National Emergency Medicine Programme

The Post-Triage Mental Health Triage Tool

A manual to assist Emergency Department Triage Nurse Education

Contents

Appendix

1. Introduction

- This manual is a resource that is intended to be used by triage trainers as part of existing triage education sessions for nursing staff in Irish Emergency Departments.

- The manual provides guidance for clinical staff on optimising Emergency Department triage assessment and immediate management of acute mental health presentations. It does this by:
  a) describing a dedicated mental health triage assessment tool, the Post-triage Mental Health Triage Tool (PTMHTT) to complement the Manchester Triage Scale for mental health presentations to the ED;
  b) providing guidance for ED staff on patient management including supervision, location of care and other actions following triage via the PTMHTT
  c) providing a series of vignettes of real-world Emergency Department mental health triage presentations for discussion and learning to optimise assessment and management using the PTMHTT
  d) providing general guidance on brief mental health assessment

2. Emergency Department Triage

- All patients who present in an emergency healthcare setting require assessment and treatment. Triage is the process in emergency settings whereby when demand outstrips resources, patients are sorted according to priority of need.

- Triage is a key component of emergency medicine care in Ireland and elsewhere. The main purpose of triage is to ensure 'clinical justice' ie '*that patients receive care appropriate to their need and in a timely fashion*'. [1]

- In Ireland, adult emergency department presentations are triaged according to the Manchester Triage system (MTS). This triage system uses a series of 52 presentation-defined flow diagrams to allow clinical categorisation of patients as well as general discriminators that assist clinical prioritisation include life threat and conscious level and certain specific discriminators (see appendix 2). All patients are allocated to one of 5 triage categories to indicate priority of clinical need.

- With unselected ED presentations, international experience with the MTS is that it has at least moderate validity with considerable performance variability including over and under triaging being common[2]

- It has long been recognised that the MTS (and its counterpart in Australia, the Australasian triage scale) does not optimally prioritise mental health need. For this reason, mental health triage of Emergency Department presentations has been developed and refined in Australia and has subsequently been recommended in the UK.[3]

3. Emergency Department Triage when there is an apparent mental health need

- 1-3% of Emergency Department attendances are mental health presentations. Patients may be brought to the emergency department by ambulance, family, Gardaí or may come in by themselves. Self-harm, suicidal thoughts, substance misuse, anxiety/depression, and psychotic illness are the most common mental health presentations at triage in the ED setting.

- It is important to be aware that patients with behavioural disturbance and/or apparent mental health needs often have underlying physical health needs. Patients presenting with organic illness may often exhibit behaviours which may look like mental illness when in fact they are not (eg behavioural disturbance or psychotic symptoms in a patient with delirium secondary to sepsis).

- Consequently it is important that all patients presenting to ED, including mental health/behavioural presentations are assessed using the MTS in the usual manner with a primary survey being completed to assist in triage process to determine urgency of physical need.

- 4 of the 52 MTS presentation-defined flow diagrams that allow clinical categorisation of patients are overt mental health presentations ie '*mental illness', 'self-harm', 'overdose' and 'poisoning',* and '*behaving strangely*'. General discriminators that assist clinical prioritisation include life threat and conscious level and certain specific discriminators (see Appendix II) allow an appropriate triage category (1-5) to be assigned that determines priority of need.

- To complement the MTS, brief mental health assessment is also required by ED staff at triage to better determine the level of urgency of mental health need. For general guidance on brief mental health assessment by ED staff, see '*The ABCs of Mental Health Assessment*' (Appendix 1).

- Dedicated mental health triage tools have now been developed for Emergency Departments to optimise how mental health presentations are prioritised.

4. Mental Health Triage

- The UK NICE guideline on the short-term assessment and management of self-harm recommends mental health triage[2]. The guideline recommends that ED Triage nurses should be trained in the use of mental health triage systems. The guideline also advocates the introduction of the Australian Mental Health triage tool describing it as '*a comprehensive assessment scale that provides an effective process for rating clinical urgency so that patients are seen in a timely manner*'.

- The National Clinical Programme for Emergency Medicine (Emergency Medicine Report, 2012), National Clinical Programme for Self-Harm (HSE Clinical Strategy and Programmes Division, March 2016) and the College of Psychiatry of Ireland has recommended the utilisation of mental health triage in Irish emergency departments.

- Mental health triage in the ED in Australia has been found to reduce the time to assessment and the proportion of patient with mental health presentations who leave prior to assessment.

- In Ireland, data from the National Self-Harm Registry indicates that 15% of ED attendees presenting following an episode of self-harm (ie an acute mental health need) leave the ED prior to assessment[4]. This could reflect lack of optimised mental health triage. Ensuring that all patients presenting to the ED following self-harm receive a mental health assessment is a key component of HSE National Policy and Connecting for Life (Ireland's Suicide prevention strategy).

5. The Post-Triage Mental Health Triage Tool (PTMHTT)

- In Ireland, the *Post-Triage Mental Health Triage Tool (PTMHTT*) was developed as an adaptation of the Victorian Emergency Department Mental Health Triage Tool which was devised in Australia. The Victorian Emergency Department Mental Health Triage tool is itself an adaptation of the South Eastern Sydney Area Health Service Mental Health Triage Scale together with the mental health descriptors of the Australasian Triage scale[5]. The tool has face validity and has also been shown to have predictive validity[6]. Triage nurses who used it were found to accurately identify the urgency of mental health presentations using defined criteria[7].

- The PTMHTT guides Emergency Department staff in prioritising and caring for patients presenting with apparent acute mental health needs. It provides descriptors of observed and reported behaviour to assist in allocating the most appropriate triage category (1, immediate; 2, very urgent; 3, urgent; 4, semi-urgent; 5, non-urgent).

- The PTMHTT also guides Emergency Department staff on the initial management of patients whose behaviour is of concern. This is not to assume disturbed behaviour equates to mental illness but to ensure that correct safeguards are put in place to manage behaviour and where clinically appropriate refer for psychiatry review.

- All ED patients will continue to be triaged first using the Manchester Triage System (MTS). The PTMHTT is then used following the identification of an apparent acute mental health need. Patients acute mental health needs will therefore have two triage scores with the higher priority score always taking precedence.

6. Case Vignettes for ED Mental Health Presentation

- 25 Case vignettes (Appendix IV) were prepared from real cases that presented to an Irish Emergency Department and that were triaged using the Manchester Triage System (MTS).

- The MTS assigns all patients to one of 52 presentations based on the presenting symptoms.

- The most common categories assigned for mental health presentations are:
    - Self-harm
    - Overdose and Poisoning
    - Behaving Strangely
    - Mental Illness

- For ten selected vignettes an optimal MTS triage category (1-5) has been assigned by consensus agreement of Senior ED Clinical Nursing and Medical staff in an Irish ED.

- As each presentation is a mental health presentation, these ten selected vignettes have also been assigned an optimal Mental health triage category (1-5) using the PTMHTT (see Appendix III) also by consensus agreement of Senior ED Clinical Nursing and Medical staff in an Irish ED.

- In addition a further 15 case vignettes of mental health presentations are also provided but unscored.

- These case vignettes may be used as part of triage education sessions to enhance learning re priority of need and actions to be taken with ED mental health presentations.

7. Suggested Triage Education session

- The duration of a triage education session may be tailored according to time.

- The triage education session should be facilitated by both an ED Triage Co-ordinator and a Mental Health Professional (ideally Liaison Mental Health team member).

- As a minimum, the session must cover the following:
  a) Background re mental health presentations and Triage (slides provided)
  b) Triage category assignment by participants of sample case vignettes using the MTS followed by the PTMHTT (slides of vignettes provided).
  c) Discussion re optimal triage category assignment for each vignette encouraged among participants.
  **In clinical triage practice there is variability between triage nurses in the triage category assigned by them. This variability has been previously also been shown in relation to mental health presentations.*
  d) Discussion re optimal actions/management for each case vignette encouraged among participants.
  **In clinical practice there is variability between triage nurses in the immediate actions/management of patients with mental health needs following triage.*
  The PMHTT provides guidance to staff on actions including supervision arrangements, location of wait and immediate management of mental health presentations.

8. References:

1. The National Emergency Medicine Programme, A strategy to improve safety, quality, access and value in Emergency Medicine in Ireland, June 2012.

2. Zachariasse, J. M., Seiger, N., Rood, P. P., Alves, C. F., Freitas, P., Smit, F. J., Roukema, G. R., & Moll, H. A. (2017). Validity of the Manchester Triage System in emergency care: A prospective observational study. *PloS one*, *12*(2), e0170811. https://doi.org/10.1371/journal.pone.0170811

3. National Institute of Clinical Excellence, Clinical Guideline 16, 2011

4. Arensman E, Griffin E, Daly C, Corcoran P, Cassidy E, Perry IJ (2018) Recommended next care following hospital-treated self-harm: Patterns and trends over time. PLoS ONE 13(3): e0193587. https://doi.org/10.1371/journal.pone.0193587

5. Broadbent M, Moxham L, Dwyer T. The development and use of mental health triage scales in Australia. *International Journal of Mental Health Nursing* (2007) *16*, 413–421

6. Sands N, Elsom S, Berk M et al. Investigating the predictive validity of an emergency department mental health triage tool. Nursing & Health Sciences, March 2014

7. Tanner R, Cassidy EM, O'Sullivan I. Does using a Standardised Mental Health Triage Assessment Alter Nurses Assessment of Vignettes of People Presenting with Deliberate Self-Harm. Advances in Emergency Medicine. August 2014

Appendix I: The ABCs of mental health assessment

(Adapted from Emergency Triage Education Kit, Department of Health and Aging, Australia)

The ABCs of a mental health assessment are as follows.

Appearance

What does the patient look like?

- Are they dishevelled, unkempt or well presented?
- Are they wearing clothing appropriate for the weather?
- Do they look malnourished or dehydrated?
- Are they showing any visible injuries?
- Do they appear intoxicated, flushed, with dilated or pinpoint pupils?
- Are they tense, slumped over, displaying bizarre postures or facial grimaces?

This information provides cues when assessing the person's mood, thoughts and ability to self-care.

Affect

What is your observation of the patient's current emotional state?

- Are they flat, downcast, tearful, distressed or anxious?
- Is their expression of emotion changing rapidly?
- Is their emotion inconsistent with what they are talking about?
- Are they excessively happy?

This information provides cues when assessing the person's mood.

Behaviour

How is the patient behaving?

- Are they restless, agitated, hyperventilating or tremulous?
- Are they displaying bizarre, odd or unpredictable actions?
- Are they orientated?
- How is the patient reacting?
- Are they angry, hostile, uncooperative, over-familiar, suspicious, guarded, withdrawn,
- Inappropriate or fearful?
- Are they responding to unheard voices or sounds, or unseen people or objects?
- Are they attentive or refusing to talk?

Possible questions:

- 'This must be distressing for you. Can you tell me what is happening?'
- 'I can see that you are very anxious. Do you feel safe?'
- 'I can see that you are angry. Can you tell me why?'
- 'Are your thoughts making sense to you?'
- 'Are you taking any medication?'

Conversation and mood

- What language is being spoken?
- Is an interpreter needed?

Conversation

- How is the patient talking?
- Does their conversation make sense?
- Is it rapid, repetitive, slow or uninterruptible, or are they mute?
- Are they speaking loudly, quietly or whispering?
- Are they speaking clearly or slurring?
- Are they speaking with anger?
- Are they using obscene language?
- Do they stop in the middle of a sentence?
- Do you think the patient's speech is being interrupted because they are hearing voices?
- Do they know what day and time it is and how they got to the ED?

Mood

- How does the patient describe their mood? Do they say they feel:
  - Down, worthless, depressed or sad?
  - Angry or irritable?
  - Anxious, fearful or scared?
  - Sad, really happy or high?
  - Like they cannot stop crying all the time?
- What do you think is the risk of suicide/homicide?
- For example, does the patient tell you that they are thinking about suicide, wanting to hurt
- others, worrying about what people think about them, worrying that their thoughts don't
- make sense, afraid that they are losing control, feeling that something dreadful is going to
- happen to them, and/or feeling unable to cope with everything that has happened to them
- Lately in relation to recent stressors?

Possible questions:

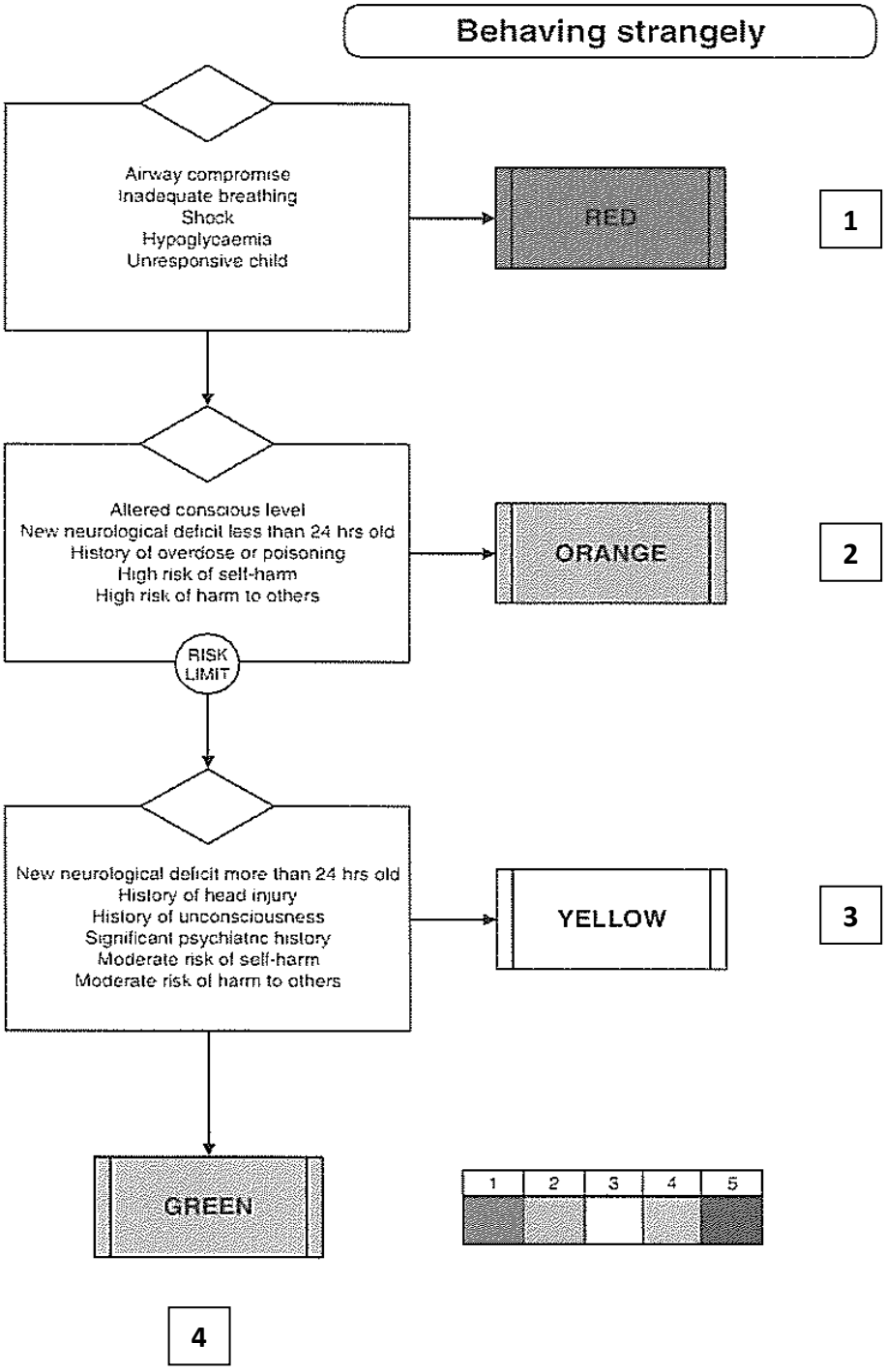
- 'Do you feel hopeless about everything?'
- 'Do you feel that someone or something is making you think these things?'
- 'Are you being told to harm yourself and/or others?'
- 'Do you feel that life is not worth living?'

Appendix II: Manchester Triage System

- From the overall list of 52 presentation-defined flow diagrams of the Manchester Triage System, the 4 most common mental health presentation categories are provided below. Ie
    - Mental Illness
    - Overdose and poisoning
    - Self-Harm
    - Behaving strangely

- General discriminators that assist clinical prioritisation include life threat and conscious level and certain specific discriminators are also provided (see appendix 2).

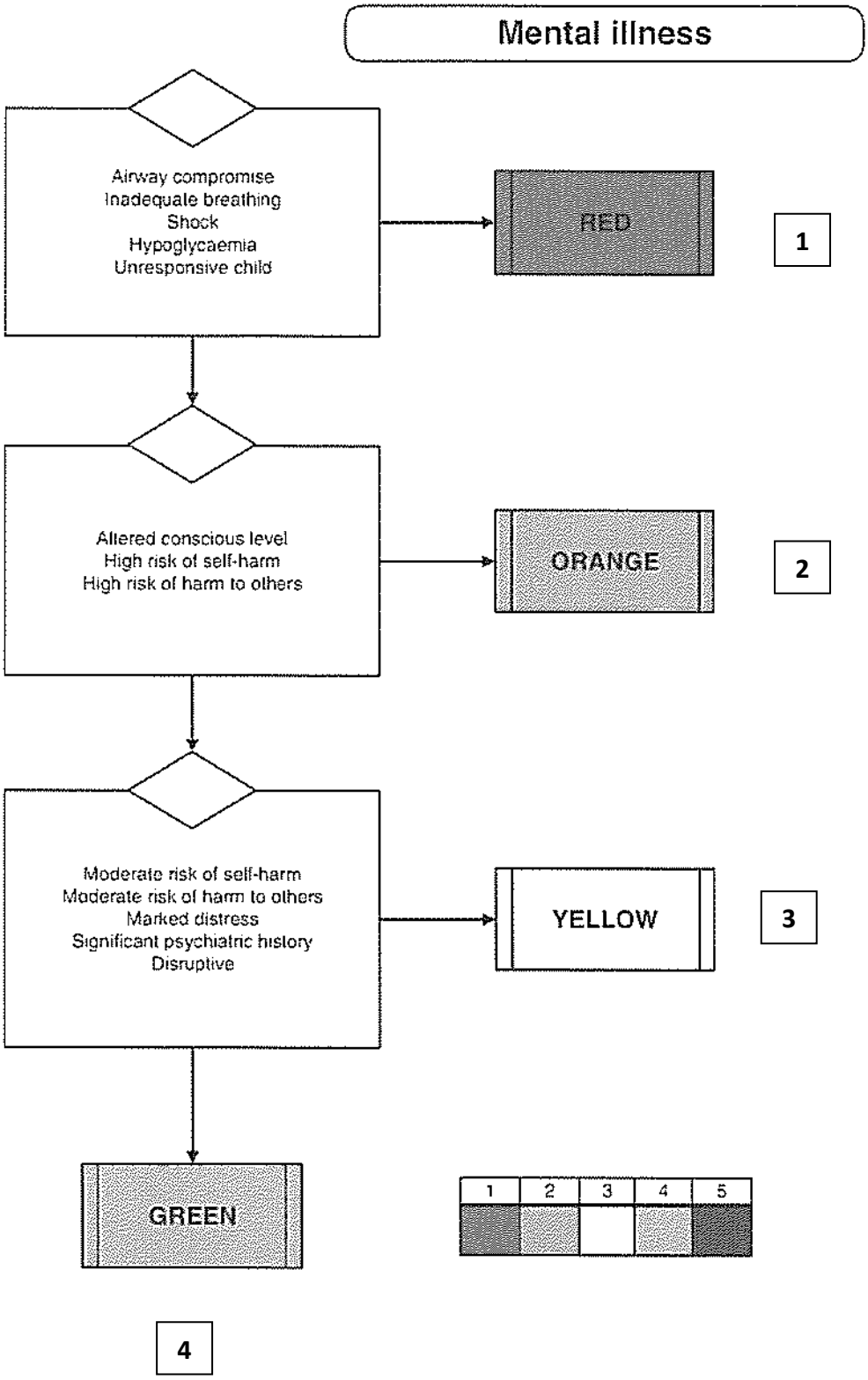
- All patients are allocated to one of 5 categories to indicate priority of clinical need ie
    - 1-Red
    - 2-Orange
    - 3-Yellow
    - 4-Green
    - 5-Blue


Behaving strangely
Airway compromise
Inadequate breathing
Shock
Hypoglycaemia
Unresponsive child
RED
1
Altered conscious level
New neurological deficit less than 24 hrs old
History of overdose or poisoning
High risk of self-harm
High risk of harm to others
ORANGE
2
RISK LIMIT
New neurological deficit more than 24 hrs old
History of head injury
History of unconsciousness
Significant psychiatric history
Moderate risk of self-harm
Moderate risk of harm to others
YELLOW
3
GREEN
1 2 3 4 5
4

Notes accompanying behaving strangely

See also	Chart notes
Apparently drunk Mental illness	This is a presentation defined flow diagram. Patients who are behaving strangely may have either a psychiatric or a physical cause for their presentation. This chart is designed to allow the accurate prioritisation of both these groups of patients. A number of general discriminators have been used including *Life threat* and *Conscious level*. Specific discriminators are used and in particular the concepts of risk of harm to others and risks of self-harm are introduced

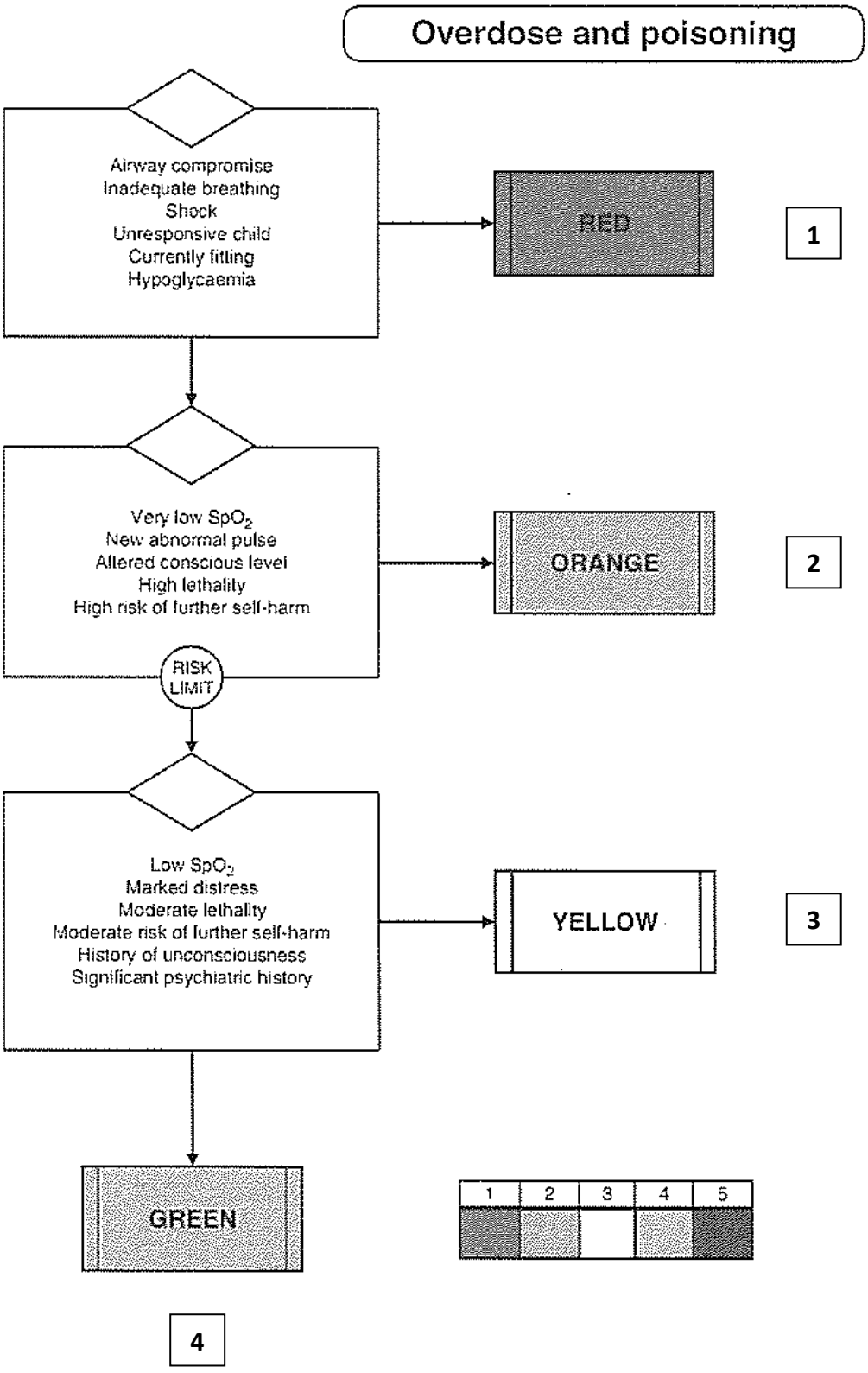
Specific discriminators	Explanation
Hypoglycaemia	Glucose less than 3 mmol/l
New neurological deficit less than 24 hrs old	Any loss of neurological function that has come on within the previous 24 hours. This might include altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function
History of overdose or poisoning	This information may come from others or may be deduced if medication is missing
High risk of self-harm	An initial view of the risk of self-harm can be formed by considering the patient's behaviour. Patients who have a significant history of self-harm, who are actively trying to harm themselves or who are actively trying to leave with the intent of harming themselves are at high risk
High risk of harm to others	The presence of a potential risk of harm to others can be judged by looking at posture (tense, clenched), speech patterns (loud, using threatening words) and motor behaviour (restless, pacing). High risk should be assumed if weapons and potential victims are available, or if self-control is lost
New neurological deficit more than 24 hrs old	Any loss of neurological function including altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function
History of head injury	A history of a recent physically traumatic event involving the head. Usually this will be reported by the patient but if the patient has been unconscious this history should be sought from a reliable witness
History of unconsciousness	There may be a reliable witness who can state whether the patient was unconscious (and for how long). If not, a patient who is unable to remember the incident should be assumed to have been unconscious
Significant psychiatric history	A history of a major psychiatric illness or event
Moderate risk of self-harm	An initial view of the risk of self-harm can be formed by considering the patient's behaviour. Patients without a significant history of self-harm, who are not actively trying to harm themselves, who are not actively trying to leave with the intent of harming themselves, but who profess the desire to harm themselves are at moderate risk
Moderate risk of harm to others	The presence of a potential risk of harm to others can be judged by looking at posture (tense, clenched), speech patterns (loud, using threatening words) and motor behaviour (restless, pacing). Moderate risk should be assumed if there is any indication of potential harm to others


Mental illness
Airway compromise
Inadequate breathing
Shock
Hypoglycaemia
Unresponsive child
RED
1
Altered conscious level
High risk of self-harm
High risk of harm to others
ORANGE
2
Moderate risk of self-harm
Moderate risk of harm to others
Marked distress
Significant psychiatric history
Disruptive
YELLOW
3
GREEN
4
1
2
3
4
5

Notes accompanying mental illness

See also	Chart notes
Apparently drunk Behaving strangely	This is a presentation defined flow diagram that has been designed to allow clinical prioritisation of patients who present with known or newly declared mental illness. This includes patients who attended with a chief complaint which would indicate mental illness. A number of general discriminators have been used including *Life threat* and *Conscious level*. This chart is designed to allow assessment of both physical and psychiatric aspects of the presentation. Specific discriminators are included to allow accurate prioritisation of patients with a known significant psychiatric history and those who have varying degrees of risk of causing harm to others or to themselves. Patients who are disruptive or who are suffering severe distress are placed in the urgent category

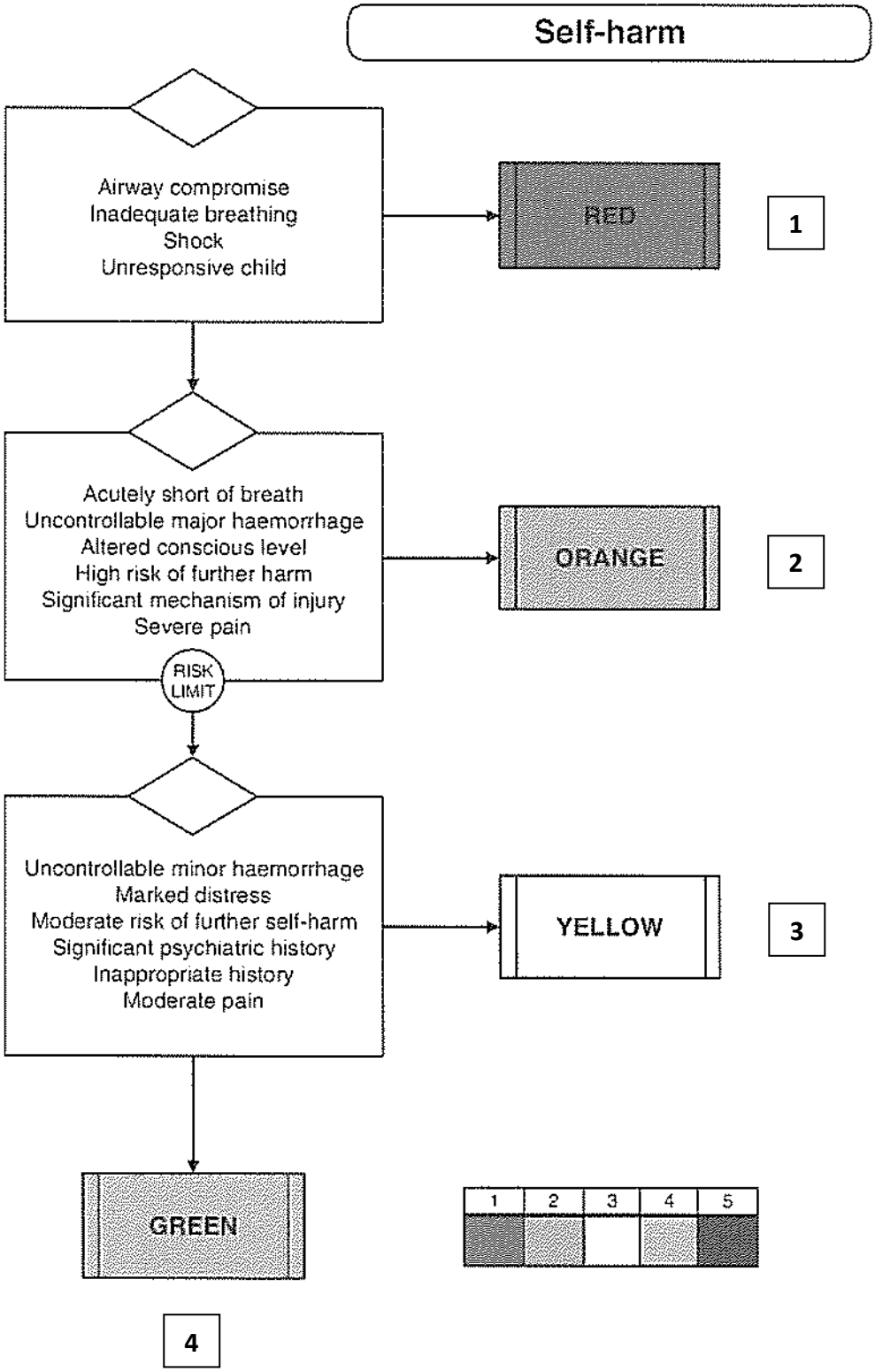
Specific discriminators	Explanation
Hypoglycaemia	Glucose less than 3 mmol/l
High risk of self-harm	An initial view of the risk of self-harm can be formed by considering the patient's behaviour. Patients who have a significant history of self-harm, who are actively trying to harm themselves or who are actively trying to leave with the intent of harming themselves are at high risk
High risk of harm to others	The presence of a potential risk of harm to others can be judged by looking at posture (tense, clenched) speech patterns (loud, using threatening words) and motor behaviour (restless, pacing). High risk should be assumed if weapons and potential victims are available, or if self-control is lost
Moderate risk of self-harm	An initial view of the risk of self-harm can be formed by considering the patient's behaviour. Patients without a significant history of self-harm, who are not actively trying to harm themselves, who are not actively trying to leave with the intent of harming themselves, but who profess the desire to harm themselves are at moderate risk
Moderate risk of harm to others	The presence of a potential risk of harm to others can be judged by looking at posture (tense, clenched), speech patterns (loud, using threatening words) and motor behaviour (restless, pacing). Moderate risk should be assumed if there is any indication of potential harm to others
Marked distress	Patients who are markedly physically or emotionally upset fulfil this criterion
Significant psychiatric history	A history of a major psychiatric illness or event
Disruptive	Disruptive behaviour is behaviour that affects the smooth running of the department. It may be threatening


Overdose and poisoning
Airway compromise
Inadequate breathing
Shock
Unresponsive child
Currently fitting
Hypoglycaemia
RED
1
Very low SpO_2
New abnormal pulse
Altered conscious level
High lethality
High risk of further self-harm
ORANGE
2
RISK LIMIT
Low SpO_2
Marked distress
Moderate lethality
Moderate risk of further self-harm
History of unconsciousness
Significant psychiatric history
YELLOW
3
GREEN
4
1 2 3 4 5

Notes accompanying overdose and poisoning

See also	Chart notes
Self-harm	This is a presentation defined flow diagram. The flow chart has been designed to allow both the physical and psychiatric aspects of overdose to be considered, and to ensure accurate prioritisation of patients from both perspectives. It also allows prioritisation of patients who have been accidentally (or deliberately) poisoned by others. A number of general discriminators have been used including *Life threat* and *Unconscious level (in both children and adults)*. Specific discriminators include the assessed lethality of the overdose (which can be decided following discussion with a poisons centre) and an assessment of the risk of further attempts at self-harm

Specific discriminators	Explanation
Hypoglycaemia	Glucose less than 3 mmol/l
Very low SpO_2	This is a saturation of less than 95% on O_2 therapy or less than 92% on air
New abnormal pulse	A bradycardia (less than 60/min in adults), a tachycardia (more than 100/min in adults) or an irregular rhythm. Age-appropriate definitions of bradycardia and tachycardia should be used in children
High lethality	Lethality is the potential of the substance taken to cause harm. Advice from a poisons centre may be required to establish the level of risk of serious illness or death. If in doubt, assume a high risk
High risk of further self-harm	An initial view of the risk of self-harm can be formed by considering the patient's behaviour. Patients who have a significant history of self-harm, who are actively trying to harm themselves or who are actively trying to leave with the intent of harming themselves are at high risk
Low SpO_2	This is a saturation of less than 95% on air
Marked distress	Patients who are markedly physically or emotionally upset fulfil this criterion
Moderate lethality	Lethality is the potential of the substance taken to cause serious illness or death. Advice from a poisons centre may be required to establish the level of risk to the patient
Moderate risk of further self-harm	An initial view of the risk of self-harm can be formed by considering the patient's behaviour. Patients without a significant history of self-harm, who are not actively trying to harm themselves, who are not actively trying to leave with the intent of harming themselves, but who profess the desire to harm themselves are at moderate risk
History of unconsciousness	There may be a reliable witness who can state whether the patient was unconscious (and for how long). If not, a patient who is unable to remember the incident should be assumed to have been unconscious
Significant psychiatric history	A history of a major psychiatric illness or event


Self-harm
Airway compromise
Inadequate breathing
Shock
Unresponsive child
RED
1
Acutely short of breath
Uncontrollable major haemorrhage
Altered conscious level
High risk of further harm
Significant mechanism of injury
Severe pain
ORANGE
2
RISK LIMIT
Uncontrollable minor haemorrhage
Marked distress
Moderate risk of further self-harm
Significant psychiatric history
Inappropriate history
Moderate pain
YELLOW
3
GREEN
4
1 2 3 4 5

Notes accompanying self-harm

See also	Chart notes
Mental illness Overdose and poisoning	This is a presentation defined flow diagram. This flow diagram has been designed to allow accurate prioritisation of patients who have caused physical harm to themselves. This chart is designed to allow assessment of both physical and psychiatric aspects of the presentation. A separate chart entitled Overdose and poisoning has been designed as well. A number of general discriminators are used including *Life threat*, *Haemorrhage*, *Conscious level* and *Pain*. Specific discriminators are included to allow accurate prioritisation of patients with significant mechanisms of injury and those who have various degrees of risk of further self-harm

Specific discriminators	Explanation
Acutely short of breath	Shortness of breath that comes on suddenly, or a sudden exacerbation of chronic shortness of breath
High risk of further harm	An initial view of the risk of self-harm can be formed by considering the patient's behaviour. Patients who have a significant history of self-harm, who are actively trying to harm themselves or who are actively trying to leave with the intent of harming themselves are at high risk
Significant mechanism of injury	Penetrating injuries (stab or gunshot) and injuries with high energy transfer
Marked distress	Patients who are markedly physically or emotionally upset fulfil this criterion
Moderate risk of further self-harm	An initial view of the risk of self-harm can be formed by considering the patient's behaviour. Patients without a significant history of self-harm, who are not actively trying to harm themselves, who are not actively trying to leave with the intent of harming themselves, but who profess the desire to harm themselves are at moderate risk
Significant psychiatric history	A history of a major psychiatric illness or event
Inappropriate history	When the history (story) given does not explain the physical findings it is termed inappropriate. This is important as it is a marker of safeguarding concerns in both adults and children

Appendix III: The Post-Triage Mental Health Triage Tool

Please note: The Post-Triage Mental Health Triage tool is to be used after MTS in those cases with an acute mental health need.

** Each ED needs to identify the appropriate location for patients who require the various levels of observation. These areas should be compliant with RCPsych recommendations.

It is not to assume disturbed behaviour equates to mental illness but to ensure the correct safeguards are in place to manage the behaviour and where clinically indicated i.e. thought to be secondary to mental illness, to refer for a psychiatry opinion

	Description	Treatment acuity	Typical Presentation	Emergency Department Guidance
1	**Definite danger to life (Self or others)**	**Immediate**	**Observed** - Displays extreme agitation or restlessness - Bizarre/disorientated behaviour - Violent behaviour - Possession of weapon - Self-destruction in ED - High risk of absconding - **An involuntary application form for detention under the Mental Health Act 2001 has been completed prior to arrival** **Reported** - Vocalises intent to do harm to self or others that the person is unable to resist	**Supervision** Continuous visual supervision 1:1 ratio ** **Location** Identify at each site i.e. Mental Health assessment area Remove equipment from cubicle **Action** - Ensure security in attendance - Alert the following staff members immediately and ensure prompt assessment of the patient: • CNM 2/Shift Leader • EM Registrar • Psychiatric Registrar# • Psychiatric Liaison Nurse# - Remove any potentially dangerous objects and/or substances from patient - Establish patient's past medical history - Ensure medical assessment is performed
2	**Probable risk to self or others**	**Very Urgent** To be seen within 10 minutes	**Observed** - Extreme agitation/ restlessness - Physically/verbally aggressive and/or restrained - High risk of absconding and not waiting for treatment - Patient actively trying to self-harm and/or leave the department - Confused/unable to co-operate - Hallucinations /delusions/paranoia **Reported** - Threat of harm to self/others	**Supervision** Continuous visual supervision 1:1 ratio ** **Location** Identify in each site i.e. Mental Health assessment area **Action** - Ensure security in attendance - Alert the following staff members immediately; • CNM 2/Shift Leader • EM Registrar • Psychiatric Registrar# • Psychiatric Liaison Nurse# - Remove any potentially dangerous objects and/or substances from patient - Provide a safe environment for patient and others - Establish patient's past medical history - Ensure medical assessment is performed -
3	**Possible danger to self or others**	**Urgent** To be seen within 60 minutes	**Observed** - Agitated/ restless - Intrusive behaviour - Not likely to wait for treatment - Withdrawn/uncommunicative - Elevated or irritable mood - Bizarre/disorientated behaviour - Confused **Reported** - Suicidal Ideation - Hallucinations - Delusions - Paranoid ideas - Thought disorders - Severe symptoms of depression	**Supervision** Close observation ** **Location** Identify in each site i.e. sub-waiting area Remove equipment from cubicle **Action** - Inform the following members of staff; • CNM 2/Shift Leader • ED medical staff • Psychiatric Liaison Nurse# - Remove any potentially dangerous objects and/or substances from patient - Ensure security aware of patient's physical appearance and location in ED - Alert Psychiatric Registrar if review deemed necessary by EM medical staff - Re-triage if evidence of increasing behavioural disturbance - Establish patient's past medical history - Ensure medical assessment is performed
4	**Moderate distress**	**Semi-urgent** To be seen within 120 minutes	**Observed/Reported** - No agitation or restlessness - Irritable without aggression - Cooperative - Gives coherent history - Pre-existing mental health disorder - Symptoms of anxiety or depression without suicidal ideation	**Supervision** Routine observation ** **Location** If patient is unaccompanied, identify suitable location i.e. waiting room or sub-wait area **Action** - Inform the following members of staff; • CNM 2/Shift Leader • ED medical staff • Psychiatric Liaison Nurse# - Alert psychiatric Registrar if review deemed necessary by ED medical staff - Re-triage if evidence of increasing behavioural disturbance - Establish patient's past medical history - Ensure medical assessment is performed if admission is required
5	**No danger to self or others**	**Non-urgent** To be seen within 240 minutes	**Observed** - Cooperative - Communicative and able to engage in developing management plan - Able to discuss concerns - Compliant with instructions - Pre-existing non acute mental health disorder - Request for medication - Financial, social, accommodation or relationship problems	**Action** - Patient to be reviewed by ED medical staff - Medical Social Work referral if appropriate **Routine observation****

Appendix IV: 10 Case Vignettes scored

Vignette 1

- **Background**
    - 52 year old of Spanish man self presenting to the emergency department at 19.15
    - He has a history of depression and has attended the community mental health team in the past.
    - He reports a two month history of hearing voices. He feels theses are getting worse.
    - He says “someone is trying to poison me”
    - He admits to alcohol and cannabis usage. He is not currently intoxicated

- **On Arrival**
    - Orientated
    - Vitals not recorded

- **Behaviour**
    - He presents as calm and co-operative.
    - He is not suicidal
    - He wants help.

TRIAGE CATEGORY	**Mental Illness**
MTS	**4**
PTMHTT	**3**

Vignette 2

- **Background**
  - 73 year old woman presenting to the emergency department at 16.30 following GP referral.
  - She has a background history of recurrent depression.
  - She has had previous admission to mental health unit
  - She reports feeling depressed and anxious for a few months
  - She hasn't been sleeping for the past few days

- **On Arrival**
  - Orientated
  - BP 120/80
  - HR 71
  - Sats 99%
  - RR 16
  - T 36.3

- **Behaviour**
  - Anxious
  - Low mood
  - Poor eye contact
  - Suicidal ideation

TRIAGE CATEGORY	**Mental Illness**
MTS	**4**
PTMHTT	**3**

Vignette 3

- **Background**
    - 39 year old woman self-presenting to the emergency department at 23.00
    - She report s that her mood is low
    - She is not feeling herself
    - She is not sleeping
    - Her appetite has reduced
    - She has an 18 year old with Cerebral Palsy and a 4 year old with Down's syndrome. She says she is under a lot of pressure at home.
    - She was seen by the community mental health team 4 years ago and was diagnosed with PTSD

- On Arrival
    - Orientated
    - T 36.8
    - HR 92
    - BP 138/76
    - Sats 97%

- **Behaviour**
    - Tearful
    - Suicidal
    - Low mood

TRIAGE CATEGORY	**Mental Illness**
MTS	**3**
PTMHTT	**3**

Vignette 4

- **Background**
    - 53 year old man referred by GP to the emergency department for mental health assessment
    - He has not been previously seen by mental health services.
    - Family report that he had been missing for 48 before coming to hospital. Reported that he had been sleeping rough in Cork city centre
    - GP Letter contains the following details:
        - Known marked anxiety for the past year but refusing treatment
        - Family supportive but feel patient is erratic
        - They think he is hearing voices
        - Unsure as to recent alcohol misuse, but this has been an issue in the past
        - Sister has gotten a protection order against patient yesterday

- **On Arrival**
    - Orientated
    - HR 96
    - Temp 37.1
    - Sats 96%
    - RR 16
    - BP 145/90

- **Behaviour**
    - Extremely agitated
    - Using profane language
    - Sexually disinhibited
    - Agreeable to assessment

TRIAGE CATEGORY **Mental Illness**

MTS **3**

PTMHTT **2**

Vignette 5

- **Background**
    - 23 year old female BIBA at 03.30 having taken an overdose of friend's medication at around 01.30 Zopiclone 7.5mg x 14, Sertraline 100mg x 15
    - She had also consumed alcohol
    - She contacted her sister who called the ambulance
    - Sister said she took another overdose 6/12 ago

- **On Arrival**
    - airway was clear,
    - RR16
    - HR 100
    - Sats 100%
    - BP 108/78
    - GCS 15/15
    - Glucose 15.6
    - On arrival, No LOC before arrival of ambulance
    - No vomiting

- **Behaviour**
    - Mildly intoxicated but coherent
    - Anxious
    - Cooperative

TRIAGE CATEGORY	**Overdose & Poisoning**
MTS	**3**
PTMHTT	**3**

Vignette 6

- **Background**
    - 41-year-old male brought in by ambulance at 02.20. found by Gardaí lying on the ground in a car park for an unknown amount of time
    - Patient was confused and drowsy with cool extremities when found
    - Patient consumed alcohol and took and unknown quantity of his parents Zopiclone (Zimovane) and Zolpidem (Stilnoct)
    - Ex-wife received texts earlier that night from patient threatening to kill himself.
    - Patient took and overdose of anti-inflammatories 1/12 ago

- On Arrival
    - Airway clear
    - HR82
    - RR16
    - Sats 100%
    - BP 119/65
    - T34.4
    - GCS 15/15
    - Laceration above his left eye

- **Behaviour**
    - Appears confused.
    - Intermittent agitation and restlessness
    - Verbally aggressive, threatening staff when approached

TRIAGE CATEGORY	**Overdose & Poisoning**
MTS	**2**
PTMHTT	**2**

Vignette 7

- **Background**
    - 49 year old female brought in by ambulance at 10.00
    - Found by her son unresponsive in bed. Left a suicide note
    - Empty packets of Olanzapine 10mg x 20, Venlafaxine (Efexor) 3g total, Paracetamol 500mg x 36.
    - Recent depression and treatment in a psychiatric unit

- **On Arrival**
    - Airway clear.
    - HR 62, Regular
    - RR24
    - T-36.1
    - Sats 95%
    - BP 101/65
    - GCS 12/15 at scene, 14/15 on arrival in emergency department.
    - Slurred speech, Glucose 4.8

- **Behaviour**
    - Withdrawn, poor communication
    - Said she is a bad person who deserves to go to hell
    - Witnessed wrapping a drip line around her neck in ED.

TRIAGE CATEGORY	**Self-Harm**
MTS	**2**
PTMHTT	**1**

Vignette 8

- **Background**
    - 30 year old male brought in by ambulance at 02.50
    - Found hanging from a door frame by bed sheets at around 01.45
    - CPR performed by the family as he was initially unresponsive but responsive when the ambulance arrived
    - Had consumed alcohol and illicit drugs earlier
    - Got out of prison recently. Known history and benzodiazepine abuse

- **On Arrival**
    - Airway clear
    - HR 60, regular sinus rhythm
    - RR 12, shallow breaths
    - Sats 99% on room air
    - BP 118/74
    - GCS 10/15 (E2, V3, M5)
    - Glucose 4.8

- **Behaviour**
    - Agitated in response to painful stimuli
    - Currently otherwise uncommunicative

TRIAGE CATEGORY	**Self-Harm**
MTS	**2**
PTMHTT	**2**

Vignette 9

- **Background**
    - 35 year old male brought in by ambulance at 23.00
    - Taken from River Lee by a Garda after he was seen jumping from a bridge 5 minutes earlier
    - Restrained by Gardai as physically aggressive at the scene
    - Known to mental health services

- **On Arrival**
    - Airway clear
    - HR 60, regular
    - RR 16
    - Sats 98%
    - BP 110/70
    - GCS 15/15
    - Glucose 5.3

- **Behaviour**
    - Is agitated and appears afraid
    - Is shouting incessantly about the devil
    - Has verbal and physical aggression when approached
    - Security present

TRIAGE CATEGORY	**Mental Illness**
MTS	**2**
PTMHTT	**1**

Vignette 10

- **Background**
    - 44 year old female brought in by ambulance at 10am
    - Jumped out from second floor window of home, found by husband at 9am
    - History of epilepsy, cluster of seizures the previous day, behaving strangely.
    - No known psychiatric history

- **On Arrival**
    - Airway clear
    - HR 80, regular
    - RR 16
    - Sats 100%
    - BP 108/67
    - GCS 15/15
    - Temp 35.5
    - Obvious pain on movement of right leg

- **Behaviour**
    - Very agitated and moaning
    - Appears confused and frightened when approached
    - Reciting Prayer “Hail Mary” repeatedly

TRIAGE CATEGORY	**Behaving Strangely**
MTS	**2**
PTMHTT	**2**

Appendix V: 15 Case Vignettes Unscored

Vignette 1

- **Background**
  - 25 year old student referred by GP at 16.45.
  - GP Letter contains the following information:
    - Patient broke down in college exam yesterday and could not function
    - She saw a knife while cutting cheese and had thoughts of cutting her wrists.
    - She attended GP in the past for low mood and was treated with antidepressants
    - She said she can't confide in mother about her mental health difficulties as her mother has "no time for mental health issues even though her sister suffers from BPAD"
    - No family members located locally.
- **On Arrival**
  - Orientated
  - Vital signs not recorded
- **Behaviour**
  - Depressed
  - Suicidal ideation

TRIAGE CATEGORY _____

MTS _____

PTMHTT _____

Vignette 2

- **Background**
    - 26 year old unemployed female brough to the emergency department by Gardai at 20.45 following a GP referral.
    - Patient reports feeling depressed and anxious with thoughts of self harm
    - GP Letter contains the following details.
        - The patient appeared to have paranoid ideas about being bullied by her neighbours.
        - When Gardai arrived at her home, she told them that she intended to kill herself. She then struck and marked her forehead with her arm.
        - She has a mild ID and attends the intellectual disability service.

- **On Arrival**
    - Orientated
    - Vitals not recorded

- **Behaviour**
    - She is agitated and talkative.
    - She does not want a hospital admission.

TRIAGE CATEGORY _____

MTS _____

PTMHTT _____

Vignette 3

- **Background**
  - 35 year old male presents to the emergency department at 16.00 following a GP referral
  - GP Letter contains the following details:
    - He has a past history of poly-substance misuse. He denies any current alcohol or drug usage
    - He is reported to be feeling low for the past ten days. He has not left his room at the house in which he is staying.
    - His sleep has become disturbed.
    - His appetite has reduced.
    - His friends have become worried about him.
    - He describes feeling that the world is fake and is worried that the world is being destroyed
- **On Arrival**
  - Orientated
  - Sats 97%
  - RR16
  - T37
  - P90
  - B/P 139/72

- **Behaviour**
  - Withdrawn
  - Willing to be reviewed by psychiatry

TRIAGE CATEGORY _____

MTS _____

PTMHTT _____

Vignette 4

- **Background**
  - 73 year old woman with a history of bipolar affective disorder self presents to the emergency department in the company of her husband at 20.45
  - She was reviewed by the community mental health team in clinic 3 days ago with low mood and suicidal ideation.
  - This evening, she had thoughts of walking under a bus, but has no plans to do so. She has a history of similar thoughts in the context of psychosocial stressors.
  - She has no history of self-harm

- **On Arrival**
  - Orientated
  - T36.3
  - Sats 97%
  - HR 57
  - B/P 126/45
  - RR 18

- **Behaviour**
  - Intermittent thoughts of self harm. No thoughts of self harm currently.
  - Agreeable to review

TRIAGE CATEGORY _____

MTS _____

PTMHTT _____

Vignette 5

- **Background**
  - 29 year old woman presents to the emergency department in the company of her fiancé following GP referral.
  - She reports she has low mood and has suicidal thoughts. She says her mood has been low for a long time, but has worsened in the last 6-8 months.
  - She has a previous history of self-harm 4 months ago and was linked in with the home based treatment team at that time.
  - She identifies the upcoming abortion referendum as a stressor.
  - She is attending a counsellor on a weekly basis. She currently finds this exhausting

- **On Arrival**
  - Orientated
  - T 37.3
  - B/P 116/81
  - HR 103
  - Sats 96%

- **Behaviour**
  - Feels hopeless about the future
  - She has suicidal ideation

TRIAGE CATEGORY _____

MTS _____

PTMHTT _____

Vignette 6

- **Background**
    - 20 year old man presents to the emergency department at 18.00 following referral from his GP.
    - The GP letter reports the following:
        - He has been experiencing auditory and visual hallucinations for the past 3/7. The hallucinations began over the weekend when he was at a wedding.
        - He had drank 15 pints and 2 bottles of vodka at the wedding.
        - The voices say that he is useless and no good.
        - He has a background history of anxiety and low mood.
        - He was on Sertraline but stopped it 2 months ago.
        - In recent weeks he has been self-isolating and not going out with friends.
        - There is no history of illicit substance usage.
        - GP gave him Quetiapine 100mg at 17.15

- **On Arrival**
    - Orientated
    - Vitals not recorded

- **Behaviour**
    - Distressed and agitated
    - Suicidal ideation
    - Crying

TRIAGE CATEGORY _____

MTS _____

PTMHTT _____

Vignette 7

- **Background**
  - 21 year old female self presents to the emergency department at 18.50.
  - She denies and overdose or other self harm behaviour
  - She reports a history of anxiety and depression
  - Patient's mother with patient in the waiting room, agreeable to stay with patient at all times.
  - Patient wishes to speak with psychiatry doctor

- **On Arrival**
  - Orientated
  - Vitals not recorded

- **Behaviour**
  - Suicidal ideation
  - Calm & co-operative

TRIAGE CATEGORY _____

MTS _____

PTMHTT _____

Vignette 8

- **Background**
  - 40 year old gentleman presents to the emergency department in the company of his father at 21.00 following referral from out of hours GP service.
  - He has a history of a psychotic illness.
  - Father reports that his son's mood is increased

- **On Arrival**
  - Orientated
  - Sats 96%
  - RR 22
  - BP 153/91
  - T 38.2

- **Behaviour**
  - He is behaving strangely
  - He speaks in Irish during triage assessment.
  - He has poor eye contact.

TRIAGE CATEGORY _____

MTS _____

PTMHTT _____

Vignette 9

- **Background**
  - 48 year old female from Brazil brought to hospital via ambulance at 16.15.
  - She has recently emigrated from Brazil.
  - She is reported to have had a panic attack in the hotel in which she was staying
  - Staff at the hotel stated that she had a "psych episode"

- **On Arrival**
  - Declined permission for observations to be carried out

- **Behaviour**
  - Patient is staring into space.
  - Guarded
  - She does not allow observations to be carried out. All were normal pre-hospital.

TRIAGE CATEGORY _____

MTS _____

PTMHTT _____

Vignette 10

- **Background**
  - 40 year old woman with a history of schizophrenia self presents to the emergency department at 12.45
  - She reports feeling unwell for the past 2 months.
  - She says that she is hearing voices and these are getting worse. She describes the voices as angry
  - She denies any substance misuse
  - She denies any history of self harm

- **On Arrival**
  - Orientated
  - Sats 97%
  - HR 88
  - BP 134/78
  - RR 16

- **Behaviour**
  - Co – operative
  - Low mood
  - No suicidal ideation

TRIAGE CATEGORY _____

MTS _____

PTMHTT _____

Vignette 11

- **Background**
  - 33 year old woman presents to emergency department at 16.45 following a GP referral.
  - She reports anxiety, palpitations and nightmares since an alleged sexual assault one week previously.
  - She was seen in the sexual assault treatment unit at the time.
  - She is requesting admission to the mental health ward.
  - Poor sleep in the past week.
  - She has a history of bipolar affective disorder and attends the community mental health team

- **On Arrival**
  - Sats 96%
  - HR 99
  - BP 130/89
  - T 37.6

- **Behaviour**
  - Anxious
  - Distressed
  - Not suicidal

TRIAGE CATEGORY _____

MTS _____

PTMHTT _____

Vignette 12

- **Background**
    - 32 year old gentleman presents to the emergency department in the company of Gardai following referral by out of hours GP service.
    - The GP letter contains the following information:
        - He lives in a supported housing complex run by a homeless charity
        - He has a background history of schizophrenia and learning disability
        - Family concerned that he had been behaving bizarrely and was agitated.
        - Family reported that he had expressed suicidal ideation to them.
        - He told family he was seeing dragons in his accommodation.
        - Patient reportedly had expressed suicidal ideation to staff at his accommodation centre.

- **On Arrival**
    - Orientated
    - BP 138/92
    - HR 98
    - Sats 99%
    - RR20

- **Behaviour**
    - Co-operative
    - Denies suicidal ideation
    - Alcohol fetor

TRIAGE CATEGORY _____

MTS _____

PTMHTT _____

Vignette 13

- **Background**
    - 72 year old man with no previous mental health history presents to the emergency department at 19.20 following GP referral
    - He had self harmed by attempted drowning. Planned act
    - He has been low in mood and agitated for the past 12 months, worse in the past month
    - No previous history of self harm
    - No history of alcohol or substance misuse
    - Daughter in attendance

- **On Arrival**
    - Orientated
    - T 36
    - HR 82
    - BP 149/94
    - Sats 95%
    - RR 18

- **Behaviour**
    - Not remorseful
    - Ongoing suicidal ideation
    - Agitated
    - Agreeable for assessment

TRIAGE CATEGORY _____

MTS _____

PTMHTT _____

Vignette 14

- **Background**
    - 17 year old female self-referral to the emergency department at 22.45 following an overdose of Piriton (10-12 x 4mg tablets) taken at 22.15
    - She has vomited and is nauseous
    - She reports being stressed at school. No known psychiatric history

- **On Arrival**
    - Airway clear
    - HR 87, regular
    - RR 18
    - Sats 96%
    - BP 105/65
    - GCS 15/15

- **Behaviour**
    - Anxious and restless
    - Wants to go home

TRIAGE CATEGORY Overdose & Poisoning

MTS **3**

PTMHTT **3**

Vignette 15

- **Background**
    - 30 year old male referred to the to the emergency department at 22.30
    - He took an overdose of his prescribed medications Mirtazepine 270mg and Escitalopram 30mg at 21.15
    - He had also consumed alcohol
    - After taking the medications, he informed his mother and she brought him to the emergency department
    - His mother found a note and said he has been attending psychiatric services.

- **On Arrival**
    - HR 100
    - RR18
    - T 36.6
    - Sats 98%
    - BP 117/85
    - GCS 15/15
    - No vomiting

- **Behaviour**
    - Withdrawn
    - Expressing a wish to die
    - Not sure he wants to stay for treatment

TRIAGE CATEGORY _____

MTS _____

PTMHTT _____