Please attach patient sticker here or record

Name: . . . .

Hosp No: ☐☐☐☐☐☐☐☐☐☐

NHS No: ☐☐☐☐☐☐☐☐☐☐

D.O.B: . . . . / . . . . / . . . . .   Male ☐   Female ☐

South Warwickshire NHS
NHS Foundation Trust

Paediatric Mental Health Assessment Matrix

Triage Nurse to complete Triage section and instigate appropriate management plan.
Medical staff will need to complete all sections relating to 'mental health' patients PLUS the section for those with deliberate self-harm

Triage Nurse Initial Assessment

Adapted Australian Mental Health Triage category (please circle)

RED	ORANGE	YELLOW	GREEN	BLUE
Immediate	**Emergency – within 10 mins.**	**Urgent – within 30 minutes**	**Semi – urgent – within 60 mins**	**Non urgent – within 120 mins.**
Violent behaviour; extreme agitation, restless, bizarre, disorientated behaviour. Possession of a weapon. Self-destructive behaviour in ED. Immediate threat to harm self or others. High risk of absconding.	Severe behavioural disturbance; extreme agitation, restless, bizarre or disorientated behaviour. Confused or paranoid. Physically or verbally abusive. Probable risk of danger to self or others. Reported attempt/threat of self-harm.	Moderate behavioural disturbance, severe distress, agitation/restless, intrusive behaviour, confused. Withdrawn and/or non-communicative and/or anxious. Risk of self-harm. Reluctant to wait for treatment or ambivalent of treatment. Showing clear signs of mental illness or distress; i.e. depressed or elated. Suicidal ideation. Moderate risk of absconding.	Showing clear signs of mental illness or distress but is cooperative and gives a clear history. Reported symptoms of anxiety/depression. Reported pre-existing mental health illness. No suicidal ideation. No immediate risk to self or others. Willing to wait. Actively seeking assistance for their distress.	No danger to self or others, no acute distress, no behavioural disturbance. Cooperative, communicative and able to engage, compliant with instruction. Patient with known chronic symptoms, minor adverse effect of medication, financial, accommodation or relationship problems.

High risk	Medium risk	Low risk
Implement this nursing care plan: • 121 continuous nursing observations • Place in Interview room • **Ensure all equipment/furniture that has the potential to be used as a ligature point or missile is removed prior to usage** • Write description of patient below; • Take accompanying adults contact details • Make all reasonable attempts to stop the person leaving hospital. • Contact Security staff and police if the person absconds. • Document actions taken in healthcare records. • Escalate to the Nurse Coordinator and A&E team for urgent review.	Implement this nursing care plan: • Close observations every 10 minutes. • Place in interview room or children's cubicle 2 • **Ensure all equipment/furniture that has the potential to be used as a ligature point or missile is removed prior to usage** • Write a description of patient below; • Take accompanying adults contact details • Make all reasonable attempts to stop the person leaving hospital. • Contact security staff and police if the person absconds. • Document actions taken in healthcare records	Implement this nursing care plan: • Can wait in main or children's waiting room with routine waiting room checks at a maximum of hourly intervals. • Suitable for admission to Macgregor Ward or Observation unit if over 17years. • Document actions taken in healthcare records

If Patient is a flight risk, take a description of patient:
Height: **Build:** **Hair:** **Skin Colour:**
Clothes: **Shoes:** **Distinguishing features:**
Accompanying Adult name and contact number

Signed: **Print name:** **Designation** **Date:**

SUICIDE RISK ASSESSMENT FORM
(Adapted from Becks Suicidal Intent Scale)

How isolated was the person when suicide was attempted?	Somebody present Somebody nearby, or in visual or vocal contact No one nearby or in visual or vocal contact	0 1 2	
Timing of suicide attempt: how likely was it that they would be found?	Intervention probable Intervention unlikely Intervention highly unlikely	0 1 2	
Were precautions against discovery /intervention put in place:	No precautions Passive precautions, e.g. avoiding others but doing nothing to prevent their intervention, alone in room with unlocked door Active precautions, e.g. locked door	0 1 2	
Did the person act to get help during/after the attempted suicide:	Notified potential helper regarding attempt Contacted but did not specifically notify potential helper regarding attempt Did not contact or notify potential helper	0 1 2	
Did the person make arrangements in anticipation of death (e.g. writing a will, buying gifts, insurance):	None Thought about or made some arrangements Made definite plans or completed arrange	0 1 2	
Did the person actively prepare for attempted suicide?	None Minimal to moderate Extensive	0 1 2	
Suicide note written?	Absence of note Note written or torn up, or thought about Presence of note	0 1 2	
Did the person communicate their intent to attempt suicide before they did?	None Equivocal communication Unequivocal communication	0 1 2	
What was the alleged purpose or intent of the suicide attempt:	To manipulate environment, get attention, revenge Components of 0 and 2 To escape, solve problems	0 1 2	
What were the person's expectations of how successful the attempt would be?	Thought that death was unlikely Thought that death was possible, not probable Thought that death was probable or certain	0 1 2	
What is the person's concept of how lethal the method used, was?	Did less to self that thought would be lethal Was unsure if action would be lethal Equalled or exceeded what s/he thought would be lethal	0 1 2	
Seriousness of suicide attempt:	Did not seriously attempt to end life Uncertain about seriousness to end life Seriously attempted to end life	0 1 2	

Attitude towards living/dying	Did not want to die Components of 0 and 2 Wanted to die	0 1 2	
What is the person's believe about whether medical attention could rescue them?	Thought death would be unlikely with medical attention Was uncertain whether death could be averted by medical attention Was certain of death even with medical attention	0 1 2	
Degree of premeditation:	None, impulsive Contemplated for 3 hours or less before attempt Contemplated for more than 3 hours before attempt	0 1 2	

RECOMMENDATIONS:

SCORING:	RISK:	SUGGESTED MANAGEMENT PLAN:
0-10	LOW	May be sent home. Liaise with ALT - ALT will arrange a follow up appointment.
11-20	MEDIUM	Assessment by CAMHS Acute Liaison Team or psychiatrist advisable. If treatment refused, CAMHS Acute Liaison Team follow up should be arranged.
20-30	HIGH	Immediate assessment by psychiatrist or CAMHS Acute Liaison Team. Psychiatric admission recommended. Involuntary admission may be required.

ACTION TAKEN: (Tick box applicable)

Admitted:	Medical Ward	
	Psychiatric Ward	
Sent Home:	With parent/carer	
Referred to:	Acute Liaison Team	
	Psychiatrist	
Letter to:	GP	
	Other (specify)	

Name: ______________________ Signature: ______________________

Date: ______________________

New Referral Process for CAMHS Patients

There is now a new referral process and paperwork for CAMHS patients

All referrals are to be sent via e fax to SPE (single point of entry) using the new 'self harm referral form'

Fax No: 02476 961579

(Can check if referral received on 0300 200 2021)

- **Please ensure that the 'referral form' and 'suicide risk assessment form' are both sent together**
- **Referrals can be sent any time of day/night, however the cut off is 16:00 for referrals to be considered the same day (Weds 11:00 cut-off for referrals due to training)**
- **Please only refer if child is medically fit to be assessed**

Guidance for completing referral form

Please include as much detail about the actual self-harm if that is the presenting problem.

Eg: If the young person has cut, how severely? Has it needed sutures, steri-strips, dressings only or no attention required? Are the wounds multiple or singular? Are there lacerations or scratches?

The Suicidal risk Assessment form is to be completed in A&E, this can be completed by nursing or medical staff

- The ALT team will provide cover 09:00-20:00 (Mon, Tues, Thurs, Friday) and 09:00-17:00 (Wed)
- ALT via St Michaels Switch 09:00-21:00 (Sat) (telephone consultation only)
- CAMHS Consultant on-call (Sunday & Out-of-Hours - via St Michaels Switch)

Contact No's for ALT

Whitestone (Base) - 02476 641799

Michelle Rudd - 07717576671

Kelly Mogano - 07899067491

Precious Nhliziyo - 07917071123

South Warwickshire NHS
NHS Foundation Trust

For Clinical Use Only
[*Please affix sticker here*]
Client Details:
Name:

Referrer details: A&E
Time of assessment:
Time of referral:
Time/Date of Self-Harm:

Admission: YES/NO

Reason for referral:

1. **Deliberate Self Harm**
2. **Suicidal Ideation**

Please describe method of self-harm e.g.: Took overdose of 40 Paracetamol tablets after an argument with parent. Got sick and informed best friend)

	YES	NO		YES	NO
History of previous self-harm			Violent attempt		
History of mental illness			Suicide note		
History of chronic physical illness			Efforts to hide attempt		
Alcohol or illicit drug consumption			Looked After Child (LAC)		
Family history of mental Illness/suicide					

INVOLVEMENT OF OTHER PROFESSIONALS:

	YES	NO		YES	NO
CAMHS			LAC		
Social Services			School Counsellor/Nurse		
YOT			CAF		

Who is involved and details: ……………………………………..

Child Protections Concerns **YES / NO**

If Yes, more information………………………………………………………………………………………

Consent to plan:

Gillick/Fraser Competent: YES / NO

Child fit to be seen:

Child/YP to sign: …………………………….. **Parent/carer:………………………**

Contact Tel Number:…………………….

PLAN:

1. Refer to SPE ☐ **(always tick)**

2. Admitted to ward ☐

3. Discharged home following advice ☐