RCEM
Royal College of Emergency Medicine

MENTAL HEALTH (SELF-HARM)

NATIONAL QUALITY IMPROVEMENT PROGRAMME

Information Pack

2022 - 2025

Published: October 2024

Quick Guide to Running an Awesome QIP

Form your QIP Team
RCEM recommends a multidisciplinary QI team.

Standards
Click here to find the standards.

Questions
Click here to find the questions.

Inclusion criteria
18 years and older are eligible.

Sample size
Recommended sample size: Please collect data.
on a minimum of 5 eligible cases per week.

Data entry portal
Log into the data entry site at https://rcem.casecapture.com

Data frequency
Recommended: enter cases each week.
Alternative: If your ED will find weekly data entry difficult, enter data fortnightly or monthly.

Inclusion Period
Data should be entered on patients attending
from 4 October 2022 – 3 October 2024, and 1 January 2025 – 31 December 2025

***For the interim reports data collection period, please see the Inclusion and data entry periods sections for details.**

CONTENTS

WELCOME

This document tells you everything you need to know if your Emergency Department (ED) wishes to participate in the 2022/25 RCEM national quality improvement programme (QIP) on Mental Health (Self-Harm).

Introduction

Patients presenting to the ED with mental health needs make up around 5% of total attendances. They may have both physical and mental health needs to be met concurrently and some present with high risks of further self-harm and suicide.

In 2018 the Healthcare safety investigation branch (HSIB) published a report on the provision of mental health care to patients presenting at the Emergency Department. A recommendation for RCEM was to improve and standardise the initial assessment of patients. This QIP is part of the ongoing response to this recommendation.

In 2022 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.

- ED Mental Health Triage process
- Observation of patients at risk of further self-harm or absconding
- ED clinician assessment

This QIP will track the current performance in EDs against clinical standards in individual departments and nationally on a real time basis over a 3-year 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.

As well as the three standards above for individual patient care, there are organisational standards for each department to consider and an emphasis on working with mental health professionals to provide joint care and parallel assessment where possible. Departments may also use this 3-year QIP period as an opportunity to consider other ways of improving care of patients with mental health problems. This could be by collecting and responding to patient feedback, initiatives to reduce stigma, improving the ED environment or reviewing the care of patients who are agitated or aggressive.

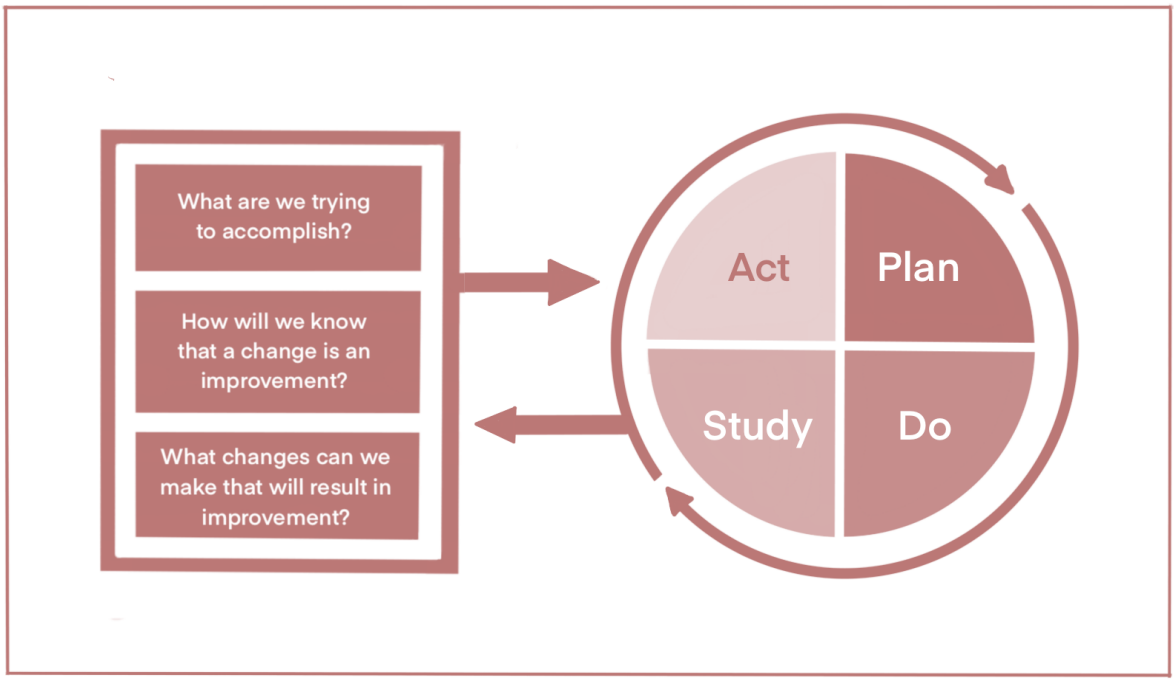
QUALITY IMPROVEMENT INFORMATION

The purpose of this QIP is to continually quality assure and improve your service whereby the patient benefits as an outcome of the programme. The RCEM system allows your team to record details of QIPs and see on your dashboard how each initiative affects your data on key outcome and process measures.

We encourage you to use this feature in your department. If you are new to QIPs, we recommend you follow the 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.

Further information on ED quality improvement can be found on the RCEM website.

The model for improvement (Institute of Healthcare Improvement)



OBJECTIVES FOR ALL RCEM QIPS

To identify current ED performance against clinical standards and previous performance

How RCEM supports you	Expert teams of clinicians and QIP specialists have reviewed current national standards and evidence to set the top priority standards for this national QIP. RCEM have built a bespoke platform to collect and analyse performance data against the standards for each ED.

Show EDs their performance in comparison with other participating departments both nationally and in their respective country in order to stimulate quality improvement.

How RCEM supports you	The QIP will be run over a 3-year period. The longer duration should allow better planning and effective iteration. This should lead to improved patient care. Participating ED's can see how they perform as compared to National mean. This should enable ED's revisit changes implemented and plan further PDSA cycles.

To empower and encourage EDs to run quality improvement (QI) initiatives based on the data collected and track the impact of the QI initiative on their weekly performance data.

How RCEM supports you	The RCEM platform includes a dashboard with graphs showing your ED's performance as soon as data are entered to benchmark against yourself. The dashboard graphs are SPC charts (where applicable) with built in automatic trend recognition, so you can easily spot statistically significant patterns in your data.

	The portal has built in tools to support local QI initiatives, such as an online PDSA template. Once you have completed a PDSA template with your team, this is overlaid onto your dashboard charts so you can easily see the impact of your PDSA. RCEM have also published a QI guide to introducing a range of excellent QI methodologies to enhance QI knowledge and skills.

STANDARDS

Organisational Standards

Standards	Grade	Reference
1. Each department should have a named Mental Health Lead.	F	
2. EDs should have a policy in place for assessing and observing patients for those considered to be high or medium risk of self-harm, suicide, or leaving before assessment and treatment are complete.	F	Recommendations | Self-harm: assessment, management and preventing recurrence | Guidance | NICE
3. EDs should have a policy which clearly states when patients can or cannot be searched. This should be compliant with relevant legislation. Searches which are for the clinical safety of the patient should be conducted by clinical staff rather than security guards.	D	Mental Health Toolkit – RCEM 2022
4. ED and mental health teams should have joint pathways which promote parallel assessment of patients with both physical and mental health needs. NICE guidance states that psychosocial assessment should not be delayed until after medical treatment is completed.	F	Side by side Consensus statement - 2020 Recommendations | Self-harm: assessment, management and preventing recurrence | Guidance | NICE
5. EDs should have an appropriate area available where patients with mental health problem can be observed (i.e., A designated quieter/safer area than a regular cubicle)	A	Quality statement 5: Safe physical environments| Quality standards | NICE
6. EDs should follow their trust's policy for restrictive intervention and should follow guidance for Rapid	F	Restrictive interventions for managing violence and aggression in adults - NICE Pathways

Tranquilisation (NICE or their own guideline).		
7. EDs should have a policy for patients under the relevant policing and mental health legislation - including section 297 (Scotland), section 130 (Northern Ireland) or section 136 (England and Wales) to ensure safety, dignity, and timely management.	F	Mental Health Toolkit – RCEM 2022
8. EDs should have an appropriate room available for the assessment and assistance of people with mental health needs. These should meet the standards of the Psychiatric Liaison Accreditation Network (PLAN).	F	Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services – RCPSYCH 2020
9. An appropriate programme should be in place to train ED nurses, health care assistants, and doctors in mental health and mental capacity issues.	F	

Clinical Standards

Standards	Grade	Reference
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.	F	Mental Health Toolkit – RCEM 2022 Recommendations | Self-harm: assessment, management and preventing recurrence | Guidance | NICE Quality statement 2: Initial assessments| Quality standards | NICE
2. Patients at medium or high risk of further self-harm or of leaving before assessment and treatment are complete should be observed closely during the period that they are considered to be high-risk/medium-risk. There should be documented evidence of either continuous observation (1:1) or intermittent checks, interactions and care delivery (recommended every 15 – 30 minutes)	F	Mental Health Toolkit – RCEM 2022 Recommendations | Self-harm: assessment, management and preventing recurrence | Guidance | NICE Quality statement 4: Monitoring | Self harm | Quality standards | NICE
3. When an ED clinician reviews a patient presenting with self-harm, they should	F	Mental Health Toolkit – RCEM 2022

record a brief risk assessment of suicide and further self- harm.

Grading explained.

F - Fundamental	This is the top priority for your ED to get right. It needs to be met by all those who work and serve in the healthcare system. Behaviour at all levels of service provision need to be in accordance with at least these fundamental standards. No provider should offer a service that does not comply with these fundamental standards, in relation to which there should be zero tolerance of breaches.
D - Developmental	This is the second priority for your ED. It is a requirement over and above the fundamental standard.
A - Aspirational	This is the third priority for your ED and is about setting longer term goals.

EQUALITY STATEMENT

The College is committed to assessing health inequalities relating to patient ethnicity and gender to support departments to provide high quality and equitable care to all.

We will be collecting ethnicity and gender data, monitoring them for systemic inequalities and reporting at the national level.

Our last attempt demonstrated difficulties collecting comprehensive ethnicity data with many reported as 'not specified' – We are exploring the cause of this to improve future data sets to increase the accuracy of ongoing analysis of such data.

MEASURES

Process Measures

Process measures include capturing the times of the key moments in the patient's journey and overall quality of care delivered in the ED.

Mental health triage of patients presenting with self-harm takes time. This will include some time to gain a rapport, asking about risks of further self- harm, or wanting to leave, considering safeguarding and mental capacity issues.

See Mental Health (MH) toolkit for examples of MH triage and documentation of observations.

From the 2018 QIP feedback, it was apparent that getting this done ≤ 15 minutes was a challenge. For this reason, a decision was made to record mental health triage done ≤15 minutes and ≤ 30 minutes. Time to mental health triage refers to the start of the mental health triage process.

- Time to Mental Health triage (15 mins and 30 mins)
- Evidence of observing patients at high and medium risk of further self-harm or absconding while in ED
- Time to ED Clinician review following mental health triage.
- Quality of brief risk assessment by the ED clinician
- Time to review by adult psychiatric liaison services in the ED following referral.
- Where possible 'parallel assessment' by both ED clinician and Adult Psychiatric liaison services

Outcome Measures

It is difficult to measure the quality of care of patients with a mental health crisis, for example have we taken time to listen to them, ask what might help them right now, explain what will happen etc? One question is included which will ask for a judgement of the reviewer if there is evidence of compassionate and practical care.

EDs can determine their own outcome measures based on local need for improvement. Examples are reduction in incidents.

- Evidence of compassionate and practical care: e.g. being offered food and drink, pain relief, usual medication and explanation of what will happen.

METHODOLOGY

Forming your QIP team

RCEM recommends forming a multidisciplinary QI team; include consultants, trainees, advanced care practitioners (ACPs), specialty and associate specialist (SAS) doctors, nursing, patient representatives and others to suit your local set up.

Data entry portal

You can find the link to log into the data entry site at https://rcem.casecapture.com (registered users only).

Inclusion criteria

Patients must meet the following criteria for inclusion:

- Patients aged 18 years and older.
- Who attended during the QIP's inclusion period.
- Who presented at an ED having intentionally self-harmed (either self-injury or self-poisoning) **AND** had a referral made by the ED for emergency mental health assessment by your organisation's specified acute psychiatric service.
- Any patient re-attending due to self-harm within the QIP period can be included irrespective of whether they had been included or not previously.

Exclusion criteria

Do not include:

- Any patient under 18 years of age
- 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)
- Patients who left before triage
- Any patient at the time of attending ED was an inpatient in a Mental health unit.
- Any patient not requiring ED care and transferred off site for a mental health assessment immediately after triage.

Sample size

Please collect a minimum of 5 randomised cases per week that meet the eligibility criteria.

Data entry frequency

Recommended: To maximise the benefit of the run charts and features RCEM recommends entering a minimum of 5 cases each week. This will allow you to see your ED's performance on key measures changing week by week. PDSA cycles should be regularly conducted to assess the impact of changes on the week-to-week performance.

Alternative: If your ED will find weekly data entry too difficult to manage, you may enter data fortnightly or monthly instead. 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 fortnightly. If you decide to enter data fortnightly, we recommend that you enter at least 10 cases fortnightly (5 cases from week 1 and 5 from week 2). You can then consider fortnightly cycles of PDSA with specific interventions and

evaluate their impact by reviewing the trend over that period.

Inclusion period

Patients who meet the inclusion criteria and attended between 04 October 2022 – 03 October 2024, or 1 January 2025 – 31 January 2025 can be included in this QIP.

Specific QIP year inclusion periods:

Year 1 inclusion period:
Patients who attended between 04 October 2022 – 03 October 2023

Year 2 inclusion period:
Patients who attended between 04 October 2023 – 03 October 2024

Year 3 inclusion period:
Patients who attended between 01 January 2025 – 31 December 2025

The programme length has been increased to allow time to understand your local service offering and establish areas of need. These can then be targeted with PDSA interventions and change monitored over enough time to embedded real change. Nationally we are aiming to improve sharing of best practice to facilitate idea development.

Data entry period

Data can be entered online between 04 October 2022 – 03 October 2024, and 14 January 2025 – 14 January 2026

Data entry period per QIP year:

Year 1 data entry period: 04 October 2022 – 03 October 2023

Year 2 data entry period: 04 October 2023 – 03 October 2024

Year 3 data entry period: 14 January 2025 – 14 January 2026

Each year's patient data must be entered within the same year's data entry period. For example, all patients attending in year 1's inclusion period must be entered to the QIP in the year 1's data entry period to be included in year 1's reporting.

> Any patients who attended within a year's inclusion period but were submitted after the same year's data entry period will not be included in that year's reporting.

It is recommended to enter data as close to the date of patient attendance as possible, and to review progress regularly. This will help your QI team spot the impact of intervention more promptly for refinement or disposal depending on the changes observed.

DATA TO BE COLLECTED

Organisational data

(please complete this section three times per ED- at the start of the QIP; One year after the start of the QIP; at the end of the QIP)

p	Does the ED have a named mental health lead?	• Yes • No
Q2	Is there a policy in place for assessing and observing patients at medium/high risk of self-harm, suicide or leaving before assessment and treatment are complete?	• Yes • No
Q3	Is there a policy in place which clearly states when patients can or cannot be searched?	• Yes • No
Q4	Is there an appropriate room available for assessment and assistance of patients with mental health needs? This room should meet PLAN accreditation standards.	• Yes • No
Q5	Is there an appropriate area in ED available where patients with mental health problem could be observed? (e.g. A designated quieter / safer area than a regular cubicle)	• Yes • No
Q6	Does the ED have a policy of parallel assessment of physical and mental health needs where possible?	• Yes • No
Q7	Is there a Policy in place for: a. Restrictive intervention? b. Rapid tranquilisation?	• Yes • No • Yes • No
Q8	Does the ED have a policy for patients under the relevant policing and mental health legislation? Including section 297 (Scotland), section 130 (Northern Ireland) or section 136 (England and Wales) to ensure safety, dignity, and timely management.	• Yes • No
Q9	Is there an appropriate programme in place to train: a. ED nurses and / or health care assistants in mental health and mental capacity issues? b. ED doctors in mental health and mental capacity issues?	• Yes • No • Yes • No

Clinical data – Attendance, Referral and Review

Q1.1	Reference (Do not use patient identifiable data e.g. NHS or hospital number.)	Free Text
Q1.2	Date and time of arrival	• dd/mm/yyyy • HH:MM
Q1.3	Date and time of mental health triage	• dd/mm/yyyy • HH:MM • Patient did not undergo mental health triage. • Time not known.
Q1.4	Ethnic category	See Appendix 1 for ECDS category details
Q1.4.1	Gender	See Appendix 1 for ECDS category details
Q1.5	Did the patient have ED clinician review?	• Yes • Not recorded • Did not wait / self-discharged. • Not seen by ED clinician, referral direct to adult psychiatric liaison services
Q 1.5.1	**Appears if Q1.5 = Yes** Date and time of ED clinician review	• dd/mm/yyyy • HH:MM • Not recorded • Time not known
Q 1.5.2	**Appears if Q1.5 = Did not wait / self-discharged** Was a Capacity assessment documented if patient did not wait / self-discharged?	• Yes • No
Q 1.5.3	**Appears if Q1.5 = Did not wait / self-discharged** If patient left prior to ED clinical review, was this acted on?	• Yes – appropriate measures taken. • No • Not recorded
Q1.6	Date and time of first referral to Adult Psychiatric liaison services (or equivalent).	• dd/mm/yyyy • HH:MM • Not recorded • Time not known.
Q1.6.1	**Appears if date is provided in Q1.6** Who made this referral?	• Triage nurse. • ED clinician • Other clinician

		• Not recorded
Q1.7	Was there an Adult Psychiatric liaison services review of patient in ED? *(Not applicable e.g. Patient admitted before review by Adult Psychiatric Liaison to ED short stay, medical ward or shifted off site for mental health assessment following ED management / acceptable safe discharge plan by ED)*	• Yes • Not recorded • Not applicable • Did not wait / self-discharged.
Q1.7.1	**Appears if Q1.7 = Yes** Date and time of Adult Psychiatric liaison services review of patient in ED:	• dd/mm/yyyy • HH:MM • Not recorded • Time not known
Q 1.7.2	**Appears if Q1.7 = Did not wait / self-discharged** Was a Capacity assessment documented if patient did not wait / self-discharged?	• Yes • No
Q 1.7.3	**Appears if Q1.7 = Did not wait / self-discharged** If patient left prior to Adult Psychiatric Liaison review, was this acted on?	• Yes – appropriate measures taken • No • Not recorded
Q1.8	Date and time of leaving ED. *(Discharged after ED and Adult Psychiatric liaison team review / admitted to ED SSU or ward / Transferred off site for mental health assessment):*	• dd/mm/yyyy • HH:MM • Time Not Known • Unknown (Patient did not wait & time entered not accurate)

Clinical data - Assessment and Observation

Q2.1	**Appears if date provided in Q1.3** Was the patient risk level of further self-harm or leaving ED before further assessment and treatment, documented at triage? (Low / Medium / High)	• Low-risk • Medium-risk • High-risk • Not recorded
Q2.1.1	**This Qn appears if Q2.1 = Medium-risk or High-risk.** Is there evidence of appropriate observation, interactions or care of the patient (for example continuous (1:1) or every 15 - 30 mins) during their whole length of stay in ED? Note: The mental health toolkit recommends that security staff should not be used for	• Yes - Good documented evidence of continuous or intermittent observation, interaction or care of the patient. • Partially met – Some evidence of continuous or intermittent observation,

	observation. It should be performed by health care personnel	interaction or care of the patient • No evidence – No recorded evidence of observation, interaction or care of the patient
Definitions: a. **Continuous (1:1):** Person designated to observe the patient at all times, this is not the same as being in the line of sight of a nurse that has other duties. Continuous observation is for service users who carry an immediate threat and will need immediate access to other members of staff if needed. b. **Every 15 - 30 mins:** This level of observation, interaction and care is for service users who are at risk however do not represent an immediate risk to self or others.		
Q2.1.1.1	**Appears if Q2.1.1= Yes/Partially met** Who were the observations carried out by? (select all that apply)	• Nurse • Health Care Assistant • Mental Health Nurse • Doctor • Others (Free text) • Not recorded
Q2.2	**Appears if Q1.5 = Yes** Was the following information documented by the ED clinician: For Q2.2 (A – D): Locally agreed form could be used as part of risk assessment by the ED clinician.	
Please Note - **Q2.2 relates to Clinical Standard 3 –** if Q2.2 A-D are all answered Yes, the standard has been met.		
Q2.2 (A)	Type of self-harm	• Yes • No
Q2.2 (B)	Reason / Trigger for self-harm	• Yes • No
Q2.2 (C)	Future suicidal thoughts and plans	• Yes • No
Q2.2 (D)	Has an adequate past psychiatric and social history been taken. (e.g. home circumstance, employment, Safe-guarding concerns, drug and alcohol issues)	• Yes (Met) – adequately explored. • Partially explored. • No/minimal – Poorly explored/not explored.
Q2.3	**Appears if Q1.5 = Yes** Has an adequate physical health assessment, relevant investigation and	• Yes – Adequate assessment.

	treatment been carried out by the ED clinician appropriate to patient presentation? (Management of self-harm or self-poisoning)	• No – Inadequate assessment
Q2.4	Is there documentation that safe-guarding concerns were considered?	• Yes • No
Q2.4.1	**Appears if 2.4 = Yes** Was there documentation that safe-guarding concerns were actioned appropriately? (e.g., no action required / appropriate referral made to social services)	• Yes • No
Q2.5	Is there documentation that drug and alcohol concerns were considered?	• Yes • No
Q2.5.1	**Appears if 2.5 = Yes** Was there documentation that drug and alcohol concerns addressed appropriately? (e.g., no action required / appropriate referral made to social services)	• Yes • No
Q 2.6	**Appears if 1.7 = Not Applicable** If not seen by Adult Psychiatry liaison and discharged by ED: Was an acceptable safe discharge plan documented?	• Yes • No
Q2.7	Is there evidence of compassionate and practical care within the notes? e.g. Food and drink offered, patient's own medication given, pain relief offered, information given to the patient, discussions with the patient documented	• Yes – Good evidence. • Partial evidence • No/minimal evidence

Clinical Data - Parallel Assessment

Q3.1	Would the patient have been able to have their mental health and physical health needs addressed in parallel? (e.g., They were fit for interview by Adult Psychiatric liaison services)	• Yes • No
Q3.2	**Appears if Q3.1 = Yes** Did a parallel assessment take place? (e.g., Parallel assessment not offered in our service, patient assessed in a different location)	• Yes • No – Other reason. (free text)

Notes	This section is provided for local use. (e.g. to record information that might help during your PDSA cycles. No patient identifiable data should be entered It will not be analysed by RCEM)

Understanding Parallel Assessment

Timing of mental health assistance should be based on the needs of both the patient and referrers. A patient should be referred to mental health services as soon as they are fit for interview, rather than waiting for medical treatment to be complete. Even prior to interview, liaison psychiatry staff can give advice based on past records, take collateral history from family or carers, support patients, advise clinical teams and plan appropriate timing for psychiatry interview. If a person is agitated, distressed or aggressive then timely assistance from mental health professionals may alleviate distress, prevent escalation, and improve both safety and patient experience [7].

Data Sources

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

> Reviewing notes is an opportunity to review cases where care was not to accepted standards and escalate these concerns. Reviewers should use their departmental incident process if there are cases where this has happened. Examples of this might be failure to follow up patients who abscond, long wait for assessments, inappropriate restraints, or evidence of stigma from staff.

For information about using the Emergency Care Data Set (ECDS) or your ED's electronic patient record to identify relevant cases, and to extract data from your system, please see Appendix 1.

Using the codes list in Appendix 1, first identify all patients attending your ED between the relevant dates, then by age at time of attendance, then through the other relevant criteria.

If your ED is reliably using the Emergency Care Data Set (ECDS), then your IT department or information team should be able to a) pull off a list of eligible cases for you, and b) extract some or all of the data you need to enter. Please see Appendix 1 and Appendix 2, for the list of codes they will need to identify eligible cases or extract the data.

Contact Us

If you have a clinical or methodology question regarding this QIP, you can email our team directly at the below email address. Our team will then pass your question onto the relevant team and respond.

> RCEMqip@rcem.ac.uk.

References

1. Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE
2. Mental Health Toolkit – RCEM 2022
3. The Patient who absconds – RCEM 2020
4. Side by side Consensus statement - 2020
5. Update information | Self-harm | Quality standards | NICE
6. CQC Guidance: Assessment of mental health services in Acute Trusts (2020)

APPENDIX 1: ECDS CODES TO SUPPORT CASE IDENTIFICATION

The codes below can be used to help initially identify potential cases. This is not an exhaustive list; other search terms can be used but all potential patients should then be reviewed to check they meet the definitions & selection criteria before inclusion in the QIP.

The ECDS codes below relate to CDS V6-2-2 Type 011 - Emergency Care Data Set (ECDS) Enhanced Technical Output Specification v3.0.

QIP question	ECDS data item name	ECDS national code	National code definition
Date and time of arrival or triage – whichever is earlier	EMERGENCY CARE ARRIVAL DATE EMERGENCY CARE ARRIVAL TIME	an10 CCYY-MM-DD an8 HH:MM:SS	Date Time
Ethnic group	ETHNIC CATEGORY	A	White British
		B	White Irish
		C	Any other White background
		D	White and Black Caribbean
		E	White and Black African
		F	White and Asian
		G	Any other mixed background
		H	Indian
		J	Pakistani
		K	Bangladeshi
		L	Any other Asian background
		M	Caribbean
		N	African
		P	Any other Black background
		R	Chinese
		S	Any other ethnic group
		Z	Not stated e.g. unwilling to state
		99	Not known e.g. unconscious
Gender	PERSON STATED GENDER CODE	1	Male
		2	Female
		9	Indeterminate (unable to be classified as either male or female)
		X	Not Known (PERSON STATED GENDER CODE not recorded)

APPENDIX 2: ANALYSIS PLAN (CLINICAL DATA)

This section explains how RCEM will analyse and display your data. You may wish to also conduct analysis locally. 'Analysis sample' shows which patient cases will be included or excluded in each chart. 'Analysis plan' defines how RCEM team will present the data in chart form, and which patient cases will meet or fail the standards.

Clinical Standards – Analysis Plan (Dashboard Charts)

Relevant questions	Chart Title	Analysis sample	Analysis plan – Conditions for the standard to be met
Q1.2 Q1.3 Q2.1	**Standard 1a - Proportion of patients who had a complete mental health triage with risk assessment by ED nurses/clinician ≤ 15 minutes of arrival**	Q1.3 IS NOT 'Patient did not undergo mental health triage' Observation: Cases where no time is provided for Q1.3 must be EXCLUDED from the sample Cases where time difference between Q1.2-1.3 exceeds 24h or is a negative value must be EXCLUDED from the sample	SPC Chart: Analysis: Sample Size/Denominator: Q1.3 date and time – Q 1.2 date and time Met Standard 1a if/Numerator: Q1.3 – 1.2 ≤ 15 mins AND Q2.1 = Low-risk OR Medium-risk OR High-risk
Q1.2 Q1.3 Q2.1	**Standard 1b - Proportion of patients who had a complete mental health triage with risk assessment by ED nurses/clinician ≤ 30 minutes of arrival**	Q1.3 IS NOT 'Patient did not undergo mental health triage' Observation: Cases where no time is provided for Q1.3 must be EXCLUDED from the sample Cases where time difference between Q1.2-1.3 exceeds 24h or is a negative value must be EXCLUDED from the sample	SPC Chart: Analysis: Sample Size/Denominator: Q1.3 date and time – Q 1.2 date and time Met Standard 1b if/Numerator: Q1.3 – 1.2 ≤ 30 mins AND Q2.1 = Low-risk OR Medium-risk OR High-risk

Q1.3	**Mental health triage**	All cases	Pie Chart Analysis: <u>Breakdown of Q1.3 answers</u>: % of answers = 'Patient did not undergo mental health triage' % of answers = 'Patient had a mental health triage' (all answers with a date entered/all answer was NOT 'patient did not undergo mental health triage')
Q1.2 Q1.3	**Time to mental health triage**	Q1.3 IS NOT 'Patient did not undergo mental health triage' <u>Observation</u>: Cases where no time is provided for Q1.3 must be EXCLUDED from the sample Cases where time difference between Q1.2-1.3 exceeds 24h or is a negative value must be EXCLUDED from the sample	Run chart with Y-Axis in Minutes Analysis: Q1.3 date and time – Q 1.2 date and time
Q 3.1 Q 3.2	**Parallel assessment**	All cases where Q 3.1 = Yes	Pie Chart Analysis: Breakdown of Q3.2 answers: % of answers = 'Yes' % of answers = 'No'
Q1.3 Q1.5 Q1.5.1	**Time to ED clinician review after triage**	Q1.3 IS NOT 'Patient did not undergo mental health triage' AND Q1.5 = Yes <u>Observation</u>:	Run chart with Y-Axis in Minutes Analysis: Q1.5.1 date and time – Q 1.3 date and time

		Cases where no time is provided or known for Q1.3 and/or Q1.5.1 must be EXCLUDED from the sample Cases where time difference between Q1.5.1-1.3 exceeds 24h or is a negative value must be EXCLUDED from the sample	
Q 1.6 Q1.7 Q1.7.1	**Time to Adult Psychiatric Liaison Service patient review in the ED following referral**	Q1.7 = Yes <u>Observation</u>: Cases where no time is provided or known for Q1.6 and/or Q1.7.1 must be EXCLUDED from the sample Cases where time difference between Q1.7.1-1.6 exceeds 24h or is a negative value must be EXCLUDED from the sample	Run chart with Y-Axis in Minutes Analysis: Q 1.7.1 date and time – Q 1.6 date and time
Q1.2 Q1.8	**Total time spent in ED before either discharged / admitted / transferred off site**	All cases <u>Observation</u>: Cases where no time is provided or known for Q1.8 must be EXCLUDED from the sample Cases where time difference between Q1.8-1.2 exceeds 7 days or is a negative value must be EXCLUDED from the sample	Run chart with Y-Axis in Hours Analysis: Q 1.8 date and time – Q 1.2 date and time
Q1.3 Q2.1 Q2.1.1	**Standard 2 Proportion of medium or high-risk patients who had an appropriate level of observation (Good evidence of continuous or**	Q1.3 IS NOT Patient did not undergo mental health triage AND Q2.1 = Medium-risk OR High-risk	SPC Chart: Analysis: <u>Sample Size/Denominator:</u> Q1.3 IS NOT 'Patient did not undergo mental health triage' AND Q2.1 = Medium-risk OR High-risk

	intermittent observation, interaction or care)		Met Standard 2 if/Numerator: Q1.3 IS NOT 'Patient did not undergo mental health triage' AND Q2.1 = Medium-risk OR High-risk AND Q2.1.1 = Yes
Q2.1 Q 2.1.1 Q2.1.1.1	**Persons carrying out observations for patients at medium or high risk of further self-harm or leaving before assessment or treatment completion**	Q 2.1 = medium OR High AND Q2.1.1 = 'yes' OR 'partially met' Observation: Multiple options can be selected for 2.1.1.1, so total number of answers will be larger than the patient sample size.	Pie Chart: Analysis: Breakdown of Q2.1.1.1 answers % Nurse % Health Care Assistant % Mental Health Nurse % Doctor % Others
Q1.5 Q2.2 (A) Q2.2 (B) Q2.2 (C) Q2.2 (D)	**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).**	Q1.5 = Yes	SPC Chart: Analysis: Sample Size/Denominator: Q1.5 = Yes Met Standard 3 if/Numerator: Q1.5 = Yes AND Q2.2 (A) = Yes AND Q2.2 (B) = Yes AND Q2.2 (C) = Yes AND Q2.2 (D) = Yes (Met) – adequately explored

Q2.7	**Evidence of compassionate and practical care**	All cases	Pie Chart Analysis: Breakdown of Q2.7 answers: % of answers = 'Yes' % of answers = 'No/minimal' % of answers = 'Partial evidence'
Q1.5 Q2.3	**Evidence of appropriate physical health assessment, relevant investigation and treatment been carried out by the ED clinician appropriate to patient presentation**	Q1.5 IS NOT = Did not wait OR Not seen by ED clinician, referral direct to adult psychiatric liaison services	Pie Chart Analysis: Breakdown of Q2.3 answers: % of answers = 'Yes' % of answers = 'No'
Q2.4 Q2.4 1	**Safe-guarding concerns**	All cases	Pie Chart Analysis: Breakdown of Q2.4 and Q2.4 1 answers: % of answers = 'Concerns not considered' Q2.4 = No % of answers = 'Concerns both considered and addressed' Q2.4 = Yes, AND Q2.4 1 = Yes % of answers = 'Concerns considered but not addressed' Q2.4 = Yes, AND Q2.4 1 = No
Q2.5 Q2.5 1	**Drug and alcohol concerns**	All cases	Pie Chart Analysis: Breakdown of Q2.5 and Q2.5 1 answers:

			% of answers = 'Concerns not considered' Q2.5 = No % of answers = 'Concerns both considered and addressed' Q2.5 = Yes AND Q2.5 1 = Yes % of answers = 'Concerns considered but not addressed' Q2.5 = Yes AND Q2.5 1 = No
Q1.5 Q1.7 Q2.6	**If not seen by Adult Psychiatry liaison and discharged by ED: Was this documented and an acceptable safe discharge plan made (where applicable)**	All cases where: Q 1.5 = Y AND Q 1.7 = 'Not applicable'	Pie Chart Analysis: Breakdown of Q2.6 answers: % of answers = 'Yes' % of answers = 'No'
Q1.5 Q1.5.3	**If patient left before ED clinician review, was this acted on?**	Q1.5 = did not wait / Self-discharged	Pie Chart Analysis: Breakdown of 1.5.3 % of answers = 'Yes – appropriate measures taken' % of answers = 'No' % of answers 'Not recorded'
Q1.5 Q1.5.2	**If patient left before ED clinician review, was a capacity assessment documented?**	Q1.5 = did not wait / Self-discharged	Pie Chart Analysis: Breakdown of 1.5.2 % of answers = 'Yes' % of answers = 'No'

Q1.7 Q1.7.3	**If patient left before APLS review, was this acted on?**	Q1.7 = did not wait / Self-discharged	Pie Chart Analysis: Breakdown of 1.7.3 % of answers = 'No' % of answers = 'Yes' % of answers = 'Not Recorded'
Q1.7 Q1.7.2	**If patient left before APLS review, was a capacity assessment documented?**	Q1.7 = did not wait / Self-discharged	Pie Chart Analysis: Breakdown of 1.7.2 % of answers = 'No' % of answers = 'Yes'