

## The standards

**Standard 1** Appropriate level of care

**Standard 2** Inpatient suicide prevention

**Standard 3** Post-discharge prevention of suicide

**Standard 4** Family or carer contact

**Standard 5** Appropriate medication

**Standard 6** Co-morbidity/dual diagnosis

**Standard 7** Post-incident review

**Standard 8** Training of staff

### STANDARD 1 APPROPRIATE LEVEL OF CARE

Criteria	Audit procedure
1. Patients that are at high risk of suicide and have complex characteristics, as set out in the corresponding audit procedure, are allocated to the Care Programme Approach (CPA).	1. Check that the care plan documents, if appropriate, the allocation to CPA of patients with the following complex characteristics*: a. suicide or violence; b. serious mental disorder; c. a combination of severe mental illness and self-harm or violence; d. homelessness; e. severe mental illness and are lone parents; f. substance misuse disorder.
2. CPA documentation forms part of case notes/electronic records and is not maintained separately.	2. Check that the care plan is filed with the case notes/electronic records.
3. The trust has an up-to-date policy on CPA.	3. Observe the written evidence or operational CPA policy. Confirm trust policy was appropriately developed and ratified in accordance with governance arrangements.

#### NOTES

1. Ask the ward manager to explain how this standard is monitored through clinical governance processes.
2. The criteria above should be monitored through clinical governance and audit care forums to assist in identifying positive themes and practice.

\* For additional examples of complex characteristics see *Refocusing the Care Programme Approach*.<sup>4</sup>

## STANDARD 2 INPATIENT SUICIDE PREVENTION

National Mental Health Development Unit's *Strategies to Reduce Missing Patients: A Practical Workbook*<sup>5</sup> is particularly helpful with respect to Standard 2.

Criteria	Audit procedure
1. Risk assessments and care plans should be undertaken by a multi-disciplinary team (MDT).	1. To ensure risk assessments and care plans are being completed correctly: <ol style="list-style-type: none"> <li>Check that staff are demonstrating the process which is documented in the risk assessments and care plans, for example, observation/engagement.</li> <li>Verify that staff remain vigilant and remove objects of potential harm such as plastic bags, phone chargers and medications from high-risk patients on continuous observation/engagement.</li> <li>Make sure that patients who have had their level of observation/engagement increased since their last documented risk assessment have been recently* risk assessed by the MDT prior to being granted leave from the ward.</li> <li>Check that the care plan refers to increased observation/engagement required in periods of increased risk.</li> <li>Obtain records of observation/engagement and check that they:               <ol style="list-style-type: none"> <li>match nationally prescribed levels of observation (National Institute for Health and Clinical Excellence (NICE) clinical guideline 25) based on the patient's risk level;</li> <li>do not contain any gaps in frequency of observation.</li> </ol> </li> <li>Ensure the notes specify actions to take account of the increased risks associated with the mood of a patient suddenly improving.</li> <li>Check that the care plan does not document periods of leave or time off the ward while patient is under observation/engagement.</li> </ol>
2. Wards are audited at least annually to identify and minimise opportunities for hanging or other means by which patients could harm themselves.	2. Ask the ward manager for a copy of an environmental risk assessment for the ward and other areas that patients have access to. Check that: <ol style="list-style-type: none"> <li>it has been undertaken within the last year;</li> <li>it recommends improvements that have been implemented, where possible;</li> <li>it identifies likely opportunities for hanging or other means of suicide;</li> <li>it includes local arrangements for removal or coverage of likely ligature points on inpatient units;</li> <li>if a separate ligature point audit has been undertaken, the results have been included in the overall audit report;</li> <li>wards have a single main exit;</li> <li>high-risk areas have been identified (e.g. bathrooms, garden areas);</li> <li>there is a local policy/guidance on the removal of high-risk items during observation and engagement.</li> </ol>
3. Observation and engagement policy and practice reflects current evidence about suicide risk found in your risk assessments.	3. To ensure your observation/engagement policy and practice reflects your trust's current risks, the following checks should be taken: <ol style="list-style-type: none"> <li>Confirm the ward has a daily therapeutic/activity programme** that high-risk patients are attending.</li> <li>Examine a copy of the current observation/engagement policy and check that it makes reference to periods of increased risk*** and includes guidance to raise or lower the level of observation.</li> <li>Ensure the ward has a clear policy on the use of agency and bank staff undertaking observation/engagement of high-risk patients.</li> <li>Make sure the trust has a policy/guidance in place for the training of agency and bank staff before they undertake any clinical procedures.</li> <li>Ensure all staff have received training on the observation/engagement policy.</li> <li>Check that the trust has a clear policy regarding search strategies and all staff are trained in this procedure.</li> </ol>
4. A protocol has been developed to allow staff to remove all items which could be used to self-harm as well as potential ligatures (belts, shoelaces, mobile chargers etc) from patients at high risk of suicide, when appropriate.	4. Ask the ward manager whether a protocol has been developed in consultation with service users and/or carers for the removal of potential ligatures and other suicide methods from high-risk patients.
5. Environmental difficulties in observing patients are made explicit and remedial action is taken as far as possible to reduce risk to the patient.	5. Identify whether or not there are environmental problems for observation and engagement and, if so, that they include local arrangements for remedial action. For example, staff could move high-risk patients to a safer area within the ward while an environmental risk is being removed. Procedures should be in place for environmental difficulties to be reported regularly to the trust's board.

\* Since the patient's observation/engagement level was increased.

\*\* This should include programmes such as cognitive behavioural therapy (CBT), daily living skills exercise, relaxation, and anxiety management.

\*\*\* Examples of periods of increased risk include evenings and night-time, times at reduced levels of observation/engagement or times where there have been gaps in observation/engagement.

## STANDARD 3 POST-DISCHARGE PREVENTION OF SUICIDE

Criteria	Audit procedure
1. Prior to discharge, inpatient and community teams should carry out a joint CPA case review.	1. The following should be completed as part of the joint CPA case review: <ol style="list-style-type: none"> <li>Check that the joint CPA review and up-to-date risk assessment (including input from inpatient and community staff) are with the inpatient notes/electronic record*. When the patient lacks capacity, the team has the authority to act in the patient's best interest.</li> <li>The discharge care plan should specify arrangements for promoting compliance/engagement with treatment.</li> <li>Ensure assertive outreach teams have been established to prevent loss of contact with vulnerable and high-risk patients.</li> <li>If assertive outreach teams have not been established, identify what plans there are to do so or who undertakes this task.</li> <li>Discharge planning should include contributions from significant others. If a patient does not consent to family/carers/significant others contributing, it is imperative that staff are aware that, in certain circumstances, they can legally ascertain this information through the MDT where there are concerns of severe harm to the patient or others.</li> <li>Check that the care plan documents that family/carers have received information on how to help patients engage with treatment plans.</li> <li>Check that the joint CPA review includes a risk assessment of the patient and evidence that the patient was involved in this process.</li> </ol>
2. Care plans take into account the heightened risk of suicide in the first three months after discharge and make specific reference to a follow up within the first 48 hours.	2. Checking the following will help to ensure staff have addressed the heightened risk of suicide patients experience post-discharge: <ol style="list-style-type: none"> <li>An agreed member of staff should establish that the patient has a discharge plan or leave that was planned with the patient's involvement. Even if consent is not given, carers should be involved if the MDT believes their involvement outweighs the confidentiality shared with the patient**.</li> <li>Check that the care plan includes actions related to heightened risk in the first three months after discharge, with the patient and carers' involvement, where appropriate.</li> </ol>
3. Patients who have been at high risk of suicide during the period of admission are supported by telephone contact with ward staff or an identified alternative when on leave or discharge. They should also have a 'return to the ward' plan identified in their care plan.	3. Check that the discharge care plan indicates whether problems with compliance/engagement are anticipated and what actions*** are to be taken.

\* This should include a list of inpatient staff, community staff and carers who attended the review.

\*\* The MDT should look at their trust's policy on family and carer involvement as well as the General Medical Council's document on *Confidentiality*.<sup>6</sup>

\*\*\* For example, visiting or interviewing the patient, adjusting prescribed medication, carer/family involvement (only if consent is given), psychological intervention, blood levels analysis etc.

## STANDARD 4 FAMILY OR CARER CONTACT

Criteria	Audit procedure
<p>1. The trust has a policy/guidance on carers discussing their views and concerns with members of staff. If a patient does not give consent to contact family/carers/significant others, it is imperative that staff are aware that, in certain circumstances, they can legally ascertain this information through the MDT where there are concerns of severe harm to the patient and/or others*.</p>	<p>1. In order to ensure carer contact was successfully managed:</p> <ol style="list-style-type: none"> <li>Check records to establish whether the patient gave consent for staff to make contact with family/carers. If consent was not given and the team still made contact, ensure their justification is appropriate and is documented in the records.</li> <li>If consent is given, ensure families/carers are given the opportunity to contribute to the gathering of information in the assessment process.</li> <li>If consent is given, check whether the patient's records document that family/carers have been given a clear procedure for making contact with an appropriate member of staff** at all times.</li> </ol>
<p>2. If consent is given, family and carers are contacted within three working days of admission and are given clear mechanisms for making contact with an informed member of the clinical team at all times. This will be recorded on the care plan and a copy given to the patient.</p>	<p>2. In cases of actual suicide or serious self-harm there is written evidence in the clinical records that a member of staff was made responsible for ensuring that the family/carers were promptly informed of actions being taken, if consent is given.</p>
<p>3. All clinical staff receive training on carer's rights and involvement in assessment, care planning and discharge.</p>	<p>3. Check that the trust has a policy/guidance on training staff in engaging with families and carers or significant others.</p>

\* It is an expectation that an adequate mental health assessment, for example, the risk assessment, seeks information from significant people but this must be undertaken with great sensitivity to respect the patient's wishes not to tell family/carers anything about their condition, treatment, care or circumstances. Justification for doing this should be recorded in the notes/electronic record.

\*\* For example, key worker, care co-ordinator, primary nurse, responsible clinician etc.

## STANDARD 5 APPROPRIATE MEDICATION

A specialist mental health pharmacist should be involved in the completion of this standard due to its pharmaceutical complexity.

Criteria	Audit procedure
<p>1. Patients who are considered to be at risk of medicine-related self-harm should have their medicines risk assessed and, where necessary, action taken to further minimise risk.</p>	<p>1. The actions below must be followed to comply with the corresponding criterion.</p> <ul style="list-style-type: none"> <li>a. There should be a periodic* review and rationalisation of patients' medicines to ensure desired outcomes continue to be achieved, whilst minimising the potential for harm through side effects or self-harm.</li> <li>b. For those patients deemed to be at risk of self-harm, the potential for harm if taken in overdose should be considered as a factor in the choice of medication. Strategies** should be put in place to minimise the opportunities for prescribed medication to be used as a means of self-harm.</li> <li>c. For patients with a history of self-harm in the previous three months, records should be checked and actions taken to ensure that they have documented plans to minimise the potential for medicines to be used as a means of self-harm and that, where applicable, carers understand all written information/guidance.</li> <li>d. Records are checked and actions taken to ensure that, where psychotropic medication has not achieved the desired outcomes (non-adherence), or clinical depression is a possible side effect of drug treatment, evidence-based strategies are implemented to improve outcomes and minimise the potential for medicine-related harm.</li> </ul>
<p>2. Patients who are prescribed psychotropic medication as a treatment choice and are considered to be at risk of medicine-related self-harm should be monitored and given appropriate information to enable them to make an informed choice and to enable carers to contribute towards the decision-making.</p>	<p>2. The actions below must be followed to comply with the corresponding criterion.</p> <ul style="list-style-type: none"> <li>a. Care plans and/or discharge letters are checked and actions taken to ensure that explicit advice is given to each patient's General Practitioner about appropriate monitoring, prescribing quantities and risks associated with any other medicines the patient is taking.</li> <li>b. Records are checked and actions taken to ensure that patients and, where appropriate, carers are given appropriate information and have had the opportunity to express their views regarding the choice of medication.</li> </ul>

\* The frequency of this review is related to each patient's individual situation and, as such, a clinical judgement must be made on an individual basis.

\*\* For example the removal of unused medication, prescribing/dispensing in limited quantities, observing administration of therapy etc.

## STANDARD 6 CO-MORBIDITY/DUAL DIAGNOSIS

Criteria	Audit procedure
1. Strategy exists for the comprehensive care of people with co-morbidity/dual diagnosis (i.e. people with mental health problems and a substance misuse disorder).	1. Ask the ward manager for a copy of the co-morbidity/dual diagnosis strategy. Check that it covers: <ol style="list-style-type: none"> <li>a. liaison between mental health and substance misuse services, statutory and voluntary agencies;</li> <li>b. staff training in co-morbidity/dual diagnosis;</li> <li>c. the appointment of key staff to lead clinical developments.</li> </ol>
2. Staff who provide care to people at risk of suicide are given training in the clinical management of cases of co-morbidity/dual diagnosis approved by employing organisations.	2. To ensure staff are provided with appropriate training: <ol style="list-style-type: none"> <li>a. Ask the ward manager whether the organisation approves training programmes in co-morbidity/dual diagnosis;</li> <li>b. Ask the ward manager for training records and identify how many staff have received approved training in co-morbidity/dual diagnosis in the last three years.</li> </ol>
3. Information for co-morbidity/dual diagnosis is collected and used to inform decision making on specialist resources.	3. Ask service directors whether the organisation collects, analyses and uses data relating to co-morbidity/dual diagnosis (e.g. in contracting, planning services and training).

## STANDARD 7 POST-INCIDENT REVIEW

Criteria	Audit procedure
1. The trust has a policy/guidance on all incident reviews.	1. Check that the organisation's Serious Untoward Incident (SUI) policy, in particular, was followed.
2. Suicides and serious suicide attempts are reviewed in a multi-agency forum within a reasonable time to include, as far as possible, all staff involved in the care of the patient.	2. To ensure the review was carried out properly: <ol style="list-style-type: none"> <li>Check that a multi-disciplinary review was undertaken within two weeks of a suicide or serious suicide attempt in order to inform the multi-agency forum.</li> <li>Check that all key staff involved in the patient's care also attended the serious incident review.</li> </ol>
3. All staff, patients and families/carers affected by a suicide or a serious suicide attempt are given prompt and open information and the opportunity to receive appropriate and effective support as soon as they require it.	3. To ensure that support was offered to the family/carers: <ol style="list-style-type: none"> <li>Check that there is a record of whether a member of staff was made responsible for ensuring that the family/carers were offered support and, with the patient's consent, were kept informed of any developments.</li> <li>Ask the ward manager for a list of all suicides and serious suicide attempts over the past year. Examine records of post-incident reviews for the following:               <ol style="list-style-type: none"> <li>Check that there is a record that family/carers were offered support.</li> <li>Check that there is a record that support for staff was made available and establish what this consisted of. Ask the manager how its adequacy is ensured.</li> </ol> </li> </ol>
4. All staff, patients and families/carers affected by a suicide or a serious suicide attempt are given an opportunity to contribute to the SUI review and the final report.	4. To ensure the SUI review is carried out properly: <ol style="list-style-type: none"> <li>Check that specific local arrangements and recommendations were identified.</li> <li>Check that a report of the review was produced and that it was shared with the family/carer.</li> <li>Check that the board received the reports that were produced and details of themes that emerged.</li> </ol>

## STANDARD 8 TRAINING OF STAFF

Criteria	Audit procedure
1. All care staff in contact with patients at risk of self-harm or suicide receive training in the recognition, assessment and management of risk at intervals of no more than three years.	1. Obtain copies of service/ward training records. If none are available, ask the ward manager for the information. Then: <ol style="list-style-type: none"> <li>a. Identify how many currently employed staff have received training in risk in the last three years (express as proportion of relevant staff).</li> <li>b. Ask the ward manager what plans there are to ensure that all care staff are trained every three years.</li> </ol>
2. The training is approved by the organisation.	2. Ask the ward manager if risk training courses are formally approved by the organisation.
3. The training is comprehensive, evidence-based and up-to-date. The quality and effectiveness of the training is continuously evaluated in light of National Confidential Inquiry reports.	3. Obtain copies of any training programmes. Check whether the following are covered by the course: <ol style="list-style-type: none"> <li>a. indicators of risk;</li> <li>b. high-risk periods;</li> <li>c. managing non-compliance;</li> <li>d. managing loss of contact;</li> <li>e. communication between services, agencies, professionals, users and carers;</li> <li>f. <i>Mental Health Act (2007)</i>.</li> </ol>