Deliberate self-harm injury — promotion of self-care utilising a ‘rescue pack’

Clinicians and patients are frequently challenged by the demands of deliberate self-harm injury, including risk of infection, and multiple attendances to accident and emergency departments and general practice surgeries (Kilroy-Findley, 2015). Intentional self-harm often carries negative associations attributed to it by society, healthcare providers and family members. Despite the national agenda and guidance prioritising mental health in the UK, there is a disparity between this patient group’s needs and what it receives in terms of physical and psychological care, particularly outside of the mental health speciality arena (Hunt, 2016a). This article examines the concept of self-care in relation to people who self-harm, and the positive impact that a simple ‘rescue pack’ has had in a general community setting.

As the burden on care delivery costs continues to strain clinical and financial resources, innovative ways of working, thinking and delivering services are essential to continue to provide evidence-based, financially viable, effective care. The concept of self-care is not new, and has existed since well before the National Health Service was founded (Macpherson, 1998). This paper looks at self-care among patients who deliberately self-harm through tissue-cutting, and explores patient experiences, wound management outcomes, and resource reprioritisation to meet psychological needs in a timely manner.

Self-care promotion

Patient and carer ownership and empowerment have become part of local and national agendas in the primary and secondary healthcare sectors, and are an important step towards supporting self-care in practice (Hunt, 2016a). Self-care can be used as a management strategy in chronic and acute conditions — including wound care, skin ailments and mental health conditions — and helps to facilitate patients’ receiving the right care at the right time (Bateman, 2015a; NHS England, 2014; While, 2015).

Self-care is a deliberate action within day-to-day activities, the care undertaken by individuals as part of an agreement with others in the context of their own healthcare needs, preferences and priorities; it can extend to the care of others (Department of Health, 2005). The concept covers health promotion, diet and hydration, physical...
activity, and the undertaking of care that is traditionally carried out by healthcare professionals — such as wound care, medication administration and device management (Hunt, 2016b).

The promotion of self-care across a wide range of patient groups has been shown to improve overall health, quality of life, patient satisfaction, experience of the illness journey, availability of resources, and physical and psychological wellbeing, while reducing the use of healthcare services (Ryan et al, 2009). It is important to recognise that self-care has limitations and is not appropriate for all patients and carers, particularly within groups that do not have the social means, physical ability or mental capacity to participate in self-care pathways (Hunt, 2016b). A full holistic assessment is essential before commencing self-care, to ensure that patients and healthcare providers have realistic expectations about the proposed interventions, and understand how to satisfactorily achieve management goals.

Self-care promotes a clearer understanding of the patients’ health wants and needs, helping align the clinician and patient definitions of what is important in the care continuum. For example, in wound care, clinicians often focus on wound healing, cost and achieving set outcomes, whereas patient concerns tend to focus on their own social impact, getting discharged from the care facility, and symptoms of their condition (Gorecki, 2012).

It is critical to the success of self-care that patients take ownership of their care and work together with providers as a member of the multidisciplinary team. The team may work with industry and academia as well, to develop care pathways and choose appropriate products and devices, so that self-care goals are met while reducing reliance upon healthcare resources (Dowsett, 2015; Bateman, 2015b).

**Self-harm injury**

Self-harm is not a modern concern, with evidence of self-harming incidents reaching far back into the Victorian era (Chaney, 2017). The motivators for self-harm activity are complex and unique to the individual. Some people who self-harm demonstrate mental health illness to which harmful actions are directly linked; others may use cutting, for example, to cope with overwhelming emotions. The risk of infection is high in the former group due to the nature of the illness and, often, resulting severity of the self-harm; however, all patients who self-harm require appropriate prevention and management support and intervention (Kilroy-Findley and Bateman, 2016).

Self-harm can be described as “an expression of acute psychological distress. It is an act done to oneself, by oneself, with the intention of helping oneself rather than killing oneself. Paradoxically, damage is done to the body in an attempt to preserve the integrity of the mind” (cited in Sutton, 2007). One in four patients who carry out self-harm behaviours move on to suicide ideation and intent, usually related to mental health illness rather than as a single coping mechanism (SelfharmUK, 2016).

Self-harm behaviours occur in all age groups, ethnicities and demographics, although they are more common in people younger than 25, females (possibly because male injury may be incorrectly attributed to other causes), and people in lower socioeconomic environments (SelfharmUK, 2016). Self-harm is related to various causes including depressive illness; bullying and harassment; sexual, physical and psychological abuse; sexual identity issues; and uncontrolled and unmanaged emotions such as anger, frustration and rejection (Kilroy-Findley and Bateman, 2016; Sutton, 2007).

Patients who self-harm may access hospitals, urgent-care centres, accident and emergency, walk-in centres or general practice surgeries when self-harm behaviours have resulted in wounds, physical injury (e.g. fractures), poisoning or systemic infection (Kilroy-Findley and Bateman, 2016). Actual figures relating to the incidence of self-harm are often approximated due to the secretive and taboo nature of the behaviours, under-reporting, and attribution to other, more ‘acceptable’, ‘accidental’ injuries such as burns or fractures (Dallam, 1997). Intentional self-harm behaviours may include:

- Cutting and burning tissues
- The patient punching or hitting themselves
- Deliberate poisioning with toxic chemicals and medication
- Misusing alcohol, drugs and food
- Starving, binge-eating or other disordered eating
- Engaging in excessive exercise (NHS Choices, 2016).

Self-harm is estimated to cost the NHS from £204 to £4,231 per hospital admission, obviously depending upon the severity of injury and complexity of mental illness (NICE, 2011).

There are many self-harm-related support networks and services available across primary and acute care that patients and carers can access to help with related health problems (SelfharmUK, 2016; NICE, 2011). These services provide social, psychological and physical support to patients and carers through a variety of channels. These services focus on helping individuals to self-care for their wounds, ensuring physical safety, and concentrating resources on the underlying mental health and emotional causes of self-harm behaviours.
Cutting appears to be the preferred form of self-injury, but a wide range of methods are used.

Cutting and burning serve different functions for individuals.

Witnessing blood holds a significant meaning for individuals.

Problems recognising and describing emotions to others, and discriminating between feelings and bodily sensations, appear to be common occurrences for individuals who self-harm.

A wide range of instruments are used, and individuals will demonstrate innovation in this regard when the urge occurs to self-harm.

Arms are the most-targeted area for cutting and burning, but other areas (e.g. the thigh) are also used.

Self-harm can persist over many years.

Scars are shameful to some and, to others, signs of survival.

Individuals often describe self-harm behaviours as addictive in nature.

An endorphin rush after self-harm activity is described by many individuals.

Clinicians must refrain from regarding patients who self-harm as time-wasters or attention-seekers, and offer non-judgemental oral and written support and timely referral to specialist services, such as a mental healthcare professional, plastic surgeon and tissue viability nurse (Dallam, 1997; Kilroy-Findley, 2015; Hunt, 2016b). Providers should focus on appropriate assessment, identification of illness, awareness of when patients need help and provision of timely support, to ensure patients feel they are being listened to and understood (SelfharmUK, 2016). It is especially important to address the underlying cause of self-harm, manage self-harm outcomes, empower patients to engage in interventions and provide knowledge tailored to their needs (Kilroy-Findley, 2015).

Can we offer more?

Despite education, awareness, service provision, understanding and acceptance of this patient group’s behaviours and resulting harm, patients continue to carry out self-harm behaviours, particularly cutting and burning, and put themselves at risk of wound development, scarring and infection (Sutton, 2007). It is this group that we see several times a week in my community general practice setting, where 10-minute appointments provide enough time only to assess the wound, clean the wound and provide a topical adhesive dressing, often with a course of antibiotics. This was the accepted norm of management due to time restrictions, lack of resources, lack of speciality focus, and patient reluctance both to attend the surgery and discuss their mental illness.

In part due to the current financial climate, government and local targets for mental health reviews were not being achieved consistently, and patients often increased attendance to urgent care centers and use of 111 services outside of surgery hours, particularly at times of individual mental health crisis. Patients who tended to self-harm through cutting and burning generally attended the surgery for systemic infection, pain and debridement rather than to focus upon the causative factors, which must be addressed to attempt to resolve or reduce the incidence of self-harm behaviours (Box 1) (Sutton, 2007).

Moving practice forward

Action was clearly needed within our practice to ensure that valuable resources could be used to manage the mental health needs of patients who self-harm, while ensuring that wound care was delivered safely and successfully, with timely referral and a supportive environment for patients and carers. A lead for mental health reviews was designated to provide consistency in assessing and devising care plans for all patients. Each patient has at least one formal review annually, achieving targets and ensuring valuable financial resources were received by the practice to support ongoing service provision.

As patients request GP reviews for their self-harm issues, they are allocated to the lead’s clinical workload list, so that consistency and a trusting relationship can be forged; patients can also request to see their regular clinician. It is essential that patient choice and clinician update and practice be maintained across the surgeries.

Because the lead is also a local and national wound care specialist, it became a natural progression that review of self-harm behaviours also occurred at mental health or emotionally affected patient reviews. Consultations focus on rationale for behaviour rather than the actual wounds, which are discussed according to patient wishes. Patient education about wounds includes how to cleanse the skin, how to prepare the skin if cutting were to occur, advice on clean instruments, the process for cleansing after the event and methods for dressing wounds. Patients are also advised to look for ‘red flags’ of infection, altered sensation or systemic symptoms.

From the author’s experience, it is the red flags of self-harm rather
than the mental health issue or emotional unrest that often forces the patient to seek medical or nursing help at the surgery, when it is the underlying problem we would wish to consult on, to support the patient in moving forward within their healthcare journey. To meet this aim, the author initiated a time-saving solution that has been effective in other patient wound groups: providing products to aid skin-cleansing and effective wound-healing.

In general practice, ‘rescue packs’ are often provided to patients who have low immunity syndromes, respiratory dysfunction, or other chronic conditions where patients can manage their symptoms and initiate care, seeking medical advice when ‘red flags’ specific to their illness occur. Success with this approach in our practice has resulted in widespread improvements in addressing illness early, reducing serious illness and minimising attendance to urgent care centers. With the support of industry, rescue packs for patients who self-harm were developed.

Basic packs include a sterile dressing pack, skin antimicrobial product (e.g. Octenilin® Wound Irrigation Solution and Octenisan® wash lotion, both schülke), topical wound therapy (e.g. Granulox® haemoglobin topical therapy, SastoMed/Infirst), clear adhesive wound dressings (e.g. Leukomed® Control, BSN), and other formulary products. The products have been tailored to the particular wounds, and antibiotic therapy is prescribed as and when the patient situation requires, often depending upon the nature of the tools used for cutting and burning.

The overall range of changes made to the mental health service at the surgery have improved patient attendance for mental health issues, allowing time to be allocated more resourcefully to address the underlying issues. Patients who self-harm have undertaken their self-care participation well and generally followed instructions, managing to clean and dress their own wounds. Mental health review targets were achieved for 2016–17, at 100%. Patient feedback with the current service is positive through the Friends and Family process; patients actively participate and request specific, named clinicians when requiring appointments — a positive change in trust levels between patients and providers at our surgery. Wound-healing results have also been efficacious for patients (Figures 1a–c; Figures 2a–b).

**Conclusion**
Patients who self-harm through cutting and burning are a challenge for clinicians, healthcare organisations, academics, researchers, industry and, ultimately, the government health agenda. In today’s current healthcare climate, where efficacious healthcare provision must be balanced with tightening resources, innovation is required to meet the demands of an ever-changing patient population. We have demonstrated a positive change in general practice to help optimise care delivery and support patients in actively taking responsibility for their own dressing regimens, skin cleansing and monitoring of ‘red flags’. This programme is clearly going to affect how services are re-structured, while continuing to meet patients’ holistic needs (While, 2015).

Care of patients who self-harm requires timely assessment, management and review, and referral to specialists as needed and appropriate. The use of an innovative ‘rescue pack’ for self-harm wounds, along with consistent clinician support, robust patient and

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**Figures 1a–c.** The female patient self-harmed by burning the upper thigh and presented with the resulting injury (1a). She performed self-care using Octenisan wash, Granulox topical haemoglobin spray twice weekly, and Leukomed Control twice weekly. Results are shown at Day 10 (1b) and Day 28 (1c).
carer education, and engagement in self-care are vital to ensuring that care is appropriate, consistent, beneficial and cost-effective.

Further work is required to focus on mental health and expand services for self-harming behaviours and emotional coping mechanisms across primary and secondary care settings, to ensure that limited resources are allocated wisely and patient safety is maximised.

References

Bateman SD (2015b) Use of topical haemoglobin on sloughy wounds in the community setting. Br J Community Nurs Suppl Wound Care S32, S34–9


Figure 2. (a) The female patient self-harmed by cutting with a knife and presented with the resulting injury. She performed self-care using Granulox topical haemoglobin spray and Leukomed Control, both twice weekly. (b) Result is shown at Day 15.