An Audit of Risk Assessments for Suicide and Deliberate Self-Harm in ED: A Retrospective Review of Quality of Assessments

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Brief back ground information:

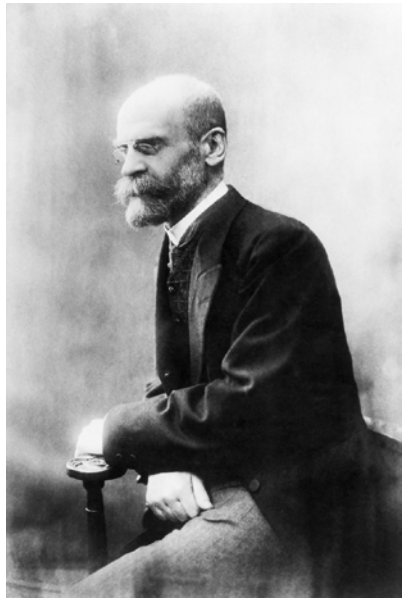
Suicide definition and terminology

- *"The termination of an individual's life resulting directly or indirectly from a positive or negative act of the victim himself which he knows will produce this fatal result"*

  Emile Durkheim (1857)

  - *"the more socially integrated and connected people are the less likely suicide… with social disintegration and isolation, suicide becomes more likely*".

- **Intent to die** versus "*suicidal gesture*"
  1. Suicide (not seen in ED)
  2. Suicide attempt with injuries
  3. Suicide attempt
  4. Suicidal act
  5. Suicidal ideas (SI)



Government Enquiry into MH and Addiction

5th December 2018

- "*Persistently high numbers of people presenting with suicidal thoughts and behaviours*"

- "*Health and social service providers reporting* ***increasingly complex individual*** *and* ***family*** *situations*."

The Office of the Chief Coroner

- Highest suicide rates -1996-1998: 23-24/ 100 000
- Upward trend of suicides in last 3-5 years.
    - In July 2016-7: 606 suicide deaths (12.64 / 100 000)
    - In July 2017-8: 668 suicide deaths (13.67 / 100 000)
- Rates of suicide are higher for **males** (2.46-3.0 x), **Māori** (23.72-28.23 / 100 000) and people living in **high-deprivation** areas.
- NZ **youth suicide rates** (15-19 & 20-24 year age groups – 23.94 and 26.87 / 100 000) are among the highest in the OECD.
    - https://coronialservices.justice.govt.nz/assets/Documents/Publications/Media-Release-August-2020.pdf

What every health worked should know about suicide

- Rare but serious condition
  - 30th June 2019: 685 deaths (i.e.13.93/ 100 000)
  - Rates of intentional self harm: 7267 (i.e.176.7 / 100 000 in 2013)
- National practice guidelines e.g. MOH
- College guidelines e.g. RANZCP, NICE etc
- Organisational policy / guidelines about DSH assessment
    - Requirement for a safety partner
- MHA laws that allow for restraint (e.g. Section 111 - prevention of leaving ED and requiring medical assessment) to involuntary admission under “Sections”.

Clinical Treatment guidelines

- RANZCP: *https://www.ranzcp.org/files/resources/college_statements/clinician/cpg/deliberate-self-harm-cpg.aspx*
- Self Harm – NICE: *https://www.nice.org.uk/guidance/QS34*
- Ministry of Health: Preventing suicide: Guidance for emergency departments - *https://www.health.govt.nz/publication/preventing-suicide-guidance-emergency-departments*
- Ministry of Health: assessment and management of people at risk of suicide. *https://www.health.govt.nz/publication/assessment-and-management-people-risk-suicide*

Who should perform the suicide risk assessment

- Nurses in non-psychiatric care facilities
- ED nurses
- Other ED staff
- Crisis team or other MH staff
- Psychiatrists

Process is as important than content outcome

- Importance of the therapeutic encounter
    - A single DSH psychosocial risk assessment can **reduce** the subsequent risk by about 40%
- The lack of therapeutic relationship should be considered as a **risk factor**
- When insufficient history or lack of rapport, this should alert clinician to seeking additional information or use MHA.
- Asking about suicide does not increase the risk of DSH or suicide (Dazzi T et al; 2014)

Clinical audit

- Determine the quality of psychiatric risk assessments conducted by staff in ED setting.
- Ministry of Health Clinical practice Guideline as the current gold standard of care
  - “Standard” against which care in NZ ED settings would be evaluated.

Methodology:

- Descriptive study
- HDEC approval
- Retrospective review of electronic notes
- Patients who presented to ED over a 12-month period – (1 July 2015-30 June 2016)
- Patients had to have been reviewed by MH clinician.
- 900 patients presented in the prescribed time period.
- Random sample – reviewed 376 files

Measurement tool

- 10-item checklist of measurable activities conducted by front line staff
- Standards like staff training and supervision for MH staff were excluded.
- Item 5 (/10) required completion of a comprehensive suicide assessment: a 16-item checklist was used

Results:

- Females: 112.6 / 100 000
- Males: 72.6 / 100 000
- 12-84 years of age
- Highest rate in 15-24 year old age group: 324.7 / 100 000
- Highest in Maori: (126.7 / 100 000) and next NZ European: (76.2 / 100 000)
- Urban settings 139.8 / 100 000 versus rural settings (67.9 / 100 000)

10-item checklist

- 1. Family / whanau involved in assessment at some point
- 2. Maori identification – culturally appropriate service in assessment
- 3. Additional attempts to verify DSH attempt
- 4. Intoxicated / sedate patients observed in safe place
- 5. Comprehensive risk assessment conducted
- 6. If not admitted, follow up in 72 hours following ED discharge
- 7. patient was included in treatment planning
- 8. Written copy of treatment plans and key contacts given to patient
- 9. GP received a full copy of the assessment
- 10. Potential for further OD considered in the way medications were to be dispensed e.g. close control, 3-7 day prescribing etc.

10- item checklist from CPG: what did we do well?

- Intention, and arrangements for follow up in 72 hours – 91 % of patients were referred for F/U review (cannot guarantee that they arrived for F/U appointments)
- GPs received a copy of Clinical Work Station (CWS) letter (78.5%) – included as a “standard process” in CWS. (But, did the copy indicating that a GP should receive a copy get posted?)
- Patient was included in future treatment planning (68.3%)

10- item checklist from CPG: marginal performance (about 50% mark)

- Family caregiver involvement / contacted (51%)
- Additional attempts to verify DSH information (validate reports / check minimisation etc) – (50. 5%)

10- item checklist from CPG: Worst **recorded** performance

- Culturally appropriate service offered (7.1%)
- Written copies of treatment plan, key contacts etc given to patient / family (25.8%)
- Close control of medications (13.6%)

16-item comprehensive assessment

- Performed best in getting historical information
- Also scored well identifying current SUD's and psychiatric conditions
- Future DSH planning was poorly addressed – "why?"
    - Access to further methods (24%)
    - Attitude to current and immediate future recorded (18.4%)
- Judgements regarding future risk also poorly documented.
- Family / whanau concerns neglected in the notes
    - Family / caregiver concerns identified (36.4%)
    - Family concerns about existing and future safety (27.9%)

Processing the study results: what can we do with the information?

- **Scholar competencies** – validity, reliability etc = what are the limitations and how generalisable are the audit results?
- Aim of CPD ultimately is **positive practice change** – small quality improvement steps in our practices (through the application of new knowledge acquired)
- Small **deliberate steps** of practice change

Psychosocial assessment improvement suggestions:

- “A single DSH psychosocial risk assessment can reduce the subsequent risk by about 40%.”

- History of event helps clarify intent BUT insufficient to determine future safety. SUICIDE RISK REDUCTION / PREVENTION FOCUS.

Psychosocial assessment improvement suggestions:

- Ask about social support systems – to mitigate ongoing risk; improve emotional support and connections

- Ask about **cultural approach** to care.
  - High rates of suicide in **Māori** (males) and DSH **Māori** females

- How can you involve the family in an ethical and safe manner?
  - *Privacy and confidentiality*

- Role of electronic note templates to guide safe practices.