# Managing Psychiatric Patients in the Emergency Department

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# Defining Psychiatric Emergencies

- Any combination of psychiatric symptoms or psychosocial stressors that exceed an individual's coping capacity and requires emergent clinical intervention to reduce the risk/prevent harm. – M. Kramer

- *"I just couldn't believe this guy! He comes into the ER because his girlfriend broke up with him! So he slashes his wrist with a box cutter and it took us about a hundred stitches and a bunch of staples to fix him up! All because some girl broke up with him! I mean this guy is only 20, what a WIMP!!"* - An otherwise squared away ED Nurse . .

# Psychiatric Emergencies

- The biggest risk . . . Missing the tree for the forest.
- Missing psychiatric acuity (especially suicide risk) due to operational factors.
- Missing medical crisis (Delirium, stroke, intoxication, etc.) psychiatric emergencies rarely develop rapidly!
- Mixing criminal behavior or social crises with acute psych.
- Missing psychiatric crisis due to substance or developmental comorbidity.
- Missing psychiatric crisis due to provider compassion fatigue, exhaustion, or burn-out or workload.

# Psychiatric Emergencies

- Psychiatric Patients in the ED are Patients At Risk of Harm.

- Most ED Patients . . . "chose" to be there, many psych patients are there against their will!

- Many Health Systems Need Horizon's Help to Manage ED Patients even if they don't know to ask.

- Healthcare reform is certain to increase ED volume making all of the above more urgent.

# TJC's New Requirements

**Starting January 1, 2014, TJC Has Added the Following Requirements . . .**

- PC.01.01.01 With the Following Specific Elements of Performance:

- 49. If a patient is boarded while awaiting care for emotional illness and/or the effects of alcoholism or substance abuse, the hospital does the following:

  - Provides for a location for the patient that is safe, monitored, and clear of times that the patient could use to harm himself or others (See Also applicable NPSG.15.01.01, EPS 1 and 2)

  - Provides orientation and training to any clinical and non-clinical staff caring for such patients in effective and safe care, treatment, and services (for example, medication protocols, de-escalation techniques). (See also HR.01.05.03, EP 13; HR.01.06.01, EP 1)

  - Conducts assessments, reassessments, and care consistent with the patient's identified needs. (See also PC.01.01.01, EP 4; PC.01.02.01, EP23)

# TJC's New Requirements, cont.

50. This element of performance will not effect the accreditation decision until <u>January 1, 2014</u>:

If a patient is boarded while awaiting care for emotional illness and/or the effects of alcoholism or substance abuse, the hospital coordinates with community resources (for example, community mental health centers, addictions programs, supportive hosing) for the purpose of expediting transfer from boarding to an appropriate setting consistent with the patient's identified needs.

(See also PC.04.01.03, EP 4)

# Translation?

If the patient is waiting in the ED for an inpatient bed, community disposition, or detox, the patient better be in a "psych-safe" area and the medical record better look like you started up the inpatient care in the ED and involved community collaterals and stakeholders!

# Life in the Emergency Department

**The Journal of the American College of Emergency Physicians (reprinted in PR Newswire) 5-2-12**

- Patients having psychiatric emergencies wait an average of 11.5 hours in the emergency department

- Psychiatric patients wait approximately 42% longer in the ED than other emergency patients

- Between 2000 and 2007, psychiatric visits to ERs grew by **231%!!**

- Just wait until millions more people are added to the Medicaid system under Obamacare.

# Life in the Emergency Department

**A nation wide survey of department directors by the American College of Emergency Physicians (June 19, 2008) showed**

– 80% said that their hospital "boards" psychiatric patients in the ED

– 60% of psychiatric patients stayed in the ED more than four hours

– 33% more than eight hours

– 6% more than 24 hours

# Life in the Emergency Department

**Key Issues with Psychiatric Patients in the ED**

- Limited and/or inconsistent treatment and medication plans
- Inconsistent/limited psychiatrist coverage
- Lack of training of nursing staff
- Patients languishing/being housed for hours and days waiting for other facilities
- Aggressive patients attacking staff and other patients
- A perception that psychiatric patients aren't "really sick"

# Life in the Emergency Department

## Key Issues with Psychiatric Patients in the ED

- Staff afraid of being harmed and unwilling to work with psychiatric patients

- Patients with primarily criminal/volitional presentations placed on involuntary commitment

- Frustration and negative relationships between community case managers, providers, and hospital staff

- Frequent re-admissions due to absent community support

- Pressure from hospital administrators regarding psychiatric patients

# Implications for ED Nursing

- Be open to understanding psychiatric conditions as serious life threatening illnesses, not lifestyles.

- Learn about common psychiatric diagnoses, 1 in 4 people will have a psychiatric diagnosis in their life, far more common than broken bones . . .

- Participate in SECURE training and practice de-escalation to improve your confidence and comfort with patients in behavioral crisis.

- Understand that sedation or security guards are not the only options.

# Implications for ED Social Workers

- Build a book of resources and develop relationships with community providers.

- Understand that giving a psychiatric patient the number for a referral isn't adequate, help them make the call.

- Take the time to build relationships with psychiatric patients, they'll be back and you'll need their trust and familiarity.

- Keep in mind you may be the only member of the team with "real" psych training, you'll need to be ready to lead and teach . . . .

# **Implications for Crisis Workers**
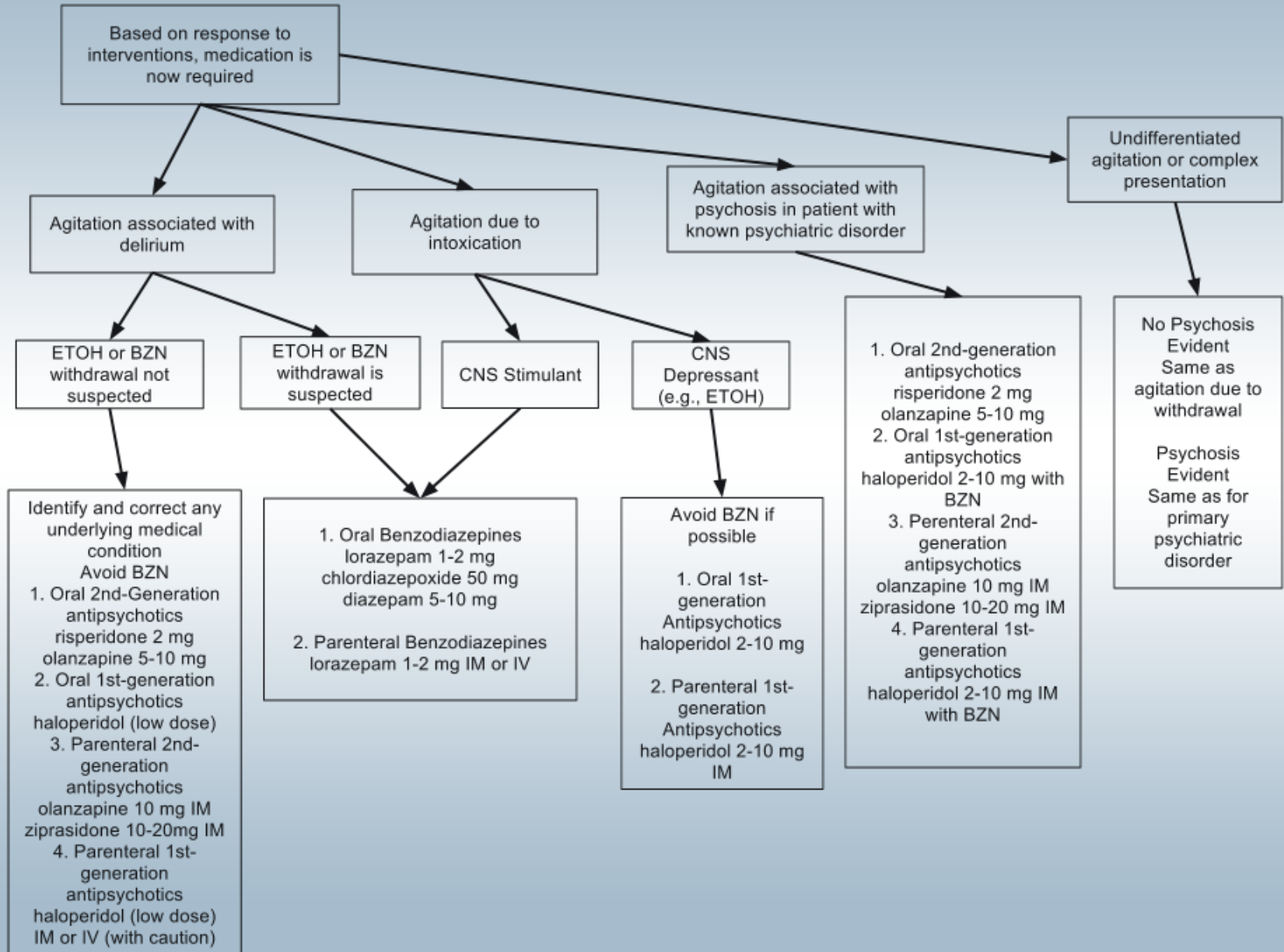
- Recognize you're working in a system that's focused on rapid stabilization and disposition not relationships.

- Recognize folks will take your lead as the Psych-Expert, praise or correct their behavior as that expert and understand your behavior is a model.

- Teach, Teach, Teach . . . ED folks may be fantastic at broken bodies, but psychiatric stuff makes them squeamish.

# Implications for ED Providers

- Avoid the tendency (and resist the pressure) for rapid sedation whenever possible. A sedated patient is very difficult to assess and transfer.

- Support other disciplines through behavior to view psychiatric conditions as serious medical issues, NOT lifestyles.

- Be open to relationships with psychiatric providers and make an effort to understand the limitations of their units.

- Understand that aggressive patients are the psychiatric equivalent of cardiac arrest, GET THERE and HELP!

# American College of Emergency Psychiatry



Based on response to interventions, medication is now required

- Agitation associated with delirium
  - ETOH or BZN withdrawal not suspected
    - Identify and correct any underlying medical condition
      Avoid BZN
      1. Oral 2nd-Generation antipsychotics risperidone 2 mg olanzapine 5-10 mg
      2. Oral 1st-generation antipsychotics haloperidol (low dose)
      3. Parenteral 2nd-generation antipsychotics olanzapine 10 mg IM ziprasidone 10-20mg IM
      4. Parenteral 1st-generation antipsychotics haloperidol (low dose) IM or IV (with caution)
  - ETOH or BZN withdrawal is suspected
    - 1. Oral Benzodiazepines lorazepam 1-2 mg chlordiazepoxide 50 mg diazepam 5-10 mg
      2. Parenteral Benzodiazepines lorazepam 1-2 mg IM or IV

- Agitation due to intoxication
  - CNS Stimulant
  - CNS Depressant (e.g., ETOH)
    - Avoid BZN if possible
      1. Oral 1st-generation Antipsychotics haloperidol 2-10 mg
      2. Parenteral 1st-generation Antipsychotics haloperidol 2-10 mg IM

- Agitation associated with psychosis in patient with known psychiatric disorder
  - 1. Oral 2nd-generation antipsychotics risperidone 2 mg olanzapine 5-10 mg
    2. Oral 1st-generation antipsychotics haloperidol 2-10 mg with BZN
    3. Perenteral 2nd-generation antipsychotics olanzapine 10 mg IM ziprasidone 10-20 mg IM
    4. Parenteral 1st-generation antipsychotics haloperidol 2-10 mg IM with BZN

- Undifferentiated agitation or complex presentation
  - No Psychosis Evident
    Same as agitation due to withdrawal

    Psychosis Evident
    Same as for primary psychiatric disorder

# Richmond Agitation Sedation Scale (RASS)

**+4** Dangerous: Overtly combative, violent, immediate danger to self or staff

**+3** Intrusive, uncooperative, verbal threats, posturing stance, eloping

**+2** Rapid speech, unpredictable mood, pacing, impulsive, demanding, yelling

**+1** Anxious, apprehensive, but not threatening; wringing hands, wandering

**0** Alert and calm

**-1** Not fully alert, but awakens to voice (eye opening/contact) > 10 seconds

**-2** Light sedation, briefly awakens to voice (eye opening/contact) < 10 seconds

**-3** Moderate sedation, movement or eye opening. No eye contact

**-4** Deep sedation, no response to voice, but movement/eye opening to physical stimulation

**-5** Unarousable, no response to voice or physical stimulation

http://www.mc.vanderbilt.edu/icudelirium/docs/RASS.pdf

# Implications for Horizon PDs and Nurse Leaders

- Build relationships early and often with ED leadership and when doors open, DIVE through them!

- Seek opportunities to show Horizon resources and depth in hospital committees (SEA – 46, etc.)

- Seek opportunities to help out with ED flow and patient experience challenges (EVERY hospital has them!)

- Leverage Horizon Resources, Especially SECURE to support ED teams, security, physicians, etc.

# Psych Knowledge for The ED

Physical Environment

- Ligature Risks

- Swallow Risk (Small items or sharps)

- Blades (Scalpels, scissors, etc.)

- Medications

- AED or other ACLS equipment

- Cords, cables

# Psych Knowledge for the ED

Easily Missed Risks

- Uncommon Risk Items require a complete search of person, usually in the context of a safety check and skin integrity assessment
- Belts
- Shoe laces
- Bras or other elastic under garments
- Make-up kits (may contain pencils or sharps)
- Cell phones or personal electronics
- Tools, Leatherman, pocket knives, etc.

# Psych Knowledge for the ED

Environment of Care

- Stimulating environments

- Bright lights

- Loud noises (Monitors, over head paging, etc.)

- Open curtains and lots of conversation nearby

- Lots of people coming and going

- ED Humor (joking and gallows humor common in critical environments)

- Over communicating to the consumer

- Failing to communicate among the care team and asking patients things repeatedly

# Psych Knowledge for the ED

Psycho-Social Factors

- Collaterals and visitors may escalate patients if conflict with family members or others is part of their escalation.

- Legal status, guardianship and Powers of Attorney

- Consent for treatment with minors

- Consent for medical care and consent for psychiatric care . . . Not the same!

# De-escalation Concerns in the ED

- The environment is NOT tolerant of threats, even when they're 100% bluster.

- The environment is NOT conducive to lengthy de-escalation interventions.

- Other patients are scared of psychiatric patients and this increases staff desire to respond too rapidly.

- EDs often have lots of non-psych staff coming in and out.

- EDs often have security present or even police who may intervene even if not requested.

# Highest Risk Patient Profiles

- <u>Frequent Flyers</u> . . . We know them, so we don't give them a full or real assessment.
- <u>Substance Addicts</u> . . . They're just a (insert derogatory label) . . .
- <u>Aggressive Patients</u> . . . They scare us and we want them GONE!
- <u>Children & Adolescents</u> . . . Their parents can care for them, they don't need the hospital.
- <u>Developmentally Disabled</u> . . . The laws don't work and the psych unit can't take them, so where do they go??
- <u>Forensic or Criminally Sophisticated</u> . . . Can be extremely difficult to assess due to malingering, can also be some of the most stigmatized and impaired.
- <u>Every Patient</u> . . . When staff are stressed, beds are full, the ambulance is unavailable or . . .

# A word about Drugs, ETOH, and Psych

- Many "psychiatric emergencies" are caused or worsened by the use of elicit drugs.
- Compassion fatigue or "burnout" can make folks pretty judgmental about co-occuring disorders, but . . .
- Risk . . . Is Risk . . . If a patient is in crisis and unsafe, the <u>Why</u> doesn't matter . . .
- We never question . . . <u>Why</u> a person is having a heart attack . . .

# Horizon Resources

- Pro-Active Risk Assessment of ED Spaces with recommendations to ED Leadership.

- SECURE Training for ED Staff (Don't forget the Docs!)

- Care Planning & Documentation Templates

- Leverage your Horizon Clinical VP too!

- Training for Medical Staff to Understand Psychiatric Illnesses and Treatment

# References

- American College of Emergency Physicians – AMED News – Krupa, Carolyne – 9-3-2012

- Draft Joint Commission Measures – Released December 2, 2011. – & - R3 Report – 4-29-2012.

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