National Clinical Programme for the Assessment and Management of Patients who Present to Emergency Department Following Self-Harm

Standard Operating Procedure

Version 2.0 – 2018

National Clinical
& Integrated Care Programmes
Person-centred, co-ordinated care

HSE Mental Health Services

READER INFORMATION

Office: National Clinical Advisor and Group Lead – Mental Health

Title: National Clinical Programme for the Assessment and Management of Patients who present to Emergency Department following Self-Harm act.

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Web: To access SOP please click:

http://www.hse.ie/eng/about/Who/cspd/ncps/mental-health/self-harm/resources/

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1. INTRODUCTION

1.1 Purpose

Self-harm is the single biggest risk factor for completed suicide, increasing the risk of suicide 40-fold, as compared to the general population (Owen et al 2002). In 2016, more than 11,000 people came to Emergency Department (ED) following self-harm.

The aim of this clinical programme is to develop a standardised and effective process for the assessment and management of all age groups who present to ED following self-harm or with suicidal ideation. It aims to ensure that all patients receive a standardised triage, bio-psychosocial assessment, have access to skilled clinicians, involvement of family / carers, emergency care plans and appropriate follow up.

By providing these interventions we aim to reduce the number of people who leave before assessment and reduce the number of repeat attendees.

This standard operating procedure (SOP) is to aid services to establish the service locally. It should be read in conjunction with National Model of Care and the Review of the Operation of the Programme. Both can be accessed at the following URL:

http://www.hse.ie/eng/about/Who/cspd/ncps/mental-health/self-harm/

1.2 Scope

All patients, of all ages, presenting in Emergency Department (ED) following self-harm, or with suicidal ideation.

Each CNS or Psychiatry NCHD on call will assess all patients who present following self-harm or with suicidal ideation to the acute hospital whether the patient comes from the Mental Health Services area or not and in line with hospital acceptance criteria.

As part of the programme each CNS should be available to provide advice and guidance on various mental health presentations to ED staff as required.

1.2.1 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.

As patients assessed under the Clinical Programme have mental health needs a child is defined as any patient under 18 years, and staff should follow the SOP recommendations related to children.

1.3 Requirements to Deliver the Clinical Programme

In 2013, 35 posts were allocated to this clinical programme. Post(s) were allocated to each ED (1 CNS per 250 presentations) based on the data from the National Registry of Self Harm Ireland. Each post is graded at Clinical Nurse Specialist (CNS). In addition, the Non-Consultant Hospital Doctor (NCHD) in Psychiatry provides assessment out-of-hours and in conjunction with the CNS and Liaison Psychiatry Team or equivalent during normal working hours.

In 2017, a full review of the operation of this clinical programme identified the need for 1 CNS per 200 presentations per annum. This additional resource allocation in all but the smallest acute hospitals will allow the CNS to provide ED assessments from 8am to 8pm 7 days a week, to follow-up on all patients assessed, including those assessed out-of-hours by the Psychiatry NCHD, and to advise and educate ED staff on self-harm and suicide awareness and management skills.

Children presenting following self-harm or with suicidal ideation require specialist input from Child and Adolescent Mental Health Specialists. This can be a Consultant Psychiatrist providing advice and supervision to a Psychiatry NCHD or Clinical Nurse Specialist. In 2018 3 CNS posts will be allocated to the programme to provide a service for children presenting to each of the 3 Dublin Paediatric Hospitals during core working hours.

2. PATIENT JOURNEY

2.1 Referrals

All patients who present following a self-harm act or with suicidal ideation should be referred for a bio psychosocial assessment by a suitably trained Specialist Nurse or Psychiatry NCHD as early as possible following presentation. Assessment can be parallel with physical assessment. A written policy on referral procedure 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.

2.2 Assessment

Each patient must have a comprehensive **biopsychosocial (BPS) assessment** by a suitably qualified CNS / Psychiatry NCHD as early as possible following presentation. Immediately following the assessment the CNS / Psychiatry NCHD must have telephone access to a Consultant or Senior Registrar. A local policy must be in place on what to do when a patient leaves before a completed assessment.

The biopsychosocial assessment should focus on providing compassionate support, completing a full assessment of the patient's needs and developing an emergency care plan with the patient and their next of kin.

Interview / assessment facilities should provide an appropriate level of safety and comfort for patients and staff and follow the recommendations from Psychiatric Liaison Accreditation Network, as described in the Model of Care and Review of the Operation of the Clinical Programme.

The assessment of a child also involves the comprehensive assessments of the parents / person in loco parentis and the ability of the parents / person in loco parentis to meet the child's needs. All staff should follow the Children's First Guidelines and be aware of the designated liaison officer in their hospital.

Patients assessed out-of-hours by Psychiatry NCHD should be recorded and a handover of patients for follow up provided to the CNS. A clear local policy and procedure should be developed for this handover. A checklist should be completed prior to handover. Refer to **Appendix 1 – Self-Harm Care Pathway** for further information.

2.3 Emergency Care Plan

A written Emergency Care Plan (ECP) that addresses clinical needs and a safety plan should be formulated and documented. The patient, and wherever possible their carer / next-of-kin, should be involved in the determination of this. A copy of this written ECP should be offered to every patient and family member / carer unless clinically inappropriate, and should be sent by secure electronic submission, such as secure email (i.e. health-mail) (depending on local arrangements) to the patient's GP surgery. Patients who are not registered with a GP should be supported in registering. (See **Appendix 3 – Sample Emergency Care Plan** for further information).

For children parents / person in loco parentis are given information and involved in care planning as developmentally appropriate.

2.4 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.

The assessment of a child also involves the comprehensive assessments of the parent / person in loco parentis and the ability of the parent / person in loco parentis to meet the child's needs.

2.5 Assertive Follow Up to Next Care Appointment

Each patient or the parent / person in loco parentis of a child discharged from ED following a presentation with self-harm or suicidal ideation, including those discharged out of hours, must be offered a telephone call within 24 hours from the Specialist Nurse (CNS), to offer support and discuss their care plan further. The CNS or psychiatry NCHD will have discussed and agreed this procedure with the patient prior to discharge from ED.

If indicated, they 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.

Where appropriate, patients should be offered referral to local Mental Health Services, with a decision taken at the time of assessment whether the referral is to inpatient psychiatric care, or to an urgent (within 1 day), early (within 1 week) or routine outpatient, day service or domiciliary appointment.

The Specialist Nurse will liaise with the appropriate next care to ensure adequate follow up prior to closing the case.

The CNS must provide on-going support and contact until the person is linked to appropriate next care. For some people who will be linked to next care within one day this involves one phone call, for others this may involve phone calls at intervals until the next care appointment.

The Executive Clinical Director (ECD) in each service should establish a forum for General Adult Psychiatrists, Child and Adolescent Consultant Psychiatrists, the Clinical Lead and the CNS to ensure the Clinical Programme is delivered effectively.

2.6 Documentation

Each CNS / NCHD should document a record of their intervention in the patients ED chart as per local policy and procedures. Patients seen on a medical or surgical ward should have their assessment and care plan recorded in the patients' chart on the ward. A copy of the ECP and discharge letter must be sent to the GP (if known) within 24 hours.

Follow up interventions should be recorded by the CNS and when the patient is discharged from the nurse caseload filed in the ED notes or medical file along with a copy of the discharge letter.

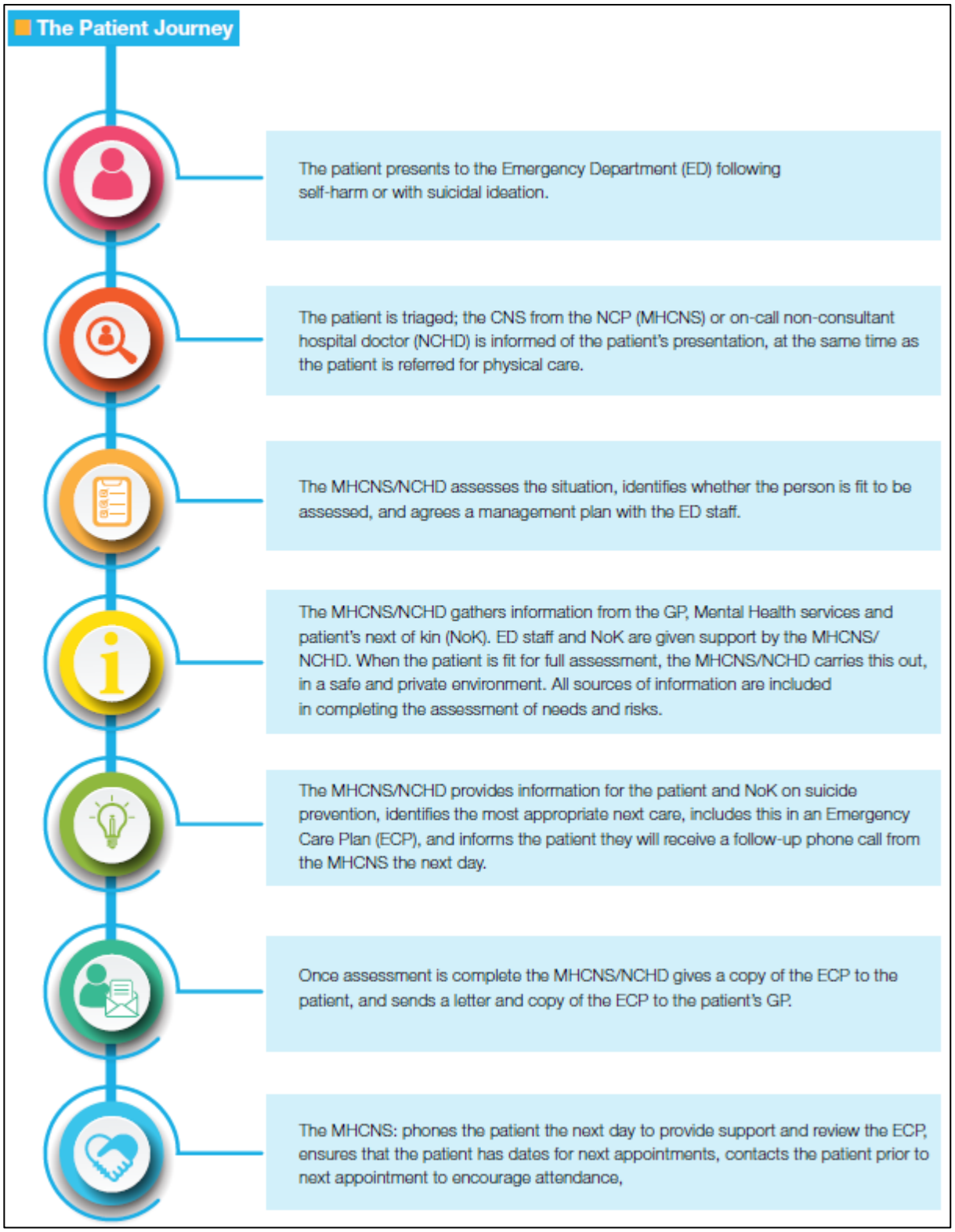
A checklist for data collection should be used and NCHDs who assess patients out of hours should complete this checklist. This will facilitate the CNS entering the data on the interactive data form.

2.7 Community Resource File

Each CNS 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).

2.8 The Patient Journey

The following flow chart summarises the patient journey from initial presentation in the ED following self-harm or suicidal ideation, through to follow-up post assessment.



3. EVALUATION

3.1 Data

Data is an important element in monitoring the implementation of this clinical programme and identifying the benefits to service users and their families. There is an agreed data collection system in place which is reviewed annually.

From 2018 data can be collected on an interactive data sheet. It is important that all people presenting to the ED following self-harm or with suicidal ideation are recorded in the data.

The data will be reviewed monthly by the Clinical Programme and information given to each service on its data. This information can be used to review trends and monitor fidelity to the programme standards.

The National Clinical Programme Office will review the Operation of the Programme and contact services at quarterly intervals to review progress.

3.2 Links with National Suicide Research Foundation (NSRF)

The National Office will collaborate with the National Registry for Deliberate Self Harm (NRSH) to optimise data collection. Each service should review its own NRSH data to establish baseline information on number of presentations, number discharged without a biopsychosocial assessment and number of repeat attendees.

3.3 Clinical Audit and Research

In 2018 Clinical Audit will be introduced and all CNSs will be expected to complete an audit within their service. A national working group on Clinical Audit and Research with agreed Terms of Reference will be established.

3.4 Patient and Family Evaluation of Service

Each service should establish a method for measuring service user and family feedback.

4. GOVERNANCE

4.1 Structure

4.1.1 Professional Reporting Relationship

The professional reporting relationship of the CNS is to the HSE Area Director of Mental Health Nursing via the Assistant Director of Nursing (ADON) or Director of Nursing (DON). The ADON is required to meet the CNS, at a minimum, every two months, to review and support personal and professional development.

4.1.2 Clinical Reporting Relationship

In each service there should be a Consultant Psychiatrist who is the Clinical Lead for this Clinical Programme.

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 nurse 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 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 that nurse.
- ***Acute Hospital with no Liaison Service.*** There must be a named HSE consultant 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.

4.2 Roles and Responsibilities

4.2.1 National Clinical Programmes Office

The roles and responsibilities of the Programme 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 Deliberate self-harm;
- Collaborate with National Officer for Suicide Prevention in delivering Connecting for Life;
- Work with others within the HSE in embedding the Clinical Programme into day to day operations.

4.2.2 Area Management Teams

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;
- Support trained staff to deliver the intervention in a timely manner;
- Facilitate staff in the area to receive supervision and training as required for the job;
- Monitor data from ED on access to and engagement with the programme and report nationally;
- Work with the National Clinical Programme Office in implementing the Clinical Programme;
- Establish clinical forum to ensure the Clinical Programme activities are well integrated with other activities of the Mental Health Service.

4.2.3 CNS Nurse Emergency Department and Clinical Lead

The roles and responsibilities of the CNS Nurse, Emergency Department and Clinical Lead include the following:

- Deliver the clinical programme standards;
- Deliver awareness training on suicide and self-harm to ED staff;
- Attend supervision and training organised in relation to this clinical programme;
- Maintain a log book of all training activities;
- Record and collate data as required.

4.3 Clinical Nurse Specialist Role

The role of the Clinical Nurse Specialist (CNS) 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 CNS 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.

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

4.4. Location and Working Arrangements

Each CNS(s) will be based in the Emergency Department of the Acute Hospital. The CNS will work under the supervision of the Consultant Psychiatrist named as Clinical

Lead. The CNS 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.

4.5 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 Senior Registrar.

It is recommended that each CNS / NCHD maintain a record of continuing professional development and that a minimum of 3 cases are supervised by a named consultant clinical lead. A sample CPD record is available.

All CNS should receive weekly supervision from the Clinical Lead. All CNS should receive, at a minimum, bi-monthly supervision from their Assistant Director of Nursing.

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

5. EDUCATION AND LEARNING

5.1 Education Days

Education days will be organised and developed by the National Office. Attendance at training is mandatory and a record should be maintained. Where possible all education is accredited by the relevant professional body.

Education will be delivered using an interactive approach and include a variety of disciplines to promote learning and cross working. Training will be provided on completing a comprehensive bio psycho social assessment for all new clinicians.

In order to promote and encourage networking the National Office will organise a National Seminar day bi-annually where services will have an opportunity to present learning and outcomes.

5.2 Awareness Training on Self Harm

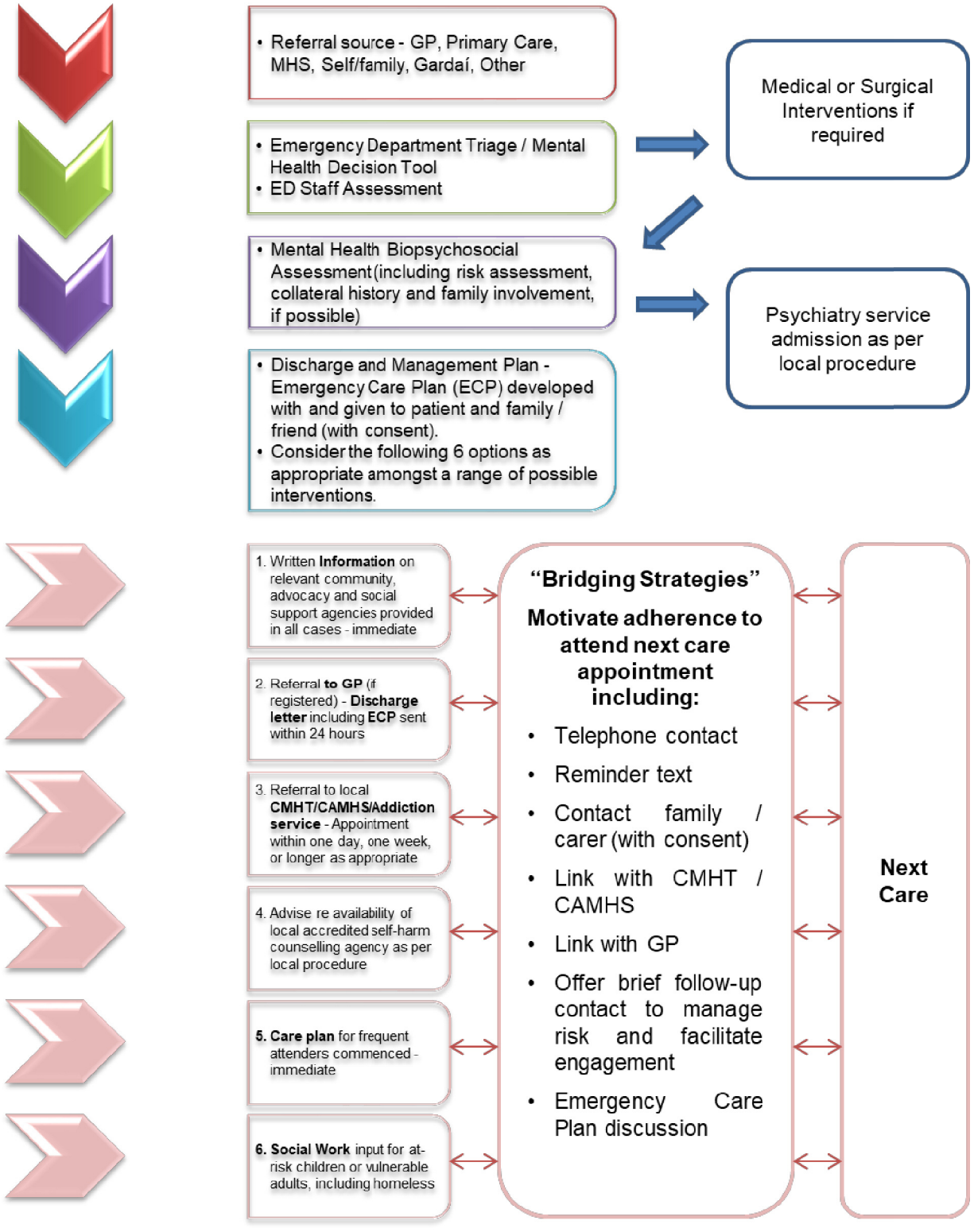
In association with the NSRF, a one day train the trainers' course on self-harm and suicide awareness and skills training programme will be offered to all the CNS self-harm nurses in post in ED. Each nurse will be expected to roll out the 2-3 hour self-harm awareness training on suicide and self-harm in pairs to all relevant ED staff.

5.3 Safeguarding Children

All CNS should ensure they receive training in safeguarding children. This can be accessed online through HSE.

APPENDIX 1: SELF-HARM CARE PATHWAY

Outlined below is a graphical representation of the proposed Care Pathway for the Assessment and Management of Patients who present to the Emergency Department following a Self-Harm act.



APPENDIX 2: SAMPLE NCHD HANDOVER SHEET

Outlined below is a sample NCHD handover sheet / checklist as a part of Care Pathway for the Assessment and Management of Patients who present to the Emergency Department following a Self-Harm act.

Demographics

Name of Patient		
Gender	Female	Male
Age		
Ethnic background		
Referred by		

Assessment

Date of assessment			
Time of assessment			
First assessment completed by (Name discipline)			
Time from referral to assessment	<2hrs	2-6 hrs	> 6 hrs □
Assessed in	ED	Medical	Surgical

Self-Harm Presentation

Self-Harm Act – Name all acts		
Suicidal ideation only	Yes	No
Was substance misuse involved?	Alcohol only	
	Drugs only	
	Alcohol and drugs	
Self-Harm history	1st Episode of Self-Harm	
	2nd Episode of Self-Harm within last 12 months	
	3rd Episode of Self-Harm within last 12 months	
Is the patient currently attending Mental Health Services?	Yes	No

Interventions

Bio psycho social assessment completed	Yes	No
Collateral history taken	Yes	No
Patient given written ECP	Yes	No
GP letter sent	Yes	No
Patient has no GP	Yes	No

NOK / Carer

NOK/carer given ECP and written advice	Yes	No
NOK/carer phoned and given advice	Yes	No
Patient request no NOK /carer input	Yes	No
Patient states no NOK	Yes	No

Referrals to Next Care and Appointment Dates Confirmed

GP	Yes	No	Date
CMHT	Yes	No	Date
CAMHS	Yes	No	Date
HSE addiction services	Yes	No	Date
Other – please specify	Yes	No	Date

ED Discharge or Admitted Time

Discharged or admitted from ED	< 6 hours
	< 9 hours
	> 9 Hours

Actions for CNS Follow-Up:

1.
2.
3.
4.
5.

Signed: _____ **Date:** _____

APPENDIX 3: SAMPLE EMERGENCY CARE PLAN

Name: _____ **DOB:** _____

Address: _____

Date of Assessment: _____

The following can make my environment safe:

_____

_____

People and places that provide me with support:

_____

_____

Person to contact in a crisis:

Name: _____ Phone: _____

_____

Professionals to contact in a crisis:

GP Name: _____ Phone _____

_____

Mental Health Professional:

Name: _____ Phone: _____

_____

Next Appointment:

Date: _____

Time: _____

Place: _____

Person: _____

A Nurse Specialist with phone you tomorrow

APPENDIX 4: SAMPLE EMERGENCY CARE PLAN (2)

Name: _____ DOB: _____

Address: _____

_____

Following your assessment at the Emergency Department the following Care Plan has been agreed:

Goal 1: _____

Action 1:

_____

_____

_____

Goal 2: _____

Action 2: _____

_____

_____

Goal 3: _____

Action 3: _____

_____

_____

Emergency Contact Numbers:

Supportive friend/family	Name:	Phone:
GP	Name:	Phone:
Other	Name:	Phone:

A Nurse Specialist will phone you tomorrow

APPENDIX 5: SAMPLE CRISIS MANAGEMENT PLAN

MENTAL HEALTH SERVICES - CRISIS MANAGEMENT PLAN

CLIENT NAME: _____ **DATE OF PLAN:** ___/___/____

STEP 1: Warning Signs

1. _____
2. _____
3. _____
4. _____

STEP 2: Internal Coping Strategies - *"What can I do to take my mind off my crisis issues?"*

1. _____
2. _____
3. _____
4. _____

STEP 3: People and Social Settings that can provide distraction

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____
4. Place_____
5. Place_____

STEP 4: People whom I can ask for help

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____
4. Name_____ Phone_____

STEP 5: Professionals or Agencies I can contact for support during crisis

- COMMUNITY NURSE Phone: _____
- LOCAL GP Phone: _____
- SOUTH DOC **1850 335 999** (6pm-8am weekdays, 1pm-8am weekends)
- ACUTE PSYCH UNIT, KGH **(066) 718 4000** (Ask for Reask or Valentia ward)
- A&E UNIT **(066) 718 4000** (Ask for A&E)

Client signature: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Professional involved: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Remember to mind your mental health on a daily basis!

Also avoid substance use!

"The best way out is always through"- Robert Frost