The Royal College of Emergency Medicine

Clinical Audits

Mental Health in the ED Clinical Audit 2014-15

National report

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Foreword

The Royal College of Emergency Medicine is very pleased to coordinate this audit of Mental Health outcomes in UK Emergency Departments.

Anyone who has been around for as long as I have will be aware that for all sorts of reasons, patients with mental health issues have not always received the standard of care that we would like to see in our Emergency Departments. Some aspects of care are difficult to measure and I salute the work of the Quality in Emergency Care Committee and Standards & Audit Subcommittee in putting this important audit together.

This audit builds on previous work by the College in this area and allows us to see the good progress we have made in establishing standards for the appropriate physical spaces for reviewing patients. At the same time it is evident that a number of challenges remain in ensuring timely review of these patients. As a College we are, and will continue to work with other agencies to ensure we best meet the needs of this group of vulnerable patients.

College audits are widely respected as a benchmark of quality care. The inspectorate bodies of each of the UK nations pay particular regard to both participation and performance in these audits. I am keen that they continue to focus on patients. There is a clear link between audit performance and patient outcomes – a welcome change from many of the process measures we are obliged to undertake.

Dr Clifford Mann, President
Dr Adrian Boyle, Chair of Quality in Emergency Care Committee
Dr Jay Banerjee, Chair of Standards & Audit Subcommittee
Dr Anne Hicks, RCEM Lead for Mental Health

Executive summary

A total of 7913 patients from 183 Emergency Departments were audited. This is an excellent sample size and a great achievement by the Emergency Departments involved. This audit was completed in nearly all acute hospitals in England, and most in the UK, and is therefore a representative sample of current practice.

Two of the standards were Fundamental ('must achieve') Standards:

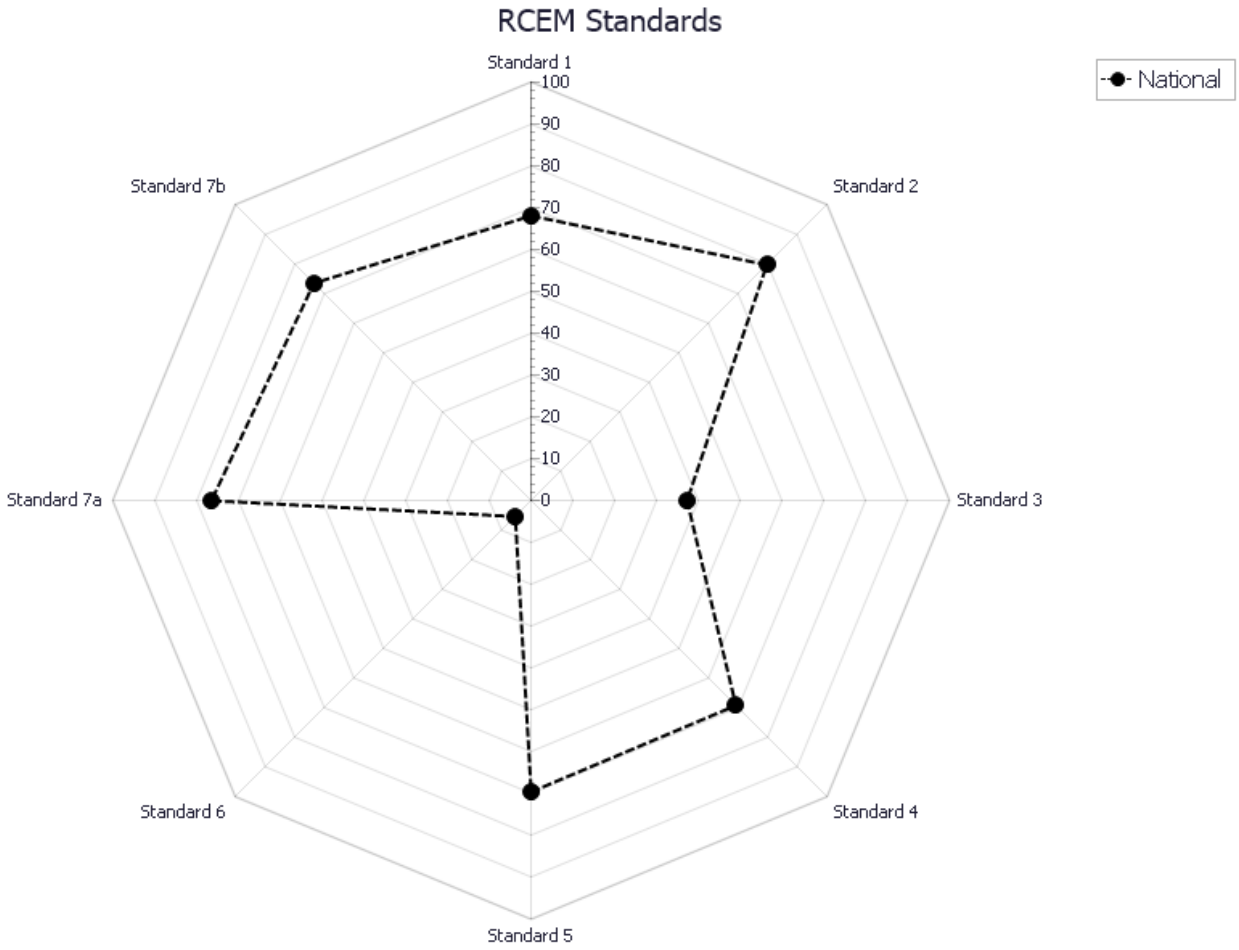
Standard 1 - Patients who have self-harmed should have a risk assessment in the ED
Standard 7 - An appropriate facility is available for the assessment of mental health patients in the ED

These standards were chosen because we believe these represent the minimum standard of safe and dignified care for patients with mental health issues and the staff who are looking after and assessing them.

A median of only 72% of patients had a risk assessment performed while in the Emergency Department. Aside from the patient care aspect, while this figure may be partially a result of inadequate recording, the legal/risk issues that this raises will should prompt Emergency Departments to review their performance in this area.

There is good compliance in ensuring a dedicated room for assessment (100%), but it seemed that many hospitals have not yet fully conformed to the safe standards for such rooms (40%), and this is clearly an on-going risk to staff and patients.

Summary plot – national performance



This graph shows how EDs performed nationally on all 8 standards for this audit.

Standard 1 – Risk assessment in the ED
Standard 2 – Previous mental health issues documented
Standard 3 – Mental State Examination recorded
Standard 4 – Provisional diagnosis documented
Standard 5 – Referral or follow-up arrangements documented
Standard 6 – Mental Health Practitioner sees patients within 1 hour of referral
Standard 7a - Appropriate assessment facility available
Standard 7b – Assessment facility meets PLAN standards

Note the almost universal poor performance on Standard 6 – patient reviewed within one hour of referral to the mental health team.

↑ Higher scores (e.g. 100%) indicate higher compliance with the standards and better performance.

↓ Lower scores (e.g. 0%) indicate that EDs are not meeting the standards and may wish to investigate the reasons.

Introduction

This report shows the results from an audit of the assessment of patients who presented at Emergency Departments (EDs) around the UK with suspected mental health needs. The report compares the findings against the clinical standards published by the Royal College of Emergency Medicine (RCEM) Quality in Emergency Care Committee (QECC) and with EDs that made audit returns.

Nationally, 7913 cases from 183 EDs were included in the audit.

Country	Number of relevant EDs	Number of cases
National total	183/230 (80%)	7913
England	163/180 (91%)	7052
Scotland	7/25 (28%)	333
Wales	8/13 (62%)	322
Northern Ireland	4/9 (44%)	156
Isle of Man / Channel Islands	1/3 (33%)	50

RCEM Standards

The audit asked questions against standards published by the College in February 2013:

Standard	Standard type
1. Patients who have self-harmed should have a risk assessment in the ED	Fundamental
2. Previous mental health issues should be documented in the patient's clinical record	Developmental
3. A Mental State Examination (MSE) should be recorded in the patient's clinical record	Developmental
4. The provisional diagnosis should be documented in the patient's clinical record	Developmental
5. Details of any referral or follow-up arrangements should be documented in the patient's clinical record	Developmental
6. From the time of referral, a member of the mental health team will see the patient within 1 hour	Developmental
7a. An appropriate facility is available for the assessment of mental health patients in the ED	Fundamental
7b. Assessment room meets all standards set by the Psychiatric Liaison Accreditation Network (PLAN)	Developmental

Understanding the different types of standards

Fundamental standards: 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.

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

Aspirational standards: setting longer term goals.

Audit history

All EDs in the UK were invited to participate. Data were collected using a new online data collection tool. This is the first time this audit has been conducted.
Participants were asked to collect data from ED/hospital records for up to 50 cases of patients aged 18 years and older who presented having intentionally self-harmed (either self-injury or self-poisoning) and required an emergency mental health assessment by the organisation's specified acute psychiatric service between 1st January 2014 and 31st December 2014.

Format of this report

The table overleaf shows the national results.
By showing the lower and upper quartiles of performance as well as the median values, the table indicates the variations in performance between departments. More detailed information about the distribution of audit results can be obtained from the charts on subsequent pages of the report. Please bear in mind the comparatively small sample sizes when interpreting the charts and results.

Feedback

We would like to know your views about this report, and participating in this audit. Please let us know what you think, by completing our feedback survey: http://ow.ly/LX5gz.

We will use your comments to help us improve our future audits and reports.

Summary of national findings

Question			RCEM Standard	National Results (7913)		
				Lower quartile	Median*	Upper quartile
Q4	**STANDARD 1:** Risk assessment taken and recorded in the patient's clinical record		100%	56%	72%	87%
Q5	**STANDARD 2:** History of patient's previous mental health issues taken and recorded		100%	72%	82%	92%
Q6	**STANDARD 3:** Mental state examination taken and recorded		100%	14%	30%	58%
Q7a	Patient asked about their alcohol & illicit substance consumption within the last 24 hours			52%	62%	73%
Q7b	Patient assessed for their level of alcohol &/or illicit substance dependency			22%	40%	57%
Q8	**STANDARD 4:** Provisional diagnosis documented		100%	52%	74%	90%
Q9	Patient assessed by a mental health practitioner (MHP) from organisation's specified acute psychiatric service			58%	70%	86%
	STANDARD 6: Assessed by MHP within 1 hour		100%	0%	0%	7%
	Where assessed by MHP	Dedicated assessment room		0%	4%	46%
		Resus area		0%	0%	0%
		Majors area		0%	0%	11%
		Minors area		0%	0%	0%
		Other		0%	4%	15%
Q12	**STANDARD 5:** Details of any referral or follow-up arrangements documented		100%	62%	71%	82%
Q13	Liaison Psychiatry service available at organisation			100%	100%	100%
Q14	**STANDARD 7a:** Dedicated assessment room for mental health patients		100%	100%	100%	100%
	STANDARD 7b: Room meets all standards set out by the Psychiatric Liaison Accreditation Network		100%	50%	50%	100%

Red = Percentage in red indicates result is below RCEM standard

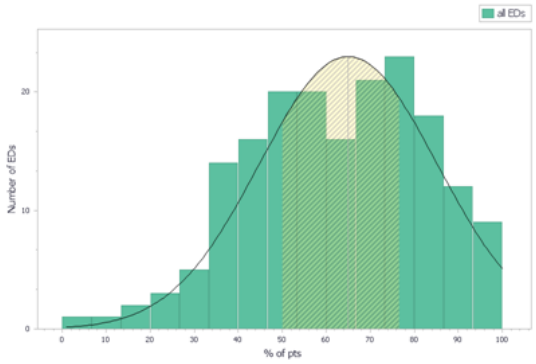
Green = Percentage in green indicates result is equal to or above RCEM standard

Notes about the results

*The median value of each indicator is that where equal numbers of participating EDs had results above and below that value.
These median figures may differ from other results quoted in the body of this report which are mean (average) values calculated over all audited cases.
The lower quartile is the median of the lower half of the data values.
The upper quartile is the median of the upper half of the data values.

Histogram charts

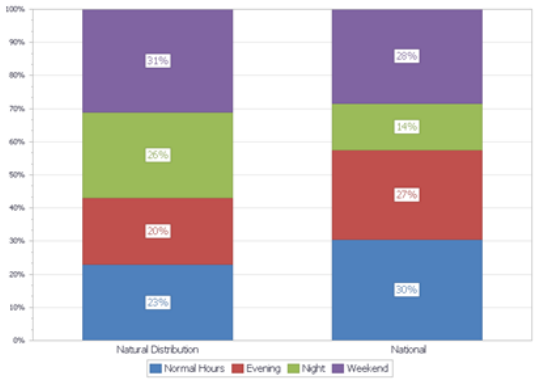
Histogram charts are used to show the distribution and frequency of results. Each histogram shows the number of EDs per % of patients as the height of each block.



The hatched area shows the interquartile range (the spread of the middle 50% of the data values). The grey line in this area shows the median.

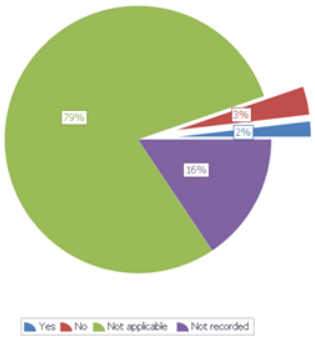
The curved line shows the normal distribution of data.

Stacked Bar Chart



Stacked bar charts show the breakdown of a group nationally.

Pie Chart

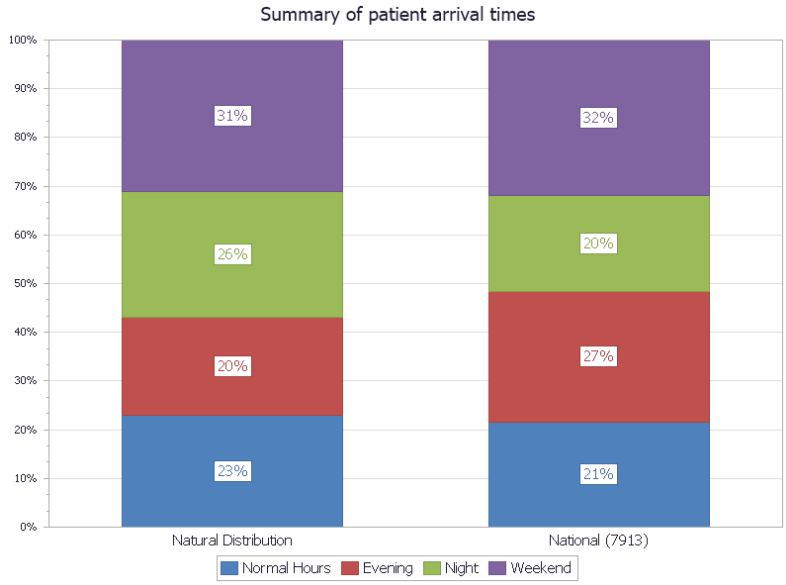


Pie charts show the breakdown of a group nationally.

SECTION 1: Case mix

How do patients attending Emergency Departments compare nationally? Use this section to help you understand more about the case mix and demographics of patients.

Q2. Date and time of arrival



Definitions

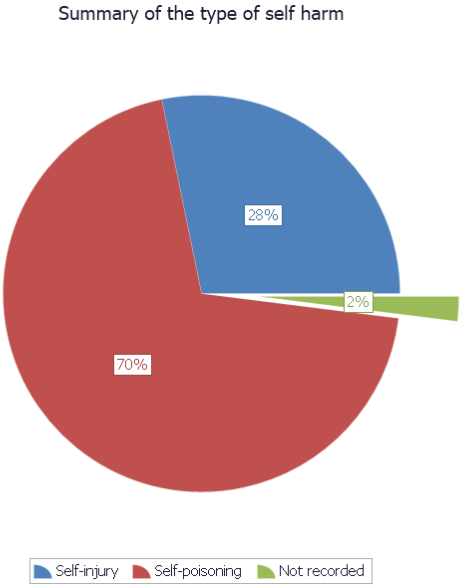
In hours:	09:00-17:00
Evening:	17:01-00:00
Night:	00:01-08:59
Weekend:	Sat, Sun or bank holiday

The natural distribution shows how the attendances would look if this event occurred equally throughout the week.

These results indicate that nationally, mental health patients present fairly much at random at any time of day or night.

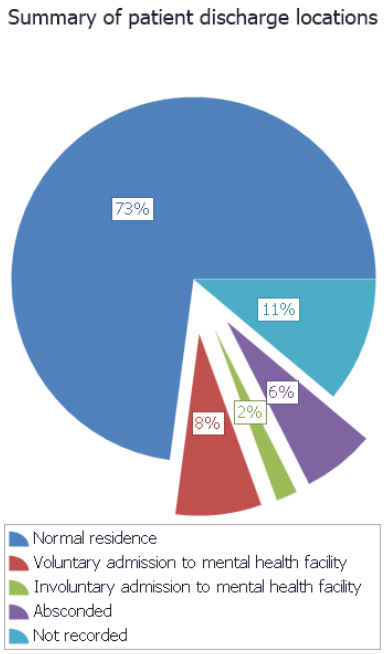
The data clearly shows the need for 24/7, and in particular, full overnight mental health cover.

Q3.Was the type of self harm recorded



It seems that recording the nature of self harm is not a problem, although it is quite possible that there is a confirmation bias as people may not document not presenting with self-harm.

Q11. Where was the patient discharged to from the ED?



A high proportion of patients were admitted to an inpatient psychiatric facility (10% nationally).

This underlines the high acuity of the mental health problems in the patient group seen in the Emergency Department.

Of equal concern is the number of patients in whom there was no discharge data.

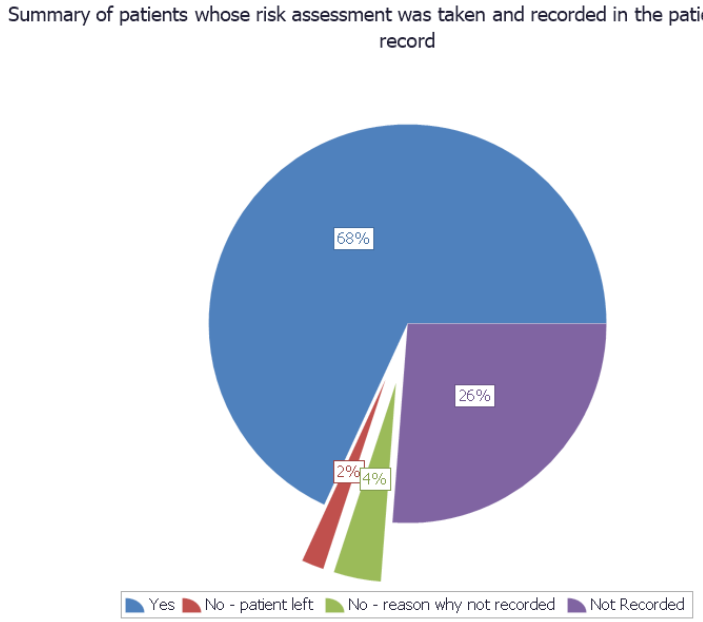
It is recognised that there are a group of patients who may be 'allowed' to abscond, but only after having had a risk assessment.

Absconding is likely to be due to delays in getting patients promptly assessed by mental health liaison psychiatry.

It may be useful for EDs to refer to the RCEM Best Practice Guideline 'The Patient Who Absconds'.

SECTION 2: Audit results

Q4a. Was a risk assessment undertaken and recorded in the patient's clinical record?

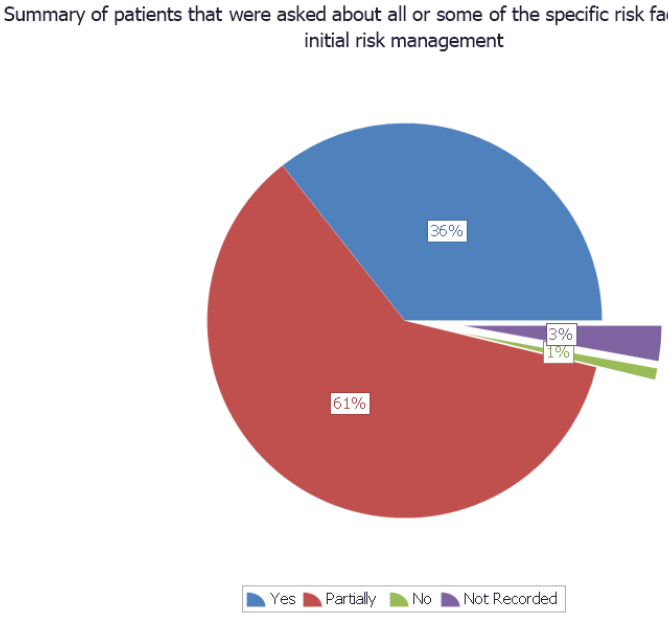


Standard 1 - fundamental: Patients who have self-harmed should have a risk assessment in the ED

Standard: 100% patients

This is a fundamental standard because it was felt that a hospital would be on very difficult ground medico-legally if a patient came to harm and it could not be shown that a risk assessment had been performed.

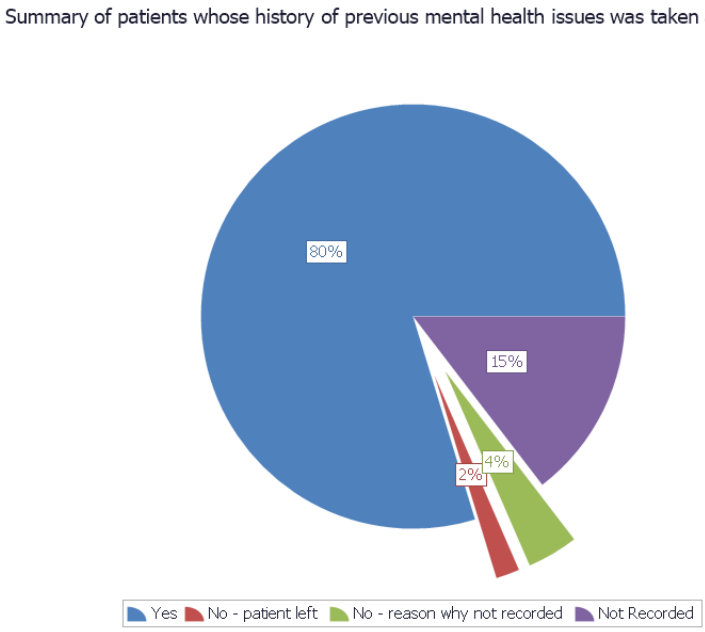
Q4c. Was the patient specifically asked about: suicidal intent and acts, safeguarding, concerns, assessing risk of repetition, assessing risk of potential harm to others?



Most patients clearly had some details recorded regarding these items.

It is likely that not everything enquired about is recorded.

Q5. Was a history of the patient's previous mental health issues taken and recorded in the patient's clinical record?



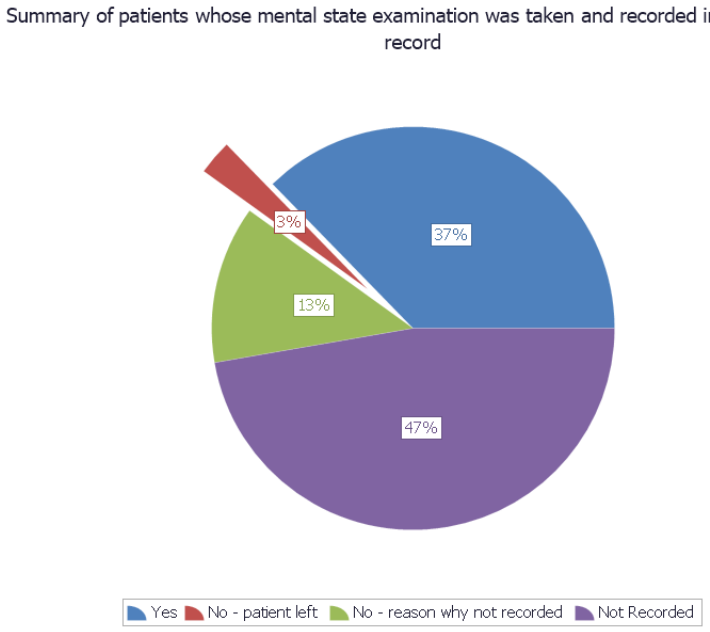
Standard 2: Previous mental health issues should be documented in the patient's clinical record

Standard: 100% patients

Previous mental health issues are a known 'red flag' for serious adverse outcomes.

A history of previous mental health issues should form part of the risk assessment.

Q6. Was a mental state examination taken and recorded in the patient's clinical record?



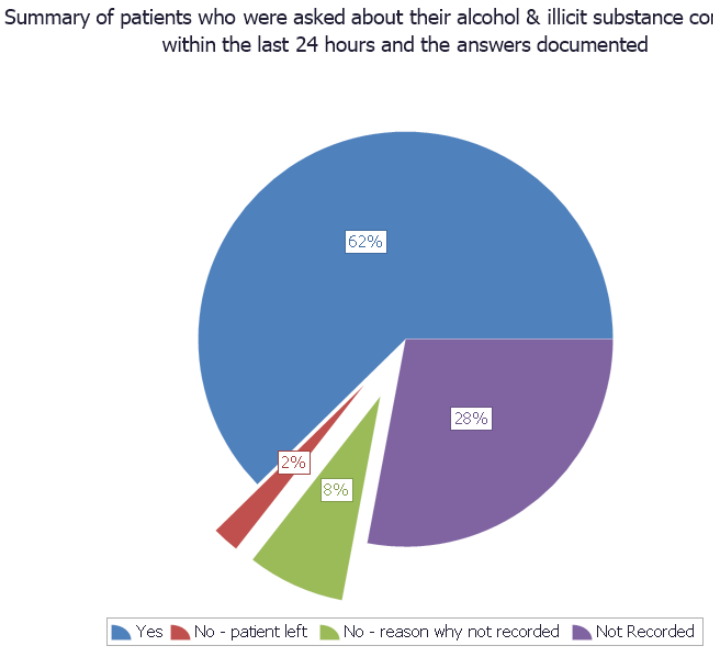
Standard 3: A Mental State Examination (MSE) should be recorded in the patient's clinical record
Standard: 100% patients

A Mental State Examination in this context was defined as including, but not limited to:

- mental capacity
- level of distress/ hopelessness
- mental health problems
- willingness to stay for psychosocial assessment.

A possible explanation for this low result might be that in an ED with a liaison psychiatry service, the ED staff do not attempt to document the MSE.

Q7a. Was the patient asked about their alcohol & illicit substance consumption within the last 24 hours and the answers documented in the patient's clinical record?

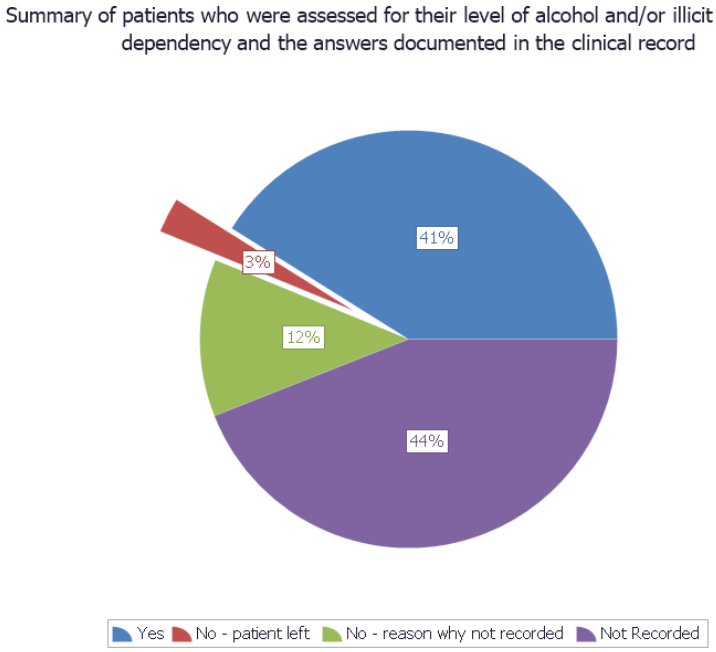


Acute alcohol consumption is recorded in approximately 2/3 of patients.

Alcohol consumption is very common in the context of self harm.

Paradoxically a lack of alcohol consumption may be a predictor of a more serious self-harm attempt.

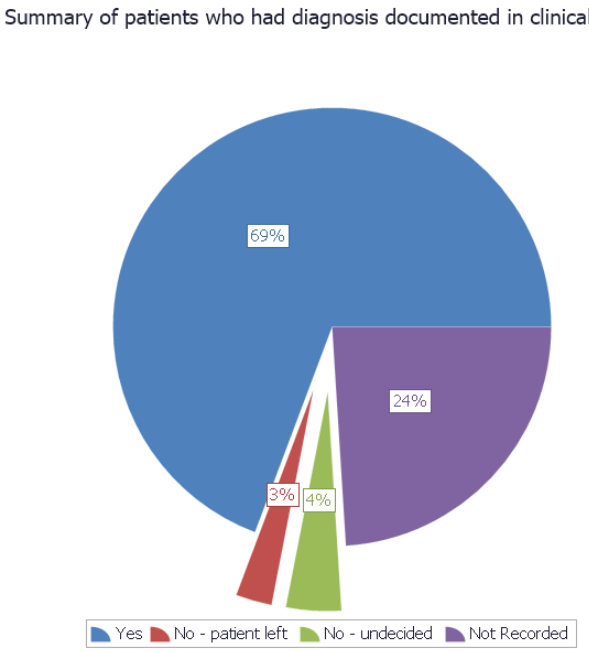
Q7b. Was the patient assessed for their level of alcohol &/or illicit substance dependency and the answers documented in the patient's clinical record?



Chronic alcohol consumption is recorded in approximately 1/3 of patients.

As a known major risk factor for poor outcomes from self-harm, we encourage all EDs to ensure this is recorded.

Q8. Was a provisional diagnosis documented and recorded in the patient's clinical record?



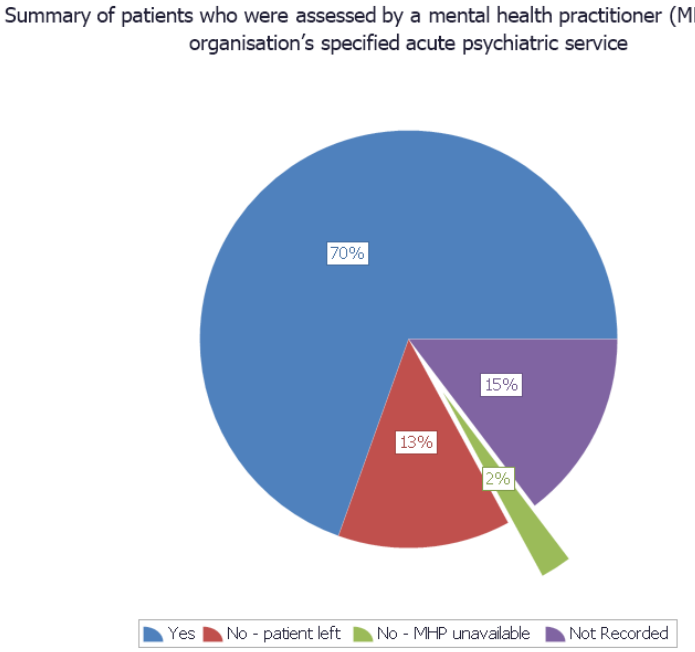
Standard 4: The provisional diagnosis should be documented in the patient's clinical record

Standard: 100% patients

Provisional diagnosis seems to be inadequately recorded in the notes.

This could be due to dual diagnosis of physical and mental health.

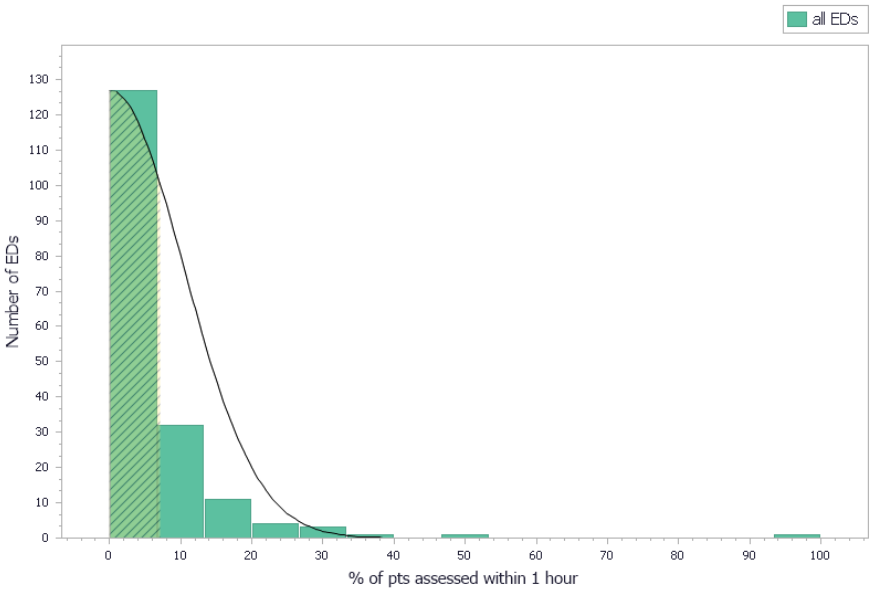
Q9. Was the patient assessed by a mental health practitioner (MHP) from the organisation's specified acute psychiatric service?



This was the standard of care but has now been overtaken by Standard 6 – see below.

More than a quarter of patients who are apparently referred to a Mental Health Practitioner do not see one.

Summary of patients who were assessed by a mental health practitioner (MHP) from the organisation's specified acute psychiatric service within 1 hour for all EDs, showing quartiles



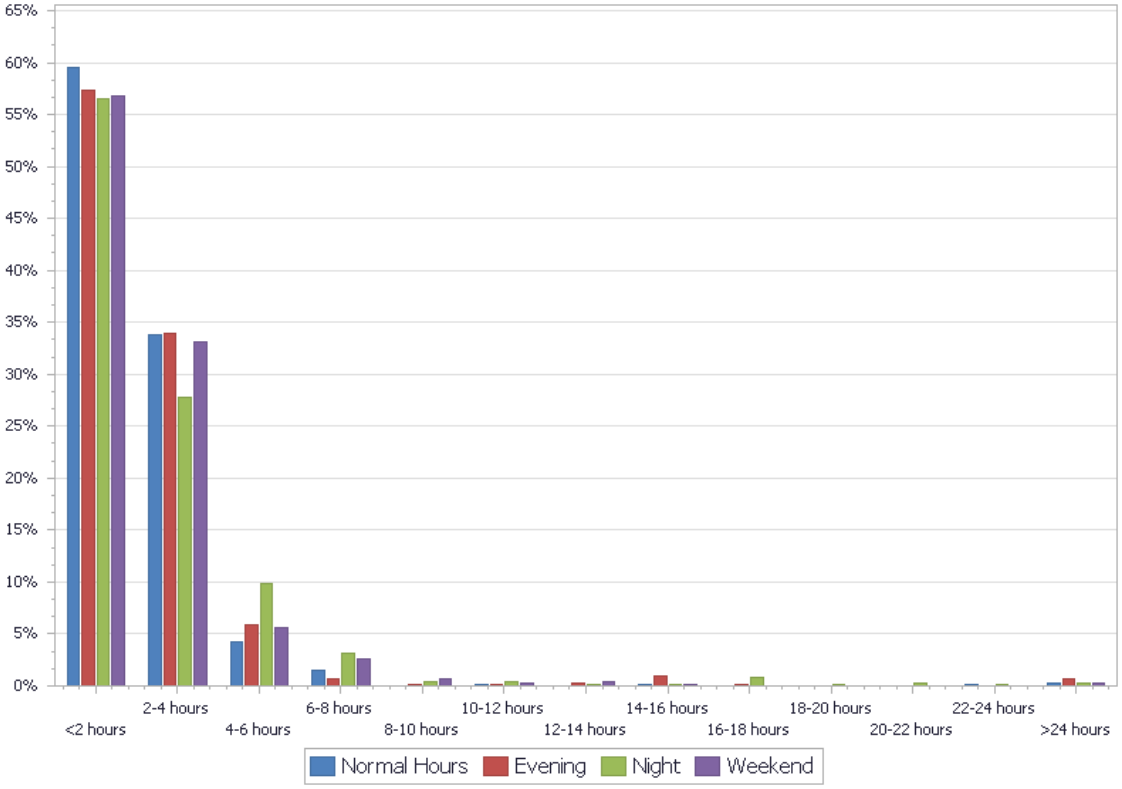
Standard 6: From the time of referral, a member of the mental health team will see the patient within 1 hour

Standard: 100% patients

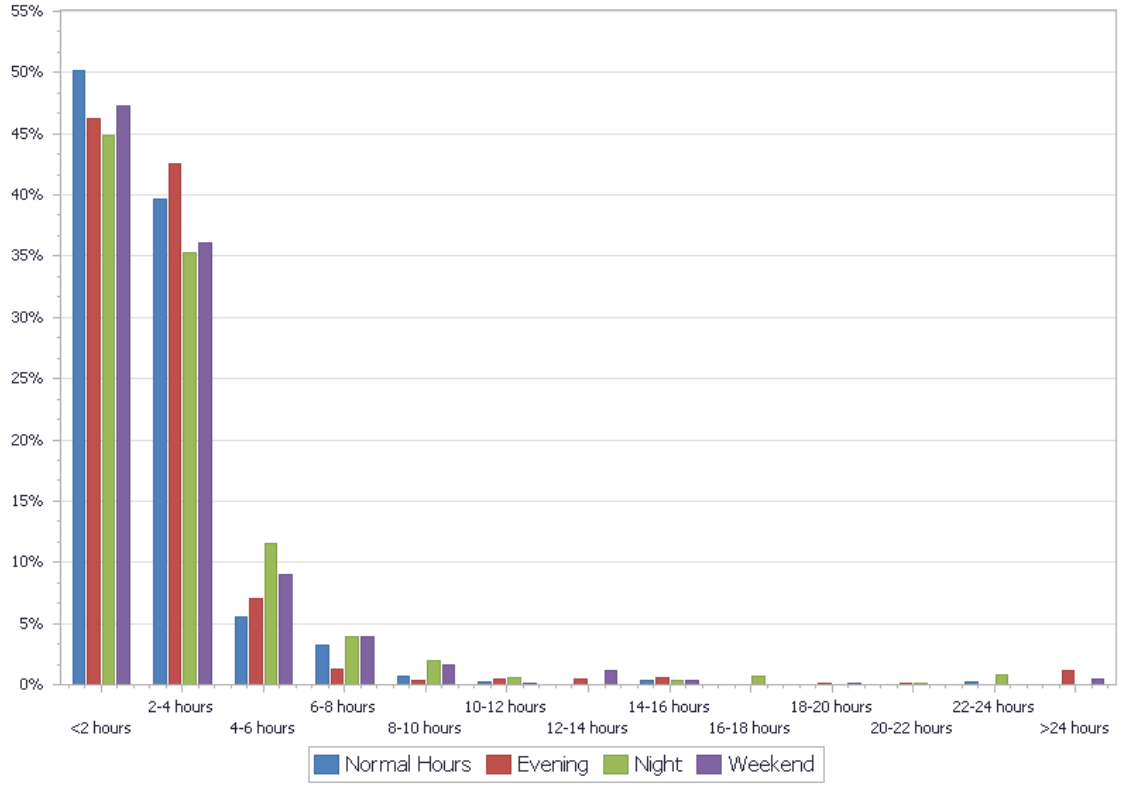
There is a clear lack of performance anywhere near the standard – the national median was 0%.

The possible causes and actions to consider are discussed in the analysis section below.

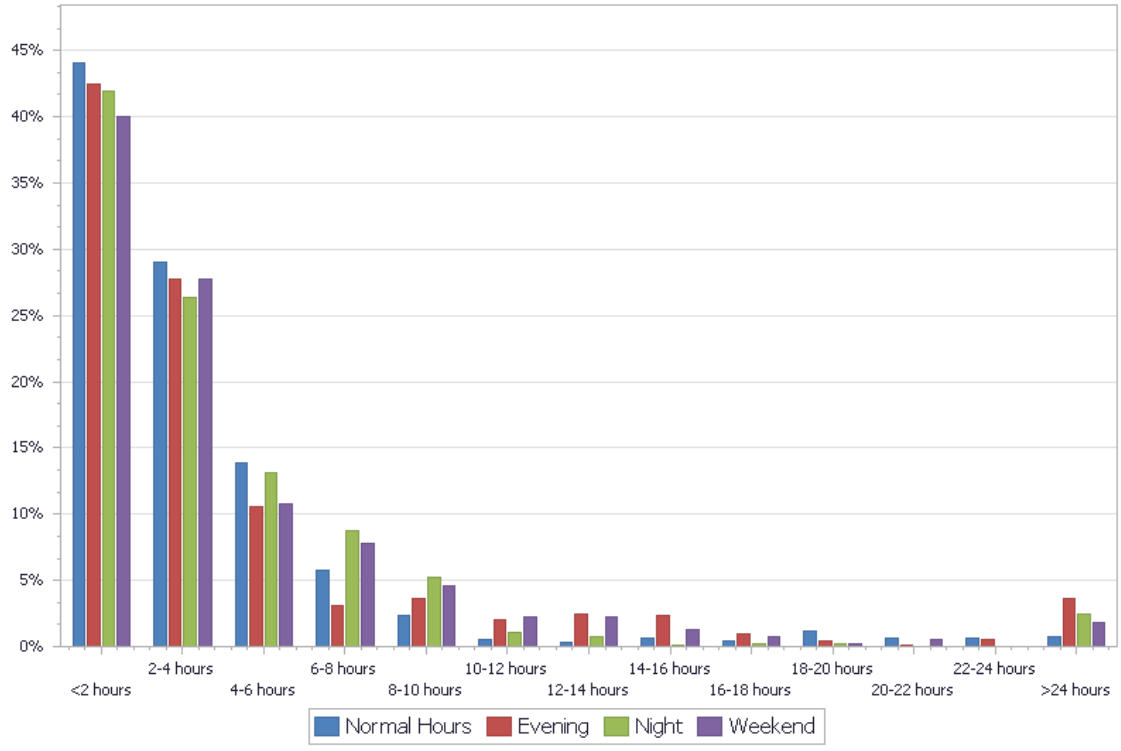
Elapsed time between arrival and risk assessment for various times of arrival



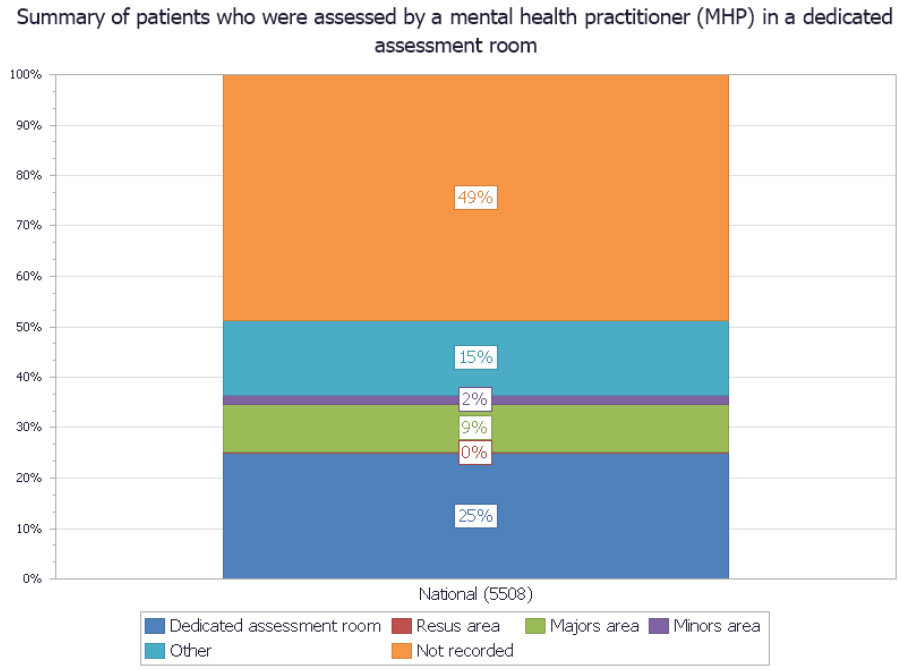
Elapsed time between arrival and mental state examination for various times of arrival



Elapsed time between mental state examination/history taken and assessment by mental health practitioner for various times of arrival



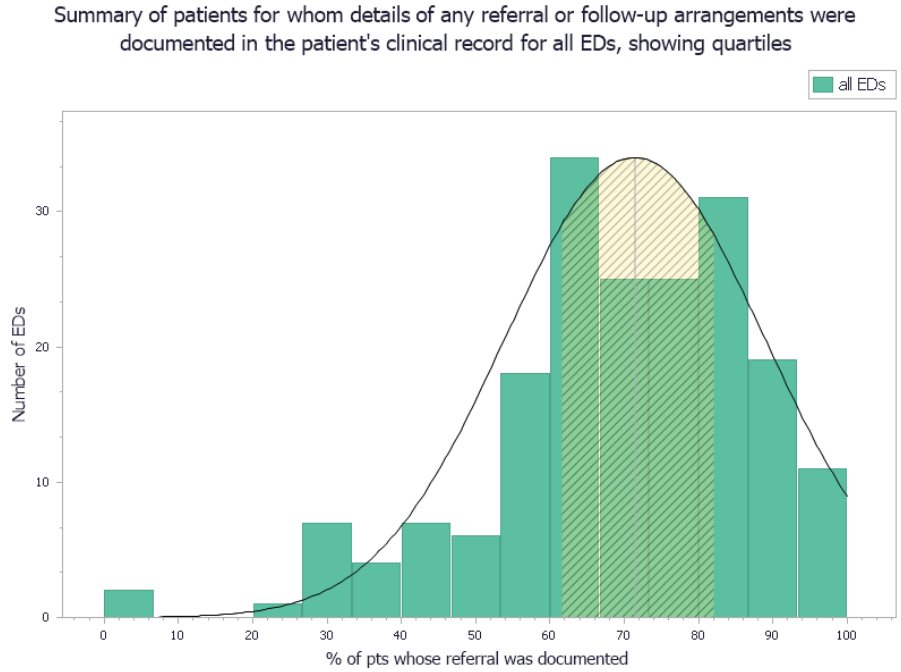
Q9c. Where was the patient assessed by the mental health practitioner?



This graph reflects that this information is not routinely collected, as 50% are uncoded.

Bearing in mind the generally good provision of dedicated assessment rooms for patients with mental health issues, it is likely the destination may be taken for granted hence not recorded.

Q12. Were details of any referral or follow-up arrangements documented in the patient's clinical record?



Standard 5: Details of any referral or follow-up arrangements should be documented in the patient's clinical record

Standard: 100% patients

Although there was quite a large degree of variation, it is possible that most patients did have a follow up plan.

Q13. Do organisations have a Liaison Psychiatry service?

The vast majority of organisations have a liaison psychiatry service.

It is possible that those that do not have a telephone triage service that may provide acute assessments.

Q14. Does EDs have a dedicated assessment room for mental health patients?

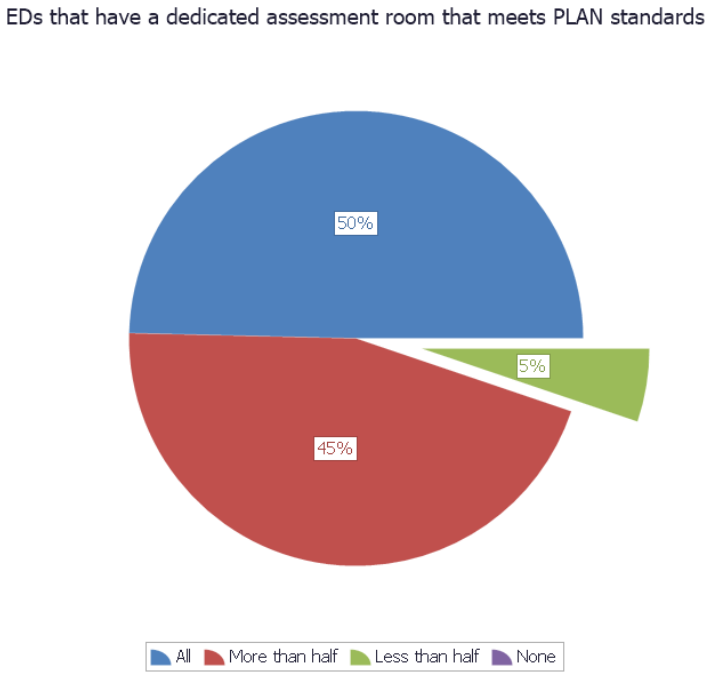
Standard 7a - fundamental: An appropriate facility is available for the assessment of mental health patients in the ED

Standard: 100%

An average of 77% EDs nationally met this standard.

However, it is encouraging these hospitals have implemented a dedicated facility that maintains dignity.

Q14b. Does the assessment room meet the standards set out by the Psychiatric Liaison Accreditation Network?



Standard 7b – fundamental: Assessment room meets all standards set by the Psychiatric Liaison Accreditation Network (PLAN)

Standard: 100%

The importance of a facility that ensures safety and dignity has clearly been received, and is being implemented.

However there is clearly some way to go before assessment rooms meet all of the PLAN standards.

Analysis

The samples sizes for each standard were:

Standard 1:	7913
Standard 2:	7913
Standard 3:	7913
Standard 4:	7913
Standard 5:	7913
Standard 6:	6412
Standard 7a:	183 (Statistic by ED, not patient)
Standard 7b:	183 (Statistic by ED, not patient)

The case numbers for all standards were considered large enough for the findings to be deemed as a valid national representation.

It was heartening to see that provision of a liaison psychiatry service and a dedicated mental health assessment room was near universal, although the safety aspects of the assessment rooms need follow up to ensure compliance with PLAN standards.

It is clear that the 'one hour response' by a member of the mental health team standard is not being achieved anywhere consistently. This standard, proposed by the Royal College of Psychiatrists PLAN should be reviewed. It may be that a study is necessary to examine the feasibility of the 'one hour response'. If the short response time is deemed necessary, it may be necessary to review which organisation should provide this service. If a timely service is to be achieved it may be more cost-effective for this to be provided by telephone triage and/or by senior nursing staff based in the Emergency Department with specific mental health training, rather than as a standalone service. It may be possible to carry out a service evaluation with application of improvement methodology to improve access and quality of care.

Limitations

We did not include phone triage as a separate category of assessment, and in a future audit we should ensure that this is recorded separately to better understand its role within the different models of service provision.

This audit did not include any questions about access to summary care/ mental health/ community records, all of which may contain information that would be helpful in managing a patient with mental health issues.

Recommendations

National

This report will be shared with other relevant national organisations.

1. Evaluate the feasibility of the 'one hour response' by a member of the mental health team, and potential value-based models for providing this.
2. Re-audit to include phone triage as a separate category of assessment, to better understand its role within the different models of service provision.

Local Emergency Departments

This audit report should be shared with Emergency Departments, Hospital Audit Leads and local Psychiatry services. If Emergency Departments have performed poorly on an audit standard, they should consider taking action. Some suggestions are below.

1. Develop a proforma for mental health assessment to help clinical staff structure and document their assessments, as well as record times of assessments in a standardised way (examples available in RCEM Mental Health Toolkit and under 'Resources' section).
2. If necessary, review the recommendations of the Psychiatric Liaison Accreditation Network regarding assessment room features and layout. Consult with estates regarding work to be done to meet the minimum standards.
3. If no liaison psychiatry service is available then consider whether this should be provided or alternatives.
4. Review timeliness of service provided with the evidence from this audit. Does this match experience on the shop floor?
5. Undertake rapid cycle quality improvement if the ED's performance on any standard is below the expected level.

Using the results of this audit to improve care

Clinical audit is a quality improvement tool. However, traditional clinical audit with an annual or biannual cycle takes too long and may fail to demonstrate a "cause and effect" which allows us to draw conclusions from implementation of changes and their actual effect on performance.

Rapid cycle audit is a better quality improvement tool that involves consulting front-line staff, and asking them to suggest changes to improve the patient care, and then

conducting short cycles of audit e.g. 10 patients at a time, and reviewing these to ensure that the performance is improving.

Sharing the results of these audits with staff is a good way of demonstrating both commitment to improve, and their ability to make changes that matter. The results are tracked using a simple run chart and the short run-in times allow more confidence in the change processes creating the needed improvement.

For further information regarding methodology please see HQIP guide on using quality improvement tools (Dixon and Pearce, 2011).

Further information

If you have any queries about the report please e-mail audit@rcem.ac.uk or phone 020 7400 6108.

Feedback is welcome at: http://ow.ly/LX5gz or https://www.surveymonkey.com/s/audit_14-15.

Details of the RCEM Clinical Audit Programme can be found under the Clinical Audit section of the College Website at www.rcem.ac.uk.

Useful resources

- PowerPoint presentation – developed to help you disseminate specific audit results easily and efficiently.
- Psychiatric Liaison Accreditation Network
- Royal College of Psychiatrists
- Mind
- Examples of local guidance and proformas: www.rcem.ac.uk/Shop-Floor/Clinical%20Guidelines/Local%20Guidelines

References

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Report authors and contributors

This report is produced by the Standards and Audit Subcommittee of the Quality in Emergency Care Committee, for the Royal College of Emergency Medicine.

Pilot sites

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- George Eliot Hospital NHS Trust

This report is endorsed by:

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Appendix 1: Audit questions

Record #		Patient reference
Q1	Date of arrival *(dd/mm/yyyy)*	
Q2	Time of arrival *(Use 24 hour clock e.g. 11.23pm = 23:23)*	
Q3	Was the type of self-harm recorded?	Self-injury
		Self-poisoning
		Not recorded
Q4	Was a risk assessment taken and recorded in the patient's clinical record? *(tick one answer option only)*	Yes
		No – reason why not recorded
		No - patient left before risk assessment
		Not recorded
	If YES, enter the time risk assessment completed *(HH:MM)*	*Enter time*
		Time not recorded
	If YES, was the patient specifically asked about: - suicidal intent and acts - safeguarding concerns - assessing risk of repetition - assessing risk of potential harm to others	Yes - all
		Partially – some of these
		No – none of these
		Not recorded
Q5	Was a history of patient's previous mental health issues taken and recorded in the patient's clinical record? *(tick one answer option only)*	Yes
		No - reason why not recorded
		Patient left before history taken
		Not recorded
	If YES, enter the time history taken *(HH:MM)*	Enter time
		Time not recorded
Q6	Was a mental state examination taken and recorded in the patient's clinical record? *(tick one answer option only)*	Yes
		No - reason why not recorded
		No - Patient left before MSE
		Not recorded
	If YES, enter the time mental state examination taken *(HH:MM)*	Enter time
		Time not recorded
Q7a	Was the patient asked about their alcohol & illicit substance consumption within the last 24 hours and the answers documented in the patient's clinical record? *(tick one answer option only)*	Yes
		No - reason why not recorded
		No - Patient left before consumption assessment
		Not recorded
Q7b	Was the patient assessed for their level of alcohol &/or illicit substance dependency and the answers documented in the patient's clinical record? *(tick one answer option only)*	Yes
		No - reason why not recorded
		Not recorded
		No - Patient left before dependency assessment
Q8	Was a provisional diagnosis documented and recorded in the patient's clinical record? *(tick one answer option only)*	Yes
		No - prov. diagnosis undecided
		No - Patient left before diagnosis reached
		Not recorded
Q9	Was the patient assessed by a mental health practitioner (MHP) from your organisation's	Yes
		No – MHP unavailable

	specified acute psychiatric service? *(tick one answer option only)*	No - Patient left before assessment by MHP
		Not recorded
	If YES, enter the time patient assessed by MHP	Enter time
		Time not recorded
	If YES, where was the patient assessed by the mental health practitioner? *(tick one answer option only)*	Dedicated assessment room
		Resus area
		Majors area
		Minors area
		Other
		Not recorded
Q10	Time patient left the ED	Enter time
		Not known - patient absconded
		Time not recorded
Q11	Where was the patient discharged to from the ED? *(tick one answer option only)*	Place of normal residence
		Voluntary admission to mental health facility
		Involuntary admission to mental health facility
		Not recorded
		Patient absconded
Q12	Were details of any referral or follow-up arrangements documented in the patient's clinical record? *(tick one answer option only)*	Yes
		Not applicable
		Not recorded

IMPORTANT – You only need to answer Q13 & Q14 ONCE in the audit as the questions are generic and apply to all patients. Please answer the questions for the 1ST record entered only.

Q13	Does your organisation have a Liaison Psychiatry service? *(tick one answer option only)*	Yes
		No
		Under development
Q14	Does your ED have a dedicated assessment room for mental health patients? *(tick one answer option only)*	Yes
		No
	If YES, does the room meet the standards set out by the Psychiatric Liaison Accreditation Network? *(tick one answer option only)*	ALL met
		Half or more met
		Less than half met
		NONE met

Appendix 2: Participating Emergency Departments

England

Addenbrooke's Hospital
Aintree University Hospital
Airedale General Hospital
Alexandra Hospital
Arrowe Park Hospital
Barnet Hospital
Barnsley Hospital
Basildon University Hospital
Bedford Hospital
Blackpool Victoria Hospital
Bradford Royal Infirmary
Bristol Royal Infirmary
Broomfield Hospital
Calderdale Royal Hospital
Charing Cross Hospital
Chelsea & Westminster Hospital
Cheltenham General Hospital
Chesterfield Royal Hospital
Chorley and South Ribble Hospital
City Hospital (Birmingham)
Colchester General Hospital
Conquest Hospital
Countess of Chester Hospital
Croydon University Hospital
Darent Valley Hospital
Darlington Memorial Hospital
Derriford Hospital
Diana, Princess of Wales Hospital
Dorset County Hospital
Ealing Hospital
East Surrey Hospital
Eastbourne District General Hospital
Epsom General Hospital
Fairfield General Hospital
Friarage Hospital
Frimley Park Hospital
Furness General Hospital
George Eliot Hospital
Gloucestershire Royal Hospital
Good Hope Hospital
Grantham & District Hospital
Harrogate District Hospital
Heartlands Hospital
Hereford County Hospital
Hillingdon Hospital
Hinchingbrooke Hospital
Homerton University Hospital
Horton Hospital
Huddersfield Royal Infirmary
Hull Royal Infirmary
Ipswich Hospital
James Paget Hospital
John Radcliffe Hospital
Kettering General Hospital
Kings College Hospital
King's Mill Hospital
Kingston Hospital
Leeds General Infirmary
Leicester Royal Infirmary
Leighton Hospital
Lincoln County Hospital
Lister Hospital
Maidstone District General Hospital
Manchester Royal Infirmary
Manor Hospital
Medway Maritime Hospital
Milton Keynes Hospital
Musgrove Park Hospital
New Cross Hospital
Newham General Hospital
Norfolk & Norwich University Hospital
North Manchester General Hospital
North Middlesex University Hospital
North Tyneside General Hospital
Northampton General Hospital
Northern General Hospital
Northwick Park Hospital
Peterborough City Hospital
Pilgrim Hospital
Pinderfields Hospital
Poole General Hospital
Princess Alexandra Hospital
Princess Royal University Hospital
Queen Alexandra Hospital
Queen Elizabeth Hospital (Birmingham)
Queen Elizabeth Hospital (Gateshead)
Queen Elizabeth Hospital (Woolwich)
Queen Elizabeth, The Queen Mother Hospital
Queen's Hospital (Romford)
Queen's Hospital (Burton)
Queen's Medical Centre
Rotherham District General Hospital
Royal Albert Edward Infirmary
Royal Berkshire Hospital
Royal Blackburn Hospital
Royal Bolton Hospital
Royal Bournemouth General Hospital
Royal Cornwall Hospital
Royal Derby Hospital

Royal Devon & Exeter Hospital
Royal Lancaster Infirmary
Royal London Hospital (The)
Royal Oldham Hospital
Royal Preston Hospital
Royal Shrewsbury Hospital
Royal Surrey County Hospital
Royal Sussex County Hospital
Royal United Hospital
Royal Victoria Infirmary
Russells Hall Hospital
Salford Royal Hospital
Salisbury District Hospital
Sandwell General Hospital
Scarborough General Hospital
Scunthorpe General Hospital
Solihull Hospital
South Tyneside District General Hospital
Southampton General Hospital
Southend Hospital
Southmead Hospital
Southport & Formby District General Hospital
St George's
St Helier Hospital (Adult)
St James's University Hospital
St Mary's Hospital
St Richard's Hospital (Chichester)
St Thomas' Hospital
Staffordshire General Hospital
Stepping Hill Hospital
Stoke Mandeville Hospital
Sunderland Royal Hospital
Tameside General Hospital
The Cumberland Infirmary
The Great Western Hospital
The James Cook University Hospital
The Princess Royal Hospital
The Queen Elizabeth Hospital (King's Lynn)
The Royal Liverpool University Hospital
Torbay District General Hospital
Tunbridge Wells Hospital
University College Hospital
University Hospital Coventry
University Hospital Lewisham
University Hospital Of North Durham
University Hospital Of North Tees
Wansbeck Hospital
Warrington Hospital
Warwick Hospital
Watford General Hospital
West Cumberland Hospital
West Middlesex University Hospital
West Suffolk Hospital
Weston General Hospital
Wexham Park Hospital
Whipps Cross University Hospital
Whiston Hospital
Whittington Hospital
William Harvey Hospital
Worcestershire Royal Hospital
Worthing Hospital
Wythenshawe Hospital
Yeovil District Hospital
York Hospital

Scotland
Forth Valley Royal Hospital
Hairmyres Hospital
Monklands Hospital
Royal Infirmary of Edinburgh
St John's Hospital at Howden
Victoria Hospital
Wishaw General Hospital

Wales
Bronglais General Hospital
Glangwili General Hospital
Morriston Hospital
Nevill Hall Hospital
Royal Gwent Hospital
University Hospital of Wales
Withybush General Hospital
Ysbyty Gwynedd

Northern Ireland
Antrim Area Hospital
Causeway Hospital
Royal Victoria Hospital – Belfast
Ulster Hospital

Isle of Man/Channel Islands
Noble's Hospital

Appendix 3: Standards definitions

Standard 1: Factors that should be recorded in an initial risk assessment include, but are not limited to:

- asking specifically about suicidal intent and acts
- safeguarding concerns
- assessing risk of repetition
- assessing risk of potential harm to others.

ED is defined as a Type 1 ED (including CDU/observation wards run by ED staff).

Standard 2: A history of the patient's previous mental health issues should be taken by an ED clinical practitioner* and should include asking about:

- the presence, absence and number of previous episodes.

Standard 3: Factors that should be recorded in an initial mental state examination should include, but are not limited to:

- mental capacity
- level of distress (patient should be specifically asked about hopelessness)
- presence of mental health problems
- willingness to remain for further psychosocial assessment.

Standard 4: A provisional diagnosis regarding the patient's mental state should be documented in the patient's clinical record.

Standard 6: Mental Health team refers to clinical practitioners working for your organisation's specified acute psychiatric service (e.g. liaison psychiatry). This standard is based on the Royal College of Psychiatrist guideline '*Liaison psychiatry for every acute hospital*' (CR183, December 2013) which states: 'Services should aim for a maximum response time of 1h for emergency referrals'.

Standard 7b: Psychiatric Liaison Accreditation Network (PLAN) standards for safe assessment rooms:

- Be located to, or within, the main Emergency Department or Acute Medical Unit
- Have a door which opens both ways and is not lockable from the inside
- Have an observation panel or window which allows staff from outside the room to check on the patient or staff member
- Have a panic button or alarm system (unless staff carry alarms at all times)
- Only include furniture, fittings and equipment which are unlikely to be used to cause harm
- Not have any ligature points.

(Note: Whilst not mandatory for accreditation, PLAN highly recommends that assessment facilities should have with two doors to provide additional security. All new assessment rooms must be designed with two doors).

* Doctor, nurse or other health professional who normally works in the ED

Appendix 4 – Calculations

Value: **Patient asked about specific issues**

Sample Group Condition: Only those entries where the answer to "Q4 Was risk assessment taken and recorded?" (Q4answer) was answered 'Yes'.

Value: **Where was the patient assessed by MHP**

Sample Group Condition:

- Only those entries where the answer to "Q9 Was the patient assessed by MHP?" (Q9answer) was answered 'Yes'.
- Count any blank answers for location as 'not recorded'

Value: **Does dedicated assessment room meet PLAN standards**

Sample Group Condition: Only those entries where the answer to "Q14 ED have a dedicated assessment room?" (Q4answer) was answered 'Yes'.

Value: **Patient asked about specific issues**

Sample Group Condition: Only those entries where the answer to "Q4 Was risk assessment taken and recorded?" (Q14answer) was answered 'Yes'.

Value: **Standard 7b**

Sample Group Condition: Only those entries where the answer to "Q14 ED have a dedicated assessment room?" (Q4answer) was answered 'Yes'.

Standard 6

Only include records who answered:-

a) 'Yes' to being seen by an MHP.
b) Recorded the time/date that the patient was seen by the MHP.
c) The time of the MHP assessment took place after the time of arrival (filtering invalid date/time values)
d) The time of the MHP assessment is within 7 days of the time of arrival (filtering invalid date/time values)

This will give the number of 'valid' entries that can then be used to determine which ones were seen within 1 hour.