This handbook has been prepared as a reference for psychiatry registrars in the inpatient ward at the Professor Marie Bashir Centre. The documents referenced in this guide were current at time of writing. Trainees are responsible for remaining up to date and in compliance with hospital and legal policies referenced in this document.
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Dear Registrar

Welcome to the Professor Marie Bashir Centre inpatient service. We are a comprehensive mental health service which includes high dependency and acute wards, as well as short stay and eating disorders units. The Centre also contains an assessment unit for walk-in patients and hospital transfers. The Consultant team covers a broad range of subspecialty interests such as first presentation psychosis, addiction medicine, personality disorders, perinatal mental illness, and intellectual disability.

The service offers a modern treatment environment with an emphasis on multidisciplinary patient management. This is in conjunction with a dynamic and well experienced nursing team who have successfully implemented a Trauma Informed Care treatment model.

This handbook was written to serve as a reference during your first months on the ward. It was compiled by previous registrars and addresses some of the issues you will be faced with during the term. Please feel free to contribute to this document and feedback for any recommended future changes.

We are looking forward to your joining the team and hope to support your work and training commitments during your time with the service. Please approach myself or any of the consultant staff if you have any questions or concerns during your term.

Sincerely,

Dr. Viktoria Sundakov,

Director of Inpatient Services

Professor Marie Bashir Centre
1. The Professor Marie Bashir Centre (PMBC)

The Professor Marie Bashir Centre was opened in 2014 by its patron, the Honourable Dame Marie Bashir AD CVO. It has been purpose built for the assistance and care of people with mental health issues.

The Professor Marie Bashir Centre hosts a range of services including:

- **The Mental Health Assessment Unit (Ground floor)**
  - The MAU is open 24/7 for assessment of clients to determine the best treatment options. It is a walk-in service to the public but also takes referrals from community clinicians.
  - Nb. public/patient access via intercom at exterior of building and internal clinician access via corridor.

- **Acute unit (Level 3 PMBC)**
  - This is a 25 bed, mixed gender unit for low-moderate acuity patients

- **High dependency unit (Level 4 PMBC)**
  - This is a gender separated, high dependency unit with 12 beds for female patients and 10 beds for male patients.

- **Short Stay Unit (Ground floor)**
  - This is a 6 bed mixed gender low to moderate acuity ward intended for people requiring admission for <72hours who do not exhibit severe behavioural disturbance
  - Patients usually come from ED or MAU but should not have unresolved significant medical/surgical issues
  - There is one dedicated Psychiatry registrar in SSU together with Drug Health registrar input.
  - There is a high turnover and handover meetings occur with nursing and SW staff each weekday morning at 9am.
  - Cases which turn out to require longer admission should be flagged for transfer to relevant acute units.

- **Peter Beaumont Eating Disorder Inpatient Unit (Level 5 PMBC)**
  - This is a 9 bed, mixed gender low acuity unit for inpatient treatment of eating disorders, primarily anorexia nervosa.

- **Eating Disorder Day Program (Ground floor)**
  - This is a Monday-Thursday day program for eating disorder patients

- **Ambulatory clinic (Ground floor)**
  - A variety of outpatient clinics are located on the ground floor of PMBC, including for Eating disorders, Drug and Alcohol, psychology and dietetics.

- **Mother-baby beds**
  - Specialist perinatal psychiatric care is provided for women and their babies in 2 specific beds on the Acute unit (Level 3).

- **Research Unit for the University of Sydney (Level 5)**

Occupancy of beds at PMBC depends on staffing levels; if fully staffed maximal occupancy levels are as shown above.

A range of medical, allied health and nursing clinicians work at PMBC. Occupational therapy offices are located on Level 4, social work offices are located on Level 3, and psychology offices are located on Level 3.
2. Registrar responsibilities and schedule

HONOS’ forms and Acute phase of care

Registrars need to ensure that patients have an admission HONOS, 35 day and discharge HONOS’ completed, and that they select ‘Acute’ Phase of Care.

Handover/MDT meetings

Every morning during the week there is an MDT meeting/handover for all the inpatients at PMBC. This is an important part of providing patient continuity of care, MDT planning and updates of progress.

HDU and acute handover commences at 8:45am in the level 4 handover room then proceeds to level 3.

Eating disorders handover commences at 8:45 on level 5.

Short stay handover commences at 9am on the ground floor at the short stay unit.

Care levels

Care levels are assigned to each inpatient and are a reflection of a patients assessed level of risk. They are assigned at admission and are usually reviewed at the morning handover meetings.

CL 1 – can be visual or within arms reach of the patient at all times.
CL 2 – patient checked every 30 minutes
CL 4 – patient checked beginning of nursing shift, at meal times and at end of nursing shift.

Teaching sessions

There are three weekly teaching sessions at PMBC on Monday and Wednesdays.

- The Monday weekly departmental meeting is at 12pm and intended for case/conference presentation, topic discussion, training or literature review. It is a more formal setting attended by psychiatrists, registrars (inpatient, CL, community), allied health, and nursing staff. Registrars, consultants, allied health and esteemed guests often present. All registrars are expected to present at least once per term so keep an eye out for an interesting case for discussion.
- The Monday journal club follows the departmental meeting and begins at 1pm, following the lunch intermission. All registrars are expected to present at least once per term.
- The Wednesday teaching session is at 1:30 pm and is a multidisciplinary education session. It is a less formal setting and is attended by registrars, consultants, medical students and allied health. All registrars are expected to present at least once per term.

Case reviews

- Every week each patient at PMBC has a multidisciplinary case review session with their allocated consultant and registrar, nurse, community team/case managers (if applicable and available), social worker and occupational therapist. The handover rooms are often used for case review but it can be elsewhere if this room is in use.
Each consultant has a set day and time for case reviews but occasionally this can change based on staff availability. The medical chart, paper folder (with legal paperwork/schedules) and a computer/laptop need to be collected for each patient to bring to the case review.

During the session the patient’s progress is discussed and reviewed. The patient attends the case review. Patient input into treatment planning is encouraged.

A new “case review” Powernote needs to be opened and data entered for every case review (including attendee’s, diagnoses, mental state, risk assessment, progress, medications, any changes to medications and the projected plan moving forward). It can be useful to begin to pre-populate these prior to the case review on the morning if time permits as case reviews can be very busy and this can save a bit of time.

It is useful to chase any loose ends or talk to family (who may be taking the patients on leave etc..) prior to this review as it can help guide the case review along with the current assessment of the patient which in turn helps with discharge planning.

It is useful to have some spare medical charts, schedules/Form 1’s etc. with you also as they may often be needed.

There are several laptops on each floor (level 3 and 4) which are for case review as the interview room may well not have computer.

MAU Duty and Roster

PMBC Registrars are required to cover the Mental Health Assessment Unit during business hours.

Staff safety and patient care are the primary priorities. Have a very low threshold for asking for help or for asking for another staff member (usually nursing) to sit in on assessments. If you have any concerns do not interview a patient without other staff present. If you have any trouble receiving support from a staff member, contact the consultant on call and do not see the patient alone. The front reception can be used to interview patients if no other patients are waiting.

Covering MAU includes;
- Reviewing all presentations and transfers from ED.
- Carrying the Clinical and Emergency Response Service (CERS) pager which will be notified of clinical reviews and CERS calls. RMO’s cannot carry CERS pagers (the reserve carries it if RMO is on for admissions)

The MAU duty roster is split into morning and afternoon shifts. PMBC registrars can expect to have 1 to 2 shifts per week. In general, the afternoon shift is busier with more frequent presentations.

For each admission the registrar is responsible for;
- Completing a current assessment, physical examination, and past history form.
- Completing a written medication chart.
- Ensuring the patient has appropriate PRN charted.
- Ensuring the appropriate legal paper work is in present eg. Schedule for detained patients (see below).

Priority
- It is understood that MAU duties generally have priority over a registrar’s day to day work, including case review. This is to facilitate rapid processing of consumers who present to the MAU.
- At the start of the week, the registrar should note when they have been rostered on duty for MAU and ensure they are available during this time.

Reserve
- A second registrar will be rostered as a reserve in the event that the MAU has multiple presentations or the allocated registrar is unable to cover the MAU

Joint assessment with ACS in MAU
The aim is to provide support to the registrar by being at the assessment and outlining possible community options. Presentations to the MAU may be well known to the ACS and they may be able to offer insights into previous history of what has worked well in the past and what options may be available. This early involvement allows ACS to have more input into the episode of care and ultimately to assist in early discharge.

Procedure
- ACS attends at the same time to complete the assessment with the registrar. This will be organised by the MAU nurse.
- The ACS will send 1 ACS clinician for attendance.
- ACS will not attend if the registrar is not available within a reasonable time frame.
- ACS is not expected to wait at the MAU for more than thirty minutes.
- ACS will not perform an assessment without the registrar.
- Hours of operation will be between 08:30 – 21:30 hours.
- The assessing registrar needs to discuss all presentations with the on call psychiatrist. The final decision about whether the admission is required needs to be deferred till discussed with the on call psychiatrist.

Liaison work/care planning

Registrars should liaise with any family, guardians, GP’s, specialists and the community mental health teams (case managers) to co-ordinate patient care and discharge planning.

Although some of the Consultants at PMBC work part time always ensure you regularly communicate with them in regards to their patients. They are always available and approachable in regards to active case management, care and discharge planning. Always involve them in decision making, if you have concerns, issues or need guidance. They are very happy to be contacted for advice and support at any time.

On discharge patients need to have follow-up in place from either the community ACS in their area or their case manager if available. It is the Registrar’s responsibility to ensure handover occurs and follow up has been arranged.

Discharge Planning

Registrars are expected to complete discharge summaries in a timely fashion, preferably on the day of discharge.

If the summary is available on the day of discharge, the nursing staff can call the community acute care services and provide a full handover. If the discharge summary is not completed due to other ward commitments, the registrar is required to call the receiving community team and provide a verbal handover. It is advisable to document that this handover occurred in the patient’s file (on eMR).

Local discharge referrals can be made by calling extension 59000 and handing over to the local ACS team. Out of area referrals can be completed by calling the Mental Health Line on 1800 011 511. All patients will have, at a minimum, phone follow up after discharge.
Patients that are known to have higher long-term risk such as chronic suicidality should have rigorous discharge plans in place. These patients require more timely discharge summaries and well documented handovers.

Requests for specialized follow up, such as child and adolescent services and older persons’ services, can be requested via the community teams and in the discharge summary. Requests for case management and specialized follow up such as early intervention and assertive outreach should be made early in the patient’s admission.

Ongoing management of the PMBC Registrar Manual

The senior registrar at PMBC is responsible for ensuring the manual is updated after each term as necessary.

Other responsibilities are covered later in this manual;

- Management of medical issues/CERS pager
- Mental health Assessment unit (MAU)
- Afterhours shifts
- Documentation and patient leave
- Mental health review tribunals

3. Managing afterhours shifts and the emergency department

- The current RPAH afterhours roster requires registrars to undertake at least 1 afterhours shift fortnightly, and at least 1 set of 5 nights every 6 months.

  Basic outline
  - Trainees should start an evening shift in the Missenden Assessment Unit (MAU) where they should pick up a CERS pager.
  - Trainees then proceed to review patients in the ED, MAU or that are handed over from day teams. On afterhours shifts, ED reviews generally take priority unless there is other clinical urgency.
  - Trainees are the first on call for Clinical Review calls and need to review patients within 30 minutes.
  - Handover occurs 30 minutes prior to the end of an afterhours shift. The CERS pager needs to be handed over from evening to night registrar.
  - Always contact the Child and Adolescent Psychiatrist on call for patients less than age 16 (usually call them first before the adult on call Psychiatrist).
  - Patients aged 16-17yrs (discretionary to contact the C&A Psychiatrist but if in doubt discuss with the adult on call Psychiatrist.)

- Time saving tips
  - Reviewing Powernotes prior to assessment of patients. The most useful documents are past discharge summaries, current assessment forms, and the Powerchart menu option of “Patient/Encounter” under the “Visits” tab.
  - Typing as you go (if clinically appropriate). There are laptops and computers in the MAU, as well as several “Computers on Wheels” in the ED.

- Calling in the ACS registrar
  - If ≥ 3 patients require assessment (or the equivalent in workload i.e. more than a two hour wait for patients), the Acute Care Service registrar should be
called in to assist via switch. If this is to occur after 1030pm (i.e. Night shift), the consultant psychiatrist must give permission for this.

- Do not hesitate to call the ACS registrar in to help if required.
- Trainees unable to fulfil their allocated on-call duties must arrange their own alternatives and notify the appropriate people i.e. RPA & Concord switchboards, On-call psychiatrist and psychiatry departmental secretary. If you are sick please notify Switchboard, contact the reserve ASAP and reciprocate when well.
- Trainees may access an overnight room on level 4 PMBC, this includes a bed with linen, a shower and a television
- Parking may be accessed in the staff multistorey car park. Use the intercom to give your name to Security who will have a copy of the overtime roster. Trainees may request Security to escort them around the campus or to their car if there are safety concerns.

For further general detail on overtime shifts, refer to the Overtime section in the SLHD Eastern Sector Psychiatry Trainee Orientation Reference.

### Overtime Shifts

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<td>Night Shift</td>
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**Shift schedule**

- **Weekdays** – on site from 5pm until 11pm (you must arrange cover if you are not able to be on site by 5pm).
- **SAT, SUN and PUBLIC HOLIDAYS** on site from 8am to 8:30pm.
- **Night shift SUN-THURS** on site: SUN on site from 8pm-8:30am, MON – THURS on site from 10:30pm-8:30am; returns to work Monday.
- **Night shift FRI** on site from 10:30pm-8:30am; does not work Friday day and returns to work Monday.
- **Night shift SAT** on site from 8pm-8:30am; does not work Monday day, returns to work Tuesday.
- **Night shift PUBLIC HOLIDAYS** on site from 8pm-8:30am.
- Handover times are incorporated into shifts.
4. Electronic medical record (eMR) documentation and patient leave

Documentation in the electronic medical record (eMR) via Powerchart is essential, including for patient encounters, case review and patient leave. A guide to documents can be found in Appendices 4 and 5.

Key Powerchart forms that are the responsibility of the registrar:

- Current assessment – to be completed at initial assessment for admission
- Physical examination – to be completed at initial assessment for admission
- Past history form – to be completed at initial assessment or earliest opportunity (the formal policy is within 3 working days of admission). Compliance with Past history forms is audited by the area health service.
  - This should include past history of (self-harm, aggression, absconding, sexual safety and other risks) as well as other relevant history.
- Case review form – to be completed at each case review
  - Includes a section on risk that should be completed
- Discharge summary (see below)
- Patient leave forms (see below)

All of these forms are found in Powerchart under the PowerNotes menu option (left hand menu column). Press "Add"

**MH Discharge/Transfer summary**

Please note discharge summary completion is audited by the area health service.

- Should be completed by the registrar on the day of discharge.
- All discharge summaries need to be sent to the message centre of the primary consultant on completion. The process is as follows;
  - Open the MH Discharge/Transfer Summary under the Powernote menu option by pressing “Add”
  - Complete the discharge summary
  - Press sign
  - Tick the request endorsement box (see image)
  - Select the primary consultant by entering their surname and first name
  - Select “sign” option under the “Type” menu
  - Press the “sign” button to sign off the PowerNote as normal
  - A message will then be sent to the consultant’s message centre
  - The consultant will then review the discharge summary and add an addendum at the end of the MH Discharge/Transfer summary
Patient Leave

- Patient leave is generally granted by the consultant psychiatrist (often after case review). Registrars are strongly advised to discuss any new leave arrangements with the consultant psychiatrist prior to authorizing them.
  - Patients will understandably request further leave outside of scheduled reviews. No change in leave should be granted without first reviewing the patient and discussing with the consultant. These requests can often be deferred by advising the patient or nursing staff that you will consider the change at case review or in the coming days.
  - Leave changes are sometimes requested in the absence of the primary registrar. These are generally higher risk as the registrar who is being asked to consider the change does not know the patient as well. These adjustments can be politely deferred if there is not time for a full assessment of the situation. If there is time, any proposed changes must be discussed with the patient’s consultant Psychiatrist or Psychiatrist on call if after hours.
- Leave should be discussed with the patient’s family or close friends who should confirm that the leave is low risk, especially in the context of child safety and domestic abuse.

- Registrars must complete Leave Approval forms on Powerchart once leave has been granted or if there is any change to leave. This is regardless of legal status.
  - A new Leave Approval form must be completed at least weekly at case review. Any subsequent changes in leave require another Leave Approval form.
  - Leave authorization forms should include the following:
    - The fact leave was discussed at a multidisciplinary team meeting.
    - The time allowed for leave.
    - Whether the leave is accompanied (with staff or family/friends) or unaccompanied.
    - Actions if patient does not return (example: Start AWOL process after 30 minutes).
    - Further instructions eg. patient undertaking a urine drug screen on return, not to drive, not to return home.
    - What to do if the patient does not return from leave.
    - Past history of absconding and any risks past and current.
PMBC Acute Inpatient Psychiatry Registrar’s Manual

- Indicate if family have been contact prior to leave and document the name of the family contact.
  - The morning handover and the case reviews will be considered MDT reviews for leave purposes.
  - Leave instructions are a collaborative effort between the nursing and medical staff. The patient and his or her accompanying family or friends should be aware of the following:
    - The mental health line contact details.
    - The ward phone number.
    - Advice on avoiding substance abuse/gambling/other risky behaviour.
    - Leave will be cancelled in future if agreed rules are not followed.
    - ACS referrals are sometimes required for patients who are on extended overnight leave.
  - All leave changes over the weekend require a discussion between the registrar, nursing staff and the consultant on call will need to occur.
  - “Smoking” should not be documented as a reason for leave.

5. Safety at PMBC

Assaults and abusive behaviour towards staff members occur infrequently and there are several measures that can be taken to reduce the number and severity of these events.

Ward acuity

It is important to remember that any psychiatric patient poses a potential risk to themselves and others. In general, patients with a history of aggression (documented incidents, convictions for assault, armed robbery etc) or with a higher risk profile are admitted to the high dependency unit on Level 4. Low to moderate acuity patients are admitted to the acute ward on Level 3. Higher acuity patients may at times be admitted to wards other than the high dependency unit. Patients can be transferred between the wards based on changes in clinical status and bed management requirements.

Duress Alarms
All staff members must carry duress devices while on the ward. OH& S requirements demand this and there are large personal and institutional fines in the case of non-compliance.

Duress alarms can be found in the Acute Unit and High Dependency Unit nurses' stations as well as in short stay/MAU. Record the number of the duress device that you take on the record book so that responding staff can trace the duress alarm to a particular staff member.

Check the device to ensure that the green display light is on and there is a full battery, prior to attaching it to a belt or clothing.

The device has a “man down” function and will activate if not held in the upright position. Press the “OK” button on the front of the device if the alarm activates unintentionally due to this function.

Press the button on top of a duress alarm twice to activate it. Alternatively, the alarm can be activated by dropping it on the ground.

Violence Prevention and Management Training (VPM)

In September 2015, the Mental Health Service (MHS) SLHD implemented Violence Prevention & Management (VPM) Training. All MHS medical staff (Registrars/Trainee Psychiatrists & Consultant Psychiatrists) are classified as Category 2 (Not directly involved in restraint processes) and must attend the Violence Prevention & Management: Personal Safety Training (1 day). Registrars will be offered training dates during the term. An extended version of the course which includes restraints is available for interested staff members. The dates of the extended courses are available through the nursing unit manager of the acute ward.

General Safety Advice

- Always consult with the allocated nursing staff member when you wish to review a patient. The nurse member will usually have a better idea of the patient's current mental state and risk. Ask the nurse to accompany you for the review if there are any concerns. Remember, your safety is the first priority at all times.
- Always carry a duress alarm while on the ward.
- Communicate your risk assessment to the nursing staff after reviewing the patient, especially if you have any safety concerns.
- Avoid reviewing patients alone. Never review patients in their bedrooms or other secluded areas alone.
- If a patient appears to be increasingly agitated during review, politely terminate the review and give them a clear pathway to exit the room.
- Interview patients in open spaces that have two exits. If there is only one exit in the room, do not block this exit with your position.
- Ensure that the interview room is clear of possible weapons/projectiles.
- Do not wear stethoscopes, ties, lanyards etc. when reviewing patients.

Chaperones

- For male registrars, do not perform a physical examination on a female patient alone. Please do so with a chaperone and record the purpose and findings of any examination.
- For all registrars, do not examine paediatric patients alone. Please do so with a chaperone and record the purpose and findings of any examination.

Medical students
• Please ensure that all medical students are given a proper brief on these safety issues.

Access to the Wards

Staff are required to have an ID badge with ward access as well as a ward key at all times. These can be difficult to obtain at the beginning of the term due to the influx of new staff and the process can be time consuming. It is recommended that these be arranged prior to commencing the term if possible.

Registrars can obtain ward access and keys via Roshni Rattan, Medico-Legal Coordinator /Secretary to Director of Psychiatry, at roshni.rattan@sswhs.nsw.gov.au or on 95151482 (pager 81359). She will provide instructions on how to get approval for ID and where to go to obtain a key and badge. Temporary keys and badges are available at times.

6. Acute sedation and related adverse events

• The aim of sedation is to control dangerous behaviour sufficiently to facilitate assessment and management.
• Consult
  o This is meant as a quick reference guide only and is in no way prescriptive of what should happen for every patient. Confirm your doses with the treating consultant as individual treatment preferences may vary.

• Non-pharmacological
  o Whilst sedation/tranquilisation is the aim of pharmacological management of a behavioural disturbance it should only be considered if other methods of aggression minimisation such as de-escalation, reassurance and distraction have been ineffective or are impractical.

• Oral option
  o Although sedation may be necessary, clients may still be persuaded to take oral medication. Oral medication is preferred as it encourages engagement between client and staff, allows the client to feel more in control and aids with future medication adherence and reduces the risk of adverse effects. The client should be given an opportunity to take oral sedation before initiating parenteral sedation.

• Think about what you’re using
  o Each patient is an individual and should be assessed and treated as such. Assess your patient’s needs based on their physical examination including vital signs, known co-morbidities, size/weight, age, previous history of exposure to antipsychotics including any known side effects or adverse reactions, allergies and behaviour.
    o For example;
      ▪ Antipsychotic naïve patient - lower dose, untested risk.
      ▪ Young, Asian males – low dose, higher risk of EPSE.
      ▪ Pre-existing Parkinson’s disease – antipsychotics will exacerbate motor symptoms

• Monitoring – after parenteral sedation, patients should be monitored for blood pressure, heart rate, respirator rate, presence of extrapyramidal side effects, and level of consciousness. These should be measured every 10 minutes for the first hour or until the consumer is fully alert and his or her observations are stable.
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<th>Dosage Form</th>
<th>Strength</th>
<th>Maximum Daily Dosage</th>
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<tbody>
<tr>
<td>Oral</td>
<td>100 mg</td>
<td>400 mg</td>
</tr>
<tr>
<td>Oral</td>
<td>200 mg</td>
<td>800 mg</td>
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<tr>
<td>Oral</td>
<td>300 mg</td>
<td>1200 mg</td>
</tr>
<tr>
<td>Oral</td>
<td>400 mg</td>
<td>1600 mg</td>
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Dosages are adjusted based on the clinical judgment of the treating psychiatrist. Close monitoring is required to assess the clinical effect and make necessary dosage adjustments.

Some patients may experience side effects such as nausea, vomiting, and sedation. If these occur, dosage adjustments may be needed.

**Drug Interactions:**
- CYP3A4 inhibitors may increase the level of lamotrigine.
- CYP3A4 inducers may decrease the level of lamotrigine.

**Contraindications:**
- Hypersensitivity to lamotrigine.
- Patients with a history of seizures or a family history of seizures.

**Warning:**
- Lamotrigine should be used cautiously in patients with renal or hepatic impairment.
- Abrupt discontinuation can lead to seizures.

**Dosage Adjustments:**
- Start with a low dose and increase gradually as tolerated.
- Monitor serum levels and adjust accordingly.

**Side Effects:**
- Nausea, vomiting, sedation, rash, Stevens-Johnson syndrome.

**Overdose:**
- Symptoms: Nausea, vomiting, sedation, seizures.
- Management: Supportive care, consider activated charcoal if administered within 2 hours, hemodialysis for severe toxicity.

**Precautions:**
- Monitor for signs of depression, suicidal ideation.
- Periodic monitoring of liver function tests and complete blood counts.

**References:**
PRINCIPLES FOR PRN CHARTING – Dr Viktoria Sundakov

IN VOLUNTARY PATIENTS
If the patient is involuntary ensure that parenteral (IM) medication is charted (unless contraindicated for medical reasons).
For all patients on anti-psychotics ensure that anticholinergic medication is available, for example, benztropine 1-2mg TDS PO/IM (for EPSEs, but contraindicated in tardive dyskinesia)
Generally speaking the following should be available:
- Oral benzodiazepines
- Oral anti-psychotics
- Intramuscular benzodiazepines
- Intramuscular anti-psychotics
- An anti-cholinergic

Never chart IM midazolam and IM olanzapine together.
Remember intramuscular olanzapine has 5x the bioavailability of oral olanzapine therefore acutely more sedating.
A crossover study in healthy subjects comparing 5 mg IM and 5 mg oral olanzapine showed that the geometric mean AUC IM/ oral ratio was 1.23. These results provide an estimate that the AUC for the IM product is on average about 23% larger than the AUC produced by the same amount of olanzapine administered orally, a difference which does not require dose adjustments (emims).

Always consider the physical health/ physical status of the patient when charting sedation
- Risk of airway obstruction (eg compromised airway, obese patients, OSA, risk of airway collapse)
- Cardiac/ cardiovascular disease
- Hydration level
- Past history of adverse effects
- Intoxication with sedating substances (eg benzodiazepines, alcohol, opiates) – use lower doses or with-hold
- Intoxication with amphetamines (high aggression may require higher doses)

Accuphase (zuclopenthixol acetate)
- Never chart accuphase as PRN
- Can be used as acute sedation but needs to be a clinical decision at the time

Remember – PRN drug total is the daily total of PRN only

Benzodiazepines (INTRAMUSCULAR)
Midazolam 5-10mg Q 4 hourly MAX 20mg/day
Do not chart with IM olanzapine
Parenteral Lorazepam is not currently available in the PMBC despite being in the sedation guidelines

Benzodiazepines (ORAL)

<table>
<thead>
<tr>
<th>Lorazepam</th>
<th>Diazepam</th>
<th>Temazepam*</th>
<th>Oxazepam</th>
<th>Clonazepam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approximate equivalent (per eTG)</td>
<td>0.5-1mg **</td>
<td>5mg</td>
<td>10mg</td>
<td>15mg</td>
</tr>
<tr>
<td>Example dose</td>
<td>1-2mg TDS Max 6mg /day</td>
<td>5-10mg QID Max 40mg d</td>
<td>10-30mg Nocte Max 30mg Nocte</td>
<td>15-30mg QID Max 120mg/day</td>
</tr>
<tr>
<td>Tmax</td>
<td>~2 hours</td>
<td>~30 – 120 min</td>
<td>~ 1.4 hours</td>
<td>~3 hours</td>
</tr>
</tbody>
</table>
**Half life**

<table>
<thead>
<tr>
<th></th>
<th>Approximate Half Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent 44-48h</td>
<td>~12 hours</td>
</tr>
<tr>
<td>Metabolite 100h</td>
<td>~8 hours</td>
</tr>
<tr>
<td></td>
<td>17-60 hours</td>
</tr>
</tbody>
</table>

*Insomnia only

**May be relatively more potent at higher doses

**Accumulates with multiple dosing and the terminal elimination half-life is slightly prolonged

**Anti-psychotics (INTRAMUSCULAR)**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Example dose</th>
<th>T max</th>
<th>Half-life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ziprasidone</td>
<td>10-20mg BD</td>
<td>&lt;60min</td>
<td>2-5h</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>5-10mg BD</td>
<td>20min</td>
<td>20h</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>5-10 mg BD</td>
<td>15-45min</td>
<td>30h</td>
</tr>
</tbody>
</table>

**Anti-psychotics (ORAL)**

Chart only one PRN anti-psychotic where possible

<table>
<thead>
<tr>
<th>Drug</th>
<th>Example dose</th>
<th>Tmax</th>
<th>Half-life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olanzapine</td>
<td>5-10mg TDS</td>
<td>6h</td>
<td>30h</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>25-300mg TDS</td>
<td>1.5h</td>
<td>Parent ~6h</td>
</tr>
</tbody>
</table>
| Chlorpromazine| 25-200mg TDS | 1-4h | Metabolite ~12h

**VOLUNTARY PATIENTS**

Generally intramuscular medications are not necessary for voluntary patients. If they are exhibiting aggression or agitation that is unmanageable with oral sedation, then it is likely they will need a clinical review and reconsideration of their sedation and legal status.

**Special Situations:**

**Alcohol withdrawal**

An alcohol withdrawal scale should be charted

- AWS 4-5, give diazepam 10mg Q.2 hourly PRN
- AWS greater than 5, give diazepam 20mg Q2 hourly PRN
- Thiamine should also be charted and if there are signs of Wernicke’s encephalopathy, parenteral thiamine should be given

**Liver disease**

- Use oxazepam (dose equivalent diazepam 5mg equals oxazepam 15mg)

Kinetic data from lexicomp; accessed via UpToDatoe online 14/03

**Common issues with Antipsychotics**

- **Hypotension**
  - All antipsychotics can lower blood pressure but in particular Olanzapine and clozapine so it is important to assess BP prior. Prescribe and adjust accordingly where possible.
  - Very disorganised or unwell patients may have had poor oral intake in the lead up to admission and so it may be important to alert nursing staff to encourage PO intake to reduce the likelihood of a significant drop in BP once antipsychotics are commenced and through the admission.
In the event of sustained low BP, always consider other causes such as sepsis, as per any medical assessment. Call for assistance/CERS/ICU assist as indicated.

- **Tachycardia**
  - Is often seen on commencement of antipsychotic medication. However, it may be due to a number of other factors including serious medical illness. These need to be excluded.

- **IM olanzapine**
  - IM Midazolam is contraindicated when IM olanzapine has been given and has been associated with acute respiratory failure and death. Oral olanzapine and IM Midazolam is acceptable.

### 7. Acute psychiatric scenarios

This is an extremely brief overview. Please refer to more complete sources for treatment and seek expert help if any of these are suspected.

**Serotonin Syndrome**

**About:** A potentially fatal syndrome of autonomic instability and neuromuscular disturbance associated with excessive serotonergic activity in the CNS. May occur in the setting of an overdose or when using multiple serotonergic agents. This is a medical emergency, requires ICU consultation and often has a sudden onset.

Suspect if symptoms develop in the context of initiation or dose increase of serotonergic agent (SSRIs, SNRIs, TCA, MAOi, Lithium and Tramadol.)

- Altered mental status (confusion/hypomania/agitation/coma)
- Hyperthermia
- Autonomic dysfunction – tachycardia, mydriasis
- Hyperreflexia (often lower more than upper limbs), Myoclonus and hypertonia

Complications can include DIC, rhabdomyolysis and myoglobinuria, renal failure, ARDS, metabolic acidosis.

**Recognise:** Maybe a spectrum of findings with rapid onset (within 24 hours) of a classic triad of altered mental state (agitation, delirium), autonomic instability (diarrhoea and vomiting, hyperthermia, hypertension and tachycardia, tremor) and neuromuscular abnormalities (hyperreflexia and rigidity, bilateral babinski +, clonus, myoclonus and seizures). Lower limb clonus and hyperreflexia are common. This may be associated with initiation or increased dose of serotonergic medication. Increased risk with MAO inhibitors. Diagnosis is clinical.

**If suspected:** Withhold serotonergic agents. Transfer to ICU as soon as possible. Discuss with consultant psychiatrist and medical registrar. Perform bloods and urinalysis. Expect elevated CK, metabolic acidosis, myoglobinuria, evidence of hepatic and renal failure and other complications.
Treatment: Cease serotonergic agents. Supportive care with hydration and O2 is mainstay. Sedate with benzodiazepines to minimise hydration and heat generation. Administer cyproheptadine (histamine antagonist + serotonin antagonist).

Patients can deteriorate very quickly. Syndrome may resolve within 24 hours after treatment instituted and medication withheld. Drugs with long half-lives such as Fluoxetine and irreversible MAOIs can prolong recovery. No role for dantrolene, bromocriptine.

Neuroleptic malignant syndrome

This is a medical emergency and requires transfer to acute medical services/ICU

Suspect if;

- rising CK on bloods
- Rigidity/increased tone
- Autonomic dysfunction - tachycardia/tachypnoea/hyper or hypotension
- confusion/altered mental status
- Increasing temperature or fever

About: A rare, potentially fatal syndrome of autonomic instability and neuromuscular disturbance precipitated by antipsychotic use or withdrawal. Thought to be malignant catatonia induced by antipsychotics. NMS risk is between 0.1-0.2% of patients on antipsychotics. Increased risk in recent commencement or increased dose of antipsychotics, depot formulations, high potency antipsychotics, history of NMS and catatonia, young males, substance and drug withdrawal (including alcohol, anti-parkinsonian, benzodiazepines), dehydration and agitation, basal ganglia disorders. Can occur after a single dose or after treatment with the same agent at the same dose for many years. One third of patients rechallenged with antipsychotics will have NMS again. 10-20% mortality with treatment – hyperpyrexia, organ failure, cardiorespiratory compromise. Other complications include renal/hepatic failure, DIC, seizures, sepsis, cardiorespiratory failure.

Recognise: Maybe a spectrum of findings. Onset within 7 days of antipsychotic administration (2-4 weeks for depot). Develops over a few days. Autonomic dysfunction (tachycardia, hypertension, hypotension, tremor, tachypnoea), rigidity (classically lead-pipe), parkinsonian features, altered consciousness (mutism, stupor, delirium), hyperthermia with diaphoresis (98% of cases). Most patients appear catatonic. ‘Atypical NMS’ can appear without rigidity or extrapyramidal symptoms or CK elevation. Differentiating from serotonin syndrome: in NMS shivering, hyperreflexia, myoclonus and ataxia, nausea, vomiting, and diarrhea are less common. Rigidity and hyperthermia is more severe in NMS.


Treatment: Hydration, cooling, muscle relaxants and supportive care in ICU is required. Dantrolene and Bromocriptine are most often used. Expect rigidity and fever to abate in 24-48 hours and other features resolved within 64 hours (up to 2 weeks if untreated). ECT may be useful when nonresponsive to medications. Most cases resolve within 2 weeks.

Refeeding syndrome
About: A potentially fatal syndrome associated with fluid and electrolyte abnormalities caused by nutritional rehabilitation in prolonged malnutrition. Key components include low electrolytes (PO4, K, Mg), thiamine deficiency, congestive heart failure and oedema, rhabdomyolysis. Pathophysiologically, refeeding with carbohydrates causes insulin release which triggers cellular uptake of glucose, K, Mg, PO4. Insulin also causes cellular productions of phosphate-requiring molecules such as ATP. Fluid overload occurs due to increase in fluid intake and reduce fluid loss such as from purging in the context of an upregulated renin-angiotensin system from prolonged intravascular depletion. Increased risk in more severe malnutrition (BMI<16), aggressive refeeding, carbohydrate rich refeeding, dehydration, prefeeding electrolyte derangements.

Recognise: The essential principle is daily electrolyte monitoring for the first 1-2 weeks during refeeding. Complications including cardiac (arrhythmias, failure, peripheral oedema, relative tachycardia), pulmonary (diaphragmatic weakness, respiratory failure), muscular (weakness, tetany, rhabdomyolysis), gastrointestinal (deranged transaminases due to fat deposition), neurologic (tremor, paraesthesia, delirium, seizures, Wernicke's) occur due to electrolyte and fluid abnormalities.

If suspected: Regular electrolyte monitoring is mandatory during refeeding. Refeeding prophylaxis with thiamine, magnesium, potassium, zinc supplementation is essential from the commencement of refeeding. Perform ECG in cases of moderate-severe electrolyte derangement or physical instability.

Treatment: Discuss with endocrine team at RPA for guidance. Treat mild-moderate electrolyte derangements with replacement (oral is ideal). Severe electrolyte derangements with or without physical instability, may need transfer to medical ward under endocrinology for monitoring and intravenous replacement.

Acute dystonias

About: These are involuntary contractions of major muscle groups commonly a result of dopamine blockade by antipsychotics.

Recognise: Usually rapid onset, and distressing. Can include torticollis, retrocollis, oculogyric crisis, opisthotonos. Rarely life threatening laryngospasm can occur. Increased risk in young, male, Asian ethnicity, previous history of acute dystonia, cocaine use.

If suspected: Treat as below, benztpine is relatively safe

Treatment: Treat with 1 to 2mg of benztpine intramuscularly. Milder dystonias can be treated with oral benztpine. The treating team should consider changing antipsychotic regimen to one with a lower tendency towards causing extrapyramidal side effects (ie less potent). Regular oral benztpine BD may be effective.

Prolonged QTC/Heart block and Torsade des Pointe

Many Psychotropic medications (e.g tricyclic antidepressants,phenothiazine derivatives, butyrophenones, benzisoxole, diphenylbutylpiperidine) can cause this and patients receiving multiple doses (and sometimes single doses) of IMI antipsychotic e.g Acuphase are at risk.
Increasing the number of different antipsychotics prescribed for a particular patient can have an additive effect and increase the risk of prolonged QTc amongst other things (particularly 3 and above).

Where possible chart the same regular antipsychotic as PRN e.g if someone is on regular olanzapine BD, chart PRN olanzapine in the case of agitation rather than quetiapine, to avoid a patient receiving more different drugs than necessary.

Be aware the QTC generated from the computer analysis of the ECG can be inaccurate particularly if the heart rhythm is irregular.

If unsure double check manually:

There is a good tool on the app “Medcalc” and other sites that guide you through a manual calculation which is fairly simple.

Depending on where you read there may be variable values noted as an abnormal QTc. According to Medcalc anything greater than 0.44 seconds is abnormal.

Remember that other medical conditions can also cause prolonged QT including but not limited to; congenital (familial) long QT syndrome, abberations in serum potassium and magnesium levels and thyroid dysfunction.

**Wernicke’s and Korsokoff’s delirium**

Wernicke’s is a Triad of confusion, ophthalmoplegia and ataxia but be aware that all three only occur together in approx 30% of cases.

“Detailed clinical and neuropathological data over 10 years revealed that all features of the triad were recognized in only one-third of patients; in most, only one or two elements of the clinical triad were apparent ... While most often associated with chronic alcoholism, WE occurs also in the setting of poor nutrition caused by malabsorption, poor dietary intake, increased metabolic requirement (eg, during systemic illnesses), or increased loss of the water-soluble vitamin thiamine (eg, in renal dialysis)” - up to date/CIAP.

Have a strong suspicion in any patient with a known or potential unknown drinking history who appears confused.

Give IMI/IV Thiamine stat and PO charted as per protocol to any patient suspected to be at risk (see the RPA intranet- EtoH withdrawl) and place patient on an AWS. Call Drug and Alcohol team for more detailed advice.

**Rhabdomyolysis**

Can occur secondary to NMS or serotonergic syndrome but also in Catatonia and after heavy IMI sedation (“long lie”) or with various medications e.g statins

May see:

- Rising CK
- Myoglobinuria
- Muscular pains
- Renal dysfunction and end organ failure

**Clozapine induced myocarditis**

Beware that Troponin rise may lag behind clinical progression- order an urgent Echo and bloods if any suspicion.
May see:
- Troponin leak (rising)
- ECG changes
- CRP rise
- Chest pain

8. Medical management and CERS

Mental health inpatients are at high risk of physical deterioration due to the medications prescribed, reduced frequency of observations, mode of admission (eg. overdose), relative complacency and inexperience of clinical staff in dealing with medical conditions. The PMBC is not located in the main hospital and it can take much longer for ICU and Arrest call responders to arrive. Similarly, due to local protocols physically unstable patients may need to be transferred via ambulance or hospital transfer to the main hospital, a process which can take hours. The policy for managing medical issues at the PMBC can be found in Appendix 2.

At RPAH the Clinical Emergency Response System (CERS) is used and the medical response to a deteriorating patient is triaged into Clinical review, ICU assist and Cardiac arrest. A CERS response can be activated by dialling 222.

- **Clinical review** (medical review within 30 minutes)
  - In hours the admitting psychiatric registrar who is responsible for carrying and handing over the CERS pager will initially assess the patient. If the treating registrar is present, the CERS registrar should handover to them to complete the CERS response. Protocols for observations post CERS call should be followed and recommended.
- **ICU assist** (medical review within 10 minutes)
  - Response is by the ICU medical and nursing team within 10 minutes
- **Cardiac arrest** (immediate response)
  - Response is by the cardiac arrest team immediately.
- **After hours** (1700-0830) – cover for medical problems after hours for PMBC inpatients is provided in the first instance by the RMO on call. All psychiatric or other management issues including re-writing medication charts is referred to the on-call psychiatric registrar. The psychiatrist on call must be notified of the transfer of any involuntary patient.

At PMBC the CERS pager (#81595) is carried by the admitting registrar in hours and the on-duty psychiatry registrar after hours. The CERS pager cannot be carried by the psychiatry RMO and must be carried by the ‘reserve’ admitting registrar. It is the psychiatry RMO’s responsibility to ensure the reserve is aware of this. The CERS pager should always be picked up from and returned to the MAU reception.

Medical assessment of patients presenting to the Missenden Assessment Unit should initially involve the assessing psychiatric registrar, these patients are not inpatients of PMBC at this point and any medical problems considered to preclude admission may need to be referred to the Emergency Department but this should occur only after discussion with the admitting ED staff specialist (Ext. 50000). For all transfers, the RPAH bed manager (in hours or afterhours) must be notified.
Consultations for medical or surgical issues will take place initially within PMBC. Patients should not be sent to the Emergency Department except in extraordinary circumstances and only when the ED consultant has approved the transfer (on duty ED consultant ext. #50000 from 0800-2400 or via switch after midnight). The Division of Medicine standard is that if consultation is sought the patient should be seen by a registrar within 24 hours. If this is required within a shorter time frame then this should be requested with appropriate rationale.

Dr Adrian Gillin has agreed to negotiate access to appropriate care if difficulty is experienced obtaining medical care for PMBC inpatients or failure of a specialty to accept responsibility for the medical care of the patient. If such circumstances arise Dr Gillin should be contacted directly by the treating psychiatrist registrar or consultant. If Dr Gillin is on leave, this role will be undertaken by Professor Paul Haber.

9. Mental Health Act

This section highlights some working aspects of the Mental Health Act relevant to the Missenden Unit. The Mental Health Act Guide Book is available here.

On admission/transfer:

- All admitted mental health patients require a schedule (if “detained for assessment and admitted involuntarily, thus becoming “assessable persons”) or a voluntary admission form (S5). The admitting registrar completes the schedule 1 if this has not yet been completed by police, paramedics, community nursing, or ED staff. The assessment time indicated on the form must be no less than 30 minutes.
- Patients without one of these documents are considered illegally detained.
- The patient’s file must contain the original documents, even if transferred to another facility.

Once a schedule has been completed, at least two assessments must be recorded on a “Form 1” document:

- Usually, the first form 1 is completed by a registrar, the second by a consultant psychiatrist. The individual who writes the schedule cannot do a subsequent form 1 on the same patient.
- The first form 1 must be completed within 12 hours. The second form 1 can be completed “as soon as possible.” Every patient requires a consultant psychiatrist form 1.
- Patients detained as mentally disordered require registrar review every 24 hours and can be detained for up to three business days (weekends and public holidays excluded) from midnight of the day the consultant form 1 is completed. Roshni Rattan, Medico-Legal Coordinator, can be contacted for guidance on completing the appropriate documentation.
- See Appendix 1 for a guide to Mental Health Act documentation.

Mental Health Inquiry

- For assessable persons detained as “mentally ill” an Initial Mental Health Inquiry is held every second Friday. The registrar attends this MHI to give expert evidence regarding the presence of mental illness as defined by the Mental Health Act and the presence of risk. The MHI is then authorised to grant an involuntary patient order for a defined period of time.
• Registrars must prepare a report outlining these issues and the requested duration for an involuntary patient order. The report should be given to the legal secretary on the day prior to the MHI. A template for tribunal reports is available in Appendix 3.
• The content of the report can be similar to a discharge summary for time saving purposes. It is advised that technical language be avoided as the audience at the inquiry is primarily non-medical.

Mental Health Review

• When the initial involuntary patient order is due for review a 3 panel MHRT will review the consumer’s admission via videolink. A MHRT also takes place in cases of electroconvulsive therapy, community treatment orders and requests for discharge.
• Community treatment orders (CTO) can be requested as follows:
  o Request a treatment plan from the relevant community case manager.
  o Arrange a date for the CTO hearing via Roshni Rattan.
  o Complete a CTO report.
Examination Procedures under s27 Mental Health Act 2007

Prior to undertaking a medical examination under s27, the authorised medical officer needs to ensure that the person has been detained under one of the mechanisms outlined in s18, and needs to ensure that any relevant documentation relating to their detention has been completed. For more information on mechanisms for detaining persons under the Act see Section 6.1 of the Guidebook.

1st examination

- neither mentally ill nor mentally disordered
- mentally disordered
- mentally ill

2nd examination

- neither mentally ill nor mentally disordered
- mentally disordered
- mentally ill

3rd examination

- neither mentally ill nor mentally disordered
- mentally disordered
- mentally ill

- discharge or offer voluntary admission
- mental health inquiry
- discharge or offer voluntary admission
10. Consent for medical procedures and surgery

- Registrars should refer to the Mental Health Act Guide Book, section 13, for more in-depth guidance on managing consent in the acute inpatient setting.
- Voluntary patients who are not under guardianship can refuse medical or surgical interventions.
- Involuntary patients requiring medical or surgical intervention should be brought to the attention of the relevant consultant psychiatrist or on call consultant. It is helpful to identify the primary carer or guardian if one has been assigned prior to escalating the issue.
- If emergency or lifesaving surgical treatment is required and an involuntary patient refuses or is unable to give consent, this can be granted on the patient’s behalf by the treating or on-call consultant. The Director of Inpatient Services (if during business hours) should be consulted prior when this process has been initiated.
- Less urgent matters such as elective surgery for non-consenting involuntary patients require involvement with the patient’s primary carer and a written application to the Secretary of the Ministry of Health as per the Mental Health Act.
- Significant matters related to consent for medical/surgical procedures should be brought to the attention of the Director of Inpatient Services as early as possible.

**Consent for Surgery for Involuntary Patients (S100, S101)**

Surgical Operation is defined in the Mental Health Act, 2007 as: “a surgical procedure, a series of related surgical operations or surgical procedures, and the administration of an anaesthetic for the purpose of medical investigation.” Involuntary Patient includes a forensic or correctional patient. (NOTE: an assessable person who has not had a mental health inquiry IS NOT an involuntary patient under this section and consent may be required from the ‘person responsible’ or the Guardianship Division of NCAT).

1) Is the surgery considered by the clinical team to be an emergency? ie necessary to save the life of the patient or prevent serious damage to health or to prevent significant pain or distress (S99)

   If YES
   - An authorised medical officer or the Secretary of the Ministry of Health (or delegate) may consent to surgery in writing
     (The Authorised Medical Officer must notify the designated carer(s) and the principal care provider S78(7) and the MHRT S99(4) “as soon as practicable” after the performance of the surgery).

2) Is the patient considered (by Authorised Medical Officer) able to give informed consent in writing?

   If YES
   - Surgery can proceed - no MHRT hearing required (if the patient is under 14 yrs of age, then consent is required from a parent or guardian)

3) If not an emergency AND patient unable to give informed consent then mental health facility MUST:

   - Inform the designated carer IN WRITING and wait 14 days.
     "may proceed sooner if considered urgent or the designated carer indicates no objection to the surgery"  
     
   - Designated carer says NO
     OR agrees but won’t agree in writing OR does not respond OR is unsure OR there is NO designated carer (14 days doesn’t apply)

   - Authorised Medical Officer must apply to the Secretary of the Ministry of Health: Mental Health and Drug and Alcohol Office
     Tel: 9391 9953  Fax: 9391 9041

   - MHRT hearing S101
     Tribunal decides if the surgery is desirable, having regard to the interests of the patient S101. 14 day notice applies but may proceed sooner if urgent and designated carer does not object

(NOTE: This flowchart does not apply to Special Medical Treatment ie sterilisations BUT does apply to terminations of pregnancies)
11. Clozapine

Resources

Please see appendix 6 at the back for supporting information and forms.

- See the SLHD guidelines on Clozapine which outlines the whole process, side effects, concerns and medical work up necessary for clozapine treatment.
- There is also an excellent resource (Clozapine folder) on both level 3 and level 4 in the medication room outlining clozapine registration for new patients and all the forms you need to begin work up and for your own registration (give this to ward pharmacist after filling out).
- There are clozapine titration charts in both med chart rooms outlining the commencing doses for clozapine both in new patients and in patients who have had it before.
- The ward pharmacists are also a very helpful source of information if you have any questions.
- Clozapine registration
  - Registrars prescribing Clozapine need to be registered with both Clopine and Clozaril. Discuss this with the ward pharmacist.
- Commencing Clozapine
  - Every new patient commencing clozapine needs to be registered (Either with Clopine or Clozaril databases - PMBC uses Clopine usually). This involves the registrar discussing Clozapine with the patient, obtaining informed consent, signing the consent and privacy forms and filling out the registration forms. These can then be given to the ward pharmacist or faxed directly.
  - Necessary pre-commencement investigations
    - Baseline ECG
    - Chest x-ray
    - Echocardiogram
    - FBC, baseline Trop, CRP, Blood group
  - There is a specialist Haematologist (number in clozapine folder or through ward pharmacist) who can advise if any concerns regarding FBC/WCC and dyscrasia’s.
- Suspect Clozapine induced myocarditis
  - Troponin leak (rising) - beware troponin rise may lag behind clinical progression- urgent echo and bloods if any suspicion.
  - ECG changes
  - CRP rise
  - Chest pain

12. Taking leave – Annual/Study/ADO/Sick

- All leave should be coordinated with Dr Sundakov and the PMBC registrars (acute registrars + 1 x SSU + 1 x eating disorders).
- In general, leave is flexible and obtainable as long as there is appropriate cover. That is;
  - A specified registrar to cover your pager
  - At least 4 registrars/residents on the acute inpatient unit on any given day.
  - Cover for SSU/eating disorders is generally performed by the MAU duty registrar or reserve if required.
    - The SSU/Eating disorders registrar (in consultation with Dr Sundakov) must organise an acute inpatient registrar for cover of annual leave/night.
Generally the acute registrar with least patients/least busy during that week will be asked (unless someone volunteers).

- Leave Calendar Excel spreadsheet
  - Located in: File explorer → MPU-user folder → MPU G Drive → Medical → Leave Calendar --> Psychiatry registrar leave calendar.
  - Preferences
    - All night shifts and preferences for annual leave/ADO needs to be charted on this as soon as possible.
    - Just because a registrar puts their leave on the spreadsheet does NOT mean this is confirmed. Prior to putting annual leave in the calendar, please negotiate with Dr Sundakov and the other registrars via email chain. If there is no disagreement from other registrars and Dr Sundakov and there is appropriate cover then leave is confirmed.
  - All leave/ADOs/study leave needs to be communicated to Roshni Rattan for her pay sheets.
- Sick – if unwell during business hours, Roshni Rattan and Dr Sundakov (or the in charge consultant) need to be notified that morning.

13. Allied Health Support

Social Work at PMBC

There are 5 social workers in the PMBC team, 2 working in the Eating Disorder Unit and the Short Stay Unit and 3 in the HDU and Acute Units. The social workers are attached to multidisciplinary teams headed by a consultant psychiatrist. There is also a welfare officer who assists with Centrelink issues, banking and bill/rental payments. Social workers are trained in understanding family systems, organizations and groups as well as in techniques of counselling, advocacy and practical and psychological support. You can refer to social workers to:

- Counsel and liaise re domestic violence, sexual assault, child protection, grief and loss and traumatic events/crisises.
- Liaise with families/carers and carer organizations such as the Family Referral Service, Carer Assist and COPMI (Children of Parents with a Mental Illness).
- Access community resources like financial, legal and gambling services or support services such as Partners in Recovery, PHAMS (Personal Help and Mentors Service) and other NGO’S.
- Assist in discharge planning and exploring accommodation options such as crisis and supported accommodation, NSW Housing, residential aged care and boarding houses.
- Liaise re: medico-legal issues such as referrals to NSW Public Trustee and Guardian for guardianship and financial management orders and provide psychoeducation re the Mental Health Act and legal rights to patients/families.
MPU OCCUPATIONAL THERAPY REFERRALS

You can refer to an Occupational Therapist for the following:

- **Living Skills Assessments**
  - Rehabilitation referral (Broughton, Bloomfield, Kirkbride)
  - Appropriate placement
  - Recommend community supports
  - Referral to MATT team
  - Guardianship application

- **Cognitive Assessment**
  - Allen's Cognitive Level Screen to determine functional capacity

- **Self Care Assessment**
  - To assess showering, dressing, feeding, grooming etc.

- **Home Visits**
  - To assess independence level/need for supports
  - Assess and organise home modifications

- **Employment Services**
  - Linkage to a range of employment services
  - e.g. Disability employment service or assistance via Jobs in Jeopardy program

- **Education Options and Linkage**
  - Liaise with TAFE/ University on currently enrolled courses
  - Link to education support services
  - Explore future education options

- **Budgeting Assessment**
  - To determine need for Financial Management Order

- **Healthy Lifestyle Education**
  - Intervention on time management, healthy eating, sleep hygiene, activity planning, drug and alcohol relapse prevention, budgeting, basic living skills.

- **Recovery and Relapse Prevention Education**
  - Education on early warning signs and symptoms
  - Develop lifestyle strategies to manage symptomatic
  - Development of collaborative relapse prevention plans

- **Specialist Interventions**
  - Dialectical Behaviour Therapy (DBT)
  - Sensory interventions, self soothing, mindfulness
  - Stress management and relaxation strategies

- **Linkage to Social Support Services**
  - Linkage to HASI, PHAMs, Partners in Recovery etc.

- **Community Leisure and Recreational Referrals**
  - Linkage to activities or recreational programs in the community e.g. Buckingham House, Leichhardt Women's Health Centre.
Clinical Psychologists & Clinical Neuropsychologist at PMBC

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Email</th>
<th>Contact Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narelle Spinks</td>
<td>Clinical Psychologist – PBU/ Acute/ HDU</td>
<td>narelle.spinks@sswahs</td>
<td>X51457, 81223</td>
</tr>
<tr>
<td>Andrew Jones</td>
<td>Clinical Neuropsychologist – PBU/ Acute/ HDU</td>
<td>andrew.jones@sswahs</td>
<td>X51455, 80282</td>
</tr>
</tbody>
</table>

Clinical Psychologists
- Narelle (and Psychology Interns) see patients for psychological assessments and interventions, using evidence based therapies including CBT, ACT, DBT, etc.
- They also provide psycho-education on specific issues (such as the psychological management of insomnia), information on specific types of therapy and options for accessing psychological therapies in the community.
- How to refer: They accept verbal or written referrals from all staff (ie. medical, nursing, allied health), provided the patient’s Consultant and the patient are aware of the referral.

Clinical Neuropsychologist:
- Andrew sees patients for neuropsychological assessments. He will conduct a thorough assessment of the patient’s cognitive functioning (e.g. memory, executive functioning...) and provide a detailed report with background, results, summary of findings, and, where appropriate, recommendations, strategies and opinion as to what factors could be causing the person’s impairments.
- Assessments can serve many purposes. For example there may be concerns the person has cognitive deficits relevant to discharge planning, goal setting, decisions about what level of community services might be needed, etc. Assessments may aid diagnosis (e.g. is there a neurodegenerative illness? Alcohol related brain damage?), or support applications for guardianship/financial management, disability support services, aged care services, etc.
- How to refer: Contact Andrew to discuss the referral, and he will also send you a referral form to complete.

14. Metabolic clinic
- Metabolic screening of inpatients should include:
  - Weekly anthropometry – height, weight, waist circumference, BMI
  - Blood investigations – LFTs, TFTs, Fasting BSL, Lipids
  - Blood pressure
  - Documentation of smoking status
- Every Wednesday afternoon a Metabolic Clinic runs on the Acute Unit and the High Dependency Unit and is attended by Dr Tania Markovic (consultant endocrinologist), allocated psychiatry registrar and Dr Tanya Dus (consultant psychiatrist).
- This clinic is intended for the management of metabolic issues in the acute inpatient population. Referral criteria:
  - BMI >30
  - Metabolic concerns including:
    - Diabetic control.
    - raised prolactin or TFTs.
- Functions may include:
  - Dietetic, exercise, smoking cessation advice.
15. Support and referral services

- Transcultural mental health
  - A NSW Health service that provides culture specific MH services for clients including assessment, treatment information, culturally specific consultations
  - Referral - 98703767

- Drug and Alcohol referral
  - Fill out an online referral (under consult on eMR orders) and then call the D&A CNC (Emily Walker or Chat)
  - For D&A medical advice or assessment of withdrawal, fill out the online referral and call the D&A Registrar

- Children of Patients with Mental Illness (COPMI)
  - A NSW wide support service for these children and their parents.
  - Referral - 9816 0374

- Hospital2home
  - A 2 month post-discharge program aiming to assist the transition of mental health patients back home.
  - Referral - Discuss with OT

- Partners in recovery
  - Referral - Discuss with OT

- Aboriginal liaison service
  - An indigenous Australian specific inpatients service that assists in engagement with indigenous mental health consumers

16. Important numbers

- To page – 4#
- Switch – 91
- Sydney Healthcare Interpreting Service (phone and face 2 face) - 95150030
- Acute unit nurses station – 51530
- HDU nurses station – 51540
- Eating disorders nurses station- 51551
- Roshni Rattan - 51482
- MAU - 51500
- Ambulatory clinic - 51430
- Emergency Department Consultant in charge - 50000
- MH hotline 1800 011 511
- Lifeline 131114
- Transcultural MH service 1800648911 or 98703767
- Hepatitis CNC (For assessment for Hep C treatment) ext: 57440 pager:87174
- Child and Adolescent CNC (David Curley) 0409565451 or ext: 59938
- Perinatal CNC (Debbie Lewis) ext: 55873 pager 85645
- Drug and Alcohol CNC (Emily Walker and Chat) ext: 56281 pager 88036
- EIPS (Early Intervention Psychosis Service) 81222
- AMS (Aboriginal Medical Service) 93195823
- Indigenous Mental Health Liaison Officer RPA ext:59277 pager 88757
17. A note on stress:

Remember to look after yourselves and seek help to debrief if you feel you need to. This is a stressful busy job that is often underestimated by other medical professionals. To quote the oxford clinical handbook “it is a common misconception that “there are no real emergencies” in Psychiatry. The billowing white coat may have gone, but then so is the back up of the arrest team. Dealing with acute situations can feel like a lonely business and doubts about the best management of given situations may prevent you getting much needed rest” Make sure you debrief with your colleagues regularly, ask for help if you need it (The earlier the better!) and never be afraid to say you don’t know- mostly others don’t either! The consultants are always friendly and available and don’t be afraid to call in ICU or medical expertise if you need it- err on the side of caution, there is a reason why mental health patients die so much younger than the general population.

Good Luck! You have chosen a wonderful, rewarding career path and job and go forth and be an advocate- for all your patients and your Profession.
Initial Detention & s27 Examinations (Form 1's)

s19 - When a person may be detained in a mental health facility

PATHWAYS TO DETENTION:
A person may be detained in a declared mental health facility in the following circumstances:

s19 - on a medical certificate given by a medical practitioner or accredited person
s20 - after being brought to the facility by an ambulance officer
s22 - after being apprehended by a Police officer
s23 - on the order of a Magistrate or bail officer (S3 Mental Health (Mental Health Provisions Act)
s23 - on transfer from another health facility
s22 - on a written request made to the authorised medical officer by a primary care, relative or friend of the person or;
s18 - Reclassification from Voluntary status

Then:
Initial examination to be done by the Authorised Medical Officer (AMO) within the first 12 hours of detention (S27 form 1 examination)

s27(a) 1st Exam:
\[ \text{Mentally Ill} \]
\[ \text{Mentally Ill} \]
\[ \text{Disordered} \] Discharges or voluntary

s27(b) 2nd Exam:
\[ \text{Mentally Ill} \]
\[ \text{Mentally Ill} \]
\[ \text{Disordered} \]

s27(c) 3rd Exam (if req):
\[ \text{Mentally Ill} \]
\[ \text{Mentally Ill} \]
\[ \text{Disordered} \]

Legal Status:
Assessable Person s27(4)
Mentally Healthy Inquiry

Assessable Person s27(6)
Mentally Healthy Inquiry

Discharges or voluntary

At the end of the 6 day Detention, patient may not be discharged if the hospital wish to continue to detain after this, then must submit an voluntary or complete s38 schedule and 2 x new form 1s.
Appendix 2

Management of Medical Problems in Missendin Mental Health Service

Introduction

- The Missenden Mental Health Service (MMHS) is an inpatient service of Royal Prince Alfred Hospital, and is located in the Professor Marie Bashir Centre on the RPAH campus.
- All patients admitted to MMHS are hospital inpatients, and should have access to the same consultative and diagnostic services available to all other inpatient wards.
- Consultations by other medical or surgical staff will take place initially within the MMHS.
- Patients should not be sent to the Emergency Department except in extraordinary circumstances and only when the ED consultant has approved the transfer; (on duty ED consultant contact ext. 50000 from 08.00 – 24.00, or via the switch after midnight).
- The RPAH Clinical Emergency Response System (CERS) is used at MMHS.

Missenden Mental Health Service – Medically Ill Patients

In Hours (0830 – 1700 hours)

Medical problems (including self harm and overdoses) arising in MMHS will be dealt with in-hours by appropriate consultation with RPAH medical or surgical staff after initial assessment by the psychiatric registrar.

The Division of Medicine standard is that if consultation is sought the patient should be seen by a registrar within 24 hours. If a consultation is needed in a shorter time frame, this should be requested with an appropriate reason.

Minor trauma (e.g. requiring X-rays or suturing) should be assessed by the psychiatric registrar in MMHS and further care arranged from the Service.

After hours – 1700-0830 – RMO Cover

Cover for medical problems requiring attention after hours for MMHS inpatients, will be provided in the first instance by the RPAH RMO on call. This is only for problems requiring attention before the next working day. This cover is for the assessment and management of medical problems only. All psychiatric or other management issues, including the re-writing of medication charts, should be referred to the on-call psychiatric registrar.

Nursing staff should contact the RMO or intern covering the MMHS via the switch and also notify the on call psychiatric registrar of the call.

Please give the doctor a clear explanation of how to enter the PMBC and where to locate the patient.

Staff providing medical consultations should check with the nurse in charge to be advised about relevant safety issues.

Missenden Short Stay Unit (MSSU)

In-Hours

Medical problems in MSSU should be assessed by the psychiatry registrar who will then notify the Drug Health and psychiatry consultants.

Urgent or serious medical problems – See Medical Emergencies below

After - Hours

For after hours medical problems the RMO covering the Missenden Mental Health Service will be called and the psychiatry registrar will be jointly notified. The drug health consultant must be notified of any medical deterioration in a patient’s condition. The psychiatrist on call must be notified of the transfer of any involuntary patient.

Missenden Assessment Unit (MAU)

Medical assessment of patients in MAU should initially involve the assessing psychiatric registrar. Although under the care of psychiatry, at this point patients are not inpatients of MMHS. Consequently
medical problems that are considered to preclude the completion of the psychiatric assessment or admission may need to be referred to the Emergency Department but this should occur only after discussion between the assessing registrar and the ED staff specialist (ext. 50000). It should be made clear during this discussion that the patient is not a MMHS inpatient.

If such patients are under the Mental Health Act they should be considered as “transfers” for the purpose of continuity of psychiatric care and their status under the Mental Health Act as voluntary or involuntary clarified for ED staff. The MMHS Superintendent (after hours the on call consultant) should be notified of the transfer of all involuntary patients.

Consultation for patients with complex medical problems
- If the patient clearly fits a particular specialty, consultation should continue to be sought from that specialty.
- Dr Adrian Gillin has agreed to negotiate access to appropriate care if difficulty is experienced obtaining medical care for inpatients of MMHS because of multiple pathology, or failure of a particular specialty to accept responsibility for the medical care of the patient. If such circumstances arise Dr Gillin should be contacted directly by the treating psychiatric registrar or consultant.
- If Dr Gillin is on leave, this role will be undertaken by Professor Paul Haber.

Management of Medical Emergencies (All Wards in MMHS)
1. The RPAH Clinical Emergency Response System should be called by dialling 222, (in and out of hours). The appropriate Clinical Emergency Response should be decided according to the clinical condition of the patient. The response hierarchy is as follows:

   i. Clinical Review – (medical review required within 30 minutes)
      In hours the MMHS Admitting Officer with CERS pager No. 81595
      After hours – Psychiatry Registrar on-call with CERS pager no. 81596.

   ii. ICU Assist – (medical review required within 10 minutes) ICU Medical / Nursing Response
   iii. Cardiac Arrest – (review / assistance required Immediately) Cardiac Arrest Team Response

2. Patients requiring transfer to the main hospital should preferentially be transferred to the appropriate inpatient ward directly from MMHS as organised by the accepting team via the RPAH bed manager.
3. Critically unwell or intubated patients should go directly to ICU / HDU as appropriate (or as directed by the medical response team).
4. Moderate to major trauma should be transferred to ED for trauma team evaluation, after appropriate negotiation with ED or between medical and ED Staff.
5. Patient flow / Bed management must prioritise the provision of acute hospital beds for MMHS patients who require transfer.
6. When there is a delay in finding an appropriate ward bed in the main hospital and this has the potential to impact on patient care, a consultant to consultant discussion between the accepting team, ICU and ED should occur to determine the most appropriate interim destination for the patient.
7. Patients will be transferred back to MMHS when medically stable and priority should be given to making a bed available. The planning for this transfer should begin immediately by collaboration between medical and psychiatric teams.

Dr Viktoria Sundakov
Acting Director of In-patient at PMBC

Dr Tamsin Waterhouse
Director of Medical Services, RPAH

July 2016
MENTAL HEALTH INQUIRY TRIBUNAL

Patient: xxxxxxxxxxxxxxx DOB: xxxxxxx MRN: xxxxxxxxx

Diagnosis:

Medications:

Request: Involuntary inpatient order for .. weeks

Background

Presenting complaint

Progress during admission

Risks

Impression and Recommendation

Thank you for your consideration of this application.

Regards,

Dr (Registrar)
Psychiatry Registrar for Dr (Consultant Psychiatrist)

Please note that this report is confidential and contains information that may cause distress to the patient. It should therefore not be shared with the patient without the express permission of the writer.
# Appendix 4

## CHOC DOCUMENTATION – Which Powernote or Powerform When?

<table>
<thead>
<tr>
<th>Point of Care</th>
<th>Documents to be Completed</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment (Inpatient or Community)</strong></td>
<td>MH Current Assessment</td>
<td>This is the default form on which the assessment is to be documented for patients presenting to Missenden Assessment Unit and CCMH Admission Office in most circumstances.</td>
</tr>
<tr>
<td></td>
<td>MH SLHD Inpatient Admission Review</td>
<td>If a patient presents for assessment and has had a MH Current Assessment completed in the last 72 hours, the assessing doctor has the choice of completing the pre-completed MH Review instead titled the note “MH SLHD Inpatient Admission Review” – this must contain a Mental State Examination.</td>
</tr>
<tr>
<td></td>
<td>MH Past History</td>
<td>If patient does not have a pre-existing MH Past History, a new MH Past History is to be created. If the patient already has a MH Past History form in the eMR, the original form is to be reviewed and updated as appropriate using ‘Correct note’ and not ‘modify note’. A new MH Past History should not be created. If the patient is to be admitted and it is not possible to complete these documents at time of assessment, the treating inpatient medical team should complete them within 2 working days of admission.</td>
</tr>
<tr>
<td></td>
<td>MH Physical Exam</td>
<td>If not possible to complete during admission process, to be completed within 2 working days of admission.</td>
</tr>
<tr>
<td></td>
<td>Domestic Violence Screen</td>
<td>For all female patients 16 years and over. If not completed on assessment, should be completed within 2 working days of admission by treating team.</td>
</tr>
<tr>
<td><strong>Assessment (ED)</strong></td>
<td>MH Current Assessment</td>
<td>Trainee psychiatrists seeing a patient referred by ED Medical Staff or ED MHLN (who will have completed an MH Triage) are responsible for completing the MH Current Assessment for all patients requiring admission or referral/notification to Community MH.</td>
</tr>
<tr>
<td></td>
<td>MH Triage</td>
<td>If a patient is judged not to require admission or referral/notification to Community MH, MHTAL or other MH service, the trainee may complete a MH Triage form in place of the Assessment Form. If a MH Triage has already been completed by an ED MHLN, and the patient does not require admission or referral to Community MH, the trainee can document their assessment in a MH Progress Note.</td>
</tr>
<tr>
<td></td>
<td>MH Past History</td>
<td>If a patient requires admission or referral to Community MH or another MH service, every effort should be made to complete or update a MH Past History Form in addition to the Assessment form.</td>
</tr>
<tr>
<td></td>
<td>MH Client Contact Form</td>
<td>Every patient seen or consulted on by a Trainee Psychiatrist in ED should have a Client Contact Form completed as below: Principle Reason for service contact: Consultation to a non-MH service unit Team responsible for service contact: [Facility] Consultation Liaison Psychiatry Service contact location type: Inpatient Health Care Setting Service delivery location: RPA Emergency/Concord Flows/Castlebar Flows.</td>
</tr>
<tr>
<td></td>
<td>HONOS- Admission</td>
<td>To be completed on or within 2 working days of admission.</td>
</tr>
</tbody>
</table>
**CHOC DOCUMENTATION – Which Powernote or Powerform When?**

<table>
<thead>
<tr>
<th>Review (ED)</th>
<th>MH Progress Note</th>
<th>Once a MH Current Assessment form has been completed for the current ED presentation the MH Progress Note can be used to document subsequent reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment or Review (General Wards or Clinics)</td>
<td>Paper or Electronic file entries</td>
<td>Enter into the medical record modality of the hosting ward or clinic, i.e., paper or electronic</td>
</tr>
<tr>
<td>MH Client Contact Form</td>
<td>To be completed both in hours by Consultation Liaison teams and out of hours by on call trainee as below: Principle Reason for service contact: Consultation to a non-MH service unit Team responsible for service contact: [Facility] Consultation Liaison Psychiatry Service Contact: location type: Inpatient Health Care Setting Service delivery location: Royal Prince Alfred / Concord / Canterbury Hospital</td>
<td></td>
</tr>
<tr>
<td>Ward Round / MDT review</td>
<td>MH Review</td>
<td>Each section should be completed</td>
</tr>
<tr>
<td></td>
<td>MH Category Level and Leave Approval</td>
<td>Leave approval is now documented on this separate powernote rather than being recorded on a pre-completed progress note</td>
</tr>
<tr>
<td>Medical Review (inpatient)</td>
<td>MH Progress Note</td>
<td>You should continue to complete rating scales and outcome measures already within eMR relevant to the patient’s episode of care</td>
</tr>
<tr>
<td>Medical Review (community)</td>
<td>MH Progress Note</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MH GP Letter Brief</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MH Client Contact Form</td>
<td></td>
</tr>
<tr>
<td>Discharge</td>
<td>MH Discharge/ Transfer of Care</td>
<td>This is to be completed as close to point of discharge as possible, preferably on the same day. Information regarding discharge medication and follow up arrangements are essential for post discharge follow up in the community. Discharge summaries can be prepared in advance and signed off by the assigned trainee or in their absence on leave by the covering trainee on the day of discharge – ‘In Progress’ discharge summaries are now viewable within the powernote and clinical note screens. See separate how-to document. Please refer to separate document outlining sign-off and endorsement processes</td>
</tr>
<tr>
<td></td>
<td>HONOS- Discharge</td>
<td>Must be completed prior to patient being discharged from inpatient episode of care</td>
</tr>
</tbody>
</table>

**Where to record and look for information regarding risk**

- There is no stand-alone ‘risk’ document within eMR – i.e., there is no electronic equivalent of the Risk Module
- Powernotes corresponding to landmark points in clinical pathway, i.e., Triage, Assessment, Review and Discharge, each contain a section where Risk Assessment is to be documented
- Each of these Powernotes also contains an ‘Action Plan’ or ‘Discharge Plan’ section where Risk Management is to be documented
- Changes in risk profile or risk management occurring between these landmark points and within the course of clinical care are to be documented in a MH Progress Note
REGISTRATION FORM FOR MEDICAL OFFICERS

All sections of this form must be completed

By prescribing Clopine® I intend to participate in ClopineConnect® and the ClopineConnect® Protocol.

I agree to abide by the obligations of a Medical Officer as described in the ClopineConnect® Protocol and I agree that, notwithstanding these obligations, I remain solely responsible for the management of patients for whom I prescribe Clopine®.

PRESCRIBING REMINDERS

1. Only patients who are registered with ClopineConnect® may be prescribed Clopine®.

2. For the first 16 weeks of treatment, no more than one weeks supply of Clopine® may be prescribed at once. After 16 weeks, no more than 28 days supply may be prescribed. The patient's haematological profile must be assessed before each prescription for Clopine® is written.

3. A WBC and Neutrophil count no more than 48 hours old must accompany each prescription for Clopine®.

* indicates areas that must be completed before form may be submitted

MEDICAL OFFICER

*FIRST NAME:

*SURNAME:

CLOPINE® CENTRE:

* DO YOU WISH TO BE REGISTERED WITH OTHER CLOPINE® CENTRES WITHIN YOUR AREA HEALTH SERVICE? YES / NO (Please code)

*PRACTICE NAME:

*PRACTICE ADDRESS:

*STATE: *POSTCODE:

*PHONE: *FAX:

MOBILE PHONE NUMBER: PAGER:

EMAIL ADDRESS:

□ General Practitioner □ Consultant □ Registrar □ Other

Expected dates of service at this location:

Note: To be registered with ClopineConnect®, this completed form must be faxed to ClopineConnect® on 1800 637 414. Registration will be confirmed by email. ClopineConnect® Phone: 1800 654 003. Requests for access to your own personal information held for registration purposes may also be directed to ClopineConnect®.
Mental Health Services

CONSENT FORM: CLOZAPINE

I, ......................................... agree that I have had the benefits and risks of clozapine therapy explained to me by Dr ............................

I have received the patient information brochure on clozapine and have had an opportunity to discuss any questions I may have in relation to commencing on clozapine.

I understand that clozapine therapy requires blood tests to check and prevent side effects."

I understand that clozapine therapy requires that my blood test results are recorded and checked on the clozapine monitoring system.

I consent to provide the following information to the clozapine monitoring system: my initials, age, sex, blood group, the results of my blood tests and the dose of my clozapine.

Name of patient: ............................

Signature of patient: ............................ Date:

Name of doctor: ............................ Date:

Signature of doctor: ............................

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REGISTRATION FORM FOR NEW PATIENTS

Patient registrations can also be submitted online (www.clopine.com.au) by the Centre Co-ordinator or Medical Officer.

Clopine* therapy must not be commenced until ClopineConnect™ has approved this registration and a Clopine® Patient Number is generated.

*Indicates areas that must be completed before this form may be submitted

<table>
<thead>
<tr>
<th>*PATIENT INITIALS:</th>
<th>*DATE OF BIRTH:</th>
<th>/</th>
<th>/</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>*BLOOD GROUP:</th>
<th>*SEX:</th>
<th>WEIGHT:</th>
<th>KG</th>
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</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>*1. HAS THE PATIENT EVER HAD AN EPISODE OF DRUG-INDUCED NEUTROPENIA?</th>
<th>YES ☐ / NO ☐</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>*2. HAS THE PATIENT EVER HAD A BONE MARROW DISORDER?</th>
<th>YES ☐ / NO ☐</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>*3. HAS THE PATIENT AGREED AND SIGNED THE PRIVACY STATEMENT?</th>
<th>YES ☐ / NO ☐</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>4. DOES THE PATIENT HAVE A FAMILY HISTORY OF SCHIZOPHRENIA?</th>
<th>YES ☐ / NO ☐</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>5. DOES THE PATIENT HAVE DIABETES?</th>
<th>YES ☐ / NO ☐</th>
</tr>
</thead>
</table>

If the answer is 'yes' to either question 1 and/or 2, do not initiate Clopine® (clozapine) therapy in this patient.

<table>
<thead>
<tr>
<th>*DATE OF PRE-TREATMENT BLOOD TEST:</th>
<th>/</th>
<th>/</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><em>WHITE BLOOD CELL COUNT</em>:</th>
<th>x 10⁹/L</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><em>NEUTROPHIL COUNT</em>:</th>
<th>x 10⁹/L</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>

*The results for the pre-treatment WBC/neutrophil count must be from a blood sample collected within 10 days of the date of treatment initiation.

<table>
<thead>
<tr>
<th>*CLOPIN® CENTRE:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>*MEDICAL OFFICER NAME:</th>
<th></th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>CENTRE CO-ORDINATOR NAME:</th>
<th></th>
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</table>

<table>
<thead>
<tr>
<th>*NAME OF PERSON COMPLETING FORM:</th>
<th></th>
</tr>
</thead>
</table>

(Preferred Print Name)

Please fax to ClopineConnect™ - 88853400

Note: This form must be faxed to ClopineConnect™ on 1800 637 414, emailed to clopineconnect@clopine.com or submitted online (www.clopine.com.au). Registration will be confirmed by email. ClopineConnect™ (Phone: 1800 637 414).
CLOPINE® (clozapine) BLOOD COUNT RECORD FORM

* Indicates areas that must be completed before this form may be submitted.

This form is for recording the patient's WBC and neutrophil count at commencement of Clopine® therapy, during treatment and after discontinuation of therapy.

Each prescription for Clopine® must be accompanied by a WBC and Neutrophil Count no more than 48 hours old. Unless a current WBC and neutrophil count has been performed and assessed as satisfactory, the next prescription for Clopine® cannot be dispensed.

PATIENT STATUS (Tick appropriate box)

☐ ON TREATMENT
☐ DISCONTINUED

DATE DISCONTINUED: / /

☐ TERMINATION OF TREATMENT FORM COMPLETED? YES/NO (please circle)

COMMENCEMENT DATE: / /

(Please Print All Details)

*PATIENT INITIALS/Clopine® PATIENT NUMBER:

*DATE BLOOD TAKEN: / /

WEIGHT: ___________________________ kg

*WBC COUNT: ___________________________ x 10^9/L

*NEUTROPHIL COUNT: ___________________________ x 10^9/L

*PRESCRIBED CLOPINE® DOSAGE: ___________________________ mg/DAY

*CENTRE:

*MEDICAL OFFICER NAME:

*MEDICAL OFFICER SIGNATURE:

*PHARMACIST NAME:

*PHARMACIST SIGNATURE:

PRESCRIPTION FILED? YES ☐ / NO ☐ DATE: / /

Note: This form must be returned/faxed to the Centre Coordinator for entry into the ClopineConnect® database.

ClopineConnect® Fax: 1800 657 434.
ClopineConnect® Phone: 1800 658 403.
<table>
<thead>
<tr>
<th>Prescription Form</th>
<th>Controlled Substance</th>
<th>Date of Prescription</th>
<th>Prescriber</th>
<th>Dose (mg)</th>
<th>Route</th>
<th>Frequency</th>
<th>Duration</th>
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<td>PMBC Acute Inpatient Psychiatry Registrar's Manual</td>
<td>45</td>
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**PMBC Acute Inpatient Psychiatry Registrar's Manual**

Acute Inpatient Psychiatry Registrar's Manual

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**CLONINE (Clozapine) Monitoring System Project Statement**

The PMBC Acute Inpatient Psychiatry Registrar's Manual is provided for educational and informational purposes only. It is not a substitute for professional medical advice, diagnosis, or treatment. In order to ensure the most accurate information, consult with a qualified healthcare provider.
CLOPINE (clonazine) Monitoring System Project Statement

Objectives:

- To establish a monitoring system for patients receiving clonazine to ensure safe and effective treatment.
- To track adverse effects and monitor for potential drug interactions.
- To provide regular reviews of patient progress and adjust treatment as necessary.

Methods:

- Implement a centralized database for recording all doses administered.
- Train all staff on the proper use of clonazine and its monitoring.
- Regularly review patient records for compliance and effectiveness.

Expected Outcomes:

- Reduction in adverse events related to clonazine use.
- Increased patient satisfaction with treatment.
- Improved overall treatment outcomes due to better management of medication.

Implementation:

- Launch the monitoring system at the beginning of the next quarter.
- Conduct a pilot phase with a select group of patients to assess feasibility.
- Roll out the system to all patients receiving clonazine within the following month.

Evaluation:

- Conduct post-implementation audits to measure success.
- Monitor patient outcomes before and after implementation of the system.
- Adjust the system as necessary based on feedback and performance metrics.

Financed by [grant agency name] through funding support [grant number].