



**"It's Complicated:  
Assessment and Safe Management  
of the Psychiatric Patient"**

Optima Healthcare Insurance Services  
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## OBJECTIVES

- Identify the degree to which psychiatric patients present in the Emergency Department.
- Identify the risks associated with the psychiatric patient in the Emergency Department.
- Identify management strategies for the psychiatric patient in the Emergency Department
- Discuss best practices in the use of restraints/seclusion
- Describe the responsibilities of ensuring and maintaining physician and nursing competencies surrounding the psychiatric patient.

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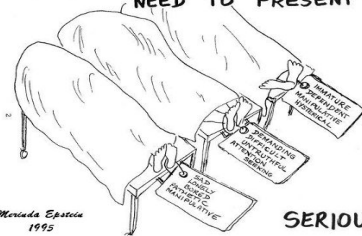
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IN ORDER TO BE TAKEN SERIOUSLY YOU  
NEED TO PRESENT AS...



Merida Espitia  
1995

**SERIOUSLY ILL**

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## Psychiatric Patients: Emergency Department



- Behavioral Health patient population is **SIGNIFICANT**
- ED is often the primary care setting
- ED stays are generally twice as long
- Not typically designed to manage the behavioral health patient

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## Emergency Department

- Over 438,000 Americans visit emergency rooms for self-inflicted injury per year.
- 8% of all visits to the ED are related to mental health problems
- 8% are related to alcohol use
- 1.2 million are drug-related visits

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## Psychiatric Patient Presentations



- Acute presentation: psychotic, overdose
- Chronically mentally ill (frequent flyers)
- “Pain” presentations
- Intoxication
- Anxiety

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**REASONS FOR VISIT**

- Emergency evaluation: PET team or police
- Lack of a primary care provider
- Lack of community resources
- Drug seeking/Intoxicated

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**High Risk Patients**

- Suicidality
- Aggression
- Elopement
- Substance abuser

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**Management of BH Patients**

*The standard of care for patient safety are the same regardless of whether the patient is voluntary, on a "hold", or pending transfer*

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## SUICIDALITY

“Every single instance of suicide is an action by the dictator or emperor of your mind. But in every case of suicide, the person is getting bad advice from a part of the mind that is in a temporarily panicked state and in no position to serve the person’s best long term interests”. *Scneidman, The Suicidal Mind*

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## Suicide

- Suicide is the 11<sup>th</sup> leading cause of death (30,000 lives)
- 17% of reported suicides involve elderly (65+)
- 25 suicide attempts per completed suicide
- 31% of the clinical population and 24% of the general population have considered suicide
- More than 90% of those who complete suicide have a psychiatric disorder

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## Suicide and the Elderly



- Elderly men are 3-4 times more likely to commit suicide
- White men over 85 have a 3 times risk than men at or below 60
- Women have an increased rate over age of 65
- 25% have attempted suicide before
- Recently seen by their health care providers before committing suicide

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## CASE STUDY

Sara, a 28 year old was brought to the Emergency Department due to dehydration from not eating/drinking. She believed that she was not worthy of food/fluids and was attempting to die.

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## Aggression



- Due to psychosis (paranoia)
- Drug related: PCP, ETOH intoxication
- Neurological disorder
- Frustration

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## Elopement

### **“Premature Patient Prompted Discharges”**

Patients who present in the ED with a psychiatric complaint are significantly more likely to leave without being seen.

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## Case Study

Rick was a 34 year old schizophrenic in the ED. Was triaged as “hearing voices” telling him to die. Sat in the ED for 45 minutes, became overly anxious and eloped.

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## Intoxicated/ Overdose patient



- Alcohol
- Benzodiazepines
- Opiates
- Other substances

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## Legal Claims Related to Psychiatric Patients

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

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## Joint Commission

- Environmental deficiencies
- Inadequate security
- Lack of suicide assessments
- Incomplete reassessment
- Inadequate staffing levels
- Incomplete or infrequent patient observations
- Incomplete communication between caregivers

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## Strategies

PATIENT SAFETY  
&  
RISK REDUCTION

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## Assessment



- Appropriate triage
- Initial suicide risk screening
- Suicide assessment by BH professional
- Assess for withdrawal
- Assess for medical versus psychiatric etiology

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## Reassessment

- Mental status changes are unpredictable
- Do not ignore
- Reassess at frequent intervals

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## Rapid Stabilization

- Treat agitation and aggression quickly
- Medicate for withdrawal symptoms
- Medicate for severe anxiety and psychotic symptoms

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## Environment of Care Strategies

- Do not leave BH patients in the waiting room
- Place in highly observable area
- Designate a specific room/area (safe room)
- Patient gowns/search
- Security in ED
- Limit number of staff who interact
- Security personnel in the ED

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## Environment of Care Strategies

- Electronic wands/metal detectors
- No plastic bags/breakable items
- Provide diversional activity
- Routine surveillance of the environment

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## Observation/Monitoring

- Q-30 minutes at a minimum
- If high risk, Q10 -15 minutes
- One to One (Sitter)
- Verbally communicate during observation
- Utilize family members if appropriate

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## communication

Between caregivers:  
MD's, Nurses, "Sitters", Security

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## Restraint/Seclusion

Mechanical restraints

Chemical restraints

Seclusion

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## Substance abusers

Management of the intoxicated/overdose patient

Yes, but what about the PESKY drug seeking patient?

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## Staff Competencies

- Basic competencies in Behavioral Health
- Training for staff and security personnel
- "Sitter" training
- Support staff training
- Utilize trained BH staff

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**Disposition/Discharge**

- Stabilize in the ED
- Safe transfers between treatment areas
- Transfer to medicine or psychiatric unit
- If involuntary and requires medical admission, one to one monitoring is recommended
- Discharge instructions

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**Documentation**

- Assessments
- Observations (Q15 minute flow sheet)
- Efforts to deescalate
- Interventions
- Discharge plan/referral

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**Enterprise risk management**



BH patients are **THROUGHOUT** the organization and pose unpredictable risk

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**Organizational Strategies**

- Policies/procedures/monitoring parameters
- Promote efforts to reduce possibility of harm
- Screening/ assessment/ reassessment
- Access to behavioral health resources
- Monitoring, analyzing, and trending of data

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**CONCLUSION**

- ✓ Behavioral health is a significant life domain
- ✓ Patients will continue to use the ED as their entry point of care
- ✓ Need safe processes to minimize risk and assure patient safety
- ✓ Competency of staff is essential
- ✓ An Enterprise Risk Management approach

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**Opportunities and Challenges**

- Overcoming stigma and staff attitudes
- Modification of the treatment setting
- Training of staff
- Enterprise Risk Approach

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## References and Resources

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## References and Resources

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- The Mental Health Report of the Surgeon General – [www.surgeongeneral.gov/library/mentalhealth/home.html](http://www.surgeongeneral.gov/library/mentalhealth/home.html)
- Rozovsky, Fay and Conley, Jane, *Health Care Organizations Risk Management Third Edition*, Chapter 12 – Behavioral Risk Management, Aspen Publishers, 2009.

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## Tool Box

- BH Design Guide
- Sitter Guidelines
- Organizational risk assessment
- ED Brief Risk Assessment tool
- Suicide Risk Screening Tool

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**THE END**

*Thank you for your participation in this seminar on  
Behavioral Health Risk*

Questions/Comments can be forwarded to:  
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or visit the website: [www.QualityPlusSolutions.com](http://www.QualityPlusSolutions.com)

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