Health Based Place of Safety Specification

Draft guidance

March 2016

Introduction

This document is a draft specification which sets out the minimum standard of care London's Health Based Places of Safety should offer. This document is an initial draft and should be used to test and develop ideas further with stakeholders across London's crisis care system.

The specification applies to Health Based Places of Safety that care for children and young people as well as adults detained under section 135 and 136. It is aimed primarily at commissioners, referrers and providers of Health Based Place of Safety sites and should be used alongside the section 136 care pathway in order to provide a consistent pathway of care across London.

The specification should also be used in addition to the Mental Health Act Code of Practice (2015), London's Mental Health Crisis Commissioning Standards and the core principles set out in the Mental Health Crisis Care Concordat.

What is a Place of Safety?

A Place of Safety is used when an individual of any age has been detained under section 135 or 136 of the Mental Health Act 1983. In law, a 'place of safety' is not clearly defined and has no specific characteristics , technically anywhere can be a Place of Safety under the Mental Health Act as long as the occupier is temporarily willing to receive the patient, this is stated in s135(6) of the Mental Health Act.

In practice psychiatric units and hospital emergency departments are most commonly used, the Mental Health Act Code of Practice (2015) instructs a Place of Safety to be a hospital or other health based place of safety where mental health services are provided; a Police station should not be used as a Place of Safety.

The reason for a Health Based Place of Safety specification:

Recent engagement with key stakeholders from across the system as well as surveys and focus groups with service users have reiterated the issues that exist in relation to London's Health Based Place of Safety provision. Individuals are being refused admission to a Health Based Place of Safety because of intoxication, physical health problems, boundary issues or lack of space. There are many descriptions of police waiting with individuals in vans, and the resulting stress the situation is placing on the relationship between police and health services.

To support the system in improving current Health Based Place of Safety services and processes, the Healthy London Partnership crisis care programme is working in partnership with stakeholders across the crisis care system to develop a specification that will outline the minimum standard of care a HBPoS should offer, covering areas such as staffing models, assessments and governance arrangements. Alongside this document a London s136 care pathway is being developed to address inconsistencies in the broader pathway and clarify roles of the different stakeholders involved.

Health Based Place of Safety Specification

1. Governance and Monitoring

Strategic Governance: Urgent and Emergency Care Networks:

1.1 London's Urgent & Emergency Care (UEC) Networks have collective responsibility for the equitable provision of care and patient outcomes across their footprint, ensuring that the key standards of care are delivered.

1.2 As such the UEC networks will have responsibility for ensuring that the Health Based Place of Safety (HBPoS) within their area of London meets this specification.

Operational Governance - Local Multiagency Groups:

1.3 A local multiagency group led by the Trust providing the Health Based Place of Safety should exist for each Health Based Place of Safety across London and be overseen by the respective UEC network. The group must be attended by representatives from the Health Based Place of Safety, local Emergency Departments, Approved Mental Health Professionals (AMHP) and Police. LAS?

1.4 The group should perform the following roles:

- Measure and analyse current performance at the Health Based Place of Safety (specific measurements to be monitored are included in Appendix 1);
- Understand the contact s136 detainees have had with mental health services previously and what alternative pathways or interventions could have been applied in order to prevent escalation to a s136 detention.
- Facilitate training initiatives on local policies and protocols which include key partners and local Acute Trusts;
- Network with other local multiagency groups across London to ensure the consistency of service;
- Ensure the Directory of Service is regularly updated showing accurate up-to-date information regarding the Health Based Place of Safety site.

2. Location and Facilities

2.1 The Health Based Place of Safety should be a hospital or other health based facility where mental health services are provided. The Health Based Place of Safety for children and young people should be based in an adolescent mental health inpatient unit. Is the ward the best place or a separate area?

Should co-location with an Acute hospital be the preferable model?

2.3 Within the Health Based Place of Safety there must be assessment rooms with the following features:

- Large enough to accommodate six people, to be able to both assess and restrain where necessary;
- Well-lit and have an observation window;

- Have good exits, with consideration being given to there being two doors at opposite ends of the room; the doors should open outwards for the safety of staff;
- Have soft, comfortable chairs in a washable fabric; furniture and fittings should be chosen so they cannot be used to cause injury by offering a weapon of opportunity;
- Have a clock visible to both staff and the detained person;
- Have no ligature points;
- An intercom inside the assessment room for staff to use if the patient is too aroused;
- Have a panic alarm system;
- Be located near to other staff and be easily accessed by a team trained in physical intervention and the use of resuscitation equipment;
- Have CCTV to enhance staff protection;
- A mattress for sleeping or resting and to assist any necessary medical examination.

2.4 In close proximity to the assessment rooms the following should be available:

- Washing and toileting facilities with appropriate security protocols;
- Provision of beverages and light snacks;
- Telephone for staff to contact family, carers and other services;
- A place for writing up notes and briefing of assessment unit staff by those involved in the detention;
- A computer for staff linked to the electronic care system to identify relevant background information, current status under the Mental Health Act, crisis plans, advanced statements or decisions;
- Leaflets for patients on Mental Health Act rights, mental health conditions and treatments and local services on offer. Leaflets should be available in less commonly used languages and available electronically where they are not otherwise immediately available;
- Facilities for carers and legal representatives, including a separate waiting area.

3. Staffing

Section 136 coordinator

3.1 Every Health Based Place of Safety should have a designated section 136 coordinator available 24/7. The s136 coordinator must be assigned to the HBPoS at all times; adequate staff must be available to ensure staff do not come off inpatient wards.

Note – Staffing should be modelled off accurate and up-to-date activity data for that area, however contingency plans should be in place for responding to demand that exceeds average usage.

3.2 The s136 coordinator should be performed by the most senior person in the s136 team; it is recommended this is no less than a Band 6 ward nurse.

3.3 There should be a service manager available on call out of hours in addition to the clinical governance hierarchy. When complex issues arise a senior manager should be available above the s136 coordinator via the service manager.

3.4 The s136 coordinator should be the first contact by the Police or Ambulance Service. The s136 coordinator will assume immediate responsibility for:

- Accepting the individual to the Health Based Place of Safety or accommodating the individual through escalation processes or other alternative arrangements;
- Identifying an appropriate Emergency Department if physical health care is required and arranging transport from the Health Based Place of Safety to the Emergency Department;
- Informing the AMHP and Doctor (preferably Section 12 doctor) of arrival of the individual when the first contact has been made and liaising promptly with care partners, family or advocates where required.

Staffing requirements within a Health Based Place of Safety should include the following:

3.6 There should be a minimum of two mental healthcare professionals (minimum of at least one registered mental health nurse) immediately available to receive the individual from Ambulance Service and the Police. One of the two mental healthcare professionals should have CAMHS competencies or access to senior CAMHS advice – for a CYP specific HBPoS.

3.7 These two roles should provide support to the s136 coordinator as well as clinical staff when performing the initial patient safety and risk assessment.

3.8 Extra clinical staff must be available at short notice if required as there should be sufficient staff to cope with all but the most challenging behaviour, without recourse to ongoing police support.

3.9 All staff must have the competencies of all age inpatient staff including the administration of rapid tranquilisation medication. The Trust commissioned to provide the Health Based Place of Safety should ensure these competencies are up to date.

3.10 The use of physical restraint should follow NICE guidelines [NG10]: Violence and aggression: short-term management in mental health, health and community settings. There must be clear protocol about the circumstances when, very exceptionally police may be used to use physical restraint in a Health Based Place of Safety.

3.11 There should be sufficiently trained clinical staff that can take over the restraint if sedation is needed within a Health Based Place of Safety, Police Officers should not be restraining when sedation is administered.

Health Based Places of Safety accessible for children and young people should have the following minimum standard:

3.12 The Health Based Place of Safety should have sufficient staffing to safely manage the mental health needs and care of the young person. This includes a minimum of two nursing

staff (of which at least one should be registered) dedicated to the management of the young person, including line-of-sight supervision and access to additional staff for de-escalation and restraint if needed;

3.13 Staff responsible for the care of a young person must be enhanced DBS checked, have level 3 safeguarding training, an understanding of Children's Act and have developmentally appropriate training (staff trained in understanding the different ways that children and young people are at different stages of psychological development);

3.14 There should be access to on-call CAMHS trained doctors as well as access to general paediatric staff when a medical assessment is required.

Health Based Place of Safety staff physical health competencies:

3.15 Health Based Place of Safety staff (including both nursing and medical staff) should have the following physical health competencies; further detail is provided in Appendix 2.

- Be able to provide basic life support;
- Recognise and refer on the acutely deteriorating patient providing initial supportive treatment, including seizures, chest pain, breathlessness, lowering of consciousness;
- Provide monitoring and basic interventions e.g. hydration to support basic physical health status;
- Manage simple open wounds;
- Screen and respond to non-acute illness including management of non-septic co-morbid infection and identification and onward referral for chronic stable disease;
- Safely administer and monitor medication used or rapid tranquilisation;
- Perform basic lifestyle screen including assessment of risk factors for CVD;
- Screen for, prevent and manage mild alcohol or substance (including nicotine) withdrawal;
- Provide full medical examination and systems review (and if appropriate blood tests) to screen for co-morbid physical health conditions to support onward referral if appropriate.

4. Availability and Access

Initial pick up

4.1 Health Based Place of Safety sites should be open 24 hours a day, 7 days a week.

4.2 Local arrangements should be in place to ensure there is always a suitable health professional for the police to consult with prior to detaining an individual under s136. However the decision to detain and the responsibility of that decision rests with the Police.

4.3 If there is a care plan in place the instructions in the care plan for managing a mental health crisis should be followed to avoid detention under s136;

4.4 Trusts commissioned to provide the Health Based Place of Safety should have dedicated 24/7 telephone numbers in place, to enable the police, ambulance service and crisis teams to always phone ahead prior to the detained individual arriving on site.

4.5 It is the Trust's responsibility to ensure the numbers are available and communicated to key partners and regularly updated on the Directory of Service.

Note: A national access and waiting time standard is being developed for mental health emergency care. In the view of parity of esteem with physical health, it has been decided that a four hour timeline should be set to ensure that mental health emergencies are treated with the same urgency and seriousness as physical health emergencies. The ability of services to meet this standard will be monitored in 2017 and refined for implementation from 2018-19.

5. Assessment

Physical and mental state assessment:

5.1 Clinical staff should be present to meet the patient on arrival at the Health Based Place of Safety. They should conduct an initial patient safety and risk assessment and receive a verbal handover from the ambulance staff or the Police1.

5.2 Healthcare staff should take responsibility for the patient within 15 minutes of arrival, including preventing the person from absconding before the assessment can be carried out. The physical and mental state assessment should occur as soon as a person arrives, no later than 1 hour of the individual being in the HBPoS.

5.3 If the individual has arrived from the Emergency Department sufficient documentation should be provided to Health Based Place of Safety staff. If insufficient or incomplete written documentation has been provided, this should not obstruct the patients care. A serious incident form should be logged which should be fed back and reviewed by the local operational group.

5.4 Staff at the Health Based Place of Safety may request the Police to remain up to a maximum of 1 hour. Any further extension to this time will only be allowed if authorised by a Police supervising officer and is justified on the basis of the risks posed by the detainee. In most cases the Police should be free to leave within 30 minutes.

5.5 Health Based Place of Safety staff must be able to summon extra help at short notice from the Trust's emergency team.

5.6 When appropriate throughout the physical and mental state assessment collateral information should be gathered from the individual's locality mental health services as well as from family and/or carers.

Need to include here the opportunity for interventions to address alcohol use.

1 Handover should include physical health findings, clear detail of mental health presenting circumstances and evolution of patient presentation over time with ambulance staff or the Police.

Transfers to the Emergency Department:

5.7 Emergency physical health needs must always be prioritised over mental health assessment needs. If emergency physical health care needs are identified once the individual is accepted into the Health Based Place of Safety then a decision to transfer a person from the place of safety should be considered by the suitability trained medical professional. In making this decision, consideration must be given to the benefits and risks of the move, any delay and distress caused and any other relevant circumstances.

5.8 If the individual requires physical health treatment at the Emergency Department, once in the department they are the responsibility of Emergency Department staff and the liaison psychiatry team.

5.9 Transporting patients between Health Based Place of Safety and Emergency Departments and vice versa are the responsibility of Mental Health Trusts and Acute Trusts respectively, led by the s136 coordinator. This should not be the Police's role unless there is mutual agreement between parties that it is in the best interest of the patient and Police have capacity to provide support. *For further information on transfers see 'London's s136 care pathway.'*

5.10 A Health Based Place of Safety should not admit an individual that is 'drunk and incapable', where this occurs the person is too high a risk to the safety of the individual or staff and access to the Emergency Department should be arranged. *For further information on the intoxication pathway see 'London's s136 care pathway.'*

5.11 If the person is not adversely affected by intoxication and is fit for interview, they should be conveyed to the Health Based Place of Safety. The Health Based Place of Safety should not be conducting tests to determine intoxication as a reason for exclusion to the site; this should be based on clinical judgement. It is the clinical decision of the suitability qualified doctor at the Health Based Place of Safety to make the final call on where the patient is admitted.

> **Note:** Further detail and definitions in relation to the intoxication pathway is provided in 'London's s136 care pathway' document.

The Mental Health Act Assessment:

5.12 The Mental Health Act Assessment process should be arranged concurrently with the initial physical and mental state assessment and completed within four hours unless there are sound clinical reasons that this should not occur.

5.13 Mental Health Act assessments should not be delayed due to uncertainty regarding the availability of a suitable bed.

5.14 Medical staff at the Health Based Place of Safety should have a direct contact to the Approved Mental Health Professional (AMHP) serving the particular borough or Trust, particularly out of hours. It is the AMHP's responsibility to ensure this number is available to all Health Based Place of Safety staff.

5.15 The Mental Health Act Assessment should include a joint assessment between a doctor and an AMHP. Two doctors should be involved from the outset if the person is likely to require detention.

5.16 One doctor should be approved under Section 12(2) of the Mental Health Act for this role. In exceptional circumstances where Mental Health Act assessments are undertaken by core psychiatry trainees who are not approved under Section 12, a discussion with the senior Section 12 doctor must occur and their name and advice must be recorded in the notes.

5.17 Both the AMHP and the Section 12 doctor should be in attendance within 2 hours in all cases where there are not good clinical grounds to delay assessment.

5.18 Should a person be seen by a registered medical practitioner first and if there is no evidence of mental disorder the person can no longer be detained and must be immediately released, even if not seen by an AMHP.

5.19 The AMHP should be expected to commence the MHA assessment within 4 hours unless there are clinical grounds for delay, such as the person being significantly intoxicated, acutely unwell following self-harm or, after being clinically assessed by the team, is deemed to require more time for their mental state to settle.

5.20 If it is unavoidable, or it is in the person's interests, an assessment begun by one AMHP or doctor may be taken over and completed by another, either in the same location or at another place to which the person is transferred.

5.21 If the doctor sees the person first and concludes that they have a mental disorder and that compulsory admission to hospital is not necessary, but that they may still need treatment or care (whether in or out of hospital), the person should still be seen by an AMHP.

5.22 If the individual is under 18 years old or has recently been referred to adult services they should be taken to an appropriate HBPoS where there is a s12 approved CAMHS specialist doctor, a s12 approved clinician with experience in CAMHS and a AMHP with knowledge and experience of caring for this age group available to undertake the Mental Health Act assessment.

5.23 The Trust commissioned to provide the HBPoS should ensure assessing doctors and AMHPs have up to date knowledge and readily available information of local alternatives to admission, these should be considered as part of the assessment.

5.24 The AMHP and assessing doctors should also have prompt access to interpreting and signing services if required.

The Mental Health At assessment may result in one of five outcomes:

- Doctor concludes there is no mental disorder and the patient is discharged;
- Doctor and AMHP conclude that the mental disorder is not of a nature or degree to warrant admission to hospital for assessment or treatment but the individual may require arrangements for support from community based services;
- Doctor and AMHP conclude that there is a mental disorder, for which the patient agrees that informal admission to hospital is necessary (under section 131 of the Act);
- Doctor and AMHP conclude that there is a mental disorder, and the patient is refusing voluntary admission to hospital. A decision will be taken as to the suitability of an application under the MHA to detain the patient for a defined period of time in a hospital;
- Doctor and AMHP conclude that there is a mental disorder and the patient is refusing voluntary admission and they are subject to a Community Treatment Order (CTO) then…..need further clarification here.

5.25 The person may continue to be detained while these arrangements are being made, provided that the maximum period of detention under s136 (24 hours[2]) is not exceeded. The 24 hour period begins at the time of arrival at the first place of safety (including if the individual needs to be transferred between places of safety).

5.26 Where compulsory admission is indicated, the AMHP should arrange for a second doctor to examine the patient in accordance with the Act.

5.27 After the outcome is agreed, the person should be discharged or transferred to hospital as quickly as possible and the local policy should identify the transport arrangements. Failure to discharge promptly compromises the individual's care.

6. Equipment

6.1 Medical equipment on-site or within close proximity to the Health Based Place of Safety should include:

- ECG Machine
- Equipment for taking routine bloods
- Blood pressure machine (sphygmomanometer)
- Thermometer
- Stethoscope
- Equipment for measuring oxygen saturation levels
- Breathalyser
- Glucose meters (with ketone readings)
- Urine dip stick testing kits
- Weight and height measurement

2 The maximum period of detention is being reduced from 72 hours to 24 hours unless there are clinical/medical reasons for a delay.

- Carbon monoxide monitor
- Peak flow test
- Equipment for measuring respiratory rate
- Resuscitation equipment including a defibrillator
- Saliva substance misuse screening or drug urine testing kits
- Decontamination facilities to remove CS spray and other noxious substances
- Tendon hammer and sensory testing equipment
- Pregnancy testing equipment
- Equipment and dressing for simple open wounds.

7.2 Health Based Place of Safety staff should be able to use the equipment above, interpret test results or have working arrangements with Trust staff in other departments who can do so.

7. Staff Training

7.1 The provision of training should be covered in the jointly agreed policies and procedures developed by the multi-agency group (refer to section 1).

7.2 Healthcare staff who work in a Health Based Place of Safety should be trained in:

- Mental state and mental health assessments
- Risk assessment and management
- Observational skill including the level and manner of detail contained in written observations
- The use of the Mental Health Act, Mental Capacity Act and the Care Act
- The use of physical intervention and safe restraint
- The ability to use resuscitation equipment
- Assessment and management of substance misuse, intoxication and withdrawals and basic physical healthcare (refer to physical health competencies in Appendix 2)
- Rapid tranquillisation procedure
- CPR
- Age appropriate life support
- Liaison with families and carers
- Up to date mandatory training in Trust protocols (i.e. information governance, safeguarding)

7.3 All staff providing care to a young person should have appropriate training in Prevention and Management of Violence and Aggression, the Children's Act and training in developmental approaches to assessment and treatment.

7.4 The Trust commissioned to provide the Health Based Place of Safety is responsible for ensuring the training for staff is regularly available.

8. Patient Information

8.1 During patient handover it is essential that a copy of all information regarding the episode and patient information is transferred. Where available, this should include a copy of investigations undertaken, diagnosis made, discharge plan and any recommended follow up, signed by the medical staff responsible.

8.2 There should be access to appropriate records from all care providers under which the patient has received an episode of care or contact. If the patient is transferred it is the transferring team's responsibility to ensure records are handed over and the receiving team's responsibility to ensure they are uploaded on the clinical notes system.

8.3 The individual should be provided with information about section 136, both orally and in writing. This should be provided in alternative languages or the Health Based Place of Safety must ensure interpreters are available. Health Based Place of Safety staff must ensure the provisions of section 132 (the giving of information) are complied with and access to legal advice should be facilitated where possible.

8.4 The PACE (Police and Criminal Evidence) Code of Practice should be adhered to which requires an appropriate adult to be available for a person who appears to be mentally disordered or mentally vulnerable. This can be a relative, guardian or other person responsible for their care or custody, someone experienced in dealing with mentally disordered or mentally vulnerable people but who is not a police officer or employed by the police.

9. Follow up or discharge

9.1 Follow up care should be arranged for people in their area of residence when they are not admitted to hospital following a mental health act assessment.

9.2 It is the role of the s136 coordinator on that shift to ensure robust systems are in place to confirm onward referrals, discharge plans or discharge letters are received by the appropriate care provider within the next working day and onward services are provided with the information gathered throughout the assessment.

9.3 If patients decline follow up care there may be other issues that need following up (e.g. safeguarding). It is still that shift's s136 coordinator's responsibility to follow up with other local services within the appropriate timeframes; however the tasks may be performed by administrative staff.

9.4 For those discharged there must be ready access to funds to pay for an appropriate mode of transport, 24 hours a day.

Appendix 1: Measurements to be monitored by the local multiagency group

- Percentage of occasions that the police brought patients to the place of safety with no paper record / under the Mental Capacity Act (instead of S136);
- Occasions when S136 was refused access for whatever reason or when police have to wait longer than 15 mins to gain access to HBPoS (e.g. no space, condition of patient);
- Percentage of occasions that police / LAS did not communicate in advance;
- Percentage of occasions police conveyed the patient to the HBPoS without LAS;
- Percentage of occasions that AMHP took over 4 hours to attend where the delay is not clinically acceptable;
- Percentage of occasions that the first S12 doctor took over 4 hours to attend where the delay is not clinically acceptable;
- Percentage of occasions that more than 3 hours elapsed before the assessment began where the delay is not clinically acceptable;
- Percentage of occasions when the HBPoS is full to capacity and Police/LAS are forced to convey elsewhere (including ED);
- Percentage of occasions where the HBPoS transfers patients to ED for physical health treatment;
- Percentage of occasions where the HBPoS is closed due to staff shortages and Police / LAS are forced to wait or convey elsewhere;
- Percentage of occasions where a police cell is used for both adults and children and young people;

  (Legislation is being amended so children and young people aged under 18 are never taken to police cells if detained under S135 or S136, and ensuring that police cells can only be used as a place of safety for adults suffering a mental health crisis if the person's behaviour is so extreme they cannot otherwise be safely managed elsewhere).
- Percentage of occasions where police had to remain for over an hour before HBPoS staff were able to take over.

Appendix 2: Physical Health Care Medical and Nursing Competencies

**M refers to medics only*

Be trained and competent in delivery of intermediate life support including appropriate use of a defibrillator.

Be able to summarise and communicate acute physical health presentation including relevant investigations in a clear, structured and efficient manner to other health professionals.

Have received training in and be competent in early identification and management of the deteriorating patient. Be familiar with the presentation and acute management of infection, physical trauma, shortness of breath, chest pain, lowering of consciousness and aware of the need for rapid response and referral.

Be able to provide emergency assessment, support, interventions and referral in the event of a seizure.

Be able to assess shortness of breath including measurement of peak flow, respiratory rate and be able to administer acute medications for shortness of breath including inhaler, nebuliser and oxygen.

Be able to perform fluid status assessment.

Be able to assess, complete and evaluate documentation regarding include food and fluid intake and output and be able to respond appropriately and in a timely way to findings.

Be aware of the risk of deterioration in suspected infection and the importance of fluid management and rapid administration of antibiotics if prescribed.

Be able to conduct a risk assessment for DVT and escalate as appropriate.

Be aware of and be able to assess for hyper or hypoglycaemia.

Be able to provide acute emergency treatment for hyper or hypoglycaemia and refer onwards as appropriate.

Be able to complete, document and act upon basic physical observations (pulse, temperature, blood pressure, heart rate, capillary glucose levels). Be aware of cut offs indicating an abnormality and be able to respond appropriately to these in accordance with NEWS/ MEWS chart monitoring and escalation protocols.

Be able to perform an ECG and understand and act upon required governance protocols surrounding conducting medical investigations by ensuring an appropriately qualified professional is shown, interprets and as appropriate acts upon the ECG.

Be able to interpret an ECG and refer onwards for more specialist advice as appropriate. (M)

Be trained in phlebotomy and be able to safely take bloods. Be aware of governance protocols surrounding conducting medical investigations and ensuring an appropriately qualified professional is alerted that bloods have been taken and assumes responsibility for following up and acting on results.

Be able to interpret and act upon abnormalities in routinely conducted blood tests. (M)

Be able to safely assess for the presence of drug or alcohol intoxication. Be able to perform assessments including urine drug screens and breathalyser to broadly identify nature of substance intoxication and provide supportive management.

Be aware of the risks associated with acute withdrawal or intoxication in respect of both physical and mental health.

Be able to initiate a treatment plan to prevent deterioration or withdrawal from alcohol or substances. (M)

Be able to identify early signs of withdrawal and initiate appropriate treatment.

Be able to apply monitoring scales to monitor and quantify symptoms of withdrawal to guide treatment.

Be able to complete a body map.

Be able to perform basic wound assessment and communicate these findings.

Be able to appropriately change simple wound dressings maintaining a sterile field.

Be able to seek advice on wound management from appropriate professionals including transfer of consented secure images for advice as required.

Be able to assess a wound and perform basic wound closure. (M)

Be able to conduct a basic health and lifestyle screen including assessment of smoking, drug and alcohol intake, diet, exercise and engagement with health providers including dentist, optometrist, GP and allied health professionals.

Be able to perform a nutrition screen including documentation of height, weight and assessment of BMI. Be able to provide basic dietary advice.

Be able to conduct a full systems review and physical examination to screen for acute and chronic medical conditions. Be able to act upon or refer onwards these conditions as appropriate. (M)

Be able to take a smoking history and establish smoking status including use of carbon monoxide assessment. Be able to deliver basic smoking cessation advice, initiate nicotine replacement therapy and refer onwards to smoking cessation support as appropriate.

Be able to take a sexual health history including risk factors for blood born viruses. Be able to counsel and consent for relevant investigations. (M)

Be able to consent an individual for a pregnancy test and carry out and interpret the test.

Be able to assess for the requirement of rapid tranquilisation and initiate treatment if required. (M)

Be able to safely and appropriately monitor individuals according to protocol after the administration of medications for rapid tranquilisation.