National Self-Harm Registry Ireland

Standard Operating Procedures Manual

Version: March 2017

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Introduction

The aim of this document is to describe the data collection and data processing procedures of the National Self-Harm Registry Ireland.

Background

The Registry is operated by the National Suicide Research Foundation (NSRF) under the directorship of Professor Ivan J. Perry, Head of the Department of Epidemiology and Public Health at University College Cork. The Registry was established at the request of the Department of Health and Children in 2000. For the period of 2002-2005, the Registry had near complete coverage of the country's hospitals and since 2006 all general hospital and paediatric hospital emergency departments in the Republic of Ireland have contributed data to the Registry.

The primary aim of the Registry is to strengthen the information base on suicidal behaviour in the Irish population. Specifically, the Registry aims to quantify the extent to which presentations are made to acute public hospitals in Ireland as a result of self-harm; to identify the groups with the highest rates of self-harm presentations and repeat presentations; to identify the methods of self-harm that are employed; and to identify the areas in Ireland with the highest rates of self-harm.

The uses of the Registry relate to patient care, public health and epidemiological research. The Registry has contributed to increased knowledge and understanding of suicidal behavior, thereby facilitating better treatment of the individuals involved. It identifies the groups and areas that most need to be targeted for prevention and intervention. Information from the Registry informed core actions included in the Irish National Strategy to Reduce Suicide in Ireland, Connecting for Life, 2015-2020.

The findings from the Registry are published via an annual report. Additionally, Registry findings are disseminated via interim reports, research bulletins and peer-reviewed publications.

In 2015, the National Self-Harm Registry Ireland was recognised by the World Health Organisation (WHO) as a template for self-harm surveillance for countries at global level. The Northern Ireland Self-Harm Registry was developed from the template of the National Self-Harm Registry Ireland and is operated by the Public Health Agency. Since 2012, the Northern Ireland Self-Harm Registry has had full coverage of all Health and Social Trust areas.

Funding

The Registry is funded by the Irish Health Service Executive's National Office for Suicide Prevention.

Ethical approval

Ethical approval has been granted by the National Research Ethics Committee of the Faculty of Public Health Medicine. The Registry has also received ethical approval from the relevant hospitals and Health Service Executive (HSE) ethics committees.

Confidentiality and ethical considerations

Confidential data is any personal information relating to an individual who can be identified either directly or indirectly by reference to an identification number or by reference to one or more factors specific to her/his physical, physiological, mental, economic, cultural or social identity.

Data presented in statistical form which is of such a type that individuals concerned can no longer be reasonably identified, are not considered to be confidential data.

Confidentiality in the use of personal data in medical research is governed both by the ethical guidelines of the medical profession and by the provisions of the Irish Data Protection Act (1998, 2003). The NSRF is registered with the Data Protection Agency and complies with Irish data protection legislation. Ethical approval has been granted to the Registry by the National Research Ethics Committee of the Faculty of Public Health Medicine. The Registry has also received ethical approval from the relevant ethics committees with responsibility for individual hospitals and health boards.

Preservation of confidentiality, as well as being an obligation, is essential to maintain the trust of those who provide the Registry with information. Hospital staff must be assured that the welfare of their patients will be respected and that the Registry staff will observe the same strict rules with regard to confidentiality that exist in the hospital. The Registry staff also have a legal and moral obligation to avoid acts that may cause suffering or distress to any individual.

In carrying out its functions, the Registry staff must adhere to the following guidelines:

- ➢ Permission for access to medical records must be sought from each individual hospital;

- ➢ An information leaflet describing the Registry (**Appendix 1**) must be made available in a suitable place within the emergency department of each participating hospital;

- ➢ No disadvantage, harm or distress may be caused to the patient by this access;

- ➢ Appropriate safeguards must be in place to preserve the confidentiality of the information in the Registry's custody;

- ➢ Reports of the Registry must not contain information which would disclose the identity of a patient.

The principles of confidentiality must apply not only within the Registry but also to any data released by it, whether for public information, or to individual researchers. As a safeguard, all Registry staff must sign a confidentiality agreement**.**

Definition and terminology

Self-harm

The Registry uses the following as its definition of self-harm*:*

> *'an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or expected physical consequences'* (Platt et al, 1992; De Leo et al, 2004).

This definition was developed by the WHO/Euro Multicentre Study Working Group and was associated with the term 'parasuicide'. Internationally, the term parasuicide has been superseded by the term 'deliberate self-harm' and consequently, the Registry has adopted the term 'self-harm'. The definition includes acts involving varying levels of suicidal intent and various underlying motives such as loss of control, cry for help or self-punishment.

Inclusion criteria

➢ All methods of self-harm are included i.e., drug overdoses, alcohol overdoses, lacerations, attempted drownings, attempted hangings, gunshot wounds, etc. where it is clear that the self-harm was intentionally inflicted;

➢ All individuals alive on admission to hospital following a self-harm act are included.

Exclusion criteria

The following cases are **NOT** considered to be self-harm:

➢ Accidental overdoses e.g., an individual who takes additional medication in the case of illness, without any intention to self-harm;

➢ Alcohol overdoses alone where the intention was not to self-harm;

➢ Accidental overdoses of street drugs i.e., drugs used for recreational purposes, without the intention to self-harm;

➢ Individuals who are dead on arrival at hospital as a result of suicide.

Please see **Appendix 6** for a detailed description of exclusion criteria.

Registry operations

National Self-Harm Registry Ireland

Data Collection
DROs

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Manual

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Case ascertainment from registration files

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Data Processing

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Section 1: Data Collection and data entry

Data Registration Officers

1.1 Key responsibilities and duties

The primary role of the Data Registration Officer (DRO) is to work within a number of emergency departments of public hospitals within a particular HSE health region to gather and collate information on cases of self-harm for the Registry. The DRO will be responsible for the identification of cases from hospital records of incidences of self-harm, the extraction of relevant information from these records, and the digital recording and uploading of this anonymous data.

The principle duties of the DRO include the following:

➢ To identify in a systematic way cases of self-harm from attendance records of acute hospitals within a particular HSE health region, using pre-defined inclusion and exclusion criteria;

➢ To extrapolate relevant information from these records, based on the coding system below;

➢ To digitally record the details for each case using the Registry data entry system;

➢ To securely upload data to the Data Manager at regular intervals;

➢ The DRO may also be required to check any coding queries, and to perform quality check activities on an annual basis;

➢ The DRO is required to work within to the guidelines of protection of data.

1.2 Hospital visits

The Registry obtains data on cases of self-harm that present to acute hospital emergency departments. All acute public hospitals are to be included in the Registry. Data collection is carried out by the Registry DROs.

Before a DRO makes a first visit to a hospital, the following should have occurred:

➢ Hospital management will have met Registry management and will have been fully informed about the Registry;

➢ Formal written permission will have been obtained from the hospital's chief executive officer or manager;

➢ The relevant emergency department staff and medical records officers will have been informed of the Registry.

Ideally the hospital chief executive officer will personally introduce the data collector to the relevant emergency department and medical records staff. If this is not possible, the emergency department consultant or staff member in charge of emergency department could make the introductions. By definition therefore, the officer's first visit to a hospital should be by appointment.

Visits to hospitals must be made on a **regular** basis, weekly, fortnightly or monthly according to the number of attendances at the emergency department of the hospital. Where practical, it is preferable to make a courtesy telephone call prior to visiting a hospital for data collection. It is useful to have contact with a member of staff who is regularly on duty e.g. an administrative officer. In larger hospitals where weekly visits are needed, it may be possible to arrange a regular time-slot which is convenient to hospital staff.

The following procedural guidelines apply to the work of the DROs in the hospitals and in general:

- DROs must make themselves known to hospital staff at each visit and Registry identification and/or authorisation issued by the hospital must be carried at all times;

- Arrangements for security and confidentiality within the hospital must be strictly observed. Medical records should never be taken from areas assigned to them without the specific permission/knowledge of hospital staff;

- DROs should always be aware of the current situation in an emergency department and be prepared to leave if necessary;

- All written material pertaining to the Registry must be kept in the possession of the Registry DRO;

- Personal details of cases should not be discussed;

- Any requests for information must be referred to the Registry office at the NSRF in Cork;

- Any material that is not relevant to the Registry should be ignored;

- Identifiable information pertaining to patients should never be discussed over the telephone.

1.3 Case definition and ascertainment

A number of guidelines must be adhered to in order to ensure a consistent and uniform approach to case ascertainment for all DROs.

The DRO must check through all entries in the casualty book or the relevant emergency department computer file that logs every attendance at the hospital's emergency department. If the hospital does not permit the Registry DRO to access the emergency department computer system then a printout must be sought that details all attendances. If the hospital will only provide such a printout for specified types of emergency department attendance then it is important that the categories are broad enough to include as close to 100% of all self-harm presentations as possible.

If there is evidence (e.g. a note written in the emergency department or medical records) that a patient did not want his/her data to be passed to an agency outside of the hospital then the patient's wish must be respected. In such a case no information should be recorded by the DRO.

All potential cases of self-harm that have presented to the emergency department should be identified. The emergency department number, date and time of attendance, along with other relevant details should be noted on a general collection sheet. The principle here is to spend as little time as possible at the casualty book or emergency department computer. The relevant emergency department chart and/or medical record should be consulted in order to confirm that the presentation meets the case-definition criteria of the Registry. **Appendix 5** contains a list of common abbreviations that may be found in emergency department and medical records.

In practice, if a Registry DRO is unsure whether a hospital presentation is a case of self-harm they should contact the Data Manager at the NSRF.

Data entry

1.4 Electronic data entry system

All data on individual cases of self-harm are entered using a standardised electronic data entry system.

Once sourced from the emergency department and/or medical records, the data items required by the Registry should be recorded by the DRO using the software system. The data items must be entered as outlined below as this ensures that individual patients cannot be identified from the information recorded.

If data is available in excel format from medical records, then the data can be checked and formatted in excel and imported into the software system

Data for each month should be provided to the Data Manager by the end of the following month.

1.4.1 Registry system controls

The system contains a toolbar of seven controls at the top of the screen:

Save

When the forms are completed the "Save" button is pressed and a message box will appear saying that the specific record number has been saved successfully to the access database. If the Mandatory Fields (Health Board, name of hospital and methods) are not complete, an error message will appear saying that they must be entered. The form cannot be saved without all three of these mandatory fields. If the Christian initials, surname initials or gender have not been entered, a warning box will appear advising the DRO that these fields should be entered.

Upload

Pressing the upload button will transfer all saved records to an excel spreadsheet, which can then be uploaded remotely by the Data Manager in the NSRF.

Clear current record

This button can be used to clear a current record at any time during data entry. Once it is pressed the cleared data cannot be returned unless the record has been saved prior.

Update

Pressing the update button will bring up an edit record box. Here the user can enter in a particular record for retrieval. The record can then be edited and resaved.

Remove records

Pressing the remove records button will bring up a message box to clear either ALL records or delete records up to and including a specified record number. This should only be carried out after consultations with the NSRF, to ensure that they have received all records successfully.

Exit

The Exit button will exit out of the application completely and should only be pressed when all records are saved and the data entry is complete.

Help

The Help button will bring the user to this document, to be used as a reference point.

View existing records

Clicking the view existing records button will allow the DRO to view the whole database but will not allow the DRO to make changes to the data.

Data is entered into the data entry system using three sections, which are presented as tabs on the right hand side of the screen: Monitoring Forms 1 and 2, and Special Cases. Users can navigate through these sections by clicking the tab.

1.4.2 Monitoring Form 1 (Appendix 2)

Mandatory fields

There are two Mandatory Fields on Monitoring Form 1. These relate to the DRO's HSE region and their subsequent hospital. As each application is tailored to the DRO, their name will be on the form and cannot be changed.

Record No.

Each entry is given a unique record number that appears at the bottom of the screen. This number will increment as each new record is saved.

Date of registration

Each record has a date of registration which is automatically recorded by the application. It is used to record when each record was entered by the DRO and can be used as a way to track data entries.

Initials

- The patient's first name is entered. If it is unknown, the *Not Known* box should be checked

- The patient's surname is then entered. If it is unknown, then check the *Not Known* box

- If the patient has a prefix to their surname, or if their surname is double barrelled, then the relevant option should be checked in the *Select Surname Type* box

- If the patient has a double barrelled surname that has a prefix on the first surname or second surname, select the *Prefix* box and the *Double Barrelled* box before entering both surnames

- Before moving to another section of the form the application will display a message box that will show the names entered and ask if this is correct

- When the record is saved, the patient's name is not recorded in the access database. Elements of the patient's name are used to create an encrypted code for each case of self-harm.

Gender

The appropriate box should be checked to indicate whether the patient is male or female or if the gender is unknown. Gender is used to create an encrypted code for each case of self-harm.

Date of birth

The date of birth should be entered in the form DD/MM/YYYY. The system automatically defaults in the 1900's however there is a drop down option for those who were born in the 2000's. Once the date of birth is entered it appears in the text box. If this is unknown, the *Not Known* box should be checked. If the date of birth is outside a particular range (>65) the system will prompt the DRO as to the age and ask to confirm this is the correct date of birth. Once the record is saved, the date of birth is used to create an encrypted code for each case of self-harm.

Date of attendance

The date of attendance is also entered in the form DD/MM/20YY. It is defaulted on the present year. If this is unknown, then the *Not Known* box should be checked.

Hour of attendance

The hour of presentation is recorded according to the 24 hour clock. If the hour of attendance is not known, then the *Not Known* box should be checked.

Brought by ambulance

The appropriate option should be selected to indicate whether the patient was brought to hospital by ambulance or not or if it is unknown.

Medical card

It should be indicated whether the patient is a medical card holder or not or if this was unknown.

Psychiatric review/ assessment

The appropriate option should be selected to indicate whether the patient received a psychiatric review or assessment in the presenting hospital for this self-harm presentation or not, or if this is unknown.

Accident and Emergency (A&E) admission

The appropriate option should be selected to indicate if the patient was admitted to an A&E ward or not during this hospital presentation, or if this is unknown. This field includes Medical Assessment Unit (MAU), A&E wards, and other observation units in an emergency department. This field should be answered regardless of the eventual admission outcome (see next).

Admission

The appropriate box should be ticked to indicate whether the patient was admitted to a ward of the treating hospital or to a psychiatric in-patient unit/ward/hospital after treatment in the emergency department or if the patient refused to be admitted or left before a recommendation/decision was made (i.e. left AMA) or was discharged from hospital after emergency treatment (i.e. not admitted).

If the patient was discharged from the hospital where they initially present (i.e. not admitted), please provide details on where the patient went after leaving the emergency department, using the categories provided (**Appendix 3**).

1.4.2 Monitoring Form 2 (Appendix 2)

Methods

The method(s) of self-harm are recorded according to the Tenth Revision of the WHO International Classification of Diseases (ICD-10) codes for intentional injury (**Appendix 4**). Up to five methods may be recorded. When selected, the methods are displayed in the box on the right. If self-harm presentations involved an overdose of drugs or other medications then the first option should be recorded. It is not necessary to rank the methods according to the lethality of the methods involved as this will be done centrally. If there is evidence that alcohol was involved in the self-harm act then the option "Self Poisoning by alcohol" should be recorded irrespective of the amount of alcohol.

When the record is saved, the methods are recorded in the access database in the form X-codes according to the WHO guidelines.

The additional drop down menu for methods is for self-harm by sharp objects. The extra box is for the level of treatment received.

Drugs

This should only be completed in cases of intentional overdose. Up to five drugs may be selected, if there are more than five drugs involved then the drug query notes field should be used. If the drug is not on the list then it should be typed into the drug query field and this will be added centrally. This list will be updated routinely. If the name of the drug is unknown, then NOTKNOWN or NOTKNOWNTABLETS should be selected.

Addresses

Patient's addresses are recorded according to the Electoral Division (ED) and Small Area (SA). In the latest version of the Automated System, it is possible for DRO's to use the Central Statistics Office website (www.cso.ie) to locate the ED, SA, and county codes for an address which may be missing from the system, or to select the correct address if there are multiple addresses. Full instructions for this procedure can be found in **Appendix 7.**

1.4.3 Special cases (Appendix 2)

The special cases form is to be used for individuals who are not private household residents e.g. hospital in-patients, prisoners etc. If a special case is selected then this will override the Region section on Monitoring Form 2.

1.5 Exporting data

The Registry obtains data on cases of self-harm that present to hospital. All acute public hospitals are to be included in the Registry. Data collection is carried out by the Registry DROs. These instructions outline the procedure for the correct upload of inputted data to the NSRF office:

- After completing each monitoring form, the save button should be pressed.

- When the DRO has saved all records for a specified time period then they are ready to upload the data to the Savenet file server.

- Use the 'upload' button on the Registry system to save the records in an excel file onto this server. Ensure that you email to the Data Manager to confirm upload of records.

- For those who do not have access to the Savenet server, contact the Data Manager who will arrange to upload the data from the laptop using Teamviewer software (please note that you must have a working broadband connection for this procedure).

1.6 Quality control

The validity of the Registry findings is dependent on the standardised application of the case-definition and inclusion/exclusion criteria.

The Registry has undertaken a cross-checking exercise in which pairs of DROs independently collected data from two hospitals for the same consecutive series of attendances to the emergency department. Initial results from this exercise indicate that there is a very high level of agreement between the DROs.

When each new case is entered the data entry automated system cases the case is automatically compared to those already stored in the system. If a case from the same hospital with the same initials,

date of birth, and date of attendance are entered the system will recognise this and prompt the DRO to check their records to see if it is a duplicate.

Section 2: Data processing

Data manager

2.1 Key responsibilities and duties

The Data manager will be responsible for ensuring the quality of the data for the Registry.

The principal duties of the data manager include the following:

➢ To perform validation and verification checks of the data being processed and monitor the efficiency and consistency of the data collection process in consultation with the Registry Manager;

➢ To liaise with the DROs to ensure quality of data and facilitation of the resolution of coding queries in consultation with the Registry Manager;

➢ To maintain and update the SPSS master-file;

➢ To provide IT Support for DROs in consultation with in-house and external IT personnel;

➢ Organisation of meetings of the DROs in consultation with the Registry Manager and the Executive Director;

➢ To assist in geo-coding of addresses where this is not possible by DROs (approx. 25% of cases);

➢ To assist in the analysis and presentation of geo-coded data;

➢ To work with the Registry Manager in preparation of the annual report.

Coding dictionary

Appendix 3 contains an overview of the data items recorded by the Registry.

Record No.

Each entry is given a unique record number that appears at the bottom of the screen. This number will increment as each new record is saved. The record number can be up to 11 numbers in length

Date of registration

Each record has a date of registration which is automatically recorded by the application. It is used to record when each record was entered by the DRO and can be used as a way to track data entries.

Initials

- The patient's Christian name is entered. If it is unknown, the *Not Known* box should be checked.

- The patient's surname is then entered. If it is unknown, then check the *Not Known* box.

- If the patient has a prefix to their surname then the *Prefix* box should be checked and the prefix selected before the surname is entered.

- If the patient has a double barrelled surname, then the *Double Barrelled* box should be selected, the first name entered and then subsequently the second surname.

- If the patient has a double barrelled surname that has a prefix on the first surname or second surname, select the *Prefix* box and the *Double Barrelled* box before entering both surnames.

- Before moving to another section of the form the application will display a message box that will show the names entered and ask if this is correct.

- When the record is saved, the application encrypts the patient's initials in a numeric format and stores them in this form in the access database.

Gender

Code	Label
1	Male
2	Female
8	Missing

Date of birth

The date of birth is not recorded in the access database as it is encrypted to form part of a unique code for each case of self-harm.

Date of attendance

The date of attendance is also entered in the form DD/MM/20YY. It is defaulted on the present year. If this is unknown, then the Not Known box should be checked.

Hour of attendance

The hour of presentation is recorded according to the 24 hour clock. If the hour of attendance is not known, then the *Not Known* box should be checked.

Brought by Ambulance

Code	Label
1	Yes
2	No
3	Other services
8	Not known

Medical Card

Code	Label
1	Medical card holder
2	Non-medical card holder
8	Not known

Psychiatric review/assessment[1]

Code	Label
1	Yes
2	No
3	Refused
8	Not known

Admission A&E

Code	Label
1	Yes
2	No
8	Not known

[1] See Appendix 4 for additional detail

Admission

Code	Label
1	Admitted to general ward
2	Admitted to psychiatric ward
3	Refused to be admitted
4	Left before decision / AMA
5	Not admitted
6	Left without being seen
8	Not known

Not admitted[2]

Code	Label
1	Discharged Home
2	Transfer to psychiatric unit/ psychiatric hospital
3	Transfer to another hospital
4	Referred for out-patient appointment
5	Refereed to GP
6	Other (Please Specify):
7	Referred to psychological services
8	Not known
9	Referred to Community Based Mental Health Teams
10	Referred to addiction services

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[2] See Appendix 4 for additional detail

Methods

Code	Label
60	Drug overdose
65	Alcohol
66	Petroleum products, other solvents and their vapours
67	Other gases and vapours
68	Pesticides, herbicides and other toxic agricultural chemicals
69	Other chemicals and noxious substances
70	Hanging, strangulation and suffocation
71	Submersion (drowning)
72	Handgun discharge
73	Rifle, shotgun and larger firearm discharge
74	Other and unspecified firearm discharge
75	Explosive material and devices
76	Fire and flames
77	Steam, hot vapours and hot objects
79	Blunt objects
80	Jumping from a high place
81	Jumping or lying before a moving object
82	Crashing of motor vehicle
83	Other specified means
84	Unspecified means
88	Not known

Method5 – Treatment received after self-cutting

This should only be completed in cases of self-harm by sharp objects (X-78). It denotes the type of treatment received by the patient, depending upon the severity of the self-cutting.

Code	Label
78	Cutting

Method5type

Code	Label
0	No treatment / Cleaned
1	Steristrips
2	Sutures
3	Plastics
8	Not known

Drugs

This should only be completed in cases of intentional overdose, where the name(s) of the drug(s) used may be entered into separate cells. Up to five drugs may be selected, if there are more than five drugs involved then the notes box should be used. If the drug is not on the list then it should be typed into the notes textbox and added centrally. This list will be updated routinely. If the name of the drug is unknown, then *NOTKNOWN* or *NOTKNOWNTABLETS* should be selected.

Drug quantity

If known, the quantity of the recorded drugs that were taken should be inputted here. If unknown, this should be explained in the notes textbox.

Address

Patient's addresses are recorded according to the County Code (CC), Electoral Division (ED) and Small Area (SA) using the street/townland indices. Codes are entered manually using the CSO website's address search tool (see **Appendix 7**).

Section 3: Data storage and data access

Storing Registry data

The Registry master datafile is stored in excel and SPSS formats on a secure server in the offices of the NSRF. Access to this server is only permitted by the Registry Manager and Data Manager.

Access to the core masterfile is highly restricted. It is used for data checking and linking of repeat self-harm presentations and for the linkage with mortality data but it is not used for general analysis purposes.

A second Registry masterfile is maintained in which the unique Registry code has been replaced by an arbitrary but equally unique patient number. This masterfile is used for analysis purposes. The file may be made available to Foundation staff and may also be provided to researchers from other institutions pending written agreement to abide by stipulated terms and conditions.

Release of data

3.1 Core Masterfile

The core Masterfile is only accessible to Registry staff (i.e. Registry Manager and Data Manager) and nominated staff of the NSRF. Where access to the core Masterfile is necessary for analysis purposes (e.g. data linkage), written agreement to abide by stipulated terms and conditions must be received from the Registry Technical Group. In addition, a confidentiality agreement must be signed by the researcher

3.2 Anonymised microdata

Registry data may also be released at the level of individual hospital presentations, i.e. microdata. In this instance the anonymised Registry masterfile is used. Such requests are dealt with on a case-by-case basis but in order for microdata to be released there must be a bona fide research purpose for the request, the data provided must be adapted to ensure there is no potential for an individual patient to be identified directly or indirectly and an agreement stipulating the terms and conditions must be signed by the requester of the data. An assessment is made of the risk that the data requester may misinterpret or misuse the data and the impact that any such misinterpretation or misuse might have. Microdata are only released if the potential risk and impact are considered negligible. Applications for using microdata must be submitted to the NSHRI Technical Group.

3.3 Aggregated data

Registry data are generally released in an aggregate format which does not allow individuals to be identified directly or indirectly. Aggregate data releases take the form of annual and other periodic reports and research bulletins, articles and presentations. They may be produced routinely or in response to a request from an agency or individual.

3.4 Data format

The standard format of the Registry Masterfile and microdata is SPSS. Anonymised microdata SPSS files are shared via secure file-sharing system (www.savenetsolutions.com). Where requested, data may also be saved in Stata or Excel formats.

Aggregated data is normally provided in excel or word documents via email. Such reports are accompanied with information about the type of data included and how the data should be referenced. Where appropriate, guidelines are provided to the end user regarding interpretation of the data (e.g. calculating rates).

3.5 Accessing Registry data

Aggregate Registry data may be accessed by completing a data request form via the NSRF website (www.nsrf.ie). To access Registry microdata for the purposes of a research project/ study, a more detailed request form must be completed. This can be requested by contacting Registry staff.

Section 5: Appendices

Appendix 1: Registry leaflet

What is self-harm?

It is a non-fatal act.

It is deliberately initiated.

The individual knows it may case physical harm to her/himself and may cause death.

Is associated with varying levels of suicidal intent and wide ranging motives.

The National Suicide Research Foundation

Is the principal Irish centre for research on suicidal behaviour.

Has been designated as a WHO Collaborating Centre for Surveillance and Research in Suicide Prevention.

Carries out a wide range of research studies in addition to operating the National Self-Harm Registry Ireland.

The NSRF is registered with the Data Protection Agency and complies with Irish data protection legislation. Ethical approval has been granted for the operation of the Registry by national and local ethics committees.

The Registry produces an annual report with key findings. This report is available on our website or by contacting our office.

Support services

If you, or someone you know, needs support or is in crisis:

Contact your local GP

Go to/contact the ED of your nearest hospital

Details of local health services are available by calling HSE Health information line CallSave

1850 241 850
(Mon-Sat, 8am-8pm)

Contact **Samaritans: 116 123** or email **jo@samaritans.org**
(24 hours a day, 7 days a week)

Useful websites

www.suicidesupportandinformation.ie
www.yourmentalhealth.ie
www.aware.ie
www.samaritans.org
www.reachout.com
www.psihq.ie

N S R F
National Suicide Research Foundation

National Self-Harm Registry Ireland

Information Leaflet

What is the Registry?

The Registry is a system of recording self-harm presentations made to hospital emergency departments in Ireland.

The Registry is an integral part of the national suicide prevention strategy and helps to improve services for this at risk of suicidal behaviour.

The Registry is operated by the National Suicide Research Foundation.

Aims of the Registry

Provide access to real time data.

Inform services, policy and interventions.

Evaluate guidelines and treatments.

Measure regional, demographic and temporal variations.

Connecting for Life

The Registry is funded by the HSE's National Office for Suicide Prevention.

Some findings from the Registry →

Information for you

This hospital is providing data to the National Self-Harm Registry Ireland.

All cases of self-harm presenting to the emergency department are recorded in a way that preserves patient anonymity and confidentiality.

This leaflet provides information on self-harm, why the data is being recorded and how the data will be used.

If you would like any more information or have any queries, please contact us at:

National Suicide Research Foundation, 4th Floor Western Gateway Building, University College Cork.

Tel: **+353 21 420 5551**
Email: **info@nsrf.ie**
Website: **www.nsrf.ie**

N S R F
National Suicide Research Foundation

2015 statistics

+9%

	Presentations	Persons
	11,189	**8,791**

2007   2015
Rate in 2015 9% higher than 2007

RATES:

Male: 20-24 year-olds (553 per 100,000)
1 in every 181

Female: 15-19 year-olds (718 per 100,000)
1 in every 139

PEAK RATES WERE AMONG YOUNG PEOPLE

METHOD:

1 in every 3 involved **alcohol**

34% Men   **29%** Women

2 in every 3 involved **overdose**   **65%**

One-quarter involved **self-cutting**   **27%**

TREATMENT:

73% received an assessment in the ED

75% received a follow-up recommendation after discharge

13% left the ED without being seen

Appendix 2: Electronic data entry system

Monitoring Form 1

Monitoring Form 2

Special cases

National Registry of Deliberate Self-Harm

National Registry of Deliberate Self-Harm

Save | Upload | Clear Current Record | Update | Remove Records | Exit | Help

Select one from these special cases.

Prisons

County	Prison	County Code	ED Code
Dublin City	Arbour Hill Prison	2	601
Roscommon	Castlerea Prison	30	602
Dublin City	Cloverhill	2	603
Cork City	Cork Prison	17	604

Psychiatric

County	Name	County Code	ED Code
Cavan	Cavan General Hospital Psychiatric Unit	32	622
Clare	Ennis General Hospital Acute Psychiatric Unit	16	624
Cork city	Cork University Hospital (GF)	17	623
Cork city	Mercy Hospital, Cork (St Michael's)	17	628

Hospitals / Hospices

County	Name	County Code	ED Code
Carlow	Carlow District Hospital	1	420
Carlow	Sacred Heart Carlow	1	501
Carlow	St Dympna's, Carlow	1	521
Cavan	Cavan General Hospital	32	424
Cavan	St Felim's Hospital, Cavan	32	523

Select a County | Hostels, homes, sheltered accommodation

County	County Code
Carlow County	1
Cavan County	32
Clare County	16
Cork City	17
Cork County	18
Donegal County	33

Location	ED Code
Homeless hostels/shelters (St Vincent de Paul's/Simon etc.) NFA, Temp...	661
Adolescent units	662
Nursing homes for the elderly	663
Residences/Boarding schools for the mentally/physically ill	664
Non-residents (i.e. tourists/visitors)	665
Asylum seekers etc.	666

Record No.   30

NATIONAL SUICIDE RESEARCH FOUNDATION IRELAND

Appendix 3: List of data items

Data item	Definition	Codes and values
Data Collector	Name of data registration officer	
Health Board	Health board region of hospital	
Hospital	Hospital of presentation	
Record Number	This is the number assigned to each record entered by a data registration officer	
Gender	Gender of the patient presenting	1=Male 2=Female 8=Missing
Date of Attendance	Date of presentation to emergency department	DD/MM/YYYY
Hour of Attendance	Hour of presentation to emergency department (24hr)	0-23 88=Missing
Ambulance	If the patient was brought to emergency department by ambulance	1=Yes 2=No 3=Other services 8=Not known
Medical Card	If the patient has a medical card	1=Yes 2=No 8=Not known
Psych review	Did the patient have a psych review or assessment	1=Yes 2=No 8=Not known
Admission A&E	If the patient was admitted to and A&E ward or MAU	1=Yes 2=No 8=Not known
Admission	Outcome of presentation	1=Admitted to general ward 2=Admitted to psychiatric ward 3=Refused to be admitted 4=Left before admission/AMA 5=Not admitted 6=Left without being seen 8=Not known
Not admitted	Recommended aftercare (if patient was not admitted only)	1=Discharged Home 2=Transfer to a psychiatric unit/ psychiatric hospital 3=Transfer to another hospital 4=Referred for out-patient appointment 5=Referred to GP

		6=Other (please specify):
		7=Referred to psychological services
		8=Unspecified:
		9=Referred to Community Based Mental Health Teams
		10=Referred to addiction services
Methods	Method of self-harm (up to five selected) based on ICD-10 coding	60=Drug overdose
		65=Alcohol
		66=Petroleum products, other solvents and their vapours
		67=Other gases and vapours
		68=Pesticides, herbicides and other toxic argricultural chemicals
		69=Other chemicals and noxious substances
		70=Hanging, strangulation and suffocation
		71=Submersion (drowning)
		72=Handgun discharge
		73=Rifle, shotgun and larger firearm discharge
		74=Other and unspecified firearm discharge
		75=Explosive material and devices
		76=Fire and flames
		77=Steam, hot vapours and hot objects
		79=Blunt objects
		80=Jumping from a high place
		81=Jumping or lying before a moving object
		82=Crashing of motor vehicle
		83=Other specified means
		84=Unspecified means
		88=Not known
Method5	If method of self-harm involved self-cutting	78=self-cutting
Method5type	Treatment received after self-cutting	0=No treatment/cleaned
		1=Steristrips
		2=Sutures
		3=Plastics
		8=Not known
Drugs	Name of drugs taken in a drug overdose (up to 5 drugs can be recorded)	Name of drug
Drug quantity	The quantity (number of tablets) taken for each of the recorded drugs	

ED Code	Electoral Divison of residency	1-325
County Code	County Code of residency	1-34
SA Code	Small area of residency	
Date of Registration	Used to record when each record was entered	DD/MM/YYYY
Age	Age of patient	Age in years
Uniquecode	Unique identifier (encoded) generated using date of birth, initials and gender	

Appendix 4: Coding guidelines

Coding guidelines for ICD-10 codes X65-X68: Breakdown of self-poisoning by substance

Code	Substances which should be coded under self-poisoning	
X65: Intentional self-poisoning by and exposure to alcohol	Aftershave Antifreeze Deicer Ethanol	Ethylene Glycol Methylated Spirits Surgical Spirits Radiator Fluid
X66: Intentional self-poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours	Acetone Baby Oil Vaseline Diesel Engine Oil Lighter Fluid Lighter Gas	Nail Polish Remover Nitromors Paint Stripper Petrol Petrol Fumes White Spirits
X67: Intentional self-poisoning by and exposure to other gases and vapours	Ammonia Bleach Butane Gas Calor Gas	Exhaust Fumes Gas Generator Fumes Smoke Inhalation
X68: Intentional self-poisoning by and exposure to pesticides	Fertiliser Fungicide Gallup Glyphosate Gramoxone Weedkiller Herbicide	Insecticide Malathion Paraquat Slug Pellets Weedol Strychnine Roundup Rat Poison
X69: Other chemicals and noxious substances	Acid Ajax Aerosols Aerosol Spray Aerosol Fumes Batteries	Jeyes Fluid Jiff Kitchen Cleaner Milton Milton Tablets Miracle Grow

	Battery Acid	Mouthwash
	Bleach	Mr. Muscle
	Car Acid	Nail Polish
	Carpet Cleaner	Nail Varnish
	Cattle Injection	Oven Cleaner
	Caustic Soda	Oxy Gel
	Chemical Cleaner	Perfume
	Cif	Parazone
	Cleaning Fluid	Persil
	Cleenol	Pledge
	Cuprinol	Radox
	Dettol	Savlon
	Deodorant	Screen Cleaner
	Disinfectant	Shampoo
	Dog Flesh Shampoo	Sheep Dip
	Domestos	Sheep Meds
	Domestos Bleach	Shoe Polish
	Drain Cleaner	Silver Polish
	Eucalyptus Oil	Skin Cream
	Fabric Softener	Skin Toner
	Fairy Liquid	TCP
	Febreeze	Toilet Cleaner
	Fire Lighters	Toilet Duck
	Flash	Washing Powder
	Flash Liquid	Washing Up Liquid
	Formalin	Windowlene
	Furniture Polish	Window Cleaner
	Glass Cleaner	Wood Glue
	Glue	
	Hair Solution	
	Handwash	
	Harpic	

Instructions for completing 'Not Admitted' variable

*Only one of these options should be selected, choose the most important.

1. Discharged home

Select this option if the patient was discharged to their original location (home, prison, health centre, custody, etc.) without a follow-up appointment / referral

2. Transfer to another psychiatric unit / psychiatric hospital

Select this option if the patient was discharged from the presenting hospital but transferred on to an external (off-campus) psychiatric unit or hospital for review and/or admission

3. Transfer to another hospital[3]

Select this option if the patient was discharged from the presenting hospital but transferred on to an another hospital for admission

4. Referred for out-patient appointment

Select this option of the patient was discharged home with an appointment for an out-patient clinic

5. Referred to GP

Select this option of the patient was discharged home with an appointment or a suggested appointment with their GP

6. Referred to psychological services

Select this option if the patient was discharged home with an appointment with psychological services (e.g. Pieta House) or a private psychologist / counsellor

7. Referred to Community Based Mental Health Teams

Select this option if the patient was discharged home with an appointment with a community services (e.g. CAMHS, CMHS, homebase referral)

8. Unknown

9. Other (please specify):

Select this option if it doesn't fit the categories above, and please state the information

10. Referred to addiction services

---

[3] In the instance of transfer to an offsite hospital/ unit for psychiatric or general admission, we still need to select not admitted and this option, as we can't be sure the patient was admitted.

Instructions for completing 'Psychiatric review' variable

1. Yes (review)

Select yes if the patient had a psychiatric review in the presenting hospital, during their stay in A&E, in relation to the presenting self-harm episode.

2. No

Select no for the following scenarios:

If the patient didn't receive a psychiatric review in the presenting hospital

If the patient was transferred on to another psychiatric unit or hospital for review which is independent of the hospital (off-campus)

3. Patient refused psychiatric review/assessment

Select this if the patient was due to receive a psychiatric review in the presenting hospital but left before this occurred OR refused the psychiatric review.

8. Unknown

Select unknown in the following scenarios

If the patient was due to receive a psychiatric review in the presenting hospital, but there is no evidence to say if this happened[4]

If there is no information about a psychiatric review/assessment occurring on the chart notes

---

[4] In this case, you should try to follow up with the psychiatric team to see if the assessment/review occurred

Appendix 5: Common abbreviations

Common abbreviations to be found in emergency departments and medical records

Code	Label
A/F	ARTIFICIAL FEED
AAA	ABDOMINAL AORTIC ANEURYSM
ABC	AIRWAY BREATHING CIRCULATION
ABG's	ARTERIAL BLOOD GASES
AC	ABDOMINAL CIRCUMFERENCE
ACE INHIBITOR	ANGIOTENSIN CONVERTING ENZYME INHIBITOR
AND	ASSISTANT DIRECTOR OF NURSING
AFR	AVERAGE FLOW RATE
AIDS	ACQUIRED IMMUNE DEFICIENCY SYNDROME
AL	ACTIVITIES OF LIVING
ALL	ACUTE LYMPHOCYTIC LEUKAEMIA
AML	ACUTE MYLOID LEUKAEMIA
AMP	AUSTIN MOORE PROSTHESIS
APH	ANTE PARTUM HAEMORRHAGE
APTTR	ACTIVATED PARTIAL THROMBOPLASTIN TIME RATIO
ARDS	ADULT RESPIRATORY DISTRESS SYNDROME
ARF	ACUTE RENAL FAILURE
ARM	ARTIFICIAL RUPTURE OF MEMBRANES
B/D	TWICE DAILY
B/P	BLOOD PRESSURE
BA ENEMA	BARIUM ENEMA
BA MEAL	BARIUM MEAL
BBA	BORN BEFORE ARRIVAL
BHCG	BETA HUMAN CHORIONIC GONADOTROPHINS
BIBA	BROUGHT IN BY AMBULANCE
BM	BLOOD SUGARS
BNO	BOWELS NOT OPEN
BO	BOWELS OPEN
BPD	BIPARITAL DIAMETER

BPM	BEATS PER MINUTE
BPP	BIO-PHYLSICAL PROFILE
BSO	BILATERAL SALPAINO ORPHERECTOMY
BTL	BILATERAL TUBAL LIGITATION
BX	BIOPSY
C&S	CULTURE AND SENSITIVITY
C2H5OH	ALCOHOL
CA	CANCER
CABG	CORONARY ARTERY BYPASS GRAFT
CCF	CONGESTIVE CARDIAC FAILURE
CCF	CONGESTIVE CARDIAC FAILURE
CCT	CONTROLLED CORD TRACTION
CCU	CORONARY CARE UNIT
CJD	CREUTZFELDT-JAKOB DISEASE
CK	CREATININE KINASE
CKMB	CREATININE KINASE ISOEMZYME
CLL	CHRONIC LYMPHOCYTIC LEUKAEMIA
CLO	CAMPYLOBACTER LIKE ORGANISM
CML	CHROMIC MYELOID LEUKAEMIA
CMST	COLOUR, MOVEMENT, SENSATION, TEMPERATURE
CMV	CYTOMEGALO VIRUS
CNS	CENTRAL NERVOUS SYSTEM
CO	CHRONIC OBSTRUCTION
COAD	CHRONIC OBSTRUCTIVE AIRWAYS DISEASE
COAG	COAGULATION
COL	CHURCH OF IRELAND
COPD	CHRONIC OBSTRUCTIVE PULMONARY DISEASE
CPAP	CONTINUOUS POSITIVE AIRWAY PRESSURE
CPC	CLINICAL PLACEMENT CO-ORDINATOR
CPD	CEPHALIC PELVIC DISPROPORTION
CPR	CARDIOPULMONARY RESUSCITATION
CRF	CHRONIC RENAL FAILURE
CSF	CEREBRO SPINAL FLUID
CSU	CATHETER SPECIMEN OF URINE
CT	COMPUTERISED TOMOGRAPHY

CTG	CARDIOTOCOGRAPH
CVA	CEREBROVASCULAR ACCIDENT
CVA	STROKE
CVP	CENTRAL VENOUS PRESSURE
CVS	CARDIOVASCULAR SYSTEM
CX	CERVIX
CXR	CHEST XRAY
DAMA	DISCHARGED AGAINST MEDICAL ADVICE
DC	DISCHARGE
DHS	DYNAMIC HIP SCREW
DIC	DISSEMINATED INTRAVASCULAR COAGULATION
DKA	DIABETIC KETOACIDOSIS
DNA	DID NOT ARRIVE
DNS	DIPLOMA IN NURSING STUDIES
DOB	DATE OF BIRTH
DOT	DIRECTLY OBSERVED THERAPY
DSH	DELIBERATE SELF-HARM
DSP	DELIBERATE SELF POISONING
DT's	DELIRIUM TREMENS
DVT	DEEP VENOUS THROMBOSIS
EBV	EPSTEIN-BARR VIRUS
ECHO	ECHOCARDIOGRAM
ECV	EXTERNAL CEPHALIC VERSION
EDD	EXPECTED DATE OF DELIVERY
EGG	ELECTROCARDIOGRAM
ENT	EAR, NOSE AND THROAT
ERCP	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY
ERPC	EVACUATION OF RETAINED PRODUCTS OF CONCEPTION
ESR	ERYTHROCYTE SEDIMENTATION RATE
ET TUBE	ENDOTRACHEAL TUBE
ET	ENDO TRACHEAL
EUA	EXAMINATION UNDER ANAESTHETIC
FB	FOREIGN BODY
FBC	FULL BLOOD COUNT
FBM	FETAL BREATHING MOVEMENT

FFP	FRESH FROZEN PLASMA
FH	FETAL HEART
FL	FEMORAL LENGTH
FM	FETAL MOVEMENT
FOB	FAECAL OCCULT BLOOD
FR	FRENCH GAUGE
FSE	FETAL SCALP ELECTRODE
FSH	FOLLICLE STIMULATING HORMONE
GA	GENERAL ANAESTHETIC
GCS	GLASGOW COMA SCALE
GCSF	GRANULOCYTIC STIMULATING FACTOR
GIT	GASTROINTESTINAL TRACT
GP	GENERAL PRACTITIONER
GTN	GLYCERYL TRI-NITRATE
GTT	GLUCOSE TOLERANCE TEST
GU	GENITOURINARY
GUM	GENITO URINARY MEDICINE
GVHD	GRAFT VERSUS HOST DISEASE
HAV	HEPATITIS A VIRUS
HB	HAEMOGLOBIN
HBV	HEPATITIS B VIRUS
HC	HEAD CIRCUMFERANCE
HCG	HUMAN CHORIONIC GONATROPHIN (PREGNANCY TEST)
HCV	HEPTITIS C VIRUS
HI	HEAD INJURY
HIV	HUMANE IMMUNODEFICIENCY VIRUS
HLA	HUMAN LEUCOCTYE ANTIGEN
HRT	HORMONE REPLACEMNET THERAPY
HVS	HIGH VAGINAL SWAB
Hx CSA	HISTORY OF CHILD SEXUAL ABUSE
Hx CVA	HISTORY OF CARDIO VASCULAR ACCIDENT
Hx	HISTORY OF
I&D	INCISION AND DRAINAGE
I&O	INTAKE AND OUTPUT
ICU	INTENSIVE CARE UNIT

IDDM	INSULIN DEPENDENT DIABETES MELITIS
IG	IMMUNOGLOBULIN
IHD	ISCHAEMIC HEART DISEASE
IHD	ISCHEMIC HEART DISEASE
INR	INTERNATIONAL NORMALISED RATIO
IOL	INDUCTION OF LABOUR
ITP	IDEOPATHIC THROMBOCYTOPENIA
IUGR	INTRA UTERINE GROWTH RETARDATION
IV	INTRAVENOUS
IVF	INTRA VITRO FERTILIZATION
IVI	INTRAVENOUS INFUSION
IVP	INTRAVENOUS PYELOGRAM
IVT	INTRAVENOUS THERAPY
JVP	JUGULAR VENOUS PRESSURE
KCL	POTASSIUM CHLORIDE
KUB	KIDNEY URETER BLADDER XRAY
KVO	KEEP VEIN OPEN
LA	LOCAL ANAESTHETIC
LAC	LACERATIONS
LAP&DYE	LAPAROSCOPY AND DYE
LAP/HC	LAPOROSCOPY/HULKE CLIPS
LFT's	LIVER FUNCTION TESTS
LIF	LEFT LLIAC FOSSA
LMP	LAST MENSTRUAL PERIOD
LOA	LEFT OCCIPUT ANTERIOR
LOC	LOSS OF CONSCIOUSNESS
LOP	LEFT OCCIPUT POSTERIOR
LP	LUMBAR PUNCTURE
LRTI	LOWER RESPIRATORY TRACT INFECTION
LSCS	LOWER SEGMENT CAESAREAN SECTION
LSO	LEFT SALPAINO ORPHERECTOMY
MANE	MORNING
MAP	MORNING AFTER PILL
MDA	MISUSE OF DRUGS ACT
MFR	MAXIMUM FLOW RATE

MI	HEART ATTACK
MMHG	MILLIMETRES MERCURY
MPH	MILES PER HOUR
MRI	MAGNETIC RESONANCE IMAGING SCAN
MRSA	METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS
MSU	MID STREAM SPECIMEN OF URINE
MSV	MID STREAM SPECIMEN
MUGA	MULTI-GATED ARTERIOGRAPHY
NACL	SODIUM CHLORIDE
NG	NASO-GASTRIC
NGT	NASO GASTRIC TUBE
NHL	NON HODGKINS LYMPHOMA
NIDDM	NON INSULIN DEPENDENT DIABETES MELITIS
NND	NEONATAL DEATH
NOCTE	NIGHT TIME
NPO	NIL PER ORUM
NPU	NIL PASSING URINE
NSAID's	NON STEROIDAL ANTI–INFLAMMATORY DRUGS
NSI	NEEDLE STICK INJURY
O/D	ONCE DAILY
O/E	ON EXAMINATION
O2	OXYGEN
OA SPINE	OSTEOARTHRITIS OF SPINE
OCP	ORAL CONTRACEPTION PILL
OGD	OESOPHAGO-GASTRO DUDENOSCOPY
OH	ALCOHOL
OPD	OUT-PATIENT DEPARTMENT
OT	OPERATING THEATRE
P/N	POST NATAL
PARA	PARITY
PCA	PATIENT CONTROLLED ANALGESIA
PCP	PNEUMOCYSTIS CARINII PNEUMONIA
PEARL	PUPILS EQUAL AND REACTING TO LIGHT
PEG	PERCUNTANEOUS ENDOSCOPIC GASTROSTOMY
PEJ	PERCUNTANEOUS ENDOSCOPIC JEJUNOSTOMY

PET	PRE ECLAMPTIC TOXAEMIA
PFA	PLAIN FILM ABDOMEN
PFR	PELVIC FLOOR REPAIR
PFT's	PULMONARY FUNCTION TESTS
PHN	PUBLIC HEALTH NURSE
PID	PELVIC INFLAMMATORY DISEASE
PID	PELVIC INFLAMMATORY DISEASE
PIH	PREGNANCY INDUCED HYPRTENSION
PKU	PHENYLKETONURIA
PLCC	PERIPHRALLY INSERTED CENTRAL CATHETER
PMB	POST MENOPAUSAL BLEED
PMHx	PAST MEDICAL HISTORY
PO	PER ORAL
POP	PLASTER OF PARIS
POST OP	POST OPERATION
POST TURP	POST TRANS URETHRAL REJECTION OF PROSTATE
PPH	POST PARTUM HAEMORRHAGE
PR	PER RECTUM
PRE OP	PRE OPERATION
PRN	AS REQUIRED
PROM	PRETERM RUPTURE OF MEMBRANES
PSA	PROSTATIC SPECIFIC ANTIGEN
PT	PROTHROMBIN TIME
PTCA	PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY
PTCH	PERCUTANEOUS TRANSHEPATIC CHOLANGIOGRAM
PU	PASSED URINE
PV	PER VAGINA
QID	FOUR TIMES DAILY
RC	ROMAN CATHOLIC
RCC	RED CELL CONCENTRATE
REFLO	BLOOD SUGARS
RH	RHESUS
RICE	REST, ICE, COMPRESSION, ELEVATION
RIF	RIGHT LLIAC FOSSA
RIP	REST IN PEACE

ROA	RIGHT OCCIPUT ANTERIOR
ROP	RIGHT OCCIPUT POSTERIOR
RSO	RIGHT SALPAINO ORCHERECTOMY
RTA	ROAD TRAFFIC ACCIDENT
RTI	RESPIRATORY TRACT INFECTION
RX	TREATMENT
S/L	SUBLINGUALLY
S/N	STAFF NURSE
SBBE	SMALL BOWEL BARIUM ENEMA
SBR	SERUM BILIRUBIN RATE
SC	SUBCUNTANEOUS
SCBU	SPECIAL CARE BABY UNIT
SHO	SENIOR HOUSE OFFICER
SI	SELF INFLICTED
SIP	SELF-INFLICTED POISIONING
SLE	SYSTEMIC LUPUS ERYTHEMATOUS
SMAC	SEQUENTIAL MULTIPLE ANALYSER AND COMPUTER
SOB	SHORTAGE OF BREATH
SROM	SPONTANEOUS RUPTURE OF MEMBRANES
STAT	IMMEDIATELY
STD	SEXUALLY TRANSMITTED DISEASE
STI	SOFT TISSUE INJURY
SUR	SUBURETRAL REPAIR
SVD	SPONTANEOUS VAGINAL DELIVERY
TAH	TOTAL ABDOMINAL HYSTERECTOMY
TB	TUBERCULOSIS
TCB	TUBERCULIN BACILLUS CULTURE
TCD	TRANSCEREBRAL DIAMETER
TED's	THROMBO EMBOLIC DETERRENT STOCKINGS
TENS	TRANSCUNTANEOUS ELECTRO NERVE STIMULATION
TFT's	THYROID FUNCTION TESTS
TIA	TRANSIENT ISCHAEMIC ATTACK
TID	THREE TIMES DAILY
TIPS	TRANSJUGULAR INTRAHEPATIC PORTOSYSTEMIC SHUNT
TL	TUBAL LIGATION

TOP	TERMINATION OF PREGNANCY
TPN	TOTAL PARENTAL NUTRITION
TPR	TEMPERATURE PULSE RESPIRATION
TSH	THYROID STIMULATING HORMONE
TURP	TRANS URETHRAL RESECTION PROSTATE
TVU/S	TRANS VAGINAL ULTRASOUND
TX	PRESCRIBED TREATMENT
U&E	UREA AND ELECTROLYTES
U/A	URINALYSIS
US	ULTRASOUND
USS	ULTRASOUND SCAN
UTI	URINARY TRACT INFECTION
VABC	VAGINAL BIRTH AFTER CEASAREAN SECTION
VDRL	VENEREAL DISEASE RESEARCH LABORATORY TEST
VE	VAGINAL EXAMINATION
VQ	VENTILATION PERFUSION SCAN
WBC	WHITE BLOOD COUNT
WCC	WHITE CELL COUNT
ZN	ZIEHL NEELSEN STAIN

Appendix 6: Exclusion criteria

Non-cases of self-harm

The following examples are **NOT** considered to be cases of self-harm.

Accidental overdoses

An individual who takes additional/extra medication in the case of illness, without any intention to self-harm

Alcohol overdoses <u>alone</u>

An individual who drinks to excess requiring hospital treatment BUT without the intention to self-harm and who does not combine alcohol with other methods of self-harm.

Accidental overdoses of street drugs

An individual who for example, takes speed and ecstasy on a regular basis without any intention to self-harm and is admitted to hospital for treatment

Individuals who are dead on arrival at hospital as a result of suicide

Specific examples of non self-harm cases

- Individual put his/her foot through the door in anger.

- Heavy intake of drugs plus alcohol. Notes revealed that the patient stopped heroin a week previously and took the tablets hoping for relief.

- Individual took usual medication twice by accident to relieve chronic back pain.

- Similar incidents where medications taken to help sleep and not to self-harm.

- Drugs taken to induce abortion.

- Accidental overdoses of street drugs e.g. O/D of naps x 20 plus alcohol, self referral and admitted.

- Alcohol poisoning as a result of excessive recreational alcohol intake.

- Self referral due to thoughts/ideation e.g. had thoughts of drowning by jumping off bridge but took no action and went to emergency for help

NB: The clinician's diagnosis/opinion, if recorded, should always be taken into consideration.

Appendix 7: Coding addresses

Coding addresses Using the CSO Website

The CSO website must be used to code all addresses of Irish residents. For each address, the following three codes must be recorded: County code, Electoral Division (ED) code, and Small Area (SA) code.

This document illustrates how to obtain these three codes using the census 2011 Small Area Population Maps (SAPMAP).

Within the Registry data entry system, on monitoring form 2, clicks 'Search the CSO website'. This launches a connection to the correct page of the CSO website (it will only work if you have internet access). The url for this page is: http://census.cso.ie/sapmap/

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The page shows a map of the Irish counties.
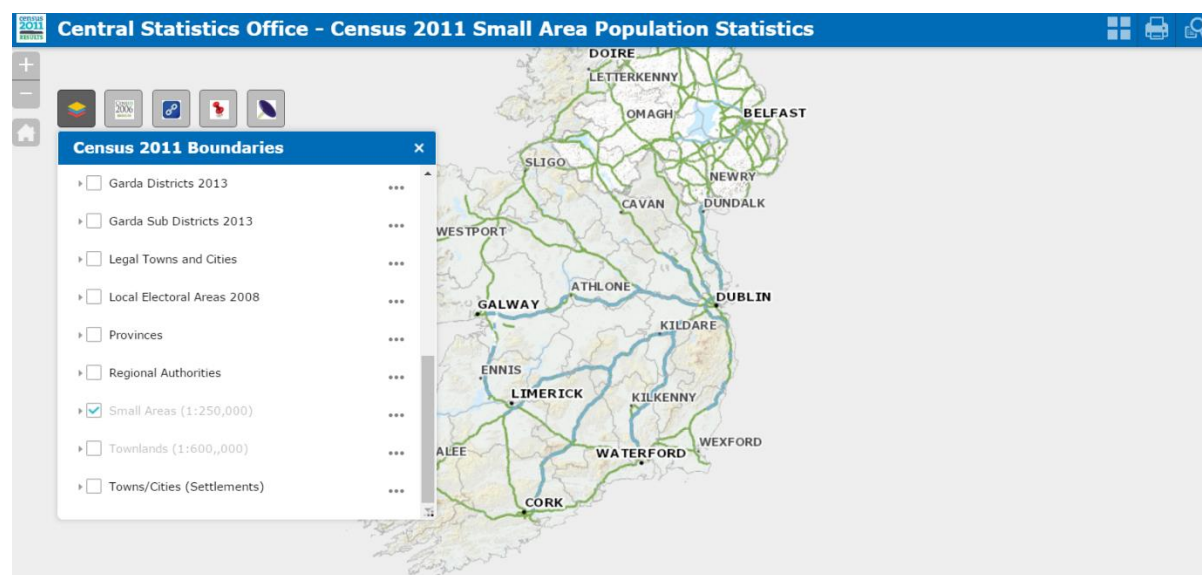
1. On the left hand side, there is a menu called 'Census 2011 Boundaries. Make sure that the options "Small Areas" and "Electoral Divisions" are ticked. Make sure that "Counties" is de-selected. This will make sure that these boundaries appear on the map when you search for a specific address.
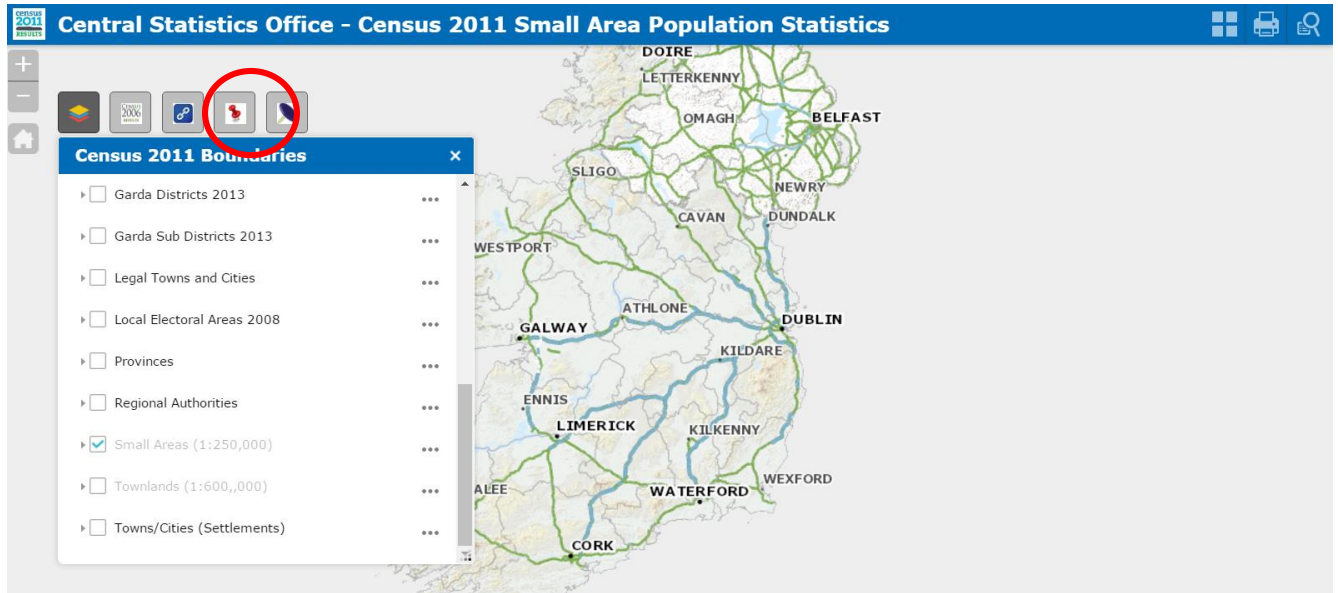
2. To search for an address, click the red pin symbol at the top of the screen (circled in the picture above). A search box will pop up (As seen in the picture below). Here you can enter the address that you wish to code (in this example it is Ashmount Court, Cork).
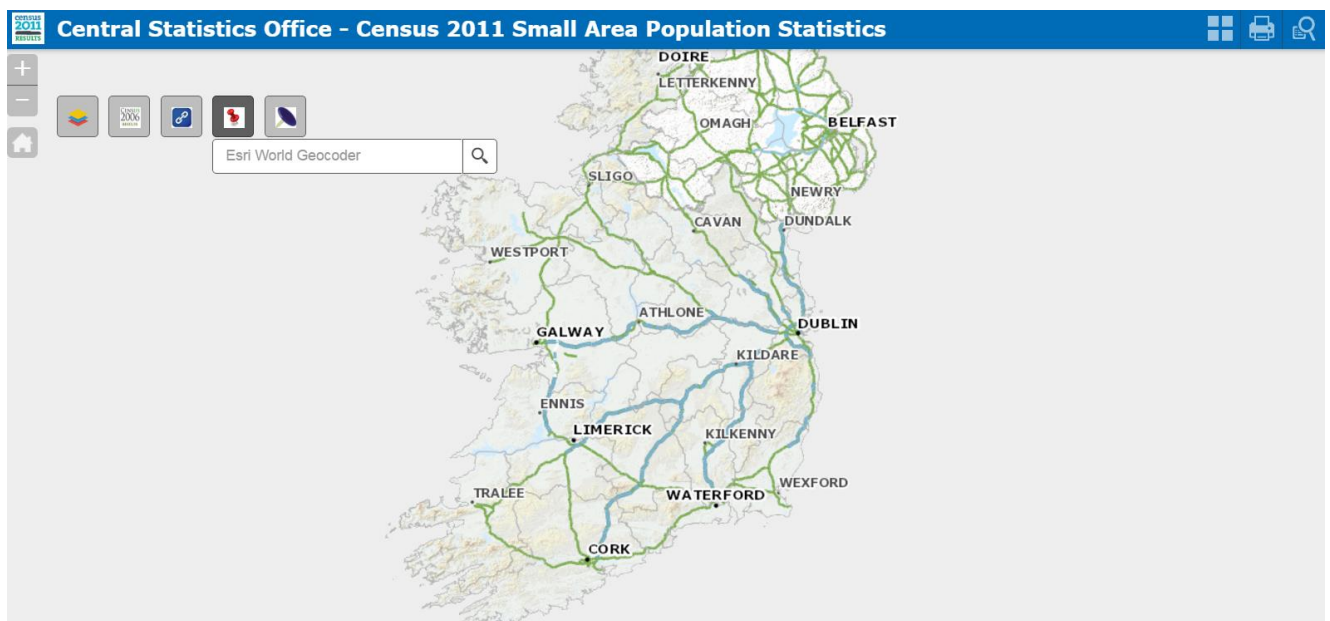
3. Select the most accurate address option from the drop-down menu. A pinpoint will highlight the location for that address on the map (see picture below).
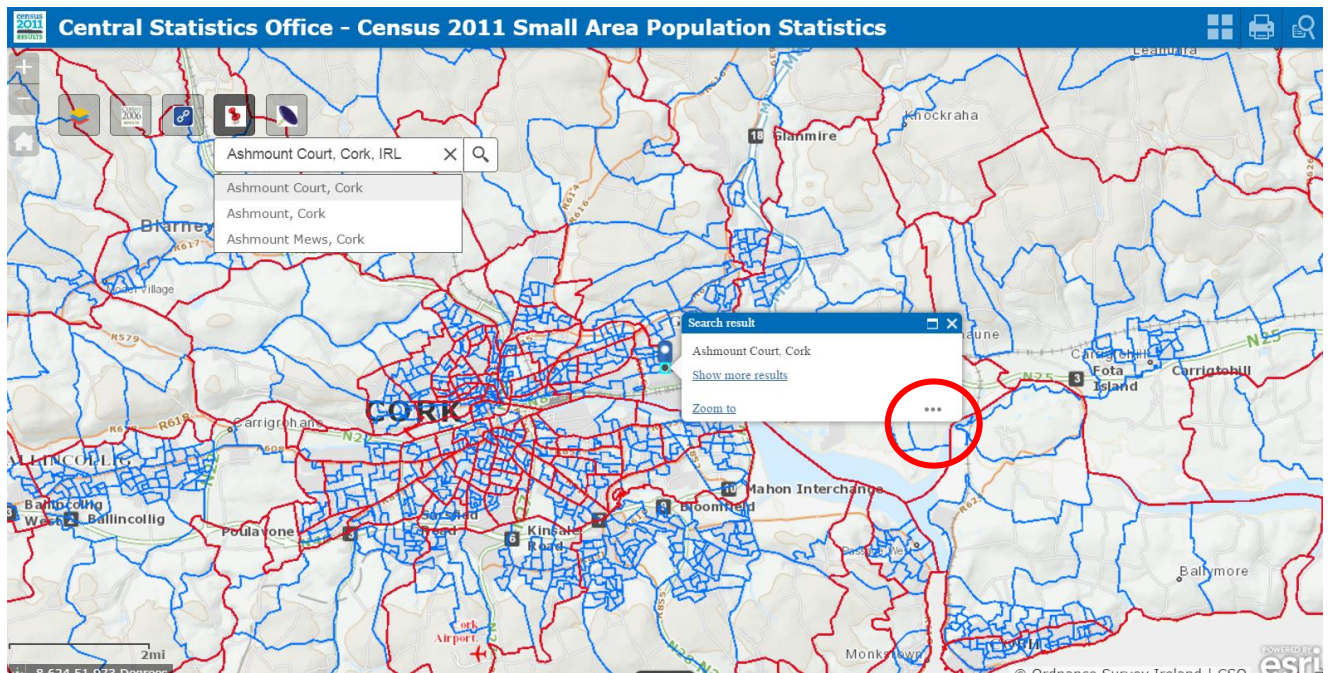
4. To find the three codes for this address, you need to click on the lower right hand corner of the small box as highlighted above (the three grey dots).
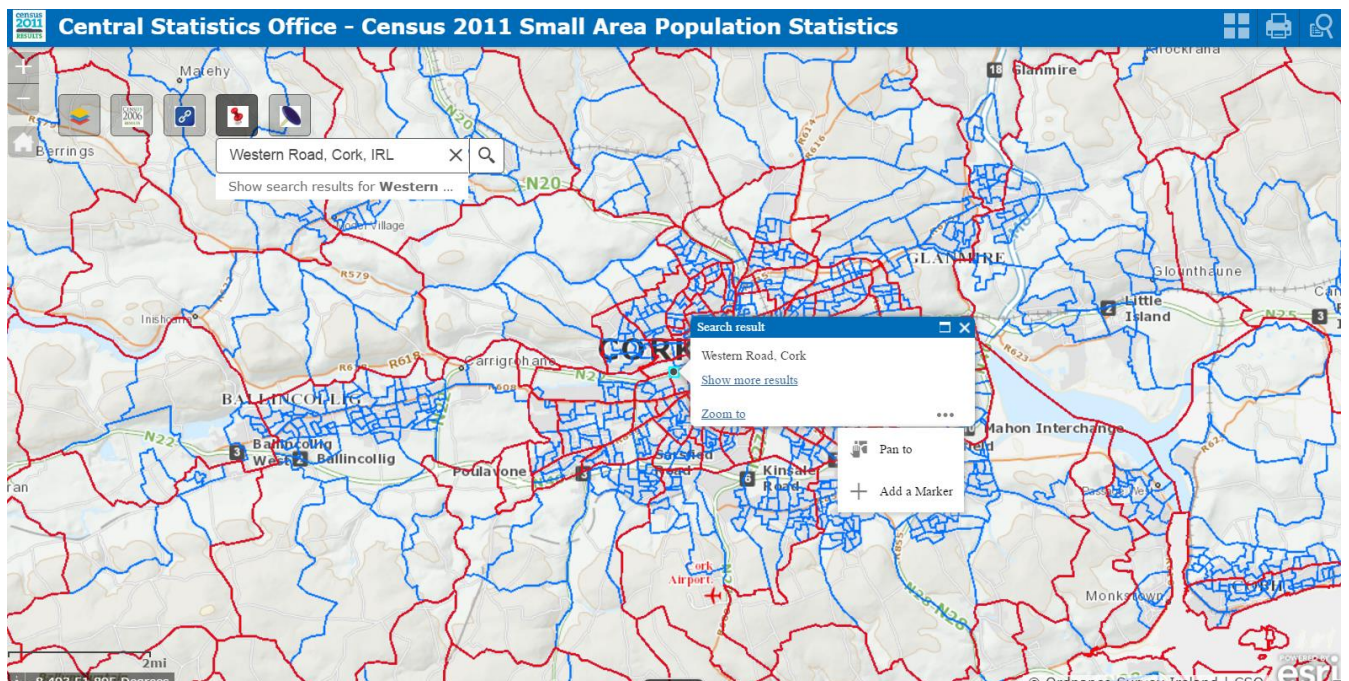
5. Click on 'add a marker. A marker will then appear on the map as seen below. Please note that if you have and use the house number, the map automatically zooms to the address and includes the marker, you then just need to click the marker to bring up the code tabs. If you enter just the estate or street name you then need to add marker and zoom to the address.
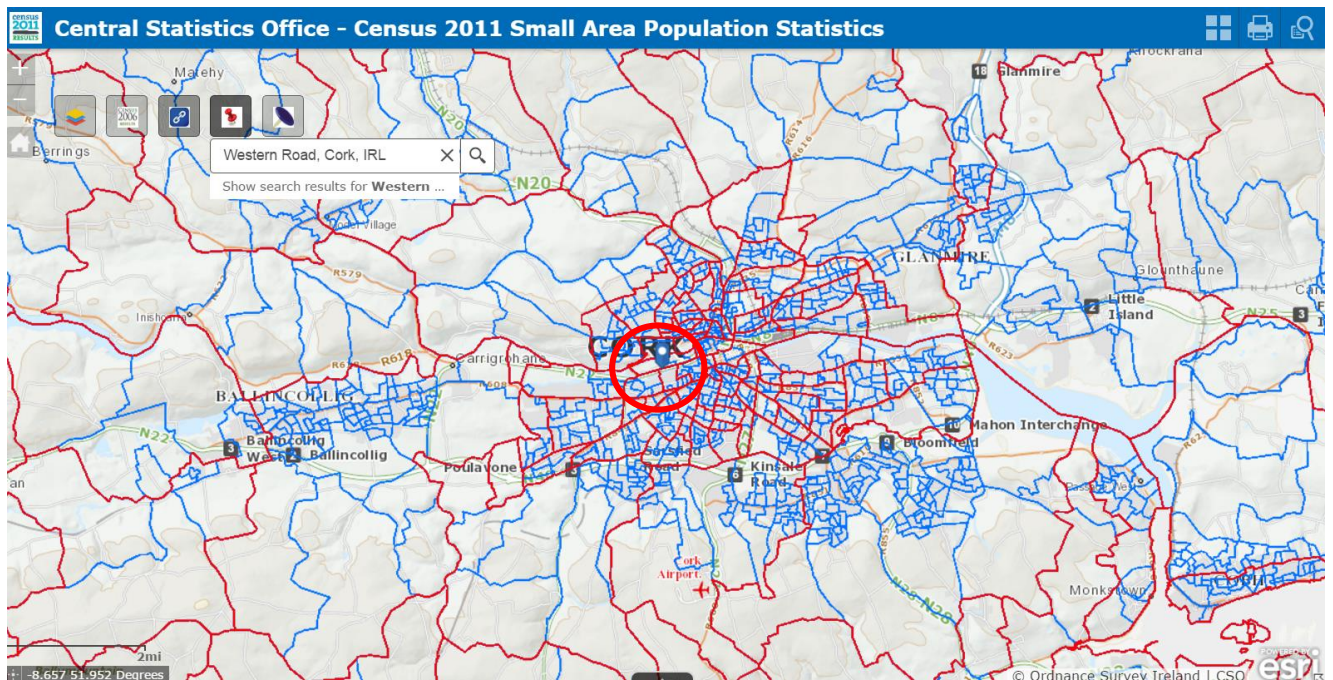
6. Next zoom into the map where the marker is located, this will highlight the area of interest in more detail.
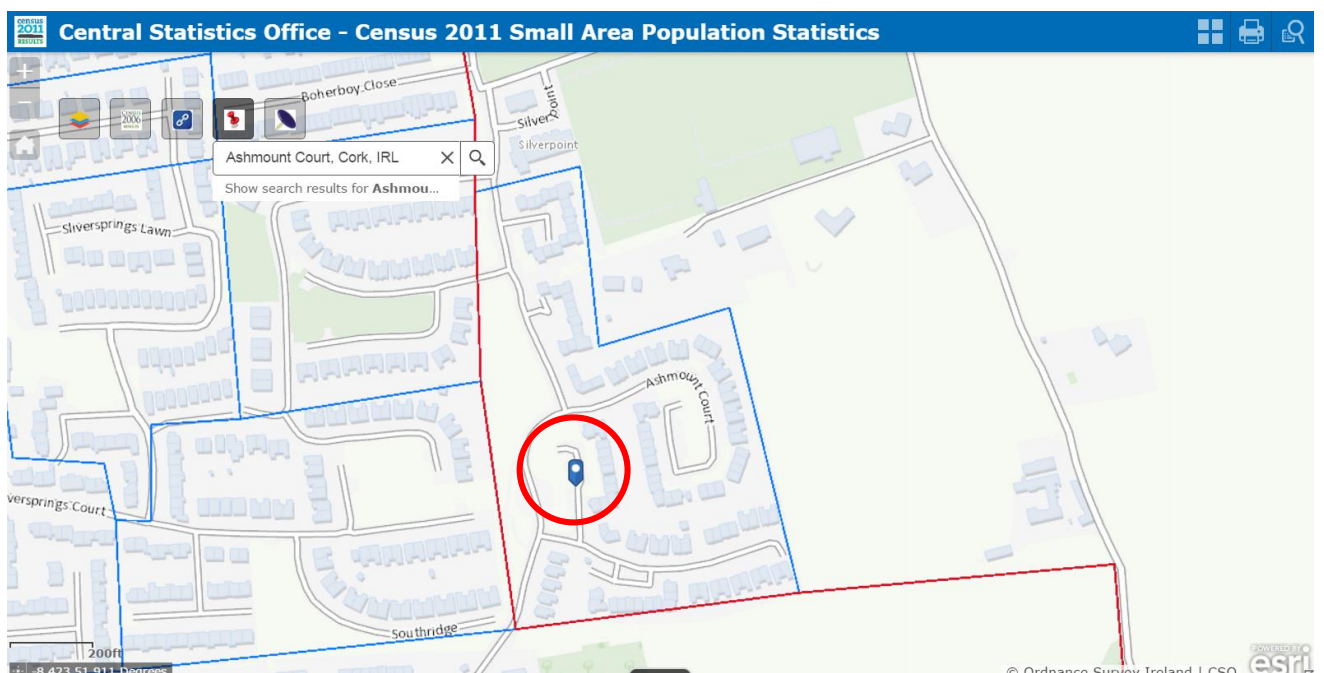
7. Click within the small area (do not click on the marker itself) to the specific address (e.g 5 Ashmount Court). This will bring up a tab with population information for the area (see below).

8. There are two pages on this tab – the first (pictured above) will give you the Small Area Code, which is a 9-digit number. In this case the code is: 047277001. To get the ED and County codes, click onto the next page of the tab using the arrow button, and in the text it says that the Electoral District is 18101. This means that the county code is 18 and the ED is 101.
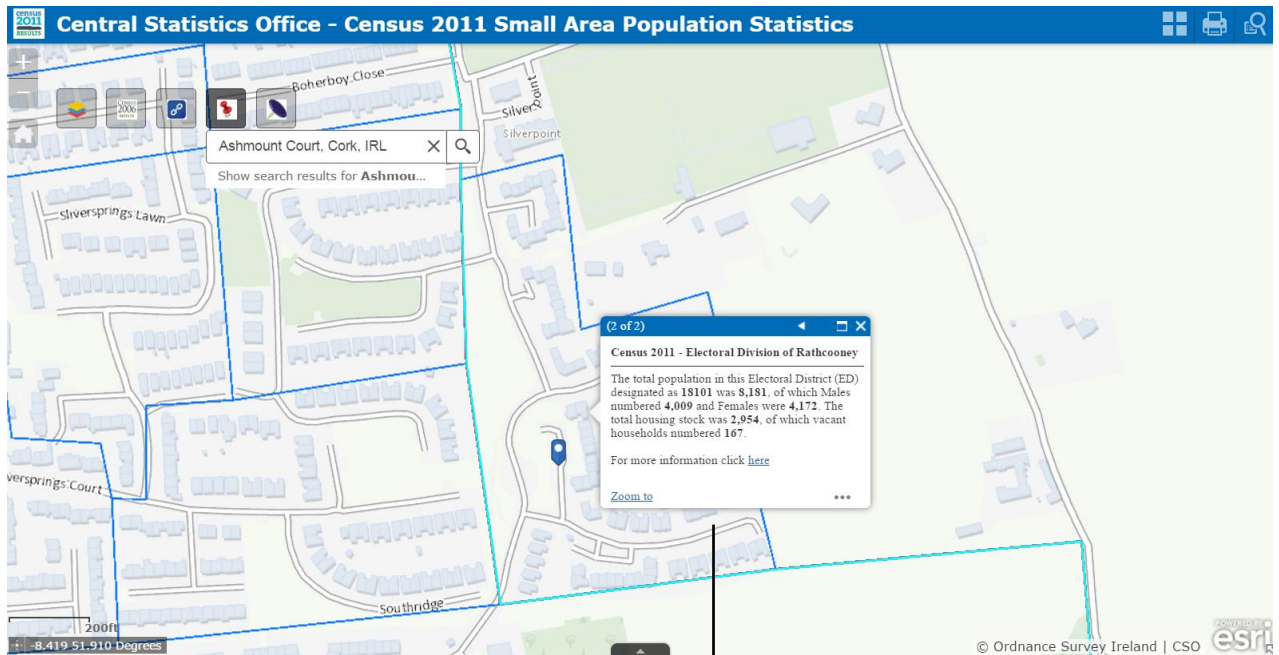
Census 2011 - Electoral Division of Rathcooney

The total population in this Electoral District (ED) designated as **18101** was **8,181**, of which Males numbered **4,009** and Females were **4,172**. The total housing stock was **2,954**, of which vacant households numbered **167**.

For more information click here

9. These codes can then be entered into the Registry data entry system.

For addresses that cannot be found on the CSO website please follow the procedure below.

1. Go to Google maps at www.google.ie/maps
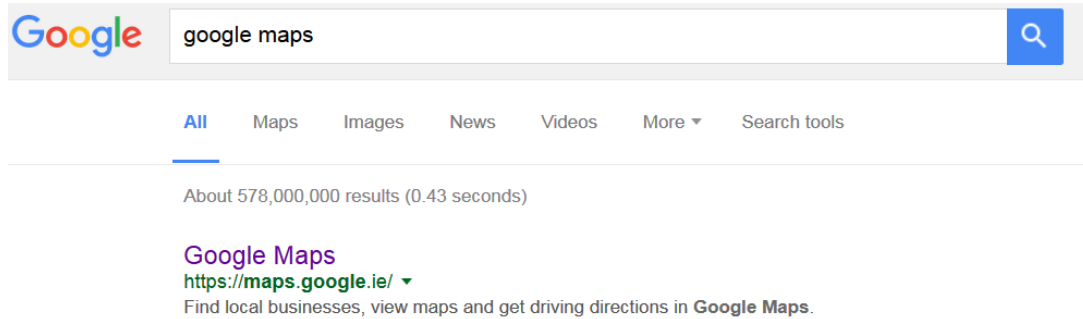
2. Enter the address into the search bar (e.g. Western Gateway Building, Western Road, Cork).
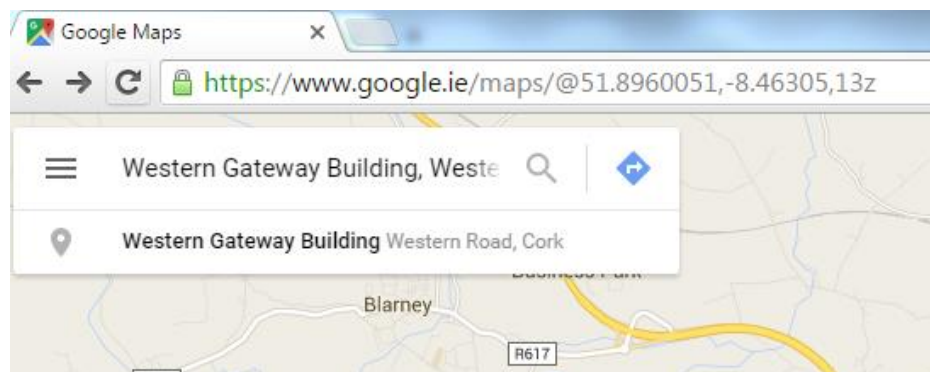
3. Locate the building on the map. Observe the nearest street or building.
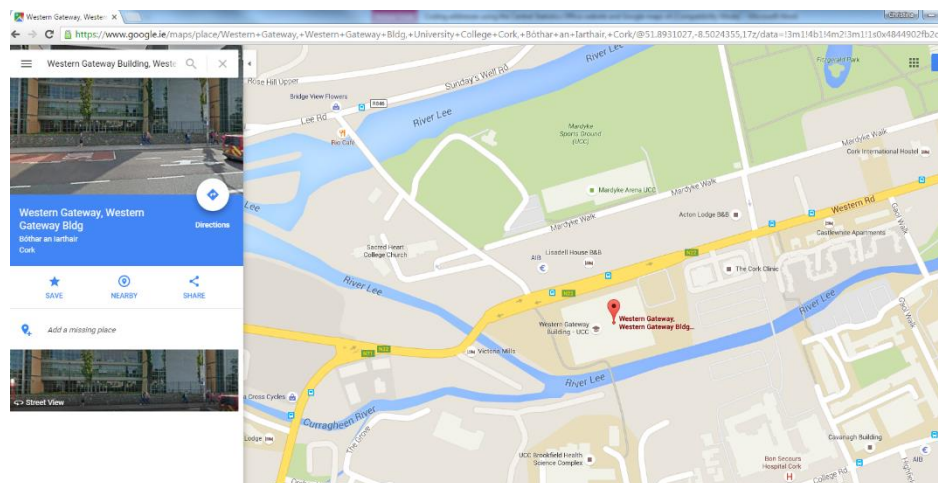
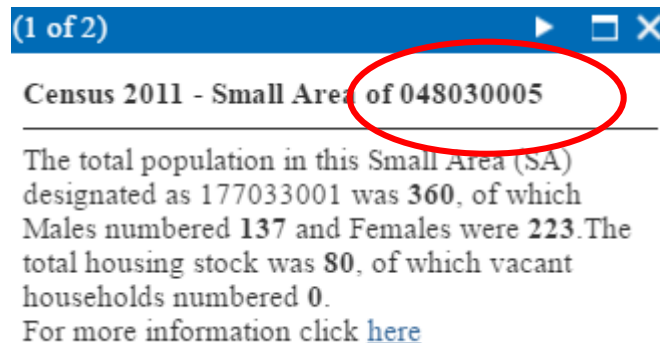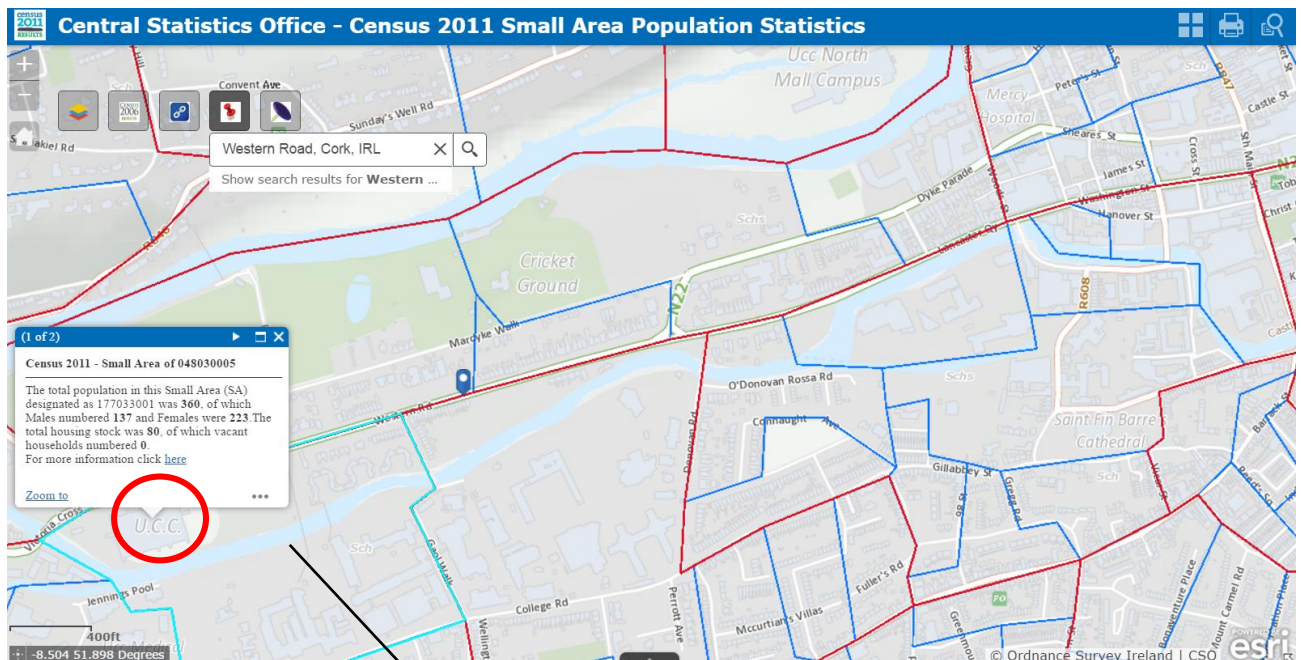4. Go to the CSO website and locate this street or building.
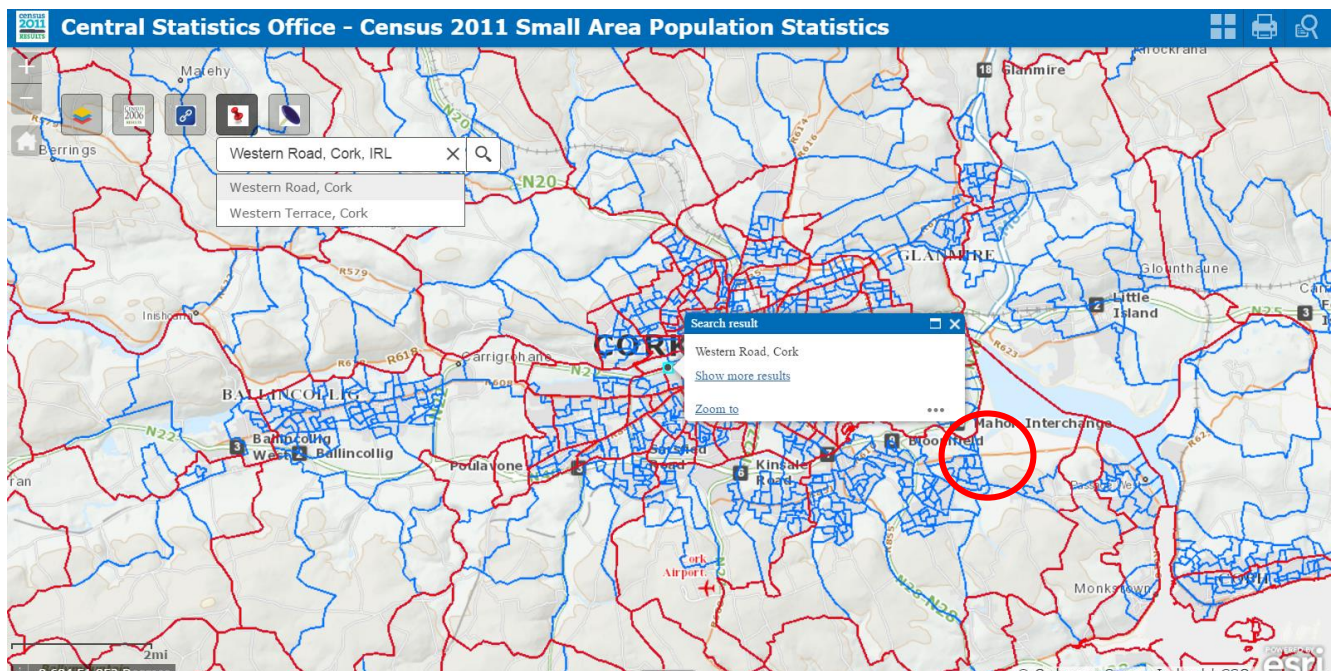
5. From here we will be able to find the building and get the codes needed for data entry. Follow the same procedure as above from point 4 to 6.
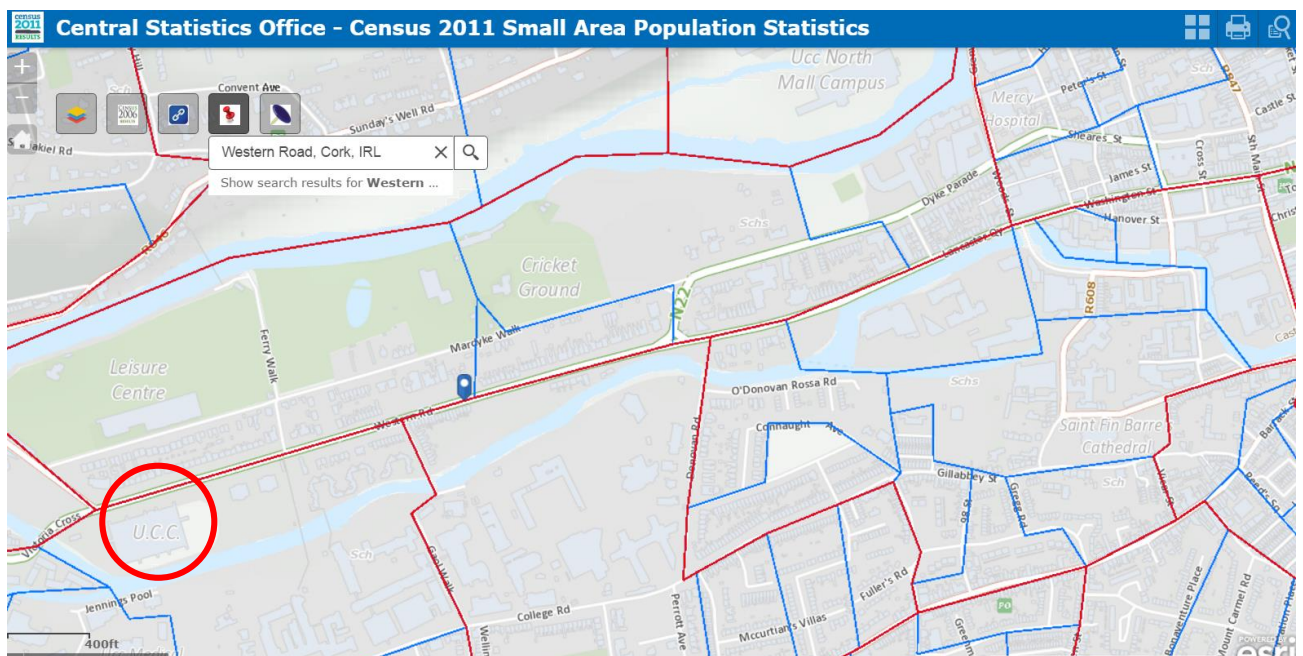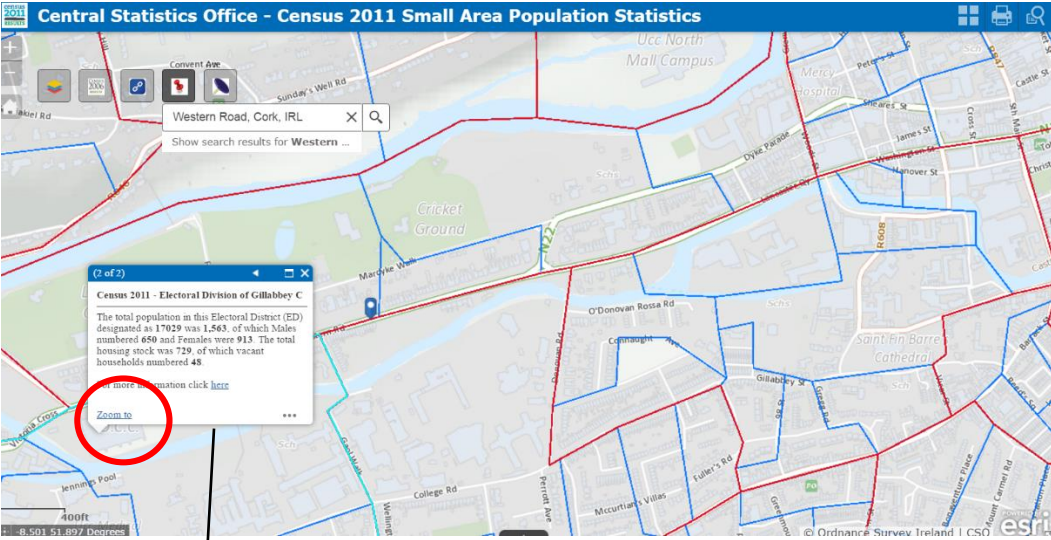
6. Click on the map to the building (e.g. UCC). This will bring up a tab with population information for the area.

STANDARD OPERATING PROCEDURES

7. There are two pages on this tab – the first (pictured above) will give you the Small Area Code, which is a 9-digit number. In this case the code is: 048030005. To get the ED and County codes, click onto the next page of the tab using the arrow button, and in the text it says that the Electoral District is 17029. This means that the county code is 17 and the ED is 029.

8. These codes can then be entered into the Registry data entry system.

If you can't find the codes for an address using these methods, you can enter the address manually into the 'address notes' field of the system.

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