27 January 2022

[redacted]
Email: [redacted]

Dear [redacted]

Official Information Act Request

Thank you for your requests dated 25 November 2021 pursuant to the Official Information Act 1982. These were received as a transfer from the Ministry of Health to Waikato District Health Board on 9 December 2021. You have requested the following information:

1. ***"Please provide Guidelines/Procedures for the management of postoperative Urinary Retention (POUR)"***

Waikato DHB does not have specific guidelines/procedures for the above, however the following are excerpts taken from Lippincott Procedures that DHB staff have access to on Waikato DHB's Intranet. Lippincott Procedures is an online resource of clinical content for standard evidence-based procedure guidance.

Lippincott Procedures - Postoperative Care Clinical Procedures
"Monitor the adult's risk of drug reactions, toxicity, and interactions. Decreased bladder capacity increases the risk for urinary tract infection (UTI). Monitor the patient closely for signs and symptoms of UTI. Decreased kidney function can lead to fluid volume overload. Monitor intake and output closely. You should treat nausea and vomiting early and aggressively. Perform a genitourinary assessment. If the patient has an indwelling urinary catheter, assess the colour, quantity, and quality of urine. Ensure that the catheter is secure and that the drainage tubing has no dependent loops".

Lippincott Procedures - Postanaesthesia Care Measures Paediatric Clinical Procedures
"Maintains adequate intake and output and electrolyte balance. Maintain continuous or intermittent IV infusion, as ordered. Use an infusion-control device, as indicated. Monitor electrolyte levels, as ordered. Monitor for signs and symptoms of fluid and electrolyte imbalances. Monitor the output of body fluids, including the output from tubes and drains. Offer fluids, as indicated. Advance the child's diet from sips of clear fluids to full liquids, as indicated and as ordered. Advancement of fluids from clear liquids to full liquids may not occur until after discharge to home or to another health

care setting. These measures help maintain vital functions, provide nutrition, and prevent dehydration and electrolyte imbalances.

Maintains urinary output. Monitor intake and output; notify the practitioner if output is less than 1 mL/kg/hour. Assess for retention or incontinence. Catherize, as ordered. Anaesthetic agents may temporarily depress bladder tone and response. Accurately recording intake and output helps in the assessment of renal and circulatory function".

Lippincott Procedures - Bladder Ultrasonography, Ambulatory Care – Clinical procedures
"Urine retention is a serious condition that may result from a neurologic disorder or from obstruction of urine flow. It's also a common complication of some types of surgery. Certain medications, such as anticholinergics, sympathomimetic agents, opioids, and some nasal decongestants, may also cause urine retention. Infection, inflammation, and trauma to the pelvis, urethra, or penis have also been implicated as causes of acute urine retention".

2. ***"Please provide Guidelines/procedure for the management/prevention of persistent Postsurgical Pain"***

Waikato DHB does not have one protocol dealing with persistent postsurgical pain, however the following inform our approach for management/prevention:

Assessment Tools for Nursing
Refer to the following attachment:
- Nursing Tools for Assessment – Pain Procedures

Everything Pain Information Hub
Everything Pain is accessible to staff through the hospital intranet and provides information on interdisciplinary pain management care to patients with acute and persistent pain. Within the service there is Inpatient Pain Service (IPS) and Outpatient Pain Service.

The following is an excerpt from the Everything Pain hub:
"Any patient undergoing major surgery involving significant amounts of pain or with a greater propensity towards a poor pain outcome is referred to the IPS for management at the time of operation. We work closely with the regional analgesia service to maximise the benefit for invasive acute pain management techniques. Outpatient Pain Service provides specialist pain interventions and assessments for patients with persistent pain. We run interdisciplinary group pain management programmes for our patients as well as limited individual treatment plans".

Further to this much of our teaching is based on:
- Clinical Updates from the International Association for the Study of Pain Collection Details : PAIN Reports (lww.com)
- Acute Pain Management Scientific Evidence Fifth edition 2020 Volume 1 Adults published for the Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine. Schug, Palmer Scott et al.

- Knowledge and Skills Framework for Pain Management Nursing put together by the Nursing Interest Group of the New Zealand Pain Society and held by them.
- NZ Pain Society resources.

3. ***"Please provide Guidelines/procedure in the treatment of patients after a suicide attempt and/or suicidal ideation"***

Refer to the following attachments:

- *Suicidal or Self Harm Thoughts, Behaviours, Management of Patients Ref: 1811.*
- *Deliberate Self Harm (DSH) Management of Patients Presenting After the Act of Ref: 3983.*

Please note 1811 is currently undergoing review, although much of the information in the attached is still relevant.

4. ***"Please provide Guidelines/procedure differentiating subtypes of primary (idiopathic) constipation"***

These types of cases are mostly managed by General Practitioners (GP) and therefore we do not have Waikato Hospital specific guideline or procedures. Therefore we are refusing your request under Section 18(e) of the Official Information Act 1982 because the document that contains the information requested does not exist. GP's can use the Community Health Pathways Te Manawa Taki/Midland Regions to aid in diagnosis and treatment options for presenting patients.

Waikato DHB supports the open disclosure of information to assist community understanding of how we are delivering publically funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released.

Yours sincerely

Kent Holdsworth
Acting Executive Director – Hospital and Community Services
Waikato District Health board

FLACC scale

Face, Legs, Activity, Cry, Consolability

Criteria	Score 0	Score 1	Score 2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, uninterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractable	Difficult to console or comfort

Used to measure and assess pain for **children** between ages of two months to seven years or **individuals unable to communicate** their pain.

G3447HWF
09/15JB

Sedation score

Alert, no sedation	**0**
Easily roused, **occasionally** sleepy	**1**
Easily roused, **frequently** sleepy	**2**
Difficult to rouse, deeply sedated	**3**

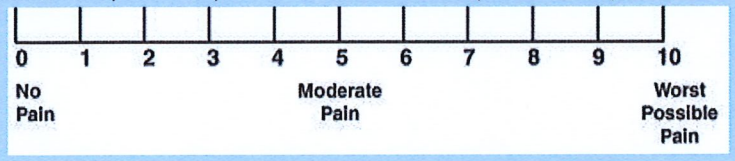
CRITICAL-CARE PAIN OBSERVATION TOOL		
The following pain assessment tool may be used for assessing intubated and nonintubated critically ill adults. It consists of four pain indicator areas scored from 0 to 2, with a total score ranging from 0 to 8. A score above 2 indicates pain.[45] Keep in mind that behavioral pain scales such as this are useful for detecting pain but not for understanding its intensity.[45]		
Indicator	**Description**	**Score**
Facial expression	No muscular tension observed	Relaxed, neutral — 0
	Frowning, brow lowering, orbit tightening, and levator contraction	Tense — 1
	All of the above plus eyelid tightly closed	Grimacing — 2
Body movements	Doesn't move at all (doesn't mean absence of pain)	Absence of movements — 0
	Slow, cautious movements, touching, or rubbing pain site, seeking attention through movements	Protection — 1
	Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed	Restlessness — 2
Muscle tension (evaluate by passive flexion and extension of upper extremities)	No resistance to passive movements	Relaxed — 0
	Resistance to passive movements	Tense, rigid — 1
	Strong resistance to passive movements; inability to complete them	Very tense or rigid — 2
Compliance with the ventilator (intubated patients)	Alarms not activated, easy ventilation	Tolerating ventilator or movement — 0
	Alarms stop spontaneously	Coughing but tolerating — 1
	Asynchrony; blocking ventilation, alarms frequently activated	Fighting ventilator — 2
OR		
Vocalization (nonintubated patients)	Talking in normal tone or no sound	Talking in normal tone or no sound — 0
	Sighing, moaning	Sighing, moaning — 1
	Crying out, sobbing	Crying out, sobbing — 2
Total score		
Reprinted with permission from: Stites, M. (2013). Observational pain scales in critically ill adults. Critical Care Nurse, 33, 68–79. Accessed September 2016 via the Web at http://ccn.aacnjournals.org/content/33/3/68.full.pdf+html		

PAIN SCALES

Various pain assessment tools exist. Be sure to choose a facility-approved tool that's appropriate for the patient's condition.

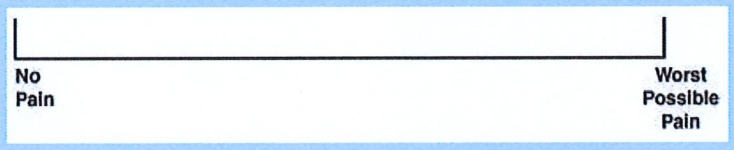
Numeric Pain Scale

A numeric pain scale is a self-report tool. To use it, the patient must have a concept of numbers and their relationship to each other. The scale can be used vertically or horizontally. The numbers range from 0 to 10, where 0 is no pain and 10 is the worst possible pain. The nurse should ask the patient to pick which number corresponds to his pain level.



Visual Analog Scale

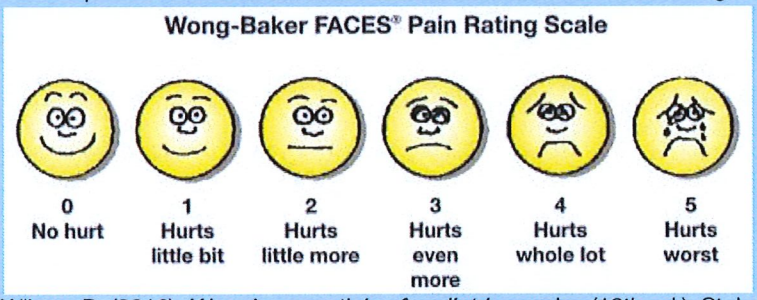
A visual analog scale is a self-report tool that consists of a straight line of a certain length (for example, 10 cm). One end is labeled "No Pain" and the other end is labeled "Worst Possible Pain." The patient marks a line at a place on the scale that best describes his pain. The nurse then measures the distance from the "No Pain" end to the mark that the patient made to determine his pain level. This measurement should be documented and later used to compare subsequent pain levels and evaluate the effectiveness of the pain management plan.



Wong-Baker FACES Pain Rating Scale

The Wong-Baker FACES Pain Rating Scale can be used with patients who have mild dementia or for those who are unable to understand a numeric pain scale. It's a self-report tool in which the patient points to the face that corresponds to his pain intensity. It can be used with a 0 to 5 or a 0 to 10 scale. Explain to the patient what each face means before having him rate his pain.

To use the FACES scale, explain to the patient that each face represents a person who feels happy because he has no pain or is sad because he has some or a lot of pain. Face 0 is very happy because he doesn't hurt. Face 1 hurts just a little bit. Face 2 hurts a little more. Face 3 hurts even more. Face 4 hurts a whole lot. Face 5 hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask the patient to choose the face that best describes how he is feeling.



From Hockenberry, M. J., & Wilson, D. (2016). *Wong's essentials of pediatric nursing* (10th ed.). St. Louis, MO: Mosby. Reprinted with permission.

Waikato District Health Board	Type: **Policy**	Document reference: **1811**	Manual Classification: **Administration and Clinical**	
Title: **Suicidal or deliberate self-harm thoughts or behaviour, management of patients**			Effective date: **01 August 2015**	
Facilitator sign/date	Sponsor authorised sign/date	Process authorised sign/date	Version: **06**	Page: **1 of 8**
Wayne de Beer ***Specialist, Mental Health and Addictions***	*Tom Watson* ***Chief Medical Advisor***	*Mo Neville* ***Director of Quality & Patient Safety***	Document expiry date: **01 August 2018**	

1. Preamble:

This policy sets Waikato District Health Boards (DHB) standard for the appropriate management of patients who have suicidal or deliberate self-harm thoughts or behaviours.

Suicidal or deliberate self-harm (DSH) may result from a wide range of causes, not necessarily mental illness. It is acknowledged that, in general, people who have attempted suicide or deliberate self-harm have done so as a result of psychological distress.

This policy assumes that staff members involved in the assessment of the people who have attempted suicide or engaged in DSH have the required knowledge and competencies to deal with this condition.

This policy relates to any Waikato DHB clinical and administrative settings (excluding the Mental Health & Addictions Service (MHAS) which have other supporting policies and procedures in place)

2. Policy

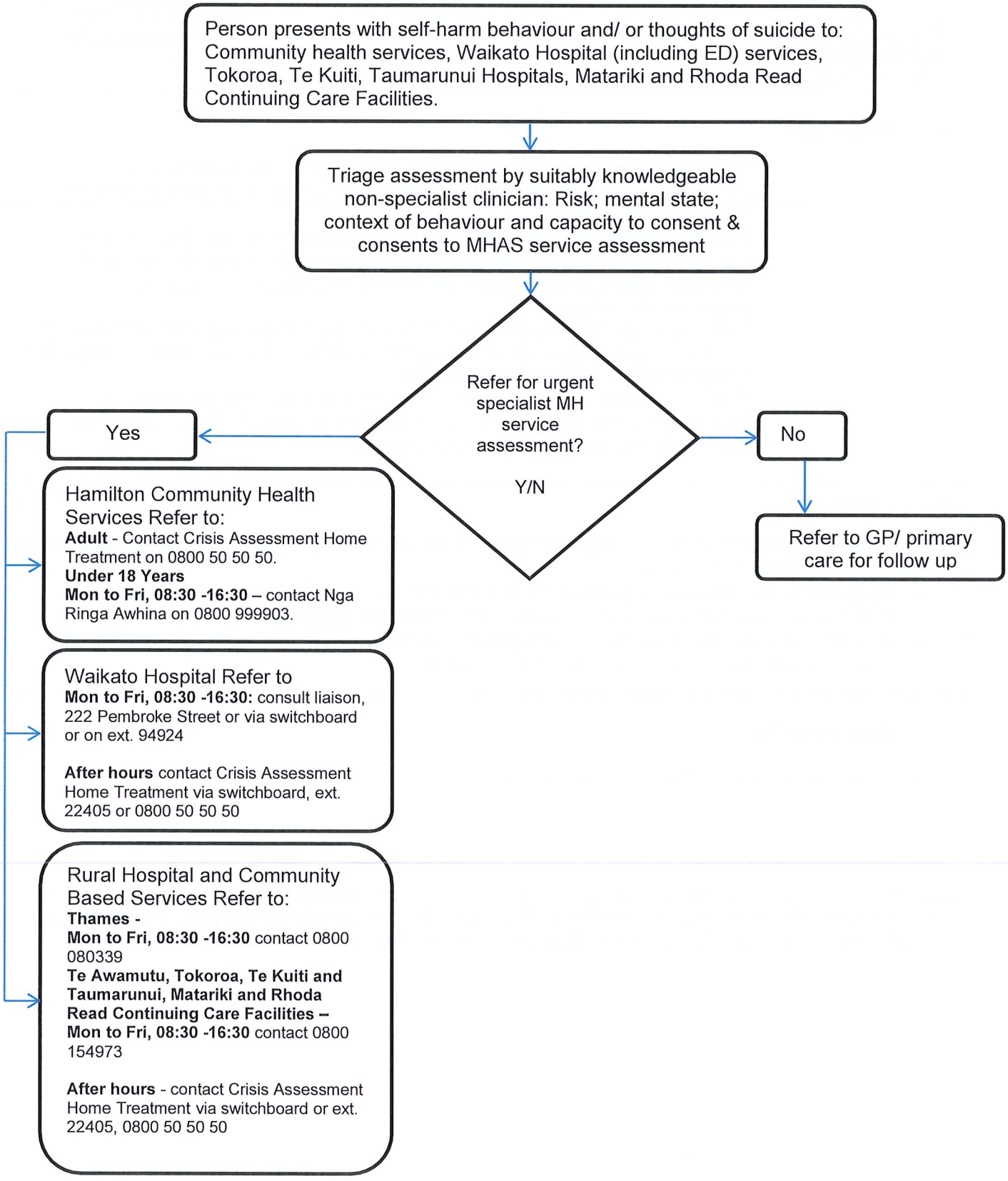
The Waikato DHB policy for management of patients who have suicidal or deliberate self harm thoughts or behaviour is that:

- **All patients who have suicidal or self-harm thoughts or behaviour must have a physical and mental health assessment completed at the earliest opportunity.**
- **All patients who have suicidal or self-harm thoughts or behaviour must be cared for in a way that minimises the risk to the patient / client.**

3. Authorisation

As signed above on behalf of the Chief Executive.

Flowchart for referrals to mental health services for people presenting to Waikato DHB secondary and tertiary services general health services with self-harm behaviour and/ or thoughts of suicide



Appendix A

1. Standards

- It is expected all staff will respond in a timely and professional manner to any people presenting with an attempted suicide attempt or engaged in DSH.
- Staff members are required to conduct a comprehensive assessment and must include a physical examination and other physical investigations deemed necessary.
- Staff members who conduct a culturally appropriate assessment of people with suicidal or DSH behaviours must be familiar with, and be guided by New Zealand Ministry of Health's Best Practice Evidence-Based Guideline: The Assessment and Management of People at Risk of Suicide. (http://www.health.govt.nz/system/files/documents/publications/suicide_guideline.pdf)
- Consult Liaison/ CAHT and ED staffundertaking assessments have access to Te Puna Oranga (Māori Health Service) Kaitiaki (General Hospital) and Kaitakawaenga (Mental Health) to assist with culturally appropriate interviews and assessments.
- The assessment must include an analysis of immediate risk and treatment plans tailored according to estimated future risk.
- When staff are uncertain about the safety risk of the patient while waiting further psychiatric assessment (e.g. admitted to a medical or surgical ward for medical observations), constant observation of the patient may be necessary.
- Where expert opinion is required staff members must refer to Mental Health & Addiction Services (MH&AS) for assistance and further management. MH&AS must be involved with the assessment when staff members request a Mental Health Act (MHA) assessment, admission to the Henry Rongomau Bennett Centre (HRBC) or support and observation in the medical / surgical setting.
- Staff may use either the referral form [R1050HWF (W19)] or the electronic referral for Consultation-Liaison Psychiatry

1.1. Role of Mental Health and Addictions Service

- The role of Mental Health and Addictions Service is to provide the professional assessment of any patient who presents to Health Waikato facilities requiring treatment for suicidal or deliberate self-harm thoughts or behaviour.

- Mental Health and Addictions Service can provide advisory information in relation to:
- Specialist assessment of the risk for further suicidal and deliberate self-harm thoughts or behaviour
- Where and how to admit (if necessary)
- Implementation of the Mental Health (Compulsory Assessment and Treatment) Act 1992.
- Strategies to assist staff in the clinical management of the patient, including observation levels / patient watching.
- Treatment options during admission or post discharge.
- All services within the Waikato DHB can access mental health and addiction expertise, 24 hours a day, seven days of the week.

Waikato Hospital: ED, In-patient services (0800-1600 hours)

- Consult-Liaison (CL) Psychiatric Service
- Monday to Friday 0800-1600 hours.
- Phone: 94924
- Fax: 94926

After Hours (1600-2330 hours)

- Crisis Assessment and Home Treatment (CAHT) Team
- Phone 0800 50 50 50 or contact via switchboard

After Hours (2330-0800hours)

- contact the Duty Co-ordinator
- Henry Rongomau Bennett Centre
  Pager 20097

Waikato Hospital: Outpatient clinics and peripheral satellite services (0800-1600 hours)

- Crisis Assessment and Home Treatment (CAHT) Team
- Phone 0800 50 50 50 or contact via switchboard

After Hours (1600-2330 hours)

- Crisis Assessment and Home Treatment (CAHT) Team
- Phone 0800 50 50 50 or contact via switchboard

Community Hospitals, Matariki & Rhoda Read

- Work hours - Monday to Friday 0830-1700 hours.
- Contact the local Rural Mental Health and Addictions Service

After hours (1700-0830 hours)

- Crisis Assessment and Home Treatment (CAHT) Team after hours
- Contact details as above

Te Puna Oranga (Māori Health Service)

Kaitiaki and Kaitakawaenga Frontline contact numbers:

- 23508 (Waikato DHB) , 25101 (Taumarunui), 25229 (Thames)

2. Responsibilities of staff when a patient with suicidal or self-harm thoughts or behaviour wants to be discharged or decline treatment

- Staff at point of clinical contact should seek advice regarding any situations falling outside the ones listed below in Appendix A, 2.1 – 2.4, from the operations / duty manager / site coordinator or legal advisor.
- Decisions and clinical rationale must be documented in the clinical record including the application for assessment and treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 if required.

2.1. Patients who have not been assessed by Mental Health and Addictions Service but are declining life saving treatment

- This is considered an emergency situation and treatment that will preserve the life of the patient can be provided without consent as per the Waikato DHB Informed Consent policy.
- The responsibility for the decision to treat in this circumstance rests with the multi-disciplinary team who has recourse to common law and consultation with the legal advisor if necessary.

2.2. Patients under the Mental Health (Compulsory Treatment and Assessment Act) 1992

- A patient being treated in the general hospital setting, and who is being compulsorily detained for assessment and treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992, is not free to leave or decline treatment for their mental health condition.
  Note: Patients can not be treated compulsorily for a physical condition under the Mental Health (Compulsory Assessment and Treatment) Act 1992; informed consent must be obtained or in the case of a medical emergency common law may be invoked.
- If the patient attempts to discharge themselves, it is appropriate to take all reasonable measures that do not place staff or other patients / visitors at risk, to prevent them from leaving.
- If the patient is noted to be missing or is unable to be prevented from leaving, staff should notify security, the police and the Mental Health and Addictions Service.
- If the patient has left the hospital grounds the matter must be referred to the police to locate the patient.
- The above scenarios should be documented using the incident reporting process.

2.3. Voluntary patients who may be considered to be at further risk to themselves

- These patients may fall into two categories:
  a. Patient who has not yet been assessed by Mental Health and Addiction Services or
  b. Patient who has been assessed by Mental Health and Addictions Service and is deemed not appropriate for compulsory assessment and treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992.
- A registered nurse may detain the patient to be reviewed by any medical practitioner for up to six hours by invoking Section 111 of the Mental Health (Compulsory Assessment and Treatment) Act 1992. They should advise the patient they are invoking this section and that the patient has the right to seek legal counsel.
  NB: The registered nurse should then immediately contact Mental Health and Addictions Service for assistance and complete the Section 111 form available from Mental Health and Addictions Service.
- Any medical practitioner can invoke Section 110 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 to detain a patient in this circumstance.
- Compulsory assessment occurs by completing Sections 8(a) and 8(b) of the Mental Health (Compulsory Assessment and Treatment) Act 1992. Mental Health and Addictions Service must be contacted immediately for assistance.

2.4. Voluntary patient identified as not being a further risk to themselves

- If no evidence of further risk to self is identified then the patient has all reasonable rights to decline treatment and/or discharge themselves against medical advice.
- Waikato DHB's Admission Discharge and Transfer policy in relation to patient self-discharge must be followed.

Appendix B

1. Definitions

Deliberate self-harm	The act of attempting to deliberately harm oneself with or without the intent to die as a result of that action e.g. sub-lethal overdose, superficial lacerations.
Patient	Refers to patient / client / consumer / tangata whaiora / service user.
Suicidal behaviour	The act of attempting to deliberately harm oneself with the intent to die as a result of that action e.g. potentially lethal overdose, attempted hanging.

2. Legislative / External Requirements

- New Zealand Bill of Rights Act 1990
- Code of Health and Disability Services Consumers' Rights 1996
- Crimes Act 1961
- Mental Health (Compulsory Assessment & Treatment) Act 1992 and Amendment Act 1999
- Criminal Procedures (Mentally Impaired Persons) Act 2003
- Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
- Privacy Act 1993
- Health Act 1956
- Health and Disability Services (Safety) Act 2001

3. Associated Documents

- Waikato DHB Admission, Discharge, and Transfer policy, 1848
- Waikato DHB Advance Directives procedure, 2181
- Waikato DHB Client Pathways for Self-Harm/Suicide
- Waikato DHB Clinical Records Management policy, 0182
- Waikato DHB Critical Incident Management for staff policy, 0175
- Waikato DHB Employee Assistance Programme policy, 0286
- Waikato DHB Incident Management policy, 0104
- Waikato DHB Informed Consent policy, 1969
- Waikato DHB Initial Risk Assessment in Deliberate Self Harm form, A1360HWF
- Waikato DHB Interpreters policy, 0137
- Waikato DHB Patient Watch form, A1138WHF
- Waikato DHB Watching of patients at risk of being harmed or harming others policy, 2188
- Waikato DHB Reference form, R1050HWF (W.19)
- Waikato DHB Restraint policy, 2162 and use of restraint procedures 1860, 1865, 2153, 2154, 2155, 2156, 2157, 2158, 2160
- Waikato DHB Risk Management policy, 0118
- Waikato DHB Security policy, 0120
- Waikato DHB Tikanga Best Practice guidelines, 2118
- Waikato DHB Visitors to Patients policy, 0125

4. References

- The Assessment and Management of People at Risk of Suicide Best Practice Evidence-based Guideline Ministry of Health May 2003
- Health and Disability Commissions information pamphlet on Advanced Directives

Waikato District Health Board

Guideline

Deliberate Self Harm (DSH), Management of Patients presenting after an act of

Guideline Responsibilities and Authorisation

Department Responsible for Guideline	Emergency Medicine – Administration
Document Facilitator Title	Emergency Physician
Document Facilitator Name	Tonia Nicholson & Anna Nienaber
Document Owner Title	Clinical Director
Document Owner Name	Ian Martin
Target Audience	Emergency Department Staff
Disclaimer: This document has been developed by Waikato District Health Board specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at their own risk and Waikato District Health Board assumes no responsibility whatsoever.	

Guideline Review History

Version	Updated by	Date Updated	Summary of Changes
05	Victoria McLean and Anna Nienaber	17/10/2017	Formatted into new template. Review and update of previous version

1. Purpose

- To ensure safe observation, treatment and disposition from ED, of patients who have attempted DSH.

- For people presenting at risk of suicide, the responsibilities of emergency staff are to:
  - triage and plan for their safety
  - diagnose and treat any concurrent non-psychiatric illness or injury
  - perform a suicide risk assessment for all people who have suicidal thoughts or have self-harmed, when they are deemed ready to interview
  - assess for the presence of red flags for short-term risk
  - identify those who require an immediate comprehensive mental health specialist assessment within the emergency department
  - identify those who can safely be discharged with a comprehensive mental health assessment follow-up within 72 hours and who have good support systems
  - identify those very-low-risk people with good support systems who can be safely discharged to the community and referred to primary care management
  - Engage with families to inform and support them.

2. Definitions

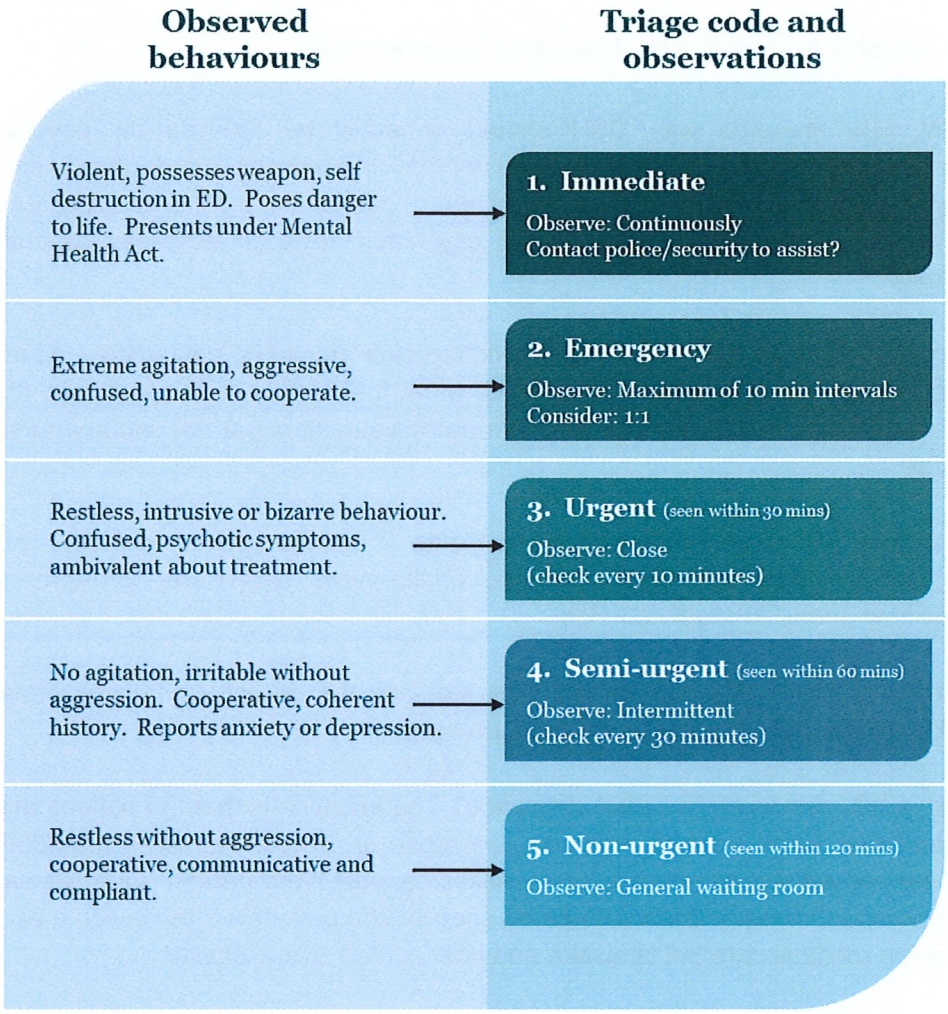
- People who present following an act of deliberate self harm (DSH) +/ or attempted suicide are often in a state of extreme distress.

- The Ministry of Health has issued guidelines on how to assess and triage such patients. These guidelines should be followed in Waikato ED. https://www.health.govt.nz/publication/preventing-suicide-guidance-emergency-departments

3. Triage

- Those patients who are assigned a mental triage score of 1, 2 or 3 will require 1 on 1 observation. Triage score 4 only need intermittent observation. Once it has been decided that observation is necessary, the nurse in charge (NIC) should be notified. They will:

  - Arrange an appropriate cubicle for the patient to go to
  - Arrange an appropriate "patient watch" e.g. family member, carer, ED attendant, hospital aid or security guard.
  - Arrange with duty manager a "watch"
  - Notify the ED consultant in charge of the shift



- Adapted version of the Australian Mental Health Triage Scale (AMHTS) as used in https://www.health.govt.nz/publication/preventing-suicide-guidance-emergency-departments

4. Risk assessment

- The "*Mental Health Patients Risk Assessment Pathway*" is available in triage and the document bookshelf by the main desk. This allows a quick risk assessment of the patient and stays in the patients notes.

5. Medical management

- Overdose, injuries and medical conditions should be dealt with appropriately

- Anxious, aggressive and uncooperative patients refer to the *Violent Patients: Management of Potentially* guideline.

6. Mental health referral and Medical clearance/interviewable

- Every patient who presents with DSH should generally be referred for psychiatric assessment. Consult Liaison Psychiatry services are the service used during normal business hours. The Crisis Team assess psychiatric patients during the evening and on weekend and public holiday days. The on-call psychiatric registrar assesses psychiatric patients overnight.

- Psych liaison, CAT team or the on call psychiatric registrar should be contacted – either by the doctor responsible for the patient or the NIC, to let them know of the presence of the patient in the department. The referral may be done by yourself or via the primary nurse or nurse in charge

- Electronic referrals are made to Consult Liaison after you have spoken to them. This is done via the clinical workstation on the patients' health views. Steps are; MH forms, MH referrals, click new and fill in required fields.

- The Crisis team can be contacted via the Operator and the on-call psychiatric registrar through the Henry Bennet Coordinator via the Operator.

- These teams usually request a "medical clearance". The intention is that the patient can be interviewed and that acute medical problems, overdose or injuries has been attended to. Psychiatric assessment should not wait for medical clearance if the person is interviewable. Inform the appropriate mental health service as soon as the patient is interviewable even if still need ongoing medical care but is awake and not sedated or intoxicated.

7. Disposition

- Some patients will be admitted by the mental health team to HBC

- After the mental health team has seen the patient and want to discharge them from ED an ED discharge letter should be done.

- Very occasionally, patients may be discharged after a period of observation without psychiatric assessment in the ED if the treating EM doctor feels that the person is at very low risk of further self-harm in the near future. This should ideally be done in consultation with mental health services to organise ongoing follow outpatient follow up