A nurse-led pathway to treat self-harm injuries

Challenges of attending accident and emergency units with patients presenting with minor injuries caused by self-harm were overcome via a nurse-led care pathway

In this article...

- Challenges of attending A&E with patients who self-harm
- What the initiative aimed to achieve
- How the pathway benefits staff and patients

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Self-harm occurs frequently in psychiatric hospitals and other mental health and outpatient settings. Many patients at the Ayr Clinic are at risk of self-harm and often access the local accident and emergency service for minor injury care.

The medical and nursing response to people who repeatedly self-harm, given increasing pressures and dwindling A&E resources, can often be one of impatience, frustration and hostility.

A nurse-led pathway was developed by the Ayr Clinic and NHS Ayrshire and Arran to fast-track the assessment and treatment of such injuries and improve health professionals’ attitudes towards these patients. This project was winner of the Nursing Times emergency and critical care award 2014.

The Ayr Clinic is provides secure, specialist mental healthcare in Scotland. Since 2013, staff have worked with NHS Ayrshire and Arran to develop a fast-track assessment and treatment pathway to be used by the clinic as well as accident and emergency staff to speed up and improve the assessment, admission and treatment of patients who present with minor injuries caused by self-harm.

The pathway was designed in response to a significant increase in A&E attendances by patients from the clinic who had deliberately self-harmed and needed minor injuries treated. Such attendances often resulted in assaults on clinic and NHS staff, as well as patients absconding.

An audit of A&E attendances before and after the service was introduced and discussions with clinic and A&E staff indicate significant value in the fast-track process.

Rationale for the new pathway

The Ayr Clinic in Ayrshire is a low-secure hospital for male and female patients with mental illness or personality disorder. Many are at risk of self-harm and their physical health is poorer than average. As a result, we need to work closely with local acute care provision.

Self-harm can be a way of coping with or expressing overwhelming emotional distress. It is encountered frequently in psychiatric hospitals and outpatient settings (Klonsky et al, 2006); patients who engage in it often have a variety of diagnoses including:

- Substance misuse;
- Eating disorders;
- Post-traumatic stress disorder;
- Major depression;
- Anxiety disorders;
- Schizophrenia;
- Personality disorders including anti-social personality disorder and borderline personality disorder.

Self-harm by patients who have a personality disorder – often resulting in a minor injury that requires frequent and repeated medical assessments and interventions – can be a difficult experience for both patients and health professionals. Because of patients’ presenting conditions and associated symptoms, including frequent self-harm, health professionals can develop strong negative feelings towards them (Sampson et al, 2006).

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- Challenges of attending A&E with patients who self-harm
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5 key points

1 Patients with a personality disorder who regularly self-harm often attend A&E for minor injuries

2 The fast-track service allows staff to manage risk to patients and escorting staff more effectively

3 Assessment of minor trauma by clinic staff ensures speedier care and treatment

4 Joint training and staff support cuts costs and improves care

5 Nurse-led management can make triage arrangements more efficient

FIG 1. A&E ATTENDANCE

Audit of patients’ A&E attendance two years after the fast-track pathway was introduced
Patients at the Ayr Clinic, who tend to present principally (although not exclusively) with a primary diagnosis of personality disorder and associated challenging behaviour have a high risk of self-harm due to their condition (Klonsky et al, 2006). Although clinical guidance from the National Institute for Health and Care Excellence (2009) states that patients with a borderline personality disorder should not be excluded from any health or social care service because of their diagnosis, staff have encountered specific challenges when they need to access health services for these patients outside the Ayr Clinic. These include:

- Negative attitudes among staff who do not consider the patient to be presenting with a “real” illness (McLoughlin, 2006). This can lead to difficulties around patients being treated in an atmosphere of respect and understanding, as recommended in NICE’s (2004) clinical guideline;
- Young people who repeatedly self-harm and consequently need frequent healthcare often being met with ridicule or hostility from the professionals they have turned to for help (McLoughlin, 2006).

These negative attitudes can be exacerbated if the patient’s primary diagnosis is personality disorder. Patients with a personality disorder can acquire significant secondary gain – such as excitement and receiving extra attention – by having time out from the clinic and being treated by staff in a different environment as a result of having to wait in A&E for long periods of time. In addition, due to patients’ challenging behaviours and absconding risks, escorting them to A&E presents risks to staff and the patients themselves.

The aims of the initiative

The team at the Ayr Clinic proposed a joint project with NHS Ayrshire and Arran, which runs the local A&E service, to look at developing a service that would more effectively assess, manage risk and treat patients who repeatedly self-harm resulting in minor injuries.

After a review of the literature, both teams were aware that confident assessment and triage of minor injuries (primarily as a result of self-harm) and targeted treatments by nursing staff in both acute and mental health settings were desirable and that, if they were implemented, well-trained staff in various settings could help to:

- Reduce the emotional trauma that patients experience before, during and after treatment;
- Reduce the number of patients attending A&E in pursuit of secondary gain;
- Promote the patient’s insight into triggers for self-harm and motivation to seek alternative ways of coping;
- Reduce potential stigmatisation of a vulnerable patient group;
- Reduce opportunities for opportunistic self-harm;
- Cut the number of opportunities a patient has to abscond from their nurse escort(s).

It was anticipated that the design, implementation and evaluation of the project would take 12 months. This would be divided into three phases; phase 1 started in August 2013.

Phase one

The first phase was composed of a series of meetings co-hosted by myself at Ayr Clinic as project lead and Laura Train, who represented NHS Ayrshire and Arran’s A&E department.

These were organised to map the existing treatment pathways for minor injuries between each service. These pathways were redesigned and this was expressed as an algorithm. This phase lasted for one month.

Phase two

In this phase, the pathways and staff education were finalised.

Instead of having to be triaged and go through the process of waiting to be seen in A&E, patients with a minor injury are triaged in the Ayr Clinic then reviewed by emergency nurse practitioners (ENPs) in the minor injuries unit.
In phase 3, which is ongoing, the treatment pathway/algorithm functionality was assessed to ensure it was fully integrated and working optimally. The team believes that the fast-track pathway has helped to develop a more-structured approach to meeting some of the challenges presented by an identified group of patients.

After an annual review of the fast-track service in December 2014, a number of developments were implemented to refine the service which have been successfully implemented (Table 1).

### Conclusion

The new pathway resulted in a marked reduction in the number of A&E visits by patients from the clinic for assessment and treatment of minor injuries. In addition, both clinic and A&E staff are more confident about dealing with this type of injury.

We have shared this example of best practice with NHS partners throughout the UK; this project can be repeated elsewhere. After the initiative was presented at an NHS Scotland event last year, several health boards in Scotland expressed an interest in duplicating the fast-track service.

The NHS is looking at the provision of A&E services and, in particular, the issue of excessive waiting times. The fast-track service could reduce waiting times as patients do not need to be assessed by A&E staff, potentially avoiding using valuable time and resources for an unnecessary assessment of a minor injury. Instead, clinic staff can assess the injury before contacting the ENPs and making an appointment to attend the minor injuries suite. Waiting times are reduced as only the cases that require a trip to A&E actually go to A&E.

### References


### Table 1: Service Developments and Consequences

<table>
<thead>
<tr>
<th>Development</th>
<th>Consequence</th>
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<tbody>
<tr>
<td>Clinic nursing staff can contact emergency nurse practitioners directly rather than having to be processed via accident and emergency staff</td>
<td>Further decreased the time between assessment at the clinic and being seen by emergency nurse practitioners</td>
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<td>Clinic staff, working closely with emergency nurse practitioners, have developed trusting, open, engaging, non-judgemental, consistent, reliable relationships in the care and treatment of a challenging patient group</td>
<td>Complies with NICE’s (2009) guideline</td>
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<tr>
<td>Emergency nurse practitioners give clinic staff a specific assessment appointment time. On arrival at A&amp;E, clinic staff and patients are escorted directly to the minor injuries suite and do not have to wait in the main sitting area until a cubicle becomes available</td>
<td>Potential for secondary gain, opportunistic self-harm and patients absconding has been reduced</td>
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<tr>
<td>The fast-track service has been made available for clinic staff who experience minor injuries during the course of their work</td>
<td>The time staff are out of the unit is reduced so clinic staffing levels can be maintained more effectively</td>
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<td>Clinic and A&amp;E staff have developed a physical healthcare early warning screening tool (a modified version of the Royal College of Physicians’ (2012) National Early Warning Score) to be used in the clinic</td>
<td>This allows clinic staff to use an evidence-based national assessment tool to assess illness severity, detect clinical deterioration and initiate a timely clinical response</td>
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<td>Clinic staff’s skills in assessment of physical trauma have been enhanced. A primary, secondary and tertiary assessment tool is used to assess injury severity and determines how the patient should be treated (ie fast-track pathway or usual A&amp;E process, usually due to systemic illness)</td>
<td>The use of NEWS and a physical healthcare assessment tool have improved staff confidence in assessing minor injuries</td>
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After a series of presentations, the treatment algorithm was embedded into practice in the Ayr Clinic and NHS Ayrshire and Arran’s A&E department (Fig 2, p18). Staff in both areas familiarised themselves with it and closer links were established between the two teams.

Clinic staff delivered training to A&E staff specifically on the care and treatment of patients who have a personality disorder. They also spent time working alongside them to develop further insight into the challenges of working in A&E medicine and refined their assessment skills in the area of minor injury trauma.

Phase two took two months to complete.

### Phase three

In phase 3, which is ongoing, the treatment pathway/algorithm functionality was assessed to ensure it was meeting the planned objectives. Ms Train and I met every three months to review progress and adjust the pathway as required. For example, clinic staff now contact ENPs at minor injury clinics rather than contacting A&E staff first. These meetings continue every three months and have further helped to improve the service.

### Results

In 2015, a year into the project, the team reviewed the number of A&E attendances of five patients before and after the pathway was introduced and we found that three out of five patients had reduced their risk profile. A second audit was completed in January 2015 on the same patient group; this showed reduced use of A&E services (for all five patients?), with no A&E attendances for three of the five patients audited for the previous 12 months (Fig 1, p17).

A&E and clinic staff report continued satisfaction with the service. In 2015, qualitative data will be gathered on the use of the fast-track service. This will include data on reducing trauma, secondary gain, and stigmatisation, and promoting insight.

Patients with a mental illness present with a complex constellation of challenges and, as such, it is not usually possible to attribute change to a single variable. However, the team believes that the fast-track pathway has helped to develop a more-effective process of meeting some of the challenges presented by an identified group of patients.

After an annual review of the fast-track service in December 2014, a number of developments were implemented to refine the service which have been successfully implemented (Table 1).