East and North Hertfordshire NHS
NHS Trust

Emergency Department Adult Mental Health Triage

Date: / / Time of assessment:

For staff use only

Hospital number:

Surname:

First names:

Date of birth

NHSno _ _ _/_ _ _/_ _ _ _

These guidelines are designed to help an assessor consider the current risk to the patient of self-harm or suicide and risk of harm to staff members. Risk assessment requires clinical judgement which may override this form in some circumstances.

Does patient have a ED management plan? ☐ Yes ☐ No

Issues to be explored through questioning

Why is the person presenting now?

Are there any events that precipitated this presentation?

Does the person have any close family/friends/social support?

Physical description – include height, build, distinguishing features, clothing, skin colour, hair colour and style

Are there any child protection issues? [ ] Yes [ ] No Consider SIF

Is this person in any way vulnerable [ ] Yes [ ] No Consider SOVA

Background, observations and behaviours

Please tick appropriate response	**Yes**	**No**
1. Does the person have any immediate plans to harm self or others or to damage property?	[ ]	[ ]
2. Is the patient obviously disturbed, threatening, agitated or unpredictable in their behaviour?	[ ]	[ ]
3. Does the person have a history of MH problems or self-harm?	[ ]	[ ]
4. Does the person have a history of violence?	[ ]	[ ]
5. Is there any suggestion that the person may abscond?	[ ]	[ ]

If you think the patient may abscond, ask for early capacity assessment

Nursing assessment

Do you think the patient has the capacity to decide to leave? [ ] Yes [ ] No [ ] Not sure

What level of risk do you think this patient has? [ ] High [ ] Medium [ ] Low

Has this patient been searched for means to self-harm, weapons or medicines? [ ] Yes [ ] No

Observation level required [ ] Red [ ] Amber [ ] None

Print name: Date: / /

Signature: Time:

Designation: Contact/Bleep number:

High level of risk	Medium level of risk	Low level of risk
1:1 Care (family/security specialising team) Patient must be in Majors area Inform NIC/Lead Dr Refer to MHLT Prioritise early ED doctor assessment Consent patient to search patients' belongings	High level intermittent emotional observation and safety check (1 hourly) Refer to MHLT Early Dr assessment Inform NIC Lead / Dr In Majors area	Refer to MHLT Low level intermittent observation (2 hourly) Can wait in SWA Inform NIC

RISK ASSESSMENT: Risk-must be re-assed whenever clinical condition changes

Date and Time	Level of Risk	Comments	Sign and Print Name

Has an information sharing form been completed and sent to safeguarding team? Yes / No

EMOTIONAL OBSERVATIONS: - Ask the following questions instead of routine medical observations, if physically well. This should be hourly or 2 hourly depending on risk level above.

1. Are you feeling ok?
2. Is there anything I can get you?
3. Let us know if you are struggling

Date and Time	Location	Obs/Safety Check Done	Comments	Sign and Print Name

Further emotional observation charts can be used and attached to this form.