Emergency Department Mental Health Triage & Risk Assessment Tool Training Package

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Learning Outcomes

• Describe how you would complete the GG&C Emergency Department Mental Health Triage and Risk Assessment Tool

• Reflect on your own attitudes and beliefs around suicide, self harm and mental health

• Describe increased confidence and competence in dealing with mental health presentations and suicide/self harm behaviour in Emergency Departments

• Identify some of the myth and stigma around suicide and self harm behaviour
Learning Outcomes
(continued)

• List some of the key facts that refute some of the myths that underpin the stigma around suicide and self harm behaviour.

• Increased knowledge, confidence and competence around adult protection, child protection and looked after children issues as they relate to people presenting within Emergency Departments

• To increase appropriate use of self help materials and follow up supporting literature available within the Emergency Departments as they relate to patients being discharged from Emergency Department
Setting the Scene
Development of the Tool

To provide guidance and a framework to allow Emergency Department staff to assess patients with mental health problems
– an assessment which nursing and medical staff often feel uncomfortable in making

– Acute interface Group
– Clinical Sub-Group
– Research/ Evidence base
– Consultation/Validation
Attitudes & Beliefs

Respecting diversity. Working in partnership with patients, carers, families and colleagues to provide care and interventions that not only make a positive difference but also do so in ways that respects and value diversity including age, race, culture, disability, gender, spirituality and sexuality

www.nes.scot.nhs.uk/media/351385/10_essential_shared_capabilities_2011.pdf
• In this part of the session we will be looking at common myths and stigma about suicide
Emergency Departments & Mental Health Clinical
Sub-Group 2013 ©

<table>
<thead>
<tr>
<th>Triage observations</th>
<th>GCS</th>
<th>BM</th>
<th>HR</th>
<th>BP</th>
<th>RR</th>
<th>SwO?</th>
<th>Teeny</th>
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<table>
<thead>
<tr>
<th>Outline of presentation</th>
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<tbody>
<tr>
<td>Alcohol related – will mention alcohol assessment</td>
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<tr>
<td>Self harm – will mention wound assessment</td>
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<tr>
<td>Other mental health presentation</td>
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<tr>
<th>Initial presentation, appearance and behaviour</th>
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<tbody>
<tr>
<td>Is the patient violent, aggressive or threatening?</td>
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<tr>
<td>Is the patient obviously distressed, markedly anxious or highly agitated?</td>
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<td>Is the patient quiet and withdrawn?</td>
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<tr>
<td>Do you think the patient is behaving inappropriately to their situation?</td>
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<td>Is the patient a known victim of violence?</td>
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<td>Do you think the patient presents an immediate risk to self, others, or to themselves?</td>
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<td>Do you think the patient is likely to abscond prior to assessment?</td>
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<tr>
<td>Do you think the patient’s presentation suggests either delusions or hallucinations?</td>
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<tr>
<td>Do you think the patient’s presentation suggests they feel their thoughts are being controlled?</td>
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<tr>
<td>Are you aware of a history of mental health problems or psychiatric illness?</td>
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<tr>
<td>Are you aware of a history of violence or self-harm?</td>
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<tr>
<td>Is the patient currently expressing suicidal thoughts?</td>
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<tr>
<th>Triage Risk Assessment</th>
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<tr>
<td>High / Moderate / Low risk of self-harm/violence/absconding in department</td>
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<tr>
<td>Triage Category</td>
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<tr>
<td>Immediate management</td>
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<tr>
<td>Patient location, supervised by...</td>
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| Other patients can be compartmentalised in Moderate Risk |
| All patients are in the Low Risk |

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<thead>
<tr>
<th>Emergency Department Mental Health Assessment</th>
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<tr>
<td>This form to be completed by healthcare professional</td>
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Completion of the Triage Tool

• Outline of Presentation
• Appearance and behaviour
• Triage/ Risk Management

Consider the patient’s
Actions, Talk, Feelings, Life Situations
First Contact with Patient at Triage

- Introduce yourself
- Outline plan and aims of assessment
- Appear confident (but not an expert)
- Listen
- Summarize throughout interview
- Friendly
- Model behaviour (lower emotional atmosphere)
- Ask the hard questions (don't be afraid!)
- Be non-judgemental.
Behavioural Clues

- Withdrawn
- Agitated
- Over co-operative
- Aggressive
- Poor or no eye contact
- Mono-syllabic answers
- Not speaking
- Overly happy despite situation
Examples of Open Questions
Roleplay practice in pairs – 5 mins

- Can you tell me how you are feeling?
- Have you had any thoughts of harming yourself recently/today?
Examples Of Open Questions

• Can you tell me about the suicidal thoughts?
• If the patient requires more direction:
  • For example, What brings them on?
  • How strong are they?
  • How long do they last?
• If you do not already know:
  • Have you made a plan? (If yes) What is your plan?
  • Do you have access to a method of suicide? A gun? An overdose?
• Do you intend to attempt suicide
Nurses Responsibility at Triage

• Initial Assessment (Physical & Mental) of presenting patient
• Determine priority for treatment
• Appropriate placement of the patient
• Commencement of appropriate initial treatment/diagnosis

– Additional Local Policy and Practice
Looked After & Accommodated Children

• It is recognised that Looked After and Accommodated Children and young people - (children in foster care or in residential homes) may be at higher risk of self harm and of suicide attempts.

• If these children and young people present at ED's and there is concern, consideration should be given regarding referral onto CAMH's even if a carer is present.
Regarding referral on to social work, although many of these children will present to ED with a key worker or carer, if there is concern, it is essential that information is passed on to the appropriate local authority for the child or young person therefore social work should be contacted including calling social work stand by in the out of hours period. It should not be assumed that a carer will undertake this task.
Adult Support & Protection

Under Adult Support and Protection Act 2007 an adult is considered at risk if they meet all three criteria of the three point test;

- They are unable to safeguard their own well being, property, rights or other interests
- They are at risk of harm;
  
  and

- They are affected by a disability, mental disorder, illness, physical or mental infirmity that makes them more vulnerable to harm than adults who are not affected in this way.
• Referrals should be made verbally to the appropriate Social work department and followed up by completing the AP1 form (available on Staffnet, search for “AP1 form”)
Hallucinations and Delusions

**Hallucinations** - Hearing, smelling, feeling or seeing something that isn’t there

Hearing voices is the most common problem. These can seem utterly real.

The voices can be pleasant, but they are more often rude, critical, abusive or annoying.

**Delusions** - believing something completely even though others find your ideas strange and can't work out how you've come to believe them.

*Royal College of Psychiatrists definitions*
Medical Triage

A framework for the assessment of patients with mental health problems presenting to the Emergency Department.

Nursing triage notes will provide a brief outline of the presentation, and patients will have been allocated a category of risk to guide their management within the department.

Patient’s situations evolve during their wait for assessment.

As for all presentations, mental health assessments become “easier” as more experience is gained, but there will still be those who are more difficult to assess than usual.
Medical Triage

Current Presentation
Establish history and background by assessing patient
Overdose or self injury – physical health takes priority
review triage info – note triage obs (is BM recorded?)
Consider other sources of information police, ambulance
PRF, relatives (by phone?) GP letter, Clinical Portal,
toxbase

Precipitating Factors
Relationships, Addictions, Housing (homelessness?),
Finances (unemployment?), Criminal justice, health
Previous Mental Health problems

Patients presenting with mental health problems often have a past history of similar issues, if there are current concerns, they may currently be ‘open’ to a community services.

Establish current medication/drugs (current compliance?)

Presentation

The record of a patient’s presentation in the six boxes Appearance, Behaviour, Speech, Mood, Thought, Insight is often as informative as the reason for the attendance.
Medical Triage

**Appearance and Behaviour** – dressed appropriately? unkempt or dishevelled? agitated or calm? distracted or withdrawn? uncooperative or intoxicated?

**Speech and Mood** – content and delivery of speech, appropriate, relevant, expressive, disconnected, random, euphoric, subdued, pressured? Does the patient’s reported mood correspond with their behaviour and speech?

**Thought and Insight** – Delusions or hallucinations, obsessive thoughts, ‘poverty of thought,’ mentally sluggish, successive random or tenuously linked ideas?

Does the patient recognise there is a problem?
Medical Triage

Risk Factors
The list of risk factors is not a scoring system. In general ‘yes’ responses are more concerning than ‘no’ responses, but there will be enormous variation between patients.
‘No’ responses in the last four categories may indicate a patient at lower risk of self-harm in the next 6 months.

Risk Assessment
This is assessing a different risk than the triage assessment and may not be the same category. It is a clinical judgement, based on the information gathered, as to the further risk of self harm in the short term.

Consider protective as well as precipitating factors.
Medical Triage

**Summary** – Give a brief outline of the main issues and the plan for further assessment.

Generally, high risk patients will require earlier assessment, often liaison psychiatry, duty doctor, or out-of-hours CPNs.

Generally, low risk patients can wait for assessment from an appropriate community service – but communication with this service should be independent of the patient.

**Discharge** - Record discharge advice and advice given to anyone other than the patient. Be aware of your particular responsibilities in dealing with young people in care (LAAC), and consider others with care needs (children and dependent adults), contact appropriate agencies.
Medical Triage

Local Policy and Practice

- Supervision, Signing Off Assessments & Discharge
- Giving supporting information and follow up materials to patients being discharged.
Questions?