NHS
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National Reporting and Learning Service

Preventing suicide

A toolkit for mental health services

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- Greater Manchester West Mental Health NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Trust
- Oxleas NHS Foundation Trust
- Suffolk Mental Health Partnership NHS Trust

Foreword

Suicide prevention continues to be a key national priority for public health and mental health services. People with mental health problems are a particularly high-risk group and it is vital that mental health services continue to strengthen clinical practice if suicides are to be prevented.

In December 2006, the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) published *Avoidable Deaths: five year report of the national confidential inquiry into suicide and homicide by people with mental illness*.[1] This report outlined a number of positive findings and reflected the continuing fall in inpatient suicides. However, this report also highlighted continuing concerns in a number of areas including:

- inpatients dying by suicide whilst being off the ward without permission;
- the transition from inpatient to community care;
- the management of risk and risk assessment.

These concerns were also reflected in the more recent annual report of NCISH, published in July 2009.[2] This reported a fall in patient suicides overall but highlighted a number of areas for improvement.

The National Patient Safety Agency (NPSA) has updated this toolkit to take account of the lessons we have learnt since the original toolkit was published in 2003. It also reflects the changes in mental healthcare that have happened since that time. The toolkit continues to provide a simple method by which mental health services can measure the extent to which they are addressing the standards outlined in the toolkit.

I am pleased to commend this revised toolkit to all mental health services.

Professor Louis Appleby
National Director for Mental Health

Contents

Introduction

The safety of inpatients on mental health wards (and prison healthcare units) is the number one priority for all staff and service users. To maintain patient safety, regular audits should take place to monitor and reduce any dangers in the design, equipment and organisation of the ward, care interventions, and the service user's experience.

The original Suicide Prevention Toolkit (produced by Greater Manchester West Mental Health NHS Foundation Trust through the National Institute for Mental Health in England) was produced following the launch of the National Suicide Prevention Strategy in 2002.[3] The key recommendations were divided into eight standards, which provided mental health services with a framework to address the patient's experience of their care pathway from crisis to admission, through to discharge.

Nationally there has been a decline in inpatient suicides over the last 10 years; however it still remains a high priority as suicide is the main cause of premature death in people with mental illness.

The aims of the toolkit are to:

- support mental health organisations in establishing a system for suicide audit which fits their local context;
- promote the use of case note review as a means of changing how mental health organisations identify risks and measure performance;
- support the development of local suicide prevention strategies;
- produce data which could potentially be merged at regional and national levels to identify trends for further learning.

By identifying risk, carrying out regular audits and focusing on the areas that need the most attention, mental health services will be able to increase their compliance with each of the standards and provide a safer service for users.

Dr Kevin Cleary
Medical Director
National Patient Safety Agency

Overview and instructions

Set out in this first section are details of how to use the toolkit, including an explanation of the assessment tools and the use of case note review, and an example completed audit form and checklist. The eight standards are then set out, and a list of useful resources. All the documents required to use this toolkit are available to download from **www.nrls.npsa.nhs.uk/preventingsuicide**

THE STANDARDS

The eight updated standards contained in the toolkit reflect changes in practice that have occurred in mental health in the last six years. The standards are organised to look at the process of admission through to discharge of a working age adult from the ward environment. Accompanying these standards are detailed audit procedures which will help you measure your current practice and identify areas for improvement.

It is necessary to read through each of the standards prior to commencing the Ward Manager Checklist or the General Audit Tool, in order to provide you with a more detailed context for each standard criteria.

ASSESSMENT

The toolkit has two levels of assessment. It is recommended that the Ward Manager Checklist is undertaken on a monthly basis and that the General Audit Tool is undertaken on an annual basis. It is recommended that organisations print the performance summary worksheet (radar diagram and performance dashboard – see figures 2 and 3) to provide both frontline staff and the board with regular feedback on the level of care. However, if your trust has a well-functioning method of updating both the frontline staff and the board on such clinical matters there is no need to adopt a new practice.

General Audit Tool

The General Audit Tool provides inpatient mental health service providers with an annual method of tracking and measuring the level of care provided to patients at risk of suicide or self-harm. It provides a comprehensive view of the level of adherence to the suicide prevention standards contained in the updated toolkit and combines a review of trust policy, environmental and patient risk assessments, and the review of a small sample of patient records. It is recommended that the General Audit Tool is used on an annual basis.

The General Audit Tool contains a radar diagram and performance dashboard that are automatically generated after completing responses to each of the questions; audit questions relevant to each of the eight standards; and an action plan that lists all actions that have not reached 100 per cent compliance in the sample of inpatient case notes reviewed.

Ward Manager Checklist

The Ward Manager Checklist can be quickly and easily used in each ward. It allows ward managers to review the level of care on a monthly basis.

The checklist provides mental health wards with an up-to-date method for measuring and tracking the patient experience. The checklist compares practice against agreed standards. A radar diagram and dashboard give a pictorial easy-reference display of performance.

Figure 1 – Ward Manager Checklist (example of completed checklist)

Please state 'Yes', 'No', or 'Not applicable' in each of the following boxes. If your answer is 'Not applicable' please state why in the comments section.

Audit Question			Patient					Comments
PATIENT RECORDS			1	2	3	4	5	
Patient records	1.1	Was the care plan filed with the case notes/electronic records?	Yes	Yes	Yes	Yes	Yes	
	1.2	Has a risk assessment been undertaken and included with the case notes/electronic records?	Yes	Yes	Yes	Yes	no	
CPA patients	2.1	Does care plan reflect that patient is allocated to CPA?	no	no	no	no	Yes	
	2.2	Has the care plan/risk assessment been shared with the multi-disciplinary team?	no	no	no	no	no	
	2.3	Prior to discharge, has the team carried out a joint CPA review?	Yes	Yes	Yes	Yes	Not applicable	Patient 5 committed suicide prior to a joint CPA review being started
	2.4	Does the joint CPA review include a risk assessment?	Yes	Not applicable	Not applicable	Not applicable	Not applicable	
	2.5	Is there evidence that the patient was involved in this assessment?	no	Not applicable	Not applicable	Not applicable	Not applicable	
Observation and engagement	3.1	Is the patient under increased observation and engagement?	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	None of our patients were under increased observation and engagement
	3.2	If the patient was allowed leave from the ward, was a recent risk assessment undertaken?	No	Yes	Yes	Yes	Yes	
	3.3	At times of increased risk does the care plan reflect increased observation?	Yes	No	Yes	Yes	No	
	3.4	Is there any discrepancy between the patient record and prevailing national guidelines (NICE clinical guideline 25) on observation?	Yes	No	Yes	No	Yes	
	3.5	Have changes in the patint's mood been recorded in the care plan?	Yes	No	Yes	Yes	Yes	
	3.6	Did the patient attend a daily therapeutic/activity programme?	Yes	Yes	Yes	No	Yes	

Figure 2 – Radar diagram (example of completed General Audit Tool)

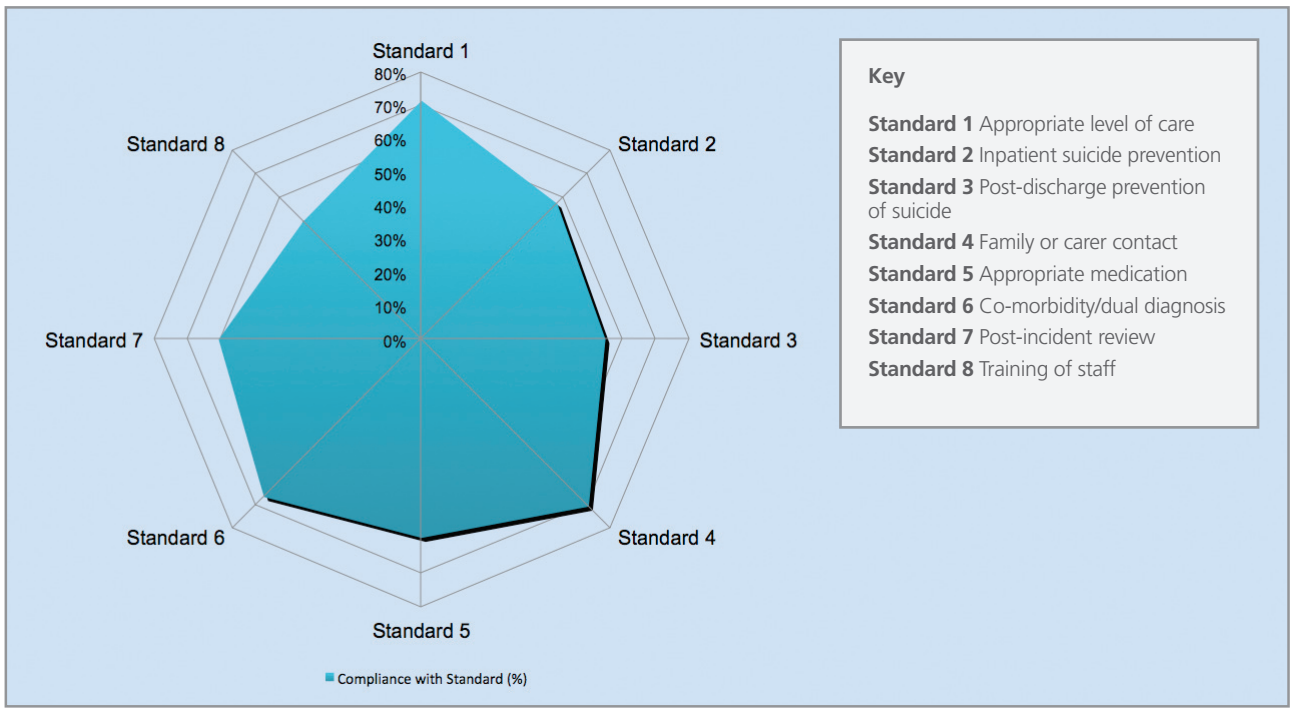
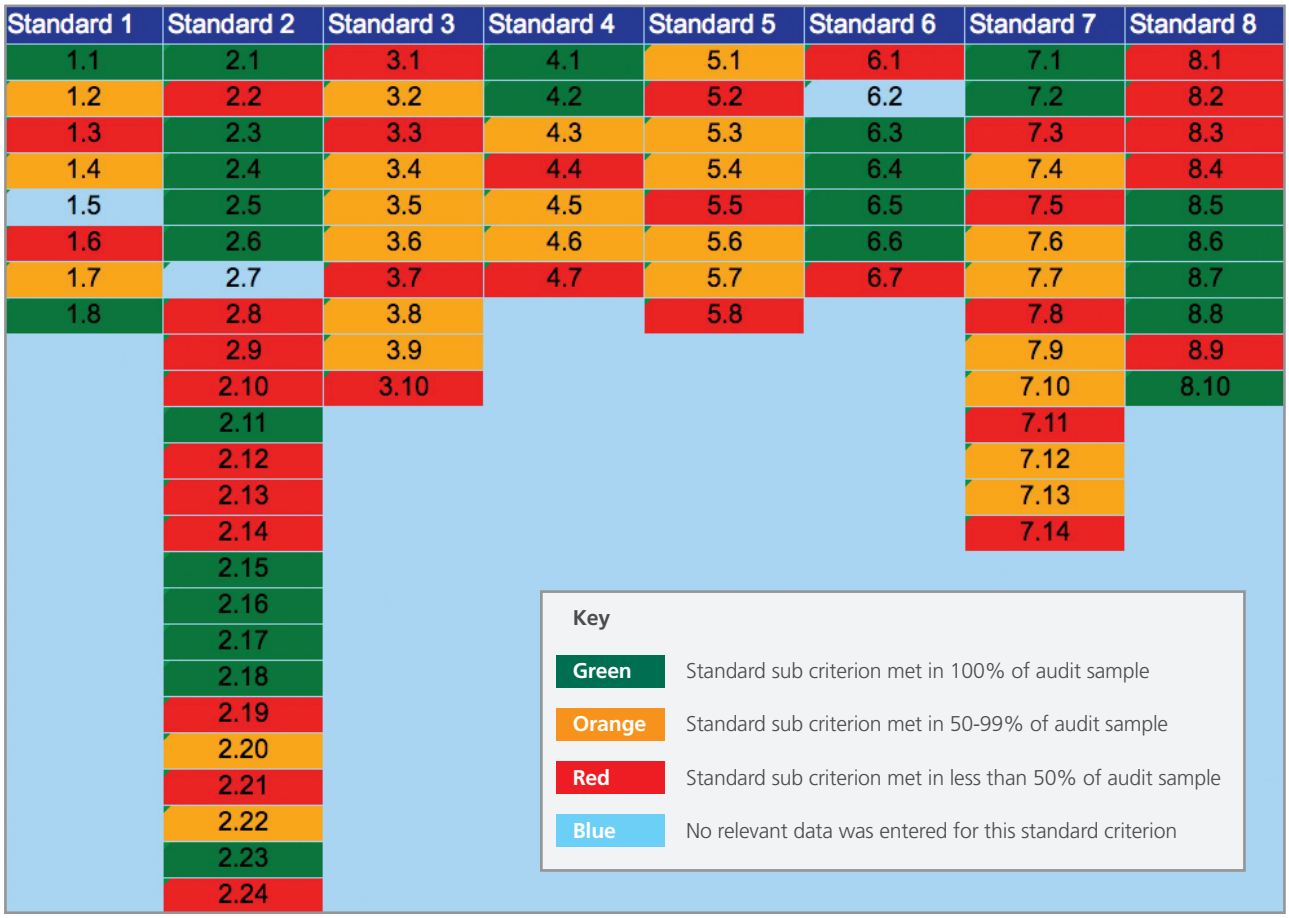


Figure 3 - Performance Dashboard (example of completed General Audit Tool)



Summary of assessment tools

	Ward Manager Checklist	General Audit Tool
Who?	Ward manager	Governance/audit team and specialist mental health pharmacist (for standard 5)
How often?	Monthly	Annually
Where applicable?	Inpatient mental health settings that provide services to working age adults	
Why?	Provides a quick, measurable overview of the organisation's performance against the standards. Auto-generates performance charts that can be shared with your colleagues on a monthly basis to assess the trust's progress against the standards.	Provides a comprehensive, measurable view of the organisation's performance against the standards. Auto-generates performance charts that can be shared with your colleagues on an annual basis to assess the trust's progress against the standards. Auto-generates an action plan based on the standards that your unit has not been fully compliant with.
Approximate time to complete?	60 minutes	6.5 hours

NOTE
In the toolkit we refer to the 'Care Programme Approach' (CPA). During the piloting of this toolkit we found many trusts do not use the term CPA internally when referring to those patients who have complex and serious cases. The most common alternate term used was ICPA which is used to abbreviate both 'Inpatient Care Programme Approach' and 'Integrated Care Programme Approach', although the Department of Health's *Refocusing the Care Programme Approach*[4] mentions that the ICPA is meant to support the CPA, not replace it.

INPATIENT CASE NOTE REVIEW

The Ward Manager Checklist and General Audit Tool assess compliance with the standards set out in this toolkit.

Suggested procedure

1. Randomly select case notes of five previous inpatients from your ward who were assessed as being at high risk of suicide or self-harm.
2. Obtain any relevant staff training records from the ward to complete the Ward Manager Checklist and General Audit Tool.
3. Speak to relevant staff members to provide clarity and context to aid the completion of the Ward Manager Checklist and General Audit Tool.
4. Post the performance summary on the ward and give it to the board so that both frontline staff and the board are able to see the progress that is being made.
5. Develop timetabled local arrangements with clinical teams to address any standards which have not been fully met.
6. Re-audit the service on the date agreed in the local arrangements.

Guidance notes

1. When reviewing each set of case notes against the standard criteria you should look at the entire duration of the patient's most recent admission.
2. Patients who attempted and completed suicide as well as those at high risk of suicide or self-harm while an inpatient should be included in your review.

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 critera 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*.[4]

STANDARD 2 INPATIENT SUICIDE PREVENTION

National Mental Health Development Unit's *Strategies to Reduce Missing Patients: A Practical Workbook*[5] 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: a. Check that staff are demonstrating the process which is documented in the risk assessments and care plans, for example, observation/engagement. b. 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. c. 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. d. Check that the care plan refers to increased observation/engagement required in periods of increased risk. e. Obtain records of observation/engagement and check that they: i. match nationally prescribed levels of observation (National Institute for Health and Clinical Excellence (NICE) clinical guideline 25) based on the patient's risk level; ii. do not contain any gaps in frequency of observation. f. Ensure the notes specify actions to take account of the increased risks associated with the mood of a patient suddenly improving. g. Check that the care plan does not document periods of leave or time off the ward while patient is under observation/engagement.
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: a. it has been undertaken within the last year; b. it recommends improvements that have been implemented, where possible; c. it identifies likely opportunities for hanging or other means of suicide; d. it includes local arrangements for removal or coverage of likely ligature points on inpatient units; e. if a separate ligature point audit has been undertaken, the results have been included in the overall audit report; f. wards have a single main exit; g. high-risk areas have been identified (e.g. bathrooms, garden areas); h. there is a local policy/guidance on the removal of high-risk items during observation and engagement.
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: a. Confirm the ward has a daily therapeutic/activity programme** that high-risk patients are attending. b. 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. c. Ensure the ward has a clear policy on the use of agency and bank staff undertaking observation/engagement of high-risk patients. d. Make sure the trust has a policy/guidance in place for the training of agency and bank staff before they undertake any clinical procedures. e. Ensure all staff have received training on the observation/engagement policy. f. Check that the trust has a clear policy regarding search strategies and all staff are trained in this procedure.
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: a. 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. b. The discharge care plan should specify arrangements for promoting compliance/engagement with treatment. c. Ensure assertive outreach teams have been established to prevent loss of contact with vulnerable and high-risk patients. d. If assertive outreach teams have not been established, identify what plans there are to do so or who undertakes this task. e. 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. f. Check that the care plan documents that family/carers have received information on how to help patients engage with treatment plans. g. Check that the joint CPA review includes a risk assessment of the patient and evidence that the patient was involved in this process.
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: a. 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**. b. 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.
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*.[6]

*** 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
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*.	1. In order to ensure carer contact was successfully managed: a. 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. b. If consent is given, ensure families/carers are given the opportunity to contribute to the gathering of information in the assessment process. c. 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.
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.	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.
3. All clinical staff receive training on carer's rights and involvement in assessment, care planning and discharge.	3. Check that the trust has a policy/guidance on training staff in engaging with families and carers or significant others.

* 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
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.	1. The actions below must be followed to comply with the corresponding criterion. 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. 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. 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. 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.
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.	2. The actions below must be followed to comply with the corresponding criterion. 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. 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.

* 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: a. liaison between mental health and substance misuse services, statutory and voluntary agencies; b. staff training in co-morbidity/dual diagnosis; c. the appointment of key staff to lead clinical developments.
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: a. Ask the ward manager whether the organisation approves training programmes in co-morbidity/dual diagnosis; 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.
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: a. 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. b. Check that all key staff involved in the patient's care also attended the serious incident review.
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: a. 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. b. 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: i. Check that there is a record that family/carers were offered support. ii. 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.
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: a. Check that specific local arrangements and recommendations were identified. b. Check that a report of the review was produced and that it was shared with the family/carer. c. Check that the board received the reports that were produced and details of themes that emerged.

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: a. Identify how many currently employed staff have received training in risk in the last three years (express as proportion of relevant staff). b. Ask the ward manager what plans there are to ensure that all care staff are trained every three years.
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: a. indicators of risk; b. high-risk periods; c. managing non-compliance; d. managing loss of contact; e. communication between services, agencies, professionals, users and carers; f. *Mental Health Act* (2007).

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Useful resources

To accompany the standards

1. Appropriate level of care

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