Royal College of Emergency Medicine

Quality Improvement Programme

Mental Health (Self-Harm)

2023 – 24

Interim Report

Background

This Quality Improvement Programme (QIP) has the purpose of identifying and improving the standards of care for patients presenting with Mental Health (Self-harm) to UK Emergency Departments (EDs).

The programme is running from 2022-25. This report presents the results from Year 2 (October 2023 to October 2024), during which 146 EDs submitted 19819 patient cases. The full charts for this period can be found in the MH QIP Full National Results Handout.

Why this QIP matters

Statement from Dr Nirmal James, Topic Lead

The central aim of the QIP was to assess the provision of timely and person-centred care to those patients attending ED with Mental Health (Self-harm) presentations.

The QIP considers various standards of quality in the assessment and treatment of these patients, creating a timeline of the patient journey, mapping their experience of triage, assessment, referral and specialist review, and assessing the documentation of measures (process and outcome) central to patient care.

This QIP is helping ED's to improve the overall patient experience and quality of care while in the ED.

For further information on the clinical standards, methodology, and approach to analysis, please see the Information pack on RCEM's Quality Improvement Webpage.

Clinical Standards

The clinical standards set for this QIP are:

- Standard 1

Patients should have a mental health triage by ED nurses/clinician on arrival to briefly gauge their risk of self-harm and/or leaving the department before assessment or treatment is complete.

- Standard 2

Patients at medium or high risk of further self-harm or of leaving before assessment and treatment are complete should be observed during the whole length of their stay in the ED.

- Standard 3

When an ED clinician reviews a patient presenting with self-harm, they should record a brief assessment of ongoing risk, including the type of self-harm, the trigger for the episode, a brief social history, and current thoughts of further self-harm.

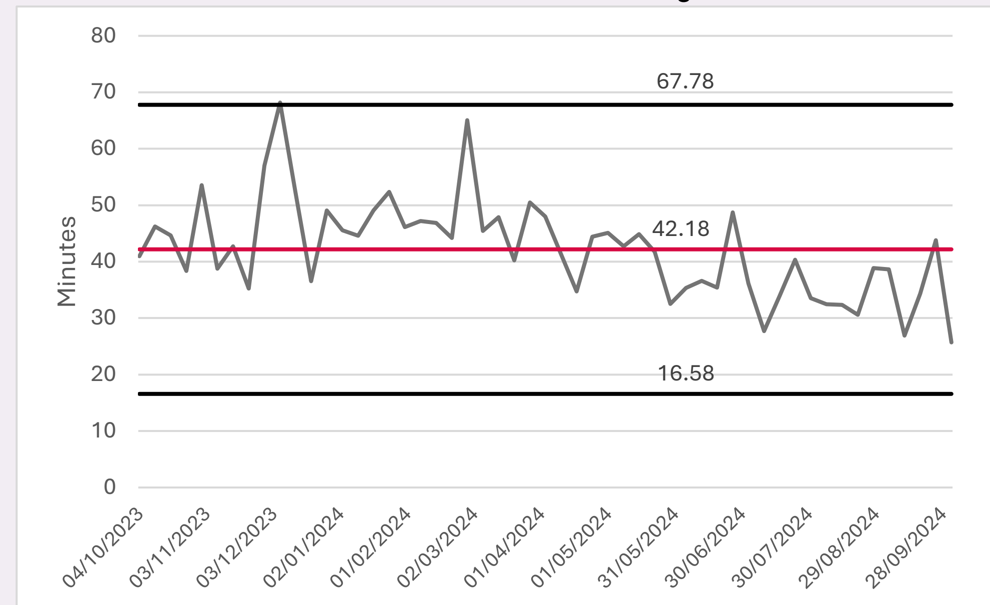
Clinical Standard 1: Mental Health Triage

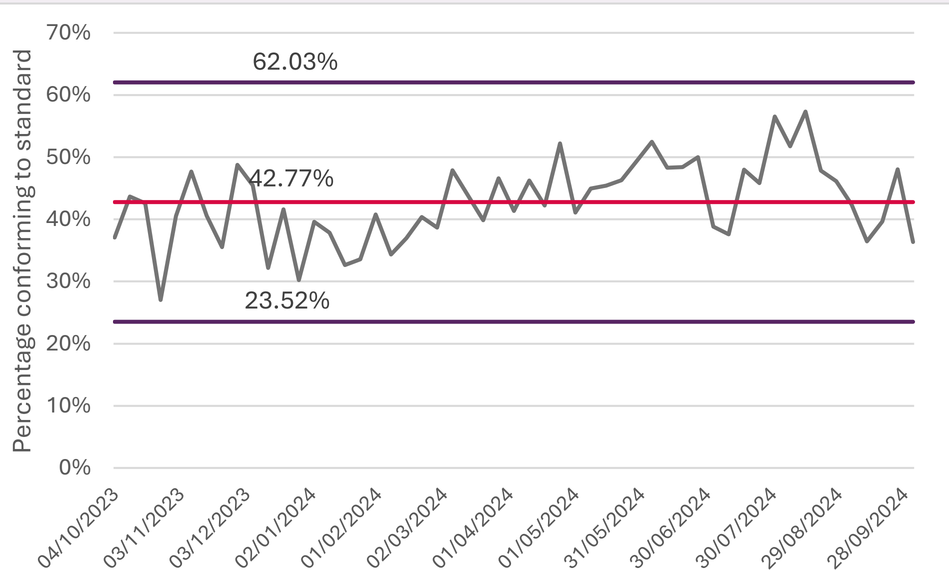
81.8% of patients presenting to the ED with Mental Health (Self-harm) had a mental health triage. This is a 7% increase from year 1 of the QIP, despite the recent pressures facing UK ED's, and is an encouraging result.

The average (mean) time to mental health triage after arrival was 42.2 minutes, an increase from year one by 3 minutes. However, there was a marginal increase in patients undergoing a mental health triage within both 15 and 30 minutes of their arrival - 31.1% of patients received a triage within 15 minutes and 44.7% received a triage within 30 minutes.

Recommendations:

- Focus on quality mental health triage, including identifying those at risk of absconding or further harm to themselves or others.
- Review local processes to explore ways of streamlining and reducing waiting time from arrival to mental health triage.





Clinical Standard 2: Proportion of medium or high-risk patients who had an appropriate level of observation (Good evidence of continuous or intermittent observation, interaction or care)

An average (mean) of 42.8% of patients deemed medium or high-risk received an appropriate level of observation during their ED stay.

This is a significant improvement compared to year one's mean of 29.1%. There was a slight improvement over the 2nd half of the cycle, with larger fluctuations from May to September 2024.

Recommendations

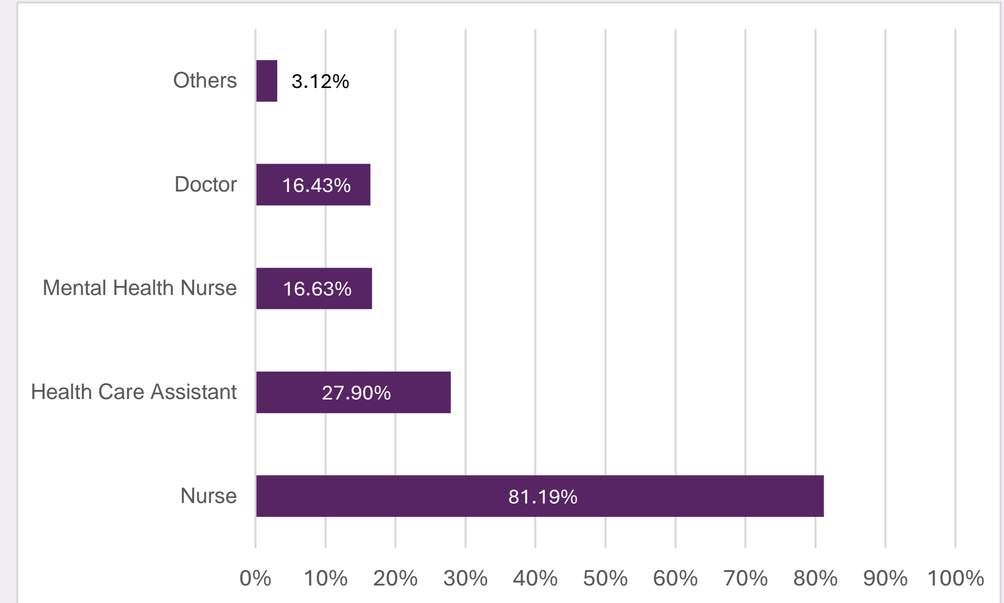
- EDs should ensure a policy for observation of high and medium risk patients is in place, including standardised recording of observations.
- Where possible, automatic reminders in IT systems should alert staff to patients requiring observation. This might operate in a manner like the alert system for National Early Warning Scores (NEWS).

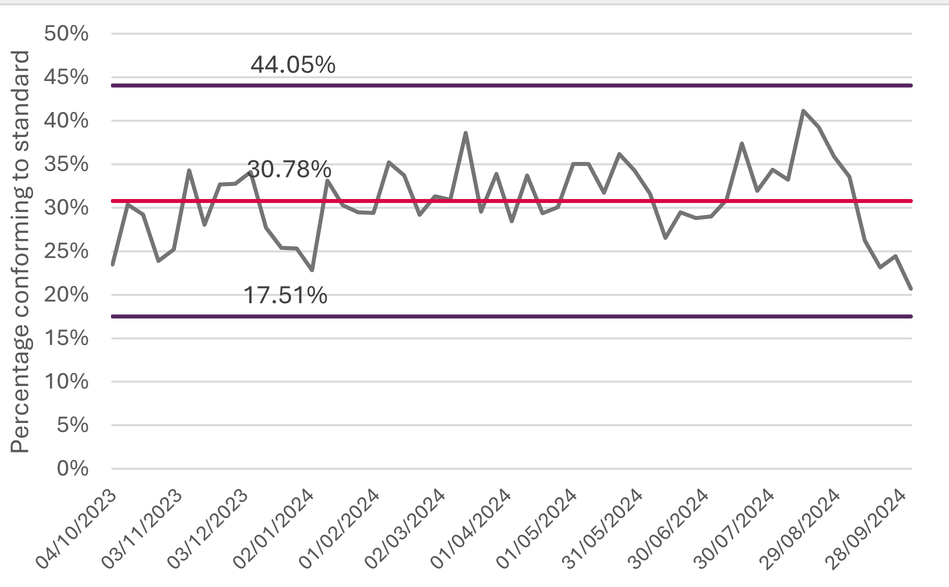
Clinical Standard 2: Persons carrying out observations for patients at medium or high risk of further self-harm or leaving before assessment or treatment completion

Most patient observations were conducted by ED nurses. This was similar to the year one results, (80.6% of observations by nurses). 36.6% of patients had observations done by varied health professionals denoting collective responsibility.

Recommendations

- Consider upskilling more HCAs to carry out mental health observations.
- If feasible, employment of dedicated mental health nurses would enable better and more dedicated patient care.
- Encourage a culture of collective responsibility when trying to observe medium or high-risk patients enabling better distribution of tasks.
- Consider novel solutions like empowering third-party agencies to assist with observations of medium or high-risk patients.





Clinical Standard 3: Proportion of patients who had a brief risk assessment by ED clinician of suicide and further self- harm and met the standard (4 out of 4)

An ED mental health assessment should document the type of self-harm, the trigger for the episode, a brief social history and future suicidal thoughts or plans (as a minimum) to inform an assessment of ongoing risk.

The ED clinician assessment was deemed adequate only if all four aspects were documented. In Year 2 an average of 30.8% met this standard, a figure unchanged from Year 1 (30.3%). Although the graph suggests an improvement over 10 months, this was not sustained into the final weeks, when some of the poorest averages were recorded (<25% of assessments adequate).

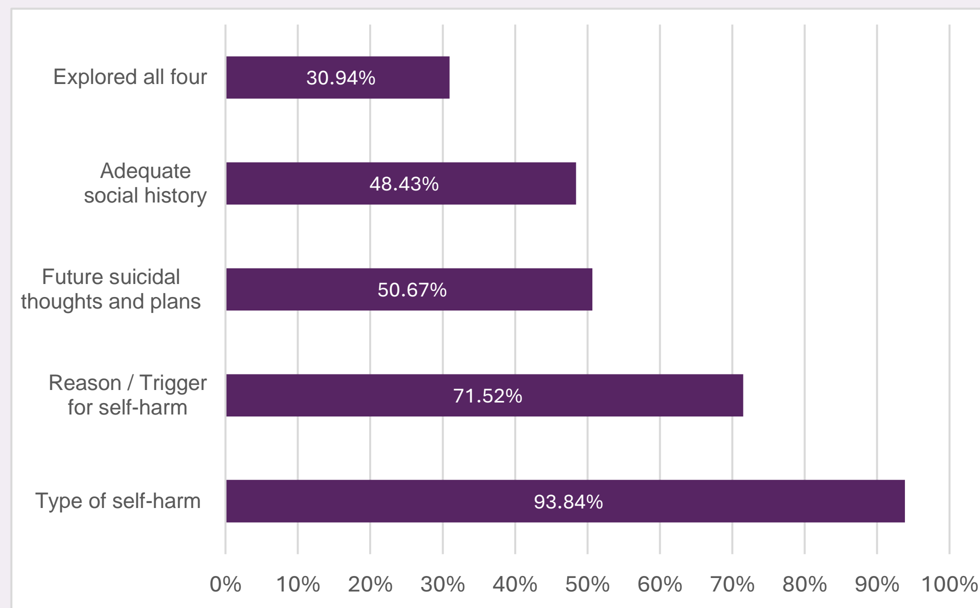
A mental health assessment may be deemed inadequate if only positive findings are documented, but it is important to document negative findings, especially in relation to ongoing suicidality or self-harming intent, or the absence of concerns in the social history which might alert to ongoing risk.

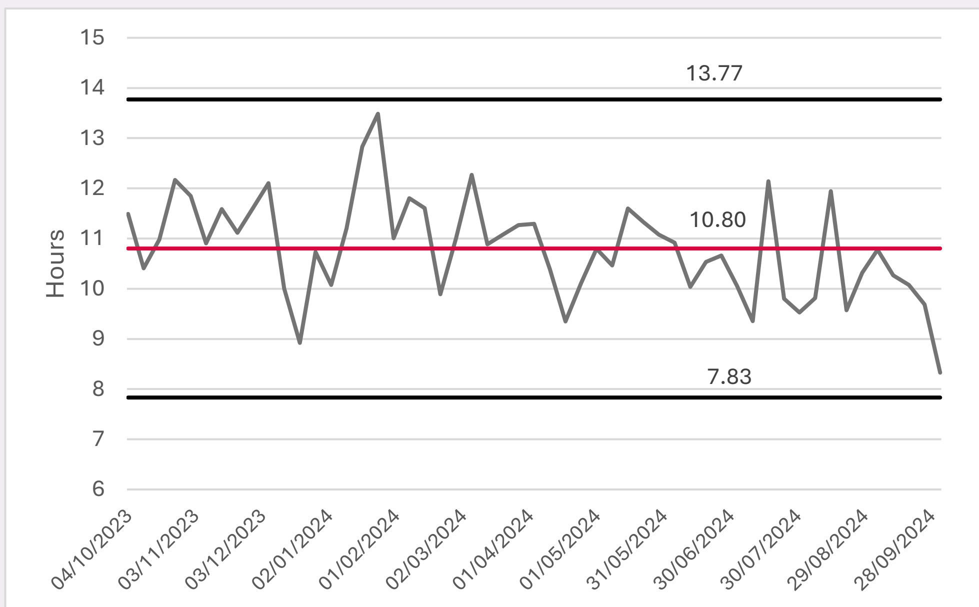
Clinical Standard 3: Proportion of patients who had a brief risk assessment by ED clinician of suicide and further self- harm and met the standard (4 out of 4)

Three of the four individual elements of the assessment were also unchanged; the type of self-harm, recorded in 93.8% of cases (94.3% in Year one), the reason or trigger for the episode, recorded in 71.5% of cases (72% in Year 1). Only 50.7% of cases had future suicidal thought and plans documented, (51.4% in Year one). More concerningly the number of patients who had an adequate social history documented declined steeply, with only 48.4% meeting this standard, compared to 76.3% in Year one.

Recommendations

- Use of a Mental Health proforma which prompts consideration of all four elements may improve the percentage reaching this standard.
- Consideration of future thoughts of suicide or self-harm is essential. If there are no immediate concerns, this should be documented.





Total Time Spent in ED

The average total time spent in the ED was 10.8 hours. This was an increase by 1 hour from year one. Medical needs may require some patients to stay in the ED, but this prolonged time will contribute to a poor patient experience.

This figure reflects organisational pressures and lack of capacity in the wider healthcare system, which inevitably creates delays at the local level. The lack of space, pressure on staff, and stretched resources potentially contribute to delayed assessment of patients presenting with Mental health (Self-harm).

Recommendations

- ED's to identify and address areas of delays in their department.
- Clinical pathways that allow patients to access services in the community.
- Streaming of patients from triage to Adult Psychiatric Liaison Services.
- Increasing capacity and efficiency of Adult Psychiatric Liaison Services that will support timely assessments including potential 24 hours on site ED presence.

Parallel Assessment

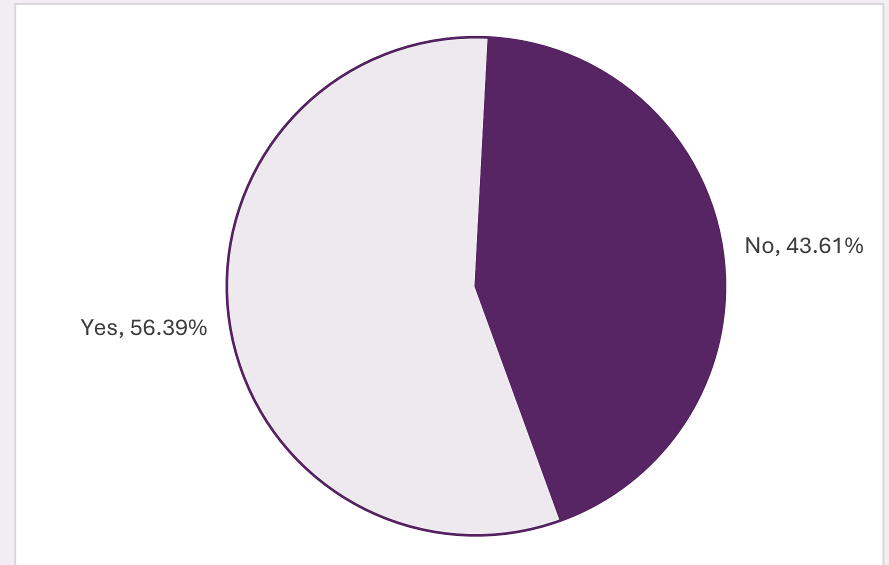
56.4% of patients who were eligible for a parallel assessment received one. This suggests that more could be done in creating an atmosphere where parallel assessment is encouraged.

The average time to review by Adult Psychiatric Liaison Services following referral is 140 minutes for the year 2023-2024. This was 139 minutes in year one.

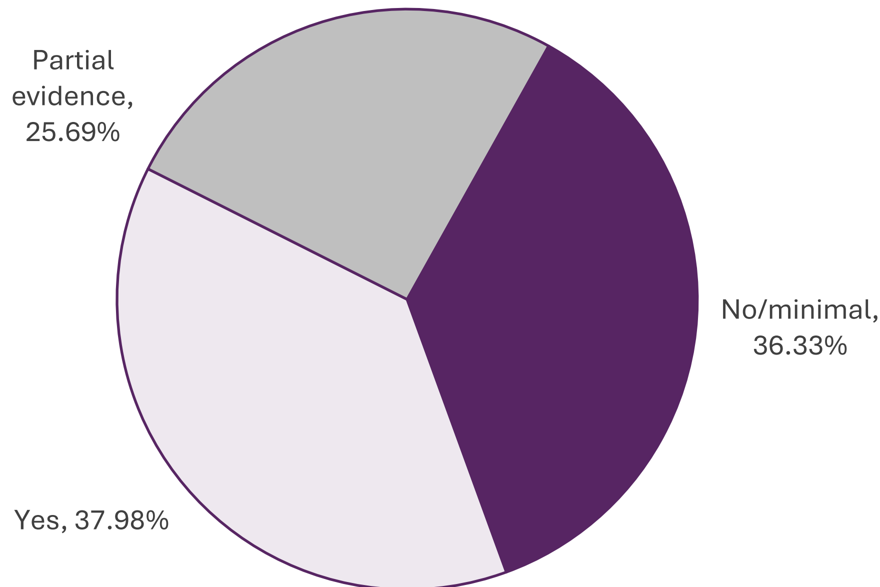
Recommendations

- There needs to be local collaboration between ED's and Adult Psychiatric Liaison Services to create an atmosphere that aids parallel assessment.
- Awaiting medical clearance prior to review by Adult Psychiatric Liaison Services should be only in exceptional cases where the medical presentation takes priority.

Percentage of patients that had or did not have a parallel assessment if they were eligible for one



Breakdown of Patients who had evidence of compassionate and practical care



Evidence of compassionate and practical care

Good evidence of compassionate and practical care for patients presenting with mental health needs in the ED was reported in 38% of cases. Although there is an improvement from the overall figures in year one (29.8%), there is potential for further sustained improvement to better support patients.

Recommendations

- Healthcare systems must prioritise enhanced training for healthcare staff, focusing on the importance of compassionate care.
- Evidence capturing for practical care must be encouraged.
- Exploring collaboration with external or third-sector organisations to provide on-site compassionate support alongside ED staff – Examples such as on-site red-cross
- Implementing patient feedback mechanisms can provide valuable insights for healthcare improvement.

Key Trends in Year 2

- Mental Health Triage

The proportion of patients undergoing a Mental health triage has increased by 7% from year 1. We would recommend EDs aim to provide mental health triage for 100% of eligible patients. This should help risk stratify those at increased risk of further self-harm or absconding.

- Evidence of compassionate and practical care

There has been an 8% increase from year 1 in capturing evidence of compassionate and practical care. It's vital that this is addressed during patient's length of stay in the ED. While it is likely that such care is being delivered there may not be effective methods of recording it. Improving this process should result in better patient experiences and outcomes.

- Safeguarding / Drugs and Alcohol concerns

Consideration and addressing of Safeguarding and Drugs/Alcohol concerns increased by 1.4% and 4% respectively. Addressing this is vital in the long run in supporting the patient. Safeguarding concerns should be raised through locally available pathways. Use of onsite drug and alcohol services should be encouraged during the patients visit to the ED when there is a history of Mental health (Self-harm).

Comparison to 2022-23 Results

- Standard 1 - Mental Health Triage

The proportion of patients undergoing a mental health triage ≤ 15 minutes was 31.1% and ≤ 30 minutes, 44.7%. This was marginally better in comparison to year one. The first year (2022-2023) for ≤ 15 minutes and ≤ 30 minutes were 29.1% and 42.4% respectively.

- Standard 2 – Observations for Medium and High-risk Patients

There was an increase in standard 2 by 13.7% going into year 2 of the QIP. This was 42.8% for the year 2023-2024 as compared to 29.1% for the year 2022-2023.

- Standard 3 - Risk Assessment by ED Clinician

30.8% conformed to the standard. This was effectively unchanged from year 1 (30.3%). However, it is worth noting that there was a marked decline in the number of patients who had an adequate social history documented. This fell to 48.4% from 76.3%. Measures to improve this individual element of the risk assessment may therefore improve the overall number of patients meeting this standard

Limitations and Considerations

During Year 2 of the Mental Health Self-Harm QIP, we encountered technical difficulties with data entry and dashboard access on the case capture system, which were beyond our control.

All issues have been reviewed, and improvements have been implemented to prevent similar challenges in Year 3. For the next phase of this QIP, RCEM will be using an in-house portal to enhance data capture and reliability.

Overall Recommendations from 2025

- Department Recommendations

1. Parallel assessment should be encouraged and incorporated into practice.
2. Evidence of compassionate and practical care should be captured better.
3. Capacity assessments should be the responsibility of all involved in care and not the sole responsibility of the triage nurse.
4. Use of a proforma document, paper or electronic, to prompt the recording of key elements of a mental health assessment is likely to improve patient care.
5. Patients leaving prior to ED clinician or Adult Psychiatric Liaison Services review should have a follow up plan arranged and documented (See The Patient who Absconds – RCEM Best Practice Guideline).

- Trust Recommendations

1. Safeguarding / drug and alcohol concerns should be considered and addressed in all cases.

Support to Improve

- RCEM Quality Improvement Guide – guidance on PDSA cycles and other quality improvement methods
- Quality Improvement Skills Training (QIST) - HEIW
- Healthcare Improvement Scotland
- Understanding_SPC_charts_Dec2018.pdf
- Quality Improvement Essentials Toolkit | Institute for Healthcare Improvement
- Mental Health in Emergency Departments – A toolkit for improving care (RCEM, April 2023)
- The Patient who Absconds –Best Practice Guideline (RCEM, 2024)

Participating sites

Thank you for taking part in this QIP.

A full list of participant EDs can be found below.

2023-24 Mental Health: Self-Harm Participant List

Authors and Contributors

This report is produced by the Quality Assurance and Improvement Committee subgroup of the Quality in Emergency Care Committee, for the Royal College of Emergency Medicine (RCEM).

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Register for 2025

Registrations for the 2025 RCEM QIPs are now open to all Type 1 UK Emergency Departments. Take part and improve patient care in 2025.

Details of the QIPs running in 2025 and how to take part can be found on at RCEM's Quality Improvement Page.

To register your ED, please complete and submit the 2025 registration form using the QR code or link below.

RCEM QIPs – 2025 Registration Form

Have Your Say

Feedback is essential for RCEM's QIPs and is incorporated in every stage of our programmes.

If you have any queries regarding the report or programme, you can contact RCEM's quality team at RCEMQIP@rcem.ac.uk.

If you have feedback on this report or another aspect of the QIPs, please complete the QIP feedback survey using the QR code or link below.

RCEM QIPs – Your thoughts and Feedback

Invited Service Reviews

RCEM undertakes reviews of emergency care services at the invitation of NHS organisations. A service review will provide a detailed assessment and key recommendations to support service's improvement at both a clinical and organisational level.

If your trust is interested in the service, please e-mail Quality@rcem.ac.uk or complete the invitation form using the QR code or link below

RCEM Invited Service Review Request

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