Policy Directive

Specialling Patients in the Emergency Care Setting

Document No: SLHD_PD2015_004

Functional sub-Group: Clinical Governance

Summary: This policy provides a comprehensive and systematic approach to care provision of at risk patients whom require a higher level of supervision in the Emergency Department (ED) setting. The policy also outlines the expectations required of staff to deliver care, and provide measures of good practice that reduce the risk of the patient absconding.

Approved By: Director, Clinical Governance and Risk, SLHD

Consultation: Director of Nursing and Midwifery, SLHD
Emergency Department Managers

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Note: Sydney Local Health District* (SLHD) was established on 1 July 2011 following amendments to the Health Services Act 1997 which included renaming the former Sydney Local Health Network (SLHN). The former SLHN was established 1 January 2011, with the dissolution of the former Sydney South West Area Health Service (SSWAHS).
Specialling Patients in the Emergency Care Setting

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Endorsed by: Director Nursing and Midwifery, SLHD
1. Introduction

The aim of this policy is to provide a comprehensive and systematic approach to care provision of at risk patients who require a higher level of supervision in the Emergency Department (ED) setting. This is to ensure that the appropriate level of care is provided and strategies implemented when a patient has been recognised “at risk”. This policy considers the specific environment of the Emergency Department (ED) and is in addition to the Sydney Local Heath District Policy (SLHN_PD2011_011).

1.1 The Risks Addressed by this Policy

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1.2 The Aims / Expected Outcome of this Policy

- Early identification and assessment of patients at risk and the requirements of ongoing assessment established
- An understanding of the role and responsibilities for the ED staff when a patient has been identified as at risk
- Risk is assessed in collaboration with nursing and medical staff and the on going risk management strategies documented in the patient’s medical records

2. Policy Statement

Patients in the ED requiring high levels of observation and supervision must have care provided by a staff member with appropriate knowledge and skills. This policy clarifies the ongoing patient assessment and the responsibilities of the members of the ED team to ensure the immediate needs and safety of the patient are met to minimize the risk of absconding and harm to self and others.

3. Principles

In the ED one-to-one observation or the provision of a ‘Nurse Special’ is utilised for patients who have been recognised as at risk due to their mental or cognitive status and to whom the ED and the organisation have a “duty of care”.

- Patients, staff and the general public are entitled to be protected from harm or injury in all settings. Patients presenting with behavioral disturbance may pose a safety risk to themselves and others. These patients may be deemed as “at risk” however the cause may arise from underlying physiological (e.g. head injury, malignancy) or mental health
(e.g. acute psychotic state) problem, or from an intoxication (e.g. alcohol or amphetamines). Regardless of the cause if the patient is “at risk” their immediate safety and the safety of others is the priority, this may require the use of a Nurse Special.

The recognition of a patient’s need for a Nurse Special can occur as soon as the patient is triaged, however can occur at any time during the patient’s episode of care. Clear guidelines and the Emergency Department Mental Health and Delirium Risk Assessment (Appendix 1) have been designed for Emergency staff to assist them in identifying and monitoring patients at risk. The risk assessment allows for focused patient care and ongoing care which is reflective of the patient’s changing needs.

The levels of observation are clearly defined in the policy ‘SLHN Observation of Patients at Risk (Specialled) in Acute, Sub-Acute and Rehabilitation Care Setting Policy’ SLHN_PD2011_011. The ED Risk Assessment Form is in line with these levels of observation and the level of patient supervision should be reflective of the level of risk assessed.

As identified in the SLHN Observation of Patients at Risk (Specialled) in Acute, Sub-Acute and Rehabilitation Care Setting Policy (SLHN_PD2011_011), when a decision has been made to allocate a nurse special, there is a medico-legal requirement, obligation and responsibility to provide a nurse special irrespective of other demands (i.e. staff must be allocated within the available resources until such a time that additional resources are able to be made available when required).

Where a patient leaves the ED without permission or clearance, staff are to follow the ‘protocol for patients potentially at risk who leave prior to formal disposition’ (Appendix 3).

4. Guidelines

4.1 Determining the Need for a Nurse Special

The level of concern about a patient’s safety and health status are the key factors in determining the need for a Nurse Special, and may be influenced by the patient’s legal status or presenting circumstances. The decision to implement a Nurse Special will be influenced by assessment of the following potential risk factors:

- The severity of the patient’s condition.
- The patient’s level of orientation, awareness and cooperation.
- The patient’s expressed willingness or unwillingness to remain for care and treatment
- The patient’s degree of impulsivity and level of distress.
- The presence of self harm or active suicidal ideation.
- Any other factors which may impact on the patient’s mental state (e.g. intoxication).
- A Schedule

Under the Mental Health Act the need for a Special is determined by nursing and medical staff in consultation with other relevant specialty teams. The decision to Special a patient should be discussed with the Staff Specialist or equivalent / Registrar and NUM/IC.
A Nurse Special might also be indicated in circumstances where:

- There is evidence to indicate that the patient is at *imminent* risk to his or her own safety (e.g. falls, self harm, wandering, absconding).
- The patient is agitated, distressed or suffering from delirium.
- There is an alert flag on Cerner indicating that the patient is an “at risk patient” due to a mental health problem or a risk of absconding.
- There is a significant risk that the patient will abscond from the clinical area.
- The patient, for whatever reason, is unable / unwilling to cooperate with necessary medical treatment.
- It is agreed that the patient requires additional supervision to ensure safety for the patient, staff or members of the community.
- Patients who are under the age of 16 years who present with behavioral disturbances require special consideration due to their increased vulnerability. (Policy number MH_PD2012_047).
- There is no alternative / less restrictive form of care available.

### 4.2 Role and Responsibilities of the Triage Nurse

Risk assessment for all patients who present to the ED starts with the Triage Nurse. Accurate mental health triage is essential for the safe and effective delivery of mental health care in the ED. The triage of any patients presenting to an ED with mental health problems should include or consider the following:

- Urgency – using the mental health/behavioral indicators of the Australasian Triage Scale
- Initial risk assessment
- Observation/supervision level that the patient requires at presentation.
- The triage category of patients who have been assessed at risk due to their mental or cognitive state must be reflective of their level of risk. Patients who may need to be triaged category 2 or above to ensure early senior medical assessment for appropriate supervision and management may include:
  - Patients who have been scheduled by police or the ambulance service. This also ensures that schedules that are not required can be lifted.
  - Patients who are at risk of harming themselves or others

The triage nurse must also triage the patient to an appropriate area within the ED appropriate for the patient’s needs. This will be dependent on each department’s available resources and internal plan. However this should be consistent with the level risk according to the Emergency Department Mental Health and Delirium Risk Assessment (Refer to Appendix 1).
4.3 Role and Responsibilities of the ED Nurse Manager (NM) / Nursing Unit Manager (NUM)/ In Charge of Shift Nurse (IC)

The ED NUM/IC nurse must liaise closely with members of the ED team involved in the care of the patient to ensure the individual assessment and needs of the patient are met.

It is the responsibility of the NUM/IC nurse to request extra staffing for the patient requiring a Nurse Special if it is not possible to facilitate this within existing staffing levels. The NUM and Team Leader must document clearly in the patient’s notes that this has been requested.

Before implementing a nurse special the following points should be considered:

- Clinical indications and risk factors
- Contra-indications
- Safety of staff
- Medico-legal issues such as the Mental Health Act, Guardianship Act and duty of care
- Staffing characteristics related to experience, attitude, teamwork, support and scope of practice
- Cultural and any other special needs
- Documented strategies and interventions for the management of difficult behavior has occurred

If additional staff are not immediately available, the ED NM/NUM/IC will be required to redeploy a member within the ED team to ensure the patient’s safety. This will be in consideration of skill mix and relevant level clinical competency required to provide safe and effective observation of the patient at risk.

Ideally the nurse(s) specialling the patient has experience dealing with patients who have diminished capacity and have had the appropriate training to support them in this role.

Liaise with Security where required about the patient and contact them if the patient attempts to leave (NB: it is not the responsibility of Security staff to special patients, only to assist if required).

Depending on the type of patient, it may be advisable to consider:

- Where there are multiple patients requiring specialing the NM/NUM/IC nurse must consider cohorting patients where appropriate and safe to do so
- Rotating the role amongst a number of nurses (rather than one nurse for the entire shift)
- Using female nursing staff if appropriate or male nursing staff if appropriate
- The use of Aboriginal Liaison Officers or the Interpreter Service where required

The need for a Nurse Special should be routinely reviewed with any changes updated in the progress notes.

The NM/NUM/IC needs to facilitate the urgent transfer of patients who cannot be managed at the presenting facility or when an in-patient bed is made available.
If the patient who has been assessed as at risk is going to be admitted to an inpatient facility however a bed is not available the ongoing Nurse Special must be continued. (NB. If there is an extended delay for an in-patient bed, an internal escalation to hospital executive should occur).

4.4 Role and responsibilities of the Medical Team

If a patient has been identified as a Level 1 risk of absconding on the Risk assessment form, it is the responsibility of the Staff Specialist or ED Registrar to review the patient as soon as practical or allocate an appropriate senior Medical Officer / Mental Health Nurse Practitioner (MHNP)/ Mental Health Clinical Nurse Specialist (MHCNS) who has the necessary skill set to do so.

The treating Medical Officer, in discussion with the Senior Medical Officer on duty must document the justification for a nurse special in the patient’s notes. The focus of the documentation should be on patient and staff safety.

Wherever practicable, the Medical Officer and / or nurse will explain to the patient (and / or carer) the reason for the Nurse Special. It is common for patients to be apprehensive and / or annoyed about such a restriction. In such a case, discussion with the patient should focus on safety issues and treatment aims.

The extent, to which the patient feels directly involved with their care and has the opportunity to influence decisions made, has a direct impact on the patient’s experience, confidence and satisfaction and compliance. The patient should be informed about their plan for care and have the opportunity to discuss their concerns.

There should also be discussion with the relevant family / carers or nominated contact person.

For patients being detained under the Mental Health Act, it is obligatory that they are provided with information on their legal rights under the Act by the treating medical officer.

The Staff Specialist or Registrar should expedite any required psychiatric review as far as possible. Where the patient requires admission, this should be done as soon as possible to ensure patient safety.

4.5 Role and Responsibilities of the Supervising Registered Nurse (RN)

The RN who is working in the area that the patient has been allocated to within ED is responsible for the patient’s care and overall management requirements. These include:

- Vital sign monitoring
- Administration of medications
- Contemporaneous shift documentation
- Documentation of the patient’s appearance and clothing in the notes and identification of the patient to other relevant staff members both on current and following shifts.
- Completion of the Emergency Department Mental Health and Delirium Risk Assessment (Refer to Appendix 1) and ensuring the Nurse Special is familiar with the form and its requirements particularly in regards to escalation if the patient’s risk has increased.
• Where behaviour and risk has changed, ongoing assessment of the patient’s needs is attended in order to minimise their agitation and ensure their comfort.

• Considering the use of gowns verses own clothing which may deter patients from leaving. However if wearing a gown increases agitation, consideration should be given to avoid the use of a gown.

• The supervision, guidance and support of the allocated Nurse Special with an understanding of their capabilities and scope of practice. This includes orientation of the Nurse Special to the area, including their familiarization with relevant documents, policies and tools. and ensure that they have read the document on Nurse Specials within the Emergency Department (Refer to Appendix 4).

• Ensuring that the Nurse Special is allocated a meal break and is relieved as appropriate.

• Providing the Nurse Special with a full report of the patient’s condition at the commencement of duty and informing them of any changes or updates to the management plan as they occur, as well as updating the NUM/IC nurse.

4.6 Role and Responsibilities of the Nurse allocated to provide observation (Refer to Appendix 4)

At the commencement of duty the Nurse Special must receive a full clinical handover of the patient and any special considerations i.e. keeping the patient strictly at arms length or alternatively allowing the patient greater personal space.

The nurse special is to stay with the patient at all times or in the direct vicinity of the patient, this includes when the patient is being assessed by medical or allied health practitioners.

The Nurse Special must wear a personal duress where available or know where the local duress systems are in departments.

Where the Nurse Special needs to leave the area in which they are allocated with the patient, they must notify the supervising RN or NUM/IC.

The Nurse Special should not leave the ED alone with the patient. If the patient requests a cigarette, a discussion with the supervising RN or NM/NUM/IC needs to occur so that another appropriate staff member may also attend where required (N.B. this may be a Security Officer).

Attend and document regular checks using the Emergency Department Mental Health and Delirium Risk Assessment (Refer to Appendix 1) and inform the supervising RN or NUM/IC of any change in behaviour, condition or risk.

Nurses caring for patients who are specialled must ensure that they make a contemporaneous entry in the progress notes. This entry should detail the nurse’s observations of the patient’s mental state, behaviour and attitude utilising the Risk Assessment Tool and Management Flow Chart (Refer to Appendices 1 & 2). Any other pertinent medical information and interactions with the patient should also be documented.
4.7 The Role of Security

Close communication between the NM[NUM/IC and security is vital. Security should receive a verbal report regarding any patient who is at risk of absconding and a plan of escalation is discussed including any potential risks for patient or staff.

If security officers are required to assist in the management, care or assisted observation, they do so under the direction of the Medical or Nursing Team Leader. The following points should be considered when security personnel are involved:

- Their scope of practice does NOT extend to specialling
- Security should NOT be left alone to supervise the patient- including going out for a cigarette
- Their role is to protect patients, staff and property
- If physical or chemical restraint is required for the safety of the patient and staff, security staff maybe requested to assist. This is done under a “Duty of Care” according to the clinician’s judgment, if security staff are requested to assist it is as health employees.

4.8 Additional Safety Considerations

- Staff must carry or have access to fixed or personal duress alarms at all times or have a mechanism for calling for immediate assistance.
- Staff should ensure that they are able to exit the room quickly and easily if necessary.
- If the room does not have more than one exit then the staff member should ensure that they are never in a position where the patient is between them and the exit.
- Nurses allocated to patients must ensure that other staff know their whereabouts at all times.
- Taking the patient out of the department must be prearranged with the treating Team and documented in the notes as part of the management of the patient.
- Staff should never attempt to restrain patients by themselves. Where the need for restraints has been identified and the patient has been assessed as requiring physical restraints, staff should seek the assistance of other trained staff to apply the restraints to avoid risk of harm to themselves, the patient and others.

4.9 What to do if the patient absconds

- Patients may abscond at a number of points in their ED stay. Being detained under the Mental Health Act or delay to admission can trigger compulsion to leave the ED.
- Recognising that patients may abscond, despite best practice, staff must take every measure to ensure the patient’s safe and timely location and return. Staff should:
  - Notify the Medical Team immediately
  - Perform a full search of the immediate areas, including the public toilets
  - Contact the patient or identified contact person where possible.
5. Performance Measures

- The numbers of patients that have absconded form the Emergency Department over a 6 month period.
- Audit of Risk Assessment forms to ascertain if patients that had Risk Assessment forms were managed appropriately and whether they absconded.
- The number of Nurse Special requests approved over a 6 month period.

6. Definitions

**Nurse Special**: A nurse who is requested by the NUM/IC or Medical Officer to provide visual supervision or observation either one-to-one or depending on degree of patient risk, a small cohort of patients.

7. Consultation

This policy was developed by the members of the ‘Review of Mental Health Patients’ Working Party, including the Director Nursing and Midwifery Services SLHD; Respiratory and Critical Care Clinical Manager SLHD; Nurse Manager Clinical Practice SLHD, ED NM[NUMs and CNCs; and SLHD ED Mental Health NP/CNC. This was also developed in consultation with Facility Directors of Nursing and Midwifery, RPAH, CRGH and TCH; The Clinical Governance Unit SLHD and ED Directors SLHD.

8. References and Links


RPAH- Speciallling Patients in the Emergency Department. RPAH PD2009_046

Observation of Patients at Risk (Specialled) in Acute, Sub-Acute and Rehabilitation Care Setting Policy SLHN_PD2011_11
SLHD & SWSLHD Access and Referral to Infant Child and Adolescent. MH_PD2012_047
Appendix 1: Emergency Department Mental Health And Delirium Risk Assessment
Appendix 2: Management Flow Chart

**EMERGENCY DEPARTMENT MENTAL HEALTH AND DELIRIUM RISK ASSESSMENT**

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<th>Level One</th>
<th>Level Two</th>
<th>Level Three</th>
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<td></td>
<td>High Risk</td>
<td>Medium Risk</td>
<td>Low Risk</td>
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**OBSERVATIONS**
- Assess the patient every 30 minutes and document score.
- Complete a nursing admission including vital signs.
- Assess the patient every 15 minutes and document score. Place the patient inside the department for easier observation.
- Continuous visual observation is required for this patient until medical assessment and a management/observation plan is documented.
- Consider Special
- Consider Special

Depending on your findings on assessment other observations may be required to be completed regularly such as neurological assessment, drug and alcohol withdrawal and circulation observations.

**TRIGGERS**
- Angry / loud speech
- Pacing / restlessness
- Confusion
- Increasing distress
- Intoxicated / withdrawal
- Thought disordered

**REFER**
- In-hours
  - Notify mental Health NP/CNC / CNS
  - Notify NUM / TL / in charge / MH CNS / MH Crisis team
- After-hours
  - Notify NUM / TL / in charge / MH CNS / MH Crisis team

- In-hours
  - Notify NUM / TL / in charge
  - Prompt referral to mental health NP/CNC / CNS

- After-hours
  - Notify NUM / TL / in charge / MH CNS / MH Crisis team

**If you are concerned about a patient ensure the NUM / In charge are Notified**

**ACTION**
- Medical and nursing staff need to consider escalation of treatment such as oral medication
- Medical and nursing staff need to consider escalation of treatment such as oral medication / IM or IV and restraint. Security may need to be involved
Appendix 3: Facility Protocols for Patients Potentially at Risk Who Leave Prior to Formal Disposition

General Practice Casualty
Balmain Hospital

Protocol for patients potentially at risk who leave prior to formal disposition

Patients potentially at risk of accidental or deliberate self-harm require a mental health risk assessment by a medical officer and/or mental health practitioners. Patients who present to GPC will require referral for a mental health assessment. If they leave GPC prior to referral, they should be considered for referral to mental health or other appropriate community based service for follow up wherever possible.

**Patient at risk leaves GPC prior to formal**

- **Not scheduled.** Discuss with senior GPC medical officer and/or Supervisor to determine risks and consider a range of options below. **It may be decided that no action is required.**

- **Scheduled under Mental Health Act**
  - **Conduct a search of GPC.** Call the patient on their mobile.
  - **Contact Supervisor and security** (if available) and inform them patient is voluntary but should be requested to return to GPC if located.
  - **Contact next of kin or significant other:** Advise patient has left the GPC. Request that GPC is contacted should patient return or make contact.
  - **Check PowerChart** to ascertain if known to MH. Contact and request follow up by community MH services. See contact details in box text below.
  - **Consider whether police notification is warranted. This certainly is not always necessary.** If so-
    - **Provide details,** advise involuntary mental health patient is missing and request patient be advised to return to GPC if found.
    - **Glebe Police may be contacted on *6 14** from any hospital phone or **95528099.**

  Accurate description of the events surrounding the patient leaving GPC and the individuals/organisations that have been notified should be recorded in the patients’ notes.

  **For advice about which team to contact call the Mental Health Telephone Access Line (MHTAL) on 1800 011 511**

  Compliance with this policy directive is mandatory
Protocol for patients potentially at risk who leave prior to formal disposition

Patients potentially at risk of accidental or deliberate self-harm require a mental health risk assessment by a medical officer and/or mental health practitioner. Patients who leave the ED prior to, or following, a mental health assessment should be considered for referral to mental health or other appropriate community based services for follow up wherever possible.

Patient at risk leaves ED prior to formal disposition

1. Notify NUM/Flow
2. Notify ONM
3. Notify MOIC

Not scheduled
Discuss with senior ED medical officer and/or senior ED nurse to determine risks and consider a range of options below - It may be decided that no action is required.

Scheduled
Under Mental Health Act

- Conduct a search of ED. Call the patient on their mobile.
- Contact security and inform them patient is voluntary but should be requested to return to ED if sited.
- Contact next of kin or significant other: Advise patient has left the ED. Request that the ED is contacted should patient return or make contact.
- In hours - contact Mental Health NP/CNC on page 82062.
- After hours - check First net to ascertain if known to MH.
- Contact and request follow up by community MH services. MHTAL 1800 011 511.
- Consider whether police notification is warranted and if so contact Campsie Police on 9784 9399.
- Provide details, advise voluntary mental health patient is missing and request patient be returned to ED if found.
- Complete missing patient form and fax to:
  - Campsie Police 9784 9311
- Document an accurate description of the events surrounding the patient leaving the ED and the individuals/organisations that have been notified should be recorded in the patients’ notes with date and time of events.
- Report incident on IIMS.
- Conduct a search of ED. Call the patient on their mobile.
- Contact security and inform them patient is involuntary and should be returned to ED if found.
- Contact next of kin or significant other: Advise patient has left the ED. Request that the ED is contacted should patient return or make contact.
- In hours Contact MH NP/CNC on page 82062 or Psychiatric Registrar on call via switch.
- After hours - check First net to ascertain if known to MH.
- Contact and request follow up by community MH services. MHTAL 1800 011 511.
- Contact Campsie Police on 9784 9399, for pt with immediate concerns.
- Provide details, advise involuntary mental health patient is missing, identify concerns and request patient be returned to ED if found.
- Complete missing patient form and fax to:
  - Campsie Police 9784 9311
  - Relevant community team
- Document an accurate description of the events surrounding the patient leaving the ED and the individuals/organisations that have been notified should be recorded in the patients’ notes with date and time of events.
- Report incident on IIMS.

For advice about which team to contact call the Mental Health Telephone Access Line (MHTAL) on 1800 011 511

Compliance with this policy directive is mandatory
Protocol for patients potentially at risk who leave prior to formal disposition

Patients potentially at risk of accidental or deliberate self-harm require a mental health risk assessment by a medical officer and/or mental health practitioner. Patients who leave the ED prior to, or following, a mental health assessment should be considered for referral to mental health or other appropriate community based services for follow up wherever possible.

Patient at risk leaves ED prior to formal disposition

Not scheduled. Discuss with senior ED medical officer and/or senior ED nurse to determine risks and consider a range of options below. It may be decided that no action is required.

- Conduct a search of ED. Call the patient on their mobile.
- Contact security and inform them patient is voluntary but should be requested to return to ED if sited.
- Contact next of kin or significant other: Advise patient has left the ED. Request that the ED is contacted should patient return or make contact.
- Contact Mental Health CNC on pager 60299 or leave notes in NUM’s Office door for follow-up if concern is not high.
- AH- check PowerChart to ascertain if known to MH
- Contact and request follow up by community MH services. See contact details in box text below.
- Consider whether police notification is warranted. This certainly is not always necessary. If so-
  - Provide details, advise voluntary mental health patient is missing and request patient be returned to ED if found.
- Complete absconded patient form and fax to:
  - Relevant community team
  - Burwood Police 9745-8411

Accurate description of the events surrounding the patient leaving the ED and the individuals/organisations that have been notified should be recorded in the patients’ notes.

Scheduled under Mental Health Act

- Conduct a search of ED. Call the patient on their mobile.
- Contact security and inform them patient is involuntary and should be returned to ED if found.
- Contact next of kin or significant other: Advise patient has left the ED. Request that the ED is contacted should patient return or make contact.
- Contact CNC or Psychiatric Registrar on call.
- AH- check PowerChart to ascertain if known to MH.
- Contact and request follow up by community MH services. See contact details below.
- Contact Burwood Police on 9745-8499, for patient with immediate concerns. Again, not always necessary, assess on an individual basis.
  - Provide details, advise involuntary mental health patient is missing, identify concerns and request patient be returned to ED if found.
- Complete absconded patient form and fax to:
  - Burwood Police on 9745-8411
  - Relevant community team

Accurate description of the events surrounding the patient leaving the ED and the individuals/organisations that have been notified should be recorded in the patients’ notes.

For advice about which team to contact call the Mental Health Telephone Access Line (MHTAL) on 1800 011 511

Compliance with this policy directive is mandatory
Patients potentially at risk of accidental or deliberate self-harm require a mental health risk assessment by a medical officer and/or mental health practitioner. Patients who leave the ED prior to, or following, a mental health assessment should be considered for referral to mental health or other appropriate community-based services for follow-up wherever possible.

**Patient at risk leaves ED prior to formal disposition**

### Not scheduled

- Conduct a search of ED. Call the patient on their mobile.
- Contact security and inform them patient is voluntary but should be requested to return to ED if sited.
- Contact next of kin or significant other: Advise patient has left the ED. Request that the ED is contacted should patient return or make contact.
- Contact Mental Health NP/CNS on pager 80616/81966 or leave notes in green basket for follow-up if concern is not high.
- AH- check PowerChart to ascertain if known to MH
- Contact and request follow up by community MH services. See contact details in box text below.
- Consider whether police notification is warranted. **This certainly is not always necessary. If so—**
  - Provide details, advise voluntary mental health patient is missing and request patient be returned to ED if found.
- Complete missing patient form and fax to:
  - Relevant community team
  - Newtown Police 9550-8199

Accurate description of the events surrounding the patient leaving the ED and the individuals/organisations that have been notified should be recorded in the patients’ notes.

### Scheduled under Mental Health Act

- Conduct a search of ED. Call the patient on their mobile.
- Contact security and inform them patient is involuntary and should be returned to ED if found.
- Contact next of kin or significant other: Advise patient has left the ED. Request that the ED is contacted should patient return or make contact.
- Contact MH NP/CNS or Psychiatric Registrar on call.
- AH- check PowerChart to ascertain if known to MH
- Contact and request follow up by community MH services. See contact details below.
- Contact Newtown Police on 9550-8199, for pt with immediate concerns. **Again, not always necessary, assess on an individual basis.**
  - Provide details, advise involuntary mental health patient is missing, identify concerns and request patient be returned to ED if found.
- Complete missing patient form and fax to:
  - Newtown police on 9550-8199
  - Relevant community team

Accurate description of the events surrounding the patient leaving the ED and the individuals/organisations that have been notified should be recorded in the patients’ notes.

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For advice about which team to contact call the Mental Health Telephone Access Line (MHTAL) on 1800 011 511
Appendix 4: Nurse Specials within the Emergency Department

Nurse Specials within the Emergency Department

The role of the nurse special is to observe, support and ensure the safety of an individual patient in their care

Roles and Responsibilities of the NUM1 or Delegate

- The NUM1 or appropriate delegate must ensure that an orientation to the department is provided to the nurse special. This should include but not limited to entry/exit points, emergency procedures, meal break times, provision of special policy etc.

- Introduction of the nurse special to the ED nurse who is responsible for the overall care of the patient must be carried out at the commencement of shift. It is the responsibility of the ED nurse looking after the patient to administer any medications that are required.

- The patient’s medical progress notes are to be provided to the nurse special so that appropriate documentation can be completed.

- The NUM1, delegate or ED nurse caring for the patient, must inform the nurse special if the patient is ‘scheduled’ under the Mental Health Act, or being managed under a ‘duty of care’.

Roles and Responsibilities of a Nurse Special

The roles and responsibilities of a nurse special includes:

- Completion of the ‘Mental Health and Delirium Risk Assessment Form’ ensuring the following:
  - A comprehensive description of the patient is documented
  - Reporting of elevated risk scores to the RN/NUM and documenting the actions taken

- Remaining in close personal range to the patient unless otherwise stipulated.

- Providing personal care (showering / mouth care) and pressure area care for the patient if required

- Remain in close personal range of the patient unless otherwise stipulated- this includes escorting the patient to other parts of the department such as the bathroom, or kitchen.

- If the patient requires to leave the department for any reason this should be undertaken in consultation with the Medical Officer in charge or NUM 1 and a risk assessment must be conducted to ensure staff and patient safety.

- Escorting the patient to and from the toilet, or the kitchen area as appropriate. This does not include escorting the patient to areas outside the Emergency Department alone (ie: outside for a cigarette)
• Developing a rapport with the patient, where appropriate. However, depending on the patient this can be a challenging task. In this case observing the patient and ensuring that they stay safe in the department is the nurse specials’ primary role.

If the nurse special feels threatened or in danger, or observes the patient imminently about to abscond, they should alert ED staff immediately.

It is imperative that any alteration in behaviour or increasing agitation is escalated to the NUM1 on duty