Waikato District Health Board

Guideline

Deliberate Self Harm (DSH), Management of Patients presenting after an act of

Guideline Responsibilities and Authorisation

Department Responsible for Guideline	Emergency Medicine – Administration
Document Facilitator Title	Emergency Physician
Document Facilitator Name	Tonia Nicholson & Anna Nienaber
Document Owner Title	Clinical Director
Document Owner Name	Ian Martin
Target Audience	Emergency Department Staff
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Guideline Review History

Version	Updated by	Date Updated	Summary of Changes
05	Victoria McLean and Anna Nienaber	17/10/2017	Formatted into new template. Review and update of previous version

Deliberate Self Harm (DSH), Management of Patients presenting after an act of

1. Purpose

- To ensure safe observation, treatment and disposition from ED, of patients who have attempted DSH.

- For people presenting at risk of suicide, the responsibilities of emergency staff are to:
  - triage and plan for their safety
  - diagnose and treat any concurrent non-psychiatric illness or injury
  - perform a suicide risk assessment for all people who have suicidal thoughts or have self-harmed, when they are deemed ready to interview
  - assess for the presence of red flags for short-term risk
  - identify those who require an immediate comprehensive mental health specialist assessment within the emergency department
  - identify those who can safely be discharged with a comprehensive mental health assessment follow-up within 72 hours and who have good support systems
  - identify those very-low-risk people with good support systems who can be safely discharged to the community and referred to primary care management
  - Engage with families to inform and support them.

2. Definitions

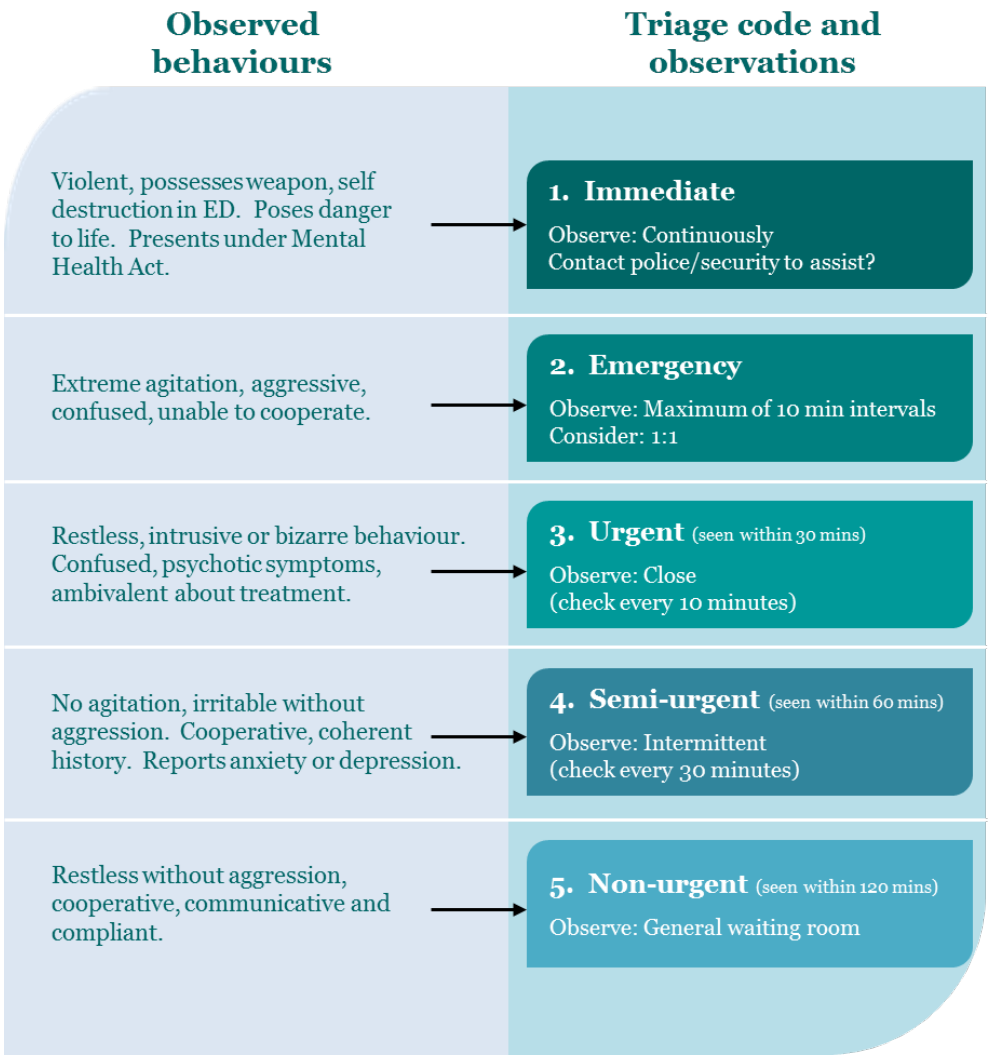
- People who present following an act of deliberate self harm (DSH) +/ or attempted suicide are often in a state of extreme distress.

- The Ministry of Health has issued guidelines on how to assess and triage such patients. These guidelines should be followed in Waikato ED. https://www.health.govt.nz/publication/preventing-suicide-guidance-emergency-departments

3. Triage

- Those patients who are assigned a mental triage score of 1, 2 or 3 will require 1 on 1 observation. Triage score 4 only need intermittent observation. Once it has been decided that observation is necessary, the nurse in charge (NIC) should be notified. They will:

  - Arrange an appropriate cubicle for the patient to go to
  - Arrange an appropriate “patient watch” e.g. family member, carer, ED attendant, hospital aid or security guard.
  - Arrange with duty manager a “watch”
  - Notify the ED consultant in charge of the shift



- Adapted version of the Australian Mental Health Triage Scale (AMHTS) as used in https://www.health.govt.nz/publication/preventing-suicide-guidance-emergency-departments

4. Risk assessment

- The "*Mental Health Patients Risk Assessment Pathway*" is available in triage and the document bookshelf by the main desk. This allows a quick risk assessment of the patient and stays in the patients notes.

5. Medical management

- Overdose, injuries and medical conditions should be dealt with appropriately

- Anxious, aggressive and uncooperative patients refer to the *Violent Patients: Management of Potentially* guideline.

6. Mental health referral and Medical clearance/interviewable

- Every patient who presents with DSH should generally be referred for psychiatric assessment. Consult Liaison Psychiatry services are the service used during normal business hours. The Crisis Team assess psychiatric patients during the evening and on weekend and public holiday days. The on-call psychiatric registrar assesses psychiatric patients overnight.

- Psych liaison, CAT team or the on call psychiatric registrar should be contacted – either by the doctor responsible for the patient or the NIC, to let them know of the presence of the patient in the department. The referral may be done by yourself or via the primary nurse or nurse in charge

- Electronic referrals are made to Consult Liaison after you have spoken to them. This is done via the clinical workstation on the patients' health views. Steps are; MH forms, MH referrals, click new and fill in required fields.

- The Crisis team can be contacted via the Operator and the on-call psychiatric registrar through the Henry Bennet Coordinator via the Operator.

- These teams usually request a "medical clearance". The intention is that the patient can be interviewed and that acute medical problems, overdose or injuries has been attended to. Psychiatric assessment should not wait for medical clearance if the person is interviewable. Inform the appropriate mental health service as soon as the patient is interviewable even if still need ongoing medical care but is awake and not sedated or intoxicated.

7. Disposition

- Some patients will be admitted by the mental health team to HBC

- After the mental health team has seen the patient and want to discharge them from ED an ED discharge letter should be done.

- Very occasionally, patients may be discharged after a period of observation without psychiatric assessment in the ED if the treating EM doctor feels that the person is at very low risk of further self-harm in the near future. This should ideally be done in consultation with mental health services to organise ongoing follow outpatient follow up