AFSP coding instructions

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The coding will be recorded using GRiST in a specially-established research group on egrist. The group will use the same population as that for the last GRiST assessment, with the default being working-age.

Two GRiST assessments are required for each patient, one to record the outcomes following the last GRiST assessment, for both SI and non-SI patients, and the other to record information in patient notes at the time of the last assessment that was not in that assessment.

Part I
SI patients

1 Download GRiST reports for all SI patients

To obtain the grist reports for analysis:

1. Headless login to humber where the GRiST ID is the identifier and also the patient name.
2. Record the number of assessments and time lapse between then for each patient, starting with the first and ending with the most recent. This is put into the Excel file of data about each patient.
3. Download the first two and last two, or all of them if 4 or less. The GRiST id is in the report name automatically.

2 Set up the GRiST data-collection patient entries

1. Create two patients for each real patient with the GRiST ID as the surname but two different first names and patient ids:
   (a) First patient:
      i. Patient id = first 6 digits of the GRiST ID then hyphen then LGNI (Last GRiST New Information):
         `######-LGNI`
      ii. First name = Date of the last grist assessment.
      iii. This patient will record data not in the last GRiST assessment but that was known at the time.
   (b) Second patient:

i. Patient id = first 6 digits of the GRiST ID then hyphen then GDLC (GRiST for Date of Last Contact):

   `######-GDLC`

ii. First name = Date of last contact.

iii. This patient will record data not in the last GRiST but that would have been in a subsequent one done when the patient was last seen by a clinician.

3 Coding scheme for LGNI and GDLC patient data

Crucial rule When closing the assessment, ONLY use the SUSPEND button.

1. Definition of each assessment states what information it should hold:

   (a) LGNI: Last GRiST New Information

      i. Record data that was available at the time of the last GRiST assessment but that was not entered.

      ii. Do not record any data that shows up *after* the date of the last GRiST.

   (b) GDLC: GRiST at the Date of Last Contact

      i. Record data that was available at the time of the last clinical contact and that should have been added to the GRiST if one had been done.

      ii. Check against the last GRiST assessment to see what was already in that one and only add information that is new or would have been updated at the last clinical contact date.

2. For both assessments:

   (a) Put 10 for any information that indicates a number along the scale or 0 if the information is no risk for that item (e.g. no problems with insight would be 0; has poor insight has 10).

   (b) Put a quote from the notes into the comment for the item so that we can subsequently estimate, if needed, the quantification of that item.

   (c) If new information contradicts what is currently in the GRiST, replace the current information with the correct information and **say in the notes that it was wrongly put into their grist**.

      i. For example, if the rating for an item was 3 but the notes suggest it should have been higher, put a 10 (i.e. flag it as new information using our method of making it either 0 or 10 so that we can produce a validated score later) and **add a comment with quotes from the notes justifying the score needs changing and helping us quantify it later**.

   (d) Dynamic risk data (i.e. no padlocks) can be recorded but only for information within 2 weeks of the date of the GRiST. It may have changed for the last one if it is any longer than that.

   (e) Start at the date of the assessment or last contact, depending on which GRiST you are doing, and work backwards. This is more efficient and makes it easier to know when dynamic data should be ignored.

3. LGNI patient:

   (a) If information is in the actions or comments associated with the overall risks but is not recorded in the GRiST assessment data itself:

i. Extract and add it to the GRiST data but put in the comments for each item added that it came from risk summary by adding **RS** for risk summary.

4. GDLC patient:

   (a) Put dates in comment boxes for all data since the date of the last GRiST and start from the most recent information.

   (b) The quantified answer will apply to the information given at the most recent date, but previous date input may still be relevant.

4 Serious Incident report and general outcome coding

Outcomes are recorded using the patient notes and the serious incident report, if the patient conducted an SI. For both sets of data, they only apply to information *after* the final GRiST assessment. However, for patients that did not have a SI, there is no obvious end-point to how far the follow-up must go. This may be obvious in that they don't have any further notes because they have been discharged. But if they are still in care, then the outcomes might stretch over a very long time.....although they should have done a GRiST assessment during that time.

1. The date of the final GRiST assessment will have been entered in the patient's date of birth item.

These reports are coded to collect information

1. Code nature of the incident.

   (a) GRiST risk-specific information, recording this particular incident only. In other words, when questions ask about the general method, for example, record this specific method. And so on for other questions that are looking for more generic risk behaviours: they should all be answered specifically for the serious incident.

   (b) Only facts about the incident must be recorded, no suppositions.

   (c) Select the appropriate risk.

   (d) Complete the incident data as if it was the only episode. It may not be, but you are only interested in this single outcome for this particular form. In general, incident data needs:

      i. Date of incident;
      ii. Method of incident;
      iii. Outcome of incident.

   (e) Use the following fields for suicide SI information:

      i. Date in the date of last attempt. Ignore any other attempts.
      ii. Seriousness and method in "How lethal was the most serious method used by the person in any of the suicide attempts (i.e. how likely to succeed in killing the person without any intervention)?".
         A. Death is 10 and near-miss is 9 (i.e. survival).
         B. Method of suicide attempt is recorded in the comment field. Give the code for the method followed by the descriptive text of the method. For example 4 overdose of prescription pills, if 4 is the code for overdose.

2. All relevant risk data between the last assessment and the SI but NOT anything prior to the last assessment.

   (a) Information may come from

      i. SI report
      ii. Patient notes

   (b) Keep a note of any information in the SI report that is **NOT** in the notes. This information must be **factual**, not supposition or inference by the report authors. It might have come from the follow-up investigation but this must be clear that this is the case rather than the authors assuming something about the patient (eg attitude to illness or hospitalisation).

   (c) Information recorded should have a date for when it became available.

3. Interventions following most recent GRiST assessment

   (a) Nature of interventions in commment box for top-level concern question about concordance with health treatment: "Are you concerned about the person's concordance with health treatment?".

   (b) Failure by services to implement treatment or care needs: "To what extent does the person fail to perceive health or social care services as supportive?"

   (c) Failure by patient to concord with intervention: "To what extent is the person failing to concord with medication or therapies, either deliberately or due to complexity of polypharmacy, for example?".

4. Any post-assessment data about the patient should be recorded as a comment with the date for when the data applied and what it is about. The comment should be for the most appropriate GRiST question. For example, if we know the patient was threatening to harm himself or someone else, this should go in the appropriate place as if this was an incident for GRiST to record but as a comment. If the quantitative answer can be given unambiguously, this could be answered as well but the comment must *always* be given with a date and specific details.

5. Trust conclusions about the SI

   (a) From the last box before the signatures.

   (b) Put it in the overall comments in GRiST that can be accessed by the "Finish" button, but only suspend the assessment from that point, don't submit it. This data goes into the Assessment Notes box on the report, which is right at the top.

   (a) The date of the last assessment.

5 Matching patients documentation

1. Discharge report
2. current medication
3. IPM Discharge form
4. Fax to GP

5. Core group meeting documentation and submitted reports (most recent)
6. Core infornation section (most recent)
7. BPRS
8. Physical health and wellbeing review
9. Care Plans
10. Medication reconciliation tool
11. Mental Health Assessment document
12. Communications sheet: diary of clinical contact with patient.

6 Analysis

When comparing between the new information and the original, only use new information if there was no quantitative answer in the original. Sometimes the new information is to add a comment to the answer the clinician already had on the rating scale.

Try stretching the clinical risk judgements and then matching with GRiST for correlations. Clincians are marking risk down as too low.