Emergency department self-harm presentations

CLINICAL AUDIT TOOL

Includes all required forms and material

New Zealand GUIDELINES GROUP
Te Rōpū Rarangi Tohutohu
Promoting Effective Health and Disability Services

Purpose of this tool

This audit tool has been developed to assist implementation of best practice in management of self-harm presentations to Emergency Departments within New Zealand. The focus of the audit reflects key recommendations from the guideline *The Assessment and Management of People at Risk of Suicide* (2003) grouped according to 4 specific target areas: Access, Assessment, Discharge and Follow-up.

For the purposes of this audit the term 'self-harm' includes the terms intentional self-harm, deliberate self-harm, and suicidal ideation and intent.

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This audit tool is available at www.nzgg.org.nz

HP 5349

Part one

For part two, see page 13

1. Background

This Emergency Department Self-harm Presentations Clinical Audit Tool has been prepared as part of the work of the Self-harm and Suicide Prevention Collaborative – Whakawhanaungatanga project. This project has been funded since 2005 to secure implementation of the clinical guideline, *The Assessment and Management of People at Risk of Suicide* (NZGG, 2003).

The epidemiological rationale for the project is New Zealand's continuing high suicide rate compared with similar OECD nations (Ministry of Health, 2009). Between 40 and 60 percent of people who commit suicide have had contact with health services, one quarter of these having presented to hospital for self-harm within one year previously (Hawton et al, 2006). Patient experience of the care provided by emergency departments for self-harm presentations is often very poor, creating a significant barrier to effective adherence with treatment and follow-up (Eastwick & Grant, 2004).

District Health Boards (DHBs) participating in the Suicide Prevention Collaborative – Whakawhanaungatanga project have made numerous system changes to improve care to patients who have self-harmed, using 4 national service quality targets developed from the NZGG guideline. The content of this audit tool addresses these 4 specific service quality target areas: Access, Assessment, Discharge and Follow-up (see box). The aim of development of this audit tool is to assist participating DHBs to sustain current improvements and to identify further improvements, and to assist all DHBs to embed improvements in the emergency department care of this patient group. The process of audit tool development has included piloting of the tool in two DHBs, Lakes District Health Board and Taranaki District Health Board.

1.1 Four national service quality targets

The targets are:

Target One: Access

Provision of a competent initial mental health assessment within one hour of arrival at ED.

This target reflects the NZGG guideline recommendation that a person at risk of self-harm or suicide should be triaged at least as code 4 (ie, seen by an ED doctor within 1 hour).

Target Two: Assessment

Provision of a comprehensive assessment, including a cultural assessment for Māori, within 72 hours.

This target reflects the NZGG guideline recommendation that a suitably-trained mental health clinician should be contacted for an assessment whenever anyone seeks assistance following an act of deliberate self-harm or suicidality, and also that the option of specialist Māori input is imperative for competent psychosocial care of Māori who have self-harmed.

Target Three: Discharge

Provision of a discharge plan to all of: the person, their family/whānau and other providers involved in their care.

This target reflects the NZGG guideline recommendation regarding provision of detailed discharge information. Evidence suggests that compliance with follow-up appointments is enhanced by good information about what follow-up to expect, about treatment recommendations, and details of a contact person for follow-up (Spirito & Lewander, 2004).

Target Four: Follow-up

For those at continued risk, follow-up within 48 hours, and follow-up of those who DNA at the follow-up appointment.

This target reflects evidence cited in both NZGG and NICE Clinical Guideline 16 (2004) that there is a period of elevated risk immediately after discharge, as well as evidence that a wait for follow-up care is a significant barrier reducing the patient's motivation to attend follow-up (Hume & Platt, 2007).

1.2 Benefits of the audit: improved care

The process of audit, using the Emergency Department Self-Harm Presentations Clinical Audit Tool, will facilitate quality improvements in clinical capability and clinical processes in relation to presentations with self-harm. Improved clinical care for people presenting with self-harm, as demonstrated by adherence to guideline best practice on the audit tool, is an important end in itself, as is improvements in the experience of care from a consumer perspective.

More timely care to patients presenting to emergency departments with self-harm will also assist DHBs in meeting the 'Shorter Stays in ED Health Target' identified by the government in 2009. In addition, DHBs who meet these standards of care meet the relevant requirements of the National Mental Health Standards (Standards New Zealand 2001).

2. Planning and conducting the audit

> Clinical audit involves a systematic process of identifying best practice, measuring care against criteria, taking action to improve care, and monitoring care to sustain improvement. The aim of this quality improvement process is to effect significant improvements in patient care and outcomes.
>
> National Institute of Clinical Excellence
> www.nice.org.uk

The following information has been compiled to provide practical assistance in conducting an audit using the Emergency Department Self-harm Presentations Clinical Audit Tool. It highlights some key actions which should be considered within the context of each individual DHB and established audit procedures.

The tool is designed for use as a small, focused audit which makes use of existing staff and other resources and which can be completed within existing team and management structures. The entire audit process including planning, reporting and follow-up as detailed below can be completed in 8 weeks or less.

2.1 Initial actions/decisions

The planned audit should have the support of the relevant DHB personnel including:

- Quality and Risk Manager
- Clinical Director, Emergency Department
- Director of Nursing (for Nurse Educators).

Completion of the audit may be undertaken within the ED ongoing clinical audit programme or as a separate exercise – for example, initiated by ED or Mental Health clinical staff with the support of management.

2.2 Two to four weeks before audit

If you are the person taking the leadership role in the audit:

2.2.1 Get the support of clinical leaders

- Meet with the Mental Health Lead in the ED (if there is one). If there is not, meet with the Clinical Director of ED, the Clinical Leader Nursing in ED and the Manager responsible for that department.
- If your DHB has a Nurse Educator ED, and/or a Quality Facilitator (who typically works to the Quality and Risk Manager), approach them both to engage their support for and input into audit planning and completion.
- Explain that the audit is looking at how well ED processes for people presenting with self-harm meet best practice as defined by the guideline *The Assessment and Management of People at Risk of Suicide* (NZGG, 2003).
- Explain how achieving those standards will also help to meet the Ministry of Health Shorter Stays in ED Health Target,* referred to in this document subsequently as the ED 6-hour target. For example, the standards relating to triage, assessment and discharge within the audit tool aid timeliness as well as appropriateness of care, and thus assist in meeting the ED 6-hour target.

  * The target, introduced in July 2009, is defined as: 95 percent of patients will be admitted, discharged or transferred from the Emergency Department within six hours. For further information on the target see www.moh.govt.nz

- Ask for a small group of staff (up to 4) to form an audit team to work with you.

2.2.2 Organise and brief the audit team

- The audit team should include an ED nurse, a Mental Health nurse (the ED Psychiatric Liaison Nurse if your ED has one) and a Mental Health Consumer Advisor. If a Mental Health Consumer Advisor is not available to participate as a member of the audit team, inclusion in the audit as an interview respondent for the Process Evaluation is strongly recommended. If a Māori advisor is available, ensure that person is also an interview respondent for the Process Evaluation if at all possible.
- Organise a meeting with the audit team. Decide who will project manage the audit, who will collect audit data and write-up its findings, when the audit will be done and how the reporting back of the findings will be done (to whom and when).
- Familiarise the audit team with the Emergency Department Self-harm Presentations Clinical Audit Tool.

- Identify who should be interviewed as part of the Process Evaluation section of the audit. Include at least the ED nurse Educator, the team leader, ED staff and ED Triage nurses. Ensure at least one ED doctor is interviewed.
- Allocate which standards on the Process Evaluation section of the audit tool each team member will audit. Provide copies of the audit tool and instructions for audit day. Ensure everyone in the team has a shared understanding of the audit technique of 'triangulation' (see box).

Triangulation:

- allows you to compare what is actually happening with what is required in order to subsequently formulate suitable recommendations
- has three components:
  - checking to see that a process is explained in a current policy, procedure or pathway
  - checking to see whether the process described meets the required standard
  - asking staff to explain how they carry out that process and if possible, observing the process in practice; this may include checking the medical record to see if it was followed.

2.2.3 Schedule the audit

- Consider completing the audit first thing in the morning, when ED staff are typically less busy. The audit can be completed over two mornings if necessary.
- Try to organise some space where the audit team can work. Ideally this will be in the ED. If this is not possible, the audit team may need to interview staff at their work stations.

2.2.4 Access documentation

Pathways, policies and procedures

- Gather together any written pathways, policies or procedures that are relevant to the care of people who present with self-harm.
- Identify how these documents will be reviewed as part of the audit and who will complete this.
- Remember that all policies, and procedures and pathways must be current, have dates and be 'signed off' by relevant managers.

Clinical records

- Contact the Clinical Records Department at least two weeks before the audit to arrange access to at least 20 Clinical Records.
- The records accessed should be for people who have presented to and were discharged from the ED with self-harm, within the last 6 months if possible. These records can be identified by a search for discharges from ED under the codes and/or descriptors that indicate self-harm (eg, overdose, wrist laceration etc).
- You will need the mental health record and the medical record for each presentation, as clinical information you need may be documented across both records (unless the DHB has fully-integrated records).
- In a small DHB, with fewer ED presentations for self-harm, you may need to find presentations from a period of six months or more.

2.3 Day of audit

2.3.1 Early morning briefing meeting

- Have an early morning briefing meeting with the audit team to make sure each member has everything they need (copies of the audit tool, guideline, etc) and is clear about the schedule for the day and the part of the audit they are responsible for completing. Divide topics/interviewees amongst team members making use of the skills and experience you have in the team. Remind the audit team of the need for confidentiality and the importance of patient privacy – especially with respect to information taken from medical records.
- Points for the audit team.
  - Be sure to acknowledge that when trying to interview ED staff, they are working. The needs of the patient come before the need to answer questions for the audit.
  - Try to be quick and efficient and note down fully all the responses and observations you make. Better notes will help you summarise valid findings and formulate recommendations.
  - Have a copy of the NZGG guideline *Assessment and Management of People at Risk of Suicide* (2003) with you for reference if needed (available at www.nzgg.org.nz).

2.3.2 Conducting the audit

- Process evaluation – each team member completes audit of the standards previously assigned, through review of documentation and interviews, using the Process Evaluation form in the audit tool.
- Clinical records evaluation – the records retrieved (20) are divided amongst the audit team and review of each is completed using the Clinical Record Evaluation form in the audit tool.
- Meet mid-morning and at lunchtime to discuss early impressions, solve any emerging problems, and agree priorities for data collection for the rest of the day.

2.3.3 End of the day

- Meet at the end of the day to agree tasks/progress over the next week.

2.4 Three days to one week after audit

Prepare an early written summary of the key findings. Check that clinical leaders are in agreement with the content, and seek their approval to circulate the summary of findings to all ED staff. ED staff should be informed that the full report and recommendations will be sent out later.

2.5 Two to four weeks following audit

A report, containing prioritised recommendations for improvement, should be written following the audit and discussed with clinical leaders.

2.5.1 Developing and prioritising recommendations

This part of the process will involve members of the audit team and may also involve discussion with other relevant ED and Mental Health staff within a meeting specially convened for this purpose.

Developing recommendations

- Review the findings of the audit (what actually happens) and compare these findings with the standard (what should happen as indicated in the audit tool).
- Identify what things need to change and how that could be achieved to meet the standard.

- Use the Recommendations Summary Form (see Part Two) to record the areas to be addressed according to the 4 target areas: Access, Assessment, Discharge, and Follow-up. Copy the relevant standard from the audit form. As the recommendations are formulated, these can be added to the form.
- In formulating recommendations, note that some changes can be readily made within current resources (eg, changing a process, developing a more appropriate form), while other changes will require a broader commitment from the organisation and management sign-off and support (eg, staff training in cultural assessment, a better interview room). These considerations will also influence your prioritisation of recommendations.

Prioritising recommendations

- Prioritise your recommendations so that your DHB has an agenda for what to improve first.
- In selecting recommendations as a priority consider:
  - current DHB priorities (ie, the ED 6-hour target)
  - the potential impact of the recommendation on improving patient outcomes or reducing the risk of harm to patients. For example, a recommendation relating to procedures to ensure people still considered at risk of self-harm are seen for follow-up within 24 hours is likely to be high priority.
- Assign responsibilities and timeframes.
- Record prioritised recommendations, assigned responsibilities and timeframes.
- Seek confirmation from clinical leaders about 3–5 priority recommendations which are to be the focus for ED implementation.

2.5.2 Dissemination of final audit report and recommendations

- Prepare a final report for review by the clinical leaders prior to distribution to other key personnel. The report should include an introduction which highlights the top 3–5 recommendations for implementation.
- Send this report to service or senior managers and others who are able to make decisions about quality improvement activities.
- Circulate a copy to ED staff so that they know what the audit findings are and what changes their clinical leaders have supported and seek to achieve.

2.5.3 Follow-up

- Ensure the summary report containing information about the results of the audit and planned quality improvements has been provided to all relevant managers (see Follow-up Checklist).
- Schedule a re-audit for 2 years time. Re-audit is an essential part of the audit cycle. It allows monitoring of the outcome of changes made, as well as of current performance against targets and offers a mechanism for achieving continuous quality improvements.

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Part two

Emergency Department Self-harm Presentations Clinical Audit Tool:

- Process Evaluation (11 pages)
- Clinical Record Evaluation (4 pages)

Also, Recommendation Summary Form

Emergency Department Self-harm Presentations Clinical Audit Tool: Process Evaluation

Criteria	Evidence sought	Findings	Source I Interview D Documented O Observed	Score (CI,FA,PA,UA, N/A)
Access				
1.0 All people who present with self-harm to the Emergency Department (ED) are seen within one hour **Guideline ref:** Pages 8, 9, 11–18, 21–25	• A current (dated and signed off) written procedure or pathway as part of triage describing how the process for completing the Mental Health (MH) rapid assessment occurs in ED (ie, who does what and when) • The rapid assessment for self-harm presentations is documented in the triage process • ED and MH staff confirm MH and/or Māori Health staff are contacted prior to medical clearance (see also 1.1)			
1.1 Any person triaged as 'at risk' is re-assessed regularly while in ED **Guideline ref:** Pages 5, 27	• There is a current (dated and signed off) written procedure for observation in ED for those who present with self-harm • The clinical risk level is reviewed and documented regularly in ED • ED is staffed appropriately, including after hours (ie, rosters show adequate cover for leave is in place and working)			

For scoring, see page 11.

Abbreviations: CMHT Community Mental Health Team; ED Emergency Department; GP General practitioner; MH mental health

Guideline ref: *see Assessment and Management of People at Risk of Suicide* at www.nzgg.org.nz. Note that page 11 on scoring is part of the Process Evaluation.

Criteria	Evidence sought	Findings	Source I Interview D Documented O Observed	Score (CI,FA,PA,UA, N/A)
1.2 ED staff contact a MH clinician and, as required, Māori health services whenever anyone presents with self-harm **Guideline ref:** Pages 8, 9, 13,14	• Current (dated and signed off) written policy and/or procedure on the communication process ED staff will use to contact MH clinicians and/or Māori health services prior to medical clearance in ED where indicated • Interviews indicated this process was known to: – ED staff – MH staff – Māori Health staff • The communication process is being followed • A current (dated and signed off) written process and policy or procedure to support application in ED of the power to detain under the Mental Health (Compulsory Assessment and Treatment) Act 1992			
1.3 ED staff access current clinical management plan for a person who presents with self-harm and is already a client of MH services **Guideline ref:** Pages 39, 40	• A system of easy access to current MH clinical management plans, especially for those who may frequently present • ED staff interviewed confirm they have this access			

Clinical Audit Tool: Process Evaluation

Criteria	Evidence sought	Findings	Source I Interview D Documented O Observed	Score (CI,FA,PA,UA, N/A)
1.4 People who present intoxicated and at risk of self-harm are provided with a safe environment until sober **Guideline ref:** Pages 15, 20	• ED has a suitable room available for use, as needed, that provides privacy and a safe environment • A current (dated and signed off) written process for ED staff to follow regarding contacting MH services if the person presenting is intoxicated			
1.5 All staff working in ED are competent to undertake a self-harm rapid assessment **Guideline ref:** Pages 11, 13	• ED staff confirm confidence in completing a rapid assessment for self-harm • A competency-based training module for ED staff. Content will include: – perspectives and understandings of working with people who present with self-harm – the assessment tool/s to be used – options for de-briefing and supervision – ED clinicians and Mental Health (Compulsory Assessment and Treatment) Act 1992 • Number of ED staff who have completed the training/the total number of ED staff (as a percentage)			

Clinical Audit Tool: Process Evaluation

Criteria	Evidence sought	Findings	Source I Interview D Documented O Observed	Score (CI,FA,PA,UA, N/A)
1.6 All clinicians who work with people who present with self-harm will be receiving regular clinical supervision **Guideline ref:** Pages 6, 41	• Supervision policy is in place • ED staff give evidence of access to supervision • Supervision contracts and logs give evidence that ED staff have access to supervision • Number of ED staff who work with self-harm presentations and have completed supervision/the total number of ED staff (as a percentage)			
1.7 ED clinicians involve family/whānau and/or significant others in the rapid assessment **Guideline ref:** Pages 5, 20	• The person presenting is asked if they wish to have their family/whānau and/or significant other involved • ED staff are completing the MH rapid assessment tool in conjunction with family/whānau, as appropriate			

Clinical Audit Tool: Process Evaluation

Criteria	Evidence sought	Findings	Source I Interview D Documented O Observed	Score (CI,FA,PA,UA, N/A)
Comprehensive assessment				
2.0 All interviews and MH assessments are conducted in a private and safe setting **Guideline ref:** Page 13	• The ED has a suitable room available for use, as needed, that provides privacy and a safe environment when needed			
2.1 A MH clinician trained in crisis response conducts structured comprehensive MH assessments in ED **Guideline ref:** Page 8	• A trained MH clinician is available 24/7 • The MH clinicians attending ED for self-harm are competent in mental health crisis response • A copy of the previous month's MH 'on call' roster is sighted • Comprehensive MH assessment includes a risk assessment and management plan where indicated			

Criteria	Evidence sought	Findings	Source I Interview D Documented O Observed	Score (CI,FA,PA,UA, N/A)
2.2 A structured comprehensive MH assessment is completed and documented in the ED and MH clinical records **Guideline ref:** Pages 19–24	• ED, MH and Māori Health staff interviewed demonstrate they know this process • There is evidence the process is being followed • The structured comprehensive MH assessment is documented in the clinical records			
2.3 The process in ED and MH supports the involvement of family/ whānau and/or significant others (as appropriate) in comprehensive MH assessment and treatment planning **Guideline ref:** Page 20	• MH and ED staff confirm involvement of family/whānau and/or significant others in the comprehensive MH assessment			

Criteria	Evidence sought	Findings	Source I Interview D Documented O Observed	Score (CI,FA,PA,UA, N/A)
2.4 Cultural and age-related services are offered to the person who presents **Guideline ref:** Pages 31–40	• A current (dated and signed off) written process that requires MH staff to contact appropriate cultural and age-related support if requested by people who present			
2.5 Māori who present with self-harm are offered access to culturally appropriate input when being assessed **Guideline ref:** Pages 33, 34	• Interview with staff demonstrates this occurs			

Clinical Audit Tool: Process Evaluation

Criteria	Evidence sought	Findings	Source I Interview D Documented O Observed	Score (CI,FA,PA,UA, N/A)
Discharge				
3.0 The continuing care provider (ie, GP, CMHT, residential support carer etc) is sent full copies of the ED and MH discharge plans on discharge from ED **Guideline ref:** Pages 17, 27, 28	• A current (dated and signed off) written procedure available to ED and MH staff that details the requirements of discharge for the continuing care provider. This should include responsibilities and timeframes • Both ED and MH discharge information should be provided – preferably on the same form • ED and MH clinical and reception staff are aware of the requirements of the procedure			
3.1 The continuing care provider (ie, GP, CMHT, residential support carer etc) is involved in discharge planning from ED as appropriate **Guideline ref:** Pages 17, 27, 28	• Interview with ED and MH staff confirms that the continuing care provider is involved where possible in the development of the discharge plan			
3.2 A written copy of the discharge plan will include information about medication, treatment plans and key contacts to call **Guideline ref:** Pages 17, 27	• A current (dated and signed off) written procedure in ED details the content of the discharge plan and includes: – next appointment – who is invited to attend (ie, family/ whānau) – information about medication – treatment plan (medical and MH) – key contacts to call – self-management strategies			

Criteria	Evidence sought	Findings	Source I Interview D Documented O Observed	Score (CI,FA,PA,UA, N/A)
3.3 If appropriate, the family/ whānau and/or significant others are involved in discharge planning **Guideline ref:** Pages 6, 20	• ED and MH staff can explain the process for involvement of family/whānau and/or significant others • Where appropriate, the discharge plan is developed in consultation with the person, their family/whānau and key support people (if appropriate) • The person's family/whānau, and key support people are informed of risks and how to support the person • There is access to clinical staff to ask questions			
3.4 Prior to discharge from ED the person presenting and their family/whānau and/or significant others will be given a written copy of the discharge plan **Guideline ref:** Pages 17, 27	• DHB Consumer Advisors and family/ whānau and/or significant others confirm that ED and MH discharge plans are provided prior to discharge from ED			

Clinical Audit Tool: Process Evaluation

Criteria	Evidence sought	Findings	Source I Interview D Documented O Observed	Score (CI,FA,PA,UA, N/A)
Follow-up				
4.0 A person still considered at risk of self-harm post discharge from ED is seen for follow-up within 24 hours **Guideline ref:** Pages 27–29	• A current (dated and signed off) written MH policy/procedure about follow-up post discharge from ED • MH staff demonstrate knowledge of the process described in the policy or procedure for the first follow-up			
4.1 A second follow-up will occur within 24 hours if the person is considered at risk and fails to attend their first follow-up appointment and/or no contact has been made **Guideline ref:** Pages 26–28	• MH and ED staff can explain how this happens in practice			

Scoring

Scoring	Definitions
CI Continuous improvement	Having fully attained the criterion the service can, in addition, clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken based on those findings, and improvements to service provision and consumers, safety or satisfaction as a results of a review process
FA Fully attained	The service can clearly demonstrate implementation (such as practice evidence, training, records, visual evidence) or the process, systems or structures in order to meet the required outcome of the criterion
PA Partially attained	1. There is evidence of appropriate process (such as policy or procedure, guideline), system or structure implementation without the supporting documentation Or 2. A documented process (such as policy or procedure, guideline), system or structure is evident but the service is unable to demonstrate implementation where this is required
UA Unattained	The service is unable to demonstrate appropriate processes, systems or structures to meet the required outcome of the criteria
N/A Not applicable	The service can demonstrate the criterion is not relevant to the service and therefore does not apply

Emergency Department Self-harm Presentations Clinical Audit Tool: Clinical Record Evaluation

Instructions: Complete for 20 records (minimum)

Standard	1	2	3	4	5	6	7	8	9	10	Comments
	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	
Access											
Date and time of presentation to ED											
Date and time of rapid mental health assessment											
Did the person wait longer than one hour?											
Person presenting with self-harm has been triaged at Category 1, 2, 3 or 4											
Were family/whānau and/or significant others present during the rapid mental health assessment?											

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Clinical Audit Tool: Clinical Record Evaluation

Standard	1	2	3	4	5	6	7	8	9	10	Comments
	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	
Were family/whānau and/or significant others involved in the assessment?											
Evidence that contact was made with Mental Health services (and/or Māori Health services if required)?											
Assessment											
Date and time of the comprehensive mental health assessment											
Evidence that the current clinical management plan (if applicable) was available to the assessing ED clinician?											
Evidence that the rapid mental health assessment completed by ED staff on presentation to ED with self-harm is included in the MH clinical record?											
Evidence of risk assessment in MH clinical records?											
Evidence of risk assessment is in the ED clinical record (ie, the medical record)											

Clinical Audit Tool: Clinical Record Evaluation

Standard	1	2	3	4	5	6	7	8	9	10	Comments
	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	
Discharge											
A copy of the ED discharge plan is in the MH clinical record?											
A copy of the MH discharge plan is in the ED (ie, medical) clinical record											
Date and time of discharge plan											
The ED and MH discharge plan includes: • next appointment and that invited to attend? • information about medication and treatment plan (MH and medical)? • key contacts to call? • information on self-management strategies? • information for family/whānau and support people on risks and how to support the person? • contact details for clinical staff if required?											

Clinical Audit Tool: Clinical Record Evaluation

Standard	1	2	3	4	5	6	7	8	9	10	Comments
	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	
Evidence that the continuing care provider (ie, GP, CMHT, residential support carer etc) has been involved in developing the discharge plan?											
Date the ED/MH discharge plan was sent to the continuing care provider (ie, GP, CMHT, residential support carer etc)											
Follow-up											
Date and time of first follow-up											
Was the person seen for follow-up within 24 hours of discharge?											
If the person did not attend first follow-up, date and time of second follow-up											

Emergency Department Self-harm Presentations Clinical Audit Tool: Recommendation Summary Form

Date:

Quality service target	Recommendations
Copy in from the audit tool the relevant criterion/ standard that relates to each recommendation	

Access

Assessment

Clinical Audit Tool: Recommendation Summary Form

Quality service target	Recommendations
Copy in from the audit tool the relevant criterion/ standard that relates to each recommendation	

Discharge

Follow-up

FREE DOWNLOAD

This audit tool is available free online at

www.nzgg.org.nz

The audit tool was developed as part of the New Zealand Guidelines Group Suicide Prevention Collaborative – Whakawhanaungatanga project.