Safe Management of Behavioral Patients in the Emergency Department

Louisiana Hospital Association

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MONICA COOKE MA, RNC, CPHQ, CPHRM, DFASHRM
QUALITY PLUS SOLUTIONS LLC

OBJECTIVES

- Identify the degree to which behavioral health patients present in the ED.
- Describe the major risks associated with behavioral health patients in the Emergency Department.
- Discuss strategies to mitigate the risk of harm to staff and patients in the ED.

Why Are We Talking Today?

Number of Americans with a behavioral health disorder?

Number of Americans that will suffer a significant behavioral health issue?

Leading cause of “healthy life lost”?

Who has behavioral health disorders?

- Out of the 10 leading causes of disability in developing countries, 4 are mental disorders.
- By 2020, MAJOR DEPRESSIVE ILLNESS will be the leading cause of disability IN THE WORLD for women and children.

Co-Morbidity is the Norm

- 68% of adults with a behavioral disorder have at least one medical disorder
- 29% of those with a medical disorder, have a behavioral disorder

Mental Health Dilemma

- Dismantling began in the 70's
- ED has become the Primary Care Provider
- Lack of BH providers due primarily to lack of parity
- Lack of inpatient/outpatient treatment
- Lack of priority to the BH population

ED Challenges

- Fast paced/little time
- Minimal competency
- Unsafe treatment environment
- Lack of transfer options
- Long lengths of stay

Long LOS

- Slows throughput
- Increase patient and staff risk
- Disrupts care of medical patients
- Need for increase resources
- Staff morale

Conundrums

- Need to “medically clear”
- Intoxicated patients
- Lack of timely assessment
- Patients -too sedated for assessment
- Unable to reconcile medications
- Patient refuses treatment
- Lack of evaluator competency
- Concern re: liabilities

Frequent Legal Claims

- Inadequate risk assessments
- Lack of a safe treatment environment
- Lack of appropriate monitoring procedures
- Untrained staff
- Untimely transfers to appropriate setting

Top Behavioral Health Risks

- Chemical Dependency
- Suicide
- Aggression
- Elopement

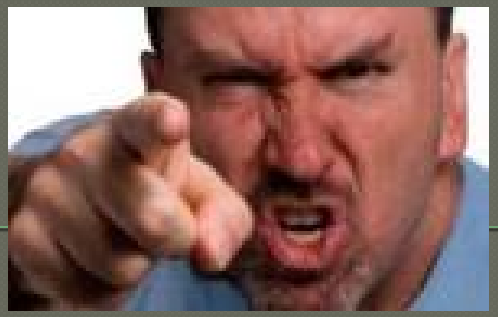
Chemical Dependency

- Intoxicated patients are at high risk for suicidality and aggression
- Often the most disruptive patients
- Opioid epidemic hitting most ED’s

Suicide

- One every 14 minutes
- 10th leading cause of death in US
- 3rd cause of death for ages 15-24
- Military/Veterans (less than 1% of the population) represent 20% of suicides = 22 per day
- 17% involve elderly (65+)
- 25 attempts per completed suicide (1,000,000 per year)
- 31% of the clinical population and 24% of the general population

Aggression



"You know, we joke around about it's not a good day if you haven't been verbally abused, spit on, or someone's taken a swing at you."

"You gotta put people in their place when they yell at you"

"If I had to do an incident report every time patients/visitors are aggressive, that is all I would do for 8 hours!"

Continuing Aggression/Violence…

- No clearly defined rules of conduct
- Weak/nonexistent policies
- Failure to take immediate action
- A nonexistent/weak mechanism for reporting
- Inadequate training on violence prevention
- Inadequate employee acquisition, supervision, and retention practices

Elopement

- Increasing anxiety that is not treated
- Feelings of inadequate treatment
- Perception of being ignored
- Easy access to the outside
- Lack of communication amongst staff

SO… RISK MITIGATION STRATEGIES?

Safety Culture Starts at the Door

- Signage for "no weapons"
- Alert the community to culture of zero tolerance

"Welcome to our Hospital. We expect that all staff, patients, and visitors are respectful and non-disruptive while in our facility. Thank you for helping us to keep everyone safe.

Environment of Care

- Safe rooms (convertible or permanent)
- Cohort multiple patients
- Close to nurses station
- Available recliners
- Design a hold area–in or out of the ED
- BH treatment area
- Secured ED egress

Security

- 24/7
- Rounding in the ED
- BH Crisis Code Response

Searches

- Electronic metal detectors
- Search procedures
- Refusal of search
- Visitor’s item search
- Personal clothing
- Belonging storage

Diversions

- Critical in reducing anxiety and agitation
- TV in the room
- Cell phones, I-pads, computers
- Music
- Activity Cart: cards, coloring books, jigsaw puzzles, etc.
- Family/friends

Timely Initial Assessment

By a BH clinician

Looks like a duck, walks like a duck, talks like a duck? Can we begin the medical clearance??

Reassessment

- By whom?
- How frequently?
- Determine continued need for treatment
- Can often discontinue involuntary status once stabilized

Medication Management

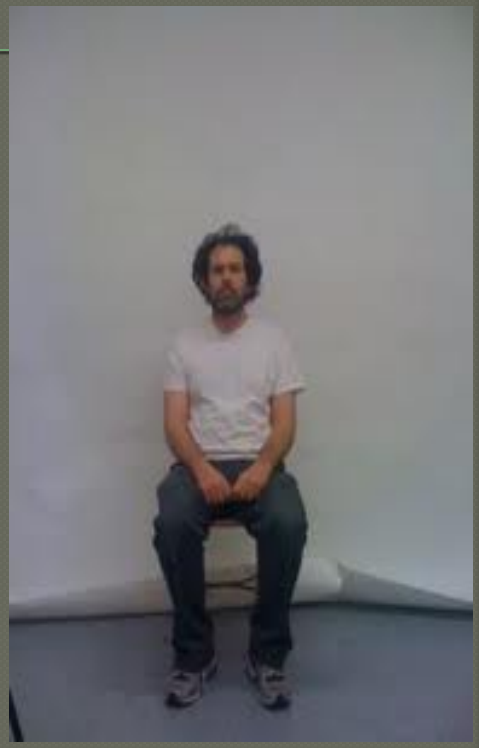
- Lower doses
- Standing order sets for substance withdrawal
- Medicate for symptoms as soon as it is observed (offer routinely)

Observation/Monitoring

- Routine one to one observation for all patients not recommended
- Policy should allow for 2:1 monitoring or higher
- Within arms reach?? NO
- Security monitoring should be the last resort

A Word About Sitters…

- Typically untrained
- Often not part of the team
- Unfamiliar with policies
- Blamed when things go wrong
- No evidence to support that sitters decrease risk with BH patients



Chemically Dependent Patients

- Risk often abates when sober
- Provide discharge script for withdrawal meds
- Withdrawal protocols
- Opioid Prescribing Policy

Frequent BH Patients

- Establish individual treatment plans
- Patient should be made aware of the treatment plan
- Involve external agencies or care providers

Involuntary commitment

- Removes patient decision making capacity
- Forced treatment is rarely effective
- Do not routinely impose this status – last resort
- Only for those who present an imminent harm and require hospitalization AND refuse treatment

Right to Refuse

- Persons with mental health conditions are capable of making their own decisions
- Can refuse care/treatment for disorder if they are not an imminent risk of harm
- Cannot force the patient to complete testing (i.e. blood or urine testing)

Aggression/Violence

- Strong workplace violence prevention program
- Intervene early
- Behavioral contracting/agreements
- Involve law enforcement

Restraint/Seclusion

RESTRICTION IN THE FREEDOM OF MOVEMENT

- Holding a patient down to medicate is RESTRAINT
- Using medication to "snow" a patient is RESTRAINT
- Confining a patient in a room with Security monitoring is SECLUSION
- Face to Face assessment within one hour

Restrictive Interventions

- Can restrain a patient who is NOT involuntary and is dangerous
- Can force meds if the person is an "imminent danger"
- Otherwise, a court order is necessary

Discharge

- Establish a Safety Plan that supports patient stability
- Safety Plan is part of the medical record
- Know your community resources and have a list for the patient

BH Resources

- Mental Health technician
- BH Nurse
- Advance Practice Clinicians
- Peer Counselors
- Tele-Psychiatry
- BH Rapid Response Team

Competencies

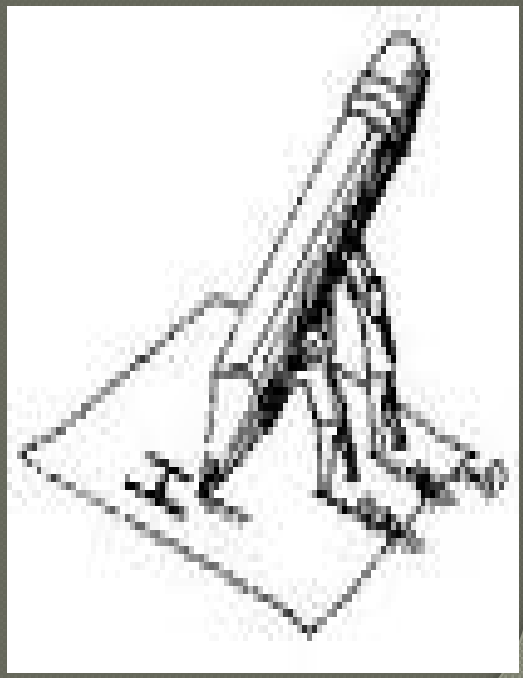
- Respectful approaches
- Assessment/Reassessment
- Predicting/identifying escalation
- De-escalation techniques
- Non-violent crisis intervention
- Restraint/seclusion
- Documentation

Communication

- Hand offs
- Huddles
- Sitters
- Security

Documentation

- Initial/Routine Assessments
- ED Provider note each shift
- Restraint & Seclusion
- Observations (Q15 min)
- Interventions
- Discharge risk assessment by the ED Provider



Quality & Risk Management

- Culture of reporting
- Immediate leadership response to aggression
- Debriefing/Learning from Defects
- Data collection, analysis/trending

Tool Box

- ED Brief Risk Assessment Tool
- Columbia Suicidality Rating Scale
- Sitter Guidelines

Resources

- Sine, David, Hunt, James. White paper: Design Guide for the Built Environment, updated, March 2017, www.naphs.org
- OSHA Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers http://www.dangerousbehaviour.com/Disturbing_News/Guidelines%20for%20PreventingViolence%20HSS.htm
- The Joint Commission, Sentinel Event Alert #56, www.jointcommission.org
- *Bennett, Stacey, et. al.,* Establishing Evidence-based Standards of Practice for Suicidal Patients in Emergency Medicine, *Top Emergency Med.* Vol. 28, No. 2, pp. 138–143.

THE END

Thank you.

Questions/comments can be forwarded to:

MCooke@QualityPlusSolutions.com

301-442-9216