National Emergency Medicine Programme

Post -Triage Mental Health Triage Tool

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Version: 1

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1.0 Guideline Statement & Purpose

The Post-triage Mental Health Triage Tool guides Emergency Department (ED) Staff in prioritising and caring for patients presenting with apparent emergency mental health needs. It provides descriptors of observed and reported behaviours to assist in allocating the appropriate triage category. The tool is intended to guide ED staff in their care of attendees whose behaviour is of concern. It is not to assume disturbed behaviour equates to mental illness but to ensure the correct safeguards are in place to manage the behaviour and where, clinically indicated i.e. thought to be secondary to mental illness, to refer for a psychiatry opinion.

2.0 Definitions

Triage: Triage is a system of clinical risk management employed in Emergency Departments worldwide to manage patient flow safely when need exceeds capacity (Manchester Triage Group 2013). The Manchester Triage System (MTS) is the 5 point triage scale system used for all adults attending EDs in Ireland.

Adult: An adult is defined as any person aged 16 years and over.

Treating Clinician: An Emergency Department doctor or an Advanced Nurse Practitioner (ANP).

Mental Health: Mental health and well-being are fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. On this basis, the promotion, protection and restoration of mental health can be regarded as a vital concern of individuals, communities and societies throughout the world (WHO April 2016).

Mental Illness: A health condition that changes a person's thinking, feelings or behaviour (or all three) and that causes the person distress and difficulty in function (NIC National Institute of Mental Health, 2010).

Supervision: The level of supervision required is divided into three levels

- *Continuous Visual*: Person is under visual observation at all times (1:1 care)
- *Close Observation*: Regular observation in an area within the ED where they can be easily observed
- *Routine Observation*: Regular observation

3.0 Scope:

All Staff members should adhere to these guiding principles when caring for patients identified as having acute Mental Health needs in the ED. All patients are triaged using the Manchester Triage System. The Post-Triage Mental Health Triage tool is used following the identification of an acute mental health need in MTS. Therefore, in these cases the patient will have two Triage scores and the higher priority score takes precedence.

4.0 Implementation

It is recommended that training on the use of the Post-Triage Mental Health Triage System is incorporated into routine Manchester triage training in the Emergency Department, with updates occurring with general triage updates. It is recommended that Liaison Psychiatry, where available, be involved in the delivery of the training of the Post-Triage Mental Health Triage Tool.

5.0 Principles

5.1 Adult patients attending Emergency Department are triaged using the Manchester Triage System. Following assessment, a clinical priority is allocated to the patient.

5.2 If the patient is describing or displaying any sign of a mental health need, the Post-Triage Mental Health Triage Tool is used as an adjunct to the Manchester Triage System.

5.3 A Mental Health Triage Category is allocated to the patient. These range from category 1 to 5 (see Appendix). This is noted in the triage documentation in the patients ED healthcare record.

5.4 The level of observation required should be documented in the patients ED healthcare record.

5.5 Triage is a dynamic process, hence the patients priority may require review if their condition changes and they have not been reviewed by a Treating Clinician. Any changes to the MTS triage / Post Triage Mental Health Triage prioritisation or monitoring regime should be clearly documented in the patients ED healthcare record.

5.6 The patients care and outcome should be clearly documented in the patients ED healthcare record.

5.7 Some patients may require an assessment of their capacity to give or withhold consent. This assessment should be undertaken by a senior EM Clinician on-duty.

6.0 Reference and Related Documents

Manchester Triage Group (2013) Emergency Triage 3rd Edition Blackwell Publishing: Oxford

Mental Health Commission Mental Health Act 2001 (online) http:/www.mhcirl.ie

National Emergency Medicine Programme (2013) A guide to assist matching of staff clinical level and mode of transport with the care needs of patients with mental health problems in the Emergency Department

National Institute of Clinical Studies (NCIS) AND Victorian Department of Human Services (2006) Victorian Emergency Department Health Triage Project 2005 – 2006 training manual. Metropolitan Health and Aged Care Services Division, Victorian Government Department of Human Service (online) http:/www.health.vic.gov.au/emergency/mental

NIH National Institute of Mental Health Public Health Service in the USA Science. Education.nc/supplements/nih5/mental/other/glossary.htm

Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

Victorian Government Department of Human Service (2007) Mental health care. Framework for emergency department services

Appendix

	Description	Treatment acuity	Typical Presentation	Emergency Department Procedure
1	**Definite danger to life (Self or others)**	**Immediate**	**Observed** - Displays extreme agitation or restlessness - Bizarre/disorientated behaviour - Violent behaviour - Possession of weapon - Self-destruction in ED - High risk of absconding **- An involuntary application form for detention under the Mental Health Act 2001 has been completed prior to arrival** **Reported** - Vocalises intent to do harm to self or others that the person is unable to resist	**Supervision** Continuous visual supervision 1:1 ratio ** **Location** Identify at each site i.e. Mental Health assessment area Remove equipment from cubicle **Action** - Ensure security in attendance - Alert the following staff members immediately and ensure prompt assessment of the patient: • CNM 2/Shift Leader • EM Registrar • Psychiatric Registrar • Psychiatric Liaison Nurse - Remove any potentially dangerous objects and/or substances from patient - Establish patient's past medical history - Ensure medical assessment is performed
2	**Probable risk to self or others**	**Very Urgent** To be seen within 10 minutes	**Observed** - Extreme agitation/ restlessness - Physically/verbally aggressive and/or restrained - High risk of absconding and not waiting for treatment - Patient actively trying to self-	**Supervision** Continuous visual supervision 1:1 ratio ** **Location** Identify in each site i.e. Mental Health assessment area **Action** - Ensure security in attendance - Alert the following staff members immediately;

			harm and/or leave the department - Confused/unable to co-operate - Hallucinations /delusions/paranoia **Reported** - Threat of harm to self/others	• CNM 2/Shift Leader • EM Registrar • Psychiatric Registrar • Psychiatric Liaison Nurse - Remove any potentially dangerous objects and/or substances from patient - Provide a safe environment for patient and others - Establish patient's past medical history - Ensure medical assessment is performed -
3	**Possible danger to self or others**	**Urgent** To be seen within 60 minutes	**Observed** - Agitated/ restless - Intrusive behaviour - Not likely to wait for treatment - Withdrawn/uncommunicative - Elevated or irritable mood - Bizarre/disorientated behaviour - Confused **Reported** - Suicidal Ideation - Hallucinations - Delusions - Paranoid ideas - Thought disorders - Severe symptoms of depression	**Supervision** Close observation ** **Location** Identify in each site i.e. sub-waiting area Remove equipment from cubicle **Action** - Inform the following members of staff; • CNM 2/Shift Leader • ED medical staff • Psychiatric Liaison Nurse - Remove any potentially dangerous objects and/or substances from patient - Ensure security aware of patient's physical appearance and location in ED - Alert Psychiatric Registrar if review deemed necessary by EM medical staff - Re-triage if evidence of increasing behavioural disturbance - Establish patient's past medical history - Ensure medical assessment is performed

4	**Moderate distress**	**Semi-urgent** To be seen within 120 minutes	**Observed/Reported** - No agitation or restlessness - Irritable without aggression - Cooperative - Gives coherent history - Pre-existing mental health disorder - Symptoms of anxiety or depression without suicidal ideation	**Supervision** Routine observation ** **Location** If patient is unaccompanied, identify suitable location i.e. waiting room or sub-wait area **Action** - Inform the following members of staff; • CNM 2/Shift Leader • ED medical staff • Psychiatric Liaison Nurse - Alert psychiatric Registrar if review deemed necessary by ED medical staff - Re-triage if evidence of increasing behavioural disturbance - Establish patient's past medical history - Ensure medical assessment is performed if admission is required
5	**No danger to self or others**	**Non-urgent** To be seen within 240 minutes	**Observed** - Cooperative - Communicative and able to engage in developing management plan - Able to discuss concerns - Compliant with instructions - Pre-existing non acute mental health disorder - Request for medication - Financial, social, accommodation or relationship problems	**Action** - Patient to be reviewed by ED medical staff - Medical Social Work referral if appropriate **Routine observation****

Please note: This Post-Triage Mental Health Triage tool is to be used after MTS in those cases with an acute mental health need.

**** each ED needs to identify the appropriate location for patients who require the various levels of observation. These areas should be compliant with RCPsych recommendations.**

The National Emergency Medicine Programme acknowledges the assistance of the Emergency Department staff in EDs nationally in the development of this guidance.

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