MANAGEMENT OF SELF HARM

Document Summary

This policy seeks to support and provide guidance to practitioners in all teams in the management of care of people who self-harm. Therefore, this policy is relevant to all teams and services. It needs to be recognised that self-harm is an issue that needs to be considered by the whole of the health community in both primary and secondary care.

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<td>Deputy Director of Quality &amp; Nursing</td>
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<tr>
<td>POLICY AUTHOR</td>
<td>Nurse Consultant</td>
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Important Note:
The Intranet version of this document is the only version that is maintained.

Any printed copies should therefore be viewed as “uncontrolled” and, as such, may not necessarily contain the latest updates and amendment.
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1 SCOPE

The principles of good clinical risk assessment and management of self-harm described in this policy are relevant to all health and social care staff in all clinical areas working in Cumbria Partnership and all staff should be aware of these standards of good practice. The standards of practice and training set out in this policy specifically relate to practitioners who have responsibility for assessing and managing individual service user risk of self harm e.g. Primary/Named Nurses, Care Coordinators, Key worker, Assessment Officer, Doctors, Social workers, Occupational Therapists.

2 INTRODUCTION

This policy seeks to support and provide guidance to practitioners in all teams in the management of care of people who self-harm. People who self harm may be referred to or be on the caseload of all services provided by Cumbria Partnership NHS Foundation Trust.

Therefore this policy is relevant to all teams and services. It needs to be recognised that self harm is an issue that needs to be considered by the whole of the health community in both primary and secondary care.

The NICE (2004) guidelines on self harm point out that self harm is poorly understood by NHS staff and recommends that collaboration needs to take place between local health organisations in order to develop properly integrated services.

Cumbria Partnership NHS Foundation Trust is committed to providing the highest standard of collaborative care for Service Users and their Carers with mental health and substance misuse problems, believing safety is at the centre of good healthcare. The trust recognises the importance of clinical risk assessment for all Service Users and the effective risk management for those who may present an increased risk to themselves.

The trust is committed to supporting Service Users their Carers and clinical services by adopting a systematic and shared approach to risk assessment and management of Self Harm at individual practitioner, team and organisational levels. Embedding key principles and processes of generic risk assessment and management in relation to self harm and specifically the service users recovery in day to day practice, enables staff to deliver empathetic support with effective objective assessment and management of the risk of Self Harm as part of the Care Programme Approach (CPA) so to achieve and sustain high quality healthcare.
3 STATEMENT OF INTENT

Key Principles

The NICE Guidelines define broad principles that all services should meet, they include:

- People who self harm need to be treated with the same care respect and privacy as any other service user. In addition healthcare professionals should take into account the likely distress associated with self-harm to the patient and others, whether or not apparent.

- Wherever possible service users who have self harmed should be offered the choice of male or female staff for both assessment and treatment.

- Service users who have self-harmed should be offered full information about the treatment options by health professionals.

- Providing treatment and care for service users who have self-harmed can be emotionally demanding and requires a high level of support. All staff undertaking this work should have regular clinical supervision in which the emotional impact upon staff members can be openly discussed and understood. (See Cumbria Partnership Supervision Policy).

- When assessing service users who have self-harmed health care professionals should ask them to explore their feelings and understanding of their own self-harm in their own words.

- When caring for service users who repeatedly self harm, healthcare professionals should be aware that triggers for self harming might be different on each occasion and therefore each episode needs to be assessed individually.

- Healthcare should involve service users who self harm and where appropriate and with informed consent their carers and/or family in all discussions and decisions made about their treatment and care.

- Healthcare professionals should take steps to understand equality and diversity issues in relation to self-harm.

- Healthcare staff should consider special issues for older people who have self harmed, by following the same principles as for the assessment for adults but also include a full assessment with special attention to the possible presence of depression, cognitive impairment, physical ill health, their social and home situation. All acts of self-harm in people over 65 should be taken as evidence of suicidal intent until proven otherwise.

- CAMHS Healthcare staff should provide consultation for the young person, their family, the paediatric team, social services, and education staff. The CAMHS
team should conduct assessment addressing needs and risks for the child (similar to adults), the family, the social situation of family and young person, child protection issues, assessors should be specifically trained and supervised to work with self harm in this age group.

- Service users who have self-harmed should receive a comprehensive assessment of needs and risk. Referral for further assessment and/or treatment should be based upon a comprehensive assessment.

- All staff that have contact in the emergency situation with service users 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 and know how to access specialist advice about the Mental Health Act.

- 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 taking the person to hospital, and 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.
4 DEFINITIONS

Self Harm
“an act with non-fatal outcome, in which an individual deliberately initiates a non habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes which the subject desired via the actual or expected physical consequences” (NICE Guidelines, 2003).

Self harming can be permanently disfiguring. It can be hidden, dramatic or ritualistic. It is important to distinguish between self harm and a suicide attempt, as confusion in Clinical practice does occur.

Incidence of Self-Harm
Self-harm is a very common reason for hospital presentation; the Registrar Generals figures for England and Wales for 2003 indicate 170,000 people presented to general hospitals for parasuicide. People who have self-harmed represent 4% to 5% of all A&E attendances, and self-harm is one of the top five causes of acute medical and surgical admissions in the UK. Although it is suggested the majority of episodes of self-harm never reach the health service.

It is estimated that 4% of the population self harms and it is one of the top five causes of acute medical admissions for adults (Wilhelm, 2000). Self harm increases the risk of subsequent suicide. Approximately 1% of people who attend hospital following a self harm attempt will die by suicide in the next 12 months and above 5% of episodes of self harm are followed by completed suicide after 9 years (Owens et al, 2002). The 5 year report of the National Confidential Inquiry into suicide and homicide by people with mental illness (2006) found that 68% of people who completed suicide had a history of self harm. This is an increase in 4% since the last report.

There is often controversy about the terminology used to describe an act of self-harm as defined above; disagreements generally revolve around the degree and kind of intent required. Descriptive labels found in literature include Deliberate Self Harm (DSH), Para suicide, Para suicidal behaviour, non fatal self harm, and more pejorative labels like suicide gestures and manipulative suicide attempts are present and their use has been argued to create blame and dislike toward the service user.

For the purpose of this policy the term self harm will be used.

Self-harm has been the subject of extensive sociological, epidemiological, psychological, biological and clinical study, research and speculation. The suggested reasons why people utilise self-harm, and the theories about the development of, and what mediates such behaviour vary. Service users can utilise self-harm as a coping strategy to deal with difficult emotions and challenging situations and has been associated with particular groups such as adolescents, service users with enduring mental illness, personality disorder or substance misuse, the victims of
sexual, physical and emotional abuse, low self esteem or self hatred, being isolated or separated, feelings of guilt and or anxiety.

5 DUTIES

5.1 The Director of Operations and Executive Nurse
Is the accountable Director for this policy.

5.2 Locality General Managers
Each Locality General Manager is responsible for ensuring that the policies and procedures are adhered to within their area of accountability.

5.3 Senior Staff
All ward managers, medical staff, nurse consultants, Allied Health Professional (AHP); Team Manager is responsible for ensuring that the policies and procedures are adhered to within their area of accountability.

5.4 All Staff
All staff within the scope of the policies and procedures are responsible for the implementation of the policy within their own area of accountability.

5.5 Care Co-ordinator
Term used in this policy to describe the qualified professional responsible for coordinating a patient’s care on a day to day basis.

5.6 Home Treatment Team & Access and Liaison service (HTT & ALIS)
Crisis Resolution and Home Treatment Team who are responsible for the monitoring of the patients mental health and risks during their care.

5.7 Named Nurse
The inpatient nurse who is responsible for collaborating with patients and carers in the development and monitoring of the care plan.

5.8 Responsible Clinician (RC)
Under the terms of the MHA this means the Approved Clinician (AC) in charge of a patient’s treatment. The role of the RC pertains only to patients who are formally detained or subject to Community Treatment Orders (CTO) under the Act. The term “Responsible Clinician” should be used in respect of informal patients on leave from hospital, meaning a clinician with responsibility for the patient’s day to day care, or a deputy acting in their place.
6 AIMS AND OBJECTIVES OF ASSESSMENT AND TREATMENT FOR CLINICIANS WHEN CARING FOR INDIVIDUALS WHO SELF HARM.

6.1 Risk Assessment

DH (Best Practice in Managing Risk 2007) Risk assessment can be defined as the gathering of information through working with the service user to help estimate how likely it is a negative event will occur, how soon it is expected to occur and how severe the outcome will be if it does occur for the patient relative, carer or the public.

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.

6.2 Positive Risk Management

Positive risk management means being aware that risk can never be completely eliminated, and aware that management plans inevitably have to include decisions that carry some risk. This should be explicit in the decision-making process and should be discussed openly with the service user. Positive risk management incorporates the service users’ quality of life and plans for recovery, whilst remaining aware of the safety needs of the service user, their carer and the public. Concepts of positive risk management include:

- Working with the service user to identify what is likely to work.
- Being willing to take a decision that involves an element of risk because the potential positive benefits outweigh the risk.
- Being clear to all involved about the potential benefits and the potential risks.
- Developing plans and actions that support the positive potentials and priorities stated by the service user, and minimise the risks to the service user or others.
- Paying attention to the views of carers, others and the service user when deciding on a plan.
- Ensuring that the service user, carer and others who might be affected are fully informed of the decision, the reasons for it and the associated plans.
- Using available resources and support to achieve a balance between a focus on achieving the desired outcomes and minimising the potential harmful outcome.

6.3 The Comprehensive Risk Assessment Self Harm

All Service users who present with threat of or incidents of Self Harm should receive a full risk and mental state examination; the findings of risk assessment of self-harm should be documented.

Risk assessment is integral to deciding on the most appropriate level of risk management and intervention with a service user, whereby the assessor aims to
make every effort to achieve harm minimization (see CPA policy). Best practice of risk assessment is a decision based on the knowledge of research evidence, knowledge of the individual Service User and their social context, the Service users own experience and clinical judgement information from other available sources such as case notes past and present, and carer and relative information / views.

Assessment of Self Harm should be conducted in conjunction with the risk domains of violence/risk to others, serious self neglect, vulnerability and exploitation and substance misuse in line with the trust GRIST risk assessment tool.

When assessing the risk of self harm particular consideration should be given to the risk assessment of suicide and the evidence that previous and present acts of self harm increase the risk of suicide, assessors should establish whether the intent of self harm was to cope or carry out suicide.

Factors to assess and establish the intent of self-harm would be, ambivalence toward dying, hopelessness, relationship problems, debt, anniversaries, significant events and mental state in conjunction with the following factors being evident:

- Potential lethal method – attempted hanging
- Attempted to conceal – discovered
- Denying or trivializing serious attempt
- Procuring the means – purchased rope
- Detailed plan / tested out
- Recently made a will
- Written suicide note
- Sold or given away possessions

Risk assessment should form the following process:

- Assessment
- Establish Risk Level
- Develop Formulation
- Risk Management Planning
- Communication of plans
- Implementation of plans
- Evaluation of plans and planned reassessment

Establishing the level of self-harm risk would involve covering the following aspects of risk with the service user to help estimate each of these aspects:

- How likely it is that the event will occur.
- How soon it is expected to occur.
- How severe the outcome will be if it does occur.
Risk factors should be considered during the assessment process. A risk factor is a personal characteristic or circumstance that is linked to a negative event and that either causes or facilitates the event to occur. Risk factors have been categorised in a number of ways:

- **Actuarial**: Use statistical information about populations to help make decisions about who might be a risk dependant on whether they belong to an identified risk group. Higher risk groups may include: older, male, substance abuser, divorced, unemployed.
- **Clinical**: Is when clinical professionals use their experience and learning to assess the level of risk, e.g. suicide.
- **Static factors** are unchangeable e.g. history of child abuse or suicide attempts.
- **Dynamic factors** change over time e.g. alcohol misuse or attitudes to carers, these can be aspects of the service user or their environment; these factors are more amenable to change.
- **Dynamic factors** that are stable and change slowly are called **Stable** or **Chronic** risk factors.
- **Acute factors** or **Triggers** change rapidly.

When assessing the risk of self-harm the following areas need to be examined in detail in particularly the previous 6-12 months:

- Risk factors
- History
- Ideation/Mental State (hopelessness & ambivalence toward harming self or suicide)
- Intent
- Planning
- Preparation

The assessor should attempt to obtain information from a variety of sources such as the Service User, GP/medical practitioners, family/carer, referrer, friends, care coordinator, medical reports/notes, MDT notes/reports, IPM eCPA. It is recognised that for service users not previously known to the service, information may be limited; however it is the responsibility of the assessor to make every effort to gain as much information as possible to aid effective risk assessment and management so to identify the support required.

All risk & Mental state examinations should be conducted jointly with the service user in a transparent manner, measurements, outcomes and formulations should be explicitly shared with the service user, carer/family (with consent). Service users opinions about the validity of assessments and formulation should be explored jointly so to inform care planning and further risk management.

Established risk levels can vary from low to high. E.g. **Low** may include having attempted or threatened self harm in the past but a repeat of such behaviour is not thought likely between now and the next scheduled risk assessment, the service user is likely to cooperate well and contribute helpfully to risk management planning.
and they may respond to treatment; there’s a sufficient number of protective factors (e.g. trusting relationship with staff, good response to treatment, supportive carer). To support ongoing desistance from self harm.

**High** risk or the risk of committing an act either planned or spontaneous which is very likely to cause serious harm, with few or no protective factors to mitigate or reduce that risk and requires long term risk management, including planned supervision and close monitoring or organised treatment.

All assessment, formulation and care planning decisions should be discussed in a multi disciplinary team when available (MDT), operating an open, democratic and transparent culture that embraces reflective practice, notes are to be recorded, and care planning is agreed jointly with the service user and their carers.

However if due to operational reasons or the time of assessment is out of hours and an MDT is unavailable, following a full risk and Mental state examination the outcome and proposed care planning decisions for an inpatient who has self harmed should be discussed with the senior nurse on duty, and consultant on call if deemed necessary.

In each case of non admitted, previously known or unknown Service User presenting who has self harmed following assessment by a medical practitioners (e.g. in A&E) full risk and Mental state examination-one should be conducted. It is recognised that not all Service Users who self harm require hospital admission, at the point consideration should be given as whether any of the following interventions are required:

- ALIS/HTT referral
- Community Mental Health Team referral
- Primary Mental Health Care Team referral
- Signposting to voluntary organisation e.g. MIND, Samaritans contact details given
- Hospital Admission
- General Practitioner referral
- Carer or Family support (with consent)

### 6.4 The Comprehensive Mental state examination

NICE guidelines require that a health care professional conducts and records a comprehensive assessment of psychosocial needs for every service user who self harms and presents to a health service. This assessment would normally include information upon the service users:

- Current problems
- Social situation (living arrangements, work, social isolation)
- Financial problems (debt)
- Family network
- Diversity (age, race, faith, gender, disability, sexual orientation)
- Physical ill health
- Personal relationships
- Recent life events, current difficulties or triggers that preceded self harm
- Psychiatric history (diagnosis, previous treatments)
- Past history of self harming behaviour (trends, patterns, relapse signature)
- Current Self harming behaviour and its implications to self or others
- Current Alcohol & substance misuse
- Coping resources and available support (protective factors what might help to reduce risk)
- Concern expressed by others
- Current mental state examination (psychiatric disorder, mood, psychosis, hopelessness, ambivalence about risk to self from self harm-possible suicide)
- Enduring psychological characteristics associated with self harm
- Function of behaviour
- Detailed account of the circumstances and motivation for the act
- Most appropriate aftercare
- Service users willingness and engagement with assessment & treatment
- Service user receiving abuse or the victimisation of others

6.5 A & E Staff contact

NICE guidelines (2014) recommend all people who have self-harmed should be offered a preliminary Mental state examination at triage or the initial assessment in primary or community settings. The standard for a Mental state examination should be completed within four hours of referral.

6.6 Comprehensive Risk Management of Self-Harm

Multidisciplinary and multiagency teams operating in an open, democratic and transparent culture that embraces reflective practice should develop risk management plans.

Risk management must always be based on awareness of the capacity for the service user’s risk level to change over time, and recognition that each service user requires a consistent and individualised approach.

Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused. Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.

Knowledge and understanding of mental health legislation is an important component of risk management. The assessment of capacity can become an important issue if the service user who refuses medical treatment for the physical injury of the self-harm. All registered Doctors should be able to assess capacity; in cases of self-harm this can be difficult as capacity may be temporarily impaired by the service users’ mental state.

Following a full risk and Mental state Examination the GRIST risk formulation and management plan should be completed or updated identifying situations in which
identified risks may occur, and the actions to be taken by practitioners and the
service user in response to negative change, reassessment should be planned. This
information should be communicated with all professionals involved and where
consent is obtained to carers or family in the process of ongoing care or as a
discharge.

6.7 Sharing Decision making with Service Users and Carers

Each stage along the process of developing a risk management plan should be
based on discussions with the service user and those involved in their care. The
service user should be given the opportunity to have a lead role in identifying risk
from their own perspective and when it comes to devising plans to deal with difficult
situations indicating the service users preference of the type of support given.

“Risk management can increase a user’s awareness of their own behaviour and of
how others view them. This can enable them to manage their lives and relationships
more effectively”. A user’s view

6.8 Diversity & Risk Assessment & Management of Self-Harm

All staff involved in risk management must be capable of demonstrating sensitivity
and competence in relation to diversity in race, faith, age, gender, disability and
sexual orientation.

6.9 Treatment for the physical consequences of self-harm

NICE guidelines for self-harm state healthcare staff should offer treatment for the
physical consequences of self-harm, regardless of the Service Users willingness to
accept Mental state examination assessment or psychiatric treatment.

Appropriate medical personnel should be alerted or accessed to provide medical
assessment and treatment as deemed necessary, whether this is facilitated by
PCAS, Accident & Emergency service, local GP, CHOC out of hours or on call
medical cover.

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.

(Appendix 1) The national self harm network self injury treatment check list can be
used at the initial triage stage to allow individuals to record information in relation to
their self harm and their treatment preferences. This will be particularly useful when
presenting at PCAS or accident and emergency, it may also help to inform care
plans in community and in patient settings.

6.10 Harm Minimisation Approaches

The objective is to provide support and advice for people who regularly self harm;
However, for people who self poison; Do Not offer harm minimisation advice regarding self poisoning –there are no safe limits, as even small ‘overdoses’ can kill. When prescribing to people who are at risk of, have previously or live with someone at risk of self poisoning always prescribe those drugs that are the least dangerous in overdose, prescribe as few as possible at one time.

Drug therapies may include antidepressants, mood stabilisers and anxiolytics to alleviate the underlying symptoms (NICE, 2014).

- If the self-harm is a form of expression of anger for example; self punishment, alternative methods of expression should be explored.
- If the self-harm is used; to provide relief from emotional distress, an individual harm minimisation plan should be developed in partnership with the service user.
- This plan may include the use of 1-1- therapeutic sessions, creative writing, CBT.
- For people who repeatedly self harm there is a risk of infection if wounds are not treated and a risk of permanent scarring.
- Therefore advice and instruction on; self management of superficial injuries (guidance should be sought from appropriately qualified professional), alongside information on threats to life.
- Information about how blood borne infections may be transmitted and how to avoid these should also be provided.
- Voluntary organisations may be able to offer support.
- A short booklet on self harm for patients, carers and professionals can be downloaded from the Royal College of Psychiatrists website www.rcpsch.ac.uk

A care plan for a person wishing to reduce or stop self harming should include the following;

- Service users preferences for treatment as identified in the assessment
- Mechanisms to meet the dignity, privacy and safety of others (based on the care environment) have been considered
- Details of agreed specific therapeutic interventions to support the service user in the development of alternative coping strategies.
- Evidence that risks to the service user have been discussed, particularly in relation to hospital infections; this will include information being provided to the service user on infection control.
- Details of interventions to secure the physical well being of the service user following an incident of self-harm. (This may include hands on physical restraint in the event of an emergency).

7 TRAINING

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.
• People who self-harm should be involved in the planning and delivery of training for staff.

• 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 Mental state examination and early management of self-harm, to be undertaken by all healthcare professionals who may assess or treat people who have self-harmed.

The importance of providing a formal system of Clinical Risk Assessment Training is highlighted in several key documents: (Nice 2015)

National Service Framework for Mental Health- standard on suicide prevention are that “Training for staff in specialist mental health services and risk assessment management is a priority, and (should be) updated at least every three years.”

The Cumbria Partnership Training Strategy identifies Clinical Risk Assessment Training as mandatory across all services for qualified staff with the responsibility to undertake clinical risk assessment and the management of clinical risk. Staff should attend updates every 3 years. A programme of Clinical Risk Assessment training is coordinated by the Trust Learning network Training Department.

### 8 MONITORING COMPLIANCE WITH THIS POLICY

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<th>Frequency of the monitoring activity</th>
<th>Group / committee which will receive the findings / monitoring report</th>
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<td>Six months</td>
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from mental health services conducts and records a comprehensive assessment of psychosocial needs for people who self-harm and present to mental health services includes:

- Social situation (living arrangements, work, debt)
- Personal relationships
- Recent life events
- Psychiatric history (including previous self-harm events)
- Mental state examination
- Enduring psychological difficulties associated with self-harm
- Motivation for the act

A healthcare professional conducts and records a comprehensive risk assessment for people who self-harm and present to mental health services

The risk assessment includes:

- Characteristics of the act of self-harm (medical seriousness, evidence of planning, precautions taken to prevent rescue)
- Characteristics of the person (hopelessness, forensic history, history of suicidal behaviour, suicidal intent)
- Circumstances of the person (social class, physical illness, recent bereavement, social isolation)

A range of treatment options are made available to people who self-harm, wherever possible

The range of treatment options may include: advice on harm minimisation, access to support groups

Evidence of carer involvement in care plan

Record audit 30%

All Staff receive Risk assessment / management training

Learning Network

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9 REFERENCES/ BIBLIOGRAPHY


7. Department of Health, (2011) no health without mental health: Delivering better mental health outcomes for people of all ages. DoH


10 RELATED TRUST POLICY/PROCEDURES

POL/001/062 Delegation of Duties for Registered Nurses and Allied Health Professionals working with Non-registered clinical support staff

POL/001/052 Clinical Supervision Policy

POL/001/043 Policy to Promote Privacy, Dignity and Respect

POL/001/029 Policy and Procedure for Managing Informal Service users Non-Compliance

POL/001/012 Policy and Procedures for Physical Examination and Care of Service Users

POL/001/010 Consent Policy

POL/001/062 Policy on Observations

POL/001/052 Information Sharing (Disclosure) Policy

POL/001/043 Confidentiality Policy
POL/001/012  MHA Guidelines for Informal Leave Arrangement
POL/001/029  Guidelines for Consent to Treatment Part IV MHA 1893
POL/001/101  Joint Operational Protocol Section 136 MHA 1983
POL/001/007  Joint Operational Protocol for Policy Assistance
POL/002/065  MHA Section 5(2) Doctors 72 Hour Holding Power
POL/002/038  MHA Section 5(4) Nurses 6 Hour Holding Power
What you need to know to make my treatment as effective as possible:

☐ I need you to examine my injury in a private room.
☐ I am distressed.
☐ I need to sit alone.
☐ I need someone to sit with me.
☐ I am happy to sit in the main waiting area.
☐ I need to wait somewhere quiet.
☐ I am happy for students to observe or treat me.
☐ I am able to discuss what happened.
☐ I prefer to be treated by a female doctor.
☐ I prefer to be treated by a male doctor.
☐ I would like to see a social worker.
☐ I would like to see a psychiatric liaison nurse.
☐ I would like to see a psychiatrist.

Any other information:

__________________________
__________________________
__________________________
__________________________
__________________________
__________________________

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To:
The Triage Nurse

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Appendix 1

Self-injury Treatment Checklist

About Me
Name ___________________________________________
Address __________________________________________
Postcode __________________________________________ Telephone _______________
Date of Birth ____________ / ____________ I last drank at ____________: ____________
I last ate at ____________: ____________ I have a Crisis Card Yes No
I have been to this hospital before Yes No
My last tetanus injection was on ____________: ____________
Known allergies __________________________________________
Current medication __________________________________________
Other current treatments __________________________________________
Other previous treatments __________________________________________
Name of GP __________________________________________

If possible please contact the following person:
Name __________________________________________ Telephone ( )
My next of kin is: __________________________________________ Telephone ( )

About my injury
Cut Injuries
I have cut myself
☐ With a blade
☐ With glass
☐ Other __________________________________________

Burn Injuries
I have burnt myself
☐ With a flame
☐ With a cigarette
☐ Other __________________________________________

Overdose
☐ I have overdosed
☐ I have vomited since
Name of drug ___________________________ quantity ___________________________
Strength ___________________________

Use the figure below to mark where you’ve hurt yourself.

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