Care services minister Norman Lamb has declared that mental and physical health are of equal importance (Department of Health 2012).

While most emergency care staff will welcome such equality of care provision, the announcement is likely to raise expectations about their ability to prevent suicide among people who self-harm. There is, however, National Patient safety agency guidance to help emergency department (ED) staff identify and care for patients who present after they have self-harmed and who are deemed likely to attempt suicide.

Associate director of patient safety at the NHs Commissioning Board Vanessa Gordon, who devised the guidance, explains: ‘Staff in emergency departments need a tool to help them identify risk and keep people safe while they are in their care.’

Ms Gordon developed the guidance, entitled Preventing Suicide: A Toolkit for Emergency Departments, after an acute NHS trust asked her to train its staff in suicide prevention. Previously, two suicides had been completed in its ED during a 24-hour period.

Although this is an exceptionally high incidence of suicide, Ms Gordon says, self-harm often occurs in emergency care settings. She says that many people who present to EDs are saying: ‘Please help me, I am in crisis.’

‘People in a crisis, whether with heart attack or due to suicide attempts, should receive the same level of treatment, but we know that they do not.’

Evidence shows that people who harm themselves often do so repeatedly and in some cases attempt suicide. Moreover, many people who complete suicide attempts are found to have recently visited EDs, although it is not always known how many of these visits were due to self-harm (Gairin et al 2003, Da Cruz et al 2011).

‘Emergency staff are geared for people who want to be there, because they want to be helped and made better. They are often unprepared people who come into emergency departments but still want to take their own life,’ says Ms Gordon.

‘You would not leave someone who has attended with a heart attack on their own so why would you leave someone who is in crisis alone? Yet such people are seen as different from each other.’

Performance assessment

Ms Gordon’s guidance, which is based on the National Institute for Health and Clinical Excellence (NICE) (2004) clinical guideline on the management and prevention of self-harm, includes the following standards:

- Consent and capacity.
- Intervention and care.
- Risk assessment to prevent suicide.
- Family and carer involvement.
- Appropriate medication.
- Discharge, transfer and follow-up care.
- Post-incident review and staff training.

Each standard is accompanied by criteria for performance assessments.

For example, in meeting the standard on suicide prevention, staff are expected to ensure that people who have self-harmed are offered preliminary psychosocial assessments at triage or during their initial assessments in primary care, and that such patients should be offered safe and supportive environments in which to wait for treatment.

The NICE guideline also includes a tool for internal or in-house annual audits and a mini-audit checklist staff can use to assess the progress made by their departments each month.

Ms Gordon thinks that some emergency staff should become more accustomed to questioning patients who self-harm about their mental health. She contrasts the treatment of patients with suspected heart attack, who may be asked to rate regularly their levels of chest pain between 1 and 10, with that of patients who have attempted suicide.
She says: ‘I have never known a nurse or doctor ask patients who have attended A&E due to self-harm to rate their intent to harm themselves again between 1 and 10.

‘If emergency care staff were to modify their practice, they would have a better idea of how these patients feel.’

Ms Gordon is aware, however, that many emergency care staff will remain unequipped to deal with such patients’ responses until they have had the relevant training, and until departmental policies and processes are in place to help them.

Ms Gordon thinks her guidance will appeal to modern matrons and charge nurses. ‘It highlights areas, such as risk assessment, transferring patients to other areas or staff training, in which the department is failing.

‘Staff who use the annual audit tool will have evidence to present to their trust boards that, for example, they have no safe area to place people who have self-harmed.’

Ms Gordon is aware that emergency nurses treating patients with psychiatric problems do not always receive timely support from psychiatric services and that they often take on more responsibility when dealing with patients who self-harm.

‘We need to think differently about how we work. I do not think we can just say we are going to wait for secondary services to pick these people up because, by the time they do, it may be too late.’

Charlie Callanan is a freelance journalist

Find out more

Preventing Suicide: A Toolkit for Emergency Departments can be viewed at http://tinyurl.com/cxjnko and a National Patient Safety Agency briefing on the toolkit is available at http://tinyurl.com/9cjy68u

References


Foundation trusts face fundamental problems breaking even, study finds

The problems faced by acute trusts with emergency departments (EDs) are compounded by a rise in the number of older people presenting to EDs, the study claims, and the failure of primary and community providers of care for older people to offer services around the clock. As a result of these problems, some older patients are admitted unnecessarily.

Solutions

The FTN study also discusses how some NHS foundation trusts have solved these problems, however. Chelsea and Westminster Hospital, for example, has set up a rapid-assessment team, Nottingham University Hospitals run a programme to avoid unnecessary testing, and South Warwickshire works with GPs to improve management of peaks in admissions.

Network chief executive Chris Hopson says: ‘We should be proud of the jobs done by our emergency departments. They deal with large numbers of patients and strive to do better by reorganising the way that they work. Many emergency departments are refining the separation of patients who have major from those with minor conditions to speed up treatments for everyone, and are providing more specialist care for frail, elderly patients.

‘The amount that NHS trusts are paid for this work is being trimmed by a policy designed to keep people out of hospital beds, yet there is only so much that hospital-based services can do to change patterns of care.

‘What is needed is a whole-system approach with a real commitment to keeping patients out of emergency departments in the first place. In the meantime, trusts should not be fined for rising numbers of patients coming into hospital through emergency departments.’

A DH spokesperson said: ‘We are encouraging local NHS services and hospitals to work together to reduce the number of patients admitted as emergencies by making sure they get the best care possible in their communities or homes.

‘We are also working with the NHS to invest in support services designed to reduce the numbers of patients being admitted to hospital unnecessarily.’

Nick Lipley reports on research that looks at different ways healthcare organisations are reducing emergency admissions

EMERGENCY DEPARTMENTS have improved efficiency and introduced innovations in practice, yet are still losing money, according to the Foundation Trust Network (FTN).

Last month, the FTN published a benchmarking study of 11 trusts that provide emergency care services.

Data from between April 2011 and January 2012 show that most of the organisations covered by the study, which range from major specialist trauma units to primary care-led urgent care centres, failed to break even.

The FTN, a trade association of more than 200 NHS foundation trusts (FTs) and NHS trusts becoming FTs, has called on acute trusts, and primary and community care services, to share responsibility for avoiding emergency admissions more fairly.

The study also highlights the need for the Department of Health (DH) to re-examine its policy of paying some emergency admissions at 30 per cent of the standard rate.

As a result, the FTN claims, primary care providers have little incentive to share responsibility for avoiding emergency admissions and hospitals earn too little for the work they undertake, despite improvements in assessment and care.