National Clinical Programme for Self-Harm and Suicide-related Ideation Operational Guidance Document for the Emergency Department Programme

Version 4 -2024

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Table of Contents

		Page
1.0	**Purpose**	3
1.1	**Scope**	3
1.2	**Objectives**	3
1.3	**Operational Guidance Document Group**	3
1.4	**Supporting Evidence**	3
1.5	**Abbreviations and Glossary Terms**	5
2.0	**Introduction**	6
3.0	**Service Aims**	6
4.0	**Service Objectives**	7
5.0	**National Database**	7
5.1	**The role of the CNSs / RANPs in data submission and national ED database**	7
5.2	**The use of the National ED database and outputs**	8
6.0	**Patient Journey**	8
6.1	**Assessment of Children**	9
6.2	**Families / Carers**	10
6.3	**Evaluation**	10
6.4	**Environment**	10
6.5	**Governance**	10
6.6	**Clinical Reporting Relationships**	11
6.7	**Programme Governance**	11
6.8	**Education and Learning**	12
6.9	**Documentation**	12
6.10	**Confidentiality**	12
7.0	**Roles and Responsibilities**	12
7.0	**National Clinical Programme Office**	12
7.1	**Area Management Teams**	13
7.2	**Clinical Nurse Specialist Nurse ED / Registered Advanced Nurse Practitioner and Clinical Lead**	13
7.3	**Location and Working Relationship**	14
7.4	**Supervision**	14
Appendix 1	**Membership of the Implementation Advisory Group (IAG)**	15

1.0 Purpose

The purpose of this Operational Guidance Document is to provide a standardised methodology to aid services to establish the Emergency Department Self-Harm Programme in the local service area.

This Operational Guidance Document outlines the process to meet the requirements fulfilled by the National Clinical Programme for Self-Harm and Suicide-related ideation (NCPSHI), in the updated Model of Care (MOC) 2022 – Chapter 3, 4, 5 and 6.

https://www.hse.ie/eng/about/who/cspd/ncps/self-harm-suicide-related-ideation/moc/mhncp-self-harm-model-of-care.pdf

1.1 Scope

The scope of this Operational Guidance Document relates to patients presenting in the Emergency Department (ED) following self-harm, or with suicide-related ideation.

The programme will be delivered through a whole team approach across mental health services and the ED team.

1.2 Objectives

To outline the process for the assessment and onward care of all patients who present following self-harm or with suicide-related ideation to the acute hospitals Emergency Department and for local services to align delivery of the service to the NCPSHI's revised MOC (2022).

To provide a standardised, safe and informative process that supports health professionals and managers of services to implement the Emergency Department component of the programme.

1.3 Operational Guidance Document Group

See Appendix 1 for the membership of the Implementation Advisory Group (IAG).

1.4 Supporting Evidence

Supporting evidence includes, but is not restricted to the following:

Bórd Altranais agus Cnáimhseachais na hÉireann (2015) *Scope of Nursing and Midwifery Practice Framework NMBI*, Dublin www.nmbi.ie

Bórd Altranais agus Cnáimhseachais na hÉireann (2017) *Advanced Practice (Nursing) Standards and requirements. NMBI*, Dublin www.nmbi.ie

Bórd Altranais agus Cnáimhseachais na hÉireann (2014) *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives NMBI*, Dublin www.nmbi.ie

Bórd Altranais agus Cnáimhseachais na hÉireann (2002) *Guidelines on Clinical Recording of Practice for Registered Nurses and Registered Midwives NMBI*, Dublin www.nmbi.ie

Data Protection Act (1988) & (2003). *Government Publications Sales Office*. Dublin

Department of Children and Youth Affairs (2017) *Children First: National Guidance for the prevention and welfare of children*. Government Publications Sales office. Dublin

Health Service Executive (2019) *HSE Child Protection and Welfare Policy*. HSE, Dublin.

Department of Health (2020) *Sharing the Vision: A Mental Health Policy for Everyone*. Dublin. https://www.gov.ie/en/publication/2e46f-sharing-the-vision-a-mental-health-policy-for-everyone/

Department of Health and Health Service Executive (2022*) Implementation Plan 2022-2024 Sharing the Vision A Mental Health Policy for Everyone.* Dublin.

Health Service Executive (2022) *National Clinical Programme for Self-Harm and Suicidal-related Ideation; Updating the National Clinical Programme for the Assessment and Management of Patients presenting to the Emergency Department following self-harm.* Dublin, HSE Clinical Design and Innovation Office. https://www.hse.ie/eng/about/who/cspd/ncps/self-harm-suicide-related-ideation/moc/mhncp-self-harm-model-of-care.pdf

Health Service Executive (2020) *Building the Capacity for the Evaluation of Social Prescribing. A publication of HSE Health and Wellbeing*. National Office of Suicide Prevention and the Department of Health. https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/social-prescribing-summary.pdf

Health Service Executive (2010) *HSE Code of Practice of Healthcare Record Management* (Abbreviations), HSE, Dublin.

Health Service Executive (2001) *Quality and Fairness*. HSE, Dublin

Kavalidou, K., Zortea, T., Griffin, E & Isabela Troya, M. (2023) Profile of people attending emergency departments with thoughts of self-harm and suicide: A descriptive study of a nurse-led programme in Ireland. *International Journal of Mental Health Nursing*, 00:1-10 doi: 10.1111/inm.13146

Mental Health Act 2001

National Office of Suicide Prevention (2020) *Connecting for Life Implementation Plan 2020-2022*. https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/cflimplementation-plan-dec-2020.pdf

National Suicide Research Foundation (2021) *National Self-Harm Registry Ireland – Annual Report* 2021. NSRF, Cork.
https://www.nsrf.ie/wp-content/uploads/2022/09/NSRF-annual-report-2021-digital.pdf

Ross, E., Murphy, S., O'Hagan, D., Maguire, A., & O'Reilly, D. (2023). Emergency department presentations with suicide and self-harm ideation: A missed opportunity for intervention? *Epidemiology and Psychiatric Sciences, 32,* E24. doi:10.1017/S2045796023000203

The above list is not exhaustive and new and emerging evidence must always be taken into consideration when using this OPERATIONAL GUIDANCE DOCUMENT to enhance the process.

1.5 Abbreviations and Glossary of Terms

ADON	Assistant Director of Nursing
Area DON	Area Director of Nursing
CMHT	Community Mental Health Team
CAMHS	Child and Adolescent Mental Health Services
CNS	Clinical Nurse Specialist
CL	Clinical Lead
CFL	Connecting For Life
ED	Emergency Department
ESP	Emergency Safety Plan
ECD	Executive Clinical Director
GP	General Practitioner
HSE	Health Service Executive
HST	Higher Specialist Trainee
IAG	Implementation Advisory Group
MOC	Model of Care
NCHD	Non Consultant Hospital Doctor
NCPSHI	National Clinical Programme for Self-Harm and Suicide-related Ideation
NICE	National Institute for Health and Care Excellence
NMBI	Nursing Midwifery Board Ireland
NOSP	National Office for Suicide Prevention

NSSG	National Suicide Crisis Assessment Nurse (SCAN) Steering Group
RANP	Registered Advanced Nurse Practitioner
PLAN	Psychiatric Liaison Accreditation Network
StV	Sharing the Vision
SCAN	Suicide Crisis Assessment Nurse
WTE	Whole Time Equivalent

2.0 Introduction

The National Clinical Programme for Self-Harm and Suicide-related Ideation (NCPSHI) recognises that people who present following self-harm or with suicide-related ideation are at increased risk of dying by suicide in the future. It is estimated that approximately half of all people who die by suicide have previously self-harmed (Foster et al 1999).

Key pillars of the revised model of care (MOC) 2022 are that people who present to health services following self-harm or suicide-related ideation should receive brief interventions in the form of an empathic, validating, compassionate and trauma-informed response; a timely expert biopsychosocial assessment and intervention, including a written emergency safety plan, and follow up and linkage to next appropriate care (NCPSHI 2022).

3.0 Service Aims

The role of the mental health professional in the ED is to provide the four clinical components of the programme – an empathetic response, an expert assessment and intervention, family/supporter involvement and follow up and bridging to next care appointment to all patients who present following self-harm or with suicidal ideation.

As part of the NCPSHI programme each CNS / RANP and Consultant Psychiatrist / Clinical Lead should be available to provide advice and guidance on various mental health presentations to ED staff as required.

4.0 Service Objectives

The mental health services should ensure that the NCPSHI in the ED is delivered 24 hours a day, 7 days a week. The service is delivered by CNS / RANP and mental health medical professionals and all should be implementing the components of the NCPSHI.

The NCPSHI is led by a named Consultant Psychiatrist serving as NCPSHI Clinical Lead and delivered by a team of MH professionals.

5.0 National NCPSHI Database

Establishing the extent of suicidal behaviour is a fundamental step in the prevention of suicide. Self-harm, defined as suicidal behaviours with and without suicidal intent, is a strong predictor of further suicide. Recent evidence indicates that those presenting to hospitals with suicidal or self-harm thoughts have a 10 fold risk of dying by suicide (Ross et al., 2023). As suicide prevention policies should be informed by "real time data" based on patients' presentations, the NCPSHI is the only source in Ireland providing data due to both self-harm and suicide-related ideations. In 2019 the National Office for Suicide Prevention (NOSP) provided an expert on suicide research and prevention, who in 2020 established the National ED database including all the assessment information collected by the CNSs / RANPs from all participating hospitals, since 2018. Currently the national ED database includes clinical information for approximately 70.000 presentations. The items/variables of the database, include among others:

- Sociodemographic characteristics and general information: gender, age, employment status, ethnicity, living situation, time of presentation, assessed or not and reasons of not being assessed, time to CMHT appointment, discharged from ED times, seen by, referred by.
- Suicidal crisis outcomes: self-harm methods, lethality of methods, suicidal ideation, self-harm ideation, suicidality history.
- Clinical information: substances contributing to the presentation, currently attending mental health services (private, voluntary, HSE), admitted to an approved centre, next referrals.
- NCPSHI interventions: follow up call for those presenting and assessed, follow up call to those not being assessed/seen, biopsychosocial assessment, collateral history, emergency safety plan, next of kin involvement.

5.1 The role of CNSs / RANPs in data submission and national NCPSHI database

The CNS / RANP appointed through NCPSHI is responsible for ensuring that data is collected and submitted to the database manager on each presentation to the ED. The CNSs / RANPs collect anonymised and de-identifiable presentation data. As the NCPSHI was established for service improvement purposes, individuals are not identified and only the characteristics of all the suicide-related attendances are contained in the national database. The data are collected through prespecified electronic templates for all hospitals and submitted to the database manager on a monthly base. As part of educational/training programme, the CNS / RANP are required to attend data training events, and ad hoc data calls.

5.2 The use of the National NCPSHI database and outputs

The national database will be utilised in order to provide data service reports to each NCPSHI participating hospital. These reports will be send to each service biannually and will present key information of each service, measuring standards against national metrics. In January 2024 the first of the service report series will be finalised and given to each service, covering

data information from 2018-2022. The ED database will also be the source of developing national NCPSHI reports, published annually at the NCPSHI webpage.

The database will be further used in research outputs in collaboration with suicide and mental health researchers, both locally in Ireland and internationally. In 2023 the NCPSHI published two studies in collaboration with researchers from the National Suicide Research Foundation (NSRF), University College Cork and colleagues from England.

The importance of the national database will be further used for internal HSE requests, HSE reports and to inform answers to PQs.

6.0 Patient Journey

Following referral from the ED medical team, the suitably qualified mental health professional is to carry out a timely, comprehensive expert bio-psychosocial assessment in the emergency department, to determine the patient's mental health and social care needs.

- A written policy on local referral procedures should be developed by services in collaboration with ED and mental health staff. This must include what to do when a patient leaves the ED before a completed assessment.
- Following assessment the CNS / RANP / Psychiatry NCHD must review the case with a Consultant Psychiatrist or Higher Specialist Trainee (HST).
- Liaise with a family member, carer or accompanying adult, for collateral information where possible and appropriate and with the patient's permission.
- Following the assessment and in collaboration with the patient and where appropriate a family member, carer or accompanying adult, to develop a collaborative written Emergency Safety Plan (ESP).
- The ESP is co-produced with the individual and their family member, carer or accompanying adult, and develops a written plan for the following 24 hours. A copy of this written ESP should be offered to every patient and family member, carer or accompanying adult unless clinically inappropriate and the reason is documented. A copy of the ESP is kept in the medical records.
- The ESP should include information on a safe environment, who to contact in an emergency and what the next professional contact should be, while addressing what the individual needs to do, what the family member, carer or accompanying adult needs to do and what the services needs to do.
- A copy of this written ESP should be sent by secure email (health-mail and depending on local arrangements) to the patient's GP surgery.
- The case should be presented to the Consultant Psychiatrist or HST. The timing of the discussion with the Consultant Psychiatrist or HST depends on the skill and experience of the clinician.
- Patients assessed out-of-hours by Psychiatry NCHD should be recorded and a handover of patients for follow up is provided to the CNS / RANP. A clear local policy and procedure should be developed for this handover process.
- It is the responsibility of the service to ensure that the ESP is completed, a letter is sent to the GP and, if required, notes or referrals are sent to the next care service.
- Each patient discharged from ED following a presentation with self-harm or suicidal ideation, including those discharged out of hours, must be offered a telephone call the next working

day from the CNS/RANP, to offer support and discuss their ESP further. The CNS / RANP or psychiatry NCHD will have discussed and agreed this procedure with the patient prior to discharge from ED.

- In some cases, additional contacts may be required, to facilitate engagement in the next appropriate care. The CNS / RANP will liaise with the appropriate next care to ensure adequate follow up prior to closing the case.
- If indicated, the patient will be offered a brief follow-up support, usually to a maximum of 3 contacts, with the aim of facilitating engagement with relevant services to address their needs.

6.1 Assessment of Children

The principles of care delivered apply equally to adults and children. The core general recommendations are also applicable to the care of children. Children should be assessed in line with the acceptance criteria / policy for that hospital emergency department and mental health service area.

As patients assessed under the NCPSHI have mental health needs a child is defined as any patient under 18 years, and staff should follow the recommendations below:

- A written policy on referral procedures should be developed by ED and mental health staff. This policy should include issues of child assent, parental consent and social work involvement for patients under 18 years.
- Timely access to Mental Health Services must be available at all times for children attending the ED with a mental health crisis.
- Each ED that is open 24/7 should have defined access to assessment by Child and Adolescent Mental Health Services (CAMHS) through a simple referral procedure.
- There should be dedicated Liaison CAMHS supported by the on call CAMHS.
- This service should be accessible 24/7 via a single point of contact.
- The service responsible for assessment of children up to the age of 18 in the ED should be explicit.
- Consent should be obtained for mental health assessment from the parent or guardian.
- Where a CAMHS Consultant-led multidisciplinary liaison team is in place, each child will receive a response from a liaison team. CAMHS services have a responsibility to ensure each child who presents to the ED following self-harm or with suicidal ideation also receives all four components of the NCPSHI.
- All staff should follow the Children's First Guidelines (2017) and the HSE Child Protection and Welfare (2019) policy and be aware of the designated liaison officer in their hospital. All staff must complete mandatory training in these areas and records kept locally.

6.2 Families / Carers

All those who present following self-harm act, or with suicidal ideation should be actively supported to nominate a family member/carer who can provide a collateral history and who will be advised on suicide prevention care before the patient is discharged.

- Every effort should be made to involve a family member or trusted adult in assessment and in safety planning.
- Family member/trusted adult should co-produce the emergency safety plan, along with the patient and the mental health clinician.
- Family member/ trusted adult should be supported in supporting their loved one, including being given a copy of; '*Would you know what to do if someone told you they were thinking of suicide?'* Copies can be ordered by services from Health Promotion website at https://www.healthpromotion.ie/
- Confidentiality is paramount but there are situations where it can be breached, such as risk to the individual. Even in situations where it is not appropriate to breach confidentiality, listening to family members/carers is important and is not precluded by confidentiality.
- Support for family members/carers can also be provided without breaching confidentiality.
- ED staff should be able to access a mental health professional to provide advice and support to family members and to take any collateral history a family may wish to give.

6.3 Evaluation

- Data is an important element in monitoring the implementation of this clinical programme and identifying the benefits to service users and their families. The CNS in self-harm and/or the CNS team / RANP collect and input data monthly into the NCPSHI prespecified electronic templates in a timely manner using agreed process. The assistant director of nursing should review the data with the team before submitting it. This is explained in detail in points 5.1, 5.2 and 5.3.
- NCPSHI clinicians should obtain feedback on the experience of people who access the service.
- The NPCSHI clinicians will engage in clinical audit and research evaluation of the service and associate issues, on a local and national basis, in collaboration with other mental health services as appropriate, aiding the involvement of patients in service development and contributing to the formation of a national clinical / academic forum.

6.4 Environment

- Interview / assessment facilities should provide an appropriate level of safety and comfort for patients and staff.
- NCPSHI will support mental health clinicians, local mental health service managers and the emergency medical clinicians and hospital managers, working together to ensure services in the ED have a suitable room for the assessment of people who require a mental health assessment. The Psychiatric Liaison Accreditation Network (PLAN) has identified standards for this assessment room as described in the MOC.

6.5 Governance

- There should be a weekly clinical supervision meeting between the CNS/RANP and mental health clinicians implementing the programme in the ED and the Consultant Psychiatrist clinical lead for the NCPSHI.

- NCPSHI and the Emergency Medical Programme promote the interface and development of good working relationships between the ED and mental health services, through quarterly meetings.
- Mental health staff should provide training for ED staff on mental health and self-harm awareness. This training should be developed and delivered in collaboration with people with lived experience.
- A local policy must be in place on what to do when a patient leaves before a completed assessment. It is the responsibility of the ED staff, working with the mental health staff, to develop a clear protocol on contacting these patients' GP where possible and ensuring they have an opportunity to link with next appropriate care.
- The NCPSHI clinical staff will participate in local clinical supervision arrangements and national peer supervision groups.
- The mental health service should provide suitable office facilities and IT equipment for clinicians implementing the programme in close proximity to the emergency department.

6.6 Clinical Reporting Relationships

- The clinical reporting relationship for CNS in Self-Harm is to an RANP or a consultant Psychiatrist. The RANP will report clinically to a Consultant Psychiatrist.
- The CNS in Self-Harm professional and managerial reporting relationship is to the Assistant Director of Nursing (ADON) and Area Director of Nursing (Area DON) or Director of Nursing. The ADON or Area DON is required to meet the CNS / RANP, at a minimum, every two months, to review and support personal and professional development.
- The CNS and RANP practitioners will meet monthly with their line manager to discuss service issues, service development, data and other professional issues that may arise.
- The service should develop a career pathway to progress to Registered Advanced Nurse Practitioners (RANP) for CNS's implementing the programme in the Emergency Department.
- Staffing of nursing team is at Clinical Nurse Specialist (CNS) grade with the progression to Advanced Practitioner (RANP) grade. The NCPSHI will support the introduction of additional resources through the annual HSE estimates process.
- There are three variants of governance arrangements as outlined below all of which are based on the principle of the nurse reporting on clinical matters to a named consultant psychiatrist.
- ***HSE Hospital with Liaison Service***. The CNS / RANP is a member of the Liaison Psychiatric Team and reports on clinical matters to the consultant psychiatrist in that team.
- ***Non HSE Hospital where the Consultant Liaison Psychiatrist is employed by that hospital.*** The CNS / RANP is a part of the Liaison Psychiatry Team and reports on all clinical matters to the liaison consultant in that team. In this situation there must be close working relationships between the Area DON Mental Health and the DON of the acute hospital to ensure a smooth professional working relationship for the nurse(s).
- ***Acute Hospital with no Liaison Service.*** There must be a named HSE Consultant Psychiatrist in the Mental Health Area to whom the nurse reports and provides supportive supervision on clinical matters.
- The variant in any particular hospital must be stated in the Local Operational Policies & Guidelines for each nurse. Good governance requires regular (e.g. quarterly) ED-Mental Health service meetings to optimise communication and risk management.

6.7 Programme Governance

- NCPSHI programme reports monthly to NCAGL Mental Health
- The NCPSHI Implementation Advisory Group (IAG) made up of clinicians, academics, service development advocates, services users and policy makers to champion, advance and support the implementation of the ED programme nationally will meet quarterly or as required.
- NCPSHI programme has established a meeting where by all CNS / RANP nurses attend regular meetings with the NCPSHI team throughout the year.

6.8 Education and Learning

- Mental health clinicians implementing the programme in the ED will participate in all mandatory training and network events organised through the NCPSHI. A series of online and in person events will be arranged by NCPSHI to address training needs and emerging evidence.
- All data reports will be reviewed locally and with NCPSHI team to advance best practice and learning. Attendance at data training is mandatory for all clinicians.
- Inter discipline learning will be encouraged.
- Each CNS / RANP as part of the team should develop a resource file of agencies, community groups, counselling agencies and others who provide relevant support and information for people in crisis (including financial and social issues).

6.9 Documentation

- Documentation resulting from referral, assessment, follow up/bridging work and onward referrals will be recorded and filed in accordance with local HSE service policy.
- Patients seen on a medical or surgical ward should have their assessment and safety plan recorded in the patients' chart on the ward.
- Follow up interventions should be recorded by the CNS / RANP. When the patient is discharged from the nurse caseload a copy of the discharge letter should be filed in the ED notes or medical file.
- A recorded procedure should be used by NCHDs who assess patients out of hours. This will facilitate the CNS / RANP in following up and entering the data on the electronic template.
- All computers, storage devices and paper documentation/files containing patient information are stored in accordance with HSE policy and GDPR legislation.

6.10 Confidentiality

- All communication should be in line with HSE policy on communication and consent and relevant legislation.

7.0 Roles and Responsibilities

National Clinical Programmes Office

The roles and responsibilities of the NCPSHI Office include the following:

- Support and co-ordinate the implementation of the clinical programme in each Emergency Department (ED);
- Develop a training model that is sustainable;
- Maintain a data base of staff appointed to each ED;
- Manage, review and report on data nationally;
- Collaborate with the National Registry of Self-Harm;
- Collaborate with National Office for Suicide Prevention in delivering Connecting for Life;
- Work with others within the HSE in embedding the Clinical Programme into day to day operations.

7.1 Mental Health Management Team

The roles and responsibilities of the Area Management Teams include the following:

- Establish a service in each ED to deliver this programme, including the appointment of a Clinical Lead;
- Develop relevant policies and procedures in collaboration with ED staff as required;
- Facilitate staff in the area to attend supervision and all training as required for the role;
- Monitor data from ED against national KPIs.
- Work with the NCPSHI Office in implementing the Clinical Programme;
- Establish clinical forums to ensure the Clinical Programme activities are well integrated with other activities of the Mental Health Service.

7.2 CNS / RANP Nurse, Emergency Department and Clinical Lead

The role of the Clinical Nurse Specialist (CNS) and Registered Advanced Nurse Practitioner (RANP) working in the Self Harm Clinical Programme is to provide a rapid response (assessment and follow-up) to people presenting to Emergency Departments with self-harm and suicidal ideation where this is the primary problem. This will include providing follow up for those patients assessed out-of-hours by Psychiatry NCHD.

In addition, the nurses will also assess and follow-up those patients who are in-patients in the acute hospitals' medical and surgical wards having required medical or surgical treatment as the first intervention for self-harm.

The nurses must work closely with the ED team, optimising communication with ED staff to ensure that standards are met and cascading skills to all ED staff in order to improve practice skills in triaging and managing patients who present.

CNS / RANP must deliver care in line with core competencies required for CNS / RANP including clinical audit, quality improvement, education and data.

The nurse must work closely with community agencies that can provide on-going support and follow-up for patients. Any CNS / RANP appointed to work with children has a role in the liaison and integration of community and acute hospital services.

The roles and responsibilities of the CNS / RANP Nurse in the Emergency Department and Clinical Lead include the following:

- Deliver the four components of NCP to all patients who present to ED following self-harm or with suicidal ideation ;
- Work with members of ED staff to provide parallel assessments. deliver awareness training on suicide and self-harm to ED staff;
- Attend and engage with clinical supervision locally and nationally as organised in relation to this clinical programme;
- Attend and participate in all training and educational opportunities provided to develop skills further in this clinical area. Maintain a log book of all training and education activities;
- Understand the importance of quality improvement including data in the development of services. Record, review and submit data monthly to Database Manager or as required.

7.3 Location and Working Arrangements

Each CNS(s) / RANP will be based in the Emergency Department of the Acute Hospital. The nurses will work under the supervision of the Consultant Psychiatrist named as Clinical Lead. The CNS / RANP will have close working relationships with the liaison team (where present), and through his/her role supplement existing service provision.

One to two nurses at Clinical Nurse Specialist (CNS) grade have been allocated to each ED which provides 24/7 access to emergency care. The number of CNSs allocated is proportionate to the overall number of self-harm presentations to that ED per year. From 2017 this number is based on data returned to the National Clinical Programme Office.

The period 8am - 8pm 7 days/week are the core hours of work and the CNS(s) should be rostered to ensure the maximum number of hours is covered at any one time.

Following assessment of the annual activity data for this clinical programme, further resources will be allocated to increase the days and hours of cover.

7.4 Supervision

All Nurses / NCHD's providing this intervention should have an appropriate level of competence in delivering the intervention and be regularly supervised by a competent Clinical Consultant supervisor. Each assessment must be discussed with a Consultant Psychiatrist or Higher Specialist Trainee.

It is recommended that each CNS / RANP / NCHD maintain a record of continuing professional development and that a minimum of 3 cases are supervised by a named Consultant Clinical Lead for a new clinician.

All CNS / RANP should receive weekly supervision from the Clinical Lead. All nurses should receive, at a minimum, monthly supervision from their Assistant Director of Nursing or Area Director of Nursing.

Nursing administration in the Acute Paediatric Hospitals and the Mental Health Service should meet regularly to review supervision.

Appendix 1: Membership of the National Implementation Advisory Group (IAG)

NAME	TITLE
Professor Vincent Russell	**National Clinical Lead NCPSHI**
Ms Sally Lovejoy	**National Nurse Lead NCPSHI**
Ms Rhona Jennings	**Programme Manager NCPSHI**
Dr Katerina Kavalidou	**Database Manager NCPSHI**
Dr Cliff Haley	**Consultant Psychiatrist – General Adult**
Dr Gerry McCarthy	**National Clinical Lead Emergency Medicine Programme**
Dr Leonard Douglas	**Consultant Psychiatrist – Psychiatry of Later Life**
Mr Ned Kelly	**Area Director of Nursing CHO4 Mental Health Services**
Ms Jenni Fouhy	**Clinical Nurse Specialist CHO4**
Ms Michelle Murray	**Clinical Nurse Specialist CHO1**
Dr Eric Kelleher	**Consultant Liaison Psychiatrist**
Ms Fiona McDaid	**National Nurse Lead Emergency Medicine Programme**
Mr. Michael Joseph Kennelly	**Person with lived experience**
Ms. Theresa Hunston	**Assistant Director of Nursing, Carlow SCAN**
Dr Mary Scriven	**General Adult Consultant Psychiatrist, Mullingar**
Dr Eamon Keenan	**National Clinical Lead in Addiction Services**
Professor Ella Arensman	**Professor in Public Mental Health UCC and Chief Scientist, NSRF**
Ms Linda Moore	**Head of Service Mental Health Group**
Ms Sarah Toye	**SCAN Nurse, Donegal Service**
Dr Anne-Marie Waldron	**Clinical Director, North Dublin CAMHS**

Mr Derek Chambers	**General Manager (Policy Implementation) – National Mental Health Operations HSE**
Dr Paul Corcoran	**Head of Research, NSRF**