

# **GUIDELINES FOR MENTAL HEALTH NURSING ASSESSMENT & REPORTS**

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**OFFICE OF THE DIRECTOR OF MENTAL HEALTH, MINISTRY OF  
HEALTH, WELLINGTON, NEW ZEALAND**

**&**

**NEW ZEALAND COLLEGE OF MENTAL HEALTH NURSING  
(Te Ao Māramatanga)**

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## Foreword

These guidelines mark an important collaboration between the Ministry of Health and Te Ao Māramatanga, New Zealand College of Mental Health Nurses.

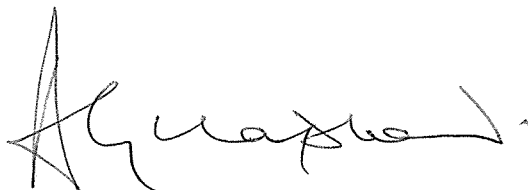
Mental health nurses have a special role when working with consumers of mental health services in their recovery journey. The distinctive values and attributes, expertise and skills of nurses are reflected throughout the range of services working with people with mental health and addiction problems and their families and whanau.

It is often the mental health nurse who has the most frequent contact with the consumer, and it is therefore this person who is called upon to prepare a range of reports, based on their assessment and practical working knowledge of the consumer.

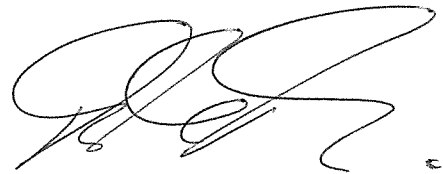
Reports prepared by the mental health nurse range from specialist reports, such as those prepared as information for a Review Tribunal, to more general reports prepared as part of regular reviews with consumers and their families and whanau, about their progress.

These guidelines reflect a request on the part of mental health nurses for guidance on the appropriate standards for writing nursing reports, for a range of purposes, from the first contact with a consumer through to specialist reports such as second health professional reports.

We acknowledge and thank all those who have taken the time to provide thoughtful and valuable feedback on the draft guidelines.



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## 1. Introduction

These guidelines have been developed by a small working group of mental health nurses, in partnership with Te Ao Māramatanga the New Zealand College of Mental Health Nurses ('the College') and the Office of the Director of Mental Health ('Office of the Director') at the Ministry of Health. They are intended to provide mental health nurses with guidance on the information that needs to be included in a wide range of mental health nursing reports.

It is acknowledged that mental health nurses work in a variety of settings, including District Health Board (DHB) inpatient and community services, non-government organisations (NGOs), primary health brief intervention services, addiction and other specialist services. The guidelines are intended to be relevant to all mental health nurses, irrespective of the environment in which they practice.

## 2. Scope

The guidelines are not intended to be prescriptive and do not reflect any particular model of nursing. Some reports will require more information, and others will need to reflect a more narrow range of considerations. For example, reports prepared for special patient reviews may have a greater focus on the risk of offending and on legal status.

## 3. Definitions

The definition of a mental health nurse is based on that used by the World Health Organisation (WHO), and accepted by the College. That definition describes a mental health nurse (referred to by WHO as a 'psychiatric nurse') as *'a graduate from a recognised, university level nursing school with specialisation in mental health nursing. ... [they] are registered at the local nursing board (or equivalent) and work in a mental health care setting.'* A mental health nurse is always a registered nurse. This includes those who have completed a hospital-based, direct entry, undergraduate psychiatric nursing programme, or completed an undergraduate comprehensive education programme and a post-graduate specialist mental health programme.

The term 'consumer' is used throughout this document, with the acknowledgement that some people choose to use the terms 'tangata whaiora', 'client' or 'service user'.

## **4. Rationale**

The decision to develop these guidelines has arisen from the experience of the Office of the Director in receiving a wide range of reports from mental health nurses. It is noticeable that reports vary considerably in quality, from those that provide concise and useful information, to those providing considerable detail with little by way of results.

Nurses are part of multi-disciplinary teams and have a substantive role in working with consumers of mental health and addiction services, on their recovery journey. Therefore, nursing assessments and reports should be part of all service reviews, incident reports and special patient/restricted patient reviews.

There are a number of situations in which mental health nurses need to assess individuals and produce reports; including courts, special or restricted patient review panels, review tribunals and in response to incidents that have occurred (including reportable events). Other reports prepared by registered nurses include second health professional reports (sections 16, 18, 21, 34 and 79 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 ('the Act')).

The Office of the Director of Mental Health receives a large number of reports prepared by mental health nurses for a range of purposes, including:

- Special and restricted patient reviews
- Serious incident reports
- Responses to requests for information about particular consumers , often arising from concerns raised with the Director or with the Minister of Health.

Robust and comprehensive nursing reports contribute significantly to the ease of decision-making and provide valuable information that is not contained in reports from other members of a multi-disciplinary team.

Mental health nurses have sought guidance on the best ways in which to prepare a range of reports. Also, when Directors of Mental Health Nursing were asked for their views, they agreed that, while there is readily available guidance about how assessments should be conducted, there is little guidance available to assist mental health nurses in preparing formal reports to an appropriate standard. Further consultation with the mental health nursing sector has resulted in strong support for the Ministry to work with the New Zealand College of Mental Health Nurses and the Directors of Mental Health Nursing to address this issue.

## **5. Principles**

These guidelines are based on the following principles:

1. Mental health nursing reports are a crucial aspect of consumer care.

2. Reports should be, wherever practicable, developed in conjunction with the consumer and unless otherwise required, (e.g. certain reports requested by the Court) with the assumption that they will be available to the consumer.
3. Reports should also reflect the involvement of family/whanau.

These guidelines also refer to mental health nursing assessment as the basis for reporting. A range of assessment tools is available to nurses. These guidelines do not set out to recommend any tool in particular, nor do they reflect any particular nursing model.

## **6. What makes a good report?**

Nursing reports need to be of a consistently high quality. Most DHBs will have guidance in place about the format of reports (e.g. layout and font) and some may also provide guidance on the kind of material that needs to be included in nursing reports. Some NGOs may also have their own processes in place, and prefer a particular format for reports. These guidelines are not intended to replace material issued by DHBs or NGOs; rather, it is intended that they will add to the body of knowledge that already exists.

As such, they should be:

- Thorough and fit for purpose – should meet the purpose for which they have been prepared, and meet the needs of the reader/end user;
- Focused, factual, logical, well-structured and succinct
- Consistent with any local service guidelines on format and structure
- Up-to-date and reflective of contemporary mental health nursing practice
- Evidence-based
- Reflective of a recovery-based focus
- Robust and defensible
- Clearly reflect the capability and competence of the writer.
- Commensurate with the level of experience of the registered nurse in mental health.

The following factors contribute to the quality of a mental health nursing report.

- The report is based on a thorough and recent assessment of the consumer
- The report acknowledges and values the culture of the consumer;
- Where possible the consumer is aware of the report and his or her views are reflected
- The report addresses the purpose for which it is prepared (e.g. consideration of legal status, clinical review etc) and is appropriate for its audience

- The report includes relevant contextual/situational/environmental information, such as feedback from others who are in contact with the consumer (e.g. general practitioner, family/whānau).
- The report is informed by a thorough understanding of the relevant legislation (including the provisions of the Privacy Act 1993).
- The author has taken adequate time to prepare the report

## 7. What makes a competent nursing report?

Some reports are required to respond to very specific questions (for example, the nursing response to sentinel event investigations requires the nurse to be guided by and respond to certain questions). Other reports rely on the nurse providing an overview or opinion.

A report prepared by a nurse is an integral part of ensuring that a comprehensive overview of the consumer is captured. A nursing report provides a **nursing perspective**; therefore it must reflect the nature of the nurse's work with the consumer and family.

A nursing report should not simply replicate the information contained in reports from other members of a multi-disciplinary team. For example, a psychiatrist's report for a special patient review panel is likely to have a strong focus on:

- History
- Mental state - generally using medical terminology and in a summarised manner, for example, *"continues to experience auditory hallucinations and persecutory delusion which are distressing for Mr P and make him suspicious of others"*;
- Medication: often focusing on its effectiveness in managing the symptoms
- Risk
- Legal status/implications.

A nurse is ideally placed to add specific context and perspective in a report based on the nurse's day-to-day observations and interactions with the consumer. A nursing report should have a focus on how the person is **functioning, coping and interacting** on a day-to-day basis. It may also provide a nursing viewpoint on some of the issues covered in a psychiatrist's report (e.g. mental state, risk). The following section provides some more information.

As discussed above, nursing reports are prepared for different purposes. However, there are certain fundamental elements that should be part of any comprehensive mental health nursing report. The appendices to these guidelines contain information on specific material that is required for reports, including:

- special patient reviews
- second health professional reports

- serious incident reports

**“So what are some of the unique aspects of a nursing report, i.e. the nursing focus?”**

*A nursing report is a summary of the observations, interactions, interventions and regular meetings that form the basis of the therapeutic relationship between the nurse and the consumer.*

## **8. Components of a nursing report**

### **8.1 Introduction / setting the scene**

The introduction to the report should establish the nurse’s credentials and relationship with the consumer (irrespective of the duration of that relationship).

**Example:** *I am a registered nurse with 5 years mental health nursing experience in a community setting, I have a Master’s degree in mental health and been employed as case manager/ key worker for Mr X for the past 2 years.*

The introductory section also needs to include comment on how the nursing focus fits with the consumer’s overall care plan, including relevant environmental and/or situational factors, including whether the assessment has occurred in the consumer’s own home, or during an inpatient stay, and whether anyone else was present or involved e.g: family/whānau, other consumers or staff.

The introductory information should include a statement about how much direct 1:1 time (including specific therapies) the nurse is spending with the consumer and how this is reflected in the consumer’s progress and other outcomes.

**Example:** *I meet with Mr X for approximately one hour each week, and more frequently if required. As his key worker, I am responsible for liaising with other health professionals and support agencies to ensure he is able to get the support he requires. The time I have spent with Mr X over the past 2 years has resulted in him becoming increasingly trusting towards me, and more able to accept help offered by others. He has become increasingly able to seek support when he feels unwell and has started to appreciate the value of early intervention.*

## **8.2 Mental state**

This part of an assessment must include current information on the consumer's mental state, with sufficient historical information to place this in context (e.g. duration of illness, history of contact with services).

### **8.2.1 Cognitive and intellectual function**

The nurse's report should include comment on issues affecting the consumer's cognitive/intellectual functioning (e.g. intellectual disability, neurological conditions or brain injury). At times it may also be appropriate to include comment on these factors in the part of the report dealing with the consumer's history.

**8.2.2 Alcohol and other drug use/addictions:** Co-existing mental health and substance use problems commonly occur. The assessment must include information on substance use/behavioural addictions (e.g. gambling) and how these issues are being addressed within the context of the consumer's integrated management plan. If the consumer's primary diagnosis is related to a substance use problem/disorder or a behavioural addiction such as gambling, then this should be the main focus of the report.

**8.2.3 Other co-existing conditions:** Mental state should incorporate aspects of physical health that impact on the consumer's condition and management. For example, physical health (e.g. low body weight/BMI).

Pregnancy or recent childbirth (including miscarriage, termination of pregnancy and stillbirth) should always be noted for female consumers.

Reporting on treatment should not consist solely of a list of medications. It must include comment on the effectiveness of treatment, willingness of the consumer to adhere to treatment (including medication), and information on side-effects and their management. It is expected that 'treatment' for a mental illness will include a range of therapies, will be responsive to the needs and wishes of the consumer and will be regularly reviewed to seek optimal results for each consumer.

## **8.3 Social functioning**

This part of the report has a focus on the 'here and now' and should reflect the consumer's current interpersonal functioning and communication. Within this context you should include comment on:

- Whether the consumer's behaviour and communication has been socially appropriate, and whether they have displayed antisocial or maladaptive behaviours that have required support and supervision and if so, how has this support and supervision been provided.
- Whether the consumer is liked by others; is victimised, or is socially isolative.

- Note: opinions must be supported by concrete examples, indicating how the nurse has arrived at that particular point of view.

This section of the nursing report should address a wide range of relationships, including with the mental health service, with peers (other consumers and friends), family/whānau and others. In the case of a special patient, this may include comment on the relationship with the victim(s) of the index offence. Reporting on relationships also needs to reflect the cultural and spiritual identity of the consumer. Factors such as impulse control, personal space, isolative tendencies and preferences about being part of a small or large group, are all important parts of this section.

**Example:** *Mr X has isolative tendencies and prefers not to mix or interact with others unless directed. He does, however, see the value in interacting with others and has developed an amicable relationship with his flatmate. He has a strained relationship with his family and states he does not have any friends. At times he presents as uncooperative and difficult, and when asked about this he states he doesn't care and has always been like this. At times Mr X demonstrates poor impulse control when confronted by others and has a tendency to get angry and loud if he feels under pressure to participate in activities he does not want to do. He states he has not had a girlfriend and discussions on relationships are often closed down.*

The assessment of relationships should also include information about steps being taken by the service to strengthen those relationships that are beneficial to the consumer, and to minimise the potential harm from relationships that could be detrimental.

Sexuality and intimacy are important aspects of human existence; no less so for people with mental illness. These aspects of an assessment will at times come within the context of comment on relationships. However, not all relationships are about sexuality, and sexuality is not always expressed within relationships. Likewise, intimacy is not always expressed sexually.

**Example:** *Mr X states that he does not like to be touched and we are exploring this, with a view to understanding this aversion and with the hope that he will be able to participate in activities involving personal contact (i.e. some exercise classes) and eventually be able to accept therapeutic touch, such as physiotherapy or massage. Mr X also demonstrates increased anxiety when around animals, and we are exploring ways in which this might start to be addressed, through his regular CBT sessions.*

### **8.3.1 Input from family, whanau and/or significant other**

Family/whanau and significant others provide a valuable source of information for nursing reports, particularly in terms of feedback about how the consumer functions with his/her family, how the consumer manages social environments, how the consumer copes with the presence of alcohol or other

drugs (e.g. at family celebrations) and the extent to which the consumer manages medication (including side-effects) while on leave.

Input from family and significant others is a key aspect of AOD assessments and should not be omitted.

**Example:** *Following her last visit home, Ms F's mother commented on how she is much more engaged with the family. Her mother noted that although Ms F was very anxious about a planned family celebration of her grandmother's birthday, and initially stayed in the kitchen, she gradually relaxed and mixed well with other family members, taking time out in the kitchen or in the back yard if she started to feel stressed. Although other family members were drinking alcohol, Ms F was able to decline and was appreciative of the fact that non-alcoholic drinks were available. Ms F manages her own medication while on leave and we regularly review this with her prescribing physician. .*

Nurses have an important role in health education, and a nursing report should summarise the ongoing education with the consumer to help develop insight into their illness, understanding of early warning signs and to assist the family/NGO in their support of the consumer.

**Example:** *Mr V and his family have struggled to come to terms with the precipitating factors in his illness, seeing alcohol and drug use as very much a part of daily life. Mr V is starting to understand that alcohol and other drugs do not help him keep well, and although he may subjectively 'feel better' after smoking cannabis, it can make his illness worse. He finds it very difficult not to consume alcohol or drugs when with family, and for this reason, is encouraged to have family visit him in the rehabilitation unit, and is at present only able to have leave to his home, under escort.*

*The kaiwhakahaere and a support worker from Supporting Families, have both met with Mr V's family on several occasions, and report that they are starting to make some progress in raising the family's understanding of Mr V's illness, how it is best managed and how they can support him.*

#### **8.4 Cultural and spiritual perspective**

Mental health nursing reports should reflect an assessment of the consumer's cultural and spiritual identity, with input from others as appropriate. Existing guidelines on cultural assessment should be used to inform the assessment process.

**Example:** *Mr X identifies as Maori but declines to be involved with cultural activities, and has refused to see the kaiwhakahaere or other cultural workers. However, he has recently taken to walking near the marae and spends some time watching and listening to activities that may be taking place there. We respect his decisions regarding his cultural identity but will continue to try to encourage him to explore his cultural identity and to make connections with his Maori culture.*

*Mrs G came to New Zealand as a child refugee from Poland, following World War II. She is proud of her Polish identity but has until recently, had limited contact with others from her culture. In recent months she has started to attend meetings of the Polish Society and contact with others from her culture, often with similar childhood experiences, is proving to be an important aspect of her recovery. Mrs G is a practising Roman Catholic and an active participant in her local church. When she is unwell, she tends to develop over-valued religious ideas, stating that as a direct descendant from the family of Jesus, she has a 'special status'. These ideas need to be addressed, while maintaining a respect for her spirituality.*

## **8.5 Symptom management**

This section of a nursing report should include information on how the author, as a nurse, is addressing the consumer's presenting symptoms.

Aspects that need to be considered include:

- The consumer's vision for his/her recovery and well being
- Steps taken by the nurse to assist the consumer in managing specific symptoms
- The extent to which the consumer experiences subjective distress as a result of his/her symptoms
- 'Negative' symptoms such as poor motivation
- Physical health
- Behaviour and impulse control, including how the consumer manages strong emotions

**Example:** *Mr P demonstrates consistent paranoid ideation in relation to a range of food and fluids, stating 'you are poisoning me'. To ensure he is well-hydrated and that these ideas are minimised it is important that he is present when his drinks are prepared. This requires him having one-on-one support in the kitchen with a staff member when no one else is around. Mr P has required direct supervision whilst eating and drinking and fluid balanced chart maintained. This has resulted in better hydration and reduced episodes of constipation. Nurses have reported fewer periods of irritability and agitation from Mr P.*

## 8.6 Activities of daily living (ADLs) / self cares

It is a nursing responsibility to assess the extent to which a consumer can undertake ADLs, and whether this ability fluctuates depending on symptoms. It is not sufficient to state that the consumer has difficulties with ADLs, without providing details. For example, in relation to personal hygiene, the assessment should consider whether the individual requires support or prompting to shower, change and wash clothes etc.

Assessment of ADLs should identify the actions that are in place, or are required to support the consumer in improving ADLs. Risk factors (such as peer pressure to lend money) should be clearly identified, and steps identified for their management.

**Example:** *Mr R's level of functioning fluctuates from one day to the next, dependent on the intensity of auditory hallucinations. When he is experiencing intrusive hallucinations it is important to delay his getting out of bed until he can have one-on-one support when the unit is less busy. When presenting like this he will require higher levels of supervision and nursing input to manage his daily activities and personal cares. To maximise the chances of him eating his meals it is important that he is present during food preparation and that staff are present when he is eating to assure him that the food is not contaminated. During days when the hallucinations cannot be decreased in intensity he does not attend any group activities so where possible we ensure that he has at least two supervised walks outside to ensure his activity levels are maintained. We also encourage extra fluids on these days.*

*Conversely, when Mr R is less bothered by auditory hallucinations and persecutory delusions he manages his ADLs and personal cares with minimal prompting. He can usually attend the group gym programme and other group activities, but generally only for 30 minute durations. Over the last six months (and since the last special patient report dd/mm/yyyy) a review of Mr R's notes indicates that approximately 50% of the time he requires higher levels of supervision and nursing input to manage his daily activities and personal cares..*

## 8.7 Medication management

The medical focus of medication management is primarily concerned with maximising therapeutic effect and controlling symptoms. However, a nursing focus is more directed towards consumer adherence and minimising adverse effects, with a view to the consumer being able to tolerate a medication that may be pivotal to their quality of life. This requires the nurse having a specific focus on lifestyle habits that are closely linked to side-effects (e.g. exercise,

general activity level, diet, sleep) and providing education to the consumer and often, to their family/ whānau.

The nursing report may include information on:

- the consumer's tolerance of medications and how they are supported to minimise adverse side-effects
- specific steps being taken to manage a side-effect (e.g. dietary changes for constipation; or potential weight gain from increased appetite)
- the ability of the consumer to manage side-effects while on leave
- the steps being taken to monitor and record side-effects.
- the ability of the consumer to safely and appropriately manage regular medication such as self-administration of insulin for diabetes
- the identification and management of sexual dysfunction secondary to side-effects of the medication and limitations of the environment
- the support to assist the consumer to identify appropriate modifications in sexual practices in response to these limitations, i.e. to find an alternative satisfying sexual activity

**Example:** *Ms K's addiction to alcohol and her long-standing abuse of cannabis are being addressed through her attendance at an abstinence focused group programme, in conjunction with naltrexone, which she finds reduces her craving for alcohol and the risk of relapse. . She has been diagnosed as suffering from an anxiety disorder and is currently prescribed Aropax 40mg mane. She was initially reluctant to accept this diagnosis, and to take the prescribed medication, stating that 'a [cannabis] joint is better for me' and expressing concern about possible side-effects. Over the past 3 months Ms K has become increasingly accepting of taking medication and has found the CBT strategies for coping with anxiety helpful. □*

## 8.8 Physical health care

A comprehensive nursing assessment must also include information about the physical health of the consumer. This is crucial, particularly given the high levels of poor physical health experienced by people with mental illness. Physical health conditions, their impact on the consumer's mental illness, and the ways in which those conditions are managed, are always relevant.

Reporting on physical health should identify that relevant assessments have been conducted. For example:

- Baseline physical observations eg: blood pressure; pulse, temperature.
- Physical parameters e.g. for adults: height; weight; BMI or for a child/young person relevant information about milestones and height/weight/growth percentile.

The report may also include information about specific nursing interventions as a result of medical investigations or tests (e.g. fasting blood glucose) or

specific nursing interventions to manage a physical condition (e.g. restricted fluid intake and fluid balance monitoring).

Reporting on physical health should go beyond simply noting the presence or absence of a particular condition. Comment should cover a range of relevant aspects of physical health, their impact and management on for example:

- Rest and sleep
- Activity and exercise
- Nutrition/diet
- Bowel function / urinary function
- Specific health conditions such as diabetes, metabolic syndrome, COPD
- Regular primary health screening programmes (e.g. breast screening)

**Example:** *Mrs J is in poor physical health, largely due to her inadequate diet, consisting largely of instant noodles or soups, supplemented by white bread or rolls. Her weight of 65 kg is somewhat lower than should be expected for her general build, and there are some concerns that she often misses meals. She has a tendency to sleep much of the day, and her medication has been reviewed to see whether there is scope for adjustment to minimise any sedating effect. She describes herself as being 'easily tired' and a full blood analysis and comprehensive physical examination has been planned, to identify any possible physical causes. In addition, Mrs J is being supported by her social worker to attend a 'Healthy Eating for One' series of evening classes, designed for people living alone and on a low income.*

## 8.9 Subjective consumer focus

It is important to outline the consumer's expectations and their perspective on their care plan and treatment, and their perspective of recovery and vision of well-being. This aspect of the report is intended to outline the consumer's readiness to participate in their care. This should be placed in the context of the extent to which the care plan addresses the consumer's questions and concerns about their treatment.

**Example:** *Mr B states that he 'has a nervous condition' but does not agree with his diagnosis nor does he consent to treatment. However, consistent messages from all members of his multi-disciplinary team and his family appear to have resulted in his becoming more accepting of treatment. He states that he is willing to accept medication and to participate in group and individual counselling, but at present is easily distracted from this outlook, particularly when he is upset by other consumers on the unit.*

*Mr B has been asked to contribute his views to his care plan, and initially declined, stating that 'it won't make any difference, what I want'. However, when given the opportunity, he was able to identify things he thinks will make a difference in terms of his recovery. He has asked to eat with one or two other people, rather than at a full table and states that he does not like to feel rushed to finish a meal. He has also suggested that more time in the community on his own would be helpful.*

## 8.10 Specific interventions

The extent to which these are covered in the nursing report will depend on which other members of the multi-disciplinary team are providing reports. For example, if a psychologist is also providing a report, it may not be necessary for this to be covered in detail in the nursing report. It may, however, be useful to comment on the impact of psychological support, in terms of how a consumer is actually progressing in their interactions and how they cope in terms of the specific interventions that they are learning.

**Example:** *Mrs N is being provided with a range of support, including psychological support and support with activities of daily living, from the occupational therapist (see accompanying reports). Due to the long-standing nature of her illness, Mrs N requires considerable support in a number of areas of daily living, but is becoming increasingly confident in seeking and accepting assistance.*

**Example:** *Miss R is receiving support to complete a recovery plan which includes relapse prevention. Through the use of her journal she is able to identify triggers associated with her bulimia nervosa and the possible gaps in her meals that may contribute to her binge/purge cycle. With nursing support she is also able to engage in learning self-management strategies to manage her anxiety which has also been a significant contributing factor to her bulimia.*

## 8.11 Care plans

Consumers should have a care plan/management plan with a clearly identified component outlining **nursing interventions**. If so, it might be appropriate that the nursing care plan is submitted as part of the overall report with comment on the patient's progress towards these goals.

## 8.12 Risk and risk management

A report arising from assessment should address the issues of risk to self, risk to others, and risk from others, and strategies in place to manage any such risk. Risk assessment is only undertaken in order to manage risk, and a plan of action must be formulated following a risk assessment. Furthermore, before undertaking a risk assessment, nurses should ensure they have the requisite knowledge and skills (see *Assessment and Management of Risk to Others: Trainee Workbook*, 2006. Te Pou)

Comments such as 'this consumer seems to be a low risk' are inadequate on their own. Comment on the level of risk must be supported by advice on how this conclusion has been reached and the steps that have been put in place to manage risk (including identifying early signs of increased risk). If the risk affects another person, there should also be information on how this is/will be communicated and managed. Information on the use of seclusion may need

to be included, with a focus on the steps that are being taken to minimise the use of seclusion.

**Example:** *Ms T's risk to herself and others is closely related to her diagnoses of bi-polar disorder and anti-social personality disorder. When she is unwell, and more particularly when her mood is elevated, she tends to become sexually disinhibited and is vulnerable to exploitation from others, particularly the gang members with whom she associates. She also smokes cannabis when unwell and this contributes to a rapid deterioration in her mental state.*

*Ms T also presents a risk to others when unwell, as she becomes irritable, argumentative and increasingly aggressive if her demands are not met or if she feels that others are thwarting her. In such instances she has a tendency to throw whatever object is at hand, including hot drinks, cooking utensils or furniture. These actions have resulted injuries to others (including hospital staff and fellow consumers) and Ms T has several times appeared before the court on related charges.*

*The approach being taken to manage the risks arising from Ms T's behaviour includes ongoing psychological and nursing interventions, with a focus on improving her insight into her bipolar disorder and engaging her in learning strategies to better manage her frustration. There are some indications that these strategies are starting to have results, as the number and severity of incidents have declined in the past 3 months.*

## 9. Conclusion

The nursing report should end with a summary and a conclusion (see glossary). In concluding the report, it is important to consider the consumer's strengths and other protective factors that increase the recovery focus of the report.

The presentation of reports is also important. Reports should be spell-checked and prepared within service guidelines regarding font and format. In particular, medical terms and the name of medicines should be correct. The nurse who signs the report is responsible for the content and quality of that document. All reports should be checked by the author and preferably a colleague or at the very least, checked using the 'spell check' function on the computer. Nurses may also wish to include their Nursing Council of New Zealand registration number.

The conclusion of a report should again summarise the purpose for which it was prepared. Reports can be closed with an offer of further information, and should be signed and dated, with the writer's name printed underneath.

There are excellent online resources available to assist in report writing. Examples include:

[www.monash.edu.acu/lis/lionline](http://www.monash.edu.acu/lis/lionline) - select 'grammar' or 'writing' sections

## Glossary

**Recovery:** Recovery is happening when people can live well in the presence or absence of their mental illness and the many losses that may come in its wake, such as isolation, poverty, unemployment, and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them. (*Blueprint for mental health services in New Zealand: How Things Need to Be*, Mental Health Commission, 1998)

**Mental health nurse:** The definition of a mental health nurse is based on that used by the World Health Organisation (WHO). That definition describes a mental health nurse as '*a graduate from a recognised, university level nursing school with specialisation in mental health nursing...these nurses are registered at the local nursing board (or equivalent) and work in a mental health care setting.*' A mental health nurse is always a registered nurse. This includes those who have completed a hospital based direct entry undergraduate psychiatric nursing programme, or completed an undergraduate comprehensive education programme and a post-graduate specialist mental health programme.

**Formulation:** Formulation is the process of making sense of the information that is gathered in an assessment, and using that information to create a productive way of helping the consumer.

**Summary:** a concise statement of information. This statement should be able to stand alone and may be at the start or end of a report. A long report will benefit from an executive summary at the beginning.

**Conclusion:** a statement that summarises the information and the 'the end or finish of an event or process' a conclusion is likely to include a statement about 'what happens next'.

## References

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Welsh I. & Lyons C.M. (2001) Evidence-based care and the case for intuition and tacit knowledge in clinical assessment and decision making in mental health nursing practice: an empirical contribution to the debate. *Journal of Psychiatric and Mental Health Nursing*, **8**, 299–305

Evans C., Humberstone V., Maniapoto W., McKenna B. G., Simpson A. J., van Altvorst S. & Wack R. (2006) Assessment and Management of Risk to Others Guidelines and Development of Training Toolkit. Te Pou, Wellington,

(2006) Assessment and Management of Risk to Others: Trainee Workbook. Te Pou, Wellington

McKenna B.G., O'Brien A. J. & O'Shea M. (2011): Improving the ability of mental health nurses to give second opinion in Judicial Reviews: an evaluation study. Centre for Mental Health Research, University of Auckland, Auckland.

## Appendix 1: Components of a mental state examination

**Note:** ensure that interpretation / observations are supported by evidence.

Appearance and behaviour:

- Physical, clothing/grooming, level of arousal, motor activity level, agitation aggression; involuntary movement, retardation, facial expression; cooperation (including physiological signs)

Rapport:

- Eye contact, relatedness to interviewer, reciprocity/empathy, social inhibition

Mood, affect (stated and observed) and functional

- Sleep, eating, weight and appetite; energy, motivation, libido, anhedonia/enjoyment; ADLs (vegetative features), anxiety/panic
- Impact of these problems on employment, living arrangements, relationships, self care
- Thoughts of being 'better off dead' or of self-harm.

Speech:

- Form and pattern; volume and rate; is it coherent, logical, and congruent with questioning? spontaneity, impediments, vocabulary

Thought content:

- Ruminations, obsessions, compulsion, ideas of reference, overvalued ideas, delusions, poverty, passivity, thought insertion, withdrawal, broadcasting
- homicidal/suicidal thoughts

Cognitive:

- Note cognitive and intellectual function; orientation to time, place and person, attention, memory (short and long term) confabulation, is the consumer able to function intellectually at level expected from his or her history?

Insight:

- How does the consumer explain or attribute his or her symptoms?

Risk: to self, to others, from others:

- Historical (previous violent/suicide attempts, forensic history, relationship instability, substance use problems, psychiatric diagnosis, personality disorder)
- Present (consider: insight, negative attitudes/emotional state/hopelessness, suicide note/preparation for death, plan & means available, active symptoms of major mental illness, impulsivity, identifiable victim(s), lack of response to treatment/recent medication change, suicidal plans/intent or threat to commit violence, lack of support/social isolation, stress, recent loss/family stressor, access to weapons/means to harm self or others, poor compliance with remediation attempts)

## Appendix 2: Special Patient Review reports

Reports for special patient review panels need to include a mental health assessment but also need to have a specific focus on the issues that resulted in the individual becoming a special patient.

These issues include:

- Offending history
  - Pre-cursors to offending such as relapse of illness, alcohol and other drug use, significant family stressors, social milieu e.g. gang association.
  - Insight into factors affecting past offending, including the index offence
  - Understanding of the impact of offending on the victim(s), including any steps taken to reconcile with family (where the offending has been within the family).
- Special patient status
  - Understanding of the meaning and impact of special patient status
- Leave and community integration
  - Summary of leave history and progression
  - Adherence to conditions of leave
  - Any breaches of leave conditions and action taken to address these
  - Development of social networks
  - Future plans for leave / social integration
  - Outcomes for the special patient
- Mental state, as per general assessment but with specific focus on:
  - Insight into illness and impact on offending / behaviour
  - Compliance with medication and understanding of its impact
  - Insight into early signs of relapse / deterioration in mental state
- Rehabilitation, including
  - The patient's plans for the future (short and medium term) and the extent to which these are achievable
  - Employment and education opportunities
  - Family/whanau support
  - Victim issues – including whether the victim/victim's family oppose rehabilitative measures such as leave.
- Legal status: addressed in the responsible clinician's report, but should also be addressed raised in the nursing report.

For information on Special patient reviews and long leave, see:

[http://www.nzcmhn.org.nz/uploads/21290/files/Applications\\_for\\_short\\_long\\_leave\\_and\\_change\\_of\\_status.pdf](http://www.nzcmhn.org.nz/uploads/21290/files/Applications_for_short_long_leave_and_change_of_status.pdf)

### Appendix 3: Serious incident reports

The Ministry has specific requirements for reporting sentinel events and other serious incidents, and it is recommended that nursing reports be part of all serious incident review processes. Such nursing reports should include the following information:

- Details of the environment in which the patient was being cared for, including:
  - Stressors in that environment (e.g. behaviour of other consumers, high levels of stimulation)
  - Stressors for the consumer (e.g. family events, admission to inpatient care, alcohol and/or other drug use, conflict with staff)
  - Staffing levels, number of experienced staff / registered nurses
  
- Any indicators / warning signs that a serious incident was possible, including:
  - staff response
  - details of how this was recorded
  
- Details of how the incident was managed, including:
  - Staff response
  - Impact on other consumers / family / community (depending on where the incident occurred)
  - Police involvement (including action taken by police)
  - Reporting procedures
  - Investigation process – including District Inspector inquiry, Coroner’s inquest, internal review
  
- Comment on how such incidents could be prevented / minimised in future, including
  - Staffing levels and skill
  - Gender mixing
  - Use of quiet space
  - Liaison with family / whanau

**Second Health Professional Opinions at Judicial Reviews / Section 16  
Mental Health (Compulsory Assessment and Treatment) Act 1992**

In a study undertaken by McKenna and O'Brien (2011) it was found that none of the nurses surveyed as part of the study, reported having received formal training on providing second health professional reports.

In most cases the "other health professional" providing second reports for judicial reviews is the consumer's nurse. Nurses should be prepared to provide written reports at hearings that comply with the requirements of the Act and are at the level of those provided by other health professionals for the judicial review. The nurse must also be prepared to provide oral evidence to the Judge or to counsel for the consumer.

Details of the process and skills required for a second opinion are set out in the attached self-directed learning package, reproduced here with the kind permission of Brian McKenna and Tony O'Brien.

**Note:** the Ministry of Health is currently developing guidelines to assist in the preparation of second health professional reports. A link to the Ministry's website will be provided once the guidelines are complete (mid-2012).