Trust Policy		Worcestershire Acute Hospitals NHS Trust

Self-harm:

Assessment, Management & Preventing Recurrence Policy

Department / Service:	Trustwide
Originator:	Deborah Narburgh Head of Safeguarding
Accountable Director:	Sarah Shingler, Chief Nursing Officer
Approved by:	Integrated Safeguarding Committee 26.03.2024 Improving Safety Action Group 07.05.2024
Date of approval:	26th March 2024
First Revision Due:	26th March 2027
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Trustwide
Target staff categories	All staff

Policy Overview:

As a healthcare provider, Worcestershire Acute Hospitals NHS Trust has a responsibility to meet the needs of our patients, and it is important that our staff all know how to best approach the issue of self-harm.
This Policy has been updated to reflect the latest National Institute for Clinical Excellence Guideline (NG225) published September 2022 and best practice guidance in line with our Trust 4ward behaviours of putting patients first and keeping patients safe.

This Policy should be used in conjunction with the Trust Safeguarding Adult and Children Policy & Procedures, the West Midlands Regional Child Protection Policy & Procedures and Adult Safeguarding: Multi-agency policy & procedures for the protection of adults with care & support needs in the West Midlands.

Relevant legislation:

- Mental Capacity Act (2005)
- Mental Health Act (1983, amended 2007)
- Human Rights Act (1998)
- Children's Act (1989)
- Care Act (2014)

Key amendments to this guideline

Date	Amendment	By:
March 2011	This updates the last policy which expired in 2009 – overlooked due to change in job role of original author Page 3 – Mental Health Assessment and treatment plan developed before transfer to ward Page 4 – Role of Mental Health Liaison Team Page 5 - Use of ground floor ward Page 6 - Designated safe areas for patients Page 10 Adult Mental Health Assessment Page 13 – Ground floor room – designated safe area Page 15 – Mental Capacity Act 2005 Page 24 – New CAMHS service Page 27 Anti –ligature points – WRH Page 35 Anti-ligature points – ALEX	S Ellson
March 2012	Insertion of Mental Health Liaison Team leaflet Appendix 6	S Ellson
May 2013	Updated with new Acute Hospital Mental Health Services	S Hardy
August 2015	Document extended for 12 months as per TMC paper approved on 22nd July 2015	TMC
November 2015	Owner of document changed	
August 2016	Document extended for 12 months as per TMC paper approved on 22nd July 2015	TMC
August 2017	Document extended for 6 months as per TMC paper	TMC
December 2017	Sentence added in at the at the request of the Coroner	
December 2017	Document extended for 3 months as per TLG recommendation	TLG
March 2018	Document extended for 3 months as approved by TLG	TLG
June 2018	Document extended for 3 months as per TLG recommendation	TLG
Nov 2020	Document extended whilst review in process	Safeguarding
February 2023	Document extended for 6 months whilst review in process	Deborah Narburgh
October 2023	Document extended for 6 months	Deborah Narburgh
2nd May 2024	Document extended for 6 months whilst under review	Deborah Narburgh
May 2024	Full Policy review and rewrite November 2023 further to NICE Guidance (NG225) published 7th September 2022. The Trust undertook a review of serious harm by ligature 2023.	Integrated Safeguarding Committee/Improving Safety Action Group

Contents page:

QUICK REFERENCE GUIDE

Adults

All adults presenting with self-harm or suicidal ideation should be referred to the Acute Mental Health Liaison Service – this is a 24hr service.

Acute Mental Health Liaison Service - Worcester bleep 195
Alexandra Hospital bleep 1234

Children & Young People

Worcestershire Children & Young People's Multiagency Urgent Mental Health Care Pathway:

Worcestershire Children and Young People's Multiagency Urgent Mental Health Care Pathway.PDF

**** please note the above document is currently under review.**

Patient Information Leaflet / Care Plan – APPENDIX 1

Referral process WRH – APPENDIX 2

Referral Process ALEX – APPENDIX 3

MHL Standard Operating Procedures – APPENDIX 4

Protocol for Managing Patients at risk from self-harm admitted to an Acute ward from A&E /AMU – APPENDIX 5

1. Introduction

Only a minority of people who have self-harmed present to hospital services, but it remains one of the commonest reasons for hospital attendance. Some estimates suggest upwards of 200,000 presentations in England every year, the majority for self-poisoning.

While prevalence statistics are unreliable because it is a problem that is sometimes hidden, a recent national study reported that 7.3% of girls, and 3.6% of boys, aged 11 to 16, had self-harmed or attempted suicide at some point. The figures for 17- to 19-year-olds were 21.5% for girls and 9.7% for boys. Self-harm can occur at any age, but there is evidence that there has been a recent increase in self-harm among young people in England.

For some people, self-harm is a one-off episode but repetition is also common, with 20% of people repeating self-harm within a year.

People who have self-harmed are at greatly increased risk of suicide, with a 30- to 50-fold increase in risk in the year after hospital presentation.
(NICE,2022).

2. Scope

This Policy is based upon best practice guidance as defined by NICE (NG225) published September 2022.

This Policy covers assessment, management and preventing recurrence for children, young people and adults who have self-harmed. It includes those with a mental health problem, neurodevelopmental disorder or learning disability.

The Policy does not cover repetitive, stereotypical self-injurious behaviour (such as head banging). In such cases, individualised risk assessment and care plans should be in place with due regard to legal frameworks surrounding mental capacity and consent.

Support and information may need to be adapted for people who may be subject to discrimination, for example, people who are physically disabled, people with neurodevelopmental conditions or a learning disability, people from underserved groups, people from Black, Asian and minority ethnic backgrounds and people who are LGBTQ+

The NICE recommendations reflected in this Policy still require professionals to take into account the individual needs, preferences and values of patients using our services. Decisions should be made appropriate to the individual, in consultation with them, and their families / carer / guardian.

3. Definitions

Self-Harm

Self-harm is defined as intentional self-poisoning or injury irrespective of the apparent purpose of the act (NICE, 2022).

Self-harm in children & young people

Self-harm is any behaviour where the intent is to deliberately cause self-harm. This could include:

- Cutting
- swallowing hazardous material or substances
- burning
- over/under-using medication, e.g. insulin
- hitting/punching/head banging
- skin picking/scratching/hair pulling
- taking an overdose of tablets
- alcohol/drug misuse
- over/under-eating
- self-strangulation / attempted hanging

Some people who self-harm may have a strong desire to kill themselves. However, there are other factors motivating self-harm, including a desire to escape an unbearable situation or emotional pain; to reduce tension and stress; to express hostility; to take control; or to punish self or others.

Self-harm has tended to be a secretive behaviour that can go on for a long time before being uncovered, although the increased incidence of self-harm, especially in young women, has removed some of the taboo and it is now more likely to be talked about than it ever was previously. Children and young people may struggle to express their feelings in other ways and use the act of self-harm to release their emotions.

The most common forms of self-harm are cutting and overdosing, with high rates of alcohol and drug use.

(https://westmidlands.procedures.org.uk/pkpht/regional-safeguarding-guidance/self-harm-and-suicidal-behaviour#s2751)

Suicidal behaviour

Attempted suicide is self-harm with the intent to take life, resulting in non-fatal injury. Suicide is self-harm that results in death.

Approximately three quarters of young people who die as a result of suicide are male and the most common methods of suicide are asphyxiation, for example by hanging, followed by overdosing. There has been a recent increase in deaths by suicide in young people, reversing a decline over the previous ten years.

Use of Language for therapeutic engagement

Professionals need to be aware of the impact of stigma and negative attitude that, although often unconscious, are detrimental to patients and their carers. Careful use of language around self-harm is particularly important for therapeutic engagement. As an example, the term ‘deliberate self-harm’ should be avoided. It implies that someone had a conscious choice to engage in their self-harm. It promotes negative and stigmatising attitudes, and a preferred term is ‘self-harm’.

Key information for staff:

Further information can be found within the West Midlands Regional Child Protection Procedures:

2.11 Self-harm and suicidal behaviour | West Midlands Safeguarding Children Group (procedures.org.uk)

4. Responsibility and Duties

Clinical Staff
All staff that have contact with people who have self-harmed should be adequately trained to assess mental capacity and to make decisions about when treatment and care can be given without consent. Staff should give full information in a form that is accessible to the person and make all efforts necessary to allow someone who has self-harmed the opportunity to make decisions in a consensual and informed way. Staff working with those who have self-harmed should understand when and how the Mental Health Act can be used to treat the physical consequences of
self-harm. Staff who have emergency contact with children and young people who have self-harmed must understand how issues of capacity and consent apply to this group.

Mental Health Liaison Team
The MHLT is an ageless service and will provide specialist expertise in the assessment, care planning, treatment and evaluation of adults admitted with self-harm or suicidal ideation. This will be part of a multi-disciplinary approach to risk assessment, reduction and risk management.

For children and young people admitted to Riverbank ward, this will be provided by Children & Adolescent Mental Health Services (CAMHS).

Divisional Director / Clinical Managers
Divisional Director and Clinical Managers are responsible for:

- The dissemination of this Policy to their staff.
- Identifying the training needs of their staff in relation to this Policy.
- Releasing staff to attend for training.
- Supporting staff who care for patients that self-harm.

Divisional Governance / Patient Safety /Health & Safety
Are responsible for identifying any trends as a result of incident reporting that requires further action, risk management or escalation.

Chief Executive
The Board of Directors delegates to the Chief Executive the overall responsibility for ensuring the Trust employs a comprehensive strategy to support the management of risk, including clinical risks associated with patient care.

5. Policy Detail

5.1 Relationship between self-harm and suicide

There is strong evidence to show that the risk of suicide among those who have self-harmed is much greater than that of the general population (Chan et al. 2016), as is the risk of premature death (Cooper et al. 2005).

5.2 Suicide Prevention

Based on evidence and data (including numbers, rates and trends), stakeholder engagement and expert views, the Department for Health & Social Care has identified the following groups for consideration for tailored or targeted action at a national level:

- children and young people
- middle-aged men
- people who have self-harmed
- people in contact with mental health services
- people in contact with the justice system
- autistic people
- pregnant women and new mothers

(Suicide Prevention Strategy 2023-2028: https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy)

5.3 Self-harm in people 65yrs+

All acts of self-harm in people older than 65years of age should be regarded as evidence of suicidal intent until proven otherwise because the number of people in this age range who go on to complete suicide is much higher than in younger adults.
Assessment should follow the same principles as for younger adults, but particular attention should be paid to the presence of depression, cognitive impairment and physical ill health, and should include a full assessment of their home and social situation.

5.4 Self-harm/suicide and the internet

The online world, especially social media, has a significant effect on the person at increased risk of suicide. All mental health professionals should recognise this, consider engagement with their patient's digital life, and include it within their clinical assessment, especially where self-harm is identified as a possible factor (Royal College of Psychiatrists, Self-Harm & Suicide in Adults, July 2020).

5.5 Risk of self-harm in patients with pre-existing long term conditions(LTC)

Webb and colleagues (2012) found significantly higher risk of self-harm in patients with asthma, back pain, COPD, coronary heart disease, diabetes, epilepsy, hypertension, osteoarthritis and stroke. Depression explained 57% of the elevated risk among all patients diagnosed with one or more long term conditions. Depression raised the risk of self-harm in two thirds of men and half of women.

Healthcare professionals working across all medical specialties should be vigilant for signs of undetected psychological symptoms when providing care and treatment to people with any LTC, and be particularly alert to the risk of suicide in younger physically ill women, especially those with multiple physical health conditions, and in anyone with significant self-harm.

Key Information for staff:

Acute Mental Health Liaison Service - Worcester bleep 195
Alexandra Hospital bleep 1234

Child & Adolescent Mental Health Service (CAMHS) Single Point of Access – 01905 768300

5.6 Principles for assessment and care by healthcare professionals and social care practitioners

When a person presents to a healthcare professional or social care practitioner following an episode of self-harm, the professional should:

- treat the person with respect, dignity and compassion, with an awareness of cultural sensitivity
- establish the means of self-harm and, if accessible to the person, discuss removing this with therapeutic collaboration or negotiation, to keep the person safe
- assess whether there are concerns about capacity, competence, consent or duty of care, and seek advice from a senior colleague or appropriate clinical support if necessary; be aware and accept that the person may have a different view and this needs to be taken into account
- seek consent to liaise with those involved in the person's care (including family members and carers, as appropriate) to gather information to understand the context of and reasons for the self-harm
- discuss with the person and their families or carers (as appropriate), their current support network, any safety plan or coping strategies.
- Focus on the assessment of the persons needs and how to support their immediate and longer term physical and psychological safety

5.7 Mental Health Liaison Service

The Mental Health Liaison Service is a 24hr, 7 days per week all age service. The service is for:

- A&E patients of any age who present with mental health issues or symptoms of mental illness, and those who present following an episode of self harm or attempted suicide
- Patients admitted to a ward exhibiting signs or symptoms of a mental illnesss requiring support, assessment or advice from specialist mental health services
- Patients who have been admitted to a ward for treatment following self-harm or attempted suicide – including care planning and safety planning
- Patients admitted for treatment relating to an eating disorder
- Patients transferred from a mental health in-patient facility to a WAHT bed
- Patients detained under the Mental Health Act
- Patients felt to require assistance under the Mental Health Act
- Admit directly onto Home Treatment or Crisis Intervention for those presenting with mental health conditions whereby Acute Hospital admission is not required
- Provide appropriate training, coaching, support, supervision to Acute Trust staff regarding their interface with people who have self-harmed or who are exhibiting signs or symptoms of mental illness

- Provide support and signposting for carers when appropriate including what to do in an emergency
- Children & Young People under 17 years and six months admitted to the Paediatric Ward or Acute Medical Unit will be seen by CAMHS Plus service 7 days a week on the wards.

Exceptions

- Prisoners who attend A&E should receive follow up via the Mental Health Team based within the prison
- Patient s returining to Police custody should be assesssed by the Forensic Medical Examiner, Liaison & Diversion Service, Custody Nurse, or Crisis Respolution Team at the Police station
- Patients detained under s136 will be referred to the s136 Assessment Suite

Record Keeping

The MHLT will ensure all risk issues are communicated to Trust staff and documented clearly within the patient record.

All patients who have presented following self-harm will receive a plan of care /safety plan.

Key information for staff:

Mental Health Liaison Service
WRH – Bleep 195
ALEX – Bleep 1234

5.8 Risk factors and red flag warning signs

A red flag is a risk factor with special significance in that it indicates that a person is at heightened risk of attempting suicide at this particular moment in time. This imminent risk requires an urgent, clinically appropriate and personalised intervention with a Safety Plan.

Demographic and social

- Perception of lack of social support, living alone, no confidants
- Males (may not disclose extent of distress or suicidal thoughts)
- Stressful life events (e.g. recently bereaved, debt/financial worries, loss of attachment/ major relationship instability, job loss, moving house)
- LGBTQ+
- Ethnic minority group.

Personal background

- Substance misuse: Alcohol and/or illicit drug misuse especially if precipitated by a recent loss of relationship
- Feeling close to someone who died by suicide (family or non-kin) or exposure to suicidal behaviour of key others (family, peers, favourite celebrity, school friend)
- Use of suicide-promoting websites or social media
- Access to lethal means; (If unable to remove lethal means ensure mitigation within a robust Safety Plan).

Clinical factors in history

- Previous self-harm or suicide attempt(s) (regardless of intent, including cutting)
- Mental illness, especially recent relapse or discharge from in-patient mental health care
- Disengagement from mental health services
- Impulsivity or diagnosis of personality disorder
- Long-term medical conditions; recent discharge from a general hospital; pain.

Mental state examination and suicidal thoughts

- High degree of emotional pain and negative thoughts (hopelessness, helplessness, guilt – e.g. 'I'm a burden')
- Sense of being trapped/unable to escape (sense of entrapment) and/or a strong sense of shame
- Suicidal ideas becoming worse
- Suicidal ideas with a well-formed plan and/or preparation
- Psychotic phenomena, especially if distressing; persecutory and nihilistic delusions, command hallucinations perceived as omnipotent (pervasive).

If there are red-flag warning signs/immediate risk of suicidal behaviour, the patient will require:

- Immediate discussion with/referral to mental health services
- A robust Safety Plan
- Adequate support
- Removal of access to means e.g knives, medications,firearms
- **In the event the patient leaves hospital grounds and there is deemed to be an immediate risk to safety /threat to life then Police should be contacted via switchboard (2222)**

5.9 Consent

Issues of consent, mental capacity and mental ill health in the assessment and treatment of people who self-harm should be understood and addressed by all healthcare professionals involved in the care of this group of people.

- All healthcare professionals who have contact, in the emergency situation, with people who have self-harmed should be adequately trained to assess mental capacity and to make decisions about when treatment and care can be given without consent.
- Primary healthcare practitioners, ambulance staff, triage nurses and emergency department medical staff should assess and document mental capacity as part of the routine assessment of people who have self-harmed. Within the bounds of patient confidentiality, and subject to the patient's consent, staff should attempt to obtain relevant information from relatives, friends, carers and other key people, to inform the assessment.
- In the assessment and treatment of people who have self-harmed, mental capacity should be assumed unless there is evidence to the contrary.
- Staff should provide full information about the treatment options, and make all efforts necessary to ensure that someone who has self-harmed can give, and has the opportunity to give, meaningful and informed consent before any and each procedure or treatment is initiated.
- If a person is assessed as being mentally incapable, staff have a responsibility, under common law, to act in that person's best interests. If necessary, this can include

detaining them to allow assessment and treatment against the person's stated wishes.

- Staff should take into account that a person's capacity to make informed decisions may change over time. Whether it has been possible to obtain consent or not, attempts should be made to explain each new treatment or procedure and obtain consent before it is initiated.
- Staff working with people who self-harm should understand when and how the Mental Health Act can be used to treat the physical consequences of self-harm.
- Staff working with people who self-harm should have easy access to legal advice about issues relating to capacity and consent at all times.

Consent - Children & Young People

Healthcare professionals and social care practitioners who have contact with children and young people who self-harm should also be able to:

- understand how to apply the principles of the Children Act 1989 and the Children and Families Act 2014 in relation to competence, capacity and confidentiality and the scope of parental responsibility
- understand how to apply the principles of the Mental Health Act 2007 to young people
- understand how issues of capacity and competence to consent apply to children and young people of different ages
- assess the young person's capacity to consent (including Gillick competence).

Further specialist advice

Further advice and support can be found through:

- Specialist advice – Mental Health Liaison, CAMHS
- Legal advice as needed.

5.10 Respect, understanding and choice

- People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm.
- Providing treatment and care for people who have self-harmed is emotionally demanding and requires a high level of communication skills and support. All staff undertaking this work should have regular clinical supervision in which the emotional impact upon staff members can be discussed and understood.
- Wherever possible, people who have self-harmed should be offered the choice of male or female staff for both assessment and treatment. When this is not possible, the reasons should be explained to the service user and written in their notes
- When assessing people who self-harm, healthcare professionals should ask service users to explain their feelings and understanding of their own self-harm in their own words.
- When caring for people who repeatedly self-harm, healthcare professionals should be aware that the individual's reasons for self-harming may be different on each occasion and therefore each episode needs to be treated in its own right.
- Healthcare professionals should involve people who self-harm in all discussions and decision-making about their treatment and subsequent care. To do this, staff should provide people who self-harm with full information about the different treatment options available.

(NICE,2022)

5.11 Information Sharing and Confidentiality
Staff working with people who self-harm should be familiar with the limits of confidentiality with regard to information about a person's treatment and care.

Staff working with people who self-harm should be aware of the benefits of involving the person's family and carers and sharing information, and should recognise the need to seek consent from the person as early as possible.

Staff working with people who self-harm should recognise that if it is necessary to breach confidentiality, they should ensure that the person who has self-harmed is still involved in decisions about their care and, where possible, is informed about the breach of confidentiality and the basis of why information has been shared.

5.12 Involving family members and carers
Ask the person who has self-harmed whether and how they would like their family or carers to be involved in their care, taking into account the factors below and review this regularly. If the person agrees, share information with family members or carers (as appropriate), and encourage them to be involved.

When thinking about involving family members or carers in supporting a person who has self-harmed, take into account issues such as:

- whether the person has consented for information to be shared and, if so, if the consent is limited to certain aspects of their care
- any safeguarding concerns
- the person's mental capacity, age and competence to make decisions
- the person's right to confidentiality and autonomy in decision making
- the balance between autonomy (in children and young people, their developing independence and maturity) and the need to involve family members or carers
- the balance between the possible benefits and risks of involving family members of carers and the rights of the person.

When involving family members or carers in supporting a person who has self-harmed:

- encourage a collaborative approach to empower and support the person who has self-harmed, minimise the person's self-harm behaviours and support the person's recovery to prevent recurrence.
- give them opportunities to be involved in decision making, care planning and developing safety plans to support the person beyond the initial self-harm episode, and through their care pathway
- ensure that there is ongoing and timely communication with the family or carers
- regularly review whether the person who has self-harmed still wants their family or carers to be involved in their care, and ensure that they know they can withdraw consent to share information at any time.
- Be aware that even if the person has not consented to involving their family or carers in their care, family members or carers can still provide information about the person.
- If the person who has self-harmed finds it difficult to vocalise their distress when they are in need of care, support the person and their family members or carers (as appropriate) in trying alternative methods of communication (such as non-verbal language, letters, emotional wellbeing passports, and using agreed safe words, phrases or emojis).

When relatives or carers are present

- People who self-harm should be allowed, if they wish, to be accompanied by a family member, friend or advocate during assessment and treatment. However, for the initial psychosocial assessment, the interview should take place with the service user alone to maintain confidentiality and to allow discussion about issues that may relate to the relationship between the service user and carers.
- Healthcare professionals should provide emotional support and help if necessary to the relatives/carers of people who have self-harmed, as they may also be experiencing high levels of distress and anxiety.

5.13 Safeguarding and self-harm

All staff who have contact with people who have self harmed should:

- understand when and how to apply the safeguarding principles of the Care Act 2014, the Children Act 1989, and the Children and Families Act 2014
- ask about safeguarding concerns, for example, domestic abuse, violence or exploitation at the earliest opportunity and, if appropriate, when the person is alone
- explore whether the person's needs should be assessed and documented according to local safeguarding procedures
- be aware of local safeguarding procedures for vulnerable adults and children in their care, and seek advice from the Trust Integrated Safeguarding Team

Key information for staff:

Integrated Safeguarding Team

Exn 33735 (M-Fri 08.30 – 16.30hrs)
wah-tr.SafeguardingWorcsacute@nhs.net

5.14 Psychosocial Assessment and Care (Mental Health Professionals)

Best practice

- Patients who self-harm should have a psychosocial assessment of need as well as their risk.
- Care and treatment should not be given according to a rating scale but according to a personalised assessment of risks and needs.
- For patients who are at risk of suicide, the care plans will also need to include a Safety Plan, co-produced with the patient. This should have explicit reference to removal and/or mitigation of means to harm themselves, list activities and coping strategies, and contain information on how to access social, psychological and emergency support.

(Self-harm and suicide in adults, Royal College of Psychiatrists, 2020)

At the earliest opportunity after an episode of self-harm, a mental health professional should carry out a psychosocial assessment to:

- develop a collaborative therapeutic relationship with the person

- begin to develop a shared understanding of why the person has self-harmed
- ensure that the person receives the care they need
- give the person and their family members or carers (as appropriate) information about their condition and diagnosis.
- Do not delay the psychosocial assessment until after medical treatment is completed.
- If the person who has self-harmed is intoxicated by drugs or alcohol, agree with the person and colleagues what immediate assistance is needed, for example, support and advice about medical assessment and treatment.
- Do not use breath or blood alcohol levels to delay the psychosocial assessment.
- If the person is not able to participate in the psychosocial assessment, ensure that they have regular reviews, and complete a psychosocial assessment as soon as possible.
- If the person who has self-harmed has agreed a care plan, check this with them and follow it as much as possible.
- Carry out the psychosocial assessment in a private, designated area where it is possible to speak in confidence without being overheard.
- Take into account the needs and preferences of the person who has self-harmed as much as possible when carrying out the psychosocial assessment, for example, by:making appropriate adaptations for any learning disability or physical, mental health or neurodevelopmental condition the person may have and providing the option to have a healthcare professional of the same sex carry out the psychosocial assessment when the person has requested this.

During the psychosocial assessment, explore the functions of self-harm for the person. Take into account:

- the person's values, wishes and what matters to them
- the need for psychological interventions, social care and support, or occupational or vocational rehabilitation
- any learning disability, neurodevelopmental conditions or mental health problems
- the person's treatment preferences
- that each person who self-harms does so for their own reasons
- that each episode of self-harm should be treated in its own right, and a person's reasons for self-harm may vary from episode to episode
- whether it is appropriate to involve their family and carers; see the section on involving family members and carers.

During the psychosocial assessment, the following will be explored to identify the person's strengths, vulnerabilities and needs:

- historic factors
- changeable and current factors
- future factors, including specific upcoming events or circumstances
- protective or mitigating factors.

5.14.1 Children & Young People Psychosocial Assessment

For children and young people who have self-harmed, a mental health professional experienced in assessing children and young people who self-harm carries out the psychosocial assessment. They should ask about:

- their social, peer group, education and home situations
- any caring responsibilities

- the use of social media and the internet to connect with others and the effects of these on mental health and wellbeing
- any child protection or safeguarding issues - this should also include the establishment where the child attends education in the event 'cluster' contagion is a factor. A cluster of suicides is a rare event, but when it happens it can affect more than families and friendship groups. The term "suicide cluster" describes a situation in which more suicides than expected occur in terms of time, place, or both. It is difficult to precisely define a cluster. A suicide cluster usually includes 3 or more deaths; however, 2 suicides occurring in a specific community or setting (for example a school) in a short time period should also be taken very seriously in terms of possible links and impacts (even if the deaths are apparently unconnected), particularly in the case of young people. It is therefore important to establish at a very early stage if there are connections between suicides or children presenting with self-harm / suicidal ideation.

5.14.2 Older People (65yrs+) Psychosocial Assessment

For older people who have self-harmed, a mental health professional experienced in assessing older people who self-harm carries out the psychosocial assessment. They should:

- pay particular attention to the potential presence of depression, cognitive impairment, physical ill health and frailty
- include an assessment of the person's social and home situation, including any role they have as a carer
- recognise the increased potential for loneliness and isolation
- recognise that there are higher rates of suicide after an episode of self-harm for older people.

5.14.3 Learning Disability Psychosocial Assessment

For people with a learning disability who have self-harmed, a mental health professional experienced in assessing people with a learning disability who self-harm carries out the psychosocial assessment.

5.15 Care Planning (Mental Health Liaison / CAMHS)

If a person has self-harmed and presents to services but wants to leave before a full psychosocial assessment has taken place, assess the person's safety and any mental health problems before they leave.

Together with the person who self-harms and their family and carers (if appropriate), develop or review a care plan using the key areas of needs and safety considerations identified in the psychosocial assessment .

Give the person a copy of their care plan, and share the plan as soon as possible with relevant healthcare professionals and social care practitioners involved in the person's care.

If a person presents with frequent episodes of self-harm or if treatment has not been effective, carry out a multidisciplinary review with the person and those involved in their care and support, and others who may need to be involved, to agree a joint plan and approach. This should involve:

- identifying an appropriately trained professional or practitioner to coordinate the person's care and act as a point of contact

- reviewing the person's existing care and support, and arranging referral to any necessary services
- developing a care plan
- developing a safety plan for future episodes of self-harm, which should be written with and agreed by, the person who self-harms.

5.16 Clinical Areas - Risk Assessment

It is essential to consider all potential risks for patients who may self harm or be at risk of suicide.These should include:

- Assessment should focus on the person's needs and how to support their immediate and long-term psychological and physical safety. Mental health professionals should undertake a risk formulation as part of every psychosocial assessment
- Mental Health team and clinical staff caring for the patient should agree the need for close observation on a case by case basis, taking in to account the persoons views and ensuring it is delivered by appropriately skilled and trained healthcare staff, with the informed consent of the individual being cared for or an appropriate legal framework, and reviewed regularly
- Risk assessment should include the environment and be individualised for the person being cared for
- Staff should be aware of any predisposing risk factors e.g. past /current medical history
- Staff should be alert for items that could be used as a potential ligature or to inflict self harm such as clothing,cutlery, pull cords, bandages or tubing, cables,call bell leads, positioning on the ward, levels of observation etc
- Wherever possible any identified risk should be removed
- Interventions and any equipment in use for either the patient, or in the environment should form part of the risk assessment
- Wherever possible high risk patients should be nursed in areas that are anti ligature compliant
- Communication is key in ensuring all involved in caring for the patient contribute to the risk assessment/ are aware of the risks (risk assessment), actions in place (mitigation) and any remaining (residual) risk and controls e.g. Levels of therapeutic observation etc

Children & Young People(CYP)

Children & Young People who have been admitted following an episode of self-harm should have:

- Access to a specialist child and adolescent mental health service (CAMHS) or all age mental health liason service 24hrs a day
- Daily review by both the paediatric team and CYP mental health team
- Daily access to family members / carers
- Regular multidiciplinary meetings between the paediatric team and mental health services

Key Information for staff

Further advice and support is available from the Mental Health Liaison team, CAMHS, Estates and Facilities, Health & Safety and Risk Management teams:

Departments A to Z (worcsacute.nhs.uk)

Ward / Departmental Managers should ensure completion of their environmental risk assessment annually in accordance with Trust risk management procedures.

Patients at risk of self harm or suicide should ideally be nursed at ground floor level.

Patients who verbally threaten self-harm or who actively try to self-harm in the ward area must be observed at all times.The level of therapeutic observation required should be risk assessed, recorded, shared with all of those involved and implemented accordingly.

5.17 Risk Assessment

Whilst it is difficult to eliminate all risks from inpatient areas, the Trust endeavours to minimise the potential risk of patients harming themselves whilst receiving inpatient care by having in place the following measures:

- Annual Environmental Risk Assessment – to include ligature risk in environmental assessments
- Controlled access systems
- All staff are aware of individual and environmental risks associated with the ward environment and or the patient via the safety handover
- Estates and facilities to consider anti-ligature design for any replacement /works

5.17.1 Ligature Risk Assessments

Ligature and ligature point risk assessment tools are a key component of the environmental risk assessment. Where a risk of self-harm is known to involve the potential for the use of ligatures then ideally, the patient should be placed in an anti-ligature room with the appropriate levels of observation in place based upon the level of risk.
In the event such a facility is not available then an individualised room risk assessment should be undertaken in conjunction with the Mental Health Liaison Team.

Key information for staff:

Anti-ligature Environmental Risk Assessment to be used alongside the department overall environmental risk assessment

Environment Assessment of Ligatu

- As the ligature risk cannot be completely removed (even if a room was deemed to class as ‘anti-ligature’ there is still a risk of self-harm by ligature) the risk should be assessed per patient at the time.
- Ensure individual risk assessment completed for high risk patients and all loose items removed if person at risk

Anti – Ligature Risk Assessment Aide Memoir

Anti Ligature Risk Assessment Aide Men

- To assist staff in understanding what might pose a ligature risk.
- This list is not exhaustive and does not mean that all itmes require automatic replacment – this is an aid to highlighting potential risk

Mental Health Liaison Service
WRH – Bleep 195
ALEX – Bleep 1234

Further advice and support is available form the Trust Patient Safety Team or Health & Safety Manager.

15.7.2 Incident Reporting Self-harm during a hospital admission
Within inpatient services all incidents of self-harm are to be reported using the Trusts electronic reporting system (Datix). The information provided on these reports will assist the clinical team in:

- Reviewing the risk management plan
- Identifying any triggers to the self-harming behaviour
- Identifying any trends in relation to self-harming behaviour
- Reviewing ward and team practice

Investigation of patient safety incidents will be in accordance with the Patient Safety Incident Response Framework (PSIRF).

15.7.3 Need for additional staffing
The need for additional staffing (with the necessary skillset) should be identified to the person with delegated responsibility for safe staffing levels for the respective clinical area (including the respective Matron).

15.8 Emergency Departments

The emergency department provides the main services for people who self-harm. Emergency department staff should assess risk and emotional, mental and physical state quickly, and try to encourage people to stay to organise psychosocial assessment.

When a person presents to a healthcare professional or social care practitioner following an episode of self-harm, the professional should establish the following as soon as possible:

- the severity of the injury and how urgently physical medical treatment is needed
- the person's emotional and mental state, and level of distress
- whether there is immediate concern about the person's safety
- whether there are any safeguarding concerns
- the appropriate level of clinical observation required
- whether the person is willing to accept medical treatment and mental healthcare

- whether the person has a care plan
- if there is a need to refer the person to a specialist mental health service for assessment
- Carry out concurrent physical healthcare and the psychosocial assessment as soon as possible after a self-harm episode.

15.8.1 Triage

When an individual presents in the emergency department following an episode of self-harm, emergency department staff responsible for triage should urgently establish the likely physical risk, and the person's emotional and mental state, in an atmosphere of respect and understanding.

The waiting area for people who have self-harmed should be close to staff who can provide care, support and observation.

A suitable private, designated area should be available for psychosocial assessments to take place.

All patients presenting with self – harm should be seen and assessed by Mental Health Liaison professionals.

Emergency department staff responsible for triage should take account of the underlying emotional distress, which may not be outwardly exhibited, as well as the severity of injury when making decisions about priority for treatment.

Triage nurses working in emergency departments should be trained in the use of mental health triage systems. The Adult Mental Health Matrix or Child & Adolescent Mental Health Matrix for under 18yrs should be completed. This document assesses the immediate risk the patient poses to themselves or others as LOW, MEDIUM, or HIGH and provides direction on the short term management of the patient.

The MHLT will undertake assessments whilst the patient is undergoing medical therapy so long as the patient is willing and able to co-operate.

Patients intoxicated with alcohol or drugs will not be assessed until sober. Sobriety is determined by the assessing MHLT clinician.

The MHLT will check and share any relevant information in order to identify any potential risks.

Side by side assessment now in place, no longer required to be approaching discharge.

All people who have self-harmed should be offered a preliminary psychosocial assessment at triage following an act of self-harm. Assessment should determine a person's mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and the possible presence of mental illness.

Information will be provided to the patient verbally and as written material in a language they understand.

Key information for staff:

Interpreting & Translation Services:

Interpreting and translation services (worcsacute.nhs.uk)

Best practice

- All frontline professionals should be able to carry out a basic mental health assessment of a patient at risk.
- All frontline professionals should be able to co-produce an immediate Safety Plan and signpost patients in distress to appropriate support.
- All frontline professionals should know how to identify and respond to patients at risk of suicide, and when it is appropriate to refer to mental health services.

(Self-harm and suicide in adults, Royal College of Psychiatrists, 2020)

15.8.2 The role of the Emergency Department Medical Team

- To complete a physical assessment and provide appropriate treatment, ensuring that this is not compromised because of the patient's mental state
- To treat all people with self-harm/suicidal ideation in a respectful and non-stigmatising way
- To gather a detailed history of the self-harm including relevant triggers, any previous history of self-harm, an assessment of mood and the level of continuing suicidal intent
- To gather relevant information about the person's psychiatric history, family, and personal circumstances
- To support the engagement not only of the patient but also, where available, family and friends
- To consult, and refer where necessary to, mental health colleagues.

Best practice

Every acute hospital should be able to provide a timely and comprehensive psycho-social assessment in line with NICE Guidelines for all patients presenting with self-harm, and have close liaison with community mental health services for follow-up.

(Self-harm and suicide in adults, Royal College of Psychiatrists, 2020)

15.8.3 Specific issues regarding treatment and care

People who have self-harmed should be offered treatment for the physical consequences of self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment.

Adequate anaesthesia and/or analgesia should be offered to people who have self-injured throughout the process of suturing or other painful treatments.

When physical treatment of self-injury is likely to evoke distressing memories of any previous sexual abuse, for example when repairing harm to the genital area, sedation should be offered in advance

15.8.4 People waiting for physical treatments

A psychosocial assessment should not be delayed until after medical treatment is complete, unless life-saving medical treatment is needed, or the patient is unconscious or otherwise incapable of being assessed.

People who have self-harmed should be provided with clear and understandable information about the care process, both verbally and as written material in a language they understand.

If a person who has self-harmed has to wait for treatment, he or she should be offered an environment that is safe, supportive and minimises any distress. For many patients, this may be a separate, quiet room with supervision and regular contact with a named member of staff to ensure safety.

15.8.5 People who wish to leave before assessment and/or treatment

For a person who has self-harmed and presents to services, but wishes to leave before psychosocial assessment has been undertaken, assessment of mental capacity and the presence of mental illness should be undertaken before the person leaves the service. This assessment should be clearly recorded in his or her notes. The assessment should be passed on to the person's GP and to the relevant mental health services as soon as possible to enable rapid follow-up.

People who have self-harmed and present to services and wish to leave before psychosocial assessment has been undertaken, and in whom diminished capacity and/or the presence of a significant mental illness is established, should be referred for urgent mental health assessment. Appropriate measures should also be taken to prevent the person leaving the service.

15.8.6 Medical and surgical management of self-harm

Self-poisoning can be treated by reducing absorption, increasing elimination and/or countering the biological effects of the poison, depending upon the nature of the poison and the route of intake. Superficial uncomplicated wounds can be closed with tissue adhesive, whilst more complicated injuries will need surgical assessment and possibly exploration.

In the treatment and management of people with self-inflicted injuries, clinicians should take full account of the distress and emotional disturbance experienced by people who self-harm additional to the injury itself, in particular, immediately following injury and at presentation for treatment.

Immediate First Aid for self-poisoning -TOXBASE & NPIS

Key information for staff:

Emergency department staff should have easy access to TOXBASE, be fully trained in its use, and know how and when to contact the National Poisons Information Service (NPIS).

TOXBASE should be available to all clinical staff involved in the emergency treatment of self-poisoning. TOXBASE should be the first point of call for poisons information.

TOXBASE – www.toxbase.org

NPIS - 0344 892 0111

15.8.7 Support and advice for people who repeatedly self-harm
Advice for people who repeatedly self-poison
Service users who repeatedly self-poison, and their carers where appropriate, may need advice about the risks of self-poisoning.
Harm minimisation strategies should not be offered for people who have self-harmed by poisoning. There are no safe limits in self-poisoning.
Where service users are likely to repeat self-poisoning, clinical staff (including pharmacists) may consider discussing the risks of self-poisoning with service users, and carers where appropriate.

Discharge and safe prescribing and dispensing
When prescribing medicines to someone who has previously self-harmed or who may self-harm in the future professionals need to consider:

- The toxicity of prescribed medicines for people at risk of overdose
- Any recreational drug or alcohol consumption, risk of misuse and possible interaction with prescribed medications
- The persons wider access to medicines prescribed for themselves or others
- The need for effective communication where multiple prescribers may be involved
- Supply – consideration for limiting the quantity of medicines supplied

15.8.8 Advice for people who repeatedly self-injure
Advice regarding self-management of superficial injuries, harm minimisation techniques, alternative coping strategies and how best to deal with scarring should be considered for people who repeatedly self-injure.

For people presenting for treatment who have a history of self-harm, clinicians may consider offering advice and instructions for the self-management of superficial injuries, including the provision of tissue adhesive. Discussion with a mental health worker may assist in the decision about which service users should be offered this treatment option.

Where service users are likely to repeat self-injury, clinical staff, service users and carers may wish to discuss harm minimisation issues/techniques. Suitable material is available from many voluntary organisations.

Where service users are likely to repeat self-injury, clinical staff, service users and carers may wish to discuss appropriate alternative coping strategies. Suitable material is available from many voluntary organisations.

Where service users have significant scarring from previous self-injury, consideration should be given to providing information about dealing with scar tissue.

Key information for staff:

The Tissue Viability Service are available for advice on treatment of acute wounds caused by self-harm. These patients may have unusual wounds that fail to respond to treatment and the patient may not openly divulge that they have a wound that is not healing.

15.8.9 Assessment of needs (Specialist Mental Health Professional)
All people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment.

The comprehensive assessment of needs should be written clearly in the service user's notes.

To encourage joint clinical decision making, service users and the assessor should both read through the written assessment of needs, wherever possible, to mutually agree the assessment. Agreement should be written into the service user's notes. Where there is significant disagreement, the service user should be offered the opportunity to write his or her disagreement in the notes. The assessment should be passed on to their GP and to any relevant mental health services as soon as possible to enable follow-up.

15.8.10 Assessment of risk (Specialist Mental Health Professional)
All people who have self-harmed should be assessed for risk: this assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent.

The assessment of risk should be written clearly in the service user's notes. The assessment should also be passed on to their GP and to any relevant mental health services as soon as possible to enable follow-up.

Consideration should be given to combining the assessment of risks into a needs assessment framework to produce a single integrated psychosocial assessment process.

15.8.11 Referral, admission and discharge following self-harm
Referral, treatment and discharge following self-harm should be based on the overall assessment of needs and risk.

The decision to refer for further assessment and/or treatment or to discharge the service user should be taken jointly by the service user and the healthcare professional whenever this is possible. When this is not possible, either as a result of diminished mental capacity or the presence of significant mental illness, this should be explained to the service user and written in their notes.

Referral for further assessment and treatment should be based upon the combined assessment of needs and risk. The assessment should be written in the case notes and passed onto the service user's GP and to any relevant mental health services as soon as possible to enable follow-up.

The decision to discharge a person without follow-up following an act of self-harm should be based upon the combined assessment of needs and risk. The assessment should be written in the case notes and passed onto their GP and to any relevant mental health services.

In particular, the decision to discharge a person without follow-up following an act of self-harm should not be based solely upon the presence of low risk of repetition of self-harm or attempted suicide and the absence of a mental illness, because many such people may have a range of other social and personal problems that may later increase risk. These problems may be amenable to therapeutic and/or social interventions.

Temporary admission, which may need to be overnight, should be considered following an act of self-harm, especially for people who are very distressed, for people in whom psychosocial assessment proves too difficult as a result of drug and/or alcohol intoxication, and for people who may be returning to an unsafe or potentially harmful environment. Reassessment should be undertaken the following day or at the earliest opportunity thereafter.

15.8.12 Mental Health Section
Patients cannot be detained to A&E. If a patient is detained to a ward under the Mental Health Act, with no further medical needs, they must be assessed by the Mental Health Liaison Team. The Team will review the detention and arrange transfer to a Mental Health Hospital or discharge to community follow up support.

15.8.13 Safety Planning
MHL will develop a safety plan in partnership with people who have self-harmed. Safety plans should be used to:

- establish the means of self-harm
- recognise the triggers and warning signs of increased distress, further self-harm or a suicidal crisis
- identify individualised coping strategies, including problem solving any factors that may act as a barrier
- identify social contacts and social settings as a means of distraction from suicidal thoughts or escalating crisis
- identify family members or friends to provide support and/or help resolve the crisis
- include contact details for the mental health service, including out-of-hours services and emergency contact details
- keep the environment safe by working collaboratively to remove or restrict lethal means of suicide.

The safety plan should be in an accessible format and:

- be developed collaboratively and compassionately between the person who has self-harmed and the professional involved in their care using shared decision making
- be developed in collaboration with family and carers, as appropriate
- use a problem-solving approach
- be held by the person

- be shared with the family, carers and relevant professionals and practitioners as decided by the person

15.9 Staff training
Clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed.

Emergency departments should make training available in the assessment of mental health needs and the preliminary management of mental health problems, for all healthcare staff working in that environment. Mental health services and emergency department services should jointly develop regular training programmes in the psychosocial assessment and early management of self-harm, to be undertaken by all healthcare professionals who may assess or treat people who have self-harmed.

Key information for staff:

Personal Safety Training - http://nww.worcsacute.nhs.uk/departments-a-to-z/education-training-development/course-directory/conflict-management-personal-protection-training/

Proposed Audience:
All frontline staff who may have to deal with non-compliant behaviour, aggression and violence in the workplace.

Topics covered:
Threat recognition and dynamic risk assessment
Avoidance skills and strategies
Communication skills
Teamwork and other support
Therapeutic holding and control skills
Post incident procedures

Enhanced Observation Guidelines

In-Patient Enhanced Observation Guidelin

Mental Health Liaison Team
Are able to offer bespoke training for clinical areas. Please contact to discuss.

15.10 Security Staff
Security staff can be contacted to help nursing staff deal with patients who are displaying aggressive or challenging behaviour, this may well be because the patient is frightened and anxious, does not understand what is happening to them or finds the environment they find themselves in very alien and frightening.

All efforts to rationalise and calm the patient should be made before security staff are called provided staff are not putting themselves at risk in order to do this.
Often the presence of security personnel is enough to calm the situation. Security staff cannot however be expected to stay with patients indefinitely, if the patient has calmed and is no longer exhibiting their original behaviour, the security staff will expect to be released to their other duties on the understanding that they will respond if the behaviour or situation deteriorates again.

15.11 Supervision
Current research shows that the death of a patient by suicide has a profound effect on the personal and professional life of many professionals, and can affect recruitment, retention, quality of professional life, and patient care (Royal College Psychiatry, 2020).

Staff who work with people of any age who self-harm should have the opportunity for regular, high quality formal supervision.

Support for staff should include clear lines of responsibility around decision making, particularly where there are challenges around the balance between autonomy and safety for a person who has self-harmed.

Escalation should be considered for cases whereby agreement / consensus cannot be reached.

Key information for staff

A number of staff who have completed Richard Swann training are available throughout the Trust – check with your Departmental Manager

Safeguarding Supervision Policy & Procedure

SAFEGUARDING CHILDREN and YOUN

Supporting Staff Involved in Traumatic Incidents / Stressful Incidents, Complaints & Claims

Supporting Staff involved in Traumatic

6. Implementation

6.1 The latest version of this Policy can be found on the Trust intranet site key document and safeguarding and mental health pages.

6.2 Dissemination

Staff will be advised of the updated Policy via dissemination by attendees of the Trust Integrated Safeguarding Committee and associated Trust Governance Forums.

6.3 Training and Awareness

This Policy will be available on the Trust intranet key document page and Safeguarding page.
Staff groups will be made aware of the Policy via mandatory safeguarding training at the required level appropriate for their job role. Further information can be found at section 15.9.

7. Monitoring and Compliance

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	Daily WREN report - key words, self-harm, suicide	Daily review by IST Named Nurse Safeguarding Children	Daily M-F	Named Nurse Safeguarding Children	Integrated Safeguarding Committee	Quarterly and annual safeguarding report
	Datix incident reporting	Divisional Governance teams / Patient Safety team	As per Datix incident review	Divisional Governance teams / Patient Safety team	Via Trust Governance structures	As per Governance schedule

8.Policy Review

This Policy will be reviewed every 3 years in accordance with WAHT Key Document review process or in the event of any significant change to procedure.

9. References

Care Act (2014).
Children Act (1989 / 2004)
Children & Families Act (2014)
Chan et al (2016) Predicting suicide following self-harm: systematic review of risk factors and risk scales - PubMed (nih.gov)
DoH Suicide Prevention Strategy 2023-2028 Suicide prevention strategy for England: 2023 to 2028 - GOV.UK (www.gov.uk)
General Data Protection Regulations (2018)
Human Rights Act (1998)
K Apps, Patient Safety - Self-Harm by Ligature Report – presented to CGG August 2023
4ward Improvement Strategy 4ward - Worcestershire Acute Hospitals NHS Trust (worcsacute.nhs.uk)
Mental Health Act (2007)
Mental Capacity Act (2005)
Multi –agency Policy & Procedures for the Protection of Adults with care & support needs in the West Midlands https://www.safeguardingworcestershire.org.uk/wp-content/uploads/2020/06/West-Mids-Policy-and-Procedures-Nov-2109.pdf
National Institute for Clinical Excellence NG225 Self-harm: assessment, management and preventing recurrence (September, 2022)
Patient Safety Incident Response Framework (PSIRF) NHS England » Patient Safety Incident Response Framework
Public Health England: Identifying and responding to suicide clusters (Sept, 2019) https://assets.publishing.service.gov.uk/media/5da5e34e40f0b631e7a47a4a/PHE_Suicide_Cluster_Guide.pdf
Royal College of Psychiatrists CR229: Self-harm and suicide in adults (July 2020) https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2020-college-reports/cr229
Regional Child Protection Procedures for West Midlands

https://westmidlands.procedures.org.uk/ykpzy/statutory-child-protection-procedures/allegations-against-staff-or-volunteers/
TOXBASE www.toxbase.org
WAHT-TP-037 - Safeguarding Children & Young People Supervision Policy
WAHT-HR-002 - Supporting Staff Involved in Traumatic / Stressful Incidents, Complaints & Claims
WAHT-NUR-085 – Enhanced Observation Guidelines - In-Patient Enhanced Observation Guideline – Adults

10.Background

10.1 Equality requirements

Refer to Supporting Document 1.

10.2 Financial risk assessment

Refer to Supporting Document 2.

10.3 Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Integrated Safeguarding Committee representatives
Sarah Shingler – Chief Nursing Officer, Worcestershire Acute Hospitals NHS Trust (WAHT)
Joanna Hendy - Advanced Clinical Practitioner, Clinical Service Manager , Mental Health Liaison Team, Herefordshire & Worcestershire Health & Care NHS Trust
BAME, LGBTQ+ and Disability Networks
Karen Apps - WAHT Patient Safety Team
Julie Noble - WAHT Health & Safety Manager
Christine Blanshard – Chief Medical Officer
Dr David Raven - Division of Urgent Care / Emergency Medicine

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Integrated Safeguarding Committee
Improving Safety Action Group
Quality Governance Committee

10.4 Approval Process

This Policy will be approved via the Integrated Safeguarding Committee, Improving Safety Action Group and Quality Governance Committee.

10.5 Version Control

Date	Amendment	By:
Nov 2023	Full revision in light of new NICE Guidance (NG225, September 2022). Trust review of self-harm by ligature 2023	Head of Safeguarding Mental Health Liaison Team Patient Safety Team Health & Safety

Supporting Document 1 – Equality Impact Assessment form

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form

Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	x	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	Deborah Narburgh – Head of Safeguarding Joanna Hendy - Advanced Clinical Practitioner, Clinical Service Manager , Mental Health Liaison Service

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Deborah Narburgh	Head of Safeguarding	deborah.narburgh@nhs.net
	Joanna Hendy	Advanced Clinical Practitioner, Clinical Service Manager , Mental Health Liaison Service	joannahendy@nhs.net
Date assessment completed	27.11.2023		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.	**Title: Self-harm: assessment, management and preventing recurrence Policy**			
What is the aim, purpose and/or intended outcomes of this Activity?	As a healthcare provider, Worcestershire Acute Hospitals NHS Trust has a responsibility to meet the needs of our patients, and it is important that our staff all know how to best approach the issue of self-harm. This Policy should be used in conjunction with our safeguarding adults and children policy /procedure. This Policy has been updated to reflect the latest National Institute for Clinical Excellence Guideline (NG225) published September 2022 and best practice guidance in line with our Trust 4ward behaviours of putting patients first and keeping patients safe.			
Who will be affected by the development & implementation of this activity?	✓ ✓ ✓ ✓	Service User Patient Carers Visitors	✓ ✓	Staff Communities Other _____
Is this:	✓ Review of an existing activity New activity Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	As detailed within reference list			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	As detailed within Policy document			
Summary of relevant findings	This Policy applies to all colleagues whether working in a paid, contractual or voluntary capacity.			

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		x		Policy applies to adults, children & young people
Disability		x		Policy applies to adults, children & young people
Gender Reassignment		x		Policy applies to adults, children & young people
Marriage & Civil Partnerships		x		Policy applies to adults, children & young people
Pregnancy & Maternity		x		Policy applies to adults, children & young people Policy circulated to Named Midwife as part of consultation
Race including Traveling Communities		x		Policy applies to adults, children & young people Policy circulated to BAME Lead as part of consultation process
Religion & Belief		x		Policy applies to adults, children & young people

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sex		x		Policy applies to adults, children & young people
Sexual Orientation		x		Policy applies to adults, children & young people Policy circulated to BAME Lead as part of consultation
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		x		Policy applies to adults, children & young people
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		x		Policy applies to adults, children & young people

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	D Narburgh
Date signed	27.11.2023
Comments:	N/A

Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

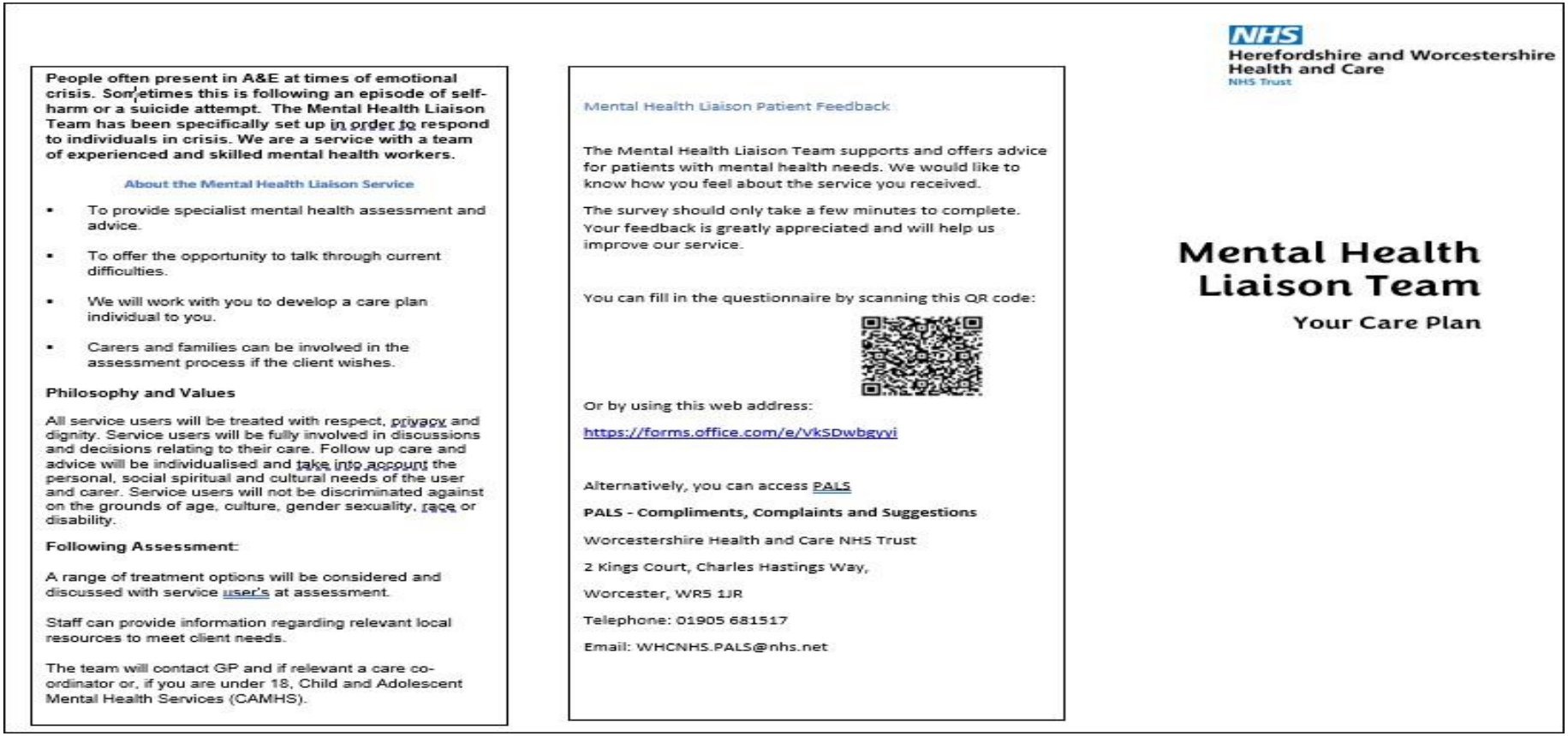
To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	N/A

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval

APPENDIX 1

MENTAL HEALTH LIAISON PATIENT INFORMATION LEAFLET / CARE PLAN



People often present in A&E at times of emotional crisis. Sometimes this is following an episode of self-harm or a suicide attempt. The Mental Health Liaison Team has been specifically set up in order to respond to individuals in crisis. We are a service with a team of experienced and skilled mental health workers.

About the Mental Health Liaison Service

- To provide specialist mental health assessment and advice.
- To offer the opportunity to talk through current difficulties.
- We will work with you to develop a care plan individual to you.
- Carers and families can be involved in the assessment process if the client wishes.

Philosophy and Values

All service users will be treated with respect, privacy and dignity. Service users will be fully involved in discussions and decisions relating to their care. Follow up care and advice will be individualised and take into account the personal, social spiritual and cultural needs of the user and carer. Service users will not be discriminated against on the grounds of age, culture, gender sexuality, race or disability.

Following Assessment:

A range of treatment options will be considered and discussed with service user's at assessment.

Staff can provide information regarding relevant local resources to meet client needs.

The team will contact GP and if relevant a care co-ordinator or, if you are under 18, Child and Adolescent Mental Health Services (CAMHS).

Mental Health Liaison Patient Feedback

The Mental Health Liaison Team supports and offers advice for patients with mental health needs. We would like to know how you feel about the service you received.

The survey should only take a few minutes to complete. Your feedback is greatly appreciated and will help us improve our service.

You can fill in the questionnaire by scanning this QR code:

Or by using this web address:

https://forms.office.com/e/VkSDwbgyyi

Alternatively, you can access PALS

PALS - Compliments, Complaints and Suggestions

Worcestershire Health and Care NHS Trust

2 Kings Court, Charles Hastings Way,

Worcester, WR5 1JR

Telephone: 01905 681517

Email: WHCNHS.PALS@nhs.net

NHS Herefordshire and Worcestershire Health and Care NHS Trust

Mental Health Liaison Team

Your Care Plan

You were seen by

You were seen today because:

In summary, we discussed:

Your name and date of birth:

You were seen on:

You received your care plan

Your signature to confirm

Your initial care plan is:

Copy of assessment offered Yes / No

Accepted ☐ Declined ☐

Useful Numbers

NHS 24/7 Mental Health Helpline: Freephone 0808 196 9127. Available 24/7.

SAMARITANS Call 116 123- 24 hrs a day. Samaritans provide confidential non-judgmental emotional support. www.samaritans.org.uk

111: Telephone service to access non-emergency medical guidance

women's aid 0808 2000 247 Freephone 24/7

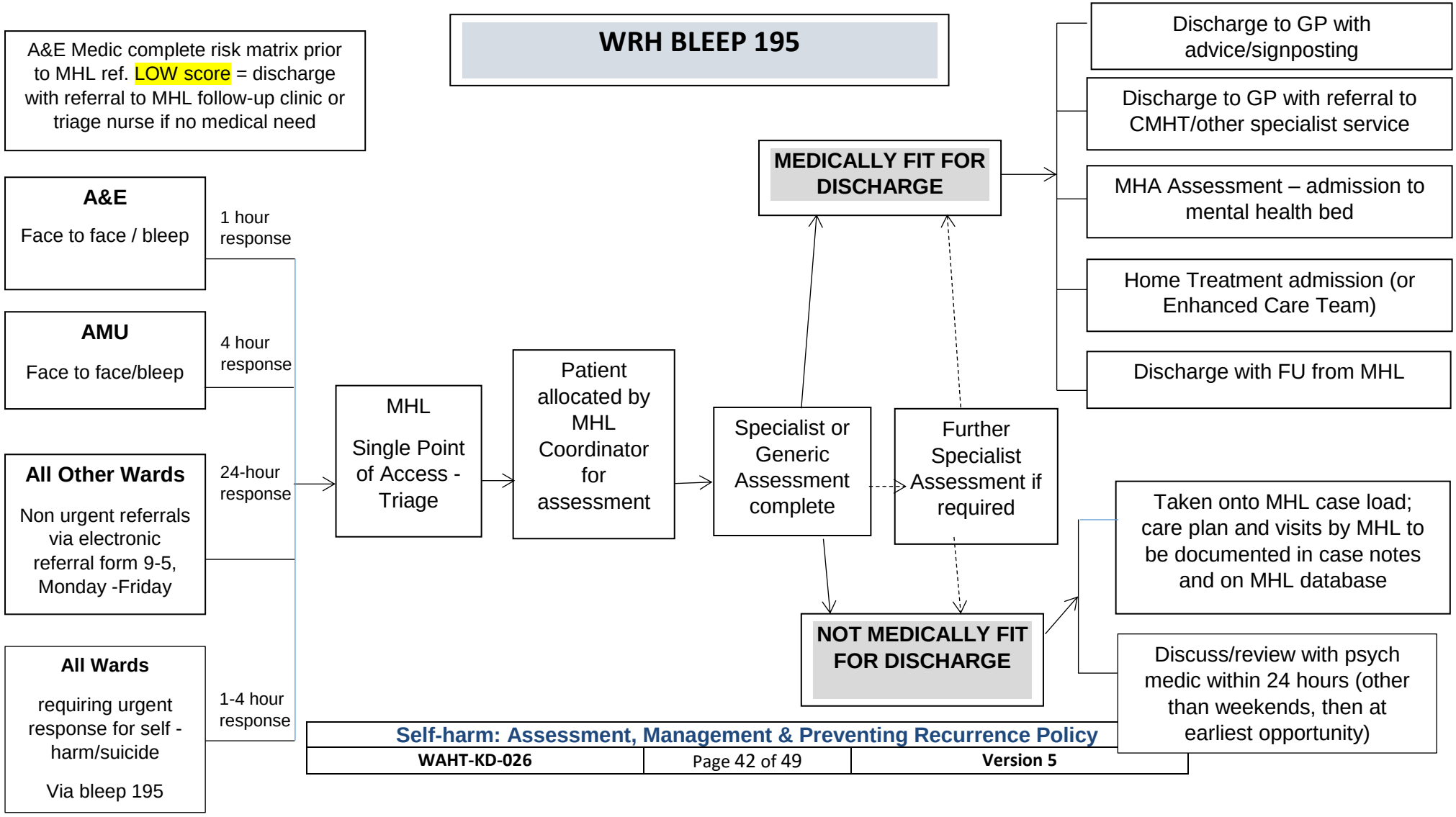
online mental health services for children, young people and adults https://kooth.com

PAPYRUS Suicide prevention charity for anyone under 35: Freephone: 0800 068 4141/ Text: 07860 039967/Email: pat@papyrus-uk.org

CRANSTOUN Adult Drug and alcohol service for Worcestershire. Call 0300 303 8200

WORCESTERSHIRE CARERS For those who are caring for another 0300 012 4272 Mon-Friday 9-7, Sat 9-12 carers@worcestershire.gov.uk

APPENDIX 2 **Mental Health Liaison (MHL) Service Referral Process for WORCESTER ROYAL HOSPITAL**



APPENDIX 3

Mental Health Liaison (MHL) Service Referral Process for ALEXANDRA HOSPITAL

A&E Medic complete risk matrix prior to MHL ref. LOW score= discharge with referral to MHL follow-up clinic.

ALEX BLEEP 1234

A&E
Face to face / bleep
1 hour response

MAU/MSSU
Face to face/bleep
4 hour response

All Other Wards
Non urgent referrals via electronic referral form 9-5, Monday -Friday
24 hour response

All Wards
requiring urgent response for self - harm/suicide
Bleep 1234
1-4 hour response

MHL
Single Point of Access - Triage

Patient allocated by MHL Coordinator for assessment

Specialist or Generic Assessment complete

Further Specialist Assessment if required

MEDICALLY FIT FOR DISCHARGE

NOT MEDICALLY FIT FOR DISCHARGE

- Discharge to GP with advice/signposting
- Discharge to GP with referral to CMHT/other specialist service
- MHA Assessment – admission to mental health bed
- Home Treatment admission (or Enhanced Care Team)
- Discharge with FU from MHL clinics (e.g. DSH, Dementia, MUS)
- Taken onto MHL case load; care plan and visits by MHL to be documented in case notes and on MHL database
- Discuss/review with psych medic within 24 hours (other than weekends, then at earliest opportunity)

APPENDIX 4

Referral process from Clinical Decisions Unit (CDU) & Ambulatory Emergency Care (AEC)

Response time from referral to assessment is 4 hours

- Patients are moved to CDU & AEC for various reasons including additional treatment, observations & to await specialist assessment. Any member of CDU/AEC staff can refer a patient.
- The staff can refer patients via the bleep, or by speaking to a clinician.
- The MHLT will offer advice for emergency referrals within the hour.
- Patients within the main A&E department will be seen as priority unless otherwise requested by the nurse in charge.
- MHLT clinicians will check local databases to obtain relevant information about the patient. This is essential to identify any potential risks, and whether it is safe to assess the person alone. If the patient is known to services, and it is within hours it is good practice to get information from the relevant services.

Mental Health Liaison:

Worcestershire Royal Hospital Bleep 195

Alexandra Hospital Bleep 1234

Outside of MHLT operational hours (2200-0800):

- Patients assessed as LOW risk on the WAHT Mental Health Matrix can be discharged from A&E overnight and their details placed in the MHLT follow up folder.
- A&E medical staff MUST complete either the Adult or Child & Adolescent Mental Health Matrix prior to the discharge of the patient.
- Only patients deemed as LOW risk should be entered into the follow up process.
- Each morning MHLT will check the follow up folder and either make contact with the patient to offer a follow up appointment with the MHLT or contact their usual care team to request that they provide follow up.
- Any CYP's discharged overnight will be referred by MHLT to CAMHS SPA for follow up.
- Patients deemed as MEDIUM or HIGH risk should be discussed with the Crisis Resolution Team who will triage the referrals, to include referrals for Mental Health Act assessments. They will provide either assessment or advice.

Crisis Resolution Team: 01905 681915

Referral process for patients admitted to WAHT wards as the result of self-harm or attempted suicide

Response time from referral to assessment for MAU is 14 hours

Response time referral to assessment for all other wards is 24 hours

- WAHT staff should refer patients admitted as a result of self-harm or attempted suicide via the bleep system; this referral can be made by any healthcare professional.
- Emergency advice can also be sought via the bleep system. The MHLT will offer advice within the hour.
- Clinicians will check local databases to obtain relevant information about the patient. This is essential to identify any potential risks, and whether it is safe to assess the person alone. If the patient is known to services, and it is within hours it is good practice to get information from the relevant services.

Children and Young People (CYP)

- CYP's admitted to Riverbank or Medical Assessment Unit Monday – Friday will be seen by CAMHS Plus service on the ward.
- MHLT will provide assessments for CYP's during the weekends and bank holidays when CAMHS services are not available to young people admitted to the wards as well as A&E.

Mental Health Liaison:

Worcestershire Royal Hospital Bleep 195

Alexandra Hospital Bleep 1234

- The Crisis Resolution Team are available for advice & also triage all referrals for Mental Health Act assessments out of hours. **Crisis Resolution Team: 01905 681915**
- The on call psychiatrist is available for advice via the Hospital Switchboard.

Referral process for patients transferred from a mental health inpatient ward to a WAHT bed.

Response time from referral to assessment is 24 hours

- Mental health inpatients remain the responsibility of inpatient services until admitted to a WAHT bed. Including Observation & supervision of patient in A&E.

- Once a patient is admitted to any ward, including a Medical Assessment Unit a full handover of mental health presentation, risks & the need for 1:1 if required should be provided by mental health inpatient ward staff to the receiving Acute Trust ward & to MHLT via Bleep.

- All patients detained under the Mental Health Act should have their Section transferred using a H4 document signed by the nurse in charge of the mental health ward that the patient originated from & the nurse in charge of the receiving ward.

- MHLT will print off the latest ward review and take it to the WAHT to add to the patient notes. The ward review covers; reason for admission, risks, medication and treatment plan as a minimum.

- MHLT consultant psychiatrist to be notified by MHL clinician if the patient is detained.

- Accompanying staff should return to their mental health ward once all of the above has been completed. WAHT are responsible for providing 1:1 supervision for patients requiring intensive support, any issues with sourcing additional staff should be escalated to WAHT managers.

- On occasion HACW managers may authorise staff remain to support patients while additional staff are sourced by WAHT, this is at the discretion of HACW managers.

- The MHLT are responsible for providing ongoing mental health support patient's referred to the service during their admission to WAHT. This will include regular review of mental state & risk which will be communicated clearly to WAHT staff verbally & will clearly documented in the patient's medical notes. This will also be documented clearly on Care Notes.

- Once medically fit for discharge MHLT will contact the bed manager to arrange readmission for detained patients.

- Once medically fit for discharge voluntary patients will be assessed by MHLT to ascertain if readmission to a mental health inpatient ward is clinically indicated.

Mental Health Liaison:

Worcestershire Royal Hospital Bleep 195

Alexandra Hospital Bleep 1234

- The Crisis Resolution Team are available for advice & also triage all referrals for Mental Health Act assessments out of hours. Crisis Resolution Team: 01905 681 915

- The on call psychiatrist is available for advice via the Hospital Switchboard.

Referral process for all other patients requiring mental health assessment including medical review admitted to WAHT wards

Response time from referral to assessment is 24 hours

This service is available Monday – Friday 0800-2000 (Excluding Bank Holidays)

- WAHT staff are responsible for referring patients identified as having mental health needs to the MHLT for assessment via the MHLT e-referral form on WHAT intranet.

http://nww.worcsacute.nhs.uk/departments-a-to-z/mental-health-liaison-team/

- The MHLT are able to provide assessment, ongoing care and treatment, medical review as well as onward referral and signposting.
- The referral form must include; Patient Name, NHS Number, Reason for admission, Presenting problem & reason for referral, patients location & referrer details.
- The MHLT team will make arrangements to see the patient, who will be seen as soon as possible, depending on clinical priority but within 24 hours. The MHLT will access as much information regarding the person as possible, from notes ambulance reports and other third party information across all databases available to MHLT prior to attending.

The MHLT are available for urgent advice via Bleep

Alexandra Hospital Bleep 1234

Worcestershire Royal Hospital Bleep 195

APPENDIX 5

PROTOCOL FOR MANAGING PATIENTS AT RISK FROM SELF HARM ADMITTED TO AN ACUTE WARD FROM A&E/AMU

Patient who has self-harmed is admitted to ward from A&E or AMU (this also includes maternity patients)

↓

Patient must be nursed in ground floor ward, designated safe bed space/room easily observed from nursing station

↓

Nurse in charge of shift to be made aware of patient's potential to self-harm by handover from A&E/AMU Nurse

↓

If patient deemed a significant risk of re-harming themselves e.g. has already attempted further harm to themselves in A&E and AMU or expresses a wish to self-harm themselves the following **must** occur

↓

Nurse in charge of ward must contact Senior Nurse Bleep holder 401/0903 out of hours/weekends, who should escalate to on-call Matron if their assessment of the situation warrants it. Also inform admitting Doctor and Mental Health Liaison Team.

↓

Senior Nurse 401/0903/Matron (in hours) to attend ward immediately and assess if ward staff have sufficient staff on duty to safely observe the patient

↓

If ward staffing deemed unlikely to be able to observe and maintain safety of the patient, Matron (in hours) to arrange extra staffing for ward (with Mental Health HCA or RMN if necessary) out of hours 401/0903 bleep holder to contact Matron on call and then arrange for extra staff to be brought in

↓

Matron in hours or Senior Nurse out of hours to maintain regular links with ward staff during the patient's admission, any deterioration in the patients mental state must be communicated to the admitting doctor and documented in the patients notes

↓

Security presence can be requested for aggressive or exceptionally difficult patients (via Switchboard).

↓

Bleep MHL Team if patient's condition deteriorates.

WRH – bleep 195

ALEX – bleep 1234

↓

Patients who verbally threaten self-harm of who actively try to self-harm in the ward area must be observed at all times – **please ensure staff document all relevant information and actions taken during the inpatient episode.**