



Management of Self Harm Presentations to Emergency Department Clinical Programme

Standard Operating Procedure

Title:	Management of Self Harm Presentations to Emergency Department - Clinical Programme
Purpose:	To provide a robust standard operating procedure to the management of self-harm presentations to Emergency Departments
Applicable to:	All staff working to this Clinical Programme Area Management Teams
Document Author:	National Clinical Programme Office
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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 2013, 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. It aims to ensure that all patients receive a standardised triage, bio-psych-social 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. For the purpose of this clinical programme self-harm also includes patients who present with suicidal ideation and/or intent and also includes patients who present with self-harm.

This standard operating procedure (SOP) is to aid services to establish the service locally.

2. Capacity to deliver Clinical Programme in each Emergency Department

In 2013, 35 posts were allocated to this clinical programme. Post(s) were allocated to each Emergency Department based on the data from the National Registry of Deliberate Self-Harm Ireland. Each post is graded at Clinical Nurse Specialist (CNS).

In addition the Non Consultant Hospital Doctor (NCHD) provides assessment out of hours and in conjunction with the CNS and liaison team or equivalent during normal working hours.

3. Target Group

In the first instance the priority population is those presenting in Emergency Department (ED) with self-harm, including suicidal ideation.

The nurses are allocated to a Mental Health Area but will cover all self-harm presentations to the acute hospital whether the patient comes from that area or not.

This Clinical Programme applies to all presentations to ED regardless of age.

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

4. Governance Structure

Professional Reporting Relationship

The professional reporting relationship is to the HSE Area Director of Mental Health Nursing via the Assistant Director of Nursing (ADON) or Director of Nursing (DON).

Clinical Reporting Relationship

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 Self-Harm 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 nurse 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 nurse is a member of that consultant's MDT.

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.

5. Clinical Nurse Specialist (CNS) Role

The role of the clinical nurse specialist 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.

In addition, the nurses will also assess and follow up those patients who are inpatients 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.

6. Location and working arrangements

Each nurse(s) will be based in the Emergency Department of the Acute Hospital. 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.

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

The National Registry of Deliberate Self-Harm Annual Report 2013 indicates that the rates of presentations are highest on Sunday, Monday and public holidays. Services should ensure that staff are rostered to cover these days.

Following assessment of the activity of this programme after one year it may be useful, if clinically indicated, to consider additional nurses to increase the hours of cover.

7. Referrals

All referrals are made to the Liaison Psychiatry. Where there is no Liaison service there must be a written procedure identifying which named consultant is providing clinical supervision on a daily basis.

8. Assessment

Each patient must have a comprehensive **bio psycho social assessment** by a suitably qualified CNS/NCHD/Psychiatrist as early as possible following presentation. A local policy must be in place on what to do when a patient leaves before a completed assessment.

The use of a semi structured pro forma by mental health staff to guide the assessment can be useful. Standalone risk assessment tools may be incorporated with the assessment process but are not a substitute for a comprehensive bio-psycho-social assessment.

Interview/assessment facilities should provide an appropriate level of safety and comfort for patients and staff.

Patients assessed by NCHD out of hours 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.

9. Care Plan

An Emergency Care Plan (ECP) that addresses clinical needs and risks 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/carer unless clinically inappropriate, and should be sent by secure fax and/or secure email (healthmail) (depending on local arrangements) to the patient's GP surgery. Patients who are not registered with a GP should be supported in registering.

10. Families/Carers

All those who present following self-harm act should be actively supported to nominate a family member/carer who will be advised on suicide prevention care before the patient is discharged.

A collateral history should be taken and documented.

11. Assertive follow up to next care appointment

Where clinically appropriate, each Patient discharged from ED following a presentation with self-harm should be offered a telephone call within 24 hours from the Specialist Nurse (CNS), to offer support and discuss their care plan further. The CNS 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 GP and /or CMHT to ensure adequate follow up prior to closing the case.

12. 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/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.

13. 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.

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.

14. Training

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

Training will be delivered using an interactive approach and include a variety of disciplines to promote learning and cross working.

Initially training will be provided on completing a comprehensive bio psycho social assessment. A one day train the trainers' course on awareness training programme on suicide and self-harm 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.

Further additional training will be planned and delivered based on the staff needs and emerging best practice.

15. Performance Management and Review

Data is an important element in monitoring the implementation of this clinical programme and the benefits to service users and their families. Data collection will be phased into the system. In year one each ED will be expected to report on a number of quantitative metrics using a standard excel template (appendix 3). This information will be collated by the National Office. This information will inform future planning and training.

The National Office will collaborate with the National Registry for Deliberate Self Harm (NRSH) to optimise data collection in the future. Each service should review its own NRSH

data to establish baseline information on number of presentation, number discharged prior to assessment and number of repeat attendees.

16. Resources

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).

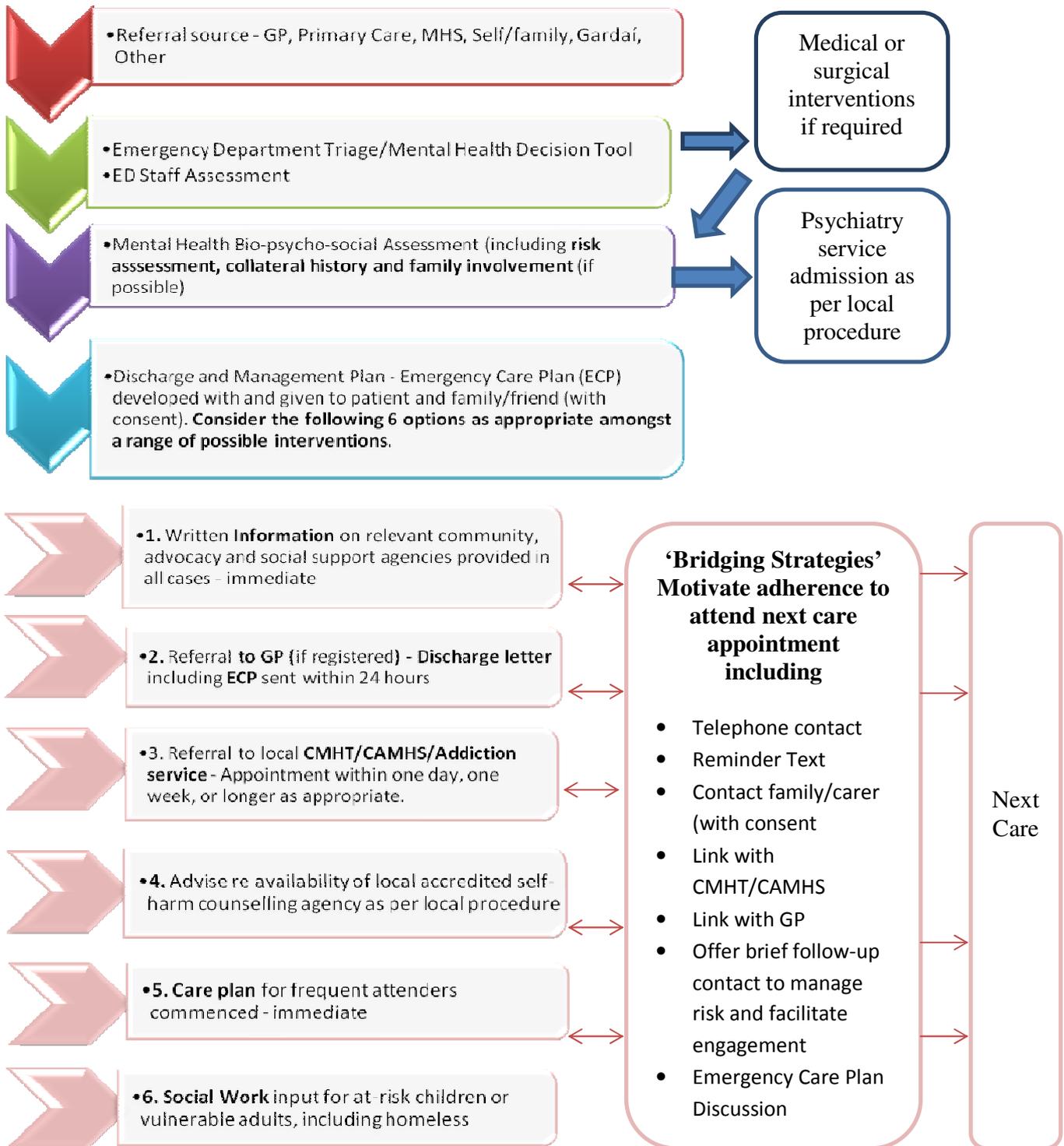
17. Self-Harm Network

A network of CNS nurses, NCHD and Consultant leads will emerge organically within local areas and at supervision and training.

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

Appendices:

1. Emergency Department Care Pathway for Management of Patients who Present following Self Harm



2. Roles and Responsibilities

National Clinical Programmes Office

- 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.

Area Management Teams

- Establish a service in each ED to deliver this programme, including the appointment of a Clinical Lead
- Establish baseline data for each ED in the area from the National Registry of Deliberate Self harm Annual Report
- 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

CNS Nurse Emergency Department and Clinical Lead

- Deliver the clinical programme standards in the ED
- 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.

3. BFT Data: Collected by each ED.

A separate excel spread sheet will be sent to services.