Government of **Western Australia**
Department of **Health**

Statewide Standardised Clinical Documentation for Mental Health Services Procedure

1. Purpose

The purpose of this Procedure is to support Health Service Provider compliance with MP 0155/21 *Statewide Standardised Clinical Documentation for Mental Health Services.*

2. Completing Statewide Standardised Clinical Documentation

2.1 General Requirements

Mandatory Requirements

- All Health Service Providers must ensure use of the most current versions of Statewide Standardised Clinical Documentation by accessing them on the Psychiatric Services Online Information System.
- Paper-based documentation can only be used if:
    - The Statewide Standardised Clinical Documentation is not available in the Psychiatric Services Online Information System.
    - The Psychiatric Services Online Information System is temporarily unavailable. If the Psychiatric Services Online Information System is temporarily unavailable and paper-based documents are used, public mental health services must place the information on the Psychiatric Services Online Information System when available.
- Completing all information fields in all Statewide Standardised Clinical Documentation is mandatory. Clinicians must indicate where a field is not applicable to a patient's circumstances.
- If a section is applicable but unable to be completed at time of assessment, the clinician must:
    - Document why the information has not been collected in the appropriate information field. For example, the clinician can document that 'the information was unavailable at the time of assessment', 'the information is not relevant to the current presentation', or 'the information has been included in another SSCD document for this episode of care'.
    - Document any follow up actions planned to obtain the information in the appropriate information field.
    - Obtain the required information and update the appropriate information field as soon as possible.
- The bottom of every page of every Statewide Standardised Clinical Document must be signed off by the clinician completing the document, including the name, signature, designation, date and time.
- When a patient is transferred from one hospital to another within the same catchment area, and an assessment/form was completed, it is deemed unnecessary for the receiving hospital to repeat the assessment/form. However, if the patient's condition and circumstances have changed, then a new assessment is required and the information is

to be recorded on a new form.
- The receiving hospital must always ensure that all of the necessary documentation and legislative requirements are completed and finalised.

Care Transfer Summary

- If the public mental health service utilises alternative electronic discharge summaries such as Notification and Clinical Summaries, these may be used in place of the Care Transfer Summary.

Supporting Documentation

- Statewide Standardised Clinical Documents are minimum mandatory requirements. This does not prevent additional records being included in the patient's care record, consistent with variations in approach or care pathways for different client groups or clinical settings.
- Public mental health services can use other program-based documentation and contemporaneous progress notes to supplement information documented in the Statewide Standardised Clinical Documentation as appropriate.
- The *Mental Health Bed Access, Capacity and Escalation Statewide Policy* states the minimum information required to consider a referral for inpatient admission. The referring hospitals can use either the Triage or Assessment document as long as the minimum information is provided.

2.2 Community or Non-Acute In-Patient Mental Health Care Setting

The below provides guidance on completing documentation in the community or non-acute inpatient mental health care setting to ensure alignment with mandatory requirements.

Physical Examination

- In the community or non-acute inpatient mental health care setting, the physical examination can be undertaken by the consumer's regular or nominated primary health care provider and recorded in either:
  - The Physical Examination Statewide Standardised Clinical Document template.
  - An appropriate format for the respective public mental health service's clinical records.

3. Storage of Statewide Standardised Clinical Documentation

As there is currently no statewide medical record process, Health Service Providers are required to ensure there is an internally agreed process for the filing of Statewide Standardised Clinical Documents, which are identified with the SMHMR90X nomenclature on the Medical Record or Electronic Medical Record (if available).

This document can be made available in alternative formats on request for a person with a disability.

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