly)
- will clearly identify key informants to the comprehensive assessment

3.02 Where clients identify as Maori, a referral and cultural assessment will be discussed with Te Rauawa o te Waka Hinengaro Hauora, the Maori Mental Health team and appropriate outcomes identified and implemented.

4.00 Individual Treatment And Recovery Plans

4.01 Treatment and recovery plans are

- required to be developed for every client.
- developed collaboratively with the client, and their family (where appropriate) based on both clinical expertise and the client's understanding and perception of their own experience
- linked to assessments which includes consideration of client's strengths and coping strategies
- based on best practice guidelines using appropriate interventions to address the client's mental health presentation and their goals.
- Inclusive of consideration of the need for social inclusion, with timely referral to community supports in daily living, education and employment.
- updated in response to changes in the client's clinical presentation, following reviews of the clients response / progress against the treatment plan
- inclusive of an ongoing re-evaluation of barriers to discharge
- inclusive of documenting changes to MHA status, leave restrictions and treatment/management of comorbid medical conditions

5.00 Risk Assessment, Risk Management, Relapse Prevention and Crisis Management Plans

5.01 Risk assessments:

- include assessment of the current situation, exploring actual risk behaviours, triggers, internal factors and situational factors
- include an assessment of actual past risk history, and context
- include a specific risk statement and formulation based on the assessment
- are updated at each change of treatment setting, at three monthly reviews and/or at times of significant change
- are linked to the risk management plan/treatment plan, and communicated to relevant others in a timely fashion
- include family involvement/feedback
- include the Family Concerns about Risk

Note: For a small number of clients with complex presentations where a consistent and coordinated service response is deemed necessary, an additional service management plan may be developed and documented. This is done after considerable discussion with the full MDT, and, ideally with the client and their family/significant others. While all efforts are made to do this in a collaborative manner, it may be done without the full agreement of the client where clinical justification can be clearly demonstrated. This plan should be communicated to the client and their family as soon as practicable.

6.00 Clinical/Progress Notes

6.01 Clinical notes will

- Provide evidence of ongoing assessment (MSE), treatment and evaluation
- Be clearly linked to the treatment and recovery plan
- Show evidence of client participation in their own treatment
- Show evidence of ongoing discharge planning
- Show evidence of family inclusive practice (where applicable)

7.00 Multidisciplinary Team (MDT) Reviews

7.01 MDT reviews include all available disciplines. They

- are undertaken every 3 months for all clients of MHS.
- are recorded in the clinical notes under the heading MDT review
- include details of who was present at the review
- document a summary of the content of the review
- document the updated plan, outlining any changes to the treatment plan

8.00 Discharge And Transfer Summary Of Care

8.01 Client and family consultation regarding discharge is to be documented.

8.02 The discharge and transfer summary of care is completed at the end of an episode of care – (i.e. when a client is discharged from an inpatient unit to a community based team, or when a client is discharged from the MHS)

8.03 It may be documented on the discharge and transfer summary of care form, or in letter format, and will cover all areas outlined on the form

8.04 Summaries may be completed by the consultant psychiatrist or by the case manager/MDT and confirmed and signed by the consultant psychiatrist.

8.05 Documentation will be completed as soon as possible following discharge or transfer (preferably same day).

8.06 Where same day completion is not possible, handover of necessary clinical information to relevant ongoing providers will occur and will be documented.

8.07 When transferring between inpatient and community teams, some information is needed at the time of transfer in order to provide safe care. This includes (at a minimum)

- Updated risk assessment information
- Discharge/transfer information
- Information regarding scripts and medication

8.08 When transferring between community and inpatient teams, the following information (at a minimum) is needed at the time of transfer to ensure safe care:

- Triage information

- Update risk assessment information
- Information regarding medication and scripts

8.09 Documentation will include of appropriate follow up arrangements, bearing in mind that the 7-10 day period following discharge is recognised as a high risk period, and sufficient, timely follow up will be demonstrated.

9.00 Clinical Outcome Measures

9.01 Clinical Outcome Measures (PRIMHD)

- are set by the Ministry of Health
- are intended for clinical utility
- must be completed following the PRIMHD business rules, with collection occurring
- on entry,
- change of treatment setting/discharge
- every 90 days (linked with MDT review)
- where significant change occurs

10.0 Standards for clinical documentation:

i. Every entry made is in permanent ink
ii. Every entry in the clinical record must be legible and clearly identify
iii. Date and time of entry, and time of contact
iv. Name, designation and signature of the person making the entry
v. An entry must be made on every shift (in patient), at every contact (out patients) and for every multidisciplinary team (MDT) review
vi. All entries are made sequentially over a shift (inpatient) with a brief summary of overall care at the end of the shift
vii. Only approved abbreviations are to be used when making entries (see attached glossary)
viii. Once an entry is made it may not be obliterated in any manner. Errors are ruled through with a single line and signed "in error". Use of 'white out' products is strictly prohibited.
ix. Entries are factual and objective, avoiding the use of judgmental language.
x. Senior clinicians overseeing or supervising the work by students or psychiatric assistants are required to countersign any entries in the clinical record.
xi. ENs, therapists and MHSW document their interventions, and comment on the client response contributing to and updating the core assessments.

11.0 Phone, Text Message and Email Communication

11.1 Phone contact, either by voice or text messaging, will be recorded in the clinical record/progress notes as it constitutes clinical communication or activity. Note: If using text messaging or voice message services, clinicians must remain mindful that receipt of messages by the intended recipients cannot be guaranteed, and care should to be taken.

11.2 Email communication with clients, sent or received will be printed and added to the clinical record/progress notes. Note: As part of the clinical record of contact, email communication with a client is a legal document, and is subject to The Health Information Privacy Code. It may be produced as evidence during legal proceedings. Information that

is confidential or sensitive in nature must not be sent through the email, unless it is via a secure mechanism approved by the WCDHB IT Department.

7. Precautions And Considerations

- An integrated clinical record is to be maintained for every patient. The clinical record is to be a multi-disciplinary
- The clinical record is to relate to the patient and is to be a continuous record of each problem for the episode of care
- All entries into the clinical record must be made in permanent ink using firm pressure and be legible

8. References

SNZ 8134-2008 Health and Disability Sector Standards

9. Related Documents

WCDHB Clinical Documentation Procedure

WCDHB Service Provision Framework

Revision History		
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