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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

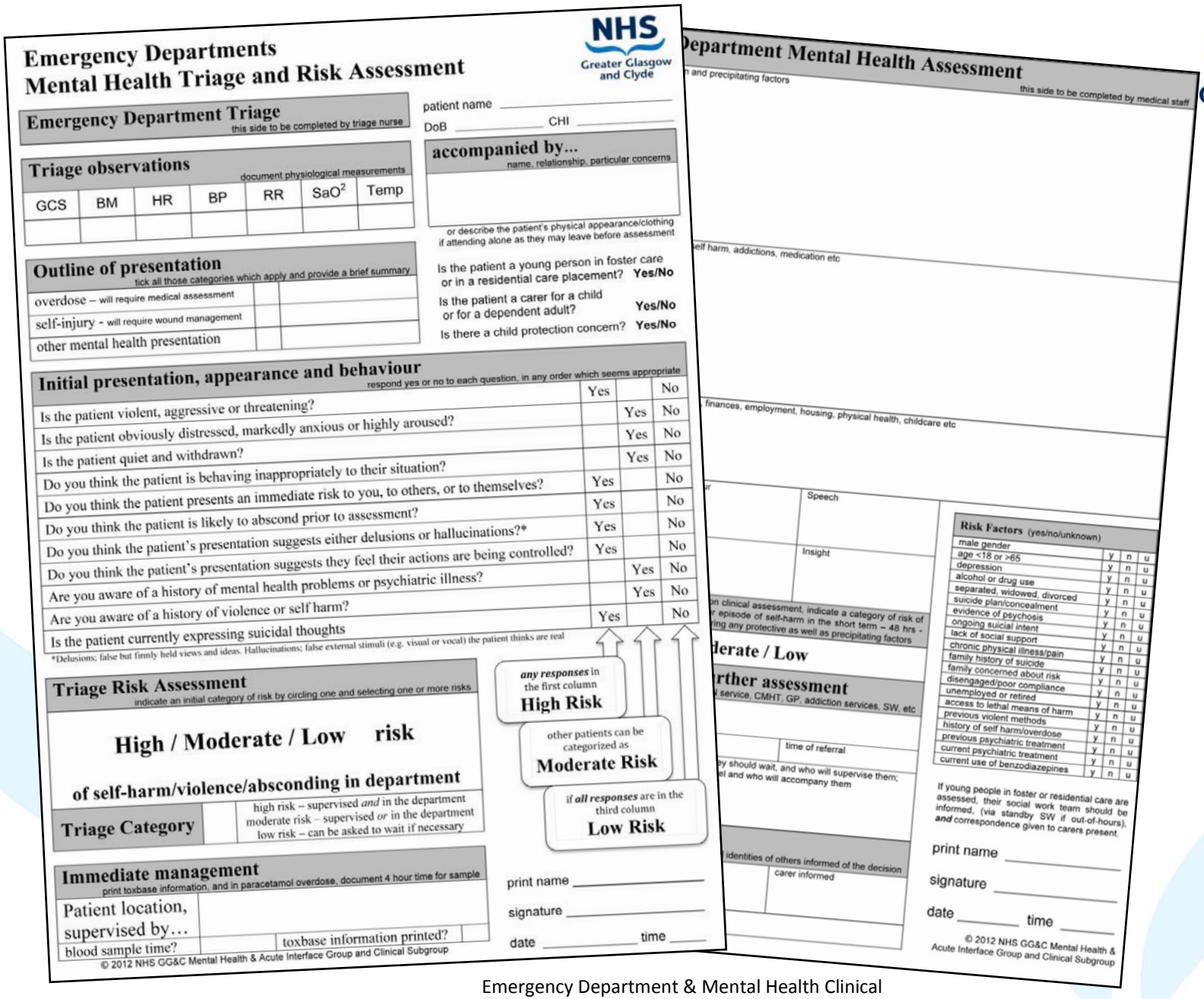
Attitudes & Beliefs

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

Myths & Stigma

- In this part of the session we will be looking at common myths and stigma about suicide



Emergency Departments
Mental Health Triage and Risk Assessment

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Emergency Department Triage
this side to be completed by triage nurse

patient name _____

DoB _____ CHI _____

Triage observations
document physiological measurements

GCS	BM	HR	BP	RR	SaO^2	Temp

accompanied by...
name, relationship, particular concerns

or describe the patient's physical appearance/clothing if attending alone as they may leave before assessment

Outline of presentation
tick all those categories which apply and provide a brief summary

overdose – will require medical assessment		
self-injury - will require wound management		
other mental health presentation		

Is the patient a young person in foster care or in a residential care placement? **Yes/No**

Is the patient a carer for a child or for a dependent adult? **Yes/No**

Is there a child protection concern? **Yes/No**

Initial presentation, appearance and behaviour
respond yes or no to each question, in any order which seems appropriate

Is the patient violent, aggressive or threatening?			Yes		No
Is the patient obviously distressed, markedly anxious or highly aroused?			Yes		No
Is the patient quiet and withdrawn?			Yes		No
Do you think the patient is behaving inappropriately to their situation?	Yes				No
Do you think the patient presents an immediate risk to you, to others, or to themselves?	Yes				No
Do you think the patient is likely to abscond prior to assessment?	Yes				No
Do you think the patient's presentation suggests either delusions or hallucinations?*	Yes				No
Do you think the patient's presentation suggests they feel their actions are being controlled?			Yes		No
Are you aware of a history of mental health problems or psychiatric illness?			Yes		No
Are you aware of a history of violence or self harm?	Yes				No
Is the patient currently expressing suicidal thoughts					

*Delusions; false but firmly held views and ideas. Hallucinations; false external stimuli (e.g. visual or vocal) the patient thinks are real

Triage Risk Assessment
indicate an initial category of risk by circling one and selecting one or more risks

High / Moderate / Low risk

of self-harm/violence/absconding in department

Triage Category

high risk – supervised *and* in the department
moderate risk – supervised *or* in the department
low risk – can be asked to wait if necessary

any responses in the first column **High Risk**

other patients can be categorized as **Moderate Risk**

if *all responses* are in the third column **Low Risk**

Immediate management
print toxbase information, and in paracetamol overdose, document 4 hour time for sample

Patient location, supervised by…			
blood sample time?		toxbase information printed?	

print name _____

signature _____

date _____ time _____

Department Mental Health Assessment

n and precipitating factors

this side to be completed by medical staff

elf harm, addictions, medication etc

finances, employment, housing, physical health, childcare etc

Speech

Insight

on clinical assessment, indicate a category of risk of episode of self-harm in the short term – 48 hrs - ing any protective as well as precipitating factors

derate / Low

rther assessment

l service, CMHT, GP, addiction services, SW, etc

time of referral

y should wait, and who will supervise them; el and who will accompany them

identities of others informed of the decision

carer informed

Risk Factors (yes/no/unknown)

male gender	y	n	u
age <18 or >65	y	n	u
depression	y	n	u
alcohol or drug use	y	n	u
separated, widowed, divorced	y	n	u
suicide plan/concealment	y	n	u
evidence of psychosis	y	n	u
ongoing suicial intent	y	n	u
lack of social support	y	n	u
chronic physical illness/pain	y	n	u
family history of suicide	y	n	u
family concerned about risk	y	n	u
disengaged/poor compliance	y	n	u
unemployed or retired	y	n	u
access to lethal means of harm	y	n	u
previous violent methods	y	n	u
history of self harm/overdose	y	n	u
previous psychiatric treatment	y	n	u
current psychiatric treatment	y	n	u
current use of benzodiazepines	y	n	u

If young people in foster or residential care are assessed, their social work team should be informed, (via standby SW if out-of-hours), ***and*** correspondence given to carers present.

print name _____

signature _____

date _____ time _____

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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

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- 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.

Looked After & Accommodated Children

(continued)

- 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.

Adult Support & Protection

(continued)

- 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

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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

Medical Triage

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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?

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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.

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Local Policy and Practice

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

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Questions?