RCEM National Quality Improvement Project 2019/2020
Mental Health (self-harm)
Information Pack

Introduction

There is a shared recognition that caring for patients with urgent mental health needs is a priority for improvement. Patients presenting to Emergency Departments (EDs) should be assessed and treated correctly, quickly, safely and have access to timely and appropriate follow-up care. The Royal College of Emergency Medicine (RCEM) is a signatory to the *Mental Health Crisis Care Concordat* (1) and the improvement project outlined below is part of RCEM's actions towards developing and improving care for mental health patients.

The Quality Improvement Project (QIP) will to track the current performance in EDs against clinical standards in individual departments and nationally on a real time basis over a 6 month period. The aim is for departments to be able to identify where standards are not being reached so they can do improvement work and monitor real time change.

The project will focus on:

- The initial assessment by ED staff
- Assessment of suicide risk
- Documentation of a mental state examination

Background

Service provision for patients with mental health issues remains challenging. Frequently ED and mental health are provided by discrete organisations, and offering a seamless service to the patient can be difficult to deliver. Much of the commissioning structure for mental health is based around different geographical and logistical domains when compared to acute services. This often results in suboptimal or absent services to patients attending the ED with mental health needs.

In March 2018 RCEM published a revised toolkit for Mental health in Emergency Departments which includes clinical standards for the care of mental health patients in the ED. The standards were developed by consensus and based on guidance published by NICE and the Royal College of Psychiatrists.

This is the first time RCEM has run a national QIP on this topic, although there has previously been a national clinical audit on this topic.

Objectives

The objectives of the QIP are:

- To identify current performance in EDs against clinical standards and show the results in comparison with performance nationally and in the ED's country in order to facilitate quality improvement.
- To empower and encourage EDs to run quality improvement (QI) initiatives based on the data collected and assess the impact of the QI initiative on their weekly performance data.

Methodology

Inclusion criteria

Patients must meet the following criteria for inclusion:

- Patients **aged 18 years and older**
- Who presented at a type 1 ED having intentionally **self-harmed** (either self-injury or self-poisoning)
- **AND** required an emergency mental health assessment by your organisation's specified acute psychiatric service (this may be provided by the organisation or an agreed partnership with separate service)

Exclusion criteria

Do not include:

- Any patient 17 years of age or under
- Any patient who was unable to undergo a mental health examination or risk assessment in the ED due to their physical condition (e.g. unconscious)
- Any patient who was **admitted** to an in-hospital ward or ITU for **medical** treatment
- Any patient who had previously attended due to self-harm within the audit period (first attendance only to be included)
- Any patient who left the ED before **any** of the assessments outlined in the RCEM standards could be done (i.e. if some assessments were completed before patient left please include in the audit – if no assessments were done before patient left do not include)

Explanation of criteria: The audit does not include patients admitted to a medical ward as they are usually seen by the mental health team on the ward, and the audit is focused on patients who require psychiatric assessment whilst in the ED.

Forming your QIP team

RCEM recommends forming a multidisciplinary QI team; including consultants, trainees, nursing, pharmacy, SAS, triage and others as needed for the topic and to suit your local set up.

Data entry information

Sample size and data frequency

The RCEM clinical audits have had a major upgrade, providing you with a range of new features and quality improvement tools. These include a live data dashboard, tracking how your data changes weekly on run charts, and the ability to have your own PDSA cycles added to your charts.

Recommended: To maximise the benefit of the new run charts and features RCEM recommends entering **5 cases per week** for patients attending between 1 August – 31 January. This will allow you to see your ED's performance on key measures changing week by week and ensure you get the full benefit of the charts such as your mean performance, upper and lower control limits and trend analysis. Please note that if the system does not have enough weekly data points it will not be able to give a mean performance for your ED as the data will not be robust enough.

Alternative: If your ED will find weekly data entry too difficult to manage you may wish to enter data monthly instead, although you should still ensure that the patient records you sample include patients attending each week within that month. The system will ask you for each patient's arrival date and automatically split your data into weekly arrivals, so you can get the benefit of seeing weekly variation if you spread the cases across the month.

Expected patient numbers	Recommended sample size	Recommended data entry frequency
<5 a week	All patients	Weekly
>5 a week	5 patients	Weekly

Data collection period

Data should be collected on patients attending from 1 August 2019 – 31 January 2020.

RCEM strongly recommends minimising missing data in your final report by ensuring that you submit patient data for as many weeks during the data collection period as possible. This data does not been to be submitted at the same time, but you will find your SPC charts much more useful if you have data that covers as many weeks as possible between 1 August 2019 – 31 January 2020.

Data submission period

Data can be submitted online at the link below from 26 August 2019 – 14 February 2020. You can find the link to log into the data entry site at www.rcem.ac.uk/audits

Data Sources

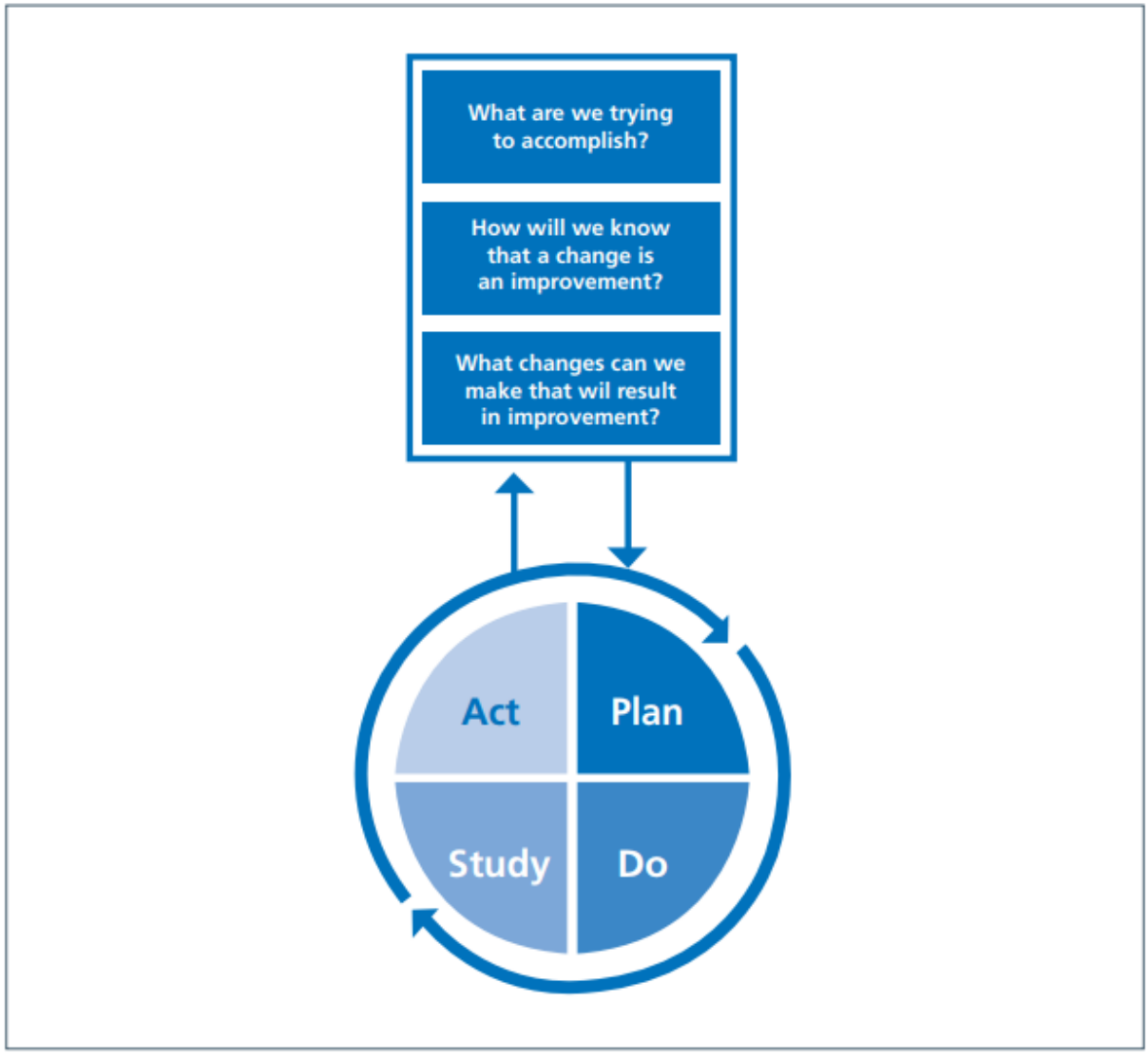
ED patient records including nursing notes (paper, electronic or both).

Quality improvement information

The purpose of clinical audit is to quality assure and quality improve your service where it is not meeting standards. The new RCEM system allows your team to record details of quality improvement projects (QIP) and see on your dashboard how each initiative affects your data on key measures.

We encourage you to use this new feature to try out QIPs in your department. If you are new to QIPs, we recommend you follow a Plan Do Study Act (PDSA) methodology. The Institute for Healthcare Improvement (IHI) provides a useful worksheet which will help you to think about the changes you want to make and how to implement them.

The model for improvement, IHI



Standards

STANDARD		GRADE
1.	Patients should have mental health triage on arrival to briefly gauge their risk of self-harm or suicide and risk of leaving the department before assessment or treatment is complete. This is used to determine what level of observation the patient requires whilst in the ED.	F
2.	Patients at medium or high risk of suicide, harm or of leaving before assessment and treatment are complete should be observed closely whilst in the ED. There should be documented evidence of action to mitigate risk, such as continuous observation or intermittent checks (for example every 15 minutes), whichever is most appropriate.	D
3.	When an ED clinician reviews a patient presenting with self-harm or a primary mental health problem, they should record a brief risk assessment of suicide and further self-harm.	D

Standard definitions

Standard	Definition
Standard 2: medium or high risk	Risk level as determined either at triage, or assessed using a national or locally developed risk assessment tool, for example Brief Mental Status Exam, Mental State Examination (MSE), or similar.
Standard 3: risk assessment	Risk should be assessed using a national or locally developed risk assessment tool, for example Mental State Examination (MSE), Brief Mental Status Exam or similar.

Grade definition

RCEM no longer sets a target percentage for different grades of standards, but rather encourages ED to review and improve their performance with the aim of achieving standards for all patients.

F - Fundamental: need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels and service provision need to be in accordance with at least these fundamental standards. No provider should provide any service that does not comply with these fundamental standards, in relation to which there should be zero tolerance of breaches.

D - Developmental: set requirements over and above the fundamental standards.

A - Aspirational: setting longer term goals.

Audit questions

Case mix

1.1	Reference (do not enter patient identifiable data)	
1.2	Date and time of arrival	dd/mm/yyyy HH:MM
1.3	Date and time of mental health triage	dd/mm/yyyy HH:MM Not done
1.4	Was the type of self-harm recorded?	Self-injury Self-poisoning Not recorded

Assessment and observation

2.1	Was a brief risk assessment taken and recorded in the patient's clinical record?	Yes – Mental State Examination (MSE)	dd/mm/yyyy HH:MM
		Yes – other national tool	
		Yes – other locally developed tool	
		No - patient left before risk assessment	
		No – other reason documented	
		No	
2.2	If Q2.1 = Yes Is there documented evidence that the patient was specifically asked about:	Suicidal intent and acts	
		Safeguarding concerns	
		Assessing risk of self-harm repetition	
		Assessing risk of potential harm to others	
2.3	What was the patient's risk level of suicide, harm or of leaving the ED?	Medium or high risk	
		Low risk	
		Not recorded	
2.4	Is there documented evidence of the following observations whilst the patient is in the ED?	Continuous observation or intermittent checks (e.g. 15 minutes)	
		Less frequent or ad hoc observation	
		Not recorded	

Notes
Optional space to record any additional notes for local use. Entries here will not be analysed by RCEM.

Question and answer definitions

Term	Definition
Q1.3: Mental health triage	Mental health triage should briefly gauge the risk of self-harm or suicide and risk of leaving the department before assessment or treatment is complete. This is used to determine what level of observation the patient requires whilst in the ED.
Q2.1: Brief risk assessment	Risk should be assessed using a national or locally developed risk assessment tool, for example Brief Mental Status Exam, Mental State Examination (MSE), or similar.

Appendix: Analysis plan for standards

This section explains how the RCEM team will be analysing your data. You are welcome to use this analysis plan to conduct local analysis if you wish. Analysis sample tells you which records will be included or excluded from the analysis. The analysis plan tells you how the RCEM team plan to graph the data and which records will meet or fail the standards.

STANDARD	GRADE	Analysis sample	Analysis plan – conditions for the standard to be met
1. Patients should have mental health triage on arrival to briefly gauge their risk of self-harm or suicide and risk of leaving the department before assessment or treatment is complete. This is used to determine what level of observation the patient requires whilst in the ED.	**F**	All patients	**Chart**: SPC **Title**: Standard 1: Mental health triage on arrival **Analysis**: time Q1.3 – Q1.2 Met: </= 15 minutes Not met: >15 minutes OR 'not done' **Additional charts:** Chart showing average time between 1.2 and 1.3 Pie chart of 1.4 answers
2. Patients at medium or high risk of suicide, harm or of leaving before assessment and treatment are complete should be observed closely whilst in the ED. There should be documented evidence of action to mitigate risk, such as continuous observation or intermittent checks (for example every 15 minutes), whichever is most appropriate.	**D**	Q2.3 = medium or high risk	**Chart**: SPC **Title**: Standard 2: Close observation of medium or high risk patients **Analysis**: Met: 3.1 = Continuous observation or intermittent checks Not met: all other answers **Additional chart:** Pie chart of 2.3 answers
3. When an ED clinician reviews a patient presenting with self-harm or a primary mental health problem, they should record a brief risk assessment of suicide and further self-harm.	**D**	All patients	**Chart**: SPC **Title**: Standard 3: Patients assessed for suicide and further self-harm **Analysis** Met: 2.1 = yes AND 2.2 = suicidal intent and acts AND 2.2 = assessing risk of self-harm repetition Not met: all other answers **Additional charts:** Chart showing average time between 1.2 and 2.1 Mini-SPC charts of the answers to 2.2 (for all patients answering 2.1 = yes)

Appendix: Privacy policy, terms of website use and website acceptable use policy

Privacy policy
The Royal College of Emergency Medicine (RCEM) recognises the importance of protecting personal information and we are committed to safeguarding members, non-members and staff (known as "The User" in this document) privacy both on-line and off-line. We have instituted policies and security measures intended to ensure that personal information is handled in a safe and responsible manner. This Privacy statement is also published on the RCEM web site so that you can agree to the kind of information that is collected, handled and with whom this data is shared with.

RCEM strive to collect, use and disclose personal information in a manner consistent with UK and European law and under the General Data Protection Regulation (GDPR). This Privacy Policy states the principles that RCEM follows and by accessing or using the RCEM site you agree to the terms of this policy.

For further information, click here.

Terms of website use
For further information, click here.

Website acceptable use policy
For further information, click here.

Appendix: ECDS Search terms to support case identification

These codes will help you and your IT team to identify cases that may be eligible for the audit. This is not an exhaustive list and other search terms can be used. All potential patients should then be reviewed to check they meet the definitions & selection criteria before inclusion in the audit.

Chief complaint of

1141111000
1141121000
1141131000
1161111000
1161131000
1161181000
1161211000
1161311000
1161411000
1161451000
1161461000
1161471000
1161481000
1181111000

With injury intent of

1121000000

Or chief complaint of

1191311000

All of these would then need treatment to include

1181150000

Or a referred to service of

1611100000
1611300000
1611500000
1612000000
1612500000
1614000000

References

1. HM Government. *Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis.* Available from: https://www.crisiscareconcordat.org.uk/wp-content/uploads/2014/04/36353_Mental_Health_Crisis_accessible.pdf [Accessed 1st December 2018].

2. HM Government. *Mental Health Crisis Care Concordat.* Available from: https://www.crisiscareconcordat.org.uk/ [Accessed 2nd November 2018].

3. NICE. *Self-harm in over 8s: short-term management and prevention of recurrence.* Available from: https://www.nice.org.uk/guidance/cg16 [Accessed November 17th 2018].

4. NICE. *Self-harm: Quality Standard QS34.* Available from: https://www.nice.org.uk/guidance/qs34 [Accessed 5th December 2018].