Working towards enhanced care for patients presenting to Plastic Surgery and Burns following self-harm

Crowley G[1], Qaqish Y[2], Clarke A[1], Barton C[1], Eldolify M[2], Green A[1]
(1) Mental Health Liaison Team (2) Plastic Surgery department, North Bristol NHS Trust, Bristol, UK

Introduction

Deliberate self-harm (DSH) is a common presentation to plastic surgery and burns teams (PSBT). In the 2014 UK Adult Psychiatric Morbidity survey, three-quarters of people who reported DSH had used cutting and around a tenth had used burning as methods of self-harm[1]. Evidence suggests that patients with DSH burns are more likely to have severe injuries, spend longer in hospital and require surgery compared to patients with accidental burns[2]. Furthermore, one in 25 patients who present to hospital following DSH will die by suicide in the next five years[3]. Survey data suggests that PSBT staff lack knowledge of national guidance for the care of these patients[4].

Aims

1. To describe all DSH encounters had by the PSBT at one tertiary Burns centre over a 10-month period.
2. To audit current practice against the NICE quality statement QS34 "*"people who have self-harmed receive a comprehensive psychosocial assessment"*[5].

Methods

- Study population: all clinical encounters with the PSBT for DSH injuries
- Study period: 1st January – 31st October (10 months)
- Data sources: database of patients provided by the surgical administration team, electronic patient record for the local mental health trust, clinical notes from the acute trust (which had been scanned and uploaded), electronic discharge summaries
- Data collection: Microsoft Excel was used to collate the data, calculate proportions and create pie charts

Results

PATIENT DEMOGRAPHICS

- Over the 10 month period, the PSBT had 90 patient encounters for DSH injuries, involving 71 individual patients
- 46 (65%) female, 25 (35%) male
- Median age: 30 years old

SURGICAL DATA

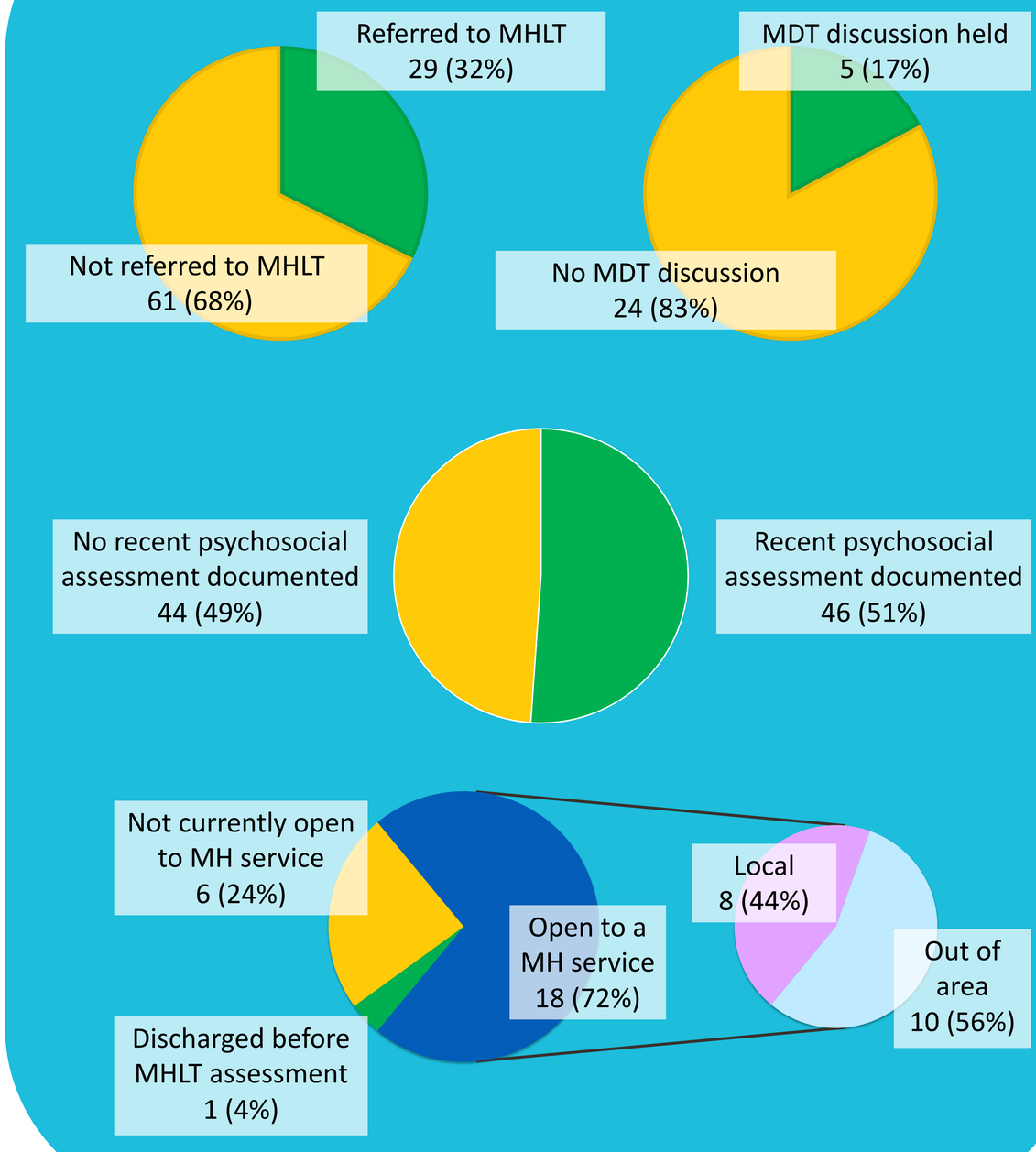
Of the 90 encounters:

- 63 (70%) burns, 27 (30%) plastic surgery
- 40 (44%) admissions, 40 (44%) outpatient clinic appointments, 6 (7%) ED reviews, 4 (5%) reviews at another site
- 24 (27%) involved a surgical intervention - 16 (67%) for patients known to the surgical team, 8 (33%) for new patients

MENTAL HEALTH DATA

- 29 (32%) of encounters were referred to the MHLT, representing 25 patients
- 26 (65%) of admissions were referred to the MHLT
- Of the 25 patients referred to the MHLT, 16 (64%) had a pre-existing mental health diagnosis and 9 (36%) had a documented history of substance misuse.

Results



Conclusions

Two thirds of patients who needed surgical intervention were already known to the PSBT, suggesting a high rate of recurrence and need for multiple surgeries among this cohort. Around a third of DSH encounters were referred to the MHLT - further investigation is required to determine what support those not referred are offered. MHLT assessments frequently require communication with "out of area" mental health teams, which has implications for information-sharing, clinical handover and arrangement of timely follow-up.

Recommendations

These findings will inform the development of Trust guidance on enhanced care for these patients. This should include (not exhaustively):

1. When/where/who should complete psychosocial assessments
2. Which patients should be referred to the MHLT
3. Minimum signposting/support for patients not referred to the MHLT
4. Procedures for communicating with out of area mental health teams
5. Procedures for organising MDT discussions. We recommend that an MDT discussion between the PSBT and MHLT be held for every inpatient. The patient's care co-ordinator or a member of their usual team should be invited to attend, if appropriate.

References

1. McManus, et al (2014). Adult Psychiatric Morbidity Survey
2. Conlin, et al (2016). DOI: 10.1177/0036933015619312
3. Carroll, et al (2014). DOI: 10.1371/journal.pone.0089944
4. Heyward-Chaplin, et al (2018). DOI:10.1177/2059513118764100
5. NICE (2013). Quality Standard QS34